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Preparing for Multi-Payer Health Care Transformation: Common Issues from SIM Test States

On September 30 and October 1, 2013, the Milbank Memorial Fund (MMF) and the Center for Health Care Strategies (CHCS) convened a meeting for representatives from the six State Innovation Model (SIM) test states, the Center for Medicare and Medicaid Innovation (CMMI), and NORC at the University of Chicago, to identify common issues facing these states as well as potential solutions. Representatives from all six test states—Arkansas, Maine, Massachusetts, Minnesota, Oregon, and Vermont—participated. A wide range of issues were discussed, but two areas of opportunity stood out as the most critical for test states and are likely to be of greatest interest to design states and others looking ahead to undertaking multi-payer health care transformation in the coming year: (1) engaging all payers in common/aligned payment reform, and (2) integrating a broader array of providers across care delivery. While these two broad categories are familiar to stakeholders already engaged in multi-payer work, states homed in on a few new issues that are highly salient for all states interested in transforming their health systems.

BACKGROUND

SIM is a CMMI-led initiative that tests whether state-level development and implementation of innovative, multi-payer payment and delivery system reform models can result in better quality, reduced costs, and improved population health for a state's population. As of December 2013, there are six "test" states, which received between $33 and $45 million in April 2013 to test an innovation model over a three-year timeframe. Each model is led by the governor's office and designated commissioners, involves both public and private payers, engages a wide range of health care providers, and will produce measureable results to be assessed by a federal evaluation contractor. An additional 19 "design" and "pre-test" states received between $756,000 and $3 million in April 2013 to develop a State Health Care Innovation Plan that could be implemented as a test. All states will have an opportunity to apply for a second round of "test" funding in early 2014.

The objectives of the MMF convening of SIM test states were threefold. First, the meeting provided a forum for states to identify common challenges in implementing aspects of SIM and potential solutions to address them. The meeting also enabled the states and CMMI to identify areas where collaboration and partnership among the states, CMMI, and other federal partners will be critical for the overall success of SIM. These two objectives fed directly into the third, which was to help pave the way for other states embarking upon similarly ambitious initiatives for broad-based health care delivery and payment reform.

KEY ISSUES FOR STATE-BASED, MULTI-PAYER HEALTH CARE DELIVERY REFORM

1. BUILDING ALL-PAYER INTERVENTIONS

Multi-payer participation and alignment are essential for states to succeed in achieving their transformation goals across a wide swath of providers. While there are several well-known challenges to multi-payer alignment, meeting participants identified two key areas within SIM where such participation is uniquely challenging: (1) Medicare, and (2) self-insured payers.

- *Medicare*: To meet SIM goals of transforming care for 80% of a state's population and to obtain provider buy-in, it is essential that test states engage Medicare as part of their SIM initiatives. While test states are eager to work with Medicare to develop a mutually beneficial plan, organizing these efforts has been challenging. One approach that states may take is to incorporate existing Medicare delivery transformation models, such as the Medicare Shared Savings Program and the Medicare Bundled Payments for Care Improvement initiative, into the SIM test model. Since federal Medicare officials may be able provide guidance on how to integrate existing programs and initiatives into state test models, active participation from that agency is essential to develop comprehensive, multi-payer payment and delivery system reforms.

- *Self-insured payers*: In many test states, securing participation from large, self-insured employers is also critical for reaching 80% of the population. These employers, particularly those with employees in other states, may hesitate to participate and pay for new care delivery and payment models under SIM, particularly if the return on investment is not clear. Due to the Employee Retirement Income Security Act (ERISA), states often lack the policy and regulatory levers needed to bring such payers on board. States should emphasize the development of a robust engagement strategy specifically targeted to securing the participation of self-insured employers in SIM. CMMI should be a helpful partner to engage large employers at a national level.

2. INTEGRATING CARE

Policymakers at both the federal and state levels are very interested in developing new models for integrating physical and behavioral health as well as long-term supports and services. They are driven by opportunities therein to reduce fragmentation, duplication, and avoidable exacerbations of illness for a very high cost subset of the population. SIM test states report facing three issues that must be addressed in order for integrated models to succeed: (1) data sharing, (2) provider collaboration, and (3) integration for Medicare/Medicaid dual eligibles.

- *Sharing Behavioral Health Data*: Sharing patient data between providers is critical for physical and behavioral health providers to successfully manage and coordinate patient care across the spectrum of services. The confidentiality requirements placed on patient information and data, pertaining to substance abuse by 42 Code of Federal Regulations (CFR) Part 2, inhibit data sharing without explicit patient consent. While there are ways to work around some of the statute's provisions to facilitate data sharing, many providers still hesitate to share patient information with their counterparts, especially through all-payer claims databases or electronic health records. States will need to work with providers and consumer advocates to establish acceptable data-sharing approaches that comply with 42 CFR Part 2. Since physical health providers are likely not as familiar with the regulations in 42 CFR Part 2, provider education around this matter may also be helpful. Defining an acceptable level of data sharing in more detail will also help facilitate data exchange by easing provider hesitancy around a complex policy. CMMI can be helpful in working on these issues with its federal counterparts at the Substance Abuse and Mental Health Services Administration (SAMHSA).

- *Collaboration with Behavioral Health Providers*: Test states report that getting buy-in from the behavioral health community to integrate processes with physical health providers is critical but can be a challenge. Reasons cited include: (1) concerns among behavioral health practices, particularly small practices, around consolidation and independence; (2) infrastructure/capacity issues, particularly among smaller practices; (3) advocacy and provider concerns about "medicalization" of behavioral health; and (4) uncertainty in respect to the benefits of certain financial arrangements, particularly shared savings. Getting behavioral health and physical health providers to communicate effectively is a prerequisite for care integration, and a good first step in this effort may be to set up learning collaboratives or leverage existing partnerships between these entities (such as health homes) to begin a conversation. States could address these concerns through strong stakeholder engagement efforts with behavioral health providers as part of implementation and governance structures, as well as facilitating open dialogue between behavioral and physical health providers. Again, CMMI can engage its SAMHSA partners in encouraging these connections.

- *Integration for Medicare/Medicaid Dual Eligibles*: Many test states are eager to leverage the opportunity that SIM presents to advance care integration to patients dually eligible for Medicare and Medicaid, in concert with the State Demonstrations to Integrate Care for the Dual Eligible Individuals program, the "duals demo." The Medicare Medicaid Coordination Office (MMCO) was created by CMS as a direct response to the Affordable Care Act's authorization of demonstrations to integrate Medicare and Medicaid financing and services for duals. Whereas states have considerable flexibility in the care delivery

and payment models they select for SIM, the duals demo has a set of more tightly defined constraints, often outlined in Medicare statute, which may conflict with state approaches. For example, one state has encountered issues of compatibility between the attribution frameworks of the duals demonstration and its Medicaid accountable care organization (ACO) initiative. If new test states plan to pursue integration of dual eligibles through SIM and participate in the duals demonstration, they will need to work closely with leaders and staff at CMMI and MMCO to ensure the alignment of these two initiatives.

CONCLUSION

To transform how care is paid for and delivered statewide, states will have to consider the issues raised above. Not only must states bring commercial payers to the table with Medicaid to create the necessary alignment for provider participation, but Medicare and self-insured employers will be essential participants as well. States must also address challenges to integrating behavioral health and care for dual eligibles in order to meet the needs of high-cost patients and achieve significant quality and cost improvements.

The SIM program is another chapter in the efforts of federal and state officials to articulate roles and responsibilities in improving the health of populations. It represents a vision of locally led and federally facilitated dramatic delivery system transformation for the entire community. But such transformation will not occur painlessly. While certainly not the only challenges states face, the topics addressed in this brief were clearly identified by multiple states as being among those most likely to significantly affect the success of states' SIM initiatives. Resolution—or at least progress—on these challenges will require focus, persistence, and hard work on the part of both federal and state authorities. The SIM states are making tremendous progress, but continued close collaboration between the states, CMMI, and its federal partners will be crucial to favorable resolution of the challenges. Future state-led efforts at comprehensive delivery system transformation—of the type envisioned by the SIM process—will clearly benefit from the experience of these leading states.

ABOUT THE FUND

The Milbank Memorial Fund is an endowed operating foundation that works to improve health by helping decision makers in the public and private sectors acquire and use the best available evidence to inform policy for health care and population health. The Fund has engaged in nonpartisan analysis, study, research and communication on significant issues in health policy since its inception in 1905. Its staff organizes and participates in meetings with decision makers and publishes reports, books, and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy.