Milbank Memorial Fund
645 Madison Avenue, 15th Floor, New York, NY 10022-1095

Christopher F. Koller
President

Tel: 212-355-8400
Fax: 212-355-8599
E-mail: ckoller@milbank.org

October 26, 2016

Centers for Medicare & Medicaid Services
US. Department of Health & Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Sir/Madame:

Request for Information on State Innovation Model Concepts

I am pleased to provide comments on the Center for Medicare and Medicaid Innovation (CMMI) Request for Information (RFI) on State Innovation Model (SIM) Concepts.

The Milbank Memorial Fund (the Fund) is a nonpartisan health foundation committed to improving population health by connecting leaders and decision makers with the best evidence and experience on key health policy topics. In particular, we provide opportunities for state health policymakers to collaborate and share information with the goal of developing or applying evidence to address emerging policy challenges.

In that context, we welcome the opportunity to provide comments on expanded or new concepts for state innovation models as described in the RFI. The specific experiences the Fund brings to this topic are three-fold:

1. Facilitation of the Multi-State Collaborative for multi-payer primary care transformation since 2009 that focuses on coordination of payment reform across multiple payers;
2. Our work with states to measure total cost of care and set limits on health care cost growth; and
3. Identification of key health policy priorities through the nonpartisan Reforming States Group, a by-product of which is the commissioning of evidence-based reports on specific topics.

The Fund does not speak for any specific states in relation to their participation in these projects, but we can summarize key points of their experience in response to the questions posed in the RFI. In general, we can say that:

- There is continuing strong interest among the states to build on current innovation models and to test new concepts that advance population health improvement through multi-payer, multi-sector collaboration.
- To successfully take on these challenges, states will need continuing policy and funding support from CMS. This could take various forms including expansion of SIM or other mechanisms to leverage Medicare's payment reform resources.

Comments on Specific SIM RFI Categories

SECTION I: MULTI-PAYER STATE-BASED STRATEGIES TO TRANSITION PROVIDERS TO ADVANCED ALTERNATIVE PAYMENT MODELS

You have requested comments on concepts for a potential future state-based model to implement broad-scale, multi-payer delivery and payment reforms to help providers participate in advanced Alternative Payment Models (APMs). Implicit in this question is a refocusing of CMS's efforts to promote state health innovation models based on the broad goal of adoption of APMs, consistent with the vision and goals set forth by the HHS Secretary. We think this refocusing is appropriate and needed.

The RFI identifies two potential pathways that states could pursue:

- A state-specific, multi-payer model that includes Medicare, Medicaid, CHIP, and commercial insurers, or
- A state-based model that aligns Medicaid and private-payer participation in an existing Medicare model [e.g., Medicare Shared Savings Program (MSSP) or Comprehensive Primary Care Plus (CPC+)].

Section I, Questions 1 (a)-(c): The RFI asks about the challenges and factors for success in developing multi-payer alignment around APMs and delivery system reform. Based on our experience, both of the pathways described in the RFI are viable, and it may be desirable to give states a choice, rather than limit future options to one or the other, because they offer specific opportunities and challenges.

The state-specific model requires states to commit to comprehensive reform strategies engaging their health care stakeholders and the public. This model would result in very broad changes within a state, but it is also likely to be limited to a very small number of states that can undertake this level of commitment. For example, Vermont and Maryland are two of the states participating in the Fund's Multi-State Collaborative and the total cost of care project. They are leveraging existing Medicare models (MSSP and Next Gen ACO), but each has adapted specific strategies tailored to their local issues. Both states started with regulation of hospital costs, and have leveraged SIM and CMS waivers to enhance Medicare's role as an essential partner to control total costs.

On the other hand, the Medicare-state alignment model could be implemented in a larger number of states. Many states have sponsored or participated in multi-payer primary care payment reform initiatives. Federal policies will accelerate Medicare value-based payment. We believe there is an untapped opportunity in speeding adoption of APMs through greater and more explicit alignment of state Medicaid payment reform efforts with Medicare payment reforms. In local markets, this could result in 60% or more of the payments to certain providers being essentially aligned, and greatly enhance prospects for delivery system reform and ultimately significant performance improvements.

Section I, Question 1 (d): The RFI asks for feedback on the resources, tools, and other types of assistance that would be helpful to support state-based alignment with Medicare and other payers. From our work with the Multi-State Collaborative and the states working on total cost of care measures, we know that these initiatives are very complex and require dedicated resources to perform myriad key functions—stakeholder convening, education, and outreach; developing consensus on all-payer or multi-payer standards; collecting, aggregating, and analyzing claims and clinical data to manage and monitor population health, just to name a few. Many state Medicaid agencies have also made significant commitments to managed care financing strategies. Learning how to accomplish and oversee contractor payment reform implementation is a new skill for these agencies.

Successful programs for multi-payer payment reform have already demonstrated that long-term investment is required, and Medicare and Medicaid should be meaningful partners to sustain that work. CMS needs to provide ongoing funding support for states to build administrative capacity to design and implement multi-payer programs. Short-term grant funding is helpful, but it is not sufficient. There should be mechanisms for ongoing Medicare and Medicaid administrative funding to build capacity for this purpose.

- Medicare is providing more data to states to support innovation models, but states still need resources to work with the data and translate it into meaningful information.
- States should have a clear path to draw down Medicaid administrative funds to support design and implementation of multi-payer models that will include Medicaid beneficiaries, similar to what Vermont has done.
- Waiver programs also need to account for the significant infrastructure investment needed to support health care transformation operations.

Section I, Questions 1 (f) and (g): A final challenge common to CMS and states is to find the right balance between national standardization in payment reform models and local variation that takes into account environmental factors and the need to learn what works. That balance is elusive and may require stronger direction and guidance from the federal government, particularly as a significant financier of Medicaid. Perhaps the availability of any funds for the Medicaid capacity building requested here could be conditioned on Medicaid agency alignment with one or more existing Medicare payment innovations. With this approach, the dual goals of spurring innovation while supporting meaningful evaluation could both be addressed.

Section I, Question 3: The RFI asks how CMS can help states get access to reliable and timely data. We think there are two components to this question:

1. Claims data is an essential component to design, administer, and evaluate multi-payer payment reform. There are a variety of approaches, including state all-payer claims databases and claims databases created by private sector groups (national and regional). CMS should ensure that regardless of who organizes the data, there is enough transparency to ensure that stakeholders trust the source and have a common view of data to answer key questions.

2. Providers need access to reliable and timely clinical and administrative data to coordinate and manage care, which in turn supports their ability to achieve performance levels for enhanced payment. Again, there are a variety of approaches including state and regional health information exchanges or specific health information technology-enabled services (e.g., emergency department admission alerts). As with claims data, CMS should ensure that stakeholders consider the state's chosen mechanism to be trusted and reliable. CMS should work with other federal agencies to further demystify policies governing data use, particularly as they relate to treatment of substance use disorders and mental health.

SECTION II: ASSESS THE IMPACT OF SPECIFIC CARE INTERVENTIONS ACROSS MULTIPLE STATES

Adoption of APMs alone will not be sufficient to improve population health, particularly for high cost/high need Medicaid populations. Future state innovation models could provide a testing ground for delivery and payment models that explicitly address social determinants of health. The Fund has collected evidence in support of investments in social services that complement or even transcend a traditional health care model. We have also prepared a practical guide explaining how Medicaid covers these services today.

A new SIM care intervention design could allow states to demonstrate cost savings and improved outcomes with the certain social services included as covered benefits in the context of a broad, multi-payer approach. As with payment reform, states need a clear path for Medicare and Medicaid participation in these new models. Most primary care and ACO models have not extended very far beyond traditional health care services, so it is timely to encourage development of new delivery and payment models that extend to social determinants and outcomes. Here are our most recent reports on behavioral health integration and social services supports.

SECTION III: STREAMLINED FEDERAL/STATE INTERACTION

The RFI asks for suggestions regarding ways to improve the federal-state partnership to support delivery and payment reform alignment. CMS has established a focal point for innovation policy and communications through CMMI. We offer three suggestions to strengthen this model:

1. It is important for CMMI to coordinate with the regular operating components of CMS and other federal agencies. States need policy approval from both Medicare and Medicaid to operate these programs. It would be greatly beneficial to state policymakers if Medicare, Medicaid, and CMMI spoke with one voice to states about APM adoption in policymaking and policy development. Similarly, states need a way for their proposals, applications, and requests for policy interpretations by CMS to be addressed in a consistent, coordinated, and expedited fashion.

2. In addition, many policies and funding streams that contribute to states' overall health and health care ecosystem are operated by other HHS components. Multi-payer alignment for delivery and payment reform can be an effective strategy, but we imagine it would be even more effective if the federal and state governments had a mechanism to look at all health-related investments to fully leverage these resources and ensure that the incentives are really aligned. For example, HRSA has a significant role overseeing funds for FQHCs and GME—these funding streams could play important complementary roles in states' funding alignment strategies.
3. Just as states need to devote significant resources to develop and implement innovation models, the federal government needs to invest in its own administrative requirements. CMS has provided important strategic direction. However, we know that strategy is not enough—the facilitation and convening roles are absolutely essential to advance multi-payer initiatives, as has been observed in MAPCP and CPC. Dedicated federal and state resources should be devoted through a collaborative model to the care and feeding of these programs at the ground level.

CONCLUSION

We greatly welcome CMS' initiative to seek comments on concepts for state-based payment and delivery system reform initiatives. As noted, CMS is currently a significant partner assisting states with innovation models through Medicaid and broader, multi-payer efforts. This is a strong foundation upon which to build, and now we have the opportunity to dramatically enhance the impact of these programs.

In our comments on the RFI, the Fund supports CMS partnering with states to accelerate and broaden adoption of Medicare APM models. We also suggest development of a standardized care intervention package that focuses on social determinants of health, utilizing policy levers to expand integrated care models beyond the health care system. Finally, we recommend that CMS further develop and coordinate its policymaking capacity, and provide funds to states for capacity building in order to most effectively manage the process of health care transformation.

Thank you for the opportunity to comment. The Fund would be pleased to answer any questions raised by this response and provide additional comments as you consider future options.

Sincerely

Christopher F. Koller
President
Milbank Memorial Fund