The Reforming States Group

Milbank Memorial Fund

Letter to the New Administration

Reforming States Group

December 2016

Introduction

The Reforming States Group (RSG) is a bipartisan, voluntary group of state health policy leaders from the executive and legislative branches that, with the support of the Milbank Memorial Fund, convenes regularly to work on solutions to pressing problems in health care. In anticipation of a new federal administration, the RSG Steering Committee established a workgroup to develop consensus policy recommendations for the new administration, and the Steering Committee has unanimously endorsed this letter.

The policy agenda represented in this letter is rooted in the widely accepted and non-controversial Triple Aim to improve population health, reduce the per capita cost of health care, and improve patient care and experience across the U.S. health care system. We provide specific examples of practical, bipartisan measures, supported by evidence and experience, focused on strengthening the states' position to improve population health. They can be implemented largely without new federal legislation, and they are designed to be cost neutral.

Our letter identifies four key concepts to guide federal-state health policy for improved population health, and 10 proposals to carry those concepts forward through concrete actions:

1. **Support state efforts for broad reforms of health care payment and delivery by:**
   a. Expanding Medicaid funding support for state health reform capacity building

b. Increasing Medicare participation in state innovations

c. Implementing new coverage and payment models for high-priced drugs

2. **Support state efforts to prevent and manage chronic illness by:**

   a. Strengthening Medicaid's role in broad-based population health improvement programs

   b. Coordinating Department of Health & Human Services (HHS) policies and funding to enhance social supports for older adults and people living with disabilities

   c. Enhancing federal community benefit requirements to improve population health

3. **Improve use of data to inform policy by:**

   a. Expanding federal policy support for state data collection and access

   b. Expanding federal policy support for state data sharing and interoperability

4. **Strengthen the state-federal partnership on health to assure the greatest impact from federal investments by:**

   a. Coordinating HHS and state-based investment strategies

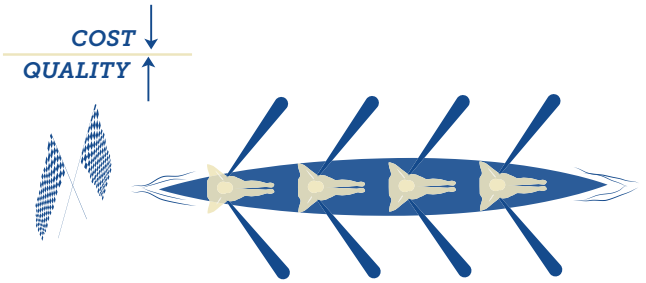
   b. Establishing a focal point to address state-federal policy consistency and dispute resolution

While much has been made of the disagreement among many state governors and legislators with various aspects of federal health care policy, there is considerable consensus among the states regarding improvements to the state-federal partnership that would lead directly to improved health of the population and a more efficient and effective health system. Moreover, while consensus-based recommendations are often watered down to a least common denominator necessary for agreement—these are not. They were refined and debated not as an academic exercise, but by individuals with unique health policy insight and the ability and authority to actually drive change locally. A stronger state-federal partnership is one concept in our policy proposals, but it is essential to making all of these proposals work. The proposals require coordinated communication and flexibility with federal agencies that can be facilitated by the new administration if made a priority.

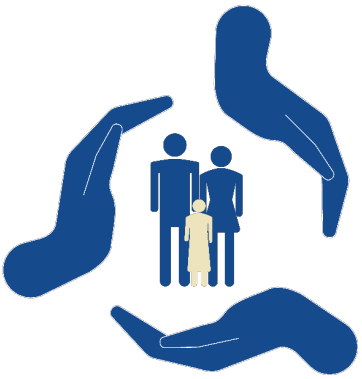
We hope that this letter, and the offer of support it represents from state officials nationally, can provide you with a source of ideas and support as you embark on the great challenge of political transition and new national leadership.

The Reforming States Group

Support state efforts for broad reforms of health care payment and delivery



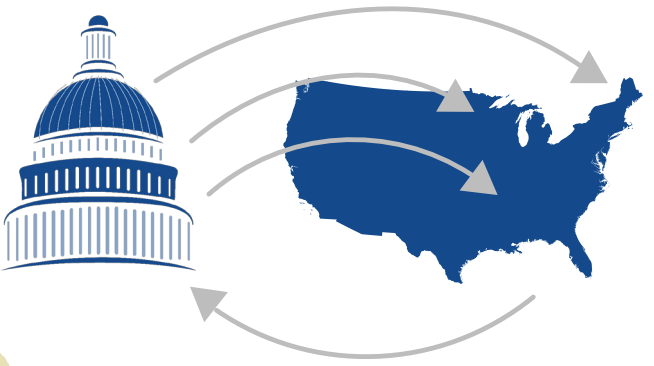
Support state efforts to prevent and manage chronic illness



FOUR WAYS TO HELP STATES IMPROVE POPULATION HEALTH

Improve use of data to inform policy

Strengthen the state-federal partnership on health to assure the greatest impact from federal investments



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Letter to the New Administration

Concept 1: Support state efforts for broad reforms of health care payment and delivery

States can play a critical role in advancing innovative health care initiatives to accomplish better outcomes, lower cost, and greater patient satisfaction. These initiatives include provider payment reforms, consumer engagement strategies, and enhanced quality measurement. States administer Medicaid and state employee health plans, oversee professional licensing, play a central role in financing and providing behavioral health care, and regulate private insurance. As such, they are well positioned to develop and test new models as payers and regulators. Federal support for and alignment with state innovation can enhance the impact of these efforts. The support should include agreement on measures of program outcomes and effectiveness.

Policy Proposal 1.1 – Expand Medicaid Funding Support for State Health Reform Capacity Building

CMS should allow Medicaid to participate in funding state administration of broad-based or statewide health transformation, as long as that effort is inclusive of Medicaid.

The Medicaid program covers state administrative costs, with expenses divided between the state and federal government at a set match rate. Administrative expenses must be "proper and efficient" for operation of the Medicaid state plan.

Neither Medicare nor Medicaid alone has sufficient scale in a given state to create or support the infrastructure necessary for population-based health care transformation. States do not have a stable source of funding for health care innovation and evidenced-based improvement activities. In addition, there are limits on how funds can be used, favoring consultant arrangements over building state staffing capacity. As a result, states often struggle to take advantage of opportunities to work with the health care sector and business community to develop new models of payment and care. States also struggle to establish data resources that can be broadly used to improve outcomes and lower costs.

The Centers for Medicare & Medicaid Services (CMS) should provide clear guidance to states to permit the use of administrative funds to support all-payer health planning, implementation, and oversight, as well as investment in evidence-based practices to improve quality and reduce costs. Where such innovations will benefit the Medicaid program, it is "proper and efficient" for the program to support their development and implementation. Today, states rely on specific grant or contract opportunities and the

funds are dedicated to technical support for a specific initiative. Under this proposal, states could draw down Medicaid financial participation to build ongoing administrative capacity in support of broad-based transformation programs.

Policy Proposal 1.2 – Increase Medicare Participation in State Innovations

CMS should provide a clear path for Medicare participation in multi-payer state health reform initiatives (e.g., bundled payments, medical homes, integration of behavioral health care with somatic medical care, and global budgets). This path should include avenues for sharing Medicare savings with states.

Medicare provides health coverage to more than 55 million Americans at a total cost of more than $600 billion per year. Medicare's size comes with extensive influence in the health care system. Medicare's approaches to paying hospitals and physicians have been widely adopted by the private sector. More recently, Medicare's new innovations in payment—including Accountable Care Organizations (ACOs), patient-centered medical homes, and global hospital budgets—are driving changes across all of health care.

Medicare's large footprint has a downside; it can be very difficult to achieve multi-payer health reform without the program's participation. For example, physicians may be unlikely to join a medical home initiative that does not include 25% to 50% of their patients; a hospital will be unable to focus intensely on preventing unnecessary admissions if it is still paid fee-for-service. As states take the lead in developing innovative solutions across payers,[1] Medicare can be a roadblock or a critical path to success. States can facilitate and accelerate Medicare reforms in care delivery and payment policy as part of a larger initiative.

CMS can address this concern by building on its current three pillars of innovation model support:

1. Medicare has developed many payment innovation models focused on shared savings, bundled payments, and enhanced care coordination; for example, the ACO shared savings model has now been replicated or adapted by Medicaid and commercial payers across the country.

2. Medicare is serving as a catalyst for multi-payer delivery system and payment reforms; for example, the Comprehensive Primary Care initiative that establishes common standards and incentives across payers.

3. The State Innovation Model program provides resources through grants and technical assistance to states to engage all payers and classes of providers in critical reform efforts.

[1] Hwang A, Sharfstein JM, Koller CF. State Leadership in Health Care Transformation: Red and Blue. *JAMA*. 2015 Jul 28;314(4):349-50. Doi: 10.1001/jama.2015.8211.

CMS can now go further by providing specific guidance to states explaining how to engage Medicare in local all-payer delivery reform efforts, including shared savings. Such efforts might be variations in existing models, such as ACOs or patient-centered medical homes. Alternatively, all-payer reform efforts could involve creative or innovative solutions unique to a state's health care system, such as statewide or regional global budgets. With clearer CMS guidance, states will be encouraged to continue leading in health reform, bringing about improved health at lower costs.

The federal government should eliminate policy and operational barriers for states to develop alternative models for dual-eligible beneficiaries. This population can be better served by an integrated system of care combining new delivery and payment models along with quality and outcome measures.

Policy Proposal 1.3 – Implement New Coverage and Payment Models for High-Priced Drugs

CMS should support state efforts to adopt new models to manage coverage and use of high-priced drugs.

Rising drug costs are imposing a significant financial burden on the health care system, including state Medicaid programs. Contributing to the challenge are escalating prices for new treatments and surprising price hikes for certain generic and long-established drugs. The federal drug rebate program requires state Medicaid programs to pay for drugs once federal rebates have been granted, limiting states' ability to modify coverage for these items.

CMS should permit states to implement innovative means to control drug expenditures while maintaining patient access; for example, states should be allowed to include pharmaceuticals in value-based payment models; to link drug authorizations to required care coordination; and, when making reimbursement and preferred drug list decisions, to apply cost-effectiveness comparisons across therapies that account for real-world conditions affecting adherence and efficacy.

Concept 2: Support state efforts to prevent and manage chronic illness

A critical challenge facing the United States is the continued rise in non-communicable chronic diseases, including diabetes, cancers, mental illness, addiction, dementia (including Alzheimer's disease), chronic respiratory disease, and cardiovascular disease. They account for an increasing portion of health care spending. To improve quality of life and life expectancy, and to control health care costs, the federal government should creatively support state innovations targeting these conditions through new ways to blend funding

streams and create non-traditional models of service delivery. This support should include agreement on measures of program outcomes and effectiveness.

Policy Proposal 2.1 – Strengthen Medicaid's Role in Broad-Based Population Health Improvement Programs

CMS should make it easier for states to combine Medicaid funding with public health funding for public health programs targeting chronic illnesses, by reducing policy and administrative barriers for Medicaid reimbursement.

Traditional preventive services (such as immunizations and cancer screenings) are covered by Medicaid and other payers, but there is growing interest in adopting a broader model of health promotion. The Centers for Disease Control and Prevention is promoting a model that works with payers to target selected high-cost conditions combined with evidence-based interventions. Examples of public health services targeting specific chronic disease issues include community-based outreach and education addressing diabetes and hypertension, or housing and environmental remediation targeting asthma and water quality.

Generally, Medicaid will only pay for clinical or condition-related services that are (1) covered in the state's Medicaid plan; (2) provided to a specific beneficiary; and (3) only for those eligible for Medicaid. However, public health and population health models require investments in services that cut across those traditional program boundaries serving targeted population segments (people at risk for or diagnosed with diabetes) or the whole community, regardless of their insurance coverage.

Given the significant fiscal impact of chronic disease on the Medicaid program, CMS should encourage states to develop and participate in population health models designed to prevent or better manage chronic disease that cut across insurance or payment sources. For example, CMS should allow state Medicaid funds to be used for health promotion, even if these are not traditional Medicaid-covered services or billed on a beneficiary specific basis, if they are part of an organized multi-stakeholder statewide or regional plan to improve population health. Costs to the Medicaid program should be allocated based on a percent of populations served or another proportional formula negotiated with states. This approach is being used to fund interventions that target chronic disease and other health determinants, including tobacco cessation and poison control activities; it could be applied to other programs, such as those designed to curb addiction to opioids or reduce obesity.

Policy Proposal 2.2 – Coordinate HHS Policies and Funding to Enhance Social Supports for Older Adults and People Living with Disabilities

HHS (in concert with other federal agencies including the Department of Housing and Urban Development, the Indian Health Service, and the Veterans Health Administra-

tion) should provide a path for states to blend funding—from Medicare, Medicaid, the Administration for Children and Families, the Substance Abuse and Mental Health Services Administration, and aging agencies—to coordinate and provide social support services for older adults and people living with disabilities aimed at better management of care transitions and improved economic and social participation.

Federal policies have promoted community-based health care options for the elderly and people with disabilities as a matter of individual choice and as a cost-effective alternative to institutional care. These populations are growing, and facing increasing health and economic challenges, which will further increase the need for social supports and community-based services.

There are many programs providing resources for individual components of community-based initiatives. However, current Medicaid policies generally restrict payment for specific items such as direct housing subsidies, and services and providers may not fit current Medicaid definitions. It is difficult to piece these programs together to build systems around individual and community needs including but not limited to Medicaid beneficiaries.

CMS should provide model state plan amendment and waiver policies that would facilitate state use of Medicare and Medicaid funds to enhance availability of services through comprehensive, flexible community-based services models for those who are most vulnerable and have complex care needs. The model state plan amendments and waivers should specify how these services are reimbursed and accounted for through managed care organizations and alternative payment models. States should be allowed to establish new categories of "service providers" payment arrangements and oversight mechanisms (e.g., certification or credentialing) that would be tested through new program models.

Current policies present a significant barrier for states looking to develop and implement innovative care delivery models that improve care coordination and health outcomes, particularly for the most vulnerable of the Medicaid population. HHS should facilitate state efforts to build new services and supports outside the health care system—from providers such as community health workers, community paramedics, and peer support specialists—and to increase supportive or temporary housing, supportive employment, and general transportation.

Policy Proposal 2.3 – Enhance Federal Community Benefit Requirements to Improve Population Health

The Internal Revenue Service (IRS) should clarify the regulations governing community health benefit requirements for not-for-profit institutions, requiring hospitals to (1) work with state public health agencies to define their role in addressing specific community health needs; and (2) create more rigorous measures of population-based health outcomes over time.

Not-for-profit health organizations—particularly hospitals—are now required to conduct community health needs assessments and document spending on "community benefits," such as community health improvement programs. As designed, community benefit requirements could direct needed resources to bolster population health improvement activities.

However, community benefit accounting mainly focuses on documenting and writing off the cost of uncompensated care provided, not demonstrating the benefit of spending on community health. Also, the current regulations differentiate between community health improvement and community building activities, requiring more extensive documentation for the latter, which may discourage investment in more "upstream" population health activities (e.g., housing). In addition, there is no requirement for hospitals to coordinate with state and local public health agencies to align with population health programs.

By further clarifying and strengthening the current IRS regulations, states would have the option to include community health benefit resources as a specific component in the design and sustainability of population health improvement models.

Concept 3: Improve Use of Data to Inform Policy

States focused on improving health and health care need actionable, specific, real-time data to design the best interventions and assess whether or not they are working to improve health and lower costs. Improved data sharing will improve program development and evaluation to address critical health needs. It is also an essential tool to modernize clinical care delivery. Data systems should be interoperable, so that insight into key health issues does not stop at state borders or silos of health care delivery.

Policy Proposal 3.1 – Expand Federal Policy Support for State Data Collection and Access

The federal government should facilitate state access to data about state residents for specific public health and health care purposes, including support for state efforts to access Medicare data and create comprehensive all-payer claims databases.

Through Medicare and other health care programs, the federal government collects and uses substantial amounts of data about U.S. residents. These data can be used to identify people at high risk during emergencies, to assess the level of illness and disability across communities, and to track the success of interventions. There is growing interest in expanded uses of this data as a component of multi-payer health care reform initiatives, and for patient-centered outcomes research, alternative payment models, and evidence-based benefits development. Data from non-health agencies, such as the Departments of Education or Agriculture, could also support broad-based health improvement initiatives.

States have limited access to federal data collected about state residents, and there is no central mechanism for requesting data across multiple federal programs. CMS has created a new pathway for states and other stakeholders to access Medicare data; however, states will have to navigate through policies and administrative processes that are unique to the Medicare program and impose specific limits on use of this data. States should also have ready access to data from the Indian Health Service and the Veterans Health Administration to advance health improvements for populations served by those programs.

In addition, many states have implemented or are developing all-payer claims databases to create state-level data repositories for all covered populations. The Supreme Court in *Gobeille v Liberty Mutual* recently struck down a state's attempt to require self-funded insurance plans to submit data to an all-payer claims database. As a result, states will have to rely on voluntary data submission from these plans.

The federal government should facilitate state access to health care data about state residents across federal programs, with appropriate assurances for privacy and security. This should include but not be limited to the following proposals:

- Federal research agencies should support investigations that establish the best ways for states to use and manage these data.
- The Department of Labor should work with states to establish a protocol for self-funded plans to contribute data to state all-payer claims databases.
- Federal policy should support state efforts to collect and publish pricing transparency data relating to providers, health plans, and pharmaceuticals.

Policy Proposal 3.2 – Expand Federal Policy Support for State Data Sharing and Interoperability

The federal government should develop interoperability standards for prescription drug monitoring programs, immunization registries, emergency communications, and other key systems, in order to facilitate data exchange between states, among state agencies, and across the health care system.

States have the primary role to administer many public health-related data resources, including vaccine registries, prescription drug monitoring programs, and communications and data exchange in emergencies.

In many cases, however, state systems do not communicate with one another. Where this is the case, an immunization registry cannot retrieve records from clinicians across a state line, and a prescription drug monitoring program fails to identify "doctor shopping" in a nearby state. Emergency communications are especially important to coordinate responses and avoid confusion during a regional disaster.

The federal government should assign responsibility to an individual or office to work with states and IT vendors to remove policy barriers and promote compatibility of key state public health data and communications across disparate public health programs and funding sources. For example, while common standards exist for exchange of data on immunizations and prescription drug monitoring programs, many state systems are still unable to communicate with one another.

In addition, states have been at the forefront of building health information exchange systems that connect to electronic health records systems and facilitate access to data across health care settings. The federal government has developed and continues to advance interoperability standards for these systems (although adoption has been slow and costly). Since states establish their own policies for consent to data access, it is difficult to establish data exchange that follows the person across state boundaries. Many states and stakeholders develop their own interpretations of the Health Insurance Portability and Accountability Act (HIPAA) requirements, creating inconsistent standards across the country. The federal government also sets specific rules for access to behavioral health data, which often differs from the state's baseline policies for data exchange. This lack of policy standardization poses a significant barrier to improving health and safety, and reducing health care costs.

HHS should adopt consistent national policies to facilitate interoperable data exchange across health care and with behavioral health, including clarification of rules under HIPAA governing permitted uses of data and clarification of rules under 42 CFR Part 2 to streamline and facilitate exchange of data relating to mental health and substance use disorder services.

Concept 4: Strengthen the state-federal partnership on health to assure the greatest impact from federal investments

States are critical partners in federal efforts to improve health and health care through programs that are implemented in communities and markets. States are not just another group of stakeholders, but have independent legal and political obligations to the public. Stronger federal-state partnerships will improve the effectiveness of policies and programs that have broad population impact. This can be achieved by establishing a strong mechanism to coordinate state engagements across multiple federal agencies and to fix problems that may arise quickly.

Policy Proposal 4.1 – Coordinate HHS and State-Based Investment Strategies

HHS should consult with states before developing new initiatives and providing major grants to private entities working in areas where the states have already established or are planning coordinated strategies to ensure alignment of strategies and outcomes.

The states and federal government have authority to take independent action on a common set of health and health care issues at the state level. Both levels of government provide funding for behavioral health services, graduate medical education, physician recruitment in health professional shortage areas, fraud and abuse prevention, care for the under-insured and uninsured, and a wide variety of other public health programs. With this funding come specific performance expectations, rules, and regulation.

In many cases, the strategic assumptions and priorities that drive federal and state action are determined independently. These uncoordinated government initiatives can lead to inefficient and ineffective implementation. For example, states are significantly involved in physician workforce development through funding and supervision of medical schools, funding of residency positions through Medicaid, and funding and administration of loan forgiveness programs to attract physicians to shortage areas. In many cases the federal government is also making the same investments. Yet there is no clearinghouse for the federal government and states to share information regarding these mutual investments much less coordinate them effectively. In addition, the timelines for federal policy actions can be unpredictable with programs cancelled or delayed with short notice, or with accelerated turnaround times for program applications. The lack of predictability can make it difficult for states and others to develop or adjust major strategic or operational plans.

HHS should work with the states to develop more effective joint strategies in key areas such as behavioral health, physician workforce development, and care for vulnerable populations. This should include joint planning and review sessions between relevant state and federal officials, processes to notify each other prior to launching or expanding state-based initiatives with sufficient time to provide input, and efforts to harmonize performance metrics and reporting between related initiatives.

Policy Proposal 4.2 – Establish a Focal Point to Address State-Federal Policy Consistency and Dispute Resolution

HHS should develop a focal point—through an existing or new office—to respond to concerns from states about incompatibilities and deficiencies in federal programs, bringing federal and state agencies together and identifying key decision makers for the purpose of implementing more effective policy.

Although responsible both to each other and to their respective elected officials and constituents to implement federal and state laws and regulations, the ability of states to effectively implement joint state-federal programs has become compromised by inefficiencies and organizational barriers at the federal level.

State Medicaid programs, for instance, increasingly face delays ranging from several months to years for approval of routine state plan amendments and waivers necessary to efficiently and effectively operate the program, and health care reform efforts are slowed by conflicting interpretations of federal policy by CMS regional offices.

HHS should establish a focal point of accountability to work with states to resolve disputes, foster mediation, and break up "log jams" within the agency; to provide guidance and assistance in solving problems with the agency; and to address general regulatory questions or concerns. This office would have the authority to review disputes and complaints on behalf of the states, bring the affected parties together in a timely manner to transparently review the issues, and recommend alternative courses of action directly to the HHS Secretary.

Reforming States Group Steering Committee

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About the Milbank Memorial Fund

The Milbank Memorial Fund is an endowed operating foundation that works to improve the health of populations by connecting leaders and decision makers with the best available evidence and experience. Founded in 1905, the Fund engages in nonpartisan analysis, collaboration, and communication on significant issues in health policy. It does this work by publishing high quality, evidence-based reports, books, and *The Milbank Quarterly*, a peer-reviewed journal of population health and health policy; convening state health policy decision makers on issues they identify as important to population health; and building communities of health policymakers to enhance their effectiveness.

About the Reforming States Group

The Reforming States Group (RSG) is a nonpartisan, voluntary group of state health policy leaders from both the executive and legislative branches who, with a small group of international colleagues, gather regularly to share information, develop professional networks, and commission joint projects—all while using the best available evidence and experience to improve population health. Supported by the Milbank Memorial Fund since 1992, the RSG brings together policymakers who usually do not meet together outside their states, to share information they cannot obtain anywhere else.

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