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

Dear Sir/Madame:

Request for Information – CMS Innovation Center New Direction

I am pleased to provide comments on the Centers for Medicare & Medicaid Services Request for Information (RFI) on the Innovation Center New Direction.

Background: 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 applying evidence to address emerging policy challenges.

The Center for Medicare and Medicaid Innovation (CMMI) provides an important resource for states and health care stakeholders to directly participate in or leverage new models of health care payment and delivery. Our perspective on the Center's role and activities is based on two distinct roles for the Fund:

- Facilitation of the Multi-State Collaborative (MC) for multi-payer primary care transformation since 2009 that focuses on coordination of payment reform across multiple payers; and
- Identification of key health policy priorities through the nonpartisan Reforming States Group (RSG), a by-product of which is the commissioning of evidence-based reports on specific topics.

The MC is preparing its own response to the RFI, so the following comments reflect the RSG's priorities. Last year, the RSG endorsed a Letter to the New Administration that identified specific administrative opportunities to improve population health by strengthening the federal-state partnership. The broad principles from the letter provide the context for our response to the RFI:

1. States can provide an effective governance and operating platform to advance health reforms on a large, population-based scale.
2. States want to build on current innovation models and to test new concepts that advance population health improvement through multi-payer, multi-sector collaboration.
3. A strong federal-state partnership will accelerate the pace and ensure more effective innovations; this requires well-defined roles and responsibilities, and regular opportunities to share information on successes and challenges.
4. To continue this partnership, states will need additional policy and funding support from CMS, and CMMI provides a vehicle for this.

The responsibility for establishing the conditions that promote the health and wellbeing of US residents rests jointly with state and federal governments. We believe that CMMI's activities must reflect a true partnership with state governments in the particular area with which CMMI is charged—namely health care provider payment reform. The principles above and the following comments reflect that central commitment to a state/federal partnership.

The Fund's specific comments will focus on three of the topics covered by the RFI: opportunities to expand participation in advanced payment models; state and local health care innovation models; and behavioral health integration.

1. **Expanded Opportunities for Participation in Advanced Alternative Payment Models (APMs)**

The Fund supports CMMI programs for multi-payer primary care transformation including expanded use of alternative payment models (APMs). This has been advanced through the CPC+ program (and its predecessors) as well as the State Innovation Model (SIM) program. We believe that successful delivery system transformation requires multi-payer alignment on payment methodologies, quality measures, and reporting and feedback to providers. Coordination or alignment across payers increases the benefit and impact of APM incentives, and reduces administrative burdens for payers and practices. 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.

To accelerate multi-payer use of advanced APMs, we think CMS should work with states to align Medicaid and private-payer participation with an existing Medicare model such as CPC+. The evidence from CMMI's efforts and work in the states is clear that to the extent a payer's provider payment mechanisms are seen as proprietary sources of strategic differentiation and competitive advantage it will retard—not accelerate—the pace of delivery system reform the US so desperately needs. As the nation's largest payer, CMS, though CMMI can both enhance payment innovation and establish an essential culture of learning and improvement across payers and providers

With federal support, the Medicare-state alignment model could be implemented rapidly in a large number of states. Many states have sponsored or participated in multi-payer primary care payment reform initiatives. Federal policy is the quickest path to accelerate 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.

We suggest that Medicare advance multi-payer APM alignment along two pathways:

1. Expanded Medicare testing of a limited number of payment models in fee-for service (FFS) populations, and
2. Leveraging Medicare Advantage contracting and Medicaid waiver and state plan amendment approvals as ways to encourage multi-payer adoption of a menu of these models through managed care plans.
   Why haven't more states advanced multi-payer provider payment reform efforts on their own? There are significant policy and operational barriers; in addition to alignment with Medicare and private payers, states need to address key questions (as summarized in a recent CMCS IAP webinar for states on VBP):

- What is the current degree of APM adoption?
- Is there a process for stakeholder engagement?
- Are/should APMS be advanced through Medicaid managed care, FFS, or both?
- How robust are the state's data systems and ability to share key information with health providers?
- What is the state of provider readiness? What training is needed?
- What are the upfront state investment and internal resources needed?

Long-term investments at the state and federal level are required, and Medicare and Medicaid need to be meaningful partners to sustain that work. This means clearly defining federal and state roles and responsibilities, including ongoing Medicare and Medicaid administrative funding to build state capacity for this purpose. Since CMMI is the focal point for Medicare payment reform policy and practice, it makes sense to build the partnership with states to advance payment reform on this chassis.

2. Broader State-Based and Local Innovation, Including Medicaid-focused Models

Adoption of APMs in Medicare alone and promotion of multi-payer alignment around them represent an important and essential starting point, but it will not be sufficient to improve population health. At the most comprehensive end of the payment model spectrum are population-based payment models that are designed to achieve broad-based cost control and population health improvements, such as global budgets and population-based ACO models. Some states have taken this challenge on and CMMI can contribute to the success of this work.

Vermont, Maryland, and Oregon—the early adopters of these comprehensive payment and cost models—have already benefitted from CMS and CMMI support. Other states are adapting these comprehensive payment reform models, such as the rural hospital global budget initiative in Pennsylvania.

CMMI can and should provide both administrative and policy support to encourage additional state and local innovation at the cutting edge of population-based payment models. The scope of these comprehensive initiatives is more robust, but the types of activities would be similar to those involving multi-payer APM models —stakeholder engagement, development of standards and policies, data aggregation and analysis, and evaluation. Again, CMMI is well-positioned to collect and disseminate information to states on what works.

3. Behavioral Health Integration

States have a unique opportunity and responsibility to improve the behavioral health (BH) of specific populations. There is a strong interrelationship between BH factors and health outcomes, so the effectiveness of health care programs hinges on better BH outcomes. States can improve BH systems as a purchaser for Medicaid and state employees; states also operate public systems that serve people with more acute or complex needs, such as forensic psychiatric patients and criminal justice-involved populations.

The Fund has published several evidence reports about BH integration models that have already served as a resource for CMS and states. We recently convened several states that are using Medicaid managed care contracts as a vehicle to promote BH

integration. States are using SIM money and exploring BH integration in the context of CPC+ and other primary care programs. Key issues to be addressed through these models include the availability and training of the BH workforce, development of new payment models and outcome measures for physical and BH integration, and supporting providers by building their capacity to participate in these models.

The challenge of BH integration cannot be seen as a Medicaid problem—it is critical to improving care for commercially insured and Medicare populations, and thus calls for CMMI engagement. We do not have a recommendation as to a specific model for CMMI to focus on. However, we would recommend two areas of focus for information sharing with states:

- HRSA and SAMHSA have both allocated significant resources to these efforts, but it is not clear if states are aware of their programs—CMS could facilitate more information sharing among the federal and state agencies responsible for BH programs.
- In addition, since payment reform is one of the key elements to BH integration, CMMI could provide a platform to facilitate information sharing across states on how that applies to BH integration models.

Conclusion:

We greatly welcome CMS' initiative to seek comments on new models for health care innovation. As noted, CMS is already 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.

Whatever models CMS chooses to support, it is important to have a focal point such as CMMI to work with states and jointly build additional capacity for innovation. In addition to coordinating policies and operations within CMS, it would be helpful to states if CMS could facilitate even greater coordination and communication with other federal agencies to ensure that federal and state resources are used most effectively.

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