November 20, 2017

Ms. Seema Verma
Administrator, Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Dear Ms. Verma,

On behalf of the Milbank Memorial Fund Multi-State Collaborative, I appreciate the opportunity to comment on the Centers for Medicare and Medicaid Services (CMS) Innovation Center (CMMI) New Direction Request for Information.

The Milbank Memorial Fund is a nonpartisan operating fund committed to improving population health by connecting leaders and decision makers with the best evidence and experience. The Fund's Multi-State Collaborative (MC) is a key source of encouragement and serves as a communication mechanism for multi-payer efforts to transform primary care, specifically through aligning payment strategy to primary care practices, quality and utilization measurement and practice improvement technical assistance. The MC, supported by the Fund since 2009, is a voluntary group of leaders representing 20 statewide and regional multi-payer primary care transformation initiatives. It provides a forum for members to share data and experience through participation in collaborative learning, and advocate for improved partnership between the states or regions and the federal government on new and ongoing initiatives, which includes several versions of advanced alternative payment models (APM). As an example of our reach and commitment, the Milbank MC held a 2 day in-person meeting for 40 representatives of 17 states or regions, with a combined agenda of didactic topical presentations and working sessions focused on achievement of the CPC+ milestones. The following comments on behalf of the Fund's Multi-State Collaborative will focus on the opportunities to expand participation in APMs and to refine them, as well.

We strongly support CMS' stated goal of spreading uptake in Advanced APMs; Medicare as the largest purchaser of health care in the country rightly must continue to take a leadership role in testing and evaluating provider-directed payment reforms. We suggest this acceleration could be achieved through CMMI's continuation and expansion of the state or region-based models that align Medicaid and commercial

payer participation with Medicare in programs such as the Comprehensive Primary Care Plus (CPC+).

There is no question that CMMI's entrance into previous demonstrations and initiatives served as a powerful catalyst for public and private payer organizations' involvement in earlier iterations of APMs. One only need to look back a few years to the Multipayer Advanced Primary Care Practice (MAPCP) demonstration and the Comprehensive Primary Care (CPC) initiative, both of which started in 2011 and ended in 2016. The MAPCP broke ground by allowing Medicare to join into already established state-based multi-payer primary care transformation programs, in contrast to the later CPCI where CMS had explicit milestones and other expectations of its participants and partners.

By taking a prominent, if at times delicately balanced leadership role, CMMI spurred on the direct involvement of the now over 60 payers in 18 states and regions involved in the CPC+, all on a voluntary basis. There is an appetite for these innovations, and if CMS takes action, the state and private payers follow suit. No matter how strong the leadership at the state or private payer level, our experience of the last 10 years has been that federal leadership around payment reform is essential to driving change.

As noted earlier, the Fund's Multi-State Collaborative supports CMMI programs for multi-payer primary care transformation, including expanded use of APMs. Specifically, primary care practices participating in the CPC+ in either Track 1 or Track 2 are considered to be advanced APM Entities, an appropriate and realizable mechanism for moving into the next phases of transformation.

We understand that CMS is giving consideration to a new model involving the concept of direct primary care. We suggest that this should be viewed as part of the continuum of advanced APMs for primary care practices, ranging from CPC+ Track 1 on one end, through Track 2 and finally to direct primary care. Regardless of the trajectory of any new model concerning direct primary care, most practices will not yet be ready to move to a payment model involving full primary care risk on day 1. Therefore, it is essential that CPC+ stay its current course as a five-year model testing the effects of Track 1 and Track 2, both relative to fee for service and relative to each other. This is consistent with CMMI's commitment to small scale (regional) testing as a start, moving the needle further as practitioners, payers, patients and other stakeholders refine and expand the models beyond the current participant populations.

In a multi payer health care environment, delivery system transformation can only continue if economic signals are consistent. Evidence is emerging from the evaluations of the CPC Initiative which supports continuation of the infrastructure found in the CPC+, including but not limited to the areas of multi-payer collaboration, data feedback and aggregation, and care delivery quality improvement activities. These areas of improvement are at risk without adequate administrative resources for the dedicated and hardworking CMMI staff, who are covering the responsibilities of their own tasks as well as numerous vacant positions.

It is critical to note that it has taken years, now moving into decades, for the impacts of interventions implemented through the CPC+ to be credibly measured and reported upon. This brings home the point that behavior change, that of systems, clinicians and most important that of patients, is a gradual process, and we applaud the relatively long-term commitment to the CPC+ through 2023. CMMI's continued participation and leadership are essential for the continuation and credibility of these interventions.

Please do not hesitate to contact me with questions.

Sincerely,

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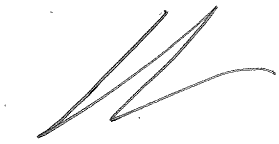

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