Center for Medicare and Medicaid Innovation
Request for Information on State Innovation Model Concepts

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS
ACTION: Request for Information (RFI)

SUMMARY
The Centers for Medicare & Medicaid Services (CMS) is seeking input on the following concepts related to state-based payment and delivery system reform initiatives:

1. Partnering with states to implement delivery and payment models across multiple payers in a state that could qualify as Advanced Alternative Payment Models (APMs) or Advanced Other Payer APMs under the proposed Quality Payment Program, to create additional opportunities for eligible clinicians in a state to become qualifying APM participants (QPs) and earn the APM incentive; [1]
2. Implementing financial accountability for health outcomes for an entire state's population;
3. Assessing the impact of specific care interventions across multiple states, and;
4. Facilitating alignment of state and federal payment and service delivery reform efforts, and streamline interaction between the Federal government and states.

DATES: *Comment date:* To be assured consideration, comments must be received by October 28, 2016.
ADDRESSES: Comments should be submitted electronically to: SIM.RFI@cms.hhs.gov.
FOR FURTHER INFORMATION, CONTACT: SIM.RFI@cms.hhs.gov with "RFI" in the subject line.

BACKGROUND
Section 1115A of the Social Security Act, as enacted by section 3021 of the Affordable Care Act, authorizes the Center for Medicare and Medicaid Innovation (hereafter, the Innovation Center) to test innovative payment and service delivery models that have the potential to reduce program expenditures while preserving or enhancing the quality of care for Medicare, Medicaid, and Children's Health Insurance Program (CHIP) beneficiaries.

CMS is issuing this Request for Information (RFI) to obtain input on potential state-based initiatives. While we seek public input on the areas described below, no decision has been made to offer awards in these areas.

Currently, CMS partners with states on state-based payment and delivery reform through the State Innovation Model (SIM) initiative. SIM was launched in 2013 to test the ability of state governments to

[1] Please see proposed rule here: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-All-Payer-Overview.pdf.

use their policy and regulatory levers to accelerate healthcare transformation efforts in their states, with a primary goal to transform over 80% of payments to providers into innovative payment and service delivery models. CMS has set ambitious goals for health system transformation, and we recognize that much of this transformation will ultimately occur at the state and community level. Our investment in SIM is a recognition of the important role states play as a locus for change to accelerate transformation, and their unique leverage point to implement models consistent with the proposed Quality Payment Program[2] under the Medicare Access and CHIP Reauthorization Act (MACRA) legislation.

Through two rounds of SIM funding, CMS has supported collaboration between states and the federal government. SIM stakeholders have reported that CMS' funding and facilitation of multiple payers and providers were vital for the success of their process. These efforts have necessarily been multi-year processes, given the scope of system transformation tackled by states and their partners, and the need to build data infrastructure and partnerships across an entire state.

The long ramp-up time needed for state-wide health care system transformation, including building the necessary infrastructure, can also require a subsequently long period to examine the impact of the initiative. This, coupled with delays in accessing data for the Medicaid population – the primarily impacted population – has created delays in timely impact results for the SIM initiative, and it is too early to attribute any quantitative results directly to SIM. However, early findings from the federal evaluation on the Round 1 states show promising results with states achieving transformation of their payment and delivery systems. Three Round 1 test states (Minnesota, Oregon, Vermont) are reaching over 50% of the state's population with SIM supported models, and two of those states (Oregon, Vermont) are reaching 80% of their Medicaid population, with significant payer and provider engagement. In addition, analyses on the Medicare and commercial populations show that SIM states were making progress on health outcomes, such as declines in hospital readmissions and reductions in emergency room visits, through initiatives pre-dating SIM and upon on which SIM efforts are building. Future analyses will determine whether SIM accelerated these trends, particularly for the Medicaid population.[3]

CMS has continued to evolve our efforts during and across the two rounds of SIM funding to better support our state partners. We have emphasized sustainability and specific alternative payment models led by the state. We have encouraged states to participate in the Health Care Payment Learning and Action Network (LAN) as a tool to gain meaningful multi-payer participation, a key to long-term sustainability. And, recognizing the important role of Medicare in all-payer alignment at the state level, we have released guidance[4] in support of Medicare participation in state-based multi-payer models.

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[2] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program.html

[3] The evaluation reports can be found at https://downloads.cms.gov/files/cmmi/sim-round1-secondannualrpt.pdf.

[4] For more information see, https://innovation.cms.gov/Files/x/sim-guidancemultipayeralignment.pdf and https://innovation.cms.gov/Files/x/sim-guidance-statesponsored.pdf.

Medicare alignment can play a critical role in the success of multi-payer models at the state level, whether through participating in a unique arrangement with a state, or by the state designing its multi-payer models to align with existing Medicare models. The multi-payer models enabled by Medicare participation hasten momentum among states to use their levers to accelerate payment and delivery transformation on a broad scale, and thereby enable states to use their unique capacity to affect improvements in the health of the *entire* state population.

CMS is interested in gathering information regarding potential state-based payment and delivery system reform initiatives in the following areas:

1. Partnering with states to implement delivery and payment models across multiple payers in a state that could qualify as Advanced Alternative Payment Models (APMs) or Advanced Other Payer APMs under the proposed Quality Payment Program, to create additional opportunities for eligible clinicians in a state to become qualifying APM participants (QPs) and earn the APM incentive;
2. Implementing financial accountability for health outcomes for an entire state's population;
3. Assessing the impact of specific care interventions across multiple states, and;
4. Facilitating alignment of state and federal payment and service delivery reform efforts, and streamline interaction between the Federal government and states.

We seek public comment on ways to support broad payer and health care provider participation in alternative payment models that could be Advanced Alternative Payment Models under the Quality Payment Program. Movement toward Advanced Alternative Payment Models under the Quality Payment Program will be challenging for many health care providers. We believe that states can play a key role to support eligible clinicians in moving into Advanced Alternative Payment Models, and help them to leverage financial incentives available through the proposed Quality Payment Program. For example, states can support the development of service delivery and payment models that align with Advanced APM or Advanced Other Payer APM criteria under the proposed Quality Payment Program rules, increasing opportunities for eligible clinicians to become QPs and earn the APM incentive, especially when all-payer concepts are introduced for the APM incentive in a few years.

CMS seeks broad input from beneficiaries, consumers, and consumer organizations; providers, Indian health care providers; purchasers and health plans; social service agencies and providers; home and community-based services providers; Health IT and Health Information Exchange (HIE) vendors and associations; Governors; state offices including Medicaid, departments of health, public health, and social services; and other private and public stakeholders. Commenters are encouraged to provide the name of their organization and a contact person, mailing address, email address, and phone number. However, this information is not required as a condition of CMS' full consideration of the comments.

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

The Secretary has set a clear goal for moving the nation toward broad-scale adoption of alternative payment models: 50 percent of fee-for-service Medicare payments tied to alternative payment models that reward the quality of care by the end of 2018. Under the proposed Quality Payment Program, significant incentives will be in place to promote adoption of Advanced APMs under Medicare. The MACRA legislation phases in incentives for certain clinicians participating in models that also include Medicaid and private payers, with incentives available beginning in 2021 based on performance in a prior period—currently proposed to be 2019. CMS is also working with private payers through the LAN to accelerate adoption of alternative payment models, recognizing that multi-payer participation—including but not limited to Medicare—is essential to meeting the Secretary's goals.

Consistent with these efforts, CMS invites comments on concepts for a potential future state-based initiative that would support states to implement broad scale, multi-payer delivery and payment reforms that support health care providers entering into models that could qualify as Advanced Alternative Payment Models. These potential future initiatives would support states that have a clear end-vision of multi-payer alternative payment models inclusive of Medicare, and have a focus on the health outcomes of the entire population of a state through alignment of care delivery and payment.

CMS recognizes that there are multiple pathways to achieving this vision, and is interested in public input on ways to support states in developing the operational and infrastructure capacity needed to implement a multi-payer model that includes Medicare and could be an Advanced Alternative Payment Model, regardless of which pathway they pursue.

We are seeking comment on two pathways, consistent with our two prior guidance documents on multi-payer models inclusive of Medicare:

1. **A state specific new multi-payer model with Medicare, Medicaid, CHIP, and private payer participation**
   This pathway could be tailored for a state to launch a multi-payer model, inclusive of Medicare, Medicaid, and private payers, which could be an Advanced Alternative Payment Model. In order for Medicare to participate in a state-led model, a state would submit a proposal to CMS demonstrating how its proposed model meets the set of principles described in the April 10, 2015 guidance for Medicare alignment, and demonstrates that Medicare participation in a state-designed model will be a test of a new or novel model or a test adapted for the unique needs of a state that could be applied on a statewide basis. In order for Medicare to participate in a state-based all payer model, the model would need to be: 1) person-centered, 2) accountable for total cost of care, 3) transformative, 4) broad-based, 5) feasible to implement, and 6) feasible to evaluate.

2. **Support states to align with existing Medicare models**
   The second pathway could be for a state to align Medicaid and private payers around one or more existing CMS models and initiatives (e.g., Medicare Shared Savings Program, Next Generation ACO Model, Comprehensive Primary Care plus (CPC+), Medicaid health homes, Medicaid integrated care models, or episode based payment models), such that a significant number of eligible clinicians in the state or region could become QPs and earn the APM incentive. This pathway is consistent with our guidance in Novermber 2015 that provided further details on ways that states could align with existing CMS programs in order to achieve multi-payer participation inclusive of Medicare.

QUESTIONS

What is the level of interest among states for state-based initiatives with an explicit goal to transition a preponderance of eligible clinicians toward Advanced Alternative Payment Models under the Quality Payment Program, within a framework of multi-payer, sustainable delivery and payment reforms that would include Medicare as well as accountability for the health of populations?

a. What challenges do states face in achieving all payer alignment, including basic Medicaid infrastructure issues and Medicare participation and alignment, consistent with the April 2015 and November 2015 guidance? What assistance would help states overcome these challenges?
b. What factors are essential to the success of multi-payer delivery system reforms that are consistent with the April 2015 and November 2015 guidance (e.g. multi-stakeholder buy in, IT infrastructure)? How could a future state-based initiative support these factors?
c. What are the unique challenges of state Medicaid programs in readying themselves to offer Advanced APMs? What specific assistance do state Medicaid programs need in order to be ready for changes set to go into effect in 2021 to support multi-payer models in the context of the Quality Payment Program[5]?
d. What resources and tools (e.g., funding, infrastructure support, technical assistance, policy changes) do states need from CMS to design and launch robust multi-payer delivery and payment reforms with Medicare participation (e.g., to align with existing Innovation Center models); develop the accountability mechanism for total cost of care, including agreement from the state on targets for Medicare savings and limits on growth in spending by other payers; improve health outcomes on a statewide basis; improve program integrity; address challenges associated with reducing disparities and improving health outcomes in rural communities; obtain broad payer and provider participation; and operationalize reforms?
e. If CMS were to launch a new state-based model, what is a reasonable performance period for states to develop a plan and build the operational capacity to implement multi-payer delivery and payment reforms that could align with the APM incentive under the proposed Quality Payment Program (e.g., 2-3 years? More than 3 years)?

[5] https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf.

f. Since we expect that models would be unique for each state, what approaches would allow CMS to ensure that models could be meaningfully evaluated?
g. What factors should CMS take into account when considering overlap of existing or new Medicare-specific models with state-specific all-payer models?

2. CMS is interested in multi-payer delivery and payment reforms with an explicit focus on having providers and the state assume financial accountability for the health outcomes of the entire state population (or a large preponderance of the population), in which states integrate population health improvement into a core care delivery and payment incentives structure that includes requirements for health IT infrastructure and interoperability, data aggregation, and the incorporation of relevant social services, program integrity, and public health strategies.
    a. Please comment on how the core delivery and payment reforms can include accountability for the health outcomes of a population. What financial incentives can states and commercial payers use? What tools and resources would payers, providers or states need to execute such methodologies? Which population health measures, social services outcomes do you currently use (or are exploring) that could be linked to payment.
    b. How can rural and tribal providers, in particular, facilitate inclusion of relevant social services and public health strategies into the care delivery and payment incentives structure? What are appropriate measures of success for successful social and public health services?
    c. How can urban providers with overlapping catchment areas best take population-level responsibility? What are the specific challenges that need to be overcome to offer population-level services across state lines?

3. Based on experiences in other states, CMS believes that data are available through a multitude of pathways (e.g., directly from hospitals, health systems, or third party payers), but CMS is interested in the input from potential participants, including providers, states and other payers, on access to data.
    a. To what extent do states, all-payer claims databases (APCDs), payers, and other key stakeholders have access to reliable and timely data to calculate spending benchmarks and to monitor Medicare and multi-payer total cost of care trends in the state? Do states have integrated Medicare-Medicaid data?
    b. To what extent do states, APCDs, payers, and other key stakeholders have access to reliable and timely data to calculate quality and population health measures on a Medicare-specific and multi-payer basis, and at the provider level and state level, and to tie payment to health outcome measures (e.g., data sources that include social services, housing, and health care data; appropriate measures)?
    c. To what extent do states have the ability to share Medicaid data with CMS, including any backlogged Medicaid Statistical Information System (MSIS) submissions? Will states be able to transition to the Transformed MSIS (T-MSIS) in time to support this work?

d. To what extent do states have the capacity, expertise, and staff resources to perform benchmark spending calculations, data aggregation and analysis, and outcomes measurement analysis to implement tying payment to health outcomes measures?
e. what support can CMS provide to improve states' access to reliable and timely data?
f. How can CMS support improve access to and linkage with health outcomes measures data?
g. To what extent do states have access to data to perform compliance and program integrity checks to ensure valid outcomes?
h. What IT infrastructure is available to states to use data to support transformation efforts? (e.g., infrastructure to support the data extraction, transport, transformation, aggregation, analysis, and dissemination of consumer and provider administrative, claims and clinical data)? What infrastructure is necessary to ensure data quality?

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

One key feature of the State Innovation Models Initiative is the flexibility afforded to states to design contextually-specific delivery and payment reforms. This flexibility is necessary given each state's unique market, population, and regulatory environment, and has resulted in a unique set of experiments in each state. For example, nearly every SIM state has implemented a care intervention to improve behavioral health services, but there is great variation across states in their approach: in terms of the types of payment mechanisms used, target populations and provider types, and the overarching models of behavioral health integration (e.g., coordinated care, co-located care, integrated care). While that was by design in SIM Round 1 and 2—these tests were looking at states' ability to use policy and regulatory levers to accelerate healthcare transformation efforts, not at the care interventions implemented as part of that transformation—CMS is also interested in seeking public input on evaluating specific care interventions.

CMS is interested in assessing the impact of specific care interventions across states. States would have the option of seeking these supplemental awards, and in return would agree to implement a standardized care intervention in areas CMS and states agree are high priority for rigorous assessment (e.g., care interventions for pediatric populations, physical and behavioral health integration, substance abuse/opioid use treatment, coordinating care for high-risk, high-need beneficiaries) and participate in a robust evaluation design led by CMS. Unlike SIM Round 1 and 2, states would forego the flexibility of varying the intervention, so as to standardize the intervention and improve the ability to make conclusions about the impact of specific interventions in multiple states.

QUESTIONS

1. CMS seeks input on using the state as a platform to evaluate the impact of care interventions. Specifically we ask for feedback on how states might use their role as regulator, payer, purchaser, and convener to implement a standardized care intervention (e.g., leverage Medicaid authority to test interventions across its entire Medicaid program).
2. Would states be willing to standardize care interventions to align with other states participating

in a federal, Innovation Center-led evaluation? Are states willing to participate if the interventions are designed with robust tools, such as randomization where appropriate? If yes, how much lead time would states need, given some of the care interventions could be specified in contracts that might need to be changed? In addition, will partnerships with academic institutions or other research experts be necessary?

3. Please comment on specific care interventions for which you believe additional evidence is required, and that would benefit from the state-led approach proposed in this section.
4. CMS seeks input on how states might leverage their role to reduce disparities across vulnerable populations who experience increased barriers to accessing high quality health care and worse outcomes and what specific care interventions and data collection efforts are needed to address health disparities for these populations.

SECTION III: STREAMLINED FEDERAL/STATE INTERACTION

States are critical partners in achieving the Secretary's goals for broad-scale adoption of alternative payment models. Accordingly, the Department of Health and Human Services (HHS) has invested in a number of initiatives across a broad range of agencies to provide funding, technical assistance, guidance, and regulations to enable, support, and accelerate state reforms—including the Innovation Center, the Office of the National Coordinator, Marketplaces, Medicare, Center for Medicaid and CHIP Services, Medicaid State Operations and Technical Assistance, the Medicaid Innovation Accelerator Program, and the Health Care Payment Learning and Action Network. While these efforts have contributed to successes—CMS estimates that it achieved its goal of tying 30 percent of Medicare payments to alternative payment models ahead of schedule—it can be difficult for states to participate in these efforts.

CMS seeks input on how to improve both coordination among related federal efforts in support of state-based delivery and payment reform efforts (e.g., workgroups within the agency or department to coordinate policy), and the way it interacts with and supports states in those reform efforts (e.g., coordinated points of contact for states).

QUESTIONS

1. CMS seeks comment from those engaged in state-led transformation efforts – either in partnership with the Innovation Center or through a state-supported effort – on whether the state has engaged with the various federal efforts and if not, why not? If so, how has the engagement contributed to their delivery system reform activities? Are there any suggestions for improved state participation in federal efforts? To what extent have states commented in CMS/HHS rulemaking or requests for information?
2. How can CMS/HHS better align in order to support state delivery system reform efforts?

SPECIAL NOTE TO RESPONDENTS: Whenever possible, respondents are asked to draw their responses from objective, empirical, and actionable evidence and to cite this evidence within their responses.

THIS IS A REQUEST FOR INFORMATION (RFI) ONLY. This RFI is issued solely for information and planning purposes; it does not constitute a Request for Proposal, applications, proposal abstracts, or quotations. This RFI does not commit the Government to contract for any supplies or services or make a grant or cooperative agreement award. Further, CMS is not seeking proposals through this RFI and will not accept unsolicited proposals. Responders are advised that the U.S. Government will not pay for any information or administrative costs incurred in response to this RFI; all costs associated with responding to this RFI will be solely at the interested party's expense. Not responding to this RFI does not preclude participation in any future procurement, if conducted. It is the responsibility of the potential responders to monitor this RFI announcement for additional information pertaining to this request.

Please note that CMS will not respond to questions about the policy issues raised in this RFI. CMS may or may not choose to contact individual responders. Such communications would only serve to further clarify written responses. Contractor support personnel may be used to review RFI responses.

Responses to this notice are not offers and cannot be accepted by the Government to form a binding contract. Information obtained as a result of this RFI may be used by the Government for program planning on a non-attribution basis. Respondents should not include any information that might be considered proprietary or confidential. This RFI should not be construed as a commitment or authorization to incur cost for which payment would be required or sought. All submissions become Government property and will not be returned. CMS may publically post the comments received, or a summary thereof.