

Areas for Medicare Alignment in Multi-Payer Models under the State Innovation Models Initiative

Background

The goal of the State Innovation Models (SIM) initiative is to test the ability of state governments to accelerate health transformation resulting in better care, smarter spend and healthier people. On April 10, 2015, we issued guidance to SIM States on the submission of state proposals for Medicare alignment in their state multi-payer models, applicable for SIM Round 1 and Round 2 Test States. In that guidance, we indicated that in certain instances we will consider states' proposals for Medicare's alignment with proposed multi-payer payment and service delivery models and that we would assess the proposals with consideration of the following principles: 1) patient-centered, 2) accountable for total cost of care, 3) transformative, 4) broad-based, 5) feasible to implement and 6) feasible to evaluate.

We have received requests from SIM awardees to provide further guidance about this specific area of focus. This document is intended to provide additional considerations for States interested in Medicare alignment in their SIM. SIM Round 1 and Round 2 Test states may submit a proposal for Medicare participation to their SIM Project Officer at any time.

A SIM State may seek Medicare alignment through several pathways. First, a SIM State may submit a proposal for Medicare alignment in their proposed multi-payer SIM model. For a SIM Round 1 or Round 2 Test State interested in this path, we expect that a proposal meets the set of principles described in the April 10, 2015 guidance, and demonstrates that Medicare participation in a state-designed model will be a test of a new or novel model or a test of a Medicare program adapted for the unique needs of a state that could be applied on a statewide basis. Alternatively, a SIM State may seek Medicare alignment through existing CMS models or programs. This guidance provides some pathways for Medicare alignment that awardees should consider as part of their SIM model for the following model types:

1. Medicare Alignment for SIM Models through Customized Statewide Models
2. SIM Model Alignment with Medicare through existing CMS models or program:
 - A. SIM Model Alignment with a CMS Accountable Care Organization (ACO) Program or Model
 - B. SIM Model Alignment with a CMS Patient Centered Medical Home (PCMH) Model

Medicare Alignment for SIM Models through Customized Statewide Models

In the April 10, 2015 guidance, we presented a set of principles that we would consider in review of a proposal for Medicare participation in a SIM model requiring specific new waiver authority to align Medicare with a state model. As stated in that guidance, a proposal for Medicare alignment in a SIM model should be a test of a new or novel model or a test of a Medicare program adapted for the unique needs of a state. We also believe the statewide nature of a SIM model could present a novel model to test. For States interested in pursuing Medicare alignment through a customized statewide model, below we present further guidance on how States can consider these principles for Medicare participation as part of their operational planning of their models or as part of the development and implementation of their models.

1. **Patient centered**: A State's proposal would be assessed for their commitment to improvement across a robust set of quality and patient experience measures in order to ensure that any cost savings are generated by improvements in both patients' health care experience and population health, as well as specific targets for improvement. With this in mind, States should consider the quality performance guidelines in their SIM model, and how their model fosters quality improvement. States may consider building the appropriate quality measure set, implementing quality reporting and determining how quality performance may be tied to payment in their SIM model. States should consider the necessary infrastructure to collect quality measures on a multi-payer basis and to share information on patient outcomes and utilization with providers. Additionally, States should consider how the model accounts for patient engagement and how patients are involved for model improvement. For a proposal for Medicare participation, States should be able to set specific statewide targets for improvement, and should consider their strategy for stakeholder engagement and alignment on a uniform quality measure set.
2. **Accountable for the total cost of care**: Medicare participation will be measured against states' commitment to reducing the total cost of care for CMS beneficiaries under their model. As part of their model development, States should consider the methodology to measure total cost of care on a multi-payer basis that is appropriate for its model. Additionally, States should consider the infrastructure and staffing required to collect healthcare expenditure data and calculate total cost of care over time on a multi-payer basis. Lastly, States should consider obtaining the necessary data use agreements (DUAs) to analyze Medicare claims data. For a proposal for Medicare participation, States should be able to set specific, actuarially sound, statewide targets to reduce total cost of care for Medicare beneficiaries.

3. **Transformative**: A State’s proposal would be assessed for the extent to which the payments to providers in a model support and reward better care, smarter spending and healthier people. We will evaluate the extent to which models emphasize statewide delivery system transformation. States should consider its strategy and milestones to shift from delivery system transformation on a multi-payer basis, as well as whether they are providing sufficient resources for providers to implement delivery system transformation. States should consider their ability to measure the proportion of payers that are participating in the model, proportion of providers that are participating in the model and proportion of residents that are covered by the model.
4. **Broad-Based**: Broad payer and provider participation is critical for health care transformation in a State. A State’s proposal would be assessed on the extent to which providers and payers are participating or would participate in the SIM model. In addition, the State’s Governor should provide support for Medicare participation. States can consider their strategy for multi-payer stakeholder engagement and multi-payer commitment for investment in the SIM model.
5. **Feasible to Implement**: Because Medicare alignment in a state designed model could require significant operational investment, we would assess the administrative feasibility of a state’s proposal. States should consider their commitment to operational investment of SIM model such as appropriate budget, work plan, staffing, IT infrastructure, data analytics support, stakeholder engagement efforts and strategy for program sustainability. States can consider their regulatory authority to implement a multi-payer model with Medicare participation, particularly if States are interested in seeking rate-setting authority. Additionally, States should consider whether changes to their Medicaid program are required.
6. **Feasible to Evaluate**: The terms of any proposal should include a discrete performance period and clarity about the baseline against which we will measure the State’s performance. States should consider the performance period for the model and the data to support the calculation of a baseline. States should consider how data sharing between CMS and the State would occur for purposes of an evaluation.

SIM Model Alignment with a CMS ACO Program or Model

The purpose of an ACO is to promote accountability of providers to a patient population and coordinate the delivery of care and services. CMS currently offers several ACO models and programs under existing authorities, and one pathway for states to expand ACOs is encouraging providers in the state to join existing CMS ACO programs or models. These programs and models include Medicare Shared Savings Program and Next Generation ACO. If States are pursuing an ACO based health care transformation strategy, States should consider encouraging

their providers to join the Medicare Shared Savings Program for Medicare alignment. Providers must be part of an ACO to apply to participate in the Medicare Shared Savings Program. CMS offers a website and toolkit to assist ACOs interested in participating in the Medicare Shared Savings Program. A link to both the website and toolkit can be found below, and the Medicare Shared Savings Program accepts ACOs on an annual basis.

Medicare Shared Savings Program: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharesavingsprogram/index.html?redirect=/sharesavingsprogram>

Additionally, the Next Generation ACO Model will have another opportunity for ACO participants to apply. We encourage States to consider opportunities to coordinate and encourage their providers to apply for Next Generation ACO. As stated on the Next Generation ACO model website, CMS will accept ACOs into the Next Generation ACO Model through two rounds of applications in 2015 and 2016, with participation expected to last up to five years. While the round one application deadline has passed, applicants can submit round two Letter of Intent electronically no later than 11:59p.m. EDT on May 1, 2016, and the application no later than 11:59p.m. EDT on June 1, 2016.

For more information on the Next Generation ACO Model, we encourage States to visit the following website:

Next Generation ACO Model: <http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model/>

For SIM States currently designing ACO programs, we have identified seven program areas that States could consider when seeking Medicare alignment. Additionally, SIM States should consider addressing these areas in their proposal for Medicare participation. The seven program areas are:

1. **Care Coordination:** ACOs must be able to effectively coordinate patient care across a range of primary care providers, specialists and suppliers in order to address patient needs while delivering high quality care. States should work to identify existing resources available to providers to support care coordination and, where gaps exist, structure ACO models with the necessary incentives to support investment in the staffing and infrastructure necessary to conduct ongoing care coordination work.
2. **Provider/Supplier Organizational Structure:** An effective ACO should consider including a diverse set of providers and suppliers with the capacity to coordinate care for an assigned patient panel. A diverse provider/supplier group improves the ACO's ability to provide a wide range of services while still coordinating care and controlling costs. States seeking Medicare participation in an ACO model should consider ensuring that there is a process in place to evaluate an ACO's network of providers and suppliers,

scope of available resources and track record of or credible plan for coordinating patient care.

3. **ACO Governance and Leadership:** ACOs should have a clearly defined governance and leadership structure that supports the goals of improved health, improved care and lower cost and emphasize patient centered care. The governance and leadership teams should include representation for patients under the ACOs care and have the necessary experience to support the organization in the areas of clinical care, operations, financial management, quality improvement and HIT/HIE. The leadership and governance structure should reflect the diverse set of providers and suppliers that comprise the ACO. States should consider including requirements that support the establishment of diverse, well qualified governing boards with patient representation when developing their ACO models.
4. **Quality Strategy:** States should consider alignment among the payers participating in the ACO model in the following areas: quality metrics, quality reporting, and using quality to determine payment incentives. For alignment, a robust measure set includes measures for clinical processes, patient safety, population health, efficiency, care coordination and patient/family engagement. States can consider how the measures align with CMS quality programs and measures for both the Medicare and Medicaid populations. For more information on the specific measures used in Medicare's ACO programs, visit: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Quality-Measures-Standards.html>
5. **Patient Attribution Methodology:** An ACO model must have a clear methodology for determining patient attribution to support care coordination, quality improvement and payment systems. Patient attribution to an ACO may be retrospective, prospective or voluntary and may be confirmed using claims data or through direct communications with patients and providers. Additionally, potential ACOs should have an attributed patient population of sufficient size to minimize upside and downside financial risk due to chance events within the patient panel. For more information on the Medicare Shared Savings Program attribution methodology, please visit the following link: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Financial-and-Assignment-Specifications.html>
6. **Payment and Risk Sharing Methodology:** ACO models may utilize a variety of payment and risk sharing approaches. Common elements of ACO payment methodologies are:
 - Established spending benchmark: The benchmark serves as the basis by which any shared savings or losses are calculated. The benchmark may be set

prospectively or retrospectively and then trended forward to determine the future benchmark spending level. Benchmarks should include methods for adjustment to reflect variation in an ACO's patient risk level and quality of care delivered. States should be able to clearly define the logic behind the benchmark methodology selected for their ACO model and any risk adjustments, quality adjustments or discounts used to adjust the benchmark over time.

- **Risk sharing:** Risk sharing under an ACO model may be one sided (ACOs eligible for shared savings only) or two sided (ACOs eligible for shared savings and liable for losses). ACO models have the most potential to promote accountable, coordinated and cost effective care when providers participate in two sided risk sharing arrangements. States should consider using one sided risk sharing arrangements as vehicles to promote participation from newly formed ACOs while they learn to manage the risk of their patient population with a defined timeline for transitioning to two sided risk arrangements.

7. **Data Sharing and Performance Measurement:** The availability of data is essential for an ACO to conduct care coordination and quality improvement work. States should consider evaluating the HIT/HIE capability of providers and suppliers applying to be an ACO to ensure that the necessary data use agreements (DUAs) and data collection, sharing and analytic capabilities are in place to support care coordination and quality improvement work. States should also consider its own HIT/HIE capabilities to enable all providers to exchange health information regardless of where the patient gets care.

SIM Model Alignment with a CMS PCMH Model

CMS Innovation Center currently has two primary care models: Multi-Payer Advanced Primary Care Practice established prior to the CMS Innovation Center, and Comprehensive Primary Care Initiative (CPCI). At this time, CPCI is not open for new practices to apply to participate. In addition, CPCI currently has not been certified for expansion by the Secretary under CMS Innovation Center expansion authority, and if the Secretary decides to expand a model, the CMS Innovation Center would announce the expansion through a notice of proposed rulemaking. However, we remain committed to and encourage investment in primary care practice transformation. Based on our experience with primary care based models, we believe the following requirements are important for Medicare alignment in a PCMH model:

1. **Primary Care functions:** We have identified five overlapping primary care functions for practices in a PCMH model that States should consider to include as practice requirements or milestones in order to align with the requirements in CMS' PCMH models.
 - **Risk stratified care management:** An effective component to comprehensive primary care is the provision of targeted care management for high-risk, high-

need patients. States should consider incorporating practice requirements for care management including identification of high risk patients; building capabilities in behavioral health, self-management support, and medication management as well as assessment and management of patients with cognitive impairment, frailty, and multiple chronic conditions.

- **Access and continuity**: Patient and family access to a primary care team is important. States should consider practice requirements or milestones to ensure that practices provide 24/7 access to care guided by the medical record to patients and families. In addition, facilitating ongoing relationships between patients and their care teams who know them well is a major priority.
 - **Planned Care for Population Health**: Primary care based models should have practices organized in a team-based model that focuses on improving population health. Practices need to have a continually updated list of patients assigned to provider teams, and should be able to understand and address their population at both a practice and team level and with attention to health disparities to improve population health. States should consider how to support practices to develop a personalized plan of care for high-risk patients and use team-based approaches like the integration of behavioral health services into practices to meet patient needs efficiently.
 - **Patient and Family Caregiver Engagement**: Optimal care delivery occurs when patients and families are engaged in the design and improvement of that care delivery. States should consider how practices will increase patient and family engagement in the design of care delivery and how to engage patients fully in their own care through strategies such as goal setting and shared decision-making.
 - **Comprehensiveness and Coordination**: Primary care practices must be able to meet the majority of their patients' basic and chronic health needs in a timely manner, either within the practice or through coordinated referrals. Practices also provide a crucial role in helping patients and families navigate and coordinate care and services. States should provide support to practices to be able to track and coordinate care, and to identify opportunities to improve transitions of care, focusing on hospital and ED discharges and high volume referrals to specialty services.
2. **Multi-payer and provider participation**: Broad multi-payer and provider participation is critical to accelerate healthcare transformation. A basic tenet of SIM is the belief that State governments can play a key role in coordinating efforts among payers and providers in their State. States should consider obtaining stakeholder commitment to primary care transformation, quality alignment, and data sharing. We expect States should, whenever possible, continue to engage in efforts to gain multi-payer support, including alignment of all the payers participating in the model. States can facilitate consensus among the payers

participating in the model to align on the payment arrangement between the payers and the practices, including alignment on the provision of a monthly care management payment to practices for attributed patients and to align on attribution among all the payers. Other areas for alignment among payers include sharing data with practices and maintaining consistent performance and/or quality metrics.

3. **Data sharing between payers and practices**: Robust data sharing is an important tool to enable primary care practices to coordinate care and take actionable steps to reduce unnecessary utilization and total cost of care for their patients. In order to align with CMS' PCMH models, States should consider requirements for data sharing in their model, including requiring practices to have Electronic Health Record (EHR) certification and to have remote access to the EHR to ensure 24/7 access to care informed by the medical record. Additionally, States can consider how to equip practices to receive and analyze data, and how payers should share data that can be used to inform clinical decision making.
4. **Shared learning**: States should consider how to accelerate change and achieve model aims through shared learning among primary care practices and payers participating in the model. The aims of shared learning would be to orient practices to understand the goals of the model, train practices to understand and utilize data for decision-making, to foster peer-to-peer learning among practices and provide support and guidance to build practice capabilities required by the model.
5. **Quality Strategy**: States should consider alignment among the payers participating in the model in the following areas: quality metrics, quality reporting, and using quality to determine payment incentives. For alignment, a measure set focused on primary care includes measures for clinical processes, patient safety, population health, efficiency, care coordination and patient/family engagement. States can consider how the measures align with CMS quality programs and measures for the Medicare and Medicaid populations. For more information on the quality measures used in CPCI, we recommend the following: <https://innovation.cms.gov/Files/x/PY-2015-CPC-EHR-CQM-Manual-v4.pdf>
6. **Payment Methodology**: PCMH models may utilize a variety of payment and risk sharing approaches. Common elements of payment methodologies are:
 - Care management payments: Care management payments for practices can be utilized to address the costs of reorganization of existing practice structures and processes, investments or upgrades in HIT requirements and as well as to implement and maintain the core primary care functions described earlier.
 - Accountability for Total Cost of Care: States can consider how practices are held accountable for attributed patients' total cost of care through a variety of

strategies such as performance incentive payments, shared savings or payment for quality improvement.

We encourage States to consider these requirements for Medicare alignment with existing CMS Innovation Center primary care models to the extent practical. Additionally, for States interested in seeking Medicare alignment through a customized statewide model, we encourage States to consider these requirements in a proposal for Medicare participation within their model.

For more information on CMS Innovation Center's primary care models, we recommend that States review the following links:

Multi-Payer Advanced Primary Care Practice: <http://innovation.cms.gov/initiatives/Multi-Payer-Advanced-Primary-Care-Practice/>

Comprehensive Primary Care Initiative:
<http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/>