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Advising Congress on
Medicaid and CHIP Policy

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November 20, 2017

The Honorable Seema Verma
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue SW
Washington, DC 20201

Re: Center for Medicare & Medicaid Innovation Request for Information

Dear Administrator Verma:

The Medicaid and CHIP Payment and Access Commission (MACPAC) appreciates the opportunity to respond to the request for information from the Centers for Medicare & Medicaid Services (CMS) concerning the Center for Medicare & Medicaid Innovation (the Innovation Center).

MACPAC is a non-partisan legislative branch agency that provides policy and data analysis and makes recommendations to Congress, the Secretary of Health and Human Services, and the states on a wide range of topics related to Medicaid and CHIP. We have carefully followed the work of the Innovation Center and numerous Innovation Center-funded activities including the State Innovation Models (SIM), the Financial Alignment Initiative, and the Medicaid Innovation Accelerator Program.

We strongly support the Innovation Center's continued efforts to support innovation and evaluation in partnership with states, providers, and other stakeholders. We have attached a summary of findings from specific MACPAC research projects related to the focus areas described in the request for information. Below we offer general observations and suggestions to consider when approaching new model designs to improve access, quality, and efficiency in Medicaid:

1. The federal government has a strong interest in seeing that Medicaid program and payment designs deliver efficient, economic, and quality care to beneficiaries, and supporting states in achieving these goals. MACPAC encourages the Innovation Center to continue to invest in payment and delivery system reform models that focus on Medicaid or

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include Medicaid as a significant partner. In so doing, we recommend that the Innovation Center take into account the considerable level of federal spending on Medicaid, the unique and major cost drivers in the program, and the special characteristics of Medicaid beneficiaries and providers.

2. SIM grants explicitly sought to test whether new models to improve care and lower costs in Medicaid and CHIP would produce better results when implemented in the context of a plan that involves multiple payers, broader state innovation, and larger health system transformation. SIM generated tremendous state activity to develop and test a variety of models built on states' unique needs and strengths. MACPAC and others have found that aligning key components of payment reform models (e.g., performance measures, quality improvement goals, and even payment methodologies) across public and private payers may help providers respond to changes constructively. MACPAC encourages the Innovation Center to continue investing in state efforts to build partnerships with private insurers and providers to help accelerate delivery system reform.

3. The Innovation Center should reach out to Medicaid agencies and stakeholders as it develops new models and grant opportunities, even when these efforts primarily focus on Medicare. This would help CMS identify Medicaid and state-led efforts that may need to be aligned or considered in model development and testing. Medicaid and Medicare provider networks can overlap substantially; payment and delivery system reforms that apply to Medicare may have spillover effects for Medicaid.

4. The Medicaid Innovation Accelerator Program provides important support to leverage states' administrative capacity by providing opportunities for states to learn from each other, and by providing direct technical assistance. At a recent MACPAC public meeting, Commissioners expressed strong support for the work being done under the Innovation Accelerator Program. The Innovation Center might consider using Innovation Accelerator Program projects as a source of ideas for future state and local innovations to support.

5. The Federal Coordinated Health Care Office works with the Innovation Center to administer the Financial Alignment Initiative and other initiatives to improve access and quality for individuals dually eligible for Medicaid and Medicare benefits. Although they are at different stages of implementation, MACPAC supports continued funding for these initiatives to ensure that the lessons learned by states and the federal government and evaluations of various approaches can be completed.

We appreciate the opportunity to respond to this request for information, and we hope that the attached information on MACPAC's analyses will be useful to inform the Innovation Center's future approach.

Sincerely,

Penny Thompson, MPA
Chair

Attachment: Comments on Specific Focus Areas Identified in the Request for Information

Cc: Hon. Orrin Hatch, Chair, Senate Finance Committee
Hon. Ron Wyden, Ranking Member, Senate Finance Committee
Hon. Greg Walden, Chair, House Energy and Commerce Committee
Hon. Frank Pallone, Ranking Member, House Energy and Commerce Committee
Hon. Michael Burgess, Chair, Health Subcommittee, House Energy and Commerce Committee
Hon. Gene Green, Ranking Member, Health Subcommittee, House Energy and Commerce Committee

Comments on Specific Focus Areas Identified in the Request for Information

The Medicaid and CHIP Payment and Access Commission (MACPAC) has engaged in sustained work regarding Medicaid payment policy and its relationship to broader policy issues, and on Medicaid's role in delivery system transformation. MACPAC has reviewed value-based payment models used by several state Medicaid programs and identified a number of mechanisms used by states to influence providers to shift away from the delivery of episodic care by multiple providers with misaligned incentives through direct financial incentives. The commonality across these models is that they build on the existing Medicaid delivery system in the state and address the priorities and capacity of the state Medicaid agency and local provider community. MACPAC has identified a number of findings that the Innovation Center could consider as it develops new models.

Alternative Payment Models

MACPAC has examined a variety of value-based payment models in Medicaid, including the features of these models that may help or hinder provider participation. We have conducted site visits to a number of organizations that assume clinical and financial responsibility for an attributed Medicaid patient population but do not operate as a health plan. Specific barriers to greater provider participation include the following:

- *Lack of capitalization.* Lack of capital appears to be a major problem. Staffing and health information infrastructure are two needed investments.
- *Access to management information.* Providers need timely, accurate and usable data to be successful. Most groups we interviewed did not have easy access to both claims and clinical data for analysis, and most had few analytic resources. They often conveyed difficulty in getting timely claims from states or Medicaid managed care organizations (MCOs).
- *Challenges inherent in serving low-income populations.* Medicaid enrollees are poor and often have disabling conditions. They also have high need for behavioral health services and social supports. This makes managing care and improving health status for this population challenging, particularly given that evidence regarding best practices is lacking (or just emerging).

If a state or the federal government decides to offer support, Medicaid providers could potentially benefit from:

- start-up capital investment;
- clearer state plan payment requirements and greater state plan payment flexibility;
- aligning state or MCO contracting parameters, including aligning Medicaid measure sets and incentives, with those used by Medicare and commercial payers;

- support for small safety-net providers' efforts to come together when size requirements dictate that they do so; and
- a health information infrastructure in place that provides timely, accurate and complete claims and clinical data to participating providers.

Many states have offered direct assistance to Medicaid providers and have stressed the importance of these interventions, particularly for small, rural, or independent primary care practices that lack infrastructure, information technology, and staff needed to improve patient care. These practice supports can include:

- practice facilitators such as on-site registered nurses who help practices assess capacity, develop implementation plans, establish new processes, and implement quality improvement plans;
- one-on-one practice transformation coaching to certified practices through the state university, by local coaches embedded in communities throughout the state, or from major health systems' training departments; and
- learning collaboratives and peer-to-peer learning opportunities, including multi-payer collaboratives.

States noted that securing the participation of provider groups in new accountability standards and payment methods often requires providing these same organizations with flexibility to implement changes and innovate on their own terms. For example:

- When working to gain stakeholder support for initiatives, several states described the importance of determining which program requirements and payment methods needed to be standardized and where flexibility could be accommodated without losing accountability for effectiveness.
- Because many Medicaid practice sites lack sufficient patients and providers to meet minimum eligibility thresholds for shared savings, some states have allowed multiple practices to pool patients virtually to achieve minimum enrollment thresholds and comply with combined quality metrics.
- States have provided ways for providers to meet certification requirements on a longer timeline; for example, providing a technical assistance glide path to National Committee for Quality Assurance certification for patient-centered medical homes (PCMH), which includes enhanced fee-for-service payments and performance incentive payments for providers based on their level of practice transformation. States have also created different tiers of enhanced payments to reward providers according to their level of PCMH certification or maturity.
- Several states emphasized that allowing providers different ways to win on quality measures—that is, rewarding providers for actual performance vis-a-vis quality benchmarks as well as improvements in performance—was important to engage a wide spectrum of providers in the practice transformation process.

MACPAC has found that there are advantages and disadvantages to alignment across payers. Aligning key components of payment reform models—such as performance measures, quality improvement goals, and even payment methodologies—across public and private payers can help providers respond to changes

constructively. Providers favor some level of standardization to limit the burden associated with complying with multiple programs and reporting requirements.
On the other hand, attempting to align and standardize program elements across payers also raises new issues for states, private payers, and providers. Increased standardization and regulation may stifle innovation and the ability to be flexible to changing conditions. An increased focus on the commercial or Medicare market can make Medicaid's involvement more challenging because the patient populations are quite different—Medicaid enrollees tend to seek care differently than those with commercial or Medicare insurance and often have different and more complex health needs. Enrollment churn is also more of an issue for Medicaid, and this can make it difficult to capture savings.

For more information, please see:

A Study of Safety-Net Providers Functioning as Accountable Care Organizations, July 2015

State Reforms to Change Care Delivery at the Provider Level, August 2015

Paying for Value in Medicaid: A Synthesis of Advanced Payment Models in Four States, February 2014

Prescription Drug Models

As prescription drug spending increases, state Medicaid programs have shown interest in new approaches to help control prescription drug costs, including value-based payments. Generally, these approaches tie payment to some form of measureable outcome, rather than volume. CMS has encouraged states and drug manufacturers to explore such arrangements, specifically arrangements that link supplemental rebates to value-based payments. At its March 2017 public meeting, the Commission heard from the SMART-D program, an initiative that helps states explore value-based payments in their Medicaid programs. Researchers with SMART-D identified a number of potential statutory and operational barriers that may hinder state efforts to implement value-based payment as part of their prescription drug benefit. The Innovation Center should be mindful of the following as it explores value-based payments for Medicaid prescription drugs:

- *Legal barriers*. Several provisions in the Medicaid law may create sufficient legal uncertainty to deter states from exploring value-based payment models for prescription drugs, including the mandatory coverage requirements, the best price provision, and rules relating to Medicaid managed care formularies. States would likely benefit from additional CMS guidance on how these provisions interact with value-based payments.
- *Stakeholder support*. Value-based payment models may require the participation of a variety of stakeholders, including providers, beneficiaries, and MCOs. Lack of interest or understanding among one or more of these groups may limit the effectiveness of models.
- *Data*. Lack of data on clinical outcomes or relative effectiveness of treatments can limit the value-based payment models states may be willing to implement.

Models also should consider the effects on beneficiary access to drugs and associated health outcomes in models that rely on restrictive formularies or heightened utilization management.

For more information, please see:

Policy Options for Controlling Medicaid Spending on Prescription Drugs, September 2017

High-Cost Hepatitis C Drugs in Medicaid, March 2017

Medicaid Payment for Outpatient Prescription Drugs, March 2017

Medicaid Spending for Prescription Drugs, January 2016

State and Local Innovation That Includes Medicaid-Focused Models

MACPAC has reviewed innovative value-based payment models in a number of states and identified a number of common themes.

At the time of our site visits and interviews, between 2014 and 2016, states commented that the current federal authorities appeared to be sufficiently flexible. State officials who were directly involved in seeking and obtaining federal authorization to move forward with their respective Medicaid payment reforms all viewed CMS as a helpful partner during the process. Several state officials said that their many conversations with CMS were substantive and collaborative, that state needs for flexibility were reasonably accommodated, and that the process of obtaining federal approval for reform was relatively smooth and timely.

An important consideration for the federal government is determining its role in encouraging and overseeing effective payment reform within state Medicaid programs, while keeping in mind the balance between state accountability in standards and outcomes on one hand and, on the other, flexibility in how states implement reform within their own unique contexts. Our key takeaway across these states was that waivers and state plan amendments appeared to be adequate tools for the federal government to use in approving state payment reforms, particularly when state needs for flexibility and turnaround were balanced with CMS needs for state transparency and reporting.

This flexibility was important, as MACPAC found that each state pursued a reform model suited to its market characteristics and environment. While at a high level all of the states we visited were pursuing common goals and responding to similar budget realities, our discussions highlighted just how important each state's unique health care business environment, Medicaid program history, and culture were in shaping how state leaders approached reform and the degree of reform pursued. States also emphasized that early conceptual models and plans for payment reform often were altered significantly as more state stakeholders became engaged in reform discussions and decision making in meaningful ways.

Delivery system reform implementation is resource intensive for states, providers, and the federal government. States require increased staff or consulting capacity and expertise in clinical quality and performance improvement. Providers need staff and contractor time to implement projects, comply with additional reporting requirements, and address data and technology limitations. Improved data are key to reform success, but require significant investment. Significant data analytics and cost and quality reporting must be established and provided to integrated provider delivery systems, group practices, and individual physicians to support provider-level change. States have reported that these data enhancements required a significant financial investment and a great deal of staff time, but were also key to reforms' success and have in some cases been a motivation for provider organizations to participate.

Related to this, states and providers have concerns about sustainability. The infusion of capital from specific delivery system transformation projects has allowed providers to enhance services for Medicaid enrollees by allowing providers to develop infrastructure, increase their capacity, or provide new services. Providers are optimistic that these enhancements will improve the quality of care for their patients, but have expressed concern that the time frame to implement projects is not sufficient to realize performance goals. Some providers have noted that without continued funding, projects would be discontinued and would not realize their goals for the transformation of care delivery and improved health outcomes. There are still questions about whether capital is needed as a one-time investment or on an ongoing basis, and the length of time necessary to realize transformation goals.

Finally, in designing Medicaid-focused models, it is important to remember that Medicaid programs face several challenges in addition to those faced by other insurers. First, the population covered by Medicaid is significantly different from the privately insured population or the non-dually eligible Medicare population in terms of health and socioeconomic status. Having more enrollees with complex health conditions, higher medical costs, and economic and social challenges is likely to make cost containment efforts more challenging because these efforts will require more coordination between multiple health care providers and between health care providers and providers of other types of services. Second, Medicaid programs have a more limited ability to directly influence the efficient use of services on the part of the enrollee due to strict limits on cost sharing for enrollees and other factors. Finally, lower Medicaid payment rates and lower patient volume than Medicare for many provider types make it more difficult for Medicaid to attract and engage health care providers in innovative reform efforts than it is for commercial payers or Medicare. For these reasons, states grapple with how to target Medicaid cost drivers within payment reform models. Additional work to integrate the highest cost populations in Medicaid, particularly individuals with behavioral health and long-term services and supports needs and the non-medical provider groups that serve these populations, will take time and innovation on the part of states.

For more information, please see:

Financial Alignment Initiative for Beneficiaries Dually Eligible for Medicaid and Medicare, July 2016

Using Medicaid Supplemental Payments to Drive Delivery System Reform, June 2015

Paying for Value in Medicaid: A Synthesis of Advanced Payment Models in Four States, February 2014

Behavioral Health

Given the large numbers of Medicaid beneficiaries with a behavioral health diagnosis and the substantial costs associated with their care, state Medicaid programs are looking for ways to improve care and reduce expenses. Substance use disorder treatment often is not well coordinated or integrated with other mental health or physical treatment. Despite the prevalence of dual diagnoses, in 2015, the Substance Abuse and Mental Health Services Administration reported that only about half of specialty substance use disorder treatment facilities offered comprehensive mental health assessments or diagnoses.

Clinicians and program administrators are looking for better ways to treat behavioral health conditions and prevent these conditions from getting worse or contributing to a decline in physical health, but there is no one-size-fits-all model for behavioral health integration. Efforts to integrate care can encompass clinical, financial, and administrative domains. State Medicaid programs are adopting different approaches to integrate behavioral health and physical health care, including comprehensive managed care, health homes, and accountable care organizations (ACOs). State Medicaid programs are responding to the opioid crisis, in particular, by covering treatment, innovating in the delivery of care, and working to reduce misuse of prescription opioids. States are using a variety of legal authorities to expand both the availability of substance use disorder treatment and the number of individuals eligible for such care. They are also working to organize and integrate physical health and substance use disorder treatment delivery systems to provide more effective care, including through Section 1115 waivers, the health homes option, and the rehabilitation option.

States are increasingly using health homes to integrate physical and behavioral health. The health homes model, authorized by the Patient Protection and Affordable Care Act (P.L. 111-148, as amended), is designed to ensure whole-person care, integrating primary, acute, and behavioral health care as well as long-term services and supports and social and family supports. The law also provides a fiscal incentive in the form of a temporary enhanced 90 percent federal match for the first two years of state health home programs. The health homes option provides flexibility for states in program design but is available only for individuals with certain chronic conditions; that is, those with two or more chronic conditions, one chronic condition and risk factors for another, or serious mental illness. As of July 2016, 19 states and the District of Columbia were operating a total of 28 approved Medicaid health home models, serving over 1 million enrollees. Of these 28 health home models, 20 are targeted to populations with specific mental health or substance use disorder treatment needs.

ACOs have recently emerged in Medicaid, and a few states are using these structures to integrate behavioral and physical health. An ACO is typically a provider-led organization composed of different types of providers who deliver care across multiple care settings for a defined population. Providers contract directly with payers. The ACO structure often marries care delivery reforms with new provider payment strategies, such as shared savings or risk programs and global payments or budgeting. States can encourage behavioral health integration by including behavioral health services in ACO payments, or requiring ACOs to include behavioral health providers or behavioral health measures in quality and performance metrics. Most Medicaid ACOs are in their infancy, and they vary significantly based on a

state's health care environment. More research is needed to understand how these models can successfully integrate behavioral health and if they can improve outcomes and reduce costs for individuals with behavioral health conditions.

Given the complexity of the substance use disorder delivery system, there are some efforts to align eligibility, financing, services, and oversight across agencies. These efforts include co-locating physical and behavioral health providers, sharing data and information, blending funding streams, and consolidating Medicaid and state behavioral health and substance abuse agencies. Some states are developing stronger or more formalized relationships between Medicaid and other agencies. For example, Medicaid agencies may work with criminal justice agencies to help transition individuals with an opioid-use disorder in and out of prison or jail, as a way to help them continue treatment. To do so, Medicaid programs may decide to suspend rather than terminate Medicaid benefits while these individuals are incarcerated.

Legal, administrative, and cultural barriers can discourage integration efforts. These barriers include billing restrictions, privacy requirements and data sharing restrictions, gaps in the continuum of covered services, and separate professional training of physical health and behavioral health providers. The ability to share data and fully integrate care delivery is limited by federal privacy rules, but it is also dependent on provider adoption of electronic health records. Behavioral health providers often have limited working capital to invest in technology, and some behavioral health facilities and providers are ineligible to receive incentive payments to adopt electronic health records. For example, behavioral health facilities are not eligible for Medicaid meaningful use incentive facility payments because only hospitals are eligible for these payments. Furthermore, only certain providers working in behavioral health—physicians, nurse practitioners and certain physician assistants—are eligible for the Medicaid incentive payments. Of behavioral health providers who are eligible, few have been able to meet meaningful use standards.

Many of the opportunities states and providers have to integrate behavioral and physical health care are only made possible by temporary or limited funding streams. For example, the health homes program has a temporary 90 percent federal match for the first two years. The CMS Medicaid Innovation Accelerator Program focusing on behavioral and physical integration does not provide states with additional funding, but does offer time-limited technical assistance and support to expand existing integration efforts. Other funding streams are limited in nature. The 2016 final managed care rule offers a sustainable federal funding source for services rendered in institutions for mental diseases (IMDs); however, it only allows for federal financial participation for up to 15 days in a given month. Section 1115 waivers offering a similar authority to states for substance use disorder treatment in IMDs are also time-limited. Without sustained funding, states and providers might have to end current behavioral and physical health integration efforts. Some may choose not to pursue integration efforts knowing that funding will be terminated or decreased over time.

For more information, please see:

Medicaid and the Opioid Epidemic, June 2017

State Policies for Behavioral Health Services Covered under the State Plan, June 2016

Integration of Behavioral and Physical Health Services in Medicaid, March 2016

Behavioral Health in the Medicaid Program—People, Use, and Expenditures, June 2015