



A Federal-State Discourse on Maintaining Momentum for Payment and Delivery System Reform

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States and the federal government have been undertaking an almost bewildering array of policy initiatives and experiments in an effort to improve value and reduce costs in the health care system. What are we accomplishing and learning from these efforts? And what's needed to sustain and advance the most promising strategies?

In July 2016, a group of federal and state policy officials met to take stock of progress to date on the path toward health care payment and delivery system reform. At this meeting, convened by National Academy for State Health Policy (NASHP) with support from The Commonwealth Fund, participants shared their enthusiasm for payment and delivery reform, their impressions of current payment and delivery reform policies and demonstrations, and discussed opportunities for improvement going forward.

Overall, participants in the discourse reported that payment for value and delivery system transformation has traction with health care stakeholders, but the journey toward a more effective health care system is complicated. Their discussion revealed a basic tension between the benefits of pursuing as many options as possible to help figure out what works, and the costs associated with complexity. Based on the discussion, NASHP concludes the following:

- Federal support has been crucial to help states and health care providers develop the capacity and infrastructure to implement health care payment and delivery system reforms.
- Federal flexibility to support innovation and experimentation in order to test what works has fostered a wide array of demonstrations.
- Collectively, however, the current patchwork of federal policies and demonstration options creates a complex landscape for states to navigate in pursuing change.
- To help manage the complexity of reform, it should be a priority to regularly assess the interaction between federal policies and demonstrations, with an eye to simplifying the landscape where possible.
- States also face complexity from the ongoing evolution of federal policies and demonstration options. Frequent changes make it difficult for states to plan and implement reforms.
- To facilitate more effective progress toward payment and delivery system reform, new mechanisms may be helpful through which Medicaid and Medicare can jointly plan, operationalize, and review policies and demonstration options.

Working together to transform health care

The broad objectives of health care transformation include improving health, reducing health care costs, and increasing the quality and value of health care. In pursuit of these ends, states and the federal government are collaborating on multiple fronts—largely spurred by the Affordable Care Act and its significant funding for the Center for Medicare and Medicaid Innovation (CMMI) at the Center for Medicare & Medicaid Services (CMS)—to develop, test, and implement new payment and delivery system models.

It's a challenging endeavor for policymakers and stakeholders, who are essentially trying to change how health care works through a complex mix of strategies aimed at developing a more holistic, interconnected system that rewards value and often shifts responsibility for the cost and quality of care to health care providers. The strategies include both mandatory federal policies and flexible demonstration options for states. These policies and options vary in breadth, from multi-dimensional efforts such as the State Innovation Models (SIM) Initiative and the Delivery System Reform Incentive Payment (DSRIP) program, to more targeted activities that focus, for example, on advancing delivery system reform under Medicaid managed care, implementing value-based payment policies for physician services under Medicare, and transforming primary care practice.

Collectively, these and other reform strategies seek to address health care inefficiencies through system- and provider-level changes, but the details of transformation are complicated, both because of the scope, variety, and complexity of reform activities, and because of the maze of federal and state policy requirements and authorities that stakeholders must navigate in pursuing change. These complications are rooted in a fragmented health care system, where patients obtain health benefits from a varied mix of public and private sources, and providers must deliver health care in accordance with the different policies of multiple payers.

The role of states in health reform

As purchasers, program administrators, and regulators, both states and the federal government touch every aspect of the health system and have significant leverage to facilitate change. States' primary avenues for shaping health care stem from their responsibilities to administer Medicaid and the Children's Health Insurance Program (CHIP), purchase health benefits for public employees, regulate private insurance, license health care providers, and in many states, administer health insurance marketplaces. For example, states can shape the health care system by implementing innovative payment and delivery arrangements under Medicaid, by using their purchasing power to demand value-based insurance products for public employees, by encouraging commercial payers to create products that support delivery system change, and by shaping benefit design for qualified health plans in health insurance marketplaces. In addition, states' responsibilities to protect public health and implement social policies can help advance a population health perspective and the integration of community-based resources in delivery system reform.

Because health care is ultimately delivered in communities and markets with different characteristics and resources, states have an advantage compared to the federal government in accounting for

local conditions and leading efforts to promote collaboration among local stakeholders. The federal government helps amplify these advantages by providing flexibility under Medicaid and a wide range of demonstration options that states can use to test new payment and delivery system strategies. Two such options that facilitate state-led change are the SIM Initiative and the DSRIP program.

State Innovation Models Initiative. The SIM Initiative is a demonstration program that provides financial and technical support for states to develop and test health care payment and delivery system reforms. This effort seeks both to facilitate comprehensive, state-based innovation, and to evaluate the ability of state governments to accelerate change through the use of different reform tools and policy levers. To date, 34 states, 3 territories, and the District of Columbia have received one or more awards. In Round One of the initiative, CMS allocated nearly \$300 million to 25 states to design or test reform models; in Round Two, more than \$660 million will go to 32 awardees.

States receive funding either to design or to implement a comprehensive, multi-payer plan for improving health, improving health care, and lowering health care costs. In addition to detailing strategies for health care payment and delivery system reform, SIM plans must address stakeholder engagement, population health, workforce development, and the use of health information technology, among other topics. Program funds can be used for a wide variety of staff and resource costs associated with model design, implementation, and evaluation. A few examples of allowable costs include: expenses related to collaborative learning, costs associated with data collection and analysis, and investments to develop infrastructure for health information exchange.

According to participants in the federal-state discourse, a key accomplishment of the SIM Initiative has been helping states develop the capacity and infrastructure for health reform. State leaders described using SIM resources to build on existing efforts and support activities that provide a foundation for value-based payment and delivery system transformation, including policy analysis, information technology development, and data sharing to support provider decision making. Several participants cited the benefits of SIM learning networks, both to increase provider engagement and to learn from the experiences of other states. Others noted success in increasing alignment between quality measures for Medicaid and public employees. Although multi-payer reform is a goal of the SIM program, several state leaders noted difficulty engaging commercial payers and self-insured employers, who resist collaboration on quality measures and payment benchmarks because of competitive concerns. Finally, several officials from states with SIM programs expressed concern about making continued progress toward reform without ongoing funding to move from planning to implementation or to continue implementation activities.

Delivery System Reform Incentive Payment program. DSRIP is a Section 1115 demonstration waiver option that allows states to reward hospitals and other providers for improving quality and implementing delivery system reform projects. Under DSRIP, states generally redirect Medicaid money that was previously used to make supplemental payments to hospitals, and instead use the resources to make incentive payments for reform. Ten states have DSRIP programs. The potential pool for incentive payments totals billions of dollars, but actual payments depend on whether hospitals and other providers achieve project goals. DSRIP projects support participating providers in changing how they care for Medicaid beneficiaries. For example, projects may focus on expanding access to primary care, integrating physical and behavioral health, or improving care transitions from hospital to ambulatory care settings.

Discourse participants from states described DSRIP as an important and highly desired tool to build infrastructure and support health care providers, many of whom lack the resources and capacity to do what is being asked of them under value-based reforms. Federal leaders emphasized the expectation that DSRIP money be used to support statewide changes in health care payment and delivery, including the development and implementation of advanced alternative payment models that satisfy requirements under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

The federal government's role in health reform

The federal government also brings significant resources and market power to the table. It works closely with states to jointly administer Medicaid and CHIP, and as the sole administrator for Medicare, the federal health insurance marketplace, and health care benefit programs for federal employees, military service members, and veterans, it sets national policies that define and influence how health care is paid for and delivered throughout the country. Two recent regulations—a final rule on managed care in Medicaid and CHIP, and a proposed rule that implements MACRA—are important and timely examples of federal policies that help drive transformation and increase alignment across health care policies and payers.

In addition to advancing payment and delivery system reform directly through policies such as MACRA and the managed care rule, the federal government has been proactive in supporting demonstration options (including SIM and DSRIP), learning networks, and other types of assistance for states and healthcare stakeholders. With its flexibility and many waiver options, Medicaid has long supported state experimentation. CMMI accelerates this experimentation with dozens of initiatives, including the Comprehensive Primary Care Plus (CPC+) demonstration (described below) and the Medicaid Innovation Accelerator Program, which provides targeted resources, technical assistance, and learning opportunities to help states pursue Medicaid-focused reform strategies. States, private payers, and health care providers are important partners in implementing these efforts.

Managed care in Medicaid and the Children's Health Insurance Program. CMS recently issued a final rule that updates managed care regulations for Medicaid and CHIP. Thirty-nine states and the District of Columbia contract with managed care plans to serve Medicaid beneficiaries, almost two-thirds of whom are enrolled in managed care.

The rule supports state efforts to advance delivery system reform and improve the quality of care for Medicaid and CHIP beneficiaries. Specifically, it clarifies that states can use contractual agreements with managed care plans to encourage or require the plans to participate in value-based activities, such as patient-centered medical homes, initiatives that support health information exchange, and purchasing approaches that link provider payment with performance on quality measures. It also seeks to align, where feasible, policy goals and operational details for Medicaid managed care and other major sources of coverage, including Qualified Health Plans and Medicare Advantage. Desired benefits from this alignment include smoothing beneficiary coverage transitions and reducing administrative burden for payers that offer coverage across multiple health care programs.

Discourse participants expressed a generally positive reaction to this rule. Federal officials noted the regulation's flexible tone, while state participants said they were still exploring the details and the resource demands to implement them.

The Medicare Access and CHIP Reauthorization Act of 2015. MACRA ended physician payment updates based on the Sustainable Growth Rate (SGR) formula and created a new, value-based payment framework for physician services in Medicare. In the short run, physicians will be paid under the Merit-Based Incentive Payment System (MIPS), which combines parts of three existing payment provisions—the Physician Quality Reporting System, the Value-Based Payment Modifier, and the Medicare Electronic Health Record (EHR) Incentive Program—into one incentive-based payment that accounts for measures of quality, resource use, clinical practice improvement, and the meaningful use of certified EHR technology. Annual payment updates will be 0.5 percent until 2019; after that, updates will be based on performance.

Beginning in 2019, physicians will be able to choose between payment under MIPS or a different option, called Advanced Alternative Payment Models (AAPMs), provided they receive enough of their payments or see enough of their patients under qualified models, such as the Comprehensive ESRD Care Model, the Medicare Shared Savings Program, or the CPC+ program. Providers who choose this option will be exempt from performance-based payment updates under MIPS and will instead be eligible for a 5 percent incentive payment from 2019 to 2024.

Discourse participants offered qualified optimism about the potential for MACRA to advance health care payment and delivery system reform. State leaders cited the 5 percent incentive payment for participation in AAPMs as an effective motivator. While they expressed concern about uncertain details under the new policy, including incomplete information about which payment models would qualify as AAPMs, they identified the model as a potential vehicle to facilitate payer alignment.

Support for experimentation and capacity building. CMMI, which was authorized under the Affordable Care Act to develop, test and evaluate new payment and service delivery models, supplies significant financial and technical support for states and health care providers to pursue a wide array of generally uncoordinated reform initiatives. The Center's efforts are organized into broad categories that focus on different reform approaches (accountable care models, primary care transformation, and episode-based payment), different populations (Medicaid and CHIP, individuals enrolled in both Medicare and Medicaid), efforts to accelerate payment and delivery system changes (including the SIM program), and efforts to accelerate the adoption evidence-based practices. All of these efforts depend, of course, on the willingness and ability of payers, providers, and other stakeholders to change how they do business. Accordingly, stakeholder outreach, collaborative learning activities, technical assistance, and investments in infrastructure are an important part of CMMI demonstrations.

To help align stakeholders and advance the adoption of alternative payment models, CMMI convenes the Health Care Payment Learning and Action Network (LAN), which brings together private payers, employers, health care providers, consumers, and states. The U.S. Department of Health and Human Services (HHS) also leads stakeholder programs to support health transformation. For example, HHS engages physicians through the Physician-Focused Payment Model Technical Advisory Committee (PTAC), which is tasked with recommending MACRA-eligible alternative payment models.

While Discourse participants emphasized the importance of CMMI support and acknowledged the value of multiple experiments to give states options and identify payment and delivery models that work, some

state leaders suggested there may be too many different policy changes and experiments underway. Similarly, some state leaders described various learning systems and supportive services as generally useful, but uncoordinated, noting the inefficiency of having multiple points of contact for different policies and programs.

Comprehensive Primary Care Plus. Discourse participants identified CPC+ in particular as one promising model from CMMI that can help to achieve delivery system transformation. CPC+ is a primary care demonstration option that seeks to improve healthcare quality and value through multi-payer payment reform and primary care practice transformation. Under this model, payers—including Medicare, commercial health insurance plans, and state Medicaid agencies—provide financial support and incentives for primary care practices to change how they deliver care.

CPC+ includes two tracks with different requirements and payment amounts. Both tracks include three payment components: a care management fee (CMF), a performance-based incentive payment, and a third amount tied to services provided. The CMF is a prospective, per-beneficiary per-month (PBPM) payment. This component is risk-adjusted to account for the care management needs of beneficiaries in each practice. The performance-based incentive payment depends on a practice's performance on clinical quality, utilization, and patient experience measures. The third amount is either a fee-for-service payment or a hybrid payment that includes an up-front amount (called the comprehensive primary care payment) and a reduced fee-for-service payment. Different payers in the CPC+ model must agree to work together to increase alignment on payment, data sharing, and quality metrics.

Primary care practices in CPC+ must demonstrate multi-payer support and the use of certified electronic health record technology. They will have access to a learning system and patient-level cost and utilization data, and are expected to make improvements in five functional areas: (1) ensuring access to and continuity of care; (2) managing care for high-risk, high-need patients; (3) providing comprehensive, coordinated care for patients; (4) engaging patients and caregivers in the care improvement process; and (5) planning both preventive care and evidence-based treatment to meet the needs of their patient population. The three-component, multi-payer payment design provides resources and flexibility for participating practices to invest in care management staff and delivery system transformation.

Because multi-payer participation is required under CPC+, alignment across payers is more likely and efficiencies for providers can result. In addition, the design's three-component payment and approval as an AAPM under MACRA together provide multiple financial incentives for providers to undertake a comprehensive effort to strengthen primary care.

General impressions and recommendations

Both individually and collectively, the health care payment and delivery system reform efforts described above are impressive. Participants in the federal-state discourse were generally positive about the overall direction of reform activities, including both required policies such as MACRA and the Medicaid and CHIP managed care rule, and demonstration options such as SIM, DSRIP, and CPC+, but all acknowledged that getting from here to there is complicated.

With so many activities underway and significant uncertainty about which reforms will ultimately be successful, the meeting revealed a basic tension between the benefits of pursuing as many options as possible to help figure out what works, and the challenges and costs associated with complexity. On the

one hand, more demonstration options means more opportunities for states to develop infrastructure and test new payment and delivery system models, often with significant financial and technical support from the federal government. On the other hand, even the abbreviated list of policies and demonstration options described above is enough to feature the challenge that stakeholders face in implementing required policies and deciding which optional policies to pursue.

With both progress to date and the above tension in mind, NASHP concludes the following:

- **Federal support has been crucial to help states and health care providers develop the capacity and infrastructure to implement health care payment and delivery system reforms.**

As the Discourse participants noted, SIM and DSRIP have provided important resources to help states and health care providers develop capacity and implement new payment and delivery system models. MACRA and CPC+ complement SIM and DSRIP by creating financial incentives and providing resources for delivery system transformation. But the journey toward a more effective health care system is just beginning and states need ongoing financial and technical support to sustain momentum for transformation.

- **Federal flexibility to support innovation and experimentation in order to test what works has fostered a wide array of demonstrations.**
- **Collectively, however, the current patchwork of federal policies and demonstration options creates a complex landscape for states to navigate in pursuing payment and delivery system reform.**

As noted above, there's an inherent tension between the benefits of evaluating a broad range of payment and delivery system models, and the costs associated with complexity. Discourse participants from states discussed how they have used both CMMI demonstrations and other Medicaid waiver options to advance reforms, but they also described being overwhelmed and subject to demonstration fatigue from the collective flood of requirements and options. Since the Discourse, CMS has announced the State Demonstrations Group (SDG) will be reorganized to better serve states. Key goals of the change include: (1) providing high-value policy and technical guidance, in consultation with agency leaders and subject matter experts, that helps states design and implement Medicaid section 1115 demonstration, and (2) improving monitoring, oversight, and evaluation to support evidence-based program changes.

- **To help manage the complexity of payment and delivery system reform, it should be a priority to regularly assess the interaction between federal policies and demonstrations, with an eye to simplifying the landscape where possible.**

Are there multiple initiatives underway to serve the same purpose? Can similar models and demonstration options be consolidated to help simplify reform options for states and health care providers? Where models and demonstration options can't be consolidated, can program

elements such as data reporting be made more consistent?

- **States also face complexity from the ongoing evolution of federal policies and demonstration options. Frequent changes make it difficult for states to plan and implement reforms.**

Evolution is important, of course, to incorporate new knowledge about the impact of payment and delivery system models, but frequent change also creates challenges for states because of the time and resources required to develop and implement policies and programs, and also because new federal policies may be poorly aligned with states' ongoing activities or future plans for reform. CMS is mindful of this issue and, since the July Discourse meeting, has published a request for information about the SIM initiative, including information to help facilitate the alignment of federal and state reform efforts, as well as to streamline interactions between the federal government and states.

- **To facilitate more effective progress toward payment and delivery system reform, new mechanisms may be helpful through which Medicaid and Medicare can jointly plan, operationalize, and review policies and demonstration options.**

Health reform is complicated by many barriers, including a fragmented healthcare system with competitive stakeholders, structural differences between Medicaid and Medicare, and mixed federal and state responsibility for health policy. Both states and the federal government are committed to advancing change, but a fragmented system complicates both state and federal efforts to align payment and delivery system reforms. The LAN provides a forum for exchange with stakeholders, and CMS has made efforts to increase communication across operating units and create a coordinated point of contact for states, but continued progress is needed to facilitate more productive collaboration and increase alignment between policies and actors.

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