**Association of State and Territorial Health Officials**

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October 28, 2016

The Honorable Andy Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services Attention: CMS-3323-NC
Submitted electronically at: http://www.regulations.gov

Re: Request for Information on State Innovation Model Concepts

Dear Acting Administrator Slavitt:

The Association of State and Territorial Health Officials (ASTHO) appreciates the opportunity to submit comments regarding this Request for Information (RFI) on next steps for the State Innovation Models (SIM) initiative under the Center for Medicare and Medicaid Innovation (CMMI). This RFI was published by the Centers for Medicare & Medicaid Services (CMS) in September 2016.

ASTHO is the national nonprofit organization representing the state and territorial public health agencies (S/THAs) of the United States, the U.S. Territories, and the District of Columbia. ASTHO's members, the chief health officials of S/THAs, are dedicated to formulating and influencing sound public health policy, and to assuring excellence in state-based public health practice. S/THAs play a critical part in improving population health in their state – they assess community needs, design, implement and evaluate programs that prevent or mitigate disease or injury, work to reduce health disparities, identify best practices, and evaluate impact, as well as convene and collaborate with stakeholders and communities. In addition, ASTHO's members have a range of responsibilities and relationships with their state Medicaid agency: ranging from statutory oversight, membership in an umbrella agency, or reporting separately to the Governor or other executive.[1] Thus, S/THAs have a unique role in payment and delivery reform efforts and activities that improve population health.

ASTHO and its members are appreciative of the opportunity to provide information and feedback on potential next steps of the SIM initative. Many S/THAs have been engaged in SIM Rounds 1 and 2. While state and territorial health officials and their public health staff may be part of cross-agency planning and testing teams, there is significant variability among the states on the leadership and expert information that they are providing to these teams. In some cases, the S/THA may have served in a governance role, be actively leading various subcommittees, and/or be well integrated into the decisionmaking processes such as defining health priorities and metrics. In comparison, they may be more of a passive participant contributing in a very limited way on discrete public health topics in other states. **Given S/THAs' leadership and expertise in population health and prevention, it is our hope that in future SIM efforts both the structure of the new opportunities and guidance from CMMI would**

[1] In six states, the state health official (SHO) has statutory oversight of Medicaid (Kansas, Maryland, Montana, New York, and Utah); in 14 states, the state health agency (SHA) and Medicaid are part of an umbrella agency, and in 31 states and DC, the SHA and Medicaid report separately to the Governor or in DC, to the Mayor.

**require and encourage greater engagement of and collaboration with S/THAs in these transformation activities.**

SIM Rounds 1 and 2 have been excellent opportunities to strenghen the capacity and infrastructure of states to pursue payment and delivery reforms. This funding has allowed states to enhance existing efforts and support other activities related to value-based payment reform, including information technology and exchange. Specifically, ASTHO and other state health organizations have heard from S/THAs that SIM funding has facilitated stakeholder outreach, collaborative learning activities, technical assistance, and investments in infrastructure.[2] S/THAs have also expanded the lens of health to engage a greater number of partners in establishing accountability for a community's health.

As such, ASTHO and its membership enthusiastically support additional SIM funding to continue infrastructure development and applaud CMS' consideration of the potential alignment of future SIM funding and ongoing state demonstrations with Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and other federal payment and delivery reforms. States across the country are already leading reform efforts that are moving towards value in the healthcare system in their Medicaid programs, while meeting the needs of the diverse populations they serve. In fact, a recent study by colleagues at the National Association of Medicaid Directors (NAMD) found that almost two-thirds of the 34 states surveyed had implemented or were planning to implement alternative payment models (APMs) that rewarded value over volume.[3] Aligning efforts between Medicaid programs and Medicare further expands the impact of these activities and reduces burdens on providers.

The complex and ever-changing reform landscape, which includes Medicaid expansion, waiver programs, managed care and patient-centered medical home reforms, Comprehensive Primary Care Plus (CPC+), and now MACRA, can be challenging for S/THAs to coordinate and manage.[4] Thus, federal guidance and consideration of alignment between SIM, MACRA, and other reforms is needed and supported to help inform states' efforts. This guidance should be provided with input from states themselves to identify areas for technical assistance, clarification of policies, and greater attention. In particular, clarification is needed about how Medicaid programs can be certified as Advanced APMs

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[2] National Academy for State Health Policy. "A Federal-State Discourse on Maintaining Momentum for Payment and Delivery System Reform." September 2016. Available at: http://nashp.org/wp-content/uploads/2016/09/Discourse-Brief.pdf. Accessed 10-11-2016.

[3] National Association of Medicaid Directors. "NAMD Comments on Medicare Program." June 27, 2016. Available at: http://medicaiddirectors.org/wp-content/uploads/2016/06/NAMD-Final-Comments-on-MACRA_6_27_16.pdf. Accessed 10-12-2016.

[4] With the complexity of health systems transformation and other reforms, states and engaged stakeholders face a number of challenges. In a 2014 survey of state health agencies, ASTHO found that for both SIM and non-SIM payment and delivery system reform, respondents (n = 47) indicated that "differing perspectives on which steps to take" was the biggest barrier to planning. In terms of implementation, "not having enough resources" was the biggest barrier for SIM activities, while "challenges related to workforce" and "differing perspectives on which steps to take" presented the greatest barriers for non-SIM payment and delivery system reform. Additional reported barriers included political challenges, turf issues, challenges with payers, reaching consensus on an integrated model, and finalizing approved plans. Source: http://www.astho.org/Health-Systems-Transformation/Payment-and-Delivery-Reform-Activities-Issue-Brief/.

would be extremely beneficial to states.[5] Moving forward, ASTHO supports CMS' alignment efforts and recommends that both high level and detailed guidance would be extremely helpful, such as reporting requirements, metric development and methodologies, and messaging.

As alluded to in the RFI, ASTHO agrees with CMS that data systems and infrastructure are a crucial and foundational part of payment and delivery reforms. With SIM funding, as well as other investments, states are developing interoperable systems, including All-Payer Claims Databases (APCDs). Despite progress made over the last several years, there is an incredible amount of work left to be done to ensure that different systems, including legacy databases, are leveraged to provide actionable data for decisionmaking and identify areas to target for interventions. We recommend that CMS and CMMI work with our partners at the National Association of Health Data Organizations (NAHDO) and SIM states to identify and share effective practices in utilizing statewide APCDs for measurement, benchmarking, and evaluation of health reform initiatives. Leveraging APCDs reduces reporting burden on individual physician practices and permits a broader view of health care delivery system performance. States welcome support from CMS to address key information gaps, including substance abuse data (e.g., 42 CFR Part 2) and Medicare Advantage data. In addition, from our public health perspective, maintaining support for enhanced public health reporting through the Merit-based Incentive Payment System (MIPS) and other programs, as well as encouraging programs such as electronic case reporting, are important to promote linkages between public health and healthcare to improve population health.

Beyond developing the data infrastructure, measures associated with payment and delivery reforms should be informed by the state or territory's health priorities identified in their State Health Assessments and State Health Improvement Plans. This linkage would allow for alignment of state public health accreditation with payment and delivery reform, to increase synergy with other activities ongoing in the state.

With regards to testing specific care interventions, ASTHO is supportive of funding to support interventions that focus on priority conditions on populations; however, would caution that many states have different priorities given the populations they serve and would need flexibility to adapt the model to their specific context. Thus, randomization may not be possible, although it is challenging to provide further input on reporting and program structure absent guidance on what specific care interventions are to be tested. Potential care interventions to be tested should not be limited to adults with chronic disease and consider other populations of focus. Interventions for further consideration include:

- Integrating behavioral health and primary care.
- Use of community health workers or health extenders.
- Interventions targeted at children and youth with special healthcare needs.
- Interventions or policy changes that provide reimbursement for preventative services delivered by nurses, social workers, pharmacists, and nutritionists that improve population health (e.g., Nurse-Family Partnership; diabetes self management education, and medication therapy management).

[5] National Association of Medicaid Directors. "NAMD Comments on Medicare Program." June 27, 2016. Available at: http://medicaiddirectors.org/wp-content/uploads/2016/06/NAMD-Final-Comments-on-MACRA_6_27_16.pdf. Accessed October 12, 2016.

However, these interventions or policy changes would likely need at least three years or more before they could be evaluated. In addition, it is worth noting that states are already making significant progress on specific care interventions, including the Million Hearts initiative and the CDC's 6|18 Initiative: Accelerating Evidence into Action, through which state public health agencies are working with their state Medicaid agencies to implement proven interventions to address six common and costly health conditions. Supporting ongoing efforts to enhance partnerships between Medicaid and public health on specific care interventions would help accelerate this work.

For both sets of activities described in this RFI, ASTHO recommends that CMMI work closely with its other federal agency partners, and in particular, the CDC. The CDC provides significant funding to support S/THAs activities on different conditions and requires different surveillance reporting to minimize inefficiencies and reporting burden on state health agencies. Further, technical assistance available to states should be coordinated between both CMMI and CDC to support infrastructure and workforce development, as well as coordinating on different ongoing intiatives that encourage healthcare payers and providers to consider the social determinants of health and interventions that focus on upstream factors (e.g., Accountable Health Communities), to avoid demonstration fatigue.

One question that arose during consideration of this RFI among ASTHO staff and state health officials who provided input was about how states who had not yet participated in SIM would be affected by a potential Round 3. States may have chosen to not participate in SIM due to a lack of gubernatorial support or other factors. However meeting states where they are, including those who are still in the early stages of payment and delivery reforms, is needed to ensure that all states have opportunities to develop the infrastructure necessary to support health systems transformation.

In conclusion, we believe that S/THAs can and should play a larger role in health systems transformation and payment and delivery reform, given their expertise in evidence-based interventions, working with vulnerable communities, engaging non-traditional partners, and evaluating population-based outcomes. Should you have questions or comments or require additional information, please contact Megan Miller, Senior Director, Health Integration at mmiller@astho.org or 202-371-9090 ext. 5421. We look forward to continued collaboration and dialogue.

Sincerely,

Jay Butler, MD
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Chief Medical Officer and Director of Public Health, Alaska Department of Health and Social Services

cc:
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