

Update to Guidance: Medicare Alignment in Multi-Payer Models under the State Innovation Models Initiative

BACKGROUND

CMS has worked to promote efficiency and quality of health care, particularly under value-based payment models in the Medicare program. CMS has invested in a number of initiatives to achieve these goals, including the Medicare Shared Savings Program, Comprehensive Primary Care (CPC) Initiative, Comprehensive Primary Care Plus (CPC+), Next Generation ACO Model, and Bundled Payments for Care Improvement (BPCI) Initiative. Advanced Alternative Payment Models (APMs) with Medicare, and beginning for the 2019 performance year, will also take into account participation in Other Payer Advanced APMs with Medicaid, Medicare Advantage, and private payers.

CMS has also recognized the important role that states play in driving health care reform, and has prioritized giving states the flexibility they need to innovate. States can tailor delivery transformation to suit the specific needs of their population, and their results can provide lessons for future innovation. The Innovation Center has invested in partnerships with states under several models, including the State Innovation Models (SIM) Initiative. The SIM initiative tests the ability of state governments to accelerate health transformation.

CMS has sought to synthesize its Medicare transformation efforts and its support for state flexibility. In April 2015 and November 2015, we issued guidance^{1, 2} to SIM states on the principles CMS prioritizes when considering Medicare fee-for-service (FFS) participation in a state-designed, multi-payer model. Since that guidance was published, the Innovation Center has launched two multi-payer models with SIM states (the [Vermont All-Payer ACO Model](#) and the [Pennsylvania Rural Health Model](#)), launched a national Medicare and multi-payer model (CPC+), and started to implement the Quality Payment Program (QPP).

By allowing states to be a partner in Medicare transformation, we can align efforts and reduce bureaucracies facing healthcare providers. We can create a streamlined and simplified delivery system that is both more effective and more efficient. The core purpose of the Innovation Center is to “test innovative payment and service delivery models to reduce program expenditures...while preserving or enhancing the quality of care.”³ Improving effectiveness and efficiency in health care delivery is a goal that states and CMS share, and a goal that resonates widely with healthcare providers, payers, and

¹ <https://innovation.cms.gov/Files/x/sim-guidancemultipayeralignment.pdf>

² <https://innovation.cms.gov/Files/x/sim-guidance-statesponsored.pdf>

³ Section 1115A of the Social Security Act.

consumers. Strengthening coordination between Medicare and state efforts is a critical link to achieve this goal.

The below updated guidance to SIM states reflects lessons learned from our earliest experiences partnering with states to launch multi-payer models; we believe this guidance will help SIM states as they continue to develop their own APMs under SIM and consider future refinements. We also share specific information on how SIM states can design and launch APMs that are consistent with the requirements of the Quality Payment Program.

This document clarifies existing guidance to SIM states on the following:

- Process for SIM states to engage CMS in the co-development of multi-payer models
- Criteria by which CMS will consider Medicare participation in multi-payer models, based on experience launching the Vermont All Payer ACO Model and Pennsylvania Rural Health Model
- How SIM states can design and implement payment and care delivery reform models consistent with the criteria to be Advanced APMs under the Quality Payment Program (QPP)

MEDICARE PARTICIPATION IN SIM MODELS

As outlined in the November 2015 guidance, a SIM state may seek Medicare alignment through one of two pathways:

- 1. Medicare Alignment for SIM Models through Customized Models:** Medicare alignment with models developed or tested under SIM (hereafter referred to as “SIM models”) could be achieved through a new, state-specific APM with Medicare, Medicaid, and private payer participation. In exchange for increased Medicare flexibility, we would hold states accountable for specific quality and cost outcomes. The opportunity for states is more control over improving quality and lowering costs based on population needs of the state with the support of CMS to achieve better results. In order for Medicare to participate in a SIM model under this pathway, the model must meet the set of principles outlined below, and be an Innovation Center test of a novel model under section 1115A authority.
- 2. SIM Models Alignment with Medicare through Existing CMS Models or Programs:** SIM models alignment with Medicare could be achieved through alignment of Medicaid and private payers within a state around existing CMS models or programs (e.g., a CMS Accountable Care Organization (ACO) Program or Model, or a CMS Patient Centered Medical Home (PCMH) Model). Under this pathway, states can use SIM and multi-payer alignment to improve provider readiness to join existing national CMS models or programs and to reduce provider burden. We would not change existing national CMS models or programs in order to obtain alignment with SIM models. Because this pathway would encourage SIM alignment with existing CMS models or programs, no new Medicare FFS payment/program waiver authority is needed for this pathway. Depending on how the state wishes to pursue alignment, the state may need to seek a Medicaid waiver pursuant to HHS’ authority under section 1115(a) of the Act, State Plan Amendment, or other regulatory authority.

Under either pathway, in order to strive for multi-payer alignment including Medicare, states should collaborate with healthcare providers and payers to align on key model components including payment mechanisms, quality measures, and data-sharing elements. Multi-payer alignment on model elements

does not mean that payer participation must be identical, but rather, multi-payer alignment can orient incentives and goals to be consistent across payers partnering in the model. This approach can create a more stable and predictable environment for healthcare providers participating in a model, and also allows for sufficient flexibility for payers to implement approaches that are aligned with the needs of their members and/or beneficiaries.

PROCESS FOR SIM STATES TO PURSUE MEDICARE ALIGNMENT IN SIM MODELS

Based on our experience to date, we expect that most SIM states will pursue SIM Model Alignment with Medicare through existing CMS models or programs, rather than pursuing a new customized model. SIM states interested in pursuing this alignment pathway are encouraged to work with their SIM Project Officer to obtain input and guidance on the alignment process. SIM Project Officers can connect SIM states with the Innovation Center model teams with which they seek to align for additional guidance on model design.

Like Vermont, Maryland and Pennsylvania, some SIM states may seek a new customized model. Under this pathway, SIM states would co-design, in partnership with CMS, a multi-payer model including Medicare FFS that addresses their population's specific needs.

Below, we outline the process for submission of state proposals for Medicare participation in a new customized model, and the criteria on which CMS will evaluate the proposal. The submission process and evaluation criteria build upon our previous guidance provided in April and November 2015, with additional insights based on our experience launching state-specific multi-payer models, and based on the most current information about becoming an Advanced APM or Other Payer Advanced APM under the Quality Payment Program. Any new model must meet all the criteria of section 1115A.

This information is in response to states' requests for additional details on the specific steps to pursue Medicare participation in their SIM models. States interested in pursuing a customized state-specific model can do so under the following steps:

1. **SIM state indicates interest in state-specific model to SIM Project Officer:** States should indicate interest in a state-specific model with their SIM project officer. There is no formal application; rather, the state should be prepared to engage in a series of discussions with the Innovation Center to co-develop their model and to develop a proposal describing key components of their model as described below.
2. **State submits proposal to CMS on state-specific model:** To initiate the co-development process, states should be prepared to describe in a proposal the overarching payment structure they are proposing, rationale for selecting that structure, and rationale for why this cannot be accomplished through an existing CMS model or program. States should also articulate their vision for payment delivery reform, how Medicare participation advances that goal, and what else it will take to achieve that vision. A proposal can be submitted to CMS at any time and can

be submitted at the same time as when a state and the Innovation Center begin to engage in a series of discussions on a potential state-specific multi-payer model.

3. **CMS and state co-develop high-level parameters of state-specific model:** Through a series of discussions, the Innovation Center and the state will work come to agreement on a viable model design that meets the criteria outlined below including the high-level parameters of the model (e.g. overview of payment structure, framework for financial targets achieved under the model, population health and quality goals under the model and goals for healthcare provider and multi-payer participation and lives covered by the model).
4. **CMS and state enter into in-depth negotiations to co-develop model:** Negotiations will include identifying the financial, quality and scale targets that the state will commit to, and identifying the Medicare program/policy waivers and operational considerations that CMS would need to provide to give the state the flexibility to operate the multi-payer model and that is necessary to test the model. The goal of the negotiations is to develop an agreement between CMS and the state on the terms of the state-specific model with Medicare participation. Such an agreement would be signed by the Innovation Center and the Governor of the state.

Based on past experience, the process of co-developing a state-specific multi-payer model and negotiating any waivers necessary for Medicare participation can take approximately 1-2 years. We note that CMS retains the ultimate authority to decide whether to move forward with a state-specific multi-payer model.

CRITERIA FOR MEDICARE PARTICIPATION IN CUSTOMIZED MODELS

In the April and November 2015 guidance, we presented a set of principles that we would consider in reviewing a proposal for Medicare participation in a state's proposed multi-payer model supported through SIM that could require specific new waiver authority to align Medicare with the model. We indicated that we would consider states' proposals for Medicare's alignment with proposed multi-payer payment and service delivery models, and that we would assess the proposals according to 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.**

Below, we present additional information on these six principles for Medicare participation that reflects our experiences working with SIM states to develop models within the constraints of the Innovation Center's statutory requirements, and also reflects feedback from those states. This additional information is particularly designed to align as much as practicable with the requirements to be an Advanced APM or Other Payer Advanced APM under the Quality Payment Program.

States should consider this information as they design and implement payment and service delivery models through SIM and if they prepare proposals to initiate conversations with CMS on Medicare participation in a state-specific model.

At a high level, Medicare participation in a state-specific model should have three key components: 1) a clearly-defined target population: either affected patients, affected healthcare providers, or both; 2) clear potential to improve quality and reduce expenditures for the covered population; and 3) demonstrated preparedness, both from eligible participants and from the state. With these three aims in mind, below is a list of elements that CMS will consider in evaluating a state's proposal for Medicare participation in a multi-payer model. CMS will evaluate state proposals based on these elements, addressing each of these elements in detail through an iterative process.

1. **Patient-Centered**: As stated in previous guidance, a state's proposal will be assessed for its commitment for improvement across a robust set of quality and patient experience measures in order to ensure that any savings are generated by improvements in both patients' health care experience and population health. In their proposal, states should set specific population health and quality targets for improvement and describe how the state proposes to achieve these goals (e.g. state regulatory levers, leveraging non-clinical providers).
 - a. **Population health and quality targets**: *In their proposal*, states should articulate specific population health and quality goals for which they will be held accountable under the model, and how the incentive structures and payment mechanism can achieve those goals. *Throughout the co-development process*, states will develop, in collaboration with CMS, population health and quality measures and targets consistent with their stated goals. Additionally, the state will work with CMS to determine quality measures that can directly impact the population health goals for which healthcare providers would be accountable under the model. States should commit to achieving improvements in quality and population health outcomes for the specified population and/or geographic region.
 - b. **Health-Related Social Needs**: *In their proposal*, states should articulate how they will leverage their resources to improve population health and quality of health (e.g. state regulatory levers, utilizing non-clinical partners). Although Trust Fund dollars may not go toward financing community services, the state can consider how to incentivize collaboration between clinical and community providers through the model.

2. **Accountable for Total Cost of Care**: As we stated in previous guidance, CMS will only consider Medicare participation in models that will impact and hold the state accountable for total cost of care across settings of care. This will be assessed based on the scope of healthcare providers and services included in the model, as well as based on the financial targets of the model.
 - a. **Scope of Healthcare Providers and Services included in Model**: *In their proposal*, states should be able to articulate what provider types and settings of care will be included in their proposed multi-payer model. Broad scope and broad accountability for total cost of care are essential for these models in order to create alignment across providers and support transformation.
 - b. **Financial Targets**: *Throughout the co-development process*, CMS will work with the state to identify both a multi-payer financial target for the model, to ensure a state's healthcare costs across payers grow at a more sustainable level, and Medicare financial target, to ensure savings to Medicare.

3. **Transformative:** A state’s proposal will be assessed for the extent to which the payments to healthcare providers in the model support and reward quality, accessibility, affordability, and improving the beneficiary experience. A state’s proposal should describe the extent to which models emphasize broad delivery system transformation. A state’s proposed multi-payer model can be focused on the entire state, region, specific population, or can demonstrate a collaboration across states.
- a. **End-State Vision:** *In their proposal*, states should be able to articulate the state’s end-state vision for payment and delivery system reform, including the type of delivery system the state seeks to create, what incentive structure is needed to support such a system, and why Medicare participation is necessary to achieve that vision. States should include a rationale for why this cannot be accomplished through an existing CMS model or program.
 - b. **Transformative Payment Model Archetype:** *In their proposal*, states should be able to describe the payment structures and payment mechanism of the multi-payer model that the state is seeking Medicare to participate in.
 - c. **Alignment with Quality Payment Program⁴:** *In their proposal*, which outlines why Medicare participation is necessary, states should be able to demonstrate how the proposed model meets all of the Advanced APM criteria under the Quality Payment Program, as specified at 42 CFR 414.1415, which are summarized below:
 - i. Require model participants to use certified EHR technology (CEHRT).⁵ To meet this criterion, the model must require at least 50 percent of eligible clinicians in each participating APM Entity group, or each hospital if hospitals are the APM Entities, to use CEHRT to document and communicate clinical care.
 - ii. Tie payments for covered professional services to performance on on quality measures that are comparable to those used in the Merit-based Incentive Payment System (MIPS) quality performance category. To be comparable, quality measures must be evidence-based, reliable, and valid. At least one of these measures must be an outcome measure, if an appropriate outcome measure is available on the MIPS measure list.
 - iii. Require model participants to bear financial risk for monetary losses and meet the nominal amount standard of risk, or be an expanded Medical Home Model under section 1115A(c) of the Act. A model meets the financial risk requirement if it withholds payment, reduces payment rates, or requires APM Entities to make repayments if actual aggregate expenditures exceed expected aggregate expenditures during a specified performance period, or if the model is a Medical Home Model, causes the APM Entity to lose the right to all or part of an otherwise guaranteed payment or payments. A model meets the nominal amount standard of risk for the 2017 and 2018 performance years if the total amount an APM Entity potentially owes CMS or foregoes under a model is at least equal to either: 8 percent of the estimated average total Medicare Parts A and B revenues of participating APM Entities; or 3 percent of the expected expenditures for

⁴ <https://qpp.cms.gov/resources/education>

⁵ We refer to the definition of CEHRT as defined at §414.1305 of the [CY 2017 Quality Payment Program Final Rule](#)

which an APM Entity is responsible under the APM; or meets the Medical Home Model nominal amount standard if the model is a medical home model.

- d. **Novelty:** *Throughout the co-development process, CMS will work with states to determine the novelty of the proposed model, and may suggest changes based on questions or topics of national interest. CMS is interested in models that offer a test of a new or novel model, or a test of a Medicare program or model adapted to the unique needs of a state.*
4. **Broad-Based:** As stated in previous guidance, broad healthcare provider and payer participation (i.e., payer alignment on key design elements) is a critical element to a multi-payer model. A state's proposal will be assessed on the extent to which healthcare providers and payers are participating or would participate in the proposed model. *In their proposal, states should commit to achieving broad scale, and should demonstrate how their model will include participation of a vast majority of healthcare providers, payers (including Medicaid), and lives across the state, region, or target population. Throughout the co-development process, CMS and the state will work to develop scale targets that describe the number or percentage of healthcare providers, healthcare spending and residents are covered by the multi-payer model.*
5. **Feasible to Implement:** Because Medicare alignment in a state designed model could require significant operational investment, a state's proposal will be assessed on the administrative feasibility of the proposed model. In their proposal, states should consider their commitment to the operational investment of the 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.
 - a. **Stakeholder Engagement and Commitment:** *In their proposal, states should demonstrate commitment of payers and healthcare providers through signed letters of support, outlining a commitment to execute on the payment model and to align on key model components including payment mechanism, quality measures, and data-sharing elements. The state should also demonstrate its commitment to work collaboratively with beneficiaries in all aspects of design, implementation, and evaluation of the model. States should describe their plan to engage beneficiaries, and to ensure measures of performance and impact should be meaningful, actionable, and transparent (e.g., may include letters of support from consumer advocacy organizations).*
 - b. **Health IT Infrastructure:** *In their proposal, states should describe the model's multi-payer health IT Strategy to support care redesign. Consistent with the requirements of an Advanced APM, the model must require that participants use certified EHR technology. Furthermore, states will need to describe the health IT infrastructure that currently exists, and their plan for developing needed capacity prior to launch of the proposed model, including the following areas:*

- i. **Coordinated and Outcome Focused Service Delivery**: Use of claims, clinical, and other non-clinical data for notifications, exchange of information services, patient attribution, consent management, etc.⁶
 - ii. **Quality and Financial Measurement for Improved Population Health**: Use of claims, clinical, and other non-clinical data for quality measurement and improvement, as well as financial measurement and total cost of care accountability.
 - iii. **Multi-Payer Payment Methodology and Operations**: Use of claims, clinical, and other non-clinical data for determining risk adjustment, executing payment to healthcare providers, and all other functions required to support payment methodology and operations.
- c. **State Leadership**: *In their proposal*, states should address the administrative feasibility of a proposed model. In particular, states will need to demonstrate gubernatorial support for the proposed model, and describe what the governor’s role will be in both the development and implementation of the proposed model. States will also need to demonstrate cross-agency leadership support for the proposed model, including, at a minimum, Medicaid and the Department of Public Health, and outline how these agencies will collaborate in the design and implementation.
- As part of the co-development process*, CMS and states will also consider their commitment to the operational investment the model will require, including appropriate budget and staffing to administer the model.
- d. **State Capacity**: *In their proposal*, states should consider their regulatory authority to implement a multi-payer model with Medicare participation. Additionally, states should consider whether changes to their Medicaid program are required for Medicaid participation. *In their proposal*, states should, at a minimum, articulate a plan to work with Center for Medicaid and CHIP Services (CMCS) within CMS to achieve Medicaid participation in the model.
6. **Feasible to evaluate**: In some respects, most of the above criteria pertain to ensuring that the proposed model is consistent with our statutory mission to test and evaluate innovative payment and service delivery models. With respect to evaluation, however, there are specific features that are critical. *In their proposal*, states should include a discrete performance period and clarity about the baseline against which we will measure the state’s performance.
- As part of the model co-development process*, states should consider the performance period for the model and the data to support the calculation of a baseline. States must agree to share data to CMS for purposes of an evaluation, including regularly updated Medicaid and private claim-level data.

⁶ Please see Appendix B of the ONC Health IT-Enabled Quality Measurement Strategic Implementation Guide for additional examples of health IT services that correspond to functions in the visual and that would combine to support this use case: https://www.healthit.gov/sites/default/files/onc_hiteqm_strategyimplementationguide.pdf