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U. S. Department of Health and Human Services
Centers for Medicare and Medicaid Services (CMS)
7500 Security Boulevard
Baltimore, MD 21244

Re: SHADAC Response to CMS' Request for Information (RFI): Innovation Center New Direction

To whom it may concern:

Thank you for the opportunity to respond to this RFI about the direction of CMS' Innovation Center, an important resource within the U. S. Department of Health and Human Services for identifying and assessing needed health delivery and payment interventions in public programs. Having served in a evaluation and technical assistance capacity on behalf of states implementing innovative ways to deliver and pay for health care, the State Health Access Data Assistance Center (SHADAC) is pleased to provide responses to three RFI questions as they relate to data needed for and evaluation of state-led innovation.

SHADAC, located within the Division of Health Policy and Management at the University of Minnesota, is a health policy research and technical assistance center with a focus on state health policy including public program financing, reform, and health outcomes. Our small, multidisciplinary team is passionate about the importance of using sound data to inform policy decisions, and works collaboratively with clients as thought partners to understand their information needs and achieve results.

SHADAC has been providing policy research, evaluation, and technical assistance to state and federal officials for over 15 years, and in that time we have worked with personnel in most states and territories. Our clients are usually state officials, data analysts, and policymakers who work in state health departments, Medicaid offices, departments of insurance, and exchanges. We also provide assistance to legislators and their staff. Thanks to our history of working with states, we have developed a deep understanding of the unique challenges and opportunities states face.

In this letter, SHADAC responds to three questions posed:

- Do you have comments on the guiding principles or focus areas? (question 1)
- Do you have suggestions on the structure, approach, and design of potential models? Please also identify potential challenges or risks associated with any of these suggested models. (question 3)
- Are there any other comments or suggestions related to the future direction of the Innovation Center? (question 7)

We draw from our recent experiences monitoring and evaluating state reforms, specifically as state evaluator of the State Innovation Model (SIM) in Minnesota as well as a Medicaid and CHIP Payment and Access Commission (MACPAC) Indefinite Delivery/Indefinite Quantity (IDIQ) prime contractor. Under the MACPAC IDIQ, SHADAC has been tasked with engaging stakeholders to discuss Medicaid advanced payment models, cataloging Medicaid initiatives focusing on integrating physical and behavioral health care, and assessing quality measurement for home and community based services and behavioral health in Medicaid. In addition, during

the timeframe of the passage of the Affordable Care Act (ACA), SHADAC provided technical assistance on data and evaluation to a variety of states as they implemented the ACA (supported by the Robert Wood Johnson Foundation) and specifically, the 13 state grantees of the Health Resources and Services Administration (HRSA) State Health Access Program (SHAP).

Comments on Select Innovation Center Principles and Focus Areas (RFI Question 1)

SHADAC appreciates the opportunity to comment on the Innovation Center's future guiding principles and focus areas (question 1) and is best suited to provide insights on transparent model design and evaluation (principle 5); and small-scale testing (principle 6); as well as the state-based and local innovation potential model (focus area or potential model 6).

Principle: Transparent model design and evaluation

SHADAC shares the Innovation Center's commitment to transparency in model design and evaluation. We make two basic points as the Innovation Center evaluates models according to this principle.

- Successful model design should include planning and discussion of parameters for evaluation. As the Innovation Center rolls out new models, it will be important to identify, in advance, the information, data, and evidence needed to determine the impact of the model. Data collection and evaluation requirements should be prioritized from the beginning and revisited over time. Evaluation requirements in the model design phase could include developing framing questions for model evaluation, determining whether model requirements are aligned with evaluation priorities (maximizing alignment where possible), assessing data needs and gaps, and seeking stakeholder input on desired and achievable short-term and long-term outcomes. A limitation of our evaluation of SIM in Minnesota was that key questions and priorities were not identified in advance of finalizing model requirements, which led to missed opportunities for prospective, standardized, data collection, and data harmonization across participants.
- Evaluations of innovations should include clear documentation of actual interventions to assess outcomes. State and local payment innovation in health care is complex, involves multiple stakeholders, and is taking place alongside other population-based reforms and in changing marketplaces and policy environments. Therefore, Innovation Center Model implementation, no matter how well-defined, may vary by participating organization or individual and local needs. Evaluations must determine how models are implemented in practice (versus planned interventions) in order to better associate interventions with changes in outcomes. For example, evaluations of Accountable Care Organization and advanced primary care models could include descriptions of core aspects of model implementation, which facilitates transparency and identification of promising practices.

Principle: Small-scale testing

States can serve as a laboratory for future, larger-scale reform efforts. SHADAC supports the assessment of future Innovation Center models in terms of the possibility of small-scale testing and has studied a variety of successful state-led innovative delivery system and payment reform approaches in its evaluation and technical assistance work with states. One consideration for the Innovation Center as it relates to small scale testing is developing the capacity to systematically monitor, similar state-based models across states to inform intervention scalability. More work is needed to develop measurement frameworks, standards for data collection, and metrics to respond to questions about efficacy of highly publicized state reforms, such as Medicaid Accountable Care Organizations (ACOs) or Accountable Communities for Health (ACHs). Another consideration is continue to provide adequate funding for state and local evaluations as well as to facilitate the

release of interim and final evaluation results in a timely manner, including documentation of innovative interventions and evaluation metrics to promote program or model accountability and shared learning.

State Medicaid ACO models, for example, are young and their structures vary significantly based on a state's health care marketplace, Medicaid program history, leadership, and culture of stakeholder collaboration. While using the term "ACO" can be helpful in describing basic concepts, it is often used inconsistently and does not convey important program elements. States implementing Medicaid ACOs or "ACO-like" models have blended various elements of differing care delivery and payment reform strategies and have adapted new models to local health care markets and political environments.

SHADAC proposes several questions the Innovation Center may want addressed related to the data needed to inform state model comparisons and scalability:

- How are models identified and defined? How are patients attributed to models?
- What specific methods are states employing to identify providers who are part of model arrangements?
- What are considered key metrics of performance and how are they determined? Do metrics track model impact on care delivery decisions and behavior at the provider level? What is missing from a patient satisfaction, access, utilization, or cost perspective? Do measures relate to near, medium, or long term impacts?
- What quantitative and qualitative data sources are states using to track model performance?
- How are states comparing outcomes for patients enrolled in models to those not receiving care from the model? Are breakouts available for specific beneficiary groups? Provider types?
- How are state agencies leveraging or thinking about leveraging broader state data resources, such as All Payer Claims Databases (APCDs), to evaluate model performance?
- What methodological issues exist? How can they be overcome?
- Who is responsible for model monitoring and evaluation activities?
- How do state efforts to monitor and evaluate their reforms differ from the data analytic activities and reporting disseminated to providers for quality assessment and payment purposes? How are these efforts aligned or not aligned?
- What data or infrastructural enhancements (or methodology changes) would be necessary to be able to compare and contrast the performance of different state models? What is the feasibility of collecting new/different data?

Potential Model: State-based and Local Innovation, including Medicaid-focused Models

SHADAC applauds the ongoing SIM initiative in terms of investing in states to design, implement/accelerate, and evaluate needed reforms in health care service delivery and payment and is pleased to learn of the potential for continued support of state and local innovation, including in Medicaid. The Innovation Center should build on the SIM framework, which supports states in all aspects of their transformation, including, for example, stakeholder engagement, health information technology, measurement, and sustainability, as well as alignment with population health goals. Other noteworthy aspects of SIM include opportunities for peer learning as well as access to a range of expertise within federal agencies or through the federal technical assistance contractor.

Lessons identified by SHADAC from its work with states implementing delivery system and payment reforms include: the need to balance flexibility in model implementation with participant accountability; and the

importance of determining and communicating the value (or return on investment) of payment reforms and developing data collection systems to support this work, particularly within the provider community.

Potential Model: State-based Innovation - Opportunities and Challenges (RFI Question 3)

SHADAC's qualitative and quantitative work to date assessing state-based reforms, including Medicaid-focused models, resulted in several lessons. Reforms studied by SHADAC included Medicaid ACO models, health information exchange (HIE) and data analytics interventions, multi-payer patient-centered medical home (PCMH) or health home models, and ACHs. We summarize study lessons in terms of implementation opportunities and challenges for states:[1,2]

Opportunities

- Access to external expertise as well as learning opportunities across participating organizations accelerated progress and facilitated learning.
- State-based APCDs were important for comparisons between intervention and control groups across payer types as well as evaluation of spillover effects. Support for states in their APCD analytic work and development is key to evaluation of market and payment reforms.
- Promising data analytics in model design encouraged provider organization participation in interventions.
- There was overlap across states in terms of the types of metrics disseminated to providers participating in reforms, underscoring commonality across states in the definition of high-priority issues.
- Delivery system or payment reforms aligned with the goals of participating provider organizations.
- Organizations participating in state-based reforms leveraged previously established relationships to facilitate patient-centered, integrated, and coordinated care across care settings.

Challenges

- Performance measurement challenges that need further attention and investment include the lack of alignment across payers and model interventions, comparability across different types of providers, transparency, access to clinical data sources, and under-developed measures for non-medical health needs.
- Claims-based data sources were insufficient for real-time care management interventions that seek to coordinate care across settings. There is demand for more timely claims data as well as the integration of provider clinical data with administrative/claims data.
- Collaboratives participating in Minnesota reforms anticipated complex data privacy legal issues, which require investments of time and financial resources to overcome.
- There was limited capacity among provider organizations for electronic data sharing outside of their own organization walls; consideration should be given to payment incentives to encourage more data sharing.

Other Suggestions: Dissemination of Evaluation Findings (RFI Question 7)

During the October 18th webinar introducing this RFI, a comment was made for responses to include, if applicable, feedback on evaluation products and dissemination to maximize meaning and use of these

[1] SHADAC, "Evaluation of the Minnesota Accountable Health Model: First Annual Report – Full," *University of Minnesota, School of Public Health*, May 6, 2016, http://www.dhs.state.mn.us/main/.

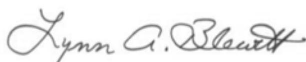
[2] Dybdal, Kristin, et.al. "State Medicaid Reforms Aimed at Changing Care Delivery at the Provider Level: Final Report." *University of Minnesota, School of Public Health*, August 2015, https://www.macpac.gov/wp-content/uploads/2015/08/State-Medicaid-Reforms-Aimed-at-Changing-Care-Delivery-at-the-Provider-Level.pdf.

deliverables. Large-scale, initiative-level evaluations of complex innovation models typically call for long, comprehensive, written reports every year or every few years. While these reports are important, SHADAC saw great value in developing more timely, concise products, as well, e.g., short, targeted, frequent memos or briefs and webinars, to disseminate findings from data analyses or evaluations. The Innovation Center should continue to encourage, as was the case under SIM, rapid-cycle feedback reporting from required state-led evaluations as well as alignment with federal reporting. As SIM in Minnesota state-led evaluation contractor, SHADAC produced several interim deliverables for the state team overseeing SIM implementation to inform progress and planning. In addition, evaluation plans and interim findings could be more accessible to participating (and non-participating) states through Innovation Center website links and up-to-date inventories, infographics, or dashboards of evaluation and monitoring methods, activities, data sources, and results.

The Innovation Center could leverage expertise and results from other required federal evaluations of state-based innovation, e.g., Medicaid State Plan Amendments, Section 1115 Waivers, as well as continue collaboration with the Health Care Payment Learning and Action Network (LAN) and the Payment Reform Evidence Hub at Duke Margolis Center for Health Policy, as examples, to support dissemination of delivery system and payment reform evaluation evidence.

SHADAC appreciates the opportunity to comment on the future of the Innovation Center and we hope our comments and insights related to needed data collection strategies to support robust evaluation are helpful. Should you have questions about our response or require additional information, please contact either Dr. Lynn Blewett at 612-624-4802 or blewe001@umn.edu or Ms. Christina Worrall at 612-624-4934 or cworrall@umn.edu. We strongly support the important work being done at the Innovation Center and will continue to be a resource to CMS and states as they seek to promote patient-centered care and payment reform interventions.

Sincerely,



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