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Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: Request for Information (RFI) on State Innovation Model Concepts
7500 Security Boulevard
Baltimore, MD 21244-1850

Submitted electronically to: SIM.RFI@cms.hhs.gov

Re: Request for Information (RFI) on State Innovation Model Concepts

Dear Acting Administrator Slavitt,

Trinity Health appreciates the opportunity to provide comments on the Centers for Medicare & Medicaid Services' (CMS) Request for Information (RFI) on the State Innovation Model (SIM) Concepts. Our response and recommendations reflect a strong interest in public policies that support better health, better care, and lower costs to ensure affordable, high-quality, and people-centered care for all. SIM, which is critical to advancing these important goals, should be continued and expanded. Valuable lessons can be learned from SIM states and their commitment to payment innovation, restructuring care delivery systems, and efforts to build healthy communities that extend beyond traditional medical providers.

Trinity Health is one of the largest multi-institutional Catholic health care delivery systems in the nation, serving diverse communities that include more than 30 million people across 22 states. We are building a People-Centered Health System to put the people we serve at the center of every behavior, action and decision. This brings to life our commitment to be a compassionate, transforming, and healing presence in our communities. Trinity Health includes 93 hospitals, 120 continuing care locations — including home care, hospice, PACE and senior living communities — that provide nearly 2.5 million visits annually. Committed to those who are poor and underserved, Trinity Health returns almost \$1 billion to our communities annually in the form of charity care and other community benefit programs. We have 31 teaching hospitals with Graduate Medical Education (GME) programs providing training for 1,951 residents and fellows in 184 specialty and subspecialty programs. We employ approximately 97,000 full-time employees, including 5,300 employed physicians, and have more than 13,800 physicians and advanced practice professionals committed to 19 Clinically Integrated Networks across the country.

Trinity Health is an organization committed to rapid, measureable movement toward value in the delivery of—and payment for—health care. Trinity Health is currently participating in 16 Medicare Shared Savings Program (MSSP) ACOs and has five markets partnering as a Next Generation ACO. In addition, we have 43 hospitals

participating in the Model 2 Bundled Payments for Care Improvement (BPCI) initiative, 13 Skilled Nursing Facilities (SNFs) in Model 3 BPCI, and 2 hospitals in the Comprehensive Care for Joint Replacement (CJR) program. Our work extends beyond Medicare as illustrated by our participation in 98 non-CMS APM contracts.

Trinity Health believes that states make great incubators for health care innovation. With facilities in nine SIM Testing states and five SIM Design states, Trinity Health has been a leader on SIM public policy development influencing the pace and process by which our states reach the goal of achieving value-based, alternative payment models (APMs) for 80 percent of their population. To support SIM efforts across our states and to advance health system transformation, we have established a [SIM Resource Center](#). This Center provides best practices, learnings, and summaries to states leaders accountable for payment, delivery, and community health transformation. Trinity Health believes that SIM efforts should be transformative, broad-based, and sustainable. Underscoring our system-wide commitment to health system transformation, Trinity Health has committed to having 75 percent of our revenue in value based arrangements by 2020 as a member of the Health Care Transformation Task Force.

We thank CMS for the opportunity to comment on this RFI and intend for our recommendations to reflect our strong interest in public policies that support better health, better care, and lower costs to ensure affordable, high quality, and people-centered care for all. If you have any questions on our comments that follow, please feel free to contact me at wellstk@trinity-health.org or 734-343-0824.

Sincerely,



Tonya K. Wells
Vice President, Public Policy & Federal Advocacy
Trinity Health

General Remarks

We are firmly committed to, and are making significant progress in, transforming our delivery system into a People-Centered Health System focused on delivering better health, better care, and lower costs in our communities. SIM grants are an important vehicle for states to develop and implement a broad plan for health system transformation. **Trinity Health strongly believes that SIM efforts are working and should continue as well as be expanded to additional states.** CMS can further advance the SIM demonstration efforts through the following four broad strategies:

1. Ensure engagement of relevant stakeholders to align public and private innovation efforts and resources.
2. Structure payment policy to support transformation.
3. Prioritize community engagement and population health efforts.
4. Fund and enable strategies that support transformation.

SIM grants are helping states improve the health of their residents and communities through care delivery transformation as well as investments in healthy living. The grants are helping states and governors drive collaboration with payers, providers, patients, and other stakeholders. SIM can help in driving these key actors to the table. We encourage CMS to refine and extend the SIM demonstration program so that more states may

participate, and participating states can progress to the Testing phase. Our comments are in support of improving the SIM demonstration program’s ability to:

1. Transform health care delivery.
2. Promote healthy living and communities.
3. Drive multi-payer, collaborative learning across states.

Multi-Payer State-Based Strategies to Transition Providers to Advanced Alternative Payment Models

Trinity Health seeks to be a national leader in SIM public policy development, sharing and supporting states in achieving their shared goal with CMS of moving 80 percent of their population into value-based APMs. Trinity Health’s SIM states are using a range of APMs, including: accountable care organizations (ACOs) in Massachusetts, Delaware, Connecticut, Iowa, Oregon, and Michigan; patient-centered medical homes (PCMHs) in New York, Ohio, Idaho, Connecticut, and Michigan; and episodes of care in Ohio. We support this varied approach and believe each has learnings to be shared.

Our engagement across these states gives us a unique perspective in contributing to the potential next phase of the SIM demonstration. We have found that evaluating and measuring progress across states is an important component in achieving bold reform and is key to successful SIM work. Trinity Health has developed, and is using, a dashboard to measure readiness and progress in our SIM states on the following dimensions: payer participation and covered populations, governance structure, payment and delivery reform implementation, and community health and well-being. Our collective experience has demonstrated that sharing best practices across states and participating in true learning collaboratives are important factors for success. We recommend that the Center for Medicare and Medicaid Innovation (CMMI) develop a tool that measures state progress in a consistent and transparent way. We believe that greater sharing of key learnings and consistency across states is needed.

Trinity Health believes that states are successful incubators for new care and payment delivery models. Though the range of innovations differs greatly between states, Trinity Health’s SIM efforts have demonstrated that buy-in and support—both financially and in terms of infrastructure—from the state are key to stability and sustainability of reform efforts.

Essential Components of Successful Multi-Payer Reforms

Multi-Stakeholder Engagement

Based on our experience, Trinity Health believes that multi-stakeholder engagement is key to developing sustainable reforms and ensuring robust participation from payers and providers. States should leverage their ability to convene multi-sector representatives to form a broad coalition and build consensus around the purpose and desired outcomes of transformation efforts. This is best reflected in the SIM governance structure. Not surprisingly, SIM governance structures vary across states. Yet almost all are convening stakeholders for input on design and implementation issues, including payment strategies, quality metrics, integration of behavioral health services, health information technology programs, and community health improvement efforts. Stakeholders should include: members of the public and private sector, including providers, consumers, advocates, representatives from health plans and local public health. A best practice, Delaware established the Delaware Center for Health Innovation, an independent, non-profit public-private partnership, to oversee its five SIM committees. In Ohio, the Health Care Payment Innovation Task Force (comprised of state agency representatives) and the Governor’s Advisory Council on Health Care Payment Innovation (including consumers, providers, and plans) jointly oversees the state’s five SIM “implementation teams.” Best practice governance structures promote stability, joint accountability, and sustainability – regardless of political or other challenges

that impact transformation efforts. **CMS should consider sharing governance structure best practices , such as those in Delaware and Ohio, with other states to ensure that SIM efforts are anchored by multi-stakeholder support and participation – and can progress across administrations and other change.**

Getting, and keeping, payer engagement and participation is especially critical. Our experience suggests negotiations over APM terms between payers and providers can be challenging. Trinity Health has found that SIM efforts are most successful when states set goals and help advance APM terms that move more individuals into value-based payments in a way that is sustainable for all stakeholders. For instance, New York successfully advanced Medicaid APMs by outlining APM requirements on issues such as patient attribution, quality measures, medical loss ratio and contracting timelines — helping make progress between payers and providers. **CMS can increase payer and provider participation in APMs by providing model terms for APMs, as well as ensuring alignment of federal and state models and new APM models, i.e. CPC+, across payers. Additionally, CMS should require payers and providers to report their APM growth.**

Robust Health Information Technology Infrastructure

Trinity Health believes that data sharing and exchange across payers, providers, and other stakeholders is essential for providing coordinated care and ensuring accountability to further the goals of better health, better care, and lower costs. SIM grants enable expanded use of technology and interoperability; both of which should be expected outcomes from SIM testing states.

States have taken a range of approaches to developing health information technology (HIT) plans and capabilities, developing nuanced approaches based on geography, patient populations, or other state-specific factors. Idaho, for example, is planning to establish virtual PCMHs to provide specialty and behavioral health services to rural patients as part of its SIM efforts. These virtual PCMHs will integrate electronic health records (EHRs), patient portals, and clinical decision tools. The state is also working to establish a statewide HIT system in 2016-2017, which will incorporate tracking of clinical quality measures among PCMHs. Similarly, Connecticut has established a HIT Advisory Council to develop a strategy for integrating mechanisms for quality measure reporting into the state's broader HIT system.

As CMS considers how SIM grants can be used to build robust, interoperable HIT infrastructure, Trinity Health recommends that the Agency identify ways to support the creation of a standardized HIT ecosystem that supports clinical decision-making in an actionable way, informing population health and promoting and monitoring movement to value-based payments. Support mechanisms could include promoting an HIT workforce, funding to support providers in using HIT data and capabilities in actionable ways, ensuring the security of health data, and expanding the use of HIT capabilities to non-traditional providers (e.g. post-acute care, behavioral health).

All-Payer Claims Databases

Some states are using SIM funding to develop All-Payer Claims Databases (APCDs). Trinity Health believes this should continue and spread. Collecting and allowing data to be analyzed across payers is critical to driving value-based purchasing and transparency. Furthermore, APCDs can advance population health goals, and provide the ongoing infrastructure to help address public health crises that may benefit from data sharing, such as the current opioid epidemic. The *Gobeille v. Liberty Mutual Insurance Co* decision has created uncertainty around, and slowed development of, APCDs. While holding that ERISA preempts state APCD reporting requirements, the Supreme Court opened the door for a federal solution. **CMS should consider ways to support states in establishing and leveraging APCDs to support health transformation efforts. This includes support for a short-term solution to the *Gobeille v. Liberty Mutual Insurance Co.* decision; specifically the Department of Labor**

(DOL) could implement a pilot program to collect health care claims data in cooperation with state APCDs. A longer-term solution includes standardized data collection across all states.

Population Health Efforts

Trinity Health believes that improving population health requires a whole-person approach to meet the full range of an individual's needs. Key elements of this approach include integration of physical and behavioral health services, as well as utilization of community-based social services to promote an integrated and seamless delivery system. It is particularly essential for Medicaid programs to play a role in model design, as state Medicaid programs are implementing and testing innovative approaches with the potential to improve population health.

Workforce innovation is a critical component of achieving population health goals. A number of states have incorporated community health worker (CHW) programs into their SIM model design, including Delaware, Connecticut, Idaho, and Michigan. Idaho developed a CHW training curriculum and is poised for broader training and deployment when funding becomes available. Nurse care managers and social workers also play a critical role, and support for these professions should be explored in SIM models as well.

Some states are developing regional community health entities committed to population health activities specific to their region. Delaware's Healthy Neighborhoods program is focused on locally-tailored efforts to bring together community organizations and local populations to promote healthy living, maternal and child health, chronic disease prevention and management, and mental health and addiction management programs. In Michigan, Community Health Innovation Regions (CHIRs) will conduct community health needs assessments to identify local and regional social determinants of health, ultimately implementing action plans to address key population health priority areas and connect providers with community partners. These organizations enable states to develop targeted population health solutions that allow for the strategic and efficient use of existing—and often limited—resources. **CMS should continue to encourage innovative community health initiatives that advance population health goals at local and regional levels. Additionally, CMS should help advance workforce development programs and opportunities to support non-traditional care providers that are key to care coordination and addressing community and social service needs.**

Behavioral Health Integration

Trinity Health recognizes the importance of integrating behavioral health into APMs. In many of our states, discussions are increasingly focused on integrating physical and behavioral health services. For instance, Delaware's SIM includes care coordination and integration of physical and behavioral health care for high-risk individuals, while focusing on effective diagnosis and treatment for all populations. Massachusetts has begun work to integrate behavioral health services into its Medicaid ACOs. Other states—including Connecticut, Iowa, New York, Idaho, and Oregon—are addressing integration of behavioral health services to varying degrees in their SIM initiatives.

Trinity Health strongly believes that collaborative care is critical to successful behavioral health integration. We encourage CMS to advance coverage of collaborative care for all providers participating in innovative, total cost of care models, such as ACOs and bundled payment programs. Aligning payment for collaborative care within APMs will ensure accountability for achieving better health, better care and lower costs. As we gain experience with integrating more populations into APMs, we are learning that APM risk arrangements must reflect the breadth of providers participating in an APM to ensure appropriate clinical management, as well as appropriate provider accountability for costs and outcomes.

Cross-Payer Quality Metric Development

Trinity Health supports greater alignment of quality measures across payers, and an overall movement to outcome-based measures, including patient-reported outcomes measures (PROMs), that are meaningful to patients rather than process-based measures. We believe that the development of a core, discrete set of cross-payer metrics allows states to evaluate the impact of models on health and costs across payers and providers, and that the current quality measure landscape not only adds growing administrative burden to providers participating in numerous quality programs, but also impedes the evaluation and comparison of new payment and delivery reform models.

Many SIM states have developed or are developing metric sets to understand the impact of SIM initiatives on health outcomes. Both New York and Delaware, for example, are developing scorecards for model evaluation. New York's scorecard is comprised of 20 measures for all payers in the SIM, including measures from NCQA's Healthcare Effectiveness Data Information Set (HEDIS), the National Quality Forum (NQF), and the Children's Health Insurance Program Reauthorization Act. Connecticut developed a provisional set of cross-payer core measures (including CAHPS care experience measures, plan all-cause readmission, and Emergency Department Usage) but following the release of the Core Quality Measure (CQM) Collaborative's core measure set, the state is reviewing its provisional set to assess potential alignment with the CQM Collaborative. Our experience demonstrates that multiple quality sets create confusion and inefficiency among providers. **We support the work of the CQM Collaborative and suggest that CMS promote its adoption across SIM states. Adoption of nationally recognized quality metrics would go a long way to promote alignment across payers. CMS should also develop a transparent model scorecard that includes quality metrics, patient experience metrics, and APM progress.**

Tracking and Transparency

States must have a tool to measure progress toward achieving their goal around the percentage of payments made through value-based payments or APMs. Connecticut, in partnership with the University of Connecticut, is developing a dashboard that will track progress of key components of the state's initiative, including health insurance transformation. New York created a Payment Reform Scorecard in coordination with Catalyst for Payment Reform, which measures the percent of payments in value-based payments, tracking progress toward the state's 80 percent value-based payment goal. Transparency of such tools and evaluation data is critical to SIM success. **CMS should support the development of standardized and transparent tracking methods and tools that states can use to gauge progress, and which would allow for cross-state comparison. Specifically, CMS should develop a model scorecard that includes quality metrics, patient experience metrics, and APM progress.**

Payment and Delivery Reforms and Population Health

Trinity Health believes that for APMs to successfully advance population health, there must be a robust network of providers to meet the varied needs of a wide range of populations. Specifically, Trinity Health believes primary care providers – and access to them – are essential to delivering better care, achieving better health outcomes, and lowering costs. Trinity Health also believes there is a strong and important role for high-performance networks, which have demonstrated the potential to hold down costs while ensuring high-quality care and increased accountability for attributed populations. **CMS can help ensure that an appropriate network of clinicians is participating in an APM by supporting the development of narrow, high-value or high-performance networks that can promote patient engagement, facilitate effective care coordination, and manage costs effectively through the network's accountability. We encourage CMS to work with states to examine the role of network adequacy, as well as clinically integrated networks (CINs), in the successful implementation of APMs.**

Assess the Impact of Specific Care Interventions Across Multiple States

Population-Health Initiatives Focus on Locally-Determined Needs

Trinity Health supports innovative population health approaches to addressing the social determinants of health. Trinity Health recently selected grant recipients for its Transforming Communities Initiative (TCI), a new initiative that will support community health improvement efforts in six communities with about \$80 million in grants, loans, community match dollars, and services over the next five years. All of the TCI programs will focus on policy and systematic reforms that will directly impact areas of high, local need.

Simultaneously, SIM initiatives are developing state-specific solutions to regional and local population health needs. A number of states are using community health needs assessments to develop population health improvement plans, including Oregon, Delaware, and Iowa. Furthermore, as previously mentioned, a number of states are using CHWs to assemble and train local community health advocates. In fact, Trinity Health worked with the Idaho Healthcare Coalition to develop Idaho's CHW training program.

Other models are using regional or local organizations to drive reform. Oregon's Coordinated Care Organizations (CCOs), Delaware's Healthy Neighborhoods, and Iowa's Community Care Coalition all are entities designed to coordinate public health and community partners and resources to target local public health needs. Trinity Health is currently participating in Wave 1 of Delaware's Healthy Neighborhoods initiative. **CMS should continue to encourage states to leverage SIM grants as a catalyst for population health initiatives, empowering local and regional stakeholders to address social determinants of health.**

Focus on High-Need Patients

Trinity Health is committed to addressing the needs of vulnerable populations and reducing health disparities. States are using a number of approaches to address health disparities across vulnerable populations, and we share their goals to improve the health of all populations – especially those who are vulnerable and with high-need. Michigan's health care innovation plan, for example, will include Community Health Innovation Regions (CHIRs) that guide patients to community services relevant to their needs. By partnering with local stakeholders—schools, charities, faith-based organizations, and others—and providing efficient and effective wrap-around services, CHIRs can help tackle upstream causes of poor health in the region. Iowa's initiative includes a number of population health activities particularly focused on reducing tobacco use, obesity, and diabetes, while Connecticut has set goals aimed at decreasing rates of diabetes, obesity, tobacco use, asthma, falls, hypertension, and depression. CMS should continue to work with SIM states to ensure that the needs of vulnerable or underserved populations are a core part of their transformation plans and APM development. **Furthermore, CMS and states should recognize the vast opportunity for state experimentation and variation in identifying unique challenges and best practices to improve outcomes for vulnerable, high-need populations.**

Streamlined Federal/State Interaction

Alignment of Flexible and Fair APMs

As federal reform initiatives continue to be announced and implemented – such as the Medicare Access and CHIP Reauthorization Act (MACRA) and Comprehensive Primary Care Plus (CPC+) – states are analyzing their efforts to determine whether and, potentially, how to align with these new efforts to advance transformation. Questions of alignment are particularly challenging in states where beneficiaries, providers, health systems, and payers may be eligible for, or are participating in, multiple initiatives with conflicting or incongruous timelines,

requirements, or measures. Providers, in particular, face enormous administrative burdens working across payers as they are often subject to different payment structures, reporting timelines, and quality measures.

In considering alignment of federal and state efforts, CMS should be cognizant that states may need a longer performance period – beyond the initial grant period – to establish a multi-payer delivery model that qualifies as an APM. Many states experienced delays with their APM decision-making (often to align with other state and federal reform efforts such as CPC+) that has shortened the implementation and evaluation period. Despite these challenges, a number of states have already started to align multi-payer models. Ohio and New York are currently focused on aligning SIM initiatives with CPC+. Starting in January 2018, Ohio will allow Medicare CPC+ practices to participate in the state’s multi-payer PCMH initiative. Additionally, all payers participating in Ohio’s SIM applied to participate in the CPC+ initiative. Likewise, New York encouraged plans participating in the state’s Advanced Primary Care Model to apply for participation in CPC+.

Trinity Health urges CMS to support flexible and fair APMs – structured around total cost of care – that incent change in the delivery of better health, better care and lower costs, recognize the significant business investments needed to support these new models, and do not prematurely push providers toward risk models. In designing any ongoing SIM initiative, CMS should prioritize and enable the alignment of federal and state – as well as commercial – efforts. CMS, for example, should consider SIM applications in concert with Medicaid and other waiver applications to further advance this movement toward health system transformation. Future SIM efforts should ensure participating states understand what is working within currently funded states and prioritize those successes in order to make payment model decisions. **CMS should consider working with states to create a “floor” for APMs by setting basic parameters for design features – such as shared savings – methods of patient attribution, use of core quality measure sets, and assessment of outcomes. This would promote common APM features across states, easing provider and other stakeholders’ ability to engage in multiple APM efforts and to transfer learnings across settings and communities.**

Conclusion

The SIM initiative has been a catalyst for stakeholder engagement around transformation; structuring payment policy to support transformation; and innovative approaches to community engagement and population health efforts. More can be done to support transformation. CMS should capture and promote learnings from current SIM efforts before expanding to additional states. Current SIM states should be permitted to expand the duration of testing in light of the shifting landscape. CMS should focus on the development of nationally recognized core quality metrics, an APM reporting tool, and standardized data collection. Going forward, CMS should negotiate APM models at the onset of SIM awards, and include consideration of relevant requests for Medicaid, Medicare, and Section 1332 waivers. SIM progress should be measured and shared publicly. There should be an expectation of transparent data reporting, infrastructure development for data collection and analytics, and adoption of uniform quality metrics. States should be encouraged to use their unique position as health care incubators to further population health.