November 20, 2017

Seema Verma
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Response to Request for Information: Centers for Medicare & Medicaid Services: Innovation Center New Direction

Dear Administrator Verma:

The New Jersey Health Care Quality Institute (Quality Institute) welcomes this opportunity to respond to the Request for Information (RFI) on developing the future direction for the Centers for Medicare & Medicaid Innovation (CMMI). The Quality Institute is a regional health improvement collaborative that undertakes initiatives that promote system changes to ensure quality, safety, accountability and cost-containment are closely linked to the delivery of health care services in New Jersey. We recognize the important work CMMI has accomplished since its creation; because of the leadership provided, CMMI was the engine that made providers, payers and health systems pay closer attention to cost and quality through alternative payment models (APMs). We appreciate that CMMI has asked for broad input for the future direction of CMMI. All new programs should be reassessed, and improvements should be made.

The Quality Institute recommends an approach that encourages and supports state-based and local innovation. With a ground-up approach, models will be designed to focus on the needs at the community level. To accurately assess improvements in care and cost savings, measurement across all payers is needed. If innovative alternative payment models have been developed by a group of providers/plans for either commercial or Medicaid markets, CMS should support a similar approach to paying for Medicare beneficiaries in that area so there can be full multi-payer support. More comprehensive models will drive quality improvement as well as address population health priorities.

We strongly agree with the feedback offered by the Network for Regional Health Improvement (NRHI):

> "CMMI should also develop a clear way for successful models to share information so that all model participants can benefit from lessons learned and best practices. Currently, findings from CMMI models are often only disseminated at the end of a performance period or after a model has ended. This prevents models from sharing insights while they are working to improve care. **Instead, we would urge CMMI to establish a learning network that could facilitate models and allow participants to benefit from each other.**

Expanding successful initiatives and shared learning would leverage success of locally focused models.

The Quality Institute is the only independent, nonpartisan multi-stakeholder advocate for health care quality in New Jersey. Our members come from every health care interest: consumer groups, physicians, nurses, health care professionals, hospitals, health plans, accountable care organizations, employers, unions, foundations, pharmaceutical companies and innovators. We work collaboratively with our members to bring all sectors together to objectively discuss policy and work together to improve health care.

Our day to day involvement in many issues under the purview of CMMI's priorities gives us the experience to comment on your RFI and offer feedback. In the past few years we have:

- undertaken a widescale review of the state's Medicaid program and released 24 recommendations for reform in our Medicaid 2.0 Blueprint for the Future
- assessed and harmonized quality measures through a State Innovation Grant, reducing the 800 existing measures to 31 measures that matter
- promoted transparent reporting of hospitals safety and quality as the state's regional leader for The Leapfrog Group
- played a key role in developing and prioritizing evidence backed quality measures through participation on the Consensus Standards Approval Committee (CSAC) of the National Quality Forum (NQF)
- worked with mayors and other local leaders to address population health challenges through our unique program, the Mayors Wellness Campaign
- as a sub-grantee of the Garden Practice Transformation Network, recruited over 4000 eligible New Jersey physicians to participate in the GPTN and created monthly educational quality improvement sessions to help them succeed under the Merit-Based Incentive Payment System (MIPS)
- tracked consumer opinions of important health questions with our Health Matters polls conducted through our partnership with Eagleton Center for Public Interest Polling at Rutgers, The State University

Our broad on-the-ground membership – which works in both government-funded programs and the commercial market – allows us to innovate across different markets and leverage changes to the health care delivery system that are more patient centered and tailored to the needs of our state. Therefore, we welcome your call for a new direction that places an emphasis on local partnerships and ground-up innovations. We see ourselves as a natural partner for CMMI, as the local innovation center. We offer the following ideas and pilots that align with your stated priorities and look forward to continuing this conversation to improve health care together.

Guiding Principles:

Transparency: The Quality Institute appreciates the release of Medicare data which helped groups such as the NQF and The Leapfrog Group to develop evidenced-based quality metrics and report cards upon which payers, purchasers and consumers can rely. Transparency through greater public reporting is the most important element in promoting choice and competition. The Quality Institute wants providers to compete based on value – the synergy between cost and quality. Measures must be evidence-based and clearly defined. It is also vitally important that measures be presented in an easily accessible and understood manner for the public and for employer-purchasers. Furthermore, data transparency is essential to the development and success of APMs as well as allowing states to identify specific population health targets. With greater data sharing, states could make health policy decisions based on data and be able to deploy resources more strategically. Some states, such as Oklahoma, South Carolina and Texas, share Medicaid data on a public, searchable, and user-friendly website to support policy decisions and improve access to health services and improve health outcomes. For example, the Oklahoma Health Authority used such cost and utilization data to launch targeted initiatives to increase use of tobacco cessation services as well as case management services for at-risk pregnant women. As a result of these targeted efforts from FY2014-FY2016, Oklahoma saw a 39% increase in calls to their tobacco cessation hotline and 175% increase in enrollment into case management for at-risk pregnant women. Based on our 50-state survey, South Carolina's website offers the most user friendly and valuable view of its Medicaid Data.

Pilots We Would Like To See From CMMI:

Physical Therapy as an alternative to Surgery and Opiates: The Quality Institute recommends allowing expanded access to physical therapy as an intervention to avoid unnecessary surgery and opiate prescribing. Healthy movement is central to our ability to thrive. Nothing keeps Americans in bed and out of work more frequently than conditions which negatively impact our ability to move (musculoskeletal dysfunction). This holds true across the lifespan with changes in movement (e.g. ability to transfer from the floor, gait speed, strength, balance, etc) known to precede and even predict health decline and mortality as we age. Early access to the services of a physical therapist (within days of the initial concern) including evaluation, coaching and treatment when necessary, has been shown to have a significant impact on downstream healthcare utilization and cost. The combination of conservative (non-pharmacological, non-surgical) interventions and properly dosed exercise and lifestyle advice, pillars of conservative care, often act as potent facilitators of self-efficacy, confidence and ultimately retained independence. Policies that encourage regular examination of movement quality and fitness by qualified professionals and early, unencumbered access to care when changes in risk are noted, can, as effective primary and secondary preventions strategies do, improve the quality of life for many citizens and slow spending related to more aggressive treatment further downstream. The Quality Institute would like to see care models that support more integrated care in which primary care providers work directly with physical therapists and mental health providers to address pain in these ways that are generally more effective in the long term than opiates.

Maternity Episode of Care: EOC payment models should be developed as they have the potential to reduce costs and greatly improve outcomes. The design of these models is consistent with the Medicare bundled care initiative as well as those being used by commercial carriers. While these models have demonstrated enormous potential to improve outcomes and reduce cost, they present additional challenges for the Medicaid population. Medicaid patients often have needs beyond clinical conditions that complicate their access to treatment such as housing, employment and child care. For these models to achieve their full potential for the Medicaid program, they should include a care coordination component to ensure that these needs are addressed those needs are part of the EOC. In New Jersey, a proposed EOC model for maternity was developed by the Quality Institute as part of its Medicaid 2.0 reform effort; high C-section rates, infant and maternal mortality rates, and NICU utilization prompted us to target this population for an EOC. The proposed model was developed as part of a broad-based stakeholder effort that included the Medicaid MCOs, large hospital systems, practitioners and community based organizations. The EOC includes requirements that the OB-GYN practice conduct a comprehensive risk assessment to determine the patient's level of need for state sponsored support services and provide linkages (either referral or warm hand off depending on risk level) to these services. Support Services included in the Quality Institute proposed EOC:

- Home visitation
- Mental Health
- Substance Use Disorder
- Domestic Violence
- Transportation
- Housing
- Group Prenatal/Centering (Strong Start)

Patient Centered Medical Home Pilot for Medically Complex Children: The Quality Institute recommends piloting a Patient Centered Medical Home Pilot for Medically Complex Children. Advances in medical technology has improved the survival rate of many children born extremely premature or with serious congenital conditions. It is estimated that nationally these children represent six percent of the total number of children enrolled in Medicaid but account for 40% of the spending on behalf of Medicaid children[1]. Medicaid provides coverage for nearly half of New Jersey's children and the program has become vital to families of children with complex medical conditions. Historically, commercial insurance coverage included limits on

[1] The Pew Charitable Trusts. Stateline. Improving Medicaid for Medically Complex Kids. http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/1/08/improving-medicaid-for-medically-complex-kids

scope and/or duration of certain services, such as private duty nursing or institutional long-term care. The costs of these services exceed the financial capacity of most New Jersey residents, leaving Medicaid as the insurer of last resort for these services for many severely ill or disabled children. Under this pilot, an estimated 50-100 children would be assigned to a medical home operated by a provider group with proven experience in serving children with medical complexities. For a monthly care coordination fee, the designated providers would coordinate all care for these patients, including the use of out-of-state providers when necessary. The medical home provider would be evaluated on quality metrics and the total cost of care. The children would be selected to participate in the pilot using the Pediatric Medical Complexity Algorithm (PCMA) developed by Washington State Medicaid[2].

Patient Centered Dialysis: Another excellent candidate for APM is an at-home hemodialysis program. This is a patient-centric model designed for geriatric patients residing in skilled nursing facilities ("SNFs") that achieves optimal patient outcomes by providing point of care hemodialysis services technically modified for the geriatric population, while significantly reducing costs. The model utilizes bundled pricing for Medicare geriatric ESRD patients residing in SNFs and are receiving home hemodialysis. The bundled payment will encompass all payments for a home hemodialysis treatment, including drugs, laboratory services, supplies, equipment, transportation, home and self-dialysis training, support services necessary for the effective performance of a patent's dialysis furnished in the ESRD facility or in a patient's home, and other capital-related costs associated with furnishing maintenance dialysis services. In addition to improved health outcomes, the model enhances patient experience and quality of life by eliminating strenuous and potentially dangerous transportation to and from dialysis facilities, missed rehabilitation sessions, missed meals, and missed social events. A reduction in payer spending will result from the total elimination of transportation from a SNF to a dialysis facility, reductions or elimination of a number of medications, and a decrease in hospitalizations and re-hospitalizations as a result of the improved medical outcomes.

Strategies to improve care for Individuals who are Dual Eligibles - Medicare Bonus: Unless Congress permits Medicare to mandatorily enroll its beneficiaries in a managed care plan, states will continue to struggle to coordinate care for dually eligible individuals. Currently, states are experimenting with a variety of strategies to convince these individuals to enroll in a Medicare Advantage (MA) plan, preferably the same one that covers their Medicaid benefits. Medicaid/Medicare Advantage Plans (MMP) and Dual Eligible Special Needs Plans (DSNPs) --for those with higher acuities -- have been available for over decade but enrollment has not grown significantly in our state. In 2017, only 21% of all Medicare beneficiaries are enrolled in a MA plan. In effect this means the vast majority of the approximately 200,000 dual eligible individuals in New Jersey are receiving hospital, physician and pharmacy benefits through fee-for-service. This disconnect leaves the Medicaid Managed Care Organizations ("MCOs") that cover the Medicaid services with little incentive to manage those services/costs covered by Medicare for which they are not responsible (i.e. hospital, pharmacy and physician care). CMMI should allow interested states to design a pilot with CMS whereby, Medicare would pay Medicaid MCOs a bonus when agreed upon quality measures are achieved and the FFS Medicare beneficiaries' total cost of care has been kept within or below pre-set total cost of care targets. The bonus would provide a direct financial incentive for MCOs to go beyond their contracts and improve patient outcomes and lower costs. This aligned incentive model would further encourage beneficiaries to enroll in the DSNPs as they see that better coordination of care leads to more person-centric and fundamentally better care.

End of Life: The Quality Institute has been running an innovative project called "Conversation of Your Life." This project has brought individual communities and their residents together to think more deeply about end of life care planning. Our April 2016 poll shows that while most residents (78%) are familiar with hospice care

[2] Official Journal of the American Academy of Pediatrics. Pediatric Medical Complexity Algorithm: A New Method to Stratify Children by Medical Complexity. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4035595/

and half (50%) know of the NJ State Advance Directive, far fewer recognize other crucial end of life care options like palliative care (45%) or POLST (27%). Introducing palliative care earlier in treatment for some chronic conditions like heart failure, will provide access to important services, including an opportunity for individuals/families to have conversations around goals of care. The Aetna Compassionate Care Model that allows palliative care to co-exist with curative care[3] should be supported. The model uses a claims-based algorithm to identify members with advanced illness who may benefit from integrated case management, allowing the member to pursue aggressive curative treatment for advanced illness as well as palliative care with the goal of treating the patient holistically. Studies show reduced cost and higher patient satisfaction with greater use of palliative care when it coexists with curative care[4]. In addition, CMMI should support state efforts to create statewide POLST Registries to easily track and allow reliable provider access to patients' POLST status.

Telehealth: CMMI should foster the expansion of the use of successful telehealth demonstration programs to improve access to specialty care, especially physician to physician eConsults and Project ECHO. eConsults are a means of addressing long standing lack of access to specialty care. In California, Connecticut and Minnesota, primary care providers are beginning to use physician-to-physician eConsults to access specialists on behalf of their patients. These eConsults allow primary care providers direct access to specialists around the country at leading academic medical centers. Early results show that eConsults substantially reduced the need for follow up specialist consultations and unnecessary medical tests because primary care providers were able to utilize the specialists' knowledge to better assess whether further testing or referrals were needed. Reducing the number of unnecessary referrals in turn reduces the wait times for specialists for those patients in true need of a specialty consultation. CMMI should expand the model offered by Project ECHO (Extension for Community Healthcare Outcomes). ECHO uses technology and hub-and-spoke knowledge-sharing networks to support and educate primary care physicians by providing best-practice specialty care through virtual clinics.

Thank you for this opportunity to offer input. We welcome any questions you may have.

Sincerely,

Linda Schwimmer, JD
President and CEO

[3] Aetna. Advanced Illness Care Coordination: A Case Study on Aetna Compassionate Care Program. http://www.ehcca.com/presentations/capgma1/krakauer_b8.pdf
[4] Health Affairs. Opportunities to Improve the Quality of Care for Advanced Illness. http://content.healthaffairs.org/content/28/5/1357.full