

Expanded Opportunities for Participation in Advanced APMs

Do you have comments on the guiding principles or Expanded Opportunities for Participation in Advanced APMs?

AHQA supports the guiding principles outlined in the RFI, however, recommends that if CMS desires providers move into Advanced APMs at a quicker pace, greater simplicity and providers' need for assistance be considered as guiding principles. Concerning simplicity, the provider community is challenged by an ever-changing health care environment and reaching a point of widespread burnout. Less complex models, including ones that align with other payer models (e.g., commercial payers), would be beneficial. To support providers in their understanding of and transition to new payment models, subsidized assistance from technical assistance contractors, such as the QIN-QIOs, would expedite the process.

What Expanded Opportunities for Participation in Advanced APMs model designs should the Innovation Center consider that are consistent with the guiding principles?

Expansion and increased promotion of the Comprehensive Primary Care Plus (CPC+) program may be a successful strategy to expanding opportunities for participation in Advanced APMs. This program incorporates other payers, which may bring more consistency for providers in how they are being reimbursed. We recommend that, for providers participating in the Medicare Shared Savings Program Track 1 and CPC+, reporting requirements be streamlined in such a way that they are not burdened by reporting through both programs. In some cases, provider practices have been unable to meet the minimum threshold for attributed patients – CMS could consider lowering this threshold to be more inclusive of small practices. There could also be increased availability of Advanced APMs designed for specialty providers or focused on high-cost conditions and procedures, which would likely increase participation. Additionally, providers would benefit from greater definition about how Patient-Centered Medical Home (PCMH) models can fit into Advanced APMs. For instance, how specific PCMH models could incorporate risk sharing in order to be considered an Advanced APM; as providers are currently trying to navigate the Quality Payment Program (QPP), this is an area of uncertainty.

If CMS desires that providers move more quickly to Advanced APMs, AHQA recommends that CMS consider increased technical assistance (TA), particularly for small and rural practices. The current QPP TA contractor programs (e.g., TCPI, QIN-QIO, QPP-SURS) are making some strides toward this shift, but the tools and resources beyond MIPS are limited. In the case of QPP-SURS, the level of funding allows for minimal direct assistance, which is primarily virtual. To move the provider community quicker and offer a high level of customer service, more intense, one-on-one assistance is vital. The QIN-QIOs have these relationships, and armed with the right educational materials and knowledge about Advanced APMs, could expedite the shift to these new models.

Do you have suggestions on the structure, approach, and design of potential Expanded Opportunities for Participation in Advanced APM models? Please also identify potential challenges or risks associated with any of these suggested models.

While increased inclusion of specialists and additional models for high-cost conditions and procedures would be advantageous, CMS should consider the risk of undue reporting burden. For multi-specialty practices, if reporting would need to be handled differently for different specialties and/or conditions or procedures, this would likely lead to a high level of dissatisfaction and lower participation. Overall, CMS should strive to relieve the reporting burden on providers.

What options might exist beyond FFS and MA for paying for care delivery that incorporate price sensitivity and a consumer driven or directed focus and might be tested as a model and alternative to FFS and MA?

CMS should continue to expand the opportunities for participation in models that focus on population health and encourage preventive care, reimbursing for value over volume. All-payer models that streamline and reduce reporting requirements could significantly expedite provider participation. Such models should allow providers the flexibility to address the social and behavioral health needs of patients, thus, shifting focus to keeping patients healthy.

How can CMS further engage beneficiaries in development of Expanded Opportunities for Participation in Advanced APM models and/or participate in new models?

CMS should consider resources and messaging designed to educate beneficiaries about new payment models and how they impact patients. The general patient population is not well informed about how payment for health care is evolving in this country, and greater investment in this knowledge spread would be a first step toward beneficiaries helping to drive improvements. The provider community is stretched thin, trying to adapt and transform, and is likely unable to take responsibility for educating beneficiaries of different backgrounds, who speak different languages, and who have varying levels of education and health literacy. CMS may want to consider how to work with local agencies to spread awareness and educate beneficiaries. In addition, CMS may want to consider having focus groups about new models before they are approved.

Are there payment waivers that CMS should consider as necessary to help healthcare providers innovate care delivery as part of a model test?

No suggestions at this time

Physician Specialty Models

The network of Quality Improvement Organizations (QIOs) has deep expertise in supporting physicians in their efforts to measure and optimize the value of their services. The QIOs have great experience with pay-for-performance initiatives, alternative payment models, and Innovation Center demonstrations. Their unique expertise will be of great value in the support of CMMI's mission to test physician specialty models.

Do you have comments on the guiding principles or Physician Specialty Models?

1. **Choice and competition in the market** – Given the standard fees in the fee schedule used by the Medicare and Medicaid programs, the primary basis for competition would be quality and outcomes. Beneficiaries would benefit from access to transparent information that informs them of these metrics. A challenge is making the information useful to the beneficiary. Current metrics are population based and can be difficult for an individual to translate to their own unique goals for care or definition of health. If the increased competition is intended to encourage health care providers to compete for Medicare beneficiary business, the quality, outcome and cost measure need to be beneficiary focused. The introduction of cost competition into the Medicare and Medicaid programs is complex and would require a degree of cost-sharing that has not historically been an element of the benefit. Current models are built around a framework of payment for performance and payment for value that places cost risk in the hands of the provider community rather than in the hands of the beneficiary.
2. **Provider Choice and Incentives** – Providers should have the option to participate in payment model demonstrations on a voluntary basis. However, the rationale should not be to avoid burdensome requirements and regulation, but instead to encourage the innovators to have the freedom and flexibility to help create new models that will allow all providers to focus on providing high-quality healthcare to their patients. Although voluntary, it will be necessary to include a range of provider types and practice settings. Once models have demonstrated their value, it is appropriate for CMS to design and implement payment incentives that encourage providers to participate in models that have undergone expansion under 1115 A(c) of the Affordable Care Act.
3. **Patient-centered care** – Patient-centeredness should be strongly encouraged in CMMI models, and outcome assessments of patient experience of care are essential to the measurement of value. Patients should have access to a full range of high-quality providers, across specialties because at its heart, patient centered care requires be establishment of a relationship between the provider and the patient. One way to foster this relationship is to build both provider and patient capacity for the co-production of health care services. This means models that support communication along with cooperatively planning and executing the chosen plan of care. The Quality Improvement Organizations have a long history of bringing patients and providers into quality improvement initiatives. Their network could facilitate beneficiary and provider input into building capacity for co-production, as well as the design and implementation of CMMI demonstrations and the support of patient-centered services.
4. **Benefit design and price transparency** – Value (quality and cost) is an essential attribute of successful payment models that CMS could expand under 1115 A(c) of the Affordable Care Act. Design should accommodate the application of high value services that result in overall benefit efficiencies. Clear data-derived metrics that assess quality, cost, and outcomes should be used to assess the effectiveness of tested models and determine those models that meet a benchmark of high value. The Quality Improvement Organizations are expert in the assessment of value and could bring that expertise to bear in both the design and implementation of CMMI demonstrations.
5. **Transparent model design and evaluation** – CMMI should continue to collaborate with provider organizations and industry stakeholders to harness innovation for the development of new models. These models should be encouraged to consider new uses of technology, virtual health and the movement from healthcare services being provided in settings to services being created in the community.
6. **Small Scale Testing** – Initiating new processes and techniques through small tests of change are a central tenet in change management. Ultimately, these tests deemed of potential value would need to be incrementally expanded to demonstrate the large-scale value that would warrant expansion under 1115 A(c) of the Affordable Care Act (the Act). A focus on payment models that encourage the efficient delivery of care would allow providers' choice in the implementation of

specific devices or equipment. It seems reasonable, however, that CMMI might also explore the impact of payment models that focus on the use of specific devices or equipment to optimize the value of high-cost interventions.

What Physician Specialty Models designs should the Innovation Center consider that are consistent with the guiding principles?

As science continues to advance and we have more specialized medications and procedures available, it can be expected that medical specialties will need to be more integrated into the overall care of patients, especially those with highly complex medical needs. Therefore, we encourage CMMI to test innovative payment models for condition-specific specialist care that is accountable for comprehensive care, coordination, and preventive care. These models would offer medical specialists, caring for patients with a chronic condition within their scope of practice, the flexibility they need to deliver high value condition-specific care most efficiently while being held accountable to the value of their patients' overall care. Because the specialist(s) would be serving in the role of primary care provider, they would be accountable to the coordination of patients through the healthcare system to ensure efficient transitions, receipt of preventive care services and other necessary care indicated for their comorbidities. For complex patients, this model is a way to maximize the specialist expertise and support for the patient. Since this cohort would be a subset of the specialist's patient population it would ideally meet the **small – scale testing** guiding principle as well as **patient – centered care**. These models must, 1. have a clear definition of the services that will be covered, 2. have clarity around the mechanism by which utilization and spending would be controlled, 3. clarify the mechanism by which good quality and beneficial outcomes are ensured, and 4. ensure adequacy of payment.

The clinical conditions that come to mind for this type of model are the common conditions such as heart failure or treatment of various cancers. However, for this model to be truly innovative it should be applied to conditions that are challenging to manage in the primary care environment and have impact beyond organ system diagnoses. By using the specialist's expertise to better manage the underlying condition, it could also have benefit on the patient's overall sense of wellness.

Example: Capitated or bundled payment of comprehensive care for schizophrenia by psychiatrists.

Schizophrenia is a severe mental illness that has a profound impact on Medicare beneficiaries. It causes significant morbidity and degrades quality of life. In addition, comorbid conditions, such as type 2 diabetes, obesity, hypertension, and dyslipidemia, are more common in patients with schizophrenia than in the general population, and these conditions increase the risk for cardiovascular disease and lead to increased mortality. However, primary care is not always adequately prepared to effectively meet the needs of these patients leading to unintended outcomes such as increase in ED use as a way to access mental health services. In schizophrenia, and other mental health disorders, addressing the whole person and his or her physical and behavioral health is essential for positive health outcomes and cost-effective care.

Integrated Care combines primary health care and mental health care in one setting. A Psychiatry Model of integrated care where the psychiatrist becomes the primary care provider

could be tested for its impact on mental health outcomes, care utilization outcomes, and comprehensiveness of care services. Such a model would incentivize the delivery of high value integrated care services rooted in the expert management of the Schizophrenia by a psychiatrist.

Example: Capitated or bundled payment for dementia care by neurologists, geriatricians, or psychiatrists.

Alzheimer's disease is now the sixth leading cause of death in the United States and the only one of the top ten without a means to prevent, cure or slow its progression. Caring for people with Alzheimer's disease will cost all payers - Medicare, Medicaid, individuals, private insurance, and HMOs -- \$20 trillion over the next 40 years. Interprofessional teams led by specialists, such as geriatricians, can improve outcomes for people with dementia, but they have not been widely adopted because of limited evidence for cost-effectiveness. These models foster integrated team care that would seek to demonstrate improved dementia care quality and outcomes, accompanied by cost savings, in both community-based and institutional care settings.

Do you have suggestions on the structure, approach, and design of potential Physician Specialty Models? Please also identify potential challenges or risks associated with any of these suggested models.

The structure and design of potential Physician Specialty Models must have the following three characteristics: 1. Flexibility in Care Delivery, 2. Adequacy and Predictability of Payment, and 3. Accountability for Costs and Quality (Value). Transparent cost and quality measurement will optimize both quality and efficiency over time.

If specialty models of care are limited to elements of the current care models, it is unlikely there will be any change as it would be essentially swapping the roles of the specialist and the primary care physician. However, if the model was allowed to incorporate and providers were able to be reimbursed for different modes of communication and care delivery, there could be improved value. Currently providers are paid based on the complexity of decision making or on time. However, most complex problems are solved in small increments over a period of time. The "bundle" could be created based on the plan of care that was designed by the patient and provider. This would include a plan for various touch points between the patient and the specialist or other members of the care team. Payment for the "bundle" is based on whether these touch points occurred and if they resulted in an outcome that was in accordance with the plan of care. This model could pull ideas from other services such as physical therapy where a plan is developed involving number of visits, etc. that is anticipated to be needed to reach on outcome or complete a course of treatment.

We encourage CMMI to test the design of simple physician and patient created bundles that are condition-specific or episode-based. The outcome of these bundles should be compared against a standard bundle where the primary care physician is serving as the coordinator of the patients care. It would be important to look at over time if there were differences in aspects of care such as alignment of outcomes with states goals of care, use of prescription medications, use of testing, time between testing and follow-up, patient and provider satisfaction, and use of ED/hospital. The goal is to inform simple payment models, easily understood by patients and physicians, will promote "buy-in", facilitate participation, and achieve the CMMI goals for more efficient care that does not sacrifice quality.

To ensure that the Physician Specialty Models promote value, these demonstrations should determine the models' impact on both clinical quality and patient satisfaction/quality of life. In addition to measuring the quality of services focused on the key condition or care episode, a necessary feature of these Physician Specialty Models must be the assessment of impact on a core set of common comorbid health conditions, measures of care coordination, and covered preventive care services. These assessments will likely add complexity (and burden) to the assessment of value, but are needed to incentivize the delivery of high-value services traditionally addressed in primary care – prevention, coordination, and comprehensiveness.

As with any innovation it is important to not only look at the benefit but to proactively consider potential unintended consequences, so they can be planned for as part of implementation. Patients that would likely benefit the most from the condition-specific specialist care are those with complex needs. While their main diagnosis may be accounting for a majority of their care needs, they likely also have significant additional conditions that add to the complexity – this is certainly true for the two examples of schizophrenia and dementia. It would be important to set up a set of pre-requisites for specialty providers interested in participating in these pilots. This would help them best prepare for the different types of workflow, communication options, and provider interaction that may be needed in the model. Without that, it is likely the specialists' practices may not be equipped to adequately test the new model. Also, it would be important to assess if the complex patients were being accepted into the model to avoid “cherry-picking” of the less complex patients or patients where there are no other complicating factors such as family dynamics, multiple co-morbidities, etc.

We strongly encourage CMMI to include audits of submitted quality measure data in all their demonstration initiatives. The Quality Improvement Organizations (QIOs) are expert in the auditing of quality measurement data. The existing QIO network could be leveraged to provide CMMI with the expert resources needed to ensure valid, efficient audits that minimize the burden on both the participating physicians and patients.

What options might exist beyond FFS and MA for paying for care delivery that incorporate price sensitivity and a consumer driven or directed focus and might be tested as a model and alternative to FFS and MA?

To date most attempts to control costs have been focused on restricting or putting up barriers to expensive testing or procedures. This has not had a significant impact on bending the curve. Therefore, we would propose incentives to the patient and provider for choosing less costly interventions. Examples may be interventions that first focus on the foundations of health such as sleep quality, exercise and movement, nutrition, stress reduction and healthy relationships. These should be tried before encouraging pharmacological interventions or procedures. Incentives could be a reduction in cost to patient or increase in reimbursement to the provider for choosing non-pharmacological/procedural interventions along with a general decrease in reimbursement for choosing pharmacological or procedural interventions.

How can CMS further engage beneficiaries in development of Physician Specialty Models and /or participate in new models?

Although there is a wide range of health literacy between patients of different ages and socioeconomic backgrounds, we must assume that all people who are seeking an interaction with the healthcare system have the goal of maximizing their health and well-being. The new models of care must be

focused on building that capacity of patients and providers to achieve this goal. AQHA believes existing well-established networks can be utilized to engage and recruit beneficiaries for focus group participation and community conversations to gain learn from individuals to help inform these models of care. Networks like CMS' Quality Innovation Network - Quality Improvement Organization (QIN/QIO) networks are optimally positioned to accomplish this as understand both the systems and processes that are needed to support new models as well as the capacity building through education, training and workflow redesign needed to make them successful.

Are there payment waivers that CMS should consider as necessary to help healthcare providers innovate care delivery as part of a model test?

We would encourage CMS to utilize waivers that allow for flexibility in the need for face-to-face interaction in order to receive reimbursement for services. With current advances in technology as well as the need to serve people in areas that are often separated by miles or lack of transportation from their providers it is important to focus first on the quality of the interaction rather than the physical proximity of the individuals involved.

For example, in the dementia care model if telemedicine or virtual visits are a viable alternative to face-to-face visits, specialists such as geriatricians or psychiatrists could be available in real-time to assist with assessment and management with the goal of reducing use of medications such as antipsychotics or trips to the ED looking for medical problems as an underlying cause of patients symptoms of agitation or increase in confusion.

State-Based and Local Innovation, including Medicaid-focused Models

Do you have comments on the guiding principles or State-Based and Local Innovation, including Medicaid-focused Models?

The American Health Quality Association (AHQA) appreciates the Centers for Medicare & Medicaid Services' (CMS') interest in stakeholder perspectives on new and innovative models that can be implemented at state and local levels to improve care. We share in the belief that care should be affordable and accessible, while most of all putting the patient first. Empowering beneficiaries as consumers is essential to ensuring positive outcomes and the solvency of our nation's health care system.

We believe that models focused on prevention of chronic disease that include instilling a sense of self-responsibility for patients will decrease overall costs in the future. For example, state and local models focused on early detection of cancer and chronic kidney disease would help identify disease, prevent exacerbation and the development of additional health complications, and significantly decreasing future spending. At this time, screening for cancer and kidney disease are substantially underused preventive health strategies in the United States.

Healthy People 2020, an initiative of the Department of Health and Human Services (HHS) – Office of Disease Prevention and Health Promotion as recommended by the United States Preventive Services

Task Force (USPSTF), only set 10-year national goals and objectives for breast, colorectal and cervical cancers. Yet lung cancer is the most frequently diagnosed cancer in the United States.¹ Additionally, the National Kidney Foundation says that one in three (73 million) Americans are at risk for developing Chronic Kidney Disease (CKD) and 30 million have CKD, but most are unaware. Greater investment in kidney screening will enable providers to identify kidney disease early and slow or stop its progression.²

1. *Cancer Incidence and Mortality in Delaware, 2009 – 2013*. Delaware Health and Social Services, Division of Public Health, 2017. http://www.dhss.delaware.gov/dhss/dph/dpc/files/im09-13_july2017.pdf
2. <https://www.kidney.org/advocacy/issues>

What State-Based and Local Innovation, including Medicaid-focused model designs should the Innovation Center consider that are consistent with the guiding principles?

A model that empowers states to implement screening programs for chronic disease would decrease disease burden. As the national association for CMS Quality Improvement Organizations (QIOs), AHQA and its members are dedicated to promoting and facilitating fundamental change that improves the quality of health care in America. Frequently, QIO efforts span beyond Medicare-funded initiatives, such as the Delaware QIO's work for the State's Division of Public Health on a local Cancer Screening Quality Improvement initiative. The QIO assists the state in increasing screening rates by monitoring practice and physician-level cancer screening National Quality Forum (NQF) measures, conducting cancer screening workflow assessments and making recommendations of evidence-based interventions, collecting data, educating physicians and even sending out birthday postcards as reminders for patients to schedule their screening.

Asking for screening testing can be intimidating, particularly colorectal cancer screening. An education campaign on the effectiveness of finding cancer early and the small chance of harm for colorectal cancer screening is needed. When detected early, the 5-year survival rate for colorectal cancer is more than 89%.¹

References: 1. *Colorectal Cancer in Kentucky – A Snapshot*. Kentucky Cancer Consortium. www.kycancerc.org. May 2017.

Do you have suggestions on the structure, approach, and design of potential State-Based and Local Innovation, including Medicaid-focused models? Please also identify potential challenges or risks associated with any of these suggested models.

A recent study by the Milbank Memorial Fund titled, "State Population Health Strategies that Make a Difference: Reducing the Burden of Chronic Diseases in Delaware and Iowa," highlighted the State of Delaware's efforts to reduce chronic disease, which resulted in an improvement in their national ranking from 32nd to 23rd.¹ Following the framework of Delaware's population health model, the innovation center could consider working with states to show similar health improvement successes by increasing

access and affordability to screening opportunities, for both cancer and kidney disease. The following elements were highlighted in the summary report as key factors that made the difference in moving the needle: ²

1. Government leaders start it. Having at least one champion in state government is critical to initiatives' successes. In Delaware, Governor Markell issued Executive Order 19, which created the Delaware Council on Health Promotion and Disease Prevention to spearhead the state's efforts.
2. Set "Goldilocks targets." Delaware chose to set appropriate targets, while striving for certain customized achievements based on the community needs. Allowing states to set their own targets will allow a greater success rate and ownership of work performed towards that target.
3. Establish multi-sector ownership for steady progress. Delaware found success by alleviating competitive interests to form common goals. State leaders encouraged stakeholders to band together to accomplish shared goals. This shared approach has proven effective not only at the local level in states like Delaware, but also nationally through multi-agency public/private partnerships like the Million Hearts[®] initiative.
4. Measure and analyze. Delaware's successes included making data publically available with user-friendly data portals. As State health information exchanges increase spread and efficacy, the ability to share data not just with other providers, but also community-based programs will facilitate further collaboration and improvement.
5. Focus on disparities. In the Milbank study, prioritizing areas of greater disparity created greater constituent engagement. It included a profile of efforts in Kentucky that identify education level as a disparity population, sighting that individuals without a high school diploma or GED are less likely to receive a colorectal cancer screening. This demonstrates the need for education about screening and outreach for populations with low education attainments.
6. Get local. The study shows that change starts at the grassroots. Involving community based organizations and stakeholders is critical to long-term success and helps leverage relationships to instill trust and follow-through.
7. Balance top down with bottom up. The study also shows that having a nationwide initiative that establishes a vision is important, but giving state and local communities the autonomy to set their own goals and develop their own policies helps attainment and ownership of the outcomes.
8. Coordinate but don't control. Again, the need for a nationwide effort is paramount and having an entity to track progress ensures continuous movement toward achievement. Allowing local flexibility promotes alignment of all stakeholders and governments while also moving towards sustainability and progress.

References: 1. *Report – State Population Health Strategies that Make a Difference: Reducing the Burden of Chronic Diseases in Delaware and Iowa*; Milbank Memorial Fund; Louis, Christopher J. PhD, Jones, David K. PhD; October 2017.

Report – State Population Health Strategies that Make a Difference: Project Summary and Findings; Milbank Memorial Fund; Louis, Christopher J. PhD, Jones, David K. PhD; October 2017.

Colorectal Cancer in Kentucky – A Snapshot. Kentucky Cancer Consortium. www.kycancerc.org. May 2017.

What options might exist beyond FFS and MA for paying for care delivery that incorporate price sensitivity and a consumer driven or directed focus and might be tested as a model and alternative to FFS and MA?

We believe that an approach combining supportive efforts and resources from CMS and the Centers for Disease Control (CDC) would not only help ignite these prevention models, but also increase their effectiveness at achieving outcome improvement. A successful example of CMS/CDC collaboration dates to 2012 with the formation of HHS’ Million Hearts® initiative. The national effort to prevent heart attacks and strokes has successfully aligned priorities and limited potential competing initiatives introduced by both agencies. As a result, the initiative has made significant strides toward preventing a million cardiovascular events.

How can CMS further engage beneficiaries in development of these models and/or participate in new models?

Engaging beneficiaries in the design of these prevention models will be critical to the success of the initiative. Preventive screenings are often intimidating to patients, and they may sometimes be wrestling with conflicting advice from family and friends. Drawing from patient input as to what might persuade them to get screened, or why they believe it is important, will be essential to the program’s success. Involving the patient in design of the campaign Patient engagement contributes to improved health outcomes and patients that are engaged, knowledgeable, and participate actively in their health care see the benefit of healthier lives and lower costs. However, more must be done to develop strategies to capture all individuals input and help everyone enjoy better health by participating in prevention education and screenings.

Are there payment waivers that CMS should consider as necessary to help healthcare providers innovate care delivery as part of a model test?

We are not aware of any payment waivers that CMS could consider.

Mental and Behavioral Health Models

Do you have any comments on the guiding principles or Mental and Behavioral Health Models?

The emergent need for a behavioral health focused payment model is here due to the rising opioid crisis, suicide as the 10th leading cause of death in the US, and the growing awareness of the impact of behavioral health co-occurring conditions leading to rising healthcare costs. This specialty area is primed for an Innovation Center alternative payment model focused on controlling costs and improving quality outcomes. Much has been done to pave the way in terms of the chronic disease management focused models within the traditional medical setting and behavioral health focused quality improvement initiatives achieved through grant funding from national agencies such as SAMSHA, NIA, NIDA, and NIH. Previously successful behavioral health models align with the guiding principles of CMMI in that they have been:

- 1) person-centered, whole person integrated care, care should be accessible to all at the point of delivery or entry into the healthcare system,
- 2) available on a continuum that meets people where they are at in respect to socio-environmental factors and self-awareness of disease,
- 3) based on data-driven, consistent nationally recognized assessment,
- 4) lead to appropriate community-based referrals when necessary,
- 5) Primary care physicians should be reimbursed for mental health screening, diagnosis and follow-up treatment, and
- 6) De-stigmatize mental health services.

What Mental and Behavioral Health Model designs should the Innovation Center consider that are consistent with the guiding principles?

A traditional APM model that supports the integration and payment of mental health professionals into the primary care or other prime specialty care offices (e.g., oncology, cardiology, endocrinology, nephrology) where mental health issues are frequently found. Also, models that test the use of telehealth for the delivery of mental health services (diagnostic, routine follow-up and counseling) would be ideal. Finally, a take on a traditional APM model targeted at community based behavioral health settings over traditional medical practices design combined with a bundled payment approach in lieu of fee for service. Voluntary model participants would have the chance to receive payment equal to the full spectrum of services they are providing and earn performance-based incentive payments directly resulting from patient outcomes. This two-part payment approach allows for funding comprehensive care and rewarding innovation which improves patient outcomes. Part one would be a per member per month (PMPM) payment to support the necessary wrap around services for the recommended duration for that level of care based on national clinical guidelines. Part 2 would be a retrospective performance-based payment based on patient specific outcomes (reduction in symptomology, participation/retention in treatment, connection with community supports, and patient satisfaction).

Do you have suggestions on the structure, approach, and design of potential Mental and Behavioral Health Models? Please also identify potential challenges or risks associated with any of these suggested models.

The structure of the models, like nurses and medical assistant staff, should incorporate mental health professionals as fully integrated into the practice setting and team. For example, social workers, psychologist, community health worker or educator (See Washington State Mental Health Integration Program (MHIP) model). Also, the structure of the models should incorporate mindfulness training and implementation (See University of Wisconsin Center for Healthy Minds) as well as depression and substance abuse screening on a quantitative scale that is remeasured in follow-up visits to measure effectiveness of treatment.

There are four main challenges that must be considered when deciding on the structure, approach, and design of a model:

- 1) Each part of the **country has different unique needs** relating to language, behavioral health stigma, and culture. Devising a national model that meets these guiding principles must be broad enough to allow for customization to meet unique community needs, while at the same time, specific enough to be consistently followed for evaluation purposes. To mitigate this risk, consideration to the method of evaluation must be considered from the start.
- 2) There is an **access to appropriate care** problem in this country, but the causes of it differ by location; some parts of the country there are no treatment options available, and in others the issue is more about appropriate and timely access to available treatment; a potential model will not succeed if it doesn't decide which part of this equation to focus on addressing, the treatment gap or the access gap. To mitigate this risk, a potential payment model should be mindful of locations for implementation and be guided by the principle of small scale testing.
- 3) The **larger specialty area** of Behavioral Healthcare is very broad in both subspecialty (e.g., mental health, substance use disorders, SPMI, dementia), continuum of care (prevention, early intervention, treatment focused interventions, or recovery maintenance), and population served (children, young adults, adults, elderly). Continuing with the principle of small scale testing, the subspecialty, type of care, and population should be very tightly focused (e.g., such as opioid use disorder prevention for young adults, or depression recovery management for the elderly)
- 4) The **complete costs of care** are also widely different given all the previously noted challenges. For the bundled payment part of an APM for behavioral health to be successful, it must be an accurate reflection of the actual costs of care necessary to improve outcomes. Historically the field of community based behavioral healthcare has not been fully funded by a FFS model. Though CMS has new revenue codes being made available, a bundled payment approach could prove more rapidly impactful. This could very well mean a greater upfront cost

What options might exist beyond FFS and MA for paying for care delivery that incorporate price sensitivity and a consumer driven or directed focus and might be tested as a model and alternative to FFS and MA?

Hybrid approaches to payment that combine bundled payments, FFS, and block grants. Quality payment models that pays on a per member per month basis incentivizes providers them to see patients. Incentivizing patients to become engaged in their healthcare by offering reduced premiums/co-pays, in response to participating in wellness activities in addition to evidenced based chronic disease management interventions

Alignment with commercial payor models – If provider knows a payor won't pay for the screening then they don't even bill for it – this alters the data around claims and true prevalence of diagnosis.

How can CMS further engage beneficiaries in development of Mental and Behavioral Health Models and/or participate in new models?

Dynamic multi-media public education campaigns are needed to let folks know this is happening. Too many people outside of the healthcare policy arena do not know about the initiatives taking place. Traditional mailings, public forums, and advertisements no longer capture the attention of the American consumer. Consider endorsements by public figures, non-traditional advertisements in social media, and/or incentives. Establish focus groups of beneficiaries for design and evaluation of the models. For evaluation purposes, have focus of beneficiaries to assess the effectiveness of the program, like the CEC ESRD Model evaluation approach.

Are there payment waivers that CMS should consider as necessary to help healthcare providers innovate care delivery as part of a model test?

Not aware of any waivers