State Innovation Model Medicare Proposal Oversight Committee

Primer on Charge and Context

August 30, 2016

SIM MPOC Charge

Short Version

To develop a proposal for Medicare alignment with innovative payment models to CMMI, according to CMS guidance, to be finalized by the SIM Steering Committee and the SIM Maine Leadership Team.

Long Version

The State Innovation Model's (SIM) initiative aims to test state governments' abilities to accelerate health transformation resulting in better care, smarter spending and healthier people. Payer alignment is critical to achieving this transformation.

In 2015, CMS announced bold goals toward moving to alternative payment models, and also provided an exclusive opportunity for SIM states to submit proposals for Medicare alignment with innovative payment models that currently exist in the SIM state.

CMS issued guidance for these proposals. CMS states that they will receive proposals for alternative payment models that consider the following principles:

1) patient-centered,
2) accountable for total cost of care,
3) transformative,
4) broad-based,
5) feasible to implement, and
6) feasible to evaluate.

Commissioner Mary Mayhew has directed the Maine SIM program to form an oversight committee to draft a proposal to the Center for Medicare and Medicaid Innovation for Medicare Alignment in Maine and you are invited to participate.

The development of this proposal will be driven by this Medicare Alignment Oversight Committee and will be overseen by SIM Governance. Oversight member accountabilities include informing and advising proposal development, including the provision of content for the proposal, and in engaging in subcommittee meetings and activities.

Maine DHHS Core Principles for the SIM Medicare Alignment Proposal

Payer Alignment
Model needs to support the principles of established commercial models and not attempt to force a new model upon the market. For MaineCare, the model needs to compliment a Medicaid Health Home model and Medicaid initiatives that MaineCare has developed

Proportional Support
Costs to support technical assistance and data analytics/reporting should be proportionately supported by all payers – e.g. population size * X $ = proportional share for each payer category.

Behavioral Health Capacity
Practices should be required to demonstrate capacity for delivering and/or relationship with BH provider(s) that have capacity to manage substance abuse as well as mental health issues

IT Requirements
Participating practices should be required to participate in Maine's HIE, with capacity to receive ADT notifications; practices should have EHR capability to generate eCQM's, or contract with HIE to perform this function (reporting of clinical performance is a requirement under CPCI and it is a function that MaineCare is expecting).

Accountability
Service delivery and payment need to be tied to process and outcomes. This principle would hold true for all aspects of the model which include medical/BH services, technical support to the delivery systems, and data analytics/reporting.

Oversight
The SIM Steering Committee will become the new "convener" of this model and will regularly review performance reports and progress toward established goals from the proposal.

CMMI Required Principles for the SIM Medicare Alignment Proposal

Option 1- Customized State Model

- Patient Centered
- Accountable For The Total Cost Of Care
- Support Better Care, Smarter Spending, Healthier People
- Feasible To Implement: Administrative Feasibility
- Feasible To Evaluate: Data Sharing With CMS And State

Option 2- Alignment with CMS ACO Program/Model

- Care Coordination
- Provider/Supplier Organizational Structure
- ACO Governance And Leadership
- Quality Strategy
- Patient Attribution Methodology
- Payment And Risk Sharing Methodology
- Data Sharing And Performance Measurement

Option 3- Alignment with CMS PCMH Model

- Risk Stratified Care Management
- Access And Continuity
- Planned Care For Population Health
- Patient And Family Caregiver Engagement
- Comprehensive Coordination
- Multi- Payer And Provider Participation
- Data Sharing Between Payers And Practices
- Shared Learning
- Quality Strategy
- Payment Methodology (Case Management Payments, Accountability For TCOC)

Ideas Considered by MPOC to Date (including Concept Paper of April 16, 2016)

Payment

Primary care payment model consistent with the CMS Health Care Payment Learning and Action Network's (HCPLAN) framework, and, as noted above, comprised of three components:

(1) Ongoing FFS payments supplemented by
(2) Risk-adjusted care management PMPM payments that enable practices to implement and sustain the infrastructure to deliver comprehensive services to high-risk populations and to provide payment by practices to Community Care Teams (HCP-LAN Category 2A); and
(3) Accountability payments in the form of performance incentives designed to promote accountability for impacting Total Costs of Care (HCP-LAN Category 3).

Accountability Payment

Adds performance-based incentives to reward practices for their performance and performance improvement. Baseline practice performance targets will be established for meaningful use, performance on a set of quality/quality improvement measures, and total cost of care and public reporting/transparency. Payers will establish annual practice performance targets which may identify performance improvement based on past experience and/or absolute performance targets based on expectations. To ensure that

practices are credited for overall performance improvement, incentive payments may be determined by assigning each target a specific value with the accumulation of target achievement determining the total incentive reward.

Primary Care Functions (examples):

- Using data to drive improvement
- Behavioral health integration
- Comprehensiveness and coordination
- Risk-stratified care management
- Leadership for advanced primary care
- Team-based care
- Access and continuity
- Promote access to telehealth services to improve access to primary & specialty care
- Practice-based care management
- Community-based complex care management (Community Care Teams)
- Planned care for population health
- Patient and family caregiver engagement
- Assessing and addressing health-related social needs

Other Characteristics Discussed

- Multi Payer Involvement
- Data sharing between Payers and Practices
- Shared learning and practice transformation support
- Quality and Accountability Strategy
- Public Health
- Long term Care
- Home Health
- Accountable Community inclusion
- Aging in Place
- Community Based Organization collaboration with Health Care