SIM Medicare Proposal Oversight Committee (MPOC)

Highlight Notes

June 15, 2016

Maine Medical Association

About the Meeting

Purpose

The primary purpose of this meeting was to understand recent CPC+ applications and decide next steps regarding the development of a Medicare alignment proposal.

Attendance

Committee Members

- Amy Dix, Dept. of Health and Human Services - MaineCare
- David Winslow, Maine Hospital Association
- Katherine Pelletreau, Maine Association of Health Plans
- Jean Nichols Wood, Anthem
- Lesley Myska, Department of Health and Human Services, Office of Aging and Disability Services
- Steve Ryan, Eastern Maine Health System (by conference call)
- Katie Fullam Harris, MaineHealth
- Jen Moore, MaineHealth
- Sara Sylvester, Genesis Health Care
- Lisa Letourneau, Maine Quality Counts
- Michael DeLorenzo, Maine Health Management Coalition
- Shaun Alfred, HealthInfoNet (by conference call)
- Michelle Probert, Bath Iron Works
- Catherine Ryder, Tri-County Mental Health Services
- Trish Roy, Consumer Representative
- Ted Rooney, Consumer Representative
- Kathryn Brandt, Primary Care Physician
- Amy Wagner, Department of Health and Human Services, Office of Continuous Quality Control Improvement
- Randy Chenard, Program Director, Maine State Innovation Model
- Gordon Smith, Independent Providers
- Karynlee Harrington, Maine Health Data Organization (by conference call)
- Rhonda Selvin, Maine Nurse Practitioner Association

Guests

- Stephanie Nadeau, Director of MaineCare/DHHS (by conference call)
- Gerard Queally, CEO and President Spectrum Generations

Interested Parties

Kim Fox, Muskie School of Public Service
Lisa Nolan, Maine Health Management Coalition
Sybil Mazzerole, DHHS - Office of Continuous Quality Improvement
Olivia Alford, DHHS - MaineCare
Peter Kraut, DHHS - MaineCare
Barbara Ginley, Medical Care Development
Emilie Van Eeghen, MaineGeneral Medical Center
Poppy Arford, Consumer

Staff

- Gloria Aponte Clarke, Maine State Innovation Model
- Craig Freshley, Good Group Decisions
- Kerri Sands, Good Group Decisions

Agenda

1:00 **Welcome and Introductions**
Facilitator Craig Freshley will explain the agenda for today and a few ground rules for a productive meeting. We will do quick introductions.

1:10 **CPC+ Update**
Now that the deadline for application has passed, let's learn about who from Maine applied. We hope to learn from each of the payers about how they responded to the CPC+ opportunity.

1:30 **How to care for behavioral health, aging and special needs populations and transform care**
Led by Rhonda Selvin, Catherine Ryder, Sara Sylvester, Ted Rooney, and Trish Roy, we will discuss how to develop a system of functional care including health and wellness for all Mainers, including those with behavioral health and mental health needs, disability, and as the population ages, allowing people to live effectively in their homes and communities.

1:55 **Next Steps**
Beginning with a reminder about our Committee Charge and the Concept Paper that was developed at the start of our work, we will discuss and decide next steps about how to proceed with developing a Medicare alignment proposal.

2:50 **Closing Comments**

Any Interested Parties who wish to make a comment will be invited to do so. Time will be limited depending on how many parties wish to make a comment. There will also be an opportunity for any Committee Member to make a brief closing comment.

3:00 **Adjourn**

Meeting Schedule Going Forward

August 3	10:00am – 12:00pm	MaineGeneral
September 7	10:00am – 12:00pm	MaineGeneral

Key Operating Guidelines

- **Raise hands and be called upon before speaking**
  - Committee members on the phone shout out and I will put you in the queue.
- **Participation is limited to Committee Members**
  - Anyone is welcome to observe or listen. Time at the end for comments.
- **Straw polls help us be efficient**
  - Show us what you think, and it's okay to change your mind.
- **We strive for consensus and agreements are documented**
  - Documents posted here: http://www.maine.gov/dhhs/sim/committees/MPOC.shtml

CPC+ Update

Payers had an opportunity to explain how they responded to the CPC+ opportunity.

Summary

- Deadline was June 8, 2016
- Have applied
  - Anthem
    - Applied nationally with the Maine market included
  - Harvard Pilgrim Healthcare
    - "more of a placeholder" – they have concerns
  - State of Maine submitted a letter

        - Applauded CMS for their efforts
        - Perplexed as a payer – why we need to sign on when we have a partnership already
        - We are significantly aligned
        - We continue to move away from volume-based and towards quality-based
        - We didn't submit an actual application but are very supportive
    - Community Health Options
- Have declined
    - Aetna
        - Applied in other parts of the country
    - Cigna
- CMS
    - Have received a robust interest from payers in many regions
    - Expect a decision in July

Discussion

- Maine Association of Health Plans (Katherine)
    - The deadline for payers was Wednesday, June 8
    - I have learned that Anthem has applied for Maine
    - Harvard Pilgrim HealthCare has applied for Maine, but with a caveat: they are concerned about whether their systems can accommodate the changes, and so their application is a placeholder application rather than a final application
    - Aetna has declined to apply for Maine, but has applied in other parts of country
    - As for Cigna, no official word, but I assume they have declined
        - Michelle confirmed that she heard Cigna had officially not applied
- MaineCare (Stephanie)
    - We submitted a letter to CMS applauding them for their effort to move to quality based payment methods. It was not necessarily an application. We believe in the direction they are going, but we are perplexed as a payer why we need to sign on when there is an existing relationship with the Federal government. We are already aligned with value based purchasing initiatives and we continue to reinforce them. We are already doing a lot of the things Medicare requested. We are interested in submitting a state based payment proposal as a SIM state.
- Anthem (Jean)
    - Yes, we applied and the Maine market was included in our proposal. We are looking forward to hearing back from CMS about what they thought of our proposal.

- Randy conveyed the following from Dr. Fran Jensen of CMS:
    - We have received robust interest from payers in multiple states and regions. We are evaluating applications now. We appreciate Maine's interest and we may contact payers with questions. We anticipate announcing the CPC regions in July.

- Comment: The provider application period begins in the middle of July so I presume the announcement would be before that.
- Question: Does anyone know if Community Health Options applied?
    - Two participants confirmed that yes, Community Health Options applied.

Caring for Behavioral Health, Aging, and Special Needs Populations

The group discussed how to develop a system of functional care including health and wellness for all Mainers, including those with behavioral health and mental health needs, disability, and as the population ages, allowing people to live effectively in their homes and communities.

Presentations

- Rhonda Selvin
    - There are special challenges for special populations and this impacts everything we are trying to do
    - Why the care of older adults and elderly is important
        - Maine = geriatrics
        - We are the "oldest" state and we have a high percentage of baby boomers
    - Let's think about function
        - The elderly are not just small adults, nor are children
        - Base: a robust population aged 55-70 are apt to be still interacting with primary care, or CBOs, or are at home or traveling
            - They are in better health and are better educated, even if they have chronic conditions or substance abuse
        - Moving up the pyramid, those populations have increased needs and a greater potential for not having needs met
    - Transitions are crucial - communications between primary care, behavioral health, and long term care
    - We need a focus on patients and caregivers
    - These populations experience a broad range of chronic medical conditions and there are also social determinants of health, nutrition, housing, transportation, etc.
    - Providers are not meeting these needs - half of those with dementia are not recognized by their primary care physician
    - There is room for improvement
        - In particular
            - Annual visits
            - Transitions
        - How to optimize current resources in current structures, even if we have not done so in the past?
    - Why CPC+ is an opportunity
        - MIPS indicators: increased opportunities for improving care

        - Use CPC+ to address specific populations
- Catherine Ryder
    - There is no whole health without behavioral health
        - They are intertwined - they can't be separated if we are expecting quality outcomes
        - In our experience, we have seen outcomes improve when integrating behavioral health
    - As we build proposals, please actively include behavioral health
        - We serve the highest and most expensive utilizers of care, so we can make an impact on clinical and financial outcomes
    - SIM currently supports some initiatives that providers won't be able to support after SIM winds down
    - ACEs study shows that early trauma has an impact on a person's medical decision making for a lifetime. We need to meet people where they are at.
    - What we can do
        - Embed help in primary care
        - Get to folks quickly
        - Reduce the number of sessions needed
            - For example, 3 visits over 120 days in a primary care setting vs. 6 months to a year at a Community Health Center
        - There are significant implications for the BHH model - seniors thriving in place
        - Community paramedicine - deploy into homes of frail elders and complex behavioral health consumers
            - Significant savings seen in Lewiston
            - Collaborative among several hospitals and agencies
        - Consider using telehealth more broadly including telepsychiatry
- Sara Sylvester
    - Long term care wants to be part of a community
    - We are not really equipped to take care of mental/behavioral health patients
        - We have to call in support from others
    - We are asking to be part of this; we need these resources
    - We want for everyone who wants to stay home to be able to
    - There is a forthcoming rule that upon discharge we are responsible for the patient for 90 days - we have to pay if they go back to the emergency department
        - We *want* to discharge skilled patients
            - For example
                - Medicine management
                - Use of scales and medical equipment
            - But our outreach costs will be huge - with no new resources
    - We also want to help diagnose delirium vs. dementia - a medical problem or a behavioral problem?
    - And we want to bring home health into the conversation to facilitate smooth transitions around discharge
    - We need resources and tools to help us do these things

- Ted Rooney
    - There is good work being done, all grant funded, by Community Based Organizations (CBOs) like
        - Area Agencies on Aging
        - Community Action Programs
        - Other agencies
    - ACOs in Maine are in the lower third of spending nationwide. What would it look like if we scaled up good work being done?
    - Conceptual model - not a proposal
        - For $2 per member per month (pmpm) for the Medicare population, the needs of top 1% of population can be addressed by building upon work already in place
        - Social determinants intervention and keeping care in the home
    - CBOs could help reduce health care spending waste
        - Waste is currently about $189 per member per month in Maine
    - How?
        - With the CPC+ opportunities, work with pilots
        - Take what's working now and scale it up
        - Resolve dilemmas among participating parties
- Trish Roy
    - From the perspective of my former work as a home health care nurse
        - I saw houses with un-shoveled snow - there was no getting out of homes for groceries, prescriptions
        - People didn't understand how to take their meds
        - They were not able to walk through their homes due to clutter - there were many falls in homes - no hand rails
        - A patient asked me to make him a can of soup and that was his only meal for the day
        - One example of a patient who was given 2-4 weeks to live and sent home
            - This patient had a highly educated family who still had no idea what equipment was needed or how to manage caring for their relative
    - We all know a situation like this - think about our own families
    - What will all this look like as we become the oldest, most aging state in the country?

Questions and Discussion

- Question (Michelle): From the perspective of geriatrics and other special populations care, do you see CPC+ as beneficial? What is your vision to address these needs?
    - Responses
        - Catherine: From the behavioral health perspective, I am hoping for a post-SIM round two, but if we go with CPC+, please consider partnerships with the behavioral health community, because CPC+ funds are not directed at behavioral health. At the least I want to raise awareness that patient care and caregiver team satisfaction is increased with such partnerships.

        - Sara: From the long term care perspective, I am hoping that via SIM, long term care could get support for coordination and for moving patients to long term care skilled units. That's where everybody is going, and we need funding for professional staff and to support home visits. We work in little islands and we need to coordinate.
        - Ted: If ACOs and health systems already have practices in place maybe we could try some new scaled up models.
- Question (Lisa): Am I hearing that some or all systems/practices would make a voluntary agreement with CBOs to provide services?
    - Response (Ted): Yes. It would be similar to what we are doing now which is cobbled together with grant funds. We would get CBOs together. There would need to be negotiation between them and the practices.
- Question (Amy): Are there specific quality measures that would be helpful with these populations?
    - Response (Rhonda): Yes, the CPC+ measures. There are four in Appendix D:
        - Dementia/cognitive assessment
        - Vaccine status rule
        - Use of high-risk medication
        - Falls
        - Rhonda offered to send this list to everyone
- Question (Katie): Where did that research about $2 pmpm come from?
    - Gerry:
        - There are 311,000 beneficiaries in Maine as of April 2016
        - 30% are dual eligible and we don't know how they are divvied up among payers
        - A specific service that AAAs have provided is a focus on the top 1% of beneficiaries, or roughly 3100 people. We know the cost of going into a home, doing a number of assessments, reporting results to primary care, and following the person for 90 days. It costs about $750-800 per patient to do that.
            - There are efficiencies with higher numbers
        - There are costs for other support services as well - transportation and home repair for example
        - All totaled the cost is $7 million, which ends up at $2 pmpm
        - Health systems agreed they would support this
- Comment (Katie): There are a lot of assumptions here. $2 pmpm may not solve all the problems of top 1% Medicare beneficiaries.
- Comment (Amy): A reminder that this is on top of other programs that exist such as CAP agency home repair and transport services. This new concept leverages current services.
- Question (David): Is any of this reimbursable by Medicare?
    - Response (Ted): No. They've talked about it, but not yet.
- Question (Randy): Do you think the elements of this proposed concept would be different if Maine was a CPC+ region or not?

    - Response (Ted): No. You'd have to convince physician practices that it would be in their interest to contract with others to provide services. I don't underestimate that challenge!
- Question (Lisa): Is there a mechanism in CPC+ other than voluntary contracting?
    - Response (Ted): That is exactly the problem - all the money goes to the provider side. Accountable care was about doing screening and navigating to services but Medicare money is only supposed to pay directly for health care. It has to be voluntary - showing and convincing providers of the value.
- Comment (Katie): I agree that Medicare is not the place to pay for it. There are other places to pay for it; it's just that they are not coordinated. Sara, you mentioned that you wanted long term care to be part of a community, but I'm not sure that community exists - not sure anyone has been excluded from something. This is part of the challenge: behavioral health is separate and distinct from transportation services which is separate and distinct from medical services. There's an opportunity to bring everything together and then identify gaps.
    - Comment (Rhonda): Yes, that's why we called out transitions.
    - Comment (Amy): I agree with Katie and this why it's important to address in Medicare. Assessments are needed to determine gaps.

Next Steps

Beginning with a reminder about our committee charge and the concept paper that was developed at the start of our work, we discussed next steps about how to proceed with developing a Medicare alignment proposal.

Our Charge

Craig summarized the charge:

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

Concept Paper

Randy summarized the concept paper:

- The original intent was to submit 3-4 pages to CMS and see if it met their criteria
- Was drafted by a small working group, as a start. The idea was to work with this group and see what changes should be made
    - For example, the points made in presentations just now
    - Or, for example, the emergence of CPC+
- It will be hard to move forward until we know what the starting point is

Ideas for Next Steps

Craig asked the group: What should be next steps in fulfilling our charge, given where we are?

Conclusions

- Let's skip the July meeting and meet next on August 3
- Let's begin our next meeting with a list of outcomes we'd like to see improved
    - Ahead of next meeting:
        - Read the CMS guidance documents (posted at http://www.maine.gov/dhhs/sim/committees/MPOC.shtml)
        - Read the AHIP Core Measures and IOM Vital Signs (posted at http://www.maine.gov/dhhs/sim/committees/MPOC.shtml)
            - Population health will be a key measure in the future
    - Randy will provide an outline - a place for people to contribute key outcomes
        - Everyone agreed to respond to an email to gather info
    - Randy will provide a brief summary of where this group is at and where we are headed (since the charge of the group does not refer to CPC+)

Summary of Comments

- Key question needs to be resolved
    - Are we interested in pursuing a pure primary care model or an accountable care model which would potentially include hospital, long term care organizations, and others?
        - Another way to frame the question: Do we include in our proposals more than just primary care organizations?
    - Potential answer
        - Primary care payments within an ACO Model
- Comments
    - It's really important that we approach longitudinal care of patients in a longitudinal way (i.e. include long term health)
        - Perhaps different payment models should be used for different types of care
    - First we need to know if Maine is chosen for CPC+
        - Does that include lives in the Medicare ACO's
        - Then we should address the scope question above
    - Start with the end in mind – what would an ideal system look like?
        - Then figure out how to support such a system within system constraints
    - We need to look at how people access services
    - We should begin by looking at what will work best for the State of Maine rather than what will fit best into "the boxes"
    - It is critical that we don't exclude the high cost drivers in the system
    - We have elements of "the ideal system" in Maine

Discussion

- The big unanswered question for me is whether the group is interested in supporting a pure primary care-based model or pursuing an accountable care model, or something different?
    - To clarify: Are we focusing purely on primary care practices or are we incorporating hospitals, specialists, and others in the more robust provider network - the network that's included in accountable care, which is an experimental payment model? In short do we include more than primary care in our model?
- Maine is in a unique spot to include both. Maybe the sweet spot is to do primary care payments within an ACO model.
- Are we also talking about behavioral health payments?
    - In concept, there are four types of payments
        - Ongoing fee for service
        - Primary care payment
        - A new special consult payment
        - And a fourth type
    - But these methods do not cover what has come out from MACRA since then, which is that ACOs would need to have a downside risk
- SIM has been unique and successful in unifying behavioral health and the rest of health. This should be part of any major initiative going forward. It's not just about primary care payments, it's about longitudinal holistic management of patients.
    - If we are going to address how the system deals with people with long term care needs we are talking about a large health care community and payment models in these communities are not the same
        - Primary care vs. chronic disease care vs. infectious disease care
    - The fee-for-service model fits certain things better. If you try to capitate it you get into trouble. It's the same if you try to bend longitudinal care payments to fee-for-service.
    - Don't try to make one type of payment fit all these models
- The big question for me is: Does Maine get selected for CPC+? And if so, does it include lives in the Medicare ACO? And then we ask whether it is a robust wraparound model or not.
- Does anyone *know* that we will get CPC+?
    - We are cautiously optimistic
- Payment reform needs to drive system redesign. We will know if it's working when beneficiaries tell us it's working. Start with what we need to support healthy patients, then back up and design a system, then back up and figure out how to get from here to there.
    - These are design experiments
    - Let's not just focus on money flow without looking at the bigger picture

- We have to step back and look at access - travel for example. Before we throw money somewhere, make system access easier for everyone. There are so many rules that we leave money on the table.
- We should be thinking about a model that will work for state of Maine rather than what model will fit in these boxes coming out of CMS. Remove those confines. There is a second SIM proposal coming up and from a Medicaid perspective it's critical to not exclude cost drivers like specialty care and behavioral health.
    - Build the system first and think about how to pay for it second
- Waiting for feedback on our applications, maybe we do backwards course design. The needs assessment can morph as we get data back from CMS. But in the meantime, why not be pie-in-the-sky?
- When we talk about the ideal system it's sometimes scary but we already have elements of an ideal system somewhere in Maine now - so it's not from scratch.
- I get nervous when we talk about "the ideal system". We can talk about needs and incentives but I am not convinced that we should ever design very particular things that should be done, because things change and there's innovation - and who will oversee and track the details?
- Maybe we could ask some carefully crafted questions of this group, or identify bright lights in Maine.
- It would be helpful for each of us (or each subgroup represented here) to identify a key metric we'd like to see improved. We have a lot of perspectives in this group.
- Worry that all the metrics would be so closely related. We are trying to adapt a fundamentally broken system. There has been a lot of conversation about this already. It might not have to be so complicated.
- There are areas of overuse and underuse. We sometimes try to transfer spending from one area to another and we probably won't have less spending overall. The point is to take money from where it doesn't do good and move it to where it is doing good.
- Maybe we come back not with metrics but goals or outcomes
- Maybe the metrics are in the key areas from the presentations today
    - Long term care
    - Behavioral health
    - Access
    - Group functioning
    - Overutilization
    - Overtreatment
    - Cost
    - Improving patient engagement and accountability
- CMS has to follow Triple Aim which includes cost
- Whatever we decide *please* make it patient centered and *please don't* throw it on the primary care provider's plate and run away
- CMS is committed to letting everybody know about CPC+ by the end of July. However, the provider application window begins July 15 and runs through September 1.
- If we get CPC+ we may still do SIM
- As much as I like "blue sky" thinking, CPC+ is not that
    - The requirements force us to narrow down our proposal

- How much does this have to be a Medicare proposal?
    - This IS a Medicare proposal - but it's intended to align to other providers
    - Many of the things we are talking about haven't had alignment with Medicare up until now
    - Medicare is waiting for a 5-page proposal from us
- Medicare has a goal they are desperate to meet, so if there is ever a time Medicare is going to be flexible, it's now
- Please keep in mind long term needs while putting together a short term Medicare proposal
- How do we communicate what we are doing to a larger population? I am supposed to be representing independent providers and they are already a difficult group to read. Is there a succinct description of what we are doing here?

Closing Comments

- Gerry
    - We have spent a lot of time detailing what we can do
    - We can offer a 2-page summary of our work - we have data on outcomes that might be of help to you
- Barbara
    - Have heard a lot of inferences or explicit references to the role that social determinants play. As we look at different sets of metrics we need to keep in mind the importance of social determinants.
    - If this is about bridging communities and systems of care then our metrics need to reflect that.
    - There are documented best practices and there is clear impact around models like community health workers, paramedicine, and other models that make connections.

The meeting adjourned at 2:45 pm.