SIM Medicare Proposal Oversight Committee (MPOC)

Meeting Report

May 4, 2016

This report is organized by topic, not necessarily the order in which things were discussed.

About the Meeting

Purpose

The primary purpose of this meeting was to understand where Maine stands in regard to newly announced proposed MACRA Rules (Medicare Access and CHIP Reauthorization Act of 2015) and the newly announced CPC+ opportunity.

Attendance

Committee Members

- 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
- Lisa Harvey-McPherson, Eastern Maine Health System
- Katie Fullam Harris, MaineHealth
- Jen Moore, MaineHealth
- Sara Sylvester, Genesis Health Care
- Darcy Shargo, Maine Primary Care Association
- Lisa Letourneau, Maine Quality Counts
- Andy Webber, Maine Health Management Coalition
- Shaun Alfred, HealthInfoNet
- Michelle Probert, Bath Iron Works
- Dale Hamilton, Community Health and Counseling Services
- Catherine Ryder, Tri-County Mental Health Services
- Trish Roy, Consumer Representative
- Ted Rooney, Consumer Representative
- Roger Renfrew, Primary Care Physician, Maine General Hospital
- 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 Provider
- Karynlee Harrington, Maine Health Data Organization (by conference call)
- Rhonda Selvin, Maine Nurse Practitioner Association (by conference call)

Guests

- Dr. Frances Jensen, Deputy Director of the State Innovations Group of the Center for Medicare and Medicaid Innovation (by conference call)

- Sarah McHugh, Team Lead, CPC+ Program, CMS (by conference call)

Interested Parties

- Carolyn Gray, Muskie School of Public Service
- Kimberly Fox, Muskie School of Public Service
- Sybil Mazerole, Department of Health and Human Services, Office of Continuous Quality Improvement
- Peter Kraut, Department of Health and Human Services, Office of MaineCare Services (by conference call)
- John Rancourt, Office of the National Coordinator for Health Information Technology (by conference call)
- Frank Johnson, Maine Health Management Coalition
- Gerald Queally, Spectrum Generations
- Dr. Terry Scriven, Health Care Provider (by conference call)
- Lyida Richards, Consumer (by conference call)

Staff

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

Opening Remarks

Facilitator Craig Freshley welcomed the group and explained a little about his role and about the planned agenda (see Appendix), making the following comments:

- Good Group Decisions has been hired to facilitate this process
- Our 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.
- Shortly after we formed, the CPC+ opportunity emerged, and this meeting was to be focused on learning about CPC+
- Since then, the proposed MACRA rules have been announced and that has a big impact on our charge, so we have revised the process again to understand all this so we can get on with our charge
- Today is about shared understanding of CPC+, the proposed rules, and what some players around table are thinking about
- Proposed "roadmap" for our deliberations over the next few meetings
    - Today: understand where Maine stands in regard to MACRA and CPC+
    - May 17, 9:00am – 11:00am, Maine Medical Association

        - Further understanding and direction regarding CPC+
        - A special meeting scheduled in light of these opportunities
        - Not sure yet what the agenda is
    - June 1, 10:00am – 12:00pm, MaineGeneral
        - The nature of Maine's SIM Medicare Alignment Proposal
        - Maybe CPC+, maybe not
        - We don't intend to decide this today
    - July 6, 10:00am – 12:00pm, MaineGeneral
    - August 3, 10:00am – 12:00pm, MaineGeneral
    - September 7, 10:00am – 12:00pm, MaineGeneral

Craig reminded the group of a few 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

Understanding Maine Options under MACRA

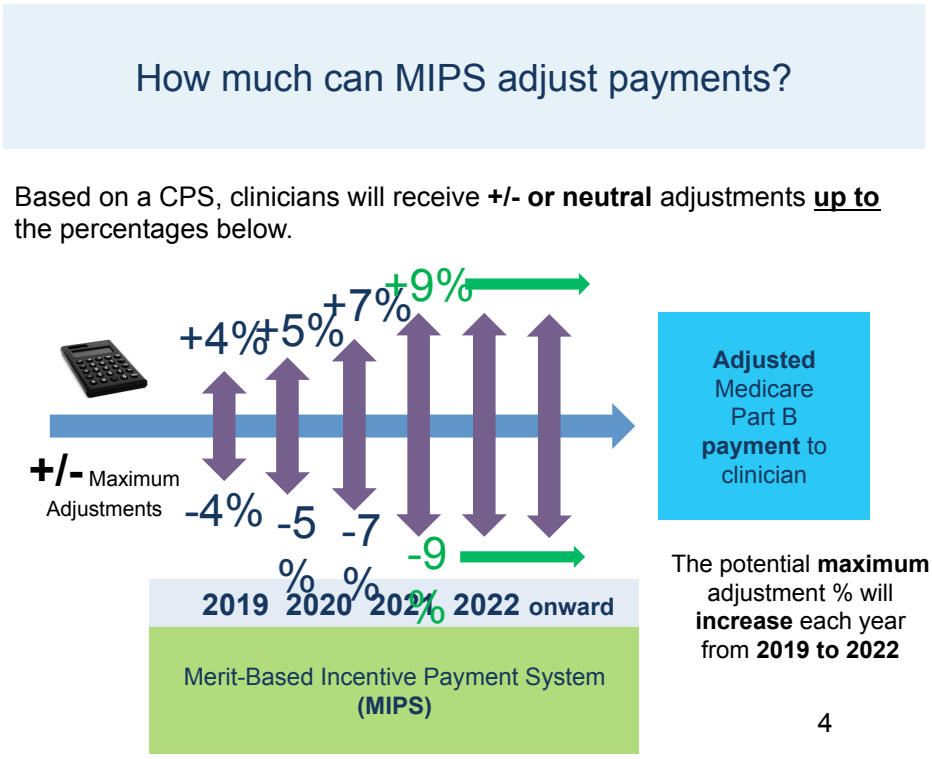
MACRA Rules and the Maine APM Landscape

Fran Jensen, Deputy Director of the State Innovations Group of the Center for Medicare and Medicaid Innovation, provided an overview of MACRA, MIPS (Merit-based Incentive Payment), and Advanced APMs (Alternative Payment Models), and a snapshot of the current landscape in Maine.

Fran's Presentation

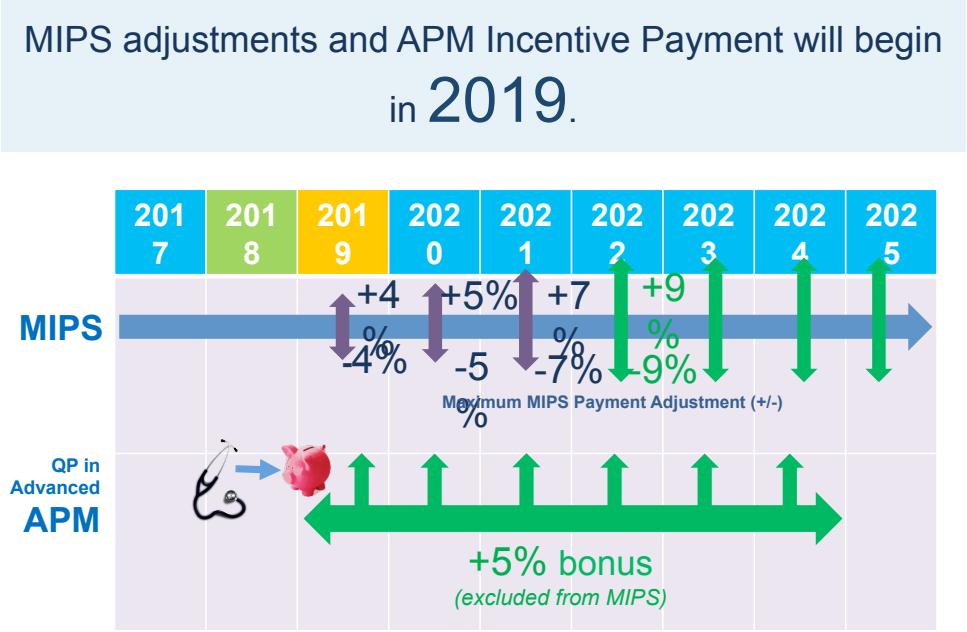
- Thanks for having me back, lots has happened since I was there in person with you last month:
    - CPC+ was announced on April 11
    - Health Care Plan Learning and Action Network Medicare Summit
    - MACRA NPRM released
- Here to explain MACRA Quality Payment Program basics
- Background
    - Medicare is evolving from fee-for-service

        - Goal: 50% of payments in alternative payment models by 2018
    - So CMS is improving and streamlining existing quality programs into a single one to will reward clinicians for coordinated care and better outcomes supported by technology
        - Changes are in response to concerns that too programs, requirements, and measures get between the clinician and the patient.
        - This is why we are trying to improve
- Important hallmarks of the Quality Payment Program
    - A better, smarter Medicare for healthier people
    - Pay for what works to create a Medicare that is enduring
    - Health information needs to be open, flexible, and user-centric
- Newly proposed rule is the next step in implementing MACRA's vision
    - Please provide comments on the rule for consideration by CMS
- MACRA replaced a patchwork collection of quality programs with a single system
    - Everyone will have an opportunity to be paid more for better care and investment
    - Two paths in this system:
        - MIPS - Merit-based Incentive Payment
        - Advanced APM - Advanced Alternative Payment Models
    - Rule development was guided by the core goals of legislation
        - Streamlining and strengthening quality-based payments
        - Rewarding participation in Advanced Alternative Payment Models that best incentivize quality and coordinated care
        - Flexibility to choose how to participate
    - Tools and education available to help get ready for performance year 2017
        - See go.cms.gov/QualityPaymentProgram
        - Groups are also being organized across the country, for local help to get ready
- About MIPS
    - Principles
        - Patient-centered approach leading to better, smarter, and healthier care
        - Program should be meaningful, understandable and flexible for participating clinicians
        - Incentive movement toward delivery system reform and APMs
        - Attention to excellence in implementation, feasibility
    - How much can MIPS adjust payments?
        - A composite performance score is calculated, based on
            - Quality
            - Resource use
            - Clinical practice improvement activities
            - Advancing care information
        - Depending on the score, payments can be adjusted up, down, or not at all for each clinician



    - Potential maximum adjustment starts at +/- 4% in 2019 - this is the amount you can get "extra" or "dinged"
    - Will increase each year from 2019 to 2022
    - In 2022, the adjustment is up to +/- 9%
  - MIPS links payment to quality more comprehensively than current systems
- Advanced APM
  - What it is: a new approach to paying for care that incentives quality and value
  - Differs from regular fee-for-service: providers accountable for both the cost AND the quality of care
  - MACRA has a specific definition for APMs
    - APMs include
    - CMS Innovation Center models
    - Medicare Shared Savings Program
    - demos under the Health Care Quality Demonstration program
    - demos required by federal law
  - MACRA defines Advanced APMs as meeting these specific criteria:
    - Basing payment on quality measures comparable to those in the MIPS quality performance category
    - Requiring participants to use certified EHR technology
    - Either (1) requiring APM Entities to bear more than nominal financial risk for monetary losses; OR (2) being a Medical Home Model expanded under CMMI authority

- Advanced APM is a very high bar to meet
- Timing
  - Bonuses to qualified participants will begin in 2019 and last until 2024
  - 5% bonus payment based on the estimated total payment received by the provider for the prior year
  - A clinician's bonus in 2019 will be based on payment for services in 2018.



- Opportunities for Maine
  - The Medicare landscape in Maine
    - Maine has the highest number of Medicare beneficiaries per capita in the country
    - As of February 2016, total Medicare enrollment in Maine: 309,563
      - 75% original Medicare
      - 232,836 represents the universe of Medicare FFS beneficiaries to be included. This is essentially the denominator for the state.
  - The APM landscape in Maine
    - Maine Medicare ACO snapshot
      - 5 Medicare Shared Savings Programs (MSSP)
      - 1 NextGen Accountable Care Organization

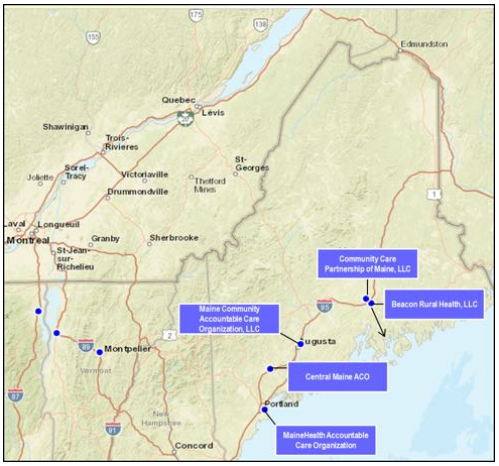
Maine Medicare ACO Snapshot

Currently, there are 5 Medicare Shared Savings Program (MSSP) and 1 NextGen Accountable Care Organizations in the Great State of Maine

2014 Maine MSSP Participants, Assigned Beneficiaries, Percentage of Original Medicare and Participating Physicians

ACO Doing Business As (DBA)	Estimated Total Assigned Beneficiaries	Number of Providers
Beacon Health	28,000	215
Beacon Rural Health LLC	10,000	
Central Maine ACO	13,408	566
Community Care Partnership of Maine, LLC		
Maine Community Accountable Care Organization, LLC	6,625	125
MaineHealth Accountable Care Organization	49,413	1,595
Total Maine MSSP Assigned Beneficiaries	107,446	2,501
% of Total	46.10%	58.10%

Note: Community Care Partnership of Maine, LLC are new as of 2015/16; Beacon Health, and Beacon Rural Health LLC are estimates from their websites are new ACOs 2105/2016; Source: MSSP performance year 4;



CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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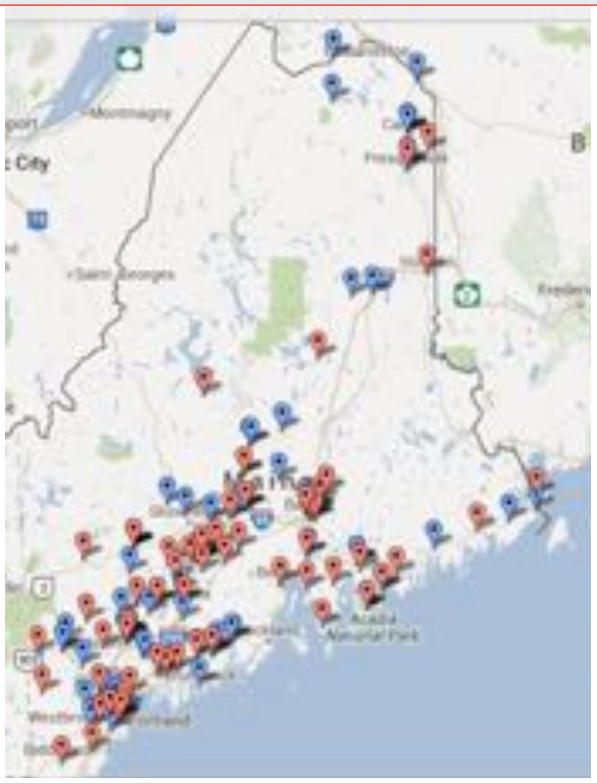
- It seems that almost half of Medicare beneficiaries - about 46% - are in either MSSP (all Track 1 with no downside risk) or Next Gen ACO
- It seems that close to 60% of the roughly 2,500 providers in Maine are delivering care in ACOs
- These numbers are estimates, from various sources - CMS, organization's websites, Kaiser Foundation, Google searching
- Numbers are not yet available for Community Care Partnerships of Maine, the newest ACO

Maine PCMH Pilot and Health Homes Practice Sites



- Maine PCMH snapshot
  - 68 multipayer practices participating in MAPCP
  - 125 health homes which are MaineCare only
  - Within MAPCP, 43,268 Medicare beneficiaries are served
  - Lisa Letourneau clarified that this map shows the PCMH universe in Maine, with Medicare and MaineCare participation. Red flags are health homes that are part of MAPCP; blue flags are additional health homes.

- Comparison of CPC+ and Medicare Alignment in SIM Pathways
  - [See Comparison of CPC+ and Medicare Alignment in SIM Pathways in Appendix]
  - CPC+ is a national model with 5,000 practices in 20 regions
    - A state is a region
    - Run by CMMI according to the requirements
    - CPC+ applications are due June 1, 2016, from payers
  - The state-specific custom model provides more flexibility compared to CPC+
    - You design it, CMS works with you to make sure it's aligned with the state's payer and provider landscape and appropriate for Medicare beneficiaries. It would have to meet the six core principles.

        - It would take longer to get through; definitely a heavier lift
        - An application for a custom model is an ongoing negotiation
- More info is coming on these programs; Fran will be sending the materials and links to Randy and Gloria as they are released

Questions and Comments

- Katie: Clarification about the 46% of Maine Medicare beneficiaries who are enrolled in ACOs currently - is the FQHCs' ACO part of the Medicare ACO program?
    - Responses from Fran and Lisa L.:
        - The FQHCs' ACO is the Community Care Partnerships of Maine, the one for which we don't have the numbers - they just started in January
        - So it's actually higher than 46%, probably more than 50%
        - We probably won't have the numbers for Community Care Partnerships for a while
- Katie: Are those are practices not eligible for CPC+?
    - Lisa L: It's not that they are not eligible, it's that they can't participate in both. If a participant gets into CPC+ they must drop out of their ACO.
- Lisa H.M.: How will the rule changes impact FQCH payments, payments for rural health center services, and payments for Critical Access Hospitals' outpatient services?
    - Fran: Not sure, but can ask colleagues at the MSSP program about this

Understanding CPC+

Sarah McHugh, Team Lead, CPC+ Program, CMS addressed questions submitted in advance by SIM MPOC members. Lisa Letourneau added clarifications.

Summary

Craig captured the following high-level summary on the screen:

- You cannot have simultaneous participation in two programs, CPC+ and an otherwise participating ACO
- Medicare alignment and SIMS – CPC+ is a national program and we are limited in the accommodations that we can make for states
- Payments for community care teams – currently payments are made directly to the practices and encouraging them to coordinate and work with their medical neighborhoods but not extraordinarily prescriptive about how services are charged. Look at the website for details on the differences between Track 1 and Track 2. Payments will continue to go directly to the practices.
- Payment components of CPC+
    - Care management fee

        - $15/beneficiary – Track 1
        - $28/beneficiary – Track 2
        - This element is not at risk
        - We expect non-visit based enhanced support
    - Fee for service
        - Track 1 – unchanged
        - Track 2 – moving practices away from the "fee-for-service treadmill"
            - Pre-paying portion of expected fee-for-service up front
            - In the end payments will be reduced by what was pre-paid
        - Not at risk
    - Pre-paid Incentive Payments
        - $2/beneficiary – Track 1
        - $4/beneficiary – Track 2
        - At risk
- For clarifications about dementia payments
    - Check out the care deliverer requirements – especially for Track 2
- For dementia quality measures – we don't expect any differences in measures
    - Can a practice select specific measures or must a practice use the whole group?
    - Not sure
- MSSP participating providers
    - Would such a provider have to leave the MMSP in order to participate in CPC+?
    - Track 1 providers would not qualify
    - Track 2 and 3 would qualify
- Attribution methodology
    - Practices must have 150 attributed lives to participate
- Private sector payer participation
    - What levels of participation would be required?
    - Goal: Having at least ½ of patients covered by participating payers
- What degree of alignment is required of private payers?
    - We want to payer proposals to support the same goals although care management fees may be different
    - Areas of alignment:
        - Financial support
        - Data sharing
        - Quality alignments
- Although Maine has a "leg up," clarified that we would need to see participation of our state Medicaid program in order to take advantage
- Choices for providers and provider owners:
    - MIPS (not preferred)
    - Advanced APM
        - To qualify:
            - Track 2
            - Next Gen ACO
                - Currently, very little Maine providers participate in this

    - Conclusion
        - 85% to 90% of all providers "have a big reason to care about doing something"
        - We have a huge interest in getting all our providers into:
            - Risk-bearing ACOs
            - CPC+
            - Middle path – a Maine-specific proposal
- MACRA gives a special dispensation for Medical Home Practices
    - Only available to providers with 50 or fewer clinicians
- How will CMS differentiate risk for total cost of care vs. individual cases
    - We have a minimum beneficiary count in place and that's why it's a regional program
        - However, when it's regionally based it tends to remove incentive
    - So, we are moving towards using quality and utilization measures related to hospitalization and ED visits (practice-level measurements)

Sarah's Remarks, and Questions and Comments

- If we get full interest in CPC+ (5,000 practices over 20 regions) and we can distribute practices evenly across regions, that would be about 250 practices per region
    - We are thinking of regions as states or as smaller commercial markets
    - We are open to where there is sufficient payer interest in partnering with Medicare fee-for-service
- In response to a question asked in advance about whether practices in a MSSP or a NextGen would qualify for CPC+, Sarah explained:
    - Lisa Letourneau's explanation was correct: if you are eligible then you can apply but would need to withdraw from the APO prior to participation
    - The rationale is that you can't get payment from 2 programs. We are limited in our ability to pay incentives in multiple programs. The intent of CPC+ is shared savings, so you can't be in another shared savings model simultaneously.
- In response to a question asked in advance about syncing up Medicare alignment and SIM, Sarah explained:
    - CPC+ is a national program and is a test
    - We are limited in accommodation that can be made for each state
    - We recognize each region is unique and brings its own perspective
    - In current CPC imitative, payers have aligned around certain measures, the learning and focus of practice changes is modified, and there are data aggregation efforts specific to regions
    - We hope that SIM and other work unique to Maine would be complementary to potential participation in CPC+
- In response to a question asked in advance about payment for Community Care Teams, Sarah explained:
    - What worked under MAPCP may be different than what is in CPC+

- The care management fee averages $15 per beneficiary per month in Track 1 and $28 per beneficiary per month in Track 2. This is paid directly to the practices, and especially in Track 2 we encourage practices to coordinate, expand understanding, and work with the medical neighborhood to make sure they are including community and social based services.
- But we not requiring this; we are not prescriptive about what practices do or how they break down care management fees.
- We have posted Year 1 care delivery expectations on the website
  - Look there to see what we are asking of a practice in Year 1
  - Track 1 and Track 2 have a lot of similarities
- We are encouraging more community based work than before, but in terms of payments, all dollars are going directly to practices not a Community Care Team

- Question from Katie: Is the care management fee an add-on to fee-for-service or is it to be trued up at the end of the contract year?
  - Sarah provided an overview of payment components of CPC+:
    - There are 2 tracks - practices are in one or the other
    - Care management fee
      - Applies to both tracks - it is not at risk
      - $15 or $28, paid prospectively for Medicare fee-for-service attributed beneficiaries
      - Payers who want to partner with CMS on this model would provide non visit-based payment - not necessarily $15 or $28
      - The idea is for multipayer alignment and full practice transformation, Medicare alone can't support all the work practices are doing to support care management, coordination, wraparound services, etc.
      - We don't expect an identical approach among all payers but we expect non-visit based enhanced support for practices
      - Practices in Track 1 will get fee-for-service unchanged - a visit gets paid
    - Comprehensive Primary Care Payment (CPCP)
      - Only in Track 2
      - A hybrid fee-for-service/prepaid approach
      - In Track 2 we are moving practices away from fee-for-service quick visits that aren't always in the best interest of patient care. We are prepaying a portion of expected fee-for-service up front to support asynchronous delivery and allow clinicians to deliver care the way they think is best for the patient. So Track 2 will get a portion up front: the Comprehensive Primary Care Payment (CPCP) per service applicable to the management code. When a patient comes for a visit, the payment will be reduced by the amount prepaid.
      - This fee is partially reconciled, which is very complicated, but not considered "at risk"

            - The theory is that neither 100% capitation nor 100% fee-for-service are the best models. It has been a struggle to risk-adjust for this, so we are doing a hybrid, and we think the best mix is around 50-50 according to our research.
        - Incentive payment
            - The third payment is for both tracks and IS at risk
            - A replacement for shared savings
            - A prepaid incentive per beneficiary per month. It totals $2.50 in Track 1, and $4 in Track 2. Practices get it up front but might have to repay all or some of it depending on quality and utilization measures.
- In response to a question asked in advance about dementia care and quality, Sarah explained:
    - Hard to answer thoughtfully on this phone call
    - Please look carefully at care delivery requirements that are posted
    - In Track 2 we are acknowledging the impact of dementia and have risk stratified the care management fee for Track 2 to take dementia into consideration, based on HCC scores and some select dementia diagnoses. We know that practices take a lot of time and care with these patients.
    - Quality measures are from PCQM chosen specific to primary care
- Question from Roger: Regarding dementia, the same thing with falls - can we choose individual indicators or do we have to take the dementia group and the falls group of quality measures?
    - Sarah explained:
        - We have proposed a list of quality measures in the RFA
        - The list of measures expected for reporting will be finalized along with proposed rules. At this time we don't expect different dementia measures; our clinical team is going to coalesce around these. Do you have measures you are working on specific to dementia?
    - Roger clarified: Looking at the list, there are 10 dementia measures - does a practice pick one of them or under PQRS are they a group?
    - Sarah explained: Can't speak to that; lots of moving parts under the proposed rule
- Question from Steve: Unclear about status of MSSP participating providers who are not in an Advanced APM. Would they have to leave the MSSP to be in CPC+?
    - Sarah explained: The proposed rule is that CPC+ *is* an Advanced APM and MSSP Track 1 is not. There are some further details about this, including organization size, but we can't say whether people should jump from one to another. They are very different programs. We encourage comments on the proposed rule.
    - Fran added: Under the proposed rule, Track 1 would not qualify as an Advanced APM, but Tracks 2 and 3 would, because they meet nominal risk criteria.
    - Sarah added that CPC+ uses the medical home definition of nominal risk.
- Question from Katie: Can you explain the attribution methodology?
    - Sarah explained: We have included the CMS Medicare fee-for-service attribution

methodology in Appendix E of the RFA which is posted online. It is based on plurality of primary care visits. In a 2-year look back this has been relatively stable; it captures 70-80% of Medicare beneficiaries who are visiting a practice. We require that practices have 150 attributed Medicare fee-for-service lives to be eligible for CPC+ In our current experience this is relatively easy to meet.

- Question from Andy: Foundational to this program is private sector payer participation. Can you give more context for the level of private payer participation you will want to see that is adequate for engagement by other payers?
    - Sarah explained:
        - The idea is that for practices to fully transform they need resources beyond Medicare. We intend for internal workflows to change and all high-risk patients to be taken care of, not just specific payers' patients.
        - We are soliciting interest from payers and on the application payers will propose lines of business, counties, number of covered lives, etc. We are doing geo-mapping to see where the interest is.
        - There is no specific number pegged. We are determining area with interested payers, and then practices within those payers apply to be part of CPC+ and in their applications they say who their revenue is from and who their contracts are with and who their patients are.
        - Our current CPC tests show that having half of patients covered by participating payers provides enough support to make the changes we are asking. But it's more complicated; we are waiting to see the strength and alignment of proposals alongside geographical distribution
        - The end goal is that regions have practices apply who have half their patients - ideally more - covered by CPC+ partner payers.
- Question from Michelle: What is the degree of alignment CMS expects from private payers, in terms of accountability for quality and would you expect private payers to have the same types of care management fees and fee-for-service Track 1 and 2 incentive payment amounts?
    - Sarah explained:
        - We want payer proposals to support the same goals. There are three "buckets" of payer alignment are financial support, data sharing, and quality alignment. We do not expect payers to have exact same care management fees - we know our population is older, sicker, and more complex than commercial payers. We do not dictate what exactly you pay but we are evaluating proposals based on whether they are well-founded and oriented toward the same goals.
        - We acknowledge the tight timeline and appreciate your position. We can't budge on the timeline, so as to ensure a January 2017 start. We hope you can propose what you think is as realistic as possible. We have heard that the Track 2 departure from fee-for-service will be the most difficult part to align to. However, there is lots of momentum around moving away from fee-for-service, so we hope it doesn't come as a complete surprise.
- Question from Lisa L.: Maine as a MAPCP state has a designated "leg up", and this is called out in the RFA. But to do this, would CMS need to see a significant number of

payers, including our state Medicaid program?
    - Sarah affirmed: Yes, we want to acknowledge the work Maine has already done in partnership with CMS and we are giving preference to regions where such partnering, like SIM programs, are already in place.
- Question from Lisa H.M.: Under CPC+ a practice assumes financial risk under the incentive payment. How is this different from assuming risk on total cost of care?
    - Sarah explained: We defined the model based on current CPC tests and regionally based shared savings. Given sizes of these practices there are actuarial limitations to doing total cost of care calculations at the practice level. For CPC+ we realized that it would be not as meaningful if regionally based; people are motivated by their own practice-level performance. So we moved away from total cost of care to a proxy for it: utilization measures based on hospitalizations and ED visits, which are huge drivers of total cost of care. These are more appropriate and actionable and measurable on a practice level. These incentive payments are based on your practice's quality experience, your patient impact and your utilization measures - not the measures of practices down the street.
- Question from Michelle: Could a practice participating in a Medicare ACO receive support under CPC+ from Medicaid or commercial payers, even if they are excluded for Medicare CPC+ payments because they are in an ACO?
    - Sarah explained: we are signing MOUs with partner payers but we don't get in between contracts the practices have with other payers. If regional practices are not in CPC+ we wouldn't stop them from getting payments under other models.

Lisa Letourneau's Remarks

- The game has totally changed; it's moving at a dizzying pace
- When we started with the concept paper under SIM, that is now two eras ago
- Then CPC+ came out and that was another era ago and there was mixed interest
- And now the game has changed again, with MACRA
- Like Fran said, the choice for providers is really MIPS or Advanced APM
    - No offense to CMS, but no one really wants MIPS - it's complicated, there are many things out of our control, there is a downside of up to 9%. It's like CMS's "stick" to move us towards Advanced APMs.
    - But remember that in an Advanced APM the only thing that qualifies is Track 2 MSSP or NextGen ACO. In this state only a subset of practices are in a NextGen ACO; everyone else - the other ACOs - are in Track 1 MSSP. Some aren't doing any programs.
    - So the number participating in ACOs is closer to 90-95%
    - There are only a few who escape the MIPS stick - practices owned by Eastern Maine in the NextGen ACO
    - MACRA legislation says there has to be more than nominal risk; we are not all going back to Track 1. So all of a sudden we all have a big reason to care about getting our primary care practices into a risk bearing ACO or CPC+ (because the money is pretty good and you are not waiting for the possibility of shared

savings) OR a Maine-specific middle path, which could be an alternative to the two ends of the spectrum that CMS is offering now.
    - The concept paper does offer a middle path - change primary care payment within a wider ACO structure.
- There is another escape valve under MACRA: a special dispensation for medical home practices that's only available to provider groups with 50 or fewer clinicians. This recognizes that small groups might not have the capital reserve to go into a risk bearing ACO, but it does nothing for the larger groups that own physical practices in Maine.
- So, the game has changed, we have more reason to care about this, and the clock is ticking on CPC+.

Payer Perspectives on the CPC+ Opportunity

Katherine Pelletreau of the Maine Association of Health Plans and Jean Nichols Wood of Anthem Blue Cross Blue Shield offered brief remarks, followed by questions and clarifications.

Summary

Craig captured the following high-level summary on the screen:

- Katherine Pelletreau - Maine Association of Health Plans
    - Members
        - Aetna
        - Anthem
        - Cigna
        - Harvard Pilgrim
    - These participation decisions are being made by the companies nationally
    - No decisions have been made and probably won't decide until the last moment
    - What they are considering as they make their decisions
        - Current alignment and/or consistency with current products and services
        - How easily will it be to match requirements
    - The timeline is very aggressive – asking quickly for a five-year commitments
    - CPC+ has implications for provider contracts, interruption of programs, payment methodologies, and may other things
    - Maine seems in a strong position
        - Multiple players are already participating in alternative payment programs
        - Progress has been made around aligning quality measures
        - SIM states have a leg up
- Jean Wood - Anthem Blue Cross and Blue Shield

- As a corporation we participated in CPC Classic in four regions of the country
- Maine has "thrown it's hat into the Anthem ring nationally" regarding the CPC+ program
- We are "investigating"
- Anthem is already doing a number of "CPC+ type practices"

Katherine's Remarks

- We have four members, 3 large and 1 small: Aetna, Anthem Blue Cross Blue Shield, Cigna, and HarvardPilgrim HealthCare
- This is a very large decision that will be made at the top levels of the companies
- There are opportunities for local input but the decisions will not be made here in Maine
- The companies are considering existing programs in multiple markets and states and which programs to apply for - they could be applying in lots of regions across different populations
- They haven't made a decision yet and probably won't decide until the last moment
- Factors payers are considering:
  - The extent to which current programs align well with what the CPC+ model is; the degree of consistency or inconsistency with what is already in the marketplace
  - The degree to which they can match CPC+ model - it doesn't have to be exact but there is lots of work to see how close they can match it
  - The very aggressive timelines, for the initial proposals but also for the expectations - this is a 5-year commitment for a program that has to be ready to roll in January 2017
  - CPC+ has implications for provider contracts and renegotiation - interruption of current programs, changes to payment methodology, costs of changes to content, frequency of data feeds, and evaluations of health plans
- Maine is in a strong position
  - We have a track record of lots of participation in payment reform, from multiple payers
  - Example: PCMHs
  - CPC+ has flexibility - that's a plus
  - Some progress has been made around aligning quality metrics, for example under SIM. These are steps in the right direction.
  - SIM states have a leg up, especially if we can show sufficient payer interest
    - We assume state Medicaid is evaluating this and hoping to participate

Jean's Remarks

- Katherine has expressed some of the global concerns of the payers
- From Anthem's perspective, we did participate at the corporate level in "CPC classic" in four regions so we have a history of interest

- Maine has thrown its hat into the Anthem ring, nationally, to say "Yes, we think we might be interested, please take a look and consider Maine as a market that you would implement this in."
    - However, we are still in an investigatory mode
- We have a robust EPHC program now with almost all eligible providers participating
- It is hard to dismantle something that's working to try something else
    - EPHC does the things that CPC is trying to do, so why change?
- Jean will keep everyone informed - nothing happens fast, but we will try to let you know in time to move forward

Questions and Comments

- Question from Randy: Would there be value for this group to provide input to Anthem if decisions are being made regionally?
    - Jean clarified that she has already made Anthem aware of this group and has shared the proposal paper
    - Katherine added that this is true across plans - the SIM states are sniffing hard around this opportunity
- Question from Andy: Can you clarify, has Maine thrown our hat in the ring on CPC+?
    - Jean confirmed yes.
- Question from Andy: Has there been any conversation about the SIM round 1 separate opportunity?
    - Jean explained: Not yet. They are focused on CPC+ at the corporate level so far.
- Comment from Lisa Letourneau: Thanks for stepping forward. Anthem is modeling paying differently up front (primary care payments under EPHC) while encouraging ACO contracts with larger groups. I don't believe that there is an overlap.
- Question from Andy: What % of commercial market does Anthem represent?
    - Katherine and Jean explained that it's about 35-40%.
- Katherine noted that if Maine decided NOT to pursue CPC+ that would be very helpful for the big plans to know. If Maine chose the middle path, that would be an important message for payers to hear and it would save a lot of work.
- Lisa L. clarified that CMS will decide, and will tell regions what practices can apply. Our action here is that we would encourage our MaineCare program to apply for CPC+ - there is no "Maine deciding and applying".
- Question from Steve: Any indication of a decision about MaineCare?
    - Randy explained that MaineCare is going through the same analysis phase as the commercials - what does alignment look like? Do we already meet the requirements?
- Question from Lisa L.: Is an endorsement from this group needed, regarding MaineCare's decision?
    - Randy explained that he hadn't heard that specifically, but an endorsement would be heard and weighted.

Health System Perspectives on the CPC+ Opportunity

Katie Fullam Harris and Jen Moore of MaineHealth, and Steve Ryan and Lisa Harvey-McPherson of Eastern Maine Health System offered brief remarks, followed by questions and clarifications.

Summary

Craig captured the following high-level summary on the screen:

- Health System Perspectives
    - Katie Fullam Harris
        - Very disappointed that Track 1 providers were not included in CPC+ because we have invested a lot in building system around Track 1
            - Still, we understand that we are in this place and trying to make the best decisions going forward
        - Concerns around potentially breaking up our ACO
            - Many of our smaller practices would not qualify
        - On the other hand, payment of care management fees are very enticing
    - Steve Ryan
        - Concern about bifurcating the current infrastructure
        - There are some potential advantages, but there are also lots of unknowns
    - Lisa Harvey-McPherson
        - ACO success is based on large populations
        - Under NextGen ACO's, waivers are critically important – and we don't see these as part of CPC+
        - We are concerned about impacts of CPC+ on Critical Care Hospitals

Katie's and Jen's Remarks

- We are disappointed that MSSP Track 1 providers are not included in the Advance APMs. We spent 6 years building a structure around total cost of care and alignment with primary care a, looking at the whole person, as the foundation, and CMS and CMMI are heading in a different direction.
- We know that we have to do something one way or another
- Looking at this opportunity has raised concerns about whether we want to break up our ACO.
    - Our primary care practices would peel off to participate
    - Our smaller independent practices would not quality, especially for the EHR certification
    - If we are looking for a foundation to support the whole, this starting to break up
- On the other hand, the care management fees are something to consider, since we

currently don't receive those from Medicare/Medicaid. That is very enticing for our primary care practices.
- We are in process of weighing this
- There are potentially very good opportunities to use this process and the SIM 2 opportunity to create something for Maine that makes sense. Many of our providers are already engaged in ACOs that would enhance care management and allow us to meet the Advanced APM test.
- Our independent practices rely heavily on ACOs for support. If we start to peel off MSSP practices, there won't be attention to and support for improving care for those populations.

Steve's Remarks

- We have the same concerns about bifurcation or pulling practices into fundamentally different models
- We have built strong systems around staffing, data management, etc. so the NextGen and MSSP hospitals and practices can work together and pursue synchronous goals. Pulling it apart is a little crazy.
- Having said that, the new opportunity has powerful dollars attached
- There are lots of financial wildcards - variables not nailed down
    - For example, there can be up to additional $100 dollar payments -how can that be stretched? Can it be applied to behavioral health and CCT and other social determinants via our community partnerships?
    - We would have to develop systems to spend money, and measure, and deliver. A lot goes into designing your own program.

Lisa Harvey McPherson's Remarks

- With a larger attributed population, the risk is more spread out and programs have greater impact
- Under the NextGen ACO we have important waivers about length of stay, post discharge home visits, and telemedicine. These are important to hospitals and we don't see them as part of CPC+. This is of great interest to us.
- The Beacon Health model is based on critical access hospitals and MSSPs - it is unclear what the impact on reimbursements for outpatient services at critical access hospitals will be under this proposal.
- I am not convinced that we will have impact like we do under MSSP. It will depend on how these hospitals employ providers.

Questions and Comments

- Question from Andy: Any consideration of going to NextGen within MaineHealth?
    - Katie explained that MaineHealth is looking at all options; the newest information just arrived

- Question from Andy: Does MaineHealth have any initial reflection on the MARCA rules and implications for integrated care delivery systems
    - Katie explained that not yet, we are reviewing it. Not sure we share Lisa's strong disagreement with MIPS. We need to look at it in the context of our ACO. We have used our ACO as a structure to create a system and CPC+ removes that structure. That's a problem. They go directly to practices. We are certainly taking steps to get to the risk requirements but the question is how fast? We have a lot to learn still and attribution doesn't help with that.
- Question from Kat: I found a good appendix with outcome measures for MIPS, but I am less clear about APM. Do we get to develop our own measures? If we choose APM or CPC+ do we have the same outcome measures?
    - Jen Moore explained that she heard on the webinar that APM participants could select their own measures from a list provided
- Comment from Michelle: A large health system / practice group in Maine asked me to share that they were seriously considering this model, and expressed interest in forgoing MSSP or pulling out of MSSP to do this instead.
- Question from Dale: Given the process for CPC+ decision making, if the state decides to go with CPC+, do we not have the option to develop a state specific plan via SIM? This seems critical.
    - Randy explained that CPC+ is not a state decision; the decision will be made by providers, payers, and MaineCare. It is important to know if providers have a strong preference in one direction. If we assume that we go with CPC+ and everyone is on board, it's not clear what would be left for another model
    - Lisa L. reminded the group that there will be limited number of practices per region for CPC+, so perhaps there will still be an opportunity.
    - Lisa H.M. added: I am not convinced that under CPC+ all practices will have engagement with community care teams, and funding those will be important. We've had great success with certain waivers and Medicare saves a lot of money. We have a critical need for behavioral health services in long term care and this impacts our dually eligibles. This is not part of CPC+. We have a lot to learn from population heath strategies that we could put into a state plan that will advance the state more effectively.
- Question from Ted: What are the odds of us getting a state specific application approved? Better than 50%?
    - Lisa L. explained: Fran says we should apply, but let's be realistic - it's a very short timeline and one could argue that CMS' capacity to handle things is limited. So some are expressing skepticism, but Fran has been very encouraging.
- Question from Ted: Clarification - on May 17 we will hear more about this. By June 1, the payers would have had to make their decisions by then, independently, right?
    - Katherine P: Each company will apply independently to CMS
    - Ted: Is the clock then started for when providers need to apply?
    - Katie: CMS has to select a region. The 7 current CPC regions are automatically included so there are actually only 13 additional regions.
        - Sarah: They are included presuming payers continue to participate. We hope they recommit.

Closing Comments

Interested Parties

- John Rancourt, Office of the National Coordinator for Health Information Technology: We need to consider health IT implications for whatever approach is decided. We are here to help think through those considerations. We are eager to support you in this work.

Committee Members

- Katherine P.: I am not confident we will have more info from our perspective by the next meeting
- Steve: It would be worthwhile to flesh out a starting framework for a Maine state model. If it is a real alternative, what would it look like and how would we choose?
- Dale: A reminder that SIM is much larger than ACOs and primary care. There are lots of systems and populations - don't lose sight of that. As we continue forward, let's not get locked into an approach that only addresses one part of one population. We should discuss this at our next meeting.
- Ted: On May 17 it would be good to hear more about what a Maine approach would look like.
- Kat: CPC+ and Advanced APM look very promising from the perspective of an in-the-trenches practitioner. I'd encourage those applying to consider them. This is as close as we have come to getting off the ineffective hamster wheel of the last 20 years.
    - Still, I have concerns that outcome model doesn't capture what we need it to
    - Continuing with SIM and really looking at simpler outcomes that capture disease management and incorporating how specialists work in the rest of the system remains extremely important
- Randy: We will be reporting back to state leadership about the continued interest in pursuing a Maine state model regardless of the decision for CPC+.

Guests

- Fran and Sarah: We appreciate the crazy timeline and we are here to answer your questions. Please reach out as you need more help. And please comment on the rules.

The meeting adjourned at 12:00 noon.

Appendix A: Agenda

SIM Medicare Proposal Oversight Committee (MPOC)

Revised Agenda

May 4, 2016, MaineGeneral, First Floor Conference Room 2 (B1102)

Purpose

The primary purpose of this meeting is to understand where Maine stands in regard to newly announced proposed MACRA Rules (Medicare Access and CHIP Reauthorization Act of 2015) and the newly announced CPC+ opportunity. At the June 1 meeting we intend to discuss the nature Maine's SIM Medicare Alignment Proposal.

Agenda

10:00 **Welcome and Introductions**
Facilitator Craig Freshley will explain a proposed "roadmap" for our deliberations over the next few meetings in light of the new MACRA Rules and CPC+ opportunity. Craig will also explain the agenda for today and a few ground rules for a productive meeting. We will do quick introductions.

10:15 **Understanding Maine Options under MACRA**
We will hear presentations as follows but also have opportunity to ask additional questions and discuss clarifications.

- **MACRA Rules and MIPS** – Dr. Frances Jensen, Deputy Director of the State Innovations Group of the Center for Medicare and Medicaid Innovation, will briefly explain the proposed rules of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and how Merit-Based Incentive Payment Systems (MIPS) and Alternative Payment Models (APMs) might work under the rules. Dr. Lisa Letourneau, Executive Director, Quality Counts, will provide additional perspective and context
- **Maine APM Landscape** - Dr. Frances Jensen, Deputy Director of the State Innovations Group of the Center for Medicare and Medicaid Innovation, will provide a snapshot of the current APMs in Maine.
- **Understanding CPC+ -** Sarah McHugh, Team Lead, CPC+ Program, will address questions submitted in advance by Committee members.

11:10 **Payer Perspectives on the CPC+ Opportunity**
We will hear a brief presentation from Katherine Pelletreau and Jean Wood followed by questions and clarifications.

11:30 **Health System Perspectives on the CPC+ Opportunity**
We will hear a brief presentation from Katie Fullam Harris, Steve Ryan, and

Lisa Harvey-McPherson followed by questions and clarifications.

11:50 **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.

12:00 **Adjourn**

Appendix B: Comparison of CPC+ and Medicare Alignment in SIM Pathways

Comparison of CPC+ and Medicare Alignment in SIM pathways

	CPC+	State-specific custom model
Scope	▪ National model with up to 5000 practices (2500 practices per track) with multi-payer participation	▪ Seeking statewide and all payer participation with broader scale
Model Design	▪ Model including Medicare payment, practice requirements and quality metrics designed by CMMI with multi-payer alignment on key design elements	▪ Model and financing designed by State with multi-payer participation. Flexibility offered in exchange for State's commitment to Medicare savings, quality improvement targets etc
Roles	▪ CMMI implements model, monitors participants, and organizes stakeholders. Payers and vendors sign MOUs with CMS; Practices sign Participation Agreements with CMS	▪ State would have responsibility with model design, implementation, monitoring and working with stakeholders. State would identify eligible practices, work with practices on transformation and work with payers on alignment.
Timeframe	▪ CPC+ is a five year model starting January 1, 2017. ▪ CPC+ Payer application now through June 2016, payers selected in July 2016, practice application with practices selected in October 2016	▪ Process to develop proposal, negotiate terms with CMS and clearance for Agreement with State is, at minimum, a one year process and can begin at any time. ▪ Would be a 5 year model