DRAFT! Version #3 Medicare Oversight Committee- Concept Paper- updated 12/9/16

A. *Introduction*

Maine is responding to the guidance released on April 10, 2015 to SIM States on the submission of state proposals for Medicare alignment with multi-payer models. The Commissioner of DHHS Mary Mayhew convened a Medicare Proposal Oversight Committee (MPOC) in order to create a response leveraging the broad Maine SIM stakeholder group. The MPOC is comprised of 24 members representing commercial payers, employers, primary care, behavioral health, long term care, Health Information Technology (HIT), health coalitions, independent providers and consumer representatives. MPOC has convened five times and puts forth the concepts for this paper. Maine seeks to leverage federal Medicare funds to create further alignment with Alternative Payment Model (APM) investments and continue to accelerate the redesign of primary care and address the social determinants of health for Mainers. The components of this concept paper will lead to larger health system transformation. The next step is to advance an innovative Medicare payer alignment alternative payment model that supports patient-centered, community health focus, population health and high-value care is critical. We propose utilizing the innovative work and governance structure of the Maine State Innovation Model (SIM) as a multi-stakeholder, community-oriented approach that builds on the Health Home (HH), Behavioral Health Home (BHH), Accountable Communities (AC), SIM efforts, the Patient Centered Medical Home (PCMH), and the numerous innovative pilot projects among Maine ACOs and Community Based Organizations. Maine's proposal advances further innovations in care delivery and payment to achieve better care, better health, and lower cost while welcoming more health care practices into APM's.

Relationship to Maine SIM

Maine state leadership obtained one of the original State Innovation Model awards with five other states in 2013 to further improve the health of Maine people, advance the quality and experience of health care, and reduce health care costs. The Maine SIM initiative has been built on six "pillars" of innovation, including strengthening primary care; integrating physical and behavioral health; developing new workforce and payment models; centralizing data and analysis; and engaging people and communities. Maine SIM innovations to date include advancing primary care innovation through support for the HHs and Behavioral Health Homes initiatives; workforce development through a Community Health Worker Pilot; the use of predictive analytics for improvements in cost, quality and utilization; public reporting on quality improvement; and advances in payment reform and value-based insurance design.

The Maine SIM effort has fueled an unprecedented partnership among physical and behavioral health providers, public and private insurers, data and system analysts,

purchasers, workforce developers, community based organizations, and consumers. The power of the innovation comes from the concurrent application of existing efforts with enhanced investments, all within a shared commitment to accountability, transparency, and quality. We now seek to leverage SIM investments to further strengthen and spread APM's that engage patients and communities in improving both health and health care.

The SIM Governance Model Continues
The state of Maine is well-positioned to leverage the existing Maine SIM governance structure to lead and support the collaboration with Medicare. Maine's SIM effort is led by the Maine Leadership Team with support of the Governor's office, and a multi-stakeholder Steering Committee and Medicare Proposal Oversight Committee (MPOC). This multi-stakeholder governance structure and participants have the relationships and experience to provide ongoing leadership for the continuing work in APM.

B. *Overview of Maine's Proposed Model*
Maine's proposed model will build from the extensive investments and learnings of Maine's progressive SIM, HHs, BHHs and PCMH experience to take the next step to a broader, more comprehensive community-based approach that continues to advance primary care redesign and links primary care practices with community partners to advance both healthcare and social service needs. In addition, Maine's ACOs have developed 8-10 innovative pilot projects linking care managers and providers in their ACOs with Community Based Organizations (CBOs) to address the social determinants of health. Our model will address care transitions, behavioral health collaboration and health IT solutions for quality improvement and reporting. We will also build from the national experience of the CMS Comprehensive Primary Care Plus initiative (CPC+) model to leverage the learnings from that effort, and link that with Maine's SIM efforts to further advance our four-part goals of improving care, improving health, lowering costs and addressing burnout and dissatisfaction among physicians and other health care workers (add citation from Annals of Family Medicine). In addition we will enhance linkages with community based organizations to advance beneficiaries stated goals of living in their homes and communities as long as possible, based on the successful ACO-CBO pilots. The outcomes measured will include quality measures consistent with CPC+ and introduce quality of life and functional measures similar to those currently in MSSP and Medicare Advantage measure sets.

C. Payment methodology
The proposed Maine payment model is comprised of three components for primary care practices, behavioral health providers and accountable communities. All payments will be linked to quality and value. Primary care payments will include (1) *ongoing fee-for-service (FFS) payments* for service delivery (for discussion capitation for chronic and preventive care); supplemented by (2) *risk-adjusted care management per member per month (PMPM) payments* that enable practices and accountable communities to

Comment [1]: Gloria, here is a quote from a journal article speaking to the "4th leg". "Healthcare's triple aim — enhancing patient experience, improving population health and reducing costs — is a widely accepted set of priorities, but new studies suggest it may be failing to address a critical component of the healthcare model: the providers.

According to Annals of Family Medicine's recent article, burnout and dissatisfaction among physicians and other healthcare workers — associated with lower patient satisfaction, reduced health outcomes and increased costs — has become endemic in healthcare, thus posing major obstacles to achieving the triple aim. The authors of the article, Thomas Bodenheimer, MD, and Christine Sinsky, MD, suggest adding a fourth leg to the triple aim that focuses on the need to improve the work life of healthcare workers to improve health system performance."

implement and sustain the infrastructure to deliver comprehensive services to high-risk populations and to provide community care team and specifically support practice-based care management, as well as payments to Community Care Teams (CCTs) for the most high-needs, high-cost patients; and (3) *accountability payments* that directly incent providers and practice teams to improve outcomes. In addition we'd like to explore allowing payments for evidenced based programs conducted by community based organizations (e.g. falls prevention, chronic disease self-management.) These latter components follow their successful implementation in the Vermont SASH model. (need citation)

The first two primary care payment elements (i.e. FFS + care management PMPM) are currently being paid by most commercial and public payers only to practices participating in the MAPCP demonstration, and by Medicaid to practices in the Health Homes initiative. The proposed model would bring multi-payer alignment to all eligible and participating primary care practices and behavioral health organizations in the state, and would add the third, element – i.e. accountability payment as a mechanism for incenting and holding practices accountable for the desired outcomes. In order to advance the principles of value-based payment, the third (new) component of accountability payments is designed to provide performance-based incentives to reward practices for performance improvement.

The results of the Medicare ACO indicate that involving Maine's ACO's would strengthen the quality and value results of the Maine based model. (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-08-25.html) The CPC+ application process approved involvement by ACO's. We agree that it is critical that primary care practices be allowed to participate in the Maine model even if they are also participating ACO models.

This effort to implement a new primary care payment model in Maine aligns with the bipartisan Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) legislation. The proposed new Maine payment model is consistent with the CMS HCP-LAN framework, and comprised of three components: (1) ongoing FFS payments for episodic care supplemented by (2) risk-adjusted care management PMPM payments for prevention and chronic disease management that enable practices to implement and sustain the infrastructure to deliver comprehensive services to high-risk populations and to provide payment by practices to enhanced Community Care Teams; and (3) accountability payments in the form of performance incentives designed to promote accountability for impacting Total Costs of Care). Of note, the proposed Maine payment model is also consistent with recommendations that emerged from previous Maine SIM efforts (i.e. SIM Payment Reform Subcommittee) which used a three tiered model for describing payment change, as outlined below:

Primary Care Payment Models	Key Elements	Current Alternative Primary Care Payment Models
Tier 1	Fixed PMPM payment as initial investment in primary care	Maine PCMH Pilot MaineCare Health Homes (HHs) Several commercial payers
	Risk-adjusted PMPM + accountability-based payments	● MaineCare HHs that participate in Accountable Communities initiative ● Anthem Enhanced Personal Health Care (EPHC) program ● Medicare CPCi ● PROPOSED Maine payment model
Tier 3	Comprehensive primary care payment	Medicare Advantage plans Capitated primary care payments

In addition, the LAN adopted principles of Patient and Family Centered Payment that "rest on the conviction that consumers, patients, and families are essential partners in every aspect of transforming health care and improving health". Finding ways to pay for evidenced-based services in the community to help beneficiaries stay in their homes and communities as long as possible is essential to fulfill these principles. In summary, the proposed Maine model leverages and significantly expands current work in Maine to advance multi-payer value-based primary and behavioral health care models that meet the needs of patients and families and aligns with both previous recommendations from Maine stakeholders and the direction of CMS through the HCP-LAN. Presently, only licensed clinical social workers and psychologists are reimbursed by Medicare. It will be critical to expand approved credentials to include licensed alcohol and drug counselors and licensed clinical professional counselors to address current workforce shortages. Behavioral Health Homes will be eligible for incentive payments that will enable them to meet behavioral health needs in a more flexible manner. Incentive payments will be provided that enable BH organizations to provide ancillary services (TBD) outside of the existing fee for service system. BH organizations must demonstrate the capacity to provide the ancillary service before they can be eligible for the incentive payment. Criteria for eligibility needs to be established that is based on being able to demonstrate adherence to the BHH structure and ability to meet defined population health metrics.

To help promote planning and accountability for using new funding to support innovative models of care, practices, behavioral health organizations and AC's and community based organizations participating in the Maine model would be required to develop an annual budget designed to articulate how the PMPM payments will be invested; practices will be asked specifically to budget for how new payments will support their efforts to deliver care management for high-risk patients; improve patient experience, use data to guide performance improvement; enhance EHR and HIE capacity; ensure care coordination across the care community; and improve patient activation. While primary care has been on the front lines for receiving meaningful use incentives,

behavioral health providers have had to implement and achieve meaningful use at their own expense. Providing funds to support continued enhancements will allow us to keep pace with our primary care colleagues.

In order to advance the principles of value-based payment, the third component of the proposed Maine model, the 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 (see Appendix), and total cost of care and public reporting/transparency. Clinical measures and the claims based measures from the SIM Measure Alignment Work will be used. (Consider results on outcomes measures in the CMS MSSP measure set like HbA1c and blood pressure, as well as considering a process measure for providers measuring patient reported outcomes.) Payers and practices will collaborate to 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. Initially, performance improvement will be measured against each practice's performance. Thus, goal attainment and improvement will be monitored and acted upon. As measurement tools becomes more robust and transformation more widespread, practice performance can be measured by Public Health District or statewide performance. In order to achieve a "data informed" care coordination workflow Maine needs standardized data from which to hold practices accountable or measure quality/population health. A health IT solution will be developed.

To facilitate payer flexibility, the model enables each payer to determine the relative weight and value each payer assigns to each measure. Incentives will be based upon specific performance related to meaningful use, quality/quality improvement, total cost of care, and transparency/public reporting. Each payer would collaborate with providers to determine the relative value of specific performance indicators for purposes of calculating performance and/or shared savings payments.

Further, each payer can base payment on either a monthly PMPM for infrastructure or strictly on performance incentives or both if an investment has already been made through another model. (to discuss if will allow flexibility) MaineCare for example could determine that sufficient infrastructure payments have already been invested. Therefore, performance would be the exclusive factor determining additional payments. Initially, failure to achieve established performance targets would result in no additional payments. In subsequent years, risk could be shared by both the payer and provider, behavioral health organizations, AC's, and the practice would assume full risk.

The merits of this approach are threefold. First, both high-performing and modestly-performing practices can achieve incentive payments through performance improvement as the incentive payments are predicated on continuous improvement. A variation on this approach is to require improved performance compared with an established best practice benchmark when available. Second, the incentives can be determined by a range of performance indicators reflecting quality, utilization, HIT, transparency and total cost of care. Since practices cannot control many facets of total cost and there is considerable variation in total cost performance, payers would be required to work with practices to base cost performance on benchmarks of prior practice experience and/or targets adjusted to reflect regional variation (with consideration for the statistical significance of the population).

D. Addressing the Social Determinants (SDH) of Health in Primary Care

In order to meet a person's whole health needs Maine will build on the existing PCMH, HH, BHH, CCT, and CPC+ models, and expand the model further to take an initial step toward identifying the health-related social needs that often create barriers to the ability to manage chronic conditions, increase health care costs, and lead to avoidable health care utilization. Maine has considerable early experience with this from numerous pilots among ACOs and community based organizations like Area Agencies on Aging, Home Health Agencies, Community Action Programs, Food Banks, etc. Key components of the Maine based SDH model will include the following:

a. Access and continuity
b. Risk-stratified care management
c. Planned care for population health
d. Patient and family caregiver engagement
e. Comprehensiveness and coordination
f. Behavioral health integration
g. Assessing and addressing health-related social needs
h. Using data to drive improvement
i. Use of community health workers

E. *Quality Reporting for the Maine Model*

As part of its commitment to promoting accountability within this new model, MPOC will work with participating primary care practices to report on a set of milestones that set clear expectations for implementing the changes in primary care processes, including the following:

1. Create a budget forecast using a standard template that outlines where money is being reinvested
2. Ensure that payment changes from payers are reflected in provider and team compensation models
3. Develop system for providing care management for high risk
4. Develop system for using one or more methods for assessing patient functionality and quality of life
5. Develop systems to use data to guide patient care at provider/team level.

6. Actively build relationships and provider engagement across the social service community
7. Routinely assess health-related social needs of patients and assisting with navigation to community-based resources to address those needs.
8. Develop system for multi- payer reporting

F. Multi-payer and provider participation

The Maine Association of Health Plans (MEAHP) which represents commercial payers in Maine is represented on the MPOC. Representative from the Maine Leadership Team will have a working meeting with representatives of all Maine Health Plans. In addition, during the September 7th MPOC meeting the representative from Anthem Blue Cross and Blue Shield stated their investment in a Maine based model. On December 9th the SIM Maine leadership and the MEAHP Board began discussing the model.

It is envisioned that for participating practices supported by ACOs, the practices will work with the ACOs to outline the support needed to implement this model and discuss PMPM infrastructure payments to fund that support. Similarly, practices would be expected to partner with a CCT, if the ACO does not provide that level of support or if the practice doesn't participate with an ACO.

G. Data sharing between payers and practices

Maine's SIM experience has significantly advanced the state's data, analytic, and reporting resources and capabilities. During the three years of SIM testing, Maine advanced its usage and coordination of data to inform the direction and detail of its healthcare delivery and payment transformations. Maine has leveraged four unique data resources in its SIM experience that position the state for success in advancing the next phase of healthcare transformation: (1) the Maine Health Data Organization's (MHDOs) All-Payer Claims Database (APCD) is used to provide data for analyses that inform decisions on direction and adjustment of healthcare transformation through performance measurement at the practice and population levels. (2) Through SIM, the State developed a 'Core Measure Dashboard', which compares results across the three populations, MaineCare, Medicare, and Commercial, on measures determined by consensus. (3) MaineCare, the state's Medicaid agency, is providing a portal based view of its attributed data for participating health homes and accountable community organizations. Additionally, HealthInfoNet is a statewide health information exchange with a centralized model for data management. (4) HealthInfoNet has introduced clinical and claims-based analytic functionality and through SIM is piloting care management functions with MaineCare, having developed prospective predictive modeling tools for the Medicaid program. These tools, leverage both clinical and claims data to accurately identify patients that are likely to be high utilizers, high cost, to be readmitted and to develop significant chronic illnesses (diabetes, CHF, stroke, acute myocardial infarction (AMI), etc.), before these events happen. In addition, HealthInfoNet has incorporated

MaineCare prescription claims information into the HIE to allow for more comprehensive care management and medication reconciliation for providers statewide. SIM has enabled the state to invest in a data analytics and reporting structure that is providing actionable information for quality improvement, program adjustments, and accountability. Even with all of SIM's year 1-3 accomplishments there is a great deal of work left to do.

Maine has also advanced its use of certified electronic health record systems as a core expectation in a transformed healthcare delivery system. All health home and patient centered medical homes are required to meaningfully use electronic health records and a very high percentage of these practices participate in the health information exchange. Through SIM, the health information exchange has on-boarded twenty behavioral health organizations and is exchanging data to facilitate coordination of care across physical and behavioral medicine. The health information exchange provides transition of care notifications to facilitate care coordination. As a result of our recent three-year SIM experience, Maine is well positioned to provide the advanced data support needed for successful clinical and administrative management of the Maine model.

This effort will build on these SIM-supported data advances, and will enhance the use of current databases and reporting techniques to support the data needs and reporting of the Maine model. The MaineCare Health Home provider portal will continue to serve as a valuable tool for practices participating in the Health Homes initiative. MaineCare and HealthInfoNet (HIN) are also collaborating on a model to test sharing of selected clinical data related to diabetes.

The introduction of accountability measures for determining performance-based payments that include clinical outcomes will require additional and far greater collaboration of data sharing among payers, providers, and health data organizations. Partners will seek the most efficient, timely, and least disruptive techniques to collect and report clinical data at the individual and aggregate level.

H. Quality & Accountability strategy

The SIM grant enabled stakeholders to develop a recommended core measure set to be used for both payment and monitoring purposes for ACO contracts. The core measure set was endorsed by the commercial plans and MaineCare with the recognition that the core set would not be the exclusive indicators of performance but would constitute the foundation of an aligned measure set. The measure set was configured with the goal of broad adoption of payers and alignment with CMS. The measures are predominantly NQF-endorsed and are deemed to have wide acceptance.

There is significant alignment with the SIM core measure set and the CMS-AHIP consensus measures. We propose to highlight the following as primary measures for this proposal:

1. A “functional measure” leading to treatment of the “whole person”. The functional measure is patient centered, transformative and innovative. Maine is currently working with CMMI to identify an evidenced based and validated measure. The SIM project, with help from the practices, will work to further develop specific tools to meet this goal in relation to varied populations served. One tool discussed preliminarily is: http://www.healthmeasures.net/index.php The SIM project, with help from the practices, will need to work to further develop specific tools to meet this goal in relation to varied populations served.
2. Non emergent ED Use (SIM CORE Measure) http://www.maine.gov/dhhs/sim/index.shtml
3. All cause readmissions (SIM CORE Measure) http://www.maine.gov/dhhs/sim/index.shtml
4. Total Cost Of Care with an AC exception
5. Also for consideration are measures from the CPC+measure set. (see below)
6. Discussion of highlighting diabetes measures given the SIM self-evaluation results

CPC+ eCQM Set - 2017 Performance Period					
	CMS ID#	NQF#	Measure Title	Measure Type/ Data Source	Domain
Report 2 of the Group 1 outcome measures:					
Group 1	CMS159v5	0710	Depression Remission at Twelve Months	Outcome/eCQM	Clinical Process/Effectiveness
	CMS165v5	0018	Controlling High Blood Pressure	Outcome/eCQM	Clinical Process/Effectiveness
	CMS122v5	0059	Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%)	Outcome/eCQM	Population/Public Health
Report 2 of the Group 2 complex care measures:					
Group 2	CMS156v5	0022	Use of High-Risk Medications in the Elderly	Process/eCQM	Patient Safety
	CMS149v5	N/A	Dementia: Cognitive Assessment	Process/eCQM	Clinical Process/Effectiveness
	CMS139v5	0101	Falls: Screening for Future Fall Risk	Process/eCQM	Patient Safety
	CMS137v5	0004	Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Process/eCQM	Clinical Process/Effectiveness
Report 5 of the 10 remaining measures (choice of Group 3 and remaining Groups 1 and 2 measures):					
Group 3	CMS50v5	N/A	Closing the Referral Loop: Receipt of Specialist Report	Process/eCQM	Care Coordination
	CMS124v5	0032	Cervical Cancer Screening	Process/eCQM	Clinical Process/Effectiveness
	CMS130v5	0034	Colorectal Cancer Screening	Process/eCQM	Clinical Process/Effectiveness
	CMS131v5	0055	Diabetes: Eye Exam	Process/eCQM	Clinical Process/Effectiveness
	CMS138v5	0028	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention	Process/eCQM	Population/Public Health
	CMS166v6	0052	Use of Imaging Studies for Low Back Pain	Process/eCQM	Efficient Use of Healthcare Resources
	CMS125v5	2372	Breast Cancer Screening	Process/eCQM	Clinical Process/Effectiveness