SIM Medicare Proposal Oversight Committee (MPOC)

Highlight Notes

January 4, 2017

MaineGeneral

Revised January 18, 2017 to reflect Rhonda Selvin's Committee Membership

About the Meeting

Purpose

The primary purpose of this meeting was to understand and react to a draft proposal for Medicare alignment with innovative payment models and determine next steps for getting the proposal finalized and submitted to CMMI.

Attendance

Committee Members

- Gloria Aponte Clarke, Maine State Innovation Model
- Kathryn Brandt, Primary Care Physician
- Michael DeLorenzo, Maine Health Management Coalition
- Amy Dix, Dept. of Health and Human Services - MaineCare
- Dale Hamilton, Community Health and Counseling Services (by conference call)
- Karynlee Harrington, Maine Health Data Organization (by conference call)
- Katie Fullam Harris, MaineHealth
- Lisa Harvey McPherson, EMHS (by conference call)
- Katherine Pelletreau, Maine Association of Health Plans (by conference call)
- Michelle Probert, Bath Iron Works
- Roger Renfrew, Maine General Hospital
- Ted Rooney, Consumer Representative (by conference call)
- Catherine Ryder, Tri-County Mental Health Services
- Katie Sendze, HealthInfoNet (by conference call, sitting in for Shaun Alfred)
- Gordon Smith, Maine Medical Association
- Erik Steele, Maine Quality Counts
- Deb Wigand, Maine CDC
- David Winslow, Maine Hospital Association
- Jean Nichols Wood, Anthem (by conference call)

Committee member Rhonda Selvin, immediate Past President of the Maine Nurse Practitioner Association, was absent due to vacation.

Guests

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

Interested Parties

- Ruta Kadonoff
- Lisa Nolan
- Barbara Ginley (by conference call)
- Gerard Queally
- Sybil Mazerolle
- Carolyn Gray
- Kimberly Fox

Facilitators

- Craig Freshley, Good Group Decisions
- Kerri Sands, Good Group Decisions

Planned Agenda

10:30 **Welcome and Introductions**

- Facilitator Craig Freshley will remind us of our committee charge and where we are in the process.
- Amy Dix will provide some clarifications about the timeline and context.
- Craig will also explain the agenda for today and a few ground rules for a productive meeting.
- We will do quick introductions.

10:50 **Draft Proposal Consideration**

- A small group has been working in collaboration with Amy Dix and Gloria Aponte Clarke to develop a draft proposal for Medicare alignment.
- We will begin by hearing a brief explanation of the proposal.
- We will then discuss the proposal, ascertain elements that garner general support, and collect feedback on aspects of the proposal that should be changed.

12:00 **Next Steps**

- Before adjourning we will make sure we are clear on what will happen next, by who, and on what timeline.

12:20 **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.

12:30 **Adjourn**

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

Committee Charge

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.

Where We Are in the Process

Facilitator Craig Freshley reminded the group of the process to date and going forward:

April to December 2016
- Changing conditions: CPC+ New MACRA Rules New Federal Administration
- Draft Proposal being developed

Today
- Understand and discuss the draft proposal for Medicare alignment with innovative payment models
- Determine next steps for getting the proposal finalized and submitted to CMMI

After Today
1. The small group will meet to consider comments made at this meeting and submitted in writing prior to the meeting. They will prepare a revised version of the proposal.
2. Others are welcome to join the small group. Let Gloria know.
3. A revised proposal will be circulated by email to the whole MPOC for review and comment.

4. A final version will be prepared by the small group for submission to Amy and Gloria, then to the SIM Steering Committee, the SIM Maine Leadership Team, and then to CMMI.

Amy Dix explained the following:

- We have laid the groundwork
- We need to be realistic about the time it will take to review internally
    - A review by DHHS will take at least 30 days
- A reminder MaineCare's original letter of response detailing what was most beneficial discussed alignment around the Department's initiatives and using the groundwork that was already put in place

Draft Proposal for Medicare Alignment

Since the last meeting a small group had been working in collaboration with Amy Dix and Gloria Aponte Clarke to develop a draft proposal for Medicare alignment. We heard a brief explanation of the proposal and then discussed clarifications, questions, and concerns.

Summary

Presentation

(Amy, Ted, Roger, Kat, and Catherine)

- Payment methodology
    - Three components
        - Ongoing fee for service
            - Would look like it does today
            - Perhaps a small pilot project with bundled or capitated rates
                - There might be a list of services available and it would be the provider's responsibility to make sure the patient gets appropriate services
        - Risk adjusted PMPM payments
            - Would allow some practices to receive a higher PMPM fee
        - Accountability payments
            - Incentive payments tied to performance
            - Would potentially be based on functionality measures
            - There is a handout available about potential functionality measures
    - We are trying to balance the need for more bundling and quality outcomes with Maine's lack of readiness for full bundled payments
        - For this reason we need to keep some of the current structure going while we transition to a new system

        - Add "functionality measures" to the "current system"
        - Give the private practices a menu of functionality performance measures from which to choose and add to their existing measures
    - We are not limiting ourselves to the confines of CPC+ or CPCi, but we are trying to be mindful of the requirements laid out in each program structure.
        - It is most important to design a model that will work for the State of Maine, rather than being specific to one model or another. Fran Jensen confirmed that CMMI will likely consider proposals that are slightly different than/outside of the proposed timelines for previously established initiatives, i.e. CPC+ etc.
    - We are also considering bundling or capitation for chronic disease management and use fee for service for other services. Although the specifics of such an initiative need to be flushed out, particularly determining if the request/idea is for a capitated payment or a bundled rate.
- The group tried to merge two sets of principles
    - Patient goals
    - System outcomes – people thriving in their communities
- We are trying to build on what we have and apply CPC+ principles
- We are also trying to address the needs of our aging population
- Functional status is the best predictor in older adults of longevity and mortality
    - This applies to the behavioral health population also
- Behavioral health providers have experience with capitated payments, through the MaineCare Behavioral Health Home program
- We have also tried to ensure that the bar is raised in terms of health information and technology
- We need to build into our model, "health of primary care", i.e. provider satisfaction.

Questions and Clarifications

- Concern about integration of primary care, specialty care, and behavioral health: lack of integration of electronic health records
    - Perhaps a waiver of federal rules would be requested
        - There was support from the group around the idea to include this as part of whatever proposal goes forward
    - Related concern: applying physical health records methodology to behavioral health - for instance, behavioral health functionality
    - There is lack of consistency across the behavioral health community
    - Perhaps we can leverage HealthInfoNet to be "the connector"
        - This could be done with new and innovative coding such as observation-based codes and with getting agreement across disciplines on how codes are used
        - HealthInfoNet is well-positioned to be a convener and coordinator of such data integration

    - Built into the CPC+ process is support for EMR coordination - let's build such support into our proposal as well
- Will participation by practices in a potential pilot that would use a bundled or capitated rate be voluntary?
    - Certainly, although we will target participation of specific practices
        - The early adopters would likely be the more sophisticated practices and/or those practices that serve a high percentage of whatever target group is identified as part of the test, i.e. primary care office with a high number of individuals diagnosed with a behavioral health disorder.
- We should not let the larger political process paralyze us but it would be good to at least name some of the issues
    - Is CPC+ still a possibility?
        - Yes, will be re-opened
        - CPC+ Round 2 information is available on the CMS website
    - Would CMMI go away if the ACA is repealed?
        - CMMI is projected to save $38m in ten years and this bodes well for its continuation
    - CMMI is hopeful that we will continue and we were recently mentioned in bipartisan legislation
- How should we think about this proposal we are developing, in relation to CPC+?
    - We are developing a proposal that will work for the state's providers and citizens regardless of CPC+ or other structures limit our proposal
    - Some people are working on CPC+ "in parallel."
        - For one thing, the proposal we are working on might not get "ratified" by Maine leaders
        - If Maine state government is supportive of this proposal we are developing, there may not be a need to continue to pursue CPC+
        - Uncertain if the CPC+ proposal being developed will have enough "covered lives" without the participation of Medicaid
    - It would be very helpful to get an "early read" from Maine state government about support for this proposal
    - If we don't do one or the other, the momentum we have built around integration will be lost
    - Wondering if the reasons we didn't get CPC+ the first time still exist
        - For instance, not enough participation by commercial payers
    - Is an 1115 demonstration waiver an option?
        - Perhaps, for Maine participation in the Maine model, but not for CPC+
- The Quality Reporting section of the Draft Proposal seems to require a budget forecast and seems to require adjustments to provider compensation. Need some clarification.
    - Concern about provider compensation being at odds with anti-trust law and too prescriptive
        - We are not expecting compensation of individual providers to be changed
        - However, providers are currently in a fee-for-service service system and it would be difficult for the government to mandate how providers are paid
        - Reminders that the goal is to have some payments not fee for service

        - Changes in how providers are compensated will make the proposal a lot less attractive to providers
    - Concern about the "budget approval" process
        - Who is going to "approve the budget?" Or disapprove the budget?
        - There should be no need for any "budget approval process" because the organizations have so much at risk anyway and will therefore "self-regulate."
    - The overall intent is to insure that the investment is going to improvement of primary care
        - The proposal needs to include provisions to ensure that happens
    - Let's use robust measures of provider and staff satisfaction
        - Such and outcome-based measure might be more acceptable to providers than mandating how they have to achieve such an outcome
    - Perhaps the proposal should include a definition of "primary care"
- How specifically are payers obligated under this proposal?
- Overview of the model
    - Continued fee for service payments
        - Appetite for bundled rate?
            - Bundles could be services "by episode"
                - Would be very challenging to do this when someone has multiple diseases
            - Bundles could also be bundles by "level of risk"
            - Any bundling would allow freedom of choice among providers
            - Bundling blurs the line between bundling and capitation
            - Conclusion – Push closer to risk
                - Perhaps allow bundling/capitation for chronic disease for those who want to participate (voluntarily) in such a pilot but not require to much bundling by too many too quickly
                - Perhaps take bundling out for now if it would significantly dissuade participation
                - Include language that would leave the door open to bi-directional alternative payment options
    - Implementation as a pilot with handful of targeted practices
    - Accountability payments tied to quality and functionality
- To participate in the pilot, it might work well for participants to participate in all components; care management and risk component
- The plans need for this to be kept simple
    - Start small
- As we further develop the proposal, let's take stock of and incorporate what works well
    - Quality measures
        - Diabetes bundle
    - Patient experience
    - Being provided with utilization data

Discussion Comments

Presentation

Gloria thanked the small group who developed the draft and others who contributed:

- Catherine Ryder
- Kat Brandt
- Roger Renfrew
- Ted Rooney
- Dale Hamilton
- Deb Wigand
- Rhonda Selvin
- Jen Moore
- Michael DeLorenzo

Amy explained the payment model in the draft:

- Payment methodology has three components
    - Ongoing fee-for-service payments, like today
        - Consider a small pilot with bundled or capitated rates
            - Lead practice gets a monthly bundled rate and they coordinate care and ensure payment to others - behavioral health, physical therapy - they contract with them and reimburse them
            - Test this on a small level before implementing on large scale
    - Risk adjusted PMPM in addition to fee-for-service
        - As the patient gets better the payment stays the same
    - Accountability incentive payment tied to performance
        - Use functionality measures rather than solely existing quality measures
            - We had very good discussion about this in the small group
    - We talked about ensuring health information technology - this proposal tries to push that forward and raise the bar, though not sure we nailed it down in the small group

Kat added:

- This does not replace what is currently happening in terms of quality measures
    - We were trying to balance:
        - The concept of needing to do more bundled/quality- outcome-based capitation models for primary care and disease, and
        - The reflection that Maine is not ready for full bundled payments. We need to keep a mixed structure for the time being.
    - And we heard from payers to keep the current quality measures - highlight a few but add functional outcome measures
    - This proposal addresses “super-utilizers” - those with high degrees of complexity, who require more integration of care, do better with functional measures. This would give private practices a menu to choose from.
    - We were trying to apply the principles of CPC+

        - Such as
            - Robust inclusion of behavioral health
            - Expanded definition of medical neighborhood for high complexity patients
    - We need to think about fee-for-service in the primary care arena - bundled/capitated might be better for chronic issues; fee-for-service better for acute issues
        - There is support from CMMI to use general functional outcomes

Ted added:

- We referenced CPC+ in that this would allow Next Generation ACOs to participate, and uses the Patient Centered Medical Home roadmap
    - More emphasis on patient goals and home care - ask patients what they want
    - Behavioral health integration and connection to community based organizations
- Would like to see if we can do CPC+ building off current models while also finding a way to fund community based services
    - CPC+ is also going down this road
- Worried about the new federal administration - this is a reason to tie to CPC+ which seems to have staying power

Roger added:

- Some of my major concerns are about how we address the aging population. Many current guidelines are not appropriate for older adults. CPC+ did bring in requirements for dealing with cognitive impairment and falls, which are often significant contributors to costs for patient care.
    - Functional status is the best predictor in older adults of longevity and mortality.
    - A simple functional status tool can provide helpful clues to diagnose problems
- What we didn't touch on is the health of primary care today. We need to build in a look at turnover in providers and staff, and the stability of practices.

Catherine added:

- In behavioral health we use a patient activation measure that has had significant outcomes; we measure the level of confidence of patients to help evaluate their status. Also, we have been under bundled payment for 2.5 years and we have experience with both the challenges and benefits.

Questions and Clarifications

- Integration of EMR
    - (Katie F.H.) Nice job capturing a future state. But how does it relate to the current state in terms of integration of behavioral health info? No HRs allow for easy

sharing of this info. Could this proposal consider seeking a waiver to 42CFR, the largest barrier?
    - (Amy) The Department will be very supportive of that
  - (Katie F.H.) How do we address challenges with EMRs designed for strict medical systems rather than more comprehensive health systems, for example, with functional status measures?
    - (Kat) It depends on the EMR. Some can incorporate functional status. Maybe we can work with the major EMRs who are under a mandate to develop such connectivity.
  - (Amy) Are the feds are hoping for ECQM measures to bridge the EMR systems?
    - (Gloria) SIM has connected 20 behavioral health organizations to HIN with a bi-directional connection. But there are many more behavioral health organizations that need to see the patients' records and connect to primary care.
  - (Amy) We talked about leveraging HealthInfoNet to be a connector, even though we know cost is a barrier
  - (Katie S.) Would like to see focused work on measures that are not currently codified in a way that allows EMRs to share in a standardized way. However, we *have* seen lots more coding become available. We can use terms to code if a patient is under specific care management. This is where the EMR field is going. It's a good idea to work with MaineHealth and look at EPIC. Lots of sharing can be done with some small tweaking and agreements about coding. We don't currently tie our workflows to these processes. HealthInfoNet can work with partners and with large Electronic Health Record vendors.
  - (Roger) In CPC+, practices are required to have agreement from an EMR provider. It's built in.
  - (Amy) Not sure how you would enforce that. Prohibit acceptance of federal dollars? Urge everyone to look at the final page of the document which has electronic clinical measures.

- Voluntary pilot
  - (David) The pilot is voluntary and practices can choose to be involved?
    - (Amy) Yes, we would try to target certain practices with high volumes of super-users, across all payers, not just Medicaid
    - (Kat) Or utilize the medical leaders who have been through the Hanley Center program about practice reform. We would really get into the weeds to nail down what this would look like at practices. It's a struggle for them to envision what this would look like: bundled payments for chronic disease has never happened.
  - (David) Early adopters are likely to be more advanced. Testing a model with a small group could make it easier to get our heads around it.
    - (Amy) Yes, this could be a factor in the selection process - which EMR is the practice using? If we did this, Medicaid would need to know if the practice would comply with Medicaid policies, or perhaps would allow them to test new standards and measures and try a more flexible model.

- Federal context and CPC+
    - (Michelle) Let's not let the larger political context paralyze us, but let's put it on the table. Is CPC+ still an option? ObamaCare is perhaps on the table, meaning CMMI might go away. MACRA is maybe more safe, but not necessarily.
        - (Gloria) CMMI is projected to save $38 billion in 10 years and MACRA is bipartisan - we have been encouraged to proceed.
        - (Fran) We are hopeful and optimistic that system reform will continue. The Innovation Center is mentioned in MACRA legislation, which is bipartisan.
    - (Michelle) In terms of CPC+ and Maine, what is the status?
        - (Fran) Yes, CPC+ II info is available and payers need to apply in February
        - Gloria offered to send the info to the group
    - (Michael) The payers are wondering "How do I think about this in relation to CPC+?" Is it an addition, a substitution, a mask for another PMPM for all commercial payers?
        - (Amy) Speaking for the Department, it is a proposal that will work for providers and the state regardless of structure. We have heard that CMMI wants to push these initiatives forward but we have not let the 5 existing structures limit this proposal.
    - (Erik) At Maine Quality Counts we have been talking about CPC+ since the original CPC proposal and hoping Maine would get engaged beyond SIM to support practice evolution and help manage the health of the population. When we heard CPC+ was open we picked up where we left off when it was apparent that CPC+ was coming. Without clarity around where this initiative was going, we didn't want to miss an opportunity to pursue CPC+ if that was going to be the only thing on the table. In mid February the insurance providers need to decide if they are interested, and if they don't do that then CPC+ is not an opportunity. We have discussed with them: "What would it take to make that decision?" We have seen this proposal as a parallel track. If the state government says yes and there's momentum, it makes sense to get behind it, but if the state doesn't, we don't want to be left with nothing.
    - (Michael) February 17 is the deadline. Will we have competing alternatives?
    - (Amy) Will you have the covered lives necessary with without Medicaid in the CPC+?
        - (Erik) Not sure. Hard to sync it all up. We might nail a proposal in 2-3 weeks and then there's 30-day review period. Can the Department start looking now? Can they say soon "there's no chance in hell" or "we like it, but tweak x, y, and z"? Like a preliminary review?
        - (Amy) I have tried to represent the Commissioner's view. She has been very receptive and responsive, but I can't speak for her until she sees the document.
        - (Erik) Fear that we will lose all the alignment we've invested in if we end up without either option.
        - (Kat) Applaud the notion of parallel tracks. To clarify: we didn't get the first round of CPC because we weren't doing enough - there were not enough commercial payers. So what to expect for the next round? Where is Medicaid at?

            - (Michael) One payer invested heavily, collects PMPM, and thinks this should be invested in. It's a systemic issue. Hospitals are worried about complexity for different tiers, and the cost of implementing. This is based on their experiences with the cost of CPC+ in other regions.
        - (Erik) If CPC+ continues we at least have a window
        - (Amy) Is a 1115 demonstration waiver an option and we are restricted to the timelines and confines of CPC+? Could we ask for Medicare's participation as a vehicle to move something forward? Meaning Medicare participation in the Maine model, not CPC+.
            - (Fran) You'd have to work through the normal Medicaid process. We would engage and work closely with them but the Innovation Center doesn't have that authority.
            - (Amy) It appears that the HHS incoming leaders are big fans of 1115
    - (Amy) The intent is same regardless of what vehicle we use to push it forward
        - (Fran) whatever it takes to get multi-payer alignment

- Quality reporting and budget forecasting components
    - (Katie F.H.) The proposal requires budget forecasts and seeks to "ensure payment changes are reflected in team compensation models". There might be red flags here around anti-trust. What is the purpose of these components?
    - (Kat) The idea was that in many large organizations, the on-the-ground payment and rewards system for providers is not in alignment with bundling payments and quality based payments going on at a higher level. Large groups are being paid by ACOs with PMPM, but on the ground providers are not seeing anything different.
    - (Katie F.H.) We would not support these components. You are right that there are shifts that need to be made to ensure that providers' compensation and contracts reflect payment models but at present we are in a fee-for-service system. And those models are constantly being discussed but we are not supportive of having the state or feds tell us how to pay our providers.
    - (Kat) If we are going to fully reform how medicine is practiced we need to look at mixed fee-for-service and capitated models. The goal is to have some things fee-for-service and some things in a primary care bundle. What's on the table is <u>not</u> having everything in primary care be fee-for-service. You can't capture longitudinal care as fee-for-service - we've been trying to do it for 15 years and there is too much bending and twisting to try and capture a lifetime issue as a fee-for-service issue.
        - (Amy) Or you continue to pay primary care fee-for-services and then an additional bundled rate for coordination
    - (Michael) Who holds people accountable for these measures? I agree with Katie regarding compensation and budget approval - this makes it much less attractive for payers to participate.
        - (Amy) We are not sure what the best model is to incentive providers within the system and would welcome suggestions
    - (Lisa) In the context of EMHS and the variety of contracts we have, in those environments where we have 80% risk, I don't see that we'd want to be involved in

a budget approval process. It's up to us to structure services, cost, volume, etc., to manage risks. We don't want an external entity to be involved when we have so much risk.

- (Ted) The budget approval component is patterned after CPC+. The dollars forward for primary care are not trying to dictate how primary care providers are paid, but to ensure that there is a benchmark for a reasonable amount to revitalize primary care.
- (Michelle) I assume that the intent is to ensure investment goes to primary care. Personally I support that intent. I am not sure we should be getting into budget tracking, but purchasers are not interested in just paying more to health systems if those investments will not be directed to primary care. We need to have something in place to ensure this.
- (Amy) I understand what people are saying. What would be appetizing? How can we accomplish ensuring that dollars are used to incentive what we want to incentivize without making unfair constraints?
    - (Roger) It comes back to robust measures of providers and staff satisfaction. We want to ensure stability of primary care.
    - (Katie F.H.) I would need to think more about this, but I would be more comfortable with an outcome than with telling us how to pay people. Also, it's not just about primary care but integrated holistic care.
- (Kat) We need to define "primary care" because I think of primary care *as* integrated and holistic. This document needs a glossary.
    - (Katie F.H.) CMS and SAMSA are totally different systems with different laws and payment models
- (Erik) We each need to take a deep look at the proposal as it stands now - the big constituencies, major systems, payers, providers - and decide if there nonstarter elements. We have heard some serious concerns that are fundamental and could be show stoppers.
    - (Michael) The fundamental question is, what's the plan other than "it would be good to have more money going to primary care?"
    - (Amy) If we do identify nonstarters, it would be most helpful if there were also alternative ideas about how each could be overcome
    - (Gloria) If a big concern is that there is not enough detail, that is for us to create
        - (Michael) For example, how big is this third piece compared to others, the piece that is not tied to quality? We hear from plans, "Okay, but what's the ask here?" Is it something existing models can fit to, or do existing models need to be tweaked, or is this totally different?
            - (Amy) Hoping this group can add some detail but let's keep in mind that if we put so much detail in we will be completely debilitated.
- (Ted) Make sure we get consumer input. See principles for consumer involvement in payment and care models provided by the Healthcare Transformation Task Force and the Health Care Payment Learning and Action Network.

- Bundling and capitation
    - (Erik) What does the plan obligate payers to? What would be their costs?
        - (Amy) Continued fee-for-service payments with the question to the group about whether there's an appetite for a bundled rate. This would be implemented as a pilot with a handful of targeted practices. Plus additional risk adjusted PMPM payments. And additional payments tied to quality.
    - (Michelle) A bundle is tied to an episode of care. If tied to a chronic condition, then we look at the total average cost of treating this issue. This is distinct from capitated ongoing primary care compensation, right?
        - (Kat) A bundle equaling an episode could mean someone's whole life. This kind of smushes the two definitions.
        - (Michael) Can you bundle, say, diabetes for complex patients?
            - (Kat) No, that's why we want to change the measures for these complex patients
            - (Amy) The appeal for systems/providers is that you can select the specialist you are working with. Members are choosing the practice and the bundle of services. You get to work with the physical therapist you know. The bundled rate idea is not set in stone.
        - (Erik) Sometimes you are taking about multiple chronic issues. Geriatrics talks about "3 or more" - which becomes a functional issue.
    - (Michelle) It is important to clarify: If I have diabetes and COPD am I getting paid a diabetes bundle and a COPD bundle or a capitated rate? It is capitated for people with chronic conditions?
        - (Michael) This challenges the notion of insurance, if you carve out all these special things.
    - (Amy) Is it too much too soon?
        - (Katie F.H.) Are you contemplating that participants would have to do all three, or just one or two? For example, the care management but not the risk?
            - (Amy) We would need them to try all three in the pilot model. But that's a good question - let's open it to the group. Practices would still have a panel of patients who were not involved. But I can't imagine that practices would want to kick people out. That would not work, going to the member level and asking them to choose among these models.
    - (Michael) Plans are saying, "Please keep it simple." Not too much more administrative complexity.
        - (Gloria) What's a simpler alternative?
            - (Michelle) Start small and define what's in the bundle. Not sure we are ready to go whole hog and say what is the capitation for a whole patient. But try an earlier stage before a capitated tiered budget. Something plans would be willing to administer and pay for and something providers can get on board with.
            - (Erik) If something is a huge change right up front it probably won't happen. Bundled payment for chronic disease - maybe include that as

part of a pilot. A practice might really want to try this, but for everyone right away, it probably won't stick.
        - (Roger) If you go back to the goals, I wonder to what extent we are too deep in the weeds and need to think more innovatively about more options that would appeal to different settings. We should broaden our thinking about options to offer to systems. We were not speaking to that small group of independent practices either.
    - (Amy) We can take out this piece if it is not appealing
        - (Katie F.H.) Pushing us closer to risk is not a bad thing but we need to keep it at a higher level. Have it in there as a goal or an option. Rather than taking it out, make it less prescriptive.
    - (Roger) Leave language in about innovative models. Leave the doors open to innovative payment pilots, bidirectional. Payers or providers could bring ideas forward and we could include small independent practices in trials.
    - (Kat) Curious about what is working well with current mixed models. What are the outcome measures and incentives?
        - (Katie F.H.) Quality. The quality measures that we have participated in the development of, along with others. We have started to move the needle on the diabetes bundle and the patient experience. Progress has been made and there's also a significant opportunity for more progress to be made
            - (Kat) We need a drill-down for this
        - (Amy) Providers also say that it works well to be provided with utilization data. This is an important piece.
        - (Michael) What works well, meaning: What success looks like. We need to include total cost of care, and real patient outcomes. We have been investing for 5 years and if we say we still need an investment, it really becomes a subsidy.

Next Steps

Summary

- Ideas
    - Each major community look at the proposal and identify "non starters"
        - Major communities:
            - Providers
            - Payer
            - The State
        - If we were to do this, it would be most helpful to hear actual proposals in the face of "non-starters"
    - Need to add more detail to the proposal before sending to review by the "major communities"
        - People need to know details

        - What's the ask
        - How specifically does the new model differ from how things work currently
    - Important to get consumer input also
        - There are two national consumer groups that have established relevant principles
    - Take stock of what works well

- Next Steps Conclusion
    a. Amy will revise the proposal and clarify the objective
        i. Add request for a waiver
        ii. Leave the bundle in but make it an option
        iii. Leave the door open for alternative models
        iv. Add a glossary
        v. Add a framework
    b. Have the next version of the proposal reviewed by major groups
        i. Review for
            1. Most significant concerns and how they might be addressed
        ii. Major groups
            1. Payers
            2. Providers
            3. The State
            4. Consumers
    c. Take stock of what works well and what success would look like
    d. Develop a more detailed proposal

Discussion Comments

- (Roger) Take the proposal out in search of nonstarters now. We already know that we need more details. Let's see if it's a no-go now, before we invest in details.
- (Michael) Can we please just get to a clear statement of what we want to achieve?
    - (Amy) Yes. Let me take a stab a pulling it together based on what we heard today. Keep in mind that this draft is the result of a Google doc written by committee. I understand that going forward we will include:
        - Revised and clarified objective using the 5 points of guidance
        - Request for waiver of 42 CFR Part 2
        - We are leaving the bundle payment in but making it an option
        - Adding option for bidirectional innovative models
        - A glossary of terms
- (Ted) People are familiar with the triple goals of better population health, better care, and provider renewal - could we say how the document advances each of those?

Craig reminded everyone that others are welcome to join the small group helping move the proposal forward through these steps. Those wanting to join should let Amy or Gloria know.

Closing Comments

Committee Members

- (Karynlee) In order to support the analytics that will be required we need to be mindful that, although we have solid data infrastructures in place now, to support these alternative payment models and understand the cost aspects we need to figure out how to report that data to MHDO. Fee-for-service is pretty straightforward in terms of claims coming in. But for new models it becomes much more complicated and we need to be mindful of how payers will report to the state. This group could help work with payers in terms of getting that moving.
    - (Katie F.H.) Karynlee, do you see challenges around the APCD ruling (all-payer claims database) as being an obstacle?
    - (Karynlee) We are probably going to maintain about 80% of the self-funded ERISA data. That's pretty good. Not perfect but better than what we hear about in other markets. We also have a Dept. of Labor proposal to require mandatory data.

Interested Parties

- (Gerard) Appreciate that the concept paper includes references to social determinants of health but the capacity of community-based health organization is maxed and we need to move away from the assumption that such organizations can continue to provide services for free. AAA, food banks, etc.
    - When MaineCare did Accountable Community Organizations, we were asked to be supportive partners but with no revenue. We still get referrals all the time. Primary care doctors don't understand why we are not supporting the system that tested well in the pilot.
    - Please strengthen language to address social determinants of health by involving community organizations in compensation discussions

Amy and Gloria thanked everyone for all the input.

The meeting adjourned at 12:25 pm.