SIM Medicare Proposal Oversight Committee (MPOC)

Member Answers to Kick-Off Questions

*April 21, 2016*

Members of the Committee were encouraged to answer three questions by e-mail in order to advance our work efficiently and productively. Questions and answers are provided below.

**1. How should we use our time at our next meeting?**

* Webber
	+ Decide on whether ACO and bundled payment reform should be included in proposal.
* Wigand
	+ It would be valuable if the research could be done prior to that meeting and we could receive a document that has the “landscape” of what exists.  I assume there might be questions from that to further clarify what potentials to consider at the meeting then.  I agree with Katherine that we won’t be able to get too far in the “weeds” before it will seem proprietary, so we need a simple descriptor for Beacon, MaineHealth ACO, MaineGeneral ACO, behavioral health positive integration with primary care. What are the strategies they each use that make sense to consider adding?
* Letourneau
	+ I’d suggest that we come prepared to discuss...
		- Any limitations/”borders” (think that was the word used at the last mtg!) that state/DHHS leadership is putting on this proposal if it were to be reconsidered as proposing something broader than just an alternative primary care payment model
		- With any such limitations in mind, identify our overarching goals in making a Maine alternative payment proposal to CMS (e.g. payment that supports alternative payment to primary care + ACO + CCTs + CHWs, etc)
		- Review the current state of alternative payment models in Maine (as best we can identify them, and/or as best payers & providers will share info on them!)
	+ 1b. (My addition!) In order to do that, what do needs to do be done before the next meeting?)
		- Identification of any limitations/borders that state/DHHS leadership is putting on this proposal if it were to be reconsidered as proposing something broader than just an alternative primary care payment model
		- Identification of the current state of alternative payment models in Maine – i.e. ask both the commercial payers & larger provider grps/health systems to describe at a high level which alternative payment models they’re either offering (payers) or participating in (providers).  I know there are potentially concerns about what they can share v/v competitive concerns, so am thinking this could potentially be done via survey (could answer anonymously) and asking about models at a high level  - e.g. are you currently offering and/or participating in any of the following alternative payment models:
			* Global payment/full capitation models
			* ACO model with shared savings based on total costs of care, and otherwise no change in FFS primary care payments
			* ACO model with shared savings based on total costs of care that includes additional/up-front primary care payment change (e.g. new pmpm for primary care)
			* ACO model with other payment change (please briefly describe)
			* Bundled payment model (one or more)
			* Advanced primary care payment model that includes up-front PMPM/partial capitation payment for advanced primary care delivery model + FFS
			* Advanced primary care payment model with full primary care capitation payment
			* Other (please describe briefly)
		- Could also set this up as a matrix so you could ask the providers whether they’re participating in any of the above with Medicare, MaineCare, and/or one or more commercial payers
* Winslow
	+ We should probably decide what the nature of a payment reform proposal to CMS should be. There was a proposal reviewed at the last meeting to continue with Maine’s efforts as they relate to primary care but I suspect that there may also be other ways to reform the Medicare payment system such as ACOs etc.
* Selvin
	+ Leveling the playing field regarding knowledge of the project and our specific goals
* Ryder
	+ Reviewing responses to these questions? Next steps…
* Brandt
	+ Agree with Catherine Ryder - review these questions. I'd also like to begin some discussion of how far into detail we sketch out a practice vision. My observation of reform to date is there is a great risk of honorable intent getting lost in the application on the ground. How does meeting new outcomes affect day to day activities? Are we adding or replacing activities. How does one document and/or report? How does one code?
* Hamilton
	+ I think we need to finalize a decision on the direction of the committee. What CMS opportunity will we pursue and what elements will/will not be included in the proposal.
* Sylvester
	+ Narrowing down the focus
* Myska
	+ I would agree with others about reviewing the responses to these questions and also using some of the time to level set with regards to the current landscape.
	+ I would specifically like to know more about the Maine ACO partnerships with the Area Agencies on Aging that Ted Rooney mentioned in his responses.

**2. What current models/practices should we know about as we craft our proposal?**

* Webber
	+ Inventory of current payer and self-insured employer payment reform initiatives.  More than the inventory of current models, what is the appetite of the payer community to engage in a all payer initiative.  We need early commitments.
* Wigand
	+ The above seem important as well as community based organizations and what they can do – Quality Counts annual meeting on April 6 included many examples – CAP agencies, Areas agencies on aging, community health workers, National Diabetes Prevention Program are a few.
* Letourneau
	+ Per above, but really need to actually ask payers & providers which ones they’re participating in (i.e. not just broadly which ones exist)
* Winslow
	+ Pioneer and Next Generation ACOs would be a good place to start. We have some in Maine.
* Selvin
	+ Always keep the policy program eye on the ball and informed by practice (those that actually practice)i.e. does this plan intervention, policy, help patients and providers?
	+ Don’t ask providers to do others work, i.e. if you need data, find a way to get it from what they already do.
	+ Make sure any efforts include staff training, training, training, retraining and sustainability.
	+ The geriatric population needs a PCMH plan.
	+ A team is a provider (MD,DO,NP,or PA) with the staff that supports this provider including BH , front desk, scheduling and administration etc…
	+ Don’t expect providers to be paid on RVU’s and to offer care other than what RVU’s reward them for.
	+ Offer your providers what they need to succeed, scribe, referral sources, CM etc
* Ryder
	+ While I note consistent reference to the PCMH, HH & CCT, there is not a consistent reference to Behavioral Health Homes (BHH) which will be critical to supporting primary care practices to manage their most complex patients. Our 2 years of experience running a BHH has demonstrated remarkable outcomes with significantly enhanced collaboration between primary and specialty care. Keeping in mind that the population traditionally served by behavioral health providers is often the top 5% of MaineCare spending, these will be the most challenging patients in primary care practices. I think leaving this out of consideration would be a miss on our part.
* Brandt
	+ Apropos of above I'd be interested to know of any advanced care practices that have succeeded in getting off the hamster wheel and how pilot homes, particularly behavioral health homes are doing day to day as well as outcomes
* Hamilton
	+ I think it is extremely important for our committee to remain as flexible and forward thinking as possible. If we arrive at a decision that limits opportunities to enhance only primary care or ACO’s we will be leaving out other essential parts of the healthcare system. Behavioral health and home health are two examples of resources that significantly impact the “triple aim”.
* Sylvester
	+ The geriatric population
* Myska
	+ The Office of Aging and Disability Services (OADS) is particularly interested in the Long Term System including Residential Care and Nursing Home facilities. We feel it is important for them to be part of this initiative, but recognize that one of the greatest barriers of participation in the PCMH pilot has been the lack of Electronic Medical Record (EMR) systems. We would be interested in exploring ways of supporting these paper based establishments without causing significant burden on the staff.

**3. What initiatives are “at risk” when SIM sunsets and which ones we should consider as we craft our proposal?**

* Webber
	+ Focus on core measures to be used in primary care and ACO arrangements.  Focus on value based benefit designs.
* Wigand
	+ I don’t think we should go down that path. Randy has a good handle on that and it will not be productive to list all the work and determine status with this large group.
* Letourneau
	+ Advanced primary care models  - i.e. payments from Medicare & several commercial payers will sunset in Dec 2016 (i.e. those currently in PCMH Pilot but without post-Pilot plan for continuing advanced primary care payment - Aetna, HPHC)
	+ Community Care Teams (CCT) – as above – payments from Medicare & commercial payers will end in Dec 2016
	+ Community Health Worker (CHW)  - i.e. haven’t actually ever had payment from payers for CHWs, but the SIM CHW pilot will not be sustainable without identifying a funding mechanism
* Winslow
	+ This is a hard question to answer because SIM was a grant and this seems to be more of a payment reform opportunity. I am not sure that we can or should “continue” any of the SIM related contracts.
* Selvin
	+ Primary care provider burnout and shortage increasing all the time. Primary care needs to be both reimbursed and delivered differently, group visits, population health, telehealth, out of office care
* Ryder
	+ While I don’t have adequate insight to primary care needs to comment intelligently, funding for HIN to support provider organizations partnering to work with high risk/high utilizing patients will be critical to continuation of those pilots. Without external funding support, many organizations will be unable to continue this critical initiative which is focused on reducing ED presentations and inappropriate inpatient admissions.
* Brandt
	+ My guess would be CHW's and real active CCT's: these are features uncovered and unbillable in the current payment models. Many PCMH's seem to manage an RN case worker or a social worker with current PMPM but not much more and not enough of those.
* Hamilton
	+ Behavioral health provider access to HealthInfonet (HIN) is at great risk. There are no financial mechanisms for behavioral health providers to cover the expense associated with HIN connectivity.
* Sylvester
	+ Not going far enough to help geriatric population
	+ Not finding a solution for mental health to aid long term care with difficult residents
* Myska
	+ OADS staff would echo Ted Rooney’s comments surrounding Medicare recipients wanting to stay in their homes/ community as long as possible. In fact, we would take that one step further to highlight that the Medicare constituent group includes not only elders, but individuals with disabilities and dementia too; who all want to stay in their own homes/ communities for as long as possible.
	+ Unfortunately OADS has not been able to determine how many of our constituents have benefited from the PCMH pilot. Our belief is that it hasn’t necessarily reached this population, which represents the highest per person costs in the Medicare system. OADS programs serve over 10,000 clients, half of which are elderly and the other half are disabled. For these clients, care coordination doesn’t happen until they are approved to receive MaineCare Waiver services and many of our clients are receiving just a single service through an Area Agency on Aging (AAA). We were aware that the AAAs had approached the medical establishments in an effort to expand the reach of the SIM funding to include social and community supports such as nutrition, housing, heating, exercise, transportation, etc, but we were not aware of the ACO partnership arrangements that Ted described. That said, we would certainly be in support of the new initiative encompassing social and community support programs.

**Other Comments**

* Probert
	+ I think it would be helpful to review a high level description of the current payer models/ programs that support primary care (this may include ACOs, etc).  E.g. what is the payment structure, does payment directly support practices, if and how are the providers held accountable for quality and cost, etc.  This should lead us to a discussion of what the strengths and gaps are in these models.
	+ It may also make sense as a group to decide what our main criteria are in deciding what kind of proposal to move forward with- this is where it may make sense to hear about the criteria either explicitly or implicitly used to create the current concept paper.  Are we looking for speed, efficiency, not recreating the wheel?  Or comprehensive, broad-brushed change?
	+ I would narrow question 3 to asking what critical initiatives aimed at system and delivery reform would end in the absence of a Medicare multi-payer proposal.  This is information that SIM should be able to provide.
* Renfrew
	+ My questions are a bit more granular.
		- Where do small independent primary care practices fit in this mix? They cover perhaps 10,000 lives, often in resource poor regions where resources are slim. A specific example is around behavioral health where there might only be one specialist within reasonable proximity and with a very different attitude to issues of shared care than c/w PCMH.
		- To what extent are we strengthening Primary Care? What is the level of satisfaction? What is the turnover in the practices? Where do Maine’s FP’s go into practice (geographic but also PCP, ED, Hospitalist)? How many open Primary Care positions are there in the State?
		- How ready is Primary Care for an aging population whose needs go beyond the routine care for younger adults?
	+ I think we have booked ourselves for a pretty high level conversation about organizational structure, but these issues have to inform this.
* Selvin
	+ Comments offered tried to focus on the provider/patient lens understanding this is only one view.
* Rooney
	+ I had sent my remarks to Craig last week but notice people are sending to everyone, so thought I’d send mine on as well. Being on the board of the Maine Assn of Area Agencies on Aging, and recently signing up for Medicare, I especially like to reflect the needs of Medicare enrollees. I thought I’d approach this from what elements are missing/at risk in our system that apply to both Patient Centered Medical Homes and ACOs, especially to what Medicare enrollees are saying: they want to live in their homes as long as possible, and where they desire, to be able to die there. I also think the health systems and community partners are doing fabulous initial work in this area that is at risk. And I thought I’d put in perspective how little this might cost in the big scheme of things. Great to be working with all of you!
		- Objective: To support payments to community based organizations to continue/expand the excellent work health systems/Accountable Care Organizations/Patient Centered Medical Homes are doing with these organizations that is currently dependent on grants, and may not be sustainable until there are true population based payments in 2-5 years.
		- Currently in the US the Institute of Medicine estimates 1/3 of all health care expenditures don’t do anything to improve health. Maine spends about $12 billion a year, so 1/3 is $4 billion. Assuming Maine is better than national average let’s use $3 billion. With a population in Maine of 1.3 million that is about $2,264 per person per year, or $188 per person per month that IOM suggests does not lead to improved health
		- Currently practices in the Patient Centered Medical Homes get $7 per person per month from CMS and Community Care Teams get $3. There is something wrong with this picture.
		- Since all surveys of older adults report they almost all want to stay in their homes/communities as long as possible, and many want to die there, there is a disconnect between our spending and what people want.
		- With the move away from a fee for service payment system to more global payments, Maine health systems are beginning/continuing to redesign to better improve health and support people in the community
		- At the Maine Quality Counts conference last week, there were excellent examples of how all 5 Maine ACOs were partnering with Area Agencies on Aging, CAP agencies, and other community organizations. What I heard is they are all strongly committed to this but a lot of the progress has been due to grant funding. They are committed to building the partnerships, but they don’t necessarily know how they will do it when the grants run out until the payment models actually shift to population based payments. This is not fair to the progressive ACOs/PCMHs, or the community organizations.
		- I am afraid the shift to enough true population payments to support these partnerships may take another 2-5 years.
		- Could this initiative focus on supporting this development of ACO/PCMH and community based partnerships, specifically by allocating funding for community based organizations to work with health systems/PCMHs, until the payment models change enough for them to be self-sustaining?
		- I think this is one of the most important changes that could come out of this initiative.
* Ryan
	+ I second your comments, Ted.
	+ One of my hesitancies about our efforts to focus on PCP payment reform is that it does not address the whole health-support system. PCPs play an important role, but they need so many adjuncts to be effective that just restructuring their payment and adding a little on the top will not break us through to the next level. Community support teams (CCTs and BHHs), social services, care coordination across settings, new infrastructure for eHealth and telehealth and mobile health, long terms care, palliative care… we need to take a system redesign approach, and not just tweak a certain component so that it can be better at its slice of the action.
	+ That is why I feel that Katie’s recommendation to include an ACO level of activity as a way to participate in a proposal is important. For this effort to try to change or focus on one component of what our ACOs are trying to accomplish across the health system is not going to be as successful as a broader effort to support system-level change.
	+ This, however, raises the question of what this proposal could add to ACOs who already have structured financial arrangements with PCP groups that are part of a larger fabric. What support is available to improve the health system and generate Savings that can be shared? Spring-boarding from Ted’s suggestions, would there be support for ACOs in maintaining our shared (and therefore cost-effective) Care Coordinators and CCTs, or for developing stronger community partnerships and broad community-based social support services, as examples.
	+ Bottom line: what funding and flexibility on the part of Medicare could be leveraged for better patient outcomes and experience of care?
* Fullam Harris
	+ Well said, Steve! Fully agree!
* Webber
	+ Steve and Ted, very thoughtful input and enthusiastically support these ideas being explored by our group.
* Letourneau
	+ Hi Ted, you make some great points, and agree it would be great to identify a new payment model that could support those services.  Not sure if you saw the recent Health Affairs blog post by Cathy Schoen et al, but they described a very interesting concept for a new model that they called “Medicare Help at Home” – see link below or attached:
	+ <http://healthaffairs.org/blog/2016/04/13/medicare-help-at-home/>
	+ Definitely goes considerably beyond our current discussions about alternative primary care payment models, but may offer some new ideas for expanded novel approaches either for this opportunity and/or future ones – FYI!
* Shargo
	+ I’d like to see the discussion go beyond ACOs. I think there are other strategies out there for improved safety and quality in primary care; I don’t believe that the ACO is the be-all, end-all in this regard. A major flaw with ACOs right now is that they tend to penalize those primary care sites already doing an outstanding job and managing quality and cost. They also disadvantage small provider types/sites, since they can’t get the economy of scale that larger (primarily hospital based) practices can. I also think that in order for primary care to recover from burn out, there needs to be a federal push to align metrics so that regardless of initiative, the sites can collect data in a consistent and meaningful way.

**Submitted after the deadline in the context of collecting questions for Fran Jensen**

* Renfrew
	+ I have just returned from a conversation with a very thoughtful colleague who is piloting our attempt at a standardized approach to dementia care. In that conversation he made 2 points which I think are pertinent to this conversation. The first is that we need to streamline data entry. The second is to set modest expectations.
	+ As you know I have a primary interest in the care of older adults. I have attached 2 items pertinent to that work. The second slide of the power point addresses that population of individuals over the age of 65 (somewhat arbitrary but that's when Medicare begins). One half of that population has 3 or more chronic illnesses or conditions. Those with the 15 most common triplets have 7-9 chronic illnesses or conditions. Geriatric syndromes; conditions which are common, frequently unrecognized, functionally impairing and often multi-factorial complicate their care. Our present ‘Quality’ Indicators do help to support this work but do not explicitly address the complexity of this.
	+ The second attachment is a draft that I have developed for work with the Maine Council on Aging regarding healthcare for older adults. It is very much a draft but hopefully will be of value to this group in thinking about the Medicare population. Critiques are welcome.
	+ I am very interested in the thinking about electronic records and how they can either support or hinder this work. The issue my colleague brought up about ease of data entry is a major challenge. Much of what we are looking for is not easily detected within standard reporting as designed by present vendors. For the particular project I referenced above, we have needed to create flow sheets which require specific data entry and do allow us to capture that data. Often it is the physician at the end of the day entering this data. So the questions that arise from this are:
	+ What thinking has CMMI done regarding use of tools such as natural language recognition or standardized templates specific to geriatrics?
	+ In addition, is there are ongoing thinking about requiring that health records incorporate data points required for PQRS (MIPS) reporting? Can the generation of data points within templates be made simpler so as to be built by users?
	+ As far as the simplification of quality improvement is concerned, it is very clear that some groupings of indicators are excessively complex for primary care. For instance, there are 13 ACOVE indicators for quality of dementia care. The dementia bundle through PQRS has 10 indicators. In our initiative here in Maine we boiled that down to 3 indicators. We then added support templates to aid with additional steps but are not measuring the specifics of that. Part of the thinking on this simplification, was that from a public health perspective if we can move the ball a substantial distance but not necessarily to perfection we have made a big impact. In addition a report in the Journal of the American Geriatrics Society in 2014 from Mission Health (1) addressed the complexity of the PQRS indicators for falls and a decision by the practices to discontinue that particular Q/I initiative. So the question here is:
	+ Can we consider more stripped down quality improvement efforts for the older population?
	+ This is down and dirty work in the weeds. At the same time primary care is becoming incredibly overburdened with very inefficient systems of support. My present riff is  ‘we are killing primary care with our love’. Anything we build must make doing the right thing easy.
* Wagner
	+ I like this approach better than Lisa’s as the starting point.  I suggestion to have Dr. Renfrew, Sara Sylvester and Dale Hamilton work together to refine this to address and include LTC and BH specific issues
	+ My thoughts are let’s plan from  “the what is being purchased” in the terms of outcomes for this population then think about how it is to be paid for versus planning only the payment and systems mechanism