**\*DRAFT \* Medicare Proposal Oversight Committee Proposal**

**Introduction:**

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. 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. Maine’s proposal will focus on measuring the effects of this model on avoidable hospitalizations and avoidable readmissions.

We will begin continuing to drive toward increasing the data available through the Health Information Exchange, the State of Maine to begin to ensure expenditures actually improve health status by focusing on clinical outcomes of care and functional status of the elderly and those with chronic illness and functional limitations

For the first time there will be alignment, which will also help to achieve the 4th aim of provider satisfaction.

Include an overall graphic giving a description of how this will help with each of the legs on the stool.

**Measures & Targets:**

***Statewide:***

* Avoidable Admissions
* Avoidable Readmissions
* Avoidable Emergency Department
* Functional status metric

***Pilot:***

* Functional status metric
* Total cost of care

**Proposal:**

***Statewide:***

* Risk adjusted Health Home PMPM-across payers
  + Which would mean that Medicare and the Commercials would have to align their VBP programs to be consistent with MaineCare’s or vice versa. Question: Could the payers identify components within each payers program that work best and cobble a redesigned program that way?
  + Include a plan to share a uniform/comprehensive quarterly data from each payer on a group on commonly agreed upon measures.
* Accountability payment
  + Metric TBD; idea-functional status measure (self-reported?) AND/OR the metric that practices are doing the worst on-collectively between all payers.

***Pilot:***

* Capitated primary care payment
* Pick 6 practices
* 2 with a high propensity of geriatric members
* 2 with a high propensity of behavioral health members
* 2 with a high propensity of avoidable admissions or readmissions or ED
* All must be connected bi-directionally to Health Information Exchange (HIE)
* Determine success based on Total Cost Of Care
* Pilot practices will try out taking on risk and would allow for financial incentive.
* A clinical measure will be included for the 6 participating practices
* Will assure HIE and prospective analytics tools are available to each practice
* Clinical trainers and workflow support staff will support each practice in a “Community of Practice” format with the goal of making “data informed” decisions that improve outcomes for patients
* Clinical outcomes will be measured based on data availability from the practices and practice locations
* Additional pilot idea: Identify xx behavioral health organizations to participate in a pilot to improve reporting of functional outcome measures. Selected providers would work with collaboratively with funders to establish a functional measure set. Providers will incorporate the measure set into their electronic health records for exchange with the HIE. Providers will receive an incentive payment (monthly, quarterly) that would support the cost of integrating data sets within electronic health records and the interface with HealthInfoNet.

**Other Components:**

* Comprehensive and uniform quarterly data reports to providers, with combined data from each participating payer
* Funding needed:
  + For data specialists who could prepare and submit the data reports, determine the risk adjusted PMPM and program coordinator and policy specialists who can help each payer institute the necessary policy changes and ensure consistency in implementation. Staff time will also be needed to manage the pilots.
  + Bridge funding for Community Based Organizations to provide social determinant of health solutions, in concert with clinical teams, for high risk Medicare and MaineCare enrollees until population based payments are more common.
* Funding to connect the remaining unconnected practices bi-directionally to HIE to allow for the production of a clinical metric and funding for development of clinical measure.
  + - Outcome measure: By the end of the pilot, we will produce a statewide clinical measure (eg. Hba1c over 9, blood pressure, and depression remission (all CPC+ metrics)
* Request a waiver to 42CFR

Advancing reporting of functional vs. process outcome measures related to the provision of behavioral health services is

a gap within our existing system. This proposal advances our ability to support the behavioral health system to report on functional outcomes which further moves our system towards better outcomes.

* A glossary is needed:
  + Primary Care- please add definition
  + Capitated rate- please add definition
  + Risk adjusted PMPM- Please add definition