Testing the Maine Innovation Model

Project Narrative

A. The State Health Care Innovation Plan Testing Strategy -

(1) Purpose: In partnership with the Governor's Office, Maine's Department of Health and Human Services proposes aligning MaineCare (the state's Medicaid program) with Medicare and commercial payers to achieve and sustain lower costs for the Medicaid, Medicare and CHIP populations, while improving the quality of care and patient satisfaction. The Maine Innovation Model is a logical continuation and advancement of delivery system and payment reform initiatives that are already transforming healthcare in Maine, and will enhance the involvement in, and impact of, the State's public payer sector on cost reduction, quality improvement, and informed patient engagement – i.e. the *Triple Aim* goals – with a continued commitment to transparency and public reporting.

As a leader in healthcare transformation, Maine currently has a number of innovative, nationally recognized programs and demonstrations in progress (See: Section 7). Although these initiatives share common themes, and all include some effort to change delivery systems and payment, they are each independently run, and lack coordination and a central or overarching statewide plan and supports to help providers and consumers make the changes needed to transform the health care system to deliver better value. While the majority of Maine's healthcare organizations are engaged in transformation activities, all are at various stages. Some are beginning to explore the medical home model, while others are developing multi-stakeholder ACOs. Within that progression are organizations and practices ready to move to the next level, but which lack funding to implement the needed practice and workforce changes. Additionally, Maine's purchasers/employers are leading payment reform efforts, pressing for faster implemen-

tation of practice transformation. Finally - some sectors, such as Behavioral Health, Public Health and Long-term Care, are not well integrated into system change.

The Maine Innovation Model (the Model) leverages current successes and brings the State's investment to the next level, supporting the formation of multi-payer ACOs that commit to value and performance-based payment reform and public reporting of common quality benchmarks, and that build on the model of MaineCare accountable communities. The Model accomplishes this by: (1) supporting and strengthening enhanced primary care; (2) supporting and strengthening alignments between primary care and public health, behavioral health, and long-term care; (3) supporting the development of new workforce models for the transformed system, and; (4) aligning measures, data and analytics across providers.

Project goals are to: (1) reduce PMPM cost for the MaineCare population; (2) improve the quality of care for this population; and (3) improve the patient experience of care and increase patient engagement. Our objectives are to: (1) implement payment reform across public/private payers; (2) spread the patient-centered medical home model of enhanced, integrated primary care, and; (3) achieve transparent understanding of the costs and quality outcomes of patients across all payers statewide. Achievement of these objectives, together with a strong evaluation, will enable the State to determine the impact of its healthcare reforms. Projected Savings - The Maine Innovation Model predicts significant savings compared to the underlying trend of the latest three years in Maine, with the following estimated cumulative savings over the three year period of the CMS cooperative agreement: $472M (MaineCare); $554M (Commercial), and; $248M (Medicare). (**Attachment:** Financial Analysis & Templates)

The CMS award will fund the following: (1) The data analytic structure for providers and purchasers needed for multi-payer claims analysis, public reporting, and secure information shar-

ing; (2) Quality improvement support, training, and collaborative learning to achieve accountable care; (3) Support for purchaser-led payment reform, including the potential for investment in performance based shared savings; (4) Shared decision-making training and tools at the practice level; (5) A range of patient and consumer engagement initiatives; (6) Support for value based benefit design; and (7) Support of new workforce models to more appropriately support the transformed system.

Widespread multi-stakeholder support and commitment for the Innovation Model is exemplified by the comprehensive and specific commitments of the participating Primary Care Providers and Health Systems, Behavioral Health Providers, Payers, Purchasers, Professional Organizations, and Educational Institutions. These commitments are detailed in Section E, and in the Letters of Commitment and Support.

(2) Scope of model and possible phase-in schedule: *(program components/services/ participating payers/ phase-in)* The Maine Innovation Model is built on a solid foundation of continuing and successful delivery system and payment reform initiatives, the underlying nature of which adds considerably to the likelihood of achieving success with the Model's individual components. The characteristics of this foundation in Maine are:

→ Cross-Sector Alignment: Maine is a Robert Wood Johnson Foundation Aligning Forces for Quality (AF4Q) community, which has helped align providers/ purchasers/ payers and consumers to support change. AF4Q's participating organizations are so ingrained in change that all major delivery and payment reform initiatives now occurring in Maine are supported by the involvement in and/or leadership of one or more of them. The Innovation Model also aligns with public payer initiatives, including MaineCare's value based purchasing strategy. Announced in 2011, this strategy includes a commitment to increased transparency of cost and quality out-

comes, rewards for performance, payment reform, and a move to Accountable Communities that include shared savings and risk and are tied to quality improvement.

→ Commitment to Enhanced Primary Care: Maine recognizes redesigned, high-value primary care as the essential foundation of any high functioning, patient-centered healthcare system. The Maine Innovation Model builds on the foundation of multi-stakeholder enhanced primary care embodied in the Maine Multi-Payer Patient Centered Medical Home (PCMH) Pilot. The CMS Maine Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP) and MaineCare Health Homes (HH) initiatives are based on the PCMH Pilot, and all include the use of Community Care Teams (CCTs) to manage high risk / high cost patients and link them to community based services. All are also moving to integrate primary care with behavioral health (BH). Enhanced primary care is also the base for the several multi-stakeholder / multi-payer ACOs emerging around the state. Commercial payers participating in these enhanced delivery / payment reform models include Anthem and Aetna, which together represent around 42% of the Maine commercial insurance market. Participating purchasers include Maine's largest employers – e.g. the State Employee Health Commission (SEHC), Bath Ironworks, the Maine University System, and others.

→ Commitment to Payment Reform: The State has chosen Maine Health Management Coalition (MHMC) as its major Innovation Model implementation partner. MHMC is a multi-stakeholder purchaser-led collaborative representing employers, providers, payers, and consumers. MHMC membership numbers over 60 employers, representing ~200,000 employees and dependents, or around a third of all commercially-insured individuals in Maine. MaineCare is a member agency. The organization leads or collaborates in a number of initiatives driving healthcare improvement and payment reform, among them: the Maine AF4Q initiative; and the PCMH

Pilot. Payment reform initiatives include data and other support for emerging multi-stakeholder primary care ACOs, development of Value Based Insurance Design (VBID), and development of consumer engagement programs.

Maine Health Management Coalition was founded in 1993 on the idea of improving the value of healthcare services for Maine businesses and patients to improve care quality and reduce costs. While Maine has been very successful in achieving very high quality care, our insurance premiums for both individuals and families remain among the highest in the country, challenging the notion that quality improvement alone will reduce the cost of healthcare. In 2012, MHMC convened the multi-stakeholder Health Care Cost Work Group to work collaboratively across all sectors to identify a priority set of actions that, if fully implemented, would result in a significant reduction in the total cost of care across Maine. These priority actions/strategies will eventually be brought to stakeholders statewide – citizens, businesses, physicians, hospitals, government leaders, etc. – who will be encouraged to support efforts to address them. This initiative will continue as part of the Innovation Model.

MHMC also serves as convener of an annual summit of healthcare industry CEOs and other leaders around issues of delivery transformation and payment reform. Consensus has grown across Maine stakeholders that moving away from fee-for-service to more flexible, global payments that enable physicians to determine best use of resources while working within a 'budget' will create the best financial model for improved care at reduced costs. Many Maine provider groups have indicated they will be moving in this direction and many Maine purchasers have indicated a preference of a payment method that transfers some risk to providers while enabling physicians to direct resources within these budgets. Some of the more advanced provider practices moving to shared risk arrangements are increasingly concerned with the pace of

change, being unable to sustain transformed care in a fee for service environment. In September, 2012, General consensus was reached at the MHMC Executive Summit that *all parties would transition to global payments to support primary care based integrated systems of care*. In the Innovation Model, MHMC will provide: (1) Data analytics; (2) Public reporting of quality measures developed through the PTE process; (3) ACO learning collaborative support through the Accountable Care Implementation Committee; (4) Continuing work and learning support around the development of Value Based Insurance Design; (5) Continuing the work of the Health Care Cost Work Group, and; (6) Development of the Behavioral Health Cost Work Group.

→ Commitment to Data Driven Change and Transparency: Central to the Maine Innovation Model is the data infrastructure to support performance measurement, quality improvement, and public reporting of quality and cost data. MHMC operates a Foundation (MHMC-F), which is the lead agency for public reporting of quality information in Maine. This information is made available to consumers on its website.[1] Through Pathways to Excellence (PTE), the Foundation identifies quality measures, promotes transparency, and encourages payers to use data as the basis for performance based rewards. The MHMC-F data system includes an inclusive all claims database and powerful analytic tools to transform health care claims data to actionable information to drive improvement. This analytic capacity provides performance measurement, analysis and feedback to providers/ employers/ insurers/ to drive delivery system change, and to consumers to drive informed choice of high-value providers through publicly reported data.

→ Continuous Quality improvement - Maine also recognizes the need for CQI for providers, purchasers/payers, and consumers around issues related to system change, and their individual and collective roles and responsibilities in the process. Maine Quality Counts (QC) is an independent, multi-stakeholder alliance working to transform health and healthcare in Maine by

leading, collaborating, and aligning improvement efforts that support patient-centered, coordinated systems of care and the resources needed to support them. QC is the lead agency for Maine's AF4Q initiative, one of the conveners of the PCMH Pilot, a member of the Maine CVE Alliance, and home to the new Better Health Better ME! patient engagement program. Additionally, the organization recently received funding from the Maine Health Access Foundation (MeHAF) to help further MeHAF's initiative to support the integration of physical and behavioral health care in PCMHs, Health Homes, and FQHCs. QC will provide Innovation Model CQI services through expansion of a current contract with MaineCare – to include an expanded PCMH / Health Homes Learning Collaborative.

→ Health Information Technology – HealthInfoNet (HIN), the designated statewide Health Information Exchange (HIE) and Maine Regional Extension Center (MEREC) has been operationally exchanging clinical health data since 2008 to support care coordination across the State. Today HIN's secure database includes records for approximately 1.1 million (~80%) of Maine's 1.3 million residents. By the end of 2012, 30 Maine hospitals (90% of the annual hospital inpatient, outpatient and ED utilization) will be participating in clinical data exchange. Five of the remaining nine Maine hospitals are under contract to connect to the HIE in 2013 and it is expected that all Maine hospitals will be engaged with the HIE by 2014. For the Innovation Model HIN will provide several services, including: (1) ED notifications to community care teams; (2) capturing Health Homes clinical outcomes from EHRs for reporting and analysis; (3) developing a behavioral health EHR incentive program for Stage B Health Home behavioral health providers similar to the meaningful use program for PCPs, and; (4) developing the Personal Health Record, with a goal of reaching 50K consumers by year three.

→ Engaged Public Health Sector - In 2009 the Maine Legislature established eight public health districts to strengthen and improve public health at the local and district levels. The Maine CDC has built local capacity to engage in chronic conditions prevention and self-management through this public health infrastructure. In the Maine Innovation Model, Maine CDC will head several initiatives, including (but not limited to); (1) a two-year Public Campaign to engage patients; (2) implementation of the National Diabetes Prevention Program, and; (3) implementation of a five site pilot for training and use of community health workers/patient navigators and asthma educators.

Component #1: Strengthen Primary Care.

(1) Expand the enhanced primary care model supported by the Innovation Plan – the PCMH with Community Care Team (CCT) support for high risk/high cost chronically ill patients. The current PCMH Pilot will expand in January, 2013, from 26 to 76 practices. Approximately 57 additional practices are eligible for MaineCare Health Homes status during 2013-2015, under the Stage A SPA (Section 2703, ACA). Health Homes are based on the PCMH Pilot model (enhanced primary care with CCTs) to offer more intensive management support services to the highest needs MaineCare patients.

(2) Expand outreach, support, and collaborative learning methods to PCPs, helping them transform to a more patient-centered model of care - provide IHI model learning collaborative opportunities for PCPs transitioning to PCMH and MaineCare Health Home status. Quality Counts will expand its current capacity to increase access to these resources.

(3) Provide leadership training to physicians and practice team leaders. The State will develop an RFP within the 6 month planning period, for provision of this training.

(4) Support recognition / incentives for PCPs transitioning to enhanced medical home status. In mid-2013, Maine Health Management Coalition will launch the Advanced Primary Care Recognition program for PCPs transitioning to the PCMH model, with specific levels of recognition in each component (good/ better/ best) determined through the Pathways to Excellence process. The 5 components are:

Office Systems	Clinical Outcomes	Patient Experience	Access to care	Cost of Care
Level 1 or higher on NCQA PPC-PCMH medical home recognition	3 or more BTE outcome measures, 1 of which need to be Depression	Recognition on CG-CAHPS patient experience survey	Recognition on access from subset of CG-CAHPS survey questions	Recognition on cost of care measures

(5) Support targeted efforts to improve care transitions to reduce avoidable readmissions and ED use, such as (but not limited to) HealthInfoNet's ED notification to CCTs, and using Community Paramedics to visit patients who are homebound, or who do not have or cannot reach a physician, and who might otherwise seek care in the ED (discussed later in this proposal)

(6) Support new workforce models to support the transformed system. Several initiatives are included in the Innovation Model, among them: (1) Supporting development of the Community Paramedicine pilots authorized by the Maine Legislature (LD 1837) to assist those receiving care at home; (2) Supporting the training of workers for the Maine CDC implementation of the National Diabetes Prevention Program, and other CDC identified trainings, and; (3) Supporting training to all PCMH/ HH practices concerning serving behavioral health patients and developmentally disabled and autistic children and adults.

<u>Component #2: Integrate primary care and behavioral health</u>.

(1) Assist in transitioning behavioral health providers to Health Home status, including patient engagement, participation in HealthInfoNet (the state's HIE) electronic behavioral health record and planned incentive program for EHR adoption similar to the meaningful use program

for PCPs. MaineCare will solicit behavioral health providers to participate in Stage B Health Homes, centered on patients with SPMI – anticipated date of RFP, early 2013.

(2) Provide a learning collaborative focused specifically on the integration of primary care and behavioral health (BH) – to include (a) technical assistance (TA) on integrating care as part of practice transformation; patient engagement; policy development; and mini-grants to expansion sites to participate in TA activities. The State will develop an RFP within the 6 month planning period for provision of the collaborative.

(3) Maine Health Management Coalition will work with behavioral health providers to develop behavioral health quality measures for public reporting, through the PTE process.

Component #3: Link to Public Health & Special Populations

(1) Increase patient engagement within the MaineCare population. The Maine CDC will develop a public health campaign focused on patient engagement.

(2) Develop stronger links between the acute care health care and public health systems – i.e. increase emphasis on population health. Maine CDC leads the Public Health system in Maine, through eight defined public health regions, which have regional health improvement targets. Maine Health Management Coalition will work with Maine CDC through the PTE process to identify align primary care and public health improvement targets in each region.

(3) Align long-term care with the enhanced primary care model. We will develop a sub-group to assess issues related to transitions to and from long-tem care facilities; regulatory issues surrounding eligibility; access to long-term care; HIT needs; and workforce needs.

Component #4 – Support Development of New Payment Models –

(1) In the absence nationally of a roadmap for organizations wishing to transition to ACO status, MHMC has developed a replicable and supportive pathway to provide this support,

including: (1) peer-to-peer education and support for specific aspects of ACO development; (2) consideration for underserved populations; (3) a common set of measures; (4) engagement of employers and payers; (5) engagement of consumers, and; (6) public education on payment reform, and system transformation. In 2011 MHMC launched the Accountable Care Implementation (ACI) Committee to move past theory to support implementation of delivery system redesign supported by reformed payment. The function of this group has become a learning collaborative for organizations transitioning to multi-stakeholder ACO status, and it will continue during the Innovation Model.

(2) Sustain the momentum of cost analysis and reduction efforts currently underway. The MHMC will continue its Health Care Cost Work Group initiative to identify actionable strategies to reduce healthcare costs. To identify strategies to reduce costs around Behavioral Health care (a significant cost driver for the MaineCare population) MHMC will add a dedicated Behavioral Health Cost Subgroup.

Component #5 – Use Centralized Data and Analysis to Drive Change -

(1) Support the use of a common measure set and public reporting, and analysis and feedback to providers and other stakeholders. The Innovation Model requires participating providers to commit to a common set of measures, a common claims data source (Maine Health Data Organization all payer database), and a single source of analysis for public reporting and statewide variation. Through the established Pathways to Excellence, MHMC will work with providers to develop a common set of measures, including working with Behavioral Health providers to develop a common set of BH measures, to be publicly reported. (These are in addition to Total Cost of Care and Patient Experience measures, which MHMC will also report). MHMC will utilize the all claims data base (MHDO) to provide analysis of these com-

mon measures, to provide system-wide analysis of healthcare trends, and to track where the state is moving as a whole. MHMC will also offer drill-down services of data to individual members for the purpose of care management (although this piece is NOT a requirement of participation in the Innovation Model). MHMC will use Prometheus to examine resources used to treat a unique episode of care, which will allow partitioning services into standard and potentially avoidable categories and use the information as a quality and efficiency measure for specialists.

Component #6 – Increase Patient Engagement –

(1) Increase the knowledge base of consumers concerning the cost of care and the need for system transformation. Provide special emphasis on reaching and engaging the MaineCare population. MHMC will broaden the MHMC Employee Activation Group and other consumer education initiatives to include additional consumers/purchasers/ payer opportunities. During the planning period, MHMC will model an outreach initiative in which MHMC will partner with cultural leaders in rural communities to develop pathways for local engagement with MaineCare members in trusted venues.

(2) Increase patient/provider interactions to improve care. The Innovation Model will provide shared decision making (SDM) training and tools to participating PCPs, with the goal of incorporating SDM into the practice workflow. We are currently considering the Choosing Wisely program, but will issue an RFP during the planning period for provision of either this or another SMD program.

(3) Measure patient experience of care. As part of the local evaluation process, patient experience of care will be measured using the CG-CAHPS survey. The Maine Quality Forum is currently conducting CG-CAHPS surveying statewide, which will establish a

baseline for comparison. Participating sites will complete additional surveys in each of the three years of the project.

Participating Payers include: MaineCare (Medicaid); Anthem Blue Cross/Blue Shield; Aetna; and Maine Community Health Options. Anthem is the largest commercial insurer in the state, insuring or administering benefits for ~400,000 Mainers (31% of the total population of 1.3 million), and processing around 6 million healthcare claims each year totaling $1.2 billion. Aetna insures around 146,000 Mainers (11% of the total population). The MaineCare population includes 89,038 adults, 139,134 children, 51,796 duals, and 31,723 disabled/elderly. Maine Community Health Options is a new insurance cooperative that will become operational during the Innovation Model period. These agencies are all active participants in payment reform initiatives statewide (PCMH Pilot, MAPCP Demonstration, emerging Multi-Stakeholder ACOs, etc.).

Phase-In Schedule: The first six months of the cooperative agreement period will be used to achieve readiness for implementing the strategies of the Innovation Model components – i.e. to coordinate resources statewide, hire administrative/grant personnel, issue required Requests for Proposals (RFPs) to contract for some of the services being offered – such as Leadership Development, Behavioral Health Learning Collaborative, and Local Evaluation, etc. During this period we will work with CMS to resolve any outstanding issues concerning the Innovation Model, including the project budget, and any changes to the detailed 3-year implementation plan and timeline that is included with this proposal. (**Attachment**)

(3) Delivery system or Payment Model(s) to be tested; The delivery model to be tested is enhanced primary care (primary care practices with practice based Community Care Teams for high risk/ high cost patients). The Innovation Model will promote and support providers that are in, or transitioning to this model. As of January, 2013, there will be 76 practices in the PCMH

Pilot (26 from the initial Phase I, and 50 new Phase II practices). In addition, MaineCare is projecting ~50 Health Homes in the next two years. A number of additional practices have transitioned or are transitioning to a medical home model, but are neither currently part of the PCMH Pilot, nor are they Health Homes or safety net providers (FQHCs). Finally, some practices have not yet begun to transition. All primary care practices in Maine are somewhere along this continuum. Providers participating in the Innovation Model will be phased in according to their needs (e.g. leadership training, practice redesign, development of analytic infrastructure, CQI and other training through QC offerings). The delivery model also supports the development of new workforce models for the transformed system, as discussed in previous sections of this narrative. This new/redesigned workforce will provide a range of services that include: patient management for high-risk high-utilizing chronically ill patients; patient navigation and peer support for at risk populations; diabetes and pre-diabetes education; and outreach to the homebound. The delivery model also includes the integration of primary care and behavioral health, better alignment with public health initiatives, and consideration for beginning to bring long-term care more appropriately into the transformed system.

The payment model to be tested is the primary care based, multi-stakeholder, multi-payer ACO with shared risk arrangements. In the MaineCare Accountable Communities program, MaineCare enters into different levels of risk-sharing agreements to partner with providers at varying levels of capacity and readiness to assume risk and meet specified benchmarks. MaineCare plans to phase in alternative payment models for all levels of the Accountable Communities program. The continuum of payment reform begins with models that include shared savings, moves to those with shared savings plus risk, then to partial capitation models, and finally to global capitation. In Maine, organizations are currently at different places along this continuum.

Initiatives include CMS shared savings ACOs, a Pioneer ACO, a Beacon Community, emerging Bundled Payment initiatives, and several multi-stakeholder/multi-payer ACOs with different savings and risk arrangements. On a national level, researchers have suggested that by "fostering local organizational accountability for quality and costs through performance measurement and shared savings payment reform", savings to Medicare with use of ACO models could occur within five years.[2] Others have suggested that many previous barriers to assuming such responsibility for care, such as the ability to track and report on timely data, have largely been resolved, and that cost savings of up to 20-30% could potentially be achieved if delivery system and payment models could be redesigned to hold providers accountable for outcomes, and reward value over volume.[3] Speaking directly to the way in which the Maine Innovation Model is designed, there is also growing appreciation of the need to build ACOs on a foundation of redesigned and robust primary care, recognizing that the goals of the ACO model will require patients to have access to timely access and coordination of care that can be delivered by enhanced primary care models, such as the patient centered medical home.[4]

(4) The Value Propositions and performance / improvement objectives to be achieved;

The Innovation Model works beyond institutional boundaries and interests and brings together public and private sectors in a collective mission to improve care and value. Because the project leverages existing efforts and organizations and will contribute to the sustainability of Maine's Medicaid program (MaineCare), the work can be sustained and will continue beyond the life of the cooperative agreement. (See Section 14).

(1) The Innovation Model will result in an enhanced alignment across the current healthcare system – specifically the alignment of primary care with behavioral health, public health, workforce development, long-term care, and multiple payment reform efforts.

(2) It will result in the alignment of common measures for public reporting, including community measures (population health) and Behavioral Health measures. Current experience shows that what is now being measured and reported back to providers/ purchasers/ payers and consumers is already driving the direction of change in the state.

(3) This improved alignment, the development of new workforce components, the introduction of SDM tools and training into primary care practices, and increased patient / consumer engagement will improve health outcomes for the targeted populations. The Community Care Team component of the PCMH and Health Homes leads to improved care management, a reduction in higher levels of care and cost, and strengthens links to community based resources.

(4) The data analytical and organizational structure for targeting cost savings opportunities and working to maximize them already exists in the multi-stakeholder MHMC Health Care Cost Work Group. Its initial findings reflect those of a recent IOM report that identified a high percentage of waste in the system, including the delivery of unnecessary services, excessive administration and other problems.[5] In coming months a Behavioral Health work group will be added to the Health Care Cost Work Group to examine ways to reduce behavioral health costs, a significant cost driver for the MaineCare population.

(5) Evidence basis for testing the model(s); A recent Congressional Budget Office analysis of Medicare Demonstrations showed no notable impact on quality or costs from most demonstrations. Of notable exception, however, the report found that certain approaches proved useful in some projects, such as gathering real time data on the use of care, using team-based care, and targeting interventions for high-risk beneficiaries.[6] These are the innovations we are proposing – i.e. strengthening primary care delivered through the PCMH model with integrated care man-

agement and behavioral health integration; identifying and providing enhanced care coordination for high-needs, high-cost high patients through Community Care Teams (CCTs) and providing enhanced support to improve care transitions (the development by Maine CDC of a community health worker/patient navigator pilot). Studies have shown that providing robust primary care services and establishing a "medical home" for patients are key to achieving better integration of care for patients and families: these studies have shown that having a strong primary care system and the presence of a medical home are directly associated with improved patient experience, improved population health outcomes, and reduced costs [7, 8, 9] – i.e. the *Triple Aim*.

This is particularly true in Maine, which has an extremely high rate of chronic disease. Chronic conditions remain the leading cause of death in the state. Close to one third of Maine's population of 1.3 million has at least one chronic disease, with diabetes being the 7th leading cause of death in the state. Thirteen percent (13%) of Maine residents have been diagnosed with three or more chronic diseases,[10] and in six of the state's 16 counties that percentage is higher (15%-17%). In 2003 the economic impact of chronic illness in Maine was estimated at $6.7 billion (treatment expenditures $1.4B, lost productivity $5.3B).[11] Projections for 2023 show a total impact of $21.6B, of which $5.8B is deemed avoidable.[12]

A new workforce configured and trained to efficiently meet the special needs of this population, is critical to the success of the Innovation Model. In addition to practice based CCTs, there is also a need for community-based health workers who can link patients more efficiently and at lower cost to a broad range of community-based services. Community health workers/ patient navigators can fill a range of roles, among them ensuring that a patient keeps a doctors appointment, fills a prescription, sees a dentist, navigates a range of community based health and social services related to a specific illness or condition. Diabetes educators speak to the needs of

those with diabetes, and individuals with certification in approaches like 'The National Diabetes Prevention Program', can work with people who are pre-diabetic or who have gestational diabetes, to prevent onset of the disease. A new class of worker, the Community Paramedic, is the key element of a new pilot in 12 Maine communities. Community Paramedics will visit patients who are homebound, or who do not have or cannot reach a physician, and who might otherwise seek care in the ED. Targeted clients are those with chronic illnesses who are at high risk for hospital readmission, and those with recurring intensive healthcare needs.

Consumers must also take a more active role in their care, and physicians must be supported to lead care transformation. The introduction of practice based shared decision-making training and tools is an important quality improvement/cost reduction element of the Innovation Model. A recent study found that introducing decision aids was linked to sharply lower hip surgeries(26%), and knee surgeries (38%), and over a six-month period resulted in 12 percent to 21 percent lower costs."[13] Another study notes that when a patient is made a partner in his or her care, self-management improves, leading to better health outcomes for those with chronic illness.[14] In late 2011 the Congressional Budget Office estimated that "up to 30 percent of care delivered in the US goes toward unnecessary tests, procedures, doctor visits, hospital stays and other services that may not improve people's health – and in fact may actually cause harm."[15] The conclusion that physicians and patients must work together to make wiser treatment decisions has led to the development of a number of programs around shared decision-making, such as *Choosing Wisely*, which encourages discussion about the overuse and misuse of medical tests and procedures, and helps physicians become better stewards of limited healthcare resources.

The involvement and support of payers/purchasers is key to payment reform. Large purchasers have, in fact, been the driving force for payment reform in the state, an acknowledge-

ment that with Maine health insurance premiums among the most expensive in the US[16], and wide cost variation among the 16 counties, employers cannot continue to meet escalating costs without limiting business viability. As many MHMC private employer members have operations or competitors in multiple states, Maine must be competitive with a broader peer group than New England. When considering the opportunity to expand and attract business to Maine, nationally competitive healthcare costs would be a strong contributor to economic development. This must be balanced with local demographic, economic and health status challenges, but it is fair to assume that there is opportunity for reducing healthcare costs in Maine while maintaining access and preserving quality. In Maine the alignment of purchasers / payers with delivery system transformation is being successfully achieved through the Maine Health Management Coalition, its many collaborative convening initiatives, including but not limited to Pathways to Excellence, development of Value Based Insurance Design (VBID), the Accountable Care Implementation Committee and other work groups, convening consensus on common quality measures, patient experience of care, and cost reduction measures, support of the enhanced primary care model, and development of data analytics to drive change.

(6) Theory of action and expected impact: The Innovation Model incorporates a number of initiatives leading to cost reductions, centered around the PCMH model with CCTs to manage high risk / high cost patients, and including integration of primary care with behavioral health. There are components for patient activation, practice reporting on cost and quality, and training. All center around a medical home approach, and expected results are informed by current information on the impacts of the medical home model. While it is impossible to predict detailed service category impacts from interventions with accuracy, reported results from at least four years of PCMH pilots can be used as guidelines since they are based on actual implementations.

Our cost savings estimates were created using the Patient-Centered Primary Care Collaborative report, *Benefits of Implementing the Primary Care Patient-Centered Medical Home: A Review of Cost and Quality Results, 2012* as guidelines. The report included results from 28 separate medical home initiatives nationwide. Analyses include academic peer-reviewed journals and industry generated reports. The average PMPM reduction for those initiatives reporting overall savings was 10%. The Maine Innovation Model estimates PMPM savings varying from 2-8%, depending on the population. Savings vary across populations for a number of reasons including service category mix, intervention impacts across service categories, the expected future trend of price per service unit, and the basic underlying empirical trend estimated from the most recent three years data. Our overall expected savings are somewhat less that the average of the pilots. While the overall savings are built from service category estimates, the actual savings per service category are imprecise estimates. The category estimates, however, taken together, yield a level of savings which has been proven through the 28 initiatives. Maine Innovation Model interventions extend beyond those strictly for PCMH interventions, such as the impact on price of payment reform. The numbers reflect high level goals which others have achieved, and there is no payment or risk attached to these.

Virtually all of the medical home pilots reported significant reductions in inpatient admissions, and this is a major factor in our Innovation Model, both because of the size of the achievable reduction in utilization, and the amount of cost in the category. This will be enhanced in the state model with the addition of CCTs. In recent work at the Maine Health Management Coalition using commercial claims from multiple payers for 30 employers, analysis showed that a reduction of 20% in admissions for patients with chronic conditions reduced the overall PMPM for all the insured population by over 3%. This alone would be a significant part of the projected

reduction of the projected PMPM reduction in the state model. While the percentage reduction in ED visits rates was similar in magnitude in the pilots, the effect on total PMPM is smaller as it represents less total cost. Other categories of outpatient care and specialist fees will be reduced with better control of ambulatory care sensitive conditions and potentially avoidable services. Shared decision making (SDM) results in patients choosing less invasive treatments. We expect savings in behavior health area with the integration of behavior health with primary care.

We expect primary care utilization to increase and have included a significant increase in the state model to capture all the addition activities associated with expanded primary care it in the medical home model. The pricing component of the model reflects combining the underlying trend and the effect of payment reforms activities, a slight upward trend in price, the least for Medicare and the most for MaineCare as the state may move the MaineCare fee schedule closer to that for Medicare. If that happens, in theory, it could put downward pressure on Private unit costs with a reduced need for cost shifting. We have not tried to predict congressional action on the SGR for Medicare. Thus - service line utilization impacts, achieved after three years, with trends as above:

Service Category	Medicaid (adult)	Private (individual)	Medicare
Inpatient admission	-20%	-20%	-20%
SNF*	N/A	2%	-3%
Outpatient Surgery	-6%	-7%	-10%
ER	-20%	-20%	
Dialysis	9%	8%	5%
Lab Services*	3%	2%	-1%
Imaging	-6%	-6%	-8%
Outpatient Other	-15%	-20%	-16%
Prof Primary Care	15%	15%	12%
Prof Specialty Care	-12%	-13%	
Home/Com Services*	-7%		
Professional Other*	9%	8%	5%
Behavior Health*	-12%		
DME*	9%	8%	5%
Home Health*	9%		

Prescription Drugs	-6%	-8%	-10%
Other	-5%		5%

*Results from medical home pilots not available.
Blank cells: claims data not available for service category from data source.

The Innovation Model predicts significant savings compared to the underlying trend of the latest three years. Savings Compared to Trend, cumulative over 3 years: MaineCare **$472 M**; Commercial **$554 M**; Medicare **$248 M**. Savings per capita are highest for the Medicare population, driven by the opportunities with the high prevalence of chronic conditions in that population. We are projecting impacts on 40% of the privately (commercially) insured, and we are projecting impacts on about 50% of the MaineCare and Medicare populations, although a higher proportion of the provider/practices will be expected to participate. ROI in the Innovation Model is large, the design broadly applies interventions across populations. Even if the per capita impact is significantly less the projected, or a smaller portion of the state population gets the intervention, the ROI would still be many multiples of the original investment.

(7) Coordinating with other federal initiatives: Over the past 5-7 years, Maine has become an incubator for pilots and demonstrations to test transformation models. The collaborative culture that has taken root during that time is the result of initiatives like Aligning Forces for Quality, and the seminal work of multi-stakeholder convening organizations like Maine Health Management Coalition, Maine Quality Counts, and Maine Quality Forum, whose projects and missions created a supportive environment for change. MaineCare has become an increasingly active player in all of this change. Approximately 23% of Maine's total population of 1.3 million is enrolled in MaineCare, and the MaineCare population is a significant cost driver in the total cost of healthcare statewide. Today there are a number of CMS /ACCA funded initiatives currently in progress statewide. They include, but are not limited to, the: (1) Maine MAPCP Demonstration;

(2) MaineCare Health Homes Initiative; (3) CMS Advanced Primary Care FQHC Demonstration; (4) Bangor Beacon Community; (5) CMS Electronic Health Record Incentive Program (meaningful use); (6) CMS Value Based Purchasing Program (hospitals); (7) CMS Pioneer & Shared Savings ACO Pilots; (8) CMS Partnership for Patient Program / Community-Based Care Transitions Program; and (9) the CMS Quality Improvement Organization Program. Additionally, a federal loan is supporting the development of Maine Community Health Options, an insurance cooperative to encourage patients to use primary care providers, and encourage PCPs to integrate physical care with behavioral health and dental care. The Innovation Model brings an overarching framework to what is currently occurring, and through its data infrastructure, various trainings, HIT enhancement, workforce development, and other initiatives for patient centered medical homes, payment reform, and patient / consumer engagement, the Model strengthens the ability of these federal initiatives to be successful and sustainable.

(8) Sustainability Plan: Maine is coming to the table with considerable interest by commercial payers and large employers/purchasers in payment reform. They have, in fact, been major drivers of reform statewide, and are fully engaged participants in initiatives like the Multi-Payer PCMH Pilot and the CMS Maine MAPPC Demonstration based on the PCMH Pilot. Maine is unique in its focus on the development of multi-stakeholder, shared risk ACOs for the more diverse, real life healthcare environment. In this multi-stakeholder, shared risk model, providers become accountable for population health and costs through a redesign of the healthcare delivery system and the use of alternative payment models. This focus is currently being piloted at MaineGeneral Health, a medium-sized health system similar to rural health systems in much of the country. Mid Coast Health Services (Mid Coast) has partnered with Bath Iron Works (BIW) to develop a primary care based ACO pilot for the Mid Coast region. Mid Coast is also using

their own employees as an incubator for their ACO, with pilot projects currently focused on behavioral health integration and on reducing the high utilization of musculoskeletal services – i.e. improving treatment for low back pain. Other multi-stakeholder, primary care based ACOs are also emerging, each of which has different risk arrangements.

Critically, Maine's major payers participate with MHMC in ACO development, including: Anthem Blue Cross Blue Shield; Harvard Pilgrim; Aetna; Cigna; new players like Martin's Point Health Care (which recently developed an insurance product); and MaineCare. Health insurance coverage among Maine's 1.3 million people is as follows: Private Health Insurance (47.5%); MaineCare (18.5%); Medicare (18.4%); Military (6.0%); and Uninsured (9.6%).[17] As noted elsewhere, MaineCare is moving to a managed care approach designed to include an ACO model by 2012. As new approaches to care prove effective in reducing costs while improving the quality of care, the expectation is that payers will work collaboratively with ACO partners to change reimbursement to reflect those new approaches, thus creating sustainability.

If the MaineCare Health Homes are successful in lowering cost, this success will be used to drive legislative appropriations for the state's Medicaid program. The experiences / lessons learned through the Innovations Model initiative will help us to inform legislative recommendations for MaineCare rates, based on performance outcomes. These results will also inform continued justification for future amendments to the State Plan.

In addition to financial sustainability, components of the Model will build organizational capacity that currently does not exist. Learning collaboratives will create a base of knowledge that will help create a permanent culture shift. Supporting the acquisition of electronic health records (EHRs) for Behavioral Health organizations will create a permanent HIT infrastructure that will help them better grow and sustain their work. Much of the Maine Innovation Model

will support foundational change, rather than the one-time use of funding to solve an immediate problem. It sets and solidifies the permanent system transformation that has already begun here.

(9) Potential to replicate in other states: As previously noted, Maine is currently the site of a number of nationally recognized, federally and privately funded system transformation initiatives, all of which have begun within the last 5-7 years. They are built on the work of organizations with much longer transformation timelines, particularly Maine Health Management Coalition, whose multi-stakeholder data driven approach to payment reform and delivery system change has informed much of what is happening across Maine today. The Innovation Model funding provides us with opportunity to tie all of these initiatives together, and leverage them to align additional components of the healthcare system for the purpose of achieving the *Triple Aim*. This tying together of various initiatives through an Innovation Model is replicable. In addition, the components and strategies of the Model are also replicable, such as the ACO Development pathway being developed by MHMC.

(10) Geographic focus area & statewide roll-out: The geographic focus area is the state of Maine. Providers in each of the 16 counties have moved or will have moved to Patient Centered Medical Home / Health Home status during the project period. Participating healthcare systems that own their primary care practices, collectively 'cover' most or all counties. The state's safety net providers of community health centers (FQHCs), tribal health centers, and healthcare for the homeless sites, are also located in every county. Roll-out by component will be geographically limited only if there is an expressed lack of need for that component, if resources are limited (e.g. funding for EHRs), or if inclusion is limited by some other factor (e.g.: the Paramedicine pilot is limited to 12 pilot communities). A detailed 3-year project plan and timeline with milestones is included with this proposal. (Attachment)

(11) Likelihood of success & potential risk factors to be addressed: The likelihood of success is high. We base this on the existence of several critical characteristics important to success that are already solidly in place in Maine. They are, as explained in Section 1: (1) Cross sector alignment, including alignment of providers/ payers/ purchasers and consumers; (2) Commitment to enhanced primary car, i.e. the patient centered medical home with practice based Community Care Workers for care management of high utilizing / high cost patients; (3) Commitment to payment reform through the development of multi-payer / multi-stakeholder alternative payment models, such as the emerging ACOs with varied risk arrangements; (4) Commitment to data driven change and transparency, exemplified by the data analysis and public reporting work of the MHMC; (5) Continuous quality improvement, exemplified by the IHI model learning collaboratives of Quality Counts, the learning opportunities of MHMC, and the learning opportunities embedded within other transformation initiatives, and: (6) Health Information Technology capacity, represented by the state's health information exchange, HealthInfoNet.

Despite this, there are challenges and potential risk factors. One major challenge is that of clinical and claims data – who owns it, who has access to it, and how it is used – sometimes contentious issues that are referred to as the "data wars". The State will continue to monitor and participate in discussions concerning developments in this arena, with the goal of best serving Maine's population. For the Innovation Model, the Maine Health Management Coalition and its Foundation have been identified as the data analytic partner(s).

Another challenge will be in operationalizing some of the recommendations of the Health Care Cost Work Group. For example, there was wide agreement among members of the group that reductions in cost of care could not come without reducing and transitioning the healthcare infrastructure. Several studies have shown that supply does drive demand in healthcare services,

and members shared the challenge of having to support fixed costs in hospitals regardless of their ability to reduce the need for hospitalizations. Given Maine's rural nature and demographics, maintaining access to needed services and managing a transition for some facilities to continue to meet community needs will be of critical importance. Early data did not confirm that multiple hospitals in a region increase that region's healthcare costs, but many members strongly argued that significant administrative and other savings could be achieved through reducing the number of acute care hospitals in Maine and/or transitioning their infrastructure to provide different services. The Development of a Healthcare Capacity Workgroup has been proposed to work on this issue. The outcome of their deliberations could potentially be extremely difficult to operationalize, and could have a far-reaching effect on both the industry and on consumers statewide. Other recommendations arising from the Health Care Cost Work Group on other issues could be equally as difficult to achieve, although we do not know at this time which recommendations these will be, nor the challenges that might be encountered to operationalize them.

Despite this, the state's multi-stakeholder approach to change, and a strong base of collaborating agencies and transformation initiatives - with considerable MaineCare involvement in all of them – provides a solid basis for achieving the goals of the Innovation Model.

(12) Current clinical quality & beneficiary experience outcomes & specific improvement targets – Much is currently happening in Maine around capturing and reporting quality measures. There are evaluation criteria for the PCMH Pilot, Medicaid specific experience measures for the MaineCare primary care provider incentive program (PC-PIP), metrics for the Maine Health Management Coalition's *Get Better Maine* initiative, the statewide CG-CAHPS baseline project currently in progress, and others. Using the Pathways to Excellence process of Maine Health Management Coalition, stakeholders will select from all of them to develop a set of key

indicators for Maine, aligning ACO quality measures with Medicare Shared Savings measures and the PCMH Pilot and Health Home measures. (Please Note: Projected service category utilization impacts after three years were discussed in Section 6).

(13) Health status by target population & target outcomes expected from model MaineCare, Maine's Medicaid program, currently provides benefits for over 294,000 individuals, including over 124,500 children, 81,000 parents, 41,400 dual-eligible, and 13,800 low income adults.[18] Notably, twenty-six percent of Maine's Medicaid population is dually eligible for both MaineCare and Medicare, the highest percentage of duals in any state.[19] An estimated 10% of the population is uninsured, with 13,000, or 5% of children uninsured.[20] Children's Medicaid/CHIP participation rate is 91.5%.[21]

There are several key health risk factors for the target population. Tobacco remains a significant health challenge, with 18.2% of Mainers still smoking. Obesity rates continue to increase each year, with 27.4% of adults now classified as obese. The level of chronic diseases also continues to increase. In the last decade, diabetes rates grew from 6% to 8.7%. Medical costs for those with diabetes are 2.4 times higher than those without diabetes, and the risk of cardiovascular disease and stroke are two to four times greater in people with diabetes. In Maine, heart disease, stroke and diabetes are, respectively, the second, fourth and seventh leading causes of death. In 2007, heart disease, stroke and diabetes together accounted for 31% of all deaths in the state. Chronic disease is also an important factor in overall health care costs across payers. Approximately 10% of the MaineCare and Commercial populations have a chronic disease, and drive approximately 30% of total spending and 40% of inpatient spending. Approximately 30% of the Maine Medicare population has a chronic disease, and drives approximately 65% of total spending and 70% of inpatient spending. Chronic disease patients also exhibit significantly

higher rates of potentially avoidable and preference-sensitive care admissions. Chronically ill people account for 40% of inpatient costs in the Commercial population, 36% of IP costs in the MaineCare population and 72% of IP costs in the Medicare population, indicating that chronic disease patients are drivers of IP costs, and therefore, of potentially avoidable admissions.

Mental health issues, which affect one in five Mainers, are associated with higher health risk, higher rates of chronic disease, and poor self care in the general population. 50% of Maine's long term Medicaid-only population has a behavioral health (BH) disorder, either mental illness, substance abuse, both mental illness and substance abuse or developmental disabilities/traumatic brain injury. These BH populations have higher rates of multiple chronic medical co-morbidities than cohort members without any BH diagnosis, higher utilization of all medical services (IP, avoidable hospitalizations, 30 day readmissions, ED and OP care), higher total and medical costs and poorer outcomes, including higher rates of death. Having a BH disorder also increases the odds of higher cost and utilization to as great a degree as having two or even three chronic medical conditions. 65.4 % of MaineCare members with a diagnosis of serious mental illness under age 65 have five or more medical conditions or co-morbidities, compared to 24% without any mental illness.[22] Another critical finding has been the association between fragmented primary care (more visits to different primary care providers) with higher utilization and cost, particularly among members with behavioral health disorders, higher levels of medical co-morbidity and worsening diabetes.

The top 5% of highest cost MaineCare enrollees (17,182 members) accounted for $1.2 billion or 55% of total claim payments. Intense areas of utilization for this group include long term care benefits such as home and community-based services, nursing home care, and ICFMR: long term care spending accounted for 53% of high cost members' claims payments. Over a

quarter (27%) of high cost members used IP hospital services compared with 8% of all service users. 33% of high cost members visited the ED during the year and had an average of 4 visits as compared to 30% of all full benefit MaineCare members, with an average of 2 visits. Mental health services were used by 42% of high cost users and accounted for 11% of their claims payments, and most (93%) of the total inpatient psychiatric hospital spending for all MaineCare members ($33.5 million) was attributed to high cost members.

Maine's ED use in 2006 was about 30% higher than the national average. Mainers use ED services at a rate that is 30% higher than the national average. Approximately 75% of Maine's ED use represents avoidable expense, with potential cost savings of up to $115 million.[23] The uninsured accounted for 9% of outpatient ED visits, which is less than their proportion of Maine's population. MaineCare ED-use was 3.2 times higher than private use.

Target outcomes of the Innovation Model were discussed earlier in this narrative.

(14) and (15) Other Medicare pay models & Medicaid waiver authorities, including anticipated section 1115 demonstration requests & description of those requests. Effect on the project if not granted. No section 1115 demonstration requests are anticipated to implement the Model. Per the Innovation Plan, the State will be pursuing three state plan amendments in support of our value-based purchasing initiative, a central feature of the Innovation Model:

SPA	Authority	Timeframe for submission	Expected launch date
Accountable Communities	Section 1905(t)(1) 42 CFR 440.168	December, 2012	May 1, 2013
Health Homes Stage A	Section 2703, ACA	October 1, 2012	January, 2013
Health Homes, Stage B	Section 2703, ACA	January, 2013	May, 2013

(16) Describe any other targeted improvements not presented here. MaineCare has a provider incentive program which is based on pay-for-performance for private primary care practices. Over the past year we have been trying to align performance measures with new MaineCare strategies, including Health Homes and Accountable Communities. This is an overall strategy change concerning the PC-PIP (primary care physician – physician incentive program).

(17) Project Processes and operational planning – The Maine Department of Health and Human Services (the State) will be the grantee, with responsibilities outlined below (see: governance). The State will contract implementation to several partnering agencies. Each of these contractors has developed a staffing and operational plan to achieve the project components for which they are responsible.

The Maine Health Management Coalition, will provide: (1) Data analytics; (2) Public reporting of quality measures developed through the PTE process; (3) ACO learning collaborative support through the Accountable Care Implementation Committee; (4) Continuing work and learning support around the development of Value Based Insurance Design (VBID); (5) Continuing the work of the Health Care Cost Work Group, and; (6) Development of the Behavioral Health Cost Work Group. Maine Quality Counts will provide a PCMH and Health Home learning collaborative under an extension of a current contract. HealthInfoNet will provide: (1) ED notifications to community care teams; (2) Capture of Health Homes clinical outcomes from EHRs for reporting and analysis; (3) Development of a behavioral health EHR incentive program for Stage B Health Home behavioral health providers similar to the meaningful use program for PCPs, and; (4) Development of the Personal Health Record, with a goal of reaching 50K consumers by year three. Maine CDC will provide: (1) A two-year Public Campaign to engage patients; (2) Implementation of the National Diabetes Prevention Program, and; (3) Implementation

of a five site pilot for training and use of community health workers/patient navigators and asthma educators.

The State will develop RFPs for the provision of other services, e.g. Leadership Development, a Behavioral Health learning collaborative, and local Evaluator who will provide data to CMMI as needed and requested and, to the extent possible, will harmonize measures to facilitate data collection/ minimize respondent burden. (**Attachment**: Plan for Performance Reporting)

Governance Model - State of Maine grantee – Has sole responsibility to CMS for insuring the timely delivery of agreed upon tasks through an approved workplan. The State of Maine will be responsible for all grant activity and report to CMS on progress in all areas, including grant management. Contracted services by vendors in the three major categories and the MHMC will have reporting responsibilities to the state aligned to the agreed upon workplan and deliverables specified in a contractual agreement with the state.

Grant Executive Committee – The committee will be responsible for policies, changes to workplan, major shifts in resource allocation, and decisions requiring senior authority. The Director of Strategic initiatives and project management staff will make monthly reports to the Committee on performance, financial, and workplan progress. The members of the Executive Committee will be appointed by the Commissioner of DHHS. The positions will be: Commissioner of DHHS or her designee; Director of MaineCare; Member Organization of MHMC; Commercial Payer; Healthcare System; Behavioral Health Organization; Executive director MHDO; Executive Director, MHMC.

SIM Steering Committee – A multi-stakeholder group providing input and direction on the progress of grant activities toward the goals and objectives outlined in the approved workplan. The Steering Committee is advisory to the state. Meetings of the Steering Committee will

be monthly. The Steering Committee membership will be appointed by the Commissioner of the DHHS and at a minimum include: Director of Strategic Initiatives within MaineCare; Member of the Hospital Association representing Hospitals; Physician Provider; Behavioral Health Provider; MaineHealth Management Coalition; 2 Large Employers; Executive Director MHDO; Director Maine CDC or her designee; Director Adult Mental Health/ SA or his designee; Director HealthInfoNet; University of Southern Maine Muskie School; University of New England; Executive Director Maine Primary Care association; Behavioral Health Provider Association; Others to be identified.

B. Expected transformation of major provider entities within Maine, rationale for their transformation, and evidence of commitment to making the specified changes – Readiness for ACO Participation - There are a number of major provider entities in the state, including several large integrated health systems comprised of multiple hospitals and related entities. Three of them- MaineHealth, Central Maine Healthcare, and Eastern Maine Health - have tertiary medical centers, and all three own a number of primary care practices. Mid-sized and small community hospitals (either affiliated with these three or not) also own primary care practices. Many of these hospital owned practices support the patient centered medical home mode, as do large independent provider groups like InterMed and Martin's Point Healthcare, or participate in various enhanced primary care initiatives (i.e. the PCMH Pilot or Health Homes).

Expansion of the PCMH Pilot from 26 to 76 sites in January 2013, the addition of MaineCare Health Homes statewide, and the transition of safety net facilities to medical home status, help create a critical mass for the move to multi-payer / multi-stakeholder primary care based ACOs. There are already several multi-payer ACOs in development (among them MaineGeneral, MidCoast Hospital, and Maine Medical Center), each tailored to the needs of the

population to be served. Meantime, small and unaffiliated primary care practices are still challenged to identify financial and other resources to successfully transition to medical home status, while other parts of the system, e.g. Behavioral Health and Public Health, are not appropriately aligned with primary care. The level of HIT capacity varies widely among practices, and is a critical need for Behavioral Health providers if they are to integrate successfully other sectors of the healthcare system. The Innovation Model provides an overarching framework and financial and other resources for delivery system transformation and payment reform for all participating providers, enabling practice redesign, alignment of services, HIT infrastructure, data driven transformation, and other support for entrée into developing ACOs. It also provides a framework and resources for participating payers and purchasers, and consumer education and engagement.

The State of Maine has two mental health facilities under its jurisdiction. The Stage B Health Homes (with focus on the SPMI population) is expected to have an impact on care transitions for this population, likely including transitions to and from inpatient care, but more likely helping to keep these patients in the community, being treated locally.

The State will also work with the array of institutions receiving funds for medical education, to collaboratively develop changes over time to the clinical and business models. These include, but are not limited to: the University of New England College of Osteopathic Medicine, the Maine Medical Center / Tufts University collaboration, and the many schools (university, community college, and hospital based) providing allied health professions training.

C. Roles of other participating payers and stakeholders – The roles of other participating payers and stakeholders are discussed in Section E (Multi-stakeholder Commitment).

D. Linkage of Models to the State Health Care Innovation Plan – The Maine Innovation Model is directly linked to the Maine State Innovation Plan – both were developed simultane-

ously with the identical aim of bringing the specific components of system transformation now occurring across the state, under an aligning and supportive umbrella of goals, objectives, and strategies for success. The Innovation Model links directly to the National Prevention Strategy (June 2011), particularly to Strategy 6 – *Enhance coordination and integration of clinical, behavioral and complementary health strategies* – including: improving the use of patient-centered medical homes and community health teams, which are supported by the ACA; encouraging the adoption of certified electronic health record technology that meets meaningful use criteria; and improving monitoring capacity for quality and performance of recommended clinical preventive services.[24] The Innovation Model includes the Diabetes Prevention Program, which helps people with pre-diabetes eat healthier, increase physical activity, and learn about other health promoting behavior modifications. (This component of the Innovation Model that will be the responsibility of the Maine CDC). By promoting a care delivery model in which primary care and behavioral health are integrated, we can begin to better address depression, another focus of the National Prevention Strategy (and a clinical outcome indicator of the MHMC advanced primary care recognition program).

The Innovation Model also links directly to the National Strategy for Quality Improvement in Health Care, whose aims include: improving the overall quality of care by making healthcare more patient-centered, reliable, accessible and safe, and; reducing the cost of quality health care for individuals, families, employers and the government.

The Innovation Model also links to the several objectives of Healthy People 2020: improving access to high quality care; improving diabetes care; improving access to health information technology; and improving care for mental health and mental disorders (specifically ad-

dressed in Maine not only through the integration of primary care with behavioral health, but also in the specific Stage B MaineCare Health Homes to serve those with SPMI.

E. Multi-Stakeholder Commitment - For the purposes of developing the Innovation Model application to CMS, the State conducted a number of informational meetings with stakeholders and stakeholder groups to explain the funding opportunity, review the components of the Maine Innovation Model to be tested, their potential roles in the project, and the State's expectations for their participation. The level of support for the application was high – and we reached consensus on specific commitments for five major participating groups: (1) primary care providers; (2) behavioral health providers; (3) payers; (4) fully insured purchasers; and (5) self insured purchasers. Support and commitment was also received from a wide range of other participating groups and organizations. (**Appendix:** Letters of Support and Commitment).

Despite the short timeline for preparation of this application, we've been able to garner considerable enthusiasm and support – and during the 6 month planning period we will meet with providers and organizations to acquire additional commitment and support from organizations that are not represented in these letters. Most of the provider organizations with "multiple PCPs" sites also have individual practices in the Maine Multi-Payer Patient Centered Medical Home Pilot (Phase I and Phase II), and/or have practices that may be in the MaineCare Health Homes (Stage A) program. All of the individual PCMH Pilot sites are listed as project location sites in the online application. The behavioral health agencies are anticipated to be engaged in the Health Homes (Stage B), so we have also listed the healthcare organizations/ systems and behavioral health agencies themselves as project location sites. During the planning period we will reach out to and solicit support/ commitment from organizations that we were unable to in-

volve during the short timeframe of the application process. **Specific commitments** from the five key groups are as follow:

Primary Care Providers will: (1) Engage in the enhanced primary care model endorsed by the Innovation Model (the Patient Centered Medical Home or Health Home with integration of physical and behavioral health, and community care teams for high risk/ high cost patients); (2) Commit to a common set of measures, which will be publicly reported; (3) Commit to a common claims data source (Maine Health Data Organization all payer database), and a single source of analysis for public reporting and statewide variation; (4) Engage in alternative reimbursement models which tie payment to accountability for cost and quality outcomes, moving toward greater accountability over time; (5) Participate in the learning collaborative(s) on medical home practice transformation and ACOs; (6) Promote patient accountability, including integrating shared decision making (SDM) at the practice level, exploring of patient incentives and benefit design, and partnerships to promote improved population health; (7) Participate in a statewide, multi-payer evaluation of the Innovations Model.

Behavioral Health Providers will: (1) Support and engage in the enhanced primary care model endorsed by the Innovation Model, with the expectation that they will apply to become Health Homes to serve individuals with serious persistent mental illness (SPMI); (2) Implement HIT to promote care coordination and integration with physical health; (3) Participate in the Behavioral Health Cost Work Group (a subgroup of the ongoing Health Care Cost Work Group initiative of Maine Health Management Coalition); (4) Commit to reporting on a common set of Behavioral Health measures, which will be publicly reported. These measures will be developed in cooperation with Pathways to Excellence (MHMC); (5) Participate in the Behavioral Health learning collaborative to be developed as part of the Model's CQI programming.

Payers will: (1) Participate in project governance – i.e. in the Project Advisory Committee; (2) Offer value based benefit design products aligned with MHMC member priorities; (3) Offer alternative risk-based reimbursement models which may include shared savings, pay for performance and global/capitated payment as requested by their clients and provider partners; (4) Align reimbursement with common measures endorsed by MHMC members; and (4) Submit data to MHMC as requested by their plan sponsors and provider partners.

Fully Insured Purchasers will: (1) Participate in project governance – i.e. in the Project Advisory Committee; (2) Ask their carrier to offer value based benefit design products aligned with MHMC member priorities; (3) Ask their carrier to offer alternative risk-based reimbursement models which may include shared savings, pay for performance and global/capitated payment as requested by their clients and provider partners; (4) Promote employee education and engagement efforts to encourage appropriate utilization and use of performance information; (5) Promote alignment of purchasing efforts that support delivery system redesign and high value care through the MHMC; (6) Ask their carrier to align reimbursement with common measures endorsed by MHMC members.

Self-Insured Purchasers will: (1) Participate in project governance – i.e. in the Project Advisory Committee; (2) Offer VBID products aligned with MHMC member priorities; (3) Offer alternative risk-based reimbursement models which may include shared savings, pay for performance and global/capitated payment as requested by their clients and provider partners; (4) Promote employee education and engagement efforts to encourage appropriate utilization and use of performance information; (5) Promote alignment of purchasing efforts that support delivery system redesign and high value care through the Maine Health Management Coalition; (6) Align reimbursement with common measures endorsed by MHMC members

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