Maine – Model Testing, 1G12012000014

RESPONSES **to TWO Additional Questions from CMS/CMMI on Monday, February 11, 2013**

These responses are **in addition** to those previously returned to CMS/CMMI last week, and further illuminate those original responses. Wherever new information has been added to / blended into the previous responses, the insertion is **noted in RED**.

Question	Response
QUESTION ONE **February 11, 2013** **What is the** Maine Innovation Model strategy to move the preponderance of care in the state to value-based alternatives to fee for service (preponderance defined as approximately 80% saturation by the end of five years). How is the SIM going to coordinate across all the value-based purchasing initiatives?	Like CMS, our aim is to move Maine forward to provide care in accordance with the Triple Aim to a preponderance of the state's population. The percentages included in our original application reflected the then-current dissemination level of system transformation efforts statewide. These efforts are ongoing and expanding, and will drive/ accelerate further change. **[NEW PARAGRAPH] Use of SIM Funds -** Funds from the SIM Grant will be used to support many initiatives that are viewed as critical to moving forward to engaging all Maine providers and consumers in VALUE-BASED health care purchasing and delivery. While it is recognized that the partners in the Maine SIM application represent a large number of health care stakeholders in the State, they do not represent all. As such, specific funding in the grant is being requested to support convening and alignment initiatives that further assure the increased involvement by all providers and patients in crucial health reform efforts. Some of these initiatives are described below: • **Patient Centered Medical Homes and Health Homes** - With its alignment of leadership, incentives, and quality improvement support, Maine has seen a marked expansion in the medical home effort to redesign both practice and payment for enhanced primary care which we recognize as foundational to wider payment and delivery system reform efforts. The MaineCare Health Homes initiative has expanded from the initially anticipated 100 practices at the time of the SIM application to 155 practices. The Health Homes initiative is aligned closely with the multi-payer Maine Patient Centered Medical Home (PCMH) Pilot, and Maine was selected as one of eight states to participate in the current CMS Maine Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration. • The multi-payer Maine PCMH Pilot entered Phase II this month (Jan 2013), adding an additional 50 prac-

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	tices, for a total of 75 practices, with nearly all (73) participating in the Health Homes initiative. An additional 80 practices that were not selected for the PCMH Pilot are participating in MaineCare's Health Homes Initiative. Together these efforts comprise the leading edge of primary care practice transformation in the state, which continues to grow at a rapid rate. These efforts are being further supported and accelerated by commercial health plans that have indicated an interest in changing payment models to support enhance primary care systems, such as Anthem Wellpoint's "Patient Centered Primary Care" (PC2) initiative. • **Pioneer ACO** - Medicare Pioneer ACO status was awarded to Eastern Maine Healthcare System (EMHS). The ACO will initially serve approximately 8,000 people in northern Maine (EMHS is also a Beacon Community). In July, DHHS announced additional ACO model awards in which three Maine health care organizations will participate to improve the health and lower the costs of Medicare patients. The three organizations participating in the Medicare Shared Savings Program (MSSP) are: MaineHealth Accountable Care Organization in southern, western, and coastal Maine, with 1,595 physicians; Central Maine ACO in Lewiston, with 566 physicians; and Maine Community Accountable Care Organization LLC in Augusta, a collaboration of nine federally qualified health centers (FQHCs) with a total of 125 physicians. • **[NEW PARAGRAPH] Accountable Communities** - All current Medicare ACOs (Pioneer and 3 MSSPs) plus MaineGeneral Health System have indicated a strong interest in participating in MaineCare's planned Accountable Communities shared savings ACO. In addition, we estimate that we could expect 3 additional MaineCare Accountable Communities made up of a hospital, a behavioral health organization, a PCP practice, a specialist, etc. Accountable Communities that are limited to 50% shared savings with no downside risk for the first three years must have a minimum of 1000 attributed patients each. Accountable Communities limited to 60% shared savings with a gradual transition toward increased downside risk must have a minimum of 2000 attributed patients each. We anticipate that Accountable Communities will begin in the Fall of 2013, year 1 of the SIM grant. We plan to re-open the application on an annual basis to welcome other interested Accountable Communities, with a goal of adding another 3-5 smaller Accountable Communities per year for years 2 and 3. • **Inclusion of Small Providers in ACOs** - Several small practices and provider groups are being included in ACO initiatives such as MaineCare Accountable Communities and others, and more are expected to come on board. Several provider groups have expressed their intent to participate since the SIM application

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	was submitted. • **Move Towards New Payment Models** - Self-insured purchasers and large employers are collectively moving towards risk based contracts and entering into commercial ACO arrangements with various health systems. Maine Health Management Coalition (MHMC) employer members have collectively committed to move to global payment arrangements with PMPM targets as adequate performance measures become available and provider and plan capability improves. Several commercial ACO contracts have been put in place since the original application and discussions continue with several others. • **[NEW PARAGRAPH] Public Reporting** - Statewide public reporting by Maine Health Management Coalition (MHMC) has driven significant improvements in quality and safety. We have documented steady increases over time against all of our publicly reported metrics, and in 2010 AHRQ identified Maine as having the largest gains in quality of any state. We also know anecdotally and through research by the University of Southern Maine that participation in the MHMC public reporting program changes behavior in participating practices and leads to higher quality care. This change accelerates when employers and plan sponsors use the publicly reported information in their benefit design as many large purchasers do. In 2013 MHMC Foundation will publicly report on "Advanced Primary Care" recognition for all practices in the state. The 4 domains of this recognition will include (1) achievement of level 2 or 3 NCQA PCMH recognition, or demonstration of Meaningful Use; (2) demonstration of excellent clinical outcomes, as measured by Bridges to Excellence or NCQA Physician Recognition programs; (3) Patient Experience ratings above national average using the CG-CAHPS national database; and (4) cost of care measured by Health Partners Total Cost of Care and Resource Use measure set. This combination of metrics will reflect achievement of the medical home capabilities and outcomes, and enable purchaser and consumer identification of medical homes. Several large public employers have already indicated they will design their networks to include only medical home practices creating the strong business case to transform. • [NEW PARAGRAPH] **Practice Reports** - In 2010 Maine Quality Counts, the Maine Quality Forum and the Maine Health Management Coalition developed and disseminated reports on comparative practice performance across the state and held regional forums with providers to understand and use the data. High levels of participation in the regional meetings and ongoing dialogue with the practices indicate strong

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	demand for this type of information that is otherwise unavailable. Through the Health Homes initiative, MHMC has developed more robust practice reports for practices in the PCMH Pilot. With the SIM grant we plan to enhance these practice reports with clinical data from the Health Insurance Exchange (HIN) and disseminate to all practices statewide. We would also offer technical assistance and support for data use and quality improvement. Because of the demand for this data by practices and because several of the measures in the practice report will also be publicly reported and ultimately used by purchasers for network design we anticipate strong statewide engagement.
	
	• **[NEW PARAGRAPH] Assuring that Clinical Coordination is Facilitated by Data –** Maine has one of the most robust query-based centralized health information exchanges in the nation (HealthInfoNet). Today, over 90% of all hospital data and 55% of all ambulatory data flows into the exchange. All Maine hospitals will be participating in the exchange by the end of 2013, and 80% of all Maine ambulatory providers will be participating by the end of 2015. This resource is a critical addition to the SIM activities as it allows us as a state to:
	  ◦ Make clinical notifications available in real-time when patients enter the health care system;
	  ◦ Advance the electronic capture of behavioral health and other "high-risk" clinical data
	  ◦ Give patients access to their statewide clinical information so that they can be better informed when making medical decisions and hold their providers accountable for the care that is delivered
	
	• **Market Forces** - The market is accelerating the move of greater numbers of patients into risk-based arrangements, including ACOs. Simultaneously large employers are moving to develop networks around Patient Centered Medical Homes, incenting the move to this model of care both within ACOs and among independent practices. Most employer members and health plans within MHMC are offering increased payments for medical homes in alignment with public payers and in direct arrangements. Anthem has also announced a statewide initiative to pay significantly enhanced fees to primary care to support practice transformation and will be working with the MHMC to align measurement and incentives. Recently the City of Portland, working with the Maine Health Management Coalition, redesigned their benefit package around a PCMH network. This benefit model is being shared with other employer members to continue the support for this model and drive the market in this direction. The University of Maine System and others are implementing similar benefit design changes to incent employees to move towards medical homes and ACOs.

Question	Response
	[NEW PARAGRAPH] As previously noted, the SIM grant will provide necessary funding to facilitate the further coordination of all these efforts. As in other regions, there is competition and this issue needs to be addressed. However, as stated above and in other response questions, by bringing the key partners together in this application, we feel as if we can make significant strides in overcoming the competitive hurdles. This requires difficult discussions and compromise. But Maine wouldn't have had so much success with early ACO activities, Patient Centered Medical Home, Employer and Payer-Driven Initiatives, and the Health Information Exchange, without the recognition in the value of these initiatives and the willingness to put aside competitive posturing for achieving the goal of an effective and efficient health care system. **Collectively these changes are very likely to impact 80% of patients in the state within 4-5 years. See below for our estimates on Provider and Patient involvement in risk-based contracting initiatives.** **[NEW PARAGRAPH]** The estimates below are based on populations of commercially insured, Medicare, and Medicaid beneficiaries. For Medicare beneficiaries, those attributed to practices currently participating in CMS Medicare Shared Savings Program and the CMS Pioneer ACO Model have been removed. Initial numbers of patients and physicians are based on the current commitment of 155 primary care practices to Medicaid Health Homes (HH) since Accountable Communities are starting Fall 2013. There is overlap of the HH practices with the multi-payer PCMH and MAPCP practices, and these are not double counted. **[NEW PARAGRAPH]** We expect growth in ACOs to drive much of the continuing move from fee for service, including growth in commercial ACOs which currently represent 10-15% of the commercial market, and growth in MaineCare Accountable Communities. As noted above, all current CMS ACOs have indicated interest in participating in MaineCare's Accountable Communities. MaineCare projects adding 3-5 Accountable Communities per year. We forecast the number of commercial ACOs to triple in the next few years, with continued growth beyond the next few years. Currently there are over 70,000 lives in commercial ACO arrangements. **[NEW PARAGRAPH]** Medical Home practices are core participants in the dimensions of the proposed project. As outlined above, we expect the number of participating practices in the proposed project to grow, including possible participation by some practices currently participating in the other CMS programs. When counting patients across payers for practices and physicians, we assume when the practice transitions to a PCMH payment model from pure fee for service, the practice will do this across payers. Alternative payment arrangements other than strict fee for service, including per member per month payments to PCHMs and bundled payments will account

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<tr><th>Question</th><th>Response</th></tr>
<tr><td></td><td>for some alternative payments models outside of formal ACOs.

[NEW CHART]

<table>
<tr><th colspan="6">Combination of Medical Home Models and ACOs</th></tr>
<tr><th></th><th>Commercial</th><th>Medicare*</th><th>Medicaid</th><th>PCP Physns**</th><th>Percent</th></tr>
<tr><td>Statewide</td><td>630,000</td><td>194,000</td><td>354,000</td><td>1,600</td><td>Alt Payment</td></tr>
<tr><td>Participation</td><td colspan="5">----------Alternative Payment Models----------</td></tr>
<tr><td>Year 1</td><td>244,125</td><td>75,175</td><td>137,175</td><td>620</td><td>39%</td></tr>
<tr><td>Year 2</td><td>309,094</td><td>95,181</td><td>173,681</td><td>785</td><td>49%</td></tr>
<tr><td>Year 3</td><td>366,581</td><td>112,884</td><td>205,984</td><td>950</td><td>58%</td></tr>
<tr><td>Year 4</td><td>417,080</td><td>128,434</td><td>234,359</td><td>1115</td><td>66%</td></tr>
<tr><td>Year 5</td><td>478,800</td><td>147,440</td><td>269,040</td><td>1280</td><td>76%</td></tr>
<tr><td>Total Bene Yrs</td><td>1,815,680</td><td>559,114</td><td>1,020,239</td><td></td><td></td></tr>
<tr><td colspan="6">* Medicare Beneficiaries currently under MSSP or Pioneer programs are removed.</td></tr>
<tr><td colspan="6">** These may be part of systems in ACOs or soley as Medical or Health Homes.</td></tr>
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[NEW PARAGRAPH] As we launch the Maine SIM initiative, the State is committed to working with the entire healthcare delivery system in Maine. While we did not have sufficient time during the planning process to work through all necessary details to secure written letters of support from two of the major health systems, Maine-Health and Eastern Maine Health System, both systems have indicated to the State their commitment to working on strategies that include value-based payment models, financial risk, and a patient-centered approach to care. Both systems are already involved in a number of the initiatives outlined in our proposal (e.g. PCMH/ Health Homes, HIT, ACO efforts) and have stated their intention to continue these transformation activities over the coming years. We fully intend to continue to work with them with the goal of full participation in SIM activities.</td></tr>
<tr><td>QUESTION TWO</td><td>System transformation work in Maine pre-dates the SIM grant and will continue after the SIM grant concludes.</td></tr>
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Question	Response
February 11, 2013 **How will the Maine Innovation Model activities be sustained after the SIM funding period has ended?**	**[NEW PARAGRAPH]** The role of the SIM grant is to seed the coordination and collaboration activities necessary to sustain these changes after the three years of the grant are concluded. As was discussed in our response above, we have data to support our attestation that with the support of the SIM and the coordination with other payment reform initiatives, we will move more than 80% of Maine's providers and patients to a risk-based / value-based purchasing and delivery model. The sustainability of that will be in creating the marketplace to support it. By taking on the model proposed, Maine has chosen to affect all stakeholders – provider, insurers, employers, and patients. **[NEW PARAGRAPH]** The model proposed builds systems where none exist today due to market forces (information technology and data-driven decision-making) but does so in a market-based business approach that has already demonstrated success. The Maine Health Management Coalition (MHMC) has been working for 20 years to achieve the objectives of improved care at lower cost and will continue that work. By working to drive improvements in the three domains of the Triple Aim – patient experience, clinical quality, and changes in resource use and costs, we are confident that the gains achieved will provide the evidence needed by private and public payers to sustain these changes with providers across the state. This grant will specifically contribute to sustainability by helping to expand the work of these initial efforts, and spread lessons learned to widely to other practices and health systems around the state. **[NEW PARAGRAPH]** MHMC's and HealthInfoNet's programs are governed by multi-stakeholder coalitions and are 'disruptive innovations' because they bring transparency to the health care market and create a level playing field of information. The resources provided by SIM will enable the state to partner with private non-profits to develop information critical to measuring care, improving care and allowing transparent understanding of quality and utilization to inform consumer choices and improvement efforts. **[NEW PARAGRAPH]** For providers across the State, once value-based and risk contracts reach a critical mass of 50 percent or more, there will be a disincentive to bear the cost of maintaining multiple payment systems. Reaching this tipping point during the SIM grant period will further reinforce the sustainability of the model beyond the duration of the grant. **[NEW PARAGRAPH]** On the State government side SIM will provide important staffing and infrastructure improvements - which will ultimately allow the State to enter into 100% risk-based contracts for its Medicaid and other HHS programs. This will ultimately bring down the Medicaid spend growth curve and allow the State to

Question	Response
	maintain this necessary safety-net service without further burdening the tax payer. While the SIM Grant will provide important funding for some needed one-time infrastructure investments, accelerate current system transformation work, and greatly facilitate the transition from current to future state of health care delivery and payment, we are confident that we will be able to sustain this work after the grant period ends because the primary drivers are embedded in the mission and ongoing work of the partnering organizations.