Maine – Model Testing, 1G12012000014
RESPONSES v2

PLEASE NOTE: **Responses to the two Additional HIT Questions sent to us on Feb 1, begin on page 4**

Program Scope and Strategy

Question	Response
(1) CMS expects Model Testing states to articulate a strategy to move the preponderance of care in their state to value-based alternatives to fee for service. As an aspirational goal, states should aim to move 80% of their total population to alternatives to fee for service within 5 years. Your proposal indicates that you will include 50% of the MaineCare population, 50% of the Medicare population and 40% of the Commercial payers (688K total). Can you provide additional detail regarding where those percentages come from as well as how you plan to reach a larger segment of your population?	Like CMS, our aim is to move Maine forward to provide 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: • **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. The MaineCare Health Homes initiative has expanded from the initially anticipated 100 to 155 practices. The Health Homes initiative is aligned closely with on the multi-payer Maine Patient Centered Medical Home (PCMH) Pilot, which was selected as one of eight states to participate in the current CMS Maine Multi-Payer Advanced Primary Care Practice (MAPCP) Demonstration. The PCMH Pilot entered Phase II this month (Jan 2013), adding an additional 50 practices, 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. (NOTE: See the response to question 5 for additional information about the Health Homes). • **Pioneer ACO** - 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:

Question	Response
	MaineHealth Accountable Care Organization in Portland, with 1,595 physicians; Central Maine ACO in Lewiston, which includes 566 physicians; and Maine Community Accountable Care Organization LLC in Augusta, a collaboration of nine federally qualified health center with 125 physicians. • **Inclusion of Small Providers in ACOs** - Small providers are being included in ACO initiatives, and more are expected to come on board. Several additional provider groups have expressed their intent to participate since the SIM application 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. 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 payors 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. **Collectively these changes are very likely to impact 80% of patients in the state within 4-5 years.**
(2)	

Question	Response
Please provide a one-page operational/phase in schedule for your various populations and programs.	An operational phase-in schedule is **attached** to this document. During our information call on January 30, CMS/CMMI also requested an organizational diagram of the project, showing who is overseeing, how contractors are integrated, and so forth. That diagram is also **attached**.
(3) Please describe how your program will interact with other CMMI initiatives and other federally-funded health IT initiatives operating in Maine and who will be responsible for coordinating with those other initiatives.	The SIM project team is deeply involved in many CMS and Federally Funded Programs across the State, including but not limited to the: Pioneer ACO at Eastern Maine Healthcare System; Bangor Beacon Community; and the CMS Maine Multi-Payer Advanced Primary Care Practice Demonstration. HealthInfoNet is the Statewide Health Information Exchange (HIE) (partnering with the State on Maine's HIE Cooperative Agreement Program) and Regional Extension Center. In addition as the HIE, HealthInfoNet's infrastructure is critical to the Bangor Beacon Program, as it supports electronic health record (EHR) interoperability statewide, care management notifications for care managers in the Beacon Program and elsewhere, provides population health monitoring and surveillance tools, and provides aggregate clinical data to support the evaluation efforts of the Beacon Project. HealthInfoNet is partnering with the Center for Integrated Behavioral Health and their Substance Abuse and Mental Health Administration (SAMHSA) and Health Resources and Services Administration (HRSA) cooperative agreement. Under this contractual partnership, HealthInfoNet is one of five organizations funded nation-wide to implement health information exchange functions for the behavioral health community. This project supported changes to the HIE architecture to allow for mental health information to be exchanged while supporting a positive consent ("opt-in") by patients, for providers and other clinical staff using the HIE, to access their sensitive (Mental Health and HIV) in the HIE. To date 25 behavioral health organizations across the state have been provide access to HIE tools. In addition to these important grant and contract programs, HealthInfoNet is serving as the clinical data provider for the Eastern Maine Healthcare Systems Pioneer ACO as well as the Maine Health Shared Savings ACO efforts. This activity involves a partnership between Eastern Maine, Maine Health, HealthInfoNet and the Northern New England ACO Collaborative (NNEAC). As the statewide HIE, HealthInfoNet collects discrete clinical data on all patients agnostic of who pays for their care or where that care is delivered. This function allows HealthInfoNet to provide comprehensive clinical data on ACO patients attributed to both these integrated delivery networks (from the ACO facilities as well as from hospitals and pro-

Question	Response
	viders that are not members of the ACO but are seeing attributed patients) to NNEAC who then runs risk analysis software and provides identification of both financial and clinical high-risk patients and management tools for care managers and providers in the ACOs. NNEAC is working with HealthInfoNet to provide these services to other ACOs emerging across the State.
ADDITIONAL HIT QUESTION (1) From CMS on Feb 1, 2013 How will you coordinate with other statewide HIT initiatives to accelerate adoption of health information technology among providers? • Please specifically address how you will reach providers in small practices and behavioral health providers. • Please describe your cost allocation plan or methodology for all of the planned IT system solutions/builds funded in part by CMS or any other federal agency.	As a core team member of the SIM Application for Maine, HealthInfoNet will be responsible for coordination of HIT efforts. As stated previously, HealthInfoNet is the statewide HIE, Regional Extension Center, Beacon Partner, and is coordinating behavioral health HIT efforts around the state. Each of these existing programs have a number of sub-project that target the acceleration of HIT adoption and Meaningful Use. The efforts of the Regional Extension Center are focused specifically on targeting providers in small practices both in Maine's urban and rural areas. Over 1,000 physician providers and 22 Critical Access and Rural Hospitals are currently enrolled in the program and. Over 900 physicians engaged through the REC program have implemented an ONC Certified EHR and over 375 of these physicians have met stage 1 Meaningful Use. The Regional Extension Center staff will be essential team members of HIT initiative for SIM. The cost for the REC team will be born by the Regional Extension Center cooperative agreement between ONC and HealthInfoNet. HealthInfoNet also has been coordinating behavioral health HIT projects across the state for the past year. This project (as described above) incorporates over 120 behavioral health and primary care statewide. This project was funded in 2012 through a contract between HealthInfoNet and the National Center for Community Behavioral Health. That project is now over and there is no duplication or overlap of funds between that project and what is being proposed for SIM. SIM resources are requested for specific projects that do not overlap with other federally funded activities including: • Providing real-time notifications from the HIE to MaineCare and health system care managers when MaineCare members are admitted or discharged from inpatient and emergency room settings; • Providing behavioral health EHR incentives (for providers and organizations that do not otherwise qualify for Meaningful Use)

Question	Response
	• Providing HIE technical support in interfacing behavioral health EHRs to the HIE • Providing a clinical dashboard for MaineCare from the HIE enabling MaineCare to clinically monitor MaineCare patient health care utilization and outcomes from the population-level down to the patient level. • Providing all Maine patients (starting with MaineCare)with access to their statewide EHR record, aggregated by the HIE and made available through certified EHR portals provided by the health systems and provider organizations across the state. Funds for HIT projects will be allocated to HealthInfoNet and the Maine Health Management Coalition based on negotiated contracts for services with the State of Maine. Specific deliverables will be identified and funds will be paid on a deliverable basis. All contractors will be required to adhere to Federal Regulations on allowable costs, non-duplication of funds across programs, capital asset allocation, regulations on use of "open-source" and non-proprietary software, and Federal audit and reporting requirements.
ADDITIONAL HIT QUESTION (2) From CMS on Feb 1, 2013 • Please describe any impact this project will have on the MMIS, and how the MMIS will be used to support the project, including whether there will be a need to add any new system functionality or enhancements to existing system functionality to support the effort. Please describe all MMIS claims, recipient, provider or other MMIS data and the specific MMIS business processes the state	The Office of MaineCare Services (OMS) is currently utilizing its MMIS to track and manage the provider and member data necessary to support its PCCM implementation and to pay out Management Fees. Additionally, the MMIS system is currently being enhanced to support the implementation of Health Homes. These enhancements will provide a framework for any additional system enhancements necessary to support Accountable Communities. OMS expects to capture and manage the provider, member, and claims data necessary to support Accountable Communities within its MMIS application. In order to accomplish this, the following steps are required: • A detailed analysis of the provider, member, and claims data requirements needed by external partners to perform actuarial and financial analysis to support this initiative. • Once the data requirements have been determined, modifications to the MMIS may be necessary to properly associate providers, practice sites, and/or service locations to the appropriate Accountable Community. • Modifications to the MMIS and/or the eligibility system may also be required to correctly associate MaineCare members to the ACO that they are assigned to. • Provider and/or Member portal applications may need to be enhanced to facilitate the capture and management of the specific data elements required to administer Accountable Communities.

Question	Response
will utilize in support of this effort. • What are the estimated planning and implementation timelines for the needed changes to MMIS, if any, and how will these timelines dovetail with the SIM project?	• The MMIS financial application and interface may need to be enhanced to support new payment or reimbursement requirements associated with Accountable Communities. • Additional data extracts, reports, and/or publication files will need to be developed or enhanced within the MMIS to provide external stakeholders with the data necessary to assess outcomes, perform actuarial analysis, assess quality, and track costs and benefits. The required changes to the MMIS have not yet been fully documented and assessed. As such, specific planning and implementation timelines have not been developed.
(4) Please describe how your program will interact with Maine's plan to align care for beneficiaries dually eligible for Medicare and Medicaid.	We initially submitted a letter of intent to the CMS Medicare - Medicaid Coordination Office stating our intent to pursue the managed Fee For Service financial alignment model to integrate care for Medicare-Medicaid enrollees through the inclusion of "Dual Eligibles" in its planned Accountable Communities and Health Homes models. Post-submission, the Coordination Office made the decision that duals engaged in the Pioneer or Medicare Shared Savings Program ACOs would need to be excluded from the initiative. Due to the potential for significant overlap between duals in MaineCare's planned Accountable Communities Initiative and the Pioneer and MSSP ACOs, the Department decided that the ROI for the intensive application and stakeholder engagement process would be lacking. However, we continue to target the dual population through our Accountable Communities and Health Homes Initiative to promote care coordination and management for this high needs population. In addition to these MaineCare efforts, duals are also served by Medicare through the CMS Multi-payer Advanced Primary Care Practice demonstration in Maine's multi-payer PCMH Pilot . MaineCare does not provide Health Homes payments to duals served by practices under the MAPCP demonstration in order to avoid duplication of payment.
(5) Clarify the relationship between the PCMH and the ACOs. Do you envision that the entire state will be composed of several ACOs, each	We do envision that the state will be composed of multiple ACOs, each made up of several Patient Centered Medical Homes (PCMHs)/ Health Homes. As will be the case in all rural states, there will be practices that will not be part of an ACO, and we are trying to bring them into the Health Homes initiative.

Question	Response
made up of several PCMHs? What if a PCMH is not part of an ACO? Who provides the care management fee for the PCMH? What level of payment are you planning to offer?	PCMHs/ Health Homes build the foundation for ACOs in Maine. Multi-payer investment in support for these medical home models ensure the provision of evidence-based, preventive care, patient engagement, care coordination and management, all activities that will aid ACOs to achieve their goals of improved health and improved care for lower costs. MaineCare's participation in the state's Multi-Payer Patient Centered Medical Home Pilot through the Health Homes Initiative (implemented January 2013) enables a statewide reach of these efforts through the enhanced 90/10 match under Section 2703 of the Affordable Care Act. In addition to almost 75 practices participating in the multi-payer PCMH Pilot, MaineCare is funding an additional 80 practices through the Health Homes Initative alone that do not currently have multi-payer support. MaineCare is providing $12 per member per month (PMPM) for MaineCare members that meet the Health Home chronic conditions eligibility criteria. In addition, Community Care Teams that partner with the Health Home practices to serve the 5% highest need patients in those practices receive $129.50 PMPM to provide intensive care management services to those individuals. Maine is developing a second stage of its Health Homes Initiative to serve individuals with Serious Mental Illness. In this second stage, medical home practices will partner with organizations with behavioral health expertise. PCMHs and Health Homes are not required to be part of ACOs. There are many smaller and/or independent practices and behavioral health organizations that may not have the capacity to engage in an ACO or risk0bearing arrangement, but that can contribute greatly to delivery system reform, improved patient outcomes and decreased avoidable costs. It is one of our aims under SIM to foster and encourage increased participation by commercial payers to support those Health Homes that are NOT part of the multi-payer PCMH. In fact, at least one commercial payer (Anthem) is currently involved in doing this, in recognition that multi-payer involvement is the emerging alignment model in the state. The first step in changing the payment model is providing care management. If Health Homes are engaged in ACOs, as we expect many to be, then we will expect payment to be linked to quality and cost measures Additionally, most plan sponsors and self insured employers in the Coalition have committed to at least $3PMPM for patient centered medical homes whether practices are owned by health systems or independent. Some large employers have entered into contracts paying up to $12PMPM for medical home practices. Several are also encouraging and/or directing their health plans to direct additional resources

Question	Response
	to practice and community based care management rather than plan based telephonic care management. Currently some plans receive over $5PMPM for telephonic care management services that are resources employers and providers are encouraging plans to more effectively integrated into the practices. In some cases employers are seeking direct and/or preferred arrangements with primary care based systems as alternatives to hospital based ACOs and are seeing lower costs. These arrangements, which encourage primary care practices to direct care to high quality and low cost tertiary and specialty care, are not unlike the Alternative Quality Contract model in Massachusetts and are of interest to several employers committed to a primary care based system. It remains too early to determine which model will prevail in Maine or if both will coexist, but in either model the PCMH is foundational to improving population health and reducing costs. The Pathways to Excellence program (of Maine Health Management Coalition) will enable purchasers and patients to select medical home practices within health systems or independent through its public reporting of 'Advanced Primary Care'.
(6) While we understand that you are still in the planning process for your initiative, can you provide us with a preliminary perspective on the following issues related to the design of your ACO model? • What formula will you use for shared savings? Will providers take on one-sided or two-sided (downside risk) risk? Will your model include a transition to population based payments? • How will you support providers as they transition to accountable care arrangements? • How will you ensure that ACOs	**MaineCare Accountable Communities Initiative**: - Providers able to achieve savings for an attributed population in comparison to a baseline projected target per member per month (PMPM) may receive shared savings payments, the amount of which is dependent on their performance on specified quality benchmarks. To date, MaineCare plans to offer two models: one with no downside risk and a maximum of 50% shared savings in order to attract, smaller, more diverse organizations; and a second with downside risk transitioned in over three years and a maximum of 60% shared savings. Maine's Governor and Department of Health & Human Services are very interested in pursuing population-based payments, particularly through an 1115 waiver outside of the 1915(b) managed care regulations in order to maintain a provider-based approach to localized care management. **Commercial Market -**The large employer members of the Maine Health Management Coalition (MHMC) have publicly acknowledged their commitment to moving to global contracts within 5 years and have shared this directly with the majority of health systems in the state. Several have announced plans to tier on a system or ACO basis, incenting employees to use medical homes and ACOs with strong quality, patient experience and cost scores. Downside risk is expected and some systems have moved past shared savings to arrangements with PMPM targets. Several have also entered into direct arrangements for bundled services in orthopedics as some provider groups have begun to offer bundled pricing with a warran-

Question	Response
enter into other payment arrangements such that they share risk for quality and financial performance for a majority of their patients by a certain time?	ty. Health plans have been unable to operationalize payment arrangements beyond FFS but have committed to developing that capacity within 3 years. **Transitioning to ACO Model -** Along with the transition to population and value-based payments, we will provide support for the transition to ACO models through expansion of our statewide learning community, beginning with a focus on supporting primary care transformation as the foundation for ACO efforts. We will build on our previous experience to offer statewide learning collaboratives to support adoption of a set of Patient Centered Medical Home (PCMH) "Core Expectations", supporting practice transformation to a patient-centered, high-value model of care. These learning collaboratives will provide structured learning opportunities and data feedback to identify and spread best practices among primary care practices, with a particular focus on building relationships, improving efficiencies and improving experience of care. As part of this effort, PCMH practices will also receive support to link with their hospital and other community partners to reduce avoidable Emergency Department utilization, hospitalizations, and readmissions.

State Levers

Question	Response
(7) Please outline your strategy for using your state's executive, regulatory and legislative authorities to align commercial payers and providers for health delivery system transformation.	Discussions are underway with the Commissioner of DHHS, who sits on the Governor's cabinet and has acted in the capacity of the Governor's healthcare advisor on recommendations for healthcare reform legislation to achieve meaningful change in healthcare costs. Maine's growth in healthcare expenditures from 1991 – 2009 was 7.4% compared to 6.5% for the U.S. average. Health care expenditures per capita for 2009 (most recent data available form Kaiser) were $8,521 compared to $6,815 a 20% difference.) Ideas being discussed are: • Establish a statewide health care cost growth goal for the health care industry in Maine, pegged at an amount no greater than the growth in the state's overall economy. • Set a Healthcare Cost Reduction Goal for MaineCare in SFY14 and 15. Equivalent to Savings Identified by the MaineCare Redesign Taskforce for Care Management. • Create a Global Medicaid Spending Cap and Provide the Commissioner of DHHS with the Power to

Question	Response
	Enforce That Cap. • All new expenditures must be analyzed to assess their impact on both cost and quality. The global spending cap means savings for state taxpayers. The cap represents the core of the state's budget neutrality argument for a future 1115 Medicaid waiver to be. • Enhance Transparency and Accountability in the Health Care Marketplace • Establish a new "Cost and Market Impact Review" to examine changes in the health care industry and the impact of these changes on cost, quality, and market competitiveness. The findings of this review inform CON process. • Develop a process to track price variation among different health care providers over time and establishes a Special Commission to determine and quantify the acceptable and unacceptable factors contributing to price variation among providers. • Leverage Maine's Health Information System • Require all licensed hospitals and medical providers that are eligible and receive CMS meaningful use incentive payments to participate in the state designated health information exchange. • Require the state designated health information exchange make 100% of its clinical data to available to qualified entities for purposes of healthcare management i.e. to support accountable care organizations and quality improvement, and public health. • Require the Maine Health Data Organization (MHDO) to develop public and performance reporting of providers using e-measures as they become available. • Use the state certificate of need (CON) process as a mechanism to assure linkage to healthcare cost reduction targets **Specific to Pricing** - There is also the potential development of a Governor's bill that would address concerns related to pricing of healthcare services that could be modeled on the Massachusetts law. Mechanisms at the Commissioner's disposal include CON approval linked to costs of care trend. MaineCare is currently working with CMS to develop a State Plan Amendment under the Integrated Care Model 9ICM) guidance released in July 2012 to develop its Accountable Communities Initiative, a shared savings Medicaid ACO model. Over the course of this grant, Maine's Governor and Department of Health & Human Services are very interested in pursuing population-based payments, particularly through an 1115 waiver outside of the 1915(b) managed care regulations in order to maintain a provider-based approach to localized care management.

Question	Response
	Specific to Health Homes - Maine is also pursuing a second Health Homes State Plan Amendment and rulemaking to institute "Stage B" Health Home model to serve adults with Serious Mental Illness and children with Serious Emotional Disturbance. **Specific to Health Information Technology** - Since its inception, HealthInfoNet and its multi-stakeholder public/private stakeholders have carefully assessed the federal and state laws that would facilitate and impede clinical health information sharing. To address these legal issues, HealthInfoNet has worked closely with its Consumer Advisory Committee (including consumers, consumer advocacy organizations such as the Maine Civil Liberties Union, literacy specialist, and government) to implement HIE policies at the organizational level that would permit safe and secure sharing of essential information. These policies include a formal consent policy allowing consumers to opt-out of participating in the exchange. The consent forms are available online and are provided to consumers by the participating provider organizations. Consumers can send the signed forms to HealthInfoNet electronically, or by mail or fax. In addition HealthInfoNet maintains a toll-free number for consumers to call with questions. Once HealthInfoNet receives the signed opt-out forms, the consumer's clinical information is deleted from the data repository. Only consumer demographic information is maintained to assure that HealthInfoNet does not collect and store any future clinical information on consumers that have opted out. Partnering with the HealthInfoNet, the State Government and other health stakeholders around the state collaborated to further strengthen HealthInfoNet's commitment and responsibilities to educate consumers on their rights and options for participation in the exchange and to assure proper security and privacy protections are in place, with the enactment in June, 2011, of LD1337, "An Act to Ensure Patient Privacy and Control with Regard to Health Information Exchange". This statute requires healthcare practitioners and facilities participating in the HIE to provide patients with written information about the HIE and to give the patient an opportunity to decline to participate, i.e. to "opt-out" of the HIE. The law also codifies HealthInfoNet's commitment to remove clinical data from the database for those who have opted out, and puts into place a formal requirement for the State Designated Health Information Exchange to conduct annual security and policy audits. Also in June of 2011, Maine's Governor signed into law LD 1331, "An Act to Increase Health Care Quality through the promotion of Health Information Exchange and the Protection of Patient Privacy". LD1331 allows the sharing of certain HIV and mental health related information through the HIE. Maine State law

Question	Response
	previously prohibited the inclusion of mental health and HIV diagnoses and HIV lab tests in the HIE. HealthInfoNet may now include this information in an individual's record managed by the HIE and make it available to clinicians accessing the HIE if that patient chooses to make this particular set of information available ("opt-in"). This information will also be available in the event of an emergency when a clinician feels access to this information would avert a serious threat to the health and safety of the individual or others. The bill prohibits a provider or health insurer from refusing to provide medical assistance or insurance coverage based on the individual's decision to participate or not participate with the HIE. The bill also prohibits a recovery for professional negligence on the basis of non-participation in the HIE and restricts admission of evidence on the non-participation of a health care practitioner, a health care facility or a patient. Mental Health and HIV related information will now be included in a patient's HealthInfoNet record, but shielded from view until the patient consents to have it made available to their providers. HealthInfoNet provides a "break the glass" mechanism for providers to access shielded information when the patient is in an emergency situation. For general medical information, state law requires HealthInfoNet to continue to follow an opt-out consent policy. Substance abuse information continues to be a challenge for the HIE. HealthInfoNet is continuing its partnership with SAMHSA and CMS to develop a strategy whereby the "opt-in" for sensitive data can include substance abuse information. These two laws demonstrate the commitment by Maine's health care community to advancing – appropriately – health system changes in a way that looks at all stakeholder interests, using legislative and regulatory levers, while continuing to put the patient/consumer at the center of the discussion.

Stakeholder Engagement

Question	Response
(8) The letters of support you provided from several commercial payers do not indicate explicit support for this process nor a specific commitment	The Maine Health Management Coalition, the project's primary implementation partner, represents over 40% of the commercial market. Members pay significant dues, many well over $100k per year, to be at the table to transform the healthcare system. The organization has over 30 data members - employers and providers who have signed legal agreements with the MHMC Foundation and directed their carriers

Question	Response
to align quality measures and payment methods. Can you provide any additional evidence of commitment from Maine's commercial payers? If not, what is your strategy to secure these commitments?	to send MHMC identified data on their employees to enable performance measurement and public reporting and to facilitate understanding of cost drivers and serve as the basis for risk based arrangements between employers and providers. Their active membership in the coalition is a demonstration of their commitment to participate in care transformation through the work of the MHMC in performance measurement and public reporting, payment reform, value based purchasing, consumer engagement. Commercial payers are challenged to adapt to local priorities, but this is true of all national health plans. Though they participate as members in the MHMC, measurement and payment alignment is not always possible. An exception has been payment to practices based on achievement on the GetBetterMaine site and tiering hospitals using the MHMC's performance metrics. The most successful strategy for alignment to date has been direction from employer clients to participate, which Maine employers have consistently done. This has been effective in obtaining direct data feeds despite resistance from health plans at the highest levels. National plans have indicated that this local employer pressure has had significant impact on their approach to local and regional efforts. Employers must continue to exert this level of leadership to move to aligned payment change and there is no indication that this will diminish among MHMC members.
(9) Similarly, there does not appear to be specific support from state specialty groups, medical organization or academic medical centers. What is your strategy to involve these important stakeholders?	We purposely solicited support for and commitment to the project from several of the general medical groups, rather than seeking detailed commitments from more specific specialty groups, garnering the support of major medical associations that represent large memberships. For example: Maine Medical Association represents over 3,700 physicians, medical students and residents, and is extensively involved in system transformation statewide; Maine Osteopathic Association represents 400 Osteopathic physicians; and Maine Health Care Association represents 90% of the state's 108 nursing homes. In Maine the majority of these organizations are members of Maine Health Management Coalition (the project's primary implementation partner), and all support and participate in various system transformation efforts, either through MHMC initiatives, or linked in some way to MHMC. Maine Health Management Coalition has a long history of successful stakeholder engagement in payment reform. **Specialists** - Engaging specialists in payment reform is a challenge nationally. Maine has had early success working directly with specialists. The local American College of Cardiology chapter has developed a set of performance metrics to be publicly reported on the Maine Health Management Coalition (MHMC) web-

Question	Response
	site and has committed to develop a second generation of measures collaboratively with MHMC staff and members. Specialists participate in MHMC member forums and MHMC has facilitated direct contracting arrangements between specialty groups and employer members. The MHMC co-hosted a forum with the Maine Medical Association in late 2012 to engage specialists and PCPs in payment reform which generated notable interest and momentum. Since the forum the Maine Medical Association sought and received a $200k grant to replicate these forums statewide for specialty groups and PCPs in communities across Maine. Maine Medical Center, an academic medical center in Maine is also an active participant in the Coalition and its Chief Medical Officer serves on our public reporting steering committee and a senior finance executive has served on the MHMC Executive Committee for over a decade. They participate in a shared savings ACO and their board chair has shared their commitment to transformation directly with MHMC leadership. While our ability to secure endorsements from additional **medical organizations, academic medical centers**, **and medical schools** was somewhat constrained by the timeframe of the application process, we are confident that we will successfully engage these organizations in our SIM efforts moving forward. Project leaders and contractors have strong relationships with key stakeholders, including the two academic medical centers and medical schools in the state, specialty societies, and additional health related organizations. Our strategy to engage these organizations will include personal outreach by project leaders, tailored communications, and alignment with existing educational meetings and events that will provide a forum for dialog regarding opportunities for collaboration. MHMC has also developed practice reports for all PCMH and Health Home pilot sites to understand their performance against key measures and benchmarks. Funding for this comes from a Health Homes Planning Grant. In 2010 MHMC distributed reports to over 200 interested practices in the state and with Quality Counts, conducted statewide provider forums to provide additional technical assistance with using the reports. Despite significant demand for additional data, due to resource constraints we have been unable to replicate this process but with SIM funding we will be providing practice performance reports for all interested practices in the state. This will meet the requirements of the Qualified Entity program to provide information to providers, it will support practice improvement as well as help measure progress towards key statewide goals. Regular report development and provider outreach will also prepare providers for public reporting on these common measures. HealthInfoNet, as a key partner on the SIM grant will work to provide clinical and quality outcome measures to participating practices and other qualified in-

Question	Response
	terested parties. We believe this will be a key engagement strategy to impact 80% of the population and will demonstrate the value of integrated data and effective analytics and outreach.
(10) Many of the letters of support you provided do not provide discrete and actionable commitments—what is your plan to further engage these stakeholders (PCPs, practices, BH providers, payers, and purchasers?)	We purposely did not request overly specific commitments in the letters, instead requesting support for and commitment to the overall concept of the project. We want to work with the project's multi-stakeholders to develop specifics based on their various needs in this dynamic environment.

Sustainability

Question	Response
(11) Given that contractors will be responsible for much of the implementation efforts, we are concerned about the long term sustainability of your program after the grant period ends. What is your plan to transition these functions internally following SIM?	System transformation work in Maine pre-dates the SIM grant and will continue after the SIM grant concludes. 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. The MHMC struggles with financial resources to achieve needed impact to transform a multi-billion dollar health system with interests vested in the status quo. MHMC's data program governed by a multi-stakeholder coalition is a critical 'disruptive innovation' because it brings transparency to the health care market and creates a level playing field of information – something that has never existed for purchasers and patients. 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. There is no other source of funding for this critical work, as it is antithetical to current business models of health plans and dominant health systems seeking to preserve market share. While the SIM Grant will provide important funding for some needed one-time infrastructure invest-

Question	Response
	ments, 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.
(12) How will the state ensure that the models are sustainable once the SIM funding runs out?	The response to this question is essentially the same as that provided above.

Waivers / SPA

Question	Response
(13) Given that the prim care/ specialist referral incentive program involves financial relationships between providers, do you believe this program will implicate federal or state laws on fraud and abuse? Are there other legal considerations that may be barriers to implementation?	Maine has sought opinions from legal experts within the State of Maine's Office of the Attorney General's Office. We believe that we can structure our work with accountable communities in a way that will not violate Stark or other antitrust laws. Behavioral health information is a critical necessity for coordination of care. Maine has developed a process that includes a release of information that satisfies 42CFR part2. That form has been reviewed by SAMHSA. Maine passed Legislation in 2010 to allow mental health and HIV data to be available for electronic exchange with consent (LD1331). Although progress has been made in these very important areas, we are still struggling with availability of PHI to allow composition and assembly of a longitudinal comprehensive health record

Evaluation

Question	Response
(14) What methods will you use to determine whether observed changes in quality and total cost of care are a result of the interventions described in your proposal versus other programs already operating in Minnesota?	While precise methodology will be developed by the evaluation partners, the structure of the interventions suggest the most powerful approach would be a combination of longitudinal analysis with properly selected control groups. Performance (in cost and quality) of panels of patients before and after (implementation) can be compared to trends in cost of patients through the same time for those practices which are not in the medical home pilots or participating in ACO arrangements. Through careful choice of appropriate control and comparison populations through time, various affects and practice characteristics can be controlled for and the effects of the interventions of this project estimated.
(15) Please attest that you can provide individual and aggregate claims data for all patients covered by program (public, commercial, and Medicare Advantage), including baseline and historical data for three years prior to the performance period (3 years back) for all patients in your ACO models.	We attest to this for Medicaid and, through the Maine Health Management Coalition, for Medicare and commercial payers. Clinical quality and outcome data from HIN will be provided to participating providers and approved project collaborators to identify and target interventions. Maine Health Management Coalition will have Medicare and Medicaid data, identifiable at the person level, for all Maine beneficiaries. The MHMC is one of 4 entities nationwide designated as a Qualified Entity by CMS and will receive complete fee-for-service Medicare data for all Maine beneficiaries from CMS for calendar year 2009 to present. The MHMC's data vendor has also signed a DUA with CMS to receive personally identifiable Medicare data for practice reporting to the MAPCP practices. These data are attributed to the MAPCP practices. Similarly MHMC will be supporting reporting to all Maine Medicaid Health Homes with patients assigned to practice based on the Health Home assignment criteria, as well as retrospective attribution. Through a relationship with MaineCare, the MHMC will have complete claims data, with history, on all Maine Medicaid beneficiaries, identifiable at the person level. This relationship is being implemented. MHMC has person identifiable claims data from 2009 through current on about a third of the commercially insured Maine population though it's database serving Coalition member plan sponsors. It has complete claims data on the entire commercially insure Maine population from 2007 forward, although not personal identifiable.
(16) Please attest that you will be able to provide: a listing of providers and	We will be able to provide this for all beneficiaries participating in the MAPCP, Health Home, and other PCMH projects. We will work to have this information for those ongoing CMMI funded ACOs by develop-

Question	Response
beneficiaries participating in each specific model, an in-state control population, a unique identifier (SSN, Medicare HIC or Medicaid ID) for all participating beneficiaries.	ing collaborative agreements with existing ACOs. Since we will have statewide Medicaid and Medicare data with person IDs (SSN, HICs, or etc.) we will be able to provide an in-state control population of those not participating. If necessary we will be able to identify beneficiaries not in existing ACOs through attribution.
(17) How will behavior health-related clinical information to providers given the restrictions on sharing behavioral health and substance abuse data under HIPAA? Do you envision a process that allows these patients to affirmatively "opt in" for data sharing?	As noted in our response to Question 3: HealthInfoNet is partnering with the Center for Integrated Behavioral Health and their Substance Abuse and Mental Health Administration (SAMHSA) and Health Resources and Services Administration (HRSA) cooperative agreement. Under this contractual partnership, HealthInfoNet is one of five organizations funded nation-wide to implement health information exchange functions for the behavioral health community. This project supported changes to the HIE architecture to allow for mental health information to be exchanged while supporting a positive consent ("opt-in") by patients, for providers and other clinical staff using the HIE, to access their sensitive (Mental Health and HIV) in the HIE. To date 25 behavioral health organizations across the state have been provide access to HIE tools.

Budget and Financial

Question	Response
(18) Though we are excited about your application and want you to be successful, we believe that your savings estimates are optimistic. If you are unable to achieve these reductions to total cost of care, this model will not save CMS money. Therefore, we believe that the total cost of your proposal is too high relative to its technical merits. In order for	In rough numbers the annual spend per payer class in Maine is: MaineCare $2.5B; $Medicare $1.3B; Commercial 3.7B. Our original project budget was approximately $30 million for three years, or about 1/4 of 1% of the spend for MaineCare and Medicare beneficiaries. Any percentage greater than the ¼ of 1% begins generating ROI. If you spread the budget over commercial as well, then break even on the SIM budget is 1/10th of 1% per year in healthcare spend. Even if the numbers aren't exactly correct, or we only 'touch' less than 80% of the population, the potential for ROI is significant if the SIM project can have any effect on per person spend. Our savings estimates: The four categories for projected savings in the budget model based on national PCMH results that we could document were: Inpatient; ER; Other Outpatients; Professions Specialty. We

Question	Response
CMS to further consider your application please reduce your budget to improve the expected ROI to the Federal Government.	ran the savings models reducing the projected savings estimates in these four categories by 50%. ROIs, depending on the populations class (MaineCare/CHP, Commercial, Medicare, etc), changed from about 45-150 for the five year horizon, to a range of 30-120. Potential dollar savings over five years ranged, by population class – and there are seven different population classes – from $200M to > $500M per population class. We could reduce projected savings by another 50% and still have significant ROI. As requested we have also rerun the numbers in the budget worksheets for just reducing inpatient admissions 10%. These were incorporated into Table 2 below. While it is true if one looks at the expected percentage reductions by service category, the percentage is the greatest for inpatient. However , PMPM for inpatient admissions is only 15-30% of the total PMPM, depending the population. Other areas of savings remain significant because they represent a larger portion of PMPM, such as other outpatient. We have, nevertheless, made a good faith effort to reduce the budget in any way that removes items without solid justification for the highest priority interventions for the project.
(19) In reducing your budget, we encourage you to consider: • The contract for practice facilitators may be duplicative of existing federal funding for Regional Extension Centers (RECs) and Quality Improvement Organizations (QIOs). • The contract for collecting ACO measures may be duplicative of existing CMS spending. • The contract to develop new ACO measures may be duplicative of ongoing national efforts in this area. It is not clear	We recognize the value of providing practice facilitators to support practice change, and feel that these services are necessary and not duplicative of other efforts in the state. Regional Extension Center (REC) services have been primarily focused on helping practices to meet federal Meaningful Use (MU) requirements, and have largely completed their contracted services, having met targeted MU goals. Also, it does not appear that the QIO currently serving the state provides practice facilitation or other QI support directly to primary care practices. Local development of ACO measures is complementary and not redundant with CMS direction. The Maine Health Management Coalition (MHMC) CEO participates on the Steering Committee of the Measure Application Partnership which advises CMS on measure selection for federal public reporting and payment programs. Patrick Conway, CMS CMO serves on the MAP and has worked with the group to identify measure gaps and has acknowledged the benefit of working with regions to test and understand measure use. Additional measures are needed for commercial populations particularly in the realm of cost and resource use measures and for populations other than Medicare. Maternity care is a prime example of an area of

Question	Response
why these national measures would not meet Maine's needs. • Payments to providers for HIT adoption.	significant cost and variable quality that has not been a priority for Medicare but is a key focus for commercial and Medicaid populations. The MHMC CEO also serves on the Board of the National Quality Forum and is involved in work to accelerate identification and approval of additional measures where no adequate measures exist. The MHMC CEO is also involved in the development of a common measure set across commercial payers at the national level. There is widespread acknowledgment that greater alignment is needed across public and private payers to target high leverage areas of under-performance and reduce reporting burden for providers. This work is directly informed by regional collaboratives such as MHMC, and their experience testing measures in communities and is complementary rather than redundant.

The data below is for informational purposes and represents information requested in the original application. Pre Communication represents what was originally proposed in your application; Post Communication should reflect any revisions. Your Pre and Post Communication numbers may or may not change based on your responses to our questions. Please fill out the information as accurately as possible. Please also submit a revised Financial Plan and SF424a.

Table 1: Federal funding request (do not include in-kind or other non-federal funding. Only include Federal Funds requested through the State Innovations Model Initiative)

	Pre Communication	Post Communication
Year 1	$7,354,595	$6,282,402
Year 2	$10,506,513	$10,632,807
Year 3	$10,830,372	$10,746,639
Year 4 (6 mo)	$5,609,290	$5,406,485
Total	$34,300,770*	$33,068,334

***NOTE:** The difference between the stated pre-communication budget total and the originally submitted budget proposal of ~$33.2M largely reflects the original submission of the incorrect budget for the contractual work of Maine Quality Counts to implement a learning collaborative for*

the expansion of the Maine PCMH Pilot and MaineCare Health Homes Initiative. The original submitted budget was for approximately $843K, while the correct amount was $1.9M. This difference accounts for approximately $1.07M. Other mathematical errors were detected and corrected as well.

***NOTE:** Throughout this budget justification "Years 1-4" have been used to categorize costs across by full 12 month period from the beginning of the 6 months of pre-testing, as follows:*

- *Year 1: 6-month pre-testing + 6 mo of Year 1 of Testing*
- *Year 2: 6 mo of Year 1 of Testing + 6 mo of Year 2 of Testing*
- *Year 3: 6 mo of Year 2 of Testing + 6 mo of Year 3 of Testing*
- *Year 4: 6 mo of Year 3 of Testing*

This reflects our understanding of how costs should be categorized based on our phone conversation with you regarding the initial budget.

Table 2: Expected gross medical expenditure savings to CMS
NOTE - The numbers in this table are calculated using the CMS SIM financial spreadsheets. Based on our informational call with CMS on 1/30/2013 we reduced projected savings from inpatient stays to 10%, a 50% reduction. Savings to CMS were calculated as savings from Medicare beneficiaries and 2/3 of the Medicaid. These are gross medical savings before sharing with providers. Also note that we increased the portion of population out of fee-for-service to a goal of 80% in 5 years as requested. This increases the expected savings after the first year as we stepped up the portion of the population by increments after the first year.

	Pre Communication	Post Communication	Computation Method (only for Post-Comm)
Year 1	$ 72,589,943	$61,384,316	e.g. 10 beneficiaries * $9,000 Baseline PBPY total cost of care * 5% gross savings = $4,500)
Year 2	$177,745,771	$183,026,727	
Year 3	$313,645,387	$379,340,293	
Total	$563,981,100	$623,751,337	

Table 3: Number of Medicare, Medicaid, and CHIP beneficiaries impacted by your proposed model (data should be cumulative and the total should sum to total beneficiary years served. For example, if you serve only 1 beneficiary in your program over all 3 years, enter 1 each year and the total will be 3).

	Pre Communication	Post Communication

	Pre Communication	Post Communication
Year 1	219,982	219,982
Year 2	219,982	241,980
Year 3	219,982	327,974
Total	659,945	791,933

Table 4: Estimated percentage of CMS beneficiaries covered by total cost of care contracts with providers or other alternatives to fee-for-service (i.e. Medicare, Medicaid, CHIP, and any other individuals). Include Medicare Advantage and Medicaid Managed Care beneficiaries only if they are covered by contracts with risk-bearing providers **We expect to get to 80% by year 5.**

	Pre Communication	Post Communication
Year 1	50	50
Year 2	50	55
Year 3	50	75
Total		

Table 5: Estimated percentage of total state population covered by total cost of care contracts with providers or other alternatives to fee-for-service (i.e. Medicare, Medicaid, CHIP, and any other individuals). Include Medicare Advantage and Medicaid Managed Care beneficiaries only if they are covered by contracts with risk-bearing providers **We expect to get to 80% by year 5.**

	Pre Communication	Post Communication
Year 1	25	25
Year 2	30	45
Year 3	50	75
Total		

Table 6: Number (FTEs) of Jobs Created (Please count only direct hires related to your proposal. Existing staff are not considered a new hire)

	Pre Communication	Post Communication
Year 1	43.4	34.4
Year 2	62.9	63.3
Year 3	62.7	63.0
Year 4 (6 mo)	31.1	31.3

	Pre Communication	Post Communication
Total	200.1	192.1

ATTACHMENTS FOLLOW:

Organizational Chart
Phase-In Plan
Revised 424 Sheets
Revised Budget Justification