Section H. Participant Retention

Refer to DRR Section H: Participant Retention Process

H1) Business Associate Agreement MHMC & MaineCare

H2) Business Assoc Agreement MQF & MaineCare

H3) Approved SPA ME 12-004 (see Appendix G12)

H4) Approved SPA ME 12-004 (see Appendix G13)

H5) Stakeholder Engagement Plan (See Appendix A5)

H6) Participant Letters of Commitment

H7) c2s091 (MaineCare Benefits Manual) (See Section G Documentation)

H8) c3s091 (MaineCare Benefits Manual) (See Section G Documentation)

H9) Maine PCMH Pilot Practice MOA Pilot Expansion 04-12

H10) MAPCP Demo Agreement with Attachments – Maine 07-11

Department of Health and Human Services

Business Associate Agreement

This Business Associate Agreement ("Agreement") is made this 1st day of _____, 2013 by and between the State of Maine, Department of Health and Human Services ("Covered Entity") and the Maine Health Management Coalition Foundation ("Business Associate") with an address at 2 Union Street, Portland, Maine 04101.

WHEREAS, Covered Entity may disclose certain information to Business Associate which may constitute Protected Health Information (defined below); and

WHEREAS, the parties intend to protect the privacy and security of all Protected Health Information in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), P.L. 104-191, codified at 42 U.S.C. §§ 1320 (d)(1)-(d)(8) and all regulations adopted pursuant thereto, as amended, federal confidentiality laws, and applicable Maine confidentiality laws, which may include some or all of the following: 5 MRS §19203; 5 MRS §20047; 22 MRS §§42, 261, 815, 824, 833, 1494, 1596, 1828, 3173, 3292, 4008, 5328, 7250, 7703, 8754; 34-B MRS §1207. (This list is for informational purposes only, and is not intended to be an all-inclusive list of the applicable statutes.)

NOW THEREFORE, the parties agree as follows:

Definitions: Capitalized terms used but not otherwise defined herein shall have the meanings provided under HIPAA, as amended, including but not limited to: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, Subcontractor, Unsecured Protected Health Information, and Use.

Specific definitions:

(a) Business Associate. "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean Maine Health Management Coalition Foundation or its agents.

(b) Covered Entity. "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this agreement, shall mean the Maine Department of Health and Human Services, Office of MaineCare Services or its agents.

(c) “HIPAA” means the Health Insurance Portability and Accountability Act of 1996, Public Law No. 104-191, as amended by the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 (2009), and its implementing regulations.

(d) HIPAA Rules. “HIPAA Rules” shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

1. Term of Agreement
This Agreement shall be effective ____ 1, 2013 and shall terminate when all Protected Health Information received by Business Associate on behalf of Covered Entity is returned to Covered Entity or destroyed. The confidentiality provisions of this Agreement shall **survive indefinitely**, even beyond the termination of this Agreement, or as otherwise provided by law

2. Termination of Agreement
Upon termination of this Agreement, the Business Associate is required, if feasible, to return to Covered Entity or destroy all PHI received from or created or received by the Business Associate on behalf of the Covered Entity and retain no copies If returning or destroying PHI is not feasible, Business Associate agrees to protect the confidentiality of the PHI to the extent required by law, and limit any further use or disclosure to those purposes that make the return or destruction of the information unfeasible. Either party may terminate the Agreement upon thirty (30) days’ written notice to the other party.

3. Termination for Cause
Upon the covered entity’s knowledge of a breach by the Business Associate, the covered entity may, at its sole discretion:

(a) Provide the Business Associate with an opportunity to cure the breach or end the violation within a timeframe and upon such conditions as established by the Covered Entity in accord with law; or

(b) Immediately terminate this Agreement in the event the Business Associate has breached a material term of this Agreement and cure is not possible; or

(c) In the event neither termination nor cure is feasible, the Covered Entity shall report the breach violation to the Secretary in accord with law.

4. Permitted Uses and Disclosures
The Business Associate shall not use or disclose PHI in violation of HIPAA or other applicable federal laws, or Maine confidentiality laws. The Business Associate may use or disclose PHI to perform functions, activities or services for, or on behalf of, the Covered Entity only as permitted by this Agreement; and required to meet the terms of the contract between the Covered Entity and the Business Associate; and allowed or Required by Law; and in compliance with the Minimum Necessary provisions of law.

The Business Associate is permitted to use or disclose PHI as set forth below:

(a) Business Associate may use PHI to carry out its legal responsibilities under this Agreement and Attachment A.

(b) Business Associate may disclose PHI to a third party for Business Associate's proper management and administration, provided that the disclosure is Required by Law or Business Associate has an executed BAA with the third party or obtains reasonable assurances from the third party to whom the PHI is to be disclosed that the third party will (i) protect the confidentiality of the PHI, (ii) only use or further disclose the PHI as Required by Law or for the purpose for which the PHI was disclosed to the third party and (3) notify Business Associate of any instances of which the third party is aware of a Breach.

(c) Business Associate may use PHI to provide Data Aggregation services relating to the Health Care Operations of Covered Entity.

(d) Business Associate may de-identify PHI consistent with applicable HIPAA requirements.

5. Documentation and Availability

(a) Business Associate is required to maintain and make available the information required to provide an accounting of disclosures in accordance with 45 CFR §164.528. Documentation will be made available as necessary for an accounting of disclosures of PHI to the individual or the Covered Entity as permitted by 45 C.F.R. §164.528.

(b) Business Associate will make PHI available to an individual to access and or copy his/her PHI as permitted by 45 C.F.R. §164.524, within thirty (30) days from the time of the request.

(c) Business Associate will make available PHI for amendment as permitted by 45 C.F.R. §164.526, within sixty (60) days from the time of request.

(d) Business Associate will make its internal practices, books and records relating to the use or disclosure of PHI received from the Covered Entity or created or received by the Business Associate on behalf of the Covered Entity, available to HHS Secretary for the purposes of determining the compliance of either the Covered Entity or the Business Associate with the Medicaid Act and HIPAA Privacy Rule.

6. Inappropriate Use and Disclosure

(a) If Business Associate becomes aware of a use or disclosure of PHI in violation of this Agreement by Business Associate or a third party to whom Business Associate disclosed PHI, Business Associate shall report the use or disclosure to Covered Entity without unreasonable delay.

(b) Business Associate will report any Security Incident involving PHI of which it becomes aware in the following manner: (a) any actual, successful Security Incident will be reported to Covered Entity in writing without unreasonable delay, and (b) any attempted, unsuccessful Security Incident of which Business Associate becomes aware will be reported to Covered Entity orally or in writing on a reasonable basis, as requested by Covered Entity. If the HIPAA security regulations are amended to remove the requirement to report unsuccessful

attempts at unauthorized access, the requirement hereunder to report such unsuccessful attempts will no longer apply as of the effective date of the amendment.

(c) Business Associate will, following the discovery of a Breach of Unsecured PHI, notify Covered Entity of the Breach in accordance with 45 C.F.R. §164.410 without unreasonable delay.

(d) The Business Associate shall exhaust, at its sole expense, all reasonable efforts to mitigate any harmful effect known to the Business Associate arising from the use or disclosure of PHI by Business Associate in violation of the terms of this Agreement.

7. Appropriate Safeguards and Technical Standards

The Business Associate will implement, to the Covered Entity's satisfaction, all reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of PHI that it creates, receives, maintains or transmits on behalf of Covered Entity. Safeguards will be implemented for paper as well as electronic versions of PHI. Business Associate will ensure that any agent or subcontractor to whom it provides PHI on behalf of the Covered Entity agrees to the same restrictions and conditions which apply under this Agreement to the Business Associate with respect to such PHI.

Business Associate certifies that any and all direct claims data feeds from the Covered Entity to the Business Associate or its agent, shall meet the NIST SP 800-53 Controls for meeting the FIPS 200 Standards as set forth by the federal Center for Medicare and Medicaid Services (CMS) for the protection of Medicare PHI data.

8. Obligations of the Covered Entity

Covered Entity shall notify Business Associate of any limitation in its Notice of Privacy Practices that would affect the use or disclosure of PHI by the Business Associate. Covered Entity shall notify the Business Associate of any changes, revocations, restrictions or permissions by an individual to the use and disclosure of his/her PHI. Covered Entity shall notify the Business Associate of any restriction to the use or disclosure of PHI that the Covered Entity has agreed to in accordance with 45 CFR §164.522, to the extent such restriction may affect the use or disclosure of PHI by the Business Associate. The HIPAA Privacy Rule allows covered entities, at their discretion, to accommodate requests for confidentiality by the subject of the PHI. If Covered Entity has agreed to accommodate a confidentiality request, it has a duty to disclose such to its trading partners in order to allow the trading partner to honor the confidentiality request.

9. **Subcontractors and Agents**

Business Associate agrees to require that any agent or subcontractor to whom it provides or entrusts PHI as defined in this Agreement agree to the same restrictions and conditions governing PHI which apply to the Business Associate with respect to such PHI under the terms and conditions of this Agreement.

10. Hold Harmless

Business Associate agrees to indemnify and hold harmless the Department, its directors, officers, agents, shareholders, and employees against any and all claims, demands, expenses, liabilities or causes of action which arise from any use or disclosure of PHI not specifically permitted by this agreement or applicable state and federal laws.

11. Miscellaneous

(a) Amendment. The parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for the Covered Entity to comply with the requirements of the Privacy Rule and HIPAA.

(b) Interpretation. Any ambiguity in this Agreement shall be resolved to permit the Covered Entity to comply with the Privacy Rule and HIPAA.

IN WITNESS WHEREOF, the parties have executed this BUSINESS ASSOCIATE AGREEMENT the day and year first written above.

	Covered Entity		Business Associate
Signature:	_____	Signature:	_____
Name:	William W. Boeschenstein, Jr.	Name:	_____
Title:	Chief Operating Officer	Title:	_____
Date:	_____	Date:	_____

ATTACHMENT A

SCOPE OF DATA TO BE PROVIDED TO THE BUSINESS ASSOCIATE AND AND USE OF SUCH DATA BY THE BUSINESS ASSOCIATE TO MEET THE TERMS OF THE CONTRACT BETWEEN THE DEPARTMENT AND MAINE HEALTH DATA COALITION.

The term **Department** means the Maine Department of Health and Human Services (Covered Entity) or its agents

The term **Provider** means the Maine Health Management Coalition (Business Associate) or its agents.

Scope of Data

The Department will make available, in mutually acceptable format(s), to the Provider claims data, including Minimum Necessary PHI, to enable the Provider to perform the functions, activities and services needed to allow provider access to, and to produce the reports, set forth below.

Claims data shall consist of eligibility, claims, pharmacy and provider data files for claims dated January 1, 2012 or after, to continue through the date the agreement terminates and in accord with access and reports as set forth below.

1. **Practice Reports**
   a. Provider will deliver semi-annual practice reports comparing measures of quality and efficiency with peer benchmarks to all practices involved in Health Homes, PCMH Pilot/MAPCP.
   b. Provider will add measures specific to the MaineCare Health Homes program as required by MaineCare;
   c. Provider will use the most recent claims data available with at least 3 months runout.

2. **Medical Provider Online Access Utilization Reports**

   Provider will make available online access to all participating practices in the Health Homes or MAPCP/PCMH Pilot program, patient-level health care data from claims, with the potential of adding other types of health care data based on MaineCare requirements for provider participation, and subject to agreement between the Covered Entity and the Business Associate.

3. **Medical Provider Online Access Early Adopters Report**

   Provider will make the following features available for 10 early adopters (Health Home practices or CCTs) with the intent to expand this access to all practices participating in the Health Homes or MAPCP/PCMH Pilot program when additional funding is available:

a. Online access will include all MaineCare patients attributed to each practice (not just Health Homes patients);

b. Provider will supply dynamic reporting capability via the online access to health care data from claims including the ability for medical providers to drill-down into patient-specific clinical and utilization characteristics; and

c. The ability to combine or isolate specific populations and develop reports.

Office of MaineCare Services

Business Associate Agreement

This Business Associate Agreement is made this 4th day of August, 2011 by and between the State of Maine, Department of Health and Human Services, Office of MaineCare Services, and Maine Quality Counts,with an address of 30 Association Drive, Manchester, ME 04351.

WHEREAS, the parties intend to protect the privacy and security of all individually identifiable health information and protected health information in accordance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), P.L. 104-91, codified at 42 U.S.C. §§ 1320 (d)(1)-(d)(8), and all regulations adopted pursuant thereto.

NOW THEREFORE, the parties agree as follows:

Definitions:

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996, Public Law No. 104-191.

"Protected Health Information" shall have the same meaning as the term "protected health information ("PHI") in 45 C.F.R.§1604.103, limited to information created or received by the Business Associate from or on behalf of the Department.

"Required by law" shall have the same meaning as the term "required by law" in 45 C.F.R.§164.103.

"Secretary" shall mean the Secretary of the U.S. Department of Health and Human Services, or his or her designee.

1. Term of Agreement

This Agreement shall be effective August 4, 2011 and shall continue to December 31, 2015. This Agreement shall automatically renew itself for an additional twelve-month period unless otherwise terminated by either party. In the event that this Agreement is automatically renewed, the Business Associate agrees to be bound by the Terms and Conditions currently in effect. The confidentiality provisions of this Agreement shall **survive indefinitely**, even beyond the termination of this Agreement, or as defined under provisions of law.

2. Termination of Agreement

Upon termination of this agreement the Business Associate is required, if feasible, to return or destroy all PHI received from or created or received by the Business Associate on behalf of the Office of MaineCare Services and retain no copies. If returning or destroying PHI is not feasible, Business Associate agrees to protect the confidentiality of the PHI to the extent required by HIPAA and any regulations promulgated there under, and limit any further use or disclosure to those purposes that make the return or destruction of the information infeasible. Either party may terminate the Agreement by 30 day written notice to the other party.

3. Termination for Cause

Upon the Department's knowledge of a material breach by the Business Associate, the Department shall either, at its sole discretion:

(a) Provide the Business Associate an opportunity to cure the breach or end the violation within a time frame and upon such conditions as established by the Department;

(b) Immediately terminate this Agreement in the event the Business Associate has breeched a material term of this Agreement and cure is not possible; or

(c) In the event neither termination nor cure is feasible, the Department shall report the violation to the Secretary.

4. Permitted Uses and Disclosures

The only permitted uses and disclosure of PHI in this agreement are stated in attachment A. Except as otherwise limited by this agreement, the Business Associate may use or disclose Protected Health Information to perform functions, activities or services for, or on behalf of, the Department provided that such use and disclosure would not violate HIPAA, the regulations promulgated there under, or the HIPAA minimum necessary policy. The Business Associate will disclose protected health information only as permitted, or required by this Agreement, or as required by law.

5. Documentation and Availability

Business Associate is required to maintain and make available the information required to provide an accounting of disclosures in accordance with 45 CFR 164.528. Documentation will be made available as necessary for an accounting of disclosures of PHI to the individual and or the Department as permitted by 45 C.F.R. 164.528.

The Business Associate will make PHI available to an individual to access and or copy his/her PHI as permitted by 45 C.F.R. 164.524, within 30 days from the time of request.

The Business Associate will make available PHI for amendment as permitted by 45 C.F.R. 164.526, within 60 days from the time of request.

The Business Associate will make its internal practices, books and records relating to the use or disclosure of PHI received from the Department or created or received by the Business Associate on behalf of the Department, available to either the Department or the HHS Secretary for the purposes of determining the compliance of either the Department or the Business Associate with the Medicaid Act and HIPAA Privacy Rule. 45 C.F.R. 164.504

In the event Business Associate has PHI in a designated record set, the Business Associate agrees to make any amendments to the Designated Record Set as the Department directs or agrees to in accordance with 45 C.F.R. §164.526 in such time-period and in such manner as the Department may direct.

6. Inappropriate Use and Disclosure

The Business Associate is required to report to the Office of MaineCare Services any inappropriate use or disclosure of the PHI of which it becomes aware, i.e. use or disclosure not permitted in this agreement or permitted by law. Business Associate will make such report to the Office of MaineCare Services Privacy Officer or designee by the end of the following business day.

The Business Associate shall exhaust, at its sole expense, all reasonable efforts to mitigate any harmful effect known to the Business Associate arising from the use or disclosure of PHI by Business Associate in violation of the terms of this Agreement.

7. Appropriate Safeguards

The Business Associate will implement, to the Department's satisfaction, all reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of PHI. Safeguards will be implemented for paper as well as electronic versions of PHI. Business Associate will ensure that any agent or subcontractor to whom it provides PHI received from, created or received by Business Associate on behalf of the Department agrees to the same restrictions and conditions which apply through this Agreement to the Business Associate with respect to such information.

8. Obligations of the Office of MaineCare Services

The Department shall notify Business Associate of any limitation in its Notice of Privacy Practices that would affect the use or disclosure of PHI by the Business Associate.

The Office of MaineCare Services shall notify the Business Associate of any changes, revocations, restrictions or permissions by an individual to the use and disclosure of his/her PHI.

The Department shall notify the Business Associate of any restriction to the use or disclosure of PHI that the Department has agreed to in accordance with 45 CFR §164.522, to the extent such restriction may affect the use or disclosure of PHI by the Business Associate. The HIPAA Privacy Rule allows covered entities, at their discretion, to accommodate requests for confidentiality by the subject of the PHI. If DHS has agreed to accommodate a confidentiality request, it has a duty to disclose such to its trading partners in order to allow the trading partner to honor the confidentiality agreement.

9. Agents

The Business Associate agrees to ensure that any agent, including a subcontractor to whom it provides or entrusts PHI as defined in this Agreement, will agree to the same restrictions and conditions governing PHI which apply to the Business Associate with respect to such information under the terms and conditions of this Agreement.

10. Hold Harmless

Business Associate agrees to indemnify and hold harmless Office of MaineCare Services, its directors, officers, agents, shareholders, and employees against any and all claims, demands, expenses, liabilities or causes of action which arise from any use or disclosure of PHI not specifically permitted by this agreement or applicable state and federal laws.

11. Miscellaneous

(a) Amendment. The Parties agree to take such action as is necessary to amend this Agreement from time to time as is necessary for the Department to comply with the requirements of the Privacy Rule and HIPAA.

(b) Interpretation. Any ambiguity in this Agreement shall be resolved to permit the Department to comply with the Privacy Rule and HIPAA.

12. Priority of Agreement

If any portion of this Agreement is inconsistent with the terms of any of the agreements listed in Attachment A, the terms of this Agreement shall prevail. Except as set forth above, the remaining provisions of the agreements listed in Attachment A shall remain unchanged.

IN WITNESS WHEREOF, the parties have executed this BUSINESS ASSOCIATE AGREEMENT the day and year first written above.

	Office of MaineCare Services		Business Associate
Signature:		Signature:	L Letourneau MD
Name:		Name:	Lisa M. Letourneau MD, MPH
Title:		Title:	Executive Director
Date:		Date:	August 4, 2011

Business Associate Agreement
Attachment A.

The following describes the purpose and permitted use and disclosure of PHI by the Business Associate:

PHI will be used by Maine Quality Counts staff solely for the purpose of improving the quality of health care provided to MaineCare members. Examples include making recommendations for redesigning care delivery for MaineCare members, identifying new models of care, and improving communication and coordination of care across settings.

LETTERS

Commitment and Support

Note concerning the letters – Despite the short timeline for preparation of this application, the project has attracted considerable enthusiasm and support statewide – 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 practices in the Maine Multi-Payer Patient Centered Medical Home Pilot (Phase I and Phase II), and/or may be in the MaineCare Health Homes (Stage I) program.

Governor's Letter of Endorsement

Office of the Governor, State of Maine	Paul LePage, Governor

Commitment - Primary Care Providers / Hospitals & Health Systems

Central Maine Healthcare	Peter Chalke, Preisdent & CEO	(**multiple PCPs**)
DFD Russell Centers	Laurie Kane-Lewis, CMPE, CEO	(**multiple centers**)
DownEast Community Hospital	Douglas Jones, FACHE, President & CEO	(**multiple PCPs**)
Eastport Health Care Inc	Holly Gartmayer-DeYoung, CEO	
Harrington Family Health Ctr	Bill Wypyski, MPA, MS, CEO	
Health Access Network	William Diggins, CEO	
Maine Health Care Association	Richard Erb, Presiden & CEO	(**nursing homes**)
Maine Medical Association	Dieter Kreckel, MD, President	
Maine Osteopathic Association	Angela Westhoff, Executive Director	
MaineGeneral Health	Scott Bullock, President & CEO	(**multiple PCPs**)
Martin's Point HealthCare	Betsy Johnson, MD, Chief Medical Officer	(**multiple PCPs**)
Mercy Health System of Maine	Eileen Skinner, MHA, FACHE, Pres& CEO	(**multiple PCPs**)
Mid Coast Hospital	Lois Skillings, President & CEO	(**multiple PCPs**)
Northern Maine Medical Center	Peter Sirois, CEO	(**multiple PCPs**)
Penobscot Community Health Care	Kenneth Schmidt, MPA, President & CEO	(**multiple PCPs**)
Pines Health Services	James Davis, CEO	
Sacopee Valley Health Center	Maryagnes Gillman, MS, RN, Executive Director	
St. Joseph Healthcare	Dennis Shubert, MD, PhD, VP Medical Affairs	
York County Community Hlth Care	Martin Sabol, Director of Health Services	

Commitment - Behavioral Health Providers

Community Care	Kate Davis	
Community Health & Counseling Svces	Dale Hamilton, Executive Director	
ESM –Augusta	Jean Gallant, President	(**multiple sites**)
Harbor Family Services	Jack Mazzotti III, President & CEO	
Health Affiliates Maine	Andrea Krebs, LCSW, Executive Director	(**multiple sites**)

Kennebec Behavioral Health	Thomas McAdam, CEO (**multiple sites**)
MaineGeneral Health	Emilie van Eeeghen, VP, Behavioral Health Svces
Spurwink	Dawn Stiles, President (**multiple sites**)
Sweetser	Carlton Pendleton, President & CEO (**multiple sites**)
Tri-County Mental Health Services	Catherine Ryder, Executive Director (**multiple sites**)
Umbrella Mental Health Services	Annalee Morris, CEO (**multiple sites**)

Commitment – Payer

Aetna	Martha Temple, President, NE Region
Anthem Blue Cross/ Blue Shield	Daniel Corcoran, President & General Manager
Maine Community Health Options	Kevin Lewis, Executive Director

Commitment – Purchaser

Maine Municipal Employees Hlth Trust	Steve Gove, Director
MEA Benefits Trust	Christine Burke, Esq, Executive Director
University of Maine System	Thomas Hopkins, Director, Compensation & Benefits
State Employees Health Commission	Laurie Williamson, Office of Employee Health & Benefits

Other - Commitment and/or General Support

AARP	Lori Parham, State Director
American Lung Association	Ed Miller, Sr. VP
Amistad	Peter Driscoll, LMSW, Executive Director
Bates College	Ken Emerson, Associate Director, Human Resources
Catholic Charities	Stephen Letourneau, CEO
Center for Health Care Strategies	Stephen Somers, PhD, President & CEO
Consumers for Affordable Care	Joseph Ditre, Esq. Executive Director
Daniel Hanley Ctr for Health Leadership	James Harnar, Executive Director
HealthInfoNet	Dev Culver, CEO (**implementation**)
Maine Association of AAAs	Jessica Maurer, Esq, Executive Director
Maine Developmental Disabilities Counc	Julia Bell, Executive Director
Maine Health Management Coalition – Maine Health Management Coalition Foundation	Elizabeth Mitchell, Executive Director (**implementation**)
Maine Quality Counts	Lisa Letourneau, MD, MPH, Exec Dir (**implementation**)
Muskie School of Public Health	Andrew Coburn, PhD, Director, Population Health / Policy
University of Maine/ Augusta	Grace Leonard, Professor & Coordinator of Mental Health & Human Services

STATE OF MAINE
OFFICE OF THE GOVERNOR
1 STATE HOUSE STATION
AUGUSTA, MAINE
04333-0001

Paul R. LePage
GOVERNOR

September 19, 2012

Michelle Feagins
Grants Management Officer
Office of Acquisition and Grants Management
Centers for Medicare and Medicaid Services
US Department of Health and Human Services
Room 733H-02
Washington, CD 20201

Letter of Endorsement: *Testing the Maine Innovation Model*

Dear Ms. Feagins:

In this time of crippling healthcare costs, rising chronic illness rates, and an aging population, developing ways to delivery high quality care at the lowest cost is critical to maintain both the physical and fiscal health of Maine's citizens. Maine's application for Cooperative Agreement funding is a logical continuation and advancement of delivery system/payment reform initiatives that are already transforming healthcare in Maine – improving care, lowering costs, and fostering patient accountability. *Testing the Maine Innovation Model* will enhance the involvement in, and impact of Maine's public payer sector (MaineCare and Medicare) on cost reduction, quality improvement, and informed patient engagement – i.e. the *Triple Aim* goals – through alignment with the commercial market and a continued commitment to transparent public reporting of cost and quality measures.

The **Maine Health Care Innovation Plan** reflects the dynamic reality of Maine's healthcare transformation initiatives, including its aligned, collaborative, and multi-stakeholder nature. It builds on the foundation of multi-stakeholder enhanced primary care embodied in the Maine multi-payer Patient Centered Medical Home (PCMH) Pilot. The PCMH Pilot is the foundation upon which the CMS Maine Multi-Payer Advanced Primary Care Practice Demonstration (MAPCP) and MaineCare Health Homes (HH) initiatives are based, and all include the use of Community Care Teams (CCTs) to manage high risk / high cost patients. All these initiatives are moving to integrate primary care with behavioral health. Enhanced primary care is also the base for the several multi-stakeholder / multi-payer Accountable Care Organizations (ACOs) that are emerging around the state to help control costs.

The Innovation Plan aligns with the Maine Department of Health and Human Services' MaineCare Value-Based Purchasing Strategy. Announced in 2011, this strategy includes a commitment to increased transparency of cost and quality outcomes, rewards for performance, payment reform, and a move to Accountable Communities that include shared savings and risk and are tied to quality improvement.

PHONE: (207) 287-3531 (Voice)
888-577-6690 (TTY)
FAX: (207) 287-1034
www.maine.gov

Testing the Maine Innovation Model (the name of our project) leverages current successes and brings the State's investment to the next level by: (1) supporting and strengthening enhanced primary care; (2) supporting and strengthening alignment 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) supporting the formation of multi-payer ACOs that commit to value and performance-based payment reform and public reporting of common quality benchmarks.

Endorsement - I am endorsing the Innovation Plan and the application for Model Testing funding under the State Innovation Models FOA (CMS-1G1-12-001).

Title of Project - *Testing the Maine Innovation Model*

Principal Contact Person:

Mary C. Mayhew
Commissioner, Maine Department of Health and Human Services
221 State St (physical address)
11 State House Station (mailing address)
Augusta, Maine 04333-0011
Tel. (207) 287-3707
mary.mayhew@maine.gov

Collaborating Organizations and Departments:

Maine Department of Health & Human Services
University of Maine System
Maine Health Management Coalition
HealthInfoNet
Maine Quality Counts!
Health systems, including hospitals, primary and specialty care
Federally Qualified Health Centers
Behavioral health organizations
Professional associations
Employers
Payers

Paul Richard LePage
Governor of Maine

Central Maine Healthcare
The Central Maine Medical Family

September 19, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of Central Maine Healthcare (CMH), I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Central Maine Healthcare is an integrated healthcare delivery system proudly serving over 400,000 people in coastal, central & western Maine. Our health system is anchored by 3 acute care hospitals, 2 of which are critical access hospitals. In addition, we employ over 375 providers including 250 physicians (140 PCP's) and 75 mid-level providers (please see attached listing). All of our facilities, practices and Rural Health Centers accept all patients regardless of ability to pay including MeCare (Maine Medicaid) which represents approximately 12% of our patient volume.

We currently participate in statewide healthcare transformation in several ways. CMH is a founding member of and active participant in the Maine Health Management Coalition (MHMC), a multi-stake holder, health care quality and cost improvement focused coalition which enjoys the state-wide participation of employers, health systems and government agencies. Many of our primary care practices participate in the Multi-Payor Patient Centered Medical Home (PCMH) initiative which will soon be expanded to include the MeCare (Maine Medicaid) Health Home pilot. In addition, we were recently designated by CMS as an ACO under the Shared Savings Program serving over 16,000 Medicare beneficiaries.

This letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Engaging primary care practices in the enhanced primary care model endorsed by the project, either through participation in a recognized patient centered medical home/ health home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.
2. Committing to publicly reporting on a common set of measures, including total cost of care and patient experience. Additional measures will be determined through the Pathways to Excellence multi-stakeholder process.
3. Committing to the MHDO All Payer Database as a common claims data source and to a single source of analysis for the purposes of statewide public reporting on the measures determined in #2, and comparative statewide variation analysis necessary to gauge progress on and advance payment and delivery system reform.
4. Engaging in alternative reimbursement models which tie payment to accountability for cost and quality outcomes, moving toward greater accountability over time.
5. Participating in the learning collaborative(s) on medical home practice transformation and Accountable Care Organizations.
6. Engaging in activities to promote patient accountability, including the integration of shared decision making (SDM) at the practice level, exploration of patient incentives and benefit design, and partnerships to promote improved population health.
7. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

Sincerely,

Peter Chalke
President & Chief Executive Officer

pchalke@cmhc.org
207-795-2701

Central Maine Healthcare - Primary Care Practices
2012 - July Inventory

Central Maine Medical Center

Primary Care	Name	Address	Town
Family Practice	Lisbon Family Practice	2 Bisbee Street	Lisbon
Family Practice	Family Health Care Associates	190 Stetson Road	Auburn
Family Practice	CMMC Family Medicine Residency Program	76 High Street	Lewiston
Family Practice	Gray Family Health Center	126 Shaker Road	Gray
Family Practice	Mechanic Falls Family Practice Center	22 Pleasant	Mechanic Falls
Family Practice	Central Maine Family Practice	12 High Street, Suite 302	Lewiston
Family Practice	Minot Avenue Family Medicine	789 Minot Avenue	Auburn
Family Practice	Norway Family Medicine	39 Main Street	Norway
Family Practice	Topsham Family Medicine	4 Horton Place	Topsham
Family Practice	Community Health Center	364 Main Street	Poland
Internal Medicine	Central Maine Internal Medicine	12 High Street Suite 400	Lewiston
Pediatrics	Central Maine Pediatrics	12 High Street, Suite 301	Lewiston

Bridgton Hospital

Primary Care	Name	Address	Town
Family Practice	North Bridgton Family Practice	14 Wyonegonic Road	North Bridgton
Family Practice	Fryeburg Family Medicine	253 Bridgton Road	Fryeburg
Family Practice	Naples Family Practice	410 Roosevelt Trail	Naples
Internal Medicine	Bridgton Internal Medicine	25 Hospital Drive	Bridgton
Pediatrics	Bridgton Pediatrics	25 Hospital Drive	Bridgton

Rumford Hospital

Primary Care	Name	Address	Town
Family Practice	Swift River Family Medicine	430 Franklin Street	Rumford
Internal Medicine	River Valley Internal Medicine	431 Franklin Street	Rumford
Family Practice	Elsmore Dixfield Family Medicine	146 Weld Street	Dixfield

Oakland

Primary Care	Name	Address	Town
Family Medicine (CMCA)	Twin Pines Family Medicine	3 Evergreen Drive	Oakland

Brunswick

Primary Care	Name	Address	Town
Family Medicine	Brunswick Family Health	329 Maine Street, Suite H	Brunswick
Family Medicine	Brunswick Family Medicine	33 Bath Road	Brunswick
Pediatrics	Brunswick Pediatrics	329 Maine Street, Suite J	Brunswick

DFD Russell
MEDICAL
DF
DR
CENTERS

180 Church Hill Road
Leeds, Maine 04263
207-524-3501
Fax: 207-524-2093
DFD Russell Medical Centers, Inc. is an equal opportunity provider and employer

September 20, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of DFD Russell Medical Centers, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance.* The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

DFDRMC through its three Central Maine sites in Leeds, Monmouth and Turner, offers comprehensive primary care, Care Management, laboratory and integrated behavioral health services to people of all ages: men and women, the uninsured and underinsured, low

income wage earners, and people receiving public assistance. The Center maintains a sliding fee scale and no one is refused any treatment or services based on an ability to pay. Services include:

- Primary health care: Basic medical treatment, examinations, on-going treatment for chronic illnesses, and acute care not requiring an emergency room or hospitalization. Family practitioners treat patients of all ages, from birth to geriatric;
- Prevention: Patient education, immunizations, early detection through screenings and self-examinations, nutrition counseling;
- Behavioral Health: Integrated within the primary care setting and coordinated with the primary care providers our behavioral health providers utilize Motivational Interviewing and Cognitive Behavioral Therapy to assist patients with positive change management for improved health outcomes.
- Care Management: Assisting patients to maintain treatment regimen, follow-up appointments, life style changes and chronic disease management, and to secure necessary benefits and services;
- 24/7 availability: Provides medical on-call coverage 365 days a year including extended evening and weekend hours for acute care needs to assist patients with avoiding inappropriate ER use.
- Referral and information: Assisting patients to establish contacts with other providers, e.g. specialists, social service agencies, alternative health options;

We currently participate in statewide healthcare transformation in several ways. DFD Russell Medical Center is NCQA Recognized as a Patient-Centered Medical Home, has achieved NCQA Recognition in Diabetes Care and in Heart/Stroke Care as well. We participate with Bridges to Excellence, are part of the Maine Patient Centered Medical Home Pilot Program and have achieved the highest status with Anthem's Quality Initiative Program. We have achieved Meaningful Use with the State of Maine under the Medicaid program for Phase I and will be submitting Phase II data by the end of the calendar year. DFD is part of the Central Maine ACO and is committed to increasing quality and reducing costs in our patient populations. Through an independent study by the Muskie Institute under a Maine Health Access Foundation Grant DFD's interventions with patients were proven to reduce ER visits and Rehospitalizations by 50% over the grant period.

As a Federally Qualified Health Center this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Engaging primary care practices in the enhanced primary care model endorsed by the project, either through participation in a recognized patient centered medical home/ health home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.
2. Committing to publicly reporting on a common set of measures, including total cost of care and patient experience. Additional measures will be determined through the Pathways to Excellence multi-stakeholder process.

3. Committing to the MHDO All Payer Database as a common claims data source and to a single source of analysis for the purposes of statewide public reporting on the measures determined in #2, and comparative statewide variation analysis necessary to gauge progress on and advance payment and delivery system reform.
4. Participating in the learning collaborative(s) on medical home practice transformation and Accountable Care Organizations.
5. Engaging in activities to promote patient accountability, including the integration of shared decision making (SDM) at the practice level, exploration of patient incentives and benefit design, and partnerships to promote improved population health.
6. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

Sincerely

Laurie Kane-Lewis, CMPE
Chief Executive Officer
Laurie.kane-lewis@dfdrussell.org
207-524-4001

Patient-focused care

Eastport Health Care, Inc.

Provider letter of Support

A primary care provider that offers Medical, Dental and Mental Health care services for the whole family, as well as a wide variety of specialty services.

P.O. Box H 30 Boynton Street
Eastport, ME 04631
p (207) 853-6001
f (207) 853-6180
Email: info@eastporthealth.org
www.eastporthealth.org

September 24, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of Eastport Health Care Inc. I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

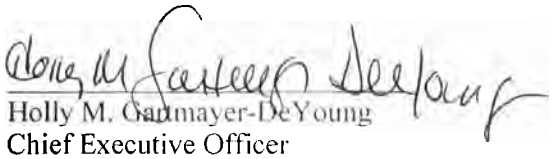
Eastport Health Care is an FQHC located Downeast. We provide services to 5690 patients, 22% of whom are Maine Care beneficiaries.

We currently participate in statewide healthcare transformation in several ways. Two of our practice sites (the only sites in Washington County) have been selected to participate in the Quality Counts Multi-Payer PCMH Pilot. Additionally we are one of nine founding members and participants in the Maine Community ACO (the only primary care practice ACO in Maine). Since November 2010, EHC has adopted a culture of transformation, demonstrated by creating a new Senior Leadership position: Chief Operating-QI Officer. A significantly competent leader (Theresa Brown) was recruited in March 2012. She has implemented numerous improvements establishing EHC as a Best Practice (Performance Improvement Program) by HRSA at a recent Operational Site Assessment. EHC CEO, Holly Gartmayer DeYoung, is a founding member of Maine Quality Counts, and is strong proponent of quality, access and limiting cost. EHC now embodies performance improvement vis a vis responsive health care that reflects quality measures that are met, access goals improving Transformation of Care MOU's with the 2 critical access hospitals in Washington County and contained cost. Financial performance measures are routinely shared with staff.

As Eastport Health Care, this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Engaging primary care practices in the enhanced primary care model endorsed by the project, either through participation in a recognized patient centered medical home/ health home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.
2. Committing to publicly reporting on a common set of measures, including total cost of care and patient experience. Additional measures will be determined through the Pathways to Excellence multi-stakeholder process.
3. Committing to the MHDO All Payer Database as a common claims data source and to a single source of analysis for the purposes of statewide public reporting on the measures determined in #2, and comparative statewide variation analysis necessary to gauge progress on and advance payment and delivery system reform.
4. Engaging in alternative reimbursement models which tie payment to accountability for cost and quality outcomes, moving toward greater accountability over time.
5. Participating in the learning collaborative(s) on medical home practice transformation and Accountable Care Organizations.
6. Engaging in activities to promote patient accountability, including the integration of shared decision making (SDM) at the practice level, exploration of patient incentives and benefit design, and partnerships to promote improved population health.
7. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

Sincerely,



Holly M. Gadmayer-DeYoung
Chief Executive Officer
hdeyoung@eastporthealth.org
207-853-4045

Down East
COMMUNITY
Our Health, Our Hospital

September 19, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of Down East Community Hospital, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance.* The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer Accountable Care Organizations (ACOs) that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Down East Community Hospital is a critical access hospital with a primary service area of approximately 15,000 individuals. Most of our physicians are hospital employed. Overall the hospital serves a Medicaid population of approximately 20%. Within our physician practices our OB/GYN's and pediatrician sees nearly 80% Medicaid.

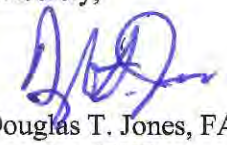
We are presently gearing up to participate in the Beacon Health, LLC, accountable care organization sponsored by Eastern Maine Healthcare Systems and expect to be a contracted member of that organization in February, 2013.

As a critical access hospital this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Engaging primary care practices in the enhanced primary care model endorsed by the project, either through participation in a recognized patient centered medical home/ health home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.
2. Committing to publicly reporting on a common set of measures, including total cost of care and patient experience. Additional measures will be determined through the Pathways to Excellence multi-stakeholder process.
3. Committing to the MHDO All Payer Database as a common claims data source and to a single source of analysis for the purposes of statewide public reporting on the measures determined in #2, and comparative statewide variation analysis necessary to gauge progress on and advance payment and delivery system reform.

4. Engaging in alternative reimbursement models which tie payment to accountability for cost and quality outcomes, moving toward greater accountability over time.
5. Participating in the learning collaborative(s) on medical home practice transformation and Accountable Care Organizations.
6. Engaging in activities to promote patient accountability, including the integration of shared decision making (SDM) at the practice level, exploration of patient incentives and benefit design, and partnerships to promote improved population health.
7. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

Sincerely,



Douglas T. Jones, FACHE
President/CEO
djones@dech.org
207-255-0223

September 21, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Dear Commissioner Mayhew:

On behalf of the Harrington Family Health Center, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Harrington Family Health Center (HFHC) is a private, non-profit community health center operating from a single site and serving western Washington County and a small portion of eastern Hancock County in the state of Maine. The Health Center was founded in 1984 and provides primary and preventive medical care, dental care, and mental/behavioral health and substance abuse services. The health center serve people with MaineCare, Medicare, private insurances and self-pay; including the use of a sliding scale. We currently deliver care to more than three thousand patients and a third of them are MaineCare members.

The health services we provide are essential given the dire health statistics in this county including having the highest state rate of obesity and cancer, one of the highest rates of diabetes, more than 16% of residents reported as having three or more chronic illnesses and a smoking rate of 31%. Additionally, this county has the highest state rate of poverty, the second lowest annual income, an unemployment rate of 11% and the highest number of residents over the age of 65.

HFHC currently participates in statewide healthcare transformation efforts. We have joined the Maine Community Accountable Care Organization along with eight other community health centers. We believe that a membership in this ACO will help us provide greater quality at a Primary Care level. We are also involved in meeting Meaningful Use criteria and becoming a certified Patient Center Medical Home. One of the key strategies is to provide care coordination services to best support our patients in getting the right care they need, when they need it, in the most cost effective manner possible.

As HFHC this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Engaging primary care practices in the enhanced primary care model endorsed by the project, either through participation in a recognized patient centered medical home/ health home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.
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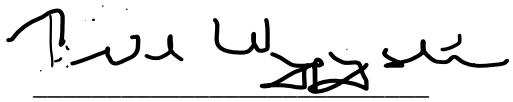
7. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

Sincerely,



Bill Wypyski, LCSW, MPA, MS
Chief Executive Officer
Harrington Family Health Center
50 E. Main Street
Harrington, ME 04643
(207)483-4502 ext. 230
bill.wypyski@harringtonfamilyhealth.org

HEALTH ACCESS NETWORK

September 21, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine04333-0040

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of Health Access Network, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Health Access Network operates 5 medical and 1 dental clinic with 25 Providers and 120 support staff. We currently serve in excess of 15,000 primary care patients of which 32% are MaineCare enrollees. HAN provides Family Practice, OB/GYN, pediatrics, podiatric, dental, occupational medicine, behavioral services and walk-in care.

We currently participate in statewide healthcare transformation in several ways including the Medicare PCMH Demonstration Project in our Medway Clinic, the expansion of the Maine statewide PCHC expansion in our Lincoln and Millinocket Clinics and the State's Medical Home project in our West Enfield and Lee Clinics.

As Health Access Network, this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

175 W. Broadway, PO Box 99, Lincoln, Maine 04457 · *ph* (207) 794-6700 · *fx* (207) 794-6777

1. Engaging primary care practices in the enhanced primary care model endorsed by the project , either through participation in a recognized patient centered medical home/ health-home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.
2. Committing to publicly reporting on a common set of measures, including total cost of care and patient experience. Additional measures will be determined through the Pathways to Excellence multi-stakeholder process.
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7. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

Sincerely

William Diggins, C.E.O.
Health Access Network
wdiggins@hanfqhc.org
(207)794-6700

MHCA
Maine Health Care Association

September 21, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of the Maine Health Care Association (MHCA), I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

MHCA represents 90% of the 108 nursing homes in Maine. According to the most recent statewide census report, our nursing homes are providing skilled Medicare rehabilitation to approximately 700 patients. All nursing home beds in Maine are dually certified for Medicaid and Medicare. MHCA is the only statewide organization that has the capacity to communicate directly with all long term care facilities.

Our organization seeks to provide support for increased cooperation between long term care providers and other entities listed in Item (2) above. To date we have been the key provider of long term care information for Maine's Value Based Purchasing initiative and the development of Accountable Care Organizations. MHCA has recently met with members of the Commissioner's staff to align our own proposal on a pay for performance plan with other statewide initiatives.

We believe that long term care facilities are an important, but often untapped, resource for state innovation and that MHCA provides the most effective way to incorporate these providers in the process. We therefore hope you will include us in this initiative.

Sincerely,

Richard A. Erb
President & Chief Executive Officer

rerb@mehca.org
(207) 623 146

MAINE MEDICAL ASSOCIATION

Dieter Kreckel, MD *President* • Guy Raymond, MD *President-Elect* • Lisa Ryan, DO *Chair, Board of Directors*
Gordon H. Smith, Esq. *Executive Vice President* • Andrew B. MacLean, Esq. *Deputy Executive Vice President*

September 21, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Dear Commissioner Mayhew:

On behalf of The Maine Medical Association, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - State Innovation Models: Funding for Model Design and Model Testing Assistance. The purpose of Maine's proposal – Testing the Maine Innovation Model – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

The Maine Medical Association (MMA) is the state's largest physician organization representing the interests of over 3700 physicians, medical students and residents. Established in 1853, MMA's mission is to support Maine physicians, advance the quality of medicine in Maine, and promote the health of all Maine citizens.

The association has previously been involved in many of Maine's ground-breaking QI initiatives including the multi-payer Patient Centered Medical Home and has established several QI initiatives under the direction of the association's Committee on Physician Quality.

As a representative of Maine's physicians, we commit to encouraging physician practices to adapt the primary care model endorsed by the project. We will publicize these efforts through the pages of Maine Medicine, our quarterly publication and the Weekly Update, our e-newsletter. These efforts include using the MHDO all-payer database as a common claims data source and encouraging the use of alternative reimbursement models.

In conclusion, the Maine Medical Association supports the goals of the proposal and encourages its funding.

Sincerely,

Dieter Kreckel, MD
President
president@mainemed.com
207-369-0146

September 19, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of the Maine Osteopathic Association, I am pleased to provide this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*.

The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

The Maine Osteopathic Association (MOA) represents approximately 400 osteopathic physicians in Maine, the majority of whom practice in primary care specialties. Our physicians are often the front line providers for Maine's families, including many MaineCare members, and work in some of the most rural and underserved areas of our state.

The MOA is a statewide member supported organization with a mission of serving the osteopathic profession through coordinated professional education, advocacy and member services in order to ensure the quality of osteopathic care to the people of Maine. A number of our practices are currently engaged in statewide

healthcare transformation projects including participation in the multi-payer PCMH pilot and in developing ACOs. The MOA also is an active member and partners with the Maine Health Management Coalition, Maine Health Data Organization and Quality Counts. We are also pleased to pledge our support to this initiative and hereby commit to supporting the *Testing the Maine Innovation Model* by participating in the following ways:

1. Engaging primary care practices in the enhanced primary care model endorsed by the project, either through participation in a recognized patient centered medical home/ health home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.
2. Committing to publicly reporting on a common set of measures, including total cost of care and patient experience. Additional measures will be determined through the Pathways to Excellence multi-stakeholder process.
3. Committing to the MHDO All Payer Database as a common claims data source and to a single source of analysis for the purposes of statewide public reporting on the measures determined in #2, and comparative statewide variation analysis necessary to gauge progress on and advance payment and delivery system reform.
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5. Participating in the learning collaborative(s) on medical home practice transformation and Accountable Care Organizations.
6. Engaging in activities to promote patient accountability, including the integration of shared decision making (SDM) at the practice level, exploration of patient incentives and benefit design, and partnerships to promote improved population health.
7. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

Once again, it is my pleasure to provide this letter of support and commend you on the efforts to tackle payment reform and delivery transformation in an effort to lower costs, improve the quality of care, and patient satisfaction. We are pleased to partner together with you and others on this important work.

Best regards,

Angela Cole Westhoff
Executive Director
Phone: 207-623-1101 ext. 2
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September 19, 2012

Mary Mayhew, Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of MaineGeneral Health and MaineGeneral Medical Center, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance.* The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Maine General Medical Center (MGMC) is the result of a merger between Kennebec Valley (KV) and Mid-Maine Medical Centers in 1997 and maintains campuses in Augusta and Waterville, Maine. Originating from the most mergers and consolidations of any hospital in the state, MGMC is guided by a single standard: *to maintain access in the KV region to an appropriate complement of coordinated primary and specialty care services.* MGMC includes MaineGeneral Physician Practices – 11 primary care groups and 14 specialty physician practices and, as a joint venture with Dartmouth Medical School, has a freestanding family medicine residency program. MaineGeneral Health (MGH), MGMC's parent company, is a medium size integrated health system in central, rural Maine. MGH also owns three other corporations: HealthReach Network, MaineGeneral Rehabilitation and Nursing Care, and MaineGeneral Retirement Community, which provide home health, behavioral health, hospice and palliative care as well as long-term care and rehab services. Within our primary care practices we serve approximately 26,000 Medicaid beneficiaries.

Of the 11 primary care practices within MGMC, 3 have been participating in the Multi-payer PCMH pilot since its start in 2010, and 3 more will join in the expansion of this pilot, beginning January 2013. As a member of the MaineHealth Management Coalition with representation on the Boards, we have been an active participant in their work on public reporting, payment reform and consumer engagement. Over the past two years we have entered into risk arrangements with the State of Maine as an employer based on access, quality and efficiency metrics. In the current year of the agreement with the State of Maine, we are agreeing to a pmpm target and will develop the analytics to move to global capitation over the next 2-3 years.

As MaineGeneral Health and MaineGeneral Medical Center this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Engaging primary care practices in the enhanced primary care model endorsed by the project, either through participation in a recognized patient centered medical home/ health home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.
2. Committing to publicly reporting on a common set of measures, including total cost of care and patient experience. Additional measures will be determined through the Pathways to Excellence multi-stakeholder process.
3. Committing to the MHDO All Payer Database as a common claims data source and to a single source of analysis for the purposes of statewide public reporting on the measures determined in #2, and comparative statewide variation analysis necessary to gauge progress on and advance payment and delivery system reform.
4. Engaging in alternative reimbursement models which tie payment to accountability for cost and quality outcomes, moving toward greater accountability over time.
5. Participating in the learning collaborative(s) on medical home practice transformation and Accountable Care Organizations.
6. Engaging in activities to promote patient accountability, including the integration of shared decision making (SDM) at the practice level, exploration of patient incentives and benefit design, and partnerships to promote improved population health.
7. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

Sincerely,

Scott B. Bullock

Scott B. Bullock
President/CEO
MaineGeneral Health
scott.bullock@mainegeneral.org
Tel: 207-872-1600

MARTIN'S POINT™
HEALTHCARE

September 20, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of Martin's Point Health Care, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Martin's Point has been caring for the health of Mainers for more than 30 years. At our nine convenient neighborhood locations we care for over 70,000 patients throughout southern Maine, Bangor, and Portsmouth, New Hampshire. We provide family medicine, internal medicine, pediatrics, ob-gyn, integrative medicine, osteopathic manipulation, travel medicine, cardiology, and more. Approximately 7% of our patients are covered by MaineCare.

We currently participate in many Maine-based healthcare transformation efforts.

- Three of our nine practices are participants in the statewide Patient-Centered Medical Home pilot.
- We operate under shared savings risk arrangements with Cigna Health Care and MaineSense. (MaineSense is an innovative employer-owned insurance program offered through a partnership between Martin's Point and the Maine Wellness Association.) We are also actively working with other payers to develop similar arrangements.

MARTIN'S POINT™
HEALTHCARE

- We are active members of the Maine Health Management Coalition (MHMC). David Howes, President and Chief Executive Officer, is Chair of the MHMC Foundation Board and staff actively participate on the Steering Committee and related workgroups in developing Advanced Primary Care standards and requirements.

As a health care delivery system, this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Engaging primary care practices in the enhanced primary care model endorsed by the project, either through participation in a recognized patient centered medical home/ health home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.
2. Committing to publicly reporting on a common set of measures, including total cost of care and patient experience. Additional measures will be determined through the Pathways to Excellence multi-stakeholder process.
3. Committing to the MHDO All Payer Database as a common claims data source and to a single source of analysis for the purposes of statewide public reporting on the measures determined in #2, and comparative statewide variation analysis necessary to gauge progress on and advance payment and delivery system reform.
4. Engaging in alternative reimbursement models which tie payment to accountability for cost and quality outcomes, moving toward greater accountability over time.
5. Participating in the learning collaborative(s) on medical home practice transformation and Accountable Care Organizations.
6. Engaging in activities to promote patient accountability, including the integration of shared decision making (SDM) at the practice level, exploration of patient incentives and benefit design, and partnerships to promote improved population health.
7. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

Sincerely

Betsy Johnson, MD, Chief Medical Officer
Martin's Point Health Care
betsy.johnson@martinspoint.org
(207) 828-2420

September 21, 2012

Mary Mayhew, Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Dear Commissioner Mayhew:

On behalf of Mercy Health System of Maine, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks. As this project develops, it is important to recognize that the health improvement and cost reduction opportunities in the commercial and Medicaid populations are quite different and that specialized providers unique to the Medicaid population must be engaged.

Mercy is a comprehensive provider network which administers physical and behavioral health care services that served 15,520 MaineCare members in 2011. Mercy is a member of Catholic Health East, a multi-institutional Catholic health system serving communities through regional healthcare systems in 11 eastern states from Maine to Florida.

Mercy has recently been selected by Cigna as a "Collaborative Accountable Care" Partner. Mercy has the distinction of being the only Hospital system in Southern Maine to have been selected. We will be working with Cigna to implement consistent population health activities that complement our Accountable Care Community. Mercy is working with another major payor to become a national ACO pilot.

"Maine Quality Counts!" has recently chosen three of our Primary Care Practices: Gorham Primary Care, Fore River Family Practice and Yarmouth Primary Care to participate in their second round of Patient Centered Medical Home (PCMH) pilots. In addition, we recently applied for and received NCQA recognition for these practices as well as Windham Primary Care. Specifically, Mercy Primary

Care is working with the State and others to change the way we deliver health care through comprehensive population health management teams. This includes partnering with interdisciplinary providers to ensure that our patients receive the high quality care they need, when they need it, and in the most appropriate and cost efficient manner. These efforts align well with the State's efforts to maximize preventative health and wellness, efficiently manage chronic disease, and reduce overall healthcare spending.

These programs will allow us to partner with both public and private payers to begin to test shared risk and Per Member per Month (PMPM) fee structures to help transition from our current fee for service model while achieving the triple aim of better health and better healthcare at lower cost.

Sincerely yours,

Eileen F. Skinner, MHA FACHE
President and CEO
Mercy Health System of Maine
skinnere@mercyme.com
207.879.3433

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MID COAST HOSPITAL

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September 21, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support and Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of Mid Coast Hospital, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction.

These "Triple Aim" goals; improving the health of the population, improving and coordinating healthcare, while lowering the cost of healthcare, will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Mid Coast Hospital is an independent, community-owned, nonprofit 92 bed hospital accredited by the Joint Commission and designated as a Magnet organization by the American Nurses Credentialing Center, providing a variety of healthcare services in the Bath-Brunswick-Topsham area of coastal Maine. The hospital is governed by a community board of directors.

We currently participate in statewide healthcare transformation in several ways. The primary care practices of Mid Coast Hospital, Mid Coast Medical Group in Bath, Primary Care and Walk in Clinic in Brunswick, and Mid Coast Medical Group in Topsham, are actively engaged in transforming healthcare delivery toward a patient-centered medical home model. Because primary care services at Mid Coast are part of an integrated delivery system of ambulatory and specialty services, acute care, home care and long term care services, there are opportunities for care coordination and efficient use of resources that are critical to any care delivery model and payment reform strategies.

Mid Coast Hospital currently has two primary care practices (Mid Coast Medical Group Bath and the Primary Care and Walk-in Clinic in Brunswick) that have been selected to participate in the CMS multi-payer PCMH expansion pilot. Our third primary care practice, Mid Coast Medical Group in Topsham, was selected as one of 10 practices in Maine to be part of the Patient Centered Medical Home Learning Collaborative sponsored by MaineHealth. As part of these projects, each practice is committed to becoming recognized by the National Committee for Quality Assurance (NCQA) as a patient centered medical home site in the next two years.

Mid Coast Hospital is a charter member of the Maine Health Management Coalition (MHMC) and have representation at the PTE, ACI and Cost Workgroups.

In 2011, Mid Coast developed a clear pathway, our "2020 Vision" for the transformation of healthcare in our community, which outlines the priorities of prevention and wellness, excellent patient experience, integrated and accountable care, continuous improvement to achieve superior outcomes and meeting community needs. The Maine Innovation Model has potential to help us to achieve this vision.

As a provider this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Engaging primary care practices in the enhanced primary care model endorsed by the project, either through participation in a recognized patient centered medical home/ health home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.

2. Committing to publicly reporting on a common set of measures, including total cost of care and patient experience. Additional measures will be determined through the Pathways to Excellence multi-stakeholder process.

3. Committing to the MHDO All Payer Database as a common claims data source and to a single source of analysis for the purposes of statewide public reporting on the measures determined in #2, and comparative statewide variation analysis necessary to gauge progress on and advance payment and delivery system reform.

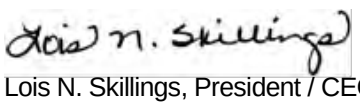
4. Engaging in alternative reimbursement models which tie payment to accountability for cost and quality outcomes, moving toward greater accountability over time.

5. Participating in the learning collaborative(s) on medical home practice transformation and Accountable Care Organizations.

6. Engaging in activities to promote patient accountability, including the integration of shared decision making (SDM) at the practice level, exploration of patient incentives and benefit design, and partnerships to promote improved population health.

7. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

Sincerely



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September 21, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of Northern Maine Medical Center, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance.* The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

MaineCare members make up 17.44% of the patients served by Northern Maine Medical Center's 26 providers.

As Northern Maine Medical Center this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Engaging primary care practices in the enhanced primary care model endorsed by the project, either through participation in a recognized patient centered medical home/ health home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.

2. Committing to publicly reporting on a common set of measures, including total cost of care and patient experience. Additional measures will be determined through the Pathways to Excellence multi-stakeholder process.
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5. Participating in the learning collaborative(s) on medical home practice transformation and Accountable Care Organizations.
6. Engaging in activities to promote patient accountability, including the integration of shared decision making (SDM) at the practice level, exploration of patient incentives and benefit design, and partnerships to promote improved population health.
7. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

Sincerely,

Peter J. Sirois
Chief Executive Officer
peter.sirois@nmmc.org
207-834-1411

Penobscot Community Health Care

President & CEO
Kenneth Schmidt, MPA

Executive Medical Director
Robert Allen, MD, FACC

Board Chair
Ann Wiersma

Founding Physician
Barbara Vereault, DO

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Bangor, ME 04402
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Bangor, ME 04402
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Bangor, ME 04402
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207-947-0768

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Brewer
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Bangor, ME 04402
207-992-2601

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P.O. Box 439
Bangor, ME 04402
207-992-2636

CAPEHART COMMUNITY HEALTH CENTER
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Bangor, ME 04402
207-992-2393

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P.O. Box 439
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MEDICAL SPECIALISTS
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HOPE HOUSE
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EASTERN MAINE AIDS NETWORK
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207-990-3626

September 20, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of Penobscot Community Health Care (PCHC), I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

PCHC is by far the largest and most comprehensive of the 19 Federally Qualified Health Centers (FQHC) in Maine and the 3rd or 4th largest of the over 100 FQHCs in New England. Our 650 employees including 180 clinicians provide fully integrated primary care services for about 60,000 people, including almost 20,000 Medicaid participants; we provide over 300,000 patient visits a year and over 100,000 visits for MaineCare participants. We provide three large family practices, a large pediatric center, all with fully integrated psychiatry-mental health services: we employ about 35 mental health providers - a ratio of one mental health provider to every two primary medical providers.

PCHC also provides dental care (23 dentists), three 340B pharmacies, almost 30 care management professionals, physical therapists, audiologists, speech therapists, podiatry, dermatology, GYN, and two clinics for homeless persons as well as a homeless shelter. In addition we provide three school clinics, an AIDS/HIV prevention and case work service, our own high complexity lab and x-ray, and other services. We are one of only 11 designated Teaching Health Centers in America and an Area Education Center training over 300 health care professionals a year. We "grow our own" by operating four residencies: an accredited General Practice Dental Residency for six dentists a year; a two year Pediatric Dental Residency for eight dentists; a Community Pharmacy Residency for four pharmacists; and one of only 4-5 Nurse Practitioner Residencies in the country, for four graduate nurse practitioners.

We currently are a leader in the state in healthcare transformation in several ways:

- PCHC was one of the first FQHCs in America for all of its practices to achieve NCQA PCMH Certification. In 2012 we will achieve all practices at Level III.
- PCHC is the only of the 19 FQHCs in Maine to be accredited by the Joint Commission.
- In fact, it is the first health care organization of any kind in Maine and only the 11th health care organization of any kind in America to be Certified by the Joint Commission as a Primary Care Medical Home.
- Three of PCHC's practices were selected among only 23 others to pioneer the Maine Patient Centered Medical Home Pilot which is called by the federal sponsoring agency – "The Beacon of Beacons". We have dramatically cut ED usage and hospitalizations by measurably and significantly improving health status among multiple chronic disease patients.
- PCHC was one of the three key health care organizations anchoring the federal Beacon Communities grant initiative in Bangor Maine.
- PCHC is one of the first FQHCs in the country and the first in Maine to join a Medicare Pioneer Accountable Care Organization (ACO) – with Eastern Maine Healthcare Systems.
- PCHC is eager to participate in the planned MaineCare ACO.
- PCHC has used electronic medical records for eight years.
- PCHC's four largest practices are open seven full days a week, as well as early mornings and weeknights until 7-8 pm. We provide 24 hour on-call provider communications for patients by telephone. We provide same day sick care, and walk in care.
- PCHC is part of the Maine Health Information Network, and our providers are the single biggest user in Maine of HIN shared patient data.
- PCHC was the first health care organization in Maine to be recognized as a Leader in LGBT Healthcare Equality.
- PCHC is a member of Maine Quality Counts and the Maine Health Management Coalition initiatives for high quality health care at reduced costs.

As a provider organization this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Engaging primary care practices in the enhanced primary care model endorsed by the project, either through participation in a recognized patient centered medical home/ health home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.
2. Committing to publicly reporting on a common set of measures, including total cost of care and patient experience. Additional measures will be determined through the Pathways to Excellence multi-stakeholder process.
3. Committing to the MHDO All Payer Database as a common claims data source and to a single source of analysis for the purposes of statewide public reporting on the measures determined in #2, and comparative statewide variation analysis necessary to gauge progress on and advance payment and delivery system reform.
4. Engaging in alternative reimbursement models, whenever feasible for PCHC, which tie payment to accountability for cost and quality outcomes, moving toward greater accountability over time.
5. Participating in the learning collaborative(s) on medical home practice transformation and

6. Engaging in activities to promote patient accountability, including the integration of shared decision making (SDM) at the practice level, exploration of patient incentives and benefit design, and partnerships to promote improved population health.
7. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

Sincerely,

Kenneth Schmidt, MPA
President and Chief Executive Officer
Penobscot Community Health Care
207-992-9200
ceo@pchc.com

PINES HEALTH SERVICES
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September 21, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

RE: Letter of Support & Commitment

Dear Commissioner Mayhew:

On behalf of Pines Health Services, a Federally Qualified Health Center serving the residents of rural central and northern Aroostook County, ME, I am writing this letter in support of the State of Maine's application for funding under **CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance***. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower health system costs, while improving quality of care and patient satisfaction. These goals (i.e. **the Triple Aim goals**) will be accomplished through public/ private collaboration of providers such as Pines, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance-based payment reform, as well as public reporting of common quality benchmarks.

Pines Health Services is a multi-specialty, multi-site physician practice designated as a Federally Qualified Health Center. Our group includes approximately 45 primary care and specialty physicians and mid-level providers (FNPs, CNMs, PA-Cs) covering a comprehensive range of outpatient and inpatient care. Within the primary care provider portion of the practice, we deliver care to over 16,000 unique patients in extreme northern Maine. Our service area is entirely rural, and population density approaches frontier status. The primary care group generates almost 60,000 patient visits annually. In the primary care arena, we offer Internal Medicine, Family Medicine, Pediatrics and Obstetrics/Gynecology. Four of our five primary care health centers offer extended early morning and late evening hours, and our Caribou Health Center is open on Saturday. Roughly one-third of our patients have Medicaid (MaineCare) as their primary source of payment for care. Medicare patients, given the substantial size of the 65+ year old population in Aroostook County (almost 24 percent), account for another one-third of our unique patients.

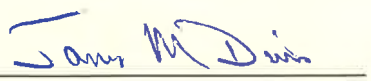
Pines Health Services currently participates in statewide healthcare transformation in several ways:

- Clinical activities - -
  - o Maine Health Management Coalition
  - o Pathways to Excellence recognition with three ribbons
  - o Anthem Blue Cross/Blue Shield recognition as a preferred provider on the basis of quality and cost of care
  - o NCQA recognition of providers in the areas of Diabetes, Heart and Stroke
  - o Application under submission to NCQA (filed with HRSA) for PCMH designation
  - o Admitted to January 2013 class of the Quality Counts PCMH Multi-Payer Pilot Expansion
  - o Recognition in recent years by the Maine CDC for exemplary performance and collaboration (Director's Award) for immunization compliance
  - o Behavioral Health integration with local partner (Aroostook Mental Health Centers) and telepsychiatry partner (Access Psychiatry)
  - o Expect to receive Meaningful Use EHR incentives for Year 1, Stage 2 in Spring 2013 (Year 1, Stage 1 received December 2011)
- Administrative => clinical activities - -
  - o Maine Community Health Options (ACA Co-op)
  - o Maine Community Accountable Care Organization (Medicare Shared Savings Program)
  - o Maine Primary Care Association – statewide PCMH Learning Collaborative

By transmission of this letter, Pines Health Services also **commits** to supporting *Testing the Maine Innovation Model* by participating to the best of our clinical, information system and administrative ability in the following manner:

1. Engaging our multi-site primary care practice in the enhanced primary care model endorsed by the project, either through participation in a recognized patient centered medical home/ health home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.
2. Publicly reporting on a common set of measures, including total cost of care and patient experience. Additional measures will be determined through the Pathways to Excellence multi-stakeholder process.
3. Utilizing the MHDO All Payer Database as a common claims data source and as a single source of analysis for the purposes of statewide public reporting on the measures determined in #2, and comparative statewide variation analysis necessary to gauge progress on and advance payment and delivery system reform.
4. Engaging in alternative reimbursement models which tie payment to accountability for cost and quality outcomes, moving toward greater accountability over time.
5. Participating in the learning collaborative(s) on medical home practice transformation and Accountable Care Organizations.
6. Engaging in activities to promote patient accountability, including the integration of shared decision making (SDM) at the practice level, exploration of patient incentives and benefit design, and partnerships to promote improved population health.
7. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

Sincerely



James M. Davis
Chief Executive Officer
E-mail: jdavis@pineshealth.org
Phone: 207/498-2359 x2022

SACOPEE VALLEY
HEALTH CENTER

Mailing Address: PO Box 777, Parsonsfield, ME 04047 • Physical Address: 70 Main Street, Porter ME 04068
Phone (207) 625-8126 • Fax (207) 625-7820
www.svhc.org

September 20, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of Sacopee Valley Health Center, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Founded in 1976, Sacopee Valley Health Center (SVHC) is a 501(c) (3) not-for-profit, single site, community based Federally Qualified Health Center (FQHC) located in a remote rural region of southwestern Maine. The mission of SVHC is providing the best healthcare for our community. SVHC is an important resource for all populations, and specifically targets low income, uninsured and underinsured service area residents, who, with the Medicaid population, make up more than 55% of the Center's users. SVHC also provides outreach clinics and health education forums in the community. As a region, Sacopee Valley is quite poor, more so than the state of Maine whose per capita income ranks 34th in the country. The service area has a population of 21,761 (U.S. Census, 2010). The Center is located 26 miles from the nearest community hospital and 45 miles from the nearest tertiary hospital in Portland, Maine. In calendar year 2011, 4,353 patients received care at SVHC. SVHC has had a fully integrated electronic medical record since 2007.

We currently participate in statewide healthcare transformation in several ways. We have been selected as a participant for round two of the multi-payer PCMH pilot and are a member of the recently formed Maine Community Accountable Care Organization.

As provider this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Engaging primary care practices in the enhanced primary care model endorsed by the project, either through participation in a recognized patient centered medical home/ health home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.
2. Committing to publicly reporting on a common set of measures, including total cost of care and patient experience. Additional measures will be determined through the Pathways to Excellence multi-stakeholder process.
3. Committing to the MHDO All Payer Database as a common claims data source and to a single source of analysis for the purposes of statewide public reporting on the measures determined in #2, and comparative statewide variation analysis necessary to gauge progress on and advance payment and delivery system reform.
4. Engaging in alternative reimbursement models which tie payment to accountability for cost and quality outcomes, moving toward greater accountability over time.
5. Participating in the learning collaborative(s) on medical home practice transformation and Accountable Care Organizations.
6. Engaging in activities to promote patient accountability, including the integration of shared decision making (SDM) at the practice level, exploration of patient incentives and benefit design, and partnerships to promote improved population health.
7. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

Sincerely,

Maryagnes Gillman, MS, RN
Executive Director
Sacopee Valley Health Center
70 Main Street
Porter, Maine 04068

207-625-8129 ext 161
mgillman@svhc.org
www.svhc.org

St. Joseph Healthcare
St. Joseph Hospital
In the Spirit of Healing
Sponsored by Covenant Health Systems
Founded by the Felician Sisters

Provider letter of Support
360 Broadway, PO Box 403
Bangor, Maine 04402-0403
ph: 207.907.1000 fax: 207.262.1922
www.stjoeshealing.org

September 20, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of St. Joseph Healthcare, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

St. Joseph Healthcare includes a community, acute care hospital, home care and hospice services, and primary and specialty physician practices. Our primary care practices serve 500 MaineCare members, which is approximately 5% of their overall patient population.

We currently participate in healthcare transformation in several ways. St. Joseph Healthcare is among the partner organizations of Bangor Beacon Community which is currently improving the health of people with chronic conditions such as diabetes, chronic obstructive pulmonary disease, congestive heart failure, and asthma. These efforts have been funded through a three-year federal grant from the Office of the National Coordinator for Health Information Technology. A natural expansion of the Bangor Beacon care management model includes a community Accountable Care Organization (ACO). We are joining the pioneer Beacon Health ACO in a collaborative effort with Eastern Maine Health Systems and Penobscot Community Health Center. Additionally, we are a long-standing member of the Maine Health Management Coalition and serve on its committees and projects. Our primary care practices will be included in the MaineCare Health Homes Initiative.

This letter also represents St. Joseph Healthcare's **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Engaging primary care practices in the enhanced primary care model endorsed by the project, either through participation in a recognized patient centered medical home/ health home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.
2. Committing to publicly reporting on a common set of measures, including total cost of care and patient experience. Additional measures will be determined through the Pathways to Excellence multi-stakeholder process.
3. Committing to the MHDO All Payer Database as a common claims data source and to a single source of analysis for the purposes of statewide public reporting on the measures determined in #2, and comparative statewide variation analysis necessary to gauge progress on and advance payment and delivery system reform.
4. Engaging in alternative reimbursement models which tie payment to accountability for cost and quality outcomes, moving toward greater accountability over time.
5. Participating in the learning collaborative(s) on medical home practice transformation and Accountable Care Organizations.
6. Engaging in activities to promote patient accountability, including the integration of shared decision making (SDM) at the practice level, exploration of patient incentives and benefit design, and partnerships to promote improved population health.
7. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

Sincerely,

Dennis L. Shubert M.D., Ph.D.
Vice-President Medical Affairs
St. Joseph Healthcare

YORK COUNTY COMMUNITY HEALTH CARE

Access to Quality Medical, Dental & Mental Health Services For All

Health Care Providers

Robert Grace, DMD
Carmella Dube, RDH
Gretchen Pianka, MD
Laura Hill, FNP
Mary Jeralds, RN
Marie Guay, DO
Marte McNally, LCPC
Karen Abendroth, LCSW

32 Patriot Lane, PO Box 72, Sanford, ME 04073
Phone: (207) 490-6900 FAX: (207) 324-0546

September 21, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of York County Community Health Care, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

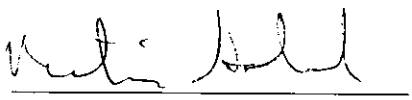
Founded in 2005, York County Community Health Care is a federally qualified health center that provides medical, dental and behavioral health care services to residents to a panel of roughly 2,400 patients living in the Sanford area. Our clinical sites are located in Sanford and at the York County Shelter in Alfred and approximately 54% of our patients have MaineCare coverage.

We currently participate in statewide healthcare transformation in several ways. We participate in the Multi-Payer Patient Centered Medical Home Pilot and the Medicare Shared Savings Program as a member of the Maine Community Accountable Care Organization. We anticipate receipt NCQA recognition as a Patient Centered Medical Home and completion of Year 2 Meaningful Use requirements by January 1, 2013.

This letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Engaging primary care practices in the enhanced primary care model endorsed by the project, either through participation in a recognized patient centered medical home/ health home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.
2. Committing to publicly reporting on a common set of measures, including total cost of care and patient experience. Additional measures will be determined through the Pathways to Excellence multi-stakeholder process.
3. Committing to the MHDO All Payer Database as a common claims data source and to a single source of analysis for the purposes of statewide public reporting on the measures determined in #2, and comparative statewide variation analysis necessary to gauge progress on and advance payment and delivery system reform.
4. Engaging in alternative reimbursement models which tie payment to accountability for cost and quality outcomes, moving toward greater accountability over time.
5. Participating in the learning collaborative(s) on medical home practice transformation and Accountable Care Organizations.
6. Engaging in activities to promote patient accountability, including the integration of shared decision making (SDM) at the practice level, exploration of patient incentives and benefit design, and partnerships to promote improved population health.
7. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

Sincerely



Martin Sabol
Director of Health Services
martin.sabol@yccac.org
207-608-4470

Community Care "Building Care and Understanding in the Communities We Serve"

September 20, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Behavioral Health Provider Organizations

Dear Commissioner Mayhew:

On behalf of Community Care I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Community Care is a private non-profit agency that serves children, families, and adult consumers throughout the State of Maine. Services are provided to clients who have behavioral health needs in a comprehensive service delivery system that includes: treatment level foster care, in-home treatment supports (HCT); targeted case management; adult community integration (case management and support); out- patient counseling/therapy; and children's medication management. During Fiscal Year 2012, Community Care served 758 individual clients—of whom 99% had Maine Care coverage.

As a **Behavioral Health** provider, this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Supporting and engaging in the behavioral health integration movement of the enhanced primary care model and MaineCare's Health Homes Initiative (the patient centered medical home with integration of physical and behavioral health, and community care teams for high risk/ high cost patients), with the expectation that participating behavioral health providers will apply to become Health Homes to serve individuals with serious mental illness.
2. Implementing Health Information Technology to promote care coordination and integration with physical health.

Post Office Box 936 • Bangor, Maine 04402-0936 • 207-945-4240 • 207-990-3660 fax • 207-945-4329 TDD

3. Participating in the Behavioral Health Cost Work Group (a sub group of the ongoing Health Care Cost Work Group initiative of Maine Health Management Coalition)
4. Committing to reporting on a mutually agreed upon common set of Behavioral Health measures, which will be publicly reported. These measures will be developed in cooperation with Pathways to Excellence (Maine Health Management Coalition).
5. Participating in the Behavioral Health learning collaborative to be developed as part of the continuous quality improvement efforts of the Innovation Model.

Sincerely

Kate Davis
kdavis@comcareme.org
207-945-4240

Caring and serving since 1883®

Community Health and Counseling Services
Home Health, Hospice and Mental Health Services

PO Box 425
Bangor, Maine 04402-0425
Tel. 207-947-0366
TTY 207-990-4730
www.chcs-me.org

September 18, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Behavioral Health Provider Organizations

Dear Commissioner Mayhew:

On behalf of Community Health and Counseling Services, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance.* The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Community Health and Counseling Services (CHCS) is a comprehensive community-based behavioral health, home health and hospice service provider. CHCS serves adults, children and families throughout seven counties, in mostly rural central, eastern, and northern Maine. CHCS is engaged in several initiatives that are focused on improving the integration of care between behavioral health and primary care. CHCS is a partner in the Bangor ONC Beacon project and holds a SAMHSA Primary and Behavioral Health Integration grant. CHCS annually serves approximately 6,000 individuals. Roughly 85% of the population served are MaineCare members. The behavioral health services provided by CHCS include: Treatment Foster Care, Targeted Case Management, Medication Management, Outpatient Therapy, Home and Community-based Treatment, Residential Group Care, Multidimensional Treatment, Crisis Services, Medication Management, Community Integration, ACT, Community Rehabilitation Services, Housing Supports, Homeless Outreach, Specialized Groups, Transitional Housing and Care Management within the Beacon project.

As a **Behavioral Health** provider, this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Supporting and engaging in the behavioral health integration movement of the enhanced primary care model and MaineCare's Health Homes Initiative (the patient centered medical home with integration of physical and behavioral health, and community care teams for high risk/ high cost patients), with the expectation that participating behavioral health providers will apply to become Health Homes to serve individuals with serious mental illness.
2. Implementing Health Information Technology to promote care coordination and integration with physical health.
3. Participating in the Behavioral Health Cost Work Group (a sub group of the ongoing Health Care Cost Work Group initiative of Maine Health Management Coalition)
4. Committing 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 (Maine Health Management Coalition).
5. Participating in the Behavioral Health learning collaborative to be developed as part of the continuous quality improvement efforts of the Innovation Model.

Sincerely

Dale Hamilton

Dale Hamilton, Executive Director
dhamilton@chcs-me.org
(207) 922-4701

September 20, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Behavioral Health Provider Organizations

Dear Commissioner Mayhew:

On behalf of ESM, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performanee based payment reform and public reporting of common quality benchmarks.

ESM is a Community Rehabilitation Agency that was established in January of 1992. ESM serves individuals with Mental Health and Intellectual Disabilities. We work with over 700 consumers throughout Central Maine. Services that we provide are Case Management, Employment Services, Children Services, Assisted Living, Community Supports, Residential Care and Clinical Services. ESM's referral and paying sourees are from the business community, self-pay, and approximately 95% are members of Maine Care.

As a **Behavioral Health** provider, this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Supporting and engaging in the behavioral health integration movement of the enhanced primary care model and Maine Care's Health Homes Initiative (the patient centered medieal home with integration of physical and behavioral health, and community care teams for high risk/ high cost patients), with the expectation that participating behavioral health providers will apply to become Health Homes to serve individuals with serious mental illness.
2. Implementing Health Information Technology to promote care coordination and integration with physical health.

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Augusta, ME 04330
Phone: (207) 622-5946
Fax: (207) 622-4667
TTY: (207) 629-5106

Northern Division:
209 North Ave.
Skowhegan, ME 04976
Phone: (207) 474-9612
Fax: (207) 474-2172
TTY: (207) 629-5106

Western Division:
336 Center St.
Auburn, ME 04210
Phone: (207) 783-2617
Fax: (207) 783-2619
TTY: (207) 629-5106

Eastern Division:
175 Union St.
Bangor, ME 04401
Phone: (207) 217-6003
Fax: (207) 217-6004
TTY: (207) 629-5106

3. Participating in the Behavioral Health Cost Work Group (a sub group of the ongoing Health Care Cost Work Group initiative of Maine Health Management Coalition)

4. Committing 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 (Maine Health Management Coalition).

5. Participating in the Behavioral Health learning collaborative to be developed as part of the continuous quality improvement efforts of the Innovation Model.

Sincerely,

Jean A. Gallant

Jean A. Gallant / President
jgallant@esm-augusta.com
(207) 622-5946

Harbor Family Services

Jack E. Mazzotti III
President & CEO

Administration & Finance
63 Elm Street, Suite A
Topsham, ME 04086
Phone: 207.725.6505
Fax: 207.798.5449
Toll Free: 1.877.777.5448

Operations
1295 Atlantic Highway
Northport, ME 04849
Phone: 207.470-7090
Fax: 207.338.5381

Human Resources
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Phone: 207.470-7090
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Community Services
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Fax: 207.470.7094
Toll Free: 1.866.463.8003

Community Services
Waldo County
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Northport, ME 04849
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Fax: 207.338.5381
Toll Free: 1.866.463.8003

Rockport I Campus
1180 Rockland Street
P.O. Box 230
West Rockport, ME 04865
Phone: 207.236.6179
Fax: 207.236.6189
Toll Free: 1.800.891.6003

Rockport II Campus
1152 Rockland Street
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West Rockport, ME 04865
Phone: 207.236.2779
Fax: 207.236.0024
Toll Free: 1.866.999.3420

Winterport Campus
1181 North Main Street
Winterport, ME 04496
Phone: 207.223.4200
Fax: 207.223.2597

September 19, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Behavioral Health Provider Organizations

Dear Commissioner Mayhew:

On behalf of Harbor Family Services, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance.* The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Harbor Family Services is a nationally accredited, state licensed, behavioral healthcare not-for-profit that served, in fiscal year 2012, more than 1000 MaineCare children and families in the greater mid-coast region of Maine by offering an expansive continuum of behavioral health programming including residential care, mental health and substance abuse outpatient counseling, medication management, case management and home and community treatment.

As a **Behavioral Health** provider, this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Supporting and engaging in the behavioral health integration movement of the enhanced primary care model and MaineCare's Health Homes Initiative (the patient centered medical home with integration of physical and behavioral health, and community care teams for high risk/ high cost patients), with the expectation that participating behavioral health providers will apply to become Health Homes to serve individuals with serious mental illness.
2. Implementing Health Information Technology to promote care coordination and integration with physical health.
3. Participating in the Behavioral Health Cost Work Group (a sub group of the ongoing Health Care Cost Work Group initiative of Maine Health Management Coalition)
4. Committing 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 (Maine Health Management Coalition).
5. Participating in the Behavioral Health learning collaborative to be developed as part of the continuous quality improvement efforts of the Innovation Model.

Sincerely,

Jack E. Mazzotti III
President & CEO
(207) 798-5448
jmazzotti@harborfamilyservices.org

) Health Affiliates Maine
P.O. Box 1150, Auburn, Maine 04211

September 19, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Behavioral Health Provider Organizations

Dear Commissioner Mayhew:

On behalf of Health Affiliates Maine, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Health Affiliates Maine is a statewide mental health agency providing outpatient therapy and case management services to adults, children, and families. Our goal is to reduce the stigma associated with accessing mental health treatment by offering services in the consumers' local communities. We provide treatment to approximately 4000 Maine residents across the state with an estimated 88% of them having MaineCare insurance.

As a **Behavioral Health** provider, this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Supporting and engaging in the behavioral health integration movement of the enhanced primary care model and MaineCare's Health Homes Initiative (the patient centered medical home with integration of physical and behavioral health, and community care teams for high risk/ high cost

) Health Affiliates Maine
P.O. Box 1150, Auburn, Maine 04211

patients), with the expectation that participating behavioral health providers will apply to become Health Homes to serve individuals with serious mental illness.
2. Implementing Health Information Technology to promote care coordination and integration with physical health.
3. Participating in the Behavioral Health Cost Work Group (a sub group of the ongoing Health Care Cost Work Group initiative of Maine Health Management Coalition)
4. Committing 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 (Maine Health Management Coalition).
5. Participating in the Behavioral Health learning collaborative to be developed as part of the continuous quality improvement efforts of the Innovation Model.

Sincerely,

Andrea L. Krebs, LCSW
Executive Director
(207) 333-3278
andrea.krebs@healthaffiliatesmaine.com

Kennebec
BEHAVIORAL HEALTH
Mental Health and Substance Abuse Specialists
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Concourse Clinic
16 Concourse West
Suite 2
Waterville, Maine
04901-6007
207-680-4635
207-872-9450 Fax

Augusta Clinics
66 Stone Street
Augusta, Maine
04330-5227
207-626-3455
207-626-3612 Fax

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207-626-3478
207-626-7586 Fax

Skowhegan Clinic
5 Commerce Drive
Skowhegan, Maine
04976-1828
207-474-8368
207-474-7794 Fax

Winthrop Clinic
736 Old Lewiston Rd
Winthrop, Maine
04364-4121
207-377-8122
207-377-8564 Fax

www.kbhmaine.org

International Center for Clubhouse Development

National Alliance on Mental Illness

Commission on Accreditation of Rehabilitation Facilities

September 19, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Behavioral Health Provider Organizations

Dear Commissioner Mayhew:

On behalf of Kennebec Behavioral Health, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance.* The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Currently, Kennebec Behavioral Health provides services for approximately 14,000 persons annually in our programs. Our service area primarily covers seven Maine counties. Approximately, 80% of our clients are MaineCare members.

As a **Behavioral Health** provider, this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Supporting and engaging in the behavioral health integration movement of the enhanced primary care model and MaineCare's Health Homes Initiative (the patient centered medical home with integration of physical and behavioral health, and community care teams for high risk/ high cost patients), with the expectation that participating behavioral health providers will apply to become Health Homes to serve individuals with serious mental illness.
2. Implementing Health Information Technology to promote care coordination and integration with physical health.
3. Participating in the Behavioral Health Cost Work Group (a sub group of the ongoing Health Care Cost Work Group initiative of Maine Health Management Coalition)
4. Committing 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 (Maine Health Management Coalition).
5. Participating in the Behavioral Health learning collaborative to be developed as part of the continuous quality improvement efforts of the Innovation Model.

Sincerely,

Thomas J. McAdam
Chief Executive Officer
tmcadam@kbhmaine.org
207-873-2136

TJM/jg

Your resource for life.
MaineGeneral Health
10 Water Street Suite 303
Waterville, ME 04901
Phone: 207.861.3400
TDD: 207.861.3498
Fax: 207.861.3419

www.mainegeneral.org

September 20, 2012

Mary Mayhew, Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment

Dear Commissioner Mayhew:

In conjunction with the letter of support and commitment from Scott Bullock, CEO and President of MaineGeneral Health, I am writing this letter on behalf of the behavioral health services provided by MaineGeneral Medical Center and HealthReach Network. We support Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across Maine-Care, Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These Triple Aim goals will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

MaineGeneral Medical Center, a community hospital and HealthReach Network, a community agency serve the greater Kennebec County region. MaineGeneral Medical Center offers inpatient psychiatric and detoxification acute care, intensive outpatient services, psychiatric medication and ECT treatment to 5000 patients annually. HealthReach Network is licensed to provide mental health and substance abuse treatment, offering Assertive Community Treatment, counseling, residential treatment and HIV risk reduction to the greater Kennebec community, and serving 1600 clients annually.

As a **Behavioral Health** provider, this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Supporting and engaging in the behavioral health integration movement of the enhanced primary care model and MaineCare's Health Homes Initiative (the patient centered medical home with integration of physical and behavioral health, and community care teams for high risk/ high cost patients), with the expectation of applying to become Health Homes serving individuals with serious mental illness.
2. Implementing Health Information Technology to promote care coordination and integration with physical health.
3. Participating in the Behavioral Health Cost Work Group of Maine Health Management Coalition.
4. Committing to reporting on a common set of Behavioral Health measures, which will be developed in cooperation with Pathways to Excellence and publicly reported.

5. Participating in the Behavioral Health learning collaborative to be developed as part of the continuous quality improvement efforts of the Innovation Model.

Sincerely,

Emilie L. van Eeghen, Vice President
Behavioral Health Services
(207) 861-3414

spurwink

Going the distance, changing lives.

September 19, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Behavioral Health Provider Organizations

Dear Commissioner Mayhew:

On behalf of Spurwink Services, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e., the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Spurwink Services is a nationally accredited non-profit that provides a broad range of mental health and educational services for children, adolescents, adults and families. Standing on a strong foundation of 50 years, we have a commitment to quality services and the recruitment of caring, compassionate professionals. Spurwink has gained a reputation for excellence in evidence-based treatment and service delivery throughout New England. In FY 2012, Spurwink provided services to approximately 5,160 individuals, 62% of whom received MaineCare.

As a **Behavioral Health** provider, this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Supporting and engaging in the behavioral health integration movement of the enhanced primary care model and MaineCare's Health Homes Initiative (the patient centered medieal home with integration of physical and behavioral health, and community care teams for high risk/ high cost patients), with the expectation that participating behavioral health providers will apply to become Health Homes to serve individuals with serious mental illness.
2. Implementing Health Information Technology to promote care coordination and integration with physical health.

3. Participating in the Behavioral Health Cost Work Group (a sub group of the ongoing Health Care Cost Work Group initiative of Maine Health Management Coalition)
4. Committing 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 (Maine Health Management Coalition).
5. Participating in the Behavioral Health learning collaborative to be developed as part of the continuous quality improvement efforts of the Innovation Model.

Sincerely,

Dawn Stiles
President
dstiles@spurwink.org
207-871-1211, ext. 2197

Sweetser

Serving Children and Families since 1828

CARLTON D. PENDLETON
PRESIDENT AND CHIEF EXECUTIVE OFFICER
207-294-4440
cpendleton@sweetser.org

September 19, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine04333-0040

Letter of Support & Commitment
For Behavioral Health Provider Organizations

Dear Commissioner Mayhew:

On behalf of Sweetser, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Sweetser is a 185 year old, not for profit, social services provider serving Maine citizens. In FY12, we served over 18,000 clients; approximately 80% were MaineCare members.

As a **Behavioral Health** provider, this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Supporting and engaging in the behavioral health integration movement of the enhanced primary care model and MaineCare's Health Homes Initiative (the patient centered medical home with integration of physical and behavioral health, and community care teams for high risk/ high cost patients), with the expectation that participating behavioral health providers will apply to become Health Homes to serve individuals with serious mental illness.
2. Implementing Health Information Technology to promote care coordination and integration with physical health.
3. Participating in the Behavioral Health Cost Work Group (a sub group of the ongoing Health Care Cost Work Group initiative of Maine Health Management Coalition)

.../1

4. Committing 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 (Maine Health Management Coalition).
5. Participating in the Behavioral Health learning collaborative to be developed as part of the continuous quality improvement efforts of the Innovation Model.

Sincerely,

Carlton D. Pendleton
President & CEO
cpendleton@sweetser.org
(207) 294-4440

TRI-COUNTY MENTAL HEALTH SERVICES

We offer hope

Referral Line: 1-888-304-HOPE (4673)
Statewide Crisis Services: 1-888-568-1112
TTY: 1-888-568-1112
MAIL TO: P.O. Box 2008
Lewiston, ME 04241-2008
www.tcmhs.org

ADMINISTRATION/ OUTPATIENT LEWISTON
1155 Lisbon Street
Lewiston, ME 04240
Main Number 783.9141
Toll Free: 1.800.787.1155

EMERGENCY & COMMUNITY BASED SERVICES
230 Bartlett Street
Lewiston, ME 04240
Main Number 783.4695
Toll Free: 1.800.550.3427

SOCIAL LEARNING CENTER
80 Strawberry Ave
Lewiston, ME 04240
Main Number 783.4672
Toll Free: 1.877.208.6134

BRIDGTON
32 No. High Street
Bridgton, ME 04009
Main Number 647.5629
Toll Free: 1.800.286.5629

FARMINGTON
144 High Street, Ste 1
Farmington, ME 04938
Main Number 778.3556
Toll Free: 1.800.559.3556

OXFORD HILLS
143 Pottle Road
Oxford, ME 04270
Main Number 743.7911
Toll Free: 1.800.750.7911

RUMFORD
49 Congress Street
Rumford, ME 04276
Main Number 364.7981
Toll Free: 1.800.371.7981

WINDHAM
744 Roosevelt Trail
No. Windham, ME 04062
Main Number 892.4623

September 18, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Dear Commissioner Mayhew:

On behalf of Tri-County Mental Health Services, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - State Innovation Models: Funding for Model Design and Model Testing Assistance. The purpose of Maine's proposal – Testing the Maine Innovation Model – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

As you know, Tri-County Mental Health Services is one of Maine's largest and most comprehensive community based mental health providers, serving approximately 10,000 people each year across a vast region of Western, Central, and Southern Maine. We are proud to be a leader in Integrated Primary Care, having two successful projects serving eight primary care practices for four years. We have seen the successful outcomes first hand – clinical and financial outcomes. We believe it is the healthcare of the future.

As a Behavioral Health provider, this letter also represents our commitment to support Testing the Maine Innovation Model by participating in the following manner:

1. Supporting and engaging in the behavioral health integration movement of the enhanced primary care model and MaineCare's Health Homes Initiative (the patient centered medical home with integration of physical and behavioral health, and community care teams for high risk/ high cost patients), with the expectation that participating behavioral health providers will apply to become Health Homes to serve individuals with serious mental illness.
2. Implementing Health Information Technology to promote care coordination and integration with physical health.
3. Participating in the Behavioral Health Cost Work Group (a sub group of the ongoing Health Care Cost Work Group initiative of Maine Health Management Coalition)
4. Committing 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 (Maine Health Management Coalition).
5. Participating in the Behavioral Health learning collaborative to be developed as part of the continuous quality improvement efforts of the Innovation Model.

Sincerely,

Catherine R. Ryder
Executive Director
cryder@tcmhs.org
207-783-9141

UMBRELLA
MENTAL HEALTH SERVICES

841 Riverside Dr.
Augusta, Me 04330
Phone: 207.213.4616
Fax: 207.213.4727

73 Biscay Rd
Damariscotta, ME
04543
Phone:
207.563.3022

43 Hooper Rd
Wiscasset, ME
Phone:
207.687.2180
Fax: 207.687.2181

September 20, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Behavioral Health Provider Organizations

Dear Commissioner Mayhew:

On behalf of Umbrella Mental Health Services, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

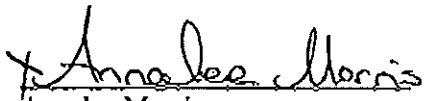
As an agency, presently we have 130 employees and 700 patients many of whom take part in multiple services. Our services include: Medication Management, Community Integration Services, Targeted Case Management, Daily Living/Skills program, Home and Community Based Therapy, as well as Outpatient Therapy. In association with some the above services we employ 2 physicians, 1 nurse practitioner and 1 PA-C and we are launching the investigational stage of entering into primary care.

As a **Behavioral Health** provider, this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

1. Supporting and engaging in the behavioral health integration movement of the enhanced primary care model and MaineCare's Health Homes Initiative (the patient centered medical home with integration of physical and behavioral health, and community care teams for high risk/ high cost patients), with the expectation that participating behavioral health providers will apply to become Health Homes to serve individuals with serious mental illness.
2. Implementing Health Information Technology to promote care coordination and integration with physical health.

3. Participating in the Behavioral Health Cost Work Group (a sub group of the ongoing Health Care Cost Work Group initiative of Maine Health Management Coalition)
4. Committing 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 (Maine Health Management Coalition).
5. Participating in the Behavioral Health learning collaborative to be developed as part of the continuous quality improvement efforts of the Innovation Model.

Sincerely



Annalee Morris
Chief Executive Officer
amorris@umbrellamhs.com
(207) 213-4616

Martha Temple
President, New England Region
151 Farmington Ave, RWAB
Hartford, CT 06156
860-273-3565

September 21, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Re: CMMI State Innovation Models Initiative

Dear Commissioner Mayhew:

On behalf of Aetna, I am writing in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. Maine's proposal – *Testing the Maine Innovation Model* – seeks to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide.

Aetna is one of the nation's leading diversified health care benefits companies, serving approximately 36.7 million people including nearly 146,000 Maine residents with information and resources to help them make better informed decisions about their health care. Our provider network in Maine includes about 1,488 primary care physicians, 2,492 specialists and 39 acute care hospitals.

Aetna currently participates in Maine's statewide healthcare transformation in several ways. As the administrator of Maine's state employees' health plan, we have committed to the development and implementation of three to five accountable care organizations. Aetna is an active participant in the multi-payer patient centered medical home pilot, which will expand to 76 practices in 2013. We also serve as board members of the Maine Health Management Coalition and as members of various MHMC committees.

Aetna supports reforms and innovations aimed at improving the health care system throughout the country. As part of our support for the State of Maine's application – "Testing the Maine Innovation Model – Aetna will:

- work with the Maine Health Management Coalition and other stakeholders in the state towards a goal of achieving better alignment on payment and contracting strategies that reward value over volume and greater consistency on quality and other performance measures.
- designate a senior level person with responsibility to represent Aetna in the project governance of these discussions and to provide technical insights and support.

Sincerely

Martha R. Temple

Martha Temple

Daniel P. Corcoran
President & GM
2 Gannett Dr., South Portland, ME 04106

Anthem BlueCross BlueShield

September 21, 2012

Mary Mayhew, Commissioner
Maine Department of Health and Human Services
221 State Street
40 State House Station
Augusta, Maine 04333-0040

Re: Letter of Support—"*Testing the Maine Innovation Model*"

Dear Commissioner Mayhew:

On behalf of Anthem Blue Cross and Blue Shield, I am pleased to submit this letter in support of Maine's application for funding under CFDA 93.624, "*State Innovation Models: Funding for Model Design and Model Testing Assistance*."

Anthem understands that the purpose of Maine's proposal, *Testing the Maine Innovation Model*, is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) seeks to bring the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Anthem Health Plans of Maine, Inc., d/b/a Anthem Blue Cross and Blue Shield, ("Anthem") is a domestic insurer organized and existing under the laws of the State of Maine, and regulated by the Maine Bureau of Insurance. Anthem is located in South Portland and employs over 800 associates in Maine, making us not only the largest health insurer in Maine but also one of the 50 largest private employers in the State of Maine. Anthem insures or administers benefits for nearly 400,000 Mainers, and processes nearly 6 million health care claims each year totaling over $1.2 billion.

Anthem is seeking to drive healthcare transformation in a number of ways. In Maine, we supported not only the initial establishment of the Patient Centered Medical Home pilot, but the recent expansion of that pilot as well. We also participate in a number of efforts including the MHMC, Quality Counts, and Pathways to Excellence.

Anthem continues to explore payment reform and innovation, including the development of accountable care organizations, patient centered primary care, behavioral health integration, and tiered networks.

By submitting this letter, we are demonstrating our support for this effort and that we will endeavor to support *Testing the Maine Innovation Model* in the following manner:

- Participating in project governance – i.e. in the overarching Project Advisory Committee;
- Exploring value-based benefit designs that meet the needs of our customers and members;
- Offering alternative risk-based reimbursement models which may include shared savings, pay for performance and global/capitated payment designed to meet the needs of our customers, members, and provider partners;
- Aligning reimbursement with nationally recognized measures; and
- Continuing to work with our plan sponsors and provider partners to address their data needs.

We look forward to working with you as you implement this project. Should you have any questions or need anything further, please do not hesitate to contact Kristine Ossenfort, Director of Government Relations (e-mail: Kristine.Ossenfort@Anthem.com, tel: 207-822-7260).

Sincerely,

Daniel P. Corcoran

Daniel P. Corcoran
President and General Manager

Maine Community HEALTH OPTIONS

PAYER LETTER

September 17, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Re: Letter of Support & Commitment

Dear Commissioner Mayhew:

On behalf of Maine Community Health Options (MCHO), I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

MCHO is a non-profit health insurance issuer in development in the state of Maine. A Consumer Operated and Oriented Plan (CO-OP) as defined under section 1322 of the Affordable Care Act, MCHO is focused on the Triple Aim as stated above. The Maine Primary Care Association and the primary care safety net of FQHCs conceived of the development of this CO-OP to address the widespread needs in Maine for greater access to affordable coverage and high quality care at lower costs. Not only is this a business imperative for this state but also a necessary action to spur economic development and business vitality. CO-OP formation is also driven by the need for payment reform that supports the transformation of health care delivery that is both fully integrated with behavioral and oral health and patient-centered through its inclusion of members in its development and operations. MCHO forecasts a subscriber base of just over 15,000 by the end of its first year of operations and approaching 50,000 in its fifth year.

We currently are modeling our benefits designs which are expected to support statewide healthcare transformation in a number of ways. Through a partnership with providers, we expect to not only participate in the multi-payer PCMH pilot, but also pay more substantially for care management that is provided at the local and regional level. In support of this effort, MCHO will partner with providers to effectively pair clinical and claims level data. MCHO will also advance behavioral health and oral health integration and foster wellness programs within its benefit structure. MCHO is already a member of the Maine Health Management Coalition and is working to put valued based insurance design principles into action. MCHO participates in the VBID workgroup.

As a health plan, this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

- Participate in project governance – i.e. in the overarching Project Advisory Committee
- Offer value based benefit design products aligned with Maine Health Management Coalition (MHMC) member priorities
- Offer alternative risk-based reimbursement models which may include shared savings, pay for performance and/or global/capitated payment
- Align reimbursement with common measures endorsed by MHMC
- Submit data to MHMC in a standardized format as needed by MHMC.

Sincerely,

Kevin Lewis
Chief Executive Officer
klewis@maineoptions.org
207-754-9516 (mobile)
www.maineoptions.org

Maine Municipal
Employees Health Trust

60 COMMUNITY DRIVE
AUGUSTA, MAINE 04330-9486
(207) 621-2645
1-800-852-8300
FAX (207) 624-0166
www.mmeht.org

September 19, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Re: Letter of Support & Commitment

Dear Commissioner Mayhew:

On behalf of the Maine Municipal Employees Health Trust (MMEHT), I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

The MMEHT is a voluntary multiple employer welfare arrangement providing medical plan coverage to over 20,000 Maine municipal, county government and special district employees, retirees and their dependents throughout the state. Started in 1983, the self-funded MMEHT includes over 450 employer groups who are committed to improving the health status of their employees, improving the quality of care delivered in Maine and reducing the cost of that care.

The MMEHT is a long standing member of the Maine Health Management Coalition and participates in a number of the Coalition supported and sponsored statewide healthcare delivery and payment reform initiatives. The MMEHT participates in the Patient Centered Medical Home program, the Coalition's Pathways to Excellence physician and hospital quality measurement and reporting initiatives and has been an active member of the Coalition's standing and ad hoc committees and workgroups aimed at improving quality, patient safety and reducing costs in Maine. The MMEHT is currently offering value based benefit plan options to its employer groups that provide incentives to Trust participants who receive care from primary care physicians and hospitals that have demonstrated the highest quality, most cost efficient care as measured by the Coalition's and nationally recognized metrics.

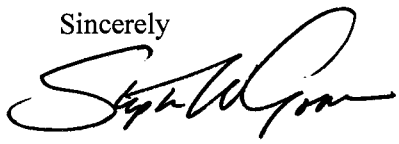
This letter also represents the MMEHT's commitment, as a self-funded plan sponsor, to support *Testing the Maine Innovation Model* by participating in the following manner:

- Participate in project governance – i.e. in the overarching Project Advisory Committee

- Offer value based benefit design products aligned with Maine Health Management Coalition (MHMC) member priorities
- 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
- Promote employee education and engagement efforts to encourage appropriate utilization and use of performance information;
- Promote alignment of purchasing efforts that support delivery system redesign and high value care through the Maine Health Management Coalition;
- Align reimbursement with common measures endorsed by MHMC members.

The MMEHT is pleased to support Maine's *State Innovation Model* application for funding to advance our state's Triple Aim goals.

Sincerely



Stephen W. Gove, Director
Health Trust Services
sgove@memun.org
207-623-8428

MEA
Benefits Trust

35 Community Drive · Augusta, Maine 04330-9487 · (207) 622-5866 · (207) 622-4418

Christine Burke, Esq. Executive Director

September 17, 2012

Mary Mayhew

Commissioner

Maine Department of Health and Human Services

221 State Street

Augusta, Maine 04333-0040

Re: Letter of Support & Commitment

Dear Commissioner Mayhew:

On behalf of the Maine Education Association Benefits Trust, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

The Maine Education Association Benefits Trust is a sister organization of the Maine Education Association. It is a separate legal entity, having its own Board of Directors. It is operated as an ERISA Trust, and it is a Voluntary Employee Beneficiary Association. We have nearly 70,000 covered lives, covering 99% of the public schools in the State.

We currently participate in statewide healthcare transformation in a number of ways. We are an active member of the Maine Health Management Coalition/Foundation, and I personally have served in a leadership capacity of both entities in the recent past. In addition, we are currently working with two of the major health systems in the state to develop an ACO pilot for our members. Finally, we are very strong supporters of the Patient Centered Medical Home Pilot in Maine, and I serve on the PCMH Working Group.

As a fully-insured plan sponsor this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

- Participate in project governance – i.e. in the overarching Project Advisory Committee
- Ask my carrier to offer value based benefit design products aligned with Maine Health Management Coalition (MHMC) member priorities
- Ask my 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
- Promote employee education and engagement efforts to encourage appropriate utilization and use of performance information;
- Promote alignment of purchasing efforts that support delivery system redesign and high value care through the Maine Health Management Coalition;
- Ask my carrier to align reimbursement with common measures endorsed by MHMC members

Sincerely

Christine Burke, Esq., Executive Director

Maine Education Association Benefits Trust

207-622-4418, Ext. 2238

cburke@meabt.org

Maine's Public Universities
UNIVERSITY OF MAINE SYSTEM

Office of Human Resources
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Bangor, ME 04401-5106

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The University of Maine

University of Maine at Augusta

University of Maine at Farmington

University of Maine at Fort Kent

University of Maine at Machias

University of Maine at Presque Isle

University of Southern Maine

September 19, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Re: Letter of Support & Commitment

Dear Commissioner Mayhew:

On behalf of the University of Maine System I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

The University of Maine System's health plan represents over 4500 employees and in excess of 10,000 members throughout the State of Maine form Kittery to Fort Kent and Farmington to Machias. Therefore, our interest in the rapid transformation of healthcare on a state-wide basis is extremely high and given the rapid and ever increasing rate of healthcare inflation, is becoming a critical priority for UMS.

As a self-insured payer this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

- Participate in project governance – i.e. in the overarching Project Advisory Committee
- Offer value based benefit design products aligned with Maine Health Management Coalition (MHMC) member priorities
- 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

- Promote employee education and engagement efforts to encourage appropriate utilization and use of performance information;
- Promote alignment of purchasing efforts that support delivery system redesign and high value care through the Maine Health Management Coalition;
- Align reimbursement with common measures endorsed by MHMC members

Sincerely,

Thomas Hopkins
Director, Compensation & Benefits
University of Maine System
16 Central Street
Bangor, ME 04401
thopkins@maine.edu
P: 207 973 3388

STATE OF MAINE
STATE EMPLOYEE HEALTH COMMISSION
220 Capitol St., 114 State House Station
Augusta, ME 04333-0114

Paul R. LePage
Governor

Brett Hoskins
Labor Co-Chair
Joyce Oreskovich
Management Co-Chair

September 19, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Re: Letter of Support & Commitment

Dear Commissioner Mayhew:

On behalf of the State Employee Health Commission, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

The State Employee Health Commission is a statutorily authorized commission of trustees from Labor and Management. It is charged with advising on issues concerning employee health and wellness, including the State Employee Assistance Program. Plan design and employee impact are within its purview. The Commission's oversight and good work impacts the benefits of close to 40,000 current and former State employees.

We currently participate in statewide healthcare transformation in a number of ways. In addition to having played a key role in supporting the establishment of quality metrics for physicians and hospitals, and being an early adopter of tiering and steering to encourage our plan participants to utilize high quality, efficient providers, we are also in the process of working with various hospitals and health systems on ACO development and other payment reform initiatives. The

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TTY users call Maine Relay 711
www.maine.gov/beh

Commission has a leadership role on the Maine Health Management Coalition Board, including its Executive Committee, and the Foundation Board of Directors. It routinely contributes to the Coalition's Pathways to Excellence initiatives, and special projects like the Cost Workgroup and annual Executive Summit. In fact, the Commission has a long and distinguished history of partnership with the Maine Health Management Coalition and has long been considered an innovative leader within it.

As a self-insured payer this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

- Participate in project governance – i.e. in the overarching Project Advisory Committee
- Offer value based benefit design products aligned with Maine Health Management Coalition (MHMC) member priorities
- 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
- Promote employee education and engagement efforts to encourage appropriate utilization and use of performance information;
- Promote alignment of purchasing efforts that support delivery system redesign and high value care through the Maine Health Management Coalition;
- Align reimbursement with common measures endorsed by MHMC members

Sincerely,

Laurie Williamson
Executive Director, Office of Employee Health and Benefits
laurie.williamson@maine.gov
207-287-4515

AARP Maine
1685 Congress Street
Portland, ME 04102

T 1-866-554-5380
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September 24, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Dear Commissioner Mayhew:

On behalf of our 300,000 AARP members in Maine, and all Maine people 50 and older, I am writing to offer this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. We agree with the premise of Maine's proposal – *Testing the Maine Innovation Model* –to align healthcare payment and delivery system reform in the state across MaineCare, Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. The only way to build a robust, quality health delivery system in Maine over the long-term is to take into account all forms of service delivery and funding streams that impact Maine people. We are happy to see the Department focused on an improved consumer experience and advancing health quality, while also working to reduce cost.

Specifically, AARP is pleased to see the following in the proposal:

- Expanded use of health homes;
- Integration of medical and behavioral/mental health services;
- Better coordination of care transitions; and
- Increased used of health information technology.

Importantly, provider incentive payments are tied to the attainment of quality benchmarks. Also, we are pleased to see that consumers will be provided with counseling and access to information to assist in the selection of high quality providers.

If DHHS is a successful applicant for the funds, we hope that there will be a strong consumer input component going forward. AARP would appreciate the opportunity to participate.

Please don't hesitate to contact me if I can provide any additional information at lpaham@aarp.org or 207-776-6304.

Sincerely,

Lori K. Parham
State Director
AARP Maine

AMERICAN LUNG ASSOCIATION®
Fighting for Air

American Lung Association of the Northeast

LungNE.org
1-800-LUNG USA

OFFICES:

Connecticut
45 Ash Street
E. Hartford, CT 06108

Maine
122 State Street
Augusta, ME 04330

Massachusetts
460 Totten Pond Road
Suite 400
Waltham, MA 02451

393 Maple Street
Springfield, MA 01105

New Hampshire
1800 Elm Street
Manchester, NH 03104

New York
155 Washington Ave., Suite 210
Albany, New York 12210

21 West 38th Street, 3rd Floor
New York, New York 10018

237 Mamaroneck Ave., Suite 205
White Plains, New York 10605

700 Veterans Memorial Highway
Hauppauge, New York 11788

1595 Elmwood Avenue
Rochester, New York 14620

Rhode Island
260 West Exchange Street
Suite 102B
Providence, RI 02903

Vermont
372 Hurricane Lane
Suite 101
Williston, VT 05495

September 21, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Dear Commissioner Mayhew:

I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance* on behalf of the American Lung Association of the Northeast. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

While the American Lung Association is not a health care provider organization or a payor, we do have a stake in the results of this proposal There are over 200,000 people living with lung disease in Maine. Like any chronic disease the ongoing management of lung disease is often a challenge for both the patient and the provider. The focus of this project on enhancing primary care and its connection to public health has great potential for people with lung disease. Just as one example, improving the flu immunization rate for those patients with asthma and COPD could have substantial health status and cost saving results.

We urge you to act favorably on this exciting and important proposal.

Sincerely

Edward Miller
Senior Vice President, Public Policy
American Lung Association of the Northeast
Augusta Maine office
207.624.0308
emiller@lungne.org

amistad
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people helping people

September 19, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Dear Commissioner Mayhew:

On behalf of Amistad, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Amistad is Maine's largest consumer run organization, and we have been a pioneer in developing and delivering *peer led* services and programs in Maine. Our experience has convinced us that peer services should play a significant role in any meaningful health care reform – peers are uniquely effective at successfully reaching out to those individuals who typically have been found to be difficult to serve – and often times are identified as high utilizers of service.

Amistad is currently leading our latest initiative – an effort to work with individuals who have been identified as frequent visitors to the psychiatric emergency room. This pioneering effort has had some remarkable success with a limited number of individuals – decreasing emergency room use by nearly 50%.

We are excited to witness the efforts currently underway in Maine to truly reform health care. We have participated in discussions with the leaders of many of these efforts, and are confident that the results will be better health care, more satisfied customers, and reduced costs.

We support this effort enthusiastically, and look forward to working with you moving forward.

Sincerely,

Peter Driscoll, LMSW
Executive Director

Bates

September 21, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Re: Letter of Support & Commitment

Dear Commissioner Mayhew:

On behalf of Bates College, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Bates College was established in 1855 and has grown to be the third largest employer in the Lewiston/Auburn area employing 750 benefit eligible employees. We have over 1100 members in our medical plan and have been fully insured through out our history.

We currently participate in statewide healthcare transformation in a number of ways. Bates College has been a member in the Maine Health Management Coalition (MHMC) since 2002 also participating as a data member since that time. The College has supported my being on the MHMC Executive Committee and Foundation Board since 2008 and I am currently a member of the Value Based Insurance Design Workgroup.

As a fully-insured plan sponsor this letter also represents our **commitment** to support *Testing the Maine Innovation Model* by participating in the following manner:

- Participate in project governance – i.e. in the overarching Project Advisory Committee
- Ask my carrier to offer value based benefit design products aligned with Maine Health Management Coalition (MHMC) member priorities
- Ask my 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

- Promote employee education and engagement efforts to encourage appropriate utilization and use of performance information;
- Promote alignment of purchasing efforts that support delivery system redesign and high value care through the Maine Health Management Coalition;
- Ask my carrier to align reimbursement with common measures endorsed by MHMC members

Sincerely

Ken Emerson
Associate Director of Human Resources
Bates College
215 College Street
Lewiston, ME 04240
kemerson@bates.edu
(207) 786-8271

Catholic Charities
Providing help and creating hope in Maine

September 21, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

307 Congress Street
P.O. Box 10660
Portland, ME 04104-6060

T. (207) 781-8550
F. (207) 781-8560

www.ccmaine.org

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of Catholic Charities Maine I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance.* The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Catholic Charities Maine (CCM) has provided community based services since 1966 serving more than 54,000 in FY 2011. Programs include mental health case management, targeted case management for children, substance abuse treatment, homemaker services, foster care, child care, dental care, food distribution services, and refugee resettlement. CCM operates statewide with the necessary infrastructure to maximize oversight and responsiveness. CCM has experience managing services effectively and efficiently through DHHS approved subcontracts with a proven track record of partnering with private agencies and state government.

Given the evolving healthcare environment, in early 2011 Catholic Charities Maine ("CCM") developed an internal committee comprised of executive leadership staff, focusing on state and federal healthcare initiatives. The CCM ACO/Value Based Purchasing Planning Committee meets routinely to aid in positioning CCM, incrementally, for an integrated healthcare environment. Said efforts include, but are not limited to, identification of and potential collaborative partnerships with regionally based physical healthcare entities and future direct marketing as a provider of ancillary social services to existing ACO's and Patient Centered Medical Home ("PCMH") pilot sites.

CCM has been a member of Maine Quality Counts ("MQC") for several years and has leveraged MQC's expertise, as a leader in the integration of behavioral and physical healthcare in Maine, through attendance at MQC forums, accessing online resources, and one on one interaction with various members of the MQC staff. The timely benefits of CCM's MQC membership compliment CCM's efforts to collaborate, more formally, with physical healthcare providers and other social service entities to continue to serve those in our communities.

It has been our pleasure working with Maine DHHS and we enthusiastically give our support for their application.

Sincerely,

Stephen P. Letourneau, CEO
sletourneau@ccmaine.org
(207) 781-8550

CHCS Center for Health Care Strategies, Inc.

200 American Metro Blvd.,
Suite 119
Hamilton, NJ 08619
(609) 528-8400
(609) 586-3679 fax
www.chcs.org

September 21, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support and Commitment for Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of the Center for Health Care Strategies (CHCS), I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

CHCS is a national nonprofit health policy resource center dedicated to improving health care quality for low-income children and adults, people with chronic illnesses and disabilities, and frail elders. CHCS works directly with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve people with complex and high-cost health care needs. CHCS supports Maine's proposal to create multi-payer Accountable Care Organizations, building upon its existing multi-payer medical homes, MaineCare health homes, and other initiatives.

CHCS has enjoyed working directly with MaineCare on a number of health transformation projects, including the Medicaid Accountable Care Organization Learning Collaborative, the Integrated Care Resource Center for Health Homes, the Aligning Forces for Quality initiative, and the CMS Value-Based Purchasing Learning Collaborative. We believe that Maine's model not only creates strong vehicles for multi-

payer alignment and transformation, but is well-aligned with the goals of the State Innovation Model and the Triple Aim. We recommend its selection for funding under this groundbreaking innovation initiative.

Sincerely,

Stephen A. Somers, PhD
President and CEO
Center for Health Care Strategies, Inc.

Consumers for AFFORDABLE Health Care

Advocating the right to quality, affordable health care for every man, woman and child

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Augusta, ME 04338-2490

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Fax: 1-888-214-5233
Website: www.mainecahc.org
Email: consumerhealth@mainecahc.org

September 20, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support

Dear Commissioner Mayhew:

On behalf of Consumers for Affordable Health Care, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. Since 1988 Consumers for Affordable Health Care has worked to protect the rights of health care consumers in Maine. We are a nonprofit, nonpartisan organization committed to helping all Maine people obtain quality, affordable health care. Our activities include research, advocacy, education, and consumer assistance.

Maine's proposal – *Testing the Maine Innovation Model* – will attempt to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. Our organization has long supported pursuit of the "Triple Aim." This proposal works through public/private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. We strongly believe that the pursuit of better quality care at lower cost is imperative to improving our state's health care system.

Consumers for Affordable Health Care participates in the Patient Centered Medical Home Working Group, the Get Better ME Operations Group and other quality initiatives here in Maine. We believe that this proposal would help propel these efforts and others throughout the state to the next level by providing the resources they need to attain their goals.

Thank you for the opportunity to express our support for this important work. We look forward to Maine receiving the grant and to continuing our work together in pursuit of these important goals.

Sincerely,

Joseph P. Ditré, Esq.
Executive Director
jditre@mainecahc.org
207.622.7083

DANIEL HANLEY
CENTER for HEALTH
LEADERSHIP

Daniel Hanley Center
For Health Leadership
P.O. Box 15275
Portland, Maine 04112-5275
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September 19, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of Daniel Hanley Center for Health Leadership, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

The Hanley Center is an independent statewide nonprofit organization whose mission is to support the transformation of Maine's health and healthcare systems by working to build a culture of greater collaboration. We fulfill this mission by bringing together diverse stakeholders to address complex issues that require collaborative solutions. We also provide leadership training to healthcare professionals and others who are leading change in today's complicated and dynamic health and healthcare environment. Much of this leadership training supports the transition to coordinated care models and interdisciplinary teams. Many of our graduates are key leaders in transformational work now under way in communities across Maine.

The Hanley Center works closely with statewide organizations such as Quality Counts and the Maine Health Management Coalition to support their critically important transformational work throughout Maine. At this time, we are convening stakeholders who are developing a comprehensive plan to accelerate the adoption of electronic medical records in Maine's behavioral health community. Over time, this work will allow behavioral health and primary care providers to better coordinate the care of common patients. The Hanley Center has long been involved in the development of Maine's statewide electronic Health Information Exchange (HealthInfoNet).

In summary, we are highly supportive of Maine's proposal because we believe its goals are closely aligned with our overall mission. We are eager to work with the State of Maine and other partners to support this highly important initiative.

Please contact me if you have any questions about the Hanley Center and our work.

Thank you very much,.

Sincerely

James A. Harnar
Executive Director
jamesharnar@hanleyleadership.org
207-523-1501

HealthInfoNet

September 21, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support & Commitment
For Provider Organizations and Primary Care Practices

Dear Commissioner Mayhew:

On behalf of HealthInfoNet I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

HealthInfoNet is the state designated statewide health information exchange serving Maine. In operation since 2006, HealthInfoNet currently supports the exchange of patient clinical data to enhance the continuity of medical care for more that one million of Maine's 1.3 million residents. Thirty-seven of Maine's thirty-nine hospitals are under contract with HealthInfoNet at this time. By the end of 2013, all Maine hospitals will be connected to and using the statewide health information exchange. Two hundred and forty physician practices are also connected to and using HealthInfoNet to support patient care which represents a solid start toward achieving inclusion of at least eighty percent of all physician providers in Maine having access to the exchange by the end of 2014. HealthInfoNet strongly supports this application for funding under CFDA 93.624 because the initiative proposed it will add significant opportunity to build upon the many unique and important projects to transform care delivery that are already under way in Maine including the development of a robust statewide health information exchange.

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phone: 207-541-9250 fax: 207-541-9258 email: info@hinfonet.org website: www.hinfonet.org

HealthInfoNet has been directly involved in a number of collaborative initiatives in Maine that are focused on enabling meaningful transformation of care delivery and payment reform. HealthInfoNet is the grantee for the State of Maine for the Regional Extension Center (REC) funded by the Office of the National Coordinator. As the manager of the REC, HealthInfoNet was the sixth state in the nation to secure contracts with target goal of one thousand priority primary care providers and is well along in bring all of these providers to attaining meaningful use Stage 1 status. As part of the Maine REC requirements, all of these one thousand providers will be required to connect to the statewide health information exchange in order to satisfy the third milestone in the grant process.

HealthInfoNet is also the single largest subcontractor to the Bangor Beacon Community grant. In its role supporting this important community-wide care improvement initiative, HealthInfoNet has successfully connected more than sixty percent of the physician providers and the two hospitals in the community to a single, shared statewide electronic health record that works in conjunction with local electronic medical record systems to enhance coordination of care across the Bangor community. HealthInfoNet is also providing patient specific clinical outcomes measures to the Bangor Beacon Community participants that are helping to demonstrate that the effort is having a measurable, positive impact on the health and cost of managing patients with chronic conditions. Because HealthInfoNet is a near real time exchange, it has also begun to play an important role in notifying care managers involved in the Bangor Beacon initiative within minutes of an event of care occurring such as an admission to the emergency room, discharge from a hospital, the receipt of a discharge summary or lab result in to the exchange. This community-wide notification for care managers is having a significant impact of enhancing both efficiency and effectiveness across the care management process. Finally, experience gained in supporting reporting requirements for the Bangor Beacon Community is building the foundation for HealthInfoNet being ready and positioned to support community-wide reporting for ACO initiatives that are now coming on line across Maine. Because HealthInfoNet has such a deep penetration throughout the provider communities in Maine at this time, it stands as a unique resource for supporting measurement that requires the ability to look across corporately unaligned provider organizations to attain a single view of a patient's care and clinical outcomes.

Improving care coordination between the behavioral health provider community and the general medical provider community has also been an important HealthInfoNet program in 2012. HealthInfoNet along with four other states was awarded a contract with SAMHSA and the National Council for Community Behavioral Healthcare to engage the behavioral health care provider community in Maine in order to continue a public-private care coordination planning effort begun in 2011. The scope of work includes sustaining four work groups that are addressing fundamental issues for coordinating care between the behavioral health community and the general medical care community including data standards information privacy and security and removing legal and operational barriers to achieving enhanced care integration. As part of this contract, HealthInfoNet is committed to connecting five community behavioral health provider organizations to the statewide health information exchange for bi-directional information sharing and twenty behavioral health provider organizations for view and download access to the general medical information maintained within the statewide health information exchange. HealthInfoNet has also brought on line a portal version of a secure messaging system that meets the standards defined by ONC for its NwHIN Direct program. Up to 200 behavioral health providers will be offered use of this secure messaging system as part of the contract with SAMHSA.

HealthInfoNet is currently working on a grant project that will demonstrate how to connect the existing statewide all payer claims database (APCD) with the statewide clinical database that is being managed by HealthInfoNet on an episode of care basis. When demonstrated, this will make Maine the first state in the nation with access to a combined claims and clinical database organized on a statewide basis. It is anticipated that the creation of this combined resource will bring essential new opportunities to improve care outcomes and plan for major reform advancements.

HealthInfoNet believes that Maine is exceptionally well positioned to optimize the demonstration of innovative and replicable transformation programs that can be subsequently introduced across the nation if Maine is awarded funding under CFDA 93.624. We stand ready to engage in making the proposed work of this grant a success.

Devore S. Culver
Executive Director and CEO

Maine Association of
Area Agencies on Aging
P.O. Box 5415
Augusta, ME 04332

September 18, 2012

Mary Mayhew, Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

RE: *Letter of Support & Commitment for Provider Organizations and Primary Care Practices*

Dear Commissioner Mayhew:

On behalf of the Maine Association of Area Agencies on Aging (M4A), I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

M4A represents Maine's five Area Agencies on Aging, Maine's trusted source for answers on aging and advocacy and support for healthy, independent living. We are the very start of the long term care system and have been working for more than three decades to keep elders living healthy in their homes and communities.

We fully support the Triple Aim goals and are committed to assisting Maine's healthcare redesign leaders in addressing the health behaviors and socio-economic factors that contribute to the cost of care. To this end, we have been working collaboratively with Maine's Patient Center Medical Home Pilot, Aligning Forces for Quality, the Maine Health Management Coalition and Maine's new Accountable Care Organizations to help achieve the Triple Aim goals in Maine.

Jessica L. Maurer, Executive Director
207-626-0972 (Phone) · 207-592-9972 (Cell) · 207-622-7857 (Fax)
www.Maine4A.org

Maine Association of
Area Agencies on Aging
P.O. Box 5415
Augusta, ME 04332

We know that in order to improve quality of care and patient health and decrease cost, we must adequately address the supports and services that are needed to keep people healthy and to help them self-manage their chronic conditions. Payment reform is a critical component to healthcare delivery reform and we fully support this application which will help to align these efforts.

Sincerely,

Jessica L. Maurer, Esq.
Executive Director

Jessica L. Maurer, Executive Director
207-626-0972 (Phone) · 207-592-9972 (Cell) · 207-622-7857 (Fax)
www.Maine4A.org

September 21, 2012

Maine Developmental
Disabilities Council
225 Western Avenue
139 State House Station
Augusta, Maine 04333-0139

Phone: 207-287-4213
Fax: 207-287-8001
Toll Free: 800-244-3990

www.MaineDDC.org

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Letter of Support and Commitment

Dear Commissioner Mayhew:

On behalf of the Maine Developmental Disabilities Council, I am writing this letter in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

The DD Council is a federally-funded, independent organization with members from across the state, including persons with disabilities, family members, and representatives of public and private agencies which provide services and/or funding for services for individuals with developmental disabilities. As required in federal law[1], we are involved in advocacy, capacity building and systemic change activities, with the goal that individuals with developmental and other disabilities of all ages are fully included, integrated and involved in their communities and the decisions impacting them.

The Maine DD Council is very supportive of this application and in particular the efforts of the public/private collaboration to strengthen enhanced primary care and create a medical home for every

[1] The Council's work is governed by the federal Developmental Disabilities Assistance and Bill of Rights Act, which defines a *"developmental disability"* as a severe chronic disability of an individual that is attributable to a mental or physical impairment or combination of mental and physical impairments, manifested before the individual attains age 22 and likely to continue indefinitely, which results in substantial functional limitations in 3 or more of the following areas of major life activity: self-care; receptive and expressive language; learning; mobility; self-direction; capacity for independent living and economic self-sufficiency.

individual that supports access to quality medical and behavioral health services, integrated with each other and long-term care services and supports, when those are necessary. Delivery of well-coordinated care designed to meet the individual needs of each person, including those with disabilities, provides a cost-effective means to promote opportunities for everyone to reach their optimum health status and pursue their individual goals.

The Maine DD Council has been involved with the Maine Department of Health and Human Services (Maine DHHS), along with the Maine Departments of Labor and Education, in an interagency collaborative effort since 2008 to address the needs of persons with autism spectrum disorders. Maine's prevalence of autism spectrum disorders (ASD) exceeds national levels, which has created a sense of urgency to assure that Maine's service systems are tooled and prepared to meet the needs of this population. The DD Council has worked particularly closely with Maine DHHS since 2010 under a federally-funded grant[2] to develop and pilot model practices to improve early identification and early intervention services for young children with ASD, and access to quality health care services for those children not only during their formative years, but also as they transition to adulthood. We recognize the benefits for not only individuals with ASD, but also those with other developmental disabilities, as the primary care medical home becomes more proficient in identifying and addressing individual needs with effective and appropriate care and support. Work with Maine DHHS and Quality Counts over the past two years has brought enhanced support to individual medical practices working to expand their capacity to meet the needs of their patients.

We look forward to being able to continue to work collaboratively with Maine DHHS on a wide variety of issues, and in particular to the opportunities that this grant will provide to use the tools and methods developed and tested in the pilot and demonstration projects that have been conducted through the HRSA grant, and achieve systemic improvements that will benefit people across the state. Beyond those efforts that may involve the DD Council directly, the broader scope of this proposal will bring opportunities to address critical factors in achieving healthcare system reforms that improve quality of care concurrently with achieving and sustaining lower costs.

Sincerely

Julia Bell

Julia J. Bell
Executive Director

[2] 93.110 Maternal and Child Health Federal Consolidated Programs, H6MMC20329-02-00 State Implementation Grants for Improving Services for Children & Youth with ASD, Department of Health and Human Services/Health Resources and Services Administration.

September 23, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Dear Commissioner Mayhew:

On behalf of the **Maine Health Management Coalition** and **Maine Health Management Coalition Foundation**, I am writing this letter in support of, and commitment to, Maine's application for funding under CFDA 93.624 - State Innovation Models: Funding for Model Design and Model Testing Assistance. The purpose of Maine's proposal – *Testing the Maine Innovation Model* – is to align health-care payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/ private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining traction statewide. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

Maine Health Management Coalition (MHMC) will be a principle contracted Innovation Model implementation partner. MHMC is a multi-stakeholder purchaser led collaborative representing employers, providers, payers, and consumers. Our membership numbers over 60 employers, representing ~200,000 employees and dependents, or around a third of all commercially-insured individuals in Maine. MaineCare, the State's public payer, is a member agency. Our organization leads or collaborates in a number of initiatives driving healthcare improvement and payment reform, among them (but not limited to them) - the Maine Aligning Forces for Quality (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 health-care 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*.

Outline of Our Commitment - As the principle contracted partner for *Testing the Maine Innovation Model*, MHMC and MHMC-F commit to being responsible for implementation of the following components of the project:

1. Data Analytics;
2. Public Reporting of Quality Measures Developed Through the *Pathways to Excellence* Process;
3. Accountable Care Organization Learning Collaborative Support Through the Accountable Care Implementation Group
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.

Sincerely,

Elizabeth Mitchell
President & CEO
Maine Health Management Coalition
Maine Health Management Coalition Foundation

September 17, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Dear Commissioner Mayhew,

I am submitting this letter on behalf of Maine Quality Counts in support of Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. We understand that the goal of Maine's proposal, *Testing the Maine Innovation Model*, is to align the delivery and payment of MaineCare services with the efforts of other public and commercial payers to achieve the goals of the "Triple Aim" – i.e. to improve patient experience of care, improve population health, and lower health care costs. Given the collaborative relationships, commitment to change, and the numerous related and concurrent transformation activities already underway in the state, we believe that Maine is uniquely positioned to succeed with initiative, and applaud the state's efforts to leverage and expand these efforts through their vision and leadership.

Maine Quality Counts (QC) is a regional health improvement collaborative committed to transforming health and health care in Maine by leading, collaborating, and aligning improvement efforts. QC leads and provides support for several important statewide improvement programs in Maine, including the Aligning Forces for Quality initiative and the Maine Patient Centered Medical Home (PCMH) Pilot. Our Member organizations include a wide range of stakeholders including physicians, hospitals, employers, insurers, consumers, policy makers, government and other parties working together to drive transformation of the health care system.

Maine Quality Counts has extensive experience in supporting quality improvement initiatives with providers, and, along with the state, serves as one of three conveners of the Maine PCMH Pilot, which participates in the CMS Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration and provides support for changing practice delivery and payment systems for 26 (soon to be 76) primary care practices across the state. QC provides quality improvement support to Pilot practices through a range of efforts, including hosting a structured learning collaborative, supporting monthly practice calls, and providing one-on-one practice quality improvement coaching for practices on the key aspects of practice transformation towards a more patient centered model of care. QC has also supported the development of the Community Care Team model to partner with primary care practices to provide additional care management support for the most high-cost, high-needs patients of each community.

We have also worked closely with the state and the MaineCare program on a number of initiatives, including working to align the PCMH Pilot with the state's plan for implementing a Health Homes initiative in accordance with Section 2703 of the Affordable Care Act. Through the Health Homes initiative, we anticipate extending quality improvement support for PCMH

transformation to more than 50 additional primary care practices in the state, providing an excellent opportunity to improve the adult quality measures of focus in this proposal.

As a key stakeholder in the SIM proposal, we also **commit** to support Maine's effort, *Testing the Maine Innovation Model*, by participating in the following manner:

1. Supporting expansion of the enhanced primary care model as outlined in this proposal (i.e. the PCMH model with integration of physical and behavioral health, and Community Care Teams to serve the most high risk/ high cost patients)
2. Promoting reporting by PCMH practices on a common set of measures, which will be publicly reported, and used for data feedback to practices to help drive their internal improvement efforts
3. Promoting efforts to measure and reporting patient experience of care and functional status, using the CG-CAHPS survey and PROMIS tools
4. Promoting integrated shared decision making within PCMH practices
5. Supporting quality improvement efforts for PCMH practices, CCTs, and ACO leaders by sponsoring a learning collaborative(s) for the *Maine Healthcare Transformation Institute*

We are confident that the state of Maine and its collaborating partners have the vision, experience, and relationships needed to successfully implement this initiative, and their bold vision for transforming the health care system in the state. I am pleased to extend our strong support for this proposal and for the important opportunity it offers to improve health and health care for the people of Maine.

Best regards,

L Letourneau MD

Lisa M. Letourneau, MD, MPH
Executive Director

UNIVERSITY OF SOUTHERN MAINE

Muskie School of Public Service

P.O. Box 9300, Portland, Maine 04104-9300
(207) 780-4430, FAX (207) 780-4549, TTY (207) 780-5646
www.muskie.usm.maine.edu

September 21, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0040

Dear Commissioner Mayhew:

On behalf of the Muskie School of Public Service at the University of Southern Maine I am pleased to support Maine's application for funding under CFDA 93.624 - *State Innovation Models: Funding for Model Design and Model Testing Assistance*. The proposed projectl – *Testing the Maine Innovation Model* – will align healthcare payment and delivery system reform in the state across MaineCare (Maine's Medicaid program), Medicare, and commercial payers to achieve and sustain lower costs, while improving quality of care and patient satisfaction. These goals (i.e. the Triple Aim goals) will be accomplished through public/private collaboration of providers, purchasers and payers to leverage and connect important work that is already gaining statewide traction. The Maine Innovation Model (the Model) brings the State's investment to the next level 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) supporting the formation of multi-payer ACOs that commit to value and performance based payment reform and public reporting of common quality benchmarks.

The **Muskie School's** academic and research programs share a common mission of educating leaders, informing policy and practice, and strengthening civic life. The School houses three academic programs, including public health, as well as nationally recognized research programs in health, social policy, the economy, and the environment. The School has a multi-disciplinary faculty and staff with extensive experience working closely with states providing policy, data, research/evaluation and other assistance in support of policy and program development and implementation.

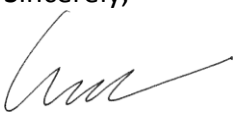
Since 1983 the School has collaborated with the state's Medicaid, public health, and other human service programs on payment and delivery system innovation, quality

improvement, and other initiatives. We are currently funded by the Department, other purchasers and payers, and funders to evaluate Maine's multi-payer *Patient Centered Medical Home Pilot* the cornerstone of delivery system and payment reform efforts in the state. The School is also working with DHHS and the Office of Maine Care Services in the design of the Value Based Purchasing Initiatives, including the Health Homes and Accountable Communities initiatives. We've also worked closely with DHHS partners to engage MaineCare members in the early planning phases of the Value Based Purchasing Initiatives ensuring that the members' perspective was represented in major design considerations.

We are also partners with DHHS in the development of a competency-based curriculum for the direct service workforce serving consumers across Maine's long term services and supports system. This work builds on a 16-year history of developing and administering the Maine's certification program for mental health professionals. Additionally, Muskie staff worked closely with the Office of Quality Improvement on a 3-year project to integrate physical health knowledge and practices into the mental health systems of care.

In short, the Muskie School has partnered closely with Maine's DHHS in model design, research, planning and technical assistance for this ambitious transformation initiative. This initiative would bolster the early efforts to implement a full model across payers for the benefit of all Maine citizens and we are delighted to offer our support in these efforts.

Sincerely,



Andrew F. Coburn, Ph.D, Professor and
Director, Population Health and Health Policy

UNIVERSITY OF MAINE AT AUGUSTA
Augusta • Bangor • Online • Centers Statewide
COLLEGE OF PROFESSIONAL STUDIES

September 19, 2012

Mary Mayhew
Commissioner
Maine Department of Health and Human Services
221 State St.
Augusta, Maine 04333-0040

Dear Commissioner Mayhew:

The University of Maine at Augusta is pleased to support Maine's application for funding under CFDA 93.624 - State Innovation Models: Funding for Model Design and Model Testing Assistance. Maine's proposal for Testing the Maine Innovation Model to align healthcare payment and delivery system reform across MaineCare, Medicare, and commercial payers to achieve and sustain lower costs within the state is a highly valued initiative. This worthy effort will surely help to improve the quality of care and patient satisfaction. One of the goals of this endeavor is of particular interest to the University of Maine at Augusta and that is to support the development of new workforce models to help transform the system.

Since 1980, the University of Maine at Augusta has held a continuous relationship and collaboration with the former Department of Mental Health and now the Department of Health and Human Services to provide training and education to people who work within or aspire to work in one of the many agencies that are funded by the State. Our experience has taught us that we must provide students with the knowledge and skills that are important for the broad spectrum of services that are provided to Maine's consumers of behavioral health services. Knowledge of social policy is of prime importance in the content of our A.S. and B.S degree programs in Mental Health and Human Services and in our relevant certificate programs. It is important to note that the Mental Health and Human Services Degree Programs hold the highest enrollments with almost 1,000 students matriculated in the A.S. and B.S. degrees.

In the 1980s our courses were designed to emphasize community mental health services as well as course work that addressed the workers employed at the two public mental health institutes. In the 1990s and through this decade, the University of Maine at Augusta has taken the lead in developing the course work for the Mental Health Rehabilitation Technician/Community state certification. The development of this certificate program originated from the AMHI Consent Decree to prepare a better informed workforce for work within Maine's Behavioral Health System. Graduates of our B.S. in Mental Health and Human Services Degree as well as graduates of the 30 credit certificate program in Mental Health Rehabilitation Technician/Community (MHRT/C) receive state certification for a range of service positions, particularly in behavioral health and substance abuse rehabilitation. Agencies that hire state

certified MHRT/C people, then can receive MaineCare (Medicaid) reimbursement.

The University of Maine at Augusta has been a leader in distance education for Maine for the past 20 years. All our MHRT/C and Mental Health and Human Services Degree courses are offered through a variety of distance education technologies including on-line, interactive television and video conferencing delivery methods. We, therefore, feel that we have the experience and ability to collaborate with the Department of Health and Human Services to prepare the workforce with whatever will help DHHS to develop new workforce models.

It is with enthusiasm that the University of Maine at Augusta supports Maine's application for the CFDA 93.624 - State Innovation Models: Funding Model Design and Model Testing Assistance Initiative.

Sincerely,

Grace M. Leonard

Grace M. Leonard
Professor and Coordinator of Mental Health and Human Services Programs
University of Maine at Augusta

Maine Patient Centered Medical Home Pilot

Memorandum of Agreement for Participation
Maine PCMH Pilot Expansion & MAPCP Demonstration

Introduction: In 2009, The Dirigo Health Agency's Maine Quality Forum, Quality Counts, and the Maine Health Management Coalition convened a multi-stakeholder effort to implement and evaluate the Maine Patient Centered Medical Home (PCMH) Pilot as the first step in achieving statewide implementation of the PCMH model. The Pilot was launched in January 2010 with 26 practices from across the state, initially planned as a 3-year effort to implement the PCMH model in a set of primary care practices. In November 2010, Maine was selected as one of eight sites to participate in the Medicare Multipayer Advanced Primary Care Practice (MAPCP) demonstration project, bringing in Medicare as a payer in the Pilot.

As a requirement of participation in the MAPCP demonstration, the original timeline of the Maine PCMH Pilot has been extended to match the MAPCP timeline (i.e. January 1, 2012 through December 31, 2014), and the participating commercial payers and Medicaid have agreed to extend their participation through this time. In addition, the Pilot is being expanded to include 20 new adult primary care practices in January 2013.

Practices applying for participation in the Maine PCMH Pilot expansion are asked to commit to full participation in the Pilot and the MAPCP demonstration. This Memorandum of Agreement serves as a formal agreement to meet the expectations of participation in the Pilot and MAPCP demo through this time period.

Mission: The Maine Patient Centered Medical Home (PCMH) Pilot will develop and implement patient centered delivery system and payment models that will provide and support effective, efficient, and accessible health care.

Vision: The Patient Centered Medical Home model will provide effective, efficient, and accessible health care supported by appropriate payment, and will deliver sustainable value to patients, providers, purchasers, and payers.

Benefits of Participation

The Maine PCMH Pilot offers an opportunity for primary care practices to make significant improvements in their systems of care for all patients in their practice, and to test a new payment model that recognizes the value of the PCMH model. Participants in the Pilot receive the following benefits:

- Recognition as a practice committed to improving primary care and a leader in transforming care to the PCMH model
- Opportunity to participate in an alternative payment model for primary care services, including PCMH payments from commercial payers and Medicaid.
- Support for transforming practice to the PCMH model through the PCMH Learning Collaborative, project staff and consultants, and collaborative learning with other practices participating in the Pilot
- Category I CME credits for attendance at PCMH Collaborative Learning Sessions
- Patient and provider tools to improve care
- Assistance in managing complex, high-needs patients from a partnering Community Care Team

Expectations of Participating Practices – Primary care practice sites selected for participation in the Maine PCMH Pilot and MAPCP demonstration are asked to commit to the following:

1. Support the Mission, Vision, and Guiding Principles of the Maine PCMH Pilot (see Appendix A), and commit to preserving access to primary care services.
2. Participate in the full duration of the Pilot and MAPCP demonstration, including a 3-month post-Pilot practice reassessment as part of the overall Pilot evaluation. Participation of Pilot practice sites means active participation of all healthcare professionals and staff in the practice site, and agreement to continually assess and improve care processes and structures within the practice, working in partnership with Pilot staff.
3. Fully implement the PCMH model as defined by the Maine Pilot, including fully implementing and maintaining *all* PCMH Pilot "Core Expectations" (see Appendix B). Practices newly entering the Pilot will be required to participate in an on-site assessment to evaluate the status of their Core Expectation implementation prior to entering the Pilot, with the practice assuming the costs of this assessment.
4. Maintain Patient Centered Medical Home recognition using the National Committee for Quality Assurance Patient Centered Medical Home 2011 Standards (NCQA PCMH 2011), maintaining or improving practice's current NCQA PCMH recognition level.
5. Submit updated provider information (provider names, tax ID numbers) to Pilot staff on a quarterly basis, or as otherwise requested, to support the process of attributing patients to the practice which is required for payers to make appropriate payments to practices.
6. Explicitly identify and use the PCMH payments from participating payers specifically to implement the PCMH model and improve systems of care within the practice.
7. Maintain a "Leadership Team" within the practice to serve as champions for PCMH improvement efforts and to attend PCMH Learning Collaborative Learning Sessions. The Leadership Team at your practice must include (at a minimum) a lead primary care physician or nurse practitioner, practice administrator, and a clinical support staff.
8. Participate in the PCMH Learning Collaborative, including consistent attendance by all members of the practice Leadership Team at 1-day Learning Sessions three times per year for the duration of the Pilot and MAPCP demonstration. A minimum of three Leadership Team members are required to attend all PCMH Learning Sessions, and practices may be required to pay a fee for attendance to help defray costs.
9. Participate actively in collaborative learning with other Pilot practices through sharing learning with other teams in Learning Sessions and participation of at least one Leadership Team member in monthly Leadership Team conference calls. Pilot practices are required to participate as a faculty/guest presenter in at least one PCMH team call or Learning Session per year.
10. Work with a PCMH Pilot-recognized Community Care Team to coordinate care and collaboratively manage the most high-needs, high-cost patients in the practice.
11. Fully participate in the Pilot and MAPCP evaluations, including the following:
    - Submit required authorizations for release of claims data to PCMH Pilot staff and evaluation team for analysis of cost and quality measures, both at baseline and over the course of the Pilot.

- Track full set of Pilot clinical quality measures using the practice's electronic medical record or registry, and report the full set of these clinical outcomes at baseline and quarterly to PCMH Pilot.
- Complete additional tools assessing practice culture as determined by the Pilot evaluation team – e.g. Practice Staff Questionnaire, Microsystems Assessment Tool.
- Participate in surveys and interviews with evaluation team, to be completed within three months of completion of the Pilot.

By signing below, I acknowledge my understanding of the goals and expectations of the Maine PCMH Pilot and MAPCP demonstration, and commit to full participation in the Pilot and MAPCP demonstration as defined by agreement to fulfill the expectations outlined above. I further understand that PCMH Pilot staff will periodically communicate our practice's adherence to these expectations to the participating Pilot payers, and that these payers may choose to discontinue PCMH payments if we do not fully adhere to these expectations.

Practice name: _____

Practice Address (site): _____

- **Physician or Nurse Practitioner Leader:**

Signed: _____ Date: _____

(Name): _____

- **Practice Manager or lead Administrator:**

Signed: _____ Date: _____

(Name): _____

- **Practice Senior Leader** *(Practices that are owned by a parent organization, hospital, or health system must obtain signature of the CEO/President of the parent organization that is responsible for operations of the practice):*

Signed: _____ Date: _____

(Name): _____

Please print and return completed MOA (Pgs 1-3) to Maine Quality Counts by May 4, 2012
PO Box 190, Manchester, ME 04351-0190, or FAX 622.3332

Maine Patient Centered Medical Home Pilot
Memorandum of Agreement for Participation

Appendix A:

Mission & Vision, Guiding Principles of the Maine PCMH Pilot

Mission: The Maine Patient Centered Medical Home (PCMH) Pilot will develop and implement patient centered delivery system and payment models that will provide and support effective, efficient, and accessible health care.

Vision: The Patient Centered Medical Home model will provide effective, efficient, and accessible health care supported by appropriate payment, and will deliver sustainable value to patients, providers, purchasers, and payers.

Definitions of Success - The Patient Centered Medical Home will:

- **Improve the health, well-being, and experience of care for all patients and families by…**
  - Transforming the experience of care for all patients in the practice, and strengthening the caring relationship between patients and their healthcare provider
  - Providing quality care that is safe, timely, effective, equitable, efficient, and patient-centered
  - Providing care that recognizes and integrates all of the patient's healthcare needs, including integrating behavioral and physical health needs
  - Educating and empowering patients to work in partnership with the practice team to achieve optimal health and promote preventive care
  - Giving patients more opportunities to be active and engaged in improving their care and their health (e.g. e-visits, group visits, community supports) without creating barriers to needed care
  - Connecting patients and families with community resources that support improved care and healthy behaviors, and are linked to Maine's emerging public health infrastructure (e.g. HMPs)
- **Sustain & revitalize primary care by…**
  - Encouraging primary care practices to take responsibility for the health needs of the entire population of patients in the practice who have agreed to partner with the practice team to receive care.
  - Enabling primary care providers to serve as leaders of practice change and advocates for their patients in a system of patient-centered care (i.e. not "gatekeepers")
  - Improving the efficiency of the practice and the satisfaction of the entire practice team
  - Providing a sustainable payment model that appropriately recognizes the value of primary care, supports the infrastructure and systems needed to deliver high quality care, rewards cost effective care, positive patient experiences and desired outcomes, and can be expanded statewide
  - Redefining the job of primary care and demonstrating how primary care can be an attractive form of practice that encourages medical students to choose training in primary care
  - Highlighting pilot practices as "best practice showcases" to help other practices learn how to transform to the medical home model and to promote spread of the model statewide
- **Promote an efficient integrated system of care by…**
  - Creating a system that enables people to be healthier and more productive.
  - Working with payers and purchasers to develop benefit designs and payment methodologies that support the mutual goals of the medical home
  - Bringing community stakeholders (e.g. primary care, specialists, hospitals) together to work towards shared goals and community benefit
  - Reducing overall costs of care (or at a minimum slowing the rate of healthcare cost increases) by reducing inappropriate utilization (e.g. avoidable Emergency Department use & hospitalizations) and decreasing unwarranted variations in care
  - Measuring outcomes that demonstrate the value (ROI) of the new model, broadly defined in terms of quality, experience of care, and costs/resource use

Maine Patient Centered Medical Home Pilot
Memorandum of Agreement for Participation

Appendix A:

Mission & Vision, Guiding Principles of the Maine PCMH Pilot

Guiding Principles for Maine Patient Centered Medical Home

The stakeholders of the Maine Multi-Payer Pilot of the Patient Centered Medical Home (PCMH) model endorse the "Joint Principles of the Patient-Centered Medical Home" as outlined by the American Academy of Family Physicians (AAFP), American College of Physicians (ACP), American College of Pediatrics (AAP), and American Osteopathic Association (AOA) in defining the medical home model – see attached.[1]

In addition to the AAFP-ACP-AAP-AOA Joint Principles, the stakeholders of the Maine Multi-Payer PCMH Pilot also identify the following additional principles that define implementation of the PCMH model in Maine:

- Given the unique geographic and demographic characteristics of the state and the need to take an inclusive approach to primary care practice, we envision a patient-centered medical home model that is delivered by practice teams that may be broad and varied in their composition but are held to a common set of expectations and consistent standard of care.
- We recognize that nurse practitioners and physician assistants are an integral part of the primary care system, and are important members of the primary care practice team.
- We consider references in the AAFP-ACP-AAP-AOA Joint Principles to "the personal physician" to be too narrow, and use the broader definition of the "personal primary care provider". Similarly, we more broadly define references to the "Physician directed medical practice" to include "primary care practice".
- We expand the description of "whole person orientation" in the Joint Principles to include a responsibility of the primary care team to recognize and integrate the patient's entire healthcare needs, including integration of behavioral and physical health needs.
- We recognize that payment for the medical home must appropriately recognize the added value provided to patients, but also must be balanced by savings from improved efficiencies and decreased costs achieved by reducing inappropriate utilization (e.g. avoidable Emergency Department use and hospitalizations, diagnostic testing not supported by evidence based guidelines) and decreasing unwarranted variations in care.

We further recognize that some stakeholders believe the definition of the Patient-Centered Medical Home as defined by the Joint Principles, and as further defined by the NCQA Physician-Practice Connection-PCMH (PPC-PCMH) standards, are limited, and/or in need of further refinement. As with any relatively new process, we are committed to continually reviewing the Joint Principles and standards, and consider them subject to potential future revision. Today, however, we recognize that they stand as the current national consensus definitions of a Patient-Centered Medical Home and endorse them as the core principles for the PCMH model when considered together with those noted above.

[1] Joint Principles of the Patient Centered Medical Home, AAFP, AAP, ACP, AOA – March 2007

American Academy of Family Physicians (AAFP)
American Academy of Pediatrics (AAP)
American College of Physicians (ACP)
American Osteopathic Association (AOA)

Joint Principles of the Patient-Centered Medical Home
March 2007

Introduction

The Patient-Centered Medical Home (PC-MH) is an approach to providing comprehensive primary care for children, youth, and adults. The PC-MH is a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family.

The AAP, AAFP, ACP and AOA, representing approximately 333,000 physicians, have developed the following joint principles to describe the characteristics of the PC-MH.

Principles

Personal physician - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

Physician directed medical practice – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

Whole person orientation – the personal physician is responsible for providing for all the patient's medical needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; end of life care.

Care is coordinated and/or integrated across all domains of the health care system (e.g. subspecialty care, hospitals, home health agencies, nursing homes) and the patient's community (e.g. family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

Quality and safety are hallmarks of the medical home:

- Practice advocates for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.
- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met

- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level

Enhanced access to care through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and office staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff work that falls outside of the face-to-face visit associated with patient-centered care management.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.
- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.

Maine Patient Centered Medical Home Pilot

Memorandum of Agreement for Participation

APPENDIX B – Maine PCMH Pilot Core Expectations

Introduction: The Maine Patient Centered Medical Home (PCMH) Pilot is a multi-stakeholder effort convened by the Dirigo Health Agency's Maine Quality Forum, Maine Quality Counts, and the Maine Health Management Coalition to implement and evaluate the PCMH model as the first step in achieving its statewide implementation. Practices participating in the Pilot confirm their commitment through a written "Memorandum of Agreement", which outlines the anticipated benefits and expectations for primary care practice sites participating in the Pilot, and includes a set of "Core Expectations", listed below. Pilot practices commit to achieving and maintaining these Core Expectations during the course of the Pilot. (NB: Expectation #10, HIT, was added July 09).

1. **Demonstrated leadership**
   - The practice can identify at least one primary care physician or nurse practitioner as a leader within the practice who visibly champions a commitment to improve care and implement the PCMH model. The primary care leader(s) takes an active role in working with other providers and staff in the practice to build a team-based approach to care, continually examine processes and structures to improve care, and review data on the performance of the practice. The primary care leader also participates as a member of the practice Leadership Team and participates in all aspects of the PCMH Learning Collaborative.

2. **Team-based approach to care**
   - The practice uses a team-based approach to care delivery that includes expanding the roles of non-physician providers (e.g. nurse practitioners, physician assistants, nurses, medical assistants) to improve clinical workflows.
   - The practice has committed redesigning primary care practice in a way that utilizes non-physician staff to improve access and efficiency of the practice team in specific ways, such as through greater use of planned visits, integrating care management into clinical practice, delegating some types of patient testing or exams (e.g., ordering of routine screening tests, diabetic foot exams) to non-physicians; expanding patient education; and providing greater data support to physicians to enhance the quality and cost-effectiveness of their clinical work.
   - Members of the practice team identify themselves as part of the practice team, and can identify their specific role and responsibilities within the team.

3. **Population risk stratification and management**
   - The practice has adopted a process for proactively identifying and stratifying patients across their population who are at risk for adverse outcomes, and direct resources or care processes to help reduce those risks.
   - "Adverse outcomes" is intended to mean adverse clinical outcomes and/or avoidable use of healthcare services such as hospital admissions, emergency department visits, or non-evidence based use of diagnostic testing or procedures.

4. **Practice-integrated care management**
   - The practice has a clear process for providing care management services, and has identified specific individuals to work closely with the practice team to provide care management for patients at high risk for experiencing adverse outcomes, including patients with chronic illness who are complex or fail to meet multiple treatment goals;

patients identified at risk for avoidable hospitalization or emergency department use; and patients at risk for developing avoidable conditions or complications of illness.
- Care management staff have clear roles and responsibilities, are integrated into the practice team, and receive explicit training to provide care management services.
- Care management staff have defined methods for tracking outcomes for patients receiving care management services.

5. **Enhanced access to care**
   - The practice commits to preserving access to their population of patients.
   - The practice has a system in place that ensures patients have same-day access to their healthcare provider using some form of care that meets their needs – e.g. open-access scheduling for same-day appointments, telephonic support, and/or secure messaging.
   - Time to 3rd next available appointment is consistently tracked and measured at zero.

6. **Behavioral-physical health integration**
   - With the assistance of PCMH Pilot staff and consultants, practice participates in a baseline assessment of their current behavioral-physical health integration capacity
   - Using results from this baseline assessment, practice has taken steps to make one or more specific improvements to integrate behavioral and physical health care– e.g.
     - Implement a system to routinely conduct a standard assessment for depression (e.g. PHQ-9) in patients with chronic illness
     - Incorporate a behavioralist into the practice to assist with chronic condition management
     - Co-locate behavioral health services within in the practice

7. **Inclusion of patients & families in implementation of PCMH model**
   - With the assistance of PCMH Pilot staff and consultants, practice has identified at least two patients or family members to be part of the practice Leadership Team
   - Practice is using one or more mechanisms for routinely soliciting input from patients and families on how well the practice is meeting their needs

8. **Connection to community – local Healthy Maine Partnership**
   - With assistance from PCMH Pilot staff, practice connects with their local Healthy Maine Partnership (HMP) to better understand community resources available to their patients
     - Practice can identify their local Healthy Maine Partnership
     - Practice leadership meets at least once with HMP staff

9. **Commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of healthcare services**
   - The practice makes a clear and firm commitment to reduce wasteful spending of healthcare resources and improving the cost-effective use of healthcare services by targeting at least 1-3 specific waste reduction initiatives – i.e. practice commits specific resources or processes in the practice towards… (e.g.)
     - Reducing avoidable hospitalizations
     - Reducing avoidable emergency department visits
     - Reducing non-evidence-based use of expensive imaging – e.g. MRI for low back pain or headache
     - Working with specialists to develop new models of specialty consultation that improve patient experience and quality of care, while reducing unnecessary use of services
     - Directing referrals to specialists who consistently demonstrate high quality and cost efficient use of resources

10. **Integration of health information technology (HIT):**
    - Practice is working towards use of integrated HIT (e.g. registry, electronic medical record, personal health records, health information exchange, provider-patient secure messaging) to support improved communication with and for patients, and to assure patients get care when and where they need and want it in a culturally and linguistically appropriate manner.

Please print and return completed MOA (Pgs 1-3) to Maine Quality Counts by December 15, 2011
PO Box 190, Manchester, ME 04351-0190, or FAX 622.3332

DEMONSTRATION AGREEMENT

DEMONSTRATION: **Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration**

State: **Maine**

Preamble

The Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration is a three year demonstration to promote the principles of the advanced primary care (APC) practice, which is often referred to as the patient-centered medical home. Advanced primary care practices, or "medical homes," utilize a team approach to care, with the patient at the center. APC practices emphasize prevention, health information technology, care coordination and shared decision making among patients and their providers. The goal is to improve the quality and coordination of health care services. For the purposes of this demonstration, an APC practice may be a solo practitioner, a group practice, or a federally qualified health center (FQHC). APC practices may be led by doctors or nurse practitioners.

Under this demonstration, CMS will join with Medicaid and commercial insurers to participate in State multi-payer medical home initiatives. Thus, each state program will vary both in design and payment requirements. The demonstration program will pay a monthly care management fee for beneficiaries receiving primary care from APC practices. The care management fee is intended to cover care coordination, improved access, patient education and other services to support chronically ill patients. Additionally, each participating State will have mechanisms to offer APC practices community support and linkages to State health promotion and disease prevention initiatives.

The authority to conduct this demonstration is provided in section 402 of Public Law 90-248, as amended (42 U.S.C. 1395b-1). Specifically, under 402(a) (1) (B), the Secretary is authorized to develop and engage in demonstrations

> "…to determine whether payments for services other than those for which payment may be made under such programs…would in the judgment of the Secretary, result in more economical provision and more effective utilization of services for which payment may be made under such program…"

Under the demonstration, beneficiaries will continue to receive all reasonable and necessary covered items and services provided for in Title XVIII and providers will continue to be eligible for payment for services covered under the Medicare fee-for-service program as they would in the absence of the demonstration. However, in addition, providers and other specified community entities will be eligible for medical home payments as specified in Attachment 2 to this agreement.

The Center for Medicare and Medicaid Innovation (hereinafter "CMMI") in the Centers for Medicare & Medicaid Services (hereinafter "CMS") awards this demonstration agreement to the state of Maine (hereinafter referred to as the "State" or "state") to conduct the Multi-payer Advanced Primary Care Practice (MAPCP) Demonstration **(**hereinafter "Demonstration" or "demonstration") and serve Medicare beneficiaries according to special terms and conditions agreed upon by both CMS and the state as set forth in this Demonstration Agreement.

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This agreement between CMS and the State is not subject to the Federal Acquisition Regulations.

Special Terms and Conditions

1. **MAPCP Demonstration**: The state agrees to implement the demonstration as specified in their original proposal including any subsequent changes as mutually agreed to by CMS and the State. Any requests for modification to the demonstration must be agreed to in writing and approved by the CMS Project Officer prior to implementation and will be by mutual agreement of CMS and the State. Any modifications shall be incorporated into this Demonstration Agreement by reference upon written CMS approval.

2. **Award Period**: This is a three year demonstration commencing with the first month for which payments are made under the demonstration. It is expected that the demonstration will be operational in mid-2011, but the exact date may vary based on the operational readiness of either CMS or the State. Significant delays from this schedule will be based on mutual negotiation and agreement by both parties.

3. **Practice and Provider Monitoring** – The State agrees to establish and maintain an ongoing system to monitor and ensure that practices, providers, and, as applicable, community based health teams or other entities participating in the demonstration meet all of the requirements and expectations of participation. This may include, but is not limited to, providing and/or coordinating the provision of medical home services to all eligible patients, submitting of any required data, meeting benchmark certification standards, if required, and participating in demonstration related activities. Practices, providers and/or community health teams that fail to meet expectations shall be so notified and, if they continue to not meet expectations, shall be terminated from the demonstration. The State shall notify CMS of any such terminations within 5 business days.

4. **Practice and Provider Information**: The State agrees to provide CMS information on APC practices, individual providers, community care organizations, and any other entity participating in this demonstration through agreements with the State. The information shall include, but not be limited to, Medicare identification numbers (e.g. PINs, NPIs) and the effective start and termination dates for participating practices, providers, and community

organizations as necessary to conduct demonstration activities including beneficiary assignment and accurate and timely payment and reconciliation. A description of the algorithms to be used in assigning beneficiaries to practices is provided in Attachment 1. A list of the information to be provided by the State is provided in Attachment 3.

a. The State shall assume responsibility for the accuracy and completeness of all data submitted as part of this demonstration. This includes, but is not limited to, data used to assign beneficiaries to practices and calculate medical home payments and any information provided to CMS and/or its contractors. The State attests that all information provided to CMS is complete, accurate, timely and truthful based on its best knowledge.

b. Should a practice or other participating organizational entity withdraw or be terminated by the State from the demonstration such that it is no longer eligible for payment, the State agrees to notify CMS in writing within 5 days of any such action in order to minimize disruption to the demonstration operations and the need to retract or otherwise retroactively adjust payments.

c. The State and its participating practices or organizations agree to cooperate and provide data requested by CMS and/or its contractors in order to conduct the operations of this demonstration.

5. **Payment –** Under this demonstration**,** CMS will pay a monthly care management fee for beneficiaries receiving primary care from participating APC practices. The care management fee is intended to cover the costs of transforming the practice into a "medical home" including care coordination, improved access, patient education and other services to support improved patient care. In addition to the fee to the APC practice, CMS may, pay a monthly fee to community health teams or similar organizations. The payment codes to be used and amounts of such payments under this State's Demonstration Agreement are provided in Attachment 2.

6. **Evaluation-** As part of its proposal, the State has agreed to conduct its own evaluation plan to monitor performance and provide feedback to participating payers, providers, and communities. In addition, CMS will be contracting with an independent organization to conduct its own independent evaluation of the demonstration in all of the participating states. The State and its partners, including all participating APCs, agree to cooperate with and provide data requested by the CMS independent evaluation contractor, including submission of cost and other program data and participation in site visits.

7. **Other Demonstrations or Programs** - The State and its participating APC practices and community organizations agree not to participate in more than one Medicare demonstration or program that covers the period between the start and end dates of the MAPCP demonstration should CMS determine such participation conflicts with the MAPCP

demonstration, would result in duplicate payment to one or more providers for services to the same beneficiary, and/or would impact the evaluation of one or both demonstrations. CMS reserves the right to exclude from participation in another CMS demonstration any State or participating practice/community organization that voluntarily withdraws from the MAPCP demonstration.

8. **Data –** The State and its partnering organizations (participating practices, providers, community organizations, third party administrative entities, etc.) shall maintain the confidentiality and security of all project-related information that identifies individual beneficiaries, APC practices and/or providers in accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA) Privacy Rule and other applicable HIPAA Provisions.

    a. In order to allow CMS to share personally identifiable patient and provider data with the state, participating APCs, and any other partners, for the purposes of facilitating care coordination and the administration or evaluation of the demonstration, the state agrees to establish business associate agreements, as necessary, to be in compliance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA) Privacy Rule and other applicable HIPAA Provisions.

    b. CMS agrees to work with all states participating in this demonstration to provide Medicare claims and enrollment data needed to support each state's demonstration project in a uniform format and frequency.

    c. The State and any of its partners that have access to personally identifiable data shall sign a CMS Data Use Agreement prior to receiving any data files from CMS. The data provided by CMS shall only be used for the purposes explicitly stated in the Data Use Agreement.

    d. Any data about the demonstration that is made public shall be anonymous or at the aggregate level and will not include any individually identifiable data as defined by HIPAA or any other CMS or federal memorandum, policies, statutes or regulations.

    e. All of the data collected by CMS during the course of this demonstration shall be confidential and will be used solely for the purpose of implementing or evaluating the demonstration. No individually identifiable (by beneficiary, APC practice or individual physician or other provider of service) data shall be made public.

9. **Ownership of Work Products** – All documents, survey instruments, data files, and any other information and products related to this demonstration created by CMS or its contractors shall be the sole property of CMS. If the State wishes to use any of the information or products created during the course of this project for purposes other than the

administration of this demonstration, it shall obtain the written permission of CMS. This shall not preclude the states from using data by CMS to provide monitoring or other feedback information to participating practices.

Likewise, all documents, survey instruments, data files, and any other information created by the State and/or any contracting entities working on its behalf to implement this demonstration will remain the property of the State and/or its contractors.

10. **Budget Neutrality** – During the course of the demonstration, CMS will monitor expenditures for claims and demonstration payments against projections to ensure that the State's project will be budget neutral over the course of the three years. CMS reserves the right, at its discretion, to negotiate with the State adjustments in payments or terminate the demonstration to ensure budget neutrality, as deemed necessary.

11. **Voluntary Participation-** Participation in this demonstration is voluntary. However, it is expected that the State intends to participate for the full duration of the demonstration.

    a. If the State decides to withdraw from the demonstration and terminate this Demonstration Agreement prior to the end of the three year demonstration period, it must notify CMS in writing 90 calendar days before the planned date of withdrawal and termination. The State must also notify all participating practices and other organizations in writing within 60 calendar days before the planned date of withdrawal and termination.

    b. Should the State decide to terminate its participation in the demonstration before the end of the three years, neither the State nor any organization participating in the State's project will be eligible for any demonstration payments for periods after the termination of this agreement. Nor will any providers or any other entities participating in this demonstration through agreements with the state be eligible for demonstration payments for periods after the termination date of this agreement.

12. **Termination by CMS**- CMS reserves the right to terminate the demonstration in whole or in part, at any time prior to end of the three year demonstration if it determines that continuing the project is no longer in the public interest or for any reason determined by CMS. CMS will promptly notify the State in writing 90 calendar days in advance of such termination, together with the effective date. The State must notify practices and other participating organizations 60 calendar days before the planned date of termination.

13. **Changes -** Changes in the terms and conditions of this agreement may be made only by written agreement of the parties.

14. Notices- Any notice required to be given by CMS to the State or by the State to CMS hereunder shall be in writing sent certified mail, return, receipt, requested and mailed to:

If to CMS: Jody Blatt
Project Officer
Centers for Medicare & Medicaid Services
7500 Security Blvd
Baltimore, MD 21244

If to the State: (insert name & address)

15. Acceptance of Demonstration Agreement- A representative of the State who can legally sign contracts and bind the State shall sign this Demonstration Agreement below indicating acceptance of all provisions contained within this demonstration agreement.

FOR CMS:

_____
[Print Name and Title]
Centers for Medicare & Medicaid Services

_____ _____
[Signature] Date

FOR THE STATE:

_____
[Print Name and Title]

_____ _____
[Signature] Date

DEMONSTRATION AGREEMENT ATTACHMENTS

State: Maine

ATTACHMENT 1: Beneficiary Assignment Algorithm

1. The look back period is the most recent 24 months for which claims are available.

2. Identify all Medicare beneficiaries who meet the following criteria as of the last day in the look back period:
   - Reside in Maine;
   - Have both Medicare Parts A & B;
   - Are covered under the traditional Medicare Fee-For-Service Program and are not enrolled in a Medicare Advantage or other Medicare health plan; and
   - Medicare is the primary payer;

3. Select all claims for beneficiaries identified in step 2 with the following qualifying CPT Codes in the look back period (most recent 24 months) where the provider specialty is internal medicine, general medicine, geriatric medicine, family medicine, nurse practitioner, or physician assistant or where the provider is an FQHC.

CPT-4 Code Description Summary
Evaluation and Management - Office or Other Outpatient Services • New Patient: 99201-99205 • Established Patient: 99211-99215
Consultations - Office or Other Outpatient Consultations • New or Established Patient: 99241-99245
Nursing Facility Services: • E&M New/Established patient: 99304-99306 • Subsequent Nursing Facility Care: 99307-99310
Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Service: • Domiciliary or Rest Home Visit New Patient: 99324-99328 • Domiciliary or Rest Home Visit Established Patient: 99334-99337
Home Services • New Patient: 99341-99345 • Established Patient: 99347-99350
Prolonged Services – Prolonged Physician Service With Direct (Face-to-Face) Patient Contact • 99354 and 99355
Prolonged Services – Prolonged Physician Service Without Direct (Face-to-Face) Patient Contact • 99358 and 99359
Preventive Medicine Services • New Patient: 99381–99387 • Established Patient: 99391–99397

CPT-4 Code Description Summary
Medicare Covered Wellness Visits • **G0402** - Initial Preventive Physical Exam ("Welcome to Medicare" visit) • **G0438** – Annual wellness visit, first visit • **G0439** – Annual wellness visit, subsequent visit
Counseling Risk Factor Reduction and Behavior Change Intervention • New or Established Patient Preventive Medicine, Individual Counseling: 99401–99404 • New or Established Patient Behavior Change Interventions, Individual: 99406-99409 • New or Established Patient Preventive Medicine, Group Counseling: 99411–99412
Other Preventive Medicine Services – Administration and Interpretation: • 99420
Other Preventive Medicine Services – Unlisted preventive: • 99429
Federally Qualified Health Center (FQHC) – Global Visit ***(billed as a revenue code on an institutional claim form)*** • 0521 = Clinic visit by member to RHC/FQHC; • 0522 = Home visit by RHC/FQHC practitioner

4. Assign a beneficiary to the practice where s/he had the greatest number of qualifying claims. A practice shall be identified by the NPIs of the individual providers associated with it.

5. If a beneficiary has an equal number of qualifying visits to more than one practice, assign the beneficiary to the one with the most recent visit.

6. This beneficiary assignment algorithm shall be run every 3 months with reports provided as designated in the CR to various entities within 15 business days of the end of the look back period and applicable to payments starting 30 days after the end of the look back period.

Attachment 2 – Payment Processing and Codes

HCPCS Code	***Description***	***Payable To***	***Allowable Charge***
G9008	Physician Coordinated Care Oversight Services	Medical Home practice	$ 6.95
G9152	MAPCP Demonstration – Community Health Teams	Community Based Entity	S 2.95

Attachment 3 –Data to be Provided to CMS by the State

I. For Participating Medical Homes, Community Health Teams, and Providers

1. Practice name
2. Practice ID (assigned by state)
3. Region (if applicable)
4. Practice Address (street, city, state, zip)
5. Practice Level Billing information for each Part B carrier/MAC billed, including:
    a. Carrier / MAC name
    b. Part B PIN (P-TAN)
    c. NPI (Group or Individual)
    d. Tax ID (and whether it is an SSN or EIN)
6. Indicator whether practice bills Medicare as an FQHC, RHC or CAH.
7. If practice is an FQHC/RHC/CAH, provide the following additional information:
    a. "Part A" provider number used for billing "global visit."
    b. 'Part B" provider number to be used for paying medical home fees.
8. Demonstration effective and termination dates
9. Contact Information (name, address, phone, email)

For each individual provider within a practice, the information shall include the following fields:

1. Practice affiliated with.
2. Provider name.
3. Individual NPI
4. Individual PIN (P-TAN) for all carriers billed
5. Individual Tax ID, if applicable
6. Date provider joined the practice
7. Date provider left the practice
8. Contact Information (name, address, phone, email)

For those States where there will be payments to community organizations providing care coordination services, the information shall include:

1. Practices affiliated with the organization.
2. Organization name
3. Billing Information
    a. Carrier/MAC name

b. Organization's P-TAN (Individual PIN).
c. NPI
d. TIN (SSN or EIN)

4. Demonstration Participation Effective Date
5. Demonstration Participation Termination date
6. Contact Information (name, address, phone, email)

For those States where there will be payments to a state designated entity for oversight and management or other similar services, the information shall include:

1. Organization name.
2. Billing Information
   a. Carrier/MAC name
   b. Organization's P-TAN (Individual PIN).
   c. NPI
   d. TIN (SSN or EIN)
3. Demonstration Participation Effective Date
4. Demonstration Participation Termination date
5. Contact Information (name, address, phone, email)

II. Billing Codes and Payment

For each entity receiving Payment

1. Procedure Code to be Used
2. Payment Amount
3. Payment Effective Date
4. Payment Termination Date

Section I. Performance Measurement of Quality, Cost, and Health Goals

Refer to DRR Section I: Quality, Financial and Health Goals and Performance Measurement Plan

Supporting Documentation Available:

I1) Hospital Ratings Methodology – March, 2013

I2) Stakeholder Engagement Plan (See SECTION A5 Documentation)

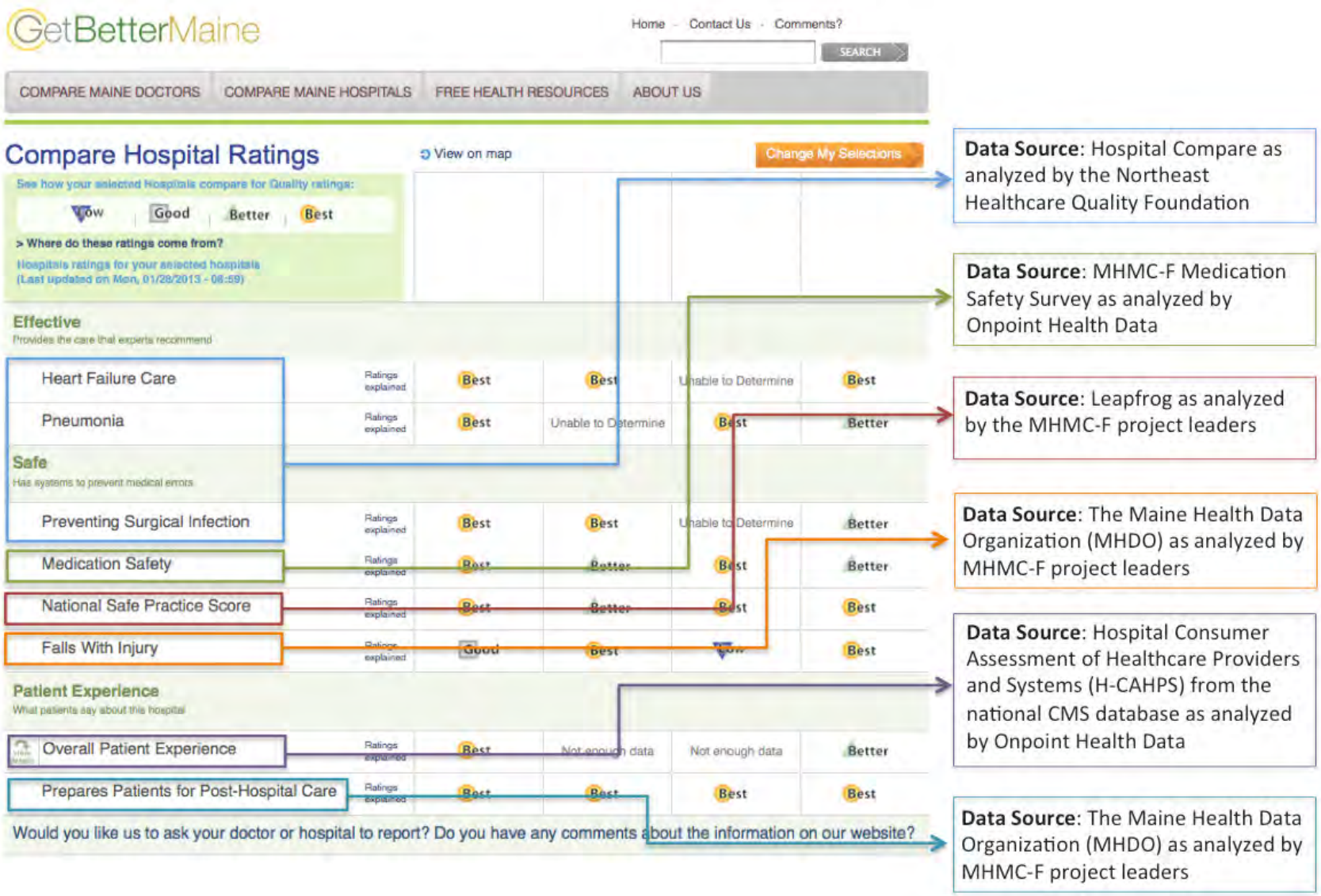
I3) Communications Matrix (See SECTION Q Documentation)

See also Documentation SECTION D

Maine Health Management Coalition Foundation

Hospital Ratings Methodology

Updated March 2013


GetBetterMaine
Home Contact Us Comments?
SEARCH
COMPARE MAINE DOCTORS
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FREE HEALTH RESOURCES
ABOUT US
Compare Hospital Ratings
View on map
Change My Selections
See how your selected Hospitals compare for Quality ratings:
Low
Good
Better
Best
> Where do these ratings come from?
Hospitals ratings for your selected hospitals
(Last updated on Mon, 01/28/2013 - 08:59)
Effective
Provides the care that experts recommend
Heart Failure Care
Ratings explained
Best
Best
Unable to Determine
Best
Pneumonia
Ratings explained
Best
Unable to Determine
Best
Better
Safe
Has systems to prevent medical errors
Preventing Surgical Infection
Ratings explained
Best
Best
Unable to Determine
Better
Medication Safety
Ratings explained
Best
Better
Best
Better
National Safe Practice Score
Ratings explained
Best
Better
Best
Best
Falls With Injury
Ratings explained
Good
Best
Low
Best
Patient Experience
What patients say about this hospital
Overall Patient Experience
Ratings explained
Best
Not enough data
Not enough data
Better
Prepares Patients for Post-Hospital Care
Ratings explained
Best
Best
Best
Best
Would you like us to ask your doctor or hospital to report? Do you have any comments about the information on our website?
Data Source: Hospital Compare as analyzed by the Northeast Healthcare Quality Foundation
Data Source: MHMC-F Medication Safety Survey as analyzed by Onpoint Health Data
Data Source: Leapfrog as analyzed by the MHMC-F project leaders
Data Source: The Maine Health Data Organization (MHDO) as analyzed by MHMC-F project leaders
Data Source: Hospital Consumer Assessment of Healthcare Providers and Systems (H-CAHPS) from the national CMS database as analyzed by Onpoint Health Data
Data Source: The Maine Health Data Organization (MHDO) as analyzed by MHMC-F project leaders

Effective and Safe - MHMC publically reports the following composite measures (i.e. percent of patients that received all appropriate care).

Reported under the "Effective" Category:

- Heart failure care
- Pneumonia

Reported under the "Safe" Category:

- Preventing surgical infections composite measures

MHMC uses a composite measure for each measurement area based on the measures below:

MEASURE NAME
Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)
Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function
Heart Failure Patients Given Discharge Instructions
~~Heart Failure Patients Given Smoking Cessation Advice/Counseling~~ *
~~Pneumonia Patients Assessed and Given Pneumococcal Vaccination~~ *
Pneumonia Patients with Blood Culture Before First Antibiotic
~~Pneumonia Patients Given Initial Antibiotic(s) within 6 Hours After Arrival~~ *
~~Pneumonia Patients Given Smoking Cessation Advice/Counseling~~ *
Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s)
~~Pneumonia Patients Assessed and Given Influenza Vaccination~~ *
Surgery patients who were given an antibiotic at the right time (within one hour before

surgery) to help prevent infection
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery)
Surgery patients who were given the right kind of antibiotic to help prevent infection
Cardiac surgery patients with controlled blood glucose
~~Surgery patients with appropriate hair removal~~ *
Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery
Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries

* Measure retired by CMS for discharges effective January 1, 2012

MHMC will calculate the composite measure in the following way to address the retired measures:

The composite measures are "all or nothing" indicator. If any of the individual measures composing the composite measure are not documented for that patient, do not count the patient in the numerator.

Assume a point where we have 2 quarters of 2011 and 2 quarters of 2012 data. The hospital's score would be as follows: the numerator would be the # of patients who passed all the measures in use in that last 2 quarters of 2011 plus the # who passed all the (reduced) measures in use in the first 2 quarters of 2012 divided by the total # of patients.

There will be no minimum case count for reporting - hospitals that treat any qualifying cases will be scored on those cases.

There are 3 benchmarks: national average, state average, and best practice or top hospitals (90th percentile or above). The method for calculation of the national average and national best practice benchmarks was revised for the April 2013 website update as follows. Prior to April 2013, only one quarter of the most recent national data was used for calculation of the average and best practices benchmarks but based on votes of the PTE Physicians Steering Committee meeting, the four most recent quarters of national data will be used. However, national data is not available as timely as Maine hospital data so the national benchmarks although based on four quarters will be one quarter behind the Maine data. For example, Maine data

posted to the GBM website April 2013 is for Q3 2011 - Q2 2012 while the national data used to calculate benchmarks is for Q2 2011 – Q1 2012.

Based on Ratings are assigned as follows:

Rating	**Scoring**
Best	Equal to or above all 3 benchmarks
Better	Equal to or above 2 of the 3 benchmarks
Good	Equal to or above 1 benchmark
Low	Below all benchmarks

Safe

Medication Safety: Medication Safety is based on a survey developed by a Committee of Pharmacists and Nurses from MHMC member hospitals. The survey addresses systems in place in hospitals that have been shown to reduce medication errors. The maximum score is 100 points. Please contact PTE Hospital project leader if you are interested in further details (e.g. algorithm, scoring criteria)

Rating	**Scoring**
Best	>=70
Better	>=55 to <70
Good	>=45 to <55
Low	0 to <45

Components of Medication Safety Survey -

1. **How prescriptions are double-checked** - What systems are in place to help doctors, nurses, and pharmacists double-check medicines before they're given to patients? A good system helps ensure that patients get the right medicines in the right doses. It also checks to see if medicines can be used together without side effects. Many hospitals use computer systems that alert providers to possible problems before they happen.
2. **How medicines are given** - What kind of record keeping system is in place to help nurses know what medicines each patient should get and when they should get it? Some hospitals use computer systems that give nurses complete and up-to-the-minute information at the press of a button. This helps the nurse to prevent errors.
3. **How medicine is stored** - How is medicine stored on nursing units? When medicines stored in a cabinet look alike and have similar names, it's easy for a nurse to reach for the wrong one. Many hospitals now use medicine cabinets that are connected to a computer. When a nurse needs a medicine, the computer opens just the cabinet compartment with the right medicine. Often, the door to the compartment will open only after a pharmacist has double-checked the prescription. These systems help keep both the nurse and the pharmacist from making mistakes.
4. **Bar-coded medication administration (BCMA) -** allows caregivers to utilize bar code scanning technology prior to administering medications, to confirm patient identity and medication information against data readily available via the Medication Administration Record. Immediate access to a patient's current results and medication administration information greatly reduces preventable medication errors. The use of bar code scanning increases accuracy and efficiency of caregivers completing medication administration records, providing physicians faster and easier access to critical information to manage patient care.
5. **Professional Pharmacy Services** This section focuses on systems that hospitals have in place for clinical review of critical areas of medication therapy such as appropriateness of dosing in patients with poor kidney function, appropriate selection of antibiotic and anticoagulant therapy.

Safe Practices: National Safe Practices is based on selected measures from the Hospital Quality Ratings produced by the Leapfrog Group. Hospitals complete a detailed survey annually with monthly updates available. MHMC uses the following sections of the Leapfrog ratings:

1. High risk procedures
    - Heart bypass surgery
    - Angioplasty
    - High risk deliveries
    - Normal deliveries
    - Weight loss surgery
    - Aortic valve surgery
    - Abdominal aortic aneurism repair
    - Pancreatic resection
    - Esophageal resection
2. Preventing medication errors
3. Appropriate ICU Staffing
4. Steps to avoid harm

Leapfrog's ratings are displayed as "bars" and a hospital receives 1 to 4 bars depending upon their performance in each measure.

1 bar = willing to report
2 bars = some progress in meeting standard
3 bars = substantial progress in meeting standard
4 bars = fully meets standard

MHMC assigns a point value to the bars as follows:

0 bars = 0 points
1 bar = 1 point
2 bars = 2 points
3 bars = 3 points
4 bars = 4 points

MHMC only uses the quality of care ratings that are designated by Leapfrog (e.g. heart angioplasty, heart bypass) and not the cost of care ratings for those procedures where Leapfrog incorporates both cost and quality.

The scoring is a two-step process. The first calculation is the Leapfrog High Risk Rating score: *Numerator* - Sum of the scores for each High Risk Procedure reported. *Denominator* - # of High Risk measures reported**.** Secondly, the total Leapfrog score is calculated: *Numerator* – The sum of the scores for: high risk procedures + prevent medication errors + appropriate ICU staffing + steps to avoid harm. *Denominator* - total # of categories reported (high risk procedures, steps to avoid harm, prevent medication errors, appropriate ICU staffing).

Note*: MHMC designates hospitals as either A or B. "A" hospitals have 100 or more beds and "B" hospitals have fewer than 100 beds based on the Maine Hospital Association guide. B hospitals are only required to report steps to avoid harm and high risk procedures. If a "B" hospital reports either the prevent medication errors, or ICU staffing measures, then MHMC will use both prevent medication errors and ICU staffing in the overall rating calculation but ONLY if these measures improve the total score based on the two required measures.*

Rating	**Scoring**
Best	>=3.5
Better	>=2.5-3.4
Good	>=1.5-2.4
Low	<1.5

Falls with Injury

Source of data: The data will be obtained from the Maine Quality Forum website.

Timing of data: The most recently available 4 quarters of data will be used in MHMC's quarterly website updates.

Hospital Review: As with other MHMC Hospital measures, the results and ratings assignment for all hospitals will be provided to each hospital for a 10 day review period prior to posting on the MHMC website. Hospitals are encouraged to review the results for accuracy and report any concerns to MHMC.

Methodology: MHMC will calculate a mean score and + and – one standard deviation based on the actual rate of falls with injury per 1000 patient days for each of the following hospital peer groups:

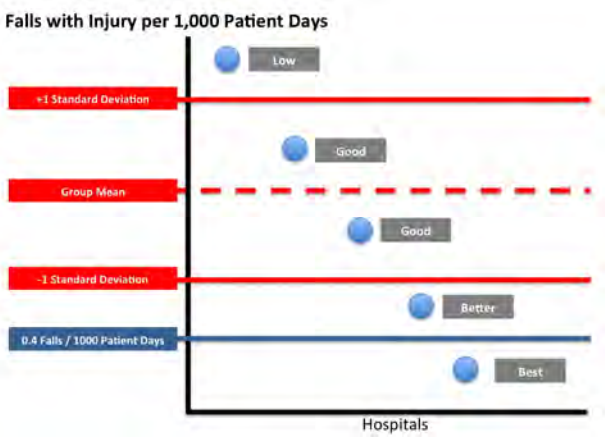
- >= 150 beds
- < 150 beds but not Critical Access Hospital
- Critical Access Hospitals
- Hospitals of any size without maternity services

Ratings will assigned as follows:

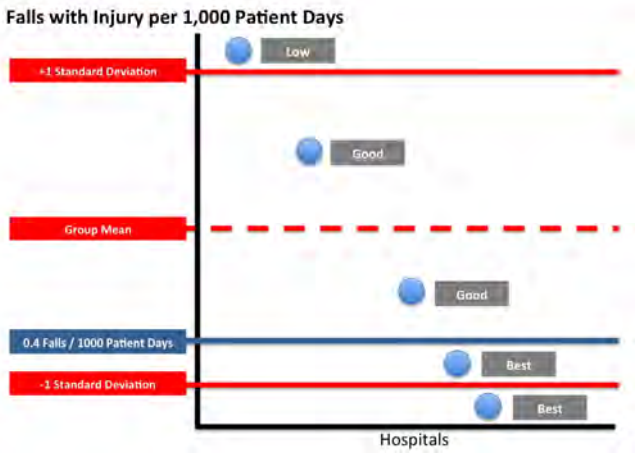
- Falls with Injury rate above +1 standard deviation above mean = Low
- Falls with Injury rate between +1 standard deviation above mean and -1 standard deviation below the mean = Good
- Falls with Injury rate below -1 standard deviation below mean = Better
- Falls with Injury rate <= 0.4 falls/1000 patient days regardless of where the rate falls relative to standard deviations = Best

The following graphics depict examples of how ratings will be assigned:

Falls – Std Deviation Method Example 1: Where the -1 Standard Deviation level is above the 0.4 Falls/1000 Patient Days best practice benchmark



Falls Standard Deviation – Example 2: Where the -1 Standard Deviation level is below the 0.4 best practice benchmark



Patient Experience - HCAHPS: MHMC uses the "top box" methodology for scoring and rating each Pt. Experience Domain:

Onpoint downloads the entire HCAHPS database for all hospitals reported and calculates the top 10% of the national performance and national and state averages for each HCAHPS domain. MHMC's Pt. Experience reporting utilizes the 8 Domains that will be used by the CMS VBP initiative. Consistent with CMS VBP program, the Cleanliness and Quietness domains will be combined and the Willingness to recommend domain will not be used.

HCAHPS Measures	2013 CMS P4P
HCAHPS Communication with Doctors	X
HCAHPS Communication with Nurses	X
HCAHPS Responsiveness of Staff	X
HCAHPS Pain Management	X
HCAHPS Medication communication	X
HCAHPS Cleanliness and quietness	X
HCAHPS Discharge information	X
HCAHPS Overall rating	X
HCAHPS Would recommend	

Points for each domain are determined by comparing a hospital's performance to state and national averages and the top 10% of national hospital performance. The following points and ratings are awarded for these thresholds: $\geq$ than national average, $\geq$ state average, $\geq$ top 10% of national average.

1 point **(Low)** = completed but did not meet any thresholds

2 points **(Good)** = met at least 1 threshold

3 points **(Better)** = met 2 thresholds

4 points **(Best)** = met all three thresholds

The scoring incorporates a "peer group" methodology in which a separate state average is calculated for each of three different hospital peer groups:

a. Critical Access Hospitals
b. Hospitals with less than 150 beds
c. Hospital with 150 or more beds

Note: This "Peer Group" methodology is being implemented to compensate for a lack of risk adjusting in HCAHPS and to mitigate the disadvantage to hospitals that see a higher percentage of patients who research has shown report poorer patient experience.

The points awarded for each of the 8 domains are averaged and rounded to a whole number to produce a summary score.

This summary score is translated into a single word icon rating in the Patient Experience section of MHMC's website as follows:

a. 1 point = Low
b. 2 points = Good
c. 3 points = Better
d. 4 points = Best

Patient Experience: Care Transition Measures:

Scoring Methodology:

Each response to each question for each hospital will be awarded points as follows:

1 = strongly disagree = 0 points
2 = disagree = 33 points
3 = agree = 66 points
4 = strongly agree = 100 points

The score for each hospital = mathematical average of all responses for all questions.

Web Reporting Methodology

BEST:	>= 90 points
BETTER:	Lower end of the hospital's confidence interval is above the state mean.
GOOD:	Hospital's confidence interval overlaps the state mean.
LOW:	The upper end of the hospital's confidence interval is below the state mean.

Using the 95% confidence interval on the arithmetic mean.

Section J. Privacy and Confidentiality

Refer to DRR Section J: Appropriate Consideration for Privacy and Confidentiality

Supporting Documentation Available:

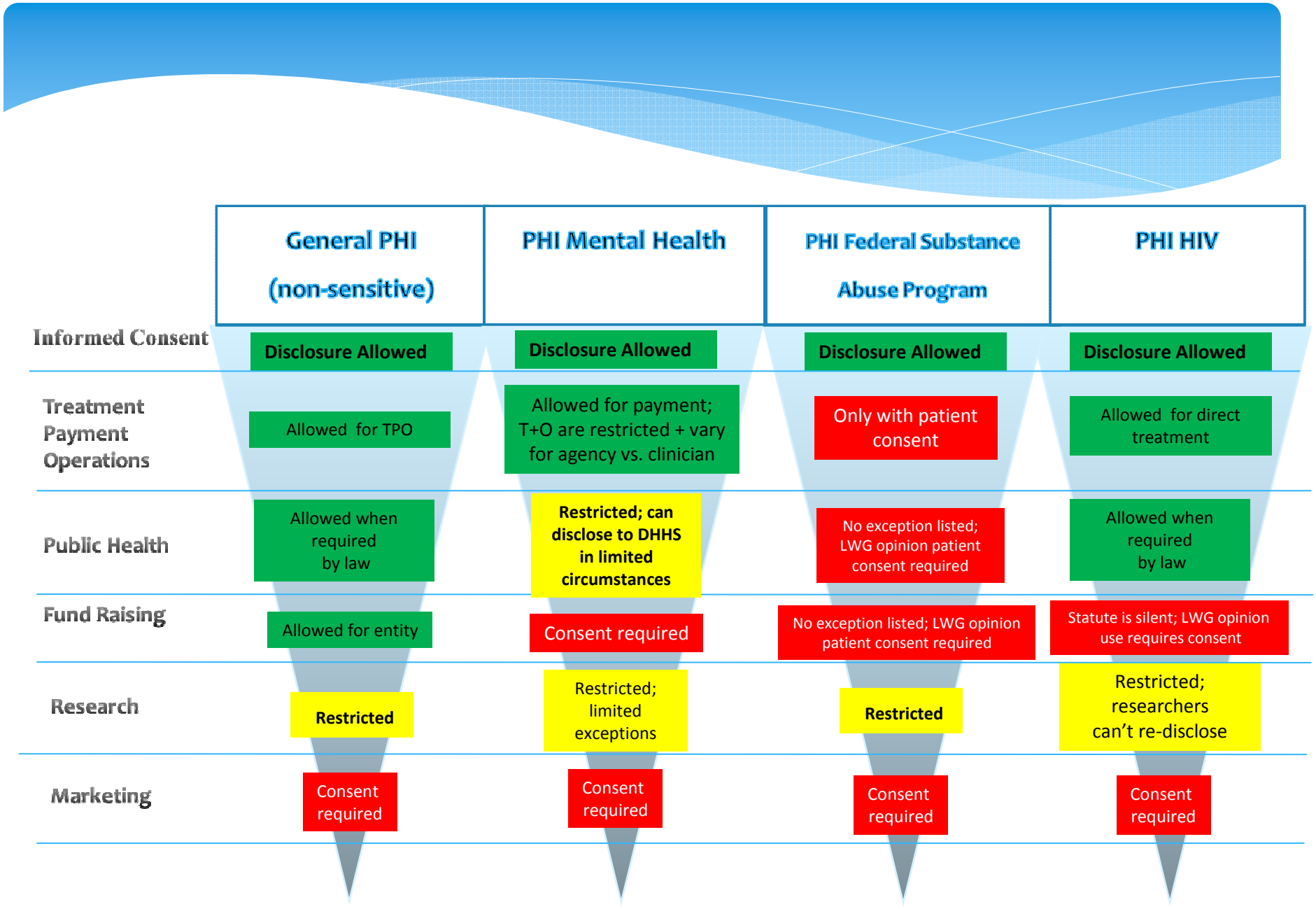
J1) HealthInfoNet opt-out web link: www.hinfonet.org/optout

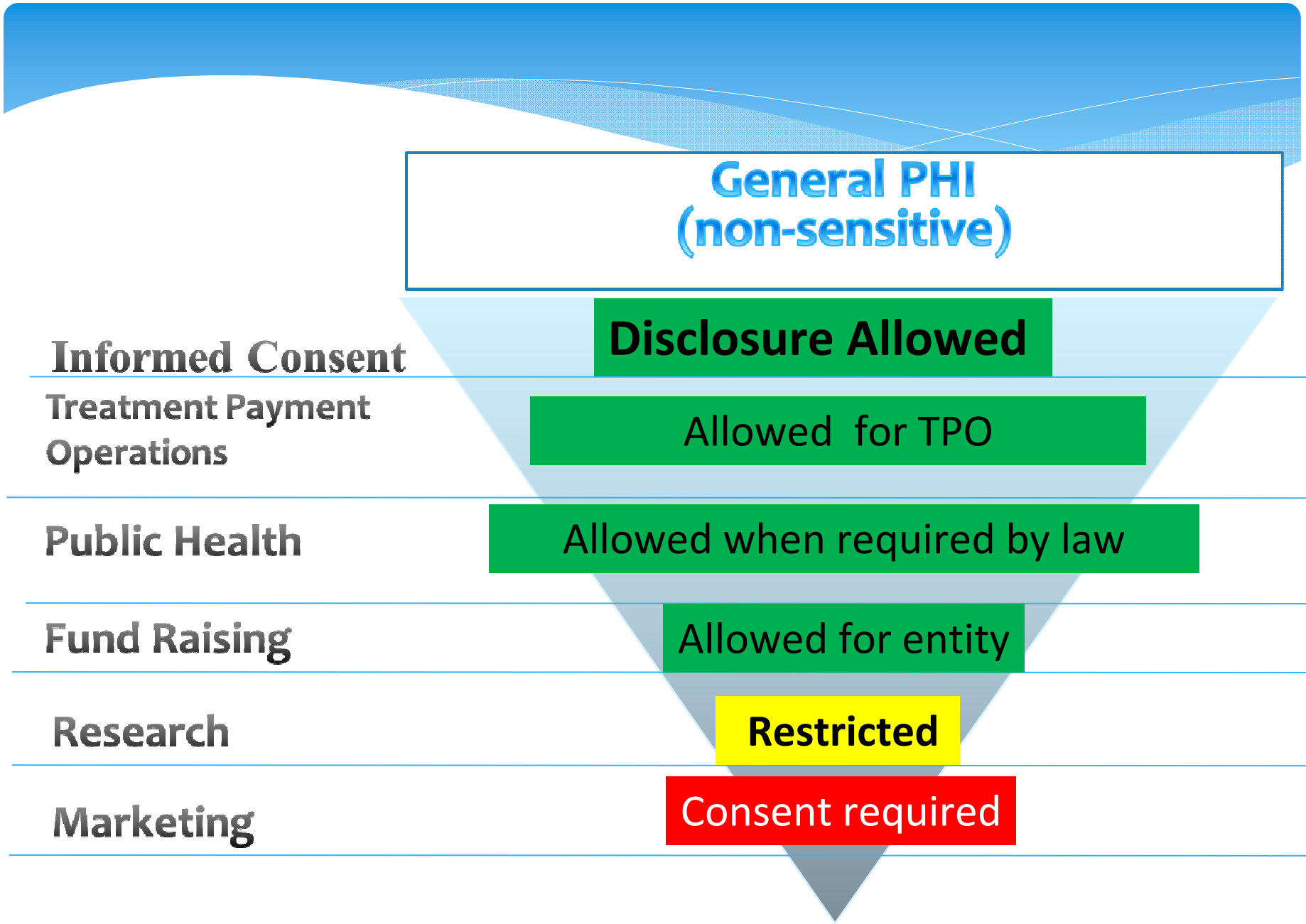
J2) HealthInfoNet opt-in web link: www.hinfonet.org/optin

J3) Legal Workgroup PHI Pyramid

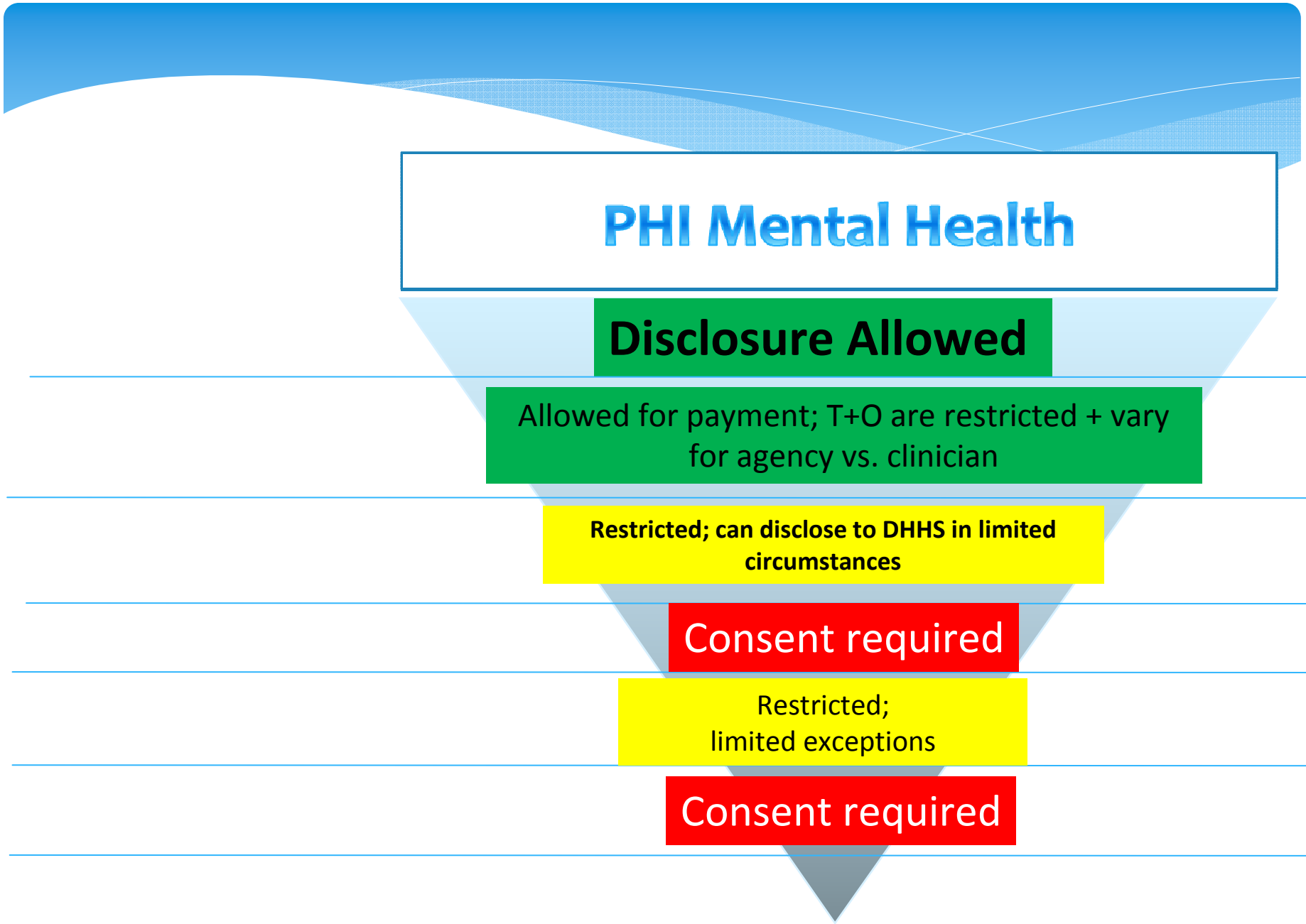
J4) Legal Workgroup Detailed Grid

Legal Work Group
PHI Pyramid

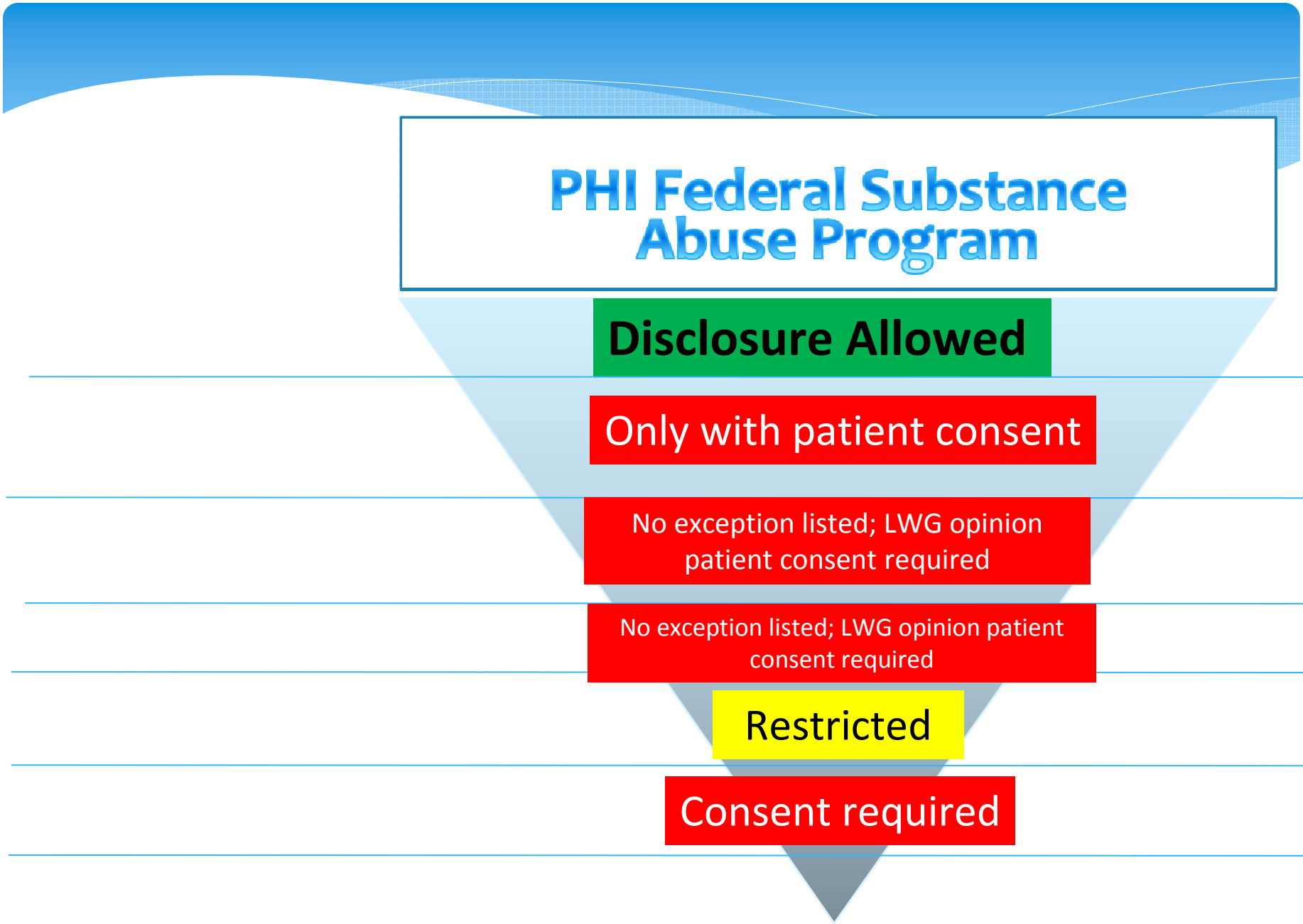

General PHI (non-sensitive)
PHI Mental Health
PHI Federal Substance Abuse Program
PHI HIV
Informed Consent
Disclosure Allowed
Disclosure Allowed
Disclosure Allowed
Disclosure Allowed
Treatment Payment Operations
Allowed for TPO
Allowed for payment; T+O are restricted + vary for agency vs. clinician
Only with patient consent
Allowed for direct treatment
Public Health
Allowed when required by law
Restricted; can disclose to DHHS in limited circumstances
No exception listed; LWG opinion patient consent required
Allowed when required by law
Fund Raising
Allowed for entity
Consent required
No exception listed; LWG opinion patient consent required
Statute is silent; LWG opinion use requires consent
Research
Restricted
Restricted; limited exceptions
Restricted
Restricted; researchers can't re-disclose
Marketing
Consent required
Consent required
Consent required
Consent required

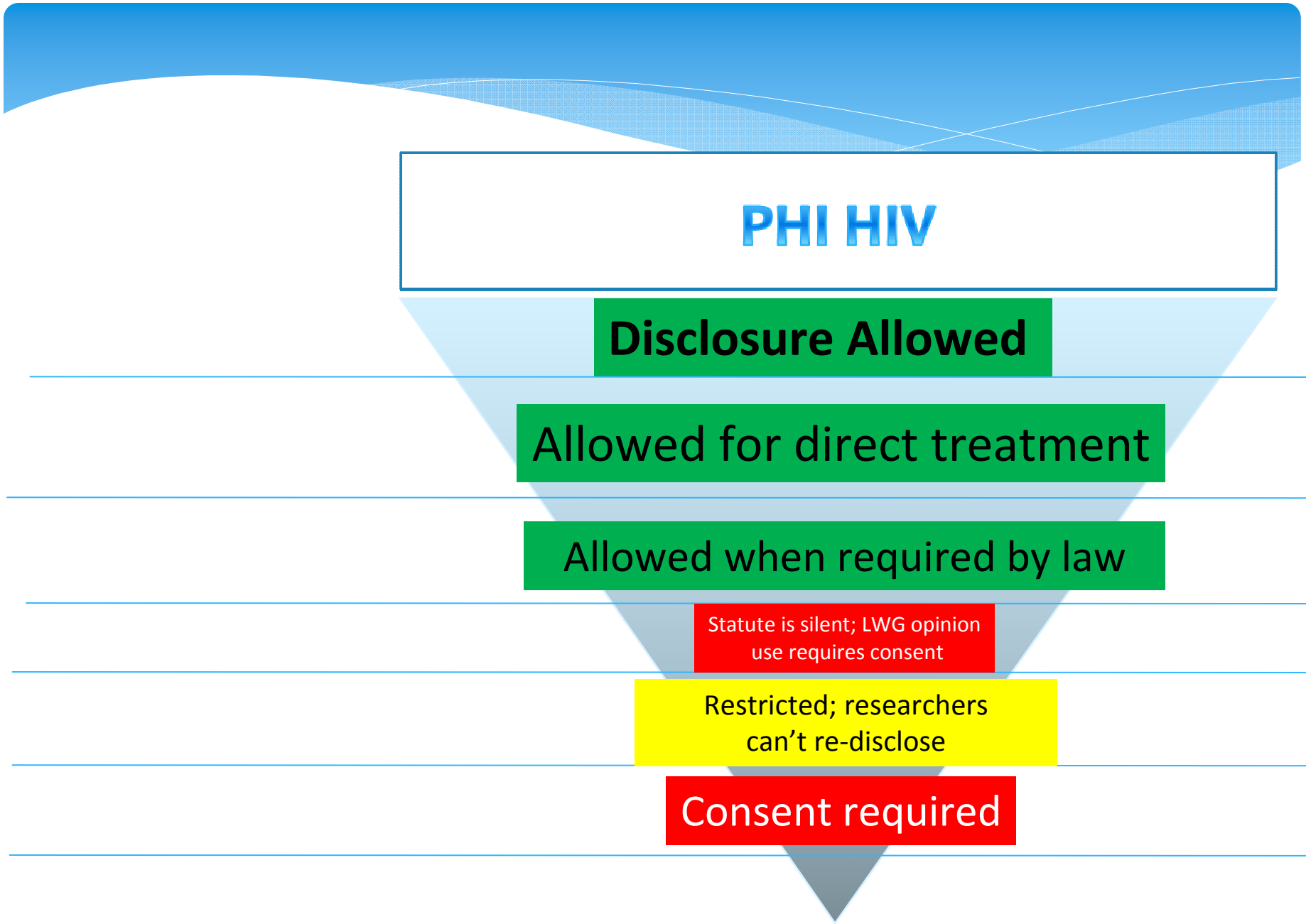

General PHI
(non-sensitive)
Informed Consent
Disclosure Allowed
Treatment Payment
Operations
Allowed for TPO
Public Health
Allowed when required by law
Fund Raising
Allowed for entity
Research
Restricted
Marketing
Consent required

PHI Mental Health



PHI Federal Substance Abuse Program




PHI HIV
Disclosure Allowed
Allowed for direct treatment
Allowed when required by law
Statute is silent; LWG opinion use requires consent
Restricted; researchers can't re-disclose
Consent required

MATRIX OF LAWS FOR PHI			
	GENERAL HEALTH		
CATEGORY OF INFO.	Allowed Restricted Prohibited	Federal Law	Maine Law
Applicability		HIPAA rules include a security rule and a privacy rule for "covered entity (CE)." (45 C.F.R. § 164.302); (45 C.F.R. §§ 164.n104, 164.500). CE is a "health plan" (individual or group plans that provide or pay medical care costs), health care clearinghouse (entities that standardize formatting (covers billing services, repricing companies, community health management information services, value-added networks if they perform the standardizing services), and every health care provider regardless of size AND who electronically transmits data). Covered entity is permitted, but not required to use and disclose PHI w/o consent to 1) individual; 2) TPO; 3) Opportunity to agree or object; 4) incident to otherwise permitted use and disclosure; 5) public interest and benefit activities; and 6) limited data set for research, public health or operations. When PHI is used or disclosed to entity that processes claims, data analysis, utilization review, and billing, the receiving entity is a "business associate" and requires a BA agreement (BAA). Expanded under ARRA/HITECH Act, to a BA with access to covered entity's PHI is bound by sam	Health Care Facilities (22 M.R.S. §1711-C(1)(D)); Health Care Practitioners (22 M.R.S. §1711-C(1)(F). Note: Maine's Privacy laws were written before federal privacy laws. Terms such as use or disclosure and release add ambiguity when trying to compare federal and state law. HIPAA law preempts state law, but allows states to have laws that provide more protection or laws that are termed "contrary" such as laws requiring provider to report public health types of info, or a law requiring health plans to report info for financial audits and for management.
Treatment, Payment, Operations	A	Entity with PHI can disclose to a receiving entity with a direct treatment relationship to patient; an entity with a direct treatment relationship can use PHI for treatment, payment, and operations purposes. (HIPAA / 45 CFR 164.502(a)(1)(ii)).	Health Care Facilities and Health Care Practitioners can disclose PHI to another Health Care Facility or Practitioner for diagnosis, treatment, or care of individuals (22 M.R.S.A. §1711-C(6)(A)); can disclose for payment (22 M.R.S.A. §1711-C(6)(L).
Public Health	R	Can disclose minimum amount of PHI necessary to Public Health Authority authorized by law to collect PHI for the purpose of preventing or controlling disease, injury, disability (HIPAA / 45 CFR 164.512(b)(1)(i)); can rely on PHA's finding of minimum amount necessary (45 CFR 164.514(d)(3)(iii)(A)); no patient authorization is needed.	Can be disclosed to gov't in order to protect the public health and welfare when reporting is required or authorized by law (22 M.R.S. §1711-C(6)(E))
Research	R	Can disclose with IRB approval (45 CFR 164.512(i)(1)(i)) to prepare for research if PHI is not removed from covered entity (45 CFR 164.512(i)(1)(ii)); Limited data sets may be disclosed under data use agreements (45 CFR 164.514(e)).	Can disclose PHI to IRB-approved researchers, FDA clinical trials without patient authorization; researchers may not redisclose identifiable PHI (22 M.R.S. §1711-C(6)(G). Other research requires patient authorization (22 M.R.S. §1711-C(3),(3-A), (3-B)); max duration of authorization: 30 months
Fundraising	R	45 CFR 164.501(6)(v) includes fundraising for benefit of covered entity as "operations" use; disclosure of demographic info & dates of care is allowed to BA or institutionally related foundation for fundraising purposes (45 CFR §164.514(f)).	Law does not expressly address; therefore disclosure to persons other than patient for fundraising is prohibited; practitioners interpreted law to allow internal use for fundraising and for provider entities to directly solicit donations from
Marketing	P	Covered entities can't use PHI for marketing without patient authorization (45 CFR 164.501, 508(a)3	Requires patient authorization (22 M.R.S. §1711-C(8))
SUBSTANCE ABUSE (Providers receiving federal assistance)			

CATEGORY OF INFORMATION	A, R, P	Federal Law	Maine Law
Applicability		In addition to HIPAA, SA laws apply only to drug or alcohol abuse (DAA) info obtained by "federally assisted" DAA for diagnosis/treating/making referral DAA. 42 C.F.R. § 2.12(a)(ii); Federally assisted means: (1) conducted in whole or in part, directly or by contract or otherwise, by any dept/agency of US; (2) carried out under a license, certification, registration, or other authorization under Medicare; (3) methadone treatment; (4) dispense a controlled substance for DAA; (5) supported by US agency (i) by federal financial assistance not used directly pay for SAA diagnosis, treatment, or referral activities; or (ii) by State/local gov through general or special revenue sharing or other forms of assistance, receives Federal funds which could be (but are not necessarily) spent for the alcohol or drug abuse program; or (iii.) IRS allowing income tax deductions for contributions/ tax exempt status . 42 C.F.R. § 2.12(b)	Federal law governs (22 M.R.S.A. 1711-C(11)), but State licensing rules also apply; 14-118 CMR Chap 5, Section 15.2.2 and 18.4 (SA licensing rules)
Treatment, Payment, Operations	R	Only with patient consent (allowed: § 2.33; specific form of consent required: § 2.31) or for medical emergencies (42 CFR § 2.51)	22 M.R.S.A. §1711-C(11) states if there is another law, that law governs. So federal rule controls.
Public Health	R	Disclosure and use are allowed for gov't audit & evaluation of the program (42 C.F.R. § 2.53(a)); Auditors can disclose only that PHI necessary for audit or evaluation purposes (42 C.F.R. § 2.53(c)(4)).	22 M.R.S.A. §1711-C(11) states if there is another law, that law governs. So federal rule controls.
Research	R	Allowed if "required determination" (complex and lengthy process) is made under 42 C.F.R. § 2.52 by the substance abuse program director. Researchers may only disclose PHI back to program where PHI originated (42 C.F.R. § 2.52(b)).	22 M.R.S.A. §1711-C(11) states if there is another law, that law governs. So federal rule controls.
Fundraising	P	Rules are silent, given that intent of law is to prohibit use & disclosure except when specified (42 C.F.R. § 2.3(b)); LWG opinion is that fundraising use or disclosure would require patient consent.	22 M.R.S.A. §1711-C(11) states if there is another law, that law governs. So federal rule controls.
Marketing	P	Prohibited without patient authorization (42 U.S.C. §290ee-3, 42 U.S.C. §290dd-3; 42 C.F.R. Part 2)).	22 M.R.S.A. §1711-C(11) states if there is another law, that law governs. So federal rule controls.
HIV			

CATEGORY OF INFORMATION	A, R, P	Federal Law	Maine Law
Applicability		There is no specific federal HIV law. HIPAA rules for General Health apply.	Applies to any person or entity with HIV PHI (5 M.R.S. §19203)
Treatment, Payment, Operations	R	Entity with PHI can disclose to a receiving entity with a direct treatment relationship to patient; an entity with a direct treatment relationship can use PHI for treatment, payment, and operations purposes. (HIPAA / 45 CFR 164.502(a)(1)(ii)).	HIV test results can only be disclosed to entities designated by patient (5 M.R.S. §19203); health care providers may not disclose HIV PHI without patient authorization (statute 5 M.R.S. §19203-D(1)); doesn't preclude disclosure of other PHI (5 M.R.S. §19203-D(1)(B)). (Note: There are a few exceptions that permit disclosure in very limited situations)
Public Health	R	Can disclose minimum amount of PHI necessary to Public Health Authority authorized by law to collect PHI for the purpose of preventing or controlling disease, injury, disability (HIPAA / 45 CFR 164.512(b)(1)(i)); can rely on PHA's finding of minimum amount necessary (45 CFR 164.514(d)(3)(iii)(A)); no patient authorization is needed.	Notifiable diseases, which includes HIV, must be reported to DHHS (statute 22 M.R.S.A §822); and DHHS rule 10-144 C.M.R. Chapter 258(2)(I)) and some very limited exceptions that would permit disclosure such as abuse, organ & tissue donation, etc.
Research	R	Can disclose with IRB approval (45 CFR 164.512(i)(1)(i)) to prepare for research if PHI is not removed from covered entity (45 CFR 164.512(i)(1)(ii)); Limited data sets may be disclosed under data use agreements (45 CFR 164.514(e)).	Can disclose to researchers; researchers can't subsequently disclose (statute 5 M.R.S.A. §19203-D(3);
Fundraising	R	45 CFR 164.501(6)(v) includes fundraising for benefit of covered entity as "operations" use; disclosure of demographic info & dates of care is allowed to BA or institutionally related foundation for fundraising purposes (45 CFR §164.514(f)).	5 M.R.S. §§ 19203 - 19203-D prohibit fundraising use & disclosure without patient authorization.
Marketing	P	Covered entities can't use PHI for marketing without patient authorization (45 CFR 164.501, 164.508(a)(3)).	Prohibited without patient authorization (Statute 5 M.R.S. §19203; 5 M.R.S.A. § 19203-D)

	MHDO		
CATEGORY OF INFORMATION	**A, R, P**	**Federal Law**	**State Law**
Applicability		HIPAA laws do not apply because MHDO is not a covered entity. Maine's Attorney General's office has advised MHDO that they are a Public Health Authority, a term created in HIPAA that allows providers and hospitals to submit PHI to the PHA. (45 CFR 164.512(b) and 160.103).	MHDO is independent State agency (22 M.R.S. §8707(3)) governed by board; has rulemaking authority; most MHDO work done under provider agreements governed by MHDO rules. (90-590 CMR Chapter 120, §9 (D)). General notion is comprehensive health database to improve health of Maine people. Collects data on claims and finance (per rule, claims data) and in/outpatient, and specific quality indicators (per rule, clinical data). By statute, MHDO, under its vendor OnPoint, sends algorithm to payors who run their provider's data through algorithm and submit to OnPoint who encrypts further and sends to MHDO. (Rule, Chapter 243) In effect, double encryption. Must make info available to the public. In addition, entities must request data in writing per MHDO rules, and requests are approved by Board. Data provided may be unrestricted (receiver may further disclose) or restricted (no further disclosure allowed) depending on the type of data.
Treatment, Payment, Operations			Under Public Access (22 M.R.S.A.) Board must release information upon request and on web (quality measures) except privileged medical information and confidential information which can only be released if individual patients are not directly or indirectly identified through a reidentification process; additional protective protocols apply.
Public Health			There is an exception to the confidentiality law for Public Health Studies (including research) or when data is used only for verification or comparison of health data and Board finds that adequate protections exist.
Research			There is an exception to the confidentiality law for Public Health Studies (including research) or when data is used only for verification or comparison of health data and Board finds that adequate protections exist.
Fundraising			Not allowed
Marketing			Not allowed

	HIN's HIE		
	A, R, P	**Federal Law**	**State Law**
CATEGORY OF INFORMATION			
Applicability		No specific federal law on HIEs. HIN / HIE is not a covered entity--it is a Business Associate under HIPAA and enters into BAAs, so from practical standpoint, is affected by HIPAA law.	SDHIE created by Executive Order. Confidentiality Statute covers SDHIE even though SDHIE not defined in law. (22 §1711-C.) No rulemaking authority. Practice is private agreements with providers govern exchange/release.
Treatment, Payment, Operations			May disclose w/o authorization if HIE has opt-out for general health information (HIE does have opt-out); based on this opt-out, may disclose for quality assurance, utilization review, billing and collection, regulatory or licensing authority; For MH and SA, HIE is opt-in. Only patients who opt-in for MH have their MH PHI disclosed. Currently, even if patient has opt-in for SA, HIN blocks SA PHI.
Public Health			May disclose to protect the public health and welfare when required or authorized by law
Research			By practice, they do not disclose for research
Fundraising			By practice, they do not disclose for fundraising.
Marketing			By practice, they do not disclose for marketing

Section K. Project Personnel Recruitment and Training

Refer to DRR Section K: Staff/Contractor Recruitment and Training

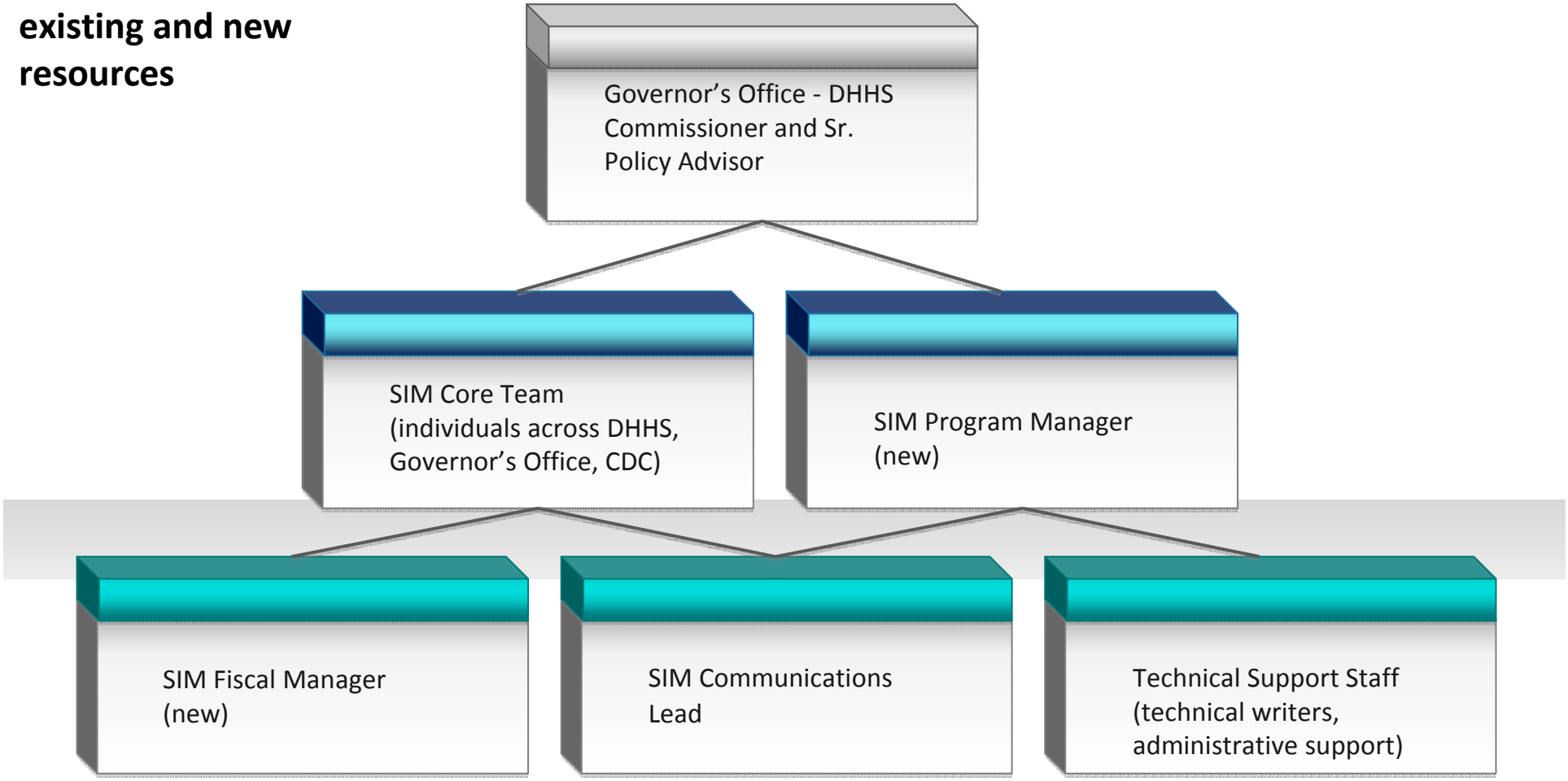
Supporting Documentation Available:

K1) Staff & Contractor Recruitment & Training PowerPoint presentation

SIM Grant – DRR Section XII
Staff/Contractor Recruitment & Training
EARLY DRAFT

June 2013

SIM Grant – Active Internal State Resource View (not including Governance) representing a mix of existing and new resources



Internal State of Maine Role Definition

SIM Position	Individual	Role
Governor's Office	DHHS Commissioner Mayhew Sr Policy Advisor – Holly Lusk	State Executive Level Sponsor for Grant
SIM Core Team (members crossing Governor's Office, DHHS, CDC)	Stefanie Nadeau (DHHS), Sam Adolphsen (DHHS), David Simsarian (DHHS), Jim Leonard (DHHS), Dr. Flanigan (DHHS), Deb Wigand (CDC), Holly Lusk (Governor's Office), Randy Chenard (DHHS), Sarah Cairns (DHHS)	Team responsible for creating the framework for the Grant planning and execution (structure, processes) & resolve critical path issues
SIM Program Manager	Randy Chenard (DHHS)	Individual responsible for developing an overall SIM Grant integrated plan, monitor progress against milestone, identify risks/mitigation strategies and escalate issues to Governance as needed
SIM Fiscal Manager	TBD – beginning sourcing process (hope to fill by 8/1/13)	Manage the SIM funds including contractor funding
SIM Communications Lead	Sarah Cairns & John Martins (DHHS)	Identify internal/external communication needs, develop required communications and coordinate communications needs across partners
Technical Support Staff	Sheryl Peavey (CDC) & Rita Malloy (Contractor) – technical writers Matt Galletta (DHHS) – project management Michelle Probert (DHHS) – project management Peggie Lawrence (DHHS) – admin support	Provide critical project support (technical writing, presentation development, meeting logistics, etc.)

External Contracted Partners

Contracted Partner	High Level Service Provided	Miscellaneous
Maine Health Management Coalition (sole-sourced)	Data Analytics - *21 FTE's	Sole-Sourced; active in contracting with completion expected in July'13
HealthInfoNet (sole-sourced)	HIE expansion (Behavioral Health) and expanded use (ED alerts) - *12 FTE's	Sole-Sourced; active in contracting with completion expected in July'13
Maine Quality Counts (sole-sourced)	Provider workforce training/support *5.5 FTE's	Sole-Sourced; active in contracting with completion expected in July'13
TBD (competitive bid procurement)	Behavioral Health Home learning collaborative	Plan is to publish RFP July'13 & winning bidder contracted by Oct'13/Nov'13
TBD (competitive bid procurement)	Shared decision-making/engagement (training/tools)	Same plan/timeline as noted above
TBD (competitive bid procurement)	Patient Engagement Media Campaign	Same plan/timeline as noted above
TBD (competitive bid procurement)	Leadership Training/Development	Same plan/timeline as noted above
TBD (competitive bid procurement)	Consumer system reform engagement/education	Same plan/timeline as noted above
TBD (competitive bid procurement)	PCP Developmental Disability/Autism Training	Same plan/timeline as noted above
TBD (competitive bid procurement)	Community Health Worker Pilot	Same plan/timeline as noted above
TBD (competitive bid procurement)	Behavioral Health Work Force Development	Same plan/timeline as noted above
TBD (competitive bid procurement)	National Diabetes Prevention Program Implementation	Same plan/timeline as noted above
TBD (competitive bid procurement)	ME SIM Triple Aim Objectives Evaluator	Same plan/timeline as noted above

SIM Grant Orientation Program

- For both existing and new staff, the orientation and context setting for the SIM Grant work includes:
  1. Self-study via documents on established, active State SIM website
  2. 1x1 or group walkthrough of high-level SIM presentations
  3. Link to CMMI SIM website for self-help
  4. Access to State Core Team members for ad-hoc inquiries

Section L. Workforce Capacity Monitoring

Refer to DRR Section L: Workforce Capacity Monitoring

Supporting Documentation Available

L1) Maine Health Workforce Forum website: http://www.maine.gov/dhhs/mecdc/local-public-health/orhpc/hwf/index.shtml

L2) Staff & Contractor Recruitment & Training PowerPoint presentation (See: SECTION K Documentation)