MAINE STATE HEALTH CARE

INNOVATION PLAN

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Introduction

The state of Maine is fortunate to have an innovative health care delivery system with strong stakeholder commitment to delivering high quality care, characteristics that are reflected in the state's high performance on many performance measures of health care delivery. The Agency for Healthcare Research and Quality (AHRQ) cited Maine in 2010 as the state having made the most progress in improving the overall quality of health care[1], and the most recent AHRQ State Snapshots showed Maine ranking third in the country for highest overall ranking in overall health care performance.[2]

However, healthcare costs in Maine are unsustainable. Maine insurance premiums- for individuals and families- are among the most expensive in the country[3]. Consensus has grown that we collectively spend too high a percentage of our state and municipal revenues, our wages, and other resources that could be invested in job growth, on health care. Maine employers- public and private- have been clear that they cannot continue to pay the ever-escalating costs of care that are limiting job growth, expansion and business viability. Key examples of the growing challenges include:

- In 2011 the State employee health plan was flat-funded by the Legislature for two years. In Year 1 (FY2012), the State Employee Health Commission implemented benefit changes requiring employees to absorb over $13 million in cost sharing. For Year 2 (FY 2013), the State Employee Health Commission forecast a $22 million gap between projected expenses and flat funding, due primarily to price inflation. In Year 2 the SEHC is seeking lowered costs from the healthcare system to supplement any additional cost sharing by employees and retirees.
- The University of Maine System was charged with reducing $24 million in healthcare spending over 5 years as budget pressure from soaring healthcare costs forced several years of salary freezes, layoffs, hiring freezes and began to eclipse academic programming in the budget.
- Other private employers are forced to compete regionally and nationally and note that Maine's high healthcare costs make expansion in Maine less viable than states with lower healthcare costs.
- In order to achieve savings in the MaineCare program, Maine's legislature voted to eliminate Medicaid for 19- and 20-year-olds, froze health insurance for childless adults, changed the income levels for parents of children on MaineCare; and made other cost-saving measures.

This State Innovation Plan seeks to address the unsustainable costs of Maine's health care system, while preserving and improving the quality delivered to Maine people. In approaching these

complex issues, Maine has a number of important assets and innovations that represent years of concerted effort and investment in building sustainable health care infrastructure, engaging stakeholders (patients, providers, purchasers), identifying and spreading what works, and strengthening accountability in both cost and quality. Maine's State Innovation Plan seeks to build on these strengths, streamline and coordinate these efforts, and use what we have learned to make lasting and sustainable improvement.

This State Innovation Plan contains a broad vision for Maine's health care system based on the Triple Aim of reducing cost, improving health, and improving the patient experience of health care. The Plan describes key features of our current health care system, and lays out specific goals for the future, as well as the strategies and existing levers we can use to achieve these goals. The Plan outlines Maine's current and future states regarding payment reform, cost, health care performance, and quality, and the specific milestones that need to be reached in order to achieve these goals. The sum represents an ambitious but achievable work plan that will set Maine's health care system on a course to be cost effective, of highest quality, and uniquely responsive to the needs of Maine people.

Vision Statement for Transforming Maine's Health System

Building on a strong foundation of health innovation and bringing together the state's leadership, the health care community, public and private payers, and the active engagement of its people, Maine will transform health care to achieve the "Triple Aim" of improvement: **advance population health, improve the experience of care, and reduce health care costs**.[4] Maine will transform care by providing a cohesive and streamlined framework for health care reform and innovation which includes *fostering engaged consumers and communities, transforming delivery systems to support accountable and integrated patient-centered primary care, and aligning public and private payment, accountability, quality, and data infrastructure.*

Our vision is that by the end of 2015, Maine will be the place where:

Consumers are engaged in and responsible for their own care within a patient-centered health care system;

Care is delivered and organized through patient-centered, primary-care based, multi-payer Accountable Care Organizations, responsible for improving population health, patient experience of care, and controlling healthcare costs; Maine's ACOs are supported by public reporting on common performance measures and through the implementation of new payment models that reward improved outcomes and reduced costs;

The rise in cost of care has been slowed or arrested;

Primary care and behavioral health are integrated;

The healthcare and public health systems are aligned to support improving chronic disease outcomes and addressing health disparities;

Overarching statewide HIT capacity connects providers, payers, consumers and community/ public health; and

Health measures and equity have been improved.

Maine Population Demographics

Maine is a large rural state with a total population of just over 1.3 million.[5] While Maine is a state widely regarded for its natural beauty and abundant natural resources, we also face demographic challenges with a population that is rural, poor, aging – challenges that contribute significantly to the ability to meet health goals. Maine's population density is 43.1 persons per square mile, less than half the national average of 87.4. While almost 50% of Maine's population is classified as urban, most of this population lives in small cities and towns distributed across a large geographic area of over 30,000 square miles. The state's population is also the oldest in the nation with a median age of 42.7- significantly above the national median age of 37.2 and up from the previous measure of 38.6 in 2000, a change attributed to an influx of seniors moving into the state, as well as a low birth rate. In addition, 16% of Mainers[6], over 200,000 people, live in poverty, with significant disparities in poverty levels across the state. With poverty levels almost twice as high in some areas – e.g. Washington County - many communities face the triple threat of age, geographic isolation, and lack of financial resources.[7]

While Maine's population is largely white (95.4%), its demographics reflect a changing picture over the past decade. The African-American population more than doubled between 2000 and 2010 (1.3%), and the number of people of Hispanic/Latino origin grew 81%, from 9,360 in 2000 to 16,935 (1.4%) in 2010.[8] There has also been a significant increase in refugees and immigrants in the state: Lewiston, Maine (Androscoggin County) saw the immigration of roughly 3,500 Somali migrants between 2001 and 2007, which as of 2009 comprised 10% of the city's population.[9] Portland, ME (Cumberland County) is also a refugee resettlement area, and local schools and clinics report the need to serve students and patients speaking more than 30 different languages.

MaineCare, Maine's Medicaid program, currently provides full MaineCare benefits for over 294,000 individuals, including over 124,500 children, 81,000 parents, 41,400 dual-eligible, and 13,800 low income adults.[10] Notably, twenty-six percent of Maine's Medicaid population is dually eligible for both Mainecare and Medicare, the highest percentage of duals in any state.[11] An estimated 10% of

the population is uninsured, with 13,000, or 5% of children uninsured.[12] Children's Medicaid/CHIP participation rate is 91.5%.[13]

State Health Issues and Systemic Challenges

Through the efforts of state leadership, policy changes, and successful alignment of market forces in the state, Maine has made substantial progress in improving its health status over the past decade, receiving an overall ranking of 8th healthiest state in 2011.[14]

While much progress has been made, however, many systemic and population health challenges remain:

Health Risk factors: obesity, smoking, substance abuse

Maine faces challenges in reducing health cost and improving outcomes with regard to key behavioral health risk factors such as smoking, obesity, and substance abuse. Tobacco remains a significant health challenge, with 18.2% of Mainers, 192,000 people, still smoking, while the rate of smoking among MaineCare recipients is over double, at about 40%[15]. Obesity rates continue to increase each year, taking an enormous toll on health and health care costs, with 27.4% of adults, or nearly 290,000 people now classified as obese. Maine also leads the nation in opiate treatment admissions[16] – recognition that use of prescription narcotics such as Oxycodone is a significant health problem in Maine.

High prevalence of chronic illness/burden of disease

As risk factors and the population rise, Maine continues to see increasing rates of chronic disease. Over the past ten years, diabetes rates have increased from 6% to 8.7%; 92,000 adult Mainers now have diabetes. Medical costs for people with diabetes are 2.4 times higher than those without diabetes, and the risk of cardiovascular disease and stroke are two to four times greater in people with diabetes. In Maine, heart disease, stroke and diabetes are, respectively, the second, fourth and seventh leading causes of death. In 2007, heart disease, stroke and diabetes together accounted for 31% of all deaths in the state.[17] Chronic disease is an important factor in overall health care costs in Maine across payers:

Approximately 10% of the MaineCare and commercial populations have a chronic disease, and drive approximately 30% of total spending, and 40% of inpatient spending.

Approximately 30% of the Maine Medicare population has a chronic disease, and drives approximately 65% of total spending and 70% of inpatient spending.

Chronic disease patients exhibit significantly higher rates of potentially avoidable and preference-sensitive care admissions.

Chronic disease members account for 40% of inpatient costs in the Commercial population, 36% of inpatient costs in the MaineCare population and 72% of inpatient costs in the Medicare population, indicating that chronic disease patients are drivers in inpatient costs, and therefore, in potentially avoidable (PA) admissions.[18]

Behavioral Health

Mental health issues affect one in five Mainers. These illnesses are associated with higher rates of health risk, higher rates of chronic disease, and poor self care in the general population.

50% of Maine's long term Medicaid- only population has a behavioral health disorder, either mental illness, substance abuse, both mental illness and substance abuse or developmental disabilities/traumatic brain injury. These behavioral health populations have higher rates of multiple chronic medical co-morbidities than members without any behavioral health diagnosis, and higher utilization of all medical services: inpatient, avoidable hospitalizations, 30 day readmissions, emergency room and outpatient care, higher total and medical costs and poorer outcomes, including higher rates of death. Behavioral health disorders are not just another co-morbidity; having a behavioral health disorder increases the odds of higher cost and utilization to as great a degree as having two or even three chronic medical conditions. 65.4 % of MaineCare members with a diagnosis of serious mental illness under age 65 have five or more medical conditions or co-morbidities, compared to 24% without any mental illness[19]

Another critical finding has been the association between fragmented primary care (more visits to different primary care providers) with higher utilization and cost, particularly among members with behavioral health disorders, higher levels of medical co-morbidity and worsening diabetes.

High Utilization of Health Care

Maine has the second highest per person medical spending in the US – 24% higher than the US average – behind only Massachusetts.[20] While some of this is because Maine has an older population, most of the difference is not explained by age[21]. Maine's utilization is driven not only by having an older and sicker population: two-thirds of Maine's health care spending is driven by how much health care we use.[22] Analysis of Maine's health service areas (HSAs) revealed significant unwarranted variation in utilization across the state that, if reduced, could save up to $300 - 400 million each year. There is room for improvement across the entire state. While a few HSAs tend to be more efficient or less efficient for a range of health conditions, the majority of HSAs are in the middle, that is, they are more efficient when it comes to some conditions and less efficient when it comes to others. By reducing commercial payors' potentially avoidable inpatient use and high cost/high variation outpatient use by 50% we could reduce commercial medical spending by 11.5%, which could reduce premiums as well. Reducing MaineCare's potentially

avoidable inpatient use and high-cost/high variation outpatient use by 50% we could reduce MaineCare's medical spend by 5.7%. [23]

Super Utilizers

The top 5% of highest cost MaineCare enrollees (17,182 members) accounted for $1.2 billion or 55% of total claim payments. This is consistent with findings in the literature that show that 5% of the population accounts for almost 50% of the total health care expense.[24] Intense areas of utilization for this group of MaineCare enrollees include long term care benefits such as home and community-based services, nursing home care, and ICFMR: long term care spending accounted for 53% of high cost members' claims payments. Over a quarter (27%) of high cost members used inpatient hospital services compared with 8% of all service users. 33% of high cost members visited the ER during the year and had an average of 4 visits as compared to 30% of all full benefit MaineCare members with an average of 2 visits. Mental health services were used by 42% of high cost users and accounted for 11% of their claims payments, and most (93%) of the total inpatient psychiatric hospital spending for all MaineCare members ($33.5 million) was attributed to high cost members.[25]

High ED Use

Maine's emergency department use in 2006 was, in aggregate, about 30% higher than the national average. Approximately 75% of Maine's emergency room use represents avoidable expense, with potential cost savings of up to $115 million.[26] The uninsured are not a disproportionate driver of ED use: the uninsured accounted for 9% of outpatient ED visits, which is less than their proportion of Maine's population. MaineCare patients accounted for 17% of the statewide population and 32% of outpatient ED visits, while the privately insured accounted for 56% of the statewide population and 33% of outpatient ED visits. MaineCare ED-use was 3.2 times higher than private use. ED use varies across Hospital Service Areas: some are consistent outliers, providing opportunity for action.

Primary care concentration is not the only factor that explains high or low ED use in a community. While urban areas have more health care providers (which may be one of the causes of lower ED-use in these areas), the fact that several rural communities have low ED-use suggests that physician concentration is not the only factor that explains high or low ED-use in a community. Other factors might include non-availability of urgent or primary care outside of school and work hours; lack of availability of telephone consultation; etc.[27]

Maine's Health system "current as is" and "future to be" states

Maine, for a small and largely rural state, has a strong health care infrastructure with many assets, including an engaged and sophisticated provider community and diverse and often cutting edge

initiatives in primary care and behavioral health. However, while health care systems are emerging and strengthening across the state, much of the health care delivery system remains fragmented.

Current State

Maine's current health system represents a patchwork of hospitals, local health systems, and provider groups, with most currently reimbursed in vast part under a fee for service system that rewards volume rather than value. Maine has 37 acute care hospitals, 16 of which are Critical Access Hospitals in rural areas of the state. Of the 37 acute care hospitals, 19 belong to one of the four major hospital-based health systems that collectively provide care for more than 75% of the population, with each health system led by a flagship teaching hospital (one of which, Maine Medical Center, is university-affiliated).

Maine's physician workforce is comprised of approximately 3500 licensed physicians, approximately 50% of which are primary care (1870) and 50% specialist physicians. Maine has seen a dramatic movement to hospital-based practice both for primary care and specialist physicians over the past 5-10 years, with estimates that 60-70% of physicians are now employed by hospitals or health systems. In addition, Maine has a 22 Federally Qualified Health Centers with over 50 practice sites that provide a substantial proportion of primary care services in the state.

Over the past four years, the state has provided significant leadership for moving to a more patient-centered, high-value model of primary care as a foundation for future health care reform efforts, and there has been significant leadership within the primary care community to adopt the Patient Centered Medical Home (PCMH) as a model. In 2009, the Dirigo Health Agency's Maine Quality Forum, Maine Quality Counts, and the Maine Health Management Coalition launched the multi-payer Maine PCMH Pilot, initially as a 3-year effort to transform primary care practice and payment with a set of 26 practices around the state. Since that time, Maine was selected by CMS as one of eight states to participate in the Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration, resulting in an opportunity to extend the timeline of the original pilot to five years (through 2014) and to expand the Pilot in January 2013 to include an additional 50 adult practices. In addition, MaineCare has been working with the Pilot conveners to align its planned Health Homes initiative, for which it is in the process of submitting a State Plan Amendment, with the multi-payer Pilot. As a result of these efforts and strong leadership by the primary care community, over 100 primary care practices in Maine - nearly 25% of all primary care practices – have now achieved NCQA PCMH recognition, and over 130 are expected to achieve this status by January 2013 and participate in the multi-payer Pilot and/or MaineCare Health Homes initiative.

Maine has also leveraged its participation in the MAPCP demonstration to create a new component of care, Community Care Teams (CCTs), as an additional strategy for serving the most high-needs, high-cost individuals in the community. CCTs are multi-disciplinary, community-based, practice-integrated care management teams designed to provide intensive care management support services to the most high-needs, high-cost individuals in a practice. CCTs were introduced into the

Maine PCMH Pilot in 2011 as a key strategy for improving care and reducing avoidable costs for patients in the Pilot, especially those with complex or chronic conditions. CCTs may be physical or virtual teams, and are typically comprised of a nurse care manager, social worker, pharmacist, behavioral health providers, community health workers, care navigators, health coaches, community service providers and others. CCTs coordinate and connect patients to additional healthcare and community resources in order to support their health improvement goals, achieve better health outcomes and reduce avoidable costs. The teams work with PCMH Pilot practices to identify patients at high risk and/or high utilization who need additional support, and link them to support services in the healthcare environment or the community.

System Reform: Accountable Care

MaineCare Value-Based Purchasing: In August of 2011, the Maine Department of Health and Human Services announced the implementation of its Value-Based Purchasing (VBP) Strategy, designed to leverage the exciting work occurring in the state through direct relationships with providers and the larger community to improve health outcomes and reduce avoidable costs. The VBP strategy is built around three major components: 1) strengthening primary care through the MaineCare Health Homes Initiative, 2) improving transitions of care, and 3) instituting system payment reform through the its Accountable Communities Medicaid ACO initiative. The integration of behavioral health is a key feature across these three components.

The Department's Accountable Communities initiative is based on a shared savings Accountable Care Organization (ACO) model for the Medicaid population. Under the initiative, providers will be able to come together to engage in an alternative contract with the Department to share in savings achieved for an assigned population. The amount of shared savings will depend on the attainment of quality benchmarks. The initiative will be open to any willing and qualified providers statewide, and will require that providers partner with community based organizations and collaborate with all area hospitals.

MaineCare convened stakeholders in October 2011 to introduce the VBP strategy, and followed up this introduction with a series of meetings with providers, associations and other interested parties. In November 2011, DHHS issued a Request for Information (RFI) seeking feedback on the structure of the Accountable Communities and Health Homes Initiatives. 28 responses were received, the majority from the behavioral health community. Throughout this time period, MaineCare met regularly with a Member Services Committee (MSC) comprised wholly of MaineCare members to integrate their ideas, concerns and feedback. Working from a synthesis of the RFI responses and the feedback from the MSC, DHHS convened a multi-disciplinary Design Management Committee from across its Offices, representing substance abuse, mental health, developmental disabilities, elder services, public health, child and family services, and others, to

structure a proposal for its Accountable Communities model. This proposal was shared with providers in three regional forums across the state in April 2012.

In addition to stakeholder engagement within Maine, the state has been involved on a national level on multiple fronts. Maine's participation in the ongoing CMS Value-Based Purchasing learning collaborative has helped CMS to develop its Integrated Care Model guidance issued as a State Medicaid Director letter in July 20912; Maine has agreed to publicly pilot the ICM "toolkit" that CMS has drafted as part of this collaborative to aid states in their ICM development. Maine held its initial call with CMS under the auspices of this process and toolkit in August 2012. In addition, Maine assisted the Center for Health Care Strategies (CHCS) in its development of a Medicaid ACO learning collaborative, and was later selected as one of seven states to participate in that collaborative which kicked off in June 2012.

Since spring 2012, MaineCare has been working with an actuarial team to structure its shared savings methodology and conduct analysis of historical and current costs and utilization to be able to project baseline per member per month amounts for Accountable Communities once they are implemented. Guidance from CMS through its VBP learning collaborative and SMD letter has helped further refine the Accountable Communities proposed model, along with further input from health systems, the Member Services Committee, and behavioral health providers. Maine is now poised to fully engage with CMS around the development of its State Plane Amendment and to issue its Accountable Communities application.

Medicare Accountable Care Organizations

Beacon, LLC was selected as one of 32 Medicare Pioneer ACOs for start up in January of 2012. Beacon, LLC, a subsidiary of Eastern Maine Health Systems, represents nearly 8,000 employees, seven member hospitals, three affiliated hospitals, multiple integrated physician groups, long-term care and home health companies, emergency transport teams, and a number of other organizations that support the health delivery system for the northern two-thirds of Maine, home to more than 40% of the state's residents.

In July 2012, three Maine organizations were certified as Medicare ACOs under the Medicare Shared Savings Program. These include:

Central Maine ACO**,** located in Lewiston, Maine, comprised of ACO group practices, networks of individual ACO practices and partnerships between hospitals and ACO professionals, including a combination of hospitals employing ACO professionals. It includes 566 physicians.

Maine Community Accountable Care Organization, LLC, headquartered in Augusta, Maine with services across the state, is comprised of nine federally qualified health centers with 125 physicians.

MaineHealth Accountable Care Organization, located in Portland, Maine, is comprised of networks of individual ACO practices, partnerships between hospitals and ACO professionals and hospitals employing ACO professionals, with 1,595 physicians.

Additionally, EMHS has been working directly with several major employers and their commercial health plans to develop accountable care relationships: the University of Maine System and Cigna; the State Employee Health Commission and Aetna; and Maine Education Association Benefits Trust and Anthem Blue Cross Blue Shield.

Similar projects emerged following the progress of the MGH/SEHC/UMS pilot, with similar but somewhat different models. Currently The Jackson Laboratories in Mount Desert Island have entered discussions with Maine Coast Memorial Hospital and Mount Desert Island Hospital, including the Maine Health Management Coalition and Aetna, to collectively improve regional population health through expansion of the Patient Centered Medical Home model and community based care. Transparent use of common data is a key attribute of this effort.

MidCoast Hospital has been in a long series of discussions with Bath Iron Works, a regional defense contractor, and the Maine Health Management Coalition to understand how best to transform care for this commercial population as well as the community. The effort has focused primarily on low back pain, given its prevalence among BIW employees, and how to create new care pathways supported by reformed payment.

Eastern Maine Health Systems has been working directly with the University of Maine System and Cigna on establishing an ACO contract and has recently expanded that conversation to include the Maine State Employee Health Commission and Maine Education Association with the Maine Health Management Coalition providing some common data and analysis. EMHS is a Pioneer ACO with Medicare and is seeking to include commercial patients in complementary arrangements.

These efforts are only a sample of the private sector ACO initiatives underway in Maine and do not include many of the arrangements between health insurers and providers.

Behavioral Health

Maine's mental health system reflects historic affiliations and recent trends in health care, with two mental health hospitals, each affiliated with one of the major health systems, private mental health providers, and a patchwork of community mental health organizations that collectively provide the vast majority of care to adults and children with serious behavioral health needs, largely under the MaineCare program.

The Office of Substance Abuse and Mental Health Services contracts with over 200 providers statewide to deliver adult mental health and substance abuse services. Maine supports a wide spectrum of behavioral health services through both Mainecare and general state dollars, including evidence-based practices such as Supported Employment and Assertive Community Treatment, as well as social clubs and drop-in centers, Self-Help/Peer Support, Community Integration Services, Crisis Stabilization, Medication Assisted Treatment (MAT) and substance abuse prevention, intervention, treatment. Targeted Case Management, In-Home Supports, and Respite are key supports for children with behavioral health needs.

Behavioral health services are – like many other sectors of Maine's health care system – largely fee for service and volume-driven. Maine has a strong tradition of Targeted Case Management for children and adults with behavioral health needs (delivered through Community Integration for adults), but challenges in coordination of complex care needs, integration with physical health care, and addressing the needs of individuals with co-occurring disorders remain.

Long Term Care

In the mid-nineties, Medical eligibility standards for Medicaid-funded nursing home care were tightened so that nursing care funds would be directed toward persons with the greatest medical need. Between 1994 and 2000, the average number of MaineCare members in nursing homes in a month dropped almost 30% while the number of people receiving Home and Community Based waiver services (HCBS) increased 50%. These trends continued from 2000 to 2006. During this time, the number of MaineCare nursing home residents declined 13%; the number of residents in residential care facilities increased 28% and the number of people using personal care services increased 88%. DHHS continues to focus most of its efforts on nursing facility diversion, rather than transition.

DHHS divides its home based services across two primary delivery models. The largest delivery model is managed by a statewide home care coordinating agency which is responsible for helping consumers implement an array of home care services. A family provider service option is available under this model, for people that want to direct their own care. The second model is consumer-directed personal assistance targeted at individuals with physical disabilities. In this model, service coordination focuses primarily on supporting consumers in the selection and payment of their employees. Both models are available as a MaineCare state plan benefit, MaineCare waiver, or as a state-funded service. Most elder and adult services are accessed through Maine's Single Entry

Point, an independent Assessing Service Agency, for determining medical eligibility for service. DHHS also administers assisted living, adult family care homes, independent housing with services, adult foster care homes, and residential care facility services. Medicaid funded nursing facility services are available to persons who meet medical eligibility criteria. Maine's five Area Agencies on Aging provide additional services in the community, including information and referral, nutrition (home delivered meals and community dining sites), and respite for caregivers for persons with Alzheimer's.

Developmental Disabilities

In 1996, Maine became one of only three states with no state-operated institution for individuals with developmental disabilities. For children, after a peak of 260 children in residential out-of-state placements in 1998, Maine had successfully reduced that number to 17 in 2008. Maine also took a very progressive approach in responding to the Olmstead decision, convening a planning body comprising consumers representing a cross-section of population groups and state staff representing five departments. Most recently Maine is launching a Money Follows the Person demonstration, to transition persons in nursing facilities to community settings.

In 1983, Maine developed a MaineCare waiver program to provide 400 new community placements to serve people moving out of Pineland, Maine's state-operated institution serving people with developmental disabilities. As a result, this waiver was designed to meet the needs of people moving out of the institution without a home or community to go back to; it provides a comprehensive package of services, including residential services. Today this comprehensive waiver program serves up to 2860. DHHS recently developed a second waiver package that assumes that the individual is already living independently or with a natural support system; this waiver provides community supports and employment services and can serve up to 2000 people. DHHS has placed a priority on community inclusion.

Public Health

Essential public health services are delivered primarily from the state level directly or through the use of contractors. There are two autonomous public health agencies in Portland and Bangor that hold a number of contracts for service delivery. The second largest city, Lewiston does not support a functional local health department. In 2009 Maine established in statute eight DHHS regional public health jurisdictions along county or multi-county lines, and in 2010 recognized a "virtual" sovereign inter-Tribal public health district serving Tribal members within the service areas of five Tribal Health Centers.

Eight regional District Public Health Units co-locate regional field staff and are coordinated by District Liaisons. The District Liaisons are the face of the Maine CDC in the District. They coordinate voluntary District Coordinating Councils made up of large and small public health

district stakeholders, including hospitals and federally qualified health centers, Area Aging Agencies, United Ways, social service agencies, county emergency management staff, and a variety of multi-sector partners reflecting each Districts jurisdiction and unique needs. Recently, the Districts received federal Community Transformation grant funding through the Maine CDC. Among the District members are Healthy Maine Partnerships, a network of 28 community health coalitions who are state nonprofit contractors. These coalitions, established with Master Tobacco Settlement Funds, have a ten year history of implementing chronic disease and substance abuse prevention and school health interventions at the community level.

The Districts and coalitions have developed health improvement plans, and work to reduce barriers to access to care through addressing social determinants of health, conducting community awareness and interventions, linking resources to primary care practices, and increasing community assets to support patient activation for self care.

Innovation and Engaged Stakeholders

Maine has a long history of innovation and engaged stakeholder participation. As a small state, Maine is able to engage its stakeholders frequently on a meaningful level, while its Department of Health and Human Services – an umbrella organization overseeing Mainecare, Behavioral Health, Long Term Care, Public Health, and related programs - works across agency lines on a number of projects. In Maine, it is possible to “get everyone in the room.” As a consequence, Maine has a rich tradition of public/private partnerships, cross-stakeholder and cross-agency collaboration, and a fluid and innovative health care environment.

An unintended consequence of this high level of engagement and creativity is some degree of “improvement overload” – the state is rife with projects, initiatives, plans and steering committees. A central goal of the State Innovation Plan is to weave these many valuable and disparate efforts together into a cohesive whole. Key initiatives, stakeholders, and resources include:

Maine Health Management Coalition: The Maine Health Management Coalition (MHMC) is a non-profit organization whose over 50 members include public and private employers, hospitals, health plans, and doctors working together to measure and report healthcare value. MHMC helps employers and their employees use health care data to make informed decisions. Since 1993, MHMC has played a leading role in healthcare quality measurement and public reporting both in Maine and nationally, and has acted as a catalyst for quality improvement. Through key initiatives such as Pathways to Excellence (PTE), MHMC currently collects and publicly reports quality data for primary care practices, cardiology and orthopedic specialty practices, and hospitals at www.getbetterme.org.

Maine’s All Payer Claims Database:[28] The Maine Health Data Processing Center (DPC) was created in 2001 as a “non-profit corporation with a public purpose” — the efficient collection and

management of healthcare claims from across the state. Designed as a public-private partnership, the DPC brings together two key organizations: the Maine Health Data Organization (MHDO) and Onpoint Health Data (formerly the Maine Health Information Center), a private nonprofit expert in the processing, normalization, and analysis of healthcare claims data. MHDO provides the leadership and regulatory authority, while Onpoint provides technical knowledge and a well-developed claims processing system with the data quality and validation edits required to ensure a reliable all-payer database.

To date, the DPC has processed more than 1 billion records, collecting and managing claims and eligibility data for dental, medical, and pharmacy services provided to Maine residents by more than 246 carrier systems, including commercial, Medicaid, and Medicare payers. The DPC also has become responsible for building and maintaining Maine's master provider index, which allows the state to more closely track healthcare outcomes by individual provider. Deemed "an essential government function" by the state, the DPC has become a widely successful joint effort and a national front-runner in the operation of an all-payer claims database. The DPC is governed by an 11-member board of directors which includes MHDO's executive director and three MHDO board members, each representing a different constituency; Onpoint's president/CEO and three Onpoint board members, each representing a different constituency; and three constituency representatives (e.g., healthcare providers, third-party payers, employers, and consumers of healthcare).

Maine Quality Counts Maine Quality Counts (QC) is a regional health care collaborative committed to improving health and healthcare for the people of Maine. QC works through a broad group of stakeholders to coordinate disparate efforts to support local, patient-centered care and the resources that support them. QC's goals are to improve health, promote consistent delivery of high-quality care, improve access to care, and contain health care costs. Pertinent initiatives include:

Aligning Forces for Quality (AF4Q), a national initiative of the Robert Wood Johnson Foundation (RWJF) designed to help communities across the country improve the quality of health care within their geographic region. Maine is one of 15 communities selected from across the country to participate in this initiative. The AF4Q initiative in Maine works with numerous stakeholder groups, including consumers, health care providers, purchasers, insurers, and public health organizations, to improve health care by aligning efforts within and across three areas or forces: quality improvement, public reporting, and consumer engagement with a particular focus on reducing disparities.

The Maine Patient Centered Medical Home (PCMH) Pilot is a partnership between Maine Health Management Coalition, Maine Quality Forum, and QC. Participating practices include a diverse mix of 22 adult and four pediatric practices from around the state, selected for their demonstrated leadership and commitment to the principles of the PCMH model; their diversity of practice size, location, and ownership; and their ability to link with and leverage existing improvement opportunities going on across the state. As part of their participation in the Pilot, practices are expected to implement a set of ten core expectations addressing key practice changes and are supported in their continued efforts to transform to a more patient-centered model of care. The

ultimate goal of this effort is to sustain and revitalize primary care to improve health outcomes and reduce overall health care costs. Planning and implementation of the PCMH Pilot is being directed by a multi-stakeholder working group and supported by many organizations in addition to MHMC, MQF, and QC, including the Maine Health Access Foundation, Harvard Pilgrim Health Care, Martin's Point Health Care, the Davis Family Foundation, the Betterment Fund, and the Bingham Foundation.

Community Care Teams (of the Maine PCMH Pilot) are being implemented in recognition of the fact that many patients have needs and barriers to care that reach beyond the capacity of even the most robust primary care physician practice. QC is working with the PCMH Pilot to create a sustainable structure and payment system to support community-based, multi-disciplinary primary care-integrated Community Care Teams (CCTs). CCTs are a key element in QC's efforts to improve care and reduce avoidable costs for Maine people, especially those with complex or chronic conditions.

Behavioral Health Integration Metrics Initiative: Maine Quality Counts recognizes the need for health care providers to address both behavioral and physical health issues, and to better integrate the behavioral and physical health care needs of patients in order to improve health and health care. With support from the Maine Health Access Foundation, QC is leading an effort to develop and implement a set of performance measures of behavioral health integration in primary care that can be used in public reporting of quality data. These measures include:

Integrating behavioral health care in primary care settings

Screening for depression

Patient experience of care

Electronic Health Record (EHR) Adoption and Meaningful Use: In an effort to help Maine physicians and other providers adopt and use electronic health records (EHRs) to improve care, the federal government has established a program to provide incentive payments and assistance for EHR use. In Maine, HealthInfoNet is the state's health information exchange and serves as the "Regional Extension Center" to support providers in their efforts to adopt EHRs to improve care and to meet requirements for federal incentive payments.

In their role as the Maine Regional Extension Center (MEREC), HealthInfoNet offers assistance to primary care physician practices to select, adopt, and use EHRs to improve patient care. HealthInfoNet and the MEREC have contracted with QC to provide quality improvement expertise, guidance, and support for linking EHR adoption with clinical improvement. QC is responsible for ensuring that the overall efforts of the MEREC and its vendors are guided by a framework of continuous quality improvement, aligning EHR adoption with other quality improvement efforts in the state, and supporting primary care providers to achieve meaningful use and meaningful improvements in care.

The Maine Quality Counts Learning Community (QCLC) is an effort to bring together existing networks of physician practices, such as the Maine Practice Improvement Network (MPIN), Physician Hospital Organizations (PHOs), and multi-site physician practices with other practice

networks and individual physician practices to promote the spread of best practices throughout the state. The QCLC is planned as a major alignment activity of the AF4Q initiative and will assess current quality improvement capacity for physician practices across the state, identify gaps, and fill these gaps by offering opportunities to connect and facilitate collaborative learning. The QCLC will offer opportunities to learn from each other and from national experts through a regular e-newsletter; a web-based repository of quality improvement tools; periodic regional improvement meetings for providers and practice staff; and opportunities for direct practice-to-practice networking to observe the implementation of best practices.

Maine Health Access Foundation: MeHAF is a statewide, grant-making organization whose mission is to promote access to quality health care, especially for those who are uninsured and underserved, and improve the health of everyone in Maine. MeHAF has been leader in Maine in convening and supporting providers and community organizations in their efforts at bi-directional integrated behavioral and physical health care. One of MeHAF's most far-reaching programs is its Integration Initiative - a ten-year, $10 million initiative launched in 2006 that focuses on promoting patient-centered care by improving coordination and seamless care delivery between behavioral health and primary care providers. Since 2007 MeHAF grants and programming supported 42 grant projects which involved over 150 collaborative partnering organizations committed to implementing integrated behavioral health and primary care in over 100 Maine practice sites. The next phase of this work focuses on embedding integrated care into other key state-wide strategies that enhance patient-centered care.

Hanley Center for Health Leadership: Following two years of planning, the Hanley Center has launched what is believed to be the nation's first independent, statewide physician executive leadership development program. Over a five year period (2011-2016) the Hanley Center's Physician Executive Leadership Institute (PELI) will build a statewide network of about 400 physician leaders who have successfully completed intensive, national-caliber professional development coursework, preparing them to provide Maine's health care communities and systems with a core of prepared physician leadership. PELI will include two distinct programs designed to develop leadership skills at the **Foundational** and **Advanced** levels. Both courses will focus on a set of core competencies that include **Systems Awareness, Strategic Focus, Key Management and Business Skills, Self-Awareness, and Health Care Trends.**

Maine Community Health Options: 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. 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. 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; the organization currently models its benefits designs with an expectation of supporting statewide healthcare transformation in a number of ways. Through a partnership with providers, MCHO expect to not only participate in the multi-payer PCMH pilot, but also pay for the care management that is provided at the local and regional level. In support of these efforts, MCHO partners 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.

Bangor Beacon Community: The Bangor Beacon Community is one of 17 nationwide sites, and is working to achieve four objectives to improve the health of people with chronic conditions by:

- Providing information technology-enhanced coordinated care management
- Improving access to, and use of, adult immunization data as recommended
- Preventing unnecessary emergency department visits and readmissions to hospitals by better coordinating care and strengthening primary care through health information technology
- Facilitating patients' access to their own records[29]

Improving the Health of Children (IHOC): In February 2010, Maine and Vermont were awarded a five-year child health quality improvement grant by CMS. The project focuses on using quality measures and information technology to improve health outcomes for children. The goal is to improve timely access to quality care for children who are insured by Medicaid. The State of Maine is working to:

- Collect and test child health measures
- Share quality data with payers, providers, consumers and the Centers for Medicaid and
- Medicare Services (CMS).
- Align the IHOC quality measures with those of private payers, professional groups, and MaineCare.
- Set up secure computer systems to collect well-child data from electronic medical records and from state government.
- Develop new, secure ways for health providers to access health assessments for children in foster care.
- Provide the American Academy of Pediatrics' Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, Third Edition, Tool and Resource Kit.
- Conduct quality improvement training with the Patient Centered Medical Home Pilot and other medical practices. The goal is to improve rates of preventive services.
- Build a child health quality improvement partnership that will continue after the grant ends.

The Project to Integrate Health into Mental Health Systems of Care: Funded jointly by DHHS and the Maine Health Access Foundation (MeHAF), this grant supported six mental health agencies to

target and improve the physical health care of their clients. Agencies created Health Teams, implemented health screening and disease registries; identified consumers with diabetes or risk for diabetes; tracked progress towards achieving appropriate diabetes care and glucose and lipid control; provided education on health literacy and diabetes self-care for consumers and agency staff; and supported consumers wellness activities and linkages to primary care. The Project developed a multi-stakeholder Steering Committee with representation from state agencies, medical and behavioral health providers and consumers, and used a Learning Collaborative to support shared learning across project participants. The Health and Wellness Toolkit (http://www.maine.gov/dhhs/samhs/mentalhealth/wellness/toolkit/index.shtml), developed by the Project, is currently being rolled out state-wide, to support other behavioral health agencies in developing competencies necessary for more effective collaboration with the larger health systems and in becoming Health Homes that serve SMI populations.

AHRQ Multiple Chronic Conditions (MCC) project: Linked with the effort to coordinate between behavioral health and health care delivery systems, the DHHS/AHRQ project analyzed the cost, utilization, quality of care and outcomes over a five year period of 63,000 long term MaineCare members with multiple medical and behavioral health co-morbidities. The project included analyses based on Medicaid services data, creation of novel metrics, creation and dissemination of health quality reports and translation of reports into pilot quality improvement projects. The project has also examined the role of behavioral health status, burden of medical co-morbidities, access to primary care, diabetes process measures, antipsychotic drugs, medication adherence, and diabetes specific medication in relation to diabetes prevalence and complications, which will inform harm reduction efforts aimed at persons with diabetes or risk of diabetes.

SAMHSA/HRSA- funded Center for Integrated Health Solutions (CIHS) cooperative agreement: Maine's project includes three major collaborators - The Office of the State Coordinator for Health Information Technology, HealthInfoNet (the statewide HIE organization), and The Hanley Center for Health Leadership. It also represents a wide range of private and public partners who are engaged in integrating behavioral health and primary care health information technology through the HIE.

The project makes recommendations and seeks clarification on state and federal policy and data standards to facilitate behavioral health information exchange, provides access to the operational statewide HIE for providers who have an EHR and for those that do not; supports consumer-driven communications to assure that consumers understand how their health data is being exchanged and why.

Maine's Future Health Care State: The Triple Aim

Maine's strong collaborative of payers, purchasers, state resources, providers, and consumers have a common goal: to see Maine achieve the triple aim of reduced cost, improved quality, and

improved patient experience of care. To achieve these goals, Maine proposes an ambitious but achievable set of inter-related strategies, building on existing levers and innovation, to align disparate initiatives toward these common goals. By engaging and creating alignment across multiple payers, health care systems, providers, and initiatives, Maine strives for the tipping point that will transform health care across the state. The vision for Maine's future "to be" state includes three major components:

- Activated consumers and communities
- Transformed delivery systems
- Aligned quality, payment, reporting, and infrastructure

#1 Activated consumers and communities

- Engaged consumers who make informed choices about their health care, and partner with their health providers in value-based, shared decision making.
- Activated communities that promote healthy behaviors and effective use of health care resources

Informed and engaged consumers are at the center of effective health care systems and high quality patient-centered primary care. Interventions to assist patients in full engagement with and responsibility for their care encompass a variety of approaches including appropriate written materials, patient shared decision making tools, self-management education and support, and access to information to assist in choosing providers who deliver high quality care.

Patient engagement is critical in a number of areas. In its report "The Practice and Impact of Shared Decision-making" Maine's Shared Decision-making Study Group noted among its findings that shared decision making leads to higher quality of care as measured by patient engagement and positive experience of care.[30] Supporting the patient decision-making process – especially with regard to preference sensitive conditions that are influenced heavily by individual patient values and perspective – can assist in reducing variation in utilization of services across health service areas. Effective self management of more complex and chronic disorders has been shown to improve patient outcomes in a number of disorders, from diabetes[31] to serious mental illness.[32]

Communities also have a role to play in the engagement of patients, families and caregivers. Community organizations – from local Area Agencies on Aging to School Based Health Centers – can play a role in supporting and engaging patients in managing their own care. Public health messaging that supports and disseminates the value of the engaged patient – with a responsibility to effectively and appropriately use health care resources – creates a coherent strategy with other initiatives.

Maine will employ a diverse set of strategies to support the activation of consumers and their communities. Key Strategies include the following:

Increased use of shared decision making tools

Use of learning collaboratives to disseminate patient engagement tools and training for providers and consumers

Increased use of advance directives/health care proxies and other long-term care planning tools

Increased public awareness of shared decision making, engagement in health care, health care self-management

Development of an electronic patient portal for patient health and wellness self-management

Engagement across payers to explore shared decision making and patient accountability incentives

Because a critical goal in the Maine's State Innovation plan is to form a cohesive strategy across existing and future health system transformation activities, the state of Maine and its partners will look to existing resources, tools and levers to support this and other strategies, including:

Patient Centered Medical Home/Health Home practice learning collaboratives

Existing consumer supports, such as *Better Health Better Me* *and* *Get Better Maine*

Maine's Public Health infrastructure and expertise

Maine HealthInfoNet

Existing patient supports; Peer navigators, Peer Supports, Community Health Workers

Strategy #2 Transformed Delivery Systems

High-value, patient-centered, and relationship-based primary care that reduces the need for avoidable and expensive hospital and specialty care

Integrated behavioral and community supports that offer coordinated, person-driven resources for individuals with complex needs.

Reducing inappropriate use of health resources, improving the quality of the care received, and improving the patient experience of care all require access to high-quality, well-coordinated and integrated primary care. Maine has made critical investments in the development and diffusion of the patient centered medical home, a model that shows great promise in providing care that is "accessible, continuous, comprehensive, and coordinated and delivered in the context of family and community" (American Academy of Family Physicians, American Academy of Pediatrics, American College of Physicians, et al., 2007). MaineCare is pursuing Health Homes as the next step in building a comprehensive and coordinated primary care infrastructure to address the needs of people with chronic conditions. Community Care Teams, a recent innovation, also hold promise as a health system resource that can connect people with complex needs to necessary services in supports in the community. These transformed care delivery systems provide Maine with a

strong foundation – supported by multiple payers, including MaineCare, Medicare and private payers – on which to build a system that reduces unnecessary utilization, improves care, and enhances patient experience.

In addition to a strong patient-centered medical home foundation, research also strongly supports the integration of behavioral health and physical health care in order to address in a cost-effective way the multi-faceted needs of individuals with chronic illness, individuals with serious behavioral health problems, and the general population. Integrated behavioral health care is essential in making real reductions in physical health care service utilization, impacting the cost of care for high-utilizers, ensuring that individuals with chronic care needs receive coordinated and appropriate services which can reduce the need for higher levels of care, and reducing unnecessary use of emergency and inpatient care.

Key strategies:

Expansion of Patient-Centered Medical Homes, Health Homes for people with chronic conditions, and Community Care Teams.

Development of Health Homes for children and adults with significant behavioral health needs

Enhanced EHR capacity and connectivity for behavioral health providers

Identification and dissemination of select integrated clinical models via learning collaboratives, e.g., IMPACT, SBIRT

Training for primary care practices: DD/ Autism, National Diabetes Prevention Program

Work force development and training to build an integrated direct care workforce in Maine

Clinical analytic tools such as quality monitoring, utilization reporting, and clinical benchmarking

Available levers to implement these strategies include:

MaineCare State Plan Amendments for Health Homes: Chronic conditions (Stage A) and SMI/SED (Stage B)

MaineCare policy development to support Health Home model (including EHR, work force requirements)

Existing multi-payer support for PCMH/HH

Behavioral health workforce development via state and community college linkages

Health InfoNET and expanding options for safety net providers to engage in clinical data sharing

Quality Counts Learning Collaboratives and related initiatives

MeHAF integrated Care Learning Collaboratives

Strategy #3: Aligned quality, payment, reporting, and infrastructure

Maine is fortunate to start from a strong foundation of state leadership, collaboration, and high

> An aligned payment and quality framework for health care services -across payers- which rewards value, and not volume.
>
> Transparency of cost, quality and outcomes across payers that informs patients, purchasers and providers.
>
> Infrastructure that supports timely, accurate longitudinal cost and quality data across payers.

levels of health care quality. Leaders in both the public and private sectors are committed to transformation of health care by aligning payment and market forces, supporting transparency and accountability in health care cost and quality through pubic reporting, and building on a shared infrastructure to support Triple Aim goals.

Payment reform across disconnected health systems and community providers can be plagued by the varied requirements, processes, and data capabilities of multiple public and private payers. Different health quality and cost measures, reporting standards, and payment incentives can lead to administrative burden, a lack of focus for quality improvement, and confusion among payers and consumers as they seek good value and quality care. Alignment of effort is therefore central to enabling transformation. Maine's Innovation Plan envisions a glide path to payment reform, supporting shared savings, risk-based capitation, as well as global payment using aligned measures and incentives.

Accountability, through an emphasis on public reporting, is also a priority. Public reporting of health care quality measures is associated with improvement in quality: providers of health care services respond to public reporting and in response often add services, change policy, and increase their focus on clinical care.[33] Information to inform health care decision-making across multiple stakeholders is critical to health reform.

Finally, Maine will also build on existing infrastructure to support health reform through streamlined reporting, unified data analytics, and data-informed clinical tools that support payment reform and quality improvement efforts.

Key Strategies:

Payer, purchaser, and provider engagement to that supports Accountable Communities, shared savings/risk, and global payment building on/expanding MaineCare's Accountability Community

An aligned quality framework: Pathways to Excellence, Medicare Shared Savings program, MaineCare Accountable Communities, IHOC

Enhanced, unified data and data analytics infrastructure

Public Reporting and accountability on key benchmarks across payers, providers

Accountable communities learning collaboratives to promote payment reform

Leadership training and development

Available levers in attaining goals:

MaineCare State Plan Amendment to support Integrated Care Models/ Accountable Communities

Participating Maine Medicare Shared Savings Plans

Engaged Payers and Purchasers: Maine Health Management Coalition

Maine's All Payer Claims Database

Existing reporting and quality framework, i.e., Pathways to Excellence

Health Information Exchanges (HIE) and Meaningful Use: Opportunities and challenges, potential strategies and approaches

The State of Maine has made great strides in the use and adoption of Health Information Technology. At the head of many of the coordination efforts for HIT in Maine are the Office of the State Coordinator for Health Information Technology (OSC), and HealthInfoNet. The OSC is currently the recipient of the State Health Information Exchange (HIE) Cooperative Agreement, from the Office of the National Coordinator for HIT (ONC), for Maine. The OSC supports and convenes the statewide HIT Steering Committee (HITSC) and a number of governance committees for HIT efforts across the state. The OSC, in partnership with Maine's health care and consumer stakeholder community, released the first draft of its HIT Strategic and Operational Plan and received ONC approval of those activities in October of 2010. HealthInfoNet, the designated statewide HIE and the recipient of the Regional Extension Center Cooperative Agreement from ONC, is a non profit organization with a community Board of Directors that has been operationally exchanging clinical health data since 2008 to support care coordination across the State.

Since 2004, Maine has moved forward on an ambitious plan to promote the adoption of electronic health records, establish one of the nation's first operational statewide electronic HIEs, and bring an ever-widening array of providers into the exchange to improve the coordination, integration and quality of patient care. Central to this strategy has been a longstanding priority to support the collaborative engagement of consumers and providers from the behavioral and physical health sector, so the use and level of deployment of HIT enhances care at the patient and provider levels.

HealthInfoNet has rapidly expanded, and today its secure database includes records for approximately 1.1 million (~80%) of Maine's 1.3 million residents. Over time, the data collected by HealthInfoNet has expanded from a focus on national standards for transitions of care to represent additional needs of the health care stakeholders in the State. In 2010, in collaboration with the

Bangor Beacon Project in support of Meaningful Use, HealthInfoNet began collecting immunization information and all secondary diagnoses. More recently, HealthInfoNet has begun to collect insurer information and other data elements to support ACOs and other activities. The HIE tools operated by HealthInfoNet were purposely chosen to be flexible, allowing all health care stakeholders to participate and be amenable to an array of messaging standards.

By the end of 2012, 33 hospitals in Maine (90% of the annual hospital inpatient, outpatient and emergency room utilization) will be participating in clinical data exchange. Five of the remaining nine Maine hospitals are under contract to connect to the HIE in 2013 and it is expected that all Maine hospitals will be engaged with the HIE by 2014.

The exchange also incorporates automated laboratory result reporting to the Maine Center for Disease Control (Maine's public health authority) for 30 of the 72 diseases mandated for reporting by the State of Maine. Moreover, HealthInfoNet is able to leverage its laboratory reporting activities and a relationship with the statewide Immunization Registry (Immpact II) to support participating providers in meeting the public health requirements of the CMS Meaningful Use of HIT incentive program. These functions form the basis for an evolving public health information infrastructure that will inform population health and emergency planning efforts in Maine into the future.

Opportunities and Challenges

Behavioral Health

In addition to these activities, in January 2012, HealthInfoNet was awarded, on behalf of the State of Maine, the SAMHSA/Health Resources and Services Administration (HRSA) funded Center for Integrated Health Solutions (CIHS) cooperative agreement. Maine's project represents three major collaborators - The Office of the State Coordinator for Health Information Technology, HealthInfoNet, and The Hanley Center for Health Leadership. It also represents a wide range of private and public partners – including DHHS' Office of Substance Abuse (OSA) - who over the project period have been and continue to be engaged in integrating behavioral health and primary care health information technology with providers statewide, through the HIE. This project continues the efforts of Maine's healthcare stakeholders to make behavioral health and primary care integration the norm rather than the exception.

In spite of these and other efforts, behavioral health providers in Maine (and elsewhere) have found it challenging to engage in meaningful use of health information technology; most behavioral health providers cannot access Medicaid Incentive funds, and additional/perceived policy barriers make adaptation to new technologies especially challenging.

ER Notification

To support improved transitions of care, reduced readmissions and appropriate ED utilization through PCMH, Health Homes, and broader ACO activities, HealthInfoNet plans to deploy near real time notifications to payer and provider care managers when identified residents receive services at Maine emergency departments and are admitted to/discharged from the hospital . HealthInfoNet currently has real-time connections to 26 hospitals across Maine with the goal to have all hospitals connected to the exchange by 2014. This will allow for accurate and timely identification of emergency department and inpatient use that can be used for active intervention and transition management by care management staff. This strategy is widely supported by MaineCare, the ACOs as well as private insurers alike and represents a true value-add that only the HIE can perform effectively statewide.

Electronic Personal Health Record

HealthInfoNet is working closely with consumers and the provider community to expand patient participation and management of their own health care by implementing consumer-facing technologies. In December 2011, HealthInfoNet signed an agreement with Method Health LLC to partner on the deployment of an electronic personal health record (PHR) that is populated by data in the exchange. This PHR has the functionality to display patient health information, collect data from the patient, communicate with other patient portals the patient may have available from their insurer and provider, and provide the patient with key push-down messaging and information tools to promote wellness and healthy behavior. Since that time, HealthInfoNet and Method Health have been working to determine a model of deployment of the PHR that could be sustained through existing and new resources. To assess the successful deployment of a comprehensive PHR built upon a HIE model, HealthInfoNet has been meeting with health care providers, health care payers, government, and consumer stakeholders throughout 2012, and a review of the proposed and final rule for Meaningful Use Stage 2 was undertaken. Findings from that review impact the deployment of the PHR, and include six observations that have a significant impact on the statewide deployment of a HIE-based PHR:

- Meaningful Use requirements for Stage 2 have pushed health care providers and health care systems to a need for a tightly integrated patient portal solution with their EHR. The requirements for scheduling, messaging, and medication refill options for patients have focused most Maine providers' attention on their EHR vendors and integrated portals to meet Meaningful Use.
- Many EHR-based portals are viewed by provider and consumer stakeholders as rudimentary in their ability to support all needs of patients; they only include limited information, the viewing portal is sometimes difficult to use and navigate through, and access management presents difficulties

- EHRs have limited ability to accept discrete clinical data from other EHRs. This prevents consumers from having a true "community view" of their care between the hospital, their primary care provider and specialists.
- EHR portals have limited ability to help the patient navigate other health care activities such as insurance eligibility, communications etc.
- There has been an identified need in the Maine community to support more transparency in both quality and cost for patients. While there are some options available today, patients would prefer a single place to access their health care information, communicate with providers, and make health care purchasing decisions.

As a result of these findings, HealthInfoNet and the State of Maine have found that a longitudinal, patient-centric, payer- and provider-agnostic personal health record platform is needed to help engage patients in ALL of their health care needs.

Current and Future Delivery System Payment Methods in Maine

The serious problems with the quality and cost of today's health care system have been well documented. A major cause of these problems is that current health care payment systems encourage *volume-driven* health care rather than *value-driven* health care. Under current payment systems, physicians, hospitals and other health care providers gain increased revenues and profits by delivering more services to more people, which in turn fuels inflation in health care costs. Research has shown that more services and higher spending do not result in better outcomes; indeed, it is often exactly the opposite. More troubling is that current payment systems often financially *penalize* health care providers for providing better quality services. Providers frequently lose revenue if they keep people healthy, reduce errors and complications, and avoid unnecessary care. This not only leads to many of the problems in health care quality that exist today, but impedes efforts to *improve* quality by forcing a tradeoff between a health care provider's financial well-being and the quality of their services.[34]

Current Delivery System Payment Methods

Maine's current payment system for its health care delivery system is largely a fee-for-service model. Since 2009, many large purchasers, providers and health plans have been at the table considering alternative payment models to remove barriers for providers working to deliver higher value care in Maine. The Maine Health Management Coalition first convened the 'Health Action Collaborative', started by MaineHealth and Hannaford Brothers (one of Maine's largest employers) to structure a productive dialogue about strengths and weaknesses of payment and incentive models. After over 2 years of educational forums seeking to understand national best practice and experience, The group developed a 'Maine Payment Model' based on the service categories of the Dartmouth Atlas that recognized the need to create budgets around 'supply-sensitive care', while

increasing access and payment to high-value effective care. This also recognized another category of 'preference-sensitive care' that requires effective shared decision making with patients to determine the best course of treatment at the right cost. This framework was then subsumed into emerging arrangements between providers and purchasers to transform care at the community level. As implementation of pilots progressed, in 2011 the MHMC launched the Accountable Care Implementation Steering Committee to move past theory to support implementation of delivery system redesign supported by reformed payment.

Also during this period, CMS announced its ACO program and Maine was home to one of the first Pioneer ACOs in the country at Eastern Maine Health Care. EMHS committed to a cost reduction of 3.9% for Medicare and is working to transform care across its system. MaineHealth, Central Maine Healthcare and the Maine Primary Care Association also entered the CMS Shared –Savings program assuming risk for management of the Medicare population with the potential to share in any realized savings. Simultaneously the multi-payer Patient Centered Medical Home Pilot brought all payers together to transform primary care at 26 practices. The work was so successful that the pilot recently expanded to an additional 50 practices and dovetailed with the development of MaineCare Health Homes to transform primary care for MaineCare patients. The leadership across the Maine healthcare system catalyzed further thinking on the need for transformed payment to support new systems of care.

Future state

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 for 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 who are 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.

General consensus was reached at the Maine Health Management Coalition's Executive Summit in September 2012 that all parties would transition to global payments to support primary care based integrated systems of care. The following statement won the general support of the majority of multi-stakeholder participants:

- With the assistance from the Maine Health Management Coalition, the stakeholders will work collaboratively to create global payments/budgets for coordinated systems of care and shared risk for all patients, with the clear understanding that stakeholders may continue to use other payment reform and benefit design levers while progress is being made in designing and implementing the global payments/budgets. The global payments/budgets will (1) cover a full range of health services, particularly mental and

behavioral health services; (2) be designed to maintain and improve the quality of healthcare services; and (3) be structured so that payers retain insurance risk (i.e., whether individuals develop health conditions) and providers take on performance risk (i.e., managing the cost and quality of healthcare services for a given set of health conditions). In addition, benefit designs should be established to encourage patient support of coordinated, efficient, quality care. The exact details of the global payments/budgets and the size of the payments/budgets may vary across payers and providers, but all payers in Maine should use global payment methodologies that adhere to a common set of principles that the stakeholders develop and that use common forms and administrative procedures to reduce administrative costs.

This evolution in thinking aligns with MaineCare's Value-based Purchasing Initiative and represents a key opportunity for alignment across health care purchasers in the state of Maine.

Given this groundwork, Maine's State Innovation Plan envisions supporting purchasers and payers at various levels of payment reform:

Under this glide path, purchasers can engage in Maine's payment reform efforts at diverse stages. MaineCare and Medicare, for instance, have made important strides in supporting Accountable Care Organizations. These Accountable Care Organizations, in turn, may be well positioned to take on additional risk and partial capitation, while other payers and health care providers or systems may be able to realize full global payment methodologies. Other innovations, such as a primary care driven system being implemented in Massachusetts by Blue Cross Blue Shield (Alternative Quality Contract) may also be a possibility. Regardless of where purchasers and payers enter on this glide path, Maine's State Innovation effort supports them with patient engagement, service delivery transformation, and aligned quality, data, and infrastructure.

Current and future delivery system quality performance

Maine currently uses a variety of quality measures and key indicators to track delivery system performance.

MaineCare

The Primary Care Provider Incentive Payment (PCPIP) pays additional compensation to providers who deliver high quality healthcare to their patients and who rank above the 20th percentile for certain measures compared to other physicians within their specialty. The goals of PCPIP are to increase access of MaineCare members to providers, reduce unnecessary/inappropriate ER utilization, and increase utilization of preventive/quality services. MaineCare tracks a number of measures (based on existing HEDIS measures) for both adults and children.

MaineCare tracks and reports on additional measures specific to MaineCare services and programs:

Health Care Quality
MaineCare Primary Care Case Management Measures MaineCare Emergency Room Visits MaineCare Dental Emergency Room Visits
Behavioral Health Quality
Changes in Level of Functioning for Adults Receiving Case Management Services Children Receiving Mental Health Services who Maintain or Improve Level of Functioning Completion of Substance Abuse Treatment Readmissions to Substance Abuse Detoxification Unit in 180 Days of Discharge
Nursing Home Quality
Nursing home residents physically restrained

Nursing home residents with pressure sores
Nursing home residents with increased need for ADL help
Nursing home residents depressed or anxious
Nursing Home Residents with Too Much Weight Loss

While some of these measures are Maine-specific, certain measures are benchmarked to national standards. Maine's nursing home measures, for instance, are linked to AHRQ State Performance ratings indicate that in most sectors, the state's nursing home system is performing at or above national benchmarks. Moreover, the state is generally improving over time.[35]

MaineCare has also identified measures for the new Health Homes state plan option under section 2703 of the Affordable Care Act. These Health Home measures focus on areas of particular interest to the MaineCare program such as reducing inefficient healthcare spending, improving chronic disease management, improving preventive care for children, and ensuring evidence-based prescribing.

In addition, MaineCare is in the development phase of its Integrated Care Model – part of its Value Based Purchasing Initiative described previously, Accountable Communities. Maine plans to align quality standards for this payment model with the Medicare Shared Savings Plan Quality Performance Standards.

Private Sector Initiatives

The Maine Health Management Coalition uses CMS Hospital Compare data to compare Maine's hospitals to those in the remainder of the United States. MHMC receives updates from the federal government every three months and updates their information accordingly.

In Maine, every hospital also reports information voluntarily to the Leapfrog Group. Leapfrog fields an annual hospital survey that is based on the quality and safety recommendations of the National Quality Forum, The Joint Commission, and the Centers for Medicare and Medicaid Services. All of these organizations work to improve the quality of health care by developing standardized methods for assessing health system performance.

MHMC has also developed its own Medication Safety Survey. The tool - the Medication Spotlight Survey - assesses the systems hospitals have in place to prevent medication errors and insure the effectiveness of medication therapy.

For primary care practices, MHMC publicly reports ratings on the following under its Pathways to Excellence initiative:

Office systems, using standard office systems survey that query practices for use of systems known to improve quality and safety, such as use of Electronic Health Records (EHRs), chronic disease registries, e-prescribing, and nurse care management.

Clinical outcomes – Adults: PTE recognizes excellence for delivery of chronic care, such as diabetes, and cardiovascular clinical outcomes, using national recognition programs such as the Bridges to Excellence (BTE) and National Committee for Quality Assurance (NCQA) physician recognition programs. MHMC will also be adding recognition for other clinical recognition programs from BTE or NCQA as they are developed.

Clinical outcomes – Pediatrics: PTE recognizes excellence for delivery of chronic care for children, including asthma, and for delivery of preventive services, such as immunizations.

PTE is also seeking to share additional practice-specific information that consumers have indicated is important to them, such as whether the practice is open to accepting new patients, and whether practices offer evening and weekend hours.

The Maine Health Management Coalition's Pathways to Excellence initiative also has a new "Advanced Primary Care" recognition program designed to recognize those practices moving toward becoming patient centered medical homes. Two components are currently being reported on the MHMC website, and 5 more are being offered in 2011-13. The initial public reporting of these new components will be for participation, with eventual public reporting of results of care. The components include:

Components	Criteria
Office System Survey	Level 1 or higher on NCQA PPC-Patient Centered Medical Home or Level 2 on NCQA PPC or Bridges to Excellence
Clinical Quality Outcomes	Level 2 (better) on two or more outcomes
Patient Experience	Currently measuring patient experience using validated instrument and rigorous process OR Patient-Family Advisory Group per Patient Centered Medical Home criteria
Cost of Care	Signed AIM statement for working on cost of care based on MHMC cost of care reports or equivalent

Behavioral Health Integration	Scores level 2 or higher on behavioral health integration survey AND Administers PHQ-2/9 annually with ≥50% of high risk population
Informed Referrals	To be developed
Access to Care	To be developed

In addition, Maine's multi-payer patient-centered medical home pilot has developed – and requires reporting on - a set of approximately 30 nationally recognized adult and pediatric clinical measures. The four pediatric practices involved in the multi-payer pilot are also testing the feasibility of extracting IHOC measures data using EHR-driven clinical data.

Future State

Maine's overarching quality structure will be based on Triple Aim goals of improving quality, reducing cost, and enhancing patient experience of care. A key objective in implementing the Triple Aim is to provide a coherent quality framework for Maine's payers and providers, one that aligns across these entities, reduces administration burden, focuses quality measurement across the state, and serves the needs of major public and private health transformation initiatives. While alignment on all measures across payers and providers is not likely (or necessarily desirable), a selection of key indicators across payers and diverse provider settings will be reported publicly to promote health care improvement as well as system transparency and accountability.

Accountable care

Mainecare will be submitting an Integrated Care Model state plan amendment for its Accountable Communities initiative, and is developing a quality framework to guide these new entities. This quality framework will include goals and objectives, specific quality measures, how quality measurement will be used to improve care, how the state will determine when care has been improved, and other components. MaineCare Accountable Communities measures will align closely with Medicare Shared Savings Plans and will be phased in over a three-year period. While measurement alignment across Medicare and MaineCare is an important goal, MaineCare recognizes 1) that the unique needs and challenges of the Mainecare population may require additional measures and/or quality improvement approaches not found in the MSSP quality plan; and 2) that individual communities in Maine may want or need to address specific health care quality issues. For these reasons, Mainecare anticipates that its Accountable Communities quality framework will include measures beyond MSSP that capture MaineCare-specific areas of quality concern. It may also include optional measures that allow entities to build in community-specific goals.

With several large Maine health care systems recently designated as Medicare Shared Savings Plans, a Beacon Community, and purchasers and payers committed to payment reform, Maine envisions that alignment across MaineCare and MSSP at the system level will provide a tipping point for other stakeholders to move forward in their support of value-based purchasing models.

Providers

Maine's quality measurement framework will benefit greatly from work done through the multi-payer patient centered medical home pilot, MaineCare's health home initiative, and the Maine Health Management Coalition's Pathways to Excellence project and Advanced Primary Care designation. Through these inter-related quality improvement and public reporting efforts, Maine has already begun a fundamental transformation of the delivery system. Through expansion of these efforts, the State Innovation Plan envisions that a preponderance of primary care practices and specialists in Maine will be participating in aligned quality improvement and quality reporting activities.

Behavioral Health

Maine has had some success in implementing pay for performance contracting for substance abuse services, and tracked measures related to retention and access to services. Maine community mental health providers also submit data to a state vendor to track a variety of process measures required under a consent decree that covers adult mental health services. However, this work has not resulted in a standard set of measures for behavioral health services that will meet the needs of public and private stakeholders in an integrated, value-based delivery system.

MaineCare will be submitting a Health Homes State Plan Amendment to develop a health homes options specifically to meet the needs of adults and children with behavioral health needs. Through this work – which will include extensive engagement with stakeholders, a Request for Information, and alignment with CMS Adult and Children's Core Measure sets - Maine will identify a set of quality measures for behavioral health that can address the needs of multiple stakeholders.

Patient Experience of Care

The Dirigo Health Agency's Maine Quality Forum, with support from Aligning Forces for Quality, Quality Counts, and MHMC, plans to conduct a statewide CG-CAHPS survey across primary care and specialty physicians, to inform consumers and support payment reform efforts.

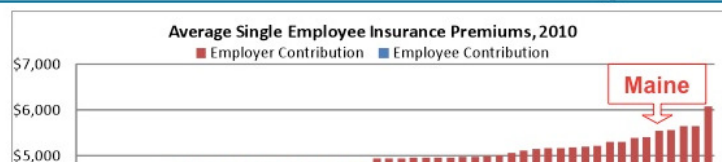
The organization or its vendor will administer CG-CAHPS surveys statewide to patients in as large a number of primary care and specialty care practices as possible. The project also plans to oversample MaineCare members to ensure that the experience of this vulnerable population is assessed and benchmarked against the entire Maine population. Through this project, Maine will have baseline patient experience of care data. Going forward, this CG CAHPS baseline will be used to identify targets for improvement.

Current health care cost performance trends

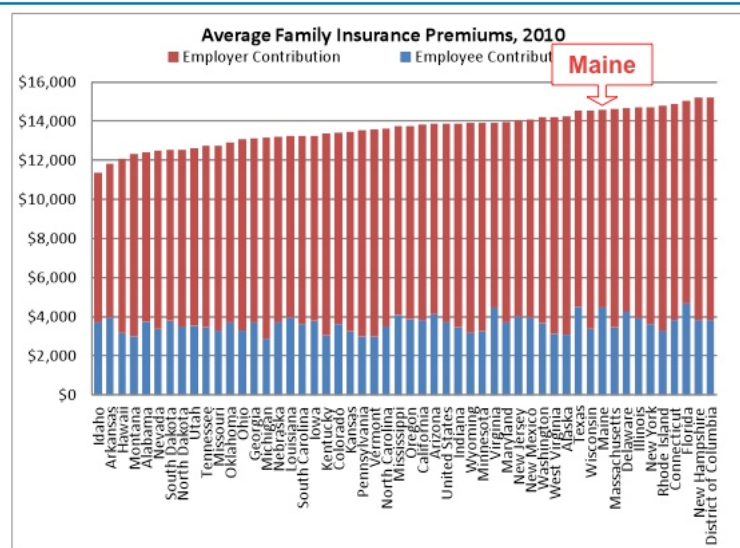
Health care costs in Maine are high, and are unsustainable for public payers, employers and private purchasers, and for Maine citizens. Maine ranks 14th highest in the nation for Medicaid per capita spending, with average annual costs of $6895 per person (2009); spending for disabled populations similarly ranking 14th highest at $17,899 per person.[36] Spending for Medicare populations has been more moderate, with Maine ranking 35th in the nation at $8821 (2009), but Medicare spending has been increasing at a rate higher than the national average; the average annual percent grown in Medicare spending in Maine in 2009 was 8.8%, compared to a national average of 8%.[37]

Significantly, commercial health insurance premiums in Maine are among the most expensive in the country for both individuals and families, and steadily increasing.[38]

Maine Has 5th Highest Insurance Premiums in U.S. For Singles



Maine Has 10th Highest Insurance Premiums in U.S. for Families



A recent report of Maine health care spending examined

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major factors of what drives health care spending, and concluded that the factors of heavy disease burden with high utilization, inefficient and variable utilization, and per unit prices each contribute heavily.[39] The study concluded that overall, two thirds of health care spending is driven by how much we use, while one third is driven by the price of each service. Specifically, the report noted:

> Disease burden is a major driver of utilization and therefore of spending.
>
> Chronic illness, like diabetes, asthma, heart and lung diseases, account for about 30% percent of private premium costs as well as a significant share of MaineCare spending.
>
> Significant savings can be achieved by supporting efforts to make people healthier through evidence-based public health strategies, which will reduce preventable demand.
>
> Additionally, it is known that much of the care provided to those with poor health does nothing to improve their health. That is, once people are sick, they are not treated as efficiently and effectively as possible:
>
> National experts agree that roughly one third of health care spending is on unnecessary or ineffective care
>
> There is considerable, unnecessary variation in how care is delivered across the state. The same person with the same illness is treated very differently.
>
> Identifying places that use and spend less without sacrificing quality can provide models for efficiency.

Maine must be competitive with a broader peer group than New England. When considering the opportunity to expand and attract business to Maine, nationally competitive health care costs are a strong contributor to economic development. This must clearly be balanced with local demographic, economic and health status challenges but it is fair to assume that there is opportunity for reducing health care costs in Maine while maintaining access and preserving quality.

Reducing healthcare costs will be difficult. There is no single intervention, program or innovation that will achieve all of the needed savings. Each intervention will have consequences for both the healthcare industry as well as local communities where hospitals and healthcare organizations may be the largest employers. However, there is growing consensus that the consequences of inaction are greater than and the risks of change. It is also clear that a multi-stakeholder forum in which employers, providers, patients, unions, health plans and other community members can understand and mutually address our collective challenges offers the best chance of success. No single constituency can achieve the necessary changes acting alone. It will require collective action on many priorities towards a shared goal to make a difference. That difference will impact the future of Maine employers, Maine state government, Maine's overall economy and public health.

Population Health and Public Health Reporting

Maine tracks overall health performance via the Maine Center for Disease Control and its Public Health Indicators. While Maine's key indicators are generally better than national averages, results show room for improvement -and alignment with cost saving strategies - when compared to

national benchmarked standards. The table below shows select chronic disease measures as compared to national and benchmark data.

2010 MAINE STATE PROFILE of SELECTED PUBLIC HEALTH INDICATORS Maine Center for Disease Control and Prevention/DHHS			
CHRONIC DISEASE INDICATORS	COMPARISONS		
	MAINE STATE (±M.E. or C.I.)	UNITED STATES	Bench-mark State (healthiest)
Diabètes Prevalence Among Adults, percent [2008]	8.3 (±0.7)	8.3	MN 5.9 [2008]
Diabetes Deaths, age-adjusted rate per 100,000 [2003-2007]	23.6 (±1.1)	23.2 [2006]	NV 12.8 [2006]
Adults with Asthma, percent [2008]	10.3 (±1.0)	8.8	FL 6.6 [2008]
Chronic Lower Respiratory Disease Deaths, 45 Years and Older, rate per	143.7 (±4.5)	114.6 [2006]	HI 55.3

100,000 [2003-2007]			[2006]
Mammogram in Past Two Years Among Women 40 and Older, percent [2008]	83.3 (±1.5)	76	MA 84.9 [2008]
Pap Smear in Past 3 Years Among Women >=18 years, percent [2008]	86.3 (±1.7)	82.9	MA 87.6 [2008]
Prostate Cancer Incidence age-adjusted rate per 100,000 [2004-2006]	164.6 (159.2-170.2)	163.1 (160.8-165.3)	n/a
Prostate Cancer Mortality age-adjusted rate per 100,000 [2003-2007]	25.0 (±1.8)	23.5 [2006]	HI 13.5 [2006]
Major CVD Deaths, age-adjusted rate per 100,000 and counts [2007]	226.4 (±7.2) 3736	261.2 [2006]	MN 190.1 [2006]

Health Disparities and Social Determinants of Health

Maine has made progress in protecting and improving health, and is ranked high relative to other states. However, health disparities - inequalities in population health status caused by social, economic, and environmental factors- continue to persist. Such inequalities are not inevitable, but are changeable and can often be prevented with existing evidence based interventions. A multi-sector, multi-level approach (such as that envisioned by this Plan) is required to eliminate health disparities and reach health equity.

Disparities in Life Expectancy: Average life expectancy rates in Maine's 16 counties vary by as much as 3.2 years (78.8 yrs. -75.6 yrs. in 2009). An egregious example of inequality is the difference in life expectancy rates of the general Maine population (76.3 yrs.) and that of members of the four Tribes in Maine, which range from 55 to 49 years. [*Waponakhi Health Assessment*, c/o Office of Health Equity, Maine CDC, 2011]. In examining long term trends in county mortality, in 2008 researchers determined that the life expectancy rates of women in Washington County had *decreased.*[40]

Geographic Disparities. The National Center for Health Statistics developed a six-level urban/rural classification system. Nine of Maine's 16 counties fall into the "most rural" classification, and two more in the next most rural. A recent report noted the prevalence of adults 18-62 who reported Fair or Poor Health (National Health Interview Survey 2008-2010) in such "most rural" counties (15.7%) was 99% higher, and 68% higher in the next "most rural" counties, than the lowest prevalence category of counties (7. 9%). [41]

As of 2011, 6% of all Maine residents live in a primary care health professional shortage area.
As of 2011, 15% of all Maine Residents live in a mental health professional shortage area.
As of 2011, 21% of all Maine residents live in a dental health professional shortage area.

With over half of Maine's 490+ towns having less than 5,000 residents, many do not have the tax base or capacity to deliver public health or healthcare services. There are two autonomous city health departments in Maine, and no county health departments. As a result, our public health systems at the state and nascent regional DHHS district levels must rely on innovative public/private voluntary collaborations to address barriers to access to healthcare and health education.

Disparities related to income and education are also noted in Maine's health outcomes. Maine's rates of diabetes and obesity for the whole population are slowly and steadily increasing, but Mainers of lower incomes, or without some post high school education, have higher rates of both of these conditions. Lower income Mainers, and those without post-high school education, are also far more likely to smoke.

Compared to the U.S., Maine has a significantly higher incidence rate of all cancers and of lung and bronchus cancers. Maine's cancer incidence rate has been generally rising from 1995 to 2006.

Delivery system quality, and population health performance goals and targets

Maine is committed to identifying achievable Triple Aim improvements in health care spending, quality, and population health through the implementation of the State Innovation Plan.

Cost

Across sectors, cost reductions will be achieved through multiple strategies including expansion of the Patient Centered Medical Home and Health Home models, use of community care teams, integrated behavioral and physical health care, investments in training, education, and HIT, engaged and activated patients, and a focus on aligned quality benchmarks coupled with timely data and public reporting. Payment reform initiatives under multi-payer ACOs will create incentives for additional innovation in cost savings and quality improvement, and alignment across payers will leverage market power to achieve these goals.

Maine will use the Health Partners Total Cost of Care and Total Resource Use measure set to evaluate progress toward a collective cost reduction goal of 7% over 3 years for the commercial sector, 7% for Medicaid and 8% for Medicare.

This magnitude of savings was calculated based largely on the impact of the Patient-Centered Medical Home Model, and research related to cost impact results from 28 separate Medical Home Initiatives nationwide[42]. Analyses include academic peer-reviewed journals and industry-generated reports. Model interventions in the State Innovation Plan extend beyond those strictly associated with Primary Care Medical Home interventions, such as payment reform initiatives across private and public payers. Additional savings may be realized through other interventions, but reliable modeling and research to quantify these savings is not available. As such, these savings estimates are reasonable - and potentially even conservative.

There are real opportunities to reduce healthcare costs in Maine. For instance, opportunities identified by MHMC's Cost Workgroup- a multi-stakeholder group designed to identify savings opportunities in Maine, do not imply rationing or limiting access to needed services but rather redesigning care delivery and payment, changing business practices and reconsidering current infrastructure and service distribution. This process also considered overall approaches to change and reached general consensus to move forward with increased risk for providers, greater flexibility in payment and firm spending targets.

Areas for savings identified by the group included the following:

- Reduce admissions and readmissions for people with chronic illness;
- Reduce variation in price and utilization of outpatient services;
- Reduce variation in prices for inpatient care;
- Reduce variation in treatment for Preference Sensitive Conditions;
- Reduce administrative costs;
- Improve mental health care;
- Reduce cost shifting from public to private payers;
- 'Right-size' healthcare infrastructure and regionalize services;
- Engage consumers through education and benefit incentives;
- Improve wellness and community health

While not all of these recommendations may be realized specifically through the State Innovation Plan, there is significant alignment. The Workgroup lays an important foundation and methodology for identifying and prioritizing any additional cost savings under the Plan going forward. Moreover, the work has added momentum to the discussion in Maine: at the Maine Health Management Coalition's Executive Summit in September 2012, nearly 100 business, health plan and health system leaders considered and voted on the following statement as a statewide goal:

- All stakeholders share a common goal for Maine to have the highest quality, most affordable healthcare in the nation, so that it can attract and retain jobs and residents. To achieve that, the stakeholders are committed (a) to limit the annual increase in risk-adjusted healthcare spending for all Maine residents to the Northeastern United States Consumer Price Index and, in addition, (b) to reduce total risk-adjusted per member per month health care spending by an additional 10% within six years. Mechanisms should be established to ensure that all purchasers and consumers within the state should benefit from the savings associated with the slower growth and overall reduction in spending. As part of the multi-stakeholder collaboration process, progress on these goals will be periodically reviewed to determine whether any revisions are needed.

While not unanimous, there was majority support for this as a target for costs in the commercial sector.

Key Quality Targets and Indicators

As discussed in previous sections, Maine's quality strategy going forward will include a robust set of measures across various domains, including system –level measures to track performance of Maine's Accountable Communities, practice-level measures for patient-centered and integrated care, reliable behavioral health measures that can provide a more accurate picture of outcomes for this service sector, patient experience of care measures via CG CAHPs, and an existing and extensive set of public health reporting measures. These measures will be supported by a reliable and timely data source, bolstered by Maine's all payer claims database and produced using an enhanced data analytics capacity.

From these quality activities **Maine will identify a set of key health quality indicators that will be reported publicly across all participating payers and providers**. These key indicators will provide an overarching framework for Maine's health care system and will be gathered from existing (and often overlapping) measure sets used currently in Maine. This set of Key indicators will align with, and not unduly add burden to, existing payer and provider reporting requirements.

Maine will work through the Pathways to Excellence process and consensus model to identify Key Indicators. This process has been used with great success to engage diverse stakeholders (payers, purchasers, providers, and consumers), present the latest research, identify and prioritize measures that will be useful and meaningful to a wide range of stakeholders, and describe data necessary to produce these measures. The end result of this process will be a set of key measures with broad support that can be publicly reported and used to bolster the quality and accountability of Maine's health care system.

Delivery system models and approaches

Maine will support changes in care and payment by working in partnership with employers, health systems, providers, and communities. Key system models and approaches will draw on Maine's extensive history of innovation, leveraging and expanding existing and emerging initiatives.

Activated consumers and communities

Increased use of shared decision making tools

Use of learning collaboratives to disseminate patient engagement tools and training for providers

Increased use of advance directives/health care proxies and other long-term care planning tools

Increased public awareness of shared decision making, engagement in health care, health care self-management

Development of an electronic patient portal for patient health and wellness self-management

Engagement across payers to explore shared decision making and patient accountability incentives

Transformed delivery systems

Expansion Patient-Centered Medical Homes, Health Homes for people with chronic conditions, and Community Care Teams.

Development of Health Homes for children and adults with significant behavioral health needs

Enhanced EHR capacity and connectivity for behavioral health providers

Identification and dissemination of select integrated clinical models, e.g., IMPACT, SBIRT

Work force development and training to build an integrated direct care workforce in Maine

Clinical analytic tools such as quality monitoring, utilization reporting, and clinical benchmarking

Aligned quality, payment, reporting, and infrastructure

Payer, purchaser, and provider engagement to that supports Accountable Communities, shared savings/risk, and global payment

An aligned quality framework: Pathways to Excellence, Medicare Shared Savings program, MaineCare Accountable Communities, IHOC

Enhanced, unified data and data analytics infrastructure

Public Reporting and accountability on key benchmarks across payers, providers

Accountable communities learning collaboratives to promote payment reform

Leadership training and development to support ACOs and payment reform

Timeline and Milestones

Maine will implement these changes over a three year timeframe.

Milestone	Date
Convene stakeholders; finalize governance, workplan	Dec 2012 - Mar 2013
PCMH expansion/ Health Homes Stage A implementation	January 2013
PCMH/ Health Homes Learning Collaboratives/ coaching begins	January 2013
Initiate PTE process to identify and report on common measures	February 2013
Provider, payer, and employer meetings initiated	February 2013
Finalize select sole source contracts for vendor partners	Mar 2013
Convene Executive and Steering Committees	Mar 2013
Finalize Workplans: Quality Improvement Workplan Workforce Development Workplan Public Health Workplan Evaluation Workplan	March-April, 2013
MaineCare Accountable Communities Implementation	April 2013
Data Needs and Availability Gap analysis	April, 2013
Convene Accountable Care Initiatives Learning Collaborative	June 2013
Contract start date for vendors selected through RFP process	July 2013
Health Home Stage B Implementation	July 2013
Health Home Stage B Behavioral/ Physical Health Integration Learning Collaboratives/ coaching begins	July 2013
Public Reporting: Primary care common quality measures identified and agreed to Behavioral Health common quality measures identified and agreed to	July 2013
Initiate development of curricula for: • direct service behavioral health workforce certification • training for peer patient navigators/ community health	July 2013

workers • training for primary care providers to better serve youth and adults with developmental disabilities and autism spectrum disorders.	
Convene first Leadership Development training session	August 2013
Kick-off Public Health Consumer Engagement Campaign	September 2013
Initiate Shared Decision making tools and training	September 2013
Personal Health Record developed	October, 2013
Implementation of Behavioral Health EHR incentive program	October 2013
Curriculum Implementation: Behavioral Health MHRTC curriculum DD/ Autism training for PCP practice Community Paramedicine Patient Navigation/ Community Health Workers training/ certification National Diabetes Prevention Program	December, 2013
Begin reporting primary care and behavioral health measures publicly	January 2014
Behavioral health HIE support and learning collaborative	April, 2014
implementation of Shared Decision Making Tools	August, 2014
Personal health record consent and security policies	September, 2014
Implementation of Personal Health Record completed	December, 2015
Evaluation	Ongoing

Policy, regulatory and/or legislative changes necessary to achieve the State's vision for a transformed health care delivery system.

Maine will be developing a new policy and regulatory framework as part of its Value-Based Purchasing Initiative. Through the VBP, Maine will be promulgating policy, regulation, and contracts to guide the development of Accountable Communities, Health Homes (Stage A) for Individuals with Chronic Illness, and Health Homes (Stage B), for adults and children with serious behavioral health needs. These policy changes are in progress now in accordance with pre-existing timeframes under that initiative. Maine is already engaged in conversations with CMS regarding

our Accountable Communities concept, and has moved forward in State Plan development for Health Homes.

While we anticipate that in the course of implementation of the State Innovation Plan additional policy, regulatory and/or legislative changes may be identified, the Plan is not contingent on, and does not specifically require, additional policy changes.

Waivers or State plan amendment requirements and their timing to enable key strategies for transformation

Maine will be pursuing three state plan amendments in support of its value-based purchasing initiative, a central feature of its State Innovation Model:

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

Conclusion

Maine's State Innovation Plan builds on existing strengths: an engaged stakeholder community, significant delivery system transformation, robust quality measurement activity, and payers and purchasers ready to engage in payment reform. Maine's Plan ties these strategies together into a cohesive whole that addresses the needs of multiple stakeholders. For payers and purchasers – including MaineCare – the Plan sets Maine on a course to reduce cost and improve quality. For providers, Maine's State Innovation Plan will provide the tools, training, and supports necessary to improve the way care is delivered, identify areas for improvement, develop necessary work force capabilities, and build HIT capacity. For consumers in Maine, the Plan enhances access to quality information, supports consumer engagement, and delivers better care and population health.

The state of Maine has an exciting opportunity and is ready to take its vision for statewide health care reform to the next level. Much of what is needed for this next-level transformation is already operational. This Plan provides the cohesive vision and infrastructure to move this work forward.

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