Section A: Governance

Refer to DRR Section A: Governance, Management Structure and Decision-making Authority

***Supporting Documentation Available*:**

A1) Governor's 09-19-2012 Letter of Support

A2) Press release DHHS 02-22-2013

A3) Press releases – various Feb 2013

A4) Announcement of Project Manager

A5) Stakeholder Engagement Plan

A6) Agenda and presentation from state Forums

A7) Legislative presentation 3-13-2013

A8) Steering Committee Minutes 06-19-2013

A9) Maine SIM initiative website: www.maine.gov/sim

A10) Reference: Staff & Contractor Recruitment & Training (See Section K: Documentation)

A11) Reference: Communications Matrix (See SECTION Q: Documentation)

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

Paul R. LePage
GOVERNOR

September 19, 2012

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

Letter of Endorsement: *Testing the Maine Innovation Model*

Dear Ms. Feagins:

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

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

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

Testing the Maine Innovation Model (the name of our project) leverages current successes and brings the State's investment to the next level by: (1) supporting and strengthening enhanced primary care; (2) supporting and strengthening alignment between primary care and public health, behavioral health, and long-term care; (3) supporting the development of new workforce models for the transformed system; and (4) supporting the formation of multi-payer ACOs that commit to value and performance-based payment reform and public reporting of common quality benchmarks.

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

Title of Project - *Testing the Maine Innovation Model*

Principal Contact Person:

Mary C. Mayhew
Commissioner, Maine Department of Health and Human Services
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Augusta, Maine 04333-0011
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mary.mayhew@maine.gov

Collaborating Organizations and Departments:

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

Paul R. LePage

Paul Richard LePage
Governor of Maine

Maine Department of Health and Human Services

Mary C. Mayhew, Commissioner **www.maine.gov/dhhs**

February 22, 2013

FOR MORE INFORMATION, PLEASE CONTACT:
John Martins, Director
Employee and Public Communications
(207)287-5012 or john.a.martins@maine.gov

NEWS RELEASE

Maine Is One of Six States to Receive Major Healthcare Innovation Award

$33 million federal grant will help transform healthcare in Maine

AUGUSTA – Governor Paul R. LePage learned Thursday that Maine will receive a $33 million three-year grant that will test whether new payment and service models will produce superior results and lower costs.

The grant supports Governor LePage's vision of an innovative healthcare system that is more transparent, uses data to guide decision-making, reforms payment and assists patients in managing their health. The effort, called the Maine Innovation Model, could result in more than $1 billion in overall savings over a three-year period.

Maine has been recognized as a leader in healthcare reform, with several innovative programs and projects under way involving healthcare providers, employers, insurers, unions and consumers. This clearly had an impact on the Center for Medicare & Medicaid Innovation awarding Maine one of six State Innovations Model testing grants.

The Maine Innovation Model will strengthen efforts already underway by aligning MaineCare, Medicare and commercial insurer payments and systems to achieve and sustain lower healthcare costs across the State. MaineCare is the State's Medicaid program. "Providers will know what to expect in terms of payments and will have clear guidance on the data they must report so they can focus their energy on transforming care for their patients,'' said Maine DHHS Commissioner Mary Mayhew. "As a

result of collecting consistent information, patients can compare different health care providers in terms of cost and quality and find practices that best fit their needs, regardless of how the bill is being paid." Mayhew said that resources will be available through the grant to assist patients in managing their own health conditions, including help to navigate the path to care from a peer who has experienced his/her health condition.

Data generated will be publicly reported, reinforcing the commitment to transparency, Mayhew said.

The Maine Health Management Coalition (MHMC) is the State's primary partner in implementing this grant. MHMC is made up of more than 60 employers who represent 200,000 employees and dependents. It is a purchaser-led collaborative representing employers, providers, payers and consumers. MHMC has been active in many of the programs under way that are driving healthcare improvement and payment reform in Maine.

Additional partners include HealthInfoNet, the state's Health Information Exchange and Maine Quality Counts (MHQ), an independent alliance working to transform health and healthcare by leading, collaborating and aligning improvement efforts that support patient-centered, coordinated systems of care and the resources needed to support them.

"This grant will help Maine's MaineCare program build on the experience and success of the MHMC's work in quality improvement, consumer education, value-based insurance design, transparency and payment reform, as well as the excellent work of others in Maine to improve healthcare for an important segment of Maine's population," said Elizabeth Mitchell, CEO of the Maine Health Management Coalition.

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The Boston Globe Metro

Maine gets $33m federal grant for health care

ASSOCIATED PRESS FEBRUARY 23, 2013

AUGUSTA, Maine — The LePage administration on Friday hailed a $33 million federal grant to the state, saying it will advance its goals of creating a more transparent and efficient health care system that could save at least $1 billion.

The US Department of Health and Human Services grant will be used to test whether new payment and service models will produce superior results for patients and lower costs for health care providers. Maine was one of six states to receive the grant. Vermont is receiving $45 million from the Centers for Medicare and Medicaid Services.

Mary Mayhew, Maine's health and human resources commissioner, said the grant will make resources available to assist patients in managing their own health conditions, including help finding care from a peer who has experienced a similar health condition.

"Providers will know what to expect in terms of payments and will have clear guidance on the data they must report so they can focus their energy on transforming care for their patients," said Mayhew.

The grant supports Governor Paul LePage's vision of an innovative, more transparent health care system that uses data to guide decisions, reforms payment, and assists patients in managing their health, administration officials said. They also said the effort could result in more than $1 billion in overall savings over three years.

Projects in states receiving grants will be broad and focus on people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program.

The Maine Health Management Coalition is the state's primary partner in implementing the grant.

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BANGOR DAILY NEWS

Maine wins $33 million to test health care innovations

By Jackie Farwell, BDN Staff
Posted Feb. 21, 2013, at 4:48 p.m.

Maine will receive up to $33 million from the federal government over the next three and a half years to test a plan to improve residents' health care while cutting costs.

Maine and five other states are the first recipients of more than $250 million in funding awards made under the federal Affordable Care Act, the U.S. Department of Health and Human Services announced Thursday. The money is designed to help states find new ways of paying for and delivering health care that could ultimately lower costs for Medicare, Medicaid and the Children's Health Insurance Program while making those programs' beneficiaries healthier.

HHS hopes to foster state-level innovations that could eventually stem the tide of rising costs in Medicaid, the state-federal health insurance program for the poor, and the Medicare program for the elderly and disabled. Maine's Medicaid program, known as MaineCare, accounts for about a third of the total state budget. Like Medicaid programs in other states, it faces critical funding shortages.

In a conference call on Thursday with reporters, HHS Secretary Kathleen Sebelius acknowledged the burden of mounting health care costs on the economy, states, businesses and consumers.

"Too many Americans receive care that's fragmented, unreliable and generates poor health outcomes," she said. "The good news is that we have numerous examples from across the country of how improvements in care delivery can both lower costs and improve health."

The grant was awarded to Maine Gov. Paul LePage's office in partnership with the Department of Health and Human Services and MaineCare.

Maine's plan is a broad effort that includes expanding the creation of "accountable care organizations," or groups of health providers that are promised incentives for better coordinating each patient's care while also trimming costs. The model, which ties payments to health care quality metrics, stresses patient safety, better management of chronic diseases, and preventive health services.

The accountable care organization model was formalized under President Barack Obama's health reform law, upheld in late June by the U.S. Supreme Court. It's being tested in regions across the country.

HHS was impressed with work done by Maine health providers in recent years to collaborate with other stakeholders to improve health care, and then broaden those efforts statewide, Richard Gilfillan, director of the Center for Medicare and Medicaid Innovation at HHS, said in the conference call.

"Many providers in Maine had come together with private entities and with payers and the state government and have been thinking about planning specific initiatives to address transforming care in their local communities," he said.

The grant will support Gov. Paul LePage's vision for a more transparent health system that uses data to guide decisions, reforms payment, and assists patients in managing their health, Maine DHHS Commissioner Mary Mayhew said Friday.

"This grant will empower patients by producing data that will help them compare health care providers in terms of quality and value for their health care dollar," she said. "Patients will be equipped to find the practices that best fit their needs regardless of how the bill is being paid."

LePage has opposed the Affordable Care Act, under which the grant was issued, and refused the legislation's call to expand the state's Medicaid program. Mayhew said the grant, unlike the federal health reform law, gives states the latitude to innovate in health care.

"This is what the governor has criticized, the lack of flexibility in the federal Medicaid program," she said.

The effort, called the Maine Innovation Model, could result in more than $1 billion in savings over the three-year period, according to DHHS.

The state will partner with the Maine Health Management Coalition, a Portland nonprofit made up of employers, hospitals, and others working to improve the quality and value of health care, to make better use of health data for more transparent and detailed reporting of costs and quality.

Additional partners include HealthInfoNet, the state's health information exchange, and Maine Quality Counts, an independent alliance working to transform health care in Maine.

All other work for the project will be contracted through a competitive bidding process, according to DHHS.

Maine's plan also calls for strengthening coordination among primary care providers and public health, behavioral health and long-term care organizations. The federal funding will allow the state to continue work to facilitate better partnerships between patients and their families and their primary care physicians.

Adults and children with developmental disabilities and autism disorders will be able to see doctors who are better trained to meet their needs, Mayhew said. Health providers also will benefit from greater consistency in how they're paid, she said.

Through electronic health records, practitioners will get real-time notification when some of their sickest patients wind up in the emergency room or are admitted to a hospital, which will lead to better follow up care, Mayhew said.

Maine's efforts to improve the value of health care will hopefully free up resources to improve residents' access to care, which has suffered in recent years amid cuts to the MaineCare program, said Mitchell Stein, policy director for the advocacy group Consumers for Affordable Health Care.

"This is a great step forward for Maine and we are very excited that the work being done in Maine is being recognized," he said.

The other five states that received the "State Innovation Model" awards were Arkansas, Massachusetts, Minnesota, Oregon and Vermont. Another 19 states will receive awards totaling $35 million to further develop proposals to transform health care, HHS said.

Continued funding will be contingent upon each state's performance and demonstrated progress, according to HHS.

http://bangordailynews.com/2013/02/21/health/maine-wins-33-million-to-test-health-care-innovations/ printed on July 11, 2013

Portland Press Herald

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February 21

Maine gets $33 million for health care reforms

By John Richardson jrichardson@mainetoday.com
Staff Writer

The U.S. Health and Human Services announced Thursday it has awarded $33 million to support healthcare reform efforts in Maine over the next three-and-a-half years.

The grant is part of a $300 million round of awards to six states that are working to improve the quality and lower health care costs through new payment models and other reforms. Along with Maine, the other states to receive awards are Arkansas, Massachusetts, Minnesota, Oregon and Vermont.

The six states will use funds to test multi-payer payment-and-service delivery models. These include ways of paying for care that rewards medical providers when they keep patients healthy and out of hospitals as opposed to the existing model in which medical providers make most of their profits from procedures and hospitalizations.

Models being tested in Maine include accountable care organizations that set quality standards and publicly report how well they meet them and enhanced primary care, which includes financial incentives to keep patients from needing expensive tests and procedures.

The federal grant will allow Maine organizations to continue developing the models and to measure their effectiveness. Future grants will depend on the performance of the efforts.

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http://www.pressherald.com/news/Maine-gets-33-million-for-health-care-reforms.html

Check the box to include the list of links referenced in the article.

Maine Wins $33M Federal Grant for Health Care Pilot Project

02/22/2013 Reported By: Keith Shortall

The federal government has awarded Maine up to $33 million to test a plan aimed at lowering health care costs, and improving the health of Maine residents. While Gov. Paul LePage has criticized the federal Affordable Care Act, and refused to expand Medicaid in Maine, the administration says this grant is in line with the governor's larger goals for improving the health care system in Maine. Keith Shortall reports.

Related Media	
Maine Wins Federal Grant for Health Care Pilot Pro	Listen Duration: 2:36

The U.S. Department of Health and Human Services chose Maine as one of six states to share more than $250 million in grant money handed out as part of the Affordable Care Act. Health and Human Services Secretary Kathleen Sebelius announced the awards yesterday in a teleconference.

"States have long been innovators and leaders in promoting these kinds of improvements through their Medicaid programs," Sebelius said. "And the awards we're announcing today will give states the freedom they need to take these efforts to the next level by coordinating efforts with private payers."

The other five states that received the awards are Arkansas, Minnesota, Oregon, Vermont and Massachussetts, which Sebelius says will get $44 million to transform primary care practices into so-called "medical homes."

"And Maine will recieve up to $33 million to support the expansion of 'Accountable Care Organizations,' that tie payments to quality outcomes," Sebelius said.

The so-called the Maine Innovation Model, says state Health and Human Services Commissioner Mary Mayhew, will strengthen efforts to align MaineCare, Medicare and commercial insurer payment systems, and could save Maine more than $1 billion over a three-year period.

"The approach that Maine is focused on is to move away from a payment system that is based on the volume of services that are delivered, to one that is based on rewarding quality care, for improved outcomes," Mayhew says - and on holding providers accountable for improving the health of the people of Maine.

While the LePage adminstration has made clear its opposition to major requirements of the federal Affordable Care Act, and has declined to expand Medicaid under the law, Mayhew says the grants announced on Thursday encourage innovation, and lower costs, all of which she says the governor wholly supports.

"We absolutely believe that this grant will allow us to move in that direction, and is aligned with the governor's principles to support greater transparency in the system and greater accountability in the system," she says.

The state's primary partner in implementing the grant over the next three-and-a-half years is the Maine Health Management Coalition, which is made up of more than 60 public and private employers, hospitals, health plans, and doctors.

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Maine gets $33M federal grant for health care

12:43 PM, Feb 22, 2013

AUGUSTA, Maine (AP) - Maine has been awarded a $33 million federal grant designed to bring new efficiencies to state health care programs.

The grant from the U.S. Department of Health and Human Services will be used to test whether new payment and service models will produce superior results for patients and lower costs for health care delivery.

Maine is one of six states chosen to receive a grant from the government. Vermont is receiving $45 million from the DHHS' Centers for Medicare and Medicaid Services.

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Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor
Mary C. Mayhew, Commissioner

Department of Health and Human Services
Commissioner's Office
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Augusta, Maine 04333-0011
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TTY Users: Dial 711 (Maine Relay)

May 30, 2013

«First_Name» «Last_Name», «Title»
«Company_Name»
«Address_Line_1»
«Address_Line_2»
«City», «State» «ZIP_Code»

Dear «Salutation»:

I am writing to you today because of your involvement in the State Innovations Model (SIM) Grant. I have recently joined the Department of Health and Human Services as the Program Manager for the grant and look forward to meeting you in the near future.

With over 20 years of experience leading organizations and managing large, complex initiatives and focusing on transformational change, I have developed a solid understanding of how collaboration and partnership impact the ultimate success of any initiative. Prior to joining DHHS, I was the AVP of Strategic Execution for Global Business Solutions with UNUM, where I was employed in many capacities and developed the skills to lead diverse organizations and cross-functional teams to significant goal achievement.

As the Program Manager, I hope to have the same impact on the SIM grant in Maine. My primary role will be to develop and manage the grant's overall integrated plan by working closely with all internal and external stakeholders. I will work closely with you, as a grant partner, to ensure positive collaboration and successful implementation of the SIM grant. There are various ways to achieve this, and I look forward to discussing the approach that works best for you.

Please feel free to contact me any time at 287-5013 or Randal.Chenard@maine.gov. I look forward to working with you.

Sincerely,

Randal Chenard
SIM Grant Program Manager

RC/klv

State of Maine
State Innovation Model
Stakeholder Engagement Plan (Planning Period)

Stakeholder(s)	Rationale for Stakeholder Involvement	Method of Engagement	Stakeholder Roles/Responsibilities	Timeframe for Stakeholder Engagement	Stakeholder outputs/deliverables
State of Maine – Governors Office	Governors Office is the awarde and provides visible leadership for healthcare policies in the state	Participant in governance and planning, Cooperative agreement awardee delegating operational responsibility to the DHHS.	Regular participation on the leadership team that has responsibility for changes in SOW, budgets, or resources.	2/2013 – 9/30/13	Any legislative actions or bills requiring Executive branch support
State of Maine – Department of Health and Human Services (DHHS)	DHHS oversees state offices that have primary responsibility for MaineCare (Medicaid) and directs health and social services to Maine's most vulnerable	Participant in governance and planning, monitoring of performance	(See MaineCare below.) Coordination with all DHHS Offices within the Department, oversight and management of cooperative agreement. Management of MaineCare's role in grant	2/2013 – 9/30/13	Defined strategic intersects and coordination of DHHS programs and SIM reflected in alignment of SIM operational plan to the DHHS strategic plan.
State of Maine – Office of MaineCare Services	MaineCare is Maine's Medicaid program	Convener and organizer	Planning, operations, oversight, grant management, reporting, contracting, and maintaining liaisons to stakeholders, contractors, and CMMI/CMS.	2/2013 – 9/30/13	Operational plan, contracts, workplan, budgets, communication plan, RFPs, convening of stakeholders, governance, fraud and abuse prevention plan
State of Maine – Maine Center for Disease Control (MECDC) Office of the Director	MECDC is the public health agency	Participant in public health planning activities. Delegate to Steering Committee	Directs public health resources within MECDC to support SIM plan as appropriate. Participates in decision making process for planning and ongoing	5/2013 – 9/30/13	Defined public health role beyond what was defined in the work with the Division of population health

			governance of SIM.		Evidence of engagement by attendance at governance meetings and participation in planning sessions.
MECDC - Division of Population Health	The Division of Population Health within MECDC is a collection of public health programs that address risks, i.e. nutrition, physical activity and diseases, i.e. diabetes, CVD.	Participant in public health and healthcare planning activities.	Develop community workforce of patient navigators and use of self management programs for chronic disease management.	2/2013 – 9/30/13	Patient navigator plan developed with specific targets for all regions of the state. Chronic disease self-management plan developed with commitments from providers statewide.
State of Maine – MECDC Diabetes Prevention and Control Program	The Diabetes and Prevention Program directs public resources and public health programs toward prevention and control of diabetes.	Participant in public health and healthcare planning activities	Develop how the evidenced based self-management plan will be operationalized for prevention of type 2 diabetes	5/2013 – 9/30/13	Diabetes prevention program strategic plan with commitment from providers availability on a statewide basis.
State of Maine – MECDC Cardiovascular Health Program	The MECDC Cardiovascular Health Program directs public resources and public health programs toward prevention and control of cardiovascular risks and disease.	Participant in public health and healthcare planning activities	Identify linkages between cardiovascular programs and VBID and other incentive programs. Identify strategies for inclusion of CVD health into SIM strategy.	5/2013 – 9/30/13	Contribute specific actionable strategies for linkages. Contribute at least three public health strategies for inclusion of CVD prevention into the SIM plan.
State of Maine – MECDC Statewide	The states eight public health districts are coordinated and	Will be invited to participate in public health and	Identify how the statewide health improvement plan and SIM plan can be coordinated to facilitate	5/2013 – 9/30/13	Develop specific actionable strategies between public

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Coordinating Council	organized through this group.	healthcare planning activities	public health and healthcare goals most efficiently		health and healthcare that would be possible in each of the eight districts, i.e. coordinated public health prevention messages through healthcare providers.
State of Maine – MECDC Office of Rural Health	Using federal and state funding, this office coordinates rural health programs including a focus on critical access hospitals and workforce development.	Will be invited to participate in public health and healthcare planning activities	Coordinate efforts related to rural healthcare resources and discuss the roles of critical access hospitals and workforce gaps that could be addressed through the SIM plan.	5/2013 – 9/30/13	Identify rural resources for SIM plan Identify existing workforce gaps in healthcare workforce
State of Maine – Substance Abuse Mental Health Services	Behavioral health is a major cost driver in Medicaid. Coordination and performance improvement activities with the BH community is expected to result in improved outcomes.	There will be a presence of substance abuse providers in the governance structure. I addition there are planning activities that this group will be invited to participate in.	Participate in strategy discussions on effective and efficient resource usage of substance abuse services and professionals linked to PCMH/health home interventions.	5/2013 – 9/30/13	Identify how existing resources can be used to implement substance abuse screenings in health homes. Develop some gap strategies for areas with insufficient resources.
State of Maine – Office of Aging and Disability Services (OADS)	The aged and disabled are responsible for large portions of costs in Medicaid and Medicare. Performance improvement and inclusion of long term care are critical to outcomes and	OADS will participate in strategic planning and on the Steering Committee during the planning stage.	As a major portion of healthcare spend in the Medicare populations is related to chronic disease and disabled populations represent large spends in the Medicaid program, the office of aging and disability is an important collaborator to SIM strategy.	5/2013 – 9/30/13	Identify community based supports for people with disabilities that have potential to improve coordination of care at or below current costs. Engage long term

	efficiencies.				care providers in focused dialogue on participating in ACO pilots.
State of Maine – Office of Children and Family Services (OCFS)	Children and families especially those in foster care represent a significant opportunity for improved service delivery through coordinated health home activities and services through accountable communities.	OCFS will participate in strategic planning during the planning stage. SIM leadership will meet with key stakeholders within OCFS to determine how the SIM plan can benefit from inclusion of OCFS	Contribute to strategy that will inform the Medicaid program on using health homes to effectively manage children with severe emotional disturbance, children at risk of institutionalization, and management of complex medical problems including behavioral health challenges	5/2013 – 9/30/13	Assist in the refinement and development of the behavioral health home SPA Contribute criteria for the Medicaid ACO's centered on children and families.
State of Maine – Professional and Financial Regulation (PFR)	"PFR" provides regulatory oversight of health insurance in the state	PFR will participate in the governance via the state of Maine leadership team.	Contribute to governance discussion on policy levers that can be used to incent payers to support alternative payment for delivery reform.	5/2013 – 9/30/13	Meaningful input to leadership discussions. One recommendation for a policy change that can be used to incent payer support of delivery system reform.
State of Maine Employee Health Commission (SEHC)	The SEHC is governing board for the self-funded state employee health plan.	SEHC will participate in strategic planning during the planning stage.	Contribute to strategy that will inform use of VBID and other value based purchasing approaches	5/2013 – 9/30/13	Contribute at least two strategies to the VBID discussion, one of which can be used in the Medicaid population.
State of Maine Attorney Generals Office	The AG office will be assisting us in development of rules and	The AG Office will be consulted with.	The AG Office will be consulted on policy and issues that could impact the delivery and reform	5/2013 – 9/30/13	Opinions will inform policy and content of models to be in line

	policies		models such as ACO providers and monopolies		with state and federal rules and regulations.
State of Maine – Office of Quality Improvement	The Office of QI has a central role in developing performance metrics within the Department. Coordination of these metrics with those being developed in SIM is essential.	OQI will participate in various aspects of the planning process	OQI will assess the data integrity plan, resources to be dedicated by external vendors, analytic platform, standards, and reports to be delivered against the data plan	5/2013 – 9/30/13	Reports will be made bi-weekly to leadership and the project manager of the SIM program on the progress of the data collection and analytic services to support the SIM strategy.
State of Maine – Office of the State Coordinator for HIT (OSC)	The OSC has primary responsibility for development and oversight of the statewide HIT plan	The OSC will participate in strategic planning and workgroups related to HIT	The OSC will facilitate discussions with its stakeholder board of 23 to review the state HIT plan and opportunities for alignment and coordination with the SIM plan	5/2013 – 9/30/13	A coordinated strategy will be developed in conjunction with the OSC and SIM Team. A plan with specic objectives within the state HIT plan will be developed and endorsed by stakeholders.
Maine Health Data Organization (MHDO)	MHDO is a quasi-state agency that oversees the all-payer claims database (APCD) and other health and financial databases.	MHDO will participate in the strategic planning activities and in workgroups related to data	MHDO and its Board will assist the SIM plan via work being done to improve the utilization of the states APCD and by addressing the ways in which administrative and clinical data can be used, including the availability of PHI to support delivery and payment reform.	5/2013 – 9/30/13	MHDO data rules will be reviewed and a position on inclusion of PHI will be issued by the Board. The Board will make a decision on its position of inclusion of clinical with administrative claims data.

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Maine Hospital Association (MHA)	The MHA represents all hospitals in Maine.	The MHA will participate in the governance of the SIM plan through the Steering Committee. MHA members will also be involved in the strategic planning activities	MHA and its members have a significant role to play in the development of both health homes and ACO's. The goals of payment reform are dependent on transitioning from high utilization of expensive hospital based services to more efficient and effective ambulatory care.	5/2013 – 9/30/13	MHA or member participation in Steering Committee meetings. Agreement to support the SIM strategy as evidenced by a willingness to participate in delivery system efforts.
Maine Tribal Leaders	Maine has five recognized tribes. The Tribal leaders represent each tribe and have authority to speak on behalf of their sovereign governments.	Maine Tribal Leaders will participate in the governance of SIM through the Steering Committee.	Maine's five tribes have high rates of poverty and unique needs in rural, underserved areas of the state.	5/2013 – 9/30/13	Identify coordination opportunities between Maine Indian Health Centers and reform models being proposed. Engage Indian Health Centers in strategies to deliver better care at lower costs.
Maine Senate	The Maine Senate is one of the two branches of the legislature. Legislative support for health reform strategies is critical to success where incentives alone won't work.	The Maine Senate will participate in the governance of SIM through the Steering Committee.	The Maine Senate representative to the Steering Committee will contribute to the SIM policy discussion and support any legislative recommendations to improve the delivery system and payment reform strategies being implemented.	5/2013 – 9/30/13	Support legislative actions, if any recommended.
Maine House of Representatives	The Maine House of Representatives is one of the two branches of the legislature. Legislative	The Maine House of Representatives will participate in the governance of SIM through the	The Maine House of Representatives representative to the Steering Committee will contribute to the SIM policy discussion and support any	5/2013 – 9/30/13	Support legislative actions, if any recommended.

	support for health reform strategies is critical to success where incentives alone won't work.	Steering Committee.	legislative recommendations to improve the delivery system and payment reform strategies being implemented.		
Consumers of healthcare	Consumer perspectives are important to the success of strategies like value based insurance design.	Consumers will participate in the governance of SIM through the Steering Committee.	Provide a consumer perspective on how the SIM plan cane be most effective in meeting consumer needs.	5/2013 – 9/30/13	Provide input into the SIM operation plan that includes at least three consumer recommended actions.
Maine Medical Association (MMA)	The MMA is the statewide association representing allopathic physicians in both primary care and specialties. This organization also represents physician assistants who as mid-levels have prescribing and treatment privileges and will be impacted by both delivery and payment reform strategies.	The MMA may participate in the governance of SIM through the Steering Committee. The MPCA will be invited to participate in the planning activities.	Provide input to the operational plan on how the respective professions in the MMA can contribute to the delivery reform.	5/2013 – 9/30/13	Define the contributions of allopathic providers to the SIM operational plan.
Maine Primary Care Association (MPCA)	The MPCA represents Federally Qualified Health Centers (FQHC's) and Rural Health Centers (RHC's).	The MPCA may participate in the governance of SIM through the Steering Committee. The MPCA will be invited to participate in the	The MPCA provides direction to 9 FQHC's that have formed a shared savings ACO. The SIM operational plan will be coordinating its work to both learn what works as well as to coordinate resources.	5/2013 – 9/30/13	Participation in the ACO and other learning communities being provided through the SIM opportunity.

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		planning activities.			
Maine Osteopathic Association	The MOA is the statewide association representing allopathic physicians in both primary care and specialties.	The MOA may participate in the governance of SIM through the Steering Committee. The MPCA will be invited to participate in the planning activities.	Osteopathic physicians are a major contributor to our medical delivery system and their roles in PCMH and medical homes are critical to success. We will be looking to their input on the operation of the model.	5/2013 – 9/30/13	MOA will provide recommendations for how osteopathic providers can contribute to the success of the SIM operational plan in delivery systems, i.e. health homes.
Association of Nurse Practitioners (ANP)	The professional association for NP's who as mid-levels have prescribing and treatment privileges and will be impacted by both delivery and payment reform strategies.	The ANP may participate in the governance of SIM through the Steering Committee. The MPCA will be invited to participate in the planning activities.	Nurse practitioners are a major contributor to our medical delivery system and their roles in PCMH and medical homes are critical to success. We will be looking to their input on the operation of the model.	5/2013 – 9/30/13	MOA will provide recommendations for how osteopathic providers can contribute to the success of the SIM operational plan. in delivery systems, i.e. health homes.
Anthem Insurance	Anthem is the largest health insurer in the state. Inclusion of major insurers in our ongoing refinement of delivery and payment reform will increase the likelihood of success with our models.	Commercial insurers will participate in governance through the Steering Committee and in the planning process.	Commercial insurers are the third payer in the market and although represent employers, their systems are used in payment and they negotiate contracts on behalf of employers.	5/2013 – 9/30/13	Recommendations on how commercial payers can incent consumer and provider change using VBID principles.
Aetna Insurance	Aetna is a major commercial health insurer. Inclusion of	Commercial insurers will participate in	Commercial insurers are the third payer in the market and although represent employers,	5/2013 – 9/30/13	Recommendations on how commercial payers can incent

	major insurers in our ongoing refinement of delivery and payment reform will increase the likelihood of success with our models.	governance through the Steering Committee and in the planning process.	their systems are used in payment and they negotiate contracts on behalf of employers.		consumer and provider change using VBID principles.
Harvard Pilgrim Insurance	Harvard Pilgrim is a major commercial health insurer. Inclusion of major insurers in our ongoing refinement of delivery and payment reform will increase the likelihood of success with our models.	Commercial insurers will participate in governance through the Steering Committee and in the planning process.	Commercial insurers are the third payer in the market and although represent employers, their systems are used in payment and they negotiate contracts on behalf of employers.	5/2013 – 9/30/13	Recommendations on how commercial payers can incent consumer and provider change using VBID principles.
Maine Community Health Options (MCHO)	Maine Community Health Options is the only Co-Op model insurance plan available in the state. MCHO is a supporter of the SIM plan and will be participating closely with ACO development.	MCHO will be asked to participate in planning and possibly in the payment reform workgroup.	Describe the unique contributions and aspects of the community health model and how our ACO and health home developments can be coordinated to the model.	5/2013 – 9/30/13	Recommendations on how the SIM model can compliment the development of the community options program
Maine Association of Health Plan (MAHP)	The MAHP has a major role in political decisions impacting health insurance and benefit design. The inclusion of the MAHP will help ensure they participate collaboratively in developing and implementing our models.	MAHP will be asked to participate in planning and possibly in the payment reform workgroup.	Commercial insurers are the third payer in the market and although represent employers, their systems are used in payment and they negotiate contracts on behalf of employers.	5/2013 – 9/30/13	Recommendations on how commercial payers can incent consumer and provider change using VBID principles.

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Maine Health Access Foundation (MEHAF)	MEHAF is a philanthropic foundation formed after the sale of the former blue Cross plan. MEHAF is a driver of change in both delivery and health reform.	MEHAF will be asked to facilitate the selection of behavioral health providers for a role on the Steering Committee and to participate in planning and possibly in one of the workgroups.	Facilitate discussions between physical and behavioral health providers as we develop a fully integrated health home and the rol of behavioral health is expanded in ACO's	5/2013 – 9/30/13	Provide recommendations to the planning process for specific ways that advanced primary care systems can be inclusive of behavioral health based on the several years of integration experience the Foundation has funded.
Statewide health information Exchange – HealthInfoNet (HIN)	HIN provides the health information exchange services in Maine. HIN will be responsible for several HIT related deliverables and coordination with them and other stakeholders is critical to success of this work.	HIN will participate in governance on the Steering Committee and through workgroups that report to the Steering Committee	Provide direction on how technology can be used to facilitate coordination of care, work with stakeholders on issues of transparency, work with behavioral health, long term care and traditional systems. Work with the OSC to align plans. Work with internal and external resources related to use of HIT in support of care delivery and for quality reporting where appropriate.	2/2013 – 9/30/13	Lead transparency workgroup Participate on Steering Committee Participate in planning activities Assist OSC in alignment of state HIT plan with SIM plan
Maine Health Management Coalition (MHMC)	MHMC provides data analytics and payment reform activities with a multi-payer emphasis. A large portion of the SIM plan is centered around using data to inform action.	MHMC will participate in governance on the Steering Committee and through workgroups that report to the Steering	Provide leadership in focused planning activities related to data analytics and processes to inform public reporting, tiering, patient engagement, behavioral health leadership development, and system reform work	2/2013 – 9/30/13	Lead a workgroup focused on payment reform Engage payers and providers in planning activities to detail the transformation activities Develop the

		Committee			strategies for multi-payer patient engagement work Initiate the data analytic and reporting work in concert with internal and external resources Engage the behavioral health community and collaborate with them on how they will be included in the PTE and MHMC cost group activities. Coordinate with state of Maine communication resources on developing a coordinated communication strategy. Development of the MHMC workplan that will be foundational to the SIM plan.
Employer	Employers are central to payment reform as they bear the burden of a large portion of healthcare in the private sector. We will have the MHMC nominate an employer to be represented on the	An employer representative will participate in governance on the Steering Committee and through workgroups that report to the	Contribute to the planning process strategies that will reinforce the triple aim goals of the SIM strategy which can be incorporated into plan design, most likely with VBID principles.	5/2013 – 9/30/13	Identify actions that employers can take that will reinforce the triple aim goals of the SIM strategy using plan design and tools such as value based insurance design.

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	Steering Committee and will look to engage with multiple employers represented in the work the MHMC performs.	Steering Committee			
University of Southern Maine – Muskie School of Public Service	USM has a long term history of academic research into health care issues in the state in support of payment and delivery reform. They are also a key academic and data resource in Medicaid and Medicare.	USM Muskie School will participate in the SIM Planning Process and may be asked to join workgroups as content experts.	Contribute to planning process and assist refinement of strategies having input as content experts. Identify the role of USM in evaluation.	5/2013 – 9/30/13	Provide content expertise in delivery and payment reform. Provide consultation on health policy and research into emerging practices Provide opinion on legal polices that may arise in ACO work where competition issues get raised. Identify evaluation issues.
University of New England (UNE)	UNE is engaged with MaineCare in examining super-utilizer issues. The academic and research arms of the institution are key to our public health and community models. We are also engaged with the schools of medicine, public health, and social work on various Medicaid initiatives.	UNE Muskie School will participate in the SIM Planning Process and may be asked to join workgroups as content experts.	Help to define the role of academic medical and social science programs in the SIM plan Identify where the public health program and community public health work can be connected. Identify the role of UNE in evaluation.	5/2013 – 9/30/13	Identify formal pathways for inclusion of the UNE school of medicine and allied schools of health in the SIM plan Identify evaluation issues that the school could contribute on.
Maine Quality Counts (QC)	QC is a statewide quality improvement organization. QC directly supports advanced	QC will participate in governance on the Steering Committee and	Lead many of the planning activities related to development of clinical teams that are the basis of advanced primary care	2/2013 – 9/30/13	Lead delivery system reform workgroup. Organize behavioral health providers and

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	primary care through learning communities and is a leader to developing quality and performance work with the behavioral health community.	through workgroups that report to the Steering Committee.	and the foundation of delivery system reform. Using the experience of the MAPCP, apply that work to the expansion of Health Home practices. Engagement with the behavioral health community. Linkage of work with other critical partners.		outline the specifics of integration activities with primary care practices. Identify how new health home practices will be included into the delivery system and meet certification requirements. Develop overall QI plan with multi-stakeholder input.
Hanley Center for Health Leadership	The Hanley Center is a foundation focused on development of physician and healthcare leadership. The Center provides training for physician and healthcare leaders in the state.	The Hanley Center will through the planning process.	Participate in planning and contribute to discussions on addressing workforce skill gaps	5/2013 – 9/30/13	Identify leadership skill development areas for multi-disciplinary teams Identify specific skill development issues with behavioral health leadership.
Maine Association of Mental Health Providers (MAMHP)	MAMHP's represents behavioral health providers in organizations that provide community mental health and their involvement is key to inclusion of the behavioral health sector of providers.	Behavioral health associations will be represented on the Steering Committee and will also be asked to contribute to development of the operational plan	Participate in development of integration of behavioral health with primary care and other integrated work.. contribute to plans to be developed on BH accountability measurement and public reporting activities.	5/2013 – 9/30/13	Recommendations to integration strategies of behavioral health and primary care. Participation in developing measurement and accountability strategies.
National Association of the Mentally Ill	NAMI is a strong voice for persons with severe mental illness in the	Behavioral health advocacy groups will be asked to	Provide a consumer perspective on how the SIM plan cane be most effective in meeting	5/2013 – 9/30/13	Provide input into the operational plan on how consumers with

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(NAMI)	state. They represent a voice of consumers and some providers of care.	contribute to development of the operational plan on the consumer inputs	consumer needs.		severe mental health illness and other challenges can contribute to delivery/payment reform through the SIM plan.
DHHS – Program Integrity	Program Integrity is a state resource focused on detection and intervention of fraud and abuse within Medicaid.	Program integrity, within the DHHS, will be consulted directly to develop a plan to address the various risks raised by the models being tested	Consultation with leadership and the program manager of SIM to identify risks and develop a mitigation strategy to address the issues	5/2013 – 9/30/13	Review of models and specific processes that could result in fraud and abuse Identification of monitoring and oversight practices to be applied and assure minimal risk of abuse and fraud. Mitigation strategy approved and implemented.
Aligning Forces for Quality (AF4Q)	AF4Q provides support for patient engagement, healthcare disparities, and consumer education. AF4Q will be an alignment partner with the work that will be focused on through SIM.	AF4Q will be asked to participate and contribute during the operational planning phase	Contribute to the consumer engagement plan.	5/2013 – 9/30/13	identify the contributions, overlap, and coordination issues.
Office of Minority Health APS healthcare	Through the MECDC, this office focuses on health disparity issues. APS acts as an ASO for MaineCare in the	The office of Minority health will be asked to participate and contribute during the operational	Contribute to the consumer engagement plan.	5/2013 – 9/30/13	Identify challenges that need to be addressed within the plan to meet the needs of minority populations that

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	behavioral health service sector.	planning phase			otherwise would not be successful.
AARP Maine Chapter	The AARP represents the interests of the elderly in the state of Maine	AARP will be asked to participate and contribute during the operational planning phase	Contribute to the consumer engagement plan.	5/2013 – 9/30/13	Identify challenges that need to be addressed within the plan to meet the needs of older populations that otherwise would not be successful.
Maine Healthcare Association	The Maine Healthcare Association represents long term care in Maine.	The Maine Healthcare Association will be asked to participate and contribute during the operational planning phase and workgroups with delivery system reform	Actively participate in contributing the LTC perspective on inclusion in emerging delivery models.	5/2013 – 9/30/13	Identify where LTC HIT solutions are seen, i.e. use of Direct in care transitions. How LTC be included in ACO and HH models
Home Care and Hospice Alliance of Maine	The Alliance represents delivery of homecare and hospice services that are pertinent to our changing focus on affordable high quality care	The Alliance will be asked to participate and contribute during the operational planning phase	Actively participate in contributing the home health and hospice perspective on inclusion in emerging delivery models	5/2013 – 9/30/13	Identify where home health and hospice HIT solutions are seen, i.e. use of Direct in care transitions. How home health and hospice be included in ACO and HH models
Maine Association of Substance	MASA represents substance abuse providers in the state.	Behavioral health associations will be represented on the	Participate in developing strategies for inclusion of substance abuse services as a	5/2013 – 9/30/13	Identify specific roles and responsibities of substance abuse

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Abuse (MASA)	These providers will be included in the SIM behavioral health strategy.	Steering Committee and will also be asked to contribute to development of the operational plan	standard within the health home models and where providers can participate in the ACO models under consideration.		providers on the advanced primary care team. Identify workforce issues and recommendations on how to address. Outline training and development issues.
Maine Network for Health	A quality improvement organization providing training and support to providers in northern and north central Maine.	Maine Network for Health will be asked to participate and contribute during the operational planning phase	Contribute to how the organization can contribute to QI efforts of practices and providers in Northern portions of the state.	5/2013 – 9/30/13	Practice supports that could be provided to resources in the northern portions of the state
Maine Public Health Association	An association and advocacy group of public health professionals and organizations that focus on public health issues and organize actions to address priority issues.	Maine Public Health Association will be asked to participate and contribute during the operational planning phase	Contribute ideas on how public health resources in non-state organizations can contribute to the SIM plan	5/2013 – 9/30/13	Public health recommendations on integration of non-state resources from organizations like ALA, American Heart Association, etc.
Martin's Point Healthcare	A statewide Medicare Advantage plan that is also focused on quality and community care issues	Martin's Point Healthcare will be asked to participate and contribute during the operational planning phase	Contributes to the discussion and plan on the role Medicare Advantage plans will have in the delivery and payment reform work.	5/2013 – 9/30/13	Strategies that include Medicare Advantage plans in deployment of delivery and payment reform work.
Northeast Quality Healthcare Foundation	The QIO for Maine, NH, and Vermont provides data to the MHMC for quality reporting and	NEQF president, Robert Aurellio will be invited to SIM planning and	Provide input into quality reporting and coordinate around provider and system reports	7/1/2013 – 9/30/13	Quality reporting input. Alignment of initiatives to avoid any duplication and

(QIO)	supports the public reporting activities of the 'Coalition	operational activities through the MHMC			overlap of work effort.

Roles and Responsibilities KEY:

a. Governance, management structure and decision making, public-private coordination and accountability of models being implemented;
b. Coordination with other CMS, HHS, Federal or local initiatives
c. Beneficiary outreach and recruitment as necessary for approved cooperative agreement purposes;
d. Information systems and data collection set-up;
e. Alignment of State HIT plans and existing HIT infrastructure with specific milestones in SIM model;
f. Enrollment eligibility and disenrollment processes;
g. Program intervention, implementation, and delivery;
h. Participant retention process, as necessary for approved cooperative agreement purposes;
i. Quality, financial, and health goals and performance measurement plan including alignment of measures across payers, reporting infrastructure and resources to ensure performance feedback drives improvement within health care settings;
j. Appropriate consideration for privacy and confidentiality;
k. Staff recruitment and training;
l. Workforce capacity monitoring;
m. Care transformation plans including resources for practice transformation, care process redesign, and integration of performance and other health information into care process improvement.
n. Sustainability plans, including for all proposed behavioral and population health management programs;
o. Administrative systems and reporting (cooperative agreement oversight, financial reporting and monitoring, data collection, and reporting);
p. Timeline for implementation and milestones for achieving beneficiary participation and other metrics included in the Recipient's application;
q. Communications management plan;
r. Evaluation plan that clearly describes a strategy for meeting all of the data requirements and program evaluation elements outlined below in "Model Test Evaluation";
s. Fraud and abuse prevention, detection, and correction (including a strategy to ensure that there is no potential for fraud and abuse between providers that may develop a new financial relationship under the new model(s)); and
t. Risk mitigation strategies.

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State Innovation Model (SIM)

June 2013

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Presentation Overview

- State Innovation Model (SIM) Introduction
- Existing MaineCare Initiatives
- SIM In Depth

For more information, please visit: www.maine.gov/sim

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SIM Overview

"…to test whether new payment and service delivery models will produce superior results when implemented in the context of a state-sponsored State Health Care Innovation Plan. These plans must improve health, improve health care, and lower costs for a state's citizens through a sustainable model of multi-payer payment and delivery reform, and must be dedicated to delivering the right care at the right time in the right setting."

Overarching High-Level View of Maine's SIM Grant

This grant will ultimately position Maine to assess the full opportunity impact associated with existing healthcare delivery test reform models by moving the test models to the next level through:

- Enhanced care delivery capabilities
- Greater access to high-value care information and data
- Enhanced care delivery "actor" (provider and patient) training / support
- Introduction of targeted incentives

Existing MaineCare Initiatives

The existing healthcare delivery test reform models include MaineCare's:

- Emergency Department initiative
- Health Homes
- Accountable Communities

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Emergency Department Initiative

- Identifying high-cost utilizers of hospital Emergency Departments and intensifying the efforts to manage their care
- Providing services in the most appropriate, cost-effective manner
- Establishing solid relationships with primary care providers and improving patient outcomes
- ED Project achieved a total savings of $4.151M in FY12 compared to FY11
- Estimated savings to-date in FY13 increased approximately $81,004 over FY12
- Total savings for FY13 are projected to be about $4.2M

Maine Health Homes

Stage A:

- Health Home = Medical Home primary care practice + CCT
- Currently have 150 enrolled practices and 10 CCTs
- Payment weighted toward medical home
- Eligible Members:
  - Two or more chronic conditions
  - One chronic condition and at risk for another

Stage B:

- Health Homes = CCT with behavioral health expertise + primary care practice
- Payment weighted toward CCT
- Eligible Members:
  - Adults with Serious Mental Illness
  - Children with Serious Emotional Disturbance

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Maine Health Homes – Stage B

•Release of Request for Information (RFI) •Meetings w/ consumer organizations to facilitate RFI comment •Review/incorporation of written RFI comments and feedback •Public report out on key RFI issues and recommendations	April/May
State Plan Amendment	July 2013
Provider Application Process	July/August
Implementation	Fall 2013
Evaluation	Ongoing

Accountable Communities

An entity responsible for population's health and health costs that is:

- Provider-owned and driven
- Possesses a strong consumer component and community collaboration
- Includes shared accountability for both cost and quality

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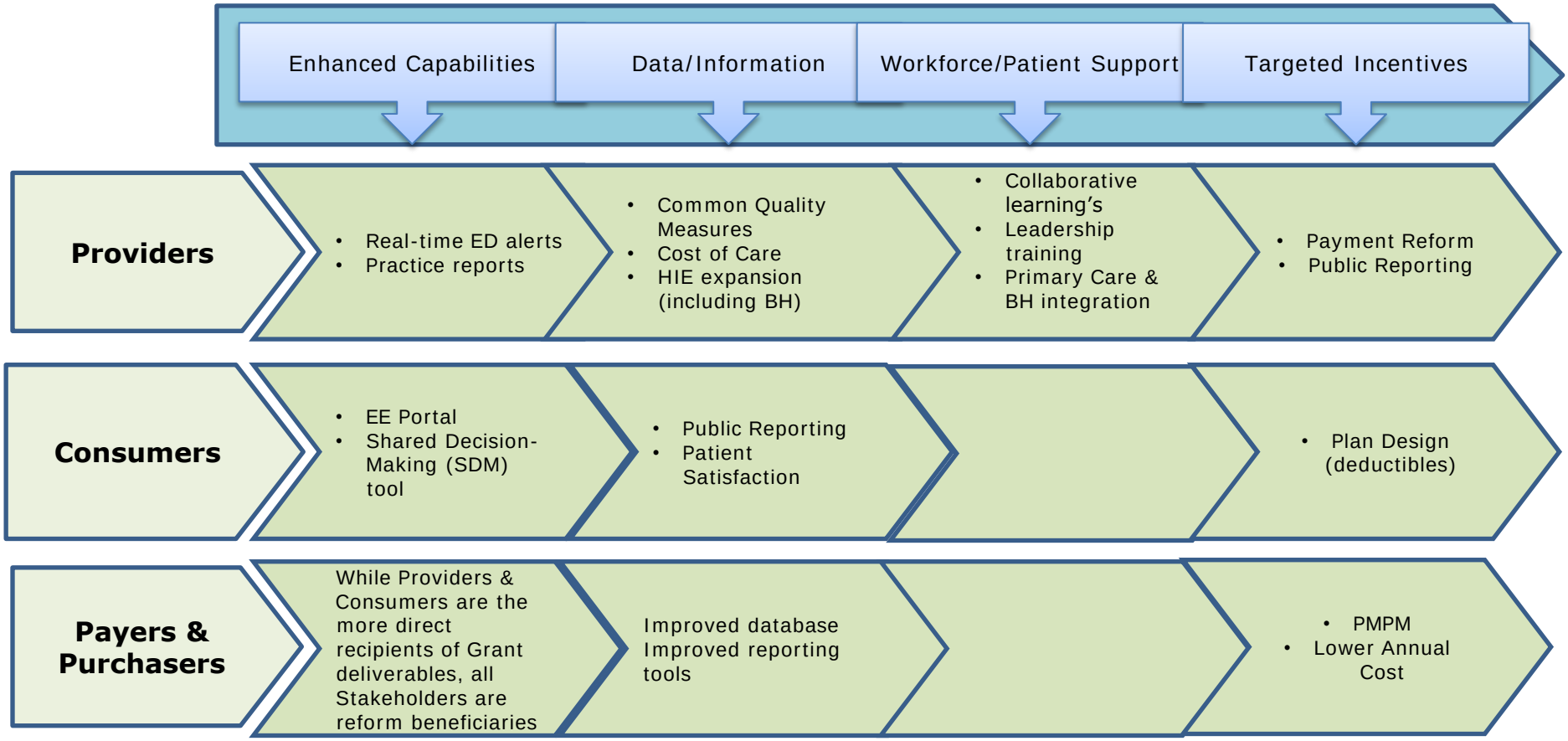
Maine's Accountable Communities: The Basic Components

- Providers will work together and propose an alternative contract to share in any savings achieved
- The amount of shared savings will depend on achieving quality benchmarks
- Open to any willing and qualified providers statewide (through an application process)
- Accountable Communities are not limited by geographical area
- Members retain choice of providers
- Alignment with aspects of other emerging Accountable Community Organizations (ACOs) is desired
- Flexible design encourages innovation

SIM's Enhancements to Test Models



Areas of Investment / Provider Benefits

Patient Accountability

- Resources for shared decision making
- Assistance with patient incentives, benefit design

Data Analytics

- EHR for behavioral health organizations
- Connection to Health Information Exchange
- Resources for other data analytic needs

Transformation Support

- Leadership training
- Practice transformation learning collaborative
- ACO learning collaborative

Payment Reform

- Greater consistency and alignment across payers/ initiatives
- Potential for grant-funded performance-based shared savings payments

SIM Key Partners

- Maine Health Management Coalition
  - Payment reform, reporting and transparency
- Quality Counts!
  - Workforce readiness and support
- HealthInfoNet
  - Clinical data and transparency

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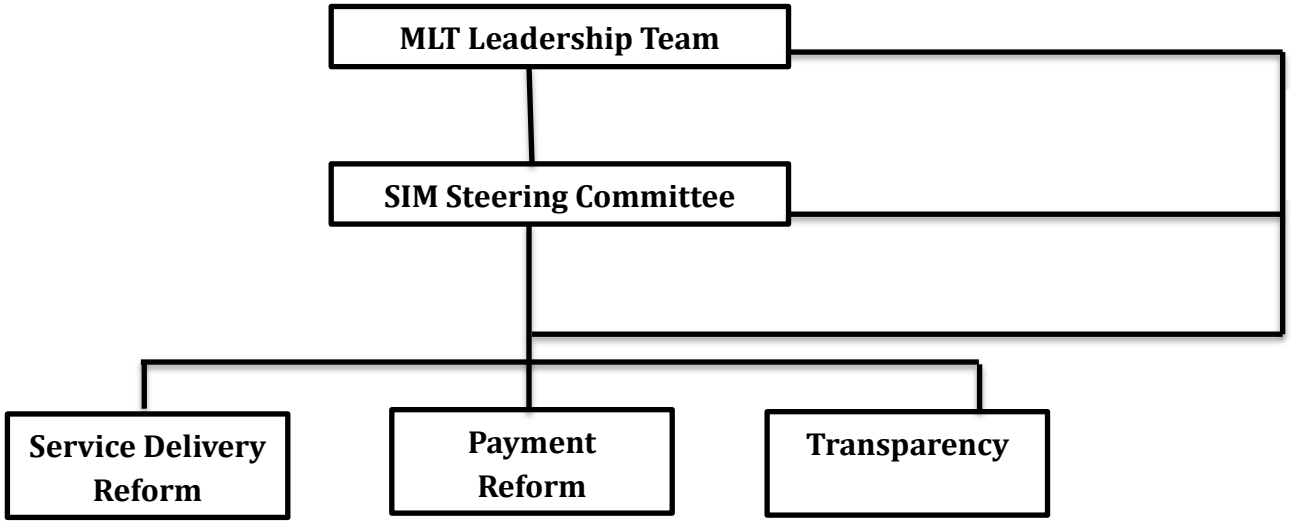
SIM Governance Structure



Executive Leadership Team

- Responsible for approval of changes to budget and scope of work.
- Accountable to fulfilling grant reporting requirements to CMMI.
- Final arbiter on escalated issues impacting scope, cost or timeline, as well as on unresolved issues among Steering Committee.
- Membership will be appointed by Commissioner of DHHS and will be comprised of State of Maine leadership from various departments.

Steering Committee

- Represents a cross-stakeholder/partner leadership group responsible for grant execution oversight and alignment of effort toward grant objectives.

- Responsible for:
  - Maintaining a consistent understanding of status of grant activity as it compares to overall plan
  - Removing barriers impeding progress and providing direction on course correction, when needed
  - Ensuring working groups focus/efforts maintain alignment with overall grant objectives
  - Approving recommendations from working groups

Steering Committee Workgroups

- Three major workgroups include:
  - Transparency
  - Payment Reform
  - Service Delivery Reform

- The workgroups:
  - Are responsible for planning and execution/delivery of specific grant deliverables
  - Leverage insights from stakeholders to help achieve stated goals
  - Identify and create awareness of dependencies and cross workgroup collaboration needs
  - Propose what escalated issues should be brought to the Steering Committee and provide recommended resolution
  - Support Program Manager and provide workgroup-level plans to inform the development and management of an overall integrated plan

Immediate Next Steps / Key Milestones

- Steering Committee kick-off meeting planned for June 19th.
- Steering Committee meetings held the first and third Wednesday of the month through October 2013 (monthly meetings, thereafter).
- Operational Plan submitted to CMMI by August 1, 2013.

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Communication Plan

- Updates provided via MaineCare listserv
- Documents and other important updates available at: www.maine.gov/sim
- For more information, please contact Randal Chenard, Program Manager: Randal.Chenard@maine.gov

MaineCare

CMMI State Innovation Model Grant

Health & Human Services

March 13, 2013

CMMI State Innovation Models

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"…to test whether new payment and service delivery models will produce superior results when implemented in the context of a state-sponsored State Health Care Innovation Plan. These plans must improve health, improve health care, and lower costs for a state's citizens through a sustainable model of multi-payer payment and delivery reform, and must be dedicated to delivering the right care at the right time in the right setting."

- Goal: lower costs for Medicare, Medicaid, and CHIP
- Rationale: Governor-sponsored, multi-payer models.. set in the context of broader state innovation → sustainable delivery system transformation
- Emphasis: in addition to ACOs and medical homes, should include community-based interventions to improve population health, with a focus on behavioral health

Grant Overview

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- Maine was one of only six states to receive a combined total of over $250 million to implement their State Health Care Innovation Plans, designed to use all of the levers available to them to transform the health care delivery system through multi-payer payment reform and other state-led initiatives.

- **Maine's Grant amount**: $33 million
- **Grant timeline**: 6 months of pre-implementation beginning April 1, followed by a 3-year testing period
- **Grant recipients**: The Governor's Office, in partnership with Maine DHHS and MaineCare
- **Grant partners**: Maine Health Management Coalition, HealthInfoNet, Maine Quality Counts

Maine's Innovation Model

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Leverage the state's investment in the Maine multi-payer Patient Centered Medical Home Pilot and MaineCare Health Homes Initiatives to form multi-payer Accountable Care Organizations that commit to:

- Tying payment to achievement of cost and quality benchmarks
- Public reporting of common quality benchmarks

The SIM Project builds off the very strong work in Value-based Purchasing under MaineCare and across the State's private sector

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Engaged Communities	•Public Health •Community Paramedicine •Universities/ Community Colleges •Long term care •Community-based consumer engagement
Accountable Care Organizations	•Providers accountable for cost and quality of assigned population •Transition to greater accountability over time
Community Care Teams	•'Hot Spotting' High Needs Patients •Care Coordination •Social and Community Support
Patient Centered Medical Home	•Care Management •Clinical/Claims Data for Population Health Management •Integrated Behavioral Health •Shared Decision Making

How will patients benefit?

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- All patients will benefit from primary care practices where:
  - The wait for appointments is shorter
  - It's easier to get seen for urgent care
  - Doctors and other medical staff coordinate with other medical providers to make sure everyone is on the same page regarding diagnoses, prescriptions, and treatment plans.
- Tools to help them better manage their own health.
- Connections with community resources, such as heating and housing assistance
- Community health workers will help them navigate the healthcare system and create their own paths to improved health.
- Adults and children with developmental disabilities and autism spectrum disorders will benefit from practices and doctors that have been trained to better meet their needs.
- Patients receiving community behavioral health services will benefit from direct service workers who understand the importance of assuring both physical and behavioral health needs are taken into consideration.

How will providers benefit?

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- Payment reform will enable providers to spend more time with patients and focus on providing quality, coordinated care. Reforms may include:
  - Shared savings, based on performance
  - Share financial risk with employers based on their ability to meet cost and quality goals.
  - Monthly payments to support patient-centered care practices that are not reimbursable through traditional fee for service payment.
- Greater consistency across payers in terms reporting requirements and payment changes. Providers can then focus on care for all patients regardless of payer.
- Behavioral health providers will have access to share, where appropriate, both behavioral and physical health information through electronic health records.
- Care management staff will receive real-time notification for when their highest-utilizing patients use the ED or are admitted to or discharged from the hospital.
- Providers will learn from each other and from national experts on how to best coordinate and provide high quality, lower cost care for all patients, including those with serious mental illness.

How will the SIM project achieve cost containment and quality goals?

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- Leverages purchasing power of the larger health care market. It aligns goals, measures, and payment and delivery reform across Medicare, Medicaid, and private purchasers.
- Provides us with statewide analysis of all payers that will allow us to see how a change in one area of the system impacts the system as a whole.
- Enhance the patient experience and brings a level of accountability across the system.
- Moves more and more payers and employers toward the connection between payment and accountability for cost and quality outcomes, which will result in better care for less cost for all patients, regardless of their insurance.

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives
Paul R. LePage, Governor — Mary C. Mayhew, Commissioner

SIM Steering Committee

Wednesday, June 19, 2013
10:00 a.m. – 12:00 p.m.

Attendance:
Noah Nesin, MD
Kristine Ossenfort, Anthem
Rebecca Ryder, Franklin Memorial Health
Rhonda Selvin, APRN
Penny Townsend, Wellness Manager, Cianbro
Deb Wigand, DHHS – Maine CDC
Jay Yoe, PhD, DHHS – Continuous Quality Improvement
Shaun Alfreds, COO, HIN
Randy Chenard, SIM Program Director
Eric Cioppa, Superintendent, Bureau of Insurance
Jack Comart, Maine Equal Justice Partners
Michael Delorenzo, Interim CEO, MHMC
Lynn Duby, CEO, Crisis and Counseling Centers
Dr. Kevin Flanigan, Medical Director, DHHS
Dale Hamilton, Executive Director, Community Health and Counseling Services
Katie Fullam-Harris, VP, Gov. and Emp. Relations, MaineHealth
Frances Jensen, MD, CMMI, Project Officer
Lisa Letourneau, MD, Maine Quality Counts
Stefanie Nadeau, Director, Office of MaineCare Services
Other Attendees:
Jim Leonard, Deputy Director, Office of MaineCare Services
Vanessa Santorelli
Katie Sendze – Health Info Net

DRAFT

Agenda	Discussion/Decisions	Next Steps
Opening Comments from Commissioner	Discussed the SIM grant and how it is built on a solid foundation. We need to be sure that the SIM remains focused on fewer, key deliverables and prevent it from being mired in complexity. There will be early focus on determining what those key deliverables are, and the metrics associated with the tracking of those deliverables. What are the proper 'low hanging fruit' metrics that SIM can focus on to determine the effectiveness of the healthcare innovation that is already occurring in the State?	
Dr. Flanigan Key Comments	Role as Chairman: Ensure that discussion is all inclusive and collaborative, order will be maintained and all who wish to speak will be able to do so. Collaboration is a key them for the Steering Committee and for the execution of the SIM grant in general. Consensus: Expectation is that the Steering Committee will make decisions by consensus versus majority rule. Dr. Flanigan will facilitate consensus decision making processes.	
Meeting Schedules	Decision that the 2nd and 4th Wednesdays of each month will be scheduled for Steering Committee meetings, with the times being 10-12. The next meeting will be on 7/10, followed by 7/24. At the 7/10 meeting, we will provide a partial draft for the Operational Plan that is being developed. The required submission time for the plan to CMMI is 8/1. The Operational Plan will still be a work in progress when the draft is provided on 7/10, but it is important to provide what is complete at this time so that the Steering Committee can begin to review. A final draft will be provided to the Steering Committee for the meeting on 7/24 for review and approval to meet the required 8/1 deadline. ***Timeframes are very tight for this submission so we appreciate the Steering Committee's focus on the Operational Plan review*** Steering Committee By-Laws were also distributed to the SC and we plan to ratify these at the 7/10 meeting	Partial draft Operation Plan will be reviewed at the 7/10/13 meeting By-Laws will be ratified at the 7/10/13 meeting.

Agenda	Discussion/Decisions	Next Steps
Future Topics/Meeting Agendas	Once SIM work commences, we will have regular reviews/status provided to the Steering Committee from each workgroup. Items that require 'escalation' from the workgroups will be presented to the Steering Committee as needed. The SC can expect the issues to be clearly articulated with clear options presented and recommendations for Steering Committee decisions. Expectation is that the Steering Committee reaches consensus on the overwhelming majority of escalated items, preventing the need for further escalation to the Maine State Leadership team. Escalation/action items will be provided ahead of SC meetings to enable time for SC members to review issues prior to discussion at SC meetings. Future Steering Committee meetings will be held in Public Hearing Rooms vs. DHHS meeting rooms.	
Questions	A question was raised regarding a lack of representation from the Long Term Care community on the Steering Committee. Consensus from the SC was that this should be addressed and commitment made to add this representation. How will stakeholders be notified of Steering Committee discussion? Intent will be to distribute meeting minutes to Steering Committee, and SC members will socialize topics as required/desired through the communities that they represent. In addition, an interested party list will be developed and maintained and notes/minutes and other relevant materials will be distributed through that list as well. All Steering Committee meeting materials, meeting minutes and other information will also be published on the Maine.Gov DHHS website. Will Public Comment be allowed at SC meeting? Yes, there will be time reserved for public comment at every Steering Committee meeting. Do we have a list of SIM deliverables yet? No, that is being compiled as part of the Operational Plan and will be distributed to the Steering Committee for review in July.	

DRAFT

Section B: Coordination Among Initiatives

Refer to DRR Section B: Coordination with Other CMS, HHS, and Federal or Local Initiatives

B1) Figure: Coordination & Workplan Monitoring Process

B2) Figure: Overlap of Fed & State Initiatives in Maine

B3) ACI Committee Agendas and Minutes (various)

B4) Executive Summit Documents, E-mails Supporting Cooperation (various)

B5) PCMH Committee Meeting Documents (various)

B6) Evidence of Coordination (E-mail Correspondence)

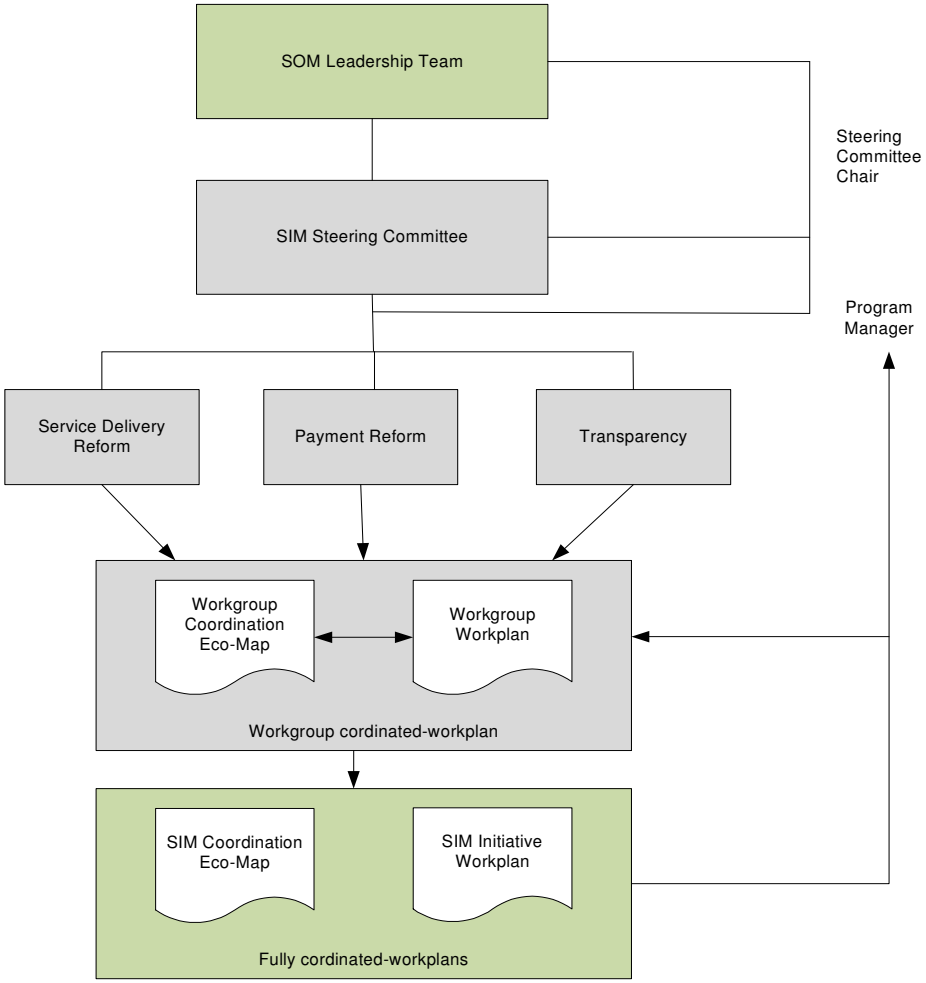
B7) Approved SPA ME 12-004 (1) (See Appendix G12)

B8) Approved SPA ME 12-004 (2) (See Appendix G13)

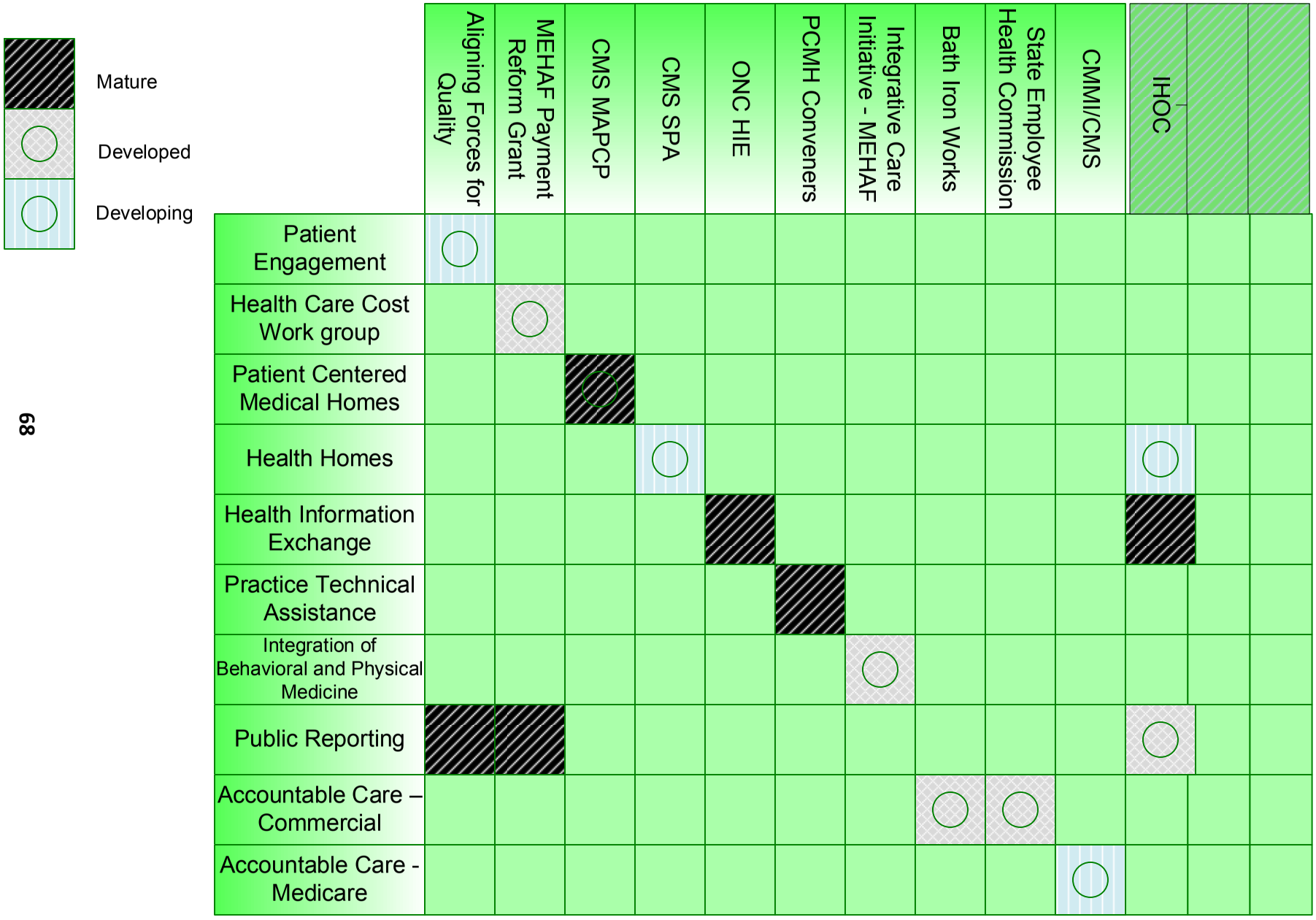
GRAPHIC

Coordination and Workplan Monitoring Process

State Innovation Model
Initiative Coordination and
Workplan Monitoring Process



Initiatives in Maine and Overlap of Strategies With SIM



Accountable Care Implementation Group
July 21, 2011
3PM-5PM
Hilton Garden Inn
Freeport

1.) Welcome and Introductions (5 minutes)

2.) The Accountable Care Implementation Group- Context, Goals, and How We Got Here- (15 minutes) Elizabeth Mitchell

3.) Primary Care Transformation within Accountable Systems of Care- (15 minutes) Lisa Letourneau, MD

4.) Identifying and Addressing Barriers to Implementation (80 minutes) Group

5.) Next Steps (5 minutes)

Maine Health Management Coalition Foundation

Maine Health Management Coalition Foundation
Accountable Care Implementation Group
DRAFT MINUTES

Participants:

Bob Mc Cue, Lois Skillings, Car Demars, J Branscombe, Steve Ryan, C Burke, Rick Morrone, M Delorenzo, Bob Downs, Rita Molloy, Lisa Letourneau, Jim Kane, Kurt Caswell, Tom Hopkins, Alexander Draghetsi, Katie Fullum Harris, Greger Vigen, Jeff Holmstrom, Tony Marple, Al Swallow, (cigna), Barbara Crowley, Frank Johnson, Harold Miller

Agenda Item Comments	Decisions	Action Items/Next Steps
1.) Elizabeth Mitchell provided a brief overview of Maine's payment reform efforts largely facilitated by MHMC. This new group will focus on those who are implementing payment reform pilots while the HAC group will still provide a high level and somewhat generic review of reform efforts . The HAC will also bring in technical expertise where the group deems appropriate. EM also discussed the need to reduce the cost of health care and move toward new mechanisms of payment.	Group agreed that we need to start demonstrating progress and that there is still value in pursuing win win win. They agreed that we need to begin to demonstrate value and create a pathway toward a broader structure of payment reform.	
2.) Lisa Letourneau, MD discussed PCMH and primary care transformation. There is currently solid support for practice transformation in the state of Maine. She reviewed the funding that they received to create and maintain PCMHS throughout the state. They are working on Cost and resource use and are in the process of distributing Practice reports and creating community health team. They will expand to an additional 20 sites.	The group agreed that Community Health Teams will play a critical role in the management of patients, especially high utilizers/high cost patients and those with chronic diseases.	

3.) The group engaged in a discussion about the barriers to implementing payment reform as well as solutions.	The group agreed to several interventions that they would all pursue as priority efforts to reduce costs in the near and medium term while working towards more comprehensive payment reform and system redesign. See attached document	These will be integrated into each local pilot site and performance will be tracked across pilots. Baseline performance, performance targets and firm timelines will be set at the next ACI meeting. Efforts will also be made to integrate with other local initiatives including the Patient Centered Medical Home multi-payer pilot.
4.) Next Meeting		The next meeting will be held on Thursday September 15th at the Hilton Garden Inn.

*You may find any handouts or presentations from this meeting at **www.mehmc.org**. Click on Member Resources and select Resource & Document Library. Scroll down to see the PTE Systems folder.*

Maine Health Management Coalition Foundation

Maine Health Management Coalition Foundation
Accountable Care Implementation Group
Minutes
February 15th 2012

Participants:

Lois Skillings,Steve Ryan, C Burke, Delorenzo, Bob Downs, Rita Molloy, Lisa Letourneau, Jim Kane, Andy Patstone, Mike Hachey Al Swallow, Mark Still, Barbara Crowley, Liz Baldwin, Jerry Cayer, Elizabeth Mahoney, Maureen Clancy, Alexander Draghetsi, Michelle Probert, Pam Beaule, Jude Neveaux, Nancy Irving,

Agenda Item Comments	**Decisions**	**Action Items/Next Steps**
1.) Elizabeth Mitchell provided a brief welcome and attendees introduced themselves.		
2.) CMMI Innovation Challenge Update •Central Maine Health Care •Franklin Community Health Network •Maine General Health •Mercy •MidCoast Hospital •Penobscot Community Health Care Sites have committed to implementing community specific interventions that include the following: (1) advanced primary care / PCMH; (2) CCTs for high risk/ high cost populations; (3) enhanced care transitions and; (4) payment reform. The **pilot sites**, their target population numbers, and projected savings over	Group agreed that data (particularly regional data) is critical to this process. While hospitals have internal data, they do not have data about where their patients may be receiving care. Attribution is critical The group agreed that there are benefit changes that need to happen to drive this	Discuss Benefit Changes with employers Establish new committee- Health Care Cost work group Group agreed that we need to collect best practices and bring them to ACI meeting Continue to challenge

three years are: (1) **Central Maine Healthcare**, an integrated health system that includes Central Maine Medical Center, two critical access hospitals, the Central Maine Heart and Vascular Institute, a 7 School of Health Professions, and affiliated long-term care facilities, clinics and practices. Five practices including an FQHC will participate, with 32,760 individuals targeted over three years. Estimated savings = $7,420,210. (2) **Franklin Community Health Network** serves 71 rural communities in 2,763 square miles between central Maine and the Canadian border. The FY 2011 payor mix included: 58.8% Medicare and 15.2% MaineCare (Medicaid). Five practices will participate, with 8,000 individuals targeted. Estimated savings = $5,712,000. (3) **MaineGeneral Health** is a medium-sized non-integrated health system in central, rural Maine. It includes MaineGeneral Medical Center, HealthReach Network, MaineGeneral Physician Practices, MaineGeneral Rehab and Nursing Care, and MaineGeneral Retirement Community. MGH is the clinical partner in an emerging multi-stakeholder ACO, and has five practices in the PCMH Pilot. Three non-PCMH practices will participate, with 4,380 individuals targeted. Estimated savings= $2,412,000. (4) **Mercy Health System of Maine (MHS)** serves a population of 250,000 in southern Maine. In 2011, MHSM delivered care to 15,520 MaineCare patients and 19,990 Medicare patients, representing 15.4% and 36.19% respectively of the payor mix. Four practices will participate with 29,000 individuals targeted. Estimated savings = $5,216,520. (5) **MidCoast Hospital** is a 92 bed independent community hospital with an active medical staff of 160 physicians in 30+ primary care and specialty areas, and is the medical partner in an emerging ACO in the Midcoast region, a key component of which is transitioning to a PCMH. Three practices will participate with 25,500 individuals targeted. Estimated savings = $4,233,000. (**6) Penobscot Community Health Care** is Maine's largest FQHC and non-hospital primary care system, serving over 50,000 patients annually through 350,000 visits in 14 clinics. Over 30 mental health	kind of change	use of diagnostics. Begin to focus on the poly pharmacy management and community formularies. Stay consumer/patient focused.

professionals are integrated into the practices. PCHC is a Maine PCMH Pilot site. Nine practices will participate with 23,569 individuals targeted. Estimated savings = $4,489,454		
3.) Data to Support Payment Reform Pilots- A Case Study (60 minutes) M. De Lorenzo • Identifying opportunities that matter	•Need to identify cost drivers as well as variations in care. • Need to identify savings opportunities and spending targets.	Health Care Cost workgroup information will be sent out to the group
4.) PTE Systems update PTE Systems timeline Total cost of care measure is being discussed at Thursday's PTE Systems meeting. Elizabeth and Ted will review the total cost of care measure that has been proposed by Health Partners		• Will send the group a summary of the PTE Systems meeting
5.) PCMH Update Conveners of the multi-payer Maine Patient Centered Medical Home (PCMH), the Dirigo Health Agency's Maine Quality Forum, Maine Quality Counts, and the Maine Health Management Coalition, announce **plans to expand the Pilot to include an additional 20 adult practices** in January 2013.		
6.) Next Meeting		May 9th at 3pm

*You may find any handouts or presentations from this meeting at **www.mehmc.org**. Click on Member Resources and select Resource & Document Library. Scroll down to see the PTE Systems folder.*

Maine Health Management Coalition Foundation

MHMC Accountable Care Implementation Steering Committee

October 10, 2012
3:00 – 5:00
Hilton Garden Inn
Freeport
Call in: 1 866 252-0050 x458756#

Agenda

1. Welcome and Introductions

2. Health Care Cost Workgroup Results (25 min)
   - Committee Roles/Relations
   - Savings Opportunities
     - HCCW
     - Physician Workgroup
     - Other

3. Pilot Updates (30 min)
   - Jackson Lab/MDI/MCMH
   - EMHS/UMS
   - State/MGH
   - Other

4. Priorities for ACI (45 min)
   - Members
   - Pilots
   - Data

5. SIM Grant (15 min)
   - MHMC Role
   - ACI/Learning Collaborative

MAINE HEALTH MANAGEMENT COALITION

Accountable Care Implementation (ACI) Meeting

November 20, 2012
3:00 to 5:00 pm.
Hilton Garden Inn, Freeport
Call in: 1 866 252-0050 x 458756
AEGNDA

1. Welcome and Introductions

2. Behavioral Health Integration from the ACO Viewpoint (60 min.)

   MaineHealth
   Central Maine Health
   MaineGeneralHealth
   Eastern Maine Health

3. MaineCare (15 min.)

4. Quality Counts (15 min.)

5. Health Plan Perspective – Anthem (15 min.)

6. Purchaser/Plan Sponsor Reaction (15 min.)

7. Next Steps

Accountable Care Implementation (ACI) Steering Committee

Meeting Minutes November 20, 2012

Attendance: Lynn Duby, Carl DeMars, Jude Neveux, Carolyn Kasabian, Michael Hachey, Jim Kane, Michelle Probert, Lisa Letourneau, Katie Fullam Harris, Eric Waters, Mary Jean Mork, Girard Robinson, Neil Korsen, Jim Harnar, Bart Beattie, Judiann Smith, Ed Kane, Matt Mulligan, Nancy Irving, Jerry Cayer, Eric Meyer, Tom Hopkins, Barbara Crowley, Barbara Leonard, Wendy Wolf, Bob Downs (phone), Larry Grab (phone), Elizabeth Mitchell (phone), Amy Deschaines, Frank Johnson.

Presentations: The MaineHealth team of Dr. Robinson, Dr. Korsen and Mary Jean Mork outlined the MaineHealth and Maine Mental Health Providers model of integrated behavioral health care. They acknowledged the support of a MeHAF grant to initiate tis project. Journal articles citing the prevalence of behavioral health is among patients with chronic conditions were identified as were studies revealing improved clinical outcomes, patient experience of care and cost effectiveness. A schematic, demonstrating the links between primary and specialty mental health care, was presented (see attached MaineHealth presentation).

Michelle Probert shared the MaineCare Accountable Communities components and requirements. It was noted that the requirements include the coordination with specialty providers, including behavioral health "core" services must include mental health, and substance abuse. Michelle further noted that CMS Health Homes require inclusion of selected chronic conditions such as mental health and substance abuse. MaineCare, through its involvement with the multi-payer patient-centered medical home pilot, is making a concerted effort to align with commercial payers.

Due to time constraints Barbara Crowley of MaineGeneral Health (see slides 17-21 of attached MGH powerpoint) and Jim Kane of Central Maine Health offered brief overviews of the integration efforts of their respective systems. Jim Kane, in particular, noted the challenges of sustainability.

Larry Grab, Director of Behavioral Health Services, at Anthem joined the group by phone. Despite some technical challenges with the phone, Larry was able to discuss a series of slides (see attached) outlining the Anthem experience. Because of the prevalence of behavioral health issues among patients with chronic conditions there is a compelling payer argument that integrated care can strengthen patient-provider relationships, improve outcomes and control costs. The central component of the Anthem model is to incentivize primary care through opening billing codes and integrating the coding for behavioral health services. Larry noted that timely credentialing behavioral health providers has presented a challenge. MaineHealth offered a testimonial for Anthem's efforts to expedite credentialing. Finally, Larry shared some very early results indicating a net decline in overall health care costs.

Lisa Letounreau of Quality Counts briefed the group on the work of the Quality Counts Behavioral Health Committee and the challenges from the behavioral health providers' perspective. In a rapidly evolving environment of delivery system change, revisions to the payment system are generally not keeping pace. Further, Lisa acknowledged the difficulty of integrating care for patients with severe behavioral health issues requiring more intense services from mental health specialists beyond the behavioral health services provided at the primary care setting.

A planned reaction panel from purchasers was deferred because of time and the absence of a representative group of purchasers.

Other items/announcements: Frank Johnson introduced Amy Deschaines of the MHMC who will be working with the ACI group on consumer/patient engagement. Frank mentioned that in response to the Health Care Cost Workgroup, a smaller work group is planned to address behavioral health integration. It is intended that this group will be comprised of ACI members, Quality Counts and other organizations invested in BH integration.

ACI meetings for 2013 will be scheduled for the third Tuesday of every other month beginning January 15th. A schedule of the 2013 meetings will be forwarded once the meeting location has been confirmed,

Accountable Care Implementation (ACI)

Meeting Agenda

January 15, 2013
3:00 to 5:00 pm
Hilton Garden Inn, Freeport

Call in: 1-866-252-0050 X 458756#

I.	Introductions	10 Minutes
II.	Update and Overview	20 Minutes
III.	Presentation and Discussion with Anthem	40 Minutes
IV.	Presentation and Discussion with Aetna	40 Minutes
V.	Wrap up and plans for 2013	10 Minutes

ACI Meeting Attendance

January 13, 2013

Bruce Wagner, Mercy
Jim Kane, CMMC
Eric Waters, Pen Bay Healthcare
Mark Still, Cigna
Pat Denning, HPHC
Bob Downs, Aetna
Pamela Beaule, St. Mary's
Liz Rogers, USM grad student
Barbara Crowley, MGH
Bob McCue, Mid Coast
Carl DeMars, Mid Coast
Laurie Williamson, State of Maine
Louise McCleery, Aetna
Barbara Leonard, MeHAF
Eileen Skinner, Mercy
Colin McHugh, Anthem
Mike Burton, Anthem
Elizabeth Mitchell, MHMC
Amy Deshaines, MHMC
Frank Johnson, MHMC

April 22, 2013

Bruce Wagner, Mercy
Jim Kane, CMMC
Katie Fullam Harris, MaineHealth
Jennifer Reck, MMA
Peter Wood, MMC PHO
Pamela Beaule, St. Mary's
Lisa Letourneau, Quality Counts
Judiann Smith, Spurwink
Laurie Williamson, State of Maine
Stephanie Nadeau, DHHS
Kitty Purington, DHHS
Chris McCarthy, BIW
Carl DeMars, Mid Coast
Amy Deshanies, MHMC
Frank Johnson, MHMC

May 21, 2013

Mary Wallen, HPHC
Patrick Denning, HPHC
Richard Perry, HPHC
Tony Fournier, HPHC
Carl DeMars, Mid Coast
Steve Ryan, MNH

Christine Worthen, EMHS
Pamela Beaule, St. Mary's
Judiann Smith, Spurwink
Barbara Crowley, MGH
Bruce Wagner, Mercy
Dr. Tom Claffey, InterMed
Libby Collet, InterMed
Dan McCormack, InterMed
Michael DeLorenzo, MHMC
Frank Johnson, MHMC

Accountable Care Implementation (ACI)

Meeting Agenda

April 22, 2013
3:00 to 5:00

Hilton Garden Inn, Freeport

Call in: 1-866-252-0050 passcode 458756#

I. **Introductions**

II. **SIM Grant overview – Stefanie Nadeau, Director Office of MaineCare Services**

III. **SIM Grant MHMC role – Elizabeth Mitchell, CEO Network for Regional Healthcare Improvement**

IV. **Re-visit original ACI role and plans to revise/expand to meet SIM expectations**

V. **Wrap-up**

Accountable Care Implementation (ACI) Steering Committee

Meeting Agenda

May 21, 2013
3:00 – 5:00

Hilton Garden Inn, Freeport

Call-in: 1-866-252-0050 passcode 458756#

I. **Introductions**

II. **The InterMed model – Dr. Thomas Claffey, Dan McCormack, Libby Collet – presentation and Q&A**

III. **Harvard Pilgrim Health Care – Dr. Richard Perry, Patrick Denning – presentation and Q&A**

IV. **Planning work to adapt ACI to align with SIM award role**

V. **Wrap-up**

Accountable Care Implementation (ACI) Steering Committee

Meeting Agenda

July 16, 2013
3:00 to 5:00 pm

Hilton Garden Inn, Freeport

Call-in: 1-866-252-0050, 458756#

I. Introductions

II. Recap ACI's role in SIM project – advancing measurement and payment alignment

III. Payment Reform Metrics developed by the Center for Healthcare Quality and Payment Reform (CHQPR) and the Network for Regional Healthcare Improvement (NRHI)

IV. Strategies for alignment with commercial, MaineCare and Medicare payment reform initiatives – what can we learn from Medicare shared savings and Pioneer projects and how do we engage Medicare in payment alignment efforts

V. Striking the balance between provider/payer innovation and system measures that facilitate peer comparisons

VI. Short-term objectives: identify modest reimbursement models to demonstrate improvements in care and reductions in cost linked to quality/utilization measures; establish work group to recommend a common set of system performance measures.

VII. Schedule and location of ACI meetings for remainder of 2013 and 2014

VIII. Wrap-up

2nd Executive Summit: Proposed Agenda

8:30 Welcome and Introductions –
Elizabeth Mitchell

8:40 Context, Goals and Purpose of Meeting
Steve Gove and David Howes, MD
- Understand the opportunities and challenges
- Concerns and objections to be addressed
- Set a target and timeline for action

9:00 Results of Health Care Cost Workgroup: Savings Opportunities
Michael DeLorenzo, PhD and Harold Miller

9:30 Options for Action: Stakeholder Roles
Harold Miller: Facilitated Discussion
- Global payment v. Managed fee for service
- Transition time and milestones
- 'Centralized' initiatives and Regional leadership pilots

10:00 Setting the Goal- What are the Implications?
George Eaton: Facilitated Discussion
- Review community scenarios for change
- Stakeholder impact

11:00 Break

11:15 Who, What, When and How Will We Get There?
George Eaton: Facilitated Discussion
- Mapping stakeholder roles
- Community engagement
- Timeline and Measures of Success

12:15 – Next Steps
Elizabeth Mitchell, George Eaton and Steve Gove

12:30- Adjourn

Date and Location
September 5, 2012: 8:30am-12:30pm
Maple Hill Farm

Invitees:
MHMC Member CEOs/COOs
MHMC Member Board Representatives
Other Stakeholders as appropriate

Facilitator:
George Eaton

DRAFT

First Name	Last Name	Title	Organization
Jud	Knox	CEO	York Hospital
William	Caron	CEO	MaineHealth
Chancellor Rich	Pattenaude		UMS
Christopher	Lockwood	Exec Director	ME Municipal Employees Health Trust
Lee	Myles	CEO/President	St. Mary's Health System
Eileen	Skinner	President	Mercy Hospital
Joanne	Abate	Director, Health & Wellness	Delhaize America
Nancy	Kelleher	Associate Director	AARP
Meredith	Tipton, PhD, MPH		AARP Board Representative
Mary	Mayhew	Commissioner	ME Dept Health & Human Services
Mike	Miles	Director of Human Resources	City of Portland
David	Howes	President	Martins Point Health Care
Frank	Johnson	Executive Director	Maine State Employees Health Insurance Program
Lois	Skillings	President/CEO	Mid Coast Hospital
Scott	Bullock		Maine General
John	Benoit	President	Employee Benefits Solutions
Rick	Morrone	Director of Benefits	Employee Benefits Solutions
Roy	Hitchings	CEO	Penobscot Bay Medical Center
Cathryn	Longley	CEO	Bowdoin
Bob	Peixotto	COO	LL Bean
Mark	Cook	Senior Manager, Benefits	LL Bean
David	Tassoni	VP Operations	Athena Health
Cindy	Brewer	HR	Bangor Hydro
John	Condon	Owner	Acadia Benefits
Dora	Mills	President	UNE
Robert	Peixotto	Sr. VP COO	LL Bean
Robert	McCue		Mid Coast Hospital
Erik	Steele		Eastern Maine Healthcare System
Eric	Watters	COO	Penobscot Bay Medical Center
Colin	McCue	VP Contracting	Anthem
Daniel	Corcoaran	President	Anthem
Daniel	McGarvey	CFO	MEMIC
Diane	Barnes	Chair, Board of Trustees	ME Municipal Employees Health Trust
John	Condon		Acadia Benefits
Sara	Burns	CEO	CMP
Doug	McKeown		Woodard & Curran
Susan	Dubuque		Woodard & Curran
Dan	Roet		Bath Iron Works
Al	Swallow	Associate V.P. Finance	Maine Medical Center
Catherine	Lamson	Sr. VP, Chief Admin. Officer	MEMIC
Vicki	Mann	CFO	Barber Foods
Tom	Hopkins		UMS
Janice	Kimball		City of Portland
Katie	Harris	Sr. Director of Government & Employer Relati	MaineHealth
Steve	Gove	Deputy Director	ME Municipal Employees Health Trust
Barbara	Crowley	Executive V.P.	MaineGeneral
Steve	Ryan	President/CEO	Maine Network for Health
Chris	McCarthy	Manager	Bath Iron Works
Robert	Downs	Senior Manger	Aetna
Wayne	Gregersen		The Jackson Laboratory
Chris	Lockwood		ME Municipal Employees Health Trust
Mark	Rees	Manager	City of Portland
Elizabeth	Mitchell		Maine Health Management Coalition
Blake	Hendrickson		Maine Health Management Coalition
Tricia	Johnson		Maine Health Management Coalition
Angus	King		

TWO PATHS TO PAYMENT AND DELIVERY REFORM IN MAINE

I. Global Payment for Population Care

- A provider organization (a physician group, IPA, PHO, or health system) would agree to provide coordinated health care services for all of a purchaser's employees or members who chose a primary care provider (physician, nurse practitioner, health clinic, etc.) who is part of that organization. Such a provider organization will be referred to as a "coordinated care organization," or CCO.
- The purchaser and the CCO would jointly agree on a per person budget for the purchaser's employees/members for the following year. This budget would be based on four factors:
  - An estimate of **current per person spending**, based on the total actual per member costs for the purchaser from the most recent 12 months of claims data available (the "base year") calculated by an independent source, such as the Maine Health Management Coalition. This would serve as a baseline for computing the subsequent year's budget.
  - The **estimated reduction in the total per member costs that could be achieved**; this would be estimated in one or both of two ways:
    1) Estimating the savings from implementing a specific set of initiatives to redesign healthcare services that the purchaser and CCO agree on. The savings from the care changes would be estimated using the most recent 12 months of data available. There would be no obligation on the part of the CCO to implement the specific changes discussed, but the purchaser would expect that the estimated savings would be achieved regardless of what care changes the CCO puts in place or how effective they are.
    2) Comparing the current total per member costs to a risk-adjusted benchmark and estimating the proportion of the difference that could be achieved in the next year.
  - The **estimated increase in unit costs of specific services**. The CCO would provide documentation justifying any increase in the unit costs of particular services beyond the general consumer price index. This could include analyses of the fixed versus variable costs associated with hospital services and the change in unit costs associated with expected reductions in the volume of certain services from the initiatives described above.
  - The **impact of any changes in the purchaser's benefits** for its employees/members (e.g., a change in the services covered or a change in cost-sharing for covered services).
- Instead of agreeing only on a budget for the following year, the purchaser and the CCO could agree on a multi-year budget, with savings phased in over time.
- The purchaser and the CCO would also agree on:
  - a **methodology for risk adjustment**, i.e., a way to determine whether an increase or decrease in expenditures was reasonably associated with changes in the health status of employees beyond the short-term control of the CCO.
  - **risk exclusions**, i.e., types of costs or utilization that are beyond the reasonable ability of the CCO to control, e.g., the amount charged by a specialized center in a distant city that treats a condition in a way that is covered by the employee/member's benefits.

  - **risk limits**, e.g., a maximum amount of spending for an individual patient that would be covered by the budget; spending beyond this amount would justify an increase in the budget.
  - a set of **quality standards/goals** that the CCO would achieve. Failure to achieve these goals would result in defined cost penalties (e.g., a reduction in the budget amount).
  - **adjustments in benefits** needed to support the proposed initiatives to reduce costs.

- The purchaser would **require the employee/member to select a primary care provider** and use that primary care provider for primary care services, but would allow the employee/member to change primary care providers at any time. The CCO would only be accountable for the costs of services for patients who chose a primary care provider associated with the CCO.
- The purchaser would not be expected to place any other restrictions on the employee/member beyond what was otherwise included in the purchaser's current benefit design unless the purchaser and CCO agreed they were needed. For example, the CCO might ask that cost-sharing for specific types of services be changed in order to discourage employees/members from using high-cost providers or services which are not part of the CCO.
- The CCO would be permitted to bill the purchaser's Third Party Administrator (TPA) for **additional service codes** that represented desirable types of care that are not otherwise billable or require higher payments than currently authorized. For example, the CCO could bill for phone calls between physicians and patients or for nurse care managers who work with chronic disease patients.
- The CCO would receive **monthly reports** from the purchaser's Third Party Administrator detailing the actual expenditures per member per month (PMPM) for the employees/members who selected the CCO's primary care providers, along with details on the nature of those expenditures in a format agreed upon by the CCO and the purchaser.
- At the end of year, the **total per person spending for the purchaser's employees/members who selected the CCO's primary care providers would be calculated and adjusted** in the following ways:
  - Spending on **all types of services provided to the employees/members would be included**, regardless of which provider delivered those services.
  - The spending amount would be adjusted up or down based on the ratio of the **average risk score** of the purchaser's employees/members during the year to the average risk score of the individuals on which the base year spending was calculated, in order to reflect changes in the types of health conditions and risk factors the employees/members had.
  - Any increase in expenditures in the **risk exclusion categories** beyond the amounts in the base year for those categories would be removed from the expenditure calculation.
  - Any spending on an individual patient beyond the **risk limits** would be removed from the expenditure calculation.
- If the adjusted expenditure total is below the agreed-upon budget, the CCO would receive an additional bonus payment equal to the difference. If the adjusted expenditure total exceeds the agreed-upon budget, the CCO would make a lump sum penalty payment to the purchaser equal to the difference.

II. Managed Fee for Service

- The purchaser would commission an **analysis of healthcare spending** for its employees/members in order to identify the specific types of healthcare services where it appeared that spending could be reduced based on either benchmarks from other employers or comparisons of the costs of different providers in the state.
- The purchaser would institute one or more of the following types of programs to achieve these savings:
  - For procedures and tests which (a) involve large amounts of spending, (b) are offered by multiple providers, and (c) where data analyses show that there are significant differences in the total episode costs for the procedures or tests among the providers, the purchaser would establish a **tiered cost-sharing system** that would require employees/members to pay all or part of the difference in cost between the provider that the employee/member uses and the lowest-cost provider that provides quality services in a reasonably accessible location to the employee/member. The purchaser would either:
    1) Determine the expected episode costs and quality for the procedures and tests for each provider based on a retrospective analysis of actual payments, and then group providers into tiers based on the cost and quality data, or
    2) Invite providers to submit prospective prices they would charge for the services to the employees/members of the purchaser and define the quality levels they would guarantee to achieve; those providers would be tiered on the basis of their price and quality levels, and providers which did not bid would be placed into the highest cost-share tier. Bidders could include out-of-state providers for high-cost procedures.
  - For procedures and tests which occur less frequently, making it difficult to accurately estimate and compare costs retrospectively, the purchaser would establish **tiered cost-sharing levels based on an analysis of the overall cost and quality of the provider organization** across all of the procedures, tests, and other services it performs. If a provider organization wanted the purchaser's members to have a lower cost-sharing level for a particular service that is not tiered separately, it could offer a fixed prospective price for that service to the purchaser and if the purchaser's analysis indicated that the proposed price was at or below the average cost of the service from other providers in lower cost-sharing tiers, the purchaser could agree to lower the cost-sharing amount for that service.
  - For procedures and tests which (a) involve large amounts of spending and (b) are only offered by one provider or where the procedure or test appears to be over-utilized, the purchaser would establish a **prior authorization program** to ensure that the services were being used only when necessary and to encourage use of lower-cost alternatives where appropriate.
  - The purchaser would contract with primary care practices to offer **patient-centered medical home and care coordination services** to those employees/members with chronic conditions or other health issues that cause them to have large amounts of expenditures. The purchaser would pay these practices an additional care management fee to provide the services, and would offer reduced cost-sharing levels for various types of non-primary care services to the employees/members who chose to use those practices.
- If a group of providers formed a Coordinated Care Organization and offered to provide care under a global payment arrangement to patients which selected the CCO's primary care providers, all services offered by the providers in the CCO would be assigned to lower cost-sharing tiers, and all prior authorization systems would be removed.

December 2011

The Maine Health Management Coalition Foundation convened its first Executive Summit on November 2, 2011. Over 50 senior executives from hospitals and health systems, public and private employers, health plans and community organizations participated to identify short, medium and long term strategies and goals to improve the value of Maine healthcare. (attendee list attached)

Please note that the recommendations and proposals included in this draft do NOT reflect formal decisions. Consensus varied on each recommendation. Next steps will include further examination of each proposal to be considered and voted on by the group before release of a consensus document.

I. How We Got Here

The MHMC is a purchaser-led partnership among multiple stakeholders working collaboratively to maximize improvement in the value of healthcare services delivered to MHMC members' employees and dependents. The members of the Coalition – over 60 public and private employers, unions, providers and health plans- have worked collaboratively for 18 years to improve quality while reducing healthcare costs. Though Maine providers have demonstrated high quality, cost pressures have only increased over this time. While the quality of healthcare delivered is the primary concern, we must recognize that the soaring costs undermine our ability to maintain access and threaten purchasers' ability to maintain coverage, create jobs and be competitive.

If current growth trends continue, future government leaders will either have to increase revenues/taxes substantially or reduce other government services dramatically to pay for health care costs. A similar dilemma is true for private employers. These trends grow even worse over time as the country ages and the baby boomer generation accesses more health care services. Coupled with the ever increasing cost of health care is the clear understanding by business- both public and private- leaders that even though they are paying more for health care benefits than ever, their employees' health outcomes are not improving for those additional costs.

MHMC members remain committed to collaborative partnerships to redesign care delivery supported by reformed payment. Coalition members agree that those who purchase health care services will develop the best solutions to improve care value by working in partnership with providers and consumers of health care services. Purchasers recognize their role in promoting and supporting healthy behaviors in the workplace and community and in providing incentives for appropriate utilization of services and to change payment to reward providers for improving health. Despite nearly two decades of deliberate, collaborative work, inadequate progress on controlling health care costs led the MHMC Board to seek to convene the top executives in the provider, health plan and business sectors to

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develop a plan to urgently address the need to reduce costs while maintaining quality and access. This plan should involve all stakeholders but must reflect the urgent need of purchasers to achieve change in the near term. To that end, the MHMC Foundation Board convened its first Executive Summit on November 2, 2011.

The Burning Platform of Healthcare Cost Reduction

Former Governor Angus King challenged the group to address several key failings of the current healthcare 'system' – which is in fact not a system at all. The urgency of addressing these failings cannot be overstated and the impact of inaction on the Maine economy will be devastating.

The growing costs of healthcare in Maine and nationally are a 'Looming Train Wreck' and our current cost trajectory means compounding dire economic consequences. From 2000-2009 healthcare costs have increased by 108% at the same time CPI has gone up by 24% and wages by 32%. If the healthcare trend went flat, it would take 23 years for wages to catch up. Healthcare costs as percentage of federal budget are now 25%; over next 20 years, it squeezes everything else out. If healthcare costs increase at the same rate over the next 40 years as during the last 40, **just Medicare and Medicaid** will equal 20% of GDP (now 4.5%). More importantly perhaps, in Maine, healthcare was 21% of median family income in 2004; has risen to close to 25% today. Similarly, energy has gone from 4% of median family income to 15% in the last 12 years; that means energy and HC combined equal close to **40% of family budgets**. As Angus put it, **'to say this is unsustainable is a gross understatement'.**

Former Governor King offered ten observations for the group to address:

1. US Healthcare is not a system in any meaningful sense (unless 5-year-olds playing soccer is considered a system)

- There are thousands of independent providers, multiple payment systems, and forms
- There is no coordination of care and very little information-sharing
- There is little standardization
- There is huge variation in costs (colonoscopy--$537 to **$3,151**)

2. We do not have the best health care system in the world, even though we're paying about double what everyone else is.

- The system is great for some (Congressmen), lousy for others.
- We can't be the best with 45 million uninsured and thousands dying annually because of lack of care.

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3. Healthcare will not reform itself. Why should it? The present system has 'created the greatest transfer of wealth in the history of the world'.

- The only force that can reform the system is consumers/purchasers, acting directly or through the government
- We are typically dumb consumers but there are examples of leadership and success (Lowe's and the Cleveland Clinic)

4. Tinkering won't do it; the problem is the structure

- Structure is policy: the structure dictates the outcomes
- An 'economist from Mars ' reviewing our system would predict that if providers define need, set prices, keep prices secret, there is no real competition + consumers don't feel costs then the likely result would be hyper inflation – which is exactly what is happening.
- Everywhere else in our society, we depend upon the **market** or strict regulation to control costs; in healthcare, we have neither.

5. The lack of Electronic Medical Records is inexcusable

6. Lack of transparency is ridiculous--we're paying the bills

- getting better thanks to the work of the Maine Health Data Organization, and the Maine Health Management Coalition, but should be much more clear, institution-specific and accessible
- what do you want to know in any transaction? price and quality—**VALUE.** This information should be available

7. Consumers have to be involved in the purchasing decision (inflation in costs parallels decline in out-of-pocket payments--from 33% in 1975 to about 14% today)

- proportional co-pays
- pay for choice of expensive options
- pay for risky life styles and poor health behaviors

8. Hospitals and physicians should not be paid for the cost of fixing their mistakes ($19.5 billion nationally; $80 million in Maine)

- Occurs in no other industry
- Non-payment would have a salutary effect on rate of mistakes

9. Insurance companies aren't the problem--they just pass along the costs--but they don't add value and add a significant cost

- $400 million a year in Maine (half the income tax)

10. We have to figure out a payment mechanism that rewards health, not illness

<u>II Purchaser Perspectives</u>

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Frank Johnson of the State Employee Health Commission shared the perspective of the joint labor/management group in charge of purchasing benefits for the State of Maine employees. The SEHC has been working collaboratively with and through the Coalition for over 17 years and, while seeing gratifying improvements in quality, have seen no positive impact on costs.

The Legislature recently flat funded the State employee benefit plan creating the need to reduce benefit costs by approximately $15m to absorb rate increases. The SEHC was forced to find all of those savings through greater cost shifting to employees -who already have not had raises or COLAs in 4 years. They are now being asked to pay considerably more for their health benefits and providers have not absorbed any of these cost reductions. In the next biennium, another $15m in savings will have to be found and the SEHC has decided that it will not come from cost shifting to employees again – providers must reduce costs and generate those savings. Several Maine hospitals serving significant numbers of state employees have been asked to reach proportional cost reduction targets.

The SEHC has actively sought collaborative partnerships with providers and will continue to work with them and do their part as purchasers – changing benefit design and reimbursement strategies as necessary. The partnerships with MaineGeneral and PenBay are examples of their preferred approach and have the full support of the Commission. The preference of the Commission is to work closely with providers in all cases to change care and payment for long term system improvement and cost reduction. If this is not possible or does not generate adequate savings they will pursue whatever purchasing strategies are required to meet the Legislative directive.

Other purchasers shared their views that they simply cannot sustain further increases. Cost reductions – not just trend reductions – are now required. Though partnership remains the ideal and purchasers are seeking local partnerships with providers with and through MHMC, purchasers can and will use any viable strategy- including steerage, limited networks and domestic tourism- to contain costs.

III. Provider Leadership

Dr. David Howes identified several of the same failings as Angus King and the view of providers trying to operate within a broken system. He noted the lack of available primary care physicians in the state and the support needed to attract and retain them. The bottom line problem is that, 'We have a low value health care system that is an unsustainable drag on our economy.'

Dr Howes identified key challenges that characterize the system:

- Lack of performance data, transparency or benchmarks;

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- Substantial administrative, operational, and clinical waste (estimated at 30% by RAND);
- Employees (patients) are insulated from/unaware of costs, and have no incentives to consider choices;
- Fee for service payment system rewards overuse; and
- Dysfunctional delivery system structure and culture with lack of coordination, integration, and accountability

Dr Howes challenged employers to commit to the following changes to support transformation:

- Support and utilize accurate, independent, transparent, performance data
- Create and drive wellness programs that identify and reduce risk factors
- Require every employee to have a primary physician
- Provide incentives to utilize high performing providers
- Require plans to provide tiered networks based on performance data with employee incentives
- Drive health plans toward performance based payment methodologies
- Create incentives and tools for employees to make wise value choices

Dr. Howes also shared several notable success stories in which costs of care came down significantly and quality was maintained or improved. For example, Theda Care reduced the cost of hospital admissions by $800 with no change in payments. Virginia Mason achieved significant cost reductions through partnerships with large employers in their region. Several examples exist nationally of notable reductions in hospital admissions within a year of establishing a Medical Home. These examples all illustrate that through physician and health system leadership, healthcare costs can come down improving value and care for both patients and purchasers.

IV. Group Discussion: How Will We Improve Healthcare Value in Maine?

Over the course of the 3 hour discussion, the group identified:

1. Attributes of an ideal healthcare system
2. Short term (18-24 months) strategies to improve care and value
3. Medium term (2-5 years) strategies to improve care and value
4. Long term strategies (5+ years) to improve care and value

The System we Want:

If we had a blank slate, all agreed we would create a different system than the one we have today. Primary care would be the foundation of any ideal system reducing the need for hospital and specialty care. Full transparency of cost, quality and outcomes would inform patients, purchasers and providers and timely, accurate longitudinal data across payers would be ubiquitous. This presumes fully functional and integrated electronic medical records without barriers across institutions or

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systems. A strong evidence base would support clinical decisions and be applied in all cases. Wellness would be supported by providers, employers and the community. End of life care would be addressed routinely at a community level as a normal part of care, reducing cultural resistance and promoting appropriate, patient centered decisions. Responsibility for personal health would also be a standard expectation and good health choices and behaviors would be supported. Appropriate access to care- even in rural areas –would be maintained through a rationalized payment system and distribution of services.

Short Term Priority Strategies

The group turned to identifying short term priority changes that could be made to move us closer to the ideal system. Recognizing that transformation will take time but that the urgency for change requires immediate action, near term (18-24 months) plans and the need for targets and collective action were the focus.

A first order priority for any effort is to establish a common understanding of healthcare quality and cost across Maine. Much of this exists from sources including the Maine Quality Forum, Onpoint, MHMC and others and should be compiled in a way that is useful to purchasers, providers and the public. Understanding how Maine compares both regionally and nationally on both quality and cost will be critical to benchmarking and setting appropriate goals. This should include a detailed understanding of variations in healthcare costs in New England and nationally. If Maine is more efficient and less costly at producing care, we should acknowledge the good work of those providers while trying to understand why purchasers' and patients' costs remain high. Analyzing available data to create performance baselines will be the precursor to moving forward but existing data limitations should not preclude us from making progress. The MHMC can create this resource.

1. **Set a statewide healthcare cost benchmark and meet it.**
   It was suggested that Maine needs an overarching cost reduction goal established through a consensus process and commitments from all parties to make needed changes to meet this goal. National best practice benchmarks and a deliberative, inclusive process should be used to establish an appropriate goal. Once established, data must be used to track progress over time and adjust strategies as needed. It may be worth framing the goal from a consumer perspective – ie healthcare costs should be no more than 17% of median family income. Any cost reduction goals and strategies must prioritize maintaining quality and access.

2. **Cost and quality transparency.**
   Transparency is the foundation of a functioning market. Currently purchasers, patients and even providers cannot get the information they need to make informed decisions about care, referrals and value. The group acknowledged the good work of the Coalition and others making quality and safety information transparent, but the limitations of available information

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limit value based purchasing, accountability and informed relationships among providers within and beyond their systems for referrals and overall population management. Additional information on infection and mortality rates are priorities for patients. For Coalition members, cost transparency was identified as the top priority for the next two years to build on and supplement existing quality information. This should include transparency of price, risk adjusted population costs and comparative costs among providers and institutions.

3. **Eliminate $100-$200 million of healthcare infrastructure costs in 3 years.** Several noted that healthcare costs would not be reduced until the healthcare infrastructure was 'right-sized'. A recommendation was made to develop and pilot a model to help transition rural hospitals to meet critical community needs as a 'Critical Access Medical Home'. Any infrastructure considerations should also be accompanied by a plan to lead to the rational regionalization of services and the reduction of duplicative services across the state.

4. **Reform payment to drive appropriate utilization and incent better care.** Provider and patient incentives are needed that encourage reduced consumption of unnecessary, low-value services. The Fee For Service payment system was characterized as a 'toxic' force in the current system incenting overuse and inappropriate care and the development of an unnecessary infrastructure laden with waste. Partial capitation or a global payment should be considered as a future model. Episode payments may also be an important tool. Alignment of payment models across purchasers, including MaineCare, is optimal. Changing health plans' legacy reimbursement systems will be challenging but achievable. An early step may be to identify the 'Top 5 Wasteful Practices' and collectively change clinical practice and payment to reduce or eliminate them.

5. **Create a common Value Based Benefit Design with a strong focus on effective wellness strategies to be adopted by all MHMC members.** An evidence and value based benefit design should be developed and adopted among all MHMC members. Wellness should be a key component of this benefit package, modeled on the successful strategies of Cianbro and LLBean. Significant premium differentials for participation in wellness programs and healthy behaviors should be included. Food policies at the worksite will also be important. This common Value Based Benefit Design should be adopted across MHMC members to eliminate or reduce waste and duplication from multiple vendors, tools and plans that often generate conflicting incentives and administrative challenges. CEO leadership will be necessary to drive cultural change.

6. **Expand and financially incent Patient Centered Medical Homes statewide as the foundation of a primary care based system.**

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The Patient Centered Medical Home model is considered to be a critical improvement to increase the value and functionality of our healthcare system. A proposal was made to set a goal of moving 90% of primary care practices to become medical homes within 2 years. This would require payment changes to adequately support more robust primary care practice and the attributes of the Medical Home model including integrated behavioral health and population health management. However, investments in medical homes will come with a corresponding expectation for downstream utilization and cost reductions.

7. **Target the top 1-5% of high utilizers to better manage their care.** It is widely established that the top 1-5% of patients drive the large majority of healthcare spending. This is most often driven by a small number of chronic conditions and care should be taken to understand the barriers faced to improving appropriate care for these patients. Timely and identifiable data is critical to the success of this strategy – providers must be able to appropriately target and treat high utilizers. Often, however, their needs are not medical, but require social support, transportation or other low-tech, low-cost community based resources. The Community Care Teams being developed for the PCMH pilot should be expanded across the state to better address the needs of high utilizers in both MaineCare and the commercial population. Public health and community providers should be identified and engaged as partners.

8. **Maintain and use an independent, shared, multipayor data source to provide timely, accessible and actionable information to all users.** Change cannot happen without timely data to inform purchasers, providers and patients. Data across all payers, including Medicaid, is needed by providers to manage population health and accept risk. A shared, common data source is needed to align information and reduce duplication and debate about data accuracy to allow a common base from which to proceed. Patients and employees need information on provider performance to make decisions and find the best healthcare; providers need information on clinical outcomes and efficiency for both quality improvement and informed referrals; and plan sponsors need transparent information for network design and accountability for resources. This priority presumes that health plans must and will share claims data. The source of data and information must be independent to avoid bias and the natural incentives of any vested interest to influence the information produced. The MHMC Foundation multipayor database has been designed to meet these needs and has been used by MHMC members for over 10 years.

In addition to the strategies identified above, **a collective effort from purchasers and providers is needed to lobby Congress on the need to increase – or at least not disproportionately cut- Medicare rates in Maine**. Improved Medicare

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reimbursement will reduce cost shifting to the commercial payers. The group should immediately and collectively pursue this strategy.

The group also identified a limited number of public policy proposals to facilitate some of the changes. These were not considered to be sufficient, but complementary to the efforts of the members and worth pursuing in the near term:

1) A ten year tax holiday for new Primary Care Physicians moving to Maine
2) Increase the cigarette tax
3) C.hange or eliminate community rating regulations

Additionally members asked for more information regarding the likely impacts of federal healthcare reform in Maine – particularly for employers. The advent of the 'Cadillac tax' on benefits going into effect on 2014 as well as the new exchanges will have significant impact on the healthcare market and should inform decisions now and into the future. MHMC will provide this information as a context for other strategies.

Medium Term Priority Strategies

Recognizing that several improvements in care delivery will not have immediate returns, the group identified important strategies that would align with and support long term goals and would likely demonstrate a positive impact within 3-5 years. Several of these priorities should be initiated and/or planned for now for their future and current benefit.

1. **Increase the efficiency of clinical practice**
   Several clinicians acknowledged that current practices involve considerable waste and care that does not benefit patients. Clinicians should lead efforts to identify and reduce care of limited value.
2. **Build community based partnerships to provide support services for the chronically ill.**
   Many services needed by people with chronic illness do not need to be provided in a hospital or doctor's office. Building a community public health infrastructure similar to Community Care Teams would provide more effective and less costly support.
3. **Wellness services should be provided in primary care offices**
   Several members said they were forced to buy wellness services from vendors because they did not occur in the course of routine primary care. Primary care should take over the role of promoting and supporting wellness.

Long Term Priority Strategies

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Several goals were acknowledged to only have impacts in the long term but were seen as important to initiate. Several of the previously identified strategies have long term components.

1. **Improve public health and community wellness**
2. **Change medical education to re-focus on primary care and change salaries to incent more medical students to choose primary care.**
3. **Reduce obesity and smoking rates in Maine through improved health behaviors**

Next Steps

The MHMC Healthcare Executive Summit identified both overarching goals for Maine's healthcare system and short term priority strategies to accomplish them. *Progress will require a time and resource commitment from all parties.* With member support, we will reconvene the Healthcare Summit Leadership Group every 6-12 months over the next 2 years to guide the efforts and monitor progress. To move the work forward we will also be convening several workgroups focused on some of the specific priority elements of the overall plan. The Maine Health Management Coalition will staff the workgroups and supply needed data. Participation from all stakeholders will be critical to the success of the efforts.

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PCMH & AF4Q Conveners Discussion

Wednesday, March 20, 2013
9:00 AM –10:50 AM

Maine Quality Counts
Hanley Building, 16 Association Dr, Manchester
(1st building on left as headed up Association Drive towards MMA!)

(Conference Call Line: tel. 877.455.0244, ID: 581-274-1449#)

AGENDA

9:00A **Welcome**
- Agenda scan, meeting goals

9:05 **SIM Update / Check-In**
- Governance issues
- MHMC, QC, HIN roles
- MHMC transition issues

9:15 **ME PCMH Pilot / Health Homes Update**
- Health Homes issues
- HDMS Practice Performance Reports – status update

9:30 **Pilot Evaluation Issues**
- Costs of additional 2 years evaluation, processing Medicare data
  - Options, next steps

9:40 **AF4Q Issues**
- AF4Q 3.0 data reporting – status update?
- AF4Q 4.0 funding - update
- AF4Q Grantee Meeting – May 8-10 (Chicago)
  - Attendees
  - "Bright Spot" highlights – EAAA & EMHS
- AF4Q technical assistance "mini-grants" – plans
- AF4Q technical assistance – peer site visit – MN
- AF4Q Evaluation Team Site Visit – May 2013

10:40 **MQF Patient Experience Matters**
- Status update
- Plans for public reporting

10:50 **Wrap Up / Other Issues**

10:55 **Adjourn**

(PCMH Working Group 11AM-1PM)

Next AF4Q/ PCMH Conveners meeting date: Wed, April 17, 9-11A, QC/Hanley Building

PCMH & AF4Q Conveners Discussion

Wednesday, March 20, 2013
9:00 AM –10:50 AM

Maine Quality Counts
Hanley Building, 16 Association Dr, Manchester
(1st building on left as headed up Association Drive towards MMA!)

(Conference Call Line: tel. 877.455.0244, ID: 581-274-1449#)

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9:30 **ME PCMH Pilot / Health Homes Update**
- Health Homes issues
- HDMS Practice Performance Reports – status update

9:40 **Pilot Evaluation Issues**
- Costs of additional 2 years evaluation, processing Medicare data
  - Options, next steps

9:45 **AF4Q Issues**
- AF4Q 3.0 data reporting – status update?
- AF4Q 4.0 funding - update
- AF4Q Grantee Meeting – May 8-10 (Chicago)
  - Attendees
  - "Bright Spot" highlights – EAAA & EMHS
- AF4Q technical assistance
  - "Mini-grants" ($200K/2yrs) – process, plans to pursue
  - Peer site visit – MN?
- AF4Q Evaluation Team Site Visit – May 2013

10:40 **MQF Patient Experience Matters**
- Status update
- Plans for public reporting

10:50 **Wrap Up / Other Issues**

10:55 **Adjourn**

(PCMH Working Group 11AM-1PM)

Next AF4Q/ PCMH Conveners meeting date: Wed, April 17, 9-11A, QC/Hanley Building

PCMH & AF4Q Conveners Discussion

Wednesday, May 15, 2013
9:00 AM –10:50 AM

Maine Quality Counts
Hanley Building, 16 Association Dr, Manchester
(1st building on left as headed up Association Drive towards MMA!)

(Conference Call Line: tel. 877.455.0244, ID: 581-274-1449#)

AGENDA

9:00A **Welcome**
- Agenda scan, meeting goals

9:05 **SIM Update / Check-In**
- Governance issues
- MHMC, QC, HIN roles
- MHMC transition issues

9:30 **ME PCMH Pilot / Health Homes Update**
- Health Homes issues

9:45 **Practice Performance Reports (HDMS)** *(Becky D)*
- Status update, overview
- Roll-out plan

10:15 **Pilot Evaluation Issues**
- Costs of additional 2 years evaluation, processing Medicare data
  - Options, next steps

10:30 **AF4Q Issues**
- AF4Q 3.0 data reporting – status update

10:40 **MQF Patient Experience Matters**
- Status update

10:50 **Wrap Up / Other Issues**

10:55 **Adjourn**

(PCMH Working Group 11AM-1PM)

Next AF4Q/ PCMH Conveners meeting date: Wed, July 17, 9-11A, QC/Hanley Building

PCMH & AF4Q Conveners Discussion

Wednesday, June 19, 2013
9:00 AM –10:00 AM

Maine Quality Counts
221 State St, Augusta – Conference Rm TBD

(Conference Call Line: tel. 877.455.0244, ID: 581-274-1449#)

AGENDA

9:00A **Welcome**
- Agenda scan, meeting goals

9:05 **SIM Update / Check-In**
- Governance issues
- Relationship to PCMH / AF4Q efforts

9:10 **ME PCMH Pilot / Health Homes Update**
- Health Homes issues
- Primary Care Practice Reports – roll-out

9:15 **Pilot Evaluation Issues**
- Supporting costs of additional 2 years evaluation, processing Medicare data

9:30 **AF4Q Issues**
- AF4Q 3.0 and 4.0 update
- Routine reporting

9:45 **MQF Patient Experience Matters**
- Status update

9:50 **Wrap Up / Other Issues**

10:00 **Adjourn**

(SIM Steering Committee: 10A-12N)

(PCMH Working Group 11AM-1PM)

Next AF4Q/ PCMH Conveners meeting date: Wed, July 17, ?9-11A, QC/Hanley Building

Maine Quality Counts
Better Health Care. Better Health.

AF4Q / PCMH Conveners Meeting
Wednesday, July 17, 2013
9:00 AM – 11:00 AM

Maine Quality Counts – Hanley Building, Manchester
Conf Call Line: Tel. 1-866-740-1260, 7117361#

AGENDA

9:00A **Welcome**
- Meeting goals, agenda scan

AF4Q Issues

9:05 **AF4Q Data & Reporting Issues**
- Updates on 3.0 & 4.0 reporting
- Plans to communicate publicly?

9:15 **Sustainability issues**
- Check-in
- Consumer engagement
- TA funds ($200,000/2 yrs)
  - Priorities
  - Process for accessing funds

9:30 **AF4Q 4.0 Reporting**
- Timing, reporting requirements

PCMH Issues

9:45 **PCMH Practice Transformation**
- Updates
- Anthem PC2 initiative
- Practice Transformation Fees

SIM Issues

10:30 **SIM Governance & Coordination with PCMH & AF4Q Efforts**
- SIM governance structure, workgroups
- Opportunities for coordination

11:00 **Adjourn**

Next meeting: Wed, August 21, 9-11AM – QC, Manchester
(PCMH Working Group meeting 11A-1P)

From: Leonard, James F. <James.F.Leonard@maine.gov>
To: 'molloyrita@aol.com' <molloyrita@aol.com>
Cc: Chenard, Randal <Randal.Chenard@maine.gov>
Subject: FW: Thank you, as well-ACO meeting
Date: Fri, Jun 28, 2013 4:08 pm

Additional ACO coordination evidence in Section B,q.6

Jim Leonard, Deputy Director

Office of MaineCare Services

Department of Health and Human Services (DHHS)

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Augusta, Maine 04333

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From: Vanessa Santarelli [mailto:vsantarelli@mepca.org]
Sent: Sunday, May 26, 2013 7:51 PM
To: Leonard, James F.; Nadeau, Stefanie; Jude Neveux
Subject: Thank you, as well-ACO meeting

Good evening, Jim, Stefanie and Dr. Flanigan:

I would just like to echo Jude's note of thanks for meeting with us about our Maine Community ACO last Thursday and your plans for rolling out a MaineCare ACO. I look forward to our continued work in these areas, and appreciate your interest in our progress thus far. I hope you are all enjoying the "fabulous" weather this weekend…..it looks like the sun is coming out just in time for us to get back to work!

Take care- Vanessa

Vanessa Santarelli

CEO

Maine Primary Care Association

207-621-0677, ext 209

vsantarelli@mepca.org

Section C. Beneficiary Outreach and Recruitment

Refer to DRR Section C: Outreach and Recruitment

Supporting Documentation Available:

C1) MaineCare Health Homes Member Lett TCM Devl Svcs Case Mgrs

C2) MaineCare Health Homes Letter TCM Member Services

C3) MaineCare Advisory Committee Meeting Notes, 2012-2013

C4) TEMPLATE Health Home Opt Out letter

C5) TEMPLATE Health Home Transfer Opt Out letter

C6) MUSKIE MaineCare Health Homes brochures

C7) Members Standing Committee (MSC) documents (varied)

C8) Consumer Provider Outreach Behavioral Health Homes

C9) Value Based Purch college-curriculum-outline 120511

C10) MaineCare VB Purchasing Strategy 06032013

C11) Value Based Purchasing 4 Public Forums notes & questions

C12) MaineCare Internal Value Based Purch Mtg 070313

C13) MaineCare Health Homes StageB Consumer Family

C14) Approved SPA ME 12-004 (1) (See: SECTION G Documentation)

C15) Approved SPA ME 12-004 (2) (See: SECTION G Documentation)

C16) Muskie Maine ED Use Study

C17) 2010 Highcost Member Summary

C18) Camden Coalition Maine High Utilizer 3 county study

Aging and Disability Services
An Office of the Department of Health and Human Services
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Department of Health and Human Services
Aging and Disability Services
32 Blossom Lane, Marquardt Building, 2nd Floor
11 State House Station
Augusta, Maine 04333-0011
Tel.: (207) 287-4242; Fax (207) 287-9915
TTY Users: Dial 711 (Maine Relay)

June 4, 2013

TO: Developmental Services Case Managers

As you may know, MaineCare has implemented a new program called Health Homes, a new Medicaid State Plan option authorized by Section 2703 of the Affordable Care Act. A Health Home is not a place where people live. It is called a "Home" because it is the primary medical care location for all health services A Health Home creates a team centered around the person served. Health Homes are designed to provide comprehensive and integrated health care services to individuals with chronic health conditions. Services authorized by this new MaineCare state plan option include:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up;
- Individual and family support, which includes authorized representatives;
- Referral to community and social support services, if relevant; and
- The use of health information technology to link services, as feasible and appropriate.

These services are linked to a Patient-Centered Medical Home primary care practice, and include access to Community Care Teams (CCTs) that provide additional care management for individuals with more significant needs.

In Maine, this service is being rolled out in two phases. Stage A includes individuals with two or more chronic conditions, or one condition and at risk for another. Qualifying chronic conditions include the following:

- Cardiac and circulatory abnormalities
- Chronic Obstructive Pulmonary Disease (COPD)
- Developmental Disorders (Intellectual Disabilities and Autism Spectrum Disorders)
- Diabetes
- Heart Disease
- Hyperlipidemia
- Hypertension

- Overweight or Obesity
- Substance Use Disorder
- Tobacco Use
- Mental Health (non-SMI/ SED only)

Individuals with Acquired Brain Injury (ABI), Asthma or Seizure disorder may also qualify if they have another qualifying condition.

Stage B will be rolled out at a later date, and will cover children and adults with serious mental health and co-occurring disorders. This letter does not address members eligible for Stage B.

Eligibility in Stage A includes certain disorders that may also qualify individuals for Targeted Case Management in Maine, specifically developmental disabilities and substance abuse. Some MaineCare members with qualifying conditions may also be receiving Home and Community based services, and receive Targeted Case Management (TCM) as a part of their waiver services.

Maine was recently informed by CMS (the federal Medicaid agency) that individuals receiving TCM **may not** receive Health Home services at the same time. CMS and federal auditors consider this a duplication of services. These individuals, according to CMS guidance, must be given a choice of providers.

MaineCare understands that the services provided to MaineCare members through TCM are often highly specialized. We do not anticipate that the Stage A Health Home services described above will replace TCM for Stage A eligible populations, including individuals receiving TCM services due to Developmental Disabilities, Autism, substance abuse, or participation in waiver programs.

Accordingly, if individuals receiving TCM services are referred to Stage A Health Home services (this would typically happen through their participating primary care practice), that individual (or a parent/guardian) will receive a letter informing them of their choice of service. The letter (a draft of which is attached) is intended to reassure parents and guardians that their services will not change unless they so choose. This letter also refers members to their TCM provider for further discussion.

We anticipate that this letter may cause some questions and concerns from individuals receiving Targeted Case Management and their families. To reiterate the message in this letter, if members do nothing, their services (both TCM and primary care) will remain unchanged. Again, we expect the majority of members to keep their existing service array, but are obligated to provide this choice of service due to guidance received from CMS.

Two conference calls have been scheduled for case managers working with individuals with developmental disabilities to answer any questions that arise from this initiative.

Tuesday, June 11, 2013 from 1-2PM

Thursday, June 27, 2013 from 10-11AM

Please call (207) _____ and use Pass Code _____ to participate in either call.

Sincerely,

Karen Mason, Program Manager
Developmental Services

Date

Member Address

Dear MaineCare Member:

You are receiving this letter because our records show that you or a family member have been referred for a new MaineCare service called Health Homes. This new service helps MaineCare members who have health needs that last a long time. We have some important information about this program to share with you.

What is a Health Home?

A Health Home is not a place where people live. It is called a "Home" because it is the first place you go for all your health care needs. A Health Home is a way to provide all around good health care. A Health Home creates a team centered around you. This team includes your primary care provider, other health care providers, and may also include community supports. Your Health Home team will help manage all of your health care services to help keep you healthy.

What about my Case Management Services?

Our records show that you or a family member work with a case manager. You can't receive both Health Home services and case management at the same time. You have a choice: 1) stay with the case management services you receive now, or 2) enroll in Health Home services. **Please note: If you do nothing, you will keep getting the services you have now and nothing will change**. You will keep the case manager and primary care provider you have now and will not be enrolled in a Health Home.

You may also want to talk to your case manager, who can help you decide if you should change to a Health Home.

If you have questions about Health Homes, please call 1-855-714-2416. You can also go online at http://www.maine.gov/mainecaremembers to find more information about Health Homes.

Sincerely,

Stefanie Nadeau, Director
MaineCare Services

Medicaid Advisory Committee

Date: March 5, 2013
Time: 10:00 am – 12:00 pm
Location: DHHS Offices, Conference Room C,
41 Anthony Ave Augusta, Maine

Community Care Teams Overview-Lisa Letourneau
Please reference the Quality Counts handout Community Care Teams/PCMH. Maine Quality Counts is a neutral non-profit convener bringing together stakeholders to improve the quality of health care.

The Medical Home Model is a model for improving primary care. Maine, a multiplayer pilot since 2008, is based on a set of 10 core expectations. These expectations are resonant with many pilots around the United States. Maine was chosen as one of 8 states to participate with Medicare's Medical homes. This allowed us to expand the model for high cost/high needs individuals. The Community Care Team (CCT) is a community based management care team. CCTs provide an extra level of supports to these patients working in partnership with the practice and connecting the patient with community resources. There are currently 10 community care teams. They identify patients by who is already utilizing a high amount of resources-highest cost/risk patients.

The Health Homes Initiative through the Affordable Care Act (ACA) Section 273 started in January of this year. There is an enhanced level of federal match for the Health Homes. Health Homes is a combination of a Primary care practice and community care teams. There are two stages- Stage A (Chronic Illness) and Stage B that focuses on Serious Mental Illness. We are still in the early stages of the design of Stage B of Health Homes.
Is there a way to get the community care teams to together to talk about common problems? They currently get together every 2 weeks to discuss these types of issues. However, CCTs have not yet gotten together with other entities; however, there is definitely opportunity in this area.

PNMI Update- Beth Ketch

State Plan Ammendment-13002. Currently this is at the commissioner's office for her review and sign-off. She is hoping to get that back today.

Reimbursement for PCA in one section of policy into consumer directed Personal Care Services. Proposed a minimum level staff qualification for all personal care services.

Establishing a standard rate for PCS.

As we started the review of Appendix C changes- there is a lot of work to do. Reviewing section 97, Changing Section 2 would need to be repealed. How many are there? There is a small number-less than 2. Section 96- separating PDN services and PCS. PCS would move into the new section of policy. How would this work with children? That

will have to be reviewed and decided. Chapter 115 and Section 12 will also need to be reviewed.

Members are assessed in different ways- it will need to be decided on how this is going to work. The goal is to minimize what will have to happen. These will be reviewed a section at a time and there will also be stakeholder meetings occurring as well.

Appendix F has been set aside. Appendix F and C are two completely different services. These will have to be reviewed in order to decide on how to move forward. Changes will also affect licensing and they are also involved in this discussion.

CMS in interested in comparability as assessed by the federal government. There is a question on reimbursement of ADLs vs IDLS and how that is going to work.

Is there a group working on how to handle room and board? The housing discussion is currently happening, but has not been finalized. There is not a solution to this question, yet.

Who is developing the eligibility criteria? There should be an assessment of the IDLs/ADL to assess their service needs. Currently, there is eligibility attached to living in a home. Would there be eligibility criteria to live in the home? How will the licensing work for living in the housing? It would be helpful to have licensing her to discuss this.

Beth will follow-up with a meeting to handle additional questions related to eligibility criteria and assessments. Crosswalk the level of cares in PDN with the current PNMI to see if they have the same level of needs?

Katie Holt from CMS would like to have an informal submission of the SPA to review it and clear up any preliminary questions.

Policy Update- Pascale Desir

Please refer to the Policy Update document. There are four rules that are brand new and already in the process and is new because of the supplemental budget.

- Section 65- 5% reduction to LCPC and LMFPs- this is at the commissioner's office for her review. This will be effective March 5th. $194.913 savings is expected. Is this a permanent cut? Beth/Pascale will find out.
- Section 45 Chapter 2, reduces waiting placement for nursing facility from 36 to a 1 day waiting period. This will not be effective on 3/25 because there is a notification period to members required. If you are in a hospital waiting placement to go into a nursing facility, they will only get paid for 1 leave day.

- Section 67-Nursing facility- reduce reimbursement of leave of absence from 10 days to 4 days in a 12 month period.

-Section 113- Non-Emergency transportation- currently with the AAG. Contracts have been sent out, negotiations have been started. Hoping to have a start date around May-June first. Have you thought about having an ER for this? We have asked this question. All of the waivers will have to be updated to reflect this change.

When you do SPAs in certain areas is it possible to send out en electronic notification that the SPA was sent out. Pascale will do this.

Section 40 Home Health Rules- Derrick is working on these.
LD710- Would undo this. What would the implication be to the contracts? The broker system is going forward until we know otherwise.

Section 32- Therese Barrows- needs to follow-up with the group on an update. They are currently working on the performance language. There are stakeholder meetings that meeting periodically.

How do you determine priorities? SPAs, Waiver Amendments, etc…It's a balance between capacity and urgency. The AG has specific instructions on how and when items can be opened.

Other related conditions waiver has been approved.

SPA/Stakeholder Update
Jack contacted CMS regarding the co-payments and not having adequate notice of this rule change. CMS did not share his concern. In the future, if you are able to share rulemaking that would help. He had a meeting with CMS and sent a follow-up letter in relation to the details of the co-pay rules. Several of Jack's concerns are included in CMS questions.

Other Business/ next month's agenda

- Section 32 Update- Theresa Barrows
- PMNI- Licensing- Ken Albert
- Dr. Flanagan/Ricker- Dental clinic in Portland
- Transportation update- (only if contracts are signed)
- Policy Update- Pascale

Medicaid Advisory Committee

Date: January 15, 2013
Time: 10:00 am – 12:00 pm
Location: DHHS Offices, Conference Room C, 41 Anthony Ave Augusta, Maine

New Chair Discussion

Ana Hick is COS for speaker of the house Marquee. What is the method for choosing the chair? The chair must be someone who is or represents members. What is the process? Sara Squires is willing to serve as the MAC chair. Does anyone object? No one object. By acclamation, Sara is the next MAC chair.

OFI Update

- Non categorical enrollment- 24,331.
- November enrollment-110074. This is down 500 from October enrollment.
- Waiting list was 22515. This may go up.

State received approval from CMS for some of the eligibility changes that were requested. Making reduction for parents and caretakers from 200% FLP to 133 %FLP. Reducing eligibility by 10%, to be completed by March 1st 2013. The rule has been adopted to make these changes. We are currently working to finalize notices to members so they can be sent to affected individual on January 29th.

Some additional affects of these changes are:

- Reducing DEL by 10% FLP- Central office-OFI phone number will be where those individuals will be directed to.
- Del is going from 185% FPL to 175% FPL.

Jack asked about the telephone numbers that will be on the notices. Those affected by the DEL changes will be directed to call the OFI central office. Parents and Caretakers will be asked to call member services. Additionally, the notice will tell individuals if they are eligible for transitional Medicaid. Majority of parents are eligible for 6-12 months of transitional Medicaid. They will be told what transitional Medicaid is and how it is different from "regular" Medicaid. Some members will be outreached individually by their caseworker if they are eligible in other categories. Doreen will send the final notices to Loretta to be distributed to the MAC group. There will be one notice to members, notices will not be sent to those members who appear to have coverage in other areas.

Number of members terminated:

- About over 12,000-13,000- parents and caretakers. But identified 1200 that potentially had coverage in another area.
- 2600 who will lose QI eligibility and DEL.
- 4000 going from SLMB to QI- no impact
- 5600 lose QMB- they will go from QMB and lose SLMB

An impact statement has been drafted for the Area Agency on Aging, for example, the impact on the Part D benefits. These agencies are gearing up to start counseling the affected members. Can they get a Medicare Supplement policy this time a year? If someone loses eligibility they get a 90 day window to apply for a Medicare supplement policy. Will they be told this in the letter? They will be referred to their Agency on Aging.

There are still discussions on what will be in the Notice of Decision vs another letter going out to members.

Policy Update

Ginger gave an update on Policy. Please see the Rule Status Update.
There was a question from Jack regarding the Methadone clinic reimbursement SPA submitted 4-1-12.

Section 91 Health Homes is in emergency rule making. By February, will see proposed rule to go with 5 emergency rules.

Section 90- There are a lot of changes to this rule coming.

Rules-PMNI- Section 97D-this would be Ann O'Brian, this was submitted the Attny general's office for review. Rules now have to go through the AGs office prior to going to the governor's office. Ginger to follow-up on an update.

SPA- Request to be on the SPA mailing list, if possible? (Jack)

CMS control #0995- Submitted RAI- received another RAI on December 20th. This is due by Friday.

Other conditions waiver update- The portion of the waiver that is around the system technology is that in tact now? Yes. There are three parts to this: 1) Assessment, 2) Equipment, and 3)

Monthly transition for the fee. Separately- home support and tel-health. There is a meeting Friday with the assistive technology group. It is located at 2B and Marquois at 10-12. Will discuss the ORC waiver and what is included in this waiver and what should be in the 21 waiver. We will also be able to handle questions and concerns.

The format of the Rule Status update format is confusing and difficult to follow, Ginger will follow-up regarding re-organizing the format. There will be a corrected version of the Rule Status coming out as there were some mistakes.

Project Update

Health Homes**-** Stage A Health Homes is now live- emergency rule went into affect on 1/1/13 and currently going through regular rules process. Emergency rule expires on 3/31 and would like to have regular rule starting after that.

SPA still under 90 day clock. Received one informal request and received two follow-up questions and we wil1 be responding tomorrow. Not sure how many states have had Health Homes approved, about 5-10 states.

There will be at least 150-160 that will be Health Homes. About 75 will be part of the Multi-payer initiatives.

CCTs are all engaged with Quality Counts and are responsible for quarterly reports and MaineCare will also be doing periodic audits on these members.

Intensive Care management for top 20%- how will this coordinate with CCCts? What is in the budget right now is the general care management of high usage individual. Commissioner is committed to the VBP strategy and additional initiatives will be integrated with current strategy. Lisa Letourneau linked CCT with care management of the top 20% individuals.

We are in the process of enrolling State A members- Individuals with multiple chronic conditions. Some of these ind are in the 5% costs. State B if focused on individual with serious mental illness/serious emotional disturbances.

Will CCT be working with family issues associated with members that are eligible for Stage B/ For example, missing appts, etc and being flexible…? Yes, the CCT will be working with these families and coordinations..

Stage B- Will be issueing an RFI within the next couple of weeks and invite folks to offer comments about questions/concerns.

Transportation Update

Completed a review of the proposal of transportation broker. January 7th sent award notification. Received 2 proposals from in state providers. Aroostook and Penobscot. Receive proposals from 4 different out of state agencies. Coordination Transportation Solutions- Connetttut won for all regions except region 3 and 8. Pequis won the bid for Penobscot, Logistic care was awarded region 8. There are 15 days to submit an appeal. By January 22, we will have a status of appeals.

If there are no appeals, then April/May implementation. If there are appeals, there will be additional months needed for implementation-July at the earliest.

Existing transportation agencies are upset about this new concept. One reason is because they can better coordinate with non-mainecare clients. Is there a way to better coordinate these services?

Based on feedback from current provider organizations, the decision was made to go in this direction. CMS concern with the current system-CMS dollars should only go to transportation towards MaineCare Services, providers are not able to do this now. In the new system, providers are required to be able to show this.

HHS Committee Discussion

Needs someone from the MAC to be represented on the HHS Committee which is being held tomorrow. Jack will be speaking on behalf of the MAC and will be sharing the MAC attendees list.

MaineCare Redesign

Did not hit target. 4.3 Million vs 5 million. Did not cut services or rates. Did come up with 11.28 million in FY16 22.59 million-FY15. It is sensible because there is not enough time to realize savings in such a short amount of time.

Smoking/Dental was recommended to put forward as separate initiatives. Very few people on the tasks force.

There is a lot of good data that is now available on the Redesign task force website. The presentations were very useful and the department works very hard to get the data.

Budget- how best to go through the budget? The document is on the budget information page and it was posted on Friday afternoon.

Next Agenda- PNMI Status
Budget Update
Dr. Letourneau Quality Counts overview- PCMH/Care Management Org and CCT Update

MaineCare Advisory Committee

September 4, 2012 Meeting

School-based- Update
MaryLou gave a brief School-based update. LD1003 passed the last session. The goal was to craft appropriate medical language. The school-based group has been meeting regularly. Currently, they are reviewing the New York Model. The subgroup meeting is focusing on birth to 5 years old. Amy Dix has been keeping to group on target. The next meeting is next week and they hope to be working with CMS soon.

Policy Update
The new policy manager, Pascale Desire, gave a policy update. There have been changes to the tobacco cessation policy. This has been eliminated for everyone accept for pregnant women. This will be reinstated in 2014 per ACA. Pascale will give clarification on the date. SPA states it is affected on 4/1/12. She will also get a copy of the SPA. Does there need to be a separate section for pregnant women? Per sec 90-04019, counseling is covered for everyone. Tim/Ana will look further into this and will follow-up with everyone.

Health Homes
Kitty informed the group that they have informally submitted draft SPAs to CMS on stage A. Currently they are in the process of responding to questions prior to officially filing the SPA. Hope for implementation in January.
Phase B- targeting members with serious mental illness and disturbance. Hoping to issue RFI in near future-in the fall.

ACO Planning- Preliminary discussions with CMS are occurring. Sent in preliminary concept paper on this which will be posted on the web. A draft application has been completed.
Still on track. A state Medicaid letter was sent to all states from CMS.

MaineCare Redesign Task Force Meeting

Ana and Mary Lou updated the group on the task force meeting. There were various presentations including one from Dr. Flanagan that explained the top 5% of DHHS users and how they account for the majority of DHHS dollars. The group will continue to meet with the goal of finding savings of $5.2 million.

Agenda for Next Month
Universal Waiver
PMNI update
School-based update

MaineCare Advisory Committee

October 2, 2012 Meeting

School-based- Update
MaryLou gave a brief School-based update. LD1003 passed the last session. The goal was to craft appropriate medical language. The school-based group has been meeting regularly. Currently, they are reviewing the New York Model. The subgroup meeting is focusing on birth to 5 years old. Amy Dix has been keeping to group on target. The next meeting is next week and they hope to be working with CMS soon.

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Agenda for Next Month
Universal Waiver
PMNI update
School-based update

Medicaid Advisory Committee

Date: December 4, 2012
Time: 10:00 am – 12:00 pm
Location: DHHS Offices, Conference Room C, 41 Anthony Ave Augusta, Maine

Sara Squires started the meeting and announced that Ana Hicks has taken another job and Sara is filling in until a new chair has been chosen.

Sara talked aobut having the discussion on the new chair during the January meeting. However, the January meeting falls on January 1st. Should we move the meeting and have the discussion then? The group decided on Tuesday, January 8th. Sarah will ask Mary Lou to facilitate the meeting as she will not be available on that day.

Rose gave an update regarding the MaineCare redesign task force. The group recommended smoking cessation and dental for pregnant women. These recommendations were not accepted. The final meeting is December 5. From 1-3, there will be a public comment, than the final report will occur after the public comment. The proposal is that care management would address the top 20% of the MaineCare users.

There was some discussion on the Health Insurance Exchange- Any additional information about coordinating the health exchange? How will the federal government help Maine? Please keep the MAC group informed. How many states are in the same place as Maine? There are about 20 states. Per Katie from CMS, there are more states deciding to expand. The numbers will be changing as more time goes by. She is expecting the numbers to go up overall.

Chapter 90 that the state passed, are there solid numbers that have been shared. CAHC will provide a Winners and Losers report.

OFI Update: Doreen McDaniel's- Non catagorical status- October enrollment continues to go down and is currently at 11,532. This is down from September- 12,050. Waiting list is at 22,515. The new numbers will be coming out in the next couple of days.
Proposed rules: 261p changes to Medicaid eligibility. 262 Change in DEL eligibility. We are still awaiting a decision from CMS regarding the SPA.

School-based Update: Amy Dix
Added Nursing services provided by an RN or LPN. Trying to finish up specialized transportation, still working on this and looking at what other states are doing.

BHP update: The proposal is to blend the BHP Curriculum and the Personal Care Assistant Curriculum. This would be the day treatment staff that would have this training either by the schools or an outside agency. The goal is to have less training hours, but a more relevant curriculum. Amy looked to the group for input on this proposed solution. There would be new rates set up for these services. How would this fit in with the departments emerging concept of PC services? There will need to be a review with the other PC-related initiatives.

Day Services- Local school is responsible for the Seed, why is that? This is a controversial issue as to weather this is a medical or educational service. Amy will follow-up on this as it affects Property Tax vs. Sales Tax.

Policy Update: Pascale Desir - Please see Rule Status update document.

Changes/Updates Physician Services. There was a fiscal impact that we are still waiting on. This will not be sent until next week. The PCP ACA PIP rate increase will be added. How will the rate increase be determined? Pascale will touch base with Dr. Flanagan and will let everyone know how it is determined. Will this go to an RFP for testing? Not sure. One of the ways this information was derived was using information from the CDC.

Section 113- Transportation Time frame has been pushed back. This is a work in progress.

Pharmacy Services- Adding language to the rule restricting the amount of oppiod medication that can be received regarding treatment for pain.

Section 85- Add language to reflect some of the changes that will be happening related to pain management
State Plan: 1113- Approved November 8th of this year.

Fiscal Impact of 12011- Hospital Outpatient, this was budget neutral.

There are two new policy writers. Matt Galletta, moved from the PERM unit. Peter Kraut- Policy writer for Physicians, Health Homes, and FQHC/RHC.

Amy Dix- will be leaving the Policy unit, she will be management CHIP. She will be keeping the schools project.

How long should items remain on the Rule Status list? The group discussed and decided that it should be removed when they are adopted. Reporting by title only when it has been approved.

Section 32 Update? There is no update on this; I will follow-up with Teresa Barrows about this.

Project Update: Kitty Purington
VBP- Stage A Health Homes. Individuals with chronic conditions update. Still planning to implement Stage A on January 1st. The SPA has been submitted and has been received and questions are back from CMS that we are working to respond to.

Opened up Health Homes enrollment until 12/14 and delayed the date that NCQA recognition is required. The application process was re-opened to get additional provider sites for Health Homes.

Letters are being sent to MaineCare members to let them know that they are currently seeing a primary care provider that is a member of a HH practice and that they can opt out of they do not want the service. Second wave of letters is an opt in letter, if they want to be in a Health Home and they are not currently. Members do not have to change providers if they do not want to, it is the member's choice. Kitty has a draft of the letter that she can share.

There is an expectation of 75 confirmed Health Homes and up to 50 additional Health Homes. Hoping by opening up there will be some additional ones.

Stage B- Getting a request for information for Stage B. Committed to getting in out in the next 10 days.

ACOs-
Had a few conversations with CMS regarding concept paper. This is still in the initial stages. Implementation is still scheduled for April 1st.

Transportation Update: Brian Sullivan

Received 34 total applications for transportation brokers across Maine. The scoring process of these applications has started. Deadline is the end of this month. Go-live date (with exception of appeals), would be looking at mid-February to March 1st for go-live date. Goal is to get this up to date within 60 days of the letters.

Next Months Agenda

New Chair
PMNI Presentation
__-what is happening on NON-C appendixes.
-MaineCare services being RFPed?
-Project Update

MaineCare Services
An Office of the
Department of Health and Human Services

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

June 14, 2013

Eligible Member: EligibleMemberName
MaineCare#:

MemberNameorCaseheadifChild
Address1
City,MEZip

Dear MemberNameorCaseheadifChild:

Welcome to MaineCare's Health Home program. This program helps MaineCare members who have health needs that last a long time. You and/or a family member are eligible for this program based on your or your family member's health care needs.

A Health Home is not a place where people live. It is called a "Home" because it is the first place you go for all your health care needs. A Health Home is a way to provide all around good health care. A Health Home helps with medical care and community services that could help you. There is no extra cost to you for Health Home services.

A Health Home creates a team centered around you, and you will be the most important person on the team. This team includes your primary care provider, other health care providers, and may also include community supports. Your Health Home team will help manage your health care services to help keep you healthy.

Your provider at ProviderName1 is a part of MaineCare's Health Home program. You do not have to change providers to get these services. You will be enrolled in the ProviderName1 Health Home. You do not need to do anything if you wish to be enrolled with this Health Home after 28 days. If you would like to be a part of the Health Home program sooner, you can call 1-855-665-4628 now. If you do not receive services at ProviderName1, please call 1-855-665-4628 and let us know.

If you do not wish to be part of the Health Home program, please call 1-855-665-4628 within 28 days of getting this letter. You will still be able to visit your provider for regular health care services. You can always join the Health Home program later if you change your mind.

If you have questions or concerns, please call 1-855-665-4628. For more information, go online at http://www.maine.gov/mainecaremembers. We hope you find this program helpful.

Sincerely,

Stefanie Nadeau

Stefanie Nadeau, Director
Office of MaineCare Services

MaineCare Services
An Office of the
Department of Health and Human Services

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

2/26/2013

Eligible member:
MaineCare#:

MemberNameorCaseheadnameifchild
123Road
CityME 04330

Dear MemberName:

Welcome to MaineCare's Health Home Program. This new program helps MaineCare members who have health needs that last a long time. You and/or a family member are eligible for this program based on your or your family member's health care needs.

A Health Home is not a place where people live. It is called a "Home" because it is the first place you go for all your health care needs. A Health Home is a way to provide all around good health care. A Health Home helps with medical care and community services that could help you. There is no extra cost to you for Health Home services.

A Health Home creates a team centered around you, and you will be the most important person on the team. This team includes your primary care provider, other health care providers, and may also include community supports. Your Health Home team will help manage your health care services to help keep you healthy.

Our records show that you are currently assigned to PROVIDERSITENAME1. Your provider at PROVIDERSITENAME2 is a part of MaineCare's Health Home Program and has referred you for these services. Because of this referral, we now plan to assign you to PROVIDERSITENAME2 You do not need to do anything if you wish to receive primary care and Health Home services from PROVIDERSITENAME2 after 28 days. If you would like to be a part of the Health Home Program sooner, you can call 1-855-665-4628 now.

If you 1) do not wish to be part of the Health Home Program and/or 2) do not wish to receive primary care services at PROVIDERSITENAME2, please call 1-855-665-4628 within 28 days of getting this letter. If we do not hear from you, after 28 days you will be enrolled in the Health Home Program at PROVIDERSITENAME2 and you will need to go to PROVIDERSITENAME2 for your primary care services.

If you have questions or concerns, please call 1-855-665-4628. For more information, go online at http://www.maine.gov/mainecaremembers.

We hope you find this new program helpful.

Sincerely,

Stefanie Nadeau

Stefanie Nadeau, Director
Office of MaineCare Services


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You and *your* Health Home Team

You and your Health Home team work together to get you the care you need to be healthy.

This team includes you, your primary care provider, other health care providers, and may also include community supports.

This team is centered around you and will work with you on decisions about your health care.


©Getty Images/Spotmatik

Each Person is Different

MaineCare's Health Home Program is designed to meet your needs so you can get quality care. Your medical care can be managed with other services to keep you healthy.

Some examples:

- If you have diabetes, your Health Home team may have a diabetic care nurse who can help you manage your symptoms.
- If you are overweight, your Health Home team may connect you to a dietician who can help improve your diet.
- If you have a lot of stress in your life, your Health Home team might include a health educator who gives you tips on how to manage stress better.

The goal of Health Homes is to help you be your healthiest.

MaineCare Services
An Office of the Department of Health and Human Services

Office of MaineCare Services
Member Services Unit
MaineCare Health Home Program
11 State House Station
Augusta, Maine 04333-0011

MaineCare Health Home Program


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Working together to improve your health

MaineCare Health Home Program: The Basics

A Health Home is not a place where people live. It's a way to provide all around, good health care. It's a team that always includes you and your primary care provider.

You and your team will work together to meet your health care needs. Your Health Home team can be helpful with health care needs that last a long time, such as asthma or heart disease.

For example, if you have heart disease, and see a lot of different providers for your health care, your Health Home team can help manage this with you.

There is no extra cost to you for Health Home services.

for more information:

To visit the MaineCare Health Home website and for a list of Health Home Providers, please go online to:
www.maine.gov/dhhs/oms/member/member_index.html

Your Health Home Team:

- Works with you to manage all your health care services
- Helps you get the services you need
- Makes sure your health information is managed and up to date
- Listens to you about what you need to be healthy
- Is available to you when you need appointments

The goal of Health Homes is to help you be your healthiest.

For questions about MaineCare Health Homes call: 1-800-977-6740

Who Is Eligible?

MaineCare members who have at least *one* of the following conditions may be eligible for Health Home services:

- Diabetes
- Depression
- Substance Abuse
- Heart Disease
- High Blood Pressure
- High Cholesterol
- Obese or Overweight
- Chronic Obstructive Pulmonary Disorder (COPD)
- Smoking/ Tobacco Use
- Developmental Disorders or Autism
- Heart and Lung Birth Defects

MaineCare members who have one of the conditions below *and are at risk for one of the conditions above* may also be eligible for Health Home services.

- Asthma
- Seizure Disorder
- Brain Injury

Talk to a Health Home provider nearest you to figure out if you may be able to be part of a Health Home.

The Health Home Program helps MaineCare members living with health care needs that last a long time.

Members Standing Committee (MSC) Minutes

Date: *11/18/2011*
Time: *1:00- 4:00 PM*
Dial In: *1-888-727-6732* ***PC:*** *810486*
Location: *MaineCare Services, Room 1A/B*
Meeting Lead: *Michelle Probert*
Purpose: *MSC Meeting*

Overview:

1) Introductions and Meeting Objectives
2) Overview of Value Based Purchasing
3) Emergency Department Project
4) Accountable Communities
5) Improving Current Projects- Patient Centered Medical Homes
6) Improving Current Projects- Primary Care Provider Incentive Program
7) MSC Helped MaineCare

Attendees:

MaineCare Members	MSC	Ana Hicks	MeJP	Interpreters	CIMaine
Katie Rosingana	Muskie School	Nadine Edris	Muskie School	Michelle Probert	MaineCare
Shannon Martin	MaineCare	Chris Nickerson	Mercy Hospital	Robert Hillman	ME Primary Care Assoc.
Burma Wilkins	Mercy Hospital				

Minutes:

Introductions and Meeting Objectives

- Explain and discuss the Department's new plan to improve members' health and lower costs.

Overview of Value Based Purchasing (VBP) Strategy

Three Main Parts:

1. Emergency Department (ED) Project
2. Accountable Communities Project
3. Improving projects we have already:
   - ✓ Patient Centered Medical Homes
   - ✓ Primary Care Provider Incentive Program (PCPIP)
   - ✓ Letting everyone know how well providers are doing providing quality care

Accountable Communities

- Groups of provider organizations called Accountable Communities provide better care to members at lower cost. In other parts of the country these kinds of organizations are often called Accountable Care Organizations (ACOs).
- MaineCare does not know what the Accountable Communities will look like right now.
- ACOs have to meet the following goals:
  - ✓ Quality standards of care for members
  - ✓ Save money on care
- ACOs are usually formed by a group of health care providers that work together to improve patient health. They can be primary care doctors, specialists, hospitals and others.
- ACOs compared to Managed Care Organizations (MCOs):

- ✓ An MCO is a separate organization that works with MaineCare providers and is responsible for member care and cost. An ACO is a group of providers directly responsible for member care and cost.
- ✓ MCOs tell members which providers they must go to while ACOs allow the member to go to any health care provider.
- ✓ MCOs were going to cover the whole state of Maine. We don't know yet if Accountable Communities will be in every part of the state.

Improving Current Projects: Patient Centered Medical Home (PCMH)

- PCMHs are primary care practices that:
  - ✓ Care for members using a team approach where the different health care providers talk together about a member's care.
  - ✓ Encourage the member and provider to have a good relationship.
  - ✓ Keep track of the member's health using computers.
  - ✓ Make it easier for members to schedule appointments when they need them.
- There are 26 PCMHs right now.
- In January, 8 community care teams will work with the PCMHs to help them provide better care to members.
- PCMHs provide better care for both the member's physical and mental health. PCMHs, Community Care Teams, and other practices will work to become Health Homes. Health Homes focus on giving better care for members with serious physical and behavioral health issues.

Update on What's Been Happening

- This is what MaineCare has been working on:
  - ✓ Meetings with provider organizations.
  - ✓ Request For Information (RFI) has been posted on our website to get help planning the projects.

Accountable Communities (AC): Working with the Whole Community

- ACs will work with health care and social service providers in the communities where members live.
- The health care and social service providers that ACs will work with includes:
  - ✓ All hospitals in the area
  - ✓ Clinics
  - ✓ Private practice offices
  - ✓ Physicians
  - ✓ Behavioral health care providers
  - ✓ Dentists
  - ✓ Members
  - ✓ Other social service agencies or organizations

Parking Lot

- Dental Care
  - ✓ Access, services geographical locations
  - ✓ Impact of dental health on the physical and mental health
- Integrated Services- Brain injury, chemical dependency, behavioral health services
- MaineCare funding

- Explore Universal Health Care (quality of life issue)
- Gainful employment
- Capacity of service systems
  - ✓ Housing for example
- Safeguards to protect members from inappropriate medications or tests
- Drug shopping
  - ✓ What can doctors do to prevent this?

Next Steps

- MaineCare will meet in or December of January to keep discussing the Value Based Purchasing Strategy.

All documents and materials concerning the Value Based Purchasing project reflect MaineCare's current thinking and are subject to change. No materials on the Value Based Purchasing web page, distributed and discussed at meetings or sent in emails or mailings are binding in any way concerning the future procurement process.

Members Standing Committee (MSC) Minutes

Date: *2/03/2011*
Time: *9:30- 12:30 PM*
Dial In: *1-888-727-6732* ***PC:*** *810486*
Location: *MaineCare Services, Conf. Room 1*
Meeting Lead: *Michelle Probert*
Purpose: *MSC Meeting*

Overview:

1. Responses to Request for Information (RFI) on Accountable Communities
2. Health Homes Overview
3. Health Homes
4. Potential Member Interest in Representation on Quality Counts Groups
5. Public Comments & Questions

Attendees:

MaineCare Members	MSC		MeJP	Interpreters	CIMaine
Katie Rosingana	Muskie School	Nadine Edris	Muskie School	Michelle Probert	MaineCare

Minutes:

Introductions and Meeting Objectives

- Explain and discuss the Department's plan to improve members' health and lower costs.

Accountable Communities: What is an ACO?

- The Department is adopting the simple definition of an ACO. It is an entity responsible for population's health and health costs that is:
  - Provider-owned and driven
  - A structure with a strong consumer component and community collaboration
  - Includes shared accountability for both cost and quality

Accountable Communities: How are they different from Managed Care?

- Managed Care Organization (MCO):
  - Members have to go to health care providers the MCO says are okay.
  - MCOs will cover the whole state.
  - Over time, the MCO will be responsible for the cost and care of all members.
- Accountable Community (AC)
  - Members can go to any health care provider.
  - ACOs can be in any part of the state. There may be parts of the state without an ACO. In these areas, MaineCare will work with providers to help members get better care.
  - MaineCare is talking to health care providers to see whether ACOs will be responsible for all members and the cost of all services for their patients.

Request for Information (RFI)

Why did the Department release an RFI?

- The RFI responses will help the Department finalize what both the Accountable Communities

and Health Homes programs look like.

- An RFI is different from an RFP (Request for Proposals).
  - It is a way for the Department to see if there is interest in participation in Accountable Communities and Health Homes.
  - It is also a way for the Department to get ideas on how to best put together programs that will work with what is currently available through the various systems (providers, hospitals) in place.
- Accountable Communities ("AC")
  - Interest of organizations
  - AC membership, governance, collaboration
  - Consumer & family involvement
  - Consumer advocacy and involvement
  - Payment models
  - Assumption of risk
  - "Impactable" costs of care
  - Performance measures
  - Data sharing and analytics
  - Member attribution
- Health Homes
  - Interest of organizations
  - Capacity to provide required services
  - Capacity to coordinate services for dually eligible individuals, including primary, acute, prescription drug, behavioral health, and long-term supports and services
- The RFI is posted on the Department's Value-Based Purchasing website at: http://www.maine.gov/dhhs/oms/vbp

RFI Responses

Twenty eight Responders:

- Health Systems (5)
  - Eastern Maine Health
  - MaineGeneral
  - MaineHealth
  - Mercy Hospital
  - St. Mary's Hospital
- Behavioral Health Organizations (BHO) (11)
  - Assistance Plus
  - Aroostook Mental Health Center
  - Crisis and Counseling Centers
  - Motivational Services
  - Community Health and Counseling Services
  - Amistad (also included as Advocacy Organization)
  - Merrimack River Medical Services,
  - Behavioral Health Community Collaborative (5 agencies)
  - Providence Service Corp

- Beacon Health Strategies
- Charlotte White Center

- Health Plans/ASO (4)
  - Anthem
  - APS
  - Magellan Health Services
  - Outcomes Pharmaceutical
- Long Term and Home Care Services (3)
  - Seniors Plus
  - OHI
  - Androscoggin Home Health and Hospice
- Advocacy Groups (3)
  - NAMI Maine
  - Maine Equal Justice Partners/Consumers for Affordable Health Care
  - Amistad
- Pharmacy (1)
  - National Association Chain Drug Stores
- Primary Care(2)
  - Maine Primary Care Association
  - Dr. Jean Antonnucci

RFI Responses: Accountable Communities

- **Interest in Accountable Communities Participation**
  - Responses showed a high level of interest in Accountable Communities Project
  - All responders support DHHS emphasis on integrating physical and behavioral care, and including community organizations in Accountable Communities.
- Several hospital systems and other providers raised the following issues:
  - Data needs: In order to track service use and costs many responders believe Accountable Communities need at least monthly data from MaineCare. Will MaineCare be able to provide this data monthly?
  - Create a similar model to Medicare: Many responders believe MaineCare should use the same or similar approach to assigning members, quality measures and data sharing as what Medicare is doing for its ACOs.
  - MaineCare cuts: How will the proposed cuts to MaineCare impact the Accountable Communities initiative?

RFI Responses: Accountable Communities

1. Models of Care- What will the Accountable Community look like?
   - Who will be includes as Accountable Communities provider participants?
     - Many behavioral health agencies would like DHHS to require that the Accountable Community show evidence of full integration and shared governance of behavioral health and social services within the Accountable Community.
   - Should DHHS limit the number of Accountable Communities, particularly in any specific region?
   - Flexibility of membership in Accountable Community – should providers be limited to one

Accountable Community?
  - Some health systems believe it will be harder to manage care and achieve goals if there are too many Accountable Communities within one area and if providers can be in more than one Accountable Communities.
- Can any health organization or provider be the lead member of an Accountable Community?
  - Is it possible for groups like Maine Primary Care Association or small provider organizations to join together to be an Accountable Community?

2. Payment Models
   - Most agree that DHHS should keep the Fee for Service (FFS) system at least at first. This is our current system – providers are paid for each service provided.
   - Most agree that Accountable Communities need to achieve high healthcare quality in order to share in any savings.
3. Risk Sharing
   - Risk Sharing means the providers in the Accountable Community can lose money (are —at risk||) if they spend more than they were supposed to.
   - Providers do not want to take on any risk in year since there is not a lot of data and the model is new.
   - Most believe that they could take on some risk in years 2 or 3.
   - Most think providers should get to choose their level of risk. Different organizations will be able to take on more or less risk.
4. What services should be included in Accountable Communities?
   Please note: Accountable Communities don't need to be responsible for all services; they can still provide some services without needing to worry that they will be responsible for how much the services cost.
   - Most hospital systems want to include all physical and behavioral health; some do not want to be responsible for long term care, developmental disabilities and substance abuse, to start out.
   - Most behavioral health organizations want to include all physical and behavioral services, including home-based services, but some do not want to be responsible for emergency, crisis and inpatient, to start out.
   - One hospital system, some behavioral organizations and the long term care providers want to include long term care.
   - Advocacy Organizations want Accountable Communities to be required to provide peer and family supports services
5. Consumer Protections
   - Some organizations want the same rules as Medicare ACOs.
   - Some organizations want Accountable Communities to handle complaints, while a separate organization would deal with appeals
   - Advocacy organizations want consumers to be able to go to one place complain
   - It's important that members can choose their providers
6. Data Sharing

- MaineCare has to give providers data on money spent and services used every month.
- It's easier for large health systems to analyze data themselves than for small organizations.
- Behavioral health organization are still working on getting computer systems to help track members' health, and need help to do better.

7. Performance measures
   - Health systems want to use national standards of NCQA
   - Behavioral health organizations want to use SAMHSA
   - Advocacy organizations want to use patient experience surveys
8. Attribution – How Members Are Assigned to Accountable Communities
   - Regularly see a Primary Care Physician (PCP) or Primary Care Case Management (PCCM)
   - If member does not have PCP or PCCM, then consider:
     - Member choice
     - Geographic location
     - Who provided most services over the past year
9. Opt out
   - It's important for members to keep their choice of providers.
   - Accountable Communities should be judged on how well they work with their members.
   - Consider letting members choose not to be in an Accountable Community only in certain situations, give the member incentives for staying in the Accountable Community.

Accountable Communities Timeline

- March 2012- Public Forums to talk about model
- May 2012- Organizations apply to be Accountable Communities
- October 2012- Accountable Communities start

CMS Health Home Requirements: Services and Match

- CMS will provide the state more money than usual to provide Health Home services to members for two years.

- Health Homes have to provide these services:
  - Care management
  - Care coordination and helping members be healthier
  - Helping members who leave the hospital stay healthy at home or in other places they go to
  - Supporting members and families
  - Referral to community and social support services
  - Use computers to keep track of members' health information
  - Help prevent and treat mental illness and substance abuse problems
  - Help members get the services they need, like help with diseases that last a long time, and long-term supports

- Health Homes may serve kids and adults on MaineCare with:
  - Serious and persistent mental illness (SPMI)
  - Serious Emotional Disturbance (SED)

- Two or more health problems that last a long time (chronic conditions)
- One health problems that last a long time that might mean they get another serious health problem.

- These health problems include:
  - Mental health
  - Substance abuse
  - Asthma
  - Diabetes
  - Heart disease
  - Being overweight

- Members who are in Medicare and MaineCare have to be able to receive Health Home services, too.

Maine's Health Homes Proposal

- Medical Homes + Community Care Teams (CCTs) = Health Homes
- Medical Homes are primary care practices that:
  - Care for members using a team approach. The member's different doctors and supports all talk to each other.
  - Focus on the member and provider having a good relationship.
  - Keep track of what's going on with a member using computers so information is not lost.
  - Make it easier for members to schedule appointments when they need them.
- Medical Homes in Maine:
  - MaineCare has 26 Patient Centered Medical Homes now.
  - Maine has close to 100 practices that are or are working to be Medical Homes.
- Community Care Teams (CCTs)
  - Based in the community
  - Pay attention to both physical and behavioral health
  - Have staff who look at things from different points of view
  - Help patients in medical home practices to get good care and have better health
  - Help patients with lots of problems to reduce avoidable costs (ED use, admits)
  - Maine has 8 Community Care Teams that started working with members in our current 26 patient centered medical homes this month.
  - With the increase in money from CMS for Health Homes, MaineCare will be able to pay for as many practices and community care teams that meet the requirements to be Health Homes!

- Maine intends to roll out Health Homes in two stages
  - Stage A:
    - ✓ Health Home = Medical Home practice + CCT (most of the payment goes to the medical home)
    - ✓ Members:
      - ➢ Two or more health problems that last a long time (chronic conditions)
      - ➢ One health problems that last a long time that might mean they get another

serious health problem.

- Stage B:
  - ✓ Health Homes = Community Mental Health Center CCT + Medical Home practice (most of the payment goes to the Community Mental Health Center CCT)
  - ✓ Members:
    - ➢ Adults with Serious and Persistent Mental Illness
    - ➢ Kids with Serious Emotional Disturbance

RFI Response: Health Homes

Next Steps

- MaineCare will meet in or February to continue the Value Based Purchasing Strategy discussion.

All documents and materials concerning the Value Based Purchasing project reflect MaineCare's current thinking and are subject to change. No materials on the Value Based Purchasing web page, distributed and discussed at meetings or sent in emails or mailings are binding in any way concerning the future procurement process.

Members Standing Committee (MSC) Minutes

Date: *04/06/2012*
Time: *9:30 AM- 12:30 PM*
Dial In: *1-888-727-6732* ***PC:*** *810486*
Location: *MaineCare Services, 242 State St*
Facilitator: *Katie Rosingana*
Meeting Lead: *Michelle Probert*
Purpose: *MSC Meeting*

Overview:

1) Introductions and Meeting Objectives
2) Maine Health Homes Proposal Overview
3) Accountable Communities
4) Parking Lot
5) Next Steps

Attendees:					
MaineCare Members	MSC	Chris Rusnov	MeJP	Interpreters	CIMaine
Katie Rosingana	Muskie School	Nadine Edris	Muskie School	Michelle Probert	MaineCare
Jana Roberts	Maine Center on Deafness				

Minutes:

Introductions and Meeting Objectives

- To explain and discuss the Maine Health Homes Proposal and Accountable Communities initiatives.

Maine Health Homes Proposal Overview

- Community Care Teams CCTs
  - ✓ Maine would like to use Community Care Teams (CCT) and Medical Homes in its Health Homes model.
  - ✓ With help of Community Care Teams (CCTs), Health Homes focus on giving better care for members with serious physical and behavioral health issues.
  - ✓ CCTs will work with all of the different care providers and organizations that provide care for the member.
  - ✓ CCTs will be made up of care providers from different areas of expertise.

- Health Homes will serve:
  - ✓ Adults with serious and persistent mental illness (SPMI)
  - ✓ Children with serious emotional disturbance (SED)
  - ✓ People with two or more chronic conditions, or
  - ✓ People with one chronic condition who are at risk for developing another

- Maine proposes 2 stages for its Health Homes:
  - ✓ Stage A:
    - – Medical Practice plus Community Care Team

  - Serving members with two or more chronic conditions, or members with one chronic condition who are at risk for developing another.
- ✓ Stage B:
  - Community Mental Health Center Community Care Team + Medical Home
  - Practice serving adults with SPMI and kids with SED.

- Chronic Conditions include:
  - ✓ Mental health
  - ✓ Substance abuse
  - ✓ Asthma
  - ✓ Diabetes
  - ✓ Heart disease
  - ✓ Overweight & Obesity
  - ✓ Other

- Maine will propose to CMS the following chronic conditions:
  - ✓ All populations:
    - Chronic Obstructive Pulmonary Disease (COPD)
    - Hypertension
    - Hyperlipidemia (high cholesterol)
    - Tobacco use
    - Developmental Disability (ID and Autism Spectrum)
    - Acquired Brain Injury (ABI)
  - ✓ Children only:
    - Seizure disorders
    - Cardiac & circulatory congenital abnormalities

- Quality Measures
  - ✓ Adult Body Mass Index assessment
  - ✓ Ambulatory Sensitive Condition admission rate
  - ✓ Care transitions record given to Primary Care Physician
  - ✓ Follow up after mental health admission
  - ✓ All-cause 30-day readmission rate
  - ✓ Depression screening & follow up
  - ✓ Treatment for alcohol/drug dependence

- State- specific Goals & Measures
  - ✓ State must set goals for health home that can be measured (example less Emergency Department visits)
  - ✓ Must choose measures to reach the goals

- Claims- based measures
  - ✓ Emergency Department (ED) admissions
  - ✓ Follow- up after any hospitalization

- ✓ Imaging rate/costs
- ✓ Well child visits (pediatrics)
- ✓ Lead screening (pediatrics)

- Clinical measures are the same as multi-payer Patient Centered Medical Home Pilot (PCMH) quality metrics

- Health Homes Timeline
  - ✓ May 2012- Community Care Teams apply to be part of Health Homes
  - ✓ Summer/Fall 2012- Stage A Health Homes start
  - ✓ January 2013- Stage B Health Homes start for members with SPMI & SED

MSC Suggestions and Questions

- What are the follow ups after a mental health inpatient include? With who?

Accountable Communities (AC)

- Accountable Communities work with Health Homes
  - ✓ An AC can be looked at as a tool or vehicle to get to where you want to go but it is not any good without a rider or health home.
  - ✓ Collaboration and coordination between providers is the best way to do the best job to reduce costs and improve the health of members.

- Stakeholder meetings
  - ✓ Design Management Committee (DMC) includes representatives from the following Offices of:
    - MaineCare
    - Maine Center for Disease Control
    - Adult Mental Health
    - Adults with Cognitive & Physical Disability Services
    - Children & Family Services
    - Elder Services
    - Health Information Technology
    - Quality Improvement
    - Substance Abuse
    - And the Muskie school of Public Services at the University of Southern Maine

- Public meetings to discuss the AC project:
  - ✓ Bangor- April 2nd from 9-12
  - ✓ Lewiston- April 17th from 9-12
  - ✓ Portland- April 19th from 9-12
  - ✓ Augusta- April 25th from 1-4

- Core Services

- ✓ The Department has to choose what services the AC will be responsible for. The AC will manage the cost and quality of these services.
- ✓ The Department can't make providers responsible for all services because some services providers don have control over.
- ✓ The Department plans to have a list of core services that all Accountable Communities will be responsible for. ACs can include services that are not on the core list if they want to.
- ✓ The Department will need to identify which services they expect most provider organizations to improve health and bring down costs by coordinating care.
- ✓ Recommended core services
  - Core: Inpatient, Outpatient, Physician, Pharmacy, Mental Health, Substance Abuse, community Integration, Emergency Department
  - Optional : Private non-Medical Institutions, Waiver, Nursing facilities, Targeted Case Management, Early Intervention, Private Duty Nursing Services, Transportation, Dental

- Member Protections: Choice
  - ✓ Many RFI responders think the Department should align with the AC member protections under the Medicare Shared Savings Program (MSSP)
  - ✓ The MSSP will have members assigned to (not enrolled to in) ACs.
  - ✓ Member freedom of choice is not restricted.
- Member Protections: Notification
  - ✓ Post signs in their facilities in settings where primary care services are given to tell members that the are part of an AC
  - ✓ Have access to written notices in plain language telling members that the provider is part of an AC. The notices also will say MaineCare may share member information with the AC. The notices will be written by the Department.
- Member Protections: Data Sharing
  - ✓ AC providers may contact their assigned members to notify them that the AC may request member information.
  - ✓ If neither the AC nor MaineCare hear back from the member within 30 days that the member does not want their information shared, the AC requests the information for the Department.
  - ✓ If a member declines to share their identifiable data:
    - Doctors may still share medical record information amongst themselves as allowed under HIPAA.
    - MaineCare may still include the member's non-identifiable information in reports and calculations.
- Member Protections: Marketing
  - ✓ The Department will limit and monitor the use of member communications related to ACs to ensure appropriate use.
  - ✓ ACs:
    - Must use template language when available.
    - Must follow the rules about not providing gifts from members.
    - May be terminated for non-compliance with these regulations.

MSC Suggestions and Questions

- How are peers involved in CCTs? What are the qualifications required?
  - ✓ Need to have medical director, care manager, peers with experience.

Parking Lot

- Case managers need to know more about the programs/services and they need to educate consumers.

Next Steps

- Michelle will provide a detailed list with conditions and services that will be included in Health Homes
- Follow up discussion on ACO covered services
- Follow up discussion on member protections

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Members Standing Committee (MSC) Minutes

Date: *05/17/2012*
Time: *9:30 AM- 12:30 PM*
Dial In: *1-888-727-6732* ***PC:*** *810486*
Location: *MaineCare Services, 242 State St*
Facilitator: *Katie Rosingana*
Meeting Lead: *Michelle Probert*
Purpose: *MSC Meeting*

Overview:

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Shannon Martin	MaineCare				

Minutes:

Introductions and Meeting Objectives

- To explain and discuss the Maine Health Homes Proposal and Accountable Communities initiatives.

Maine Health Homes Proposal Overview

- Medical Home + Community Care Teams CCTs = Health Homes
- Health Homes will serve:
  - ✓ Adults with serious and persistent mental illness (SPMI)
  - ✓ Children with serious emotional disturbance (SED)
  - ✓ People with two or more chronic conditions, or
  - ✓ People with one chronic condition who are at risk for developing another
- Public Forums
  - ✓ Bangor, Lewiston, Portland, Augusta
  - ✓ Each public meeting had approximately 50- 60 attendees
- Chronic Conditions include:
  - ✓ Mental health
  - ✓ Substance abuse
  - ✓ Asthma
  - ✓ Diabetes
  - ✓ Heart disease
  - ✓ Overweight & Obesity

- ✓ Other

- Maine will propose to CMS the following chronic conditions:
  - ✓ All populations:
    - Chronic Obstructive Pulmonary Disease (COPD)
    - Hypertension
    - Hyperlipidemia (high cholesterol)
    - Tobacco use
    - Developmental Disability (ID and Autism Spectrum)
    - Acquired Brain Injury (ABI)
  - ✓ Children only:
    - Seizure disorders
    - Cardiac & circulatory congenital abnormalities

- How do we define chronic conditions and how will we identify eligible members?
  - ✓ MaineCare claims data of people with certain diagnoses and/or receiving certain services
  - ✓ Health Home practices can identify eligible member through electronic medical records, to see who is overweight, who smokes, etc.

- Stage A Proposed Metal Health Diagnosis
  - ✓ Stress and adjustment disorders
  - ✓ Personality disorders
  - ✓ Disturbance of Emotions
  - ✓ ADHD Hyperkinetic
  - ✓ Neurotic Disorders
  - ✓ Depression not elsewhere specified

- State B Proposed Diagnoses for Serious Mental Illness (SMI) in Adults
  - ✓ Schizophrenic Disorders
  - ✓ Major Depression
  - ✓ Bipolar and other affective disorders
  - ✓ Other psychoses

- Stage B Proposed Diagnoses for SMI in Children by Procedure Codes
  - ✓ Home & Community-Based Treatment
  - ✓ Children's ACT
  - ✓ PNMI Stay
  - ✓ Inpatient Psychiatric Stay

- Chronic Condition Identification
  - ✓ ICD-9 code lists
  - ✓ Any mention of the diagnosis on any claim type will be considered
  - ✓ Service use will be used to identify:

  - Developmental Disability- MR Waiver service use ad ICFMR service use
  - Acquired Brain Injury (ABI)- Rehabilitative service use
  - Diabetes- Insulin use

- Identification of Members At-Risk for a Second Chronic Condition
  - ✓ Mental Health
  - ✓ Substance Abuse
  - ✓ Diabetes
  - ✓ Heart Disease
  - ✓ Obesity
  - ✓ COPD
  - ✓ Hypertension
  - ✓ Hyperlipidemia (high cholesterol)
  - ✓ Tobacco Use
  - ✓ Developmental Disability
  - ✓ Cardiac and circulatory abnormalities

- Core Set of Quality Measures
  - ✓ Adult Body Mass Index assessment
  - ✓ Ambulatory Sensitive Condition admission rate
  - ✓ Care transitions record given to Primary Care Physician
  - ✓ Follow up after mental health admission
  - ✓ All-cause 30-day readmission rate
  - ✓ Depression screening & follow up
  - ✓ Treatment for alcohol/drug dependence

- State- specific Goals & Measures
  - ✓ State must set goals for health home that can be measured (example less Emergency Department visits)
  - ✓ Must choose measures to reach the goals

- Proposed Maine- Specific Goal Areas and Quality Measures
  - ✓ Reduce inefficient healthcare spending:
    - Emergency Department (ED) admissions
    - Non evidence-based imaging use
  - ✓ Improve children's health:
    - Well child visits (pediatrics)
    - Developmental screening
    - Behavioral health measure TBD
    - Potential SCHIP servey re patient experience of care TBD
  - ✓ Improve chronic disease management:
    - Hedia measures on diabetes, cardiovascular, COPD, asthma
    - Chronic disease admission rate
  - ✓ Ensure evidence-based prescribing:

- Percent participation in Prescription Monitoring Program
- Psychotropic drug use measure TBD
- Med reconciliation measure TBD
- Potentially avoidable prescription practice measures TBD

- Health Homes Timeline
  - ✓ June 2012- Community Care Teams apply to be part of Health Homes
  - ✓ Fall 2012- Stage A Health Homes start
  - ✓ Winter 2013- Stage B Health Homes start for members with SPMI & SED

MSC Questions and Suggestions:

- How are behavioral health experts defined?
- What will the behavioral health experts qualifications be?
- Can we partner peers with behavioral health experts?
- You say we will receive a 9:1 match from CMS, who does it go to and who will oversee the funds to ensure doctor's are meeting quality outcomes?
- Add the following:
  - ✓ Chronic vision impairment
  - ✓ Dental
    - Dental issues and infections lead to other health issues
    - Medications and chronic conditions affect dental health

Accountable Communities (AC)

- Lining up Accountable Communities with Medicare ACOs: Proposed Model
  - ✓ Two Medicare ACO programs
    - Medicare Shared Savings Program (MSSP)
    - Pioneer ACO
  - ✓ MaineCare will match a lot of its ACs requirements with the MSSP to make participation easier for providers
- Under both ACs and the MSSP:
  - ✓ Patients keep their choice of doctors
  - ✓ Patients are assigned to the ACO where they get most of their primary care services
  - ✓ ACOs can share in savings they find in their patients' care
  - ✓ ACOs can choose to:
    - Share up to 50% of savings
    - Share in up to 60% of savings if they share up to 10%of costs if the care costs more than planned.
- Forum Attendees Feedback about Community Participation
  - ✓ Many providers (especially behavioral health organizations) are concerned that larger hospitals and health systems would want to do everything themselves and will not work with community organizations and providers or let them be part of the AC.

- Community Collaboration: What else should the Department do?
  - ✓ Conduct forums and outreach through Department offices to make sure providers are aware of and understand the AC initiative.
  - ✓ Require that ACs involve community organizations in AC leadership.
  - ✓ Let providers know what other organizations are interested in being part of different ACs so they can find each other.
  - ✓ Provide learning opportunities through Department offices to help ACs work well within the community.

- Choosing Core Services

✓ The Department has to choose what services the AC will be responsible for. The AC will manage the cost and quality of these services.

✓ The Department can't make providers responsible for all services because there are some services providers don't have control over. For example, providers don't decide how much waiver services cost or who should get those services.

✓ The Department plans to have a list of "core services" that all Accountable Communities will be responsible for. The Accountable Communities can include services that are not on the "core" list if they want to.

✓ The question the Department has tried to answer is: "For which services should we expect most provider organizations to improve health and bring down costs by coordination of care?" Coordination of care means all doctors, specialists, hospitals, and others have to work together.

- Forum Attendees Questions and Concerns

✓ If PNMI and/or residential treatment are not a part of the core services, AC provides may try to send members to PNMI/residential treatment. By doing this, the members don't cost the AC as much but the members may not need the residential level of care and would be more expensive for the state.

  – DMC appreciates this concern and would like to have the goal of including residential treatment and other services currently under PNMI in the AC core services. However, we have to wait to see what PNMI services will look like in the future. Providers need to deliver these services for a year so we know exactly how much they cost. We need to know how much the services cost before we can expect ACs to save money on them.

✓ Will School-Based Services and Home Health & Hospice be included as core services?

  – Many providers of school-based services are the same providers of services outside of the school. However, school-based services often provide access to services for kids that might not get any services otherwise. The Department needs to discuss if including school-based services under the AC core services could make it harder for kids to get services.
  – Home Health & Hospice should be included under the core services. They are short term services that can reduce other hospital-related costs for members.
  – DMC decision: We need to have three categories of services: "excluded" as well as

"core" and "optional." This is because transportation will have a separate risk-based system and there is too much changing with PNMI to include it right now.

MSC Suggestions and Questions

- ACO need benchmarks to show that community partners are engaged.
- MaineCare should provide incentives to make better and healthy choices to improve health (examples could be gift cards or gym membership).

Parking Lot

Next Steps

All documents and materials concerning the Value Based Purchasing project reflect MaineCare's current thinking and are subject to change. No materials on the Value Based Purchasing web page, distributed and discussed at meetings or sent in emails or mailings are binding in any way concerning the future procurement process.

Members Standing Committee (MSC)
August 24, 2012

ACCOUNTABLE COMMUNITY DESCRIPTIONS, INFORMATION FOR MEMBERS DRAFT

What is an Accountable Community?

- An Accountable Community is a group of doctors, hospitals, and health care providers that work together and with MaineCare to give you better service and care.

- The goal of an Accountable Community is for all of your doctors and other health care providers to "talk." When all your providers are talking, you will get better quality care. When all of your providers know what you need and about the services you are getting, they can meet your unique individual needs.

- An Accountable Community may be rewarded when they talk to all of your providers and give you better care.

Can I pick what doctor I see?

- Your MaineCare benefits are not changing. You still have the right to choose any doctor or hospital who accepts MaineCare at any time.

- Your doctor may continue to suggest that you see a doctor for a specific health need but it's always your choice about what doctors or hospitals you visit.

Is my personal information safe?

- To help us give you the right care, in the right place and at the right time, MaineCare and health care providers will share information. We will share information starting on (MONTH, YEAR). The information we share will include things like visits to the doctor or hospital, medical conditions, and referrals for other doctors or services.

- Having this information is very important to your providers in the Accountable Community. Having up-to-date information will allow them to give you the best care. The information will tell MaineCare if a service that you aren't getting may help you. It will also tell us if the doctors are giving you good care.

- Your privacy is very important to us. You control the use of your personal information. We put important safeguards in place to make sure all your personal information is safe and confidential.

MEMORANDUM

TO: **Members of the Members Standing Committee (MSC)**

FROM: **Katie Rosingana, Muskie School of Public Service**

MSC Meeting on August 24, 2012

With this memo you will find the agenda for the MSC meeting on **August 24th**, as well as some discussion questions. MaineCare wants your ideas on how to get information to members now, and in the future. These questions are for you to think about ahead of time so we can talk about your ideas at the meeting.

Michelle Probert will give an update on the Value Based Purchasing activities and timeline at the beginning of the meeting. We have shortened the meeting to end at 12:00 noon because Michelle does not have a long update this month.

Thank you and I look forward to our meeting on the 24th!

MSC Member Feedback Questions for Future Member Engagement

1. How can members of the MSC get information to other MaineCare members about the Value Based Purchasing initiative?

2. What is the best way for MaineCare and its providers to educate members on all the new things that are happening, such as Accountable Communities and Health Homes?

3. MaineCare will let members eligible for Health Homes know what Health Homes are, and who/where Health Home providers are in their area of the state, in case members want to receive care from a Health Home. What is important to let members know in these communications?

4. What information is **most** important for members in a Health Home or Accountable Community Organization?

Members Standing Committee (MSC) Minutes

Date: *08/24/2012*
Time: *9:30 AM- 12:00 PM*
Dial In: *1-888-727-6732* ***PC:*** *810486*
Location: *MaineCare Services, 242 State St*
Facilitator: *Katie Rosingana*
Meeting Lead: *Michelle Probert*
Purpose: *MSC Meeting*

Overview:

1) Introductions and Meeting Objectives
2) VBP Updates
3) VBP Timelines
4) MSC Feedback for Future Member Engagement
5) Follow Ups and Next Steps

Attendees:					
MaineCare Members	MSC	Michelle Probert	MaineCare	Interpreters	CIMaine
Katie Rosingana	Muskie School	Shannon Martin	MaineCare		

Minutes:

Introductions and Meeting Objectives

- To explain and discuss the Maine Health Homes Proposal and Accountable Communities initiatives.

Value Based Purchasing Updates

- Health Homes
  - ✓ About to send Stage A State Plan Amendment to federal government
  - ✓ New Community Care Teams in Aroostook and Washington counties, the midcoast area, and the southern Maine/Portland area.
- Accountable Communities
  - ✓ Started talking with CMS (federal government) about the model
  - ✓ Working on statewide grant application that would bring together MaineCare, Medicare, and the commercial health insurance plans to create Accountable Care Organizations. The state will be able to track the cost and quality of healthcare for all patients.

Value Based Purchasing Timelines

- Health Homes
- July 2012
  - ✓ Health Homes Practices selected
  - ✓ Community Care Team application issued
- August 2012
  - ✓ Submit State Plan Amendment to CMS for Stage A
  - ✓ Issue Request for Information (RFI) for Stage B

- October 2012
  - ✓ Community Care Teams selection
- January 2013
  - ✓ Implementation of Stage A Health Homes and multi-payer Maine PCMH expansion
  - ✓ Submit Stage B Health Homes SPA for individuals with Serious Mental Illness
- May 2013
  - ✓ Implementation of Stage B Health Homes
- Accountable Communities
- August 2012
  - ✓ Start discussions with CMS about the State Plan Amendment
- September 2012
  - ✓ Issue Accountable Communities application
- November 2012
  - ✓ Turn in SPA to CMS
- December 2012
  - ✓ Select Accountable Communities
- April 2013
  - ✓ Start Accountable Communities

MSC Feedback for Future Member Engagement

1. How can members of the MSC get information to other MaineCare members about the Value Based Purchasing initiative?
   - Word of mouth
   - Face to face
   - Depends on demographics of those I am talking to
   - Take info from website to share
   - Take info to parent groups or other committees
   - Monthly meetings
   - Talk in terms they can understand depending on level of understanding
   - Small bits of information at a time so not to overwhelm people
   - Providers don't know what we are talking about or what that means to them

2. What is the best way for MaineCare and providers to educate members on all the new things that are happening, such as Accountable Communities and Health Homes? What's the best way to learn about these initiatives?
   - Flyer/pamphlet in mailing
   - Forums
   - Website
   - Eye catching mailings

- Multiple ways- elderly may get information from mail when younger generation might go on the internet
- Email
- Easy to read and understand plain language
- Regional offices are swamped
- What about providers having the information? Should they give out information concerning health homes or ACs?
- Languages

3. MaineCare will let members eligible for Health Homes know what Health Homes are, and who/where Health Homes provides are in their area of the state, in case want to receive care from a Health Home. What is important to let members know in these communications?
    - Not a physical structure
    - Types of services available
    - What is a Health Home?
    - My "home team" for medical care
    - Still have choice
    - Choice to be in the health home or not- need phone # to opt out on letter (can opt out/in at any time)
    - Choice of who you see for doctors/providers
    - Why is MaineCare doing this? Goals? Improve quality and costs "most bang for the buck"
    - More services that are of no extra cost to member
    - What changes will a member see? Targeted letter if high need individual?
    - Community Care Team will reach out to those who need a little extra help managing their health (high needs). CCT would reach out to high needs individuals
    - Team based approach to care
    - How does someone opt out of being in a Health Home?
    - For more information: phone #, website link
    - HH initiative overall= MaineCare
    - HH itself (provider qualifications, who you will work with)= practice
    - Advocacy information to help understand letters and information
    - How to share information be shared between two different health homes?
    - Notify members when they may be contacted by CCT in another letter if they qualify
    - Who will get this information? Who will the HH share my information with?

Follow Ups and Next Meeting

- Next meeting- September 21st
- Topics for the September Meeting
    - ✓ Sample letters –list of things that need to happen with VBP initiative and what MSC has contributed to strategy

- MSC members would like to see a copy of the draft State Plan Amendment (SPA). Michelle will need to see if she can share the document with the group.

All documents and materials concerning the Value Based Purchasing project reflect MaineCare's current thinking and are subject to change. No materials on the Value Based Purchasing web page, distributed and discussed at meetings or sent in emails or mailings are binding in any way concerning the future procurement process.

Leonard, James F.

From: Purington, Kitty
Sent: Monday, July 15, 2013 11:48 AM
To: Nadeau, Stefanie; Leonard, James F.; Cousins, Guy; Cahill-Low, Therese; Wheeler, Sheldon; Miller, Geoff; Jiorle, Kristen; Tweed, Lindsey; Barrows, Teresa
Subject: RE: Consumer and provider outreach and education/Behavioral Health Homes: Agenda
Attachments: Timeline 7 15.ppt

A few points for discussion at noon:

- Review of timeline for Behavioral Health Homes (see attached)
- Consumer outreach and education: adults, families
- Provider outreach, education, preparedness
- Longer term/next steps: monitoring and oversight of Behavioral Health Homes

-----Original Appointment-----
From: Nadeau, Stefanie
Sent: Tuesday, July 02, 2013 11:41 AM
To: Nadeau, Stefanie; Purington, Kitty; Leonard, James F.; Cousins, Guy; Cahill-Low, Therese; Wheeler, Sheldon; Miller, Geoff; Jiorle, Kristen
Subject: FW: Consumer and provider outreach and education/Behavioral Health Homes
When: Monday, July 15, 2013 12:00 PM-1:00 PM (GMT-05:00) Eastern Time (US & Canada).
Where: 242 State St - conf. room 1; call-in number: 877-455-0244 code: 8108964985

Kitty;
Any chance we can do a call in- we have meetings before and after this one over here and it creates a lot of running back and forth?
Thanks
Guy

Call-in number: 877-455-0244

Code: 8108964985

-----Original Appointment-----
From: Nadeau, Stefanie
Sent: Tuesday, July 02, 2013 11:41 AM
To: Nadeau, Stefanie; Leonard, James F.; Purington, Kitty; Cousins, Guy; Cahill-Low, Therese; Wheeler, Sheldon; Miller, Geoff; Jiorle, Kristen
Subject: Consumer and provider outreach and education/Behavioral Health Homes
When: Monday, July 15, 2013 12:00 PM-1:00 PM (GMT-05:00) Eastern Time (US & Canada).
Where: 242 State St - conf. room 1

As a follow to a conversation I had with Jim and Stefanie yesterday, can you please set up a meeting next week with Jim, Stefanie, myself, and the following people: Guy Cousins, Geoff Miller, Therese Cahill-Low, Kristen Jiorle, and Sheldon Wheeler.

The topic is consumer and provider outreach and education/ Behavioral Health Homes.

Thanks very much – let me know if you need any additional information.

Kitty Purington
Project Manager
Value-Based Purchasing Initiative
MaineCare
207-624-6921 (office)
207-939-6646 (cell)

Module 1: **Examining What You Have, Determining What You Want**

In this session, the group will review their current benefit package as it relates to their contemporaries and learn the meaning of common terms used in health benefit plans. The group will also explore the cost of poor healthcare delivery in economic and human terms and acquire an understanding of the state of healthcare around the world and learn how other countries are providing better, safer, less expensive healthcare than the US and why.

Recommended Reading: The Healing of America by TR Reid.

Module 2: **Bright Spotting: Best Practice Locally, Regionally and Nationally**

Participants in this class will learn about other areas and employers that have adopted different, more successful models of healthcare delivery.

Recommended Reading: The Triple Aim Journey: Improving Population Health and Patient's Experiences of Care at www.commonweatlhfund.org

Module 3: **Securing High Quality Healthcare Services**

Strategies for buying better healthcare outcomes will be explored with an emphasis on value based insurance design principals.

Recommended Reading for the Truly Committed: Redefining Healthcare: Creating Value Based Competition on Results by Michael Porter and Elizabeth Olmsted Teisberg

Module 4: **Preventing Poor Health**

When providers, patients and employers work together to prevent and arrest healthcare problems early, significant costs savings can be achieved. During this session, participants will learn how to critically examine a health improvement program.

Module 5: **Monitoring Your Benefits Package to Respond to Your Group's Needs and Assure the Best Value for Benefit Dollars**

During this session, representatives of the Maine Health Management Coalition's Data Department will be on hand to reveal trends in the group's past healthcare spending and how to predict what future trends are likely to be. They will also address how personal data is protected and how to monitor the impact of your benefit design.

Module 6: **Designing Your Benefit Package**

This guided, interactive assembly will be lead by Maine Health Management staff but will be assisted by a highly regarded actuary who will help the group understand what changes to their benefit package will likely increase or decrease their costs.

Module 7: **Selling and Satisfying Benefit Plan Users**

Attendees at this final, formal session will learn the latest thinking in positioning benefit changes to secure beneficiary satisfaction and acceptance. Role playing will be employed to help participants answer questions of their constituents.

Course Results:
Identification of the key deliverables of a health benefit plan: affordable illness and injury prevention, comprehensive evidenced based coverage, safe and effective care delivery, patient centered options and optimum outcomes.

Knowledge of proven methods for achieving the components above
Development of a strategic plan and evaluation program
Mastery of the principals of consumer adoption

MaineCare Services
An Office of the
Department of Health and Human Services

MaineCare

Value-Based Purchasing Strategy

DHHS Design Management Committee Meeting

June 3, 2013

Agenda

MaineCare Services
An Office of the Department of Health and Human Services

- VBP and DHHS budget initiatives
- Accountable Communities
  - Scope and phase in
- Stage B
  - Review of Timeline
  - Stage B Work Group initial recommendations/discussions
- Stage A Implementation Updates
  - Stage A/B eligibility
  - SPA/NCQA

Accountable Communities

MaineCare Services
An Office of the Department of Health and Human Services

Existing Plan for Accountable Communities Roll Out:

The program will target all MaineCare members who receive full MaineCare benefits, including:

- Categorically Needy
- Medically Needy
- SSI-related Coverage Groups
- Home and Community-based Waiver members, others.

For Discussion:

Phase-in scenarios, including by population (TANF, SS-related coverage groups, etc)

Stage B Timeline

Release of RFI and design development	Comments due on RFI by June 19th
Review by DMC	August 5
Consultation with SAMHSA	July/August, 2013
Final SPA Submission	August 30, 2013
Provider Application	October, 2013
Implementation	January, 2013

Behavioral Health Homes Framework

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Eligibility:

- Eligibility based on service utilization and eligibility criteria for certain community mental health services (see attached)
- Children and adults included, but design will need to reflect varied requirements

Service design:

- Primary locus of service is at the Behavioral Health Home, with close coordination/partnerships with primary care
- Assignment of members through the Behavioral Health Home
- Multi-disciplinary team that includes both medical and behavioral health professionals (see attached)
- Quality measures – opportunity to align with current SAMHS/consent decree work

Provider Requirements

- Expertise in serious mental illness (as evidenced by licensure OR other criteria: Rider E, OCFS contract provisions, etc.)
- Ability to implement integrated care model (in-house primary care; co-location; facilitated referral) w/ processes and procedures in place to support the model;
- Medical Director (part-time/x number of hours per week)
- Ability to provide psychiatric medication management services in addition to HH services and/or have an MOA with a psychiatric provider;
- EHR Capacity TBD with criteria at start up, at six months, at 12 months

Eligibility

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Children	Adults
Section 65 Children's Home and Community Based Treatment Multi-systemic Therapy Functional Family Therapy Children's Behavioral Health Day Treatment Children's Assertive Community Treatment (ACT) Sec 13 Targeted Case Management services for children with behavioral health disorders Section 97 Appendix D: Child Mental Health- Level I Child Mental Health – Level II Intensive Mental Health for Infants and/or Toddlers Crisis Stabilization Residential Services Therapeutic Foster Care Therapeutic Foster Care- Multidimensional Temporary High Intensity Service	Section 17 Community Integration Services 17.04-2 Community Rehabilitation Services 17.04-3 Intensive Case Management 17.04-4 Assertive Community Treatment 17.04-5 Daily Living Support Services 17.04-6 Skills Development Services 17.04-7 Day Supports Services 17.04-8 Specialized Group Services Section 97: Appendix E Appendix F: for Persons with Severe and Prolonged Mental Illness ONLY

Team Composition

MaineCare Services
An Office of the Department of Health and Human Services

- Medical Director (PCP, Psychiatrist, other?) at least 4 hours per month;
- Nurse Care Manager (x hours per assigned HH member)
- Team Leader (MSW/LCSW) x hour per assigned HH member)
- HH coordinator x hours per assigned HH member (MHRT + HH trained)
- Peer Support Specialist x hours per assigned HH member

Stage A Implementation: Updates

MaineCare Services
An Office of the Department of Health and Human Services

- Stage A/B Eligibility
  - Opt out letters out last week
  - 21,000 new members identified from eligibility changes and new claims run
- TCM
  - Holding off on communications until MaineCare can review issue with CMS, identify opportunities to serve individuals w/ TCM in the HH structure
- NCQA
  - Submitted SPA late last week to remove NCQA date
  - Reopened HH application
  - Received/approved 9 new HH applications – total of 159

Maine Department of Health & Human Services

Issues & Questions

Value-Based Purchasing Public Forums

This document summarizes issues and questions raised by participants during four public forums held in April 2012 about the Department's Value-Based Purchasing initiative. After an overview of the whole project, the forums focused on the Department's Health Homes (HH) and Accountable Communities (AC) initiatives. The presentation from these forums can be viewed here: http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/04252012_VBP_Forums.pdf

Domain	Issue	DHHS Response
Health Homes Timing	When will Health Homes Stage A and B be implemented?	The goal is to submit the SPA in May 2012, implementing Stage A in September 2012 and Stage B in January 2013.
Health Homes Community Care Teams	Do Community Care Teams in Stage B not provide BH services? What are they supposed to do?	They are not intended to take the place of services provided in Stage A or Stage B; they should assess the members' gaps in care and work with the member and the team to address these gaps.
Providers	Is OMS' goal to move away from community-owned practices and towards provider-owned system. If so, why?	OMS is actually trying to promote larger community integrated systems. Large providers may be just a piece of this, and each AC will all look a little different. OMS is purposely leaving some of this open to interpretation to encourage creativity and a wide variety of participants.
Accountable Communities & Health Homes	How will the inter-relationship between AC and HH work, if at all?	This is all so new it is hard to say at this point. From an evaluation standpoint, it may be hard to evaluate which has more impact on costs and service quality.
Providers- AC	Is a PCP required to be the "lead" in an Accountable Community?	No.
Providers- AC	Concerns about larger providers getting better savings i.e. a provider with 20 practice sites vs a provider	Accountable Communities should not favor larger providers, as everyone in an AC will receive a PMPM payment and get back a percentage of shared savings, plus eligible ACs can choose to only

Domain	Issue	DHHS Response
	with 200 practice sites, and is an AC unfairly skewed towards larger providers or health systems.	share in savings and not in downside risk, similar to Medicare (MSSP model).
Providers, Shared Risk- AC	With no shared risk in Year 1, and then increasingly shared risk in Years 2 and 3, doesn't this favor the larger systems? Smaller systems would not have the cash balance to cover shared risk.	Smaller systems can opt to only share in savings and not in downside risk.
Accountable Communities Core Services	Where is home health, home care and hospice? Are they core services?	
Accountable Communities Core Services	Are school-based behavioral health services included in AC core services? Should any children's BH services be included in the core services?	
Accountable Communities Core Services	Is there any incentive for ACs to pick up some/all optional services?	The incentive would be if the AC thinks they can help control costs and receive shared savings by being held accountable for and managing these services.
Accountable Communities Core Services	Will PA and UR still occur for core services?	Yes, PA and UR will still apply, there are no plans to changes the PA/UR process.
Accountable Communities Core Services	If member has need of specialist not in AC, who would contract for these services?	The member will still have a choice about who they see. It will still be a FFS environment and the specialist would be paid. OMS is leaving it up to AC as to how they structure their relationships with specialists. So if the member chooses to go outside of the AC, how will that be calculated? AC will be accountable for costs of their members' core services, and any optional services the AC chooses

Domain	Issue	DHHS Response
		to be held accountable for, no matter where the member receives services.
Accountable Communities Core Services	Discussion about concern re: cost shifting to be able to show savings in the core services, by placing members in what could be more expensive service buckets or general funded services to show Medicaid savings. Is the PA/UR process able to prevent this from happening- if not will it be adequate in time for ACs?	
Accountable Communities Core Services	If someone is on the HCBS waiver and receiving Targeted Case Management (TCM)- which is an optional service under AC- that would not be part of savings calculation if the AC does not opt to be held accountable for TCM?	That is correct.
Member Choice Accountable Communities	Can a member opt out of participation in an AC and still see the provider?	
Member Choice Accountable Communities	Can providers offer gym memberships as part of their service package if it is not marketed as an incentive for the AC?	Yes.
Member Choice Accountable Communities	What is the thinking on incentivizing members to stay in the AC?	There is very clear language on this from CMS- providers are not allowed to incent members with gifts etc to stay in their Accountable Community.

Domain	Issue	DHHS Response
Children, Children's Services	Concerns were raised about "incentivizing group care" for children in Accountable Communities, i.e. providers will move kids into group care instead of services in the home and community, if group care is not an accountable cost. This may show tremendous savings to the AC but not to the state's bottom line, and is counter-intuitive to the work done by OCFS in the last 2 years to serve children in the home and community, moving away from group care model.	
Children, Children's Services	Question about what percent of the "5% high users" are children.	DEPT SAID THEY WOULD RESPOND TO THIS.
Claims System	There were questions and concerns about the current claims system and its ability to get the information needed to calculate savings. Providers are worried about delays in claims, being attributed for services they did not provide etc. Michelle and Jim stated that the Department is cognizant of all the issues and there is a plan in place to fix this and get it ready for the new AC system.	
Providers	Do AC participants have to participate in HealthInfoNet- there are a number	Participation in HealthInfoNet will not be a requirement to be part of an AC.

Domain	Issue	DHHS Response
	of providers who do not have this ability?	
Providers	Question about 42 CFR Part 2 which deals with sharing health information- will providers need business agreements?	OMS is talking with AG's office on this and other issues. SAMSHA is interested in how this will work as well and OMS has been talking to them about it. Maine has begun to address sharing health information electronically with LD 1331 and Is one of 8 states selected by SASHA to work on electronic health records.
Quality	Meeting the 30th percentile on 70% or more of the quality measures seems low. It is 30th percentile of what?	This is a national measure, and the Department realizes that it is low- but really wants to get providers reporting in Year 1 so have set the bar low. The Department recognizes the need to, and plans on, raising the bar in Years 2 and 3.

MaineCare Services
An Office of the
Department of Health and Human Services

MaineCare

Internal Value-Based Purchasing Meeting

July 3, 2013 – Conference Room 1

Agenda

MaineCare Services
An Office of the Department of Health and Human Services

1. DHHS Budget Initiatives and VBP

2. Health Homes Stage A
   - Health Home Portal and Operational Updates
   - Health Home Rules and SPA

2. Stage B - Kitty
   - Timeline
   - SPA and Rulemaking

Leonard, James F.

From: Purington, Kitty
Sent: Thursday, July 18, 2013 10:39 AM
To: Cousins, Guy
Cc: Nadeau, Stefanie; Leonard, James F.; Barrows, Teresa; Tweed, Lindsey
Subject: Follow up w/ Consumer Council

Guy,

As a follow up to our discussion on consumer/provider outreach for health homes last week, my thoughts on a brief "statement of work" for the Consumer Council to get us started:

1. Convene a consumer-family advisory group/subcommittee/work group on Behavioral Health Homes to assist in outreach and education of families/consumers
2. Develop written materials for dissemination to consumers/families about Behavioral Health Homes
3. Convene family and consumer groups for education and outreach about health homes (either through existing meetings or meeting to be convened for this purpose)

Timeframe is, as we discussed, ASAP – it would be great have people working on this in August. Outreach and education would need to be very intense throughout the fall and during the first three months of the year.

Please let me know if you would like to discuss further, or if you need additional information/detail prior to initiating discussions with the Consumer Council.

Thanks very much for your help with this – it is greatly appreciated!

Kitty Purington
Project Manager
Value-Based Purchasing Initiative
MaineCare
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ANALYSIS OF
EMERGENCY DEPARTMENT USE in MAINE

A Study Conducted on Behalf of the
Emergency Department Use Work Group of the
Maine Advisory Council on Health System Development

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January, 2010

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and a Cooperative Agreement Between the Cutler Institute
and the Maine Department of Health and Human Services

Acknowledgements

The authors would like to thank the many individuals, physicians, nurses, nurse practitioners, hospital administrators and practice managers who generously shared their thoughts and experiences with us on the topic of emergency department utilization. We would, in addition, would like to express our appreciation to the MaineCare program participants who participated in focus groups and shared their experiences with us.

Karl Finison at Onpoint Health Data produced the analyses based on hospital discharge data that are included in the report. He and the research analysts at Onpoint Health Data are valued colleagues in this research. The analysis of potentially preventable visits presented in this report borrows a methodology developed by Mr. Finison with medical consultants in the New Hampshire Medicaid Program.

Finally, we would like to express our appreciation to the Maine Health Access Foundation and the Maine Department of Health and Human Services who, together, provided the funding to support this research.

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EXECUTIVE SUMMARY

In 2008, Maine's Advisory Council on Health System Development established a Work Group to study hospital emergency department utilization and, based on an analysis of utilization patterns, to make recommendations for policy interventions. This report presents findings from research to support that effort.

An earlier report described analyses based on hospital discharge data and medical claims data that analyzed and compared rates of emergency department use by health service areas within Maine, by different age cohorts, and different insurance coverage groups.

This report presents additional statewide analysis of emergency department (ED) utilization and also the results of a comparative analysis of six health service areas in Maine, three selected for above average rates of emergency department visits, and three selected for below average rates of emergency department visits.

The statewide analysis focused on identifying high volume diagnoses and potentially preventable emergency department visits both statewide and for specific patient cohorts identified by age and payer source (insurance coverage). These analyses were based on 2006 hospital discharge data. Key findings from this analysis include:

- Among infants under age one, top volume diagnoses do not vary among privately insured, MaineCare, and uninsured children and include, otitis media, upper respiratory infection, fever, and unspecified viral infection.
- Infants covered by MaineCare and uninsured infants made frequent visits for diagnoses including diaper rash, teething problems, and "fussy infant." These diagnoses were far less frequently seen among privately insured infants.
- The top diagnostic reason for an emergency department visit among both MaineCare and uninsured young adults aged 15 through 24 *and* adults aged 25 through 44 was dental disease.
- Fourteen diagnoses, all conditions that are frequently seen and treated in office and clinic settings, account for between a fifth and a quarter of total emergency department visits, depending on the health service area of the state. Most of these visits are preventable if care can be provided in an alternative setting.

The comparison of six health service areas in Maine was based on focus groups with MaineCare emergency department users in each selected area, interviews with hospital administrators and providers in each area, and analysis of population health, demographic and health system factors and data. The purpose of this analysis was to try to identify factors that can explain the reasons for high or low emergency department use. Key findings from this analysis include:

- The high use health service areas have substantially higher rates of emergency department visits for the fourteen potentially preventable visit diagnoses.

- A larger percent of the populations in the high use areas use the emergency department than in the low use areas.
- There was no discernable pattern associating high or low ED use with poverty rates, mortality rates, prevalence of health risk factors or chronic disease, or insurance status.
- While there is a statistically valid correlation between high and low emergency department use rates and physician to population ratios, there are many exceptions to the pattern. In addition, almost all providers interviewed stated that trends over time have been toward higher provider ratios at the same time that ED use has increased rapidly. Thus provider shortages cannot be implicated directly in driving high emergency department use.
- Health system factors that appear to mitigate emergency department visit rates include: availability of walk-in clinics, reserving slots in primary care practices for same day appointments, and availability of after-hours medical advice and triage.
- Patients who make emergency department visits complain of long waits for medical appointments, high physician turnover (in rural high use areas), difficulty taking time from work for medical appointments, and the inefficiency inherent in going one place for an appointment and another for diagnostic testing or treatment.

The comparative analysis, particularly interviews with providers, indicated that the problems encouraging emergency department use are endemic and the differences between high and low use areas are a matter of degree rather than absolutes.

Based on a synthesis of findings from the various analyses undertaken, the report identifies eight areas to be considered for policy interventions. These areas are:

- Reimbursement: current reimbursement systems reward high utilization and provide no incentives for providers to work to reduce ED use.
- Lack of sufficient service availability for same day, urgent care needs.
- Lack of sufficient service availability for medical advice and consultation in evenings and on weekends.
- Poor patient understanding of the importance of a functional provider/patient relationship and preventive health.
- Poor access for both preventive and acute dental care needs.
- Medication management: insufficient access to medical records and insufficient use of central drug use data banks hinder the ability of providers to assure patient safety and detect patient substance abuse.
- EMTALA: determining the extent to which federal “anti-patient-dumping” laws constrain treatment options and billing options at hospitals.
- MaineCare primary care case management program: the high rate of ED use by MaineCare enrollees indicate that the PCCM program is not meeting the goals of providing care management for some individuals in the program.

I. INTRODUCTION

Maine's Advisory Council on Health System Development was given a charge by the legislature in 2008 to study rising health care costs in the State of Maine, determine cost drivers, and make recommendations to the legislature on policy interventions that might mitigate the rate of increase in health care spending. In response to this charge, the Council established a Work Group to study hospital emergency department (ED) utilization and, based on an analysis of ED utilization patterns, to make recommendations for policy interventions to improve efficiency and quality of care in emergency department services in Maine. A list of members of the Workgroup is included in Appendix 3.

This report presents findings from the second phase of a study intended to inform the development of policy recommendations by the Work Group and the Advisory Council on Health System Development. The analyses included in this report were conducted by the Cutler Institute of the Muskie School of Public Service and Onpoint Health Data. This work was supported jointly by a grant from the Maine Health Access Foundation and a Cooperative Agreement with Maine's Department of Human Services.

The first phase of this study used hospital discharge data and insurance claims data to profile patterns of emergency department use and uncover differences in ED use associated with different age cohorts, health service areas, and insurance coverage groups in Maine. These findings are presented in a separate report (Kilbreth et al, 2009). Among the key findings from phase one were:

- Maine's emergency department use in 2006 was, in aggregate, about 30 percent higher than the national average.
- Maine's rate of use in every age cohort was higher than the national average. The age groups where Maine's experience was most disproportionate compared to national norms was among 5 to 14 year olds and 15 to 25 year olds.
- Use of emergency department care by MaineCare members in 2006 was substantially higher than privately insured residents. A higher rate of admissions resulting from emergency department visits among MaineCare members suggested a higher level of morbidity in this population. However, the high percentage of MaineCare members using the emergency department for at least one visit suggests that other factors contribute to ED use by this population.
- The rate of emergency department use varies substantially by health service area in Maine, with the highest use area having a rate almost 90 percent above the state average and the lowest use area having a rate 26 percent below the state average. High use areas are found in both urban and rural locations. In high use areas, ED visit rates are higher for both privately insured and MaineCare populations, suggesting causal factors that affect the entire population. However, having a high concentration of MaineCare residents also contributes to raising the average rate of a health service area.

The purpose of the phase two analyses presented in this report was to determine, to the extent possible, the reasons for different rates of use revealed in the study's phase one by examining emergency department use patterns of specific age and health coverage cohorts and of specific health service areas. The ED study group selected three health service areas in Maine with per capita ED use rates higher than Maine's average rate, and three health service areas with ED use rates lower than the average. In each of these areas, research staff have gathered the following information:

- Area profiles of disease prevalence, age distribution, income distribution, and employment.
- Health Service Area-specific emergency department use data based on further analysis of hospital discharge data.
- Area profiles of numbers of primary care providers, dentists, and selective information on physician practice hours of operation, scheduling protocols, and after hours policies.
- Interview data from hospital administrators and emergency department clinical providers providing information on hospital policies as well as hospital and provider perspectives on use patterns and utilization drivers.
- Interview data from community-based primary care physicians providing a physician perspective on use patterns and utilization drivers.
- Focus groups with participants in the MaineCare program who have made at least two Emergency department visits in the past year, to gain a patient perspective on reasons for ED use.

In addition to the comparative study of the six health service areas, this study includes three additional statewide analyses based on hospital discharge data. These analyses are: a review of per capita rates of certain potentially preventable ED visits within each health service area in the state; a review of the most frequently seen diagnoses by specific age/insurance cohorts; and an analysis of the correlation, statewide, of the primary care physician-to-population ratio and ED use rates.[1]

Section II describes the study methods. Section III of the report presents the findings from the new statewide data analyses. Section IV presents the comparative analyses of the six selected health service areas, based on hospital discharge data and secondary data collection. Section V summarizes findings from the focus groups with MaineCare emergency department users. Section VI presents an analysis of health system characteristics associated with high and low emergency department use, based on the study of six health service areas. Section VII presents an analysis of patient characteristics that contribute to high emergency department use, based on the focus groups with MaineCare emergency department users and interviews with providers. In Section VIII, we present options for consideration for policy changes targeted to reducing potentially avoidable emergency department visits.

[1] The correlation analysis is presented courtesy of the Maine Health Quality Forum which assembled the necessary physician data and conducted the correlation analysis.

II. STUDY METHODS

The purpose of this study was to analyze factors that may contribute to high rates of use of hospital emergency departments in Maine. The study builds on prior analysis using hospital discharge data and insurance claims data to describe patterns of emergency department use in the state.

The basic framework for the study was a comparative analysis of six Maine health service areas (HSAs) – three selected for emergency department use rates that were above the state average rate in 2006 and three selected for below average use rates. In addition, some analyses were conducted looking at the emergency department use of specific age cohorts and insurance coverage cohorts to better understand use patterns that contribute to high ED use.

This study made use of multiple data sources including: interviews with hospital administrators, emergency department providers, and community providers; focus groups with MaineCare enrollees; analysis of hospital discharge data; and collection and analysis of population health and demographic data on a county and health service area specific basis. Each of the data sources and methods of analysis is described below.

Hospital Discharge Data

Maine Health Data Organization (MHDO) hospital reports provide information on all emergency department visits for all users of Maine hospitals including uninsured, Medicare, Medicaid, privately insured and self-pay patients. We analyzed data for the year 2006 because our earlier analysis of Maine hospital experience used 2006 data. In order for the analyses in this report to build a more complete picture of ED use on a health service area specific basis, or an age-cohort specific basis, it was important to maintain continuity of the data. Otherwise, it would be difficult to determine whether differences found in the present analysis derived from changes over time or from new variations in utilization not discerned in the earlier analyses.

Hospital discharge analyses were restricted to residents of Maine. Visits to Maine hospitals by residents of other states or countries were not included. Conversely, we did not have access to data for visits made by Maine residents to hospitals out of state.

Emergency Department visits were tabulated by age group, gender, Hospital Service Area (HSA) and source of payment defined as follows:

- *Hospital Service Area*
  There are 32 hospital service areas in Maine comprised of the towns surrounding a hospital location where the plurality of residents' care is received at that hospital. When two hospitals are located in the same town or city, they share a service area.

- *Source of Payment*
  The expected source of payment coding available on the hospital discharge records can be aggregated into five groups as follows: Medicare, Medicaid, privately insured, uninsured, and

other. In this report, emergency department use is reported for the three groups: Medicaid, privately insured, and uninsured.

- *Emergency Department Visit*
  Emergency department visits were identified using standard coding systems for hospital billing: Uniform Billing (UB) Revenue Codes or CPT codes (Current Procedural Terminology). Both of these systems include multiple codes that refer to emergency department care. The comprehensive list of codes applied in this study follows the system developed by the National Committee for Quality Assurance (NCQA) Health Effectiveness Data Information Set (HEDIS). This method assured that this study's findings with regard to Maine can be compared to national studies of ED use.

  Outpatient emergency department visits that did not result in a hospitalization and visits that resulted in a hospitalization are reported separately. Throughout the report, when the term "outpatient emergency department (ED) visit is used, the data exclude visits that result in a hospital admission.

- *Diagnosis*
  The clinical diagnosis associated with each ED visit was assigned using the ICD-9-CM (International Classification of Diseases, Ninth Revision) code available on the hospital discharge data and administrative claims.

- *Frequent Users*
  Frequent users are defined as individuals who make four or more visits to an emergency department over the course of a year.

Analysis Methodology

The hospital discharge data is used in four types of analyses: determining population rates of emergency department visits; determining the proportion of visits attributable to high users and the proportion of visits that result in a hospital admission; measuring the proportion of visits attributable to certain diagnoses selected because they are conditions that are likely to be treatable in office or clinic settings; identifying high volume diagnoses for specific age and payer group cohorts and health service areas.

Rates of Use

Rates of use are calculated as the number of ED visits generated by a given population divided by the number of people included in the population. Rates are presented in terms of the number of ED visits for every 1000 persons. In order to calculate rates, it is necessary to have a count of the total people included in the population. We are not able to calculate rates for uninsured people in Maine because we do not have an exact count of the number of uninsured. Similarly, while we have total population counts by health service area (HSA), we do not have counts of individuals who fall into particular age groups or

coverage groups and thus can provide overall use rates for HSAs but not for specific age cohorts or sub-groups within HSAs.

Proportions of High Users and Admissions

Admission rates for specific ED users are calculated by adding total outpatient ED visits and visits that result in an admission for the population of interest to arrive at the total visit count, and then calculating the percent of total visits that resulted in an admission. The proportion of high users is calculated by developing a count of all individuals in the population of interest with four or more ED visits within a year and then calculating that number as a percent of total users within the population.

Potentially Preventable Visit Diagnoses

Fourteen diagnoses were selected that consist of conditions that likely are treatable in a non-hospital or office-based setting and thus may be preventable emergency department visits. The criteria for selection of the included conditions were: 1) matching diagnostic codes of conditions seen frequently both in hospital emergency departments and in primary care settings; 2) eliminating any diagnoses that, when seen in an emergency department, result in the patient being admitted more than 5 percent of the time; 3) a review of the list of diagnoses generated through this process by clinicians with emergency department experience and selection by the clinicians of a sub-set of conditions that, based on their clinical judgment, met the criterion of usually being an avoidable ED visit.

The clustering of these fourteen diagnoses into a single category is not intended to provide a comprehensive inventory of all potentially preventable visits but rather to create a uniform subset of frequently seen diagnoses that constitute a substantial portion of overall ED use and where the likelihood is that most of these visits could have occurred in an alternative care setting. The uniform category provides a basis for comparing ED utilization across different health service areas and population groups.

We calculated rates of use for the category of potentially preventable visits by counting total visits of the included diagnoses and dividing the number in the total population by the number of visits. We calculated the proportionate distribution of the selected potentially preventable visits by calculating the total number of potentially preventable visits as a percent of total visits.

High Volume Visits

Using 2006 hospital discharge data, total statewide emergency department visits were ranked in order of frequency and lists generated of the 30 diagnoses with the highest volume seen within each group and each insurance category. Some diagnoses were combined to create broader diagnostic categories. For example, all visits related to dental disease (Disorder of teeth and supporting structure, periapical abscess, apical periodontitis, and dental caries) were combined into a single diagnostic category of dental disease. “Headache” and “migraine” were combined, “abdominal pain, unspecified site” and “abdominal pain other specified site” were combined, and “lumbago” was combined with “lumbar strain and sprain.”

Focus Groups

Focus groups with MaineCare members were conducted in each of the study's six health service areas to gain an understanding of member attitudes about receiving care in emergency departments and the barriers that prevent them from getting care in other settings such as family practices and health centers. Focus group participants were recruited by telephone from lists of enrollees who had made at least two emergency department visits within the last twelve months. Five focus groups included adults who had used emergency departments for their own health care needs and/or those of their children. One focus group conducted in Bangor was made up of parents who had taken a child age 4 or under for treatment at an emergency department. In addition, a seventh focus group of MaineCare individuals with behavioral health diagnoses was held in the Portland. Volunteers for this focus group were recruited with the assistance of staff at the Amistad Peer Support and Recovery Center.

Seventy-two people were recruited to attend one of the 6 focus groups and 32 participated. Participants were provided with $50 grocery store gift certificates as tokens of appreciation for their time and insights. Initial recruitment was done at least a week prior to the scheduled time. Reminder phone calls were made to individuals the day before the scheduled event.

All participants were informed of the purpose of the study and signed informed consent statements agreeing to participate. Sessions were tape recorded and the tapes transcribed for analysis. The same semi-structured interview format and questions were used at each focus group. The interview protocol is included in Appendix 1.

The transcripts of the focus groups were analyzed to identify common themes and areas of difference. The content was analyzed to identify any patterns that were associated with high and low use health service areas and any patterns associated with urban and rural health service areas.

Provider Interviews

Research staff conducted interviews with thirty providers and hospital administrators in the six health services areas of the study. Interviews included, at a minimum, the Chief of the Emergency Department and the Nurse Director or Manager of the ED at each of the eight hospitals included in the study. In addition, community-based primary care providers were contacted in each health service area. An effort was made to include provider representatives of both federally qualified health centers and primary care practices owned by hospitals. Interviews were conducted by telephone and were one-on-one with the research interviewer. All participants were asked a uniform set of questions (interview protocol included in Appendix 1.).

In addition to the interviews with providers, research staff contacted the office staff of a sample of community-based practices in each of the study health service areas, including hospital-owned physician practices, private practices, and federally qualified health centers, to obtain information on practice hours, policies with regard to scheduling same day appointments or urgent visits, and after hours coverage.

The information from the interviews was summarized in matrices highlighting similarities and differences between high use and low use HSAs and examined for patterns associated with urban or rural location. A summary case study of each HSA was developed. Synthesized findings are presented in the report.

Population and Health Services Characteristics Data for Six Health Service Areas

Using U.S. Census, state Labor Department, and health department data, project staff collected demographic information for each of the study sites including: population density; age distribution; and percent of population in poverty; unemployment rates; and health insurance status. Population health characteristics included in the analysis were: overall age-adjusted mortality rates and mortality due to various diseases; leading causes of death; and the prevalence of various chronic diseases and behavioral risk factors.

Data on primary care provider to population ratios were provided by the Maine Quality Forum based on data tabulated by the Maine Medical Association from Maine's Bureau of Licensure. Where possible, information was collected on whether the providers treat MaineCare patients and whether or not their practice is open to new MaineCare patients. We also determined the number of federally qualified health centers and school-based health centers within each study area. Information on dentists was collected from the Maine Office of Data, Research and Vital Statistics and the Maine Dental Association.

Much of the data is available only for counties or the state as a whole. Several of the health service areas study sites are not contiguous with the state's county boundaries. They cross county boundaries and embrace only portions of some counties. In cases where health service areas encompass more than one county, statistics were collected for both counties that fall within a health service area.

Matrices of summary secondary data were developed allowing comparison of high use and low use HSAs and urban and rural HSAs. Full matrices, together with data source are included in Appendix 2. Summary findings are presented in the report.

III. FINDINGS FROM ANALYSES OF STATEWIDE EMERGENCY DEPARTMENT USE

Frequent Diagnoses Among Selected Age and Health Coverage Cohorts

Prior analysis of emergency department use in Maine has shown that Maine's overall rate of emergency department visits is about 30 percent above the national rate of use. In addition, emergency department use within selected age groups is high by national standards (Kilbreth, et al. 2009). In order to better understand some of the factors that contribute to unusually high use by particular age groups, the project research team reviewed the patient complaints that generate the highest volume of emergency department visits by specific age cohorts of privately insured, MaineCare insured, and uninsured patients. We further compared the high volume diagnoses of frequent emergency department (ED) users with individuals in the same age cohorts who made fewer visits. Frequent users were defined as individuals with four or more ED visits within a twelve month period. The age cohorts, selected by the ED Use Work Group, are infants below the age of one, young adults between the ages of 15 and 24, and adults between the ages of 25 and 44.

Table 1 compares the top eight diagnoses for each cohort of interest. (A rank order list of 30 highest volume diagnoses for each age and coverage cohort is included in Appendix 2.) Table 2 highlights differences in the most frequently seen diagnoses between Medicaid, privately insured, and uninsured populations within the same age cohorts.

Diagnostic Patterns among Infants

Among infants, the same four diagnoses – otitis media, upper respiratory infection, fever and unspecified viral infections – were responsible for generating the largest number of visits in all three insurance coverage categories. Although the MaineCare program covers about one in four children in the state, in 2006 MaineCare-covered children generated about three times as many visits for these four diagnoses as did privately insured children. All four of these illnesses can vary in severity from mild, non-threatening conditions to serious and even life-threatening illnesses. It is not possible to ascertain definitively whether the larger volume of visits among MaineCare-covered children arose from a higher incidence of serious illness in this population or a greater propensity to bring a baby in for evaluation and treatment for mild illness. However, in each insurance category, fewer than 2 percent of the infants' emergency department visits for these four diagnoses resulted in an admission, suggesting that many of the visits in all insurance cohorts were for less severe cases and that the higher volume in the MaineCare population arose from more visits for non-severe illness. In the MaineCare population, a substantially higher proportion of the visits in all the highest volume diagnoses were generated by high users. This difference between the MaineCare and the privately insured and uninsured suggests that some of the difference in rates of use within this age cohort can be attributable to a subset of the total MaineCare population who turned to the emergency department repeatedly for care or evaluation of their infants.

For the diagnoses ranked below the top four, numbers of visits dropped off fairly precipitously. A number of differences emerged among visits from privately insured infants in comparison to visits from

MaineCare infants and uninsured infants. Among the most frequently seen diagnoses for MaineCare and uninsured infants were "fussy infant" (7th most frequent reason for a visit among MaineCare babies), diaper rash (15th for MaineCare and 18th among the uninsured) teething syndrome (21st for MaineCare) and feeding problems in newborn (24th among uninsured babies) (Table 2). These diagnoses did not appear among the top 30 among privately insured infants. The disparity suggests that MaineCare and uninsured families utilize the emergency department for primary care at a higher rate than privately insured families, either because of financial or structural barriers to primary care in settings other than the emergency department or because of insufficient education in home care for infants and appropriate triggers for emergency visits.

Diagnostic Patterns among Individuals Aged 15 through 24

Among young adults, disparities in patterns of emergency department use by insurance status are immediately apparent. The top diagnostic reason for visits to the ED among both MaineCare enrollees and the uninsured in 2006 was dental disease. MaineCare enrollees in this age group made more than 3400 emergency department visits for complaints ranging from tooth decay to periapical abscess and apical periodontitis. Forty-five percent of visits for dental complaints by MaineCare participants were made by frequent ED users.[2] Among the uninsured, a third of dental visits were generated by frequent users. Although we do not know whether the repeat use among those who presented at the ED with dental disease was for dental care in each instance or for other medical problems, it is apparent that unmet dental care needs among ED users is associated with frequent visits. Also prevalent among MaineCare recipients and the uninsured and less so among the privately insured, were emergency department visits for mental health problems, specifically, depression and anxiety. Taken together, these two diagnoses constituted the fourth most frequent reason for an ED visit among MaineCare enrollees in this age group and the 6th most frequent among uninsured young adults. Among privately insured young adults, depressive disorders ranked as the 13th most frequently seen diagnosis while anxiety was not among the top 30 diagnoses. Among MaineCare enrollees, 43 percent of visits related to mental health diagnoses were generated by individuals making more than four visits in a year. Among uninsured young adults, 29 percent of mental health visits were generated by frequent users. High volume diagnoses shared by all young adults regardless of coverage status were acute pharyngitis, abdominal pain, and ankle sprains and strains.

Asthma is a frequently seen diagnosis among MaineCare and uninsured young adults (ranked 9th and 10th), but is not listed among the top 30 diagnoses for their privately insured counterparts (Table 2). Care for complications of pregnancy is the 9th most frequent diagnosis among MaineCare enrollees in this age group – a diagnosis that does not appear among the top 30 for the other cohorts of young adults. Visits for treatment of nondependent alcohol abuse were frequent among the privately insured and the uninsured (ranked 22nd and 23rd) but not among MaineCare enrollees of this age.

[2] Dental care is a covered benefit under MaineCare for children up through age 20. MaineCare adults do not have coverage for dental benefits, except tooth extraction.

Diagnostic Patterns among Adults Aged 25 through 44

Disparities in patterns of emergency department use similar to those among younger adults are seen in the cohort of adults aged 25 through 44. While chest pain was the top ranked diagnosis among privately insured adults, ED visits for dental disease far outranked all others among both MaineCare enrollees and the uninsured. As with the younger adults, about 4 in 10 dental visits among MaineCare enrollees and 3 in 10 among the uninsured were generated by frequent users. Among MaineCare recipients, close to 5000 visits were made for dental complaints in 2006. The next most frequent diagnosis treated in this cohort, lumbago and lumbar strain, generated a little over 2500 visits. Among uninsured adults, over 2400 visits related to dental pain and disease were made compared to about 950 for lumbago, the second ranked diagnosis. Visits for treatment of anxiety and depression were the fourth most frequent diagnostic category among both MaineCare and uninsured adults. Neither dental disease nor mental health problems were among the top 30 diagnoses for privately insured adults.

Except for the high prevalence of mental health and dental complaints among two of the three adult cohorts, the high volume diagnoses among all the adult groups were similar. All three groups included chest pain, acute pharyngitis, abdominal pain, bronchitis, and headache among the top eight reasons for ED visits. Uninsured adults were the only group where treatment for alcohol abuse was among the top 30 diagnoses.

Discussion

The review of high volume diagnoses among specific age and coverage groups suggest that Maine's unusually high ED use rates among young age cohorts are driven by a high volume of potentially preventable visits. Three situations are particularly noteworthy. The prevalence of dental emergencies suggests severe barriers to office-based dental care. Lack of insurance coverage for adults (including many with private health insurance) may impose substantial financial barriers for many Maine adults. In addition, workforce shortages may contribute to the problem. A high incidence of mental health visits among MaineCare and uninsured adults suggests undiagnosed or inadequately treated illness – or both. Finally, the frequency with which MaineCare-enrolled and uninsured infants are treated in emergency departments for conditions such as diaper rash, usually treated in a pediatrician's or family practice office, merits additional investigation. For uninsured families, financial barriers to office-based pediatric care may encourage ED use. For MaineCare recipients, barriers might arise from lack of established relationships with providers, from inability to get timely appointments, from transportation difficulties or lack of clarity on the part of parents on the appropriate use of emergency departments. These questions were explored with MaineCare enrollees and a discussion of these issues is presented in Section V of this report.

Table 1: Number of Visits and Percent of Visits Attributable to Frequent Users for Top Diagnoses in Rank Order for Specific Age and Payer Cohorts in Maine, 2006

Privately Insured			**MaineCare**			**Uninsured**		
Diagnosis	Number Visits	% Freq. User	Diagnosis	Number Visits	% Freq. User	Diagnosis	Number Visits	% Freq. User
Cohort Under Age 1								
1. Otitis media	366	18.6%	1. Upper respiratory infection	1,253	30.5%	1. Upper respiratory infection	85	9.4%
2. Upper resp. infection	302	14.6	2. Otitis media	1,126	34.5	2. Otitis media	54	20.4
3. Fever	251	10.8	3. Fever	557	25.0	3. Fever	32	9.4
4. Unspec. viral infect	120	10.8	4. Unspec. viral infection	428	40.9	4. Unspec. viral infection	23	21.7
5. Contus. Of face scalp & neck	88	12.5	5. Vomiting alone	264	31.4	5. Fussy infant	16	18.8
			6. Conjunctivitis	193	32.6	6. Vomiting alone	14	28.6
6. Vomiting alone	78	10.3	7. Fussy infant	192	31.8	7. Candidiasis of mouth	13	15.4
7. Acute bronchiolitis	68	11.8	8. Noninf. Gastroenteritis	178	32.6	8. Rash	13	15.4
8. Croup	67	7.4						
Cohort Ages 15 through 24								
1. Acute pharyngitis & strep throat	1914	11.5%	1. Dental disease	3430	44.8%	1. Dental disease	1149	33.4%
			2. Acute pharyngitis & strep throat	2291	25.5	2. Acute pharyngitis & Strep throat	751	14.2
2. Ankle sprain & strain	1116	5.6						
3. Abdominal pain	994	21.2	3. Abdominal pain	1669	44.4	3. Bronchitis	392	21.4
4. Urinary tract infection	859	10.9	4. Mental health problems	1243	42.9	4. Urinary tract infection	351	17.4
5. Neck sprain and strain	796	14.2	5. Upper respiratory infection	1173	37.1	5. Abdominal pain	350	14.6
6. Open finger wound	643	8.5	6. Urinary tract infection	1170	38.4	6. Mental health problems	347	29.1
7. Upper respiratory infection	586	16.2	7. Lumbago & lumbar strain	1098	43.7	7. Lumbago & lumbar strain	340	34.4
8. Otitis media	492	9.3	8. 1 sprain & strain	1011	28.0	8. Ankle strain and sprain	272	14.7
Cohort Ages 25 through 44								
1. Chest pain	2502	9.4%	1. Dental disease	4949	43.6%	1. Dental disease	2432	28.7%
2. Acute pharyngitis	2009	6.4	2.Headache & Migraine	2587	56.9	2. Lumbago & lumbar sprain	949	26.3
3. Abdominal pain	1877	9.5	3. Lumbago & lumbar sprain	2581	31.0	3. Acute bronchitis	727	21.2
4. Lumbago & lumbar sprain	1692	4.4	4. Abdominal pain	2096	45.8	4. Mental health problems	620	24.3
5. Bronchitis	1485	12.2	5. Mental health problems	1723	45.4	5. Abdominal pain	602	30.1
6. Headache	1241	48.3	6. Acute bronchitis	1710	35.2	6. Chest pain	587	18.2
7. Open finger wound	1218	N.A.	7. Chest pain	1607	31.4	7. Acute pharyngitis	518	14.9
8. Neck sprain and strain	1109	11.9	8. Acute pharyngitis	1204	28.4	8. Headache	398	30.4

Table 2: High Volume Diagnoses Unique to Payer Cohorts within Age Groups Based Top 30 Diagnoses in 2006

Privately Insured			**MaineCare**			**Uninsured**		
Diagnosis	Number Visits	% Freq. User	Diagnosis	Number Visits	% Freq. User	Diagnosis	Numb er Visits	% Freq. User
Rank			Rank			Rank		
			15. Diaper rash	105	39.0%	14. Fetal neonatal jaundice	9	11%
29. Febrile convulsion	16	N.A.	21. Teething synd.	68	29.4	18. Diaper rash	8	12.5
30. Dehydration	15	N.A.	24. Abdom. Pain, unspec	57	26.3	19. Abdominal pain, unspec	8	N.A.
			29. Contact dermatitis	50	36%	22. Constipation	7	N.A.
			30. Esophageal reflux	48	N.A.	24. Feeding prob in newborn	6	16.7
Rank			Rank			Rank		
17. Syncope & collapse	355	N.A.	9. Current maternal CCE	879	41.0%	9. asthma	271	36.5%
20. Infectious mononucleosis	271	N.A.	antepartum			22. Nondep alcohl abuse	163	N.A.
23. Nondep alcohl abuse	260	15.4%	10. asthma	821	44.5%			
Rank						Rank		
26. Dizziness & giddiness	462	N.A.				23. Non-dep alcohl abuse	255	30.6%
28. Cellulitis & Abscess leg	435	33.3%						
30. Palpitations	425	N.A.						

Potentially Preventable Emergency Department Visits

In this section, we present information for all Maine Health Service Areas (HSAs) on a uniform sub-set of emergency department visits. The selected diagnoses consist of conditions that likely were treatable in a non-hospital or office-based setting and thus may have been preventable. The criteria for selection of the included conditions were: 1) matching diagnostic codes of conditions seen frequently both in hospital emergency departments and in primary care settings; 2) eliminating any diagnoses that, when seen in an emergency department, result in the patient being admitted more than 5 percent of the time; 3) a review of the list of diagnoses generated through this process by clinicians with emergency department experience and selection by the clinicians of a sub-set of conditions that, based on their clinical judgment, met the criterion of usually being an avoidable ED visit.[3] The fourteen conditions included in the category of potentially avoidable visits are shown below.

Potentially avoidable ED visits

- Sore Throat
- Viral infection (unspecified)
- Anxiety (unspecified or generalized)
- Conjunctivitis (acute or unspecified)
- External and middle ear infection (acute or unspecified)
- Upper Respiratory infections (acute or unspecified)
- Bronchitis (acute or unspecified)
- Asthma
- Dermatitis and rash
- Joint pain
- Lower and unspecified back pain
- Muscle and soft tissue limb pain
- Fatigue
- Headache

Analysis of the selected cluster of diagnoses provides a window – albeit an imperfect one – for comparing utilization patterns by different populations and different health service areas. The diagnostic information that is available on hospital discharge records and insurance claims data is insufficient to determine whether a particular episode of care required emergency department treatment. Some conditions that are treatable in a physician's office during the day might appropriately require emergency department care if an exacerbation occurs in the middle of the night. Some conditions which, after assessment, are determined to need minimal treatment might have required diagnostic testing available in a hospital in order to eliminate the possibility of a more serious injury or illness. Thus visits grouped using the selected diagnosis codes may include some visits that were not avoidable. Conversely, many visits with diagnoses not included on our list may be avoidable. However, because the conditions included in the selected diagnostic cluster are high volume and are *usually* treatable in an office setting, in aggregate, they provide a measure of a portion of ED use that might be transferable to alternative care settings and they provide a uniform basis for comparing differences in ED use by health service area and by different population groups.

[3] This methodology was developed by Onpoint Health Data in collaboration with New Hampshire's Office of Medical Assistance. The conditions selected for analysis in New Hampshire were used for the Maine analysis with one exception. New Hampshire's avoidable visit condition list included abdominal pain. This condition was eliminated from the Maine list of potentially avoidable visits.

Use Rates for Potentially Avoidable Visits by Hospital Service Area

Table 3 shows the age-standardized rate of visits per 1000 population for the selected group of potentially avoidable ED visits for each health service area in the state as well as the rate of use for all ED visits. The population rates of use for this cluster of visits vary more than three-fold from the highest use HSA to the lowest. This is a higher rate of geographic variability than is seen for ED use inclusive of all visits – where the highest use rate is about 2.5 times the lowest – suggesting there is more variability in rates of potentially preventable visits than in visits for true emergency care. The selected cluster of potentially preventable visits also varies substantially as a proportion of overall ED use in different health service areas. Table 3 shows that in Caribou, which has the highest overall ED visit rate, the selected cluster of potentially preventable visits makes up more than 25 percent of total outpatient ED volume. By contrast, in two general service hospitals with among the lowest overall ED use rates, Bar Harbor and Midcoast, the cluster of potentially preventable visits constitute 16 percent and 18 percent, respectively, of overall use.[4]

The strong correlation between health service areas with high overall ED use rates and those with a high proportion of potentially preventable visits suggests that strategies undertaken to provide alternative care settings for potentially preventable visits could successfully bring ED use rates in high use areas closer to the norm in Maine.

Figure 1 shows that, while the highest use rate for the cluster of potentially preventable ED visits tend to be in rural areas, this relationship is not uniform. Caribou, for example, has the highest use rate for the selected diagnoses in Maine, while neighboring Fort Kent is below the state average.

[4] HSAs with low ED use community hospitals were selected for this comparison rather than Portland or Bangor (both of which have very low population ED use rates) because Portland and Bangor house tertiary care hospitals and are major trauma centers and, thus, have a different mix of ED visits that is likely to differ from other hospitals in the state.

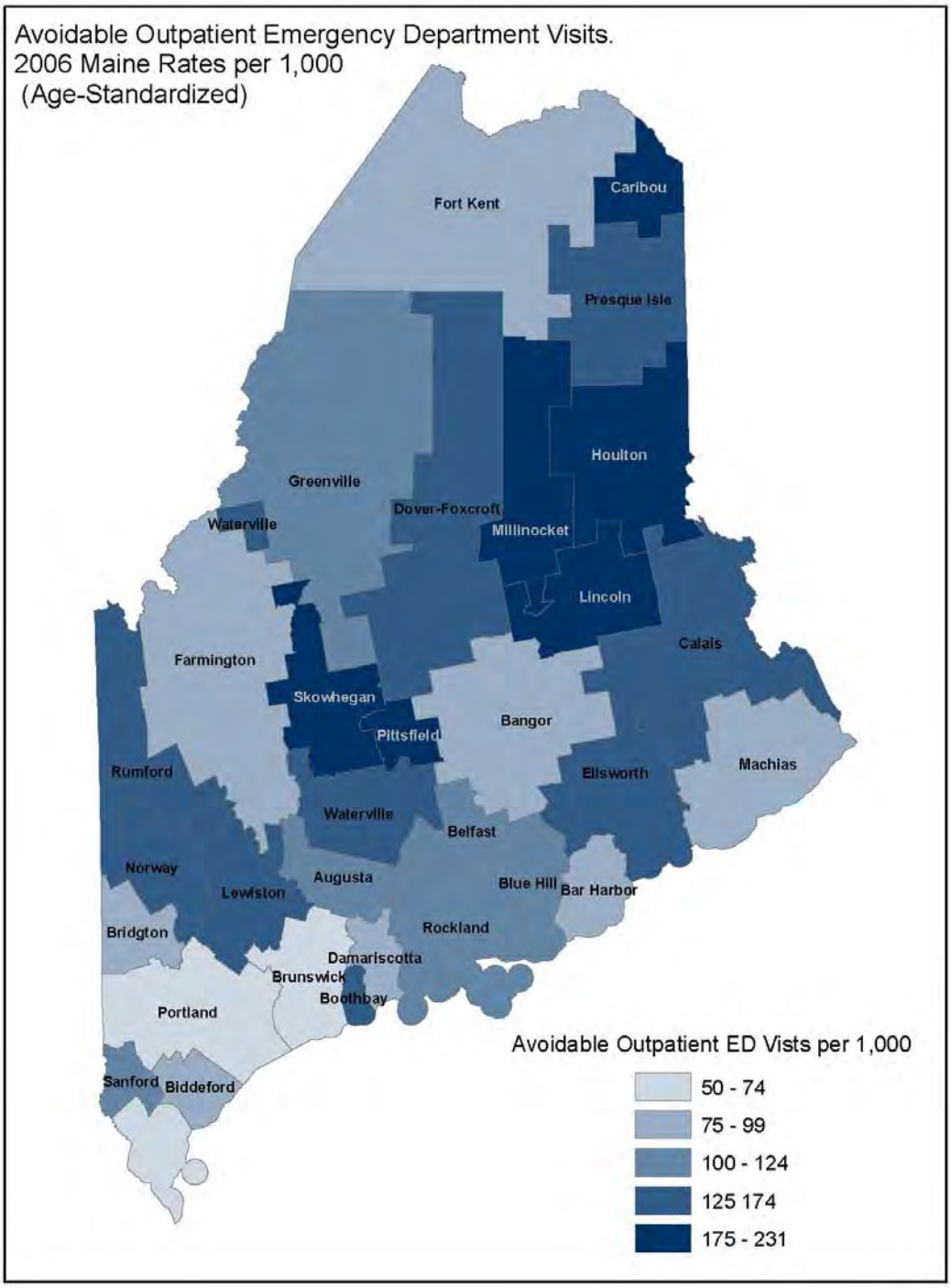
Table 3: 2006 Maine Emergency Department Use by Health Service Area: Age-Standardized ED Use Rates, All ED Visits and Selected Potentially Preventable Diagnoses[5]

Hospital Service Area	Population Estimate	Total ED Visits Age standardized rate per 1000	Selected PPD Visits Age Standardized rate per 1000	PPD Visits as a percent of Total Visits
Caribou	17,057	905	230	25.4%
Millinocket	7,962	786	190	24.2
Lincoln	13,108	728	188	25.8
Pittsfield	15,386	719	183	25.4
Houlton	18,874	721	179	24.8
Skowhegan	28,965	762	175	23.0
Calais	12,867	765	174	22.7
Waterville	72,460	639	159	24.9
Rumford	15,816	650	148	22.8
Presque Isle	24,828	609	139	22.8
Dover-Foxcroft	19,775	621	139	22.4
Ellsworth	25,386	579	134	23.1
Norway	24,861	581	129	22.2
Lewiston	121,611	571	128	22.4
Boothbay	6,281	620	127	20.5
Belfast	22,493	585	123	21.0
Greenville	2,468	609	120	19.7
Rockland	49,355	483	109	22.6
Augusta	61,435	487	103	21.1
Sanford	35,224	499	101	20.2
Blue Hill	11,110	490	100	20.4
Machias	16,260	508	95	18.7
Damariscotta	12,082	490	93	19.0
Bridgton	18,530	458	90	19.7
Farmington	33,874	408	90	22.0
Fort Kent	14,710	423	86	20.3
Biddeford	74,963	423	82	19.4
Bangor	131,548	409	81	19.8
Bar Harbor	11,402	471	76	16.1
Brunswick	74,200	367	68	18.5
Portland	265,702	359	68	18.9
York[6]	61,012	272	54	19.9

[5] Highlighted HSAs on those included in comparative analysis. See page 21.

[6] York area may be low due to border crossing. Data source only includes Maine hospital data.

Figure 1. Avoidable Outpatient Emergency Department Visits



IV. COMPARISON OF SIX MAINE HEALTH SERVICE AREAS

This section of the report presents a comparative analysis of six health service areas in Maine, three selected because they have emergency department use rates above the state average and three selected because their ED use rates are below the state average. Bangor and Lewiston are compared as urban areas with contrasting use rates (Bangor, low and Lewiston, high). Two low use rural areas, Damariscotta and Farmington, and two high use rural areas, Calais and Caribou form the remaining study sites.

Project staff undertook a multi-method research approach to collect information that might uncover patterns associated with either high or low ED use rate and allow deductions as to factors that contribute to ED use. The research project included: collection and analysis of secondary data on population demographics and health status and health service area characteristics; analysis of age and payer defined subsets of ED users within the selected HSAs; analysis of the most frequently seen ED diagnoses in each HSA; interviews with emergency department administrators and ED and community-based clinicians in each selected site; and focus groups with MaineCare enrollees at each site who have received emergency department care within the past year.[7]

ED Use Rates by Age in High and Low Use Health Service Areas

Tables 3 and 4 show the population emergency department use rates in total and across different age cohorts for the six health service area study sites in 2006. Lewiston, in comparison to Bangor experienced about 150 more ED visits per 1000 residents (Table 3). However, the rates of visits resulting in an admission in these two urban areas were the same. The proportion of the population making frequent ED visits (more than four in a year) in Lewiston was more than double the proportion in Bangor. Taken together, these statistics suggest that the higher rate of ED visits in Lewiston, compared to Bangor arises from a combination of a larger number of visits with less urgency and multiple visits from a small proportion of the population. The rate of use in Lewiston is higher in every age group, but the disparity is particularly striking among infants, where the rate of use in Lewiston is 17.5 visits per 1000 infants compared to 2.8 visits in Bangor.

[7] A sixth data collection effort, an on-site survey of ED users at each hospital in the selected sites, had to be postponed due to the risk posed to interviewers by the high prevalence of H1N1 virus in the emergency departments in the winter months. This data collection effort will be completed in the spring and the findings released as an addendum to this report.

Table 3: Comparison of Emergency Department Use Rates by Selected Age Groups, Bangor and Lewiston

Age Group	Rate of ED visits per 1000	Rate of ED visits resulting in admission per 1000	Number of Frequent Outpatient ED Users	Frequent Users as a Percent of total Population Age Group Cohort
Bangor Total	420	59	1903	1.4%
Lewiston Total	578	59	4051	3.3%
Bangor <1	593	36	41	2.8
Lewiston <1	1105	49	263	17.5
Bangor 1-4	473	13	74	1.4
Lewiston 1-4	798	13	508	9.1
Bangor 15-24	508	13	499	2.2
Lewiston 15-24	859	28	1642	9.7
Bangor 25-44	507	27	788	2.2
Lewiston 25-44	660	39	2005	6.0
Bangor 45-64	327	64	426	1.2
Lewiston 45-64	394	59	1088	3.3

The overall ED visit rates of the two rural, high use areas were about double the rates of the two low use areas in 2006 (Table 4). Calais, one of the high use areas, had a substantially lower rate of visits resulting in a hospital admission than the other study areas, but Caribou, the second high use area, had a higher rate of admission. The proportion of the population who make frequent ED visits is substantially higher in the two high use areas than in the two low use areas.

Calais had a particularly high rate of use among infants under age one in comparison to all the other study areas. Twenty-seven percent, or more than one in four infants in the area visited the emergency department more than four times over the course of a year. Caribou and Calais, the two high use areas, had higher rates of use in each age cohort and higher proportions of frequent users.

Over all ages, Calais had a low percent of admissions arising from ED visits compared to the other study areas.

Table 4: Comparison of Emergency Department Use Rates by Selected Age Groups, Calais, Caribou, Damariscotta and Farmington

Age Group		Rate of ED visits per 1000	Rate of ED visits resulting in admission per 1000	Number of Frequent Outpatient ED Users	Frequent Users as a Percent of total Population Age Group Cohort
Calais, Total		759	20	494	3.8%
Caribou, Total		894	76	928	5.4
Damariscotta, Total		476	65	223	1.8
Farmington, Total		412	54	566	1.7
Calais	<1	2263	51	37	27%
Caribou	<1	1785	21	30	20.8
Damariscotta	<1	1188	0	4	5.8
Farmington	<1	1010	60	24	8.0
Calais	1-4	1282	16	63	11.3
Caribou	1-4	1285	3	68	11.0
Damariscotta	1-4	627	14	10	2.8
Farmington	1-4	581	21	31	2.5
Calais	15-24	833	10	61	3.7
Caribou	15-24	1131	16	213	9.1
Damariscotta	15-24	565	10	40	3.0
Farmington	15-24	491	19	184	3.1
Calais	25-44	746	17	141	4.5
Caribou	25-44	995	31	286	7.1
Damariscotta	25-44	553	26	60	2.4
Farmington	25-44	464	35	194	2.3
Calais	45-64	574	25	101	2.7
Caribou	45-64	689	69	214	4.1
Damariscotta	45-64	332	34	49	1.2
Farmington	45-64	282	45	88	0.9

Visit Rates for Potentially Preventable Diagnoses by Health Service Area

Fourteen diagnoses frequently seen in both emergency departments and in primary care settings were selected for a comparative analysis of the six study areas (see discussion of selection process, page 5). In aggregate, the rate of visits for this cluster of diagnoses ranged from 223 per 1000 in Caribou to 83.5 per 1000 in Bangor in 2006 (Table 5). Of the individual diagnoses, the greatest disparity was for upper respiratory infections where the rate of visits in Caribou was more than 56 per 1000 compared to about 17 per 1000 in Bangor and Damariscotta. Calais had an unusually high rate of diagnoses for viral infections – 20 per 1000 compared to under 10 in the other five HSAs. It is possible that some of the disparity is due to differences in coding practices from hospital to hospital. However, the high use health service areas had consistently higher rates of visits within each diagnosis as well as in aggregate.

The number of persons within each health service area that had at least one ED visit for one of these potentially preventable conditions was proportionately larger in the higher use health service areas, ranging from 16 percent of the population in Caribou to about 7 percent in Bangor and Damariscotta.

For purposes of comparison, Table 6 shows the population rate of visit in 2006 for two frequently seen conditions likely to merit immediate medical attention and resources available in an emergency department – chest pain and an open wound of the finger. Given the non-discretionary need for immediate medical care and – in the case of a finger wound – the unpredictability of injury, one would hypothesize that the rate of visits for these conditions across different geographic areas would vary less than for conditions where care can possibly be delayed or provided in a non-hospital setting. Indeed, the visit rates per 1000 in 2006 for these two conditions showed less extreme variability than the diagnoses reported in Table 5. However, the same underlying pattern is evident even with these diagnoses. Bangor and Lewiston, which vary from each other substantially on potentially preventable diagnosis visits, have rates that are less disparate in Table 6 although Lewiston rates are still higher. The highest population visit rates for these non-discretionary visits were in Caribou and Calais. Some of the disparity for visits related to chest pain may be attributable to the higher prevalence of risk factors for heart disease seen in these health service areas (see discussion, p. 11). Higher use rates may also be associated with less successful disease management of individuals with chronic illnesses in high use areas.

Table 5: ED Visit Rates and Percent of Population Making a Visit for Selected Potentially Preventable Diagnosis (PPD) Visits

	Bangor		Lewiston		Calais		Caribou		Damariscotta		Farmington	
	Rate per 1000	% with visit	Rate per 1000	% with visit	Rate per 1000	% with visit	Rate per 1000	% with visit	Rate per 1000	% with visit	Rate per 1000	% with visit
Total PPD Visits	83.5	7.0%	131.0	9.9%	172.2	13.1%	223.4	16.0%	84.8	7.2%	89.9	7.5%
U.R.I.	17.6	1.6%	28.6	2.6%	29.0	2.6%	56.3	4.9%	16.9	1.6%	20.0	1.9%
Ear Infections	10.0	0.9%	18.4	1.6%	25.5	2.2%	35.4	2.9%	11.8	1.1%	10.3	0.9%
Bronchitis	9.6	0.9%	16.5	1.5%	24.2	2.2%	38.0	3.3%	13.2	1.2%	7.3	0.7%
Unspecified lower back pain	9.3	0.8%	10.9	0.9%	14.1	1.2%	19.5	1.4%	7.2	0.6%	9.4	0.9%
Asthma	5.0	0.4%	8.5	0.7%	17.6	1.4%	13.1	1.1%	5.1	0.4%	4.2	0.3%
Joint pain	6.5	0.6%	7.5	0.7%	7.8	0.7%	10.9	1.0%	4.2	0.4%	8.2	0.8%
Viral Infection	3.5	0.3%	7.7	0.7%	20.1	1.8%	8.1	0.8%	2.6	0.2%	6.1	0.6%
Muscle/soft tissue pain	4.1	0.4%	7.7	0.5%	6.1	0.6%	9.0	0.8%	3.3	0.3%	4.7	0.5%

Table 6: ED Visit Rates for Frequently Seen Diagnoses Usually Requiring Emergency Care

	Bangor	Lewiston	Calais	Caribou	Damariscotta	Farmington
	Rate per 1000	Rate per 1000	Rate per 1000	Rate per 1000	Rate per 1000	Rate per 1000
Chest Pain	16.8	18.0	20.0	33.0	19.1	16.0
Open wound of finger	5.5	8.5	9.6	9.9	8.5	5.6

Population Profiles and Provider Availability in Six Health Service Areas

Using U.S. Census, state Labor Department, and health department data, project staff collected demographic information for each of the study sites including: population density; age distribution; percent of population in poverty; unemployment rates; and health insurance status. Population health characteristics included in the analysis were: overall age-adjusted mortality rates and mortality due to various diseases; leading causes of death; and the prevalence of various chronic diseases and behavioral risk factors.

To measure the availability of primary care in the selected sites, we obtained data on the number of primary care physicians and dentists (measured as number of doctors per 100,000 population) and, where possible, collected information on whether the providers treat MaineCare patients and whether or not their practice is open to new MaineCare patients. We also determined the number of federally qualified health centers and school-based health centers within each study area.

Much of the data is available only for counties or the state as a whole. Several of the health service areas study sites are not contiguous with the state's county boundaries. They cross county boundaries and embrace only portions of some counties. In cases where health service areas encompass more than one county, statistics were collected for both counties that fall within a health service area.

Site Characteristics Associated with High or Low Emergency Department Use

Matrices of all the data collected, organized by health service area, along with information on data sources is included in the report appendices. Here, we report only on patterns that emerged that might bear a relationship to emergency department use.

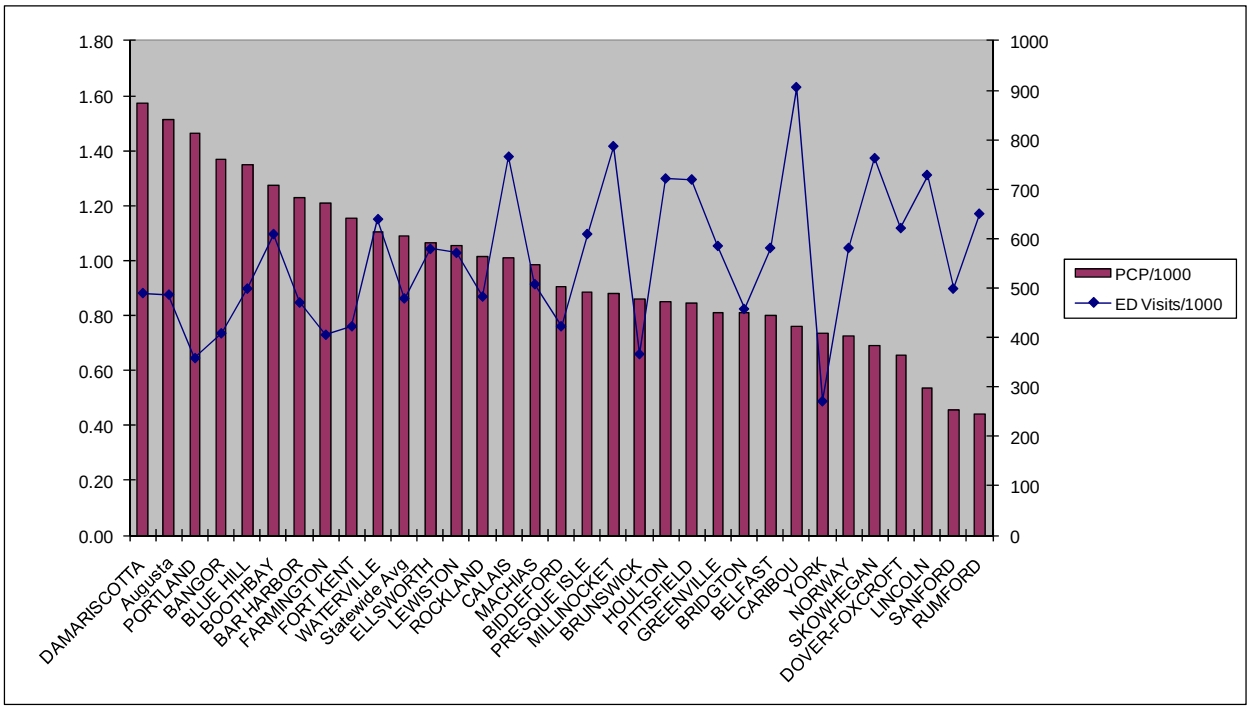
Of all the measures we examined, only one aligns with ED use rates in the six health service areas of our study – primary care physicians per population. Overall, across the state, the PCP to population ratio is 109 physicians per 100,000 population. In the three health service areas selected for study with high ED use rates, the PCP to population ratios were 76 and 101 per 100,000, respectively in the two rural health service areas, and 105 per 100,000 in the urban high ED use health service area. By comparison, the ratios in the three low use HSAs (while still below the state average) were 121,137 and 157 (Table 7).

Table 7: Primary Care Physicians per 100,000[8]

			Above Average ED Use			Below Average ED Use		
	National	State	Caribou	Calais	Lewiston	Bangor	Farmington	Damariscotta
PCP per 100,000	124	109	76	101	105	137	121	157

The inverse relationship between numbers of primary care physicians and emergency department use holds up across the state (Figure 2). While the relationship is not exact, statistical correlation analysis shows that the general association of high ED use rates with lower primary care doctor availability and vice versa, is sufficiently strong in Maine that it is unlikely to be due to chance.[9]

Figure 2. ED Visit Rates in Relation to PCP to Population Ratios



The relationship of numbers of providers to ED use remains, nevertheless, a puzzle. Almost all providers interviewed across the six HSAs of the study commented that, over the past 10 to 15 years, their area had seen declining population, an increase in the number of providers and, yet, a near doubling of the

[8] Data sources: National: 2006 Maine State Health Plan (2008/2009); County: 2005 State and Maine Quality Forum
[9] Analysis conducted by Jim Leonard of the Maine Quality Forum.

rate of emergency department visits. Given patterns over time, differences in ED use rates cannot be attributed solely to physician-to-population ratios.

Providers and administrators familiar with the patterns of ED use in their areas uniformly point to inadequate access to dental care as a major contributor to preventable ED use (see discussion, Section III). Our data collection did not discern an association between ratios of dental providers and high and low ED use rates. However, our data affirms that there are shortages of dental providers, generally, and for MaineCare participants, in particular. In the six health service areas under study, the number of general practice dentists with active practices per 100,000 population ranged from about 25 to 37. The number of active general practice dentists who treat MaineCare patients ranges from 7 to 24 per 100,000; and the number of dentists that are still accepting new MaineCare patients ranges from under 2 per 100,000 (in Androscoggin County) to 11 per 100,000 (in Aroostook County) (based on 2006 data from the Maine Office of Vital Statistics) (Table 8).

Table 8: Active General Practice Dentists per 100,000[10]

		Above Average ED Use			Below Average ED Use		
	State	Caribou	Calais	Lewiston	Bangor	Farmington	Damariscotta
Active (GP) dentists per 100,000	35.29	24.96	30.51	32.70	36.76	24.58	34.48
GP dentists that treat MaineCare per100,000	15.67	20.80	24.41	6.54	19.87	9.83	11.49
GP dentists that accept new MaineCare per100,000	6.08	11.09	18.30	1.87	10.43	3.69	2.87

There were no major differences between HSAs in terms of prevalence of depression or substance abuse according to the Maine CDC Health Indicator Report, 2004 – 2006 (Appendix 2). However, mental health resources are unevenly concentrated. From a review of Maine's Office of Mental Health Services resource guide by town, it is apparent that there are more mental health agencies in urban settings (Bangor and Lewiston have 18 and 21 agencies respectively) than in rural areas (range from 3 to 10

[10] Data source: data as of 1/1/06 – Maine Office of Data, Research, and Vital Statistics

agencies).[11] While crisis services, such as the crisis hotline, are available statewide 24 hours a day, Bangor has the highest number of agencies providing crisis services; some areas such as Calais and Damariscotta do not have any agencies providing these services.

There is a higher rate of emergency department visits and admissions for mental health diagnoses in the HSAs with more resources than in those with fewer (Table 9). It is possible that individuals with serious mental illness migrate to the parts of the state where more services are available. It is also possible that emergency department providers in the urban, more highly resourced HSAs are more likely to diagnose a complaint as having a mental health component of anxiety or depression than ED providers in rural areas with fewer mental health providers.

Table 9: Population Visit Rates for Depressive and Anxiety Disorders by HSA, 2006

	Above Average ED Use			Below Average ED Use		
	Calais	Caribou	Lewiston	Bangor	Farmington	Damariscotta
ED Visit Rate per 1000	Not among top 30 diagnoses	Not among top 30 diagnoses	6.57	5.85	1.44	1.00

Health Service Area Differences not Associated with High or Low Use

While the primary care physician to population ratio was the only factor we examined that aligned with high and low ED use rates, other differences among the HSAs may be indicative of differential burdens placed on providers in different parts of the state. Three of the six sites for our study have poverty rates substantially above the state average. In 2005, Caribou (high use) and Farmington (low use) both had about 17 percent of adults living in poverty, and Calais (high use), about 19 percent in poverty, compared to a state rate of 12 percent (based on 2005 county level census data) (Table 7). By contrast, Damariscotta (low use) had a poverty rate of 11 percent – a little below the state average. Both Lewiston (high use) and Bangor (low use) were at the state average of 12 percent. The relative wealth of Damariscotta (and greater availability of providers) may explain its advantage on population health measures compared to the other study sites. Damariscotta's age-adjusted mortality rate from all causes is 764.8, well below the national average of 898.6 and well below all the other study HSAs which ranged from 966.8 (Calais) to 831.5 (Farmington). Damariscotta was also below the national and state averages and the other five study sites on many specific causes of death included in the analysis.

[11] If an agency was located in more than one town in the HSA, the agency was counted more than once.

The rural sites other than Damariscotta each have elevated disease rates and/or high risk behaviors, but the results are not consistent. Calais has rates of smoking, obesity, and high blood pressure higher than the other sites. Caribou has elevated rates of asthma and diabetes. Calais has a high rate of death from motor vehicle accidents, as does Somerset County (a part of the Farmington HSA).

Lewiston fares slightly worse than Bangor on most health risk factors but outcomes as measured by age-adjusted mortality rates present a mixed picture. Death from coronary artery disease is substantially higher in the Bangor HSA than in Lewiston (179.1 and 164.4 in Hancock and Penobscot counties, respectively, compared to 150.6 in Androscoggin County). (See Appendix 2 for presentation of health risk factors and death rates).

All of the study HSAs with the exception of Damariscotta have MaineCare enrollment rates above the state average including two of the low use areas, Bangor (with a 26 percent enrollment rate) and Farmington (with a 29 percent enrollment rate).[12] Five of the six HSAs have a higher proportion of uninsured persons than the state average with the exception being Lewiston (Androscoggin County), where the uninsured rate of 7 percent is below the state average. (Appendix 2).

These mixed findings generally suggest that population health measures, coverage rates and poverty do not explain differences in ED use by health service area. Damariscotta, a low ED use area with higher than average income and health care resources, stands in contrast to Farmington, another low use area with substantial poverty and fewer providers. Differences in population characteristics between Bangor and Lewiston do not seem sufficient to explain why Bangor has a substantially lower ED use rate than Lewiston.

Table 10: Health Service Area Differences Not Associated with High or Low Use

			Above Average ED Use Rate			Below Average ED Use Rate		
	National	State	Caribou	Calais	Lewiston	Bangor	Farmington	Damariscotta
Poverty rate adult[13]	11.9%	12.3%	16.6%	19.1%	12.0%	Hancock (H)-10.4% Penobscot (P)-12.8%	Franklin (F)-16.9% Somerset (S)-16.9%	11.0%

[12] Private coverage rates (shown in the table in Appendix 2) are calculated from counts of persons with private insurance in the Maine Health Data Organization database. No other data source provides coverage information at the county level. Because some national companies in Maine are not obligated to report to the MHDO, these counts underestimate the actual population with private coverage, so, although the data estimates are included, they are not discussed in the report.

[13] Data sources: National: 2006 Census, Maine Department of Labor (ages 18-64); State and County: 2005 Margaret Chase Smith Policy Center UMaine Poverty in Maine, 2008.

			Above Average ED Use Rate			Below Average ED Use Rate		
	National	State	Caribou	Calais	Lewiston	Bangor	Farmington	Damariscotta
Causes of Death per 100,000 – age-adjusted[14]								
All causes of death[15]	898.6	N/A	889.3	966.8	859.1	H-851.1 P-892.5	F-831.5 S-910.1 (874.9-945.4)	764.8
Health Statistics								
Smokers	20.1	21% (+/- 1.6)	24.3%	27.5%	24.7%	H-22.5% P-24.5%	F-20.1% S-26.5%	17.2%
Obesity	34%	25.2%	15.4%	25.0%	24.6%	H-17.7% P-22.6%	F-22% S-23.2%	16.8%
High Blood Pressure	32%	25.4% (+/-1.6)	24.6%	32.4%	25.1%	H-15.1% P-23.5%	F-24.6% S-29.8%	27.7%
Diabetes	10%	7.3 (+/- 0.6)	10.0%	6.6%	6.7%	H-5.8% P-8.5%	F-9.3% S-9.8%	4.3%
Asthma	8.5%	9.6% (+/-1.2)	13.3% (includes Caribou - VanBuren)	8.5%	9.3%	10.7%	9.4%	10.4%

[14] See Appendix for data sources.
[15] Data source: 1999-2003 CDC National Center for Health Statistics – Community Health Status Report

V. MAINECARE ENROLLEE FOCUS GROUP REPORT

Introduction

Per capita use rates of hospital emergency departments are higher among enrollees in the MaineCare program than among privately insured Maine residents in both high and low use health service areas. Focus groups with MaineCare members were conducted in each of the study's six health service areas to gain an understanding of member attitudes about receiving care in emergency departments and the barriers that prevent them from getting care in other settings such as family practices and health centers. Focus group participants were recruited by telephone from lists of enrollees who had made at least two emergency department visits within the last twelve months. Five focus groups included adults who had used emergency departments for their own health care needs and (in some cases, for their children, as well). One focus group conducted in Bangor was made up of parents who had taken a child age 4 or under for treatment at an emergency department. In addition, a seventh focus group of MaineCare individuals with behavioral health diagnoses was held in the Portland. Volunteers for this focus group were recruited with the assistance of staff at the Amistad Peer Support and Recovery Center.

In October, November and December 2009, six focus groups with a total of 32 participants were conducted in Caribou, Damariscotta, Lewiston, Farmington, Calais, and Bangor. Of the 32 participants, the median age for adults was 32 and the median age for the children of participants was 8. Twenty-eight of the focus groups' participants were female. When asked to rate their health status, 8 participants reported that they were "healthy", 21 "somewhat healthy" and 3 "not healthy." Twelve people (8 women and 4 men) attended the focus group for individuals with behavioral health diagnoses in Portland. Findings for this group are reported in a separate section.

Researchers anticipated that there would be a larger study population. Seventy-two people were recruited who initially indicated that they would attend one of the 6 focus groups. However, only 32 participated, despite reminder phone calls and offers of $50 gift certificates for attendees. In order to understand this poor attendance, recruiters made follow-up phone calls to some non-participants to ask why they didn't attend. Reasons cited included illness, and a more vague answer of "something came up." In one instance, a person said that she was not able to find the site because its name was not familiar. Research staff had booked a room from an individual who referred to the site as the "municipal building" when people more commonly refer to it as the police and fire station. Another possible reason, hinted at by one participant's comment that she was worried about "being set up," was that people were fearful of repercussions that might affect their MaineCare benefits – despite the fact that they were assured of anonymity and that the purpose of the study was to improve health services. Even after questioning a number of non-attendees, researchers still don't fully understand the reasons for this poor attendance.

Limitations of the study

Focus groups provide individual contextual information, not statistically reliable data that can be generalized to a larger population. The poor attendance at these focus groups is another reason to be cautious in drawing conclusions. Those who attended may be different from those who were "no shows" in ways researchers cannot discern.

Questions

Project researchers asked focus group participants a series of questions intended to help elucidate the factors that led to ED use, and, alternatively, the factors that influenced the decisions people made to seek out medical care in other locations. Care was taken to ask questions in a manner that did not suggest that some ED use is either appropriate or inappropriate. Similarly, questions about use of community-based health care services were phrased so as not to suggest any causal link between community resources and ED use. Rather, focus group participants were asked to describe the reasons for their ED visits in their own terms and, as a separate discussion item, to describe their usual sources of care in the community.

As a final question, participants were asked: "For you, what is the most important change Maine could make so you can get the care you need? "

Findings

Some patterns of ED use suggested by participants were common to all focus groups, while others were unique to the particular service area. Responses to focus group questions can be grouped into 3 general categories of reasons why participants chose emergency departments: availability and access; convenience; and quality of patient/physician interaction.

Availability and Access

The availability of and access to health care in settings other than EDs reportedly influenced the choices some people made about where and when to go for treatment, whenever they or their children were sick. The patterns of participant responses to questions about access and availability can be grouped as: wait times; finding doctors and dentists; and on-call coverage.

Wait Times Focus group participants in Lewiston, Farmington, Bangor, Caribou and Calais reported that they were more likely to seek ED treatment for illness or pain when they could not be treated by their primary care provider, community health center or walk-in clinic within a reasonable period of time. Reportedly long wait times for PCP visits by adults were most common in the northern rural regions and in Lewiston, all high ED use areas. Study group participants from Caribou and Calais said that, on average, they waited, or would have had to wait, 3-5 months before being seen by their doctors. In Lewiston, waits ranging from 3 to 7 months to see a PCP for adult care were reported by almost half of the participants. One individual in Caribou estimated that he would have had to wait 4 months to see his doctor for treatment of back pain. He said "It's just ridiculous. I hurt my back and I didn't even

bother calling the doctor. There's no point calling your physician because you call in August and you can't be seen until December." In another instance concerning access to preventive care, a woman who recently moved to Caribou said that she called in August for an appointment to get birth control and was given an appointment for December.

In contrast, the focus group participant in Damariscotta, a low ED use area, said that generally speaking she could see her physician within two days, eliminating the need to go to the ED for reasons that could be avoided. "I believe my family practice has always done an excellent job at doing sort of a modified triage over the phone." In response to a question about the availability of same-day service, this participant reported that 6 to 8 months ago her physician practice, comprised of 4 doctors, adopted a new open-access policy. The practice reserves appointments for last minute patients. Patients can call in the morning for appointments with one of the practice's physicians that day.

Finding Doctors Finding doctors with open practices who would accept MaineCare patients was reportedly difficult for a number of participants, suggesting to them that the only option for urgent care was the ED. Reasons cited for needing to find a new physician, dentist or psychiatrist included: a move to a new community; decision to leave the provider for personal reasons; the "three strikes and you're out rule;"[16] frequent provider turnover; and, in one case, death of a physician. A participant in Lewiston reported that she had to make as many as 12 calls before finding a PCP with an open practice who would accept her daughter as a patient. Waits of 5 months to see a new PCP were commonly reported.

Access to dentists Lack of access to practicing dentists, to dentists who accept MaineCare, and to adult dental coverage other than for extractions, was also cited as the reason for going to EDs for treatment of dental pain. In most focus groups, participants complained of not having dentists and adequate dental services available to them as adults. Lack of dental care was of such importance that participants frequently commented about it in focus group discussions and also cited it when asked to recommend improvements in their community healthcare systems.

Several participants commented that while MaineCare provides better dental coverage for children than for adults, access or timely access can be problematic. One mother in Caribou said that it usually took 4 to 6 months to get her children in for dental treatment. Another mother commented, "My three-year-old son cracked a tooth off the gum line and got an infection and kept getting one and they still wouldn't get him in. This was back in July and they got him in, in September." A woman in Farmington remarked, "You can't get in there [community dental clinic serving children]. They just say, if they are in pain, bring them to the emergency room. You bring them there and they are like, here's some pain medicine, go see a dentist."

[16] "Three strikes and out" is a policy adopted by some practices around the state that reserves for the practice or individual provider, the right to remove a patient from the practice for three or more violations. Violations include non-compliance with self-management contracts, particularly with regard to substance abuse, and no-shows for appointments.

On-Call Coverage While access to PCPs for advice after hours and on weekends was reported to be helpful to some participants, most reported that they still ended up in EDs. For example, many participants, after consulting with on-call doctors, reported that they were referred directly to the ED, particularly if the on-call doctor didn't know them. Commenting from Damariscotta, the participant said, "[The] on-call system now includes a few doctors that are in practices of their own and they share on call. I will say, I believe many times, if it is not one of my doctors from my own practice, I wind up being sent to the emergency room."

In some cases, on-call doctors gave medical advice, but also suggested that the patient go to the ED if "you think you should" or if the symptoms persist. In one case, a participant from Caribou reported that the response to her calling after hours was a recorded message to go directly to the ED. Whatever the details of the on-call process, in a majority of cases, participants reported that they ended up in EDs rather than at some other "next day" treatment setting such as a family practice or community healthcare center. A comment from a woman in Lewiston serves as a summary statement: "Usually on-call is pretty useless for me. They are not going to go to the hospital to meet you."

Convenience

Convenience, timeliness, and guaranteed treatment were cited by participants as reasons for using EDs for non-emergent care. Participants' comments included: open access 24/7; the convenience of having diagnostic equipment and treatment available in one location; the surety of getting treatment; and avoiding long waits to see PCPs just to ask for referrals to specialists. One woman in Caribou stated, "The one thing that they do makes it more appealing to go to the ED. You go to your physician, they say we have to do this test and this test, but you have to go to the hospital to get them done at the lab. Whereas if you go to the ER, you get it all done in one shot." A participant in Lewiston explained that she would usually just go to the ED because getting in to see her doctor was so hard. "I call and I have to wait for hours for them to call me back. It's just easier sometimes to go to the ED. It's the only place that won't turn you away. When you need an answer, you got to get an answer." Another participant discussed the dilemma she and other working parents face. She said that a lot of employers in Lewiston don't provide sick time and parents can't afford to take time off work to take their children for sick or regular doctor visits during the day. This concern was echoed by a parent participant in Caribou who travels long distance to her job and has found it very difficult to schedule medical care visits for her child.[17]

Several participants also commented that unnecessary office visits affected their healthcare decisions. According to a woman in Lewiston, MaineCare has a requirement that new patients make an appointment to "meet and greet" their new PCP before scheduling an appointment for care. "They called, sent me a letter saying I needed to come in for an appointment to meet this doctor. I said, no, I don't need to go to meet this doctor. When I'm sick or my children are sick, then I'll make an

[17] This concern regarding time off from work was also cited by ED staff as an explanation for after hours visits. Most of the MaineCare focus group participants were not working so this issue arose less in the group discussions than it might in groups of working adults and parents.

appointment and meet this doctor." Others commented that having their PCPs call in prescriptions for medical conditions already known by them to reoccur (e.g., strep throat, yeast infections) would improve efficiency of treatment in community healthcare settings, thereby eliminating the necessity to go to the ED.

Quality of Patient/Physician Interaction

In many cases, the perceived quality of the patient-physician interaction influenced care setting choices. The absence of a trusting, personable, caring and responsive primary care physician who takes time to carefully listen and check things over was cited by several participants as the reason they avoided seeing their PCPs. In Caribou, two participants stated that they went to the ED precisely because they liked the ED doctor better. In contrast, a participant in Farmington stated that her husband preferred the more impersonal interaction afforded in the ED.

Several participants commented that the doctors that treated them were not competent, didn't treat them well, or didn't like patients very much. As a result, they stopped seeing their doctors and received no treatment until something serious arose, when they had to go to the ED. Perhaps the most common complaint made by participants about their PCPs involved how little time their PCPs spent diagnosing and treating them. One person commented, "In and out; it ruins trust." A participant in Bangor, speaking of her children's pediatrician, remarked, "Like I said, they are only in the room and actually looking at you for five minutes or less, almost every single time."

Several participants remarked that it was very difficult to change physicians when they were not satisfied with the care they were getting. They stated that MaineCare requires members to get permission first, a fact disputed by a number of participants. A mother in Bangor commented, "They should make it easier to switch pediatricians because to switch a pediatrician you have to call MaineCare, get permission from MaineCare, and then you have to go through the process of finding a new pediatrician. It is hard. I mean, around here there are not very many people [who] are taking new patients." In Farmington, a participant commented, "Forget trying to switch doctors. You have to prove that you're being killed and they might still say no."

A common subject of some sensitivity raised by participants in 5 locations--Farmington, Damariscotta, Calais, Caribou and Lewiston--involved their perception of unequal treatment and lack of respect by PCPs because they are on MaineCare. A participant in Lewiston said, "They [PCPs] make you feel like a low life because you are on MaineCare. It's like, that's too bad, you are on MaineCare so we're going to punish you. You know, you go to the back of the line." One individual claimed that he was treated better in the ED.

During discussions, at least one participant in Lewiston, Farmington, Bangor, Caribou and Calais commented that the high illicit drug use in their communities negatively affected the treatment they received or would have received from their PCPs and ED doctors. As MaineCare members, participants

believed that they were routinely judged to be "drug seekers" and therefore undeserving of quality health care and appropriate pain relief.

Parents with young children in Bangor

The Bangor focus group was specifically designed to consist of parents who had taken a child 4 or younger for treatment in an emergency room. These 7 participants were asked the same questions that were posed to participants in the other 5 focus groups, even though the medical conditions for taking children to the ED were often different from those leading to adult visits. Within the Bangor focus group, 8 of 12 cases of parents taking young children to EDs were cases of high fevers, vomiting, dehydration, ear infections, upper respiratory infections and inconsolability. In addition, several parents remarked that their children never seemed to get sick or injured during normal office hours, but in the middle of the night, on weekends and holidays.

Pediatric care provided by pediatricians and family doctors was rated very highly by parents in Bangor as it was by participating parents in most focus group locations. One participant, with corroboration from a number of others, stated, "When it comes to pediatric care for my kids, I give them a 5. They do an amazing job." MaineCare also received high ratings. As one parent in Lewiston said, "I think, for children, MaineCare is really good."

Whereas, deficiencies such as long wait times, lack of available primary care, impersonal physicians, and inadequate on-call services were commonly cited by participants in other groups, these conditions did not generally seem to apply as barriers to seeking pediatric care. Consequently, the only solid recommendation from this group for improving the system of care was to lower the patient-to-doctor ratio.

People with behavioral healthcare diagnoses in Portland

A seventh focus group comprised of individuals with behavioral health diagnoses, who had used an emergency department for treatment within the past year, was held in Portland. For this convenience sample, participants were recruited with the assistance of staff at Portland's Amistad Peer Support and Recovery Center. Twelve people from Amistad (8 women and 4 men) attended.

Participants in this focus group were asked to share their experiences and opinions about the factors that contributed to their ED use when other sources of treatment and support for behavioral health problems might have been available and appropriate. To a large degree, findings from the Amistad focus group were similar to the findings of the six high use/low ED use focus groups. Factors contributing to ED use for potentially avoidable reasons included: lack of timely access to outpatient clinical treatment; limited access to on-call support after hours and on weekends; and the convenience, certainty and perceived safety of treatment in EDs.

Focus group participants named the following alternatives to the ED: publicly funded community mental health centers; the homeless health clinic; a "warm line" operated by the peer support and recovery center; crisis response teams; and a crisis hotline. While these places were said to make an enormous

difference in the lives of people with mental illness by helping them "keep safe," participants noted a range of reasons why they either went directly to the ED or were referred there.

One participant commented that getting access to outpatient psychiatric treatment can be a very difficult process and that there can be a wait of up to 6 weeks to get an appointment with clinicians in one key agency. A peer counselor said, "I had somebody who was really in a rough state. We called and they said we'll call you in 6 weeks. If you don't hear back from us, call us." He also reported that, while people try to hang on in the interim, sometimes their only option is to go to the ED because they know they can get help and will feel safe there. Reportedly, this key agency has to reserve a certain amount of appointments for people being discharged from in-patient psychiatric settings. Therefore, if someone in the community is in crisis and cannot wait, they are sometimes advised by their case managers to go the ED, first for treatment, but also for speedier access to outpatient treatment.

Participants reported that, for most people living in the community, there is limited availability or ineffective on-call clinical services at night and on weekends. According to one person, there is only so much time or amount of advice on-call crisis staff can give. After hours, people are either referred to the ED or go on their own to the ED, where they feel protected and have someone to talk to.

When asked what steps they took to avoid ED use, participants reported that they applied the practice of the "crisis pyramid" and relied on their circle of friends, whenever possible, to feel safer and to avoid unnecessary hospitalizations. In this "crisis pyramid," participants first talked with their friends, then to a clinician, then to peers on the warm line, next to a crisis clinician, and finally to a physician in the ED.

In this focus group, the recommendations for systemic change were largely aimed at refining the system, by re-structuring the ED, increasing training for first responders, nurses and teachers, and providing more funding to strengthen existing programs.

Participant Recommendations

As a final question, participants were asked: "For you, what is the most important change Maine could make so you can get the care you need? " The responses are itemized below by high and low ED use.

Participants in Caribou and Calais said:

1. Stop the rotation of visiting doctors and traveling nurses. "These healthcare providers are in the community for 6 months and sometimes as short as a month, then they are gone."
2. Provide preventive care.
3. Provide more dentists.
4. Provide after-hours, on-call services.
5. Get better [trained, sociable and non judgmental] doctors.
6. Evaluate patient satisfaction with primary care physicians.

Participants in Lewiston, Farmington and Bangor said:

1. Provide more dentists.
2. Provide more walk-in clinics.
3. Reduce the time it takes to get approval for payment of non-generic drugs.
4. Get doctors who listen to patients.
5. Have more doctors accept MaineCare.
6. Expand MaineCare coverage for adults.
7. Provide preventive care.
8. Make available a bridge or safety net between the ED and PCP.
9. Provide more behavioral health services.
10. Lower the patient to doctor ratio so doctors get to know their patients.
11. Make it easier to switch pediatricians.

Participants with behavioral health needs in Portland said:

1. Make a paradigm shift. Instead of viewing frequent visits to the ED as a deficit, look at them as strengths; people are getting what they need in the absence of other resources.
2. Split up the ED into sections, one that serves people with physical problems and one that serves people with mental problems.
3. Improve police promptness to calls for help.
4. Provide better crisis training for police.
5. Provide access to case managers outside of normal office hours, especially for people who are homeless.
6. Provide more funding to staff the statewide "warm line" so people don't have to wait too long in the queue; also provide more funding for marketing and peer volunteer training.
7. Make sure that the ED doctors write prescriptions that are covered by MaineCare.
8. Change MaineCare rules to permit people to see their psychiatrists and therapists on the same day.
9. Teach counseling skills to nurses and teachers.

Discussion

Most MaineCare recipients (175,000 members) are enrolled in primary care case management (PCCM). Under MaineCare PCCM, providers are paid an enhanced fee to manage the care of patients who select or are assigned to them as their primary care provider (PCP). PCPs are required to provide coverage or access to medical advice 24 hours a day 7 days a week.

The comments from MaineCare participants in the focus groups suggests that the PCCM program is not working as intended for some MaineCare recipients. Some of the problem arises from recipients who have not experienced or do not perceive the value of an ongoing relationship with a PCP and so do not

understand the need for a baseline visit or understand the value to the provider of a medical history. It also appears from the comments of some participants, particularly in remote rural areas, that rapid turnover of community-based providers can stand as a barrier to establishing or maintaining a relationship. “Three-strikes” policies are an understandable response from providers who want to reduce inefficiencies from no-shows and to protect themselves and their staffs from abusive or irresponsible patients. However, the outcome of this strategy may be the creation of a permanent cohort of rootless, high-user patients who receive no care management and spend a lot of time in emergency departments.

VI. HEALTH SYSTEM FACTORS RELATED TO ED USE

In an effort to understand health system factors that may impact on high or low rates of emergency department use, research staff conducted interviews with hospital administrators, clinical staff within emergency departments, and community-based primary care physicians in each of the six study health service areas. In addition, we gathered data, to the extent possible, on practice hours, policies with regard to same day appointments, evening and weekend coverage, and whether a practice is open to new patients and/or accepting new MaineCare patients. Findings from these interviews or perspectives gained from the providers have been incorporated throughout the report, where relevant. The discussion, below, of health system factors related to ED use is derived almost exclusively from these interviews.

The findings from our interviews, taken together with information from the health service area profiles and focus group discussions, reinforce the perception that high rates of ED use constitutes a complex problem with no single "silver bullet" solution. However, several health system arrangements and practices emerged that have a significant impact on ED use.

Meeting Acute Care Needs in the Community

Every source of information we have examined points to barriers to primary care in the community as being directly related to increased use of emergency departments for acute primary care episodes. Barriers may be self-imposed by patient non-compliance, related to external constraints such as difficulty in taking time from work, or related to primary care practice choices such as hours of operation and open booking policy. At the simplest level, the ratio of primary care providers to total population is statistically correlated in an inverse relationship with total rates of ED use within health service areas in Maine (Figure 2).[18] Damariscotta, one of the low use study areas, has the highest provider to population ratio of any health service area in the state. Farmington, our second low-use study area is also above the state average in PCP to population ratio, while Caribou has the eighth lowest ratio of PCPs to population in Maine and Calais is at the state average. A similar relationship is observed with the two urban health service areas in the study. Bangor has 137 PCPs per 100,000 population compared to Lewiston's 105 PCPs.

However, factors other than numbers of providers affect access and rates of ED use. Figure 2, on page _ shows that the relationship between providers ratios and ED use is far from exact. Through data analysis, interviews and focus groups we identified four health system arrangements and practice patterns that appear to impact ED use positively or negatively.

[18] The counts of primary care providers are derived from data within the Licensure Division of the Department of Human Services and were gathered by an intern at the Maine Medical Association. The figures include M.D.s and D.O.s but do not include mid-level practitioners such as nurse practitioners or physician assistants.

Availability and Flexibility of PCP Care

We found some, but not systematic differences among primary care practices in different health service areas with regard to practice hours. Only in the low-use urban HSA did we find a family practice Saturday office hours. In addition, Cary hospital has Saturday clinics in the months from September through May. Administrators at Miles Memorial and Franklin Memorial hospitals both commented that weekend clinics had been tried but were terminated due to insufficient volume. Franklin Memorial Hospital holds a weekend clinic every fifth weekend (both Saturday and Sunday), a practice that seems satisfactory to both providers and the hospital. In six communities surveyed, there were primary care practices that had office hours as late as 8 pm, usually, one day a week.

Nevertheless, there were differences in total hours of availability. In one high use rural HSAs, for example, the physicians in the hospital owned practice see patients 32 hours a week and have one day designated as a "paper day." This same community uses hospitalists for inpatient care so office-based physicians are not obligated to manage the care of their patients in the hospital. In another high use HSA, Friday is a half day for patient appointments. Caribou has lost six physicians in recent years and has had difficulty replacing them.

Where substantial differences were noted between the rural high and low use study areas were protocols with regard to same day appointments and after hours urgent care. Calais Regional Medical Services (the hospital owned practice) does not leave any schedule openings for same day appointments and the practice is booked out for three months. The providers try to doublebook to fit in a patient who needs to be seen. However, the provider interviewed in Calais believed that the majority of patients who call in are not able to get appointments the same day. Eastport Health Care, an FQHC 28 miles from Calais has two providers and reserves four appointment slots a day for patients who call in. Eastport has no evening coverage, with patients referred by tape recording to the hospital emergency department. In Caribou, evening coverage of patients' calls is provided by an out-of-state nurse line without direct access to an on-call doctor. The answering service conducts phone triage to determine whether the patient should be advised to go to the emergency department or call his or her physician the next day.

In Farmington and Damariscotta, the low use rural areas, the family practices contacted all reserved times in each day's schedule for same-day appointments. In Damariscotta's Full Circle Family Medicine practice, 2/3 of the schedule is kept open and one provider, on a rotating basis, stays after the office closes from 5 to 6 pm each evening to handle unscheduled acute care visits. The Franklin Health Family Practice holds from 2 to 3 slots in the morning and 2 to 3 slots in the afternoon each day for acute visits. Both communities have shared physician on-call coverage to provide patient consultation after hours.

"Fast Track" or "Walk-in" Care availability outside of the hospital Emergency Department

One particularly salient delivery system component that takes pressure off of hospital emergency departments is alternative urgent care "walk-in" centers. In Bangor, the walk-in clinic, located in a location entirely separate from the EMMC campus, sees 25,000 patients a year. In 2006, 36,938 individuals in the Bangor HSA made a total of about 63,000 emergency department visits. If one

assumes that each of the 25,000 patients seen in the walk-in urgent care center had, instead, made at least one visit to the emergency department, that would have increased the ED volume by close to 40 percent. Patients who enter the emergency department at EMMC cannot be referred to the walk-in clinic, regardless of the level of severity of the complaint, according to the hospital's interpretation of EMTALA.[19] However, physician practices in the health service area appear to be aware of the availability of the walk-in clinic and refer "over-load" acute care patients there, rather than to the emergency department.

In contrast, Central Maine Medical Center, St. Mary's, Franklin Memorial and Cary Hospital all have "Fast Track" care systems set up within their emergency departments. These systems are specifically designed to provide timely and efficient care to lower acuity patients who present at the emergency department, frequently through use of mid-level practitioners. The system relieves congestion within the emergency department and increases patient satisfaction with wait times. However, because the care is provided in the emergency department, the overhead costs are high and the visits are billed as emergency department visits. It is also likely that these systems reinforce patient beliefs that the hospital emergency department properly functions as an urgent care center and a convenient resource for primary care at any time of the day. A dynamic referenced by a number of interviewees in both Caribou and Calais is that the emergency department physicians are the longest standing members of the medical community, are very popular with patients, and many patients see these doctors as their primary care providers.

Structure of Financing Incentives

The rate of reimbursement for a potentially avoidable visit treated in a hospital emergency department is substantially higher than for identical treatment provided in a physician office. As more and more physician practices come under the ownership of hospitals or their parent entities, the incentives to divert care from physician offices to the ED mount. This point was made very bluntly by a hospital administrator in a rural HSA (not one of the study HSAs). He stated, "Why should we ask our physicians to hold their offices open until 5 pm or 5:30 to see a patient with an acute need when we can see the patient in our emergency department and receive four times the revenue for that visit?"

This dynamic may also be particularly pronounced in areas where it is difficult to recruit and hold physicians, since it allows the hospital to limit physician work hours. However, ED providers in all the study HSAs, regardless of volume or provider ratios, indicated that the concern they heard from hospital management was how to keep ED volume up or to increase it – not how to reduce ED volume.

The structure of incentives is also evident in the wide-spread upgrades to hospital EDs recently undertaken by hospitals. Six of the eight hospitals in the study HSAs are currently undergoing or have recently undergone major renovations in the EDs to increase capacity and improve flow.

[19] The federal Emergency Medical Treatment and Active Labor Act, an "anti-dumping" law that forbids hospital emergency departments from refusing treatment.

Availability of Dental Care, particularly for acute care needs

Urgent care needs for teeth and supporting structures were among the 20 most frequently seen diagnoses in all six study areas, ranking third and fourth in Farmington and Lewiston, respectively. In interviews, providers in all the emergency departments mentioned the frequency of visits related to dental care needs and pointed out that emergency room providers are generally limited to prescribing antibiotics for infection and medications for pain control but do not have the resources for repair or restoration. Many complained of limited resources in their community for referring care out.

In 2006, 11,960 emergency department visits related to dental care needs were made in Maine just by adults between the ages of 15 and 44 (see table 1). Clearly, one area where early intervention and alternative care sites could reduce emergency department utilization is across the full spectrum of dental care from preventive care to dental surgery.

VII. PATIENT BELIEFS AND BEHAVIORS RELATED TO EMERGENCY DEPARTMENT USE

Two factors regarding patient behaviors and beliefs are likely significant contributors to over-use of emergency departments. These issues – insufficient connection to a primary care provider and drug dependence – were raised in interviews both by patients and providers.

Insufficient Connection to Primary Care Providers

The patients we spoke to (Mainecare enrollee emergency department users) and emergency department clinical providers all indicated that patients, when asked, state that they have a primary care provider (PCP). However, when probed, it frequently turns out that this relationship is tenuous. Patients in Washington and Aroostook counties complained of rapid turnover of providers which curtailed their ability to establish a relationship. Also, general shortages resulted in very long waits (five or six weeks or longer) for appointments. Further, many stated that the time pressures on physicians were such that the face-to-face time they had with providers was insufficient to get questions answered.

Another dynamic described both by providers and patients clearly reflects a misunderstanding between the parties. Providers complain that their office will get calls from patients with acute care problems when the patient has never before been to the office and there is no medical record or history. Most primary care practices give scheduling priority to existing patients and have slots for "new patients" booked out several months. Some MaineCare enrollees, on the other hand, assigned a provider by DHS, told us they see no purpose in making an appointment to "meet and greet" a physician. "I'll make an appointment when I need to see a doctor, not before," we were told. Then they are surprised and frustrated when they call with a medical complaint and are told they can be seen in five or six weeks. The emergency department is the logical alternative and once the pattern is established, these patients are unlikely to call the physician office the next time and self refer to the hospital.

Drug Dependence

Another issue raised by both patients and providers is the prevalence of emergency department traffic from individuals with dependency to pain medications seeking prescriptions. MaineCare enrollees that we spoke to raised this as a concern because they felt that the behavior of a small cohort cast suspicion upon all MaineCare recipients and made it more difficult for them to get legitimate medical problems appropriately treated. Almost all ED providers interviewed acknowledged drug seeking as a problem but had very little idea how to measure the extent of the problem. Among the ED top diagnoses seen across the state are complaints of headache, back pain, and dental pain – all difficult problems for measuring severity except based on patient self report and all difficult, in some circumstances to pinpoint an underlying pathology that can be treated. Over 11,000 visits to the ED across Maine in 2006 among adults between the ages of 15 and 44 were for diagnoses related to headache, back pain and dental

pain.[20] If just 20 percent of these visits were preventable through treatment of drug dependence, that would result in a decrease in ED visits of almost 2,300 visits.

[20] The specific ICD-9 code diagnoses included in this calculation are: headache, unspecified disorder of teeth and supporting structure, unspecified migraine, lumbago, unspecified backache, lumbar strain, and dental caries.

VIII. RECOMMENDATIONS FOR POLICY OPTIONS AND FURTHER ANALYSIS

The use of emergency departments for treatment of illnesses and conditions that can be appropriately managed in an office or clinic setting is a wide-spread phenomenon affecting all hospitals (in Maine and elsewhere). Our analyses indicate that the higher than average emergency department use experienced by some hospitals in Maine is predominantly a result of increased potentially preventable visits rather than a higher rate of use for emergency care and, therefore, should be amenable to interventions that would reduce ED use. The factors contributing to high use are complex, involve both health system arrangements and patient behaviors and are frequently mutually reinforcing. Moreover, the incentives built into the health care reimbursement system reduce motivation to introduce changes that would reduce ED use.

While provider to population ratios were among the few factors identified that show a general pattern of association with high and low ED use, this factor does not explain the very substantial growth in ED use over the past 10 years. As numerous providers in high use areas pointed out, primary care provider availability has increased in their area, population has decreased, and ED use has, nonetheless, doubled. Changes in practice patterns, patient expectations, and hospital messaging about ED purpose and availability have probably all contributed to changes in use.

Some areas where policy interventions might reduce emergency department volume, shift care to appropriate treatment locations, and reduce unnecessary health care spending, are identified below for consideration, by the ED Work Group.

1. Reimbursement Incentives

   Currently, joint hospital/physician practice systems receive greater revenue for the same care provided in an emergency department as opposed to an office setting. Physician practices, regardless of ownership, have no financial incentives to hold unscheduled slots for same day appointments. Realigning financial incentives could stimulate provider-driven innovations to direct more patients to appropriate settings where care would be less fragmented and care management, possible.

   A logical starting point for testing one or more new reimbursement models would be Maine's Patient Centered Medical Home Pilot Program. Overtime, payment models that worked satisfactorily for payers and providers in the context of the demonstration project, could be adopted more widely across the state.

2. Availability of same day, unscheduled urgent care visits

   Most of the providers interviewed for this study agreed that patients who cannot be seen the same day that contact a provider for a problem they deem to be urgent, will default to the emergency department. Our analysis indicated that the most critical health system factors that impact a community's rate of ED use are whether or not "walk-in" urgent care or open

scheduling of same day appointments are available.

3. Availability of medical advice and consultation in evenings and on weekends.
   Both our research and the research literature suggest that the availability of medical advice during times when primary care provider offices are not open can reduce emergency department visits.

4. Patient understanding of the importance of a functional provider/patient relationship and preventive health
   A complaint we heard from primary care providers related to new patients, not previously seen in the office, who call for an urgent care appointment when they are acutely ill. Providing care in the absence of a medical history is problematic for the providers and working patients in on short notice is prioritized to established patients over new patients. From the patients we heard complaints that when they called with an acute problem, they were offered an appointment weeks later. Strategies that encourage patients to establish and maintain an ongoing relationship with a provider or clinic could reduce frustrations on both sides.

5. ED visits related to dental disease
   Visits for dental complaints are the highest volume complaint among teens and young adults in the MaineCare Program and among the uninsured. Emergency departments are not staffed or equipped to deal with dental emergencies and are limited to providing pain medication and antibiotics, as appropriate. The diversion of this critical care need to an appropriate setting and improved prevention could substantially reduce ED volume.

6. Medication management in EDs.
   All ED providers we contacted acknowledged that some ED patients have developed a dependency on prescription medication and generate visits to seek medications. While small in number, these individuals may be repeat visitors. Another dynamic that can result in unnecessary visits are requests for prescription refills on weekends when patients can't reach their regular provider. Finally, ED providers can be handicapped in treating patients without access to their medical record and accurate information on current medications. Each of these issues could benefit from interventions.

7. Understanding EMTALA's constraints on creating alternative venues for patients with non-emergent care needs and billing services.

8. Limits to the efficacy of the MaineCare PCCM program.
   Hospital discharge data show that the rate of ED use by the MaineCare population is substantially higher than that of privately insured people in Maine. This fact in addition to the complaints we heard in focus groups with MaineCare participants indicate that some individuals in the MaineCare program are insufficiently linked to the primary health care system and use emergency department care as a substitute.

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APPENDIX 1.

Data Collection Instruments

ED Questions
Community Provider

1. What is your position and how long have you worked in this practice. What have been your other clinical practice experiences? Is this practice owned by the hospital or by the physicians?

2. Please describe the staffing of your practice – number of locations/offices, physicians, nurses, midlevels. How many patients are seen by your practice (total number)? Can you estimate the daily number of patients you see in the office?

3. Please describe the times available for patient office visits (days and hours). Does you practice offer any office hours on evenings, weekends? If so, has that been successful and what has been the feedback from patients?

4. What is the method of triage within your practice regarding scheduling of office visits by patients and determining acuity of complaints? Do you leave openings for scheduling same day appointments? How many?

5. What is the average wait time for an appointment for an established patient with a new complaint?

6. Does your practice have policies about referring patients to the ED after hours or on the weekend? What is your practice's call coverage arrangement?

7. Are you accepting new patients in your practice? If so, how long does a new patient wait for an appointment?

8. What are your patients instructed to do if they need prescription orders outside of the normal office hours?

9. How frequently (on a weekly basis) do you refer patients to the ED?

10. How and when do you find out if one of your patients is in the ED?

11. How often do you believe your patients self-refer to the ED? (Do not call the office before going to the ED). Probe – frequency, any particular age group, diagnoses?

12. Our ED study showed that in Maine the emergency room among infants and 19-24 year olds is much higher than the national average. Do you have any opinion about why those groups are using the ED in greater proportion? Do you have a high percentage of those age groups in your practice?

13. What do you believe are the most frequent reasons that patients use the local hospital ED for non-emergency reasons? Do you think this is a problem in your community?

14. What factors do you believe would reduce or prevent unnecessary ED use? Probes – more PCPs, more urgent care facilities at hospital, extended hours by PCPs, better chronic disease management, greater availability of home care services.

15. Is there anything unique about your community that might be affecting ED use rates?

ED Study
Provider (P)/Hospital Administrator (A) Interview Questions

I. Background

1.What is your position in the hospital, how long have you worked in this ED/hospital; what other ED experiences have you had? (A/P)

2.Describe ED staffing – number of physicians, nurses, midlevels, other staff; any idea of the volume of ED visits? Have there been any changes in staffing, resources devoted to ED in recent years? (A/P)

3. What are the peak times and days of ED use (P).

4. Please describe the hospital protocol for triage (P).

II. ED utilization

1. We are interested in the non-emergent use of EDs in Maine. Do you have any opinion about non-emergency use of the ED at your hospital? Do you think it has increased in the last two years, stayed about the same, or decreased? What do you think are the primary reasons for non-emergency visits at the ED: (A/P)

Probes: i. not enough PCPs in the community
ii. inability to schedule visits with PCP s (long waits or no extended hours)
iii. no or not enough urgent care resources in community,
iv. perception that ER provides better care than doctor's office
v. perception that ER is same as a primary care clinic.

2. Which would you say has greater impact on your ED service, high numbers of infrequent or one-time users, or a small number of frequent users?

3. How would you define a frequent user of your ED in terms of number of visits per year? Are there diagnoses that are typical of the frequent users? Do you think that the number and kind of frequent users has changed over the last year or two? Do you believe chronic ED users are a significant population in your ED? (A/P)

4. What kind of data does the hospital collect around ED use? Is data regularly collected around volume, patterns, amount of outpatient care, number of admissions from ED, DX. How often does this data get reviewed and how is data used? (A/P)

5. Our ED study showed that Maine shows a much higher rate of ED use among infants and 19-24 year olds compared to the national average.
Why do you believe that those groups are visiting EDs in Maine in greater proportion than the national average? Does that pattern reflect your hospital's experience? (P)

6. Are you aware of whether patients you see in the ED have a PCP? If so, what do you estimate is the percentage of ED patients with PCPs? How do you communicate, if at all, with PCPs regarding their patient's use of the ED? (P)

7. Do you believe that many ED patients look upon the ED as a place to receive primary care services? (A)

8. Please comment on the frequency of patients coming to the ED with the following problems. (A/P)

1. oral health problems
2. prescription refills
3. mental health problems
4. common childhood conditions typically seen in a PCP office

9. Do you ever hear the following comments from your patients in the ED; if so how frequently (P)

a. I'm here because I can't get in to see my PCP
b. I don't have any other provider
c. I'd rather come to the ED than see my PCP

III. Community and Hospital Resources

1. Do you think there is anything unique about your community/hospital and its ED use, compared with other Maine hospitals and communities? (A/P)

2. Are you aware of any policies of the medical practices in your community about referring patients to the ED? Does the hospital have guidelines for hospital-owned practices regarding referrals to the ED and arrangements for after hours care? (A)

3. Has the hospital has undertaken any actions to address non-emergency use of ED? If so, what are they? What have been the results? (A)

4. What do you think are the strategies that would reduce or prevent non-emergent use of the ED:

Probes:
1. More ED resources
2. More urgent care facilities
3. Extended hours/weekend hours for PCP
4. More PCPs better access to health care
5. Better health promotion about alternative resources
6. Patient education
7. higher copays

(A/P)

Focus Group Discussion Guide

Introduction (10 minutes)

Thank you for joining us today. I'm Danny Westcott from the Muskie School at the University of Southern Maine. I'm the moderator for today's discussion and part of the team looking into emergency room use in Maine communities. My goal is to learn from you what you've experienced getting medical care for yourself, someone in your family or someone you know well. Let me introduce [**NAME]**, s/he is here to help and will take notes.

Some background information--In an earlier study, we learned that Maine has a higher emergency room use than other states. The Department of Health and Human Services in Augusta is funding this research project because it's interested in where people go for health care and why.

Again, thanks for being here. We really appreciate your help in finding the answer to this question: Where do you go for health care in your area and why?

Before we begin, I'd like to take a moment to say a few things.

- Our discussion will last approximately 90 minutes. We should be done by **[Time]**.
- It's very important to stay for the entire discussion. Does anyone have to leave early?
- If you need to use the restroom or get a drink during the discussion, please feel free to do so. The bathrooms are (give directions). Water and snacks are over there (point).
- We will only use first names when we talk with each other. If it's OK with you, please write your first name—or the name you like to be called—on the card and put it on the table in front of you. If you'd rather not, that's fine.
- I ask that you not talk with anyone about our discussion outside of this room. It's important for you to know that people working on the project, including me, will not give your name to anyone or share any personal information about you.
- Your participation is voluntary. You can leave at any time if you want to.
- With your permission, we will tape record this session to make sure we don't miss anything you've said. [**Name]** will be assisting me by taking notes. When we type up our notes and the discussion that's recorded on tape, we will delete your names. We will also destroy the tape after it is transcribed.
- Please speak clearly, one at a time, so that we hear each other and the tape recorder can pick up each voice.
- Please remember that while we have asked everyone here to respect each other's privacy and not share anything said here with anyone else, we can't guarantee that this will happen.
- The findings of this discussion will be included in a report to the Department of Health and Human Services about use of emergency rooms in various parts of the state. If you'd like a summary of the report, please email Beth Kilbreth at bethk@usm.maine.edu or call Danny Westcott at 228-8038. We hope that the report will finished in the fall.
- And finally, as a thank you for your thoughts, time and travel, we will give you a gift card for $50 when you leave.

Focus Group Discussion Guide

Consent to Participate (5 minutes)

I believe that consent forms were sent to you so you could read them before you got here. In case you didn't get one or didn't bring the form with you, I have another one here. Please read it and if, after thinking about it, you want to take part in today's discussion, please sign it and date it. Thanks, are there any questions I can answer before we start?

Focus Group Questions (45 min)

Ice Breaker

1. Please tell us your first name, where you live, and what you like most about summertime.

Introductory Question:

2. Tell me about the kinds of places that you can go to get medical care in your area.

Transition:

3. Now think for a moment about **the last time you** went to an emergency room.

Key Questions:

4. Was the ER the **first place you contacted** about the medical care you needed? Y/N

5. What are some of the **reasons** you went to the emergency room?

6. How long had you been dealing with this issue before going to the emergency room?

7. Do you think your care could have taken place **somewhere other than** in the emergency room? Y/N

8. What made it difficult for you to get care **somewhere else**?

   ☐ after office hours ☐ no longer eligible for MaineCare/uninsured ☐ prescription refill/primary not available ☐ can't get appointment that day-need referral

   ☐ told to go there ☐ couldn't take off work /lose pay? ☐ transportation problem

   ☐ can't find doctor who'll take MaineCare ☐ child care problem

**FU Q. Of all these you've mentioned, which problem is the most difficult one you faced.

9. You've already talked about this some but to be sure it's clear, what kinds of places are available for getting health care in this area?

   ☐ doctor's office (family practice/primary care physician) ☐ walk-in clinic ☐ ER
   ☐ dentist's office ☐

10. Are these places available when you need them? For instance, if you, a family member or someone you know well is sick in the evening or on a weekend, who would you contact? FU Q: When you saw your doctor, did the doctor tell you what you should do in case you need to see someone*? [Hypothetical scenarios could be asked here – see addendum]*

Transition:

11. Now, I'd like to talk about family doctors and other places you can go for regular care. Do you have a family doctor or a regular doctor who you see for routine care? If you don't have a doctor right now, think about a time when you did have a doctor. Y/N

12. If you have a family doctor or a place to go for routine care, did you contact them before going to the emergency room? Y/N

Key questions:

13. If you call the doctor because you are sick, how long do you typically have to wait for an appointment?

14. Does your doctor have someone on call if you need help after business hours?

15. You've already talked about this some, but to be sure it's clear, are there other problems you have getting medical care from your doctor?

    ☐ hard to get a referral ☐ hard to get a telephone consult ☐ don't like doctor

Transition:

16. For this last set of questions, I'd like to talk about things like walk-in clinics or urgent care centers—places you can go to get outpatient health care without an appointment. Do you have any of these places in this area? Y/N

Key questions:

17. What do you like about these places?
18. And what do you dislike about them?

Closing question:

19. You talked about [**cite examples**] as being some of the reasons you went to the ER rather than to your regular doctor or walk-in clinic. For you, what is the most important change that Maine could make so you could get the care you need somewhere else?

    ☐ paid sick leave ☐ child care ☐ transportation ☐ other health system improvements

20. On a scale of 1-5, how would you rate access to non-emergency care available in your area? 1 = not good, 3 = OK, 5 =excellent

    ☐ For example, # options, convenience, quality

21. Is there anything I've missed?

Many thanks again for your time and participation. The things you talked about today will be very helpful to us.

Addendum:
Hypothetical Scenarios

A. It's Monday at 5:00 PM and your baby is crying and fussing with a fever of 101 degrees. Do you have a doctor or nurse you can call?
B. It's Friday at 5:00 PM and your back pain isn't getting any better. You have already been out of work one day because of the pain, and aspirin has not made it any better.
C. You have been out of work for two days with a fever and a bad sore throat. Aspirin has helped with the fever, but the fever still comes back. You feel like you're getting worse and not better.

APPENDIX 2.

Analysis Support Documents Matrix

	National	State	Caribou (Aroostook)	Calais (Washington)	Lewiston (Androscoggin)	Bangor (Penobscot, Hancock)	Farmington (Franklin, Somerset)	Damariscotta (Lincoln)	Years and Source		
High or Low ED Use			**High**	**High**	**High**	**Low**	**Low**	**Low**	**National**	**State**	**County (by county, unless noted)**
Rural or Urban			**Rural**	**Rural**	**Urban**	**Urban**	**Rural**	**Rural**			
Population											
Pop (2008 census)	304,059,724	1,316,456	71,676	32,499	106,877	201,788	81,234	34,628	2008 Census	2008 Census	2008 Census
Pop (2006 census)	298,754,819	1,314,910	72,122	32,778	107,031	201,316	81,382	34,806	2006 Census	2006 Census	2006 Census
Population by HSA (2005)	N/A	N/A	17,057	12,867	121,611	131,548	33,874	12,082	N/A	N/A	By HSA Maine Quality Forum
Pop per square mile (2000 census)	79.6 (2000) 86 (2008)	41.3 (2000) 43 (2008)	11.1	13.2	220.8	Hancock- 32.6 Penobscot - 42.7	Franklin-17.4 Somerset-13	73.7	2008 Census	2008 Census	2000 Census
Pop living below poverty (2007 census)	13%	12.2%	17.4%	20.1%	14.1%	H-9.9% P-13.5%	F-16% S-17.2%	10.8%	2007 Census	2007 Census	2007 Census
Employment											
Unemployment Rate	4.6%	4.0%	6.0%	5.7%	4.3%	H-3.4% P-4.8%	F-5.4% S-5.5%	3.4%	2006 Maine DOL Center for Workforce Research and Information - not seasonally adjusted	2006 Maine DOL Center for Workforce Research and Information - not seasonally adjusted	2006 as of 8/06 Maine DOL Center for Workforce Research and Information - not seasonally adjusted
Poverty rate adult	11.9% (2006 18-64)	12.3%	16.6%	19.1%	12.0%	H-10.4% P-12.8%	F-16.9% S-16.9%	11.0%	2006 Census Maine DOL	2005 Margaret Chase Smith Policy Center UMaine, Poverty in Maine (2008)	2005 Margaret Chase Smith Policy Center UMaine, Poverty in Maine (2008)
Poverty rate child (0-17 years)	18.3% (2006)	16.7%	22.3%	28.4%	18.1%	H-15.5% P-15.3%	F-22.3% S-25.3%	16.2%	2006 Census Maine DOL	2005 Margaret Chase Smith Policy Center UMaine, Poverty in Maine (2008)	2005 Margaret Chase Smith Policy Center UMaine, Poverty in Maine (2008)
Ages											
under 19	27%	24%	21%	22%	24%	22%	23%	20%	2006 Census (19 and under)	2006 Census (19 and under)	2005 Census CHSR
19-64	60%	61%	61%	60%	62%	64%	63%	62%	2006 Census (20-64)	2006 Census (20-64)	2005 Census CHSR
65-84	11%	13%	15%	15%	12%	13%	12%	16%	2006 Census	2006 Census	2005 Census CHSR
85+	2%	2%	2%	3%	2%	2%	2%	3%	2006 Census	2006 Census	2005 Census CHSR
Insurance Coverage											

	National	State	Caribou (Aroostook)	Calais (Washington)	Lewiston (Androscoggin)	Bangor (Penobscot, Hancock)	Farmington (Franklin, Somerset)	Damariscotta (Lincoln)	Years and Source		
High or Low ED Use			**High**	**High**	**High**	**Low**	**Low**	**Low**	**National**	**State**	**County (by county, unless noted)**
Rural or Urban			**Rural**	**Rural**	**Urban**	**Urban**	**Rural**	**Rural**			
Uninsured	45,657,200 (2007)	118,900 (2007)	7,914	3,832	7,792	H - 6,860 P - 16,144 Total=23,004	F-3,064 S-5,895 Total=8,959	4,810	2007 Census	2007 Census	2006 Census Small Area Health Insurance Estimates (SAHIE) (<age 65)
Uninsured Percentage (#/population) 2007 state/national; 2006 county	15%	9%	11%	12%	7%	11%	11%	14%	Calculation based on 2007 population Census	Calculation based on 2007 population Census	Calculation based 2006 population Census
Medicare Elderly	35224339	189,693	12,866	6,233	14,403	H- 8,878 P-20,616 Total=29,494	F-4,662 S-7,048 Total=11,710	6,665	2006 CMS - as of 7/06	2006 CMS - as of 7/06	2007 CMS - as of 7/07
Medicare Elderly Pecentage 2006 state/ 2007 county	12%	14%	18%	19%	13%	15%	14%	19%	Calculation based on 2006 population Census	Calculation based on 2006 population Census	Calculation based on 2007 population Census
Medicare Disabled	6,689,118	48,309	4,118	1,499	4,934	H-1,620 P-7,060 Total=8,680	F-1,233 S-2,470 Total=3,703	1,041	2006 CMS - as of 7/06	2006 CMS - as of 7/06	2007 CMS - as of 7/07
Medicare Disabled Percentage 2006 state / 2007 county	2%	4%	6%	5%	5%	4%	5%	3%	Calculation based on 2006 population Census	Calculation based on 2006 population Census	Calculation based on 2007 population Census
Medicaid	39,296,400	316,947	6,006	4,094	34,705	34,322	9,755	2,263	2007 Census Kaiser Family Foundation (KFF)	CY2008 based on claims data	By HSA CY2008 based on claims data
Medicaid Percentage 2008 (2007 national)	13%	24%	35%	32%	29%	26%	29%	19%	Calculation based on 2007 population Census	Calculation based on 2008 population Census	Calculation based on 2007 HSA population
Private	173,853,200	588,058	5,378	3,543	56,085	57,482	11,947	4,353	2007 Census KFF	2006 claims analysis commercial average members (member months/12)	By HSA 2006 claims analysis commercial average members (member months/12)
Private Percentage 2006	58%	45%	32%	28%	46%	44%	35%	36%	Calculation based on 2007 population Census	Calculation based on 2006 population Census	Calculation based on 2007 HSA population
Death											

	National	State	Caribou (Aroostook)	Calais (Washington)	Lewiston (Androscoggin)	Bangor (Penobscot, Hancock)	Farmington (Franklin, Somerset)	Damariscotta (Lincoln)	Years and Source		
High or Low ED Use			**High**	**High**	**High**	**Low**	**Low**	**Low**	**National**	**State**	**County (by county, unless noted)**
Rural or Urban			**Rural**	**Rural**	**Urban**	**Urban**	**Rural**	**Rural**			
All causes of death (per 100,000 - age-adjusted)	898.6	N/A	889.3 (862.4-916.3)	966.8 (925.5-1008.1)	859.1 (829.1-889.2)	H-851.1 (819.1-883) P-892.5 (864.9-920)	F-831.5 (787.2-875.8) S-910.1 (874.9-945.4)	764.8 (729.3-800.4)	1999-2003 median for all US counties age adjusted NCHS CHSR	N/A	1999-2003 age adjusted NCHS (CDC - National Center for Health Statistics) CHSR (Community Health Status Report)
Causes of death by age									N/A	N/A	1999-2003 NCHS CHSR
15-24	N/A	N/A	• Injuries – 68% • Suicide – 14%	• Injuries – 64% • Suicide – 14%	• Injuries – 59% • Cancer – 10% • Suicide – 17%	o Hancock county • Injuries – 63% • Suicide – 13% o Penobscot county • Injuries – 60% • Suicide – 16%	o Franklin county none listed o Somerset county • Injuries – 48% • Suicide – 24%	• Injuries – 62% • Suicide – 14%	N/A	N/A	1999-2003 NCHS CHSR
25-44	N/A	N/A	• Injuries – 22% • Cancer – 17% • Heart disease – 18% • Suicide – 13%	• Injuries – 33% • Cancer – 23% • Suicide – 14%	• Injuries – 25% • Cancer – 21% • Heart Disease -14% • Suicide – 11%	o Hancock county • Injuries – 23% • Cancer – 24% **o** Penobscot county • Injuries – 23% • Cancer – 20% • Heart disease – 14% • Suicide – 12%	o Franklin county • Injuries – 29% • Cancer – 17% • Heart Disease -14% • Suicide – 17% o Somerset county • Injuries – 32% • Cancer – 13% • Heart Disease – 17%	• Injuries – 29% • Cancer – 21% • Heart Disease -20%	N/A	N/A	1999-2003 NCHS CHSR
45-64	N/A	N/A	• Cancer – 40% • Heart disease – 26%	• Cancer – 35% • Heart disease – 27%	• Cancer – 40% • Heart disease – 21%	o Hancock county • Cancer – 39% • Heart disease – 23% o Penobscot county • Cancer – 37% • Heart disease – 21%	o Franklin county • Cancer – 44% • Heart disease – 22% o Somerset county • Cancer – 37% • Heart disease – 23%	• Cancer – 44% • Heart disease – 22%	N/A	N/A	1999-2003 NCHS CHSR
65+	N/A	N/A	• Cancer - 21% • Heart Disease - 32%	• Cancer - 24% • Heart Disease - 30%	• Cancer - 21% • Heart Disease - 27%	o Hancock county • Cancer - 23% • Heart Disease - 31% o Penobscot county • Cancer - 22% • Heart Disease - 29%	o Franklin county • Cancer - 22% • Heart Disease - 26% o Somerset county • Cancer - 24% • Heart Disease - 31%	• Cancer - 26% • Heart Disease - 25%	N/A	N/A	1999-2003 NCHS CHSR

	National	State	Caribou (Aroostook)	Calais (Washington)	Lewiston (Androscoggin)	Bangor (Penobscot, Hancock)	Farmington (Franklin, Somerset)	Damariscotta (Lincoln)	Years and Source		
High or Low ED Use			**High**	**High**	**High**	**Low**	**Low**	**Low**	**National**	**State**	**County (by county, unless noted)**
Rural or Urban			**Rural**	**Rural**	**Urban**	**Urban**	**Rural**	**Rural**			
Infant Mortality (deaths per 1000 live births)	6.8	5.5	4.9	3.9	4.1	H-4.4 P-5.6	F-5.1 S-4.4	4.2	2001-2005 Maine CDC report (2008)	2001-2005 Maine CDC report (2008)	1999-2003 NCHS CHSR
Death measures - causes of death (age adjusted to year 2000 standard; per 100,000 pop)											
Breast Cancer (Female)	24.5 (24.4,24.6)	23.4 (21.9,24.9)	17.8 (12.0,23.9)	26.2 (17.5, 38.1)	27.6 (22.2,33.9)	H-25.9 (19.0,34.8) P-28.3 (23.6,33.8)	F-28.5 (18.5,42.4) S-19.3 (13.3,27.4)	20.3 (13.3,30.2)	2002-2006 National Vital Statistics public use data file; calculated by National Cancer Institute	2002-2006 National Vital Statistics public use data file; calculated by National Cancer Institute	2002-2006 National Vital Statistics public use data file; calculated by National Cancer Institute
Colon and Rectum Cancer	18.2 (18.1,18.3)	18.7 (17.8,19.7)	22.9 (18.8, 27.6)	24.2 (18.2,31.7)	16.0 (13.0,19.5)	H-18.9 (14.6,24.2) P-18.2 (15.3,21.4)	F-22.7 (15.9,31.4) S-17.8 (13.3,23.3)	15.5 (11.1,21.4)	2002-2006 National Vital Statistics public use data file; calculated by National Cancer Institute	2002-2006 National Vital Statistics public use data file; calculated by National Cancer Institute	2002-2006 National Vital Statistics public use data file; calculated by National Cancer Institute
Coronary Heart Disease	172 211.1 (2005)	182.7 (2005)	209.3	191.7	150.6	H-179.1 P-164.4	F-136.9 S-184.9	124.4	1999-2003 NCHS CHSR 2005 Maine CDC Burden of Chronic Disease Report ("diseases of the heart")	2005 Maine CDC Burden of Chronic Disease Report ("diseases of the heart")	1999-2003 NCHS CHSR
Lung and Bronchus Cancer	53.4 (53.3,53.5)	61.9 (60.1,63.7)	64.4 (57.5,72.0)	75.7 (64.8,88.1)	66.4 (60.1,73.3)	H-58.3 (50.5,67.1) P-65.9 (60.4,71.8)	F-50.7 (40.5,62.7) S-69.3 (60.3,79.4)	57.2 (48.2,67.6)	2002-2006 National Vital Statistics public use data file; calculated by National Cancer Institute	2002-2006 National Vital Statistics public use data file; calculated by National Cancer Institute	2002-2006 National Vital Statistics public use data file; calculated by National Cancer Institute
Motor Vehicle Injury	14.8	13.8 (+/-0.9)	18.8	23.5	15.4	H-15.4 P-14.7	F-16 S-21.1	18.1	1999-2003 NCHS CHSR	2001-2005 Maine CDC Health Indicator Report	1999-2003 NCHS CHSR
Stroke	53	42.8 (2005)	57.8	68.8	53.2	H-59.9 P-64	F-62.1 S-54.5	45.6	1999-2003 NCHS CHSR	2005 Maine CDC Burden of Chronic Disease Report	1999-2003 NCHS CHSR
Suicide	10.8	13.9 (+/-1)	11	14.9	8.2	H-9.8 P-13.7	F-13.1 S-14.7	9.5	1999-2003 NCHS CHSR	2001-2005 ages 10+ Maine CDC Health Indicator Report	1999-2003 NCHS CHSR

	National	State	Caribou (Aroostook)	Calais (Washington)	Lewiston (Androscoggin)	Bangor (Penobscot, Hancock)	Farmington (Franklin, Somerset)	Damariscotta (Lincoln)	Years and Source		
High or Low ED Use			**High**	**High**	**High**	**Low**	**Low**	**Low**	**National**	**State**	**County (by county, unless noted)**
Rural or Urban			**Rural**	**Rural**	**Urban**	**Urban**	**Rural**	**Rural**			
Unintentional Injury	37.3	41.1 (2005)	14.9	26.9	18.8	H-26.5 P-19.6	F-20.8 S-24.3	20.9	1999-2003 NCHS CHSR	2005 Maine CDC Burden of Chronic Disease Report	1999-2003
Substance Abuse and Mental Illness											
Adult depression (moderate/severe)	N/A	7.6% (+/-1)	5.8% (+/-3.3)	7.8% (=/-3.1) (Washington, Hancock)	5.6% (=/-2) (Franklin, Oxford, Androscoggin)	13.3% (+/-3.9) (Penobscot, Piscataquis)	5.6% (=/-2) (Franklin, Oxford, Androscoggin)	6.1% (+/-2.2) (Lincoln, Sagadahoc, Knox, Waldo)	N/A	2004-2006 Maine CDC Health Indicator Report	2004-2006 Maine CDC Health Indicator Report
Substance Abuse Admissions (all ages) per 100,000	N/A	1320	1275	1141 (Washington, Hancock)	901 (Franklin, Oxford, Androscoggin)	1391 (Penobscot, Piscataquis)	901 (Franklin, Oxford, Androscoggin)	878 (Lincoln, Sagadahoc, Knox, Waldo)	N/A	2006 BRFSS Maine CDC District Health Profle (2007)	2006 BRFSS Maine CDC District Health Profle (2007)
Recent Drug Users (within past month)	N/A	N/A	5335	2403	7959	H-3901 P-11537	F-2426 S-3713	2501	N/A	N/A	2005 CHSR
Recent Drug Users (within past month)	8.1%	9.6% (8.31-11.08)	7%	7%	7%	8%	8%	7%	2006-2007 SAMHSA	2006-2007 SAMHSA	Calculation based on 2005 population Census
Have Major Depression	N/A	N/A	5275	2389	7549	H-3883 P-10453	F-2116 S-3653	2574	N/A	N/A	2005 CHSR
Have Major Depression	7.65%	8.98% (7.03-11.40)	7%	7%	7%	7%	7%	7%	2004-2005 SAMHSA	2004-2005 SAMHSA	Calculation based on 2005 population Census
Health Statistics											
Smokers	20.1	21% (+/- 1.6)	24.3%	27.5%	24.7%	H-22.5% P-24.5%	F-20.1% S-26.5%	17.2%	2006 adults Maine CDC Health Indicator Report	2006 adults Maine CDC Health Indicator Report	2000-2007 CDC BRFSS CHSR
Obesity	34%	25.2%	15.4%	25.0%	24.6%	H-17.7% P-22.6%	F-22% S-23.2%	16.8%	2005-2006 NCHS	2008 obese ages 20+ CDC US Obesity Trends - BRFSS	2000-2007 CDC BRFSS CHSR
High Blood Pressure	32%	25.4% (+/-1.6)	24.6%	32.4%	25.1%	H-15.1% P-23.5%	F-24.6% S-29.8%	27.7%	2003-2006 ages 20+ Health United States (2008)	2005 Maine CDC Health Indicator Report	2000-2007 CDC BRFSS CHSR
Diabetes	10%	7.3 (+/-0.6)	10.0%	6.6%	6.7%	H-5.8% P-8.5%	F-9.3% S-9.8%	4.3%	2003-2006 diagnosed & undiagnosed Health United States (2008)	2004-2006 adults Maine CDC Health Indicator Report	2000-2007 CDC BRFSS CHSR
High Cholesterol	16%	36.4 %(+/-2)	29.3% (includes Caribou - VanBuren)	31.3%	28.5%	27.9%	28.2%	27.7%	2003-2006 ages 20+ Health United States (2008)	2005 adults Maine CDC Health Indicator Report	By HSA Maine Quality Forum Charts

	National	State	Caribou (Aroostook)	Calais (Washington)	Lewiston (Androscoggin)	Bangor (Penobscot, Hancock)	Farmington (Franklin, Somerset)	Damariscotta (Lincoln)	Years and Source		
High or Low ED Use			**High**	**High**	**High**	**Low**	**Low**	**Low**	**National**	**State**	**County (by county, unless noted)**
Rural or Urban			**Rural**	**Rural**	**Urban**	**Urban**	**Rural**	**Rural**			
Asthma	8.5%	9.6% (+/-1.2)	13.3% (includes Caribou - VanBuren)	8.5%	9.3%	10.7%	9.4%	10.4%	2006 Maine CDC Health Indicator Report	2006 adults Maine CDC Health Indicator Report	By HSA Maine Quality Forum Charts
Dentists											
Dentists per 100,000	80	60 note - Cumberland 64.4 and York 30.2	31.4	26.9	39.8	H-42.9 P-42.2	F-30.3 S-27.1	39.7	2008 ADA KFF	2008 ADA KFF	2005 HRSA CHSR
Routine Dental Care in Past Year (adullts)	70.3%	70.2% (+/-1.8)	61.2% (+/-7.8)	69.7% (+/-5.5) (Washington, Hancock)	70.7% (+/-4.5) (Franklin, Oxford, Androscoggin)	66.9% (+/-5.1) (Penobscot, Piscataquis)	70.7% (+/-4.5) (Franklin, Oxford, Androscoggin)	69.8% (+/-3.7) (Lincoln, Sagadahoc, Knox, Waldo)	2006 Maine CDC Health Indicator Report	2006 BRFSS Maine CDC District Health Profle (2007)	2006 BRFSS Maine CDC District Health Profle (2007)
# Active General Practice (GP) Dentists	N/A	464	18	10	35	H-20 P-54	F-8 S-12	12	N/A	2006 as of 1/1/06 Maine Office of Data, Research and Vital Statistics (ODRVS)	2006 as of 1/1/06 Maine ODRVS
Active General Practice (GP) Dentists per 100,000	N/A	35.29	24.96	30.51	32.70	36.76	24.58	34.48	N/A	Calculation based on 2006 population Census	Calculation based on 2006 population Census
# Active GP that treat MaineCare	N/A	206	15	8	7	H-14 P-26	F-5 S-3	4	N/A	2006 as of 1/1/06 Maine ODRVS	2006 as of 1/1/06 Maine ODRVS
Active GP that treat MaineCare per 100,000	N/A	15.67	20.80	24.41	6.54	19.87	9.83	11.49	N/A	Calculation based on 2006 population Census	Calculation based on 2006 population Census
# Active GP that accept new MaineCare	N/A	80	8	6	2	H-8 P-13	F-3 S-0	1	N/A	2006 as of 1/1/06 Maine ODRVS	2006 as of 1/1/06 Maine ODRVS
Active GP that accept new MaineCare per 100,000	N/A	6.08	11.09	18.30	1.87	10.43	3.69	2.87	N/A	Calculation based on 2006 population Census	Calculation based on 2006 population Census
Number of Practices Cataloged	N/A	N/A	2	6	38	67	17	7	N/A	N/A	By HSA 2009 MaineCare list and online list ADA
Primary Care Providers											
PCP per 100,000	124	109	76	101	105	137	121	157	2006 Maine State Health Plan (08/09)	2005 Maine Quality Forum	By HSA 2005 Maine Quality Forum

	National	State	Caribou (Aroostook)	Calais (Washington)	Lewiston (Androscoggin)	Bangor (Penobscot, Hancock)	Farmington (Franklin, Somerset)	Damariscotta (Lincoln)	Years and Source		
High or Low ED Use			**High**	**High**	**High**	**Low**	**Low**	**Low**	**National**	**State**	**County (by county, unless noted)**
Rural or Urban			**Rural**	**Rural**	**Urban**	**Urban**	**Rural**	**Rural**			
Specialists per 100,000	N/A	N/A	45.06	38.87	67.57	H-50.32 P-95.19	F-30.3 S-34.84	59.59	N/A	N/A	2005 BRFSS Supplement (2006)
Number of Practices Cataloged	N/A	N/A	7	8	35	34	15	5	N/A	N/A	By HSA 2009 MaineCare list and online list MMA
Resources											
# School Based Health Centers	1709	27	0	2 (Calais Mid/HS)	8 (Lewiston Mid/HS; Auburn Mid/HS; Monmouth Elem/Mid/HS; Livermore Elem)	2 (Brewer Mid/HS)	5 (Dental outreach to Livermore Mid/HS; Jay Elem/Mid/HS)	3 (SAU #74 Schools Elem/Lincoln Academy HS/Matanawcook Academy)	2004-2005 National Assembly on School-Based Health Care	2009 Maine Assembly on School-Based Health Care (2009) Maine Children's Alliance (2009)	By HSA 2009 Maine Assembly on School-Based Health Care (2009) Maine Children's Alliance (2009)
# Mental Health Agencies	N/A	293	3	3	21	18	10	3	N/A	2009 Maine DHHS OMHS Mental Health Resources (includes counseling, crisis, residential, leisure, medication clinic, etc.) Count by agencies in each town.	By HSA 2009 Maine DHHS OMHS Mental Health Resources (includes counseling, crisis, residential, leisure, medication clinic, etc.) Count by agencies in each town.
# Mental Health Agencies - Crisis Services	N/A	32	1	0	1	3	1	0		2009 Maine DHHS OMHS Mental Health Resources Count by agencies in each town.	2009 Maine DHHS OMHS Mental Health Resources Count by agencies in each town.

	National	State	Caribou (Aroostook)	Calais (Washington)	Lewiston (Androscoggin)	Bangor (Penobscot, Hancock)	Farmington (Franklin, Somerset)	Damariscotta (Lincoln)	Years and Source		
High or Low ED Use			**High**	**High**	**High**	**Low**	**Low**	**Low**	**National**	**State**	**County (by county, unless noted)**
Rural or Urban			**Rural**	**Rural**	**Urban**	**Urban**	**Rural**	**Rural**			
# Community Health Centers	1,067 FQHC 3,751 Rural Health Clinics	18 FQHC 38 Rural Health Clinics	4	4	13	14	4	0	2007 FQHC National Association of Community Health Centers, Inc. KFF 2009 Rural Health CMS KFF	2009 HRSA Find a health center	2009 HRSA Find a health center
# Urgent Care Centers	8,113	N/A	0	0	1 Concentra	2 Concentra EMMC Walk-In Care Center	0	0	Weinick RM, Bristol SJ, Marder JE, DesRoches CM. *Urgent Care Update: The Search for the Urgent Care Center* . Journal of Urgent Care Medicine. January 2009	N/A	By HSA 2009 online search and interviews

2010 Maine Hospital Emergency Department Use Statewide for Selected Age Groups Requested by Payer: Top 30 Outpatient Emergency Department Volume

For this report the top 30 volume diagnoses in total and the top 30 diagnosis within each payer type were determined.

Age Group	Payer	Diagnosis Description	Outpatient Emergency Department Visits	Emergency Department Visits Resulting in Inpatient Hospitalization
<1	Commercial	UNSPECIFIED OTITIS MEDIA	366	0
<1	Commercial	ACUTE URIS OF UNSPECIFIED SITE	302	7
<1	Commercial	FEVER	251	7
<1	Commercial	UNSPEC VIRAL INF CCE & UNS SITE	120	4
<1	Commercial	CONTUS FACE SCALP&NECK EXCEPT EYE	88	0
<1	Commercial	VOMITING ALONE	78	0
<1	Commercial	ACUT BRONCHIOLITIS-OTH INF ORGNSMS	68	8
<1	Commercial	CROUP	67	3
<1	Commercial	FUSSY INFANT	55	0
<1	Commercial	UNSPECIFIED CONJUNCTIVITIS	54	0
<1	Commercial	COUGH	51	0
<1	Commercial	UNS NONINF GASTROENTERIT&COLITIS	48	1
<1	Commercial	HEAD INJURY, UNSPECIFIED	47	0
<1	Commercial	OBSERVATION FOLLOWING OTH ACCIDENT	39	0
<1	Commercial	OBSERVATION OTH SPEC SUSPECTED COND	39	0
<1	Commercial	PNEUMONIA, ORGANISM UNSPECIFIED	30	4
<1	Commercial	RASH&OTH NONSPECIFIC SKIN ERUPTION	26	0
<1	Commercial	DIARRHEA	26	2
<1	Commercial	ACUTE BRONCHIOLITIS DUE TO RSV	25	30
<1	Commercial	BRONCHITIS NOT SPEC AS ACUT/CHRONIC	25	0
<1	Commercial	RESPIRATORY SYNCYTIAL VIRUS	23	0
<1	Commercial	UTI SITE NOT SPECIFIED	23	3
<1	Commercial	FLU W/OTH RESPIRATORY MANIFESTS	22	1
<1	Commercial	UNSPECIFIED CONSTIPATION	21	0
<1	Commercial	INTESTINAL INF DUE OTH ORGANISM NEC	18	7
<1	Commercial	CANDIDIASIS OF MOUTH	18	0
<1	Commercial	UNSPECIFIED ACUTE CONJUNCTIVITIS	18	0
<1	Commercial	ASTHMA, UNSPECIFIED, UNSPECIFIED	18	3
<1	Commercial	FEBRILE CONVULSIONS SIMPLE UNSPEC	16	2
<1	Commercial	DEHYDRATION	15	6
<1	Medicaid	ACUTE URIS OF UNSPECIFIED SITE	1253	8
<1	Medicaid	UNSPECIFIED OTITIS MEDIA	1126	2
<1	Medicaid	FEVER	557	7
<1	Medicaid	UNSPEC VIRAL INF CCE & UNS SITE	428	6
<1	Medicaid	VOMITING ALONE	264	2

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Age Group	Payer	Diagnosis Description	Outpatient Emergency Department Visits	Emergency Department Visits Resulting in Inpatient Hospitalization
<1	Medicaid	UNSPECIFIED CONJUNCTIVITIS	193	0
<1	Medicaid	FUSSY INFANT	192	0
<1	Medicaid	UNS NONINF GASTROENTERIT&COLITIS	178	2
<1	Medicaid	PNEUMONIA, ORGANISM UNSPECIFIED	158	13
<1	Medicaid	ACUT BRONCHIOLITIS-OTH INF ORGNSMS	143	21
<1	Medicaid	OBSERVATION OTH SPEC SUSPECTED COND	131	0
<1	Medicaid	COUGH	128	0
<1	Medicaid	CONTUS FACE SCALP&NECK EXCEPT EYE	126	2
<1	Medicaid	CANDIDIASIS OF MOUTH	105	0
<1	Medicaid	DIAPER OR NAPKIN RASH	105	0
<1	Medicaid	CROUP	104	3
<1	Medicaid	RASH&OTH NONSPECIFIC SKIN ERUPTION	103	0
<1	Medicaid	UNSPECIFIED CONSTIPATION	91	2
<1	Medicaid	DIARRHEA	86	2
<1	Medicaid	HEAD INJURY, UNSPECIFIED	80	0
<1	Medicaid	TEETHING SYNDROME	68	0
<1	Medicaid	INTESTINAL INF DUE OTH ORGANISM NEC	65	8
<1	Medicaid	BRONCHITIS NOT SPEC AS ACUT/CHRONIC	63	0
<1	Medicaid	ABDOMINAL PAIN, UNSPECIFIED SITE	57	0
<1	Medicaid	ACUTE BRONCHIOLITIS DUE TO RSV	54	31
<1	Medicaid	UNSPECIFIED VIRAL EXANTHEM	53	0
<1	Medicaid	ASTHMA, UNSPECIFIED, UNSPECIFIED	51	3
<1	Medicaid	OTHER DISEASES NASAL CAVITY&SINUSES	50	0
<1	Medicaid	CONTCT DERMATIT&OTH ECZEMA-UNS CAUS	50	0
<1	Medicaid	ESOPHAGEAL REFLUX	48	5
<1	Medicare	ACUTE URIS OF UNSPECIFIED SITE	16	0
<1	Medicare	UNSPECIFIED OTITIS MEDIA	13	0
<1	Medicare	FEVER	10	0
<1	Medicare	DIAPER OR NAPKIN RASH	3	0
<1	Medicare	FUSSY INFANT	3	0
<1	Medicare	CROUP	2	0
<1	Medicare	ACUT BRONCHIOLITIS-OTH INF ORGNSMS	2	0
<1	Medicare	UNSPECIFIED CONSTIPATION	2	0
<1	Medicare	UNSPECIFIED FETAL&NEONATAL JAUNDICE	2	0
<1	Medicare	COUGH	2	0

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For this report the top 30 volume diagnoses in total and the top 30 diagnosis within each payer type were determined.

Age Group	Payer	Diagnosis Description	Outpatient Emergency Department Visits	Emergency Department Visits Resulting in Inpatient Hospitalization
<1	Medicare	VOMITING ALONE	2	0
<1	Medicare	CONTUS FACE SCALP&NECK EXCEPT EYE	2	0
<1	Medicare	OBSERVATION OTH SPEC SUSPECTED COND	2	0
<1	Medicare	UNSPEC VIRAL INF CCE & UNS SITE	1	0
<1	Medicare	CANDIDIASIS OF MOUTH	1	0
<1	Medicare	UNSPECIFIED ACUTE CONJUNCTIVITIS	1	0
<1	Medicare	OTOGENIC PAIN	1	0
<1	Medicare	OTH SPEC CIRC SYSTEM DISORDERS	1	0
<1	Medicare	ACUTE BRONCHITIS	1	0
<1	Medicare	PNEUMONIA DUE TO RSV	1	0
<1	Medicare	BRONCHITIS NOT SPEC AS ACUT/CHRONIC	1	0
<1	Medicare	CNTC DERMATIT&ECZEM-FOOD CNTC-SKIN	1	0
<1	Medicare	TOXIC ERYTHEMA	1	0
<1	Medicare	TRANSIENT ALTERATION OF AWARENESS	1	0
<1	Medicare	FEBRILE CONVULSIONS SIMPLE UNSPEC	1	0
<1	Medicare	SWELLING MASS OR LUMP IN HEAD&NECK	1	0
<1	Medicare	DIARRHEA	1	0
<1	Medicare	ABDOMINAL PAIN, UNSPECIFIED SITE	1	0
<1	Medicare	CONCUSSION WITH NO LOC	1	0
<1	Medicare	OTHER SPEC OPEN WOUND OCULAR ADNEXA	1	0
<1	Other	UNSPECIFIED OTITIS MEDIA	53	0
<1	Other	ACUTE URIS OF UNSPECIFIED SITE	27	0
<1	Other	FEVER	26	0
<1	Other	CONTUS FACE SCALP&NECK EXCEPT EYE	15	0
<1	Other	UNS NONINF GASTROENTERIT&COLITIS	11	0
<1	Other	CROUP	9	0
<1	Other	RASH&OTH NONSPECIFIC SKIN ERUPTION	9	0
<1	Other	UNSPEC VIRAL INF CCE & UNS SITE	8	0
<1	Other	PNEUMONIA, ORGANISM UNSPECIFIED	7	1
<1	Other	COUGH	7	0
<1	Other	FUSSY INFANT	6	0
<1	Other	DIARRHEA	6	0
<1	Other	RESPIRATORY SYNCYTIAL VIRUS	5	0
<1	Other	ACUT BRONCHIOLITIS-OTH INF ORGNSMS	5	1

2010 Maine Hospital Emergency Department Use Statewide for Selected Age Groups Requested by Payer: Top 30 Outpatient Emergency Department Volume

For this report the top 30 volume diagnoses in total and the top 30 diagnosis within each payer type were determined.

Age Group	Payer	Diagnosis Description	Outpatient Emergency Department Visits	Emergency Department Visits Resulting in Inpatient Hospitalization
<1	Other	DIAPER OR NAPKIN RASH	5	0
<1	Other	UNSPECIFIED CONJUNCTIVITIS	4	0
<1	Other	UNSPECIFIED CONSTIPATION	4	0
<1	Other	OTH SPEC CONDS ORIG PERINTL PERIOD	4	0
<1	Other	VOMITING ALONE	4	0
<1	Other	OBSERVATION FOLLOWING OTH ACCIDENT	4	0
<1	Other	ASTHMA, UNSPECIFIED, UNSPECIFIED	3	0
<1	Other	UTI SITE NOT SPECIFIED	3	0
<1	Other	OBSERVATION OTH SPEC SUSPECTED COND	3	0
<1	Other	INTESTINAL INF DUE OTH ORGANISM NEC	2	1
<1	Other	ACUTE BRONCHIOLITIS DUE TO RSV	2	0
<1	Other	PNEUMONIA DUE TO RSV	2	0
<1	Other	CONTCT DERMATIT&OTH ECZEMA-UNS CAUS	2	0
<1	Other	ALLERGIC URTICARIA	2	0
<1	Other	FEEDING PROBLEMS IN NEWBORN	2	0
<1	Other	FEEDING DIFFICULTIES&MISMANAGEMENT	2	0
<1	Uninsured	ACUTE URIS OF UNSPECIFIED SITE	85	1
<1	Uninsured	UNSPECIFIED OTITIS MEDIA	54	0
<1	Uninsured	FEVER	32	0
<1	Uninsured	UNSPEC VIRAL INF CCE & UNS SITE	23	1
<1	Uninsured	FUSSY INFANT	16	0
<1	Uninsured	VOMITING ALONE	14	0
<1	Uninsured	CANDIDIASIS OF MOUTH	13	0
<1	Uninsured	RASH&OTH NONSPECIFIC SKIN ERUPTION	13	0
<1	Uninsured	OBSERVATION OTH SPEC SUSPECTED COND	12	0
<1	Uninsured	UNSPECIFIED CONJUNCTIVITIS	11	0
<1	Uninsured	CROUP	11	0
<1	Uninsured	PNEUMONIA, ORGANISM UNSPECIFIED	10	0
<1	Uninsured	COUGH	10	1
<1	Uninsured	UNSPECIFIED FETAL&NEONATAL JAUNDICE	9	1
<1	Uninsured	CONTUS FACE SCALP&NECK EXCEPT EYE	9	0
<1	Uninsured	OTHER DISEASES NASAL CAVITY&SINUSES	8	0
<1	Uninsured	UNS NONINF GASTROENTERIT&COLITIS	8	0
<1	Uninsured	DIAPER OR NAPKIN RASH	8	0
<1	Uninsured	ABDOMINAL PAIN, UNSPECIFIED SITE	8	0

2010 Maine Hospital Emergency Department Use Statewide for Selected Age Groups Requested by Payer: Top 30 Outpatient Emergency Department Volume

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Age Group	Payer	Diagnosis Description	Outpatient Emergency Department Visits	Emergency Department Visits Resulting in Inpatient Hospitalization
<1	Uninsured	OBSERVATION FOLLOWING OTH ACCIDENT	8	0
<1	Uninsured	UNSPECIFIED VIRAL EXANTHEM	7	0
<1	Uninsured	UNSPECIFIED CONSTIPATION	7	0
<1	Uninsured	OTH SPEC CONDS ORIG PERINTL PERIOD	7	0
<1	Uninsured	FEEDING PROBLEMS IN NEWBORN	6	0
<1	Uninsured	HEAD INJURY, UNSPECIFIED	6	0
<1	Uninsured	TEETHING SYNDROME	5	0
<1	Uninsured	DIARRHEA	5	0
<1	Uninsured	OBSERVATION UNSPEC SUSPECTED COND	5	0
<1	Uninsured	BRONCHITIS NOT SPEC AS ACUT/CHRONIC	4	0
<1	Uninsured	ASTHMA, UNSPECIFIED, UNSPECIFIED	4	0
<1	Total	ACUTE URIS OF UNSPECIFIED SITE	1682	16
<1	Total	UNSPECIFIED OTITIS MEDIA	1612	2
<1	Total	FEVER	876	14
<1	Total	UNSPEC VIRAL INF CCE & UNS SITE	580	11
<1	Total	VOMITING ALONE	362	2
<1	Total	FUSSY INFANT	272	0
<1	Total	UNSPECIFIED CONJUNCTIVITIS	262	0
<1	Total	UNS NONINF GASTROENTERIT&COLITIS	245	3
<1	Total	CONTUS FACE SCALP&NECK EXCEPT EYE	240	2
<1	Total	ACUT BRONCHIOLITIS-OTH INF ORGNSMS	221	30
<1	Total	PNEUMONIA, ORGANISM UNSPECIFIED	205	18
<1	Total	COUGH	198	1
<1	Total	CROUP	193	6
<1	Total	OBSERVATION OTH SPEC SUSPECTED COND	187	0
<1	Total	RASH&OTH NONSPECIFIC SKIN ERUPTION	151	0
<1	Total	CANDIDIASIS OF MOUTH	138	0
<1	Total	DIAPER OR NAPKIN RASH	135	0
<1	Total	HEAD INJURY, UNSPECIFIED	135	0
<1	Total	UNSPECIFIED CONSTIPATION	125	2
<1	Total	DIARRHEA	124	4
<1	Total	BRONCHITIS NOT SPEC AS ACUT/CHRONIC	94	0
<1	Total	OBSERVATION FOLLOWING OTH ACCIDENT	91	0
<1	Total	INTESTINAL INF DUE OTH ORGANISM NEC	87	17
<1	Total	TEETHING SYNDROME	85	0

2010 Maine Hospital Emergency Department Use Statewide for Selected Age Groups Requested by Payer: Top 30 Outpatient Emergency Department Volume

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Age Group	Payer	Diagnosis Description	Outpatient Emergency Department Visits	Emergency Department Visits Resulting in Inpatient Hospitalization
<1	Total	ACUTE BRONCHIOLITIS DUE TO RSV	84	63
<1	Total	ABDOMINAL PAIN, UNSPECIFIED SITE	83	1
<1	Total	ASTHMA, UNSPECIFIED, UNSPECIFIED	76	6
<1	Total	OTHER DISEASES NASAL CAVITY&SINUSES	71	0
<1	Total	UNSPECIFIED VIRAL EXANTHEM	70	1
<1	Total	UTI SITE NOT SPECIFIED	67	11
15-24	Commercial	ACUTE PHARYNGITIS	1583	2
15-24	Commercial	UNSPEC SITE ANKLE SPRAIN&STRAIN	1116	0
15-24	Commercial	UTI SITE NOT SPECIFIED	859	1
15-24	Commercial	NECK SPRAIN AND STRAIN	796	1
15-24	Commercial	ABDOMINAL PAIN, UNSPECIFIED SITE	647	2
15-24	Commercial	OPEN WOUND FINGER W/O MENTION COMP	643	0
15-24	Commercial	ACUTE URIS OF UNSPECIFIED SITE	586	1
15-24	Commercial	UNSPECIFIED OTITIS MEDIA	492	0
15-24	Commercial	HEADACHE	492	0
15-24	Commercial	CONTUS FACE SCALP&NECK EXCEPT EYE	492	1
15-24	Commercial	UNSPEC VIRAL INF CCE & UNS SITE	451	3
15-24	Commercial	CONTUSION OF HAND	399	0
15-24	Commercial	BRONCHITIS NOT SPEC AS ACUT/CHRONIC	397	0
15-24	Commercial	DEPRESSIVE DISORDER NEC	396	6
15-24	Commercial	UNS NONINF GASTROENTERIT&COLITIS	395	7
15-24	Commercial	ACUTE TONSILLITIS	381	3
15-24	Commercial	SYNCOPE AND COLLAPSE	355	5
15-24	Commercial	ABDOMINAL PAIN OTHER SPECIFIED SITE	341	6
15-24	Commercial	STREPTOCOCCAL SORE THROAT	330	1
15-24	Commercial	LUMBAR SPRAIN AND STRAIN	287	0
15-24	Commercial	INFECTIOUS MONONUCLEOSIS	271	19
15-24	Commercial	OPEN WND HND NO FNGR ALONE W/O COMP	270	0
15-24	Commercial	NONDPND ALCOHL ABS UNS DRUNKENNESS	260	5
15-24	Commercial	ACUTE BRONCHITIS	260	0
15-24	Commercial	UNSPEC D/O TEETH&SUPPORTING STRCT	254	0
15-24	Commercial	SPRAIN&STRAIN UNSPEC SITE KNEE&LEG	251	0
15-24	Commercial	PAINFUL RESPIRATION	248	0
15-24	Commercial	HEAD INJURY, UNSPECIFIED	248	2
15-24	Commercial	UNSPECIFIED CONJUNCTIVITIS	247	0

2010 Maine Hospital Emergency Department Use Statewide for Selected Age Groups Requested by Payer: Top 30 Outpatient Emergency Department Volume

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Age Group	Payer	Diagnosis Description	Outpatient Emergency Department Visits	Emergency Department Visits Resulting in Inpatient Hospitalization
15-24	Commercial	SPRAIN&STRAIN UNSPEC SITE WRIST	247	0
15-24	Medicaid	ACUTE PHARYNGITIS	1899	0
15-24	Medicaid	UNSPEC D/O TEETH&SUPPORTING STRCT	1755	0
15-24	Medicaid	ACUTE URIS OF UNSPECIFIED SITE	1173	0
15-24	Medicaid	UTI SITE NOT SPECIFIED	1170	5
15-24	Medicaid	ABDOMINAL PAIN, UNSPECIFIED SITE	1060	2
15-24	Medicaid	UNSPEC SITE ANKLE SPRAIN&STRAIN	1011	0
15-24	Medicaid	OTH CURRENT MATERNAL CCE ANTEPARTUM	879	20
15-24	Medicaid	DEPRESSIVE DISORDER NEC	800	19
15-24	Medicaid	HEADACHE	799	4
15-24	Medicaid	UNSPECIFIED OTITIS MEDIA	795	0
15-24	Medicaid	BRONCHITIS NOT SPEC AS ACUT/CHRONIC	736	0
15-24	Medicaid	UNSPEC VIRAL INF CCE & UNS SITE	622	1
15-24	Medicaid	LUMBAGO	619	0
15-24	Medicaid	AC APICAL PRDONTITIS PULPAL ORIGIN	604	0
15-24	Medicaid	CONTUSION OF HAND	603	0
15-24	Medicaid	UNSPECIFIED DENTAL CARIES	601	0
15-24	Medicaid	ABDOMINAL PAIN OTHER SPECIFIED SITE	601	8
15-24	Medicaid	UNS NONINF GASTROENTERIT&COLITIS	585	11
15-24	Medicaid	OPEN WOUND FINGER W/O MENTION COMP	481	0
15-24	Medicaid	LUMBAR SPRAIN AND STRAIN	479	0
15-24	Medicaid	UNSPECIFIED BACKACHE	477	2
15-24	Medicaid	PERIAPICAL ABSCESS WITHOUT SINUS	470	2
15-24	Medicaid	CONTUS FACE SCALP&NECK EXCEPT EYE	460	1
15-24	Medicaid	ANXIETY STATE, UNSPECIFIED	443	0
15-24	Medicaid	NECK SPRAIN AND STRAIN	440	1
15-24	Medicaid	ASTHMA UNSPECIFIED W/EXACERBATION	435	17
15-24	Medicaid	STREPTOCOCCAL SORE THROAT	392	0
15-24	Medicaid	UNSPEC SX ASSOC W/FE GENIT ORGN	387	0
15-24	Medicaid	ASTHMA, UNSPECIFIED, UNSPECIFIED	386	1
15-24	Medicaid	UNSPECIFIED SINUSITIS	382	0
15-24	Medicare	UNSPEC D/O TEETH&SUPPORTING STRCT	79	0
15-24	Medicare	DEPRESSIVE DISORDER NEC	51	1
15-24	Medicare	ACUTE PHARYNGITIS	45	0

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Age Group	Payer	Diagnosis Description	Outpatient Emergency Department Visits	Emergency Department Visits Resulting in Inpatient Hospitalization
15-24	Medicare	UTI SITE NOT SPECIFIED	42	1
15-24	Medicare	ACUTE URIS OF UNSPECIFIED SITE	38	0
15-24	Medicare	HEADACHE	35	0
15-24	Medicare	UNSPEC SITE ANKLE SPRAIN&STRAIN	35	0
15-24	Medicare	ABDOMINAL PAIN, UNSPECIFIED SITE	30	0
15-24	Medicare	CONTUS FACE SCALP&NECK EXCEPT EYE	30	0
15-24	Medicare	ASTHMA UNSPECIFIED W/EXACERBATION	29	1
15-24	Medicare	BRONCHITIS NOT SPEC AS ACUT/CHRONIC	27	0
15-24	Medicare	OPEN WOUND FINGER W/O MENTION COMP	25	0
15-24	Medicare	UNSPECIFIED OTITIS MEDIA	24	0
15-24	Medicare	LUMBAGO	24	0
15-24	Medicare	UNSPECIFIED BACKACHE	24	0
15-24	Medicare	VOMITING ALONE	23	0
15-24	Medicare	ANXIETY STATE, UNSPECIFIED	22	0
15-24	Medicare	OTH CURRENT MATERNAL CCE ANTEPARTUM	22	1
15-24	Medicare	UNSPEC SX ASSOC W/FE GENIT ORGN	21	0
15-24	Medicare	UNSPECIFIED PSYCHOSIS	20	3
15-24	Medicare	NAUSEA WITH VOMITING	20	0
15-24	Medicare	ABDOMINAL PAIN OTHER SPECIFIED SITE	20	0
15-24	Medicare	PAIN IN SOFT TISSUES OF LIMB	19	0
15-24	Medicare	STREPTOCOCCAL SORE THROAT	18	0
15-24	Medicare	UNSPEC VIRAL INF CCE & UNS SITE	18	0
15-24	Medicare	OTHER CONVULSIONS	18	0
15-24	Medicare	UNSPECIFIED DENTAL CARIES	17	0
15-24	Medicare	UNS NONINF GASTROENTERIT&COLITIS	17	0
15-24	Medicare	ABDOMINAL PAIN RIGHT LOWER QUADRANT	17	0
15-24	Medicare	CONTUSION OF HAND	17	0
15-24	Other	OPEN WOUND FINGER W/O MENTION COMP	690	0
15-24	Other	UNSPEC SITE ANKLE SPRAIN&STRAIN	162	0
15-24	Other	OPEN WND HND NO FNGR ALONE W/O COMP	155	0
15-24	Other	LUMBAR SPRAIN AND STRAIN	126	0
15-24	Other	ACUTE PHARYNGITIS	95	0
15-24	Other	CONTUSION OF HAND	87	0
15-24	Other	SPRAIN&STRAIN UNSPEC SITE WRIST	81	0

2010 Maine Hospital Emergency Department Use Statewide for Selected Age Groups Requested by Payer: Top 30 Outpatient Emergency Department Volume

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Age Group	Payer	Diagnosis Description	Outpatient Emergency Department Visits	Emergency Department Visits Resulting in Inpatient Hospitalization
15-24	Other	LUMBAGO	79	0
15-24	Other	NECK SPRAIN AND STRAIN	74	0
15-24	Other	CONTUS FACE SCALP&NECK EXCEPT EYE	72	0
15-24	Other	CONTUSION OF FINGER	71	0
15-24	Other	SPRAIN&STRAIN UNSPEC SITE KNEE&LEG	67	0
15-24	Other	SPRAIN&STRAIN UNS SITE SHLDR&UP ARM	66	0
15-24	Other	THORACIC SPRAIN AND STRAIN	64	0
15-24	Other	ATTENTION TO DRESSINGS AND SUTURES	60	0
15-24	Other	UTI SITE NOT SPECIFIED	59	0
15-24	Other	ABDOMINAL PAIN, UNSPECIFIED SITE	57	0
15-24	Other	SUPERFICIAL INJURY OF CORNEA	57	0
15-24	Other	HEADACHE	50	0
15-24	Other	CONTUSION OF FOOT	50	0
15-24	Other	UNS NONINF GASTROENTERIT&COLITIS	49	0
15-24	Other	OPEN WND KNEE LEG&ANK W/O COMP	49	0
15-24	Other	HEALTH EXAM DEFINED SUBPOPULATION	49	0
15-24	Other	OPEN WOUND FOREARM W/O MENTION COMP	47	0
15-24	Other	OPEN WOUND SCLP W/O MENTION COMP	45	0
15-24	Other	DEPRESSIVE DISORDER NEC	43	0
15-24	Other	CRUSHING INJURY OF FINGER	43	0
15-24	Other	FB UNSPEC SITE EXTERNAL EYE	41	0
15-24	Other	OTH CURRENT MATERNAL CCE ANTEPARTUM	40	2
15-24	Other	UNSPECIFIED BACKACHE	40	0
15-24	Uninsured	ACUTE PHARYNGITIS	605	0
15-24	Uninsured	UNSPEC D/O TEETH&SUPPORTING STRCT	525	0
15-24	Uninsured	UTI SITE NOT SPECIFIED	351	0
15-24	Uninsured	UNSPEC SITE ANKLE SPRAIN&STRAIN	272	0
15-24	Uninsured	ACUTE URIS OF UNSPECIFIED SITE	254	0
15-24	Uninsured	OPEN WOUND FINGER W/O MENTION COMP	227	0
15-24	Uninsured	NECK SPRAIN AND STRAIN	224	0
15-24	Uninsured	DEPRESSIVE DISORDER NEC	219	3
15-24	Uninsured	PERIAPICAL ABSCESS WITHOUT SINUS	214	0
15-24	Uninsured	ABDOMINAL PAIN, UNSPECIFIED SITE	213	1
15-24	Uninsured	UNSPECIFIED DENTAL CARIES	209	0

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Age Group	Payer	Diagnosis Description	Outpatient Emergency Department Visits	Emergency Department Visits Resulting in Inpatient Hospitalization
15-24	Uninsured	BRONCHITIS NOT SPEC AS ACUT/CHRONIC	201	0
15-24	Uninsured	AC APICAL PRDONTITIS PULPAL ORIGIN	201	0
15-24	Uninsured	HEADACHE	197	0
15-24	Uninsured	UNSPECIFIED OTITIS MEDIA	194	0
15-24	Uninsured	ACUTE BRONCHITIS	191	0
15-24	Uninsured	UNSPEC VIRAL INF CCE & UNS SITE	187	1
15-24	Uninsured	CONTUSION OF HAND	178	0
15-24	Uninsured	UNS NONINF GASTROENTERIT&COLITIS	174	3
15-24	Uninsured	LUMBAGO	172	0
15-24	Uninsured	LUMBAR SPRAIN AND STRAIN	168	0
15-24	Uninsured	CONTUS FACE SCALP&NECK EXCEPT EYE	165	1
15-24	Uninsured	NONDPND ALCOHL ABS UNS DRUNKENNESS	163	2
15-24	Uninsured	ACUTE TONSILLITIS	159	0
15-24	Uninsured	ASTHMA UNSPECIFIED W/EXACERBATION	153	2
15-24	Uninsured	OPEN WND HND NO FNGR ALONE W/O COMP	149	0
15-24	Uninsured	STREPTOCOCCAL SORE THROAT	146	0
15-24	Uninsured	ABDOMINAL PAIN OTHER SPECIFIED SITE	137	3
15-24	Uninsured	ANXIETY STATE, UNSPECIFIED	128	1
15-24	Uninsured	ASTHMA, UNSPECIFIED, UNSPECIFIED	118	0
15-24	Total	ACUTE PHARYNGITIS	4226	2
15-24	Total	UNSPEC D/O TEETH&SUPPORTING STRCT	2634	0
15-24	Total	UNSPEC SITE ANKLE SPRAIN&STRAIN	2596	0
15-24	Total	UTI SITE NOT SPECIFIED	2481	7
15-24	Total	ACUTE URIS OF UNSPECIFIED SITE	2083	1
15-24	Total	OPEN WOUND FINGER W/O MENTION COMP	2066	0
15-24	Total	ABDOMINAL PAIN, UNSPECIFIED SITE	2007	5
15-24	Total	HEADACHE	1573	4
15-24	Total	NECK SPRAIN AND STRAIN	1550	2
15-24	Total	UNSPECIFIED OTITIS MEDIA	1537	0
15-24	Total	DEPRESSIVE DISORDER NEC	1508	29
15-24	Total	BRONCHITIS NOT SPEC AS ACUT/CHRONIC	1396	0
15-24	Total	UNSPEC VIRAL INF CCE & UNS SITE	1311	5
15-24	Total	CONTUSION OF HAND	1284	0
15-24	Total	UNS NONINF GASTROENTERIT&COLITIS	1220	21
15-24	Total	CONTUS FACE SCALP&NECK EXCEPT EYE	1219	3

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Age Group	Payer	Diagnosis Description	Outpatient Emergency Department Visits	Emergency Department Visits Resulting in Inpatient Hospitalization
15-24	Total	OTH CURRENT MATERNAL CCE ANTEPARTUM	1186	27
15-24	Total	LUMBAGO	1139	0
15-24	Total	ABDOMINAL PAIN OTHER SPECIFIED SITE	1132	17
15-24	Total	LUMBAR SPRAIN AND STRAIN	1073	0
15-24	Total	AC APICAL PRDONTITIS PULPAL ORIGIN	936	0
15-24	Total	STREPTOCOCCAL SORE THROAT	908	1
15-24	Total	UNSPECIFIED DENTAL CARIES	899	0
15-24	Total	ASTHMA UNSPECIFIED W/EXACERBATION	884	29
15-24	Total	ACUTE TONSILLITIS	876	4
15-24	Total	ACUTE BRONCHITIS	862	0
15-24	Total	UNSPECIFIED BACKACHE	822	2
15-24	Total	OPEN WND HND NO FNGR ALONE W/O COMP	820	0
15-24	Total	PERIAPICAL ABSCESS WITHOUT SINUS	799	2
15-24	Total	ANXIETY STATE, UNSPECIFIED	783	2
25-44	Commercial	ACUTE PHARYNGITIS	1580	0
25-44	Commercial	OTHER CHEST PAIN	1361	87
25-44	Commercial	HEADACHE	1241	10
25-44	Commercial	OPEN WOUND FINGER W/O MENTION COMP	1218	0
25-44	Commercial	ABDOMINAL PAIN, UNSPECIFIED SITE	1110	9
25-44	Commercial	NECK SPRAIN AND STRAIN	1109	6
25-44	Commercial	UNSPEC SITE ANKLE SPRAIN&STRAIN	1031	0
25-44	Commercial	UNSPECIFIED CHEST PAIN	1022	32
25-44	Commercial	UTI SITE NOT SPECIFIED	924	10
25-44	Commercial	LUMBAGO	887	7
25-44	Commercial	BRONCHITIS NOT SPEC AS ACUT/CHRONIC	882	2
25-44	Commercial	UNS MIGRAINE W/O INTRACT MIGRAINE	846	5
25-44	Commercial	ACUTE URIS OF UNSPECIFIED SITE	802	0
25-44	Commercial	LUMBAR SPRAIN AND STRAIN	796	2
25-44	Commercial	ABDOMINAL PAIN OTHER SPECIFIED SITE	749	18
25-44	Commercial	UNS NONINF GASTROENTERIT&COLITIS	724	28
25-44	Commercial	UNSPECIFIED OTITIS MEDIA	619	0
25-44	Commercial	ACUTE BRONCHITIS	598	3
25-44	Commercial	UNSPECIFIED SINUSITIS	592	2
25-44	Commercial	UNSPEC VIRAL INF CCE & UNS SITE	586	12

2010 Maine Hospital Emergency Department Use Statewide for Selected Age Groups Requested by Payer: Top 30 Outpatient Emergency Department Volume

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Age Group	Payer	Diagnosis Description	Outpatient Emergency Department Visits	Emergency Department Visits Resulting in Inpatient Hospitalization
25-44	Commercial	PAINFUL RESPIRATION	558	6
25-44	Commercial	UNSPEC D/O TEETH&SUPPORTING STRCT	526	0
25-44	Commercial	PAIN IN SOFT TISSUES OF LIMB	496	2
25-44	Commercial	UNSPECIFIED BACKACHE	494	2
25-44	Commercial	OPEN WND HND NO FNGR ALONE W/O COMP	466	0
25-44	Commercial	DIZZINESS AND GIDDINESS	462	3
25-44	Commercial	ASTHMA UNSPECIFIED W/EXACERBATION	443	32
25-44	Commercial	CELLULITIS&ABSCESS LEG EXCEPT FOOT	435	40
25-44	Commercial	STREPTOCOCCAL SORE THROAT	426	3
25-44	Commercial	PALPITATIONS	425	2
25-44	Medicaid	UNSPEC D/O TEETH&SUPPORTING STRCT	2140	0
25-44	Medicaid	LUMBAGO	1631	7
25-44	Medicaid	HEADACHE	1462	5
25-44	Medicaid	ABDOMINAL PAIN, UNSPECIFIED SITE	1248	17
25-44	Medicaid	ACUTE PHARYNGITIS	1204	3
25-44	Medicaid	UNS MIGRAINE W/O INTRACT MIGRAINE	1125	4
25-44	Medicaid	BRONCHITIS NOT SPEC AS ACUT/CHRONIC	1087	0
25-44	Medicaid	PERIAPICAL ABSCESS WITHOUT SINUS	979	2
25-44	Medicaid	UTI SITE NOT SPECIFIED	975	10
25-44	Medicaid	AC APICAL PRDONTITIS PULPAL ORIGIN	952	0
25-44	Medicaid	DEPRESSIVE DISORDER NEC	951	40
25-44	Medicaid	LUMBAR SPRAIN AND STRAIN	943	0
25-44	Medicaid	UNSPECIFIED BACKACHE	934	0
25-44	Medicaid	ACUTE URIS OF UNSPECIFIED SITE	923	0
25-44	Medicaid	UNSPEC SITE ANKLE SPRAIN&STRAIN	896	0
25-44	Medicaid	UNSPECIFIED DENTAL CARIES	878	0
25-44	Medicaid	OTHER CHEST PAIN	857	57
25-44	Medicaid	ABDOMINAL PAIN OTHER SPECIFIED SITE	819	12
25-44	Medicaid	ANXIETY STATE, UNSPECIFIED	722	5
25-44	Medicaid	NECK SPRAIN AND STRAIN	681	1
25-44	Medicaid	UNSPECIFIED OTITIS MEDIA	676	0
25-44	Medicaid	UNSPECIFIED CHEST PAIN	669	24
25-44	Medicaid	PAIN IN SOFT TISSUES OF LIMB	635	0
25-44	Medicaid	ACUTE BRONCHITIS	620	3
25-44	Medicaid	OPEN WOUND FINGER W/O MENTION COMP	611	0

2010 Maine Hospital Emergency Department Use Statewide for Selected Age Groups Requested by Payer: Top 30 Outpatient Emergency Department Volume

For this report the top 30 volume diagnoses in total and the top 30 diagnosis within each payer type were determined.

Age Group	Payer	Diagnosis Description	Outpatient Emergency Department Visits	Emergency Department Visits Resulting in Inpatient Hospitalization
25-44	Medicaid	UNS NONINF GASTROENTERIT&COLITIS	593	18
25-44	Medicaid	UNSPECIFIED SINUSITIS	558	0
25-44	Medicaid	PAINFUL RESPIRATION	542	4
25-44	Medicaid	ASTHMA UNSPECIFIED W/EXACERBATION	539	31
25-44	Medicaid	ASTHMA, UNSPECIFIED, UNSPECIFIED	533	1
25-44	Medicare	HEADACHE	487	2
25-44	Medicare	DEPRESSIVE DISORDER NEC	465	16
25-44	Medicare	UNSPEC D/O TEETH&SUPPORTING STRCT	437	0
25-44	Medicare	UNS MIGRAINE W/O INTRACT MIGRAINE	430	1
25-44	Medicare	LUMBAGO	375	3
25-44	Medicare	ABDOMINAL PAIN, UNSPECIFIED SITE	329	5
25-44	Medicare	OTHER CHEST PAIN	280	21
25-44	Medicare	BRONCHITIS NOT SPEC AS ACUT/CHRONIC	275	2
25-44	Medicare	UNSPECIFIED CHEST PAIN	257	9
25-44	Medicare	ANXIETY STATE, UNSPECIFIED	251	0
25-44	Medicare	UNSPECIFIED BACKACHE	240	2
25-44	Medicare	OTHER CONVULSIONS	232	14
25-44	Medicare	ACUTE PHARYNGITIS	216	0
25-44	Medicare	UTI SITE NOT SPECIFIED	206	13
25-44	Medicare	UNSPEC SITE ANKLE SPRAIN&STRAIN	203	1
25-44	Medicare	ABDOMINAL PAIN OTHER SPECIFIED SITE	202	11
25-44	Medicare	ACUTE URIS OF UNSPECIFIED SITE	188	0
25-44	Medicare	PAIN IN SOFT TISSUES OF LIMB	179	0
25-44	Medicare	PAINFUL RESPIRATION	174	6
25-44	Medicare	LUMBAR SPRAIN AND STRAIN	173	0
25-44	Medicare	AC APICAL PRDONTITIS PULPAL ORIGIN	166	0
25-44	Medicare	UNSPECIFIED DENTAL CARIES	159	0
25-44	Medicare	UNSPECIFIED OTITIS MEDIA	155	0
25-44	Medicare	PERIAPICAL ABSCESS WITHOUT SINUS	155	1
25-44	Medicare	OPEN WOUND FINGER W/O MENTION COMP	154	0
25-44	Medicare	NONDPND ALCOHL ABS UNS DRUNKENNESS	137	1
25-44	Medicare	ACUTE BRONCHITIS	137	1
25-44	Medicare	ASTHMA UNSPECIFIED W/EXACERBATION	132	12
25-44	Medicare	UNS NONINF GASTROENTERIT&COLITIS	126	13
25-44	Medicare	BIPOLAR DISORDER UNSPECIFIED	124	7

2010 Maine Hospital Emergency Department Use Statewide for Selected Age Groups Requested by Payer: Top 30 Outpatient Emergency Department Volume

For this report the top 30 volume diagnoses in total and the top 30 diagnosis within each payer type were determined.

Age Group	Payer	Diagnosis Description	Outpatient Emergency Department Visits	Emergency Department Visits Resulting in Inpatient Hospitalization
25-44	Other	OPEN WOUND FINGER W/O MENTION COMP	898	0
25-44	Other	LUMBAR SPRAIN AND STRAIN	361	0
25-44	Other	UNSPEC SITE ANKLE SPRAIN&STRAIN	305	0
25-44	Other	OPEN WND HND NO FNGR ALONE W/O COMP	251	0
25-44	Other	LUMBAGO	239	0
25-44	Other	NECK SPRAIN AND STRAIN	174	0
25-44	Other	SUPERFICIAL INJURY OF CORNEA	161	0
25-44	Other	SPRAIN&STRAIN UNS SITE SHLDR&UP ARM	143	0
25-44	Other	CONTUSION OF HAND	133	0
25-44	Other	SPRAIN&STRAIN UNSPEC SITE WRIST	125	0
25-44	Other	SPRAIN&STRAIN UNSPEC SITE KNEE&LEG	124	0
25-44	Other	THORACIC SPRAIN AND STRAIN	107	0
25-44	Other	FOREIGN BODY IN CORNEA	107	0
25-44	Other	UNSPECIFIED BACKACHE	103	0
25-44	Other	CONTUS FACE SCALP&NECK EXCEPT EYE	103	0
25-44	Other	CONTUSION OF FINGER	101	0
25-44	Other	PAIN IN SOFT TISSUES OF LIMB	91	0
25-44	Other	CONTUSION OF KNEE	88	0
25-44	Other	CONTUSION OF CHEST WALL	85	0
25-44	Other	HEADACHE	82	0
25-44	Other	OPEN WOUND FOREARM W/O MENTION COMP	80	1
25-44	Other	FB UNSPEC SITE EXTERNAL EYE	80	0
25-44	Other	ATTENTION TO DRESSINGS AND SUTURES	79	0
25-44	Other	OTHER CHEST PAIN	73	2
25-44	Other	OPEN WOUND SCLP W/O MENTION COMP	73	0
25-44	Other	CRUSHING INJURY OF FINGER	72	1
25-44	Other	CONTUSION OF FOOT	71	0
25-44	Other	PAIN IN JOINT, SHOULDER REGION	67	1
25-44	Other	SPRAIN&STRAIN UNSPECIFIED SITE BACK	65	0
25-44	Other	PAIN IN JOINT, LOWER LEG	64	1
25-44	Uninsured	UNSPEC D/O TEETH&SUPPORTING STRCT	885	0
25-44	Uninsured	PERIAPICAL ABSCESS WITHOUT SINUS	598	4
25-44	Uninsured	LUMBAGO	524	0
25-44	Uninsured	ACUTE PHARYNGITIS	518	2

2010 Maine Hospital Emergency Department Use Statewide for Selected Age Groups Requested by Payer: Top 30 Outpatient Emergency Department Volume

For this report the top 30 volume diagnoses in total and the top 30 diagnosis within each payer type were determined.

Age Group	Payer	Diagnosis Description	Outpatient Emergency Department Visits	Emergency Department Visits Resulting in Inpatient Hospitalization
25-44	Uninsured	AC APICAL PRDONTITIS PULPAL ORIGIN	501	1
25-44	Uninsured	UNSPECIFIED DENTAL CARIES	448	0
25-44	Uninsured	LUMBAR SPRAIN AND STRAIN	425	0
25-44	Uninsured	BRONCHITIS NOT SPEC AS ACUT/CHRONIC	424	0
25-44	Uninsured	HEADACHE	398	3
25-44	Uninsured	OPEN WOUND FINGER W/O MENTION COMP	382	0
25-44	Uninsured	DEPRESSIVE DISORDER NEC	355	15
25-44	Uninsured	ABDOMINAL PAIN, UNSPECIFIED SITE	349	1
25-44	Uninsured	UNSPEC SITE ANKLE SPRAIN&STRAIN	334	0
25-44	Uninsured	OTHER CHEST PAIN	316	19
25-44	Uninsured	NECK SPRAIN AND STRAIN	304	0
25-44	Uninsured	ACUTE BRONCHITIS	303	0
25-44	Uninsured	UTI SITE NOT SPECIFIED	281	1
25-44	Uninsured	ACUTE URIS OF UNSPECIFIED SITE	272	0
25-44	Uninsured	ANXIETY STATE, UNSPECIFIED	265	0
25-44	Uninsured	UNSPECIFIED CHEST PAIN	265	6
25-44	Uninsured	UNSPECIFIED OTITIS MEDIA	263	0
25-44	Uninsured	UNSPECIFIED BACKACHE	261	0
25-44	Uninsured	NONDPND ALCOHL ABS UNS DRUNKENNESS	255	3
25-44	Uninsured	ASTHMA UNSPECIFIED W/EXACERBATION	253	10
25-44	Uninsured	ABDOMINAL PAIN OTHER SPECIFIED SITE	249	4
25-44	Uninsured	PAINFUL RESPIRATION	236	2
25-44	Uninsured	OPEN WND HND NO FNGR ALONE W/O COMP	210	0
25-44	Uninsured	UNS NONINF GASTROENTERIT&COLITIS	201	2
25-44	Uninsured	UNSPEC VIRAL INF CCE & UNS SITE	196	2
25-44	Uninsured	CELLULITIS&ABSCESS LEG EXCEPT FOOT	194	12
25-44	Total	UNSPEC D/O TEETH&SUPPORTING STRCT	4011	0
25-44	Total	HEADACHE	3670	20
25-44	Total	LUMBAGO	3656	17
25-44	Total	ACUTE PHARYNGITIS	3580	5
25-44	Total	OPEN WOUND FINGER W/O MENTION COMP	3263	0
25-44	Total	ABDOMINAL PAIN, UNSPECIFIED SITE	3082	32
25-44	Total	OTHER CHEST PAIN	2887	186
25-44	Total	UNSPEC SITE ANKLE SPRAIN&STRAIN	2769	1
25-44	Total	BRONCHITIS NOT SPEC AS ACUT/CHRONIC	2712	5

2010 Maine Hospital Emergency Department Use Statewide for Selected Age Groups Requested by Payer: Top 30 Outpatient Emergency Department Volume

For this report the top 30 volume diagnoses in total and the top 30 diagnosis within each payer type were determined.

Age Group	Payer	Diagnosis Description	Outpatient Emergency Department Visits	Emergency Department Visits Resulting in Inpatient Hospitalization
25-44	Total	LUMBAR SPRAIN AND STRAIN	2698	2
25-44	Total	UNS MIGRAINE W/O INTRACT MIGRAINE	2641	15
25-44	Total	UTI SITE NOT SPECIFIED	2422	34
25-44	Total	NECK SPRAIN AND STRAIN	2392	8
25-44	Total	UNSPECIFIED CHEST PAIN	2260	72
25-44	Total	ACUTE URIS OF UNSPECIFIED SITE	2204	0
25-44	Total	DEPRESSIVE DISORDER NEC	2194	93
25-44	Total	PERIAPICAL ABSCESS WITHOUT SINUS	2096	8
25-44	Total	ABDOMINAL PAIN OTHER SPECIFIED SITE	2069	45
25-44	Total	UNSPECIFIED BACKACHE	2032	4
25-44	Total	AC APICAL PRDONTITIS PULPAL ORIGIN	1954	1
25-44	Total	UNSPECIFIED OTITIS MEDIA	1741	0
25-44	Total	ACUTE BRONCHITIS	1691	7
25-44	Total	UNSPECIFIED DENTAL CARIES	1690	0
25-44	Total	UNS NONINF GASTROENTERIT&COLITIS	1686	64
25-44	Total	ANXIETY STATE, UNSPECIFIED	1611	8
25-44	Total	PAIN IN SOFT TISSUES OF LIMB	1595	3
25-44	Total	PAINFUL RESPIRATION	1555	18
25-44	Total	UNSPECIFIED SINUSITIS	1450	2
25-44	Total	UNSPEC VIRAL INF CCE & UNS SITE	1415	18
25-44	Total	ASTHMA UNSPECIFIED W/EXACERBATION	1389	86

APPENDIX 3.

Council on Health System Development
ED Use Workgroup

APPENDIX 3.

EMERGENCY DEPT. USE WORKGROUP

Trish Riley, Chair	Director, Governor's Office of Health Policy
Tim Beals	Executive Director, Delta Ambulance
Art Blank	President/CEO, Mt. Desert Island Hospital, Member ACHSD
Jay Bradshaw	Public Safety Manager, Emergency Medical Services
Rev. Bob Carlson	President, Penobscot Community Health Care
Carol Carothers	Executive Director, NAMI-Maine
Dr. Ken Christian	Chief of ED, Maine Coast Memorial Hospital
Dr. Josh Cutler	Director, Maine Quality Forum, Member ACHSD
Bob Downs	Director of Operations and Development, Harvard Pilgrim Health Care
Geoff Green	Deputy Commissioner, DHHS
Chris Hastedt	Public Policy Advisor, Maine Equal Justice Partners
Dr. Scott Kemmerer	Medical Director, Emergency Dept., MaineGeneral Medical Center
Dr. Maroulla Gleaton	Ophthalmologist, Member ACHSD
Anne Graham	Maine Neurology, Member ACHSD
Katie Fullam Harris	Director, Government Relations, Anthem Blue Cross Blue Shield
Tony Marple	Director, OMS, DHHS
Carol Minnis	ER Nurse, Waterville Campus of MGMC
Deb Nichols	Schaller Anderson
Dr. Brian Rines	Psychologist, Chair ACHSD
Dr. Erik Steele	Chief Medical Officer, Eastern Maine Healthcare Systems
Ron Welch	Director, OAMHS, DHHS
Dennise Whitley	Director of Advocacy-Maine, American Heart Association
Richard Willett	CEO, Redington-Fairview General Hospital
David Winslow	Vice President of Financial Policy, Maine Hospital Association
Dr. Wendy Wolf	President and CEO, Maine Health Access Foundation

Department of Health and Human Services
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Paul R. LePage, Governor
Mary C. Mayhew, Commissioner

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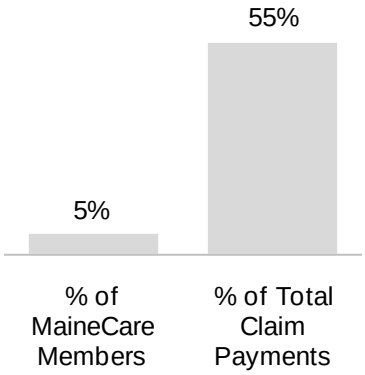
MaineCare SFY 2010 High-Cost Member Fact Sheet

In state fiscal year 2010, MaineCare provided coverage to 449,193 members at some point during the year. Claims payment for services totaled $2,311,382,913[1] with 343,649 members receiving services.

The top 5% of highest cost MaineCare enrollees (17,182 members) accounted for $1.2 billion or 55% of total claim payments.[2] This is consistent with findings in the literature that showed that 5% of the population accounted for almost 50% of the total health care expense.[3]



High Cost Member Characteristics

- Adults age 21-64 constitute 51% of high cost members and 57% of high cost claim payments.
- About one in five high cost members is 75 or older.
- Over half (61%) of the high cost members are enrolled in MaineCare due to disability and 27% are elderly (age 65+).
- High cost members average annual costs per year was $74,215 and ranged from $51,234 for members age 75+ to $82,956 for members age 18 to 20.
- 46% of high cost members are dually eligible for both Medicare and MaineCare.
    - Medicare pays for most of the acute and pharmacy care, while MaineCare pays for co-pays, deductibles and services not covered by Medicare, primarily mental health and long term care services.

"Nearly half of all high-cost members are dually eligible"

- With the exception of out of state residency (8%)[4], high cost users as a proportion of all MaineCare service users are equally distributed throughout the state on a county to county basis, representing about 5% in most counties.

[1] Costs throughout this report reflect claim payments and do not consider any off-claim settlements or adjustments. General acute hospital payments are estimated based on a proportion (cost to charge ratio) of the allowed amount on the claim.
[2] For this analysis, members were ranked on their total annual cost per member. The top 5% of all MaineCare members that received any services (i.e., had a paid claim for services) during sfy2010 were considered high cost members.
[3] Agency for Healthcare Quality Research in Action, 2006 available at http://www.ahrq.gov/research/ria19/expendria.pdf

- Cumberland, Kennebec and Penobscot Counties are slightly higher at 6% and Waldo County is slightly lower at 3%.
- The largest number of high cost users (2,952) are found in Cumberland County.

- The Medicaid-only high cost users (excluding members dually eligible for Medicare) were examined separately. Member characteristics were consistent across both groups with the exception that the percentage of elderly members, which drops from 27% including the dual eligibles to 4% for Medicaid-only.

Table 1: Distribution of MaineCare Service Users and Claim Payments by Age Groups, SFY2010

	Total					High Cost Users 5%				
Age Groups	Members	Percent Members	Paid	Percent of Paid	Ave Annual Cost per Member	Members	Percent Members	Paid	Percent of Paid	Ave Annual Cost per Member
Ages 0 to 17	116,623	34%	$518,277,018	22%	$4,444	3,061	18%	$237,094,517	19%	$77,457
Ages 18 to 20	17,914	5%	$103,942,713	4%	$5,802	590	3%	$48,944,243	4%	$82,956
Ages 21 to 64	155,467	45%	$1,297,000,210	56%	$8,343	8,790	51%	$726,716,853	57%	$82,675
Ages 65 to 74	21,720	6%	$110,726,712	5%	$5,098	1,096	6%	$75,658,219	6%	$69,031
Ages 75+	31,925	9%	$281,436,260	12%	$8,816	3,645	21%	$186,747,022	15%	$51,234
Total	**343,649**	100%	$2,311,382,913	100%	$6,726	**17,182**	100%	$1,275,160,854	100%	$74,215

High Cost Member Service Use

- Long term care, which includes nursing home, all Home & Community Based waivers, ICFMRs, private duty nursing, and personal care, is the largest percentage of costs.
  - 71% of high cost members use long term care and this reflects 53% of the high cost members' claim payments.
  - The home and community based waiver for members with developmental disabilities (MR Waiver) was the largest claims expenditure at $294 million with an average annual cost per member of $89,618; 19% (N=3,285) of high cost members received this service.

"71% of high-cost members use long term care"

  - 26% of high cost members (N=4,508) used a nursing facility for a total of $204 million in claims payments and an average annual cost per member of $45,548.
  - Less than 2% of high cost members used any of the other home and community based waiver services.
  - 20% of the high cost members (N=3,357) received PNMI[5] services for a total of $173 million in claims payments and an average annual cost per member of $51,707.

[4] Residents residing out of state are generally receiving residential services and treatments in specialty facilities.
[5] This includes all types of PNMI providers that are reimbursed by MaineCare.

- General hospital services, including both inpatient and outpatient services, represent 20% of high cost members' payments[6].
    - Combined inpatient and outpatient hospital spending is estimated at $255 million for high cost members, approximately 44% of the total estimated payments to hospitals for all MaineCare members.
    - Over a quarter (27%) of high cost members used inpatient hospital services compared with 8% of all service users.

"High-cost members account for 44% of total estimated hospital payments"

    - 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.
    - ED expenditures for high cost members are estimated at $11 million for an average cost of $530 per visit.
    - 457 of high cost members (3%) had an avoidable hospitalization[7], accounting for $5.6 million (3%) of high cost members' estimated general inpatient spending.
- Mental health services were used by 42% of high cost users and accounted for 11% of their claims payments.
    - 13% (2,245) of high cost members received community support services accounting for $23 million in claims payments. The average annual cost per high cost member for community support services was $10,151.
    - Most (93%) of the total inpatient psychiatric hospital spending for all MaineCare members ($33.5 million) was attributed to high cost members.
- 42% of high cost members received some level of case management and accounted for $25 million in claims payments – an average of $3,478 per service user.
- High cost member service use was similar whether or not members dual eligible for Medicare were excluded from the analysis, with the exception that the percentage of hospital payments out of total high cost user payments rises from 20% including duals to 36% for Medicaid-only.
- Approximately one-in-four (27%) high cost MaineCare members are enrolled in the Primary Care Case Management Program (PCCM). Average annual expenditures for those enrolled in PCCM ($67,627) were less than members not enrolled in PCCM ($76, 628).
    - Many of the criteria for exemptions or exclusion from the PCCM program are applicable to high cost members including dual eligibles, children in the Katie Beckett program, members in nursing homes, ICF-MRs or receiving home and community care benefits.

[6] In SFY2010, MaineCare reimbursed hospitals on a prospective payment system with a cost settlement. These payments are not reflected in claims, so payments shown in this report are estimated based from claims payment using the OMS approved methodology.

[7] Based on Agency for HealthCare Research and Quality (AHRQ) Quality Indicators, potentially avoidable hospitalizations for ambulatory sensitive conditions (ACSA) was calculated. Potentially avoidable hospitalizations involve admissions that evidence suggests could have been avoided, at least in part due to better access to quality outpatient care. This measure is a composite of avoidable hospitalizations for asthma, pneumonia, severe eye, nose and throat (ENT) infections, kidney urinary tract infection (UTI), Congestive Heart Failure (CHF) and gastroenteritis. Avoidable hospitalizations and the costs associated with these stays were identified.

- The top four primary diagnoses observed accounted for 55% of high cost members' claim expenditures and were all behavioral health related including:
    - Intellectual disabilities (25% of members, 27% of costs),
    - Other psychosis (37% of members, 15% of costs),
    - Neurotic, personality, & other non-psychotic mental disorders (44% of members, 10% of costs), and
    - Organic psychotic conditions (15% of members, 3% of costs).

Policy Implications for DHHS

- DHHS' strategy to achieve higher value healthcare must:
    - Address members with dual Medicare and Medicaid enrollment
    - Emphasize integration of behavioral and physical health
    - Achieve coordination with long term service providers and existing care management resources.
- The current Patient-Centered Medical Home (PCMH) Pilot and emerging Community Care Teams (CCT)are well positioned to achieve these goals, given Medicare's participation in the Pilot and the opportunity through the ACA to transition the PCMHs and CCTs to become "Health Homes" focused on providing integrated care to the highest need individuals.
- Emergency Department use and avoidable hospitalizations are a relatively small part of the picture for high cost users. However, given the high rate of ED visits for the MaineCare population as a whole and especially for the top 5% high cost users, the ED is a natural place to identify and begin care management of high cost users, which would result in cost savings and better health across all services.
- Despite the relative uniformity of the distribution of high cost users at a county level across the state, exploring the data at zip code, census tract, and street levels reveals important information that DHHS should utilize for:
    - MaineCare to target sites for ED collaborative care management project priority and PCMH/Health Homes expansion.
    - Community Care Teams to target specific communities where there is a large proportion of high cost users and/or scarce health resources.

MaineCare Hospital Utilization Analysis for Cumberland, Kennebec, and Penobscot Counties, FY2009 & FY2010

About the Project

The Camden Coalition of Healthcare Providers (CCHP) is an nine-year old strategic initiative with a mission to improve the quality, capacity, and accessibility of the healthcare system for vulnerable populations in the City of Camden. The Camden Coalition of Healthcare Providers has compiled the Camden Health Database, a citywide all-payor, all-provider claims database that contains data on all hospital encounters from 2002 through 2010. The Camden Health Database has shown to be a tremendous tool for quantifying and analyzing local health trends. Using its expertise in managing and analyzing claims data, CCHP has analyzed 2 years of Medicaid claims data from the MaineCare database. Data was extracted for three counties (Cumberland, Kennebec, and Penobscot) for the 2009 and 2010 fiscal years.

Summary of Findings

For the study area in 2009, MaineCare payed $123.7 million for 73,821 ED visits and 12,877 Inpatient (IP) visits made by 38,485 unique patients. For the study area in 2010, MaineCare payed $136.8 million for 78,723 ED visits and 12,880 Inpatient visits made by 41,339 unique patients.

614 (1%) of patients accounted for 31.6% of total hospital costs during the 2 year period ; 12,228 (20%) patients accounted for 87% of costs during the 2 year period.

High utilizer patients are defined as those patients with 6 or more ED visits and/or 3 or more IP visits during the 2 year time period. 6,121 patients (9.9%) met this "High Utilizer" definition. While High Utilizer's represented less than 10% of all MaineCare patients they accounted for 46% of all hospital costs.

Inpatient High Utilizers
The three most prevalent inpatient diagnosis for High Utilizers were "alcohol-related disorders", "mood disorders", and "chronic obstructive pulmonary disease and bronchiectasis". Inpatient High Utilizers are 2.12 times more likely to have an Inpatient stay with a diagnosis of "alcohol-related disorders" compared to non-High Utilizers, 1.97 times more likely to have an inpatient stay with a diagnosis of "chronic obstructive pulmonary disease and bronchiectasis", and 1.81 times more likely to have a diagnosis of "diabetes" compared to non-High Utilizers. 72% of all IP High Utilizers were over age 34

ED High Utilizers
The three most prevalent emergency department diagnosis for High Utilizers were "sprains and strains", "disorders of teeth and jaw", and "other upper respiratory infections". ED High Utilizers are 1.46 times more likely to have an ED visit with a diagnosis of "anxiety disorders" compared to non-High Utilizers, 1.46 times more likely to have an ED visit with a diagnosis of "spondylosis; intervertebral disc disorders; other back problems", and 1.38 times more likely to have a diagnosis of "Headache; including migraine". 67% of all ED High Utilizers were under age 35

Portland (993), Bangor (462), Waterville (426) and Augusta (357) had the highest prevalence of High Utilizer patients. Together, these four towns contain 46% of all high utilizers. Of all towns with at least 200 MaineCare members, Waterville (14.95%), Lincoln (12.78%), and Winslow (12.25%) had the highest rate of High Utilizers.

Camden Coalition of Healthcare Providers
www.camdenhealth.org

MaineCare Hospital Utilization Analysis for Cumberland, Kennebec and Penobscot Counties: 7/1/2008 - 6/30/2010

Total Patients, Visits, and Costs*, ED and Inpatient

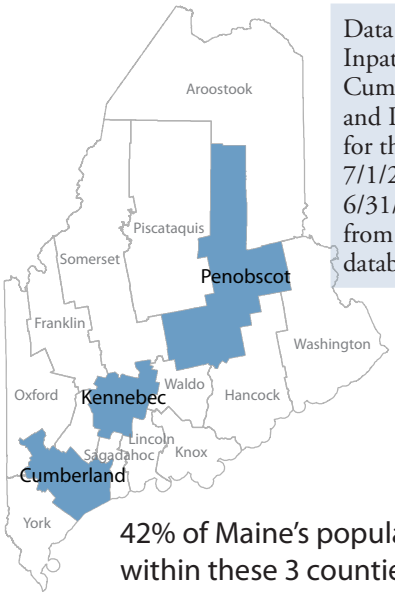
Emergency Room

Year	Patients	Visits	Charged	Allowed	Paid
FY09	35,270	73,821	$63,973,283	$47,651,409	$25,681,140
FY10	37,931	78,723	$72,429,885	$54,342,377	$30,072,805

Inpatient

Year	Patients	Visits	Charged	Allowed	Paid
FY09	7,310	12,877	$167,713,214	$152,870,768	$98,025,526
FY10	7,691	12,880	$186,698,504	$168,151,559	$106,692,703

Fiscal years (FYs) begin 7/1 and ends 6/30



42% of Maine's population lives within these 3 counties

Data Source: All ED and Inpatient claims for Cumberland, Kennebec, and Penobscot counties for the period beginning 7/1/2008 and ending 6/31/2010, extracted from the MaineCare State database.

Concentration of Total ED and Inpatient Costs*

Top % by cost	Patients	Total Paid (in millions) Amount	Total Paid (in millions) Percent	Inpatient Visits	Inpatient Percent	Emergency Department Visits	Emergency Department Percent
1 percent	614	$82.2	31.6%	3,260	15.3%	4,951	3.3%
5 percent	3,069	$154.7	59.4%	8,765	41.1%	17,552	11.7%
10 percent	6,138	$190.9	73.3%	12,578	59.0%	29,925	19.9%
20 percent	12,276	$226.5	86.9%	17,980	84.3%	49,415	32.8%
30 percent	18,414	$240.6	92.4%	19,627	92.0%	74,839	49.7%
40 percent	24,552	$247.4	95.0%	19,894	93.3%	94,249	62.6%
60 percent	36,828	$255.0	97.9%	20,189	94.7%	119,857	79.6%
80 percent	49,104	$258.9	99.4%	20,397	95.6%	136,402	90.6%
100 percent	61,380	$260.5	100.0%	21,327	100.0%	150,492	100.0%

top 1% of patients 31.6% of costs	next 4% of patients 27.8% of costs	next 5% 13.9% of costs	next 10% 13.6% of costs	bottom 80% 13.1% of costs

20% of patients account for 86.9% of costs

Distribution of ED & Inpatient Visits

Inpatient

	Visits	Patients	Percent	Total Paid (in millions)	per Patient
	1	10,190	74.6%	$80.6	$7,912
	2	2,038	14.9%	$39.8	$19,507
High Utilizers	3-5	1,136	8.3%	$48.1	$42,299
High Utilizers	6-10	248	1.8%	$27.0	$108,704
High Utilizers	11-20	51	0.4%	$8.0	$157,319
High Utilizers	>20	4	0.0%	$1.3	$324,204
	All	13,667		$204.7	$14,979
	High Utilizers	1,439	10.5%	$84.3	$58,605

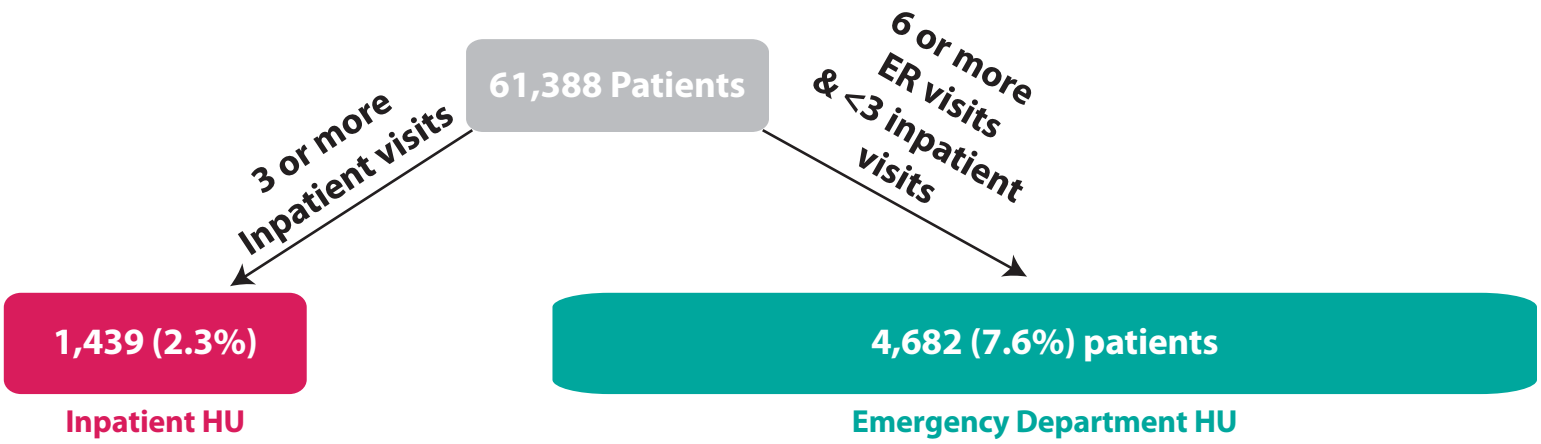
Emergency Department

	Visits	Count	Percent	Total Paid (in millions)	Per Patient
	1	26,504	46.8%	$9.5	$358
	2-3	19,095	33.7%	$15.7	$823
	4-5	5,914	10.4%	$9.2	$1,551
High Utilizers	6-10	3,805	6.7%	$10.6	$2,783
High Utilizers	11-25	819	1.4%	$4.1	$5,006
High Utilizers	26-50	265	0.5%	$2.1	$7,673
High Utilizers	51-100	100	0.2%	$1.0	$10,329
High Utilizers	100-200	144	0.3%	$2.2	$15,089
High Utilizers	>200	35	0.1%	$1.0	$28,890
	All	56,687		$55.8	$983
	High Utilizers	5,168	9.1%	$20.9	$4,134

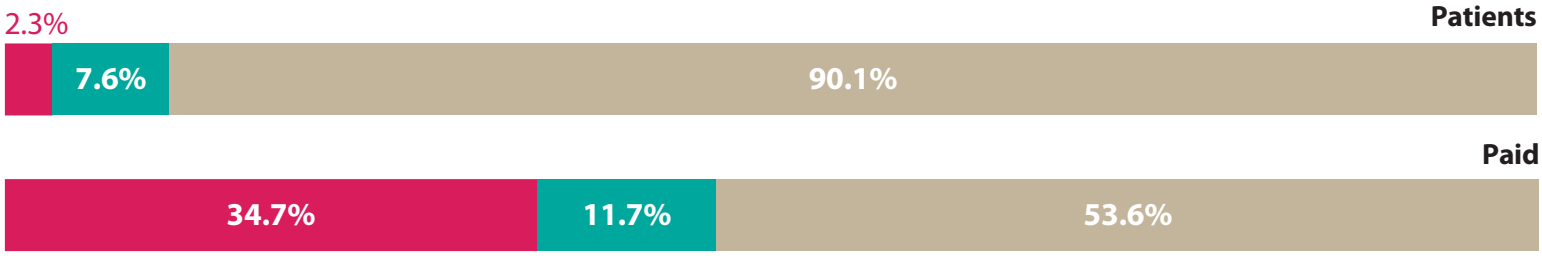
*Costs throughout this report reflect claim payments and do not consider any off-claim settlements or adjustments. General acute hospital payments are estimated based on a proportion (cost to charge ratio) of the allowed amount on the claim.

MaineCare Hospital Utilization Analysis for Cumberland, Kennebec and Penobscot Counties

How we define a High Utilizer

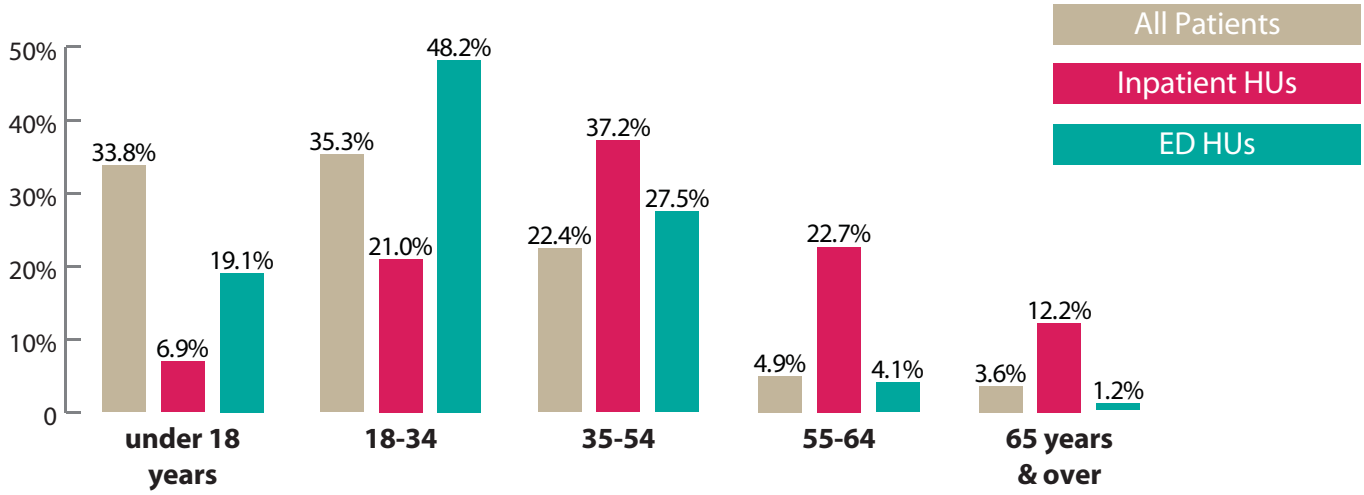


High Utilizers as a percentage of all patients and costs

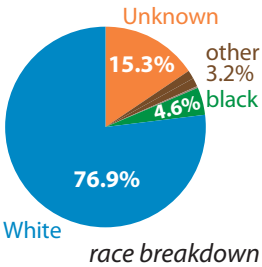


Demographic profile of patients

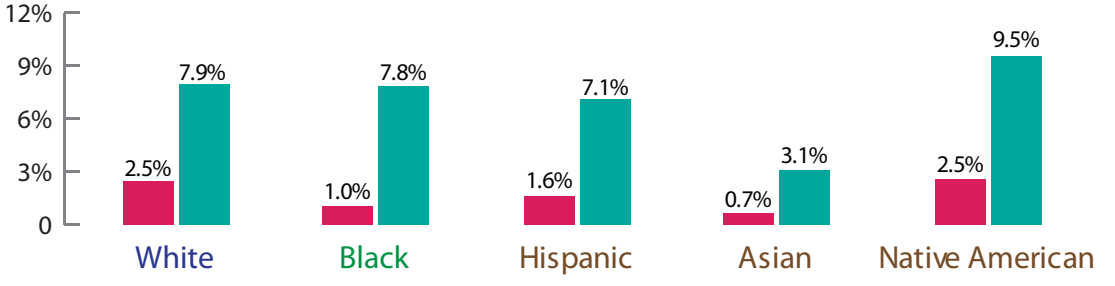
Age



Race



race breakdown for all patients



Cumberland, Kennebec and Penobscot MaineCare patients by inpatient and emergency visits, FY09 – FY10			
Emergency Department Visits	Inpatient Visits		
	0 - 1	2	3 or more
0 to 3	**Normal Utilization Range** Patients: 39,246 (79%) Total ED amount paid: $19.5 million (44%) Avg ED amount paid per visit: $348 Total IP amount paid: $56.6 million (33%) Avg IP amount paid per visit: $7,911	**Potential High INP Utilizers** Patients: 1,335 (3%) Total ED amount paid $1.0 million (2%) Avg ED amount paid per visit: $490 Total IP amount paid $26.1 million (16%) Avg IP amount paid per visit: $9,790	**High Inpatient Utilizers** Patients: 1,132 (2%) Total ED amount paid $4.5 million (10%) Avg ED amount paid per visit: $588 Total IP amount paid $66.0 million (41%) Avg IP amount paid per visit: $12,616
4 to 5	**Potential High ED Utilizers** Patients: 4,425 (9%) Total ED amount paid: $6.6 million (15%) Avg ED amount paid per visit: $341 Total IP amount paid: $5.0 million (3%) Avg IP amount paid per visit: $6,783		
6 or more	**High ED Utilizers** Patients: 3,422 (7%) Total ED amount paid: $11.5 million (26%) Avg ED amount paid per visit: $363 Total IP amount paid: $6.2 million (4%) Avg IP amount paid per visit: $7,698	**High ED Utilizers** Potential High INP Patients: 326 (1%) Total ED amount paid $1.7 million (4%) Avg ED amount paid per visit: $463 Total IP amount paid: $4.8 million (3%) Avg IP amount paid per visit: $7,380	

Most Prevalent High Utilizer ED Diagnoses

Rank	Primary Diagnosis	High Utilizer Incidence	Total Incidence	odds ratio
1	Sprains and strains	2,672	8,408	1.08
2	Disorders of teeth and jaw	2,604	6,658	1.34
3	other upper respiratory infections	2,556	10,381	0.82
4	Superficial injury; contusion	2,535	9,080	0.94
5	Abdominal pain	2,472	6,897	1.22
6	Spondylosis; intervertebral disc disorders; other back problems	1,855	4,347	1.46
7	Headache; including migraine	1,279	3,149	1.38
8	Skin and subcutaneous tissue infections	1,180	3,476	1.15
9	Mood disorders	1,168	3,101	1.28
10	Otitis media and related conditions	1,068	4,865	0.73
11	Other connective tissue disease	971	2,832	1.16
12	Other nervous system disorders	929	2,311	1.36
13	Urinary Tract Infection	870	2,793	1.05
14	Other non-traumatic joint disorders	801	2,138	1.27
15	Nonspecific chest pain	792	2,959	0.90
16	Nausea and vomiting	782	2,629	1.00
17	Anxiety disorders	765	1,780	1.46
18	Other complications of pregnancy	727	2,270	1.08
19	Asthma	709	2,224	1.08
20	Other lower respiratory disease	698	2,596	0.91

Most Prevalent High Utilizer Inpatient Diagnoses

Rank	Primary Diagnosis	High Utilizer Incidence	Total Incidence	odds ratio
1	Alcohol-related disorders	593	914	2.12
2	Mood disorders	256	746	1.07
3	Chronic obstructive pulmonary disease and bronchiectasis	239	392	1.94
4	Pneumonia	185	538	1.08
5	Complication of device; implant or graft	179	296	1.91
6	Complications of surgical procedures or medical	175	339	1.63
7	Nonspecific chest pain	174	367	1.49
8	Substance-related disorders	174	680	0.79
9	Diabetes	171	299	1.81
10	Pancreatic disorders (not diabetes)	158	292	1.71
11	Septicemia (except in labor)	155	346	1.41
12	Rehabilitation care; fitting of prostheses; and	145	253	1.81
13	Respiratory failure; insufficiency; arrest (adult)	140	233	1.89
14	Maintenance chemotherapy; radiotherapy	130	143	2.87
15	Congestive heart failure; nonhypertensive	123	220	1.76
16	Fluid and electrolyte disorders	117	247	1.49
17	Other complications of pregnancy	115	608	0.58
18	Coronary atherosclerosis and other heart disease	112	238	1.48
19	Skin and subcutaneous tissue infections	111	356	0.97
20	Schizophrenia and other psychotic disorders	107	263	1.27

ED diagnoses for all individuals under 18 years old

Primary Diagnosis for Visit	Patients	Visits	Charges	Paid
Other upper respiratory infections	4,390	5,368	$2,418,647	$1,128,656
Otitis media and related conditions	3,018	3,796	$1,610,963	$806,380
Superficial injury; contusion	2,927	3,289	$1,689,790	$689,227
Fever of unknown origin	1,730	2,011	$1,198,701	$552,812
Viral Infection	1,526	1,673	$774,510	$342,159
Open wounds of head; neck; and trunk	1,511	1,630	$1,065,351	$556,887
Sprains and strains	1,387	1,601	$1,000,689	$388,633
Other injuries and conditions due to external causes	1,278	1,368	$935,037	$390,978
Allergic reactions	1,103	1,215	$467,479	$244,624
Nausea and vomiting	976	1,094	$602,589	$294,256
Open wounds of extremities	1,025	1,086	$723,160	$365,145
Abdominal pain	899	1,057	$1,239,219	$417,107
Fracture of upper limb	855	914	$1,106,261	$501,458
Other lower respiratory disease	758	805	$459,724	$225,815
Asthma	624	792	$608,546	$297,042
Inflammation; infection of eye (except that caused by tuberculosis)	634	671	$234,941	$120,414
Other ear and sense organ disorders	595	645	$240,129	$123,289
Skin and subcutaneous tissue infections	548	637	$338,613	$163,241
Pneumonia	550	614	$573,171	$239,203
Other skin disorders	566	601	$210,073	$107,325
Other gastrointestinal disorders	502	550	$338,141	$138,201
Noninfectious gastroenteritis	523	547	$346,004	$149,354
Attention-deficit, conduct, and disruptive behavior disorders	365	546	$382,679	$196,561
Urinary Tract Infection	417	480	$351,113	$136,843
Influenza	459	476	$262,782	$118,703
Acute bronchitis	431	468	$357,120	$165,635

Inpatient diagnoses for all individuals under 18 years old

Primary Diagnosis for Visit	Patients	Visits	Charges	Paid
Pneumonia	141	179	$1,424,997	$855,393
Acute bronchitis	129	156	$1,310,839	$771,710
Asthma	104	146	$708,316	$416,705
Liveborn	67	93	$3,760,772	$2,198,113
Fluid and electrolyte disorders	71	87	$381,808	$226,747
Epilepsy; convulsions	68	86	$902,186	$542,781
Maintenance chemotherapy; radiotherapy	17	82	$982,609	$571,205
Appendicitis and other appendiceal conditions	54	69	$970,338	$601,638
Complication of device; implant or graft	38	69	$1,759,369	$1,026,929
Mood disorders	50	64	$1,005,412	$648,639
Other upper respiratory infections	50	58	$280,446	$165,777
Skin and subcutaneous tissue infections	49	55	$458,521	$277,133
Cardiac and circulatory congenital anomalies	33	53	$2,731,951	$1,608,390
Urinary Tract Infection	35	52	$280,689	$168,015
Other perinatal conditions	39	48	$850,821	$484,688
Fever of unknown origin	36	43	$583,191	$342,886
Other gastrointestinal disorders	27	40	$682,227	$404,202
Complications of surgical procedures or medical	29	40	$897,834	$516,658

ED diagnoses for all individuals 18 - 49 years old

Primary Diagnosis for Visit	Patients	Visits	Charges	Paid
Sprains and strains	4,799	6,150	$4,400,980	$1,708,166
Disorders of teeth and jaw	3,593	6,005	$2,865,540	$1,474,033
Abdominal pain	3,482	5,200	$8,962,659	$2,821,222
Superficial injury; contusion	3,953	5,013	$4,059,488	$1,444,951
Other upper respiratory infections	3,819	4,639	$2,365,519	$1,056,093
Spondylosis; intervertebral disc disorders; other back problems	2,450	3,489	$2,531,268	$1,093,021
Headache; including migraine	1,783	2,581	$2,940,309	$1,201,590
Skin and subcutaneous tissue infections	1,641	2,444	$1,812,431	$847,147
Mood disorders	1,445	2,408	$2,427,834	$1,119,714
Other complications of pregnancy	1,562	2,300	$2,162,912	$1,007,451
Urinary Tract Infection	1,658	2,055	$2,026,096	$728,675
Other connective tissue disease	1,708	2,047	$1,313,468	$559,828
Open wounds of extremities	1,777	2,033	$1,718,766	$839,857
Nonspecific chest pain	1,447	1,948	$3,760,319	$1,520,138
Other nervous system disorders	1,435	1,845	$1,550,292	$609,043
Other non-traumatic joint disorders	1,236	1,495	$949,001	$398,175
Other injuries and conditions due to external causes	1,317	1,460	$1,510,803	$559,576
Anxiety disorders	1,017	1,389	$1,114,052	$505,725
Nausea and vomiting	1,080	1,370	$1,587,187	$662,348
Other lower respiratory disease	1,215	1,369	$1,431,947	$551,832
Chronic obstructive pulmonary disease and bronchiectasis	1,152	1,289	$1,006,907	$420,142
Asthma	889	1,219	$1,069,547	$489,771
Allergic reactions	1,024	1,194	$644,506	$321,939
Alcohol-related disorders	606	1,165	$1,575,459	$658,034
Viral Infection	1,016	1,082	$739,802	$294,090
Open wounds of head; neck; and trunk	914	1,029	$1,041,280	$446,792
Otitis media and related conditions	921	1,027	452,629	223,447

Inpatient diagnoses for all individuals 18 - 49 years old

Primary Diagnosis for Visit	Patients	Visits	Charges	Paid
OB-related trauma to perineum and vulva	988	1,122	$6,615,152	$4,245,861
Other complications of birth; puerperium affecting	647	780	$6,674,315	$4,138,255
Other complications of pregnancy	558	715	$4,864,503	$2,969,565
Substance-related disorders	520	696	$4,298,701	$2,993,821
Alcohol-related disorders	283	658	$3,692,344	$2,659,478
Mood disorders	415	614	$5,967,122	$3,773,585
Previous C-section	488	595	$6,368,049	$3,940,177
Prolonged pregnancy	459	522	$4,212,755	$2,611,158
Normal pregnancy and/or delivery	339	378	$1,708,417	$1,052,137
Polyhydramnios and other problems of amniotic	296	339	$3,158,203	$1,913,253
Fetal distress and abnormal forces of labor	263	305	$2,701,620	$1,701,147
Hypertension complicating pregnancy; childbirth and the	245	295	$3,375,659	$2,072,074
Early or threatened labor	216	279	$1,973,410	$1,190,771
Malposition; malpresentation	204	237	$2,596,037	$1,600,724
Skin and subcutaneous tissue infections	170	235	$2,270,454	$1,428,629
Pancreatic disorders (not diabetes)	118	223	$2,782,116	$1,650,512
Diabetes	82	217	$2,109,560	$1,272,322
Pneumonia	145	200	$2,887,179	$1,839,766
Nonspecific chest pain	115	197	$1,533,994	$971,080
Poisoning by other medications and drugs	115	187	$1,388,190	$887,053
Umbilical cord complication	167	183	$1,111,741	$690,508
Schizophrenia and other psychotic disorders	98	179	$1,677,082	$1,104,207

ED diagnoses for all individuals 50 years and older

Primary Diagnosis for Visit	Patients	Visits	Charges	Paid
Nonspecific chest pain	662	967	$2,309,369	$895,309
Superficial injury; contusion	722	875	$759,063	$250,877
Abdominal pain	542	802	$1,563,138	$441,915
Spondylosis; intervertebral disc disorders; other back problems	533	776	$534,284	$213,568
Sprains and strains	595	745	$601,735	$219,601
Alcohol-related disorders	242	743	$964,570	$398,957
Chronic obstructive pulmonary disease and bronchiectasis	468	728	$916,217	$338,471
Other connective tissue disease	447	530	$395,631	$148,258
Disorders of teeth and jaw	346	480	$217,815	$110,669
Skin and subcutaneous tissue infections	333	469	$379,231	$156,278
Other lower respiratory disease	389	464	$572,870	$205,800
Other upper respiratory infections	375	456	$267,276	$102,372
Other nervous system disorders	330	422	$474,965	$171,989
Other non-traumatic joint disorders	327	407	$268,303	$101,825
Mood disorders	251	389	$407,067	$173,054
Headache; including migraine	241	366	$411,279	$158,360
Anxiety disorders	186	308	$216,013	$94,999
Open wounds of extremities	275	304	$227,410	$98,957
Urinary Tract Infection	226	294	$305,534	$91,883
Other injuries and conditions due to external causes	260	282	$368,570	$124,339
Asthma	154	249	$255,132	$112,481
Residual codes; unclassified	212	239	$297,140	$95,812
Nausea and vomiting	190	229	$297,907	$103,682
Conditions associated with dizziness or vertigo	191	227	$291,753	$93,501
Pneumonia	194	218	$310,206	$115,636

Inpatient diagnoses for all individuals 50 years and older

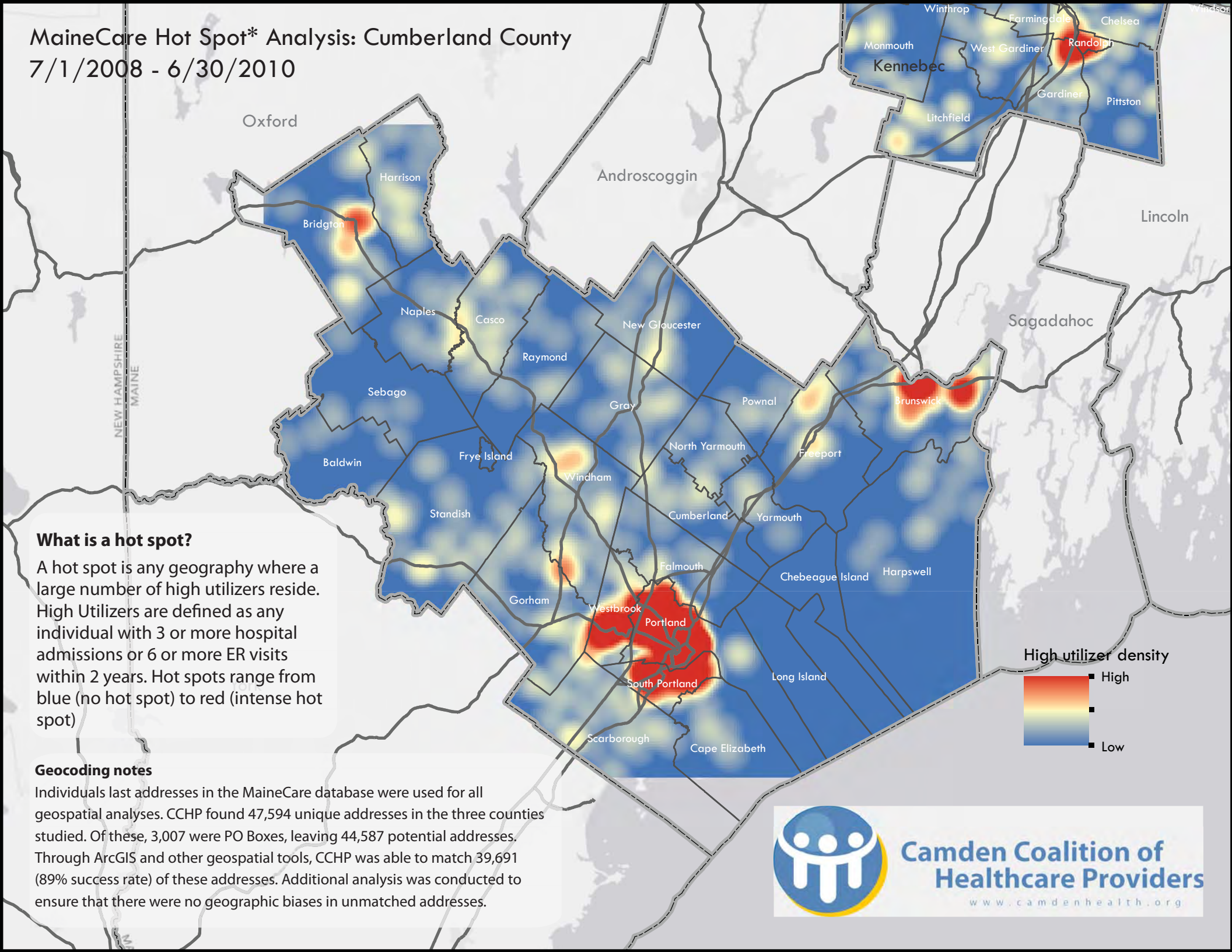
Primary Diagnosis for Visit	Patients	Visits	Charges	Paid
Chronic obstructive pulmonary disease and bronchiectasis	221	478	$4,216,411	$2,151,327
Alcohol-related disorders	175	416	$2,920,169	$2,042,556
Respiratory failure; insufficiency; arrest (adult)	112	294	$4,400,332	$2,396,912
Septicemia (except in labor)	172	292	$7,720,849	$4,377,668
Pneumonia	185	282	$3,021,937	$1,594,784
Nonspecific chest pain	168	250	$1,733,547	$1,029,170
Congestive heart failure; nonhypertensive	134	221	$2,935,058	$1,298,613
Coronary atherosclerosis and other heart disease	153	219	$5,457,305	$2,927,829
Acute myocardial infarction (AMI)	136	212	$4,042,676	$2,110,939
Rehabilitation care; fitting of prostheses; and	160	209	$4,032,899	$2,244,709
Mood disorders	117	194	$2,977,767	$1,677,150
Complications of surgical procedures or medical	122	177	$3,877,685	$2,121,142
Osteoarthritis	127	171	$4,250,454	$2,394,620
Schizophrenia and other psychotic disorders	71	164	$1,810,266	$951,985
Cardiac dysrhythmias	107	160	$1,920,202	$966,771
Complication of device; implant or graft	89	142	$4,002,734	$1,855,960
Skin and subcutaneous tissue infections	88	138	$1,690,728	$974,123
Acute cerebrovascular disease	94	128	$3,179,557	$1,468,345
Pancreatic disorders (not diabetes)	56	123	$1,618,950	$931,599
Acute and unspecified renal failure	85	122	$1,376,749	$613,959
Diabetes	80	122	$1,760,447	$950,450
Fluid and electrolyte disorders	86	115	$695,339	$432,150
Secondary malignancies	56	111	$1,707,931	$916,477
Urinary Tract Infection	65	104	$1,077,308	$441,643

MaineCare Hospital Utilization Analysis for Cumberland, Kennebec and Penobscot Counties

Geographies

Town	Total members that reside in town	# of inp visits from residents of town	# of ED visits from residents of town	# of High Utilizers that are residents of town	Percent of town's members that are High Utilizers	This town has what percentage of all members	This town has what percentage of all High Utilizers	This town has what percentage of all inpatient visits	This town haas what percentage of all ER visits
Enfield	129	28	371	20	15.50%	0.26%	0.41%	0.17%	0.31%
Waterville	2,849	834	8,957	426	14.95%	5.71%	8.73%	4.94%	7.43%
Veazie	97	37	241	14	14.43%	0.19%	0.29%	0.22%	0.20%
Lagrange	97	20	243	13	13.40%	0.19%	0.27%	0.12%	0.20%
Lincoln	947	256	2,648	121	12.78%	1.90%	2.48%	1.52%	2.20%
Winslow	939	286	2,473	115	12.25%	1.88%	2.36%	1.70%	2.05%
Newport	471	133	1,310	57	12.10%	0.94%	1.17%	0.79%	1.09%
Clifton	109	34	235	13	11.93%	0.22%	0.27%	0.20%	0.20%
Portland	8,360	3,007	23,728	993	11.88%	16.76%	20.35%	17.82%	19.69%
Pownal	59	18	124	7	11.86%	0.12%	0.14%	0.11%	0.10%
Brunswick	1,481	674	3,654	175	11.82%	2.97%	3.59%	3.99%	3.03%
Plymouth	195	39	540	23	11.79%	0.39%	0.47%	0.23%	0.45%
Alton	85	39	232	10	11.76%	0.17%	0.20%	0.23%	0.19%
Benton	391	114	973	46	11.76%	0.78%	0.94%	0.68%	0.81%
Oakland	786	195	2,089	92	11.70%	1.58%	1.89%	1.16%	1.73%
Millinocket	712	178	1,898	83	11.66%	1.43%	1.70%	1.05%	1.57%
Bradley	88	26	232	10	11.36%	0.18%	0.20%	0.15%	0.19%
Medway	108	34	271	12	11.11%	0.22%	0.25%	0.20%	0.22%
Augusta	3,237	1,158	8,235	357	11.03%	6.49%	7.32%	6.86%	6.83%
Clinton	399	113	1,052	44	11.03%	0.80%	0.90%	0.67%	0.87%
Casco	328	100	758	36	10.98%	0.66%	0.74%	0.59%	0.63%
Bangor	4,490	1,721	11,084	462	10.29%	9.00%	9.47%	10.20%	9.20%
Vassalboro	391	102	983	40	10.23%	0.78%	0.82%	0.60%	0.82%
Bridgton	560	182	1,331	57	10.18%	1.12%	1.17%	1.08%	1.10%
Chester	69	22	183	7	10.14%	0.14%	0.14%	0.13%	0.15%
Dexter	783	214	1,941	78	9.96%	1.57%	1.60%	1.27%	1.61%
Sidney	373	97	866	37	9.92%	0.75%	0.76%	0.57%	0.72%
Belgrade	215	74	539	21	9.77%	0.43%	0.43%	0.44%	0.45%
Randolph	270	94	659	26	9.63%	0.54%	0.53%	0.56%	0.55%
Exeter	105	37	225	10	9.52%	0.21%	0.20%	0.22%	0.19%
North Yarmouth	107	26	272	10	9.35%	0.21%	0.20%	0.15%	0.23%
Corinth	325	112	727	30	9.23%	0.65%	0.61%	0.66%	0.60%
Etna	168	63	434	15	8.93%	0.34%	0.31%	0.37%	0.36%
Cumberland	125	52	234	11	8.80%	0.25%	0.23%	0.31%	0.19%
East Millinocket	311	71	766	27	8.68%	0.62%	0.55%	0.42%	0.64%
Brewer	854	351	1,983	74	8.67%	1.71%	1.52%	2.08%	1.65%
Harpswell	188	69	403	16	8.51%	0.38%	0.33%	0.41%	0.33%
Westbrook	1,775	690	3,890	151	8.51%	3.56%	3.09%	4.09%	3.23%
Freeport	356	142	706	30	8.43%	0.71%	0.61%	0.84%	0.59%
Winthrop	460	188	900	38	8.26%	0.92%	0.78%	1.11%	0.75%
South Portland	2,027	604	4,590	167	8.24%	4.06%	3.42%	3.58%	3.81%
other towns	13,705	4,499	26,704	866	6.32%	21.6%	15.07%	21.05%	18.14%
All Geographies	**49,886**	**16,873**	**120,515**	**4,880**	**9.78%**	**100.00%**	**100.00%**	**100.00%**	**100.00%**

MaineCare Hot Spot* Analysis: Cumberland County
7/1/2008 - 6/30/2010



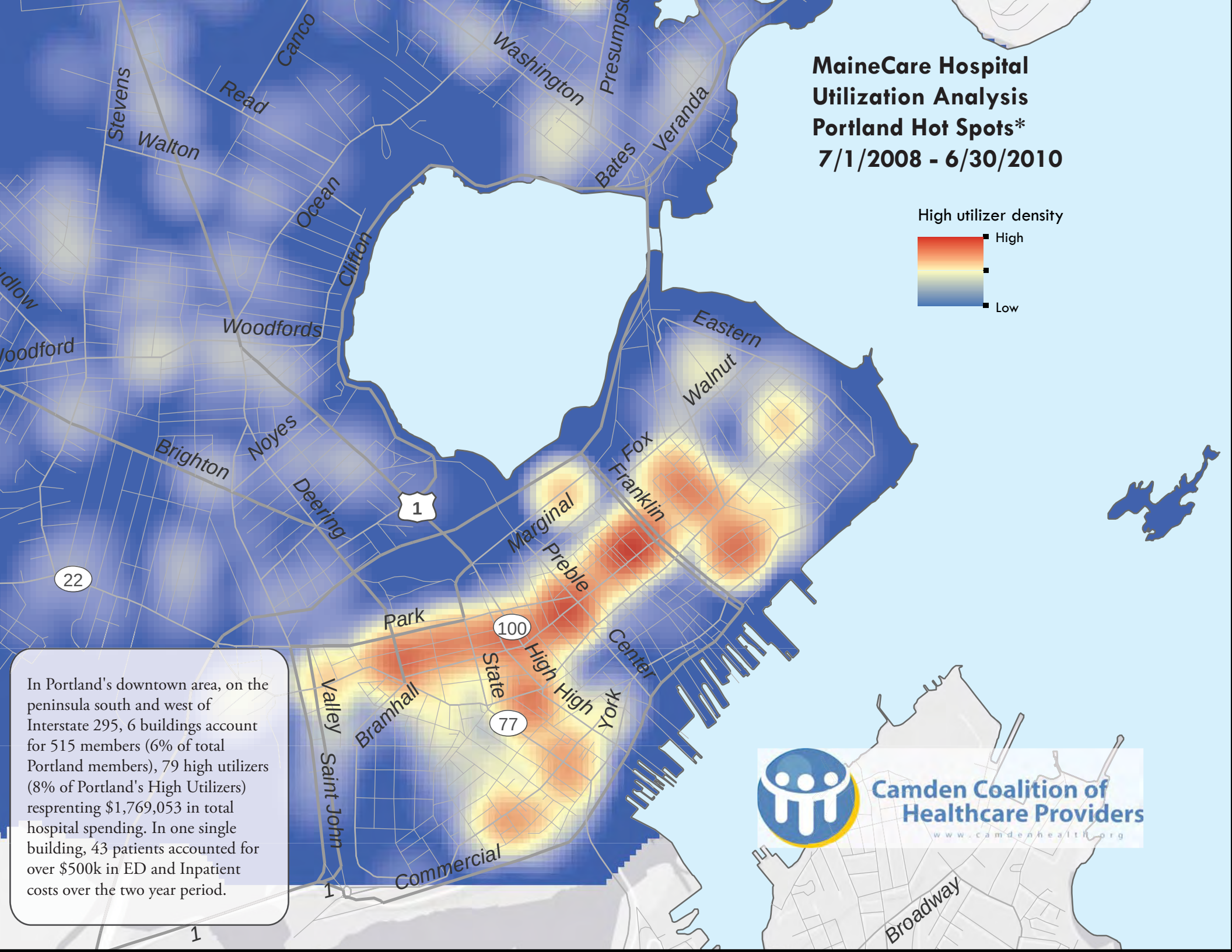
What is a hot spot?

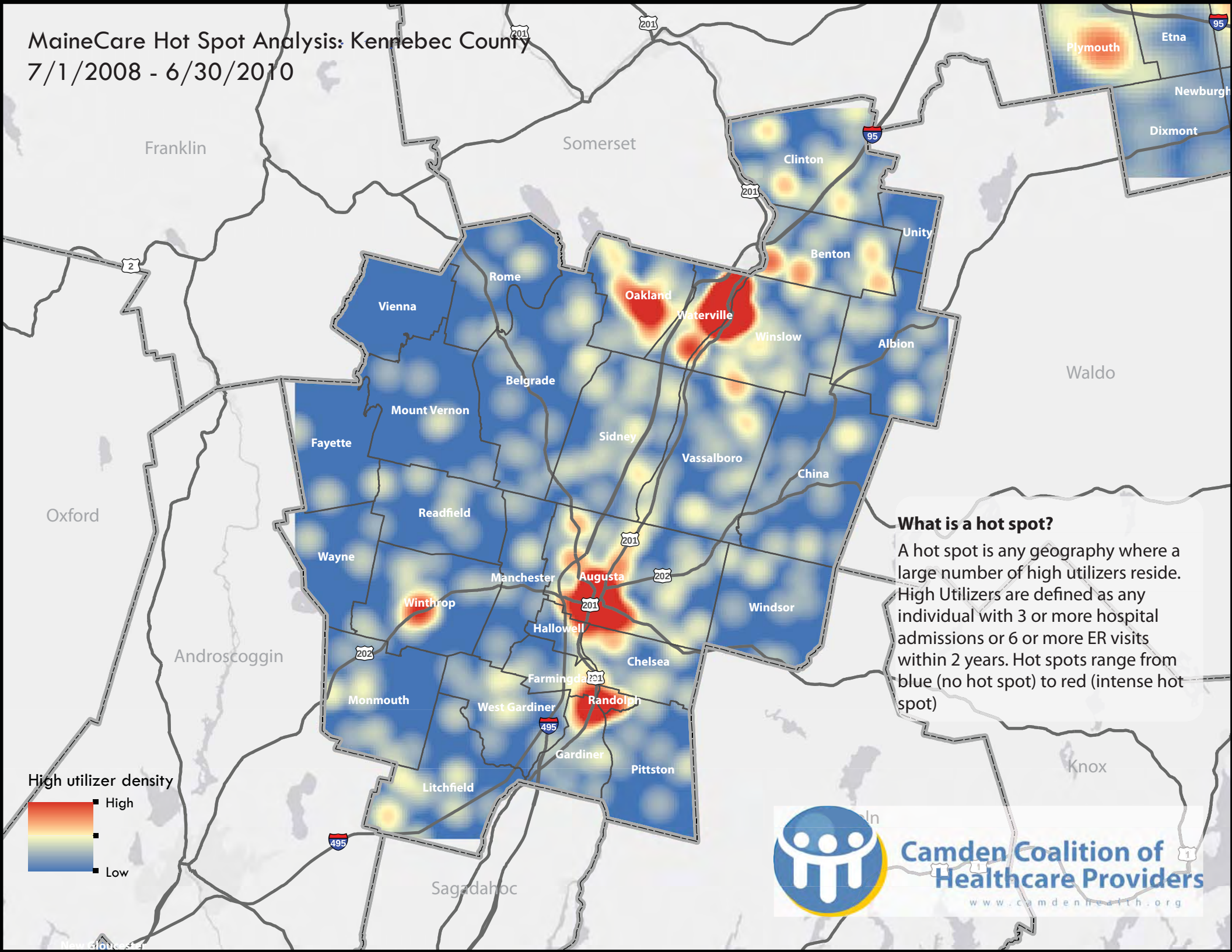
A hot spot is any geography where a large number of high utilizers reside. High Utilizers are defined as any individual with 3 or more hospital admissions or 6 or more ER visits within 2 years. Hot spots range from blue (no hot spot) to red (intense hot spot)

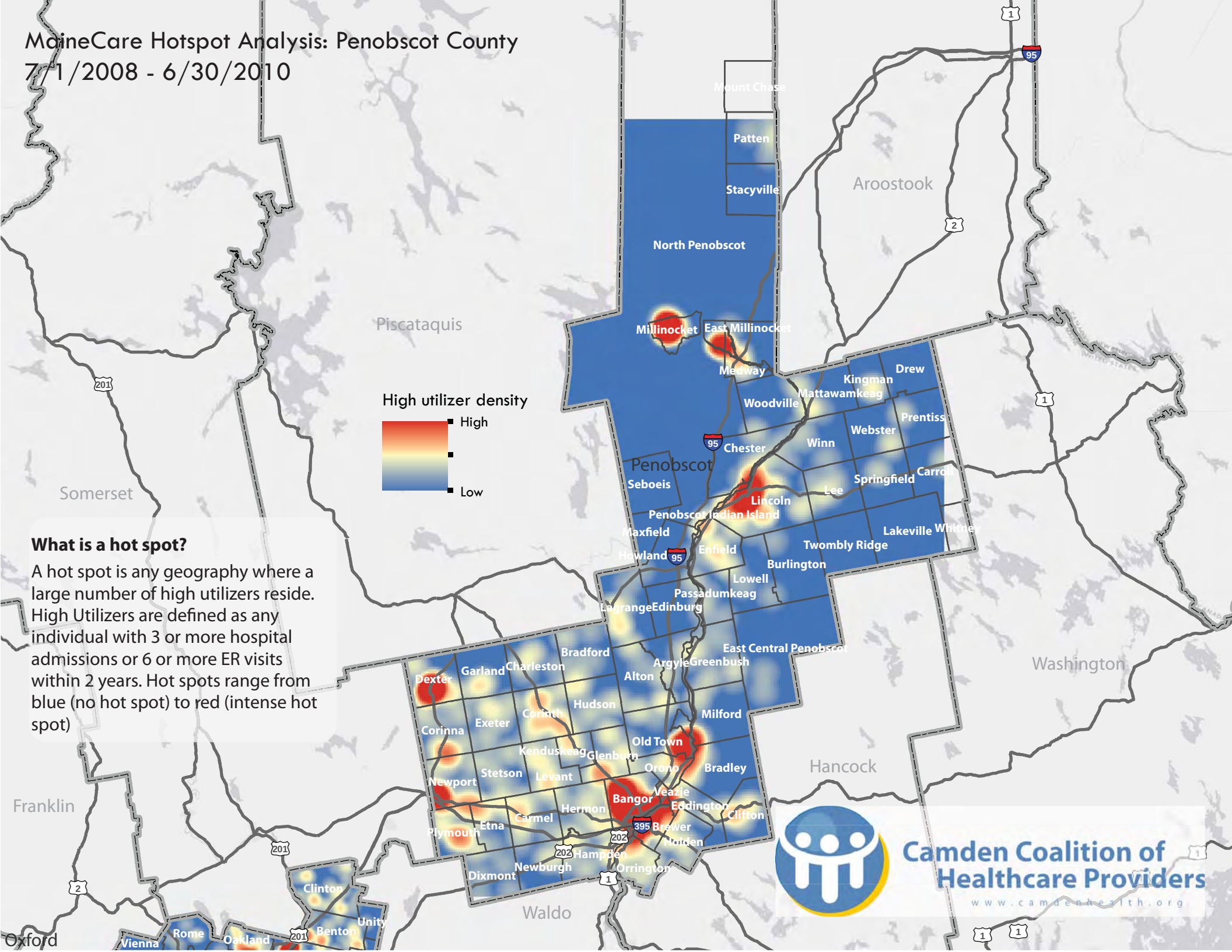
Geocoding notes

Individuals last addresses in the MaineCare database were used for all geospatial analyses. CCHP found 47,594 unique addresses in the three counties studied. Of these, 3,007 were PO Boxes, leaving 44,587 potential addresses. Through ArcGIS and other geospatial tools, CCHP was able to match 39,691 (89% success rate) of these addresses. Additional analysis was conducted to ensure that there were no geographic biases in unmatched addresses.

Camden Coalition of Healthcare Providers
www.camdenhealth.org


MaineCare Hospital
Utilization Analysis
Portland Hot Spots*
7/1/2008 - 6/30/2010
High utilizer density
High
Low
In Portland's downtown area, on the peninsula south and west of Interstate 295, 6 buildings account for 515 members (6% of total Portland members), 79 high utilizers (8% of Portland's High Utilizers) resprenting $1,769,053 in total hospital spending. In one single building, 43 patients accounted for over $500k in ED and Inpatient costs over the two year period.
Camden Coalition of Healthcare Providers
www.camdenhealth.org
Stevens
Canco
Read
Washington
Presumpscot
Walton
Bates
Veranda
Ocean
Clifton
Woodfords
Eastern
Walnut
Brighton
Noyes
Deering
Fox
Franklin
Marginal
Preble
Park
Center
State
High
York
Valley
Bramhall
Saint John
Commercial
Broadway
1
22
100
77


MaineCare Hot Spot Analysis: Kennebec County
7/1/2008 - 6/30/2010
Franklin
Somerset
Waldo
Oxford
Androscoggin
Sagadahoc
Knox
Plymouth
Etna
Newburgh
Dixmont
Clinton
Unity
Benton
Rome
Vienna
Oakland
Waterville
Winslow
Albion
Belgrade
Mount Vernon
Fayette
Sidney
Vassalboro
China
Readfield
Wayne
Manchester
Augusta
Winthrop
Hallowell
Windsor
Chelsea
Farmingdale
Monmouth
West Gardiner
Randolph
Gardiner
Pittston
Litchfield
2
95
201
202
495
What is a hot spot?
A hot spot is any geography where a large number of high utilizers reside. High Utilizers are defined as any individual with 3 or more hospital admissions or 6 or more ER visits within 2 years. Hot spots range from blue (no hot spot) to red (intense hot spot)
High utilizer density
High
Low
Camden Coalition of Healthcare Providers
www.camdenhealth.org


MaineCare Hotspot Analysis: Penobscot County
7/1/2008 - 6/30/2010
High utilizer density
High
Low
What is a hot spot?
A hot spot is any geography where a large number of high utilizers reside. High Utilizers are defined as any individual with 3 or more hospital admissions or 6 or more ER visits within 2 years. Hot spots range from blue (no hot spot) to red (intense hot spot)
Mount Chase
Patten
Stacyville
Aroostook
North Penobscot
Piscataquis
Millinocket
East Millinocket
Medway
Drew
Kingman
Mattawamkeag
Woodville
Prentiss
Webster
Winn
Chester
Penobscot
Seboeis
Carroll
Springfield
Lee
Lincoln
Penobscot Indian Island
Maxfield
Lakeville
Whitney
Twombly Ridge
Howland
Enfield
Burlington
Lowell
Passadumkeag
LagrangeEdinburg
East Central Penobscot
Somerset
Bradford
Garland
Charleston
Dexter
Alton
ArgyleGreenbush
Washington
Hudson
Milford
Corinna
Exeter
Corinth
Old Town
Kenduskeag
Glenburn
Orono
Bradley
Stetson
Levant
Newport
Veazie
Bangor
Eddington
Clifton
Hermon
Carmel
Etna
Plymouth
Brewer
Holden
Hampden
Orrington
Dixmont
Newburgh
Hancock
Franklin
Waldo
Clinton
Unity
Benton
Rome
Vienna
Oakland
Oxford
Camden Coalition of Healthcare Providers
www.camdenhealth.org