

Robert Wood Johnson Foundation Payment Reform Evaluation Project
Aligning Forces for Quality Payment Reform and Piloting Population-Based Health Metrics for ACOs
The Maine Health Management Coalition Foundation

Autumn 2012 Site Report

Context

The subject of this report is two integrated projects funded by the Robert Wood Johnson Foundation (RWJF) and undertaken for the past four years by the leadership of the Maine Health Management Coalition Foundation (MHMC-F). The first project (henceforth referred to as the reimbursement model project), begun in 2009 and overseen by MHMC-F as part of the Aligning Forces for Quality (AF4Q) initiative, involves development of an incentive-based reimbursement model focused on reducing unwarranted variation in service categories identified in the Dartmouth Atlas. Building on previous work, the project is analyzing current data for outcomes in the categories of preference-sensitive care, supply-sensitive care, and effective care in three Maine service areas. The second RWJF-funded project (henceforth referred to as the ACO pilots), begun in 2011 and also led by MHMC-F, includes a variety of activities to set performance targets and metrics for advancing payment reform initiatives in Maine. The payment reforms are being developed in conjunction with delivery system changes based on a primary care-centered accountable care organization (ACO) framework.

The ACO pilots are being built on the foundation of the Maine Patient Centered Medical Home (PCMH) Pilot, which is convened by the Maine Quality Forum, Quality Counts, and MHMC. Twenty-six primary care practices are currently participating in the PCMH Pilot, and an additional 50 adult practices joined it on January 1, 2013.¹ Payers participating in the PCMH Pilot are Medicare, Medicaid, Anthem Blue Cross, Aetna, and Harvard Pilgrim Health Care.

The underlying premises connecting the two projects are that the ACO is accountable to the community, and this requires measurement of performance coupled with a centralized reporting function. Following this reasoning, the first phases of the ACO pilots have involved innovations in primary care delivery through the PCMH Pilot practice, and joining that delivery system transformation with the public reporting of individual hospital and physician performance (the initial focus of the first project). Specific payment models to support delivery system reform and to encourage optimal performance and health behaviors by providers and patients, respectively, are then built on that platform. As one leader put it, “The first [project] is more about different kinds of care, buckets of utilization, and how you pay for those [services]” and the second project is “about how you might structure organizations to deal with

¹ <http://www.mainequalitycounts.org/articles/57-141/maine-pcmh-pilot-crosses-half-way-mark/6> Accessed February 1, 2013

that.” Another manager characterized the linkage of the two projects as follows: “The first is the set-up, and the second is the execution.”

Maine is a small state, both in terms of geography and population size, with a history of innovation and multi-stakeholder collaboration. Since community-minded leaders have worked together at some point, trust has been created. The state’s sense of community has influenced patterns of health care provision, in that the continuum of health services is delivered predominantly within the state with little geographic leakage, except for certain trauma and specialized acute services. The workforce is generally stable. National insurers account for roughly 90 percent of Maine’s covered lives, which can sometimes complicate local efforts to engage those insurers in community-based health care initiatives.

In particular, while the quality of health care is perceived to be relatively high, health care costs are seen as problematic. Inadequate progress on containing health care costs prompted the Maine Health Management Coalition (MHMC) Board to convene an Executive Summit of providers, health plans, and businesses on November 2, 2011, for the express purpose of developing a **statewide** plan for reducing costs without compromising quality or access. (MHMC is a not-for-profit organization composed of public and private employers, unions, hospitals, health plans, and providers.) During 2012 to early 2013 there has been increasing public pressure from purchasers on total cost of care and pricing. Jim DiMartini of Bath Iron Works (BIW) recently highlighted the health care cost problem:

“By 2016 Maine is projected to have the highest cost in the nation for employer-sponsored family coverage...Our challenge to remain competitive in light of these circumstances is significant...Continuing to spend millions of dollars a year on inefficient health care delivery is a luxury that BIW, the business community and our families cannot afford.”²

Exemplifying the drive from purchasers for lower costs through payment reform and data to support analysis and benchmarking, three purchasers recently terminated their contracts with a major insurer due largely to perceived lack of responsiveness to purchaser needs, especially around data sharing with the MHMC. As further indication of increasing purchaser focus on restraining rising health care costs, in 2012-2013 the state Medicaid program (MaineCare), leading private insurance carriers, selected provider systems, the State Employee Health Commission (SEHC), and the Centers for Medicare and Medicaid Services (CMS) have become increasingly active in ACO pilot implementation. MaineCare is aggressively pursuing a value-based purchasing strategy – moving toward global payment for PCMHs and community care teams (CCTs). Simultaneously, MHMC is challenged in harnessing the positive

² Quoted in presentation by Elizabeth Mitchell; Multi-stakeholder payment reform and system redesign: the critical need for primary care. Slides for Presentation at PCMH Learning Session - February 5, 2013: Leading a Movement: Transforming Practice to Deliver Patient Centered Care. Augusta Civic Center, Augusta, Maine. http://www.mainequalitycounts.org/image_upload/LS_E%20Mitchell_02.05.13.pdf

momentum for public reporting and payment reform by countervailing forces: provider systems building their own data infrastructures and seeking to control dissemination of information on prices and costs³, and health insurance carriers fashioning independent payment arrangements with specific provider organizations. The latter marks an important development in 2012-13, private insurers are taking the design and execution of risk contracts in-house – still using the Coalition database as foundational, but forming their own business arrangements rather than multi-payer risk contracts. Antitrust concerns have played a role in discouraging multi-payer contracts.

Since 1993, MHMC and its Foundation (MHMC-F) have fostered a partnership of purchaser and provider communities focused on measuring and reporting value in health care. For example, the GetBetterMaine website in 2012/2013 allows comparisons of medical practices⁴ and hospitals on dimensions of effectiveness, safety, patient experience, and efforts to control costs. Systems (hospitals and their affiliated medical practices) will also be rated on three dimensions: total costs of care, total quality score, and total patient survey score. MHMC serves as Maine’s designated Leapfrog site (a national Business Roundtable program for recognition of hospital quality and safety), and is also a Chartered Value Exchange for the U.S. Department of Health and Human Services. The Coalition stakeholders currently include 16 private employers, five public purchasers, 21 hospitals, 14 medical groups, and five health plans (collectively representing 35 percent of the commercial health insurance market)⁵.

For 13 years, MHMC members have maintained a multi-payer database that facilitates quality and cost analyses. Four years ago the members decided to bring this effort in-house to enable analysis more responsive to member needs. These data are **de-identified**, however, which limits their utility for analyses of cost, quality, and safety. Current efforts in the Pathways to Excellence (PTE) Physician Steering Committee seek to raise that type of data to a new level of transparency.⁶ The vendor has

³ For example, one major medical center produced a report for large employers, illustrating modest increases in price over a 3-year period, but not showing the entire 5-year history including large price hikes in the first two years (data available through the Coalition’s all-payer database).

⁴ <http://www.getbettermaine.org/compare/adult> Compare practice ratings. Accessed January 31, 2013.

⁵ Mitchell, E. Multi-stakeholder payment reform and system redesign: the critical need for primary care. Slides for Presentation at: PCMH Learning Session - February 5, 2013 Leading a Movement: Transforming Practice to Deliver Patient Centered Care. Augusta Civic Center, Augusta, Maine.

http://www.mainequalitycounts.org/image_upload/LS_E%20Mitchell_02.05.13.pdf

Accessed February 1, 2013

⁶ <http://www.mehmc.org/pte-physician-steering-committee.html>. Accessed November 16, 2011. Recent work in the Coalition also is examining total cost of care, using a methodology developed by Health Partners.

<http://www.mehmc.org/presentations-and-webinars.html> Accessed January 31, 2013.

Another video presentation: Accountability and Establishing Populations for Measurement, also discusses Maine’s efforts to establish appropriate metrics for public reporting of system performance (PTE Systems Meeting (October 2012) : See http://www.youtube.com/watch?feature=player_embedded&v=HuiZMeJiVMs Accessed January 31, 2013

evolved to support purchaser needs for good analytics and desktop access to the data warehouse for protected health information enabling population management. The MHMC has operated a separate multi-payer claims database for over a decade. The Coalition now receives direct feeds from all commercial plans in Maine and has been designated as a Qualified Entity by CMS, and thus MHMC will be receiving **identified** Medicare data. The Coalition also is preparing to receive identified Medicaid data from the state, so the MHMC multi-payer database is becoming a distinct “all-payer” database. Separately, the state of Maine’s APCD data is used for benchmarking and to complete the commercial claims data set. The state’s APCD is unable to provide timely identified data, however.

Historically, private carriers seem to have been of two minds concerning the Coalition’s database. On the one hand, as the carriers became more engaged in producing analytics and facilitating ACO arrangements for their clients, there was potentially more competition and redundancy with MHMC. In contrast, now that the Coalition is producing valid and reliable multi-payer data, carriers want to be at the table. To some extent, this is making it easier for the Coalition to acquire the necessary data from carriers and third party administrators. Collaboration with health insurance brokers is mixed; some value the “brand” of MHMC, see MHMC as good for their business, and promote its projects, while others favor health plan-driven arrangements that displace Coalition initiatives.

Selected provider systems are collaborating with each other on payment reform and ACO development and have become among the most intensive users of the Coalition’s all-payer database. One system is tapping the database to better understand its patient population. Rather than pursuing either a Medicare Pioneer ACO or shared savings model at this time, that system is considering whether its physician-hospital organization (PHO) might constitute a solid foundation for a shared savings ACO model with leading commercial insurance carriers and Medicaid, based on quality and cost targets.

Providers feeling the squeeze of purchaser pressures on costs and prices are also assessing the potential gains of eliminating the intermediary: that is, developing their own health plan for purposes of provider-sponsored risk-contracting and ACO development. One system, for example, recently eliminated its third party administrator (TPA) and is consulting with a large out-of-state provider organization that operates a health plan to explore the operational details and pros and cons of owning and operating its own plan.

Objectives

The originally stated objectives of the incentive-based reimbursement model of the reimbursement model project were to attain cost containment and data transparency and to reduce unwarranted variation in health services across geographic areas. The reimbursement model under development still seeks to correct both overuse and underuse of health services by restructuring incentives for three types of health care utilization:

- (1) Supply-sensitive care, in which diagnostic and treatment choices are likely to be significantly influenced by provider supply conditions (e.g., number of hospital beds, number and specialty mix of physicians, and existing referral patterns).
- (2) Preference-sensitive care, representing clinical conditions and health care options for which there are multiple treatment options, so patient values and preferences play a particularly significant role in determining optimal diagnostic and treatment choices.
- (3) Effective and safe care, for which outcomes and patient compliance with preventive and treatment regimens are critical factors.

The original objective of the second project, piloting population-based health metrics for ACOs, was to achieve organizational accountability for quality and health outcomes within a set of ACOs. Starting with the PCMH pilot practices has been a natural extension of this logic because strengthening primary care is an important step in preparing to accept organizational accountability for appropriate and effective care. The ultimate objective, as stated in MHMC's vision, remains to create "value," measured as achieving appropriate and effective care with the most efficient use of resources.

To support these original objectives, in 2012-2013 Coalition stakeholders are seeking some short-term "wins," for example, putting into place some risk arrangements – creating a sense of urgency, especially since purchasers are displaying flexibility, considering a variety of risk and gain-sharing contracts. One immediate goal is to translate the database into actionable measures. The Coalition is working on consumer engagement, specifically to educate the public to use good cost and quality information in order to "buy right."

Approach

General Approach

The incentive-based reimbursement model being developed in the first project addresses both provider and patient incentives. The project examines small-area variations in utilization. Once areas of underuse and overuse are identified, the project will calculate risk-adjusted annual per capita spending in those geographical areas. The primary deliverable for this project will be the Maine Value Based Payment Model that controls health care costs and gives financial incentives to providers so that access to high-quality health care services can be preserved and ultimately expanded. Elements of the Prometheus model⁷ of bundled payment for episodes of chronic illness will probably be used in developing the value-based payment model. The provider systems recognize that implementation of bundled payment entails a whole new set of administrative tasks. As they seek additional expertise in bundled payment, some are

⁷ <http://www.hci3.org/node/62/#/2/1> Accessed January 28, 2011. The Prometheus payment model is based on Evidence-Informed Case Rates, or ECR[®], which are global payments for the services covered during a typical episode for a single illness (e.g., hospital, physician, pharmacy, laboratory, rehabilitation services). The ECR payment is adjusted for severity of the condition and incorporates an allowance for potentially avoidable complications.

looking to the State and to other potential partners, e.g., a health plan, to collaborate in these new payment arrangements.

One system will start with its own employees and add risk as it learns-by-doing. The same provider system is receiving PMPM payments from several programs directly to its physician-hospital organization (PHO) in return for providing enhanced care management, while some affiliated PCP practices are receiving payment based on their PCMH status and performance on cost and quality metrics. Multi-disciplinary, community-based, integrated care teams, referred to as community care teams (CCTs), support patients & practices in PCMH pilot sites, assist high-needs patients overcome barriers to care (especially social needs) and improve outcomes⁸. The community care teams (CCTs) receive direct payments for complex management as well. The system's leadership is advocating for aligned payments from multiple health plans to reinforce primary care practices' movement toward PCMH. The system has fashioned a \$1 million, full-risk global budget with the State of Maine.

MHMC is also responding to the primary care physicians (PCPs), who do not wish to be held accountable for factors they are unable to control. Hence, the Coalition is emphasizing accountability at the **system** level, and the primary care practices will define the system with which they are affiliated. Interestingly, the system most concerned about this was attentive to how to control risk for PCP practices that are not part of the ACO. At this point, the Coalition is stressing flexibility: the breadth of a practice's and system's joint accountability would reflect the parties' respective capacities and mutual comfort zone. MHMC is seeking broad agreement across industries at the "C-suite" level. Another aspect of the Coalition's approach is exemplified in the Beacon Health Pioneer ACO, in which three public purchasers are collaborating on joint principles and strategies.

For supply-sensitive care, the initial concept was to provide global payment (e.g., bundled payment per episode of care, capitation per-member-per-month) for providers and relatively high copayments by patients to discourage overuse of services. The payment approach for preference-sensitive care would be structured to incent informed, evidence-based choice jointly by provider and patient, and patient copayments would be reduced as an incentive to participate in shared decision making. The payment design for effective and safe care would emphasize health outcomes; on the patient side, cost barriers would be eliminated and incentives for compliance would be built into cost-sharing structures. At this point, a uniformly structured, value-based insurance design (VBID) has not been implemented across the State, but several purchasers (e.g., the State Employee Health Commission) are tiering patient cost-sharing for supply-sensitive conditions to reflect cost, quality, and safety, as well as incenting preventive care. The MHMC developed a comprehensive VBID plan with the City of Portland which differentiates

⁸ <http://www.nga.org/files/live/sites/NGA/files/pdf/1206HOTSPOTTINGLETORUNEAU.PDF>

Accessed February 28, 2013. Lisa Letourneau. Maine PCMH Pilot & Community Care Teams: A Targeted Strategy to Improve Care & Control Costs for High-Needs Patients. July 2012.

coverage and reimbursement between the categories of care. This has been approved by the Labor-Management group and is pending final votes from each union.

The second project (population-based health metrics for ACO pilots) is supporting the following five activities to address measurement deficits:

- (1) Use a balanced scorecard to expand and enhance public reporting of important measures. Health care organizations are receiving incentive payments and bonuses for good performance on the publicly reported metrics on GetBetterMaine.org (GBM). To the extent that scorecards include these metrics, they are receiving additional payments. There are also benefit incentives for employees to use facilities and providers who score well on the metrics on GBM. In at least one arrangement, a hospital system is at risk for \$1 million against the agreed measures in their scorecard.
- (2) Develop a tool for risk modeling and prioritization to help identify priority-improvement opportunities based on local data.
- (3) Establish pilot ACO cost, use, and quality targets.
- (4) Provide actuarial support to develop global budgets and risk-based contracts.
- (5) Support and collaborate with other related payment reform efforts in Maine, as well as regional reforms, which include some efforts in New Hampshire.

Four “pillars” (described on the Coalition’s website⁹) underpin the overall Value-Based Purchasing (VBP) strategy of MHMC:

- Standardized performance measurement.
- Transparency and public reporting.
- Payment reform, which stresses two key principles: differential reimbursement tied to differential performance, and redesigned payment methods to better match financial incentives with desired outcomes.
- Informed choice.

Two activities illustrate how Coalition stakeholders are innovating with consumers on incentives to use public reports on performance and with purchasers on benefit redesign. In 2006 the State Employee Health Commission (SEHC) introduced a waiver of the \$200 annual deductible for using “preferred” hospitals (those that met an evolving set of cost and quality metrics).¹⁰ This effort continued and in 2008 the SEHC introduced copayments of \$100 per day for inpatient admissions and \$50 per event for

⁹ Maine Health Management Coalition. Member Resources: Value-Based Purchasing. <http://www.mehmc.org/value-based/> Accessed February 1, 2013.

¹⁰ *Steering Employees Toward Safer Care*, Wendy Lynch and Brad Smith, Altarum Center for Consumer Choice in Health Care, November 28, 2012.

outpatient surgery, which were waived for admissions and services at preferred hospitals.¹¹ The idea was to build awareness of standardized, validated, publicly reported measures of quality. In a second example, the University of Maine System (UMS) sought to bend the trend of health care cost increases for its employees downward from a seven percent rate of increase to three percent. The strategy was to “tier” patient cost-sharing for hospital care according to a combined measure of costs and quality and to tier benefits for physicians according to quality. UMS noticed the biggest impact with respect to hospitals, where consumer awareness of performance differences (in cost and quality) rose markedly.

MaineCare is working with MHMC on its payment reform initiative and participates actively in the Accountable Care Implementation Group. On November 15, 2011, the Maine Department of Health and Human Services announced the release of a Request for Information regarding certain aspects of its Value Based Purchasing Strategy, focusing on the The Accountable Communities Initiative, in which MaineCare has entered into risk-based contracts with qualified provider organizations that align financial incentives for those providers to work together with the community to improve value and decrease avoidable costs.

The Department has taken advantage of Section 2703 of the Affordable Care Act (ACA) to establish Health Homes serving MaineCare and Medicare-Medicaid dual enrollees with chronic care needs. As part of MaineCare’s Value-Based Purchasing Strategy, in July 2012 the State announced the expansion of the multi-payer Maine PCMH Pilot, which has recruited additional CCTs to serve new primary care practices entering the PCMH Pilot or planning to participate in the MaineCare Health Homes Initiative¹². Building on this CCT-enabled platform, the State also applied in September 2012 for a State Innovation Models grant from CMMI, with the following intent:

“... leverage the successes of MaineCare, the Maine Health Management Coalition and Maine Quality Counts! as conveners of one of the country’s few multi-payer Patient-Centered Medical Home Pilots. The Pilot incorporates Community Care Teams that build off Jeff Brenner’s “Hot-spotting” approach to target super utilizer patients. Maine’s proposal will bring the state’s investment to the next level through the formation of multi-payer Accountable Care Organizations that commit to value- and performance-based payment reform and public reporting of common quality benchmarks.”¹³

¹¹ *Case Study: State of Maine Ranks Providers Based on Quality*, Vida Foubuster, The Commonwealth Fund, March/April 2009.

¹² MaineCare Services, DHHS. 2012 Community Care Team Application: <http://www.maine.gov/dhhs/oms/vbp/index.html#HH> Accessed February 4, 2012.

¹³ Center for Medicare & Medicaid Innovation State Innovation Models Initiative: http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/SIM_summary_sheet08242012.pdf

Progress and Results

A major achievement in 2012 has been implementation of a multi-payer claims data infrastructure that can deliver actionable information for discussions of payment reform between the Coalition, employers, and provider systems. The claims database allows those parties to identify the primary cost drivers and improvement opportunities in the population for which the provider is willing to accept risk, and then to determine PMPM and utilization by service category by clinical condition. (The contracts using this information are developed by the members without Coalition involvement because antitrust prohibits MHMC from being involved in price discussions.) One system is using this “near real-time” data to build out more primary care, support care managers and disease management programs, and produce reports on high-cost claimants. With respect to clinical data, HealthInfoNet, Maine’s designated statewide health information exchange currently supports exchange of patient clinical data for more than one million of Maine’s 1.3 million residents. The exchange is participating in a demonstration project to connect the statewide APCD with the statewide clinical database on an episode of care basis.

The ACI group met for the first time on July 21, 2011, and agreed to several activities that all members would pursue as priority efforts to reduce costs in the near and medium term while working towards more comprehensive payment reform and system redesign. These activities would be integrated into each local pilot site. Performance would be tracked across pilots and, when possible, publicly reported through the PTE process. Baseline performance, performance targets, and firm timelines will be set at subsequent ACI meetings. Efforts also will be made to integrate with other local initiatives, including the Patient Centered Medical Home multi-payer pilot.

The ACI group originally outlined the following explicit process for its work:¹⁴

- (1) Using data from the MHMC database and criteria identified by the Center for Healthcare Quality and Payment Reform, priority interventions will be determined for each system based on local utilization data.
- (2) Common interventions across sites may be selected in addition to local priorities. The interventions reflect common interventions endorsed by the ACI Steering Group but others may be identified at any time.
- (3) Baseline outcome, utilization, and cost information will be identified for each pilot site.
- (4) Based on current performance and projected impact, performance targets for outcomes and costs will be identified and measures selected.
- (5) Payment, benefit, and other changes required to achieve performance targets will be identified.
- (6) Timelines will be established for reaching performance goals.
- (7) A “leader” will be chosen for each initiative (in each system). Ideally, there should be physician leadership for all of these initiatives as this will help ensure that this culture of change is truly

¹⁴ Maine Health Management Coalition Foundation. Endorsed Process and Interventions from MHMC’s Accountable Care Implementation Steering Group. Minutes of ACI Steering Group Meeting, July 21, 2011.

infused across the organizations. This leader will work on establishing a well-defined team to ensure success.

(8) Performance will be monitored and reported monthly to the ACI Steering Group.

The ACI Group originally agreed to several core initiatives: (1) hospital readmission reduction; (2) disease management programs and/or community health teams to reduce the costs of caring for individuals with chronic and high-cost conditions by decreasing avoidable visits to the emergency department and improving use of primary care; (3) designing a project to encourage e-visits and reimburse providers for telemedicine as a means of reducing health care costs; and (4) pharmacy management.

After initial progress, the announcement of the Medicare Shared Savings Program and Pioneer ACO program consumed the majority of providers in the state. Maine has three systems participating in the MSSP and one Pioneer. The CMS requirements did not always align with commercial initiatives and became the focus of the work the systems were doing. The ACI continued as a multi-stakeholder learning forum about payment reform and system redesign with plans to launch a formal IHI-style Learning Collaborative in 2013. This group meets on a range of issues related to payment reform including current private ACO arrangements, payment changes from commercial health plans and delivery system changes and how they are impacted by payment.

Beginning in January 2012, a report has been generated that identifies the 50 patients with the highest utilization so that care management interventions can be implemented (called “hot-spotting”). There are currently ten community care teams (CCTs)¹⁵ to help manage hot-spotting in Maine, with resources trained in care management, motivational interviewing, and support for preventive care. Medicaid initiatives also are supporting the hot-spotting efforts. One of the large health systems is putting central resources in place to support the CCTs and ensure accurate attribution of Medicare and Medicaid (MaineCare) patients to the delivery system. The system has begun to produce reports of high-cost, high-inpatient use and ER visits for each practice. Medicare, Medicaid, and commercial payers are contributing per member per month payments to this initiative.

In a presentation to the MaineCare Redesign Task Force in September 2012,¹⁶ the Health Care Cost Workgroup identified possible opportunities to lower health care costs per capita (i.e., PMPM) in the State. The analysis centered on measuring geographic variation in PMPM and isolating determinants of that variability. Using the all-payer claims database of adult member commercial claims for October

¹⁵ Maine Patient-Centered Medical Home Pilot-Community Care Teams:
<http://www.mainequalitycounts.org/page/896-654/community-care-teams> Accessed February 1, 2013

¹⁶ Maine Health Management Coalition Foundation. Results of Health Care Cost Workgroup: Savings opportunities. Presentation to MaineCare Redesign Task Force. September 12, 2012.
<http://www.maine.gov/dhhs/mainecare-task-force/september12-2012/MD-MHMCF-HealthCare-CostSavingsOpp.pptx>

2009 – September 2010, the group examined total per capita costs and found a 40 percent range in total PMPM across counties. Thirty percent of that variation was explained by health risk score (morbidity). Focusing on inpatient care, the group’s analysis revealed that 70 percent of the regional (county) variation in inpatient PMPM was explained by price differences. A wider range in PMPM (> 80 percent difference from low to high) was observed for outpatient care, even after adjusting for risk score. The group concluded that most interventions on price and utilization might achieve reductions of 1-3 percent (or more) in PMPM. Ultimately, the group concluded that through a combination of actions -- e.g., better integration of behavioral and mental health, reductions in readmissions, and diminution of cost-shifting from public to commercial payers – total savings of 17 percent in PMPM health costs would be achievable over four years.

The state of Maine was recently awarded a major \$33 million grant from CMMI for public reporting and patient decision support¹⁷. The approach underlying the Maine Innovation Model is to facilitate comparisons by patients of different health care providers in terms of cost and quality and to find practices that best match their needs. Grant resources will 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.

ACO and Payment Models under Development. As of January 2013, several organizations in Maine have initiated ACOs¹⁸:

- The Beacon Health Medicare Pioneer ACO: Eastern Maine Healthcare System - Central, Eastern, North ME, is focusing on outpatient care management, care transitions, an effective network, and standardized measurement for approximately 14,000 Medicare beneficiaries. In the first two performance years, the Pioneer Model tests a two-sided risk model (shared savings and shared losses) payment arrangement with higher levels of reward and risk than in the Shared Savings Program. Shared savings would be computed in comparison to the ACO’s benchmark, which is based on previous CMS expenditures for the group of patients attributed to the Pioneer ACO. In year three of the program, if the Pioneer ACO has shown savings over the first two years, it will be eligible to move to a per-beneficiary per month payment amount that would replace some or all of the ACO’s fee-for-service (FFS) payments with a prospective monthly payment¹⁹.
- Central Maine Medicare Shared Savings Program (MSSP) ACO in Lewiston began with the Central Maine HealthCare employees in 2010, initiated its MSSP ACO starting in July 2012 for roughly 16,000

¹⁷ <http://www.mehmc.org/news-events/mhmc-in-the-news/sim-grant/> Accessed April 4, 2013

¹⁸ Maine Quality Counts and Maine Health Management Coalition. ACO Series: Introductory Session. January 22, 2013.

http://www.mainequalitycounts.org/image_upload/QCLC_BBF_ACO%20Series%20Intro%20Session_01-22-13.pdf Accessed January 31, 2013.

¹⁹ Information from CMS Pioneer ACO Fact Sheet:

<http://innovation.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf> Accessed February 4, 2013.

Medicare beneficiaries, and during 2012-13 is adding an estimated 22,000 commercial enrollees. The main intervention strategies are PCMH implementation, population management, building an internal and “partnered” analytics capacity, risk stratification, targeted interventions by care managers and health coaches, and other community and individual interventions.

- Maine Community ACO, LLC in Augusta also started its MSSP in July 2012, targeting approximately 12,000 Medicare beneficiaries. Hosted by the Maine Primary Care Association and Community Health Systems, its principal strategies are patient engagement, provider engagement, adaptive technologies, and expert consultation.
- The MaineHealth Accountable Care Organization in Portland instituted its MSSP program with more than 40,000 Medicare enrollees in July 2012. The ACO is hosted by the Maine Health ACO in collaboration with the Maine Medical Center Physician Hospital Organization (PHO). Beginning January 1, 2013, the Maine Health ACO is contracting with Anthem Health Partners for approximately 13,000 commercial enrollees and Aetna for roughly 7,500 fully insured commercial lives.
- The MaineCare Accountable Communities Initiative, hosted by MaineCare, is scheduled to accept applications in winter 2013 and to begin implementation in summer 2013. This initiative is focusing on all fully eligible Medicaid recipients, including dual Medicare/Medicaid eligibles. The provider organization incentive model has two components: (1) shared savings (one-sided risk) for a minimum of 1,000 attributed patients; (2) shared savings and losses (two-sided risk) for a minimum of 2,000 patients. Intervention strategies emphasize a shared savings approach linked to achieving quality outcomes, integration of behavioral and somatic health, community-based collaboration, retention by members of choice of provider, and alignment with other ACOs.
- Maine General and the State Employee Health Commission (SEHC) are developing a co-sponsored ACO over 2011-2015. This ACO is targeting a population of roughly 8,000 insured persons in Maine. Their key strategies -- built on a primary care foundation -- emphasize population stratification, care management, benefit design coupled with consumer engagement, and data development.

A generic multi-payer payment reform model is not being implemented in the state, but the above projects exemplify the range of payment initiatives that are integrated with ACO development for both commercially insured, Medicare, and Medicaid populations. These ACO-related activities are strengthening the foundation for broad payment reform in Maine. Three areas in the state are directly involved with the payment reform and ACO pilot activities: Portland, Bangor, and Augusta. Augusta is a replacement for Lewiston, which is participating in the Coalition’s payment reform in a general sense, but not as an ACO pilot. The MHMC management team is trying to implement a project in southern Maine to secure a full spectrum of the state.

The market has evolved dramatically over the past two years and the pilots that were “led” by MHMC have in many instances been subsumed in health plan or provider ACO efforts. MHMC is supporting

multiple payment reform pilots across the state in all regions but that support has migrated largely to data and analytic support, as provider and purchasers have assumed greater leadership.

Payment reform in Maine is best characterized as moving toward global payment on a PMPM basis, but in phases: beginning with PMPM for care coordination in patient-centered medical homes, while maintaining the base of fee for service (FFS) payment; evolving toward shared savings and two-sided risk models in ACO structures, and eventually to global payment. One purchaser is working with two carriers to introduce new primary care billing codes for e-mail communications and to change referral mechanisms and payment codes for occupational and physical therapy in their manufacturing workforce. While provider organizations have not substantially altered their individual physician compensation methods for either PCPs or specialists, PCPs are increasingly interested in access to a total cost of care measure and to be able to track utilization of specialists to whom they refer – especially if they are to be held accountable for total costs of care, e.g., under ACO arrangements.

Logic Model

The Coalition has not articulated a specific logic model for the two projects, but the explicit process outlined above by the ACI Group reflects a set of specific activities that represent key steps toward achieving cost containment, data transparency, and creation of value. There are several moving parts: plans, sponsors, doctors, health systems, and the cost and quality data. A central entity, Health Data & Management Solutions (HDMS), manages all the data and is establishing direct feeds for all partners. The strategic intent is to create the impetus to engage the plan sponsors, to use HDMS tools with the pilot sites to target the right approaches, and potentially to create the business case for each site. One of the central themes in Maine's implementation is the consistent involvement of labor leaders and management as powerful decision makers. The logic is that one changes the conversation by bringing business leaders into the room: providers see them (labor and management) as representatives of their patients.

One useful organizing framework for the payment reform and ACO pilot projects is captured in a 2009 graphic prepared by the Center for Healthcare Quality and Payment Reform. The graphic suggests that the best opportunities for short-term significant success require the presence of four initial conditions:

- Willing and able clinical leadership.
- Identification of health conditions affecting many patients.
- Services with evidence of overutilization.
- Low-cost interventions with significant short term impact.

Put differently, the last three bullets above constitute the “low-hanging fruit” for MHMC and its collaborating stakeholders to address in the short run, e.g., encouraging doctors to prescribe generics

and ensuring that patients fill prescriptions and take the medication properly. The savings can possibly be shared with or transferred to the community care teams within the PCMH pilot practices or to consumers.

Facilitators and Barriers

The facilitators and barriers are presented in no particular order of importance.

Facilitators

Committed leadership is a great strength of the MHMC-facilitated payment reform and ACO pilot initiatives. Providers are very invested in the ACO model. In a small state with a history of cooperation, providers are able to collaborate across organizational boundaries, even as they compete in health care delivery. As one interviewee stated, “You might get primary care in a critical access hospital, but then go to a tertiary, so we have to get along in terms of sharing market share.”

Stability of the workforce also encourages employers to take the long-run view toward health care for their employees. As a membership organization, the Coalition benefits from a stable base of financial support from employers, whose membership dues are more than \$1 million of MHMC’s approximately \$1.3 million annual budget. The Maine Health Management Coalition has secured very broad representation in the ACI Group of senior executives of payers and of most large employers. MHMC is a major source of support and infusion of resources.

There has been considerably increased engagement among plan sponsors, as these organized purchasers (mostly employers) become better organized and empowered to exert pressure on the carriers and provider systems. In effect, the plan sponsors have come closer to acting as true equal partners with the health plans and provider systems in payment reform. As one interviewee declared: “Plans have told the systems, you’ll deal with three of us, no more divide and conquer with discounts.” The purchasers’ realization that they need to bend the cost curve downward has prompted those plan sponsors to confront health plans and provider systems with the need to significantly constrain rates and total PMPM. The movement toward global payment also has shifted the emphasis from single interventions, e.g., reduced readmissions, toward more comprehensive, multi-faceted solutions likely to achieve substantial total cost savings.

MaineCare has become much more engaged with Coalition and its commercial members, and that has advanced the Coalition’s work, now that MaineCare has committed to aligning its initiatives with those of the Coalition and with evolving arrangements in the commercial market.

The efforts of a health analytics consultant and the payer group were crucial in catalyzing applications for Pioneer ACO grants. The expertise of Harold Miller and the Network for Regional Health

Improvement have been important assets in Maine’s payment reform initiatives. Individual pilot sites are also experiencing success in achieving more consumer representation.

MHMC-sponsored forums have allowed consensus building among the stakeholders. The stakeholders are acutely aware of the value of the all-payer database and the data analytic support provided by the Coalition. The Coalition has established a positive impression in the community and has built extensive partnerships and community engagement.

The state of Maine’s all-payer claims database (APCD) enables pilot-level reporting. The Coalition has several years of historical claims data, and the first health plan has signed up for monthly data feeds. In addition, as one interviewee noted, “The HDMS database has the capability to marry clinical and claims data.” The web-based portal on HDMS allows participating physicians to access the data electronically from any site. The database has varying levels of encryption and displays different views and levels of aggregation for employers and providers. The dynamics among health insurers, provider systems, and employers are changing significantly, as all three parties recognize the credibility and utility of the multi-payer claims database managed by the Coalition – not only for their work together within MHMC programs, but also for their independent payment reform initiatives. Public reporting of performance measures for PCPs, specialists, hospitals, and systems is prompting tiered benefit designs and is reinforcing quality improvement initiatives.

The health insurers are becoming more engaged in trying to produce data analytics for their members and to facilitate ACO development. As they move in that direction, and now that the Coalition has the data, health plans increasingly want to be at the table and part of the stakeholder groups working with the Coalition.

The broad-gauged support among plan sponsors, health insurers, and provider systems for development of the Multi-Payer, Patient-Centered Medical Home Pilot and a wide array of ACO initiatives in the state has also galvanized interest and commitment to payment reform.

The Dartmouth Institute is a very powerful collaborator, particularly through access to national Dartmouth Atlas data that pinpoints small area and regional variation in utilization patterns. These benchmarks allow teams to do hot-spotting. Quality Counts and other learning collaboratives throughout New England are helpful in performance improvement efforts.

Barriers

Historically, there have been several data-related barriers:

- Access to data formerly was the biggest challenge to the payment reform efforts of the Coalition and its stakeholders. The vendor previously was not able to provide sufficient support for the

Coalition's efforts in reporting and analytics. Many providers in small practices not aligned with hospitals do not have an EMR to efficiently input their clinical data to the HDMS database. Health insurance carriers have been somewhat reluctant to share data and expressed concerns that it might undermine their value proposition, which to some extent involves delivery of data services. However, this resistance has begun to change in the last 12 months (through March 2013), as the utility of the MHMC's multi-payer database has become more apparent to the carriers and as a vibrant coalition of employers has begun to insist on such data. Several major carriers, which previously were unwillingly to share data with MHMC are now doing so. This represents major progress in the past year, and reflects a change in national policy by one of the major carriers.

- Some provider organizations also have been reluctant to share their own data with employers, raising issues of data control and testing the mutual commitment to transparency. HIPAA considerations of privacy and data security can be barriers to data sharing, but these problems are generally surmountable. Depending on the nature of specific collaborative arrangements between payers and providers and among providers, legal and antitrust challenges can emerge.

Plans have also been concerned that providers might work directly with employers. This can be a significant impediment to full collaboration, given that roughly half the plans' covered lives are within self-insured arrangements, in which the plan is acting as a third-party administrator. Two large sponsors recently dropped health plans because of the plans' reluctance to implement changes necessary to advancing ACO efforts.

To realize their full potential, the payment reform and ACO pilot initiatives in Maine struggle to engage the employers consistently, so that the discussions do not become provider-heavy. The employers are committed, but payment and delivery reform is not their "day job." Lacking expertise in health care issues, certain employers might struggle to discern their role in the work.

Securing significant consumer involvement continues to be challenging. One interviewee noted that issues of entitlement that are present in Medicare and Medicaid also play out in the commercial market. The Coalition and its stakeholders are seeking to determine the appropriate venues for educating patients on the payment and delivery issues. The current approach to this challenge is to implement patient advisory councils, which are in place in six primary care practices in one of the health systems. That system is also attempting to connect those primary care councils to a central, system-wide patient advisory group.

However, consumer awareness and involvement take significant time to develop, and volunteers are scarce. In this context, labor management groups are engaged and can make a positive impact on consumer engagement: benefit negotiation and creating value for employees are major components of

their customary work. Labor management can wield real power and influence, align with management, and create trust among their members when benefit changes are being considered. Those groups also have access to communication channels to stimulate interest among members regarding publicly available performance measures for their health care providers.

Evaluation and Sustainability

As the regional stakeholders evaluate their progress, it has become clear that the existing positive momentum will not carry itself. There are several different components of the payment reform and ACO development, and an important challenge for sustainability is to manage and integrate those multiple efforts. Collaboration with the health plans on data use will be critical, especially given the provider organizations' growing interest in moving forward on ACO development. Employers and health insurance brokers will play important roles in sustainability: the former in energizing employees and applying leverage to health plans and the latter in facilitating cooperation with the Coalition.

Lessons Learned

There are substantial challenges in bringing together a multifaceted collaboration of employers (including labor and management), health care provider organizations, and health plans, while also securing patient engagement. The integrated projects in Maine seek to link payment reform with delivery system innovation through patient-centered medical homes and development of ACOs. As the potential financial and organizational consequences of payment reform increase, collaboration becomes exponentially more difficult. In contrast to quality improvement, where "win-win" alliances emerge more naturally, the act of changing payment levels and methodologies inevitably reduces income and adds financial risk for some parties (e.g., certain provider systems and specialists), even as it raises income and reduces risk for the "counterparties" to those contractual arrangements (e.g., plan sponsors, consumers, and PCPs). The positive opportunity is to build in a transition toward value-based payment that will generate sufficient long runs gains to offset the short term losses that arise from such disruptive innovation. MHMC plays an important part as neutral facilitator and convener of divergent stakeholders. By enhancing and sustaining cooperation over the longer term, the Coalition continues to build trust and improve relationships among a diverse set of sometimes competing interests. Those relationships are incredibly important because multi-stakeholder cooperation on payment reform takes substantial time, energy, and agreement on tradeoffs among stakeholders and among priorities. The trust emerging from positive, long-run ties serves to sustain the parties' engagement in the face of unintended consequences and short-term setbacks.

Sharing clinical and claims data among employers, health plans, and providers raises considerations of privacy, confidentiality, control over data, and antitrust. In particular, it will be important to address concerns about health plans' willingness to share data and provider organizations' development of their own potentially redundant data systems. As discussed earlier in this report, the employers, plans, and providers increasingly recognize that the all-payer database and analytic capacity accompanying it are a

valuable and unique resource. That reality represents a “centripetal” force that to some extent countervails the centrifugal forces of each player seeking to maximize self-interest.

Access to all-payer data and integration of claims and clinical data for the collaborating parties are crucial, especially if the stakeholders are to take advantage of the synergies between creation of medical homes and ACOs on the delivery system side with efforts of payment reform directed to supply-sensitive and preference-sensitive health services and safe and effective care. Development of the balanced scorecard for medical practices and the employer dashboard supports coordinated action. Patient engagement will require continued effort and exploration of appropriate venues and forums for securing effective patient involvement.

There are important questions pertaining to the role of the state and state entities putting together APDB and integrating clinical data with it. The role and scope of the state agency will need to be determined and integrated with the work of MHMC. There is a significant opportunity -- with appropriate coordination of planning, design, and implementation processes -- to agree on common claims data and clinical measures and to avoid redundant data collection, reporting, and maintenance functions. A cooperative public-private endeavor is underway to determine needs of key stakeholders, which entity has the comparative advantage in maintaining the database, and a mechanism for governance of the data infrastructure and operations.