

**The Maine Health Access Foundation's
Advancing Cost Containment and Payment Reform Program:
How Has It Moved the Needle on Health Reform?**

Final Report: Advancing Payment Reform Evaluation

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Executive Summary

Introduction

In September 2010, just as implementation of the Affordable Care Act (ACA) was getting underway, the Maine Health Access Foundation (MeHAF) issued a Request for Proposals (RFP) for a new program, “Advancing Cost Containment and Payment Reform Strategies in Support of the Affordable Care Act” (Advancing Payment Reform). The goal was to leverage changes being brought about by the ACA to support and accelerate robust payment reform projects in Maine to “advance payment reform and cost containment efforts that can bend the cost curve without sacrificing access and quality of care.”¹ Applicants were expected to demonstrate engagement of MeHAF’s priority populations (uninsured and medically underserved individuals) in their change strategies. Over the four years of the program, MeHAF funded a total of 14 organizations representing nearly all sectors in the health system, each with a unique and different strategy for payment and/or delivery system reform. Rather than prescribe specific payment and delivery system strategies, the Foundation expected grantees to undertake strategies that fit with local needs, priorities, and capacity. As such, the Advancing Payment Reform program represented a “complex adaptive initiative” which tackled systems change, policy change, and program innovation with unpredictable outcomes operating in a highly dynamic environment. In keeping with the grantmaking strategy, the evaluation of this program was designed to identify and assess the implementation experience of the funded projects and the cross-cutting lessons that could inform the continued development and evolution of each project and the group of grantees as a whole. This final evaluation report summarizes key cross-cutting issues and lessons that emerged over the four years of the Advancing Payment Reform program and discusses how, in the context of a dynamic and changing health system, the program influenced payment and delivery system reform in Maine.

Key Findings and Observations

The program stimulated new ways of thinking about health system transformation.

The Advancing Payment Reform program stimulated cross-organizational learning that informed the design and implementation of each grantee’s project. It also contributed across the cohort of projects to a broader understanding of what it takes to undertake complex, organizational and system change. Grantees and MeHAF discovered the importance of organizational structures and culture in effecting changes needed to transform financing and delivery systems. Throughout the four-year program, several senior leaders of grantee organizations actively participated in the funded projects and in the learning collaborative, along with their grantee project directors and managers. Such visionary leadership helps hardwire innovation into governance and management, sustaining the commitment to the hard work of system change.

The projects highlighted the challenges (and strategies for overcoming them) involved in effecting functional, multi-disciplinary, and inter-organizational systems to support patients. The program also highlighted the important role data and data sharing play in all phases of the transformation process, from project design to operations.

The learning collaborative model used in this program fostered education, communication, and collaboration across grantees that continuously informed and shaped their projects.

In an environment with scant evidence and validated best practices, the learning collaborative was a safe place to be candid about challenges and get helpful feedback. As a neutral convener, MeHAF was able to engage grantees in difficult and sometimes sensitive conversations which otherwise may not have been possible among industry competitors. The learning collaborative also served an important incubator function, nurturing grantees with less experience and fewer resources.

The program helped prepare grantees for the rollout of ACA reforms and provided seed money for model development that helped secure federal funding for further systems transformation work.

Strengthening the core infrastructure needed to support a transformed delivery system, including primary care, health data, and care management, was central to a number of the funded projects and enabled them to secure federal support through sources created in the ACA. The alignment of the Advancing Payment Reform program with the payment and delivery system reform already underway in Maine provided vital funding and learning opportunities that allowed organizations to develop and test specific strategies, such as the development of meaningful patient engagement initiatives, central to larger reform strategies such as accountable care.

The program demonstrated varying approaches to engaging priority populations² in payment reform.

In some projects where the primary strategy was to design new payment systems, the focus on these priority populations was indirect. Other projects directly addressed the needs of vulnerable populations such as the uninsured and under-insured. The experience of these grantees illustrates the critical importance of engaging vulnerable populations when moving from a medical model to a more community-based approach, involving social service and other community agencies and stakeholders.

Final Thoughts

This program was both an incubator and accelerator of promising innovations with the shared connection points being leveraging ACA opportunities and ensuring the inclusion of MeHAF priority populations. The financing and delivery system problems and solutions that the projects addressed could not have been encompassed by a single approach or model. There was enormous diversity in approach among healthcare organizations to implementing and operationalizing such strategies as “patient engagement” or “developing care management systems.” The virtue in diversity of approach is that there is a greater likelihood of good fit and sustainability than if uniform models were imposed on local systems. Other considerations for the Foundation include: (1) the implications for how funders evaluate the impact of their programs, whether programs are “catalytic” or “contributory” to change; (2) the importance of involving professional evaluators early in the program design process; (3) the importance of technical assistance to the success of some grantees as well as the program; and (4) the different ways that MeHAF’s focus on vulnerable populations can be operationalized, even in a systems focused program.

Introduction

Maine has been a leader in pursuing private and public initiatives to transform healthcare payment and delivery with the Maine Health Management Coalition's Pathways to Excellence public reporting initiative and Maine's Robert Wood Johnson Foundation-funded Aligning Forces for Quality project setting the stage for the development of Accountable Care/Shared Savings arrangements, Maine's Multi-payer Patient Centered Medical Home Pilot, and MaineCare's (Maine's Medicaid program) Health Homes and Accountable Communities initiatives.* In March 2010, passage of the ACA signaled the beginning of a concerted, national effort to expand access and transform how we pay for care. Anticipating passage of the law, Maine's 2010 State Health Plan noted the opportunities in the federal legislation "for payment reform, including demonstration projects focused on system reform through development of accountable care organizations (ACOs) and innovative payment models."³ Maine's implementation of payment and delivery system reform provisions in the ACA, including the Medicare Shared Savings Program, the Multi-Payer Advanced Primary Care Practice demonstration, and the Medicaid Health Homes options, has significantly accelerated public and private efforts to change healthcare payment systems and transform healthcare delivery in the state.

As the largest nonprofit health foundation in Maine, the Maine Health Access Foundation (MeHAF) saw the opportunity in 2010 for Maine to take advantage of the ACA to accelerate progress on payment reform and transforming health care delivery systems. In September 2010, just as implementation of the ACA was getting underway, MeHAF issued a Request for Proposals (RFP) for a new program, "Advancing Cost Containment and Payment Reform Strategies in Support of the Affordable Care Act" (Advancing Payment Reform). The goal was to leverage changes being brought about by the ACA to support and accelerate robust payment reform projects in Maine to "advance payment reform and cost containment efforts that can bend the cost curve without sacrificing access and quality of care."¹ As such, the Advancing Payment Reform program was designed as a "system reform" initiative through which the funded projects would advance health system change in Maine. Applicants were expected to demonstrate engagement of MeHAF's priority populations (uninsured and medically underserved individuals) in their change strategies and to ensure that the needs of these populations were being considered within payment reform and delivery system redesign efforts.

...the Advancing Payment Reform program represented a "complex adaptive initiative" which tackled systems change, policy change, and program innovation with unpredictable outcomes operating in a highly dynamic environment.

Over the four years of the program, MeHAF funded a total of 14 organizations representing nearly all sectors in the health system, each with a unique and different strategy for payment and/or delivery system reform. Rather than prescribe specific payment and delivery system strategies, the Foundation expected grantees to undertake strategies that fit with local needs, priorities, and capacity.

This report is the final in a series prepared by the Muskie School as part of the evaluation of the Advancing Payment Reform program.⁴ This final evaluation report addresses the question of how, in the context of a dynamic and changing health system, the program influenced payment and delivery system reform in Maine. Following a brief overview of the program and the evaluation approach, the report summarizes key cross-cutting issues and lessons that emerged over the four years of the

* Brief descriptions of each of these and other payment and delivery system initiatives and various ACA-related terms are included in the Glossary in Appendix 1.

program and describes how the program influenced both thinking and action among grantees. The final section discusses the implications for MeHAF, and the field of health philanthropy, of broad system change initiatives such as the Advancing Payment Reform program.

Overview: The Advancing Payment Reform Program and Evaluation Approach

Background: Funded Projects

MeHAF's Advancing Payment Reform program was designed to support a broad diversity of projects and organizations across the state to test innovative models of payment and delivery system reform. Over three rounds of funding, the Foundation awarded grants to a diverse set of 14 organizations that employed very different strategies for achieving reform (Table 1). Across the three cohorts of projects, awards averaged \$100,000 per year for up to two years, with grantees ranging from statewide quality organizations, hospitals and health care systems, community/public health partnerships, insurers, and health data providers.

The strategies represented in the RFPs and funded projects evolved over time, with each subsequent round specifying topical areas that had not yet been fully addressed in earlier rounds. Cohort 1 represented some of the early adopters of payment and delivery system reform. In Cohort 2 MeHAF engaged interest among statewide organizations including, for example, (1) two payors, MaineCare, and Maine Community Health Options (MCHO), a new ACA-supported Consumer Operated and Oriented health insurance Plan (CO-OP),⁵ and (2) HealthInfoNet, the statewide health information exchange. The final cohort sought projects promoting a patient-centered approach to care delivery.

Over the course of the four-year program, the pool of grantees grew from five in Cohort 1, to eight with the addition of Cohort 2, to a total of 14 grantees in the final two years. By January 2013, midway through the program, the three cohorts represented almost every sector of the health care system in Maine – public and private payors, delivery systems, data infrastructure, the two largest health systems in the state, and a diversity of large and small, urban and rural health organizations across the state.

Evaluation Approach

As a systems-change initiative, the Advancing Payment Reform program was intentionally designed to fund and test a diversity of strategies for payment and health systems reform that reflected the specific needs, priorities, and capacities of grantees, their stakeholders, and communities. Although the RFPs identified potential strategies that applicants might consider, there was never an expectation that project strategies and expected outcomes would align across grantees. Rather, the Foundation sought to catalyze and support initiatives that, together, might advance payment and delivery system reform. As such, the Foundation and the evaluation team expected that funded projects would evolve and adapt to changing circumstances, challenges, and opportunities. In her August 2013 presentation to the MeHAF Board, Tanya Beer from the Center for Evaluation Innovation distinguished between grantmaking focused on “adaptive initiatives” versus those focused on testing “models.” In adaptive initiatives the “pathways to change” and program outcomes change in response to dynamic and evolving organizational, policy, and other circumstances.⁸ Consistent with Beer's framework, the Advancing Payment Reform program represented a “complex adaptive initiative” which tackled systems change, policy change, and program innovation with unpredictable outcomes operating in a highly dynamic environment.

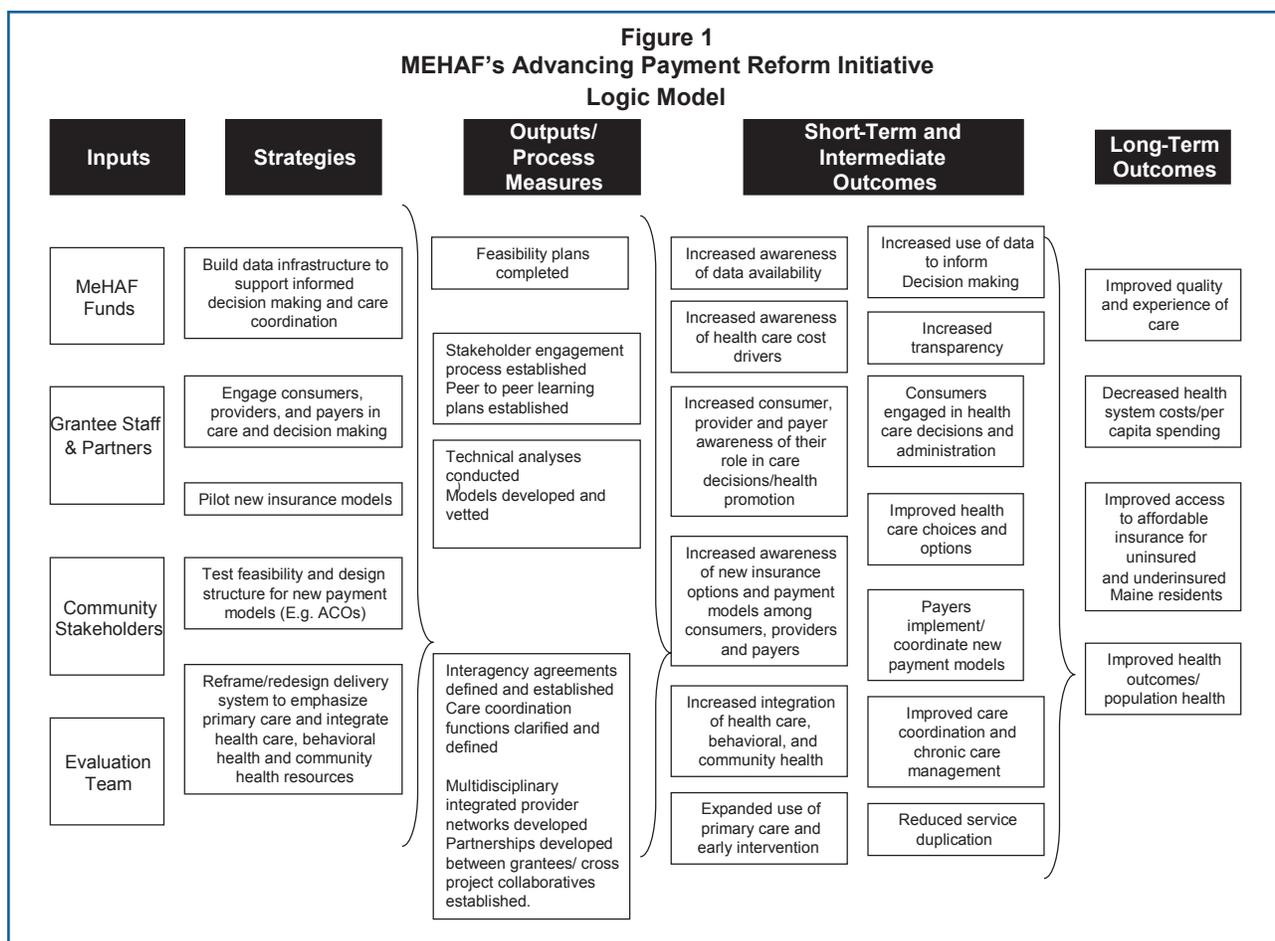
Table 1 | Projects Funded Under Advancing Payment Reform Program

Cohort/Grantee	Period of Funding and Project Description	Strategy
Cohort 1	January 2011-December 2012⁶	
Maine Health Management Coalition ⁷ (MHMC)	Provided technical assistance for ACO development, payment modeling, and data analysis to support providers	Infrastructure support, training, and data analytics
MaineGeneral Health (MGH)	Piloted primary care practice redesign through greater patient and family engagement	Direct service delivery; patient engagement
Medical Care Development (MCD)/ Somerset Public Health	Developed worksite wellness products for rural micro-businesses as an add-on to current insurance coverage products to prepare for ACA tax credits for worksite wellness programs	Payment model for wellness tax credits; community engagement for health activities
Prescription Policy Choices (PPC)	Developed quality measures and payment proposals related to prescription drug policy with stakeholders, based on ACA provisions	Advocacy for policy change; technical expertise to other organizations
Quality Counts (QC)	Developed a model structure for multi-disciplinary Community Care Teams (CCT) to support Patient Centered Medical Homes (PCMHs) to be reimbursed by private and public payers	Direct service delivery; patient engagement; care coordination
Cohort 2	January 2012-December 2013	
Maine Primary Care Association (MPCA)	Sought federal support to design and implement a Maine-based CO-OP, an alternative insurance product offered through the ACA for small group and individual markets	New value-based insurance model; consumer and patient engagement
Maine Department of Health and Human Services (DHHS)	Designed and implemented MaineCare's Health Homes Initiative to improve the quality of care for members with chronic diseases through an enhanced primary care PCMH model linked with CCTs and MaineCare's Accountable Communities program supporting both practice and payment change within health systems, hospitals, and provider groups	Value-based insurance plan for medical homes and ACO-like provider groups within Medicaid
HealthInfoNet (HIN)	Investigated the feasibility of linking clinical information in the state health information exchange with Maine's all-payer claims data in its data warehouse to expand capacity for predictive modeling and risk assessment	Infrastructure support and data analytics for new payment models and population health measures
Cohort 3	January 2013-December 2014	
The Aroostook Medical Center (TAMC)	Connected frequent users of emergency department (ED) services with primary care providers, ensuring that these patients have a primary care home, and reducing their use of the ED and walk-in care	Direct service delivery; patient engagement; care coordination
Eastern Maine Medical Center (EMMC)	Conducted return on investment (ROI) evaluation for engaging uninsured and underinsured patients within a PCMH to inform ACO model design and explored whether and how using a Patient Activation measure within a PCMH approach: a) improves the quality of care; b) improves the patient's experience; and c) reduces healthcare costs	Direct service delivery; ROI evaluation and analyses; patient engagement
Franklin Community Health Network (Franklin)	Implemented Franklin C.A.R.E.S. (Care Access, Resource, Education & Support) to serve financially disadvantaged individuals in need of healthcare services by providing a wider array of community services and insurance enrollment	Direct service delivery; patient engagement; care coordination
Mercy Hospital	Formed the Mercy Medical Neighborhood Project—a collaboration with community partners and insurers that addresses the needs of the most costly charity care patients through an improved care and cost management program	Direct service delivery; patient engagement; care coordination; peer to peer learning
MaineHealth	Sought to develop a scalable primary care payment and compensation model that would remove barriers to delivering team-based care; provide high quality, efficient, patient care; and be financially sustainable under current and future payment arrangements	New payment model for primary care practices
Maine Medical Education Trust	Educated and provided legal and accounting tools to support independent physician practices in transitioning to an accountable care environment	Provider education and technical support

In keeping with the grantmaking strategy, our evaluation approach was to identify and assess the implementation experience of the funded projects and the cross-cutting lessons that could inform the continued development and evolution of each project and the group of grantees as a whole. Instead of the traditional evaluator role as an outside observer measuring predetermined outcomes, we used a process evaluation strategy with the evaluator as advisor, engaging with both grantees and funder as a team member involved in a more collaborative synergistic learning role. The constantly changing environment and complexity of the projects required regular readjusting of the evaluation strategy to ensure it aligned with the changing dynamics of the program.

To help define synergies across grantees, frame our evaluation questions, and identify shared key issues around which to organize our evaluation work, we worked with MeHAF staff and the grantees to develop a Program Logic Model (Figure 1) that grouped the individual grantees' strategies into broader categories and identified short and longer-term outcomes that might be expected to result from those strategies. While we did not evaluate individual grantees' implementation of strategies identified in the logic model, over the course of our work we found that collectively, grantees implemented most of the strategies and process measures identified in this logic model as well as achieving some of the identified short-term outcomes.

In adaptive initiatives the “pathways to change” and program outcomes change in response to dynamic and evolving organizational, policy, and other circumstances.



Based on strategies and outcomes in the logic model, we developed the following questions which have guided our evaluation of this program:

1. How are the strategies and activities of these projects targeting and achieving measurable healthcare cost containment?
2. Have the projects had an impact statewide, regionally, or locally?
3. How is the MeHAF program preparing stakeholders (e.g., health systems, providers, consumers and other organizations) to meet the new payment and delivery system reforms projected in the ACA?
4. What barriers and opportunities have the projects encountered?
5. How have barriers and opportunities been addressed, and what are the lessons for others?
6. How have the needs of uninsured and medically underserved people been addressed by each project? Are there specific lessons about how best to include these populations in payment reform efforts?
7. Is there synergy between and among projects? How are projects changed or augmented by coordination with the other grantees' work?
8. Based on the lessons from these projects, how could the effectiveness and impact of this program be enhanced?

With these questions in mind and with the objective of promoting synergistic learning across projects, the evaluation team, together with MeHAF and the projects, identified a series of key issues—organizational change, access to and use of health data, and patient engagement—around which the evaluation team would work to understand the experience of the funded projects which, together with the research evidence, could help us identify insights to inform the projects' ongoing work. For each of these three areas, the evaluation team surveyed and/or interviewed project staff, reviewed quarterly progress reports, and conducted a review of the relevant literature to produce a Policy Brief that summarized the key cross-cutting issues and observations from the program.⁹

What Changed as a Result of MeHAF Funding?

As noted earlier, the evaluation team has maintained contact with each of the grantees through quarterly learning collaborative meetings, periodic surveys of project leaders, and interviews with project leaders and staff conducted in conjunction with each of the three Policy Briefs. In addition to gathering insights about each of the projects and the program as a whole, we have tried to put these funded projects into the broader context of health reform in Maine. The observations about what has changed as a result of this program are not empirical results. Rather, they are our informed, qualitative assessment of some of the key “lessons” that have emerged from this program. In each case we offer some examples to illustrate the point. Although many more examples from the funded projects could have been provided, we resisted the temptation to be exhaustive in the interest of space. The three Policy Briefs contain more detailed information on each of the funded projects.

The Advancing Payment Reform program stimulated cross-project learning that informed the design and implementation of each of the grantee's projects and contributed across the cohort of projects to a broader understanding of what it takes to undertake complex organizational and system change.

The program stimulated new ways of thinking about health system transformation.

The Advancing Payment Reform program stimulated cross-project learning that informed the design and implementation of each of the grantee's projects and contributed across the cohort of projects to a broader understanding of what it takes to bring about complex organizational and system change. This learning occurred as a result of grantee discussions in the learning collaborative meetings and through formal and informal cross-project collaboration. Additional learning was fostered by sharing results of grantee interviews which the evaluation team conducted with each of the projects in preparing the three Policy Briefs. The following summarizes some of the specific ways that thinking about payment reform and health system transformation changed among the grantees over the life of this program.

- *Grantees and MeHAF discovered the importance of organizational structures and culture in effecting changes needed to transform financing and delivery systems.*

Payment and delivery system reform usually involves disruptive changes in the roles and responsibilities of managers, providers, and patients. There is rarely a quick fix or “lean technology” solution to health system transformation challenges. The Aroostook Medical Center encountered this in their efforts to address the problem of high utilizers in the ED. Beyond establishing a patient navigator for ED users, the project discovered that building buy-in from ED staff and relationships with community agencies to obtain supportive services were vital to changing outcomes. MaineGeneral Health's project focused on bringing the patient voice into their efforts to transform the health system. After setting up a patient advisory council, they discovered that this simple solution was not enough and that there were many other settings and strategies for having the patient's voice reflected in how the system operates. They had to map how patients experience the system and ask hard questions about how the system could be more engaging of those patients. So, for example, they found that patients voiced the priority for more patient-friendly and accessible signage. They also built patient engagement into their system by making it an explicit element of their employee handbook.

Transformation is an iterative process which involves building relationships and knowledge across organizational silos and projects. Speaking to the grantees at a learning collaborative meeting, Dr. Jay Want noted that organizational culture is among the hardest challenges.¹⁰ The grantees described this process as “culture change without a clear roadmap.” Thus, some changes, such as patient engagement, require significant changes in professional norms and organizational culture that are difficult to achieve, will take time, and the success of which are hard to measure.¹¹

Transformation is an iterative process which involves building relationships and knowledge across organizational silos and projects.

- *The program attracted the interest and active involvement of senior leaders from the grantee agencies.*

Throughout the four-year program, several senior leaders of grantee organizations maintained an active participation in the funded projects and in the learning collaborative, attending along with their grantee project directors and managers. These early adopters and champions demonstrated leadership and support for organizational change through their commitment and continuing

contribution to collaborative learning. Such visionary leadership helps hardwire innovation into governance and management, sustaining the commitment to the hard work of system change.

- *The program highlighted the importance of data in all phases of the transformation process, from project design to operations.*

All grantees were hampered by the persistent absence of real time data and the ability to connect clinical, claims, and other information. By way of example, several grantees, without the benefit of accurate data, initiated their projects to address high ED use based on false assumptions about charity care patients and why/how they use the health care system. By actively engaging patients and analyzing their data, grantees discovered a very different picture of the high ED utilizer population and their needs. Based on the information and data they gathered, a number of the grantees concluded that many patients have rational economic and other reasons for visiting the ED rather than a primary care office. This finding suggested to the grantees that making it easier to access primary care and demonstrating the value of primary care to patients was critical in reducing unnecessary ED use. Grantees also noted the distinction between data and information. The Policy Brief on health data concluded that the functional capacity of program and clinical implementers was often eclipsed by a flood of data and a lack of analytic capacity on the hospital or practice level to turn the data into useful information.¹¹

... early adopters and champions demonstrated leadership and support for organizational change through their commitment and continuing contribution to collaborative learning. Such visionary leadership helps hardwire innovation into governance and management, sustaining the commitment to the hard work of system change.

- *The program demonstrated the importance of, and strategies for, moving outside the silos of facility-based acute and primary care to community support systems to achieve transformation goals and outcomes.*

Successful patient engagement relies on activating a large array of community resources to address the non-medical needs of patients. Many of the most complex and costly chronic health problems are the result of non-medical factors that contribute to disease and require more than medical care to address. Many patients' highest priority needs are social, not medical. A number of grantees undertook projects to address these underlying social and community factors. They focused on building care management, worksite wellness, ED diversion, and other interventions that required the development of functional connections between the traditional acute and primary care system and community organizations such as employers and public health agencies to connect the healthcare system with social and other community support services. For example, MCD Public Health and Somerset Public Health collaborated on a project to bring worksite wellness to very small employers by linking the capacity of public health to employers and employees in Somerset County. Other grantees demonstrated the use of multi-disciplinary care teams and peers to extend the capacity of healthcare providers to engage patients whose conditions or care were complex and high cost.¹²

Successful patient engagement relies on activating a large array of community resources to address the non-medical needs of patients.

The experience of these projects highlights the challenges (and strategies for overcoming them) involved in effecting functional, multi-disciplinary, and inter-organizational systems to support patients. For example, several grantees had to overcome the problem of sharing patient-related data across multiple, collaborating organizations by developing innovative data sharing agreements. They also had to gain organizational buy-in for broadening staffing of projects to support the needs of patients with complex health conditions beyond nurse care managers to include social workers, health educators, nutritionists, and community health workers. This community-based and patient centered approach required a redefinition of what kind of support is most important to patients' health, who provides what care, and how members of the care team work together.

The learning collaborative model used in this program fostered education, communication, and collaboration across grantees that continuously informed and shaped their projects.

The learning collaborative model used in this program was an innovation designed to promote learning and collaboration across projects and organizations and to provide the evaluation team access to real-time information about what the grantees were doing in their projects and what they were learning from the implementation experience as the projects unfolded. The quarterly grantee meetings were an opportunity to learn about what worked and what did not.

Grantees often commented that they felt they were “building and flying the plane at the same time.” The synergy among the grantees had a significant impact on how projects evolved. In an environment with scant evidence and validated best practices, the learning collaborative was a safe place to be candid about challenges and get helpful feedback. As a neutral convener, MeHAF was able to engage grantees in difficult and sometimes sensitive conversations which otherwise may not have been possible among industry competitors.

The learning collaborative served an important incubator function, nurturing the grantees with less experience and fewer resources. The connections were particularly important for grantees in more remote parts of Maine who have more limited opportunities to compare notes with colleagues engaged in similar efforts. The opportunity to meet those who do not work in your specific “silo” or industry led to important cross-disciplinary relationships and connections. For example, as a new health plan, MCHO learned from Quality Counts how the operation of the CCTs could be coordinated with their care management functions. Similarly, HealthInfoNet, the state’s health information exchange, had the opportunity to hear firsthand from the delivery system users how they used, or wanted to use, the information in the exchange.

The learning collaborative also provided an opportunity for MeHAF to bring in national experts on issues and topics relevant to the grantees. For example, Bev Johnson, President and CEO of the Institute for Patient and Family Centered Care, who advised MaineGeneral on its project, spent time with the learning collaborative discussing her work on family and patient engagement. Dr. Judith Hibbard from the Center for Advancing Health at the University of Oregon, a national

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expert on patient activation, presented to the learning collaborative on the Patient Activation Measure, also used by several grantees. And finally, Dr. Jay Want, CEO of WantHealthcare spoke about the challenges and strategies of engaging providers in health reform. Each of these sessions served to inform the grantees' thinking about their projects and potentially add or refine strategies.

The program prepared grantees for the rollout of ACA reforms and provided seed money for model development that helped secure federal funding for further systems transformation work.

- *The program provided critical funding that helped build infrastructure that prepared grantees for payment and delivery system innovations contained in the ACA.*

Strengthening the core infrastructure needed to support a transformed delivery system, including primary care, health data, and care management was the goal of a number of the funded projects and also addressed in the ACA. To illustrate, the following are examples from the portfolio of funded projects:

- ◆ The development of CCTs was central to Maine's ability to expand its PCMH Pilot to include the Medicare program under the national Medicare Advanced Primary Care Practice demonstration authorized by the ACA.
- ◆ MCD Public Health and Somerset Public Health's worksite wellness program funded under this program was designed to enable employers to take advantage of tax credits available under the ACA.
- ◆ MaineHealth's primary care payment redesign project was directly tied to that system's need to realign payments with new incentives embodied in their ACO arrangements under the Medicare Shared Savings Program and other ACO contracts.
- ◆ The Maine Health Management Coalition's health data infrastructure building project was explicitly designed to enhance Coalition members' ability to use all-payer claims information to inform both operations and strategy.
- ◆ Support of the MaineCare program contributed to the design and implementation of the State's "Value-based Purchasing" program, including the Health Homes and Accountable Communities initiatives.
- ◆ In the case of MCHO, MeHAF funding was instrumental in supporting the development of this new health plan which has captured 80% of the market in the new federal marketplace. The health plan, Maine's cooperative health plan authorized under the ACA, is changing the insurance market landscape in Maine.

The initiative provided critical funding that helped build infrastructure that prepared grantees for payment and delivery system innovations contained in the ACA.

The precise value and benefit of MeHAF's contribution to helping these organizations build the programs and infrastructure needed to support health system transformation is impossible to quantify; nor are we able to assess the ultimate outcomes of these transformation efforts. That said, the alignment of the Advancing Payment Reform program with the payment and delivery system reform already underway in Maine (through Maine's Robert Wood Johnson Foundation-funded, Aligning Forces for Quality and other ACA-supported initiatives) allowed organizations to develop and test specific strategies, such as meaningful patient engagement, central to larger reform strategies such as accountable care.

- *MeHAF funding helped grantees secure federal funding for further systems transformation work.*

There are a number of examples in which MeHAF funding contributed to the grantee's ability to scale up promising smaller projects in order to secure national funding. The award to the Maine DHHS of a \$33 million, three-year State Innovation Model (SIM), one of six national State Innovation Model (SIM) grants from the Centers for Medicare and Medicaid Services (CMS) is a good example of the collaborative and synergistic benefit of MeHAF's investment.¹³ MeHAF's funding of both planning for and developing Quality Counts' CCTs and DHHS' value-based purchasing strategy contributed to the implementation of MaineCare's Health Homes and Behavioral Health Homes, which were statewide interventions included in the SIM grant application. MeHAF's funding provided critical planning and implementation support in establishing CCTs within the framework of Maine's PCMH Pilot and the Medicare Multi-Payer Advanced Primary Care Practice demonstration and helped demonstrate Maine's capacity to be immediately ready to implement the SIM model statewide. Although MeHAF funding did not create the original CCTs, the grant funding supported the core administration and coordination for the CCTs and allowed the CCTs to expand statewide, to experiment with different models, and seek outside expertise from other states to solidify care management standards and practices. The Maine SIM model will expand and sustain many of the objectives and goals identified in the MeHAF program, particularly in the areas of forming multi-payer ACOs, strengthening enhanced primary care, and aligning measures, data, and analytics across providers to implement payment reform across public and private payers. The early progress and positive steps made through the MeHAF program helped build the foundation to develop more sustainable systems under the SIM funding.

The CO-OP health insurance program was included in the ACA to increase insurance market competition and consumer choice. The MeHAF program provided Maine Primary Care Association (MPCA) with the funds necessary to develop a strong application and create MCHO which went on to secure one of the first eight national CMS loans. MCHO has received about \$64 million in loans to support the establishment of the core insurance plan infrastructure and to provide capital to fund risk reserves. When MeHAF became aware that the CMS terms precluded using any federal funds for marketing, MeHAF awarded MCHO additional funds to start marketing its product to compete in the health insurance marketplace.¹⁴

...the alignment between the Advancing Payment Reform program with the payment and delivery system reform already underway in Maine allowed organizations to develop and test specific strategies central to larger reform strategies such as accountable care.

The early progress and positive steps made through the MeHAF program helped build the foundation to develop more sustainable systems under the SIM funding.

As noted earlier, MCD Public Health and Somerset Public Health's worksite wellness project was designed to take advantage of the new wellness tax credit provided under the ACA. The first phase of this project, which centered on 24 businesses and 110 employees in Skowhegan, proved to be so successful that it gained the attention of the national Centers for Disease Control and Prevention (CDC). CDC awarded one of its Community Transformation Grants to the Maine Development Foundation and its Healthy Maine Streets program to expand the project to 19 communities throughout Maine (now serving 213 businesses and 1,860 employees). While the insurance tax credit feature of this grant has not yet been pursued, the linking of wellness and economic health of communities has been very successful and is now being modeled statewide and nationally.

MeHAF and grantees learned to adapt to a changing policy and political environment.

In the last months of Governor Baldacci's administration in 2010, the statewide Advisory Council on Health Systems Development issued the State Health Plan recommending that Maine establish a state-run health insurance exchange and expand the Medicaid program. The plan also discussed the Medicaid program's plan to move to a contracted managed care initiative. Those plans changed dramatically after the November 2010 election. Five years later, Maine has a federally run health insurance marketplace, has not expanded its Medicaid program, and has retracted coverage to some groups such as childless adults. In addition, the State's Medicaid Managed Care plan evolved to a strategy of building on Maine's PCMH and ACO development efforts with a broad-based value-based purchasing initiative. How did the MeHAF program and grantees adapt to these changes?

Ultimately, the change in the State's Medicaid managed care approach led to a successful public/private partnership with MeHAF grantee Quality Counts. MeHAF's inclusion of the DHHS in the second cohort (2012) provided important resources in support of the Quality Counts-DHHS partnership which, in turn, contributed to building the Health Homes and Accountable Communities initiatives. Both initiatives were centerpieces of the State's successful \$33 million SIM proposal in 2013.

The program demonstrated varying approaches to engaging priority populations in payment reform

The degree of focus on vulnerable populations varied across funded projects. Some directly addressed the needs of vulnerable populations such as the uninsured and underinsured. In other projects where the primary focus was on designing new payment systems, the focus on these priority populations was more indirect. Mercy Health System's Medical Neighborhood project is an example of a project that targeted these populations. The project created a local, collaborative care management system for vulnerable populations in Portland. Similarly, both the Franklin Community Health Network and The Aroostook Medical Center projects sought to build care management systems for the population of uninsured patients who use their ED and hospital facilities.

Some grantees learned that assumptions they had made about these patients were erroneous. Several were surprised, for example, to find that obtaining insurance was not necessarily considered an asset by some uninsured patients. Being a charity care patient in the ED has been satisfactory to some uninsured patients who find the anonymity of the ED preferable to the engagement that is required in the primary care setting. These patients may not perceive or value the benefits of primary and preventive care.

Grantees also found that the social needs of many of the uninsured and disengaged patients often outweighed their medical needs, perhaps contributing to their perceptions of the value of primary and preventive care. Addressing these social needs was often necessary before patients could

engage in addressing their medical problems. The experience of these grantees illustrates the critical importance of engaging vulnerable populations and social service and other community agencies and stakeholders as the system moves from a medical model to a more community-based approach. Based on data rather than assumptions, grantees have begun to understand how the uninsured and underinsured populations use the health system. Next steps include the hard work of system redesign.

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Final Thoughts: Funding Strategies and Design

The Virtues and Drawbacks of a Diverse Intervention Strategies Funding Approach

MeHAF deliberately sought a portfolio of projects with diverse payment and delivery system change strategies. The Foundation viewed this program as both an incubator and accelerator of promising innovations and efforts with the shared connection points being leveraging ACA opportunities and ensuring the inclusion of MeHAF priority populations. The financing and delivery system problems and solutions the projects addressed could not have been encompassed by a single approach or model.

Although we use terms and general concepts to describe reform strategies such as the PCMH and ACO financing and delivery system “models,” the reality is there is no single roadmap for determining what those strategies look like in the local context. As discussed throughout this report and in our previous Policy Briefs, there was enormous diversity in approach among healthcare organizations to implementing and operationalizing such strategies as “patient engagement” or “developing care management systems.” The virtue here is that there is a greater likelihood of good fit and sustainability than if uniform models were imposed on local systems.

The down side, of course, is that the “see what grows” strategy increased the complexity of the evaluation design. It was unrealistic to expect that each initiative could be evaluated with respect to the traditional measures of outcomes and impact. The resources needed to do that would have been prohibitive. Moreover, the traditional approach to evaluation was inconsistent with the core expectations that this program was fundamentally about supporting broader systems change through cross-project learning and action. Working with dynamic and complicated systems means an increased amount of uncertainty with regard to the traditional metric of results: did the intervention change outcomes? In our patient engagement brief, we noted that important areas, such as patient experience of care and measuring patient reported outcomes, are still in their infancy. What are the measures to assess whether we have strengthened primary care?

Working with dynamic and complicated systems means an increased amount of uncertainty with regard to the traditional metric of results: did the intervention change outcomes?

Some important lessons emerged from the evaluation of this complex adaptive program. All evaluation plans and particularly those of complex initiatives should be designed concurrently with the initiative design. Unfortunately, the evaluation team did not become involved until midway through the first year of funding. However, even had an evaluation plan been formulated along with the original program design, modifications would have been likely as the program added funding cycles and extended the funding of many projects. These changes compelled a regular updating of the evaluation plan and resources.

Additionally, evaluation of complex systems change leads to different relationships with grantees and funder. Rather than the traditional role of objective observer, the evaluation team role involved a deeper level of collaboration with grantees and also with the funder than would normally be expected. For example, the team worked closely with MeHAF staff in setting meeting agendas and contributing to the learning collaborative discussion.

Complex Programs Require a Shift in Resources

The diverse group of grantees required different levels of support, beyond funding, from MeHAF. For example, some grantees with very little grants management experience needed extra technical assistance and mentoring and additional time to be able to accomplish their work plans. The additional work of organizing quarterly grantee learning collaborative meetings required MeHAF to engage the support of a consultant to help provide access to payment reform tools, websites, and publications in this very fast paced learning environment.

MeHAF's decision to renew Cohort 1 grantees and to include Cohort 2 grantees in the learning collaborative for a final year after conclusion of their grant funding enhanced the richness of the learning collaborative and kept the same group together for a full two years. Grantees from Cohort 1 and 2 became important mentors for later grantees. Grantees with four years of funding saw their projects evolve, mature, and change in ways probably unlikely within a two year window.

Remaining Challenges and Obstacles

As Dr. Jay Want told the learning collaborative, the tolerance for failure needs to increase drastically; experimentation and failure with different approaches to payment and delivery system reform are essential for figuring out what works. While the Advancing Payment Reform program can claim many positive results, probably every grantee could make a list of approaches and strategies that did not work as well as expected and challenges that were unforeseen.

Certain challenges and obstacles to payment reform are beyond MeHAF's control. We face a classic chicken and egg problem: How can we expect significant delivery system reform that aligns with value as long as we largely remain in a fee-for-service payment system? The move toward payment reform is progressing in Maine with a growing number of ACO arrangements, MaineCare's value-based purchasing initiatives, and the all-payer PCMH and Health Homes demonstrations. Currently, the State's SIM project is providing the forum for the discussion of payment reform in Maine. But the SIM project ends in 2016. It is not clear whether or how the collaborative synergy and learning that has taken place through the MeHAF and SIM initiatives will be sustained.

Despite the diversity of the grantees in this program, some voices were missing. We struggled to get the voice of the purchaser, patient, and consumer. The projects emphasized primary care, but the important role of specialists in payment and delivery system reform remains to be addressed. There is a misalignment of incentives between specialists and primary care providers and a lack of participation of specialists in public reporting.

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Data issues were a major focus of the learning collaborative and our evaluation. Persistent problems with data continue to handicap many efforts. The development of real-time data to support providers and care coordinators and predict and benchmark for cost, utilization, and quality is proving to be a major challenge. Data sharing among payers, providers, and purchasers is another challenge yet to be fully overcome.

Much of the transformation work currently underway is focused on larger health systems with the capacity and resources to prepare for the new world of value-based payment. This program has highlighted the important needs of smaller providers and systems, some of which were grantees, who will continue to need support and assistance to engage in this transformation work.

Payment and delivery system reform will continue in Maine driven by many policy and market forces. In January 2015, Secretary of Health and Human Services Sylvia Burwell announced HHS's goals for moving the Medicare program to value-based payment programs. The agency's ambitious timeline surprised many and suggests the urgency with which federal policy makers are moving to transform health care delivery by changing payment systems. Locally, health systems are moving aggressively to develop the infrastructure and delivery systems needed to be effective in the Medicare Savings, private, and other payment reform initiatives.

Considerations for MeHAF

The experience and results of the Advancing Payment Reform program raise a number of considerations for the Foundation as it develops other health system reform funding programs.

Catalyst or Accelerator of Innovation and Change?

Whether programs are catalytic or contributory to change has implications for how funders evaluate the impact of their programs. Health funders' programs play different roles both as catalysts of innovation and change and/or as accelerators of change that is already underway. Even as catalysts, however, funders are likely building on emerging ideas and initiatives. For example, MeHAF's behavioral health integration funding program was catalytic in spreading the capacity for primary care-behavioral health integration throughout Maine, but built on existing integration ideas and efforts. Likewise, the Advancing Payment Reform program was both catalyst and accelerator. Some of the funded projects were truly catalytic, enabling grantees to undertake novel initiatives that they would not otherwise have been able to pursue. In other cases, MeHAF funding enabled organizations to accelerate their reform efforts or add components that they would not otherwise have undertaken.

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The Role of Evaluation

Too often evaluation is considered once a program has been designed and launched. This was the case with the Advancing Payment Reform program. To get the most out of the resources invested in evaluation however, it is critical that funders involve professional evaluators early in the program design process to ensure, for example, that the funders' expectations of program outcomes and benefits are consistent with the planned interventions and that the goals and objectives of the program align with the planned evaluation approach. Larger foundations have evaluation staff who perform this function. Smaller funders can obtain this help from evaluation consultants who are not likely to be bidders for the evaluation work.

Technical Assistance

The Advancing Payment Reform program highlights the importance of technical assistance to the success of some grantees as well as to the program. The fact that several of the grantees either had limited experience with grant funded programs and/or had limited staff was a strength of this program. Yet, it was clear from the beginning that these grantees would need more assistance than others, both with administrative functions and requirements, and with program design and implementation. Like evaluation, therefore, it is important in the process of program design to consider the potential technical assistance needs that might arise, and how they might be met. In the case of this program, even the larger, more experienced grantees had significant technical assistance needs that were met through expert consultants. The learning collaborative meetings also served as an important technical assistance resource for all grantees.

The Advancing Payment Reform program highlights the importance of technical assistance to the success of some grantees as well as the program.

Vulnerable Populations

Focusing on vulnerable populations is central to MeHAF's core mission. The Advancing Payment Reform program highlights the different ways this focus can be achieved, even in a program as systems focused as this one. As discussed earlier, some of the grantees, like Mercy Hospital's Medical Neighborhood project, had an explicit focus on designing and implementing delivery system changes for vulnerable populations. In other projects, however, the more technical focus on payment reform strategies and initiatives meant that the emphasis on, or implications for, vulnerable populations were less discernable. Even in these instances, however, the Foundation's RFP process and grant reporting requirements served to continually require grantees to consider and articulate how their projects might involve and/or affect vulnerable populations. While several of the expert speakers discussed patient engagement and activation, the learning collaborative meetings did not focus on how grantees were addressing the needs of vulnerable populations and what they were learning about these populations, beyond having several grantees share their own experiences with the group. There might have been additional opportunities for enhancing the vulnerable populations focus of the program.

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ENDNOTES

1. Maine Health Access Foundation, Advancing Cost Containment and Payment Reform Request for Proposals; 2010
2. MeHAF's priority populations are individuals who lack health insurance or are under-insured and who are disproportionately underserved by the health system or who experience health inequities.
3. Governor's Office of Health Policy and Finance. 2010-2012 Maine State Health Plan: Making Us Better: Improving Health and Lowering Costs. Augusta, ME: Governor's Office of Health Policy and Finance; July, 2010. Note: The Governor's Office of Health Policy and Finance was eliminated after the second term of Maine Governor John Baldacci; no state health plans have been published between July 2010 and the writing of this report.
4. Shaw B, Coburn A, Fox K, Rogers E. The Role of Organizational Change in Health System and Payment Reform. Portland, ME: USM Muskie School of Public Service; 2013. Issue Brief; Shaw B, Coburn A, Fox K, Gerstenberger A. Accessing and Using Health Data to Support Health System Transformation: The Early Experience of MeHAF Payment Reform Grantees. Portland, ME: University of Southern Maine, Muskie School of Public Service; 2014. Issue Brief; Shaw B, Coburn A, Fox K. Engaging Patients in Health System Transformation: The Experience of the Maine Health Access Foundation's (MeHAF) Advancing Payment Reform Initiative. Portland, ME: University of Southern Maine, Muskie School of Public Service; June, 2015. Issue Brief.
5. Maine Primary Care Association (MPCA), a nonprofit organization that represents Federal Qualified Health Centers in Maine, was the original MeHAF grantee which submitted the successful application for federal CO-OP loan funding. Once funded, the MCHO was created and replaced MPCA as the MeHAF grantee.
6. In the fall of 2011, all Cohort 1 grantees applied for and received renewals of their projects that extended their participation in the program through December 2014, with the exception of one grantee (Prescription Policy Choices) whose funding terminated in 2013.
7. MHMC was also part of RWJF Payment Reform for High Value Care Program; some of the work funded by MeHAF was part of the RWJF project.
8. Beer, T. "Fit for Purpose: Principles of Evaluation for Foundation Boards" presented to MeHAF Board. August 2013
9. Shaw B, Coburn A., Fox K. Engaging Patients in Health System Transformation: The Experience of the Maine Health Access Foundation's (MeHAF) Advancing Payment Reform Initiative. Portland, ME: University of Southern Maine, Muskie School of Public Service; June, 2015. Issue Brief.
10. MeHAF Payment Reform Grantee Meeting presentation by Jay Want, MD (August 2013) owner and principal of Want Healthcare LLC, and Chief Medical Officer for the nonprofit Center for Improving Value in Health Care (CIVHC), a public-private partnership purposed to catalyze health care reform in Colorado.
11. Shaw B, Coburn A, Fox K, Gerstenberger A. Accessing and Using Health Data to Support Health System Transformation: The Early Experience of MeHAF Payment Reform Grantees. Portland, ME: University of Southern Maine, Muskie School of Public Service; 2014. Issue Brief.
12. Mercy used Amistad peers in the ED and community health workers in community outreach and MaineGeneral developed patient navigators for chronic illness support.
13. In addition to DHHS, the other SIM partners are MeHAF grantees MHMC, QC, and HIN.
14. This funding was separate from the Advancing Payment Reform program.

APPENDIX

Glossary of Terms/Initiatives

Affordable Care Act (ACA) is the acronym commonly used for the Patient Protection and Affordable Care Act (PPACA) the landmark health reform legislation passed by the 111th Congress and signed into law by President Barack Obama in March 2010. The most well-known provisions of the ACA extend coverage to millions of uninsured Americans to provide access to affordable and adequate health insurance for all citizens and establishes the federal government as a market regulator, imposing new requirements to eliminate industry practices that include rescission and denial of coverage due to pre-existing conditions. The ACA also includes many healthcare payment and delivery system reform provisions including initiatives and demonstrations to lower health care costs and improve system efficiency in the Medicare and Medicaid programs. These initiatives, along with similar efforts by commercial payers to reform payment from fee-for-service reimbursement to value-based purchasing, are the impetus behind emerging healthcare delivery system reforms.

Aligning Forces for Quality (AF4Q) was funded until 2015 by the Robert Wood Johnson Foundation (RWJF) and led by Maine Quality Counts (QC) in Maine, in partnership with the Maine Health Management Coalition (MHMC) and the Dirigo Health Agency's Maine Quality Forum (MQF). Established in 2004 by a network of 35 organizations, QC is a multi-stakeholder statewide regional health care collaborative committed to working across organizations and communities to improve health care systems and outcomes for the people of Maine. The three convening organizations (QC, MHMC and MQF) worked to coordinate existing but disparate efforts across the state that promote local, coordinated systems of care and the resources that support them. The goals of the Maine AF4Q Alliance were to improve health status, promote consistent delivery of high quality care, improve access to health care and contain costs.

Consumer Operated and Oriented Plan (CO-OP) programs were created by the ACA and are designed to help foster and create nonprofit, member-controlled health insurance plans that will offer ACA-compliant policies in the individual and small business markets. The Affordable Care Act initially provided \$6 billion in loans and grants to develop these new non-profit organizations, although this funding level was rolled back by Congress. A 15-member advisory board makes recommendations to HHS regarding grants and loans for CO-OPs. In 2015, 26 states had CO-OP plans available in their insurance exchanges. CO-OPs are run by their customers and are meant to offer consumer-friendly, affordable health insurance options to individuals and small businesses. They can be sold both inside and outside the health insurance exchanges, depending on the state. Nationally, CO-OPs enrolled 450,000 people in their first year or 18 percent of the people who signed up through the exchanges.

Maine's **Community Health Options** is Maine's first nonprofit, consumer operated and oriented health insurance plan and is a member-directed health insurance plan partnering with people, healthcare providers, and small businesses. <http://www.healthoptions.org/home> In 2014, MCHO was responsible for enrolling 80 percent of Maine's 44,000 insurance marketplace enrollees.

Community Care Teams (CCT) are multi-disciplinary, community-based, practice-integrated care management teams that work closely with the Patient Centered Medical Home (PCMH) Pilot practices to provide enhanced services for the most complex, most high-needs patients in the practice. The CCT model, which was established and found to be highly successful in other states such as North Carolina, New York and Vermont, has been in place in Maine since 2012. Currently, there are Ten Community Care Team (CCT) providers supporting the patients and providers in one or

more Maine PCMH and Health Home practices. Quality Counts serves as the organizational hub and technical assistance provider for Maine's CCTs.

Maine's **Health Information Exchange (HIE)** links medical information from separate health care sites to create a single electronic patient health record, which allows authorized providers to access that record to support patient care. The HIE went live in 2009 and now contains records for close to all of Maine residents and is connected to the majority of health care facilities in Maine. These facilities include hospitals, physician practices, federally qualified health centers, long-term care and home health facilities, behavioral health providers, and independent laboratories.

HealthInfoNet is an independent, nonprofit organization incorporated in 2006 responsible for managing Maine's health information exchange (HIE), for doctors, hospitals and other providers to share important health information and improve patient care, quality and safety. <http://www.hinonet.org/> HIN is governed by a voluntary community-based board of directors and several board advisory committees representing medical providers, public health, patients, government and business. In addition to managing the HIE for the state, HealthInfoNet also provides a number of services including assisting providers with meaningful use attestation, single sign-on to the state prescription monitoring program, public health reporting, event of care notifications, and population analytics and reporting services. HealthInfoNet also provides tools to support the needs of Accountable Care Organizations such as member aggregation services and predictive modeling solutions. The organization is funded through fees charged for products and services as well as state and federal grants or contracts.

Maine Health Management Coalition (MHMC) is a non-profit organization whose 70+ members include public and private purchasers, hospitals, health plans, and doctors working together to measure and report health care value. <http://www.mehmc.org/> MHMC helps employers and their employees use this information to make informed decisions.

Maine Quality Counts (QC) is an independent multi-stakeholder regional health improvement collaborative that brings together people who give care, get care and pay for care to improve health care quality and transform health and health care in Maine by leading, collaborating and aligning improvement efforts. <http://www.mainequalitycounts.org/>

MaineCare's Accountable Communities engages in shared savings arrangements with provider organizations that, as a group, coordinate and/or deliver care to a specified patient population. Accountable Communities that demonstrate cost savings, as well as the achievement of quality of care standards, share in savings generated under the model. This initiative is offered statewide as a Medicaid State Plan option, and was approved by the Centers for Medicare and Medicaid Services (CMS) in June 2014. Accountable Communities are expected to achieve the triple aim of better care for individuals, better population health and lower costs through shared savings based on quality performance, practice-level transformation, coordination across the continuum of care including primary care, acute, behavioral health and long term services and supports, and community-led innovations.

Medicaid Health Homes. Supported through an optional Medicaid State Plan benefit created by the Affordable Care Act of 2010, Section 2703, Medicaid Health Homes are designed to coordinate care for people with Medicaid who have 2 or more chronic conditions, who have one condition and are at risk for a second, or who have one serious and persistent mental health condition. States were given flexibility in designing payment methodologies and were eligible to receive a 90% enhanced Federal Medical Assistance Percentage (FMAP) for specific health home services for the first eight quarters the program is effective. HH services include comprehensive care management, care coordination, health promotion, comprehensive transitional care/follow-up, patient and family

support, and referral to community and social support services. Health homes are expected to integrate and coordinate all primary, acute, behavioral health, and long-term services and supports to treat the whole person.

MaineCare's Health Home initiative, is a central component of the state's Value-based Purchasing strategy, a multi-pronged initiative designed to improve the healthcare system, improve population health, and reduce cost. Starting in Jan 2013, and building off the Maine PCMH Pilot, it is a partnership between an enhanced Health Home primary care practice and one of ten Community Care Teams (CCTs) around the state. Both organizations receive a per member, per month (PMPM) payment for Health Home services provided to MaineCare eligible members who have two chronic conditions or one chronic condition and at risk for another as defined by the state. Health Home services include care coordination, case management, individual and family support, and health promotion/education. In April 2014, Health Home practices began partnering with Behavioral Health Organizations to serve members with serious mental illness/emotional disturbance.

MaineCare Behavioral Health Homes are a partnership between a licensed community mental health provider (the "Behavioral Health Home Organization" or BHHO) and one or more Health Home practices (an HHP) to manage the physical and behavioral health needs of eligible adults and children. Both organizations receive a per member, per month (PMPM) payment for Health Home services provided to enrolled members. Behavioral Health Homes build on the existing care coordination and behavioral health expertise of community mental health providers. Both HH and BHH services are entirely voluntary, and members can opt out of the service at any time.

Medicare Shared Savings Program is a voluntary demonstration program that was established by section 3022 of the Affordable Care Act as a new approach to the delivery of healthcare and is a key component of the Medicare delivery system reform initiatives included in the Affordable Care Act. Congress created the Shared Savings Program to facilitate coordination and cooperation among providers to improve the quality of care for Medicare Fee-For-Service (FFS) beneficiaries and reduce unnecessary costs. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization (ACO). The Shared Savings Program ACOs are groups of doctors and other health care providers who voluntarily work together with Medicare to give high quality service to Medicare Fee-for-Service beneficiaries. The goal of coordinated care is to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, it will share in the savings it achieves for the Medicare program.

Multi-Payer Advanced Primary Care Practice (MAPCP) demonstration is Medicare's major Patient Centered Medical Home (PCMH) demonstration project initiated in 2010. Maine is one of one of 11 states to participate. The MAPCP builds on Maine's Patient Centered Medical Home (PCMH) Pilot by adding Medicare as a payer and introducing Community Care Teams (CCTs) as a new component of care for high-needs patients.

Pathways to Excellence is the name of the public reporting initiatives of the Maine Health Management Coalition (MHMC). MHMC currently measures and publicly reports quality data on primary care practices, behavioral health clinicians and hospitals at <http://www.getbettermaine.org/>.

Patient Centered Medical Home (PCMH) Pilot is a multi-payer initiative convened by the Dirigo Health Agency's Maine Quality Forum, Maine Quality Counts, and the Maine Health Management Coalition. <http://www.mainequalitycounts.org/page/2-659/patient-centered-medical-home> Initially developed as a three-year effort launched in January 2010 with 26 primary care practices from across the state, the PCMH Pilot was designed to improve quality of care, efficiency, and patient/family

satisfaction provided by primary care practices as the first step in achieving statewide implementation of the PCMH model in Maine. Its premise is that the resources provided to practices through the Pilot (including enhanced payments, training, consultation, and learning collaborative) will help transform primary care practices to reach a higher level of functionality as medical homes, which in turn will lead to improvements in quality of care, efficiency, and patient/family satisfaction. Pilot practices commit to transforming to a PCMH model of care by implementing a set of ten “Core Expectations” and receive medical home payments from the major payers in the state (initially Medicaid, Anthem BCBS, Aetna, and Harvard Pilgrim Health Care and expanding to include Medicare as of 2012). Since 2012, Pilot practices partner with one of eight “Community Care Teams” that also receive payment from the major payers to provide community-based, practice-integrated, multi-disciplinary care management to their most high-needs patients. The Pilot has been expanded twice, in 2012 to include Medicare as part of the Medicare Advanced Primary Care Payment demonstration and 50 additional practices and in 2013 to include MaineCare Health Homes.

State Innovations Model (SIM) program was authorized under Section 3021 of the Affordable Care Act and administered by the Center for Medicare and Medicaid Innovation (Innovation Center). SIM is focused on public and private sector collaboration to transform the state’s delivery system and is based on the premise that state innovation with broad stakeholder input and engagement, including multi-payer models, will accelerate delivery system transformation to provide better care at lower costs. SIM provides financial and technical support to test the ability of state governments to use their regulatory and policy levers to accelerate health transformation. In Round 1, CMS provided over \$250 million to support six Model Test states, including Maine, to implement statewide health transformation strategies.

Maine’s SIM program intends to achieve the Triple Aim goals of improving the health of Maine’s population, improving the experience Maine patients have with their care, and reducing the total costs of care. <http://www.maine.gov/dhhs/sim/> The model has a foundation in emerging healthcare initiatives, promising community-based demonstration projects, and evidence-based strategies that empower consumers with long-term health conditions and includes application of existing efforts with enhanced investments, all within a shared commitment to accountability, transparency, and quality. The SIM grant in some cases accelerates and broadens the current innovations (e.g. MaineCare Health Homes and PCMH) occurring throughout Maine, and in other cases introduces new capabilities to Maine’s healthcare reform efforts. SIM enables these innovative tests to more effectively determine what reform efforts are working, and, just as importantly, to determine what is not working as effectively as expected.