Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State

Wednesday, October 22, 2025
10:00 a.m. – 3:00pm

REVISED MEETING AGENDA (10.20.25)

10:00 am Welcome
Chairs, Senator Mike Tipping and Representative Michelle Boyer

10:05 am Commission Discussion- Preliminary Reflections on First Meeting and Public Comment

10:45 am Presentation on current Maine antitrust laws and the State's role in reviewing for-profit acquisitions of nonprofit health care entities
Christina Moylan, Assistant Attorney General,
Maine Attorney General's Office

11:30 am Presentation on other states' laws and approaches to regulatory review and oversight of health care transactions
Maureen Hensley-Quinn, Senior Director, Coverage, Cost and Value Team, National Academy for State Health Policy

12:15 pm Break

1:00 pm Presentation on development of Connecticut legislation addressing role of private equity in health care transactions
Sen. Saud Anwar, Connecticut Legislature
Deputy President Pro Tempore, Chair of Public Health Committee and Vice Chair of Insurance and Real Estate Committee

1:30 pm Presentation on role of private equity in health care transactions
Dr. Zirui Song, Associate Professor of Health Care Policy and Medicine, Department of Health Care Policy, Harvard Medical School; Internal Medicine Physician, Department of Medicine, Massachusetts General Hospital

2:15 pm Commission Discussion of Next Steps and Planning for Future Meetings
- Review of materials and information requests
- New requests for information

3:00 pm Adjourn

Public access also available through the Maine Legislature's livestream:
https://legislature.maine.gov/Audio/#202

CHAPTER 9

ATTORNEY GENERAL

§194. Public charities

1. Definition. As used in this section and sections 194-A to 194-H and section 194-K, "public charity" means an entity formed primarily for charitable purposes, including but not limited to:

A. A corporation formed under Title 13 or Title 13-B primarily for charitable purposes; and

B. A charitable trust.

2. Application; funds. The Attorney General shall enforce due application of funds given or appropriated to public charities within the State and prevent breaches of trust in the administration of public charities.

3. Gift. A gift to a public charity made for a public charitable purpose is deemed to have been made with a general intention to devote the property to public charitable purposes, unless otherwise provided in writing in the gift instrument.

4. Party to proceedings. The Attorney General must be made a party to all judicial proceedings in which the Attorney General is interested in the performance of the Attorney General's duties under subsection 2.

5. Investigation. The Attorney General may conduct an investigation using the methods set forth in subsections 6 and 7 if:

A. The Attorney General reasonably believes that a public charity has engaged or is about to engage in one of the following acts or practices:

(1) Consummation of a conversion transaction as defined in section 194-B without compliance with the applicable provisions of sections 194-C through 194-H; or

(2) The application of funds or assets of a public charity:

(a) In violation of statute;

(b) For noncharitable purposes unrelated to the operations of the public charity; or

(c) For private inurement or excess benefits provided to directors, officers, disqualified persons or others deemed insiders under applicable federal law for tax-exempt organizations; and

B. The Attorney General has applied to a Justice of the Superior Court for approval to conduct the investigation and the justice has granted that approval. The application for approval may be filed ex parte, and the justice shall approve the application if the justice finds that the conditions set forth in paragraph A have been met.

6. Scope and powers related to investigation. The authority of the Attorney General to conduct an investigation under this section is limited to investigation of the acts or practices described in subsection 5, paragraph A. In conducting the investigation, the Attorney General has authority to:

A. Take testimony under oath;

B. Examine or cause to be examined any documentary material of whatever nature relevant to such acts or practices; and

C. Require attendance during examination of documentary material under paragraph B of any person having knowledge of the documentary material and take testimony under oath or acknowledgement in respect to that documentary material.

7. Taking testimony; examining documents. The taking of testimony and examination under subsection 6 must take place in the county where the testifying person resides or has a place of business or, if the parties consent or the testifying person is a nonresident or has no place of business within the State, in Kennebec County.

A. Notice of the time, place and cause of the taking of testimony, examination or attendance under this subsection must be given by the Attorney General at least 30 days prior to the date of the taking of testimony or examination, except that, upon application and good cause shown, a Justice of the Superior Court may order a shorter period of notice, but not less than 10 days.

B. Service of a notice under paragraph A may be made by:

(1) Delivering a duly executed copy of the notice to the person to be served or to a partner or to any officer or agent authorized by appointment or by law to receive service of process on behalf of that person;

(2) Delivering a duly executed copy of the notice to the principal place of business in this State of the person to be served; or

(3) Mailing by registered or certified mail a duly executed copy of the notice, addressed to the person to be served, to the person's principal place of business.

C. Each notice under this subsection must:

(1) State the time and place for the taking of testimony or the examination and the name and address of each person to be examined, if known, and, if the name is not known, a general description sufficient to identify the person;

(2) State the general subject matter of the investigation, the alleged violation that is under investigation and the title and section of statute, if any, governing the alleged violation;

(3) Describe the class or classes of documentary material to be produced with reasonable specificity to fairly indicate the material demanded;

(4) Prescribe a return date by which the documentary material must be produced; and

(5) Identify the members of the Attorney General's staff to whom the documentary material must be made available for inspection and copying.

D. A notice to produce documentary information or to give testimony under this subsection may not contain a requirement that would be unreasonable if contained in a subpoena duces tecum issued by a court of the State and may not require the disclosure of any documentary material that would be privileged or that for any other reason would not be required by a subpoena duces tecum issued by a court of the State

E. Any documentary material or other information produced by a person pursuant to this subsection and subsection 6 may not, unless otherwise ordered by a court of the State for good cause shown, be disclosed to a person other than an authorized agent or representative of the Attorney General unless with the consent of the person producing the documentary material

F. The Superior Court for Kennebec County or a Superior Court in any other county in which a person who is served notice pursuant to this section resides or has that person's usual place of business may issue orders concerning compliance with the notice, modification or quashing of the notice and contempt in the same manner as if the notice were a subpoena governed by Rule 45 of the Maine Rules of Civil Procedure. The recipient of a notice under this section has the protections accorded by Rule 45 to a person who is subject to a subpoena.]

8. Authority regarding conversion proceedings. If a public charity files notice of a conversion transaction under section 194-D or applies for approval of such a transaction under section 194-E or 194-F, the authority of the Attorney General with regard to the notice or approval and the proceedings for approval are governed by sections 194-B to 194-K and the provisions of this section do not apply.

9. Notice to the Superintendent of Insurance. If the Attorney General intends to conduct an investigation of a public charity that is subject to regulation by the Superintendent of Insurance, the Attorney General shall notify the superintendent that an investigation is being initiated. The Attorney General shall also notify the superintendent of the resolution of any such investigation.

[§194-A. Nonprofit hospital and medical service organizations]

§194-B. Definitions

As used in this section and sections 194-C to 194-K, unless the context otherwise indicates, the following terms have the following meanings.

1. Control. "Control" means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of an individual, whether through the ownership of voting securities, by contract other than a commercial contract for goods or nonmanagement services or otherwise, including but not limited to situations in which the power is the result of an official position with the person or a corporate office held by an individual.

2. Conversion transaction. "Conversion transaction" means the sale, transfer, lease, exchange, transfer by exercise of an option, conveyance, conversion, merger or other disposition or the transfer of control or governance of the assets or operations of a public charity to a person other than a public charity incorporated or domiciled in this State. A disposition or transfer constitutes a conversion transaction regardless of whether it occurs directly or indirectly and whether it occurs in a single transaction or a related series of transactions. If exercise of an option constitutes a conversion transaction, any consideration received for the granting of the option must be considered part of the transaction for purposes of applying the review criteria in section 194-G. "Conversion transaction" does not include a transaction that supports or continues the charitable activities of the public charity, including but not limited to:

A. Granting of encumbrances in the ordinary course of business, such as security interests or mortgage deeds with respect to assets owned by the public charity or any wholly owned subsidiary to secure indebtedness for borrowed money, the net proceeds of which are paid solely to the public charity or its wholly owned subsidiaries or are applied to the public charity's charitable mission, and the foreclosing or other exercise of remedies permitted with respect to such encumbrances;

B. Sales or transfers for fair market value of:

(1) Any interest in property owned by the public charity or any wholly owned subsidiary, the net proceeds of which are paid solely to the public charity or any wholly owned subsidiary; or

(2) Money or monetary equivalents owned by a public charity or any wholly owned subsidiary in exchange for an interest in property, including securities as defined in Title 32, section 16102, subsection 28, to be held by the public charity or any wholly owned subsidiary;

C. Awards, grants or payments to or on behalf of intended beneficiaries, consistent with the public charity's charitable purpose; and

D. A change in the membership of the board of directors or officers of a public charity.

3. Fair market value. "Fair market value" means the most likely value or range of values that assets, tangible or intangible, being sold would have in a competitive and open market under all conditions requisite to a fair sale, with the buyer and seller each acting prudently, knowledgeably and in their own best interest and a reasonable time being allowed for exposure in the open market. If the value of the assets being converted is $500,000 or more, the appraisal must include a value representing volunteer efforts and tax exemptions, if any, received during the operation of the public charity.

4. Independent appraisal of the fair market value. "Independent appraisal of the fair market value" means an appraisal conducted by persons independent of all parties to a proposed conversion transaction and experienced and expert in the area of appraisal of the type and form of property being valued. The appraisal must be conducted using professionally accepted standards for the type and form of property being valued. The appraisal must contain a complete and detailed description of the elements that make up the appraisal values produced and detailed support for the conclusions reached in the appraisal.

5. Person. "Person" means an individual, partnership, trust, estate, corporation, association, joint venture, joint stock company or other organization.

6. Public charity. "Public charity" has the same meaning as in section 194.

§194-C. Notice and approval for conversion transaction

1. Notice or approval required. Prior to completing a conversion transaction, a public charity must:

A. If the fair market value of assets to be converted in the transaction is $500,000 or more, obtain approval of the court in accordance with section 194-F;

B. If the fair market value of assets to be converted in the transaction is less than $500,000 but at least $50,000, obtain approval from the Attorney General in accordance with section 194-E or, if the Attorney General does not approve the transaction, obtain approval from the court in accordance with section 194-F; or

C. If the value of the transaction is less than $50,000, provide notice to the Attorney General in accordance with section 194-D.

2. Appraisal required. Fair market value must be determined by an independent appraisal for conversion transactions with a fair market value of $50,000 or more. If the appraisal provides a range of values, the highest point of the range determines which section of law applies to the transaction pursuant to subsection 1.

3. Failure to comply with this section or sections 194-D to 194-H. A transaction consummated in violation of any provision of this section or sections 194-D to 194-H is voidable. Officers and directors who receive private inurement or excess benefits from such a transaction are subject to the civil penalties provided in section 194-K.

4. Applicability to nonprofit hospital or medical service organizations. This section, section 194-B and sections 194-D to 194-K do not apply to a corporation or other entity licensed under Title 24, chapter 19. A conversion of a corporation or other entity licensed under Title 24, chapter 19 is governed by section 194-A and Title 24, section 2301, subsection 9-D.

§194-D. Conversion transactions less than $50,000

A public charity shall provide written notice to the Attorney General of its intent to enter into a conversion transaction if the value of the transaction is less than $50,000. The notice must include the name of the public charity, the value of the assets to be converted and the entity to which the assets will be transferred. Twenty days after providing notice to the Attorney General in accordance with this section, the public charity is deemed to be in compliance with section 194-C and this section unless the Attorney General notifies the public charity within those 20 days that the value of the transaction is $50,000 or more or that the filing otherwise fails to comply with this section.

The Attorney General is not required to take any action on notices received under this section, except that, upon request of a public charity that has properly provided notice under this section, the Attorney General shall issue a letter indicating that the public charity has complied with its obligation under this section, section 194-C and sections 194-E to 194-H. [PL 2001, c. 550, Pt. A, §2 (NEW).]

§194-E. Attorney General approval without court review

1. Filing with Attorney General. To obtain approval of a conversion transaction when the independent appraisal of the fair market value of the assets to be converted is $50,000 or more but is less than $500,000, a public charity must file a written request for approval with the Attorney General at least 90 days prior to consummating the transaction. The written request must include a conversion plan, a plan for distributing proceeds of the conversion consistent with section 194-H and any other information reasonably necessary for the Attorney General to complete a review of the transaction. Failure to provide the information described in this subsection in a timely manner is sufficient grounds for the Attorney General to refuse to approve the transaction.

2. Attorney General approval. The Attorney General shall approve a conversion transaction under subsection 1 if the Attorney General determines that the criteria set forth in section 194-G have been met. The Attorney General shall refuse to approve a transaction if the Attorney General reasonably believes that the fair market value of the transaction is $500,000 or more.

3. Public notice. Within 5 days of filing the request for approval under subsection 1, a public charity shall publish notice to the public of its intent to enter into a conversion transaction. Notice must be published once per week for 3 weeks in a newspaper of general circulation in the public charity's service area and must meet the following criteria.

A. A notice under this subsection must describe the proposed transaction, including the parties, the value of the transaction, the timing of the transaction, the potential impact on services to the public and the proposed plan for utilizing the proceeds. The public notice must also provide information on opportunities for the public to provide comment on the proposal to the Attorney General.

B. A notice under this subsection must be published in languages other than English whenever a significant number or percentage of the population eligible to be served or likely to be directly affected by the service or purpose of the public charity needs information in a language other than English to communicate effectively. For the purposes of this paragraph, "significant number" is defined as 5% or 1,000, whichever is less, of the population of persons eligible to be served or likely to be directly affected

4. Public comment. The Attorney General shall accept public comments regarding a proposed conversion transaction under this section for a 60-day period commencing the day that proper notice has been provided to the public of the proposed conversion.

5. Public hearings. The Attorney General may hold public hearings if the Attorney General determines that a conversion transaction under this section is likely to cause a significant impact on access to services in the community served by the public charity.

6. Public records. All documents submitted to the Attorney General by a person filing a request under subsection 1 in connection with the Attorney General's review of a proposed conversion transaction are public records subject to Title 1, chapter 13, subchapter I except records made confidential by statute or privileged under the Maine Rules of Evidence.

7. Attorney General rejection of or failure to act on request for approval. If the Attorney General refuses to approve a conversion transaction under this section or fails to act on the request for approval within 90 days of receipt of the request, a public charity may request court approval of the transaction under section 194-F.

8. Contracts with consultants; reimbursement for costs. To assist in the review of a proposed conversion transaction pursuant to this section, the Attorney General, at the Attorney General's sole discretion, may contract with experts or consultants the Attorney General considers appropriate.

A. Contract costs incurred by the Attorney General pursuant to this subsection may not exceed an amount that is reasonable and necessary to conduct the review of a proposed conversion transaction. A public charity filing a request under subsection 1 shall pay the Attorney General promptly upon request for all costs of contracts entered into by the Attorney General pursuant to this subsection but is not required to pay any amount that exceeds 5% of the fair market value of the assets to be converted.

B. The Attorney General is exempt from the provisions of applicable state laws regarding public bidding procedures for purposes of entering into contracts pursuant to this subsection.

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§194-F. Court approval

1. Filing of court action. To obtain approval of a conversion transaction when the independent appraisal of the fair market value of the assets to be converted is $500,000 or more, a public charity must file an action in Superior Court in the county in which the public charity's service area is located or in Kennebec County. Concurrent with filing an action in Superior Court, a public charity must file with the court and the Attorney General a conversion plan and a plan for distributing proceeds of the conversion consistent with section 194-H. The Attorney General must be made a party to the action.

2. Court action. The court shall approve a proposed conversion transaction under subsection 1 if the court finds by a preponderance of the evidence that the criteria set forth in section 194-G have been satisfied. The court may deny approval of a conversion transaction or may approve the transaction with or without modifications or conditions. The court may require any entity that receives the assets of the public charity as a result of the conversion to report annually to the Attorney General and the public and may require the entity to submit to monitoring and oversight by the Attorney General.

3. Public notice. Within 5 days of filing an action under subsection 1, a public charity shall publish notice to the public of its intent to enter into a conversion transaction. Notice must be published once

per week for 3 weeks in a newspaper of general circulation in the charity's service area and must meet the following criteria.

A. A notice under this subsection must describe the proposed transaction, including the parties, the value of the transaction, the timing of the transaction, the potential impact on services to the public and the proposed plan for utilizing the proceeds. The public notice must also include the court docket number and provide information on opportunities for the public to provide comment on the proposal to the Attorney General.

B. The notice must be published in languages other than English whenever a significant number or percentage of the population eligible to be served or likely to be directly affected by the service or purpose of the public charity needs information in a language other than English to communicate effectively. For purposes of this paragraph, "significant number" is defined as 5% or 1,000, whichever is less, of the population of persons eligible to be served or likely to be directly affected.

4. Public access to conversion plan. The Attorney General shall make a conversion plan, the plan for distribution of proceeds, the valuation and any other documents filed under subsection 1 that are public records under Title 1, chapter 13, subchapter I and that are available electronically available for viewing on the Attorney General's publicly accessible site on the Internet as soon as feasible after the documents are filed with the Attorney General.

5. Contracts with consultants; reimbursement for costs. To assist in the review of a proposed conversion transaction pursuant to this section, the Attorney General, at the Attorney General's sole discretion, may contract with experts or consultants the Attorney General considers appropriate.

A. Contract costs incurred by the Attorney General pursuant to this subsection may not exceed an amount that is reasonable and necessary to conduct the review of the proposed conversion transaction. Costs must be approved in advance by the court. The public charity filing an action under subsection 1 shall pay the Attorney General promptly upon request for all costs of contracts entered into by the Attorney General and approved by the court pursuant to this subsection.

B. The Attorney General is exempt from the provisions of applicable state laws regarding public bidding procedures for purposes of entering into contracts pursuant to this subsection.

6. Filing with Secretary of State. A public charity shall file a copy of the court's approval under this section with the Secretary of State.

§194-G. Review criteria

1. Required determinations. The Attorney General may not approve or recommend that a court approve and the court may not approve a proposed conversion transaction unless the Attorney General or the court, as appropriate, finds that:

A. The public charity will receive fair market value for its charitable assets. The fair market value must be based upon an appraisal conducted in accordance with subsection 3 and must use the projected closing date of the conversion transaction as the valuation date;

B. The proposed distribution of proceeds of the transaction complies with section 194-H; and

C. The public charity considered the proposed conversion as the best alternative in carrying out its mission and purposes.

2. Considerations. In determining whether the criteria in subsection 1 are met, the Attorney General or the court, as appropriate, shall consider, as applicable, whether:

A. The public charity will receive fair market value for its charitable assets;

B. The terms and conditions of the agreement or transaction are fair and reasonable to the public charity;

C. The fair market value of the public charity's assets to be transferred has been manipulated by the actions of the parties in a manner that causes the fair market value of the assets to decrease; [

D. The agreement or transaction will result in inurement to any private person or entity;

E. The proposed conversion transaction will result in a breach of fiduciary duty or violate any statutory or common-law duty or obligation on the part of the directors, trustees or other parties involved in the transaction, including but not limited to conflicts of interest related to payments or benefits to officers, directors, board members, executives and experts employed or retained by the parties;

F. The governing body of the public charity exercised due diligence in deciding to dispose of the public charity's assets, selecting the acquiring entity and negotiating the terms and conditions of the disposition;

G. The Attorney General has been provided with sufficient information and data by the public charity to evaluate adequately the agreement or transaction and the effects of the agreement or transaction on the public;

H. The proceeds of the conversion of the public charity are distributed to either an existing or new public benefit corporation or foundation pursuant to section 194-H;

I. The proceeds of the proposed conversion transaction will be used in accordance with the rules of any trust under which the assets were held by the public charity and the proceeds will be controlled as funds independent of the acquiring entity or entities related to the acquiring entity; [

J. The entity surviving after the conversion transaction will be financially viable and competently managed;

K. The transaction will diminish the availability and accessibility of services to the affected community; and

L. The conversion plan and transaction complies with all applicable laws including the Maine Nonprofit Corporation Act and state tax code provisions.

3. Valuation. A public charity shall submit to the Attorney General and the court an independent appraisal of the fair market value of assets to be converted under subsection 1. To the extent that the appraisal is based on a capitalization of the pro forma income of the converted assets, the appraisal must indicate the basis for determination of the income to be derived from any proceeds of the sale of stock and demonstrate the appropriateness of the earnings-multiple used, including assumptions made regarding future earnings growth.

A. To the extent that an appraisal under this subsection is based on the comparison of the capital stock of the converted entity with outstanding capital stock of existing stock entities offering comparable products, the existing stock entities must be reasonably comparable to the converting entity in terms of such factors as size, market area, competitive conditions, profit history and expected future earnings.

B. If the value of assets being converted is $500,000 or more, the appraisal must include any element of value arising from the accomplishment or expectation of the conversion transaction,

including any value attributable to projected operating efficiencies to result from the conversion, net of the cost of changes to produce such efficiencies.

C. If the Attorney General or the court determines that an appraisal under this subsection is materially deficient or substantially incomplete, the Attorney General or the court may deem the entire conversion plan materially deficient or substantially incomplete and reject or decline to further process the application for conversion.

D. A converting entity shall submit to the Attorney General and the court information demonstrating to the satisfaction of the Attorney General or the court the independence and expertise of any person preparing the appraisal or related materials under this subsection.

E. An appraiser under this subsection may not serve as an underwriter or selling agent under the same conversion plan and an affiliate of an appraiser may not act as an underwriter or selling agent unless procedures are followed and representations and warranties made to ensure that an appraiser is separate from the underwriter or selling agent affiliate and the underwriter or selling agent affiliate does not make recommendations or in any way have an impact on the appraisal.

F. An appraiser may not receive any other fee except the fee for services rendered in connection with the appraisal.

§194-H. Distribution of proceeds

1. Requirements. The proceeds of a conversion transaction must be distributed to an existing or new foundation or public benefit corporation that meets the following requirements.

A. The foundation or public benefit corporation must operate pursuant to 26 United States Code, Section 501(c)(3) or 501(c)(4), and, regardless of whether the foundation is classified as a private foundation under 26 United States Code, Section 509, the foundation or public benefit corporation must operate in accordance with the restrictions and limitations that apply to private foundations found in 26 United States Code, Sections 4941 to 4945.

B. The foundation or public benefit corporation and its directors, officers and staff must be and remain independent of the for-profit company and its affiliates. A person who is an officer, director or staff member with influence over a conversion decision of a public charity submitting a conversion plan, at the time the plan is submitted or at the time of the conversion transaction or within 5 years thereafter, is not qualified to be an officer, director or staff member of the foundation. A director, officer, agent or employee of the public charity submitting the plan or the foundation receiving the charitable assets may not benefit directly or indirectly from the transaction.

C. A foundation or public benefit corporation must have or establish formal mechanisms to avoid conflicts of interest and to prohibit grants benefiting the for-profit corporation or members of the board of directors and management of the for-profit corporation.

§194-I. Intervention in court proceeding

This section relates to intervention in proceedings under section 194-F.

1. Right to intervene. Except as provided in subsection 2, the court, on timely application made pursuant to Rule 24(a) of the Maine Rules of Civil Procedure, shall allow any person who is interested in the outcome of a conversion proceeding to intervene as a party to that proceeding, notwithstanding the presence of the Attorney General in the action.

2. Court power to manage process. This section does not limit the power of the court to manage its cases by limiting the number of intervenors or by consolidating parties with similar interests.

§194-J. Attorney General authority

1. Rules. The Attorney General may adopt rules the Attorney General considers appropriate to implement this section, sections 194-B to 194-I and section 194-K. Rules adopted pursuant to this subsection are routine technical rules as defined in chapter 375, subchapter II-A.

2. Attorney General authority not limited. This section, sections 194-B to 194-I and section 194-K do not limit the common-law authority of the Attorney General to protect charitable trusts and charitable assets in this State. The penalties and remedies provided in section 194-K are in addition to and are not a replacement for any other civil or criminal action the Attorney General may take under common law or statute, including an action to rescind the conversion transaction or to obtain injunctive relief or a combination of injunctive relief and other remedies available under common law or statute.

§194-K. Penalties

1. Attorney General to bring action. The Attorney General may initiate an action in Superior Court to:

A. Void a conversion transaction pursuant to subsection 2. Such an action may be brought in Superior Court in Kennebec County or in the county in which the assets of the public charity to be transferred are located;

B. Seek a civil penalty against an individual pursuant to subsection 3. Such an action must be brought in the Superior Court of Kennebec County or in the county in which the individual resides; and

C. Obtain on behalf of the public charity the return or repayment of any property or consideration received as private inurement or an excess benefit in violation of Title 13-B standards.

2. Transaction voidable. The Superior Court may void a conversion transaction entered into in violation of applicable provisions of sections 194-C to 194-H. If the court voids the transaction, it may also grant any orders necessary to restore the public charity to its former position, including removing the board of the public charity or voiding contracts.

3. Penalties against individuals. An individual officer, director, trustee or manager in a position to exercise substantial influence over the affairs of a public charity is subject to a civil penalty if that person, in violation of the standards established under Title 13-B for conduct by directors or officers or for avoiding conflicts of interest:

A. Receives property or consideration from the public charity that constitutes private inurement; or

B. Receives excess benefits that exceed the fair market value of anything provided in return.

The civil penalty under this subsection may be an amount up to 100% of the excess benefit or private inurement received and may be recovered in addition to costs and fees incurred by the Attorney General in bringing the action.

§1102-A. Acquisition of assets of person engaged in commerce which tends to create a monopoly

No person engaged in commerce in this State may acquire, directly or indirectly, the whole or any part of the stock or other share capital, or the whole of any part of the assets of another person also engaged in commerce in this State, where in any line of commerce or any activity affecting commerce in any section of this State, the effect of the acquisition or use of that share capital, or the acquisition of those assets, may be substantially to lessen competition or tend to create a monopoly.

This section does not apply to persons purchasing these stocks solely for investment and not using the same by voting or otherwise to bring about, or in attempting to bring about, the substantial lessening of competition, nor may anything contained in this section prevent a corporation from causing the formation of subsidiary corporations for the actual carrying on of their immediate lawful business, or the natural and legitimate branches or extensions thereof, or from owning and holding all or a part of the stock of those subsidiary corporations, if the effect of that formation is not to substantially lessen competition.

This section does not apply to the acquisition of stock, share capital or assets of a public utility when the acquisition has been approved by the Public Utilities Commission

Any financial institution subject to the provisions of Title 9-B is exempt from this section.

Highlight of State Health Market Transaction Oversight Activity

Maureen Hensley-Quinn, NASHP

October 22, 2025

Overview

- A Look at Maine's Biggest Health Systems
- State Legislative Overview: Addressing Consolidation
- Market Transaction Program Considerations
- State Highlights
- Discussion

Role of Consolidation in Price

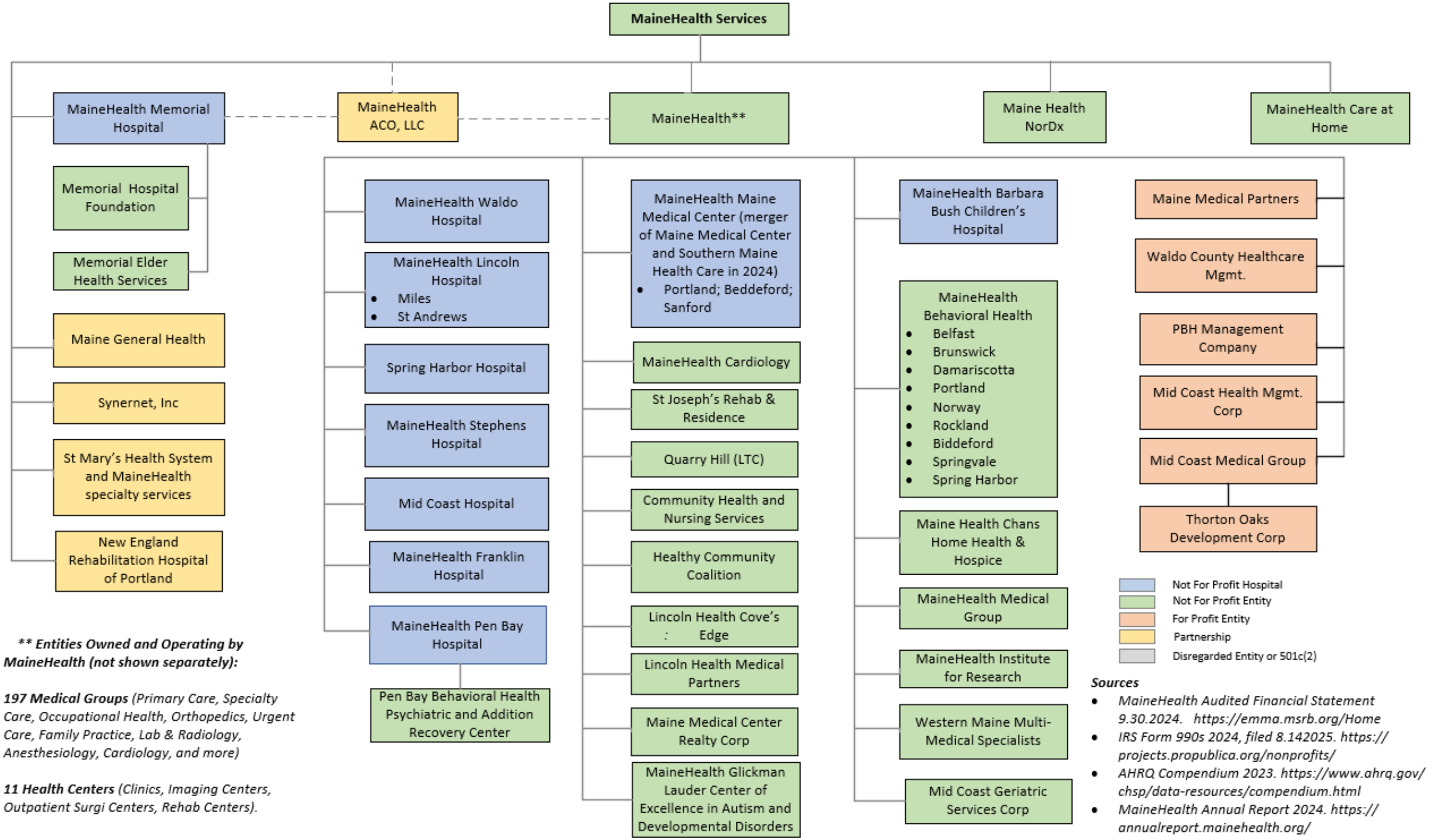
The drivers of high and variable prices:

It all comes down to market power

Market power is amassed through consolidation (mergers, vertical consolidation, joint ventures)

The vast majority of hospital markets and specialty physician markets are highly concentrated

Slide from: E. Fuse Brown NASHP Conference, Boston, MA
August 2023 presentation



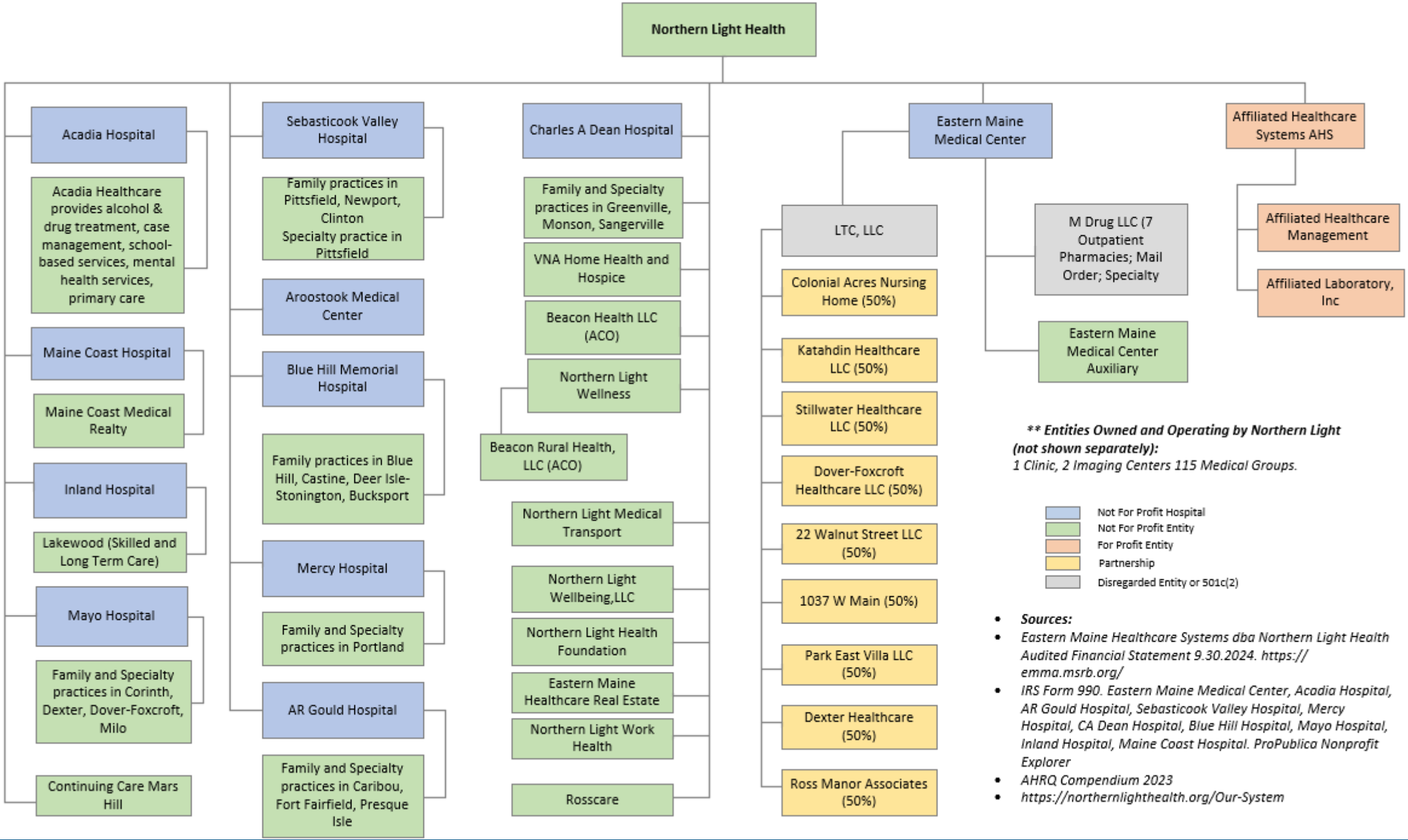
***** Entities Owned and Operating by MaineHealth (not shown separately):***

197 Medical Groups *(Primary Care, Specialty Care, Occupational Health, Orthopedics, Urgent Care, Family Practice, Lab & Radiology, Anesthesiology, Cardiology, and more)*

11 Health Centers *(Clinics, Imaging Centers, Outpatient Surgi Centers, Rehab Centers).*

Sources

- *MaineHealth Audited Financial Statement 9.30.2024. https://emma.msrb.org/Home*
- *IRS Form 990s 2024, filed 8.142025. https://projects.propublica.org/nonprofits/*
- *AHRQ Compendium 2023. https://www.ahrq.gov/chsp/data-resources/compendium.html*
- *MaineHealth Annual Report 2024. https://annualreport.mainehealth.org/*


Northern Light Health
Acadia Hospital
Acadia Healthcare provides alcohol & drug treatment, case management, school-based services, mental health services, primary care
Maine Coast Hospital
Maine Coast Medical Realty
Inland Hospital
Lakewood (Skilled and Long Term Care)
Mayo Hospital
Family and Specialty practices in Corinth, Dexter, Dover-Foxcroft, Milo
Continuing Care Mars Hill
Sebasticook Valley Hospital
Family practices in Pittsfield, Newport, Clinton
Specialty practice in Pittsfield
Aroostook Medical Center
Blue Hill Memorial Hospital
Family practices in Blue Hill, Castine, Deer Isle-Stonington, Bucksport
Mercy Hospital
Family and Specialty practices in Portland
AR Gould Hospital
Family and Specialty practices in Caribou, Fort Fairfield, Presque Isle
Charles A Dean Hospital
Family and Specialty practices in Greenville, Monson, Sangerville
VNA Home Health and Hospice
Beacon Health LLC (ACO)
Northern Light Wellness
Beacon Rural Health, LLC (ACO)
Northern Light Medical Transport
Northern Light Wellbeing,LLC
Northern Light Health Foundation
Eastern Maine Healthcare Real Estate
Northern Light Work Health
Rosscare
Eastern Maine Medical Center
LTC, LLC
Colonial Acres Nursing Home (50%)
Katahdin Healthcare LLC (50%)
Stillwater Healthcare LLC (50%)
Dover-Foxcroft Healthcare LLC (50%)
22 Walnut Street LLC (50%)
1037 W Main (50%)
Park East Villa LLC (50%)
Dexter Healthcare (50%)
Ross Manor Associates (50%)
M Drug LLC (7 Outpatient Pharmacies; Mail Order; Specialty
Eastern Maine Medical Center Auxiliary
Affiliated Healthcare Systems AHS
Affiliated Healthcare Management
Affiliated Laboratory, Inc
** Entities Owned and Operating by Northern Light (not shown separately):
1 Clinic, 2 Imaging Centers 115 Medical Groups.
Not For Profit Hospital
Not For Profit Entity
For Profit Entity
Partnership
Disregarded Entity or 501c(2)
Sources:
Eastern Maine Healthcare Systems dba Northern Light Health Audited Financial Statement 9.30.2024. https://emma.msrb.org/
IRS Form 990. Eastern Maine Medical Center, Acadia Hospital, AR Gould Hospital, Sebasticook Valley Hospital, Mercy Hospital, CA Dean Hospital, Blue Hill Hospital, Mayo Hospital, Inland Hospital, Maine Coast Hospital. ProPublica Nonprofit Explorer
AHRQ Compendium 2023
https://northernlighthealth.org/Our-System

State Legislative Action to Address Consolidation: 2020-2025

	2020	2021	2022	2023	2024	2025	Total Laws
# of States	3	10	15	15	20	18*	-
Total Laws Enacted	3	11	23	24	27	35*	123
CON	0	7	15	13	19	19*	73 laws/28 states
Facility Fee, Site Neutral Payment	3	2	5	4	3	2*	19 laws/13 states
Transaction Oversight	N/A	2	2	4	5	5*	18 laws/10 states
Corporate Practice of Medicine	N/A	0	1	3	0	6*	10 laws/9 states
Ownership Transparency	N/A	0	0	0	0	3*	3 laws/3 states

**2025 legislation current as of October 10*

Market Changes in Ownership of Healthcare Related Entities				
Activity	Provider: A) Nonprofit	Provider: B) For profit	Insurance Carrier (Payer)	All Other Healthcare Related Entities
Notice of Transaction	CA, CO, CT, HI, IL, IN, MA, MN, NV, NH, NM, NY, OR, PA, RI, VT, WA	CA, CO, CT, HI, IL, IN, MA, MN, NV, NH, NM, NY, OR, RI, VT, WA	CA, NV, NH, NM, NY, OR, WA	CA, CO, CT, HI, IL, IN, MA, MN, NV, NH, NM, NY, OR, PA, RI, VT, WA
State Review / Referral of Transaction	CA, CO, CT, HI, IL, IN, MA, MN, NH, NM, NY, OR, PA, RI, VT, WA	CA, CT, HI, IL, IN, MA, MN, NH, NM, NY, OR, RI	CA, NH, OR	CA, CO, CT, HI, IL, IN, MA, MN, NH, NM, NY, OR, PA, RI, VT, WA
Authority to Approve, Approve Conditionally, Deny Transaction	CA, CO, CT, HI, IL, MA, NH, NM, NY, OR, PA, RI, VT, WA	CT, HI, IL, MA, NH, NM, NY, OR, RI	NH, OR	CO, CT, HI, IL, IN, MA, NH, NM, NY, OR, PA, RI, VT
Monitoring and Compliance of Transaction	CA, CO, CT, HI, IL, NM, OR, PA, RI, WA	CT, HI, IL, IN, NM, OR, RI	OR	CO, CT, HI, IL, IN, OR, PA, WA, RI

Market Transaction Program Needs and Considerations

State Market Transaction Program Needs

- Identify or create a home for the state's oversight authority – i.e. program/office/agency
- Require prior notice of proposed transactions to state oversight program and Attorney General (AG)
- Authorize state (via the oversight program or AG) to block or impose conditions *without* a court order
- Establish review criteria to assess whether the transaction is in the public interest
- Have robust mechanisms for monitoring compliance with conditions, including noncompliance penalties
- Consider time/resource needs for implementation of health care market oversight programs

Models for Enhanced Health Care Market Oversight — State Attorneys General, Health Departments, and Independent Oversight Entities by Erin C. Fuse Brown and Katherine L. Gudiksen

Key Considerations

- Which health care entities and transactions should be reviewed?
  - Financial transaction threshold? Provider type?
- Review criteria?
  - Harm market competition? Increase price? Reduce access to service?
- What data should be made public?
  - Financial health of an entity? Service capacity? Patient complaints?
- How long is a state review?
  - Balance – comprehensive review with need of health entity seeking transaction

State Examples of Health Care Market Oversight

Massachusetts

Chapter 224 – An Act Improving the Quality of Health Care and Reducing Costs (2012)

- Health Policy Commission conducts cost and market impact reviews (CMIRs)
  - Triggered by required notice of transaction (material change to operations or governance structure, merger, affiliation, potential shift in market share, etc.)
  - Commission has 185 days to review and write report; data can be kept confidential
  - CMIR examines impact on cost (related to the state's established cost growth benchmark), quality and access to services
    - Report can be referred to AG to take action to protect consumers under the law
- **MA also leverages Determination of Need (DON) conducted by Dept of Health

Massachusetts – Expanded Review

MA H 5159 (2023-2024)

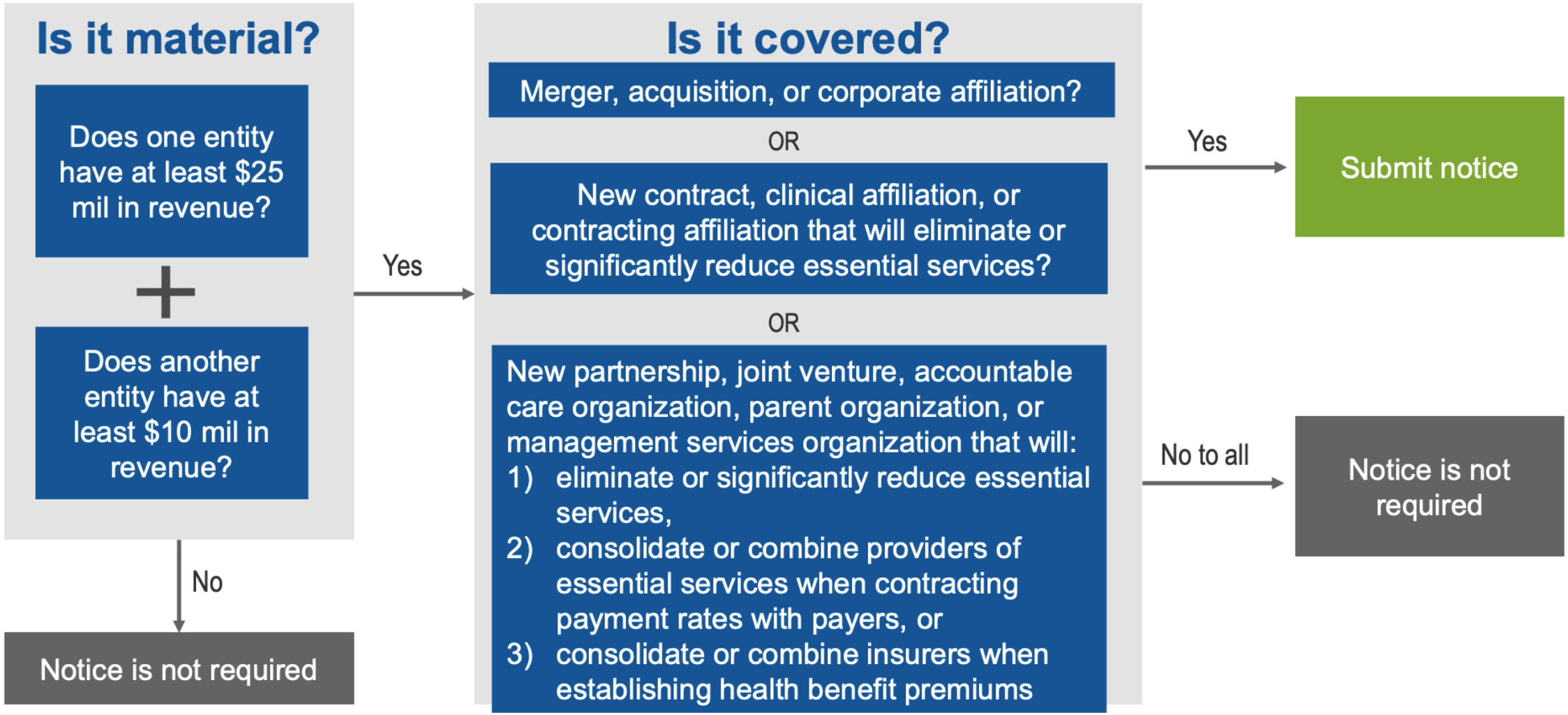
- Expands notice requirements and review of transactions to capture significant equity investors (SEI) and real estate investment trust (REIT) arrangements, includes management service organizations (MSOs)
- Expands ownership transparency to include PE, REIT, MSO financial statements, assets and liability information that may affect provider financial condition, including real estate sale-leasebacks
- Holds owners and investors liable for knowledge of false claims and failing to report
- Expands penalties for not complying with reporting requirements
- Allows post-transaction impact review for up 5 years

Oregon – Transaction Review

Oregon HB 2362 (2021), effective March 1, 2022

- Created the Health Care Market Oversight (HCMO) program within the Oregon Health Care Authority to review health market deals involving hospitals, insurance companies, and provider groups
  - Requires notice of transaction and review process with state authority to deny, approve, condition and monitor approved transactions for 1, 2, 5 years
  - Aims to ensure consolidation supports statewide goals related to health equity, lower costs, increased access, and better quality
  - Reviews led by OHCA staff and consultants, funded by fees assessed to health care entities requiring a review

What transactions are subject to review?



https://www.oregon.gov/oha/OHPB/MtgDocs/HCMO%20educational%20webinar%20for%20OHPB_April%209,%202024.pdf

	Preliminary Review	Comprehensive Review
What is it?	Initial analysis of potential impacts	Deeper analysis of potential impacts
Timeline	30 days	180 days
Public comment?	Yes	Yes
Outside Advisors?	No	Yes, as warranted
Community Review Board?	No	Yes, as warranted. See Criteria for Community Review Board.
Public Hearing?	No	Yes, as warranted
Outcome	Approved, approved with conditions, or requires comprehensive review	Approved, approved with conditions, or disapproved

https://www.oregon.gov/oha/OHPB/MtgDocs/HCMO%20educational%20webinar%20for%20OHPB_April%209,%202024.pdf

Oregon Market Transaction Review Tally

- As of Oct. 2025 – HCMO website lists 50 transactions
  - 5 = In process
  - 13 = Approved
  - 8 = Approved with conditions
  - 12 = In post-transaction review timelines
  - 6 = Withdrawn
  - 6 = Exempt/not subject to review
  - 0 = Denied

Oregon – Corporate Practice of Medicine

Oregon SB 951 (2025)

- Aims to address private equity's utilization of management service organization (MSOs) agreements in health care
  - Prohibits MSOs from owning or controlling clinical operations, decision making, or employment
  - Establishes criteria for non-compete, non-disclosure, and non-disparagement agreements to be valid and enforceable

New Mexico – Transaction Review

New Mexico HB 586 (2025), updates SB 15 (2024)

- Requires notice of proposed transactions, and authorizes a review by the NM Health Care Authority to approve, conditionally approve, or disapprove
    - Authorizes Attorney General to provide input relative to antitrust or other state and federal laws
- Requires the NM Health Authority annually post on its website hospital ownership information
- Establishes whistleblower protections for reporting wrongdoing or undisclosed transactions

Minnesota – Transaction Review

Minnesota HF 402 (2023)

- Requires certain health care entities involved in a transaction provide notice and certain information to the Attorney General (AG) and Commissioner of Health
    - Requires different information based on revenue of entities
    - Nonprofit health care entities have additional requirements
- Requires the Commissioner of Health provide data and research on how the transaction will affect cost, quality, access, and consolidation
- Authorizes AG bring an action in district court to stop a transaction, if the transaction is contrary to the public interest

Questions

State Health Planning Statutes Overview

The 120th Legislature in 2003 enacted LD 1611, "*An Act To Provide Affordable Health Insurance to Small Businesses and Individuals and To Control Health Care Costs*."

The law, in part, enacted State Health Planning in the Executive Branch (Title 2, MRSA, chapter 5). Among other things, the law required the Governor or the Governor's designee to establish a limit for allocating resources under the certificate of need (CON) program in Title 22, chapter 103-A, called the capital investment fund, and to develop and issue a biennial State Health Plan ("the plan").

Capital Investment Fund

The capital investment fund is a limit for resources allocated annually under the CON program in Title 22, chapter 103-A.

The law specified that the process for determining the capital investment fund amount must be set forth in rules and may include the formation of an ad hoc expert panel to advise the Governor. The process must include the division of the total capital investment fund amount into nonhospital and hospital components, must establish large and small capital investment fund amounts within each component and must be based on 3rd-year capital and operating expenses of projects under the CON program.

The process must consider:

- The plan;
- The opportunity for improved operational efficiencies in the State's health care system;
- The average age for the infrastructure of the State's health care system; and
- Technological developments and the dissemination of technology in health care.

Upon enactment in 2003, the law specified that for the first 3 years of the plan, the nonhospital component of the capital investment fund must be at least 12.5% of the total. In subsequent years, this was amended to 6 years and then 7 years. Eventually, it was amended to remove any "first years" requirement and simply said that the nonhospital component of the fund must be at least 12.5% of the total.

State Health Plan

The plan must set forth a comprehensive, coordinated approach to the development of health care facilities and resources in the State based on statewide cost, quality and access goals and strategies to ensure access to affordable health care, maintain a rational system of health care and promote the development of the health care workforce.

The law specified what the plan must do, including, among other things:

- Assess health care cost, quality and access in the State based on, but not limited to, demographic, health care service and health care cost data;

- Develop benchmarks to measure cost, quality and access goals;
- Establish and set annual priorities among health care cost, quality and access goals;
- Prioritize the capital investment needs of the health care system in the State within the capital investment fund;
- Outline strategies to promote health systems change, address factors influencing health care cost increases and address major threats to public health and safety in the State;
- Provide recommendations to help purchasers and providers make decisions that improve public health and build affordable, high-quality health care system;
- Be consistent with the requirements of the certificate of need program described in Title 22, chapter 103-A; and
- Include report cards on health status by district issued by the Maine Department of Health and Human Services, Maine Center for Disease Control and Prevention (ME CDC) and the Statewide Coordinating Council for public health to monitor progress in improving health. The plan must also use survey and other health tracking systems available in or to the ME CDC to monitor rates of preventive risk factors and diseases among the uninsured.

The plan must be used in determining the capital investment fund amount and must guide the issuance of certificates of need by the State and health care lending decisions by the Maine Health and Higher Education Facilities Authority.

A CON or public financing that affects health care costs may not be provided unless it meets goals and budgets explicitly outlined in the plan.

Certificate of Need

The law amended the CON statutes to provide that, based solely on review of the record created by the Department of Health and Human Services in the course of its review of an application, the Commissioner of the Department of Health and Human Services shall approve an application for a CON if the commissioner determines that, along with other criteria, the project is consistent with the plan and can be funded within the capital investment fund.

The law also changed threshold amounts for review on capital expenditures and acquisitions of major medical equipment to require that the threshold must be annually updated by the commissioner of DHHS to reflect the change in the Consumer Price Index medical index.

Advisory Council on Health Systems Development

To carry out the statutory goals, the law established the Advisory Council on Health Systems Development ("the Council"). Members were appointed by the Governor and confirmed by the Legislature. The Council was also given the statutory charge of advising the Governor in the development of the plan to the extent that data and resources are available. The statute spelled out specific duties that the council must take, including holding at least 2 public hearings on the plan and the capital investment fund each biennium and conducting a systematic review of cost drivers in the State's health care system.

Repeal

The 125th Legislature in 2011 repealed the State Health Plan in Public Law 2011, c. 90 (LD 1333). The State Health Plan for 2010-2012 was the final plan published in July 2010. A copy of the plan was shared electronically prior to the meeting and is posted on the Commission's website; the executive summary from this report is attached.

2010-12 Maine State Health Plan

Issued by
The Governor's Office of Health Policy and Finance
with
The Advisory Council on Health Systems Development

July 2010

15 State House Station
Augusta, Maine 04333
Phone: 207-624-7442
www.maine.gov/gohpf

2 MRSA § 101 requires the Governor to develop and issue a state health plan every two years and provide an annual report to the public assessing the progress toward meeting goals of the plan and provide any needed updates. **The Plan provides guidance to the Certificate of Need (CON) process- any application that is approved shall be consistent with and further the goals of the State Health Plan. 22 MRSA § 335 (1).**

Chapter VIII was produced with support from a grant from US Health and Human Services/Health Resources and Services Administration to the Governor's Office for Health Policy and Finance.

JOHN ELIAS BALDACCI
GOVERNOR

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

July 1, 2010

To the People of Maine:

The 2010-2012 State Health Plan provides the vision and strategies for improving our health, eliminating waste and inefficiencies from our health care system, and reforming how we pay for health care. It builds on the extensive work we have already done to expand affordable access to health care, improve quality and contain costs.

While I am proud of our accomplishments, I also realize that Maine cannot sustain the high costs of health care and must find measurable and sustainable savings by reducing our dependency on high cost emergency room and inpatient care and revitalize essential prevention and primary care services throughout the State.

We also must align our work with opportunities available under national health reform, including participation in important demonstrations and pilots for testing innovative approaches to health service delivery. We must work closely with consumers in assuring that health services are used appropriately, and that consumers engage in self-education and self-care.

The 2010-2012 State Health Plan is targeted on key strategies. In determining priority elements of the Plan, we looked to areas where there was an urgent need, where sufficient evidence is available to address the need, and where substantial savings could result. While not all things to all people, I believe this Plan offers the direction, insight and guidance going forward to continue our path to becoming the healthiest state in the nation with the most efficient and effective health care system.

Sincerely,

John E. Baldacci
Governor

PHONE: (207) 287-3531 (Voice)

888-577-6690 (TTY)
www.maine.gov

FAX: (207) 287-1034

This plan was developed by the Governor's Office of Health Systems Development under the review and guidance of the Advisory Council on Health Systems Development.

MEMBERS

Maine Advisory Council on Health Systems Development

Brian Rines, PhD, Chair
Pyschologist
Gardiner

Lani Graham, MD, MPH, Co-Chair
Portland

Maroulla S. Gleaton, MD
Atlee Gleaton Eye Care
Augusta

Anne P. Graham, MSN, RN, CPNP
No. Yarmouth

Andrew F. Coburn, PhD
Muskie School of Public Service
Portland

Nona O. Boyink
Maine General Medical & HealthReach Network
Waterville

Arthur J. Blank, President & CEO
Mount Desert Hospital
Bar Harbor

Edward F. Miller
American Lung Association of Maine
Augusta

David H. Brenerman
UNUM
Portland

James Highland, PhD
Compass Health Analytics, Inc.
Portland

Senator Peter Bowman
Legislator
Kittery

Robert K. Downs
Universal American
Pittsfield

Dora A. Mills, MD, MPH
Maine Center for Disease Control
Augusta

D. Joshua Cutler, MD
Maine Quality Forum, Dirigo Health Agency
Augusta

Senator Peter Mills
Skowhegan

Representative Anne Perry
Legislator
Calais

Representative Charles Priest
Legislator
Brunswick

Representative Wesley Richardson
Legislator
Warren

John P. Carr
Maine Council of Senior Citizens
York

Gail Dana-Sacco, PhD, MPH
Wabanaki Center
Orono

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Executive Summary

The State Health Plan is an action plan for and by all stakeholders and people of Maine to guide us toward becoming the healthiest state in the nation. Building on past Plans, this Plan targets our efforts to expand prevention and primary care while producing real and reasonable savings by eliminating waste and inefficiency. It links evidence-based public health strategies with measureable outcomes to lower the trajectory of health care costs and improve the health of Maine people. It also provides a roadmap and identifies policy options provided Maine through newly enacted national health reform.

Where We've Been

Maine is poised and ready to continue efforts underway since the enactment of Dirigo Health Reform in 2003, which provided a comprehensive approach to reduce cost, improve health, increase access, and improve quality. Public health and prevention efforts and infrastructure have been considerably strengthened, and efforts have paid off. According to America's Health Rankings, in 2003, Maine was the 16th healthiest state, and by 2009 we ranked 9th best. Through insurance reforms and expansion of health care coverage to low income Mainers, Maine increased access and in 2009 was ranked the 6th best in covering the uninsured, up from 19th among the states in 2003. Maine has begun to bend the cost curve, where costs for employer based health insurance premiums and deductibles have grown more slowly in Maine than in the US; through use of a health information exchange, by studying what is specifically driving costs, by working toward integrated health care delivery systems, and supporting innovative ways to strengthening primary care, the cost curve is shifting for the better. Simultaneously, health care in the state is of a higher quality; in 2003, Maine ranked 12th in the percent of surgical patients receiving the appropriate care to prevent complications, and in 2007 it ranked 1st.

Where We Are Going

The 2010-2012 State Health Plan provides a framework for Maine to propel forward on the considerable work already done. In addressing problems of waste and inefficiency, we know that we can achieve improved outcomes, better health status, and affordable health care for all Maine people. The vision for this Plan is to:

- Reduce inefficient practices and waste
- Strengthen community-based public health and prevention
- Pay for what matters
- Align policies and practices to support primary care and prevention
- Guide our Certificate of Need program to support priority goals

While more narrow than in the past, the scope of the activity of the Plan was based on three criteria: the urgency of the need to address the problem, a clear, evidence-based path to improvement, and measureable savings or return on investment that can be documented.

Reduce Waste and Inefficiency

The 2008-2009 State Health Plan documented that Maine has the second highest per-capita healthcare spending in the nation. To better understand the drivers of high costs in Maine, three major initiatives were undertaken in 2009: medical procedures, categories of costs, and types of

populations affecting state spending were identified, an Emergency Department workgroup examined patterns and practices of ED use, and a statewide plan was developed for reducing the incidence of healthcare-associated infections.
In order to address these findings, Maine must reinvigorate the state's primary care system through pilot projects for Medical Home, increased access initiatives for 24/7 call systems and telehealth. We must also reduce duplicative and unnecessary lab tests and advanced imaging and reduce the incidence of healthcare-associated infections.

GOAL IV.1 - Reinvigorate the State's primary care system to ensure timely and appropriate access to preventive, primary and disease management services.

GOAL IV.2 – Enhance access to primary care through the introduction of 24/7 call systems, evening and weekend hours, and patient follow-up calls after discharge.

GOAL IV.3 – Assess the potential role of telehealth in improving 24/7 access.

GOAL IV.4 - Reduce duplicative and unnecessary laboratory tests and advanced imaging.

GOAL IV.5 - Reduce the incidence of healthcare-associated infections and improve patient safety.

GOAL IV.6 – Improve access and adherence to medication prescriptions.

Strengthen Public Health and Prevention

Chronic diseases are among the most common, costly, and preventable of health problems, and in Maine they account for 28% of all spending for commercial populations, 30% for DHHS MaineCare, and 63% of spending for Medicare. Prevention strategies can help address these disease trends, and the strengthened public health infrastructure, with the new Tribal District, is the perfect avenue to coordinate efforts around the charge to lower healthcare costs while increasing the health of Maine people. By focusing on the measureable costs of avoidable hospitalizations, Maine can save approximately $52 million, but coordinated efforts between all stakeholders are essential to achieving these targets. Progress will be tracked using these avoidable hospitalization rates and population health indicators in *Performance Reports*, and learning collaboratives will be convened so that districts and the state can learn what is working and how to apply lessons learned.

GOAL V.1 – Design and convene learning collaboratives to engage the public health and clinical communities in developing effective and coordinated improvement initiatives in priority areas.

GOAL V.2 - Develop a mechanism for producing annual Performance Reports and use findings for health improvement.

GOAL V.3 – Incorporate evidence-based strategies for addressing identified health priorities in the Tribal District.

GOAL V.4 – Learn and apply promising models for addressing alcohol and substance abuse dependencies, and co-occurring conditions.

GOAL V.5 – Promote methods, such as Keep Me Well, to educate, engage and support consumers in self-care and management.

GOAL V.6 – Clarify, strengthen and assure accountability for the public health infrastructure.

Pay for What Matters

Our traditional fee-for-service approach to payment creates financial incentives to provide more costly services but does not have adequate incentives to improve the efficiency and quality of care and keep people healthy. Over one-third of every health care dollar in Maine goes to hospital care. In order to determine what the best model of payment reform should be, different strategies, such as Accountable Care Organizations, are being tested and reported on. Many stakeholders are working to develop a structure for implementing payment reform efforts.

GOAL VI.1 - Develop and implement a structure for implementing payment reform efforts in Maine.

GOAL VI.2 - Develop pilot projects that include Medicaid and Medicare with emphasis on care to complex and vulnerable populations.

Align Policies and Systems

Many factors influence how well our healthcare system works to improve the health of Maine people. There must be a qualified workforce to meet the needs of the population, we must have an accurate and complete data set and system, health information needs a roadmap for continued implementation, and the Certificate of Need program continues to guide systems development with Plan priorities.

Workforce: Our efforts have focused on identified current and projected shortages in a number of health occupations—over 30% of all dentists in Maine are over the age of 60, and 68% are over the age of 50. One out of every 5 physicians in Maine is nearing retirement age, and registered nurses are older than the national average. The distribution of health care workers in Maine is a serious issue. We must, and are, working to ensure an adequate number of qualified professionals are in Maine to provide high quality care. Oral health care is, and continues to be, an important focus.

GOAL VII.1 - Ensure an adequate number of qualified professionals to provide accessible, quality and cost effective health care.

GOAL VII.2 – Integrate comprehensive oral health care into overall health care and expand access to such care.

GOAL VII.3 – Increase access to oral health care through the support, education and training of dental hygienists, denturists and other health professionals.

Data: Maine must have a robust data infrastructure to support our efforts, and efforts continue to compile and organize data from multiple sources and to use the sources, such as Maine's first-in-the-nation all-payor database, to their fullest capacity. We must also make sure that complete and reliable data is collected for all of our people, especially for vulnerable populations with serious health disparities.

Goal VII.4: Develop a roadmap for continuing to build Maine's health data, analysis, and research infrastructure to support health care payment, delivery system reform, workforce development, and health system performance monitoring to improve health status.
Goal VII.5 Improve and enforce the collection of data that will enable Maine to assess and eliminate disparities in health status and service use.
Goal VII.6 Support and improve data to assess workforce shortages and supply and to evaluate the impact of interventions.

Health information: Efforts to reduce costs, improve quality, and extend access will be enhanced by health information exchanges, allowing clinicians to share electronic health information. This will expand access to care, improve the coordination of care, reduce unnecessary and duplicative testing, and lower costs while improving quality.

Goal VII.7 Align state health information technology efforts to achieve efficient and effective health care delivery.
Goal VII.8: Assess the current status of health information technology in Maine.
Goal VII.9: Assure the security and privacy of health information.

Certificate of Need: The Plan must guide determinations on the level of capital investment Maine will make in health care each year, and the law requires that a certificate of need application cannot be provided unless a project is consistent with the goals outlined in the Plan. Underlying the purpose is the desire to control costs, assure quality, and maintain access, and it is required for the expansion of facilities, the establishment of services, or substantial reductions in services.

Goal VII.10: Advance state priorities and reduce costs through provider incentives under the state's certificate of need program.
Goal VII.11: Assure that projects approved for certificate of need are consistent with the goals of the State Health Plan.

Implement Federal Health Reform

In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Affordability Reconciliation Act of 2010, legislation that makes major changes to the nation's health care system. Key elements include: an individual insurance mandate if affordable to individuals and families, expansion of the Medicaid program to all citizens earning up to 133% of the federal poverty level ($10,380 per individual), requirements that larger employers provide coverage or pay an assessment and incentives for small businesses to cover their employees, cuts in growth of Medicare payments to providers and new incentives to promote health care quality, care-coordination, and preventive care, changes in insurance market rules, payment reform incentives, opportunities to improve access to primary care, new taxes to contain health sector business, and support for states to improve public health, prevention, and health care quality.

Maine has a long history of health reform, is well positioned to implement the PPACA, and now faces major policy questions and choices in 2010. The Plan serves to outline these options, especially with regard to an Exchange, payment and system reform, eligibility expansions, insurance reforms, and assessing Dirigo as we move forward. Options will be reviewed and recommendations from work plans will be released as implementation of key activities are reviewed.

Goal VIII.1: To assure timely, effective and transparent implementation of PPACA in Maine

I Introduction

The State Health Plan is a roadmap to guide us further toward a goal of becoming the healthiest state with an integrated, high performing delivery system that is accessible and affordable to all. This is an action plan of, for and by all stakeholders and the people of Maine – not just state government.

Previous State Health Plans documented and addressed costs and inefficiencies, focused on improving health status and laid the groundwork for implementing national health reform. This plan targets our efforts to improve health and health status through expanded primary care and prevention while producing real and reasonable savings by eliminating waste and inefficiency. It links evidence-based public health strategies with measurable outcomes to lower the trajectory of health care costs. Importantly, it lays out a path and identifies the policy choices now provided Maine through newly enacted national health reform law. Enactment of The Affordable Care Act makes health reform the law of the land and provides an opportunity to both protect and expand the coverage gains Maine has made in the past. By 2014, nearly all Americans will have access to affordable coverage and the path Maine helped forge through years of innovation will be supported by new federal investments in access, cost and quality innovation.

II Where We've Been

To plan for the future, we need to know what progress we have made to date and build upon it. APPENDIX 1 describes major activities and initiatives that were undertaken in response to goals in the 2008-2009 State Health Plan. Each of the following sections highlights our progress.

Public Health and Prevention

> In 2003, Maine was the 16th healthiest state; by 2009, we ranked 9th best.
>
> SOURCE: America's Health Rankings, United Health Foundation

As reflected in previous State Health Plans, the public and private sectors in Maine – both independently and collaboratively – have identified and addressed challenges in health and health care delivery. A new, more efficient public health system now exists under Maine law with funding that has been streamlined and targeted. Through eight new geographically based Public Health Districts, and one Tribal district, supported by out-stationed CDC staff liaisons, a more robust system of local Healthy Maine Partnerships, and a strengthened system of certified

local health officers, Maine now has enhanced capacity to improve health. And a new focus on Tribal public health will strengthen the commitment to improving health and working collaboratively with Maine's Tribes. Maine people are empowered through a new, free web-based health risk assessment, Keep ME Well, to help identify risks and connect to resources that can reduce and eliminate them. Thanks to the Maine Health Access Foundation, nearly $10 million have been invested to find new models for coordinating behavioral and primary care.

Access

Maine ranked 19th among the states in covering the uninsured in 2003; by 2009 we were 6th best.

SOURCE: United Health Foundation, America's Health Rankings

Maine has a long tradition of insurance reforms and using the Medicaid program to provide health care coverage to low income Mainers. In 2003, the Dirigo Health Reform was enacted, and included comprehensive reforms to increase access, improve quality and lower costs. While not fully funded, the law further expanded access by subsidizing private health insurance coverage to those not eligible for Medicaid but too poor to afford health insurance premiums and funded a modest DHHS MaineCare expansion to cover parents whose children were already on the program. Funding limits required the subsidized insurance product, which opened to enrollment in 2005, to cap enrollment in 2007 while its waiting list grew. The Legislature resolved the funding issue, and the Dirigo Health Agency worked to revise and improve the program, allowing it to re-open Summer 2010.

Access has been further secured by maintaining DHHS MaineCare eligibility through difficult economic times and expanding eligibility through a new Federal grant from the federal Health Resources and Services Administration. That grant, awarded to the Governor's Office of Health Policy and Finance in 2009, serves as a bridge to national reform and allows the Dirigo Health Agency to cover up to 3,000 uninsured, low income, part-time and direct care workers in large businesses who have access to employer sponsored health insurance but cannot afford it. Vouchers will be given to eligible employees to purchase any private insurance coverage through whatever insurance company the employer chooses. This voucher program, like the health insurance exchange required by Federal law to be operational in 2014, works with multiple insurers and, coupled with Dirigo's existing capacity to negotiate on behalf of DirigoChoice enrollees, gives Maine important experience and readiness for that transition. Finally, transparency, insurance reforms, rate regulations and voluntary hospital cost targets enacted through Dirigo helped stem the growth of premium costs for employers.

Cost

Maine has begun to bend the cost curve – costs for health insurance premiums and deductibles have grown more slowly in Maine than in the U.S.

SOURCE: Shadac, 1999, 2003, and 2008 Medical Expenditure Panel Survey, Insurance Component

Access to coverage is more attainable by making it more affordable, especially to those who now have it and fear their ability to continue to pay for it. Maine still has the second highest per person medical spending in the U.S. – that's spending from all sources, private and public. This suggests that our higher costs are not explained by cost shifting from public payors. Costs are driven by how much health care we have (supply) and use (demand) ; what we pay for it (cost), and the significance of our disease burden (health status).

Health Information Exchange

Maine has invested in an electronic health information exchange that can reduce costly mistakes and duplication by providing clinicians with timely access to medical information. Maine's non-profit HealthInfoNet is demonstrating success in serving almost half of Maine's population already. Federal Recovery Act funds created an Office of the State Coordinator to assure statewide implementation and sustainability of electronic health information exchange.

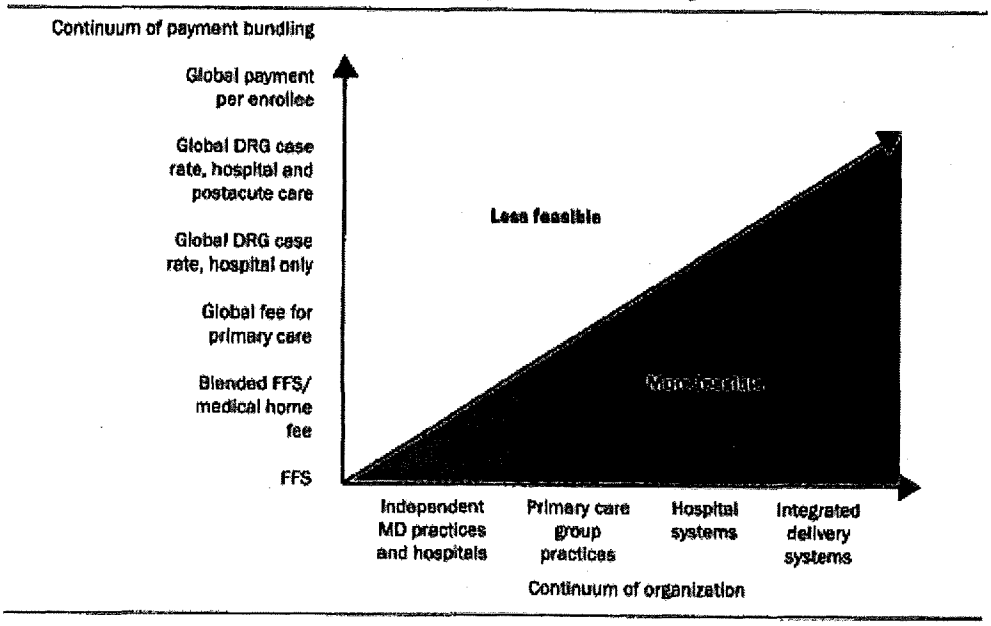
Cost Drivers

As directed by the last State Health Plan, we have documented specific cost drivers. We now know more about why Maine has a 30 percent higher use of emergency departments than the national average and that there is considerable variation in emergency use across the State. The Dirigo Health Agency Maine Quality Forum's cost driver study[1] identified nearly $365 million in potentially avoidable hospitalizations and high use outpatient services. These avoidable health care costs reflect the way we pay for care and how we organize it. In short, we get what we pay for. If we want better health outcomes and lower costs we need to create a health care system that is integrated and pays based on outcomes, not on volume.

Maine, both the private and public sectors, has begun to restructure provider payments so that payment is aligned with outcomes.

[1] All-Payer Analysis of Variation in Healthcare in Maine. Conducted by Health Dialog on behalf of Dirigo Health Agency's Maine Quality Forum and The Advisory Council on Health Systems Development. April, 2009

CHART 1: MOVING THE DELIVERY SYSTEM TO INTEGRATION



SOURCE: S. Guterman, K. Davis, SC Schoenbaum, and A. Shih. "Using Medicare Payment Policy to Transform the Health System: Framework for Improving Performance." Health Affairs. Web exclusive (Jan 27, 2009). W238-w250

Integrated Health Care Delivery System

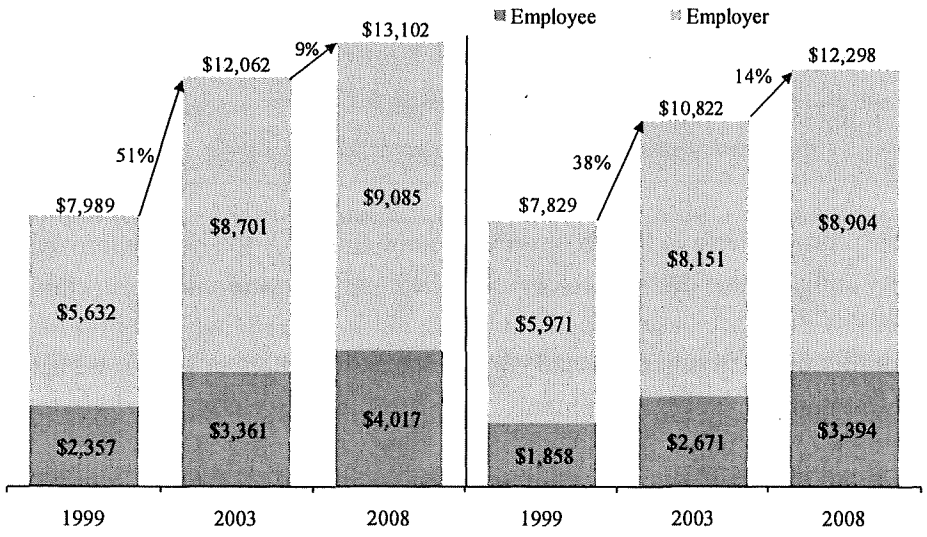
As this chart shows, getting more effective and efficient care means we need changes in how we deliver care and what we pay for. The more we move toward systems of care or integrated care and global payments, the more effective and efficient we can be. Past State Health Plans supported the movement toward integrated delivery systems and included certificate of need criteria that prioritized a systems approach to delivery. The amended Hospital Cooperation Act was used for the first time this year to support the merger of two hospitals. The Maine Health Management Coalition, CIGNA, Martin's Point Health Care, State Employees Health Commission and other payors and providers are engaged in payment reform models and the Legislature has directed the Advisory Council on Health Systems Development to study that work and report back in January 2011 with recommendations to advance it.

Patient-Centered Medical Home

Through a public/private collaboration, 26 primary care practices, Maine's private insurance companies and DHHS MaineCare have launched a Patient Centered Medical Home Demonstration to pay for improved primary care and prevention.

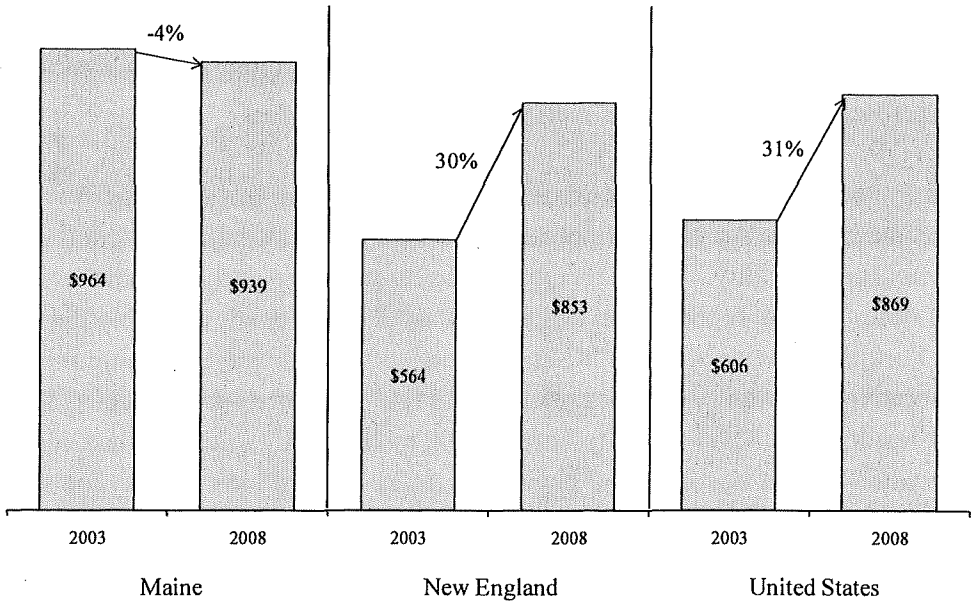
While Maine's health insurance costs are too high, our private/public focus on costs, including hospital compliance with voluntary cost targets and new insurance rate regulation on medical loss ratios and transparency, has shown success. As the charts below show, Maine has begun to bend the cost curve – costs for job based health insurance premiums and deductibles have grown more slowly in Maine than in the U.S.

TABLE 1 – AVERAGE ANNUAL FAMILY PREMIUM COSTS FOR COVERED WORKERS IN MAINE AND U.S., 2003 AND 2008 (08 DOLLARS)



SOURCE: 1999, 2003 and 2008 Medical Expenditure Panel Survey (MEPS) - Insurance Component
Note: Family definition excludes employee plus one after 2001

TABLE 2 – AVERAGE ANNUAL FAMILY DEDUCTIBLES FOR PRIVATE-SECTOR EMPLOYEES IN MAINE, THE REST OF NEW ENGLAND AND U.S., 2003 AND 2008 (08 DOLLARS)



Note: New England includes MA, RI, CT, VT and NH but excludes ME
Note: Represents average deductible for the approximately 70% of plans that have a deductible

Quality

In 2003, Maine ranked 12th in the percent of surgical patients receiving the appropriate care to prevent complications; by 2007, Maine ranked 1st.

SOURCE: The Commonwealth Fund State Scorecard, 2009

Access to affordable, comprehensive health coverage is not enough – the health care delivered must be high quality and produce desired outcomes. The costly variation in health care could be reduced or eliminated if evidence based practice was the norm. Improving patient safety, reducing and preventing medical mistakes, and empowering consumers to know and act upon best practice guidelines are the essential elements of a higher quality health care system.

Maine has made important strides through public/private collaboratives such as Quality Counts, Maine Health Access Foundation, and Aligning Forces for Quality, through the work of the Maine Health Management Coalition, and other business leaders and through Dirigo's Maine Quality Forum. Electronic exchange of clinical health information is an essential tool in quality. The Maine Quality Forum was instrumental in securing funding through the American Recovery and Reinvestment Act to support statewide planning and the important work of HealthInfoNet. A collaborative of critical access hospitals, convened and supported by the Maine Health Access Foundation and the Maine Quality Forum, is working to improve patient safety. All 14 Critical Access Hospitals successfully completed medication safety improvement initiatives to improve staff and patient education and protocols for dispensing medications. The Legislature expanded the authority of the Department of Health and Human Services to assure more robust reporting and oversight of so-called sentinel events – preventable medical errors.

Maine provider systems have received consistently high rankings from such notable organizations as the Institute for Health Improvement, the Commonwealth Fund, and the Agency for Health Research and Quality. These accomplishments are particularly impressive in our small and rural state. Public reporting on hospital acquired infections is available through the Maine Quality Forum and, with Maine CDC and private sector partners, the Maine Infection Control Collaborative is at work to assure patients in Maine's hospitals are protected against infection. As a result of the Maine Quality Forum's "In a Heartbeat" initiative, launched collaboratively with Maine's hospitals and physicians, more Mainers can identify the signs and symptoms of heart attacks and best practices in treatment are underway in emergency departments and emergency medical services statewide.

Quality Counts began in 2003 as a diverse group of stakeholders including healthcare providers, employers, payers, and policymakers to promote the need for improved systems of chronic illness care. Today, Quality Counts continues to support providers in quality improvement

initiatives, facilitates learning collaboratives on new models of care, and engages consumers in become active participants in their own care. The Maine Health Management Coalition uses clinical measures to report primary care practice quality, reports on hospital quality, and works with employers and healthcare providers in designing new payment and delivery systems. Aligning Forces for Quality, a Maine-based initiative of The Robert Wood Johnson Foundation, is a multi-stakeholder statewide regional health care coalition committed to working across organizations and communities to improve health care systems and outcomes for the people of Maine. Its mission is to coordinate existing, but disparate, efforts across the state that promote local, coordinated systems of care and the resources that support them.

The state of Maine, partnering with the state of Vermont, received an $11.2 million federal demonstration grant over five years for improving child health outcomes in both states. Maine will be collecting recommended federal child health quality measures, working with Health InfoNet to automate data collection and provide data back to pediatricians and family practice doctors to improve care, and testing and evaluating new payment strategies and learning collaboratives in patient-centered medical home pilot participants serving children.

III Where We're Going

The 2010-2012 State Health Plan must provide a framework for Maine, outlining the provisions of the new federal health reform, The Affordable Care Act, and what choices and opportunities are available for Maine. Work needs to start now and this Plan charts a course, recognizing the importance of broad stakeholder input and the need for policy discussion and action. But, the Plan also propels us forward on the considerable work underway in our State to improve the health of all Mainers, with keen attention to addressing disparities among us, and to reducing inefficiencies and other factors that drive costs.

This is our value proposition: Solving structural problems of waste, overuse of services that have no value, and underuse of effective care can lead to improved outcomes, better health status and make affordable health care possible for all Mainers. The vision for this State Health Plan is to:

- Reduce inefficient practices and waste
- Strengthen community-based public health and prevention
- Pay for what matters
- Align policies and practices to support primary care and prevention
- Guide our Certificate of Need program to align our public policies and support priority goals

Nine principles guide the Plan:

1. Evidence-based practices that improve safety and quality must drive treatment and payment decisions.
2. There must be measurable systems-wide savings or returns on the investments we make that accrue to improving our overall health care.
3. Our strategies must be population-based and system wide.
4. We must balance the interests of consumers, payors and providers.
5. Consumers must be engaged participants.
6. Health care professionals should practice to the full extent of their training, experience and skills.
7. System redesign should result in clear points of accountability for cost and quality.
8. Our efforts must reduce disparities in access and outcomes and improve health
9. These principles must assure that Maine maintains health care coverage gains and expands access to high quality, affordable health care.

The State Health Plan is targeted on key strategies. There is much work underway and other tasks that need to be done that are not reflected here. Rather, this State Health Plan is focused on limited and specific strategies to improve the health of all Mainers and lower the rate of growth in health care expenditures. We also acknowledge that the data upon which our priorities are based are sometimes limited, especially those related to ethnic/racial health disparities. We have therefore identified specific strategies to improve data collection efforts in these areas. We recognize that even with improvements in these areas, efforts to collect data to account for the full range of disparities must continue. In selecting the limited scope of activity for the Plan, we used three criteria:

- Is there an urgent need to address this problem?
- Is there a clear, evidence based path to improvement?
- Are there measurable systems-wide savings or return on investment that can be documented which accrue to improving the health care system?

Further, the tasks included in the Plan build on work underway statewide and are critical elements to successfully implement the provisions of The Affordable Care Act.

IV Reduce Inefficient Practices and Waste

Maine's 2008-2009 State Health Plan documented that Maine has the second highest per-capita healthcare spending in the nation. Yet we know that higher costs do not yield higher quality outcomes for Mainers. On the contrary, spending on inappropriate care and wasteful practices reduces our capacity to fully fund prevention and primary care efforts known to improve health.

To better understand the drivers of high costs in Maine, three major initiatives were undertaken in 2009:

- The Advisory Council on Health Systems Development and the Dirigo Health Agency's Maine Quality Forum commissioned Health Dialog to identify medical procedures, categories of costs, and/or types of populations affecting the state's spending. [Copies of the final report can be found at: http://www.maine.gov/governor/baldacci/cabinet/health_policy.html]

- The Advisory Council on Health Systems Development established an Emergency Department Use Workgroup to take on the issues of inappropriate emergency room use. The Muskie School of Public Service examined patterns and practices in emergency room use within the state. [Copies of the final report can be found at: http://www.maine.gov/governor/baldacci/cabinet/health_policy.html]

- The health care communities worked with the Maine Center for Disease Control to develop a statewide plan for reducing the incidence of healthcare-associated infections that are largely preventable, costly and lead to increased morbidity and death.

As a result of these efforts, we are able to identify and address persistent patterns of spending that do not contribute to health improvement. As importantly, these studies provide a useful quantitative baseline for tracking whether our interventions going forward are successful at reducing the impact of cost drivers in healthcare spending.

Major Findings

- Nearly one-third of inpatient care in Maine is potentially avoidable through the use of evidence-based medicine and reduced reliance on high-cost procedures that are not supported by the evidence. Reducing 50 percent of these admissions is estimated to save $141.8M; a 75 percent reduction is estimated to save $212.7M.

TABLE 3: Savings from Potentially Avoidable Admissions by Type of Admission

Type of Admission	Total PA Cost	Savings with 25% Reduction	Savings with 50% Reduction	Savings with 75% Reduction
Cardiac-Circulatory	$56.5M	$14.1M	$28.3M	$42.4M
Musculoskeletal	$18.1M	$4.5M	$9.1M	$13.5M
Respiratory	$52.0M	$13.0M	$26.0M	$39.0M
GI	$37.2M	$9.3M	$18.6M	$27.9M
Sub-Total top 4 PA Admission Types	$163.8M	$40.9M	$82.0M	$122.8M
All Other	$119.8M	$30.1M	$59.9M	$89.9M
Total	$283.6M	$71.0M	$141.8M	$212.7M

SOURCE: All-Payer Analysis of Variation in Healthcare in Maine. Conducted by Health Dialog on behalf of Dirigo Health Agency's Maine Quality Forum & The Advisory Council on Health Systems Development. April, 2009

- Five categories of outpatient spending were found to be high cost, subject to high variation across regions, and avoidable to reduce unnecessary spending. Lab tests alone accounted for 6.8 percent of outpatient costs, likely due to the common practice of duplicative lab testing.

TABLE 4: OUTPATIENT COSTS – AREAS OF HIGH COST AND HIGH VARIATION

Type of Service	Commercial	MaineCare[1]	Medicare	Dual	Total	% of OP cost
Total OP Costs	$674.4M	$292.8M	$173.1M	$175.9M	$1,316M	100%
Lab Tests	$58.8M	$9.6M	$13.5M	$7.7M	$89.6M	6.8%
Advanced Imaging	$45.3M	$8.4M	$8.0M	$4.9M	$66.6M	5.1%
Standard Imaging	$35.6M	$4.1M	$8.4M	$4.0M	$52.1M	4.0%
Echography	$19.5M	$6.6M	$4.3M	$2.0M	$32.4M	2.5%
Specialist Visits	$40.9M	N/A	$15.3M	$7.9M	$64.1M	4.9%
Total High Cost & High Variation	$200.1M	$28.7	$49.5M	$26.5M	$304.8M	23.3%

[1] *Specialty codes were not available for MaineCare data*

SOURCE: All-Payer Analysis of Variation in Healthcare in Maine. Conducted by Health Dialog on behalf of Dirigo Health Agency's Maine Quality Forum & The Advisory Council on Health Systems Development. April, 2009

- Fourteen diagnoses, all conditions that are frequently seen and can be treated instead in office and clinic settings, account for 20 – 25 percent of total emergency department visits. For infants, otitis media and respiratory infections were the most frequently cited diagnoses; Dental disease was the top diagnostic reason for an emergency room visit among both DHHS MaineCare and uninsured young adults aged 15 -24 and adults aged 25 through 44 years of age.

- Approximately 30 percent of Maine's Medicare population has a chronic disease and drives an estimated 65 percent of total spending and 70 percent of total inpatient spending. Approximately 10 percent of Maine's Medicaid members and commercial populations have a chronic disease, together accounting for 30 percent of total spending and an estimated 40 percent of inpatient spending. Preventing and managing chronic disease could significantly impact the State's healthcare spending.

- Healthcare-associated infections are infections acquired in healthcare settings while receiving treatment for other conditions. It is estimated that 5 to 10 percent of inpatients develop and die from infections every year, yet we know that many of these deaths can be avoided through careful surveillance and prevention. The average cost per hospital stay is typically $32,000 higher for a patient who develops a hospital-associated infection.[2] One of the most common causes of healthcare-associated infections occurs when large catheters inserted into the veins of a hospitalized patient become infected. Studies show that these "central line associated bloodstream infections" can be almost entirely eliminated by the implementation of simple and inexpensive practices[3] While Maine's overall central line infection rate compares favorably with the national averages, all Maine hospitals fall below the call for "zero tolerance" of these infections.

[2] State of Oregon Study
[3] 2006. Pronovost, P et al. An intervention to decrease catheter-related bloodstream infections in the ICU. NEJM, 355:2725-2732

Action Steps

Our efforts to date shine a light on major drivers of our healthcare spending and opportunities where resources can be re-directed to both reduce costs and improve outcomes. But acting on these findings requires changing long-held patterns of how consumers seek care, providers deliver care, and payors reimburse for care. The following goals and tasks translate findings into action to reduce inefficiency in Maine.

GOAL IV.1 - Reinvigorate the State's primary care system to ensure timely and appropriate access to preventive, primary and disease management services.

The strongest antidote to inappropriate use of hospitals and emergency rooms is the return of primary care to its rightful place as the "medical home" of patients where clinical, social supports, oral health, mental/behavioral health specialists and others can work in a coordinated manner to improve health and health status. Maine's Patient-Centered Medical Home Pilot is a model for understanding what it takes at the practice level to deliver integrated, continuous and comprehensive patient-focused care and how payment can support those changes. The pilot is in the first year of a three-year demonstration with support from Maine's private and public payors. Maine's network of federally qualified health centers and rural health clinics play essential roles in providing the primary care safety net to Mainers, including chronic disease management. CIGNA, Martin's Point Health Care and others are designing and testing new ways of primary care delivery and payment models.

Tasks

1. Quality Counts, Maine Health Management Coalition, Maine Quality Forum, and Office of MaineCare Services – by September 2012.
    - Secure funding, including access to Medicaid federal matching funds when appropriate, and evaluate the Patient-Centered Medical Home pilot, including clinical performance, patient and provider satisfaction, service use and cost, and integration with mental and public health services. The evaluation should specifically assess the impact of medical homes on the health and health status of vulnerable populations, including Medicaid and persons with disabilities, and those with complex medical and social needs (including transportation).
    - Identify essential attributes of a medical home with special consideration of models for delivering care management, including prescription assistance.
    - Develop a plan to analyze success of the pilot and, as appropriate, propose any needed revisions to transition from pilot to permanent status.
    - Document and spread learning from the pilot that can be instructive in expanding or modifying Medical Home models to expand beyond the 26 existing sites. In doing so, we wish to identify innovative models for meeting the needs of complex patients, such as group meetings and peer-to-peer supports.
    - Efforts should recognize the evolution of "medical homes" to a broader definition of "Medical Homes" that encompass the full array of supports required to bring about positive health outcomes for individuals.

GOAL IV.2 – Enhance access to primary care through the introduction of 24/7 call systems, evening and weekend hours, and patient follow-up calls after discharge.

The Emergency Room Study sponsored by the Advisory Council on Health Systems Development demonstrated the challenges faced in reducing inappropriate use of emergency rooms. A combination of health system arrangements, patient behaviors, and payment models contribute to and reinforce a pattern of unnecessary emergency care use. In Chapter VI we discuss the role of payment reform in realigning incentives; below we discuss structural changes identified in the Emergency Room Report to reduce avoidable emergency room use.

Tasks

1. Advisory Council for Health Systems Development – by September 2012
   - Work with insurers, consumers and others to make certain savings resulting from reduced emergency room use accrue to improved primary care and to payors, including consumers
   - Identify specific payment changes for MaineCare and state public purchasers that remove incentives for hospitals to promote emergency room use and offer new incentives that reward primary care practices that achieve lower rates of emergency room use for their patients.
   - Work with the Maine Health Access Foundation and other funders to secure funding to repeat Emergency Room Study by the Muskie School to determine if permanent reductions in avoidable emergency room visits have been achieved. Any future evaluation should provide an in-depth clinical review of reasons for emergency room visits, including the possible over/under/inappropriate use of medications.
2. Maine Medical Association and Maine Osteopathic Association
   - Discuss findings of the Emergency Department Use Study at professional conferences and Continuing Medical Education meetings.
3. Maine Patient-Centered Medical Home Pilot
   - Identify promising models for improving 24/7 access to primary care that can be broadly instructive to other practices, especially among vulnerable populations.
   - Determine the potential role of telemedicine in improving 24/7 access Identify and promote strategies for integrating medication reconciliation into primary care practices.
4. Maine Hospital Association and Maine Dental Association
   - Develop business model for reducing emergency room visits related to oral health based on joint project at Rumford Hospital.
   - Present findings and opportunities for application at professional association meetings and continuing education programs.

GOAL IV.3 – Assess the potential role of telehealth in improving 24/7 access.

Many rural communities are without access to primary or specialist care. For more than ten years, telehealth networks have provided an electronic bridge in Maine to vital consultative and specialty care as well as routine monitoring of vital signs, continuing medical education, and call centers.

Tasks

1. Statewide Coordinating Office for Health Information Technology – by June 2011
   - Review findings and recommendations of Telehealth Work Group to determine barriers and opportunities for implementation of telehealth in the state.
   - Assess status of telehealth in the state with Office of Rural Health.
   - Develop a strategic plan for telehealth to build capacity, provide training and coordinate services.

     Determine data collection requirements that would support the strategic deployment and evaluation of telehealth,
2. Maine Bureau of Insurance –by October, 2011
   - Monitor the implementation of new Maine law[4] requiring commercial carriers to reimburse for services provided through telemedicine that would otherwise be covered if rendered in-person.
   - Assess barriers to implementation, especially as they impact access to specialists in rural area.
3. MaineCare
   - Examine the use of telehealth among MaineCare providers and assess potential barriers to its implementation

4

GOAL IV.4 - Reduce duplicative and unnecessary laboratory tests and advanced imaging.

Our fee-for-service payment system promotes the unnecessary use of laboratory tests and advanced imaging. As we move to payment reform, it will be important to better understand how to define inappropriate use and track progress that is made in reducing its occurrence.

Tasks

1. Maine Quality Forum – by June, 2011
   - Determine method for tracking unnecessary laboratory tests and advanced imaging.
   - Using the all claims database, conduct a baseline of unnecessary duplicative imaging and estimate a cost to the system for these tests.
   - Evaluate change in use and spending related to laboratory tests and advanced imaging among HealthInfoNet demonstration participants.
   - Evaluate provider and patient experience and perspectives on the impact of health information exchange on lab and advance imaging referrals and make recommendations on how the system can be improved.
2. Payment Reform Work Group
   - Assure that models of payment reform address incentives for reducing inappropriate laboratory testing and advanced imaging.

GOAL IV.5 - Reduce the incidence of healthcare-associated infections and improve patient safety.

Patients with healthcare-associated infections have an increased chance for serious problems and death, longer stays in hospitals, more intense treatment by health care professionals, and incur higher and avoidable costs. The infection control and epidemiology community in Maine is working hard to reduce infection rates. The American Recovery Act made funds available to state health departments to enhance their capacity to prevent healthcare associated infections. Under this funding, the Maine Center for Disease Control developed and adopted a statewide plan to reduce healthcare associated infections. The Maine Infection Prevention Collaborative (a collaborative formed by infection prevention professionals from all Maine hospitals, the Dirigo Health Agency's Maine Quality Forum, the Maine Hospital Association, and the Northeast Health Care Quality Foundation) will serve in an advisory role in accomplishing the goals set out in the statewide plan. In addition, the Maine Infection Prevention Collaborative has set goals for itself for the next year.

Many other patient safety initiatives are occurring throughout the State but we lack a full understanding of their scope and impact on patient safety outcomes.

Tasks

1. Maine Center for Disease Control (in collaboration with the Maine Infection Prevention Collaborative) by September 12, 2011
   - Establish a healthcare associated infections surveillance, prevention and control program within Maine CDC.
   - Increase enrollment of Maine hospitals in the federal Centers for Disease Control's National Healthcare Safety Network.
   - Publically report through the National Healthcare Safety Network on the incidence of hospital-acquired methicillin-resistance staphylococcus aureus (MRSA) infections in all Maine hospitals against national benchmarks, by January 2011.
   - Implement and publically report status of national prevention targets in each of the following areas
     - Reduce central line bloodstream infections by at least 50 percent from baseline in critical care
     - Reduce multidrug resistant organisms, such as MRSA, by 25 percent from baseline.
     - Adhere to process measures to prevent surgical site infections by 95 percent.
   - Promote effective practices through learning collaboratives, consultations with national experts, and the dissemination of common protocols for reducing the incidence of healthcare associated infections.
   - Build public awareness about drug-resistant organisms to raise understanding of the role of hygiene in community transfer of drug-resistant infections.
   - The Maine Quality Forum will report on the prevalence of MRSA colonization in members of high risk populations admitted to Maine's hospitals.
2. Maine Department of Health and Human Services by March 2011
   - Require the use of standard transfer forms that identify healthcare acquired infections when patients transferred between nursing facilities to hospitals or hospitals to nursing facilities.
3. Maine Quality Forum, Maine Hospital Association, Maine Health Management Coalition and Consumers for Affordable Healthcare by July 2011
   - Document current patient safety efforts that are occurring within the State.
   - Compare Maine's patient safety achievements with national metrics, such as those used by the National Committee for Quality Assurance.
   - Promote public access to patient safety data.

GOAL IV.6 – Improve access and adherence to medication prescriptions.

Medication adherence is a significant problem in maintaining health quality and reducing unnecessary costs. Many individuals forego medications because they cannot afford to buy them. Others fill medications but take them inappropriately. Both can lead to adverse medication-related events that can result in unnecessary use of other health services such as emergency departments. A Muskie School evaluation of an initiative funded by the Maine Health Access Foundation from 2006-2009 to assist uninsured and underinsured Mainers in accessing free and low-cost drug programs offered through private drug manufacturers and through state programs and providing counseling, education, and assistance in managing complex drug regimens, found that these relatively low-cost interventions had a positive impact on self-reported health outcomes and patient self-management of their medications. The interventions reduced self-reported use of health care services including medical provider visits, use of the emergency room, and hospitalizations. This study highlights the importance of medication access and management as a quality improvement and cost containment strategy. Medication management needs to be added to the toolkit of strategies for reducing system costs while improving residents' quality of life. This can be accomplished by integrating medication management into the essential functions of primary care practices and patient centered medical homes and providing payment for these services. Federal health reform includes some demonstration funds for testing new models of medication management that the state may want to pursue.

Tasks

1. Maine Primary Care Association and Quality Counts
   - Work with professional and provider associations, Maine Quality Forum, Maine Medical Association and others with interest in Medical Home models to disseminate and discuss findings from the medication management initiative and its implications for primary care practice.
   - Connect work to federal Health Resources and Services Administration's Patient Safety Pharmacy Collaborative.
   - Identify and pursue opportunities under Federal Reform for testing new models of medication management.
   - Identify opportunities to promote and support prescription assistance programs at the community level.
2. Maine Medical Association, Maine Office of Substance Abuse and Maine Primary Care Association
   - Promote and make more accessible Maine's Prescription Monitoring Program for use by clinicians in better understanding and tracking patient prescription habits.
   - Review findings from the Muskie School epidemiological analysis of the program data to assess further opportunities for education and training.
   - Build clinician awareness of follow-up programs that can assist with persistent drug seeking and use habits.

Desired Outcomes

Our goals and strategies to reduce unnecessary spending focus on the root causes of why inefficient and wasteful practices exist. If our interventions are successful, the following outcomes will be achieved.

1. Reduction in avoidable hospital admissions, emergency room admissions, and unnecessary care.
2. Reduction in duplicative and unnecessary laboratory tests and advanced imaging.
3. Increased number of Mainers with a stable relationship with a primary care practice.
4. Reduction in healthcare-associated infections.
5. Improved access to specialist consultations through telemedicine.
6. Improved access to prescriptions and compliance with prescription regimes.
7. Reduce the inappropriate use of legally prescribed controlled drugs.

V Strengthen Public Health and Prevention

Chronic diseases, such as heart disease and diabetes, are among the most common, costly, and preventable of health problems. In Maine, chronic disease accounts for 28 percent of all spending for commercial populations, 30 percent for DHHS MaineCare, and 63 percent of spending for Medicare.[5] Not only is chronic disease costly, it is largely preventable. Through implementation of prevention strategies, education and disease management programs, costs can be reduced, health improved and lives saved.

Strong action at the community level is critical to reversing chronic disease trends. Over the past two years, Maine has built a local public health infrastructure to serve as the nexus for bringing public health educators, clinicians, schools, town officials, community groups and consumers together to target chronic diseases and their major risk factors – tobacco and alcohol use, insufficient physical activity, and poor nutrition. The Public Health Districts, 28 Healthy Maine Partnerships, and a Local Health Officer system, comprised of 492 municipal health officers, are making strides to achieve the needed policy, systems, and environmental changes to reduce the incidence, burden and costs of chronic disease. Each District is currently working to translate their community profiles/assessments into action through a district health improvement plan. These plans outline strategies to address District and statewide priorities, and each District will be held responsible for showing progress over time toward the goals outlined in these improvement plans. The work of the Districts will continue to inform the work of the Statewide Coordinating Council, and both the District and Statewide Coordinating Councils will continue to work together to provide guidance for future State Health Plans. Also, Maine CDC and the Tribal District are working to gather data and to design evidence-based strategies to eliminate health disparities in this district to guide the development of a Tribal District health improvement plan.

The charge to our public health system is enormous but our resources are limited. It is only by combining forces with all who have a stake in improving health that we can impact both the incidence of chronic diseases and their underlying causes. No longer the domain of single purpose strategies, public health must target and link disparate community interventions so that they can have the maximum impact on multiple risk factors and desired outcomes. This requires a new set of skills for our Public Health Districts, ones that promote communication and coordination with the broader clinical community in their areas.

[5] All-Payer Analysis of Variation in Healthcare in Maine. Conducted by Health Dialog on behalf of Dirigo Health Agency's Maine Quality Forum & The Advisory Council on Health Systems Development. April, 2009

Priority Areas

Given resource limitations, we must also focus on areas of highest priority – where there are significant problems, high costs and known interventions. Also, we have looked to define issues that span public health and clinical care, knowing that our goal is not only to reduce health care spending but to address the underlying causes of disease that got us there in the first place. We have been guided in these efforts by an analysis of Maine's cost drivers and extensive discussions with the Maine Center for Disease Control and its state and district public health coordinating councils. Five categories of preventable hospitalizations have been identified representing areas of high variation across the state, high spending, and evidence-based strategies for reduction. These include certain hospital admissions related to adult asthma, bacterial pneumonia, chronic obstructive pulmonary disease, congestive heart failure, hypertension and diabetes.

The federal Agency for Healthcare Research and Quality has found that many of these hospitalizations can be avoided with good preventive and primary care and when patients actively participate in their care and engage in healthy lifestyle behaviors. For example, patients with diabetes may be hospitalized for diabetic complications if their conditions are not adequately monitored (e.g., regular foot exams and blood tests) or if they do not receive the patient education needed for appropriate self-management. These hospitalizations, as well as indicators related to these chronic diseases, will be tracked in *Performance Reports,* further described below. It is also known that once chronic diseases are diagnosed, access to affordable medication and adherence to protocol are important factors in managing chronic disease, avoiding hospitalizations, and reducing health care expenditures. While prescription assistance programs are clinical in nature, collaborative efforts between primary care providers and patients in Medical Homes will be important for promoting effective prevention and management of these diseases.

Integration with Substance Abuse and Mental Health

In recognizing the complexity of the etiology and management of chronic diseases, there will also be a focus on substance abuse and mental health. While unique problems requiring unique care, substance abuse and mental illness significantly contribute to the severity, complexity and cost of chronic diseases. Substance abuse and mental health also take a huge toll on quality of life. According to the Maine DHHS, substance abuse and mental health co-occur approximately 60 percent of the time and are treated together. Improperly managed mental illness can prevent management of an individual's overall health and can lead to increased substance use, poor nutrition, tobacco use, and other behaviors that cause chronic disease. Conversely, poor management of personal health can exacerbate the management of substance abuse and mental illness.

Substance abuse and mental illness (diagnosed and undiagnosed) can compromise the role that public health has and must continue to play in chronic disease prevention. While it is complex, we must devise ways to successfully integrate care for co-occurring conditions, such as mental illness and substance abuse, into our surveillance, screening, educational and data exchange systems. As care is integrated, therapies for mental and behavioral health must be monitored to ensure that any new treatment does not worsen existing physical conditions, such as diabetes or obesity—a delicate balance must be found for effective and efficient care of both physical and mental health. *Performance Reports* will serve as a way to track comprehensive prevention efforts, with the understanding that substance abuse and mental illness must be addressed in these efforts in order to effectively bend the curve.

Accountability

To assure our efforts are having the intended effect, we must be able to measure our progress and hold ourselves accountable. This requires the adoption of objective indicators that can be reliably and consistently measured across each of our public health districts. These indicators must capture both the short term impact of our efforts in reducing preventable hospitalizations and the longer term impact on health and social determinants related to the underlying disease. Continued efforts to address sedentary lifestyle, obesity, and high-risk behaviors such as tobacco and substance use will be tracked alongside downstream measures of diabetes, congestive heart failure, chronic obstructive pulmonary disease, hypertension, asthma, and bacterial pneumonia. Through prevention, early detection, and proper management of disease, it is known that hospitalizations for these downstream problems could be avoided, and by transparently tracking prevention efforts in conjunction with these more clinical measures, the work of the public health infrastructure will be connected to the work of others. No one entity can do this work alone, yet statewide improvements depend on each community sector being held accountable for doing its part.

Our priorities for public health and the indicators for monitoring change have come together in the form of district *Performance Reports* [see APPENDIX 2 for a statewide report]. By creating public reports, we are calling attention to the complex nature of these problems and the need for all sectors to develop effective and coordinated strategies, and for all sectors to be held collectively accountable for impacting these measures.

Major Findings

- In 2007, some of the preventable hospitalizations driving costs in Maine were:

Preventable Hospitalization Indicator	Admission Rate per 100,000	Potential cost savings given a 50% reduction
Bacterial pneumonia	379.6	$16,230,065
Adult asthma	71.7	$2,198,165
Chronic obstructive pulmonary disease	224.0	$8,640,570
Congestive Heart Failure	352.2	$14,759,440
Hypertension	21.3	$663,860
Diabetes short-term complication	40.8	$1,469,695
Diabetes long-term complication	90.1	$5,335,710
Uncontrolled diabetes	7.2	$199,715
Rate of lower-extremity amputation among patients with diabetes	28	$2,598,615

- In 2005, the total estimated cost of substance abuse in Maine was $898.4M.
- Approximately 19,593 admissions for drug and/or alcohol related treatments, representing 15,884 distinct individuals, were reported during 2005 in Maine.

Action Steps

The *Performance Reports* focus on preventable hospitalizations as well as traditional public health measures that relate to health indicators. Our goal is to make them a springboard for bringing the public health and clinical communities together to design coordinated strategies and track the effectiveness of those strategies. Our hope is that they serve as a catalyst for coordinated, sustained action, recognizing change will take time and collective diligence.

GOAL V.1 – Design and convene learning collaboratives to engage the public health and clinical communities in developing effective and coordinated improvement initiatives in priority areas.

Preventable hospitalizations occur at the intersection of public health, primary care and specialty/acute care. They represent areas where the system has failed to prevent disease or treat it on a timely basis through good primary care. Learning Collaboratives help in understanding the barriers to preventing, detecting and treating these diseases and assuring that our improvement strategies are evidence-based and coordinated. Structured exchange will also avoid having to reinvent the wheel district to district, and allow districts to learn from the success and challenges of their peers.

Tasks

1. Statewide Coordinating Council for Public Health and the Maine Quality Forum by 9/30/11

   Identify existing resources, models, and initiatives that may be instructive in opening dialogue between public health and primary care practices on priority areas. For example, practices participating in Maine's Patient-Centered Medical Home are required to develop a relationship with the Healthy Maine Partnership in their areas.

   - Identify high performing communities and practices in each priority area to assess factors that may be contributing to low rates of preventable hospitalizations. Design and convene at least two learning collaboratives representing public health, clinicians, policy makers, free clinics, and others whose responsibilities impact the priority area to discuss the determinants, risk factors, clinical guidelines and improvement strategies for impacting preventable hospitalizations.
   - Include the availability and performance of hospital-managed prescription assistance programs/ medication access resources in utilization assessment and as a topic for collaborative learning.
   - Provide technical and clinical consultation to public health districts in the design and execution of their improvement strategies.

GOAL V.2 - Develop a mechanism for producing annual Performance Reports and use findings for health improvement.

Title 22, Chapter 152 requires the Maine Center for Disease Control and Prevention to develop, distribute and publicize an annual brief report card on health status statewide, and for each District by June of each year. Renamed *Performance Reports*, the design and first year publication of these reports were completed this year. However, its publication requires data from multiple sources (Maine's all-payor claims data base, survey data from the Risk Factor Surveillance System, vital statistics, etc). An ongoing method for integrating *Performance Reports* into health improvement efforts at the District and state levels must be developed.

Tasks

Maine Center for Disease Control and Statewide Coordinating Council by Dec 2010

- At least annually, review district *Performance Reports* to determine opportunities for improvement and priorities for inclusion in district Health Improvement Plans.
- Annually report to the Advisory Council for Health Systems Development and the public on progress in meeting goals, trends, and efforts to advance improvement.
- With the Maine Quality Forum, develop an analysis plan that identifies responsibilities and timelines for obtaining data for annual *Performance Reports.*
- Review the science base for priority preventable hospitalizations and assure that subsequent Performance *Reports* conform to known evidence.
  - Review, revise and establish benchmarks for evaluating district performance.
  - Determine financial and other incentives related to high performing districts.
- Once performance reports are reported, develop methods to support the activities of Health Maine Partnerships in the implementation of health improvement plans tied to State Health Plan priorities.

GOAL V.3 – Incorporate evidence-based strategies for addressing identified health priorities in the Tribal District.

Maine CDC and a Tribal District liaison are currently working to gather data, specifically population health indicators, included in Behavioral Risk Factor Surveillance System (BRFSS) modules for the four federally recognized tribes in Maine; data is set to be gathered in 2010. Once data are gathered, Maine CDC and the tribes will collaborate to design strategies for addressing the identified health priorities of the tribes.

Tasks

Maine Tribal District Public Health Liaisons, in collaboration with the Maine CDC Offices of Minority Health and Local Public Health:

- Analyze population health indicators collected from the 2010 Maine Tribal Health Assessment.
- Develop actionable strategies to address the identified priorities.
- Report strategies in a Tribal Health Improvement Plan.

GOAL V.4 – Learn and apply promising models for addressing alcohol and substance abuse dependencies, and co-occurring conditions.

Alcohol and drug abuse causes illness, disability, and premature death. As reported by Maine's Office of Substance Abuse, its burden on society includes "costly health care resources, significant productivity loss due to morbidity, serious injuries from motor vehicle accidents, and criminal activity resulting in property damage and incarceration". Substance abuse and addiction are preventable.

Tasks

DHHS Maine Office of Substance Abuse

- Create a Task Force representing public health, mental, and behavioral health authorities at the state and local levels, education, corrections, providers, consumers, and employers to identify and create a plan to overcome barriers to effective integration of care. Propose policy, program, or practice changes to promote and adopt the use of evidence based intervention and treatment strategies for co-occurring behavioral health problems by public health agencies.
- Review models for integrating substance abuse, mental, and behavioral health prevention and early intervention into the public health agenda. Assure models address those with persistent mental illness.
- Report best practices for integrated care to the Advisory Council on Health Systems Development by April 30th, 2012.
- Identify and assess standardized measures and data collection tools to reliably assess the prevalence of substance use/abuse and addictions, including the prevalence of emergency department use connected to pain medication and narcotic seeking and the impact on health services within Maine's public health districts. Develop ways to connect existing data sources and fill gaps to ensure valid and reliable data.
- Serve as a resource to public health districts as they design and implement integrated strategies, based on the work of this taskforce and the work of the Co-Occurring State Integration Initiative (COSII).

GOAL V.5 – Promote methods, such as Keep Me Well, to educate, engage and support consumers in self-care and management.

An individual's involvement with his or her own healthcare is crucial to improving the health status of a population, and there is a need to educate people about the consequences of behavior on health and to engage the public in these efforts. The Keep Me Well online tool was developed to comply with Public Law 22, part 2, §411. It is both an online resource tool kit and health risk assessment to help consumers assess their risks for chronic diseases, improve their health through education, and links them to local community support and programs that can help them decrease their risk of chronic disease and improve their health.

Tasks –

1. Dirigo Health Agency
   - Promote Keep Me Well to all current and future enrollees of DirigoHealth.
   - Disseminate and promote a Wellness Toolkit for use by small businesses in Maine.
   - 2. Maine CDC with District Coordinating Councils and Healthy Maine Partnerships Promote the use of Keep Me Well to assure compliance with target goals in annually released Performance Reports.
   - Report annually against the measures in the district Performance reports to document increased use of Keep Me Well and identify strategies that work best in achieving outreach goals.

GOAL V.6 – Clarify, strengthen and assure accountability for the public health infrastructure.

Maine's nascent public health infrastructure is an essential resource at the local level and has been given heightened visibility and roles in this State Health Plan. Yet we know that our Public Health Districts have limited resources and rely extensively on the voluntary commitment and contributions of community members. As we proceed to implement the *Performance Reports* and take on the tasks of using our Public Health Districts as focal points for reducing preventable hospitalizations, more durable and formal lines of authority and reporting will may be needed to enhance the effectiveness and efficiency of the advisory roles served by the Statewide Coordinating Council and District Coordinating Councils. .

Tasks

Maine CDC, Statewide Coordinating Council and District Coordinating Councils by 9/30/11

- Develop proposals that use existing resources to address any gaps in accountability for the Statewide Coordinating Council and District Coordinating Councils to perform their primary roles as defined in statute (providing input into the development of the State Health Plan, serving as a vehicle for assuring that the State Health Plan is implemented, assuring the public health system's readiness for accreditation, and assuring that the ten essential public health services are addressed in each district). These proposals should include strategies for using existing resources to reinforce and strengthen Maine's public health infrastructure.
- Report to the Advisory Council on Health Systems and Development on proposals.

Desired Outcomes

Improvements in the underlying causes of chronic disease will take substantial time even with the persistent and focused efforts of many. Meanwhile, we expect more short-term signs of progress by improving the management of chronic disease through better and more accessible primary care.

1. Increased collaboration within and support for Public Health Infrastructure by all stakeholders
2. Reduction in Emergency Department over-use, preventable hospitalizations, and increased cost savings associated with the reduction in preventable hospitalizations
3. Accountability for change by annually measuring and reporting improvement progress
4. Reduced incidence of population health indicators and, over time, chronic diseases associated with them (trends demonstrated in *Performance Reports*)
5. Consumers engage in self-education, self care and the appropriate use of health care services.
6. More efficient and accountable public health infrastructure.

VI Pay for What Matters

Our traditional fee-for service approach to payment creates financial incentives to provide more costly services but does not have adequate incentives to improve the efficiency and quality of care and to keep people healthy. Payments do not always reflect the true cost of providing quality services. Preventive and primary care is not well funded while inefficiencies and inappropriate care contribute to avoidable costs.

Over one-third of every health care dollar spent in Maine goes to hospital care.[6] If we wish to control costs and improve health, Maine must focus on this reliance on hospital care, and as described in Chapter IV, the inefficient practices and waste throughout our healthcare system. While strong, efficient and quality hospitals are essential to our health care delivery system, we must change how we pay for care by hospitals, physicians and other providers and the incentives we create to prevent illness, manage chronic disease at home, and promote effective use of emergency departments and hospitals only when needed. To do so requires a significant disruption of the status quo for consumers, payors and providers. While several states have established commissions to design new payment systems, no state has yet implemented its reforms nor has a single best payment reform model emerged.

In response to a Legislative request, the Advisory Council on Health Systems Development established a Payment Reform Sub-Committee in 2009 to solicit input and develop strategies for payment reform in Maine. A review of payment models and practices was conducted and compiled into a *Payment Reform Primer* by the Governor's Office for Health Policy and Finance to aid the efforts of the Payment Reform Work Group [see http://www.maine.gov/governor/baldacci/cabinet/health_policy.html for *Primer*]. The Payment Reform Sub-Committee submitted its report and recommendations to the Maine State Legislature in March, 2009.

Major Findings

In its report to the Maine State Legislature, the Payment Reform Sub-Committee submitted the following findings.

- Payers and providers have taken the leadership in moving payment reform in Maine. Voluntary efforts to date lay important groundwork for system reform and underscore the importance of local momentum and leadership in bringing about change.

[6] The Henry J. Kaiser Family Foundation, StateHealthFacts.org, http://www.statehealthfacts.org/profileind.jsp?ind=593&cat=5&rgn=21 (accessed 5.1.10).

- It is not clear at this point what the best model(s) of payment reform should be in Maine. A combination of one or more of the following strategies will likely be needed given the diversity of Maine's delivery system and needs:
    - Accountable care organizations (ACO's) or groups of providers who come together in a formal or contractual manner to accept responsibility for the quality and cost of health care services provided to a defined set of patients.
    - Episode of care payment systems (bundled payments) made to a group of providers to cover all of the services a particular patient requires during a defined episode of illness.
    - Global payment systems which are prospectively paid, fixed dollar amount payments for a specified range of services provided to patients over a set period of time.
    - Payments for coordinating the care of patients with complex or chronic conditions to prevent complications of disease and reduce costs by reducing the need for costly interventions related to those complications.
    - Performance-based incentives for health care providers that achieve target levels of performance.

- Payment reform should be driven by clear and measurable goals. In its report to the Legislature, the Payment Reform Work Group identified six core principles for use in the design, implementation and evaluation of payment reform efforts:
    - Support integrated, efficient and effective systems of care, delivery and payment
    - Promote a patient-centered approach to service delivery and payment
    - Encourage and reward the prevention and management of disease
    - Promote the value of care over volume to measurably lower costs
    - Support payment and processes that are transparent, easy to understand, and simple to administer for patients, providers, purchasers and other stakeholders
    - Balance the interests of patients, payers and providers while pursuing necessary change.
- State government has a legitimate and essential role to play in supporting and shaping payment reform. First, government articulates and protects the public's interest when weighing the merits of potential policy or statutory changes proposed by payment reform sponsors, especially as they impact vulnerable populations. Second, government facilitates the inclusion of public purchasers in payment reform efforts. Third, government can act proactively in advancing reform as needed through participation in national demonstrations, applications for federal waivers, and establishing a regulatory environment aligned with core principles and federal reforms. Finally, government monitors payment reform efforts so that good experiments can be identified and expanded and those not serving the public's interest discontinued.

Action Steps

In response to the Payment Reform Sub-Committee's report, the Maine State Legislature passed LD 1819, *An Act to Implement the Recommendations of the Advisory Council on Health Systems Development Relating to Payment Reform.* This bill designates the Advisory Council as the oversight structure for working collaboratively with sponsors of payment reform models in Maine and connecting the state's initiatives to national health reform efforts. The following actions take advantage of federal opportunities while recognizing the importance of assuring that payment reform remains relevant and responsive to Maine needs.

GOAL VI.1 - Develop and implement a structure for implementing payment reform efforts in Maine.

Tasks

1. Advisory Council for Health Systems Development – by January 2011
   - Invite the Bureau of Insurance and Attorney General's Office to serve as technical advisors on the Payment Reform Sub-Committee
   - Review activities of Payment Reform Sub-Committee and submit findings and recommendations to Legislature no later than January 2011 as required by LD 1819.
2. Payment Reform Sub-Committee – initial report by January 2011
   - Encourage multiple community-based pilots of payment reform
   - Assess the merits of emerging models against core principles
   - Identify legislative or regulatory reforms needed to advance payment reform models
   - Examine the Hospital and Medical Care Provider Cooperation Act to assure adequate protections exist to foster the collaboration needed to support payment reform models.
   - Recommend proposed policy or regulatory changes to the Advisory Council that could be granted for a three-year demonstration period that will enable us to learn, in a controlled environment, about successful models.
   - Monitor payment reform demonstrations and report findings to the Advisory Council.
   - Recommend to the Advisory Council any permanent changes to state policy and/or statute to advance payment reform.

   Nothing in these actions precludes payment reform models, not requiring government action and in compliance with existing requirements, from proceeding under terms established by their sponsors.

GOAL VI.2 - Develop pilot projects that include Medicaid and Medicare with emphasis on care to complex and vulnerable populations.

Tasks

1. Advisory Council for Health Systems Development – by January 2012
   - Collaborate among DHHS MaineCare, Patient-Center Medical Home pilot, CIGNA, Martin's Point Health Care, other emerging primary care models, Dirigo Health Agency and U.S. DHHS in the development of pilot goals consistent with core principles established by the Advisory Council and supported in law.
   - Integrate activities with the work of Payment Reform Sub-Committee.
   - Identify state policy and/or statutes needed to advance the goals of the pilot.
   - Consider alternative models of paying for primary care, such as excluding primary care from insurance premiums and instead make direct, pre-negotiated capitated payment to practices that includes the cost of routine visits as well as time for non-visit based services (phone calls, email, and care coordination) to achieve more patient-centered care.
   - Partner with quality improvement initiatives in the state to support participating practices to reach quality and cost targets.
   - Develop methods for monitoring goals and reporting findings to the Legislature.
   - Design and seek funding for pilot implementation and an evaluation of pilot effectiveness and impact on cost, quality, access and core principles.
   - Determine whether and how Maine private and public payors could "piggyback" with payment reform demonstrations in Medicare, including one that will share savings with providers deemed as qualified accountable care organizations.

2. MaineCare and Maine Office of Rural Health by July, 2011
   - Consider organizational, management and financial structures that would enable Maine's safety net providers (including federally qualified health centers, community health centers and critical access hospitals) to become active partners in MaineCare's managed care initiative.
   - Identify barriers and challenges to implementing new models that may require special considerations or exemptions to Payment Reform Sub-Committee.

Desired Outcomes

Payment reform has two primary goals: to control unnecessary spending while promoting positive outcomes. Desired outcomes must reflect the interdependence of these dual purposes.

1. Reduction in avoidable hospital admissions, emergency room admissions, and unnecessary care.
2. Reduction in cost shifting from the public sector to private purchasers.
3. Increase in provider payment arrangements based on quality outcomes.
4. Slower growth in health care spending.
5. Enhanced transparency of provider performance data for use in consumer and purchaser decision making.

VII Align Policies and Systems

Many factors influence how well our healthcare system works to improve the health of Mainers. There must be a qualified workforce to meet the needs of a changing population and delivery system. As the State emphasizes and expands access to primary care, we must adopt new skills and better use the existing education, training and competence of health professionals to the fullest extent possible. We also must assure that expanded insurance coverage brings with it access to oral health and health care services in our rural areas. Our regulatory system must be sufficiently nimble to encourage innovation in how services are delivered and reimbursed while also steadfast in protecting the public's interest and safety. We must have accurate and timely information to support clinical management, payment arrangements, and consumer and purchaser decision-making. Data also must be available to evaluate our progress in achieving desired outcomes and to assess geographic, economic or ethnic disparities that remain, and to inform workforce planning and development.

This chapter is divided into four sections: Workforce, Data, Health Information, and Certificate of Need. A summary of the issues, findings, action steps and desired outcomes are presented for each.

Workforce

The Maine CDC's Health Workforce Forum was established by the Maine State Legislature in 2005 to review current health workforce data and recommend policy and planning changes needed to assure a qualified and sufficient health professional workforce. This multi-disciplinary group of health professionals, employers, state licensing boards, health educators and Department of Labor and Health and Human Services administrators recently completed a recommendations and progress report with a *Recommendations Guide to Ensure an Adequate Supply of Skilled Health Professional in Maine.* Their guide sets forth immediate and long term actions to coordinate training, employment and regulatory practices that will utilize current workers and prepare future workers to fill positions and skills gaps in shortage areas and occupations to support our transition to a healthcare system based on prevention, primary care and evidence-based clinical decision making. Aware that our resources must be used wisely, the report calls for a review of scope of practice acts and workforce regulations necessary to meet professional, employer and patient needs in the most effective and efficient way possible.

The Governor's Task Force on Expanding Access to Oral Health Care for Maine People set forth a series of recommendations in 2008 to increase access to oral health care throughout the state.[7] As found in our study of emergency department use, dental disease and the medical complications that follow are a major cause of inappropriate visits to emergency rooms, especially among our MaineCare members.

Maine's public education and workforce development systems, private institutions, and Maine's network of Area Health Education Centers offer significant statewide resources to supply and support Maine's health workforce needs. An *Act To Encourage Maine Residents To Attend Medical School and Practice in Maine* creates the Doctors for Maine's Future Scholarship Program, which provides tuition scholarships for Maine residents to support their medical educations at Tufts University and the University of New England. Participating educational institutions in Maine include the Maine Medical Center, A related program is under development between Eastern Maine Medical Center and the University of Vermont. Pharmacists have a growing role in the provision of safe, effective and efficient health care. The first class of doctoral students at the University of New England's School of Pharmacy began classes Fall, 2009. A pre-pharmacy undergraduate program enrolled its first class in 2007. Clinical training

[7] Maine Department of Professional & Financial Regulation, Report of the Governor's Task Force on Expanding Access to Oral Health Care for Maine People, submitted to the Joint Standing Committee on Business, Research and Economic Development and the Joint Standing Committee on Health and Human Services pursuant to Executive Order 06 FY 08/09. December 1, 2008.

and research partnerships have been established with multiple health care facilities, community hospitals, and pharmacies.

The federal National Health Service Corps program provides $50,000 in student loan repayment to physicians, nurse practitioners and other providers in exchange for two years of services in one of Maine's 222 facility, population-based or geographically-based health shortage areas. If a bond issue for the creation of a dental school in Maine is approved by the voters, new resources will be made available in the state to address dentist shortages.

Federal grants and state appropriations are supporting program development in University and Community College science, technology, engineering and math disciplines as well as, allied health, nursing, nurse practitioner and advanced practice training programs. Private institutions are expanding pharmacy, physician residency, dental and physician assistant programs, and Maine's Area Health Education Centers are working with academic and community partners to provide clinical training and continuing education to medical and other health professionals and students. These resources offers opportunities to supply, prepare and re-tool our health care workforce in the skills and practices needed to transform into a Patient-centered primary care system, and address our emerging public health and health information technology workforce needs.

Major Findings

Our efforts to date have focused on the identification of current and projected shortages in a number of health occupations and strategies for coordinating our systems, policies and practices to ensure an adequate supply and distribution of skilled health professionals to provide accessible, quality care and efficient, cost effective services.

- Over 30 percent of all dentists in Maine are over the age of 60, and over 68 percent are over the age of 50.
- One out of every five physicians in Maine is at or nearing typical retirement age.
- Registered nurses in Maine are older than the national average, averaging 48.9 years of age.
- The distribution of health care workers, occupations, skills and clinical experience is a significant issue in Maine.
- The healthcare industry is the largest in Maine with an average of 84,200 jobs in 2008, accounting for 14 percent of all wage and salary employment. As Maine shifts the focus of our health care system from acute and specialty care, and expands electronic records/health information technology, attention must be given to using and supplementing the skills and experience of incumbent and displaced workers, and to collaboratively plan with education and training programs to ensure employee and student access to relevant, competency-based academic and clinical training programs.

Action Steps

Addressing Maine's health workforce needs and issues will require a strategic and coordinated development plan that takes into account the dynamics of state and regional health service needs, the economy, health policies, licensing and regulatory policies, the demographics and distribution of the current workforce, employers, the education and employment systems and their pipeline of students that supply the future workforce.

GOAL VII.1 - Ensure an adequate number of qualified professionals to provide accessible, quality and cost effective health care.

The *2009 Recommendations and Progress Report* of the Maine Center for Disease Control's Health Workforce Forum provides the foundation for a strategic planning process and state health workforce development plan. Their Report underscores the need to identify priorities and establish the leadership to oversee Maine's health workforce planning, research and development initiatives that is aligned with health reform and service needs and regional resources, and has the long term and cross-system support necessary for comprehensive planning and coordinated implementation of evidence-based workforce and professional practices. The Forum's strategic planning process includes the identification and engagement of key stakeholder, to include the organizations responsible for implementing workforce development initiatives. The Forum will continue to have the primary functions to convene stakeholders, build cross-system partnerships to support workforce initiatives, assess workforce needs and issues, and to gather and disseminate information. We hope to support this work through federal health reform funding, as appropriate.

Tasks

1. The Health Workforce Forum's Steering Committee will review findings of the Forum's Report with a designated point of authority in DHHS and the Advisory Council for Health Systems Development to confirm and prioritize strategic objectives and workforce development activities, and to determine the appropriateness of the Health Workforce Forum serving as the advisory group to oversee workforce planning efforts by Fall, 2010.
2. The Health Workforce Forum's Steering Committee will initiate a communications, membership outreach, and organizational development and implementation plan by Fall 2010 – December 2011
3. Maine DHHS will review and amend as necessary statutes (Title 2, section 257) to authorize the Forum's purpose, structure, work plan/timelines, and reporting responsibilities by Fall 2010/Spring 2011.
4. Maine DHHS will assess and secure statute terms and resources to continue, improve and coordinate the collection, analysis and reporting of health workforce data by the Department of Labor, Office of Data Research and Vital Statistics, and the Office of Licensing and Regulatory Services by Fall 2010 – December 2011.

5. The Health Workforce Forum will develop a Workforce Plan to guide the recruitment, retention and training of a qualified work force to meet the needs of the people of Maine. Special focus should be given to ensuring sufficient resources for the enhancement of Maine's emerging public health system and the primary care workforce including all members of the team – physicians, nurse practitioners, physician assistants, nurses, medical assistants, behavioral health providers, and health IT specialists.
6. The Health Workforce Forum will develop a sub-committee to address the need for cultural competence among health care providers and the use of auxiliary workers to enhance access to health care, such as medical interpreters, cultural brokers, community outreach workers, peer-to-peer support programs and translators.

GOAL VII.2 – Integrate comprehensive oral health care into overall health care and expand access to such care.

We know that oral health is a critical part of overall health. Poor oral health leads to tooth decay, periodontal disease, partial or complete tooth loss, chronic oral conditions, poor nutrition and speech impairments, decreases quality of life, and often has a negative effect on employability. The impact of oral health on overall health and its relationships to systemic health and to many chronic health conditions has become increasingly well documented. Poor oral health contributes to increased visits to hospital emergency rooms and the high costs related to those services, as well as to the overall costs of health care.

There is a general need to increase understanding and recognition of the importance of oral health to overall health and to integrate oral health concerns into broader health programs. Both the Governor's Task Force Report and Maine Oral Health Improvement Plan emphasize that oral health promotion and dental disease prevention programs are a cost-effective way to reduce the incidence and prevalence of oral and dental diseases, and to contain and reduce costs associated with their treatment. Both documents also suggest that oral health services can be delivered more effectively and with maximum quality by enhancing partnerships and collaborations within the existing oral health infrastructure, along with the development of new or alternative dental providers.

Tasks

1. Maine Center for Disease Control working with Department of Education, medical and dental professional organizations, and stakeholder entities by June 2012
   - Develop and maintain community based approaches that include coordinated public education strategies to increase understanding of the importance of oral health and preventive practices.
   - Use relationships with Healthy Maine Partnership organizations, regional public health districts, and school health education initiatives for coordination and dissemination of messages.

- Promote messages across health care organizations related to oral health integration (e.g., cardiology, teams of health professionals treating cancer patients, OBGYNs, services to aging population) and develop systems to support oral disease prevention and oral health integration.
- Encourage appropriate organizations within and outside of state government to incorporate oral health content with other health messages, for example, those that could promote the integration of oral health promotion messages into existing cancer prevention and tobacco-use reduction efforts.
- Promote the development of policy and environmental changes that in turn promote oral health.

2. Maine Center for Disease Control working with dental professional organizations and stakeholder entities – June 2012
   - Identify innovations and enhancements to the health care infrastructure that facilitate integration of the delivery of oral health care services with overall health care.
     - Promote and/or facilitate training for primary care health providers in basic oral health concepts, screening and assessment, and interdisciplinary training for dental and non-dental health providers to enhance their mutual understanding of integrating oral health and overall health for better patient outcomes.
     - Use best practice and evidence-based approaches to develop demonstration and/or pilot programs to test out the applicability of innovative programs to Maine.
     - Explore mechanisms or models and funding for collaborations between hospitals and health care systems, and dental providers to integrate/facilitate access to dental services.
     - Incorporate oral health objectives and activities into Maine's public health district structure.
     - Continue to include a specific section for oral health in Maine's State Health Plan.
     - Encourage professional associations to regularly and collaboratively provide interdisciplinary training opportunities.

3. Maine Primary Care Association
   - Assess existing oral health capacity and shortages in Maine's community health centers.
   - Develop strategy to expand effective and efficient oral health care in those settings.

GOAL VII.3 – Increase access to oral health care through the support, education and training of dental hygienists, denturists and other health professionals.

Access to oral care is limited, especially in our rural areas and among vulnerable populations. In addition, as found in Maine's Emergency Use Study, "access barriers to dental care resulting in a high volume of emergency department visits arise both from financial barriers and provider shortages." The Report of the Governor's Task Force on Expanding Access to Oral Health Care for Maine People suggests that the state's dental hygienists and denturists may be under-used in addressing oral health needs in Maine. Furthermore, we have yet to fully test the contribution of technology in bringing skills and consultative services to under-served areas. The following tasks to increase support and use of dental professionals were identified in Maine's Oral Health Improvement Plan, published in 2007, and by the Governor's Task Force in 2008 and remain relevant today.

Tasks

1. Maine Center for Disease Control and Prevention's Health Workforce Forum, working with the MCDC's Oral Health Program, dental professional organizations, the Department of Education, FAME, the Maine Technical College System and others – by June 2012
   - Increase effectiveness of the dental workforce by redefining and expanding the roles of dental and medical professionals, within and according to their respective scopes of practice.
   - Promote and support distance learning technology to provide dental professional training programs more broadly throughout Maine.
   - Promote expansion of dental professional educational loan forgiveness programs, especially for those serving at-risk and underserved populations, including in Maine's free dental clinics.
   - Support the expansion of Expanded Function Dental Assistant training programs, and encourage the use of uniform (core) curricula by all teaching institutions.
   - Encourage the expansion of dental professional education loan forgiveness programs, especially for those serving at-risk and underserved populations.

2. Department of Professional and Financial Regulation with the Maine CDC, dental professional organizations, and stakeholder entities – by 2012
   - Work with dental professional associations and other stakeholders to identify appropriate expansions of existing scopes of practice and/or new or alternative dental providers, for the purpose of increasing access to and efficiencies in the delivery of dental care.
   - Develop the role(s) and educational pre-requisites for a new or alternative dental practitioner and alternatives for the establishment of appropriate education and training programs in Maine, through the collaborative efforts of professional associations of dentists, dental hygienists and denturists.

- Develop a model (or models) for the delivery of oral health services that will ensure the integrity of the dental team approach to providing quality and cost-effective oral health care while also expanding access to care.
- Report to Advisory Council for Health Systems Development on progress by January 2012.

Desired Outcomes

- People understand the importance of oral health.
- Oral health is effectively integrated into prevention and primary care.
- Maine has a sufficient and qualified workforce that uses the skills, experience and competencies of workers.
- Maine people will have improved oral health that positively impacts learning in children, adult employment and overall health.

Data

Maine must have a robust data infrastructure to support our efforts to monitor and improve health system performance and to implement financing and delivery system reforms. While Maine has been a leader in the collection and use of clinical and financial healthcare data, improving this resource is vital for implementation of health reform. We must enhance our capacity to use health data to support health care providers and systems, purchasers, government, and researchers to understand the performance of the health system in Maine at all levels. Although some data will be available from national sources, our ability to support state and regional analysis of health system performance will depend on having coordinated, integrated, and efficient health data systems.

Major Findings

- Maine has been a leader in developing hospital inpatient and outpatient all-payer claims databases and developed an early reputation for its use of hospital data for understanding variations in health care use and outcomes.

- The timeliness and efficiency of the all-payer data system have been problematic with significant lags in the availability of data and reports.

- Until recently there has been limited use of the all-payer data. There is a prevailing view that access to timely use of the all-payer data is hindered by (a) lags in receiving and producing the database, (b) the high costs associated with use, and (c) the limited analytic and research capacity in Maine.

- The implementation of Maine's Health Information Exchange has raised questions regarding whether and how clinical data that could be extracted from the Exchange might be linked with claims to produce a more robust source of data for understanding quality and efficiency. Currently, national provider identifications are not collected as part of the HIE data and these data will be necessary if the clinical and claims data are to be accurately linked. In addition, the unencrypted patient names in the clinical data will need to be rectified with the encrypted member names in the claims data.

- In addition to the hospital data, all-payer claims, and HIE data, Maine has multiple other sources of important health data that are critically important but largely uncoordinated. These include data and data systems that reside in the Maine CDC, DHHS MaineCare, behavioral health and other offices in DHHS. There are also recurring population surveys such as the Behavioral Health Factor Surveillance System (BRFSS) and the annual Children's Health Insurance Program (CHIP) survey, that collect a variety of data on health status, health risks and behavior, and healthcare access data, and health workforce data, among others.

- Maine also lacks complete and reliable data to better understand and eliminate health disparities

- The Maine Department of Labor 2006 and 2007 health occupations reports provide sector and employment information to characterize the dynamic nature and challenges of workforce and health sector analysis. To build on the information in these reports and to determine the effectiveness of implemented strategies, a more clearly defined research plan is needed to prioritize and direct the collection and analysis of workforce data and evaluate recommended strategies.

Action Steps

Goal VII.4: Develop a roadmap for continuing to build Maine's health data, analysis, and research infrastructure to support health care payment, delivery system reform, workforce development, and health system performance monitoring to improve health status.

Tasks

1. Advisory Council for Health Systems Development – December 2010
   - Under the auspices of the Advisory Council for Health Systems Development, convene and staff a Health Data Workgroup representing the Advisory Council, Maine Health Data Organization, health plans, healthcare providers and systems, purchasers, Maine Quality Forum, CDC Health Workforce Forum, Health InfoNet, Office of the State Coordinator, Governor's Office of Health Policy and Finance and consumers.
   - Conduct an inventory and assessment of current health data sources and systems (including policy and legal basis) and data production and analysis capacity
   - Identify and assess models from other states for organizing, funding, and using health data for system performance monitoring and evaluation. Develop a vision for Maine's health data and data use infrastructure.
   - Identify technical, organizational, policy/legal, financial, and other gaps and barriers in Maine's health data systems and capacity.
   - Develop a roadmap of policy or other actions needed to move Maine toward the health data and data use infrastructure that will be needed.
   - Develop data sharing agreements with Maine's tribes and other communities reluctant to share data necessary to understand and address Maine's health disparities.

Goal VII.5 Improve and enforce the collection of data that will enable Maine to assess and eliminate disparities in health status and service use.

Hospitals, per Ch.241-Uniform Reporting System for Hospital Inpatient Data Sets and Hospital Outpatient Data Sets, must report race and ethnicity data. These data are frequently missing and are essential in analyzing health disparities in Maine. There is a need to educate hospitals about collecting the data, how the data will be used, and assure the accuracy of the data that is being submitted.

Tasks

1. Maine Health Data Organization and the Maine Hospital Association- by September 2011.
    - Identify current legal and regulatory requirements (State, Federal, local) for the collection and reporting of race and ethnicity data from hospitals and other health care provider organizations and report on baseline data, and identify barriers and opportunities for improvement.
    - Collaborate with hospitals, consumers, community health centers, providers, health systems, government agencies, universities, and others to develop and implement strategies to increase the standardization and accuracy of race, ethnicity, and language data collection[8] and the application of findings to help eliminate disparities in health status and health service use. Ensure that this collaborative process includes a comprehensive group of stakeholders, including individuals and organizations with insight and expertise regarding Maine's racially and ethnically diverse populations.

Goal VII.6 Support and improve data to assess workforce shortages and supply and to evaluate the impact of interventions.

Currently multiple organizations and agencies have responsibility for the collection and an analysis of data which can be duplicative, inefficient and, when viewed in isolation, may not provide an adequate and accurate assessment of Maine's workforce needs.

Tasks

CDC Health Workforce Forum, Department of Labor, Office of Licensing and Regulation, Maine CDC, educational institutions, Vital Statistics and Muskie School

- Complete an inventory of available data and sources that are currently being collected of and about Maine's healthcare workforce.
- Determine gaps, redundancies and inefficiencies in the collection and use of that data.
- Develop a strategy for streamlining and enhancing the use of workforce data to inform decisions about health workforce planning, policies, practices and opportunities.

[8] 2009. Institute of Medicine Subcommittee Consensus Report. Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement. Board on Health Care Services (HCS)

Desired Outcomes

1. Determination of Maine's health data systems and policy, regulatory and/or other changes needed to address identified gaps.
2. Strategy and implementation work plan for enhancing data capacity.
3. Improved consistency, quality, timeliness and usefulness of health workforce data.

Health Information

Efforts to reduce costs, improve quality and extend access are predicated on the ability of a treating clinician to have real-time access to a person's health information. Health information exchanges facilitate the sharing of electronic health information by providing the services and technology that allow providers (including physicians, nurse practitioners, nurses, mental and behavioral health providers, hospitals, laboratories, and public health agencies) to receive information about patients from other providers' records. Passage of the federal HITECH Act provided an unprecedented opportunity to advance adoption and use of health information technology in Maine. The goal is to harness the power of HIT to improve quality and efficiency of health care for individuals and the population as a whole. Maine has been a leader in health information exchange with one of three functional exchanges in the country. After nine months of a demonstration phase, HealthInfoNet has over 700,000 individuals (over 50 percent of the state's population) in the exchange. The long term goal is to have 100 percent of hospitals and 80 percent of the primary care system to have access to the exchange by 2015 and for healthcare systems to be exchanging information in a meaningful way across providers. The details of this plan can be found at http://www.maine.gov/HIT.

In March 2010, Governor Baldacci signed an executive order creating the Office of the State Coordinator for health information technology which will serve as a clearinghouse for assuring coherent and collaborative cross-agency planning, disseminating public information about healthcare information technology through partnerships with stakeholders, and working collaboratively with the state's designated health information exchange, HealthInfoNet. A Health Information Technology Strategic Plan was developed by the Office of the State Coordinator with a workgroup and vetted by the HIT Steering Committee. The draft plan includes an outline of the state's HIT infrastructure and a governance structure to address security and privacy concerns related to exchange of health data.

As clinical data become more robust and widespread adoption of electronic systems more commonplace the value of health information exchanged throughout the state will be recognized by increased efficiencies, reductions in errors, and greater safety. The system improvements realized through better use of information and information systems include, but are not limited to:

- Expanded access to care for all Maine residents;
- Improved coordination of care and communication among providers and patients across all health delivery systems;
- Improved transparency through assessment and reporting of quality of care, patient experience, and health outcomes.
- Reductions, of unnecessary and/or duplicative medical testing;

- Lower costs and greater quality care; and
- Connection to Maine's public health system for increased public safety, availability of community based public health resources to prevent and/or manage chronic disease at point of care, coordination of immunization efforts, use of clinical data for reducing unwarranted variation in care and to better inform health system planning.

Major Findings

1. The HiTech Act presented an unprecedented opportunity to invest in health information technology capacity building. Maine received significant funding to build its HIT infrastructure:

    - $6.6 million was awarded by the Office of the National Coordinator to the Governor's Office of Health Policy and Finance to (1) build a statewide health information exchange; (2) develop policies and governance to assure a standard based system that is secure and private and supports the meaningful use of health information technology is sustainable for the foreseeable future. Most of the funds are sub-contracted to HealthInfoNet.

    - HealthInfoNet, the state health information exchange, was awarded a $4.7 million dollar grant by the Office of the National Coordinator to provide technical assistance to ensure the successful implementation and meaningful use of electronic health records for the purposes of health care quality improvement.

    - Eastern Maine Health System was awarded by the Office of the National Coordinator a $12.7 million dollar grant to implement a community based demonstration showing how health information technology and coordination among community providers will result in improved efficiency, effectiveness, and quality. The collaborative nature of EMHS' application, which included the active involvement of federally qualified health centers, was key to the applicant's success.

2. MaineCare received a $1.4 million planning grant from CMS to produce the State of Maine's Medicaid HIT roadmap that describes the steps necessary to implement the State Medicaid HIT Plan.

3. Kennebec Valley Community College received a $400,000 grant to provide health information technology training. The training is envisioned to add capacity to the state's HIT workforce.

Action Steps

Goal VII.7 Align state health information technology efforts to achieve efficient and effective health care delivery.

Tasks

- MaineCare and the Office of State Coordinator, with advise from the HIT Steering Committee, will align the 2010 HIT Strategic Plan and the MaineCare HIT Plan by June 30, 2010
- MaineCare will submit a finalized MaineCare HIT Plan to the Centers for Medicare & Medicaid Services (CMS) to qualify for funding to implement MaineCare's HIT incentive program by 9/30/2010.
- The Office of State Coordinator and HealthInfoNet will coordinate technical assistance by the Regional Extension Center to maximize provider opportunities to receive incentive payments by CMS for achieving meaningful use by 12/31/2010.
- The HIT Steering Committee will coordinate with Eastern Maine Health Systems to transfer lessons learned from the Beacon Community Program to other healthcare systems by 12/31/2012.
- The HIT Steering Committee will coordinate with Kennebec Valley Community College and the Department of Labor on reaching training goals of the HIT Training Program 12/31/2011 .

Goal VII.8: Assess the current status of health information technology in Maine.

Tasks

- The Office of the State Coordinator and MaineCare will work with the Muskie School to establish a baseline of health information technology infrastructure in the state that can serve as a baseline for monitoring progress 8/31/2010 .

Goal VII.9: Assure the security and privacy of health information.

Tasks

1. HealthInfoNet and the Office of State Coordinator
   The Privacy and Security Sub-committee, a multi-stakeholder group representing consumers, health systems, and healthcare advocacy organizations in coordination with the Consumer Advisory Committee, will conduct quarterly reviews of policies, procedures, and performance of the health information exchange to assure that the health information exchange meets federal Health Insurance and Portability Accountability Act (HIPAA) requirements and standards; and that policies and protocols for assuring that all health care information shared and stored electronically adhere to the most strict privacy, security, and confidentiality requirements as defined by the collaborative work of HealthInfoNet, the State Government (including the

Attorney General) and where possible the guidelines provided through federally supported projects. Quarterly reviews to begin in July 2010.

2. The Office of the State Coordinator
   A study will be conducted of state and federal healthcare laws to determine inclusion of protected groups in the health information exchange without violating confidentiality of protected information. The study will begin in August and conclude December 2010. The results of the study will inform any recommendations for changes to state statute to be brought to the Legislature in 2011.The process involves a review of statutes by the Legal Work Group with recommendations reviewed and input by the Consumer Advisory Committee and the Health Information Technology Steering Committee (HITSC) before any presentation to the legislature in the first session of 2011.

Desired Outcomes

- 90 percent of all hospital beds will be in the HIE by 1/15/2011
- 99 percent of all hospital beds will be in the HIE by 1/15/2013
- 100 percent of FQHC's in the HIE by 12/30/2012
- 100 percent of large affiliated group practices in the HIE by 12/31/2012
- 80 percent of ambulatory care practices in the HIE by 2015

Certificate of Need

Under the State's certificate of need statute, the State Health Plan must guide determinations on the level of capital investment Maine will make in health care each year as well as guide the approval of applications seeking to expand existing services or facilities, the establishment of new services, or substantially reduce capacity of certain types of providers. Specifically, the law requires that a certificate of need application or request for public financing cannot be provided unless the project meets a range of statutory requirements and is consistent with goals explicitly outlined in the State Health Plan.

Certificate of Need

Certificate of Need is a regulatory program currently in effect in 36 states and the District of Columbia that reviews and either approves or denies certain types of projects undertaken by health care facilities. In Maine, certificate of need review is required for the expansion of existing services or facilities that cost more than a certain amount, the establishment of new services, or substantial reductions in capacity of certain types of providers. Underlying the purpose of certificate of need determinations is the desire to control costs, especially unnecessary capital costs, assure quality, and maintain access, particularly for underserved populations. Historically, certificate of need has been a reactive function. Today, certificate of need has a role in providing proactive guidance and incentives to encourage the transformation of the status quo into systems of care that can provide a continuum of services across providers and settings, prospectively manage budgets, and be held accountable for quality outcomes.

The Capital Investment Fund

One of the constraints the law puts on certificate of need is three-year limit – called the Capital Investment Fund (CIF) – on the third year operating costs *(i.e.,* the annual cost to the health care system once a project is fully implemented). Its purpose is to ensure that the infusion of new capital into Maine's health care system remains balanced with Maine's ability to financially support the added costs of those new investments.

The CIF is determined annually by the Governor's Office with review and comment by the Advisory Council for Health Systems Development and after public comment following a process set out in regulation and approved by the Legislature. Depending on the costs of proposed projects, the CIF may or may not be large enough to accommodate approval of all pending applications, reinforcing its purpose as a cost containment tool.

Major Findings

- In years 2-4 of the Capital Investment Fund (2006-2008), an average of 7.1 percent of the CIF was not expended. In year 5 (2009), 48.9 percent of the CIF was not expended.

- The average amount that has been approved under the last five years of the Capital Investment Fund is $8.2M. This is 33 percent below the annual average in the eight years before the Fund went into effect.

Action Steps

Goal VII.10: Advance state priorities and reduce costs through provider incentives under the state's certificate of need program.

The ***Health Initiatives for System Savings*** program (HISS) will be established to further the goals of the State Health Plan while benefiting hospital providers who voluntarily engage in priority initiatives when no certificate of need is required. The HISS program provides a credit toward an applicant's future capital investment fund charges for an approved certificate of need application. The initiative is a voluntary collaboration between an applicant, the certificate of need unit and the Advisory Council on Health Systems Development in a way that moves health systems voluntarily to systems redesign that reduces the cost of health care.

The amount of the credit will be based upon documented savings, generated by an applicant, through new or expanded activities identified as priorities in the State Health Plan. Additionally, HISS applicants could receive priority review by the certificate of need unit off-cycle. HISS eligible projects are those which create measurable, quantifiable savings that do not otherwise require a certificate of need.

Process

1. Healthcare providers may propose new or expanded activities that meet one or more of the following priorities of the State Health Plan:

    - Advances in telemedicine activities between hospitals and nursing facilities or between hospitals that improve access to medical care while reducing patient transfers and re-admissions.
    - Reduces avoidable and non-emergent emergency room use in the service area.
    - Creates lower cost alternatives to emergency room use through improved access to primary care with evening and weekend hours.
    - Addresses state-identified cost drivers, such as potentially avoidable hospital admissions, high variation service use, high cost outpatient services.
    - Creates measurable efficiencies for health systems that will drive down service use and cost for all payers or in ways that do not cost shift to other payers

- Redirects low volume, high cost services to create efficiencies for all payers or in ways that do not cost shift to other payers.
- Achieves savings through applied use of health information technology.

2. The Healthcare Provider would propose the State Health Plan priority being addressed including:
   - The health care system that will be impacted, benchmarks, systems savings (must be measurable, quantifiable savings to all payers and consumers or in ways that do not cost shift to other payers or increase costs in other services); and

   - Expected service use and methodology for measuring savings and other outcomes including all assumptions. Savings must be generated within one year of approval. Projects shall, at a minimum, propose $200,000 in systems savings (operating costs) and will receive a Capital Investment Fund credit, dollar for dollar on a future certificate of need project. Savings must assure that all payers benefit so that no cost shifting or increase in other services results from the initiative. The credit will roll forward and will not expire.

3. The Certificate of Need Unit will review the HISS proposal for demonstrated system savings and present a summary to the Advisory Council for Health Systems Development for review and comment on whether the project furthers the goals of the State Health Plan.

4. A credit in the amount of actual documented savings generated will be established for the healthcare provider or system. The amount of this HISS credit can be used by the healthcare provider or system to offset charges to the capital investment fund on future projects. The certificate of need unit would report the results of the HISS program in the CON Annual Report.\

5. After one year of implementation, the Advisory Council for Health Systems Development will evaluate the impact of the Health Initiative for Systems Saving, with respect to cost savings, access, and patient experience.

Goal VII.11: Assure that projects approved for certificate of need are consistent with the goals of the State Health Plan.

Maine statute requires that a certificate of need application cannot be approved unless the project meets a range of statutory requirements and is consistent with goals outlined in the State Health Plan. The purpose of this goal is to provide clear guidance to DHHS and applicants regarding project attributes that will be deemed a consistent with the goals of the State Health Plan, and to prioritize the capital investment needs of Maine's health care system within the Capital Investment Fund in the event that there is not enough room under the Fund for all meritorious projects to be approved. As discussed in Section VI, the incentives created by adding these criteria to certificate of need reviews would be greatly strengthened by payment reforms which do not reward providers financially for increasing the volume of services provided.

The order of the following attributes does NOT reflect the relative order of importance of each attribute, as different attributes might be needed to different degrees in different circumstances and geographic areas. Projects that meet more of these attributes will receive higher priority than projects that meet fewer of these attributes. These criteria do not apply to nursing facilities.

1. **The applicant redirects resources and focuses on population-based health and prevention.** This includes addressing – at a population level as opposed to an individual patient level – the most significant health challenges facing Maine – cardiovascular disease, cancer, chronic lung disease, diabetes, depression and substance abuse.
    - "Population-based" means all people in the service area, not just those who become patients. The applicant should ensure that it has accurate and adequate racial, ethnic, and language data and services in order to demonstrate that all populations in its service area are served. It may also be a specific "at-risk" population within the targeted service area.
    - Applicants that include in their application a new, sustainable investment in public health programs/activities or an additional investment in existing programs/activities will be a higher priority than those applicants simply citing extant activities.
    - Applicants hoping to meet this priority should demonstrate the need for the investment by engaging with their local Public Health Districts in community assessments (known as MAPP – Mobilizing for Action through Planning and Partnerships) and the development of district health improvement plans.
    - Applicants proposing new or expanded public health initiatives must include evidence the proposed strategies will: meet community needs, engage the public health infrastructure, are effective evidenced-based strategies, and will effectively evaluate the effectiveness and impact of the initiative. Applicants proposing new or expanded public health initiatives must also include in their application a plan to collect data to report the impact of their new efforts. To meet this priority, applicants citing extant activities must present evidence of the effectiveness of their current efforts, as well as an explanation of why new activities are not feasible and/or necessary at this time.
    - An example of an investment that could meet this priority includes, but is not limited to: the creation of an endowment, the interest from which would support evidence-

based effective efforts, preferably using existing public health infrastructure, for primary and secondary prevention of chronic disease, with the long-term result being a reduction in the need for the services proposed in the application.

- Smaller hospitals or other applicants who do not have as many resources as larger hospitals could meet the priority to make new investment in public health by, for example, establishing a partnership with or making some form of financial or other contribution to existing public health infrastructure with activities in the service area.
- The certificate of need unit may also consider community partnerships as a possible way to meet this priority, provided that the hospitals present evidence of the effectiveness of their proposed and/or extant public health efforts.
- Applicants that demonstrate success in coordinating their activities with local public health infrastructure – thereby leveraging existing resources and avoiding redundant efforts – will receive higher consideration than those who fail to do so.

2. **The applicant has a plan to reduce potentially avoidable and non-emergency emergency room use.** While there no "right" rate of use, data with regard to potentially avoidable and non-emergent emergency room use has important uses for certificate of need application review. It may be an indication that the entire local health care delivery system is not providing the right care at the right place at the right time to treat a person efficiently and effectively. All hospital service areas – whether above or below the state median – have room for improvement. Accordingly, applicants that demonstrate how their project and/or other new or expanded activities proposed by the applicant will lessen potentially avoidable and non-emergent emergency room use in their hospital service area will receive higher priority in the certificate of need review than if it does not.

   A study by the Muskie School and the Maine Health Information Center with funding from the Maine Health Access Foundation found that Maine's emergency department use in 2006 was, in aggregate, about 30 percent higher than the national average, while Health Dialog found that approximately 75 percent of Maine's emergency room use is potentially avoidable, with costs of up to $115 million. The Muskie School study also showed variation in avoidable emergency room use by payor and hospital service area. The full report is available at www.maine.gov/gohpf. **DHHS will use the data in the Muskie School report to assist in evaluating the need for a plan to reduce non-emergent emergency room use in the applicant's hospital service area.**

3. **The applicant demonstrates a culture of patient safety, that it has a quality improvement plan, uses evidence-based protocols, and/or has a public and/or patient safety improvement strategy for the project under consideration and for other services throughout the hospital,** as well as a plan – to be specified in the application – to quantifiably track the effect of such strategies using standardized measures deemed appropriate by the Maine Quality Forum. Measures deemed appropriate include relevant structural, process, and outcome measures chosen from among those approved by the National Quality Forum. In the absence of NQF-endorsed relevant measures, measures developed by medical specialty societies or other medical care quality organizations such as AQA or HEDIS which are related to the project goals should be used.

4. **The project leads to lower cost of care / increased efficiency through such approaches as collaboration, consolidation, and/or other means.** Projects that clearly demonstrate that they will generate cost savings either through verifiable increased operational efficiencies or through strategies that will lead to lower demand for high cost services in the near and long term. These types of projects may include projects that address areas of local duplication, that include collaboration such as envisioned by the Hospital Cooperation Act, that physically consolidate, down-size, or right-size hospitals or services that serve all or part of the same area, and that demonstrate an appropriate, cost effective use for the "abandoned" infrastructure.

5. **The project improves access to necessary services for the population.** Projects that improve access to necessary services – as defined in 22 MRSA 335(7)(C) – that were previously unavailable to the population – or that expand the availability of extant necessary services to populations who did not previously have access to such services – will be deemed as higher priority than projects that do not.

6. **The applicant has regularly met the Dirigo voluntary cost control targets as required under Title 22, section 1722, subsection 1.**

7. **The impact of the project on regional and statewide health insurance premiums, as determined by the Bureau of Insurance, given the benefits of the project, as determined by the certificate of need unit.**

8. **The applicant (other than those already participating in the HealthInfoNet Pilot) has employed or has concrete plans to employ electronic health information systems to enhance care quality and patient safety.** Applications of electronic health record systems might include computerized physician order entry, pharmacy systems, PACS (picture archive and communications systems), and systems which allow information transfer between physician offices and the hospital. Preference will be given to applicants demonstrating commitment and progress toward full implementation of interoperable Certification Commission for Health Information Technology (CCHIT)-certified electronic health records in their institutions to meet the meaningful use standards issued by the US DHHS Office of the National Coordinator for HIT and the Centers for Medicare and Medicaid Services, and a plan for compatibility and integration with the statewide health information exchange. DHHS shall consult with the Maine Quality Forum and the Office of the State Coordinator for Health Information Technology regarding this attribute.

9. **The project meets at least "Gold Standard" certification by the Leadership in Energy and Environment Design (LEED) by incorporating "green" best practices in building construction, renovation and operation to minimize environmental impact both internally and externally.**

10. **All applicants seeking approval for a project that would add high-cost, high-variation outpatient services shall address whether their hospital service area's rate of use of those services is warranted by the population's health needs and how the project will impact use. Any project – regardless of whether it would add high-cost, high-variation services – will receive higher priority in certificate of need review if it includes actions to lessen unwarranted use of high-cost, high-variation outpatient services in the applicant's hospital service area or includes a credible plan to evaluate the impact of the applicant's proposal to less potentially avoidable admissions and unwarranted use of high-cost, high-variation outpatient services and report those outcomes to the certificate of need unit.** The Health Dialog study[9] identified significant unwarranted variation that, if reduced, could save up to $300-$400 million each year. Specifically, this report showed use rates for each payor category (Medicare, Medicaid, and commercial) in each of 24 geographic hospital service areas for the following four potentially avoidable inpatient admissions[10] and five high-cost, high variation outpatient service categories (the amounts shown below are statewide totals (in millions) in 2006 across all hospital service areas and payors in the study):

TABLE 5: HIGH-COST AND HIGH-VARIATION INPATIENT AND OUTPATIENT AREAS

Inpatient				Outpatient	
	Total $(M)	Potentially avoidable		5 Highest cost/var services	**$304.8**
Cardiac-circulatory	$193.3	$56.5	29%	Lab tests	$89.6
Musculoskeletal	$114.5	$18.1	16%	Advanced imaging	$66.6
Gastrointestinal	$86.9	$37.2	43%	Standard imaging	$52.1
Respiratory	$72.4	$52.0	72%	Echography	$32.4
All Other	$446.9	$119.8	27%	Specialty visits	$64.1
Total	$916.0	**$283.6**	31%	All Other Outpatient	$1,011.4
				Total Outpatient	$1,316.2

Desired Outcomes

- Projects are approved under the HISS program that create substantial savings for the system and improve healthcare efficiency and effectiveness.
- Approved certificate of need projects advance the goals of the State Health Plan.

[9] All Payer Analysis of Variation in Healthcare in Maine, April 2009.

[10] Potentially avoidable does not mean hospitals did anything inappropriate in admitting the patient. Rather, it means that for a range of reasons, the entire local health care delivery system is not providing the right care at the right place at the right time to treat a person efficiently and effectively.

VIII Implement Federal Health Reform

Background

In March 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Affordability Reconciliation Act of 2010, legislation that makes major changes to the nation's health care system. National health care reform aspires to universal coverage, improved health care quality, strengthened public health and prevention, and cost containment by promoting shared responsibility among individuals, government, employers, health care providers, and insurers. Key elements include:

- An individual insurance mandate that requires individuals and families to purchase insurance if it is affordable for them;
- Expansion of the Medicaid program to all Mainers and qualifying immigrants earning up to 133% of the federal poverty level or FPL ($10,380 per individual) and federal tax credits to provide insurance subsidies for low- and middle-income earners up to 400% ;
- Requirements that larger employers provide coverage or pay an assessment; incentives for small businesses to provide coverage to their employees;
- Cuts in the growth of Medicare payments to providers and new incentives to promote health care quality, care-coordination, and preventive care;
- Changes in insurance market rules that allow more people to buy and retain private coverage;
- Payment reform incentives and pilots favoring primary care, medical home and global payments;
- Opportunities to improve access to primary care by expanding the number of primary health care settings and the primary health care workforce;
- New taxes on certain health sector business, high-income families, and high-cost health plans; and
- Support for states to improve public health, prevention and health care quality.

While the federal government, through the PPACA, retains control of the implementation of many of the public health and quality initiatives included in the law, national reform relies on states to carry out and monitor many of the major changes, particularly regarding the Medicaid expansion; new insurance market rules; promotion of quality, service delivery and payment reforms; and creating state-level insurance markets called Exchanges. State insurance regulators and the National Association of Insurance Commissioners (NAIC) have been given a significant role in the development of the new federal standards, as well as their implementation and enforcement.

Maine has a long history of health reform and is well positioned to implement the PPACA. Specifically, Maine has been a leader in expanding access to the uninsured through insurance reforms, Medicaid expansions and the enactment of Dirigo Health reform in 2003. In 2009, Maine was one of 13 states to be awarded a State Health Access Program grant from the US

Health Resources and Services Administration. This grant, renewable until 2014, provides funding to develop a voucher program, offered through the Dirigo Health Agency, to uninsured lower income part-time and direct care workers who have access to employer coverage but cannot afford it. Multiple insurance companies will participate in the voucher program providing eligible workers with vouchers supporting a variety of affordable health insurance products. Coupled with the Dirigo Health Agency's current capacity to negotiate on behalf of DirigoChoice enrollees, the experience in this grant of working with multiple insurers and a voucher program provides additional experience to inform Maine's transition to an Exchange, as required in 2014.

Because the SHAP program is a limited 5-year demonstration, a condition of the grant was to develop a plan to ensure sustainability of coverage when grant funds end. The enactment of federal health reform provides just such an opportunity to sustain our coverage initiatives. Using our HRSA grant funds, Maine is able to quickly develop this health care reform implementation plan to implement health reform in Maine and assure that people now covered by various Dirigo access initiatives will continue to have sustainable coverage when national reform is fully implemented.

State reforms instituted in 2003 have improved Maine's uninsured rate to the sixth best in the nation in 2009 (up from 19th in 2003) and the state population's health status to thirteenth best in the nation in 2009(up from 25th in 2003). Through the state Medicaid and Children's Health Insurance Program (CHIP), Maine currently provides generous publicly funded health benefits. MaineCare already covers childless adults, a group not ordinarily eligible, and families at income levels above the federally required minimum. In addition to dramatically improving health care access since 2003, Maine has developed significant health system infrastructure to support reform. Specifically:

- Multiple state agencies and legislative committees are dedicated to overseeing the state's health care system and driving innovation;
- Prior state-level reforms place Maine ahead of the coverage curve and align the state's insurance market regulations with the new federal rules;
- Maine's commitment to quality measurement and data reporting give the state a head start on federal reforms and provide a good foundation on which to build future efforts;
- Newly established public health infrastructure and innovative initiatives such as Keep Me Well and the Wellness Council can be leveraged to further advance individual and employee health programs under federal reform;
- The state already administers health care tax credits, insurance subsidies, a large employer insurance voucher program, and a consumer-focused website through the Dirigo Health Agency; and
- A MaineCare managed care initiative, consistent with PPACA principles, is in the planning stages.

Financing federal reform

The federal health reform law dedicates more than nine-hundred billion dollars over ten years to expand insurance coverage, implement new insurance rules and Exchanges, and support delivery system change. These costs are offset by savings in the Medicare and Medicaid programs and by new taxes on individuals and businesses. The Congressional Budget Office estimates that national health care reform will reduce the federal deficit by $124 billion over ten years. New federal spending for Medicaid and CHIP, in the form of an increase in the rate at which the federal government matches state spending, and for insurance subsidies to help low- and moderate-income people afford coverage, will directly affect Maine's state spending on health coverage for its residents. Federal insurance subsidies for small businesses will also be available to urge small employers to offer coverage. About 37,000 small businesses in Maine could benefit.

Revenue Provisions

Funding for federal health care reform comes in part from several new taxes and assessments on businesses and individuals, and in part from spending reductions, in Medicare, largely by eliminating subsidies provided to insurance companies that run Medicare Advantage plans. Some policy experts predict that new quality, care-coordination, payment reform and service delivery changes will produce additional savings for the government and other payers, but the Congressional Budget Office did not account for most of these initiatives in its cost estimates because their implementation and impact are not yet clear.

Medicare savings come from reductions in the growth in Medicare provider rates and the introduction of a productivity adjustment, which will advantage some providers and disadvantage others. The law restructures the Medicare Advantage program and reduces Disproportionate Share Hospital (DSH) payments under the Medicare program. The law also increases the rebate drug manufacturers pay to state Medicaid programs, with the incremental proceeds (and, in Maine's case, some additional rebate funds as well) going to the federal government and reduced rebate revenues for states.

Revenue will also be generated through new taxes and fees on high-income earners and on certain health sector businesses such as pharmaceutical and medical device companies. The law levies taxes on health insurers, including an excise tax on high cost health plans that will phase in beginning in 2018. Individuals who earn more than $200,000 per year and couples who earn more than $250,000—between 1.5% and 1.9% of Maine taxpayers—will face a 0.9% increase in the Medicare payroll tax on income over that threshold and will owe a 3.8% tax on unearned income such as rents, investments, and dividends.

Maine's role in implementing federal reform

The federal government will provide significant support for states to implement health care reform, but state action and new expenditures will be required in some key areas. Implementing the health reform law will require significant attention and activity by both the Executive and Legislative branches of government in Maine over the next several years. This state health plan chapter frames the most urgent policy issues and tasks identified to date. As the federal government begins to release draft regulations and shape the features included in the PPACA, new policy issues undoubtedly will arise. As described further below, Maine has put in a place a structure within the Executive Branch through its Health Reform Steering Committee and its Advisory Council on Health System Development to implement health reform in a thoughtful and transparent manner. Further, the Legislature has also established the Joint Select Committee on Health Reform. These structures will allow for both the Governor and the Legislature to be well informed of the implications of the health reform law in Maine and to receive comprehensive policy options, analysis and recommendations.

Policymakers in Maine will face the following major policy questions in 2010 and beyond:

1. Will Maine establish a state health insurance Exchange that meets the federal requirements while serving the needs of the individuals, families, and businesses that use this marketplace or allow the federal government to do so? If Maine elects to run an exchange, how will it do so?
2. Whether Dirigo assessment on businesses will be needed and if so, how will it be utilized going forward?
3. Will Maine enforce the insurance market reforms, or allow federal regulators to assume these responsibilities? PPACA does leave the regulation of insurance to states but does so within a federal fallback provision through which federal HHS steps in to enforce the federal insurance requirements if the state fails to substantially enforce them
4. What strategic opportunities can the Maine Medicaid program (MaineCare) take advantage of under the PPACA? How will the eligibility expansions, payment rules and benefit requirements impact the current program?
5. How will Maine coordinate its system for public program eligibility determinations with the exchange given the new federal requirements?
6. What criteria and priorities will guide Maine's pursuit of grants, demonstration projects, and payment reform pilot programs offered through the PPACA?

The state faces numerous other choices about whether to take action on specific policy matters throughout the implementation process during the coming years. These opportunities range from promoting workforce development and wellness and public health and prevention programs to beginning the process of reforming the payment system and implementing innovative care delivery models. While Maine has a responsibility to take some actions due to new federal requirements, the state also has a wonderful opportunity to pursue its own path for reform given the flexibility provided under the PPACA.

This chapter highlights the major policy options delineated above and provides a detailed list of key activities that the state should consider as implementation moves forward in 2010 and beyond. This planning document will serve as a framework – a key document in the implementation of health reform, but identified state agencies will develop their own health reform work plans to direct specific activities identified here that fall within their responsibilities.

Major Policy Options

Maine will need to consider a number of policy options throughout the implementation of the PPACA. This section presents five core areas where significant decision-making will need to occur in the short-term: 1) Exchange governance and infrastructure, 2) Dirigo assessments, 3) insurance reforms, 4) expansion of publicly funded coverage, and 5) payment and system reform and related funding opportunities. Other areas for consideration are presented in the Key Activities section below; as implementation activities begin it is possible that other planning questions will rise to the level of a major policy option.

Exchange

Maine already conducts many of the functions envisioned in an exchange in the Dirigo program. There are several first-order decisions that state policymakers must consider regarding the governance and structure of an exchange. The first is whether Maine will accept responsibility for administering its own exchange. The PPACA provides states with an option to develop and manage their own exchange or to default to the federal government to operate the exchange.

Operating an Exchange

States accepting responsibility for the exchange must establish an American Health Benefit Exchange to serve individuals who receive tax credits as well as others who are purchasing insurance on their own. The law also requires states to establish a Small Business Health Option Programs (SHOP) for employers with fewer than 100 employees. States can opt to operate both of these pooling entities under a single exchange. Unless state policymakers choose to have the federal government regulate insurance in Maine, the Bureau of Insurance would be responsible for reviewing and approving the policy terms and premium rates for the insurance products and regulating the market conduct and financial condition of the insurers offering coverage through the exchange, as it does for other insurance products.

In considering whether to operate an exchange or to default to the federal government, there are a number of issues to consider, including:

- Coordination with other health coverage programs
- Capacity
- Flexibility
- Efficiency
- Uniqueness of market characteristics

It would be advantageous for states to manage their own exchanges for several reasons. It would likely be less complex to coordinate benefits and eligibility across all state programs if the exchange operates in-state. Additionally, although federal standards for the state-level exchanges will be determined, it may be desirable to customize an exchange to best meet the needs of a state's residents. Relinquishing this responsibility to the federal government would likely create more work for agencies required to coordinate with the exchange and may not provide enough flexibility regarding implementation issues that arise.

Potential for Development of a Regional Exchange

Another important decision is whether Maine should establish or join a regional exchange. As with the initial question of whether Maine should administer an exchange at all, considerations include coordination, capacity, flexibility, efficiency and how similar the market characteristics (including demographics of those who will be purchasing through the exchange, number and type of carriers and plans, employer offer rates, etc.).

The advantages of a regional exchange include some economies of scale, in addition to some added portability that could result from having product availability across contiguous states. However, given the ambitious federal timelines, challenges of working across states with multiple state agencies and Maine's differing provider and insurance carrier profiles compared with neighboring states (NH, VT and MA) it is unlikely that a regional exchange would be initially desirable. In addition, federal start-up funds will be available to states and Maine should take advantage of this opportunity initially to build the needed infrastructure-including effective and seamless eligibility systems- for the overall reform activities. This option would not preclude some regionalization of certain aspects of the exchange such as data sharing and opportunities for regional demonstration projects or grants.

Who Administers the Exchange

If Maine decides to implement its own exchange, subsequent choices arise such as whether the state should establish one or more exchanges and where to house the exchange(s). Maine will want to consider its population demographics, carrier market share, provider networks, capacity and resource requirements to determine whether one or more exchanges are warranted. In addition, estimates of the numbers of individuals and businesses expected to enroll in an exchange is important when considering whether to establish one or more exchanges. Whether to establish a new entity or build upon current state infrastructure is the next question that Maine faces. The exchange needs the capacity to accomplish an extensive list of tasks—including (but not limited to) processing applications, confirming eligibility for tax credits, billing premiums, monitoring employer contributions, reconciling payments, developing and maintaining a website, payment of commissions, ongoing marketing and outreach, assuring appropriate consumer protections are in place and developing and maintaining an electronic interface.

The exchange could be housed in a governmental agency. Housing the exchange in a non-profit organization could be perceived by some to be more agile and business-friendly, particularly for the SHOP exchange, but it also further removes the state from important and time-sensitive decision-making. Two separate exchanges would duplicate functions and could lead to added complexity and confusion for consumers. Moreover, Massachusetts experience of fewer than

expected small businesses purchasing through its exchange, may make it unlikely that an entirely new organization focused only on small businesses would be large enough to justify its start-up and on-going operational costs.

Creating a new state agency to house the exchange may be viewed as redundant since so much of the functionality already exists within another state entity. It would also create additional administrative burdens for carriers and others who will be required to report to and/or work with a growing number of state agencies. Another disadvantage is for recipients of benefits who may endure issues with continuity of coverage because of lack of coordination among the various agencies.

Regardless of where it sits, the exchange will require significant interface with other state agencies including, at a minimum, our Medicaid agency, the Bureau of Insurance and Maine Revenue Services.[11] In addition, Maine will want to evaluate the capabilities of organizations that play an intermediary role in our state to determine whether they have some of the needed capabilities to operate various functions of the exchange through a sub-contract.[12] These decisions will be critical in the short-term to meet federal deadlines for establishing the exchange.

Funding to Support Development of the Exchange

One of the many funding opportunities included within the PPACA is federal support to states for the development of the exchange. These federal funds become available within one year of the bill's enactment and continue through January 2015. The Governor's Office of Health Policy and Finance should submit an application for such funding, when it becomes available. This opportunity will allow the state to conduct detailed analysis on the advantages and disadvantages of operating its own exchange, joining a regional exchange or defaulting to the federally-run exchange by the required notification date to HHS of their intention to operate an exchange by January 1, 2013.

Eligibility Determinations

The PPACA requires streamlined eligibility across the Medicaid, CHIP and subsidy programs, providing a seamless point of entry common to Medicaid and subsidized insurance. This will require information system development likely subsidized by CMS.

Specifically, the law directs the U.S. Department of Health and Human Services to establish a system that offers a single application for Medicaid, CHIP, and federal subsidies.[13] Further, the law requires applicants to have the option to apply for benefits and subsidies through a website that provides a comparison of available benefits across plans participating in the Medicaid

[11] Maine Revenue Services is likely to be involved in assisting the exchange in verifying individual and small business eligibility for subsidies based on individual income and employer size.

[12] For example, in Massachusetts the exchange subcontracts with an intermediary to provide sophisticated information technology needs without having to duplicate effort.

[13] The PPACA provides states with the option to develop a Basic Health Plan for individuals between 133-200% of the FPL. If Maine opts to develop such an option, eligibility for the Basic Health Plan must also be included in this streamlining effort.

program and the exchange. The federal law requires that Medicaid and CHIP programs accept eligibility determinations made by the exchange without any further determination. Likewise, the exchange must accept eligibility determinations for subsidies made through Medicaid and CHIP.

Today, the Dirigo Health Agency operates eligibility functions for subsidies and vouchers. The Maine Department of Health and Human Services (DHHS) operates an integrated eligibility system that performs eligibility functions for 26 public assistance programs, including MaineCare, Cub Care (CHIP) and Maine's prescription drug programs, and also including TANF and the Supplemental Nutrition Assistance Program. This integrated eligibility system provides streamlined "one-stop" access to services for Mainers that is not available in most states. DHHS is in the process of developing a web portal to its integrated eligibility system that will provide an electronic option for eligibility determinations, enrollments and re-certifications.

Specific policy questions to be answered include:

- Will the current web-portal activity being undertaken by DHHS accommodate the requirements under the PPACA that requires streamlined, on-line eligibility for subsidies and/or MaineCare be accessible to all?
- Will the web-portal serve as the only entry into the system or will there be other methods for eligibility applications to be accepted (e.g., provide for a "no wrong door approach")
- What modifications need to be made to the state's current eligibility system to provide for streamlined eligibility? What resources are needed? How long will such system modifications take to make?

In addition to deciding where eligibility determinations are made, Maine will also need to analyze its current determination of eligibility to meet the new federal requirement that eligibility be based on modified gross income and the elimination of an asset test for nonelderly applicants. The PPACA provides a specific definition of Modified Adjusted Gross Income, including an across the board 5% income disregard, and prohibits states from utilizing any other income disregards when determining eligibility, premiums and cost-sharing.

Longer Term Decisions

In the longer term, the state will have the opportunity to consider the impact of the exchange on health coverage generally and the insurance market specifically. First, in 2017, Maine will have the opportunity to consider seeking a five-year waiver from the federal government permitting the state to opt out of certain new health insurance requirements if the state is able to demonstrate that it provides universal coverage that is as comprehensive as the coverage required under an exchange plan and that such a waiver would not increase the federal budget deficit. Assuming the state determines it would like to maintain the federal health reform construct, the state also may want to consider how to implement the requirement that plans must be allowed to sell outside the Exchange. It is conceivable that a State could require any product sold outside the Exchange to be sold within it as well but states will need to await further federal guidance. Many of the first-order policy decisions outlined above should occur within a 6-month time frame. Maine will want to well prepare itself to respond to the federal government regarding

start-up exchange funds and seek to influence implementation decisions at the federal level. Once the high-level decisions are made, Maine can begin to contemplate the myriad of smaller policy decisions inherent in getting the exchange up and running.

It must be noted that all deadlines established in this chapter are subject to change, pending additional federal guidance

Goal VIII.1: To assure timely, effective and transparent implementation of PPACA in Maine

Task 1: The Health Care Reform Implementation Steering Committee will develop option papers, with guidance from ACHSD, identifying and analyzing policy options to provide recommendations for the Governor and Legislature.

Decision Points – Exchange

Date	Action
By 12/31/10	Decision to create exchange, and whether one exchange or two
	Decision on where exchange should be housed
	Form planning group to develop exchange; create work plan
By 6/30/11	Secure federal planning funds
By 1/30/12	Begin efforts to modify state eligibility systems, as needed to comply with federal law
By 1/1/13	Enact legislation creating exchange
1/1/14	Launch exchange

Dirigo and the Federal Financing of Reform

A central feature of the PPACA is the additional federal funding that will be available to support expansions in MaineCare coverage and to subsidize the purchase of private insurance for low- and moderate-income people not eligible for public coverage. The new federal dollars will supplant some and possibly all state subsidies available through DirigoChoice, and thus raise important policy questions about Dirigo's existing funding mechanism.

Dirigo Financing

DirigoChoice provides subsidized health insurance premiums on a sliding scale for individuals and families with incomes up to 300 percent of the Federal Poverty Level (FPL).[14] The Dirigo subsidies are funded by a 2.14 percent assessment on claims paid by Maine health insurers and by third party administrators who run self-insured plans. The assessment is expected to generate $42.1 million in State Fiscal Year 2010.

[14] The 2010 federal poverty level for an individual is $10,830 and $18,312 for a family of three.

New Federal Subsidies

Beginning in 2014, federal premium credits will subsidize the purchase of health insurance through the Exchange for individuals and families with incomes between 133 percent and 400 percent FPL. The credits are structured so that people at the low end of this range would be responsible for paying 2 percent of their income toward a premium; at the upper end, 9.5 percent. There are also subsidies available to help people up to 250 percent FPL to pay their deductibles and copayments. Most people with incomes less than 133 percent FPL[15] will be eligible for Medicaid, with enhanced Federal funding.

Many current subsidized DirigoChoice enrollees will be eligible for the new federal tax credits. In fact, eligibility for the federal credit extends beyond the eligibility limit of 300 percent FPL for Dirigo subsidies, to 400 percent FPL. Small businesses will be eligible for time-limited tax credits for 50 percent of their costs of employee coverage if they pay half the employee premium. Small business tax credits will serve as a bridge until Exchanges are fully operational, when they are expected to negotiate more competitive rates for small businesses. As further described in the Coverage Expansion section below, it is also possible for Maine to shift some members with incomes between 133 percent and 200 percent FPL who are currently enrolled in MaineCare into a basic health plan in the Exchange to leverage more federal dollars or simply to transition them to coverage in the exchange.

Because the federal revenues for premium and cost sharing tax credits will replace state spending for most if not all DirigoChoice subsidies, the assessment dollars now collected from health plans may no longer be needed for subsidies. However, a portion of the assessment currently is utilized to fund statewide quality initiatives through Dirigo's Maine Health Quality Forum and the need for such funds remains. Maine may consider options for future assessments as follows:

- **Repeal the assessment beginning in 2014.** No longer collect an assessment on health insurance claims. In repealing the assessment, the state could require health insurers to apply the savings to reduce health insurance premiums. In repealing the assessment, Maine will need to consider what funds will be available to continue to fund statewide quality initiatives.
- **Retain assessment – either at the current level or a reduced rate.** The assessment on health claims provides significant funds to support Maine's current health care system. Despite the influx of new federal dollars into Maine, there will undoubtedly be gaps in funding that the state may want to consider. If federal tax subsidies are no longer available to small businesses or if they and the Exchange's buying power do not make small business costs more affordable, the state may want to continue some form of subsidy. In addition, Health InfoNet, Maine's electronic health information exchange needs sustainable funding, although would require only a small percentage of the current assessment. HIN has the potential to yield a positive return on investment through the improved efficiency of medical care, reduced medical errors, and lower cost. Some may

[15] The federal law builds in a standard 5% of income disregard into the gross income test, making the actual income level for eligibility 138% of the FPL.

be used to continue to fund the work of the Maine Quality Forum. As noted below, the state may choose to continue mandates and will need a source of funds to pay for them. Both initiatives could be conducted with a reduced assessment level that would reduce, but continue a cost borne by premium payers.

- **Supplementing the federal subsidy to improve benefits. The federal** premium tax credit is tied to the value of a specific benefit plan which has not yet been defined.[16] While the federal plan must include preventive care and pediatric services, it is possible that the federally-specified benefits will not be as extensive as the benefits available in Maine today. To the extent that Maine currently has insurance mandates that are not included in the federal plan, or desires a richer (and so more costly) benefit package for individuals and families purchasing coverage through the Exchange, the State would be required to pay those costs. The state would need to review a variety of options, including using some of the assessment, to supplement the federal subsidy so that enrollees would not pay a larger share of their income than the federal law requires.

- **State subsidy to maximize coverage.** Some Mainers will be exempted from the requirement to have insurance because available options are too expensive given their family income levels. Assessment funds could be used for a state subsidy to help those who do not qualify for the federal tax credit to afford coverage

Prior to the start of the federal tax subsidies in 2014, Maine will undertake a detailed analysis of these and other options to determine the disposition of the Dirigo assessment.

Public Option

The PPACA permits states to develop a Basic Health Program for individuals with incomes between 133-200 percent of the FPL instead of providing such individuals with subsidies to purchase health insurance. However, these individuals and all those below 400 percent of poverty would be eligible for subsidies in the Exchange. Creating a Basic Health Plan would establish another program and may cause confusion. Conversely, the program could provide important benefits to lower income parents and, if coordinated with or an expansion of MaineCare, would provide an opportunity for parents and children to remain in the same plan while the Children's Health Insurance Program is in place. The state may consider whether it is interested in establishing a Basic Health Program and what would be entailed to meet federal requirements. A notable feature is that the PPACA restricts the funds available for a Basic Health Program to 95 percent of the premium and cost sharing subsidies that enrollees would have received if they were enrolled in a health plan through the Exchange. Under the PPACA, the Basic Health Program would become effective in January 2014 at the same time as the exchange.

[16] The federal law requires HHS to define four benefit categories to be provided through an exchange. The basic plan, for which subsidies will be available, must provide minimum essential coverage at the actuarial value of 60% while the highest plan will require an actuarial value of 90%.

Task 2: The Health Care Reform Implementation Steering Committee will develop option papers, with guidance from ACHSD, identifying and analyzing policy options to provide recommendations for the Governor and Legislature.

Decision Points – Dirigo and Federal Financing

Date	Action
By 12/31/10	Develop list of options for disposition of Dirigo assessment
	Analyze cost and feasibility of assessment options
	Decision on whether to develop Basic Health Program
By 12/31/11	Decision on disposition of Dirigo assessment
By 6/30/13	Enact legislation to change Dirigo assessment Enact legislation to create Basic Health Plan, if appropriate
1/1/14	Changes to Dirigo assessment in effect Launch Basic Health Program, if applicable

Insurance Reform

Although federal reforms include many of the types of insurance market reforms Maine has already implemented, it will be important to review Maine's laws to ensure that they meet the minimum federal standards. PPACA (similar to earlier federal HIPAA reforms) largely relies on state insurance regulators to monitor compliance. If a state is unable or unwilling, then federal regulators are allowed to come into a state and take over regulation to ensure compliance with national standards.

A key decision for Maine's policymakers will be whether to modify Maine's laws to ensure that the state's laws meet the minimum standards set out in federal law. Generally, state insurance regulators can only enforce state insurance laws, not federal laws. Absent modifications to state insurance law, federal enforcement would be necessary.

In addition, PPACA recognizes that insurance markets vary and that states have chosen a variety of ways to protect consumers. PPACA preserves the right of states to continue to do that. Because federal law sets a minimum standard, states have flexibility and can have and enact other laws and additional consumer protections.

Some key policy decisions that Maine will need to make immediately and before 2014 regarding the insurance market include:

- When to expand the definition of the small group market to include businesses with up to 100 employees
- Whether to merge the small group and individual markets

- How to participate in the development of national standards, directly and through the NAIC
- Whether to take an active role in enforcing the insurance market reforms, or allow federal regulators to assume these responsibilities
- What revisions to make to Maine's insurance laws to meet the minimum federal requirements, including medical loss ratio standards, rate review, and a variety of other consumer protection standards
- Whether to maintain or reduce the state's mandated insurance benefit requirements
- Whether to amend Maine's community rating bands to comply with lower federal requirements
- Whether to participate in interstate insurance compacts, beginning in 2016, that would allow for the sale of insurance products across state lines

Individual and Small Group Markets

One of the important considerations in this arena is whether to merge the non-group and small group markets. The Blue Ribbon Commission on Dirigo studied this issue and unanimously recommended that sole proprietors be allowed to purchase in the small group market and asked for a work group to study and report on three options, including merging the individual and small group markets.(January 2007) As a result, the Bureau of Insurance issued a report in May 2007 that examined the three options that determined that while there are several advantages to a merger, a merged market was likely to cause a decrease in individual premiums but an increase in premiums in the small group market under current market conditions The extension of the small group market to firms with 100 employees or fewer (up from 50 or fewer), coupled with the individual mandate, substantial financial subsidies to individuals and employer incentives, may now provide enough of a buffer against increased risk to merge the markets without causing an increase in small group premiums.

Maine will need to consider the advantages and disadvantages of merging these markets in a reformed environment. PPACA also increases the threshold for large employer status from 50 to 100, effective in 2014, but allows states to opt out during 2014 and 2015. Maine will have to decide whether to allow the expansion to take effect immediately or postpone implementation.

Medical Loss Ratio

As Maine does today, the PPACA requires health insurance plans to report medical loss ratios. Under the PPACA there is a minimum MLR of 85 percent in the large group market and 80 percent in the individual and small group market. Maine does not now regulate large group rates, and there are significant differences between Maine's current MLR requirements and the federal definitions. These inconsistencies will need to be examined and the state will likely need to amend its laws to comply with the minimum MLR allowable to be consistent with the federal law.

In addition to considering the minimum MLR, Maine will also need to consider how its current definition of MLR compares to the final regulation to be issued by the federal Department of Health and Human Services (HHS). The language used in the PPACA, which is the subject of a request for comments by HHS, is different from the definitions used in Maine and other states. This makes the comparison between current Maine requirements and the new federal requirements more complex. In addition, the regulations call for the issuance of partial premium rebates to consumers whose plans have MLRs that fail to meet federal standards. Maine currently requires premium rebates on a pro rata basis. The state may need to modify its process for monitoring a health insurer's premium rebates depending on the language of the upcoming federal regulations

Rate Review

The PPACA establishes a process for reviewing the reasonableness of health insurance premiums. While Maine already reviews and approves premium rates set by insurers in the non-group market, small group premium prices are not subject to prior approval as long as the insurer agrees to issue coverage on a guaranteed MLR basis. For guaranteed MLR products, rates are reviewed but not subject to prior approval. Large group market rates are filed for informational purposes.

Maine should consider whether there are further actions that could be taken by the Superintendent of Insurance to review rates and whether the state may qualify for grant funds to review health insurance increases. These funds become available in 2010.

Consumer Protection and Rating Standards

The PPACA establishes new federal minimum standards in a number of areas, including but not limited to protections for consumers with health conditions, expansion of dependent coverage, transparency in health insurance documents and communications, appeal processes, and limits on variations in premium rates. Although Maine law equals or exceeds federal requirements in many areas, other federal requirements are new, or are structured differently from their Maine counterparts.

Maine needs to evaluate its insurance laws and to make changes as appropriate. If states do not enforce the federal requirements, HHS is given the authority to step in.

State Mandates

The PPACA requires states to evaluate the cost of their state insurance mandates that are not included in the essential benefit plan that will be determined through federal regulation. Any person receiving federal tax credits for insurance through the exchange will not be credited for benefits above this basic benefit plan.

Once the regulations are promulgated for the essential benefit plan, Maine will need to determine whether or not it wants to fund any additional mandates through a state-only revenue source, such as the Dirigo assessment or general funds.

Interstate Insurance Compacts

The PPACA allows states, on a voluntary basis, to form "health care choice compacts" that allow insurers to sell policies in any state participating in the compact. As a starting point, Maine will need to determine whether it is interested in forming or joining a compact, and, if so, which states would likely be partners. Choice of state partners is a key decision as, under the federal law, an insurer is required to follow some but not all state insurance laws by each of the states participating in the compact. The insurer is only required to follow all the state insurance laws for the state in which the insurer is domiciled. For example, if Maine has stronger consumer protection laws than some of its state partners, Maine residents that purchase through the compact may not receive those same protections as Maine's insurance regulators may not be able to fully enforce Maine's laws. Federal regulations for interstate compacts will not be issued until 2013; with compacts beginning operations in 2016.

Task 3: The Health Care Reform Implementation Steering Committee will develop option papers, with guidance from ACHSD, identifying and analyzing policy options to provide recommendations for the Governor and Legislature.

Decision Points – Insurance Reform

Date	Action
ongoing	Work with NAIC and HHS on development of federal insurance standards
By 9/30/10	Review Insurance Code provisions and Bureau of Insurance rules for consistency with federal requirements
By 12/31/10	Decision on whether to increase small group to firms with 100 employees; merge small and non-group markets
By 12/31/10	Apply for grant funding to review health insurance provisions, when available
By 12/31/11	Decision on whether to fund state insurance mandates in excess of federal mandates using state dollars
By 12/31/13	Decision on interest in forming an interstate insurance compact

Expansion of Publicly Funded Benefits

Maine is ahead of most states in its use of MaineCare to cover low income people.[17] The PPACA provides for expansion of public programs through a combination of expanded Medicaid eligibility, enhanced federal match for Medicaid and CHIP, and the development of a subsidy program for the purchase of private insurance through an exchange for individuals with incomes

[17] Today, MaineCare covers children to 200% of the FPL through a combination of Medicaid and CHIP; parents to 200% of the FPL; and pregnant women to 185% of the FPL. (200% if under 19)MaineCare also covers disabled individuals at varying income levels depending on whether income is earned and unearned.

up to 400 percent of the federal poverty level (FPL).[18] At the same time, the PPACA modifies the current prescription drug rebate policy in a way that reduces Maine's revenue by retaining a greater level of savings from prescription drug rebates for the federal government. Specifically, the PPACA expands eligibility for Medicaid to all individuals under the age of 65 to 133 percent of the FPL beginning in 2014. Enhanced Medicaid federal match rates will offset state funding for childless adults with incomes less than 100 percent FPL who now have coverage under MaineCare. Maine will also receive enhanced federal funding beginning in 2014 to cover childless adults earning between 100 percent FPL and 133 percent FPL, as well as those under 100 percent FPL who are on the program's waiting list. Because Maine previously provided coverage to some of the new mandatory categories, Maine is considered an expansion state under the federal law. As an expansion state, federal dollars will fully support the expansion of individuals between 100 and 133 percent of the FPL for the first three years. Like all states, Maine will be required to contribute a small percentage of this population's coverage costs beginning in 2017 (the state share increases each subsequent year and settles at 10 percent for 2020 and beyond). Maine will also receive enhanced match based on a statutory formula for those childless adults below 100 percent of the FPL who are already covered in Maine which will significantly reduce state funds required to cover these populations going forward, provided the state maintains current eligibility levels for the Medicaid and CHIP program, including for coverage of parents, pregnant women and persons with disabilities with incomes above 133 percent of FPL. Maine will also receive significant enhanced funding (23 percent points) for children covered in the state's CHIP program up to 200 percent FPL from 2014-2019.

The PPACA also creates a new mandatory categorical eligibility for former foster care children, regardless of income, until the age of 26. This section is effective on January 1, 2014.

While the expansions do not become mandatory until 2014, it is essential to immediately conduct analysis of the increases and decreases in federal revenue through the federal law and the long-term impact on required state-funding for these expanded benefits. Once the analysis is complete, Maine has a number of options to quickly consider including:

- Whether to allow childless adults into MaineCare prior to 2014 (at regular match), including potential movement of individuals currently in DirigoChoice and outright expansion
- Will the state be required to proactively identify former foster children for enrollment in Medicaid if they are under age 26 but have already aged out of the foster care system
- Assess whether Maine will have a budget deficit between January 1, 2011 and December 31, 2013, and if so, whether Maine will consider reducing eligibility for non-pregnant, non-disabled parents to 133 percent of the FPL and the impact on rates of uninsured in so doing

[18] The 2010 federal poverty level for an individual is $10,830 and $18,312 for a family of three.

Task 4: The Health Care Reform Implementation Steering Committee will develop option papers, with guidance from ACHSD, identifying and analyzing policy options to provide recommendations for the Governor and Legislature.

Decision Points - Expansion

Date	Action
12/31/10	Conduct financial analysis of impact of expanding to childless adults prior to 2014
	Determine additional state dollars for such expansion
	Make decision on whether to expand prior to 2014
7/1/13	Determine how will identify former foster children to enroll in Medicaid program
7/1/10; 7/1/13	If budget deficit, determine whether will consider reducing eligibility as maintenance of effort requirement will be waived

System and Payment Reform

Fundamental system reform that addresses public health, prevention and wellness, and how necessary health care is provided, paid for and monitored is a key focus of the PPACA. Maine is host to a large number of initiatives, both public and private, to improve the health of Mainers and the ways they receive and pay for health care. The Maine Wellness Council and the Healthy Maine Partnerships are examples of collaborations that improve the health and wellbeing of people who live and work in Maine. Dirigo's Maine Quality Forum leads efforts to improve the quality and safety of health care.

Payment reform efforts are described in detail in Chapter VI. Several payment reform initiatives are underway with state employees and the private sector, including the Maine Health Management Coalition's payment reform planning process for the state's largest employers and an initiative is underway with CIGNA, Bath Iron Works and providers. A 26 site patient centered medial home demonstration is also underway. The Legislature has tasked the Advisory Council on Health Systems Development to report back in January, 2011 with recommendations for action based on the models mentioned above.

The initiative that Maine's government, nonprofits, and businesses have taken to improve health care may put the state in a good position to take advantage of new opportunities in the health reform law. The PPACA takes a decentralized approach to promote payment and delivery system reform, through funding for demonstration projects, pilot programs, and grants targeted to states, municipalities, medical schools, hospitals, nursing homes, and other providers. Many of these projects focus on areas that have been a priority for Maine, including these examples (among many others):

- **Preventive Care:** Grants for medical schools to provide preventive care training for medical residents; support for non-profits, community-based organizations, and

governments to promote evidenced-based preventive health activities in local communities.

- **Wellness:** Funding for a wellness program demonstration and a preventive benefits outreach campaign; incentives to prevent chronic diseases in Medicaid
- **Quality:** Grants to institutions to adapt and implement models and practices that promote evidence-based quality and reductions in health disparities, and to states to develop quality measures and establish community health teams to support patient-centered medical homes
- **Expansion of Primary Care Health Care Settings and Workforce:** State health care workforce development grants, workforce diversity grants, and demonstrations to address health professions workforce needs and expand access to primary care through federally qualified health centers.
- **Payment reform:** Funding for demonstrations on global and bundled payments and pediatric accountable care organizations, planning grants for creating medical homes for people with chronic illness. Funding provides key opportunity for public purchasers, including Medicaid and Medicare, to lead or participate in multi-payor payment reform efforts.
- **Medical Malpractice Demonstration:** Funding available for development for an alternative medical malpractice system

Maine will need to review all of the relevant opportunities in the law, quickly prioritize them and develop relationships with researchers and others in order to best meet the state's goals for improved quality and system reform. As appropriate, the payment and system reform initiatives will be integrated into the Medicaid Managed Care initiative currently in the planning stages. Because each of these grants opportunities will be of interest to various stakeholder groups, there will be pressure on the state to apply for as many as possible. However, given the fact that most of these grants require some level of state matching funds or resource commitment and that the state has finite resources to implement, manage and monitor available opportunities, the Health Care Reform Implementation Steering Committee should develop a recommended set of criteria, with input from the Advisory Council on Health System Development, to follow in considering the application or support of such grants. Examples of appropriate criteria include:

- Priority in the State Health Plan
- Related initiatives underway in Maine
- Broad coalition of support
- Level of state funding required (lower is better)

In addition to developing a prioritization for grants that require the state to act as a lead, it is also important for Maine to develop an overall workforce development strategy to guide local organizations and health care providers on which grants are likely to be of the most benefit to Maine and support statewide priorities. These funds begin coming available in 2010.

Task 5: The Health Care Reform Implementation Steering Committee will develop option papers, with guidance from ACHSD, identifying and analyzing policy options to provide recommendations for the Governor and Legislature.

Decision Points –System & Payment Reform

Date	Action
8/1/10	Review all grants provided for under PPACA and group into state led and other grants
	Develop a set of criteria to use in prioritization of grants; may require different criteria for different types of grants
	Prioritize state led grants and assign responsible state agency for each grant to lead development
9/1/10	Develop a strategy for state outreach to organizations and providers around available grants and how they fit within state priorities

Key Activities

Implementation of health care reform will require considerable state staff resources over the next several years. As described above, the PPACA provides states with the opportunity and responsibility to administer much of the federal reforms. Through an Executive Order issued on April 22, 2010, Governor Baldacci established a Health Reform Implementation Steering Committee chaired by the Director of the Governor's Office of Health Policy & Finance and including leaders of key agencies that will be charged with implementing the reform at the state level. All official work of the Health Reform Implementation Steering Committee will be done through public meetings. The Executive Order further identified the Advisory Council on Health Systems Development to serve as the advisory stakeholder group to advise the Steering Committee on health reform implementation.

Task 6: During its monthly meetings, the Advisory Council will review state agency analysis, options and recommendations regarding the major policy decisions described above and will provide its recommendations to the Governor and the Legislative Joint Select Committee on Health Reform. Over its next several meetings, the Advisory Council will take up the following major policy decisions:

- Exchange
- Payment and System Reform: Criteria for Applying for Grants
- Eligibility expansions
- Insurance Reforms
- Dirigo: Assessments going forward

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
		Administrative Activities			
Grant Prioritization	Maine will need to develop criteria to help prioritize efforts to obtain and support federal funding available through grants available through PPACA (whether or not state must serve as the lead)	- Review grants and bucket into groups that delineate opportunities for states to apply for grants and opportunities for other stakeholders to apply for grants; determine which grants require state or other matching funds - Develop a set of criteria to assist in prioritization of grant opportunities that state will lead or support - Based on criteria, prioritize grants for which state must be lead - Assign grant development to appropriate state agencies - Develop a set of criteria to prioritize state support for non state-led grants	Steering Committee; ACHSD	Provide state matching funds	8/10
Evaluation	Plan for evaluation of major policy changes	- Determine with Advisory Council on Health Systems Development and the Legislature's Joint Select Committee on Health Reform how to evaluate health reform and its impact on Maine; - Determine which agencies and/or organizations will perform evaluation of key policies and reforms; - Agencies to establish measures and begin collecting baseline data.	Steering Committee	Provide money for evaluation and/or authorize agencies to seek outside funding	9/10

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Monitor Federal Activities	Review federal activities related to health reform on ongoing basis for impact on Maine activities	- Serve as liaison to federal government and clearinghouse for federal issues - Review federal regulations, bulletins and other information about interpretation of PPACA provisions - Inform state agencies of activities - Coordinate Maine response to federal requests for input -consult with and engage appropriate state agencies -Consult with and engage appropriate state agencies	GOHPF	Inform	Ongoing
Status Reports	Provide ongoing status reports to ACHSD and Legislature on progress in implementing health reform activities	- Develop a template for ongoing status report to be utilized by state agencies; - Draft report and submit to ACHSD and Legislature every 90 days	Steering Committee	Inform	Every 90 days (ongoing)
Access					
High Risk Pool	Monitor implementation of high risk pool	- Monitor implementation of high risk pool (to be implemented in 8/10) - Consult with BOI	GOHPF; Dirigo Health Agency	Inform	8/10
Reinsurance fund for retirees ages 55-64	Obtain reinsurance funds for state funded retirees	- Apply for reinsurance funds (ASAP as funds on first come, first serve basis) -Analyze impact of state funds on state budget and provide Legislature with information - Educate private employers regarding availability of money; - Consult with BOI on outreach	GOHPF: Dept. of Admin & Financial Services; DECD	Inform; May allow for reduced state money	9/10

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Medicaid					
Medicaid drug rebate	Consider changes to the state Medicaid drug formulary	- analyze fiscal impact of changes to federal Medicaid rebate law identify potential changes to Medicaid drug formulary; - analyze fiscal impact of proposed changes to state Medicaid drug formulary - amend state regulations or sub-regulatory materials - provide appropriate notice to beneficiaries and providers	DHHS	Inform; if financial loss may require new state money	8/10
Medicaid expansion prior to 2014	Decide whether to expand eligibility for childless adults up to 133% FPL prior to availability of enhanced FMAP in 2014.	- Conduct financial analysis of expansion prior to 2014, including determination of whether any state funds are available to fund early expansion	DHHS	Statutory change required to change coverage level to 133% for childless adults; would require additional state funds	8/10
Medical provider-acquired infections	Ensure that state rules prohibiting payment for never events is inclusive of provider-acquired infections as contained in PPACA	- Confirm that federal rules on prohibiting payment for provider-acquired infections are consistent with Maine's current rules prohibiting payment -Incorporate hospital acquired condition exclusion in DRG payments, consistent with Medicare DRG methodology.	DHHS		1/11

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Home and community-based services	Consider adopting federal options to enhance home and community based service state plan options	- Analyze impact of adding state plan option for these benefits, including determination of population to be included and potential fiscal implications (both with and without enhanced federal funding) - Consider extent to which Maine qualifies for enhanced funding based on current balance of long term care services - If decide to utilize option, a number of next steps (draft state plan amendment; ensure sufficient community services; define population and extend new services; provide proper notice and rights of appeal (etc)	DHHS	Would require statutory change; may require new state funds	Various dates beginning 10/10
Payment and delivery system reform	Consider applying for grants to assist with delivery system and payment reform in Maine: pilot program on Medicare payment bundling, global payment demonstration, Pediatric ACO demonstration, grants for medical homes for chronically ill patients.	- Prioritize payment and delivery system reform opportunities and develop criteria with Advisory Council on Health Systems Development to be used in deciding which grants to pursue; -Determine partnerships for grant opportunities - Consider where state can be a lead vs. play a supporting role - Draft or assist leads in drafting of grants and by providing letters of support	GOHPF; DHHS with ACHSD	Provide letters of support as needed;	Various dates; programs begin in 9/10

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Provider payments: DSH and primary care payments in Medicaid	Project potential net effects of increased federal revenue in 2013-14 and loss of federal revenue from reduced DSH allotments; consider options for redirecting additional funds.	- Consider impact of increased rates to Maine providers through Medicaid (both short term and when enhanced funds end - Consider impact on psych IMD DSH - Confirm that Maine is protected from DSH reductions based on waiver - Develop transition plan if reductions go in place when waiver period ends	DHHS; GOHPF	Inform; Provide additional funds as necessary	10/11
Provider rates	Increase Medicaid rates for primary care to 100% of Medicare; 100% federal funding of incremental cost in 2013-14.	- Determine difference b/w current rates and Medicare rates; - Make appropriate changes in MMIS to pay primary care providers 100% of Medicare; - Develop report showing difference in state developed rates and 100% of Medicare; Consider implications of existing PCCM, PCMH payments. - Submit claim for difference to CMS based on rules to be developed	DHHS	Legislative authority to provide higher payment rate and plan for sunset of federal dollars	1/13
Federal Medicaid expansion to 133% FPL	Expand Medicaid eligibility to 133% FPL; adjust DirigoChoice eligibility and enrollment accordingly.	- Amend MaineCare statute and regulations to allow for increased enrollment; - Provide notice to individuals enrolled in Dirigo that have opportunity to move to MaineCare - Make eligibility systems changes (including to decision trees and notices)	DHHS	Statutory change	1/14

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Insurance Reforms					
Web-based insurance marketplace	Participate in designing federal and state websites and web-based capacity for exchange and insurance market to help consumers identify affordable coverage options.	- Bureau of Insurance to continue to work with NAIC on input into federal website, with input from Dirigo - Exchange to design state specific website to provide detailed information on specific Maine coverage options in exchange	Bureau of Insurance; DHA	Inform	12/10
Small business tax credits	Inform and educate small employers about the availability of tax credits to subsidize insurance coverage for employees.	- Develop fact sheets on availability of tax credits - Hold forums with small businesses to help understand tax credit opportunity (ongoing through 2014)	Bureau of Insurance; GOHPF; DECD	Inform	8/10 (ongoing)
Conform Maine insurance rules to new federal rules	Review and Amend Insurance Laws and Regulations to Conform with PPACA	- Review differences in federal law and state law for all insurance changes in federal law - As necessary, draft legislation and regulations conforming to federal law - Educate insurers on new requirements, including reporting requirements	Bureau of Insurance	Amend statute to conform to federal law	Various dates; begins 9/10
Medical Loss Ratios	Insurers that fail to maintain adequate medical loss ratios will be required to provide rebates; monitor insurers to ensure compliance	- Develop a method to oversee and monitor insurers activities	Bureau of Insurance	May require amending of MLR statute	1/11
Co-Op Plans	Oversee possible development of private, non-profit, member-run Consumer Operated and Oriented Plan (CO-OP).	- Bring together stakeholders for discussion of development of CO-OP - Consider pros/cons of development of such a CO-OP; - Consider regulatory and legislative changes necessary to allow for operation of new CO-OP	Bureau of Insurance	Review statutory authority for CO-OP to operate in Maine and ensure licensing	1/13

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Standardize systems for eligibility and enrollment, claims and payment	Disseminate and start to enforce standardized rules for the simplification of insurance records in the areas of eligibility/enrollment, claims/payment, encounter, and authorization.	- Educate Maine providers and insurers on federally developed standardized rules to administratively simplify insurance records - Include MaineCare and worker's comp insurers to ensure consistency across all interactions with providers	Bureau of Insurance; DHHS	Require insurers & Medicaid to be involved	Various dates
Individual and employer mandates; penalties for non-compliance	Raise awareness of start of individual and employer mandates and penalties beginning 2014.	- Determine potential mandate exemptions for individuals and employers (e.g., unaffordable coverage or provision of free choice voucher) - Develop fact sheets and FAQs to educate individuals and businesses about responsibilities under law - Consider conducting media campaign to promote enrollment to meet the mandate - Coordinate outreach and education activities with other ongoing outreach and education efforts	GOHPF, Bureau of Insurance		1/14

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
New federal insurance rules and protections	Implement new reforms at the state level: • Limit out-of-pocket spending below 400% FPL • ESI waiting period no longer than 90 days • Add federal-contracted multi-state plans to Exchange; Maine may want to require additional benefits (at state cost) • Consider merging individual and small group markets	- Evaluate existing laws for consistency with federal requirements - Develop regulations for insurers to comply with federal rules - Develop method within Exchange and MaineCare to ensure out-of-pocket maximums are tracked and complied with - Consider whether Maine will include state mandated benefits (at state cost) - Consider merging individual & small group market	Bureau of Insurance; State Exchange; DHHS	Statutory changes; decision on state mandated benefits & merging of individual and small group markets	Various dates; mostly 1/14
Exchange					
Setting up a state Exchange	Pursue planning grant for developing Exchange and SHOP; identify state agency to house Exchange.	- Apply for grant funds to help develop exchange - Work with Advisory Council on Health Systems Development and Legislature to identify state agency or other nonprofit to house Exchange - Consult with BOI and DHHS	GOHPF; DHA	Review and approval; Enact enabling legislation	12/10
Insurance subsidies for individuals, families, and businesses	Consider state tax implications of federal insurance subsidies	- Review federal changes to determine whether cause automatic changes to state taxes - Based on review, identify if need to make changes to law either to extend same subsidy to state taxes or to not extend it	Maine Revenue Services, GOHPF	Potential legislative change	12/10

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Building a state Exchange	Begin planning structure and functions of Exchange	- Identify key functions of Exchange - Determine changes to current personnel needs in transition to an Exchange - Work collaboratively with MaineCare on how eligibility and subsidy payment will work	GOHPF, DHA	New statutory language authorizing a Exchange	10/10
State Exchange	Launch the state Exchange and begin offering minimum essential coverage to individuals and small businesses.	- Begin operations effective Jan 1, 2014 - Provide outreach and education of exchange offerings - Provide coverage for insurance with assistance of subsidies to both individuals and businesses - Consult with BOI and assure plans sold through the exchange comply with Maine insurance rules	State Exchange	Monitor; receive status reports	1/14

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Outreach and Education					
Educate all parties about health law	Inform the public and key stake-holders about policy changes and other reforms.	- Develop fact sheets and FAQs for all stakeholders (e.g., consumers, providers, businesses, insurers, etc) to clearly explain law and its implications - Hold forums across the state to assist in understanding of new law - Continue to provide outreach and education, particularly regarding eligibility for subsidies & tax credits; as well as potential for penalties	Steering Committee; ACHSD		8/10
Prevention and Wellness					
Wellness program grants	Raise awareness among small employers of grants (through 2015) to establish comprehensive wellness programs	- Develop materials describing availability of grants to small businesses - Participate with small business advocacy organizations in development of forums - Inform small employers or coalitions of small employers of ability to receive grant funding to develop a tool kit to assist businesses with establishing wellness programs or availability of tool kit developed through Dirigo	GOHPF DHHS DECD		1/11

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Wellness incentives	Raise awareness among employers of the option to provide employees with rewards in the form of reduced premiums based on participating in a wellness program.	- Develop materials describing options for employers to reduce premiums based on participation in wellness - Participate with business advocacy organizations in development of forums for businesses to describe opportunity -Eliminate co pays in public programs for preventive services and apply increased match.	GOHPF; Bureau of Insurance; DHHS; State Exchange		1/13

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Wellness through the Exchange	Consider applying to conduct a Wellness Demonstration project that applies rewards in the individual market; evaluate whether Maine's existing wellness initiatives are consistent with new wellness options.	- Work with insurers to consider Wellness Demonstration in individual market; - Based on current practices and potential changes, determine whether to develop a demonstration project to reward with premium incentives	GOHPF; State Exchange; Bureau of Insurance		1/14
Quality					
Health Care Disparities	Maintain focus on reducing health care disparities	- Ensure disparities are considered in quality improvement activities; measurement, and evaluation - Enhance collection and reporting of data, including access and treatment data for people with disabilities	DHA; MQF; MCDC		3/12

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Medical malpractice	Consider applying for demonstration grant to develop alternatives to medical malpractice rules to reduce provider practice of defensive medicine	- Work with key stakeholders (physicians, hospitals, and trial attorneys to develop a coalition to apply for demonstration grant - Consider if state can be a lead vs. play a supporting role - Assist leads in drafting of grants and by providing letters of support	GOHPF; DHHS; Bureau of Insurance DHA-MQF Trial Court	Provide legislative authorization for med mal demos	

Issue	State Role	Key Tasks	Lead Agency	Legislative Role	Due Date
Long Term Care					
CLASS	Raise awareness among individuals and employers of the opportunity to save for the eventual need for long-term supports using payroll deductions in the Community Living Assistance Services and Supports (CLASS) program.	- Develop/distribute objective information to individuals and businesses about CLASS; - Inform the public about CLASS at public forums and events -Conduct financial analysis on impact of CLASS on MaineCare long term care costs - Consult with BOI	DHHS	Inform	1/11
Indian Health					
Indian Health Care Improvement Act	Consider amendments to Indian Health Care Improvement Act	-Review Indian Health Care Improvement Act, which is reauthorized & amended in the PPACA -Consider impact of amended requirements on American Indians residing in Maine -Consider whether any corresponding changes are needed in Maine state law	Tribes; DHHS MCDC	Inform	8/10

Appendix 1

Summary Progress Report

	2008-09 State Health Plan Task	2008-2009 State Health Plan Progress Report
1	Streamlined Statewide Public Health Infrastructure	• In 2009, LD1363, "An Act to Establish and Promote Statewide Collaboration and Coordination in Public Health Activities to Enact a Universal Wellness Initiative" was enacted and formalized the Public Health Infrastructure. • The Statewide Coordinating Council (SCC) was convened in 2008 and has met quarterly since that date. Membership reflects expertise in the 10 Essential Public Health Services and includes representatives from the eight District Coordinating Councils. • Two SCC members sit on the ACSHD and update the Council on issues related to public health infrastructure development. • Infrastructure and processes are now in place to provide aligned, comprehensive health planning processes at local, district, state, and national levels. • Eight District Coordinating Councils (DCCs) were formed in 2008 and include broad representation from district public health stakeholders. The DCCs meet on a quarterly basis and advise Maine CDC on ways to improve the effectiveness and efficiency at the district level. • DCC membership includes participation from health delivery systems, including hospitals, primary care providers, and mental/behavioral health care providers. • Local Health Officer (LHO) statutes were updated during 2008 with passage of "An Act to Modernize Local Health Officer Statutes", legislation which served to narrow LHO functions, strengthen the LHO system, and establish ongoing training and support. • Rule changes were made to clarify LHO qualifications, training, and experience and to ensure that all LHOs meet minimum qualifications within six months of appointment. • In 2009, an on-line LHO certification training was developed and has been taken by more than half of all LHOs in the state. Other LHO training modules are in development, and in-person training opportunities were offered in each district in 2009. • Maine CDC staff positions and funds were reorganized to enable hiring of eight District Public Health Liaison positions, with all positions filled by January 2010. Public Health Units have been convened in all districts and include co-location of Maine CDC public health nurses, health inspectors, epidemiologists, and district liaisons. Two Tribal Liaisons were hired. • Existing Maine CDC resources were aligned to create the Office of Local Public Health, which includes District Public Health Liaisons, an LHO Coordinator, and comprehensive health planner. • Based on recommendations from the ACSHD Cost Driver report, the GOHPF and Maine CDC worked with the eight Districts in 2009-2010 to develop District Performance

	2008-09 State Health Plan Task	2008-2009 State Health Plan Progress Report
		Reports, documents that connect socioeconomic status, population health indicators, preventable hospitalization rates, and cost savings associated with preventable hospitalizations. These reports will be annually reported and used by the multi-stakeholder DCCs to track progress in their efforts to prevent avoidable and costly chronic diseases.
2	Patient Centered Medical Home	• Maine Quality Forum (MQF), Quality Counts, and Maine Health Management Coalition developed a 3-year demonstration project with 26 primary care practices, with extra costs financed by MaineCare, Aetna, Anthem, and Harvard Pilgrim. There is an evaluation plan in place.
3	Coordination of Public Health and Behavioral Health Systems	• Depression and mental health modules continue to be conducted by BRFSS. • The SCC and DCCs have increasingly included behavioral health stakeholders • Maine CDC, Division of Chronic Disease received a 3-year Systems Transforming grant from MeHAF focused on better linking public health and mental health systems • MeHAF has invested nearly $10 million in grants to 43 grantees and their 150 partner organizations, convening key leaders, providing technical assistance, and conducting policy research on care integration • In March 2010, DHHS and MeHAF held a conference on integrated care with APS • Maine Patient-Centered Medical Home pilot includes integrated services in its approach to care at 26 sites • A statewide Integration Policy Committee comprised of health care leaders and consumer advocates has been convened to identify payment and regulatory, licensure, reimbursement, workforce development, day-to-day practice, and other policy improvements needed to support integrated care
4	Other Maine-Based Integration Initiatives	• MeHAF has kept the ACHSD appraised of information and lessons learned from integration grants and their study of barriers to integration
5	Worksite Wellness	• The Maine Leadership Group for Worksite Wellness completed a set of guidelines in 2010 called "Criteria for Worksite Wellness Health Programs" that establishes a set of evidence-based criteria to guide development of employer-based worksite wellness programs
6	Supporting Dirigo's Goal of Universal Access During	• The Legislature enacted the Governor's proposal to stabilize financing for the Dirigo Health Agency and enabled the Agency to conduct an examination to restructure and develop less costly alternatives for coverage. The Board completed that work, presented to the Legislature and has made the program reforms. As a result, the program will re-open to

	2008-09 State Health Plan Task	2008-2009 State Health Plan Progress Report
	Challenging Economic Times	enrollment in July 2010. • GOHPF received an $8.5 million grant from the Health Resources and Services Administration to establish a voucher program in the Dirigo Health Agency available to part-time and direct care workers in large business who have access to employer sponsored coverage but cannot afford it. Uninsured workers whose incomes are below 300% of the poverty level are eligible. The program launched in May 2010. • The enactment of the Patient Protection and Affordable Care Act will directly address concerns in the State Health Plan regarding the individual and small group market and achieve near universal access to coverage by 2014. Maine is well positioned to implement reform since we already have many of the insurance reforms in place, have expanded our Medicaid program nearly as far as the new federal requirements and the Dirigo Health Agency is conducting many of the functions envisioned in the Exchange that will become operational in 2014. • When the Dirigo Health Reform was enacted in 2003 Maine ranked 19th among the states in the number of uninsured; today, we rank 6th. (Source: America's Health Rankings) • The Bureau of Insurance has regularly reported through Dirigo's Chapter 945 reporting requirements on the financial conditions of Maine's insurance carriers. As a result of Dirigo's medical loss ratio requirements in the small group market, last year one carrier returned $6.6 million to small business members.
7	Implementation of the Oral Health Improvement Plan	• The Maine Dental Access Coalition developed a "Dental Dozen" list of policy priorities, extracted from the Oral Health Improvement Plan. Each priority has at least one measureable, time-framed objective. • The "Dental Dozen" will be reviewed biannually and updated annually, and as priorities have been accomplished or issues resolved, they will be replaced on the list. • The Oral Health Improvement Plan is scheduled to be updated by 2012 beginning in 2010 with a series of activities intended to assure specificity and relevance. • In 2009, the Legislature enacted a bond issue to support a new dental school in Maine.
8	Rural Health	• Regional meetings took place in Fort Kent, Farmington and Machias and feedback was solicited and then incorporated into the final version of the State Rural Health Plan which was posted to the Maine CDC Office of Rural Health and Primary Care website on October 30th 2008. • A Strategic Plan for the Rural Hospital Flexibility Program was developed and presented to the Critical Access Hospital CEO Collaborative at the January 2009 Small and Rural Hospital Conference sponsored by the Maine Hospital Association.

	2008-09 State Health Plan Task	2008-2009 State Health Plan Progress Report
		• The Healthcare Workforce Forum meets monthly in Augusta and has a membership that includes over 80 representatives from organizations that range form health care professional groups, small and large employers, institutions of higher learning, and government agencies. Meeting agendas and minutes can be found at http://www.maine.gov/dhhs/boh/orhpc/hwf/index.shtml • A report was published in March 2010 that is the combined effort of four New England rural Hospital Flexibility Program Coordinators. It creates a single place where indicators of performance and quality that are relevant to small and rural hospitals are identified. Discussions among CAH CEOs and QI Directors across the four states are taking place in May 2010.
9	Telemedicine	• Key stakeholders were identified and an ongoing forum was launched in the summer of 2009. It currently connects healthcare service providers at sites in Northern, Eastern, Southern, and Central Maine for a videoconference on the third Thursday of each month. A Maine Telehealth Collaborative website for forum members has been created. To learn more visit http://telemedicinemaine.sc29.info/ • A sub-committee of the forum will be working on a strategic planning document throughout the spring and summer. The projected date of completion is August 2010. • A representative of the New England Telehealth Consortium (NETC) is a regular contributor to the Maine Telemedicine Forum. • Annual reports of progress began in 2009. A 2010 report is being prepared for posting on the Collaboratives website and for submission to the ACHSD by the end of April, 2010.
10	Possible Role for Federally Qualified Health Centers (FQHC's) in Providing Veterans' Care	• MPCA has had preliminary discussions with the VA and Maine's Congressional delegation, but no action has been taken to date. MPCA remains interested in the possibility of FQHC's contracting with the VA to provide care for Maine's veterans.
11	Emergency Department Over-Utilization	• The GOHPF convened a workgroup representing key interested parties to investigate Emergency Department over-utilization and worked with the Muskie School to conduct the Phase I ED Study (which showed that Maine emergency department use was about 30% higher than the national average and treatment of illnesses and conditions can often be appropriately managed in an office or clinic setting and over-utilization is predominantly a result of increased potentially preventable visits, which should be amendable to interventions) • The GOHPF commissioned the Muskie School to conduct a Phase II comprehensive

	2008-09 State Health Plan Task	2008-2009 State Health Plan Progress Report
		analysis of statewide ED utilization and completed a comparative analysis of six health service areas in Maine. Major findings included: o Among infants under the age of one, top volume diagnoses did not vary among privately insured, MaineCare, and uninsured children o Infants covered by MaineCare and uninsured infants made frequent visits for diagnoses including diaper rash, teething problems, and "fussy infant" (diagnoses far less frequently seen among privately insured infants) o The top diagnostic reason for an emergency department visit among both Maine Care and uninsured young adults 15-24 years of age and 25-44 years of age was dental disease o Many of the 14 frequent diagnoses are preventable if acre can be provided in an alternative setting o In the comparative analysis, it was found that there was no pattern associating high or low ED use with poverty rates, mortality rates, prevalence of health risk factors or chronic disease, or insurance rates • Recommendations from the Phase II report included: o Make payment and reimbursement changes to realign provider incentives to deliver care in non-emergency department settings and expand the availability of same day, unscheduled, urgent care visits o Improve access to dental care through strategies to address provider shortages and financial access barriers o Consider implementation of an intervention targeting patients with substance abuse disorders
12	Reducing Variation in Medical Practice	• Variation charts ("butterfly charts) have been updated through 2007, with information used, for example, to help correct unwarranted variation in spinal fusion use in St. Mary's Health System and to help inform reports on local utilization in Maine's eight Public Health Districts • MQF and Maine Dialog completed a study in 2009 of inpatient and outpatient cost drivers based on Maine's first-in-the-nation all-payer database. Major findings included: o There is significant variation across the 24 Healthcare Service Areas (HSAs) identified o There is room for improvement across the entire state o If commercial payors' potentially avoidable inpatient use and high-cost/high variation outpatient use can be reduced by 50%, commercial medical spending could be reduced by 11.5% (which would reduce premiums) o Inpatient spending accounts for $916 million (39%) of the spending in the state, and approximately 1/3 ($284 million) is spent on chronic conditions (which are potentially avoidable) o 31% of inpatient spending is for hospitalization that is potentially avoidable o "Preference sensitive care" accounts for $138 million (15%) of statewide inpatient spending o Outpatient spending accounts for $1.3 billion (56%) of the spending in Maine

	2008-09 State Health Plan Task	2008-2009 State Health Plan Progress Report
		(23% is accounted for by 5 high-cost, highly variable services: lab tests, advanced imaging, standard imaging, echography, and specialist visits)
13	Prototypes for Evidence Based Medicine-In A Heart Beat and Stroke Systems of Care	• In A Heartbeat o MQF worked on a project which focused on development of best-practice treatment protocols for acute myocardial infarction (AMI) patients in emergency rooms and hospitals as well as spread information to consumers and patients about symptoms of AMI and how to properly respond to them o Six train-the-trainer sessions were held throughout the state February-April 2008 to enhance community awareness and appropriate citizen response (over 138 participants, with 1923 participants in subsequent trainings) o There are now a total of 50 recognized HeartSafe Community services (a certifying process for EMS providers), serving a population of over 780,600 Maine residents in over 256 towns o BRFSS follow-up in 2009 on heart attack and stroke recognition demonstrated a significant increase in the percentage of Mainers who can identify signs and symptoms of an AMI • Stroke Systems of Care o Statewide symptom recognition/call 911 initiatives to increase community awareness were expanded in 2009 to include a multi-media approach (statewide television public service announcement aired May 4-31, 2009, statewide press release, stoke outreach packets sent to HMPs, hospitals, HeartSafe Communities, Tribal Health Directors, Stroke Care Workgroup, American Stroke Association, message integrated into a statewide newsletter). There is a similar campaign planned for 2010. o Provider training includes ongoing participation in Northeast Cerebrovascular Consortium, statewide EMD training and certification, with 100% compliance, effective January 2007 o HeartSafe Communities include a focus on stroke outreach and response capacity o Work continues with regional EMS offices to develop consistent curricula for various levels of pre-hospital providers o Mid-Coast EMS Seminar attracts providers from all over Maine, included multiple stroke tracks in November 2009 o Work with four MCVHP Acute Stroke Diagnosis and Treatment grants to implement projects continued (Maine Med and MaineGeneral implemented a Telestroke pilot, Cary Medical worked with local and regional EMS to implement protocol that involves collection of blood for labs and pre-notification of the ED, Penobscot Bay is wrapping up a year-long mentorship to bring MaineGeneral and MidCoast to the level to apply for JC Certification for stroke)
14	Finding the Right Place of Care for	• A HRSA grant was secured by GOHPF to provide affordable coverage to some direct care workers

	2008-09 State Health Plan Task	2008-2009 State Health Plan Progress Report
	the Elderly and Disabled in Need of Assistance	• DHHS established functional criteria for PNMI • DHHS received an additional million dollars for home-based services • An elder health profile was partially completed, but then postponed due to H1N1 work. A completed elder health profile will be completed in 2011. There are currently 5 different EB healthy programs in Maine and a 6th EB program for caregivers of people with dementia.
15	Medicare Equity Project-Hospital Reimbursement	• This task was not completed but the enactment of the Patient Protection and Affordable Care Act includes efforts to examine the equity of Medicare payments particularly in rural areas.
16	Medicare Equity Project-Medicare Hospice Benefit	• A workgroup was convened and met several times but was unable to develop a focused agenda that would provide a pathway to higher utilization of hospice benefits. This is unfinished business and needs to be continued.
17	HealthInfoNet	• MQF lead development of strategies to secure ARRA funding for HIT initiatives (health information exchange and regional extension centers through development of a state strategy HIT Plan), leading to the creation of the Office of State Coordinator for Health Information Exchange (responsibilities of this entity include protection and privacy of health information records, coordination with MaineCare on a health information technology plan, coordination with ConnectMe on Maine's broadband project to bring fiber optic cable and expanded system capacity, develop sustainability plans to assure long-term stability of a health information exchange infrastructure) • In 2008, MQF worked with MeHAF to establish a loan fund to be used by primary care providers to adopt electronic medical records and use technical assistance to implement changes in office practices. Discussions continue to be held with MeHAF and HealthInfoNet to release loans to qualified practitioners. • MQF and HealthInfoNet engaged a researcher in 2008 to assess the potential return on investment associated with an electronic health information exchange, and it was found that services will generate broad annual healthcare savings • The passage of the HITECH Act in February 2009 lead to the HIT Workgroup developing a statewide HIT Plan and Maine's HIT/HIE infrastructure was expanded • HealthInfoNet's secure database now contains clinical information on approximately half of Maine's 1.3 million people and has become Maine's state-designated health information exchange

	2008-09 State Health Plan Task	2008-2009 State Health Plan Progress Report
		• In 2010, HealthInfoNet worked with the GOHPF to secure federal grants from the Office of the State Coordinator to support expansion of health information technology (this will allow for expansion of HealthInfoNet to reach all healthcare providers in the state) and coordination and oversight of this initiative
18	Deepening the Analysis of Maine's Healthcare Cost Drivers	• In April 2009, the ASCHD presented a report and recommendations for addressing health care cost drivers in Maine based on two studies- a study from Health Dialog and MQF that revealed significant unwarranted variation that, if reduced, could save the state of Maine $300-400 each year and a study by the Muskie center of hospital emergency department use which showed that Maine uses 30% more emergency services than the national average. Recommendations include: o Support for public health policies that prevent disease and promote health o Support for an interconnected electronic medical record system through HealthInfoNet o Development of efficiency measures that can be used to offer incentives for patients to choose efficient, high quality providers o Support for fundamental payment reform o Identification and implementation of strategies to reduce Emergency Department use o Development of a consumer checklist for health insurance o Posting of a consumer-friendly summary of insurance company information o Expansion of CON criteria in the State Health Plan to address health care variation and high emergency department use o Enactment of legislation to amend CON to eliminate the exception of replacement equipment, lower CON thresholds, and elimination of indexing
19	Using Maine's Existing Research and Analytic Capacity to Greatest Effect	• GOHPF did not convene a workgroup to examine data issues. This is unfinished business and will be addressed in the 2010-2012 State Health Plan.
20	Healthcare Associated Infection	• MQF measured and reported hospital performance, formed and continued support of Maine Infection Prevention Collaborative, helped secure ARRA funds for Maine CDC for increased capacity for HAI prevention, control and reporting • MQF reported hospital metrics of HAI prevention processes and outcomes publically on MQF website and in annual reports to the legislature (a three year comparison on hospital performance on 13 HAI metrics shows overall improvement in performance, with most hospitals exceeding national averages) • In response to Resolve 2009 Chapter 82, a multi-stakeholder workgroup was convened to

	2008-09 State Health Plan Task	2008-2009 State Health Plan Progress Report
		define high-risk patients for MRSA (methicillin-resistant staphylococcus aureus) colonization. Hospitals will report a new HAI measure to MQF, which will be publically reported • The Maine Infection Prevention Collaborative was established, with accomplishments including development and adoption of instrument for measurement hand hygiene compliance and facilitation of training for hospital personnel on National Healthcare Safety Network platform for reporting on nosocomial infections
21	Sentinel Event Reporting	• DHHS sponsored a bill in the first session of the 124th Legislature to expand the number and type of sentinel events required to be reported to include those reported to NQF as "never events" (this bill also created voluntary reporting for reporting near miss events). Critical definitions were modified, and new parameters around ambulatory outpatients services were created. Rules were promulgated that required an educational component so providers and staff are aware of the law, what an event is, and how to report an event. The penalty for non-reporting was doubled.
22	Critical Access Hospital (CAH) Collaborative	• Maine Hospital Access Hospital Patient Safety Collaborative established, which includes 14 of Maine's 15 critical access hospitals—each hospital member received planning and subsequent implementation funding from MeHAF for projects in area of patient safety, particularly in the area of medication management. This Collaborative received the President's Award of the New England Rural Health Roundtable in October 2009. • Since 2008, 14 CAHs have joined the MQF, Maine Office of Rural Health and Primary Care, and MeHAF to strengthen medication safety and management • All 14 Critical Access Hospitals successfully completed their medication safety improvement initiatives. In addition to process improvements, technology and training implementation and patient education activities in each of the projects, a few of the specific results are highlighted below: o At Mayo Hospital in Dover-Foxcroft, extensive patient and staff education resulted in an increase in patient satisfaction with discharge information to 98%. o Rumford Hospital established pediatric medication safety processes, equipment and training, which resulted in one infant life saved. They also reduced their pediatric medication near-miss events from three to zero in the current reporting period. Rumford Hospital has taken a leadership role in their healthcare system to improve pediatric medication safety. o A new remote pharmacist monitoring system was established at Redington-Fairview Hospital in Skowhegan that provided 24-hour access to a pharmacist. The new system resulted in 98% or more of medication orders reviewed prior to the first dose given. The incidence of medication errors during the hours not previously covered by a pharmacist dropped 90%. o St. Andrews Hospital in Boothbay Harbor implemented a medication

	2008-09 State Health Plan Task	2008-2009 State Health Plan Progress Report
		reconciliation process. The target goal of less than 5% unreconciled medication upon inpatient admission was achieved. A medication error rate of 0% was also achieved and maintained through the use of an automated Pyxis medication dispensing program. Project staff also improved patient medication teaching and documented improvement on the HCAHPS survey question "New Medications Were Explained Clearly" from a score of 61% to 99%. • CAHs have participated in facilitated learning sessions to learn from national best practices and each other—projects focus on improving communication about medications, using new technology, and using personal health folders so that patients have up-to-date medication lists
23	Certificate of Need and the Capital Investment Fund	• MQF participated in CON application review of 9 applications since 2008 with the CON unit in DHHS' Division of Licensing • Based on recommendations from the ACHSD 2009 cost driver report, the CON criteria was amended to address health care variation and high emergency department use o Applicants that demonstrate how their project will lessen potentially avoidable and non-emergent ER use will receive higher priority in CON review o Any project—regardless of whether it would add high-cist, high variation services—will receive higher priority in CON review if it includes actions to lessen unwarranted utilization of high-cost, high-variation outpatient services in the applicant's HAS or includes a credible plan to evaluate the impact of the applicant's proposal

Appendix 2

Statewide Performance Report

A Call to District Action: Linking Public Health Strategies to Reduction of Avoidable Hospitalizations

MAINE (2010)

GOALS: To reduce avoidable hospitalizations by 50% by 2015 (through prevention, proper management, and appropriate treatment of disease).

	Prevention Quality Indicators (PQI's) that measure the potentially avoidable hospitalization rates that are major cost drivers in the state of Maine*:	Current Rates (Adjusted rate of admissions per 100K)	Goal (Reduction by 50% by 2015)	Cost savings in Maine given a 50% reduction by 2015
	Respiratory Infections			
1	Adult asthma admission rate*	72	36	$2,198,165
	Bacterial pneumonia admission rate*	380	190	$16,230,065
	Chronic obstructive pulmonary disease admission rate*	224	112	$8,640,570
	Heart Failure			
2	Congestive heart failure admission rate*	352	176	$14,759,440
	Hypertension admission rate*	21	11	$663,860
	Diabetes			
3	Diabetes short-term complication admission rate*	41	21	$1,469,695
	Diabetes long-term complication admission rate*	90	45	$5,335,710
	Uncontrolled diabetes admission rate*	7	3	$199,715
	Rate of lower-extremity amputation among patients with diabetes*	28	14	$2,598,615
		Total potential cost savings for Maine:		$52,095,835

Population Health Indicators: If these indicators are addressed comprehensively by the system, there will be a measureable reduction in the rates of avoidable hospitalizations.

		Maine	USA	Goal (Movement of trend)
1,2,3	Percent of adults that are obese (report a BMI >=30) [2008]	26	26	↓
1,2,3	Percent of high school youth that are overweight or obese [2007]	26	29	↓
1,2,3	Percent of adults that have not exercised in the past 30 days [2008]	23	n/a	↓
2,3	Percent of high blood pressure among adults [2008]	31	28	↓
2,3	Percent of high cholesterol among adults [2008]	41	38	↓
2,3	Prevalence of diabetes among adults (%) [2008]	8	8	↓
3	Percent of adults with diabetes who have received a Hemoglobin A1c test at least once yearly [2008]	93	n/a	↑
1	Percent of adults with asthma [2008]	10	9	↓
1	Percent of child and youth asthma, <18 years old [2007]	9	9	↓
1,2,3	Percent of adults that report smoking at least 100 cigarettes and that they currently smoke [2008]	18	20	↓
1,2,3	Adolescent smoking prevalence, 6-12 graders (%) [2006]	14	n/a	↓
1,2,3	Percent of adults that report binge drinking in the past 30 days [2008]	16	16	↓
2,3	Previous 30-day alcohol use, 9th-12th graders (%) [2008]	35	n/a	↓
1,2,3	Percent of adults reporting fair or poor health status in last 30 days [2008]	13	14	↓
1,2,3	Mean physically unhealthy days/month for adults [2008]	3.5	3.6	↓
1,2,3	Mean mentally unhealthy days/month for adults [2008]	3.5	3.4	↓
1,2,3	Percent of adults with >=14 days of frequent mental distress in past month [2008]	10	n/a	↓
1	Percent ever had Pneumococcal vaccine, >=65 Years [2008]	72	n/a	↑
1	Percent, Influenza vaccine past year for adults >18 years [2008]	41	n/a	↑
1,2,3	Access to primary care physician (population to physician ratio) [2004]	978:1	1351:1	↓
2,3	Percent of adults with a routine dental visit in past year [2008]	70	n/a	↑
1,2,3	Number of unique visits to KeepMEWell.org (count)	2,185	n/a	↑

Context: Socioeconomic status.

	Maine	USA
Total population [2008]	1,316,456	304,059,724
Percent individuals living in poverty [2007]	12	13
Population density (people per mi²) [2008]	37	86
Percent of population non-white [2008]	17	34
Percent of population between the ages of 18-64 years old [2008]	65	63
Percent 65 years and older [2005-07]	14	13
Percent of adults with lifetime educational attainment less than high school [2000]	15	9
Percent of householders >=65 Living Alone [2000]	11	9
Percent of adults with no health insurance	11	15
Percent of children age 0-18 years without health insurance	7	12

* Prevention Quality Indicator (PQI): Risk adjusted for age and sex, number of admissions per 100,000 population. Generated by the Maine Quality Forum using a tool created by the Agency for Healthcare Research and Quality (AHRQ).

Certificate of Need Laws Relating to Oversight of Ambulatory Surgical Centers

Definition

Under Maine law, an "ambulatory surgical center" is defined in Title 22, section 328, subsection 2 as follows.

> ***2. Ambulatory surgical facility.*** *"Ambulatory surgical facility" means a facility, not part of a hospital, that provides surgical treatment to patients not requiring hospitalization. "Ambulatory surgical facility" does not include the offices of private physicians or dentists, whether in individual or group practice.*

In other state CON laws, ambulatory surgical centers are also referred to as outpatient surgical centers or free-standing surgical centers, but generally defined in a similar manner as in Maine law.

CON Review of Ambulatory Surgical Centers

While 35 states have laws establishing certificate of need (CON) programs, the laws and requirements of each state vary widely. One of the variations is which types of health care facilities are subject to review. Based on a review of CON laws and resources compiled by the National Conference of State Legislatures and National Academy of State Health Policy, there are 19 states that require CON review for the establishment of ambulatory surgical centers, including Maine and the other New England states with the exception of New Hampshire. New Hampshire repealed its CON law in its entirety in 1996.

Exemptions

The other state laws that require CON review and approval to establish ambulatory surgical centers do vary in scope and there are instances where certain exemptions are provided from full CON review. Exemptions found in other state laws are based on different factors such as:

- The capital investment required to construct a new ambulatory surgical center. For example, Hawaii and Illinois exempt new facilities that require a capital investment lower than a threshold of approximately $4,000,000;
- The size of the facility. For example, Maryland does not require full CON review approval for ambulatory surgical centers with 2 or fewer operating rooms or ambulatory surgical centers that have only procedure rooms; or
- The type of services provided. For example, Iowa exempts ambulatory surgical centers that provide cosmetic, reconstructive or plastic surgery services from review and Mississippi recently amended its law and regulations to exempt single-specialty ambulatory surgical centers from review.

Scope and Impact of Private Capital Investments in Health Care Delivery

Maine Commission to Evaluate the Scope of Regulatory Review and Oversight over Health Care Transactions That Impact the Delivery of Health Care Services in the State

October 23, 2025

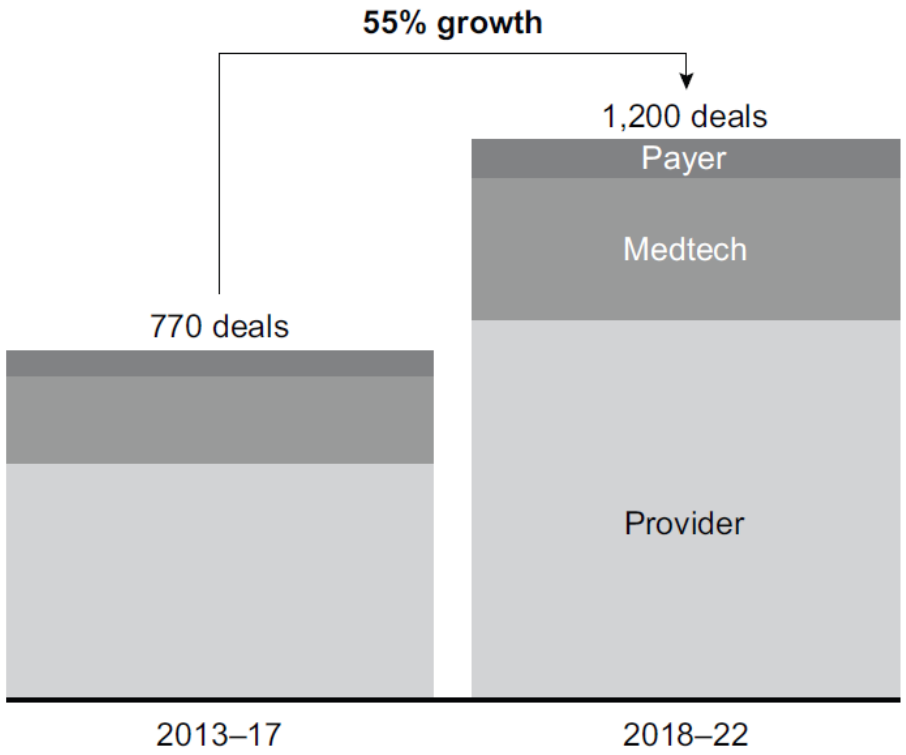
Zirui Song, MD, PhD
Harvard Medical School
Massachusetts General Hospital

BREAKING NEWS

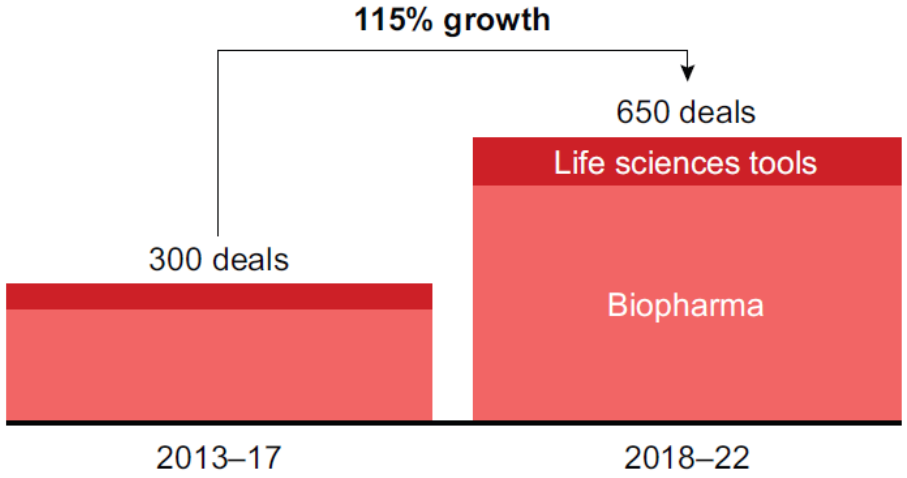
Steward Health Care, operator of 8 Massachusetts hospitals, files for bankruptcy

Global Private Equity Deals in Health Care

Global healthcare deal volume for provider, payer, and medtech sectors



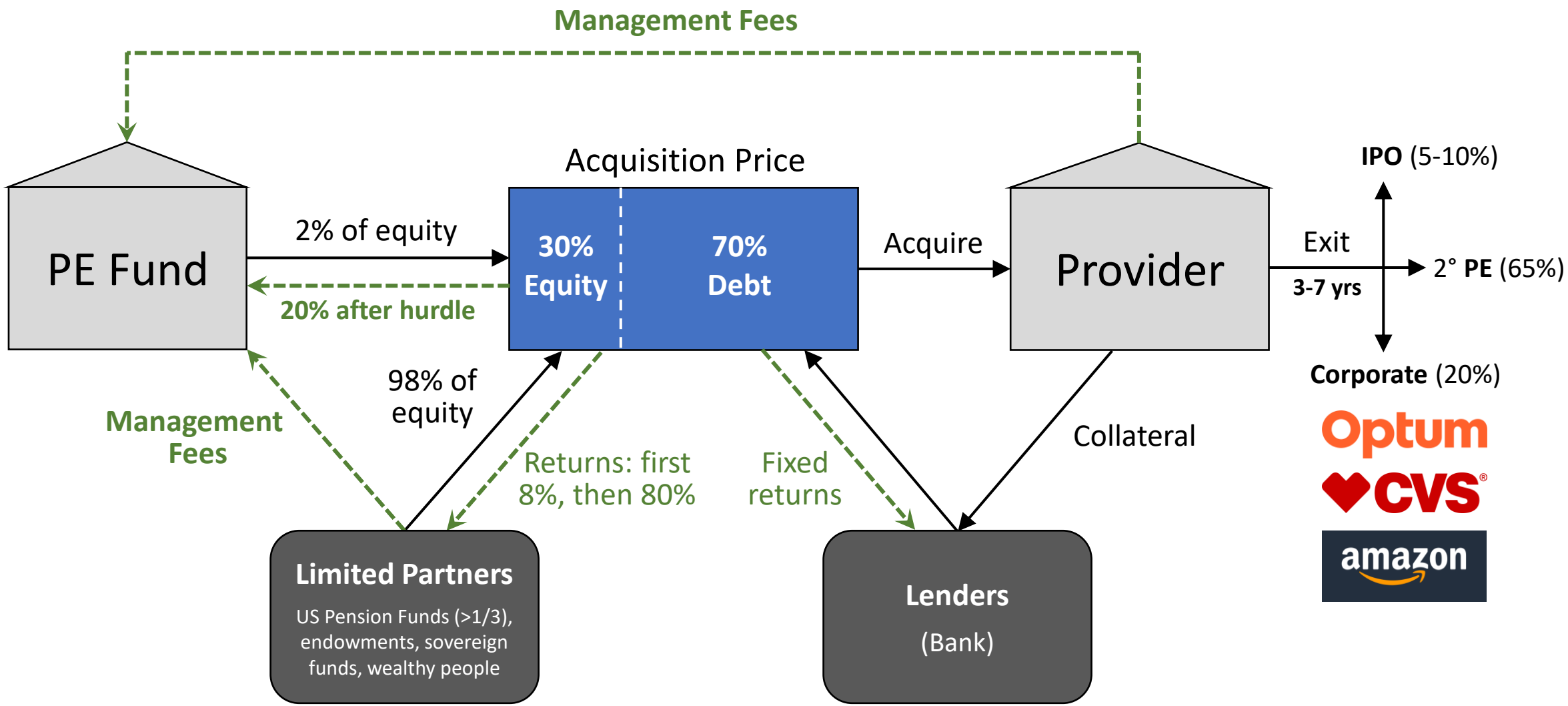
Global healthcare deal volume for biopharma and life sciences tools sectors



Notes: Excludes spin-offs, add-ons, loan-to-own transactions, special purpose acquisitions, and acquisitions of bankrupt assets; based on announcement date includes announced deals that are completed or pending, with data subject to change; deal value does not account for deals with undisclosed values; values updated based on Dealogic 2020 sponsor classifications; values include net debt where relevant; deal totals are rounded
Sources: Dealogic; AVCJ; Bain analysis

Bain and Company, 2023

Classic Model of a Private Equity (PE) Acquisition



Management fees = 2/3 of revenue for PE general partner

Song Z. In progress

Private Equity and Primary Care: Lessons from the Field

Umar Ikram, MD, PhD, Khin-Kyemon Aung, MD, MBA, Zirui Song, MD, PhD

NEJM Catalyst

Table 1. Comparison of Venture Capital, Growth Equity, and Traditional Private Equity

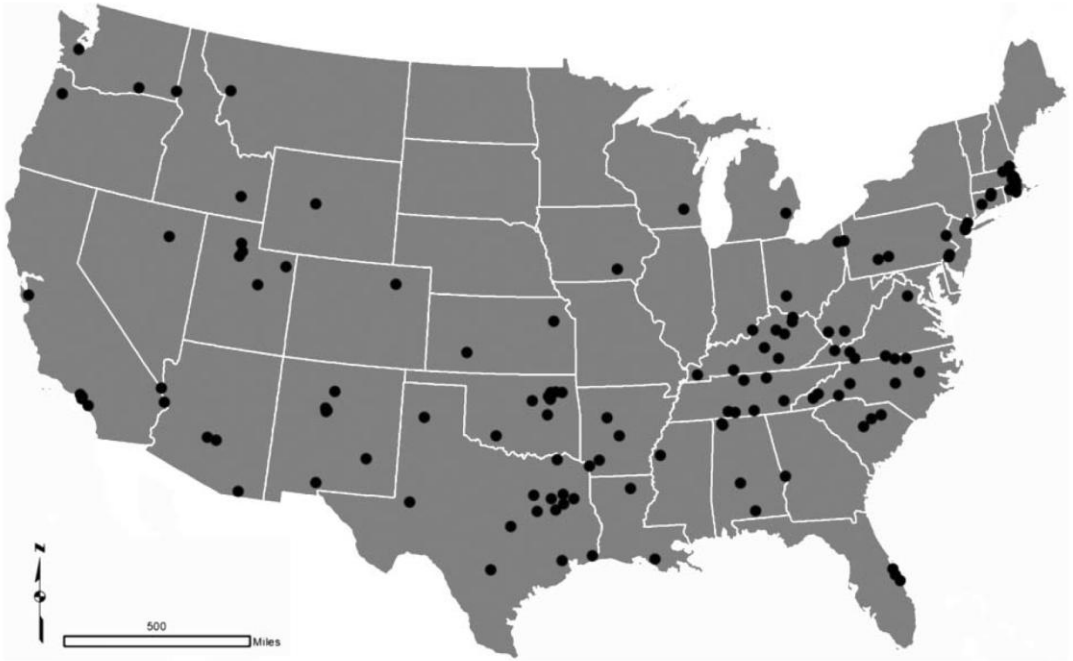
	Venture Capital	Growth Equity	Traditional Private Equity (Leveraged Buyout)
Stage of investment	Early stage	Later stage	Mature
Types of companies targeted	Start-ups or early-stage ventures with less of a proven business model, but with high growth potential	Organizations with stronger revenues and operating with proven business models, but in need of financing to pursue further growth	Established businesses that are undervalued or underperforming with inefficiencies that could be addressed through changes in operations, financial engineering, or governance
Amount of investment	Minority stake, <50% ownership	Usually minority stake, <50% ownership	Majority stake, >50% ownership
Exit time frame (on average)	5–10 years	3–7 years	3–7 years
U.S. deal value total in 2019*	$136.5 billion	$92.8 billion†	$627.3 billion
Number of U.S. deals in 2019*	10,777	1,678†	5,133
Estimated average investment size	$12.7 million	$55.3 million	$122.2 million
Expectations for returns	At least 10×; ideally, 50–100× returns for the most successful companies	At least 3–6× returns per deal	At least 2–4× returns per deal
Examples of firms	Venrock, Accel, Benchmark, Sequoia Capital, Madrona Venture Group	TPG Growth, Blackstone Growth, Summit Partners, General Atlantic, Insight Partners	The Carlyle Group, The Blackstone Group, KKR, TPG Capital, Warburg Pincus

*Data from Pitchbook. †Numbers reflect North America and Europe, not U.S. alone. Source: The authors

Geographic Distribution and Penetration

Hospital Acquisitions

Figure. Locations of private equity–owned hospitals in 2018.

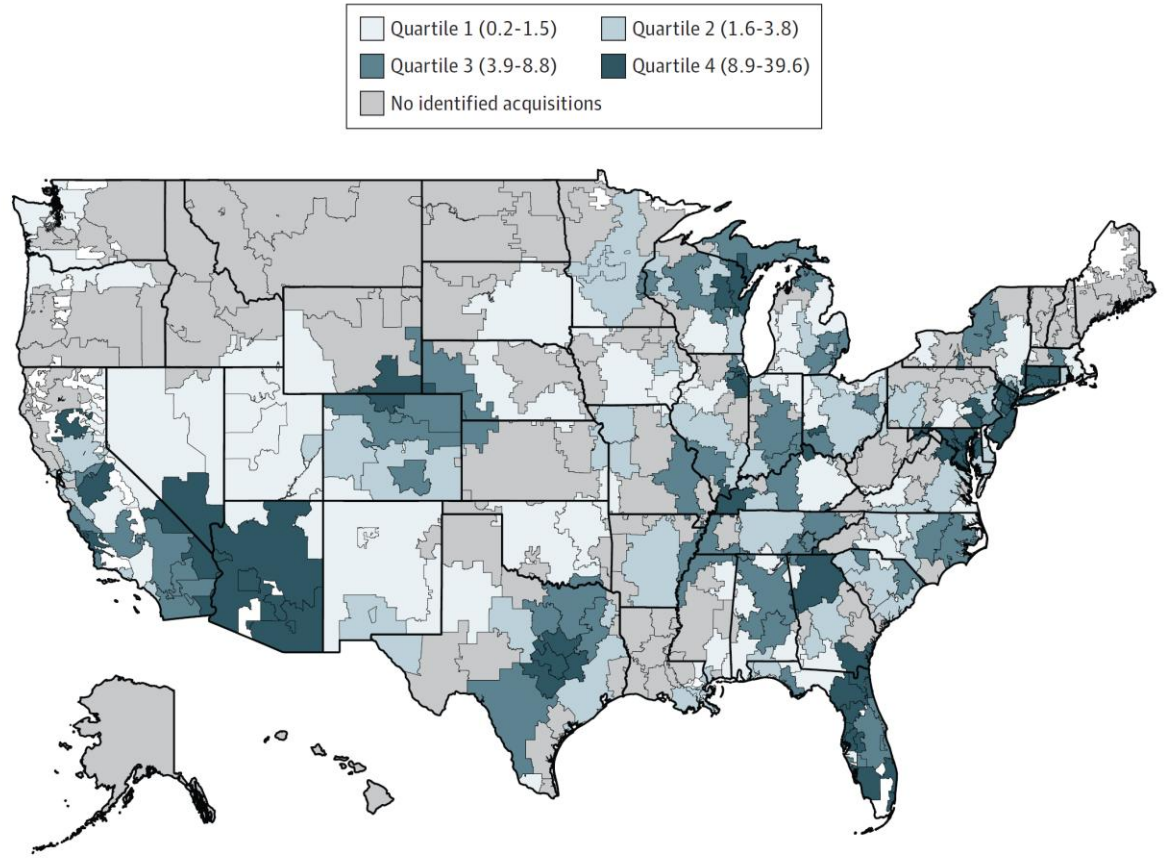


Using Medicare cost reports, the addresses for the 130 private equity–owned hospitals in 2018 were identified. There were no such hospitals located in Hawaii or Alaska.

Bruch J, Zeltzer D, Song Z. Ann Intern Med (2020)

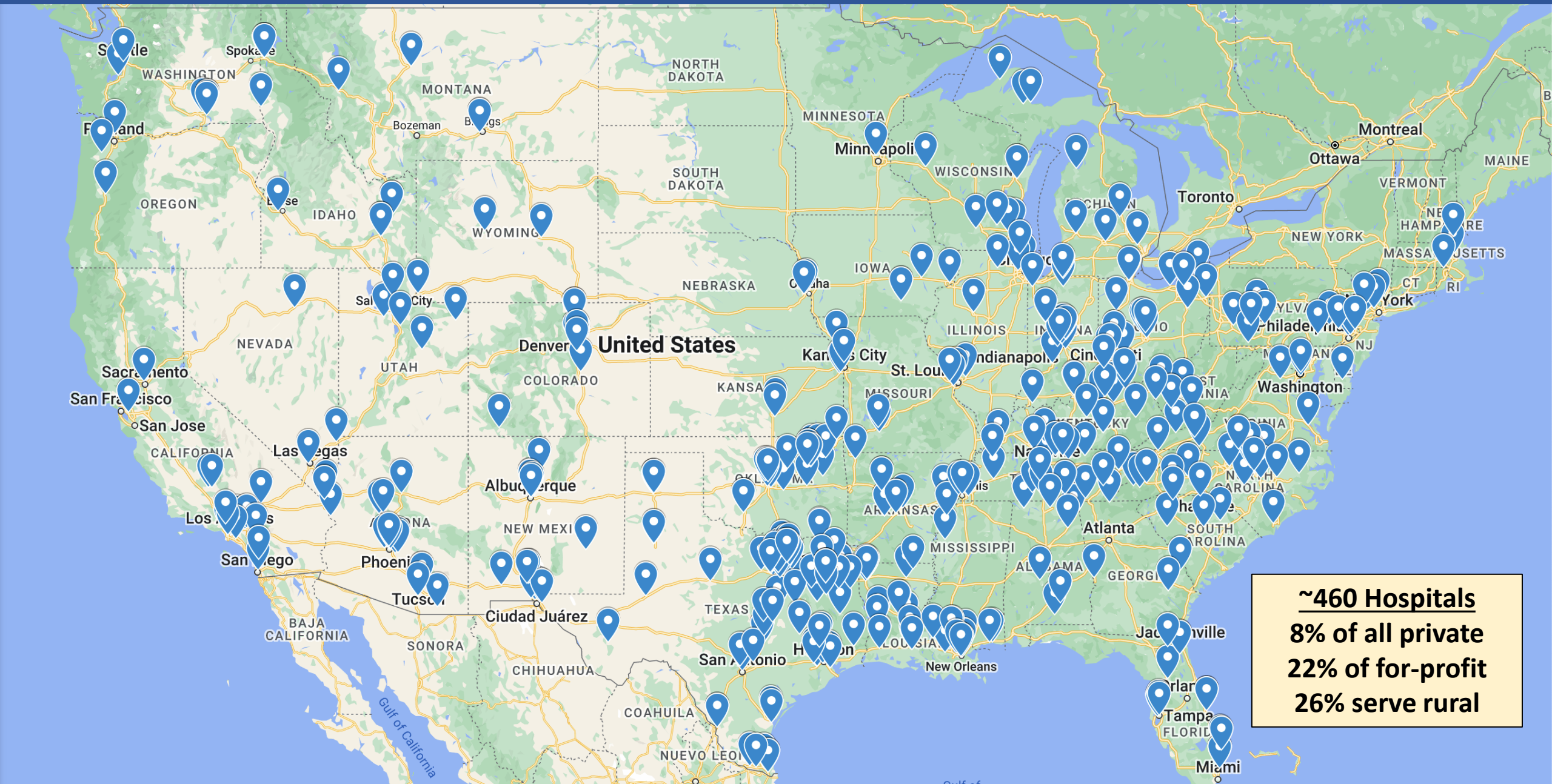
Physician Practice Acquisitions

Figure 1. Private Equity (PE) Penetration Across 6 Office-Based Specialties by Hospital Referral Region (HRR)



Singh Y, Zhu JM, Polsky D, Song Z. JAMA Health Forum (2022)

Private Equity Hospitals in 2024



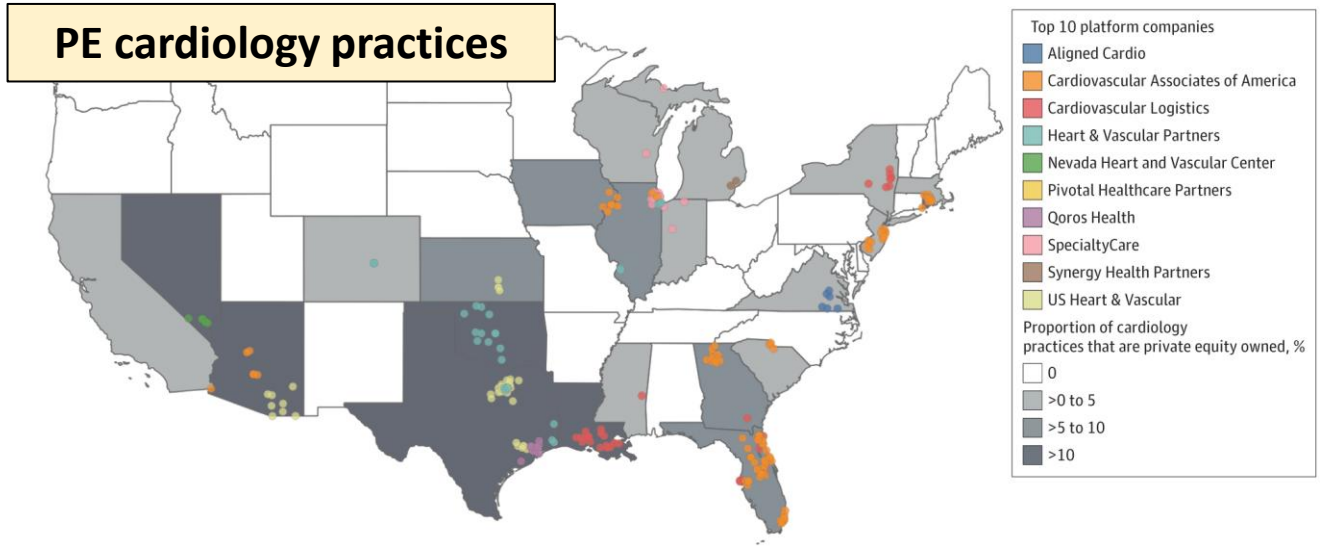
~460 Hospitals

8% of all private

22% of for-profit

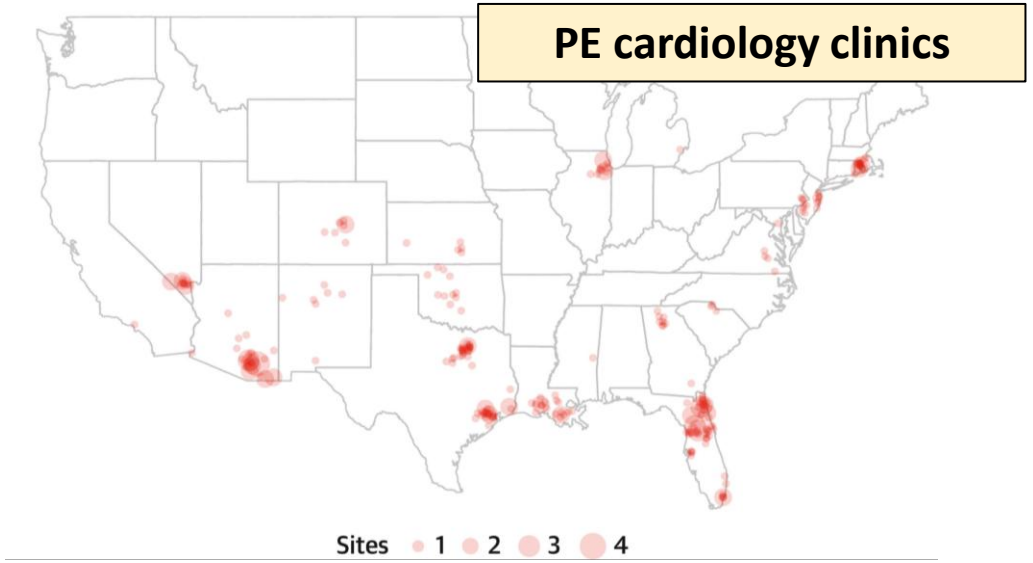
26% serve rural

PE cardiology practices

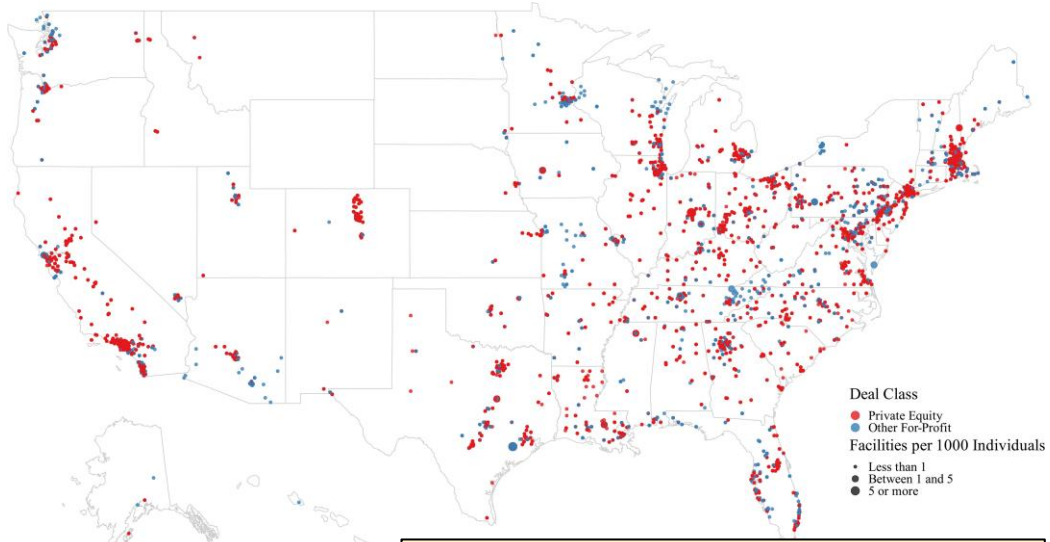


Singh Y, Reddy M, Whaley C. JAMA Health Forum (2024)

PE cardiology clinics

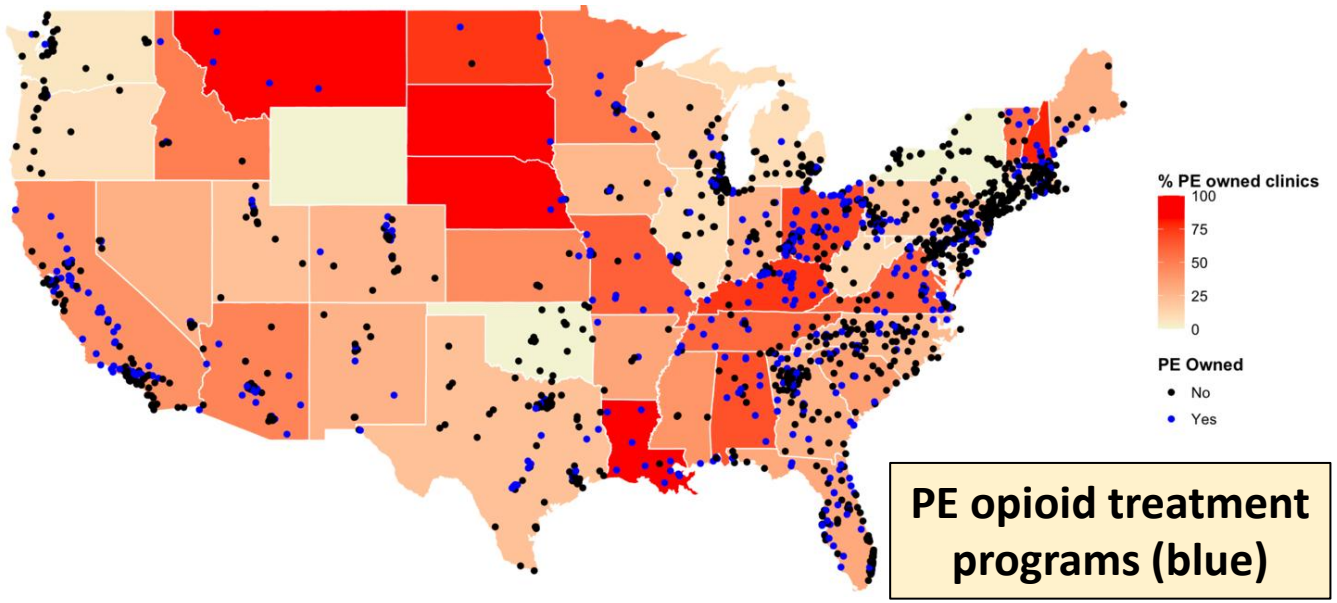


Bartlett VL, Liu M, Ati S, Yeh RW, Zheng Z, Wadhera RK. J Am Coll Cardiol (2024)



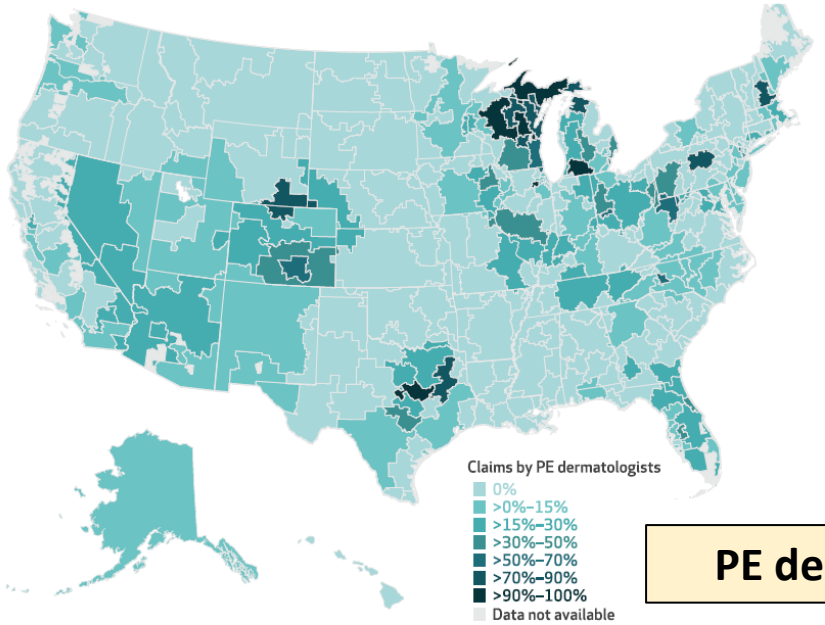
PE behavioral health facilities

Thornburg B, McGinty EB, Eddelbuettel J, et al. Health Affairs Scholar (2024)



PE opioid treatment programs (blue)

Zhu DT, Song Z, Kannan S, Cai C, Bajaj SS, Gondi S. JAMA Psychiatry (2025)

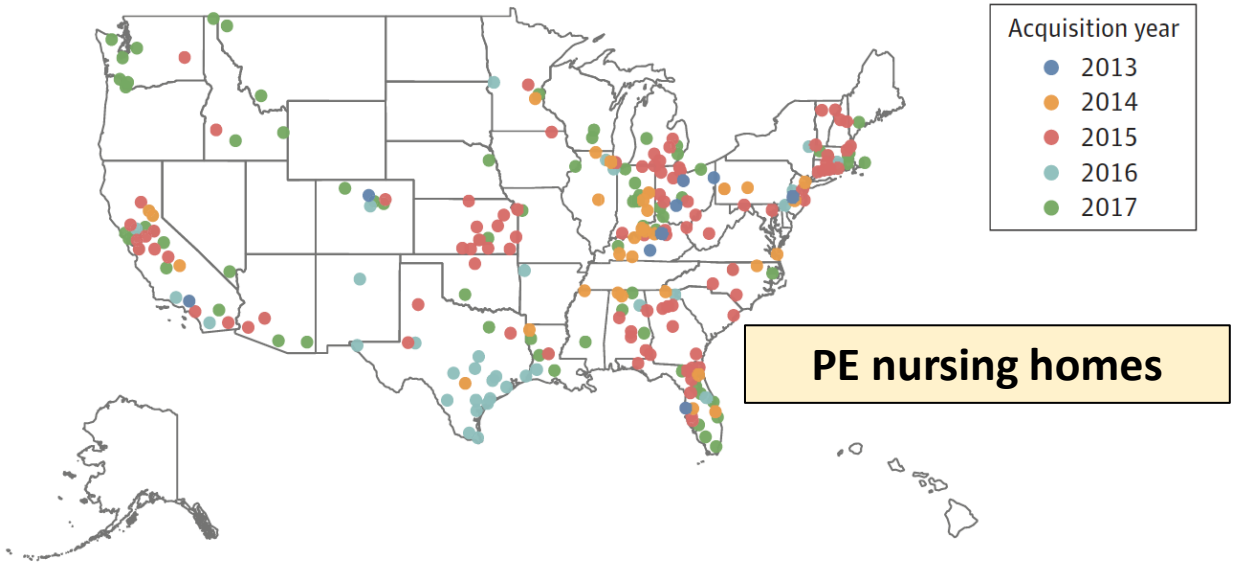


PE dermatology

Braun RT, Bond AM, Qian Y, Zhang M, Casalino LP. Health Affairs (2021)

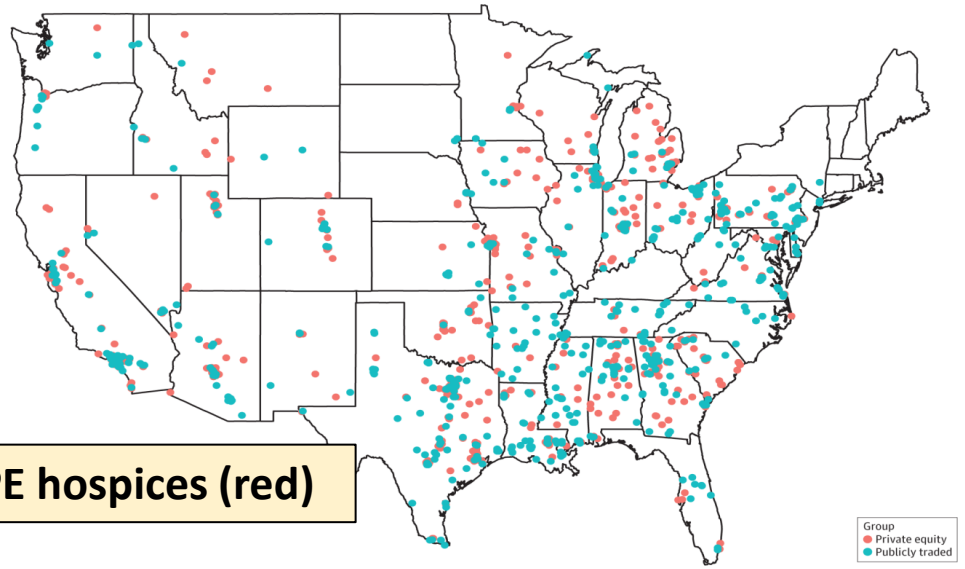
PE OB/GYN practices

Bruch JD, Borsa A, Song Z, Richardson SS. JAMA Internal Medicine (2020)



PE nursing homes

Braun R, Jung HY, Casalino L, Myslinksi L, Unruh M. JAMA Health Forum (2021)



PE hospices (red)

Braun RT, Unruh MA, Stevenson DG, et al. JAMA Network Open (2023)

Acquisitions of Hospitals → ↑ Income, Charges, Case Mix, Commercial %

JAMA Internal Medicine | Original Investigation

Changes in Hospital Income, Use, and Quality Associated With Private Equity Acquisition

Table 1. Characteristics of 204 Private Equity–Acquired Hospitals and 532 Control Hospitals[a]

Characteristic	Hospitals, No. (%)	
	Private equity acquisition	Control
Hospital ownership		
Nonprofit	29 (14.2)	76 (14.3)
Government	3 (1.5)	8 (1.5)
For profit	172 (84.3)	448 (84.2)
Geographic region		
South	125 (61.3)	325 (61.1)
West	37 (18.1)	97 (18.2)
Northeast	21 (10.3)	55 (10.3)
Midwest	21 (10.3)	55 (10.3)
Teaching hospital	55 (27.0)	139 (26.1)
Hospital size by total No. of beds, mean No.	212	200
Small (<150 beds), %	30.9	40.8
Medium (150-350 beds), %	56.4	45.1
Large (>350 beds), %	12.8	14.2

Figure. Total Charge to Cost Ratios Before and After Private Equity Acquisition

Bruch JD, Gondi S, Song Z. JAMA Intern Med (2020)

Acquisitions of Hospitals → ↑ Income, Charges, Case Mix, Commercial %

JAMA Internal Medicine | Original Investigation

Changes in Hospital Income, Use, and Quality Associated With Private Equity Acquisition

Relative to control, PE acquisitions increased:

Net income	27%
Charges per day	7%
Charge/cost ratio	7%
Charge/cost ratio (ED)	16%
Case mix	1.4%
Medicare %	-2.4%

Figure. Total Charge to Cost Ratios Before and After Private Equity Acquisition

Bruch JD, Gondi S, Song Z. JAMA Intern Med (2020)

Hospital-Acquired Conditions (Adverse Events)

Hospital Acquired Condition	Eligible Hospitalizations
Foreign body retained after surgery	All
Air Embolism	All
Blood Incompatibility	All
Pressure ulcers	All
Falls	All
Catheter-associated urinary tract infection (CAUTI)	All
Central line-assoc. bloodstream infection (CLABSI)	All
Surgical site infection (SSI) for CABG, Orthopedic Surgeries, and Bariatric Surgeries	Hospitalizations with performed CABG, Orthopedic Surgeries, or Bariatric Surgeries
Poor glycemic control	All
Deep vein thrombosis/ pulmonary embolism (DVT/PE)	Hospitalizations with performed Hip/Knee Replacements

RTI and CMS (2010, 2012)

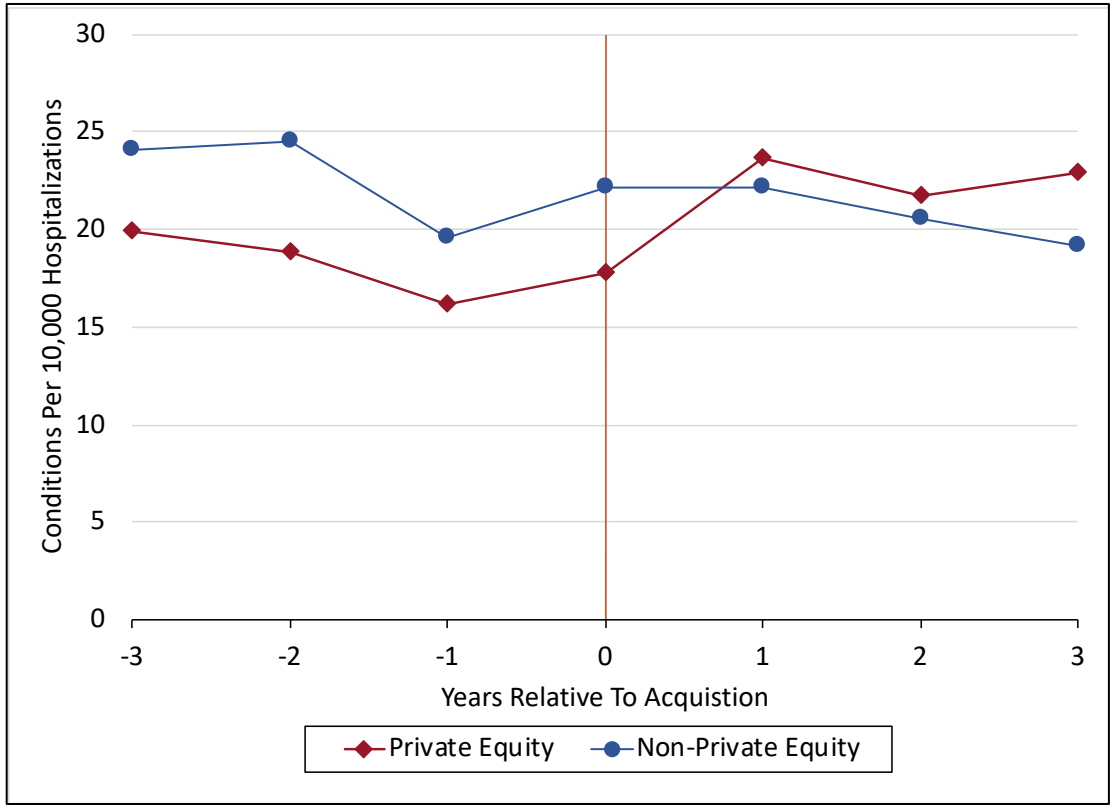
Acquisitions of Hospitals → ↑ Hospital-Acquired Complications

JAMA | **Original Investigation**

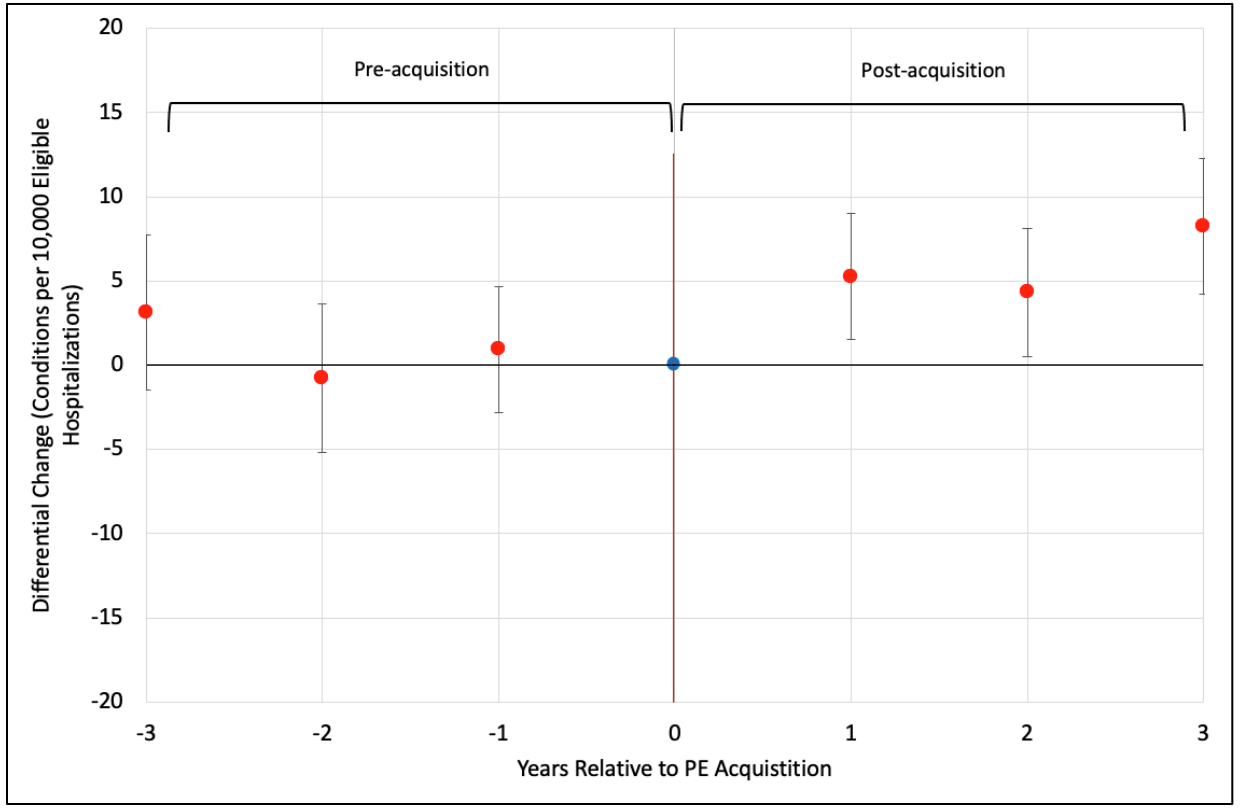
Changes in Hospital Adverse Events and Patient Outcomes Associated With Private Equity Acquisition

Sneha Kannan, MD; Joseph Dov Bruch, PhD; Zirui Song, MD, PhD

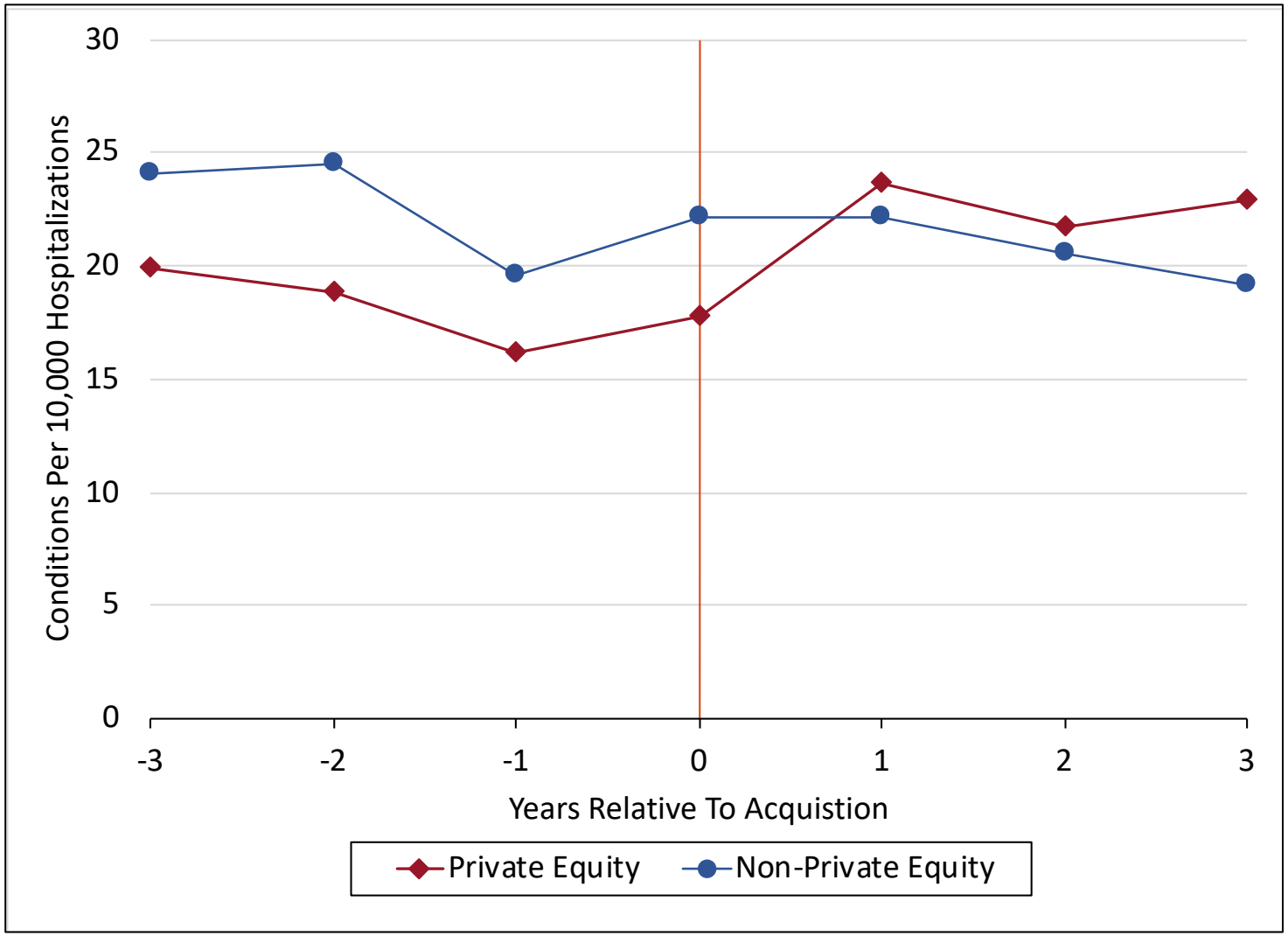
Unadjusted Levels



Adjusted Estimates (Differential Change)



Acquisitions of Hospitals → ↑ Hospital-Acquired Complications



Relative to control, PE acquisitions increased:

Composite HACs	25%
Falls	27%
Central line infections	38%

(Despite 16% fewer central lines)

Surgical site infections doubled at PE hospitals, while declining at controls.
(Despite 8% fewer surgeries performed)

Kannan S, Bruch J, Song Z. JAMA (2023)

The Boston Globe

They died in hallways. In line. Alone. Their deaths are the human cost of Steward's financial neglect.

This story was reported by Liz Kowalczyk, Chris Serres, Jessica Bartlett, Elizabeth Koh, Mark Arsenault, and Yoohyun Jung. It was written by Arsenault and edited by Brendan McCarthy.

Published Sept. 6, 2024

Annals of Internal Medicine

ORIGINAL RESEARCH

Hospital Staffing and Patient Outcomes After Private Equity Acquisition

Sneha Kannan, MD, MS; Joseph Dov Bruch, PhD; José R. Zubizarreta, PhD; Jennifer Stevens, MD, MS; and Zirui Song, MD, PhD

Background: After private equity acquisition, hospitals may experience changes in staffing with implications for patients.

Objective: To examine hospital staffing and patient outcomes in emergency departments (EDs) and intensive care units (ICUs) before and after hospitals were acquired by private equity.

Design: Matched difference-in-differences analysis.

Setting: 100% Medicare Part A and B claims and Cost Report data from 2009 to 2019.

Patients: 1 007 529 ED visits and 121 080 ICU hospitalizations across 49 private equity hospitals were compared with 6 179 854 ED visits and 760 377 ICU hospitalizations across 293 matched control hospitals.

Measurements: Hospital ED and ICU salary expenditures, patient mortality, length of stay, and transfers. Secondary outcomes included hospital-wide salary expenditures and full-time employees.

Results: After acquisition, private equity hospitals reduced ED salary expenditures by 18.2% (−$12.63 per inpatient bed day; 95% CI, −$22.74 to −$2.52; $P = 0.015$) and ICU salary expenditures by 15.9% (−$8.46 per inpatient bed day, CI, −$13.21 to −$3.72; $P < 0.001$) relative to control. This occurred alongside average hospital-wide reductions in full-time employees by 11.6% and salary expenditures by 16.6%, relative to control. Beneficiaries in EDs of private equity hospitals experienced 7.0 additional deaths per 10 000 visits after acquisition relative to control (13.4% increase from a raw baseline of 52.4 deaths per 10 000; $P = 0.009$). No differential change in ICU mortality was observed. However, patients in private equity EDs and ICUs experienced a 4.2% and 10.6% increase in transfers, respectively, to other acute care hospitals after acquisition relative to control. On average, ICU length of stay shortened by 0.2 days. Sensitivity analyses produced qualitatively similar findings.

Limitation: Potential unmeasured confounding; lack of generalizability to other acquisitions or patient populations.

Conclusion: After private equity acquisition, hospitals on average reduced salaries and staffing relative to nonacquired hospitals, notably in the EDs and ICUs, which are higher-acuity and staffing-sensitive areas. This decreased capacity to deliver care may explain the increased patient transfers to other hospitals, shortened ICU lengths of stay, and increased ED mortality.

Primary Funding Source: National Institutes of Health and Agency for Healthcare Research and Quality.

Ann Intern Med. doi:10.7326/ANNALS-24-03471
For author, article, and disclosure information, see end of text.
This article was published at Annals.org on 23 September 2025.

Annals of Internal Medicine ORIGINAL RESEARCH

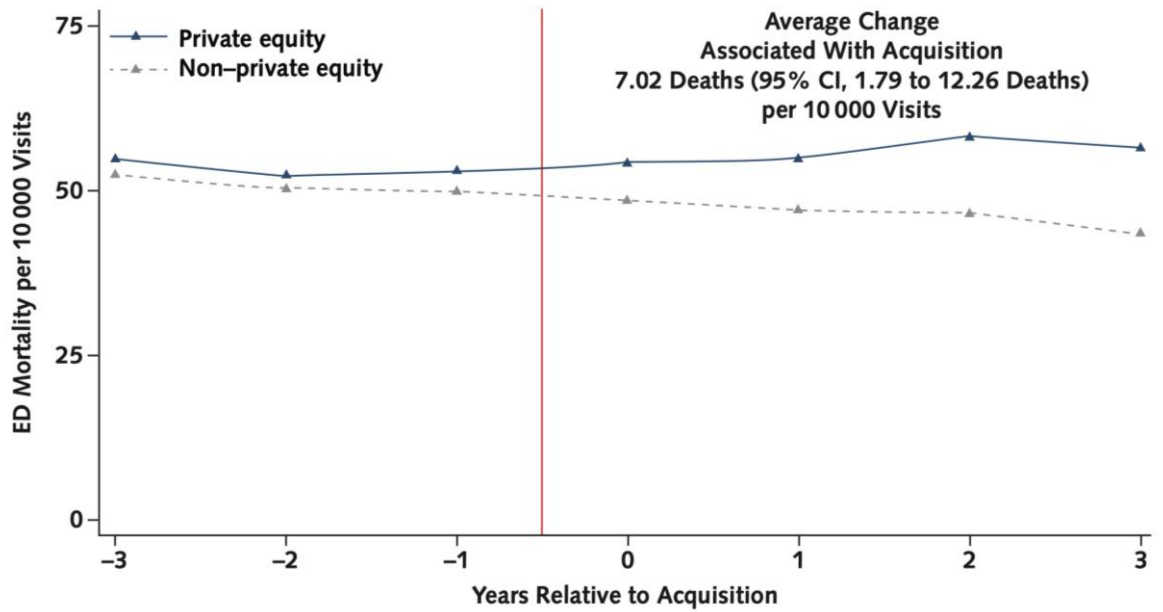
Hospital Staffing and Patient Outcomes After Private Equity Acquisition

Sneha Kannan, MD, MS; Joseph Dov Bruch, PhD; José R. Zubizarreta, PhD; Jennifer Stevens, MD, MS; and Zirui Song, MD, PhD

Table 2. Changes in Patient Outcomes in Private Equity and Control Hospitals*

Outcome	Private Equity		Control		Unadjusted Between-Group Difference†	Adjusted Between-Group Difference‡ (Percentage) [95% CI]	*P* Value
	Preacquisition	Postacquisition	Preacquisition	Postacquisition			
	(*n* = 49)		(*n* = 293)				
Hospital salary expenditures					-	-	-
ED salary expenditures per inpatient bed day, $	69.37	65.96	81.59	89.03	−10.84	−12.63 (−18.2) [−22.74 to −2.52]	0.015
ICU salary expenditures per inpatient bed day, $	53.25	48.90	57.53	60.39	−7.20	−8.46 (−15.9) [−13.21 to −3.72]	<0.001
	(*n* = 1 007 529)		(*n* = 6 197 854)				
ED visits					-	-	-
In-hospital mortality per 10 000	52.35	57.10	49.37	44.61	9.50	7.02 (13.4) [1.79 to 12.26]	0.009
Transfer to acute care hospital, %	2.65	3.65	2.82	2.89	0.94	0.11 (4.2) [0.04 to 0.18]	0.002
	(*n* = 121 080)		(*n* = 760 377)				
ICU hospitalizations					-	-	-
ICU length of stay, *d*	4.12	3.76	3.79	3.68	−0.24	−0.20 (−4.8) [−0.26 to −0.13]	0.006
In-hospital mortality, %	11.25	11.07	11.02	10.61	0.23	−0.13 (−1.1) [−0.54 to 0.29]	0.55
Transfer to acute care hospital, %	4.41	5.10	4.11	4.09	0.66	0.47 (10.6) [0.18 to 0.74]	0.024

Figure 3. Emergency department mortality at private equity and control hospitals.



(2025)

Annals of Internal Medicine ORIGINAL RESEARCH

Hospital Staffing and Patient Outcomes After Private Equity Acquisition

Sneha Kannan, MD, MS; Joseph Dov Bruch, PhD; José R. Zubizarreta, PhD; Jennifer Stevens, MD, MS; and Zirui Song, MD, PhD

Figure 1. Emergency department and intensive care unit salary expenditures at private equity and control hospitals.

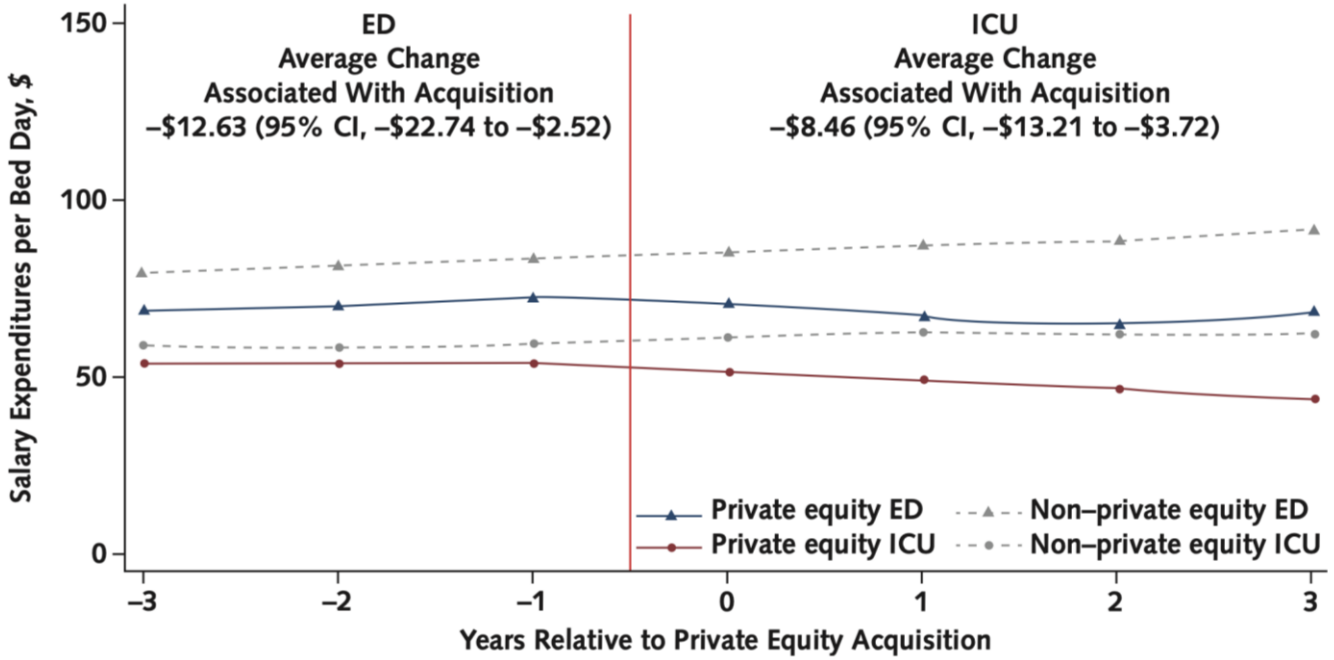
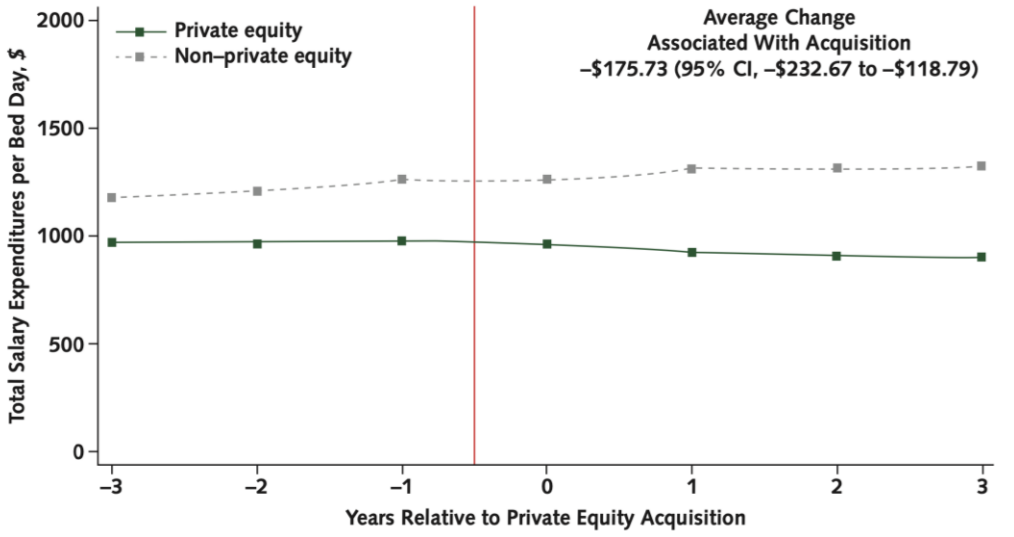
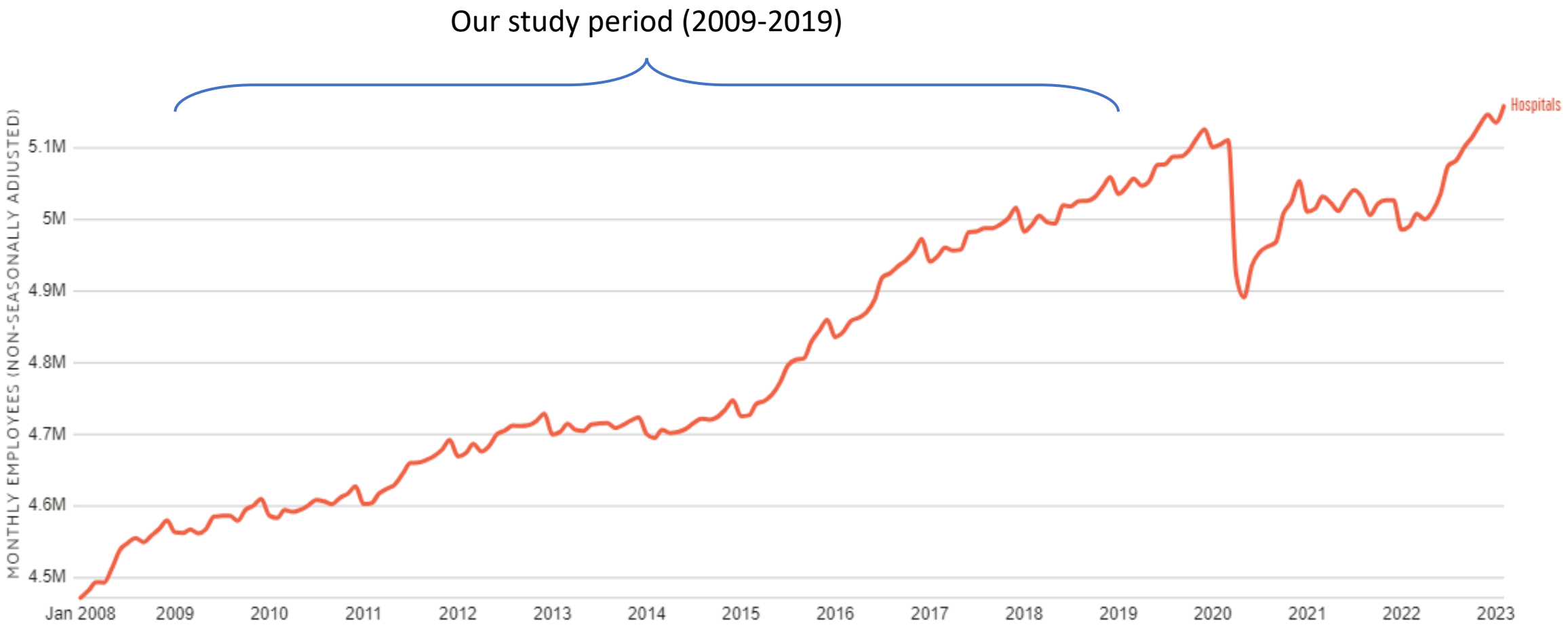


Figure 2. Total salary expenditures at private equity and control hospitals.



(2025)

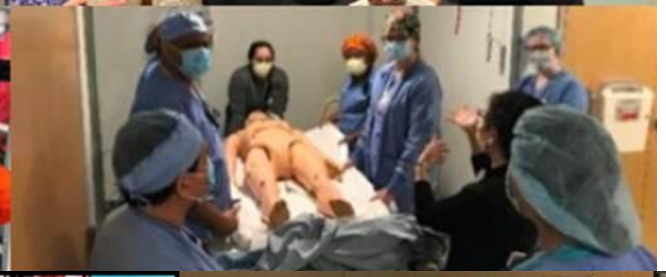
National Trends in Hospital Employees



U.S. Bureau of Labor Statistics (2023)

What About During COVID?



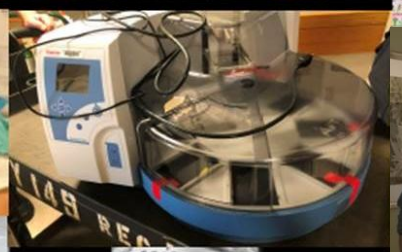









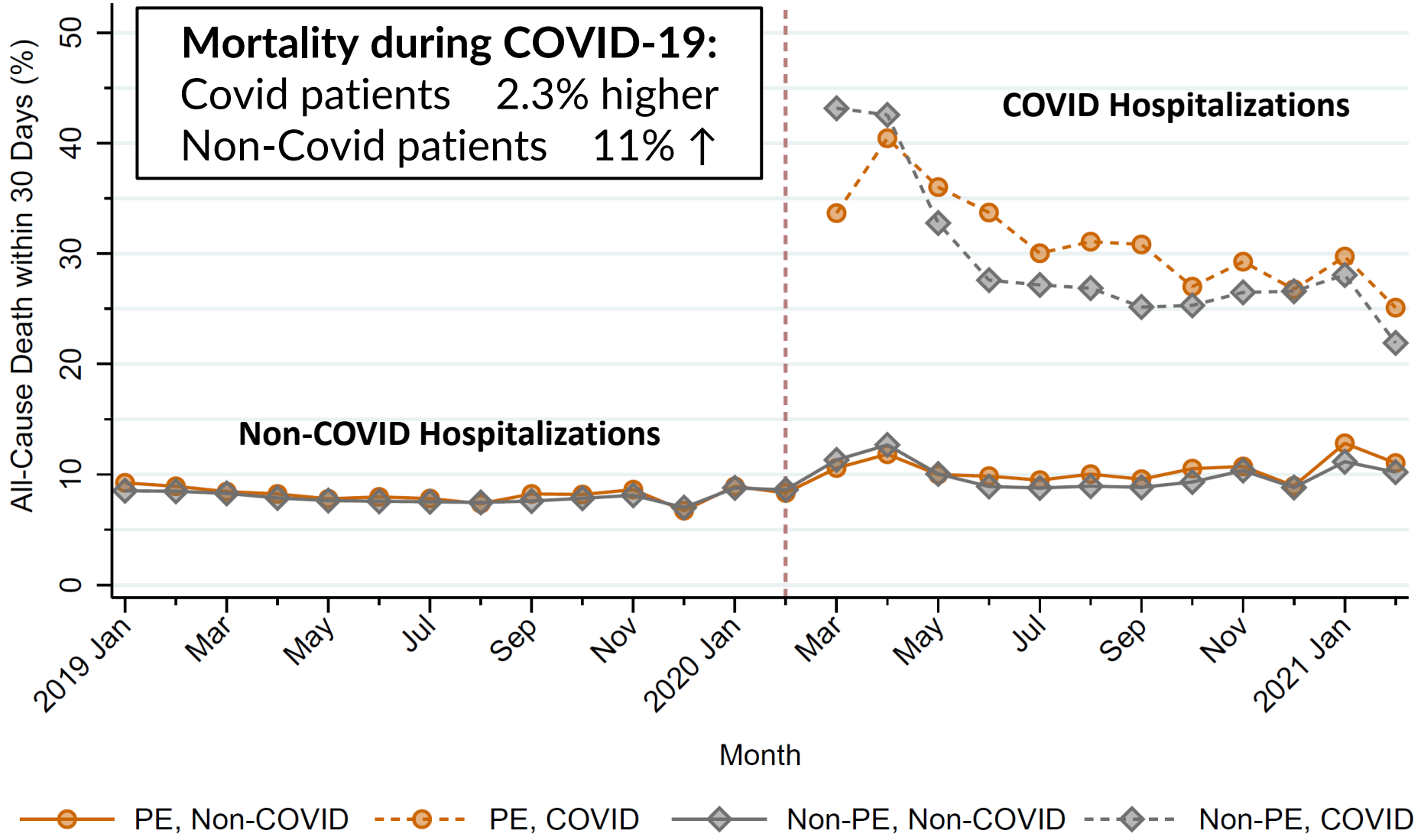




Colleagues at MGH

30-day Mortality for COVID and Non-COVID Hospitalizations



Song Z, Patterson L, Bruch J, Zhang X, Haas D. In progress

Policy Question 1: Does Private Equity Buy Distressed Hospitals?

242 PE Hospitals vs. 870 Matched Control Hospitals

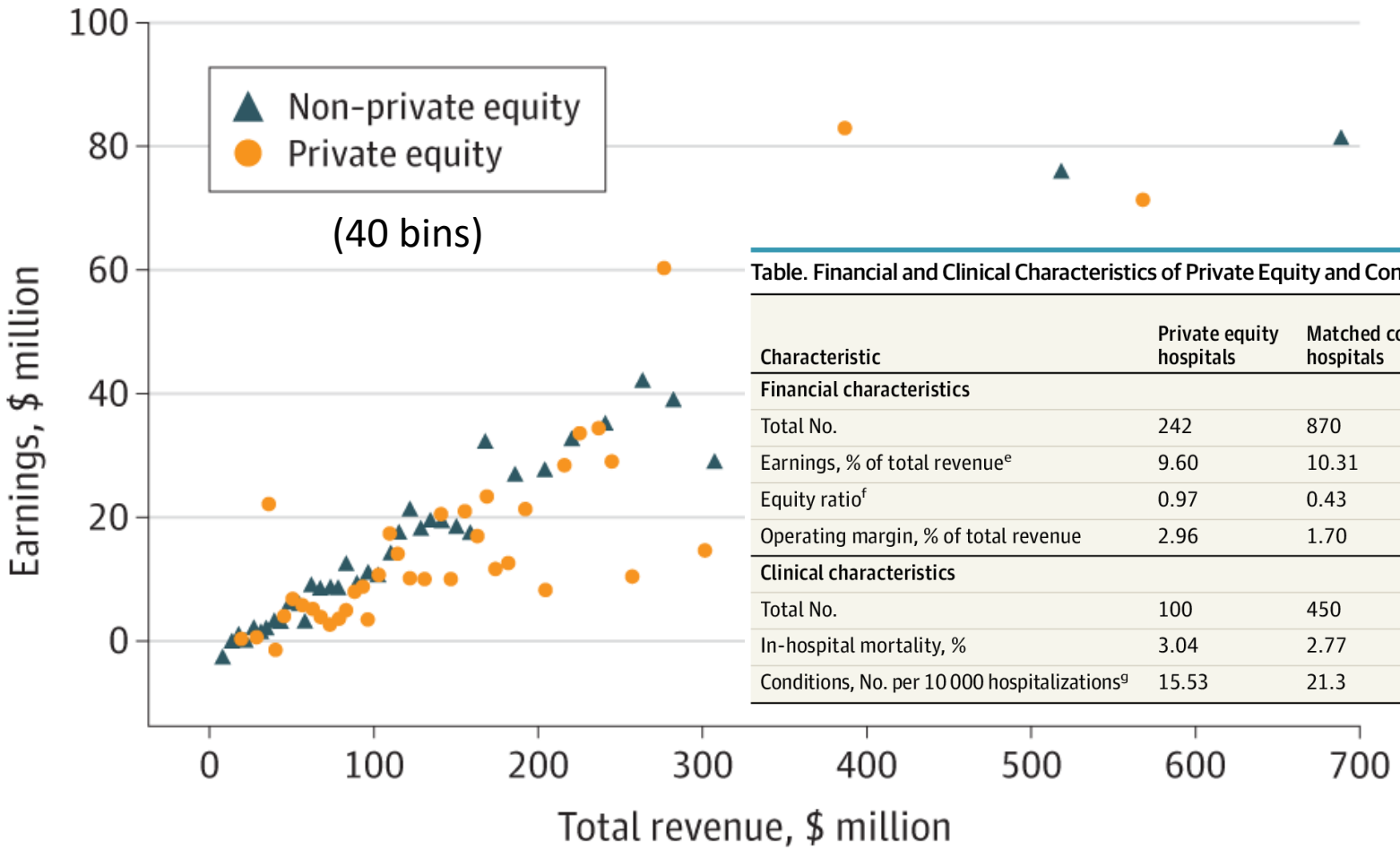


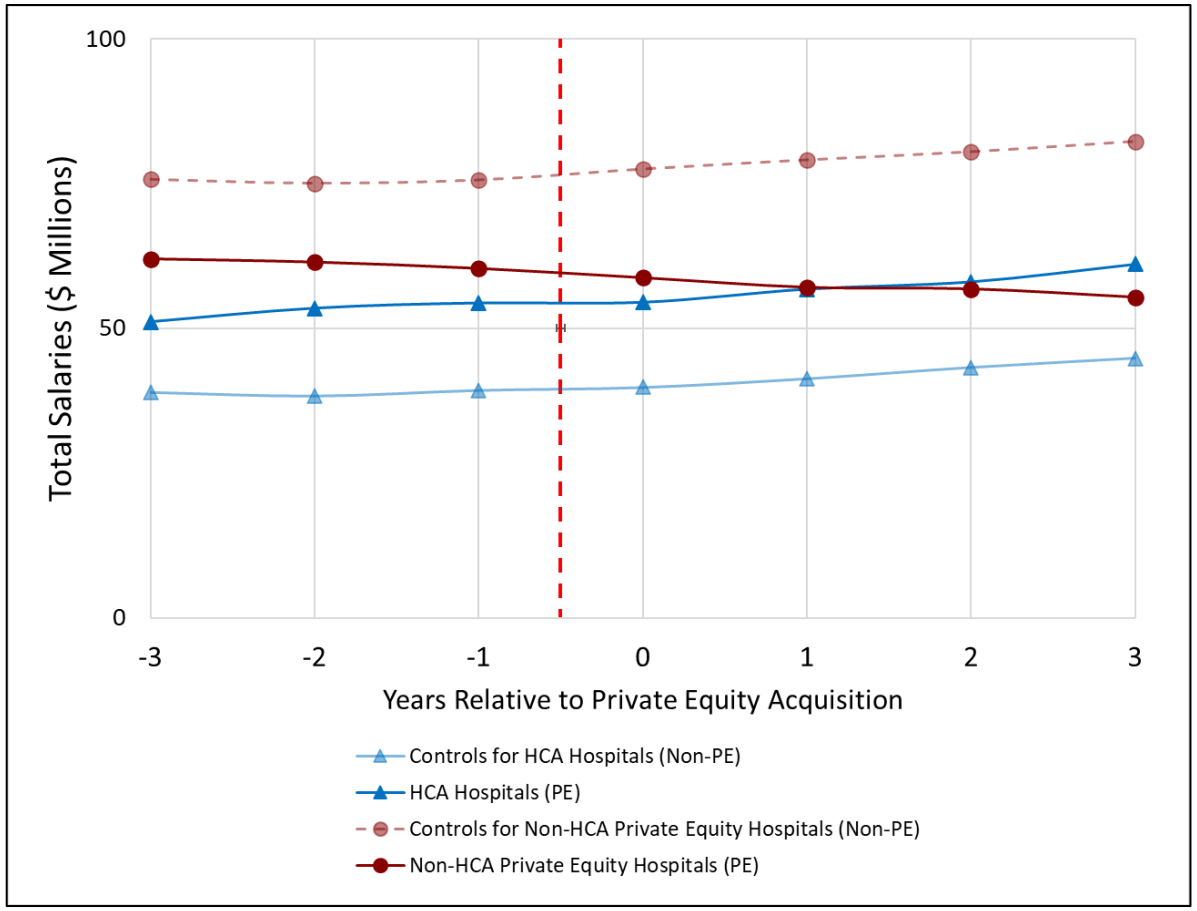
Table. Financial and Clinical Characteristics of Private Equity and Control Hospitals in the Year Before Acquisition[a]

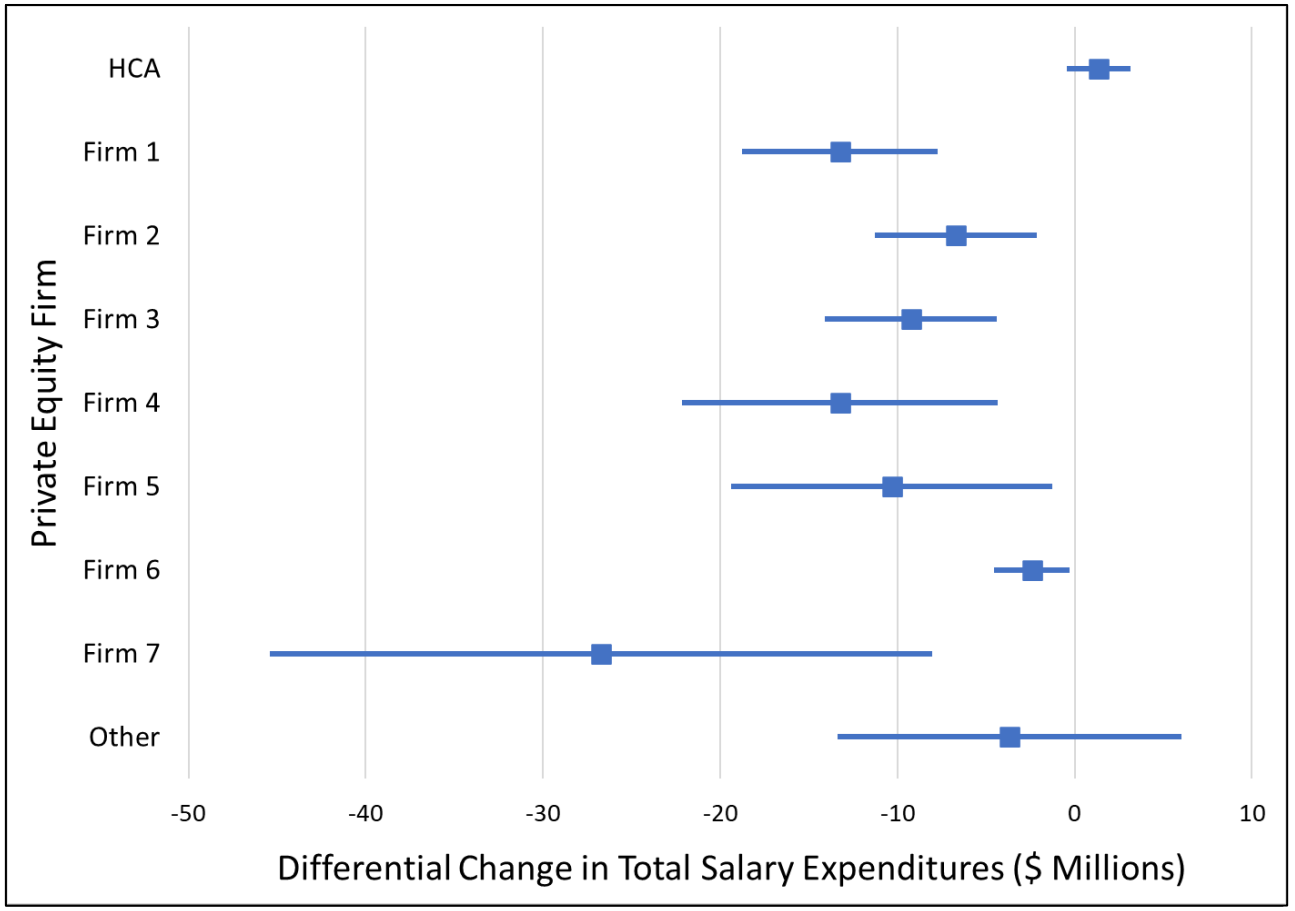
Characteristic	Private equity hospitals	Matched control hospitals	Unadjusted difference, %[b]	Adjusted difference, % (95% CI)[c]	*P* value	
					Unadjusted	Bonferroni adjusted[d]
Financial characteristics						
Total No.	242	870	NA	NA	NA	NA
Earnings, % of total revenue[e]	9.60	10.31	−0.22	−0.37 (−2.65 to 1.92)	.75	>.99
Equity ratio[f]	0.97	0.43	0.50	0.47 (0.33 to 0.61)	<.001	<.001
Operating margin, % of total revenue	2.96	1.70	1.12	0.87 (−1.12 to 2.87)	.39	>.99
Clinical characteristics						
Total No.	100	450	NA	NA	NA	NA
In-hospital mortality, %	3.04	2.77	0.42	−0.02 (−0.24 to 0.19)	.84	>.99
Conditions, No. per 10 000 hospitalizations[g]	15.53	21.3	−4.09	−0.80 (−11.66 to 10.05)	.88	>.99

Kannan S, Song Z. JAMA Internal Medicine (2024)

Policy Question 2: Do Private Equity Firms Differ in Strategy?

Changes in Total Salary Expenditures

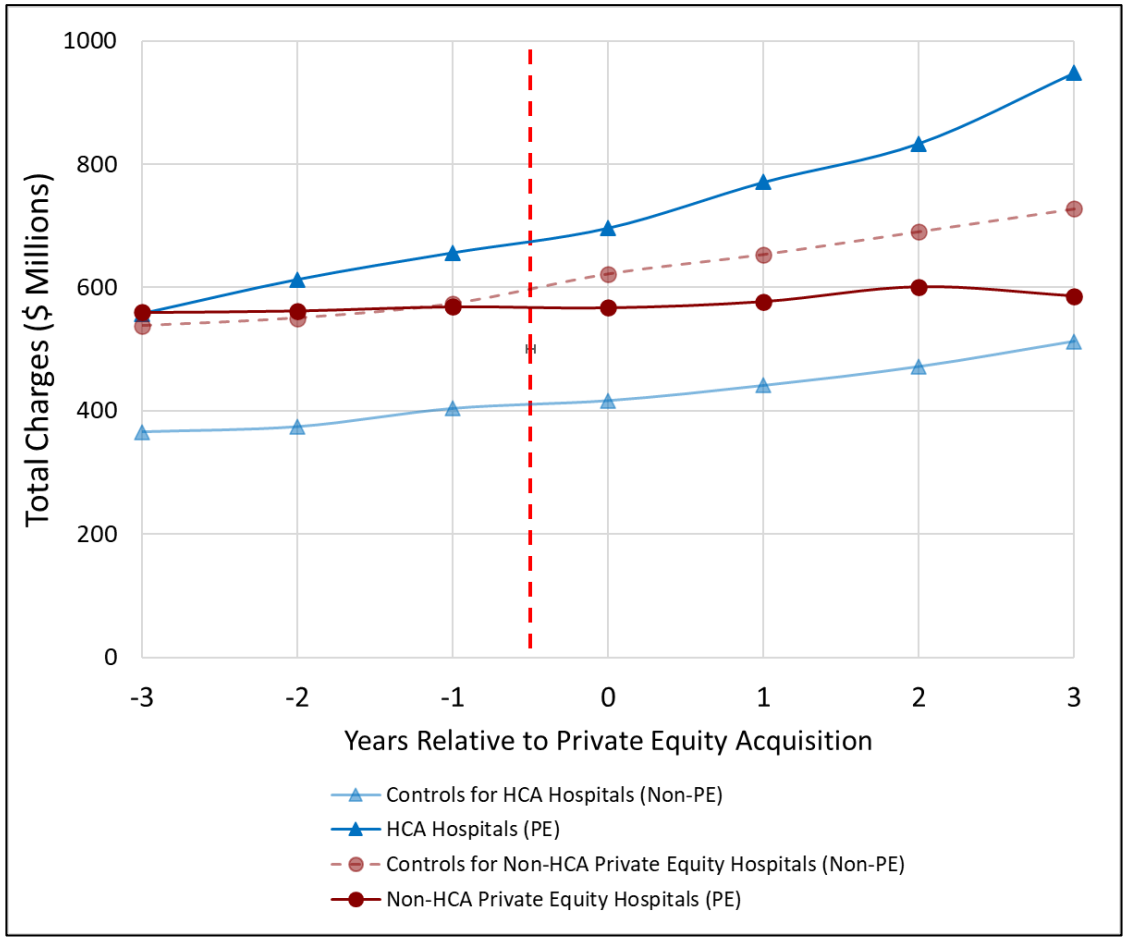


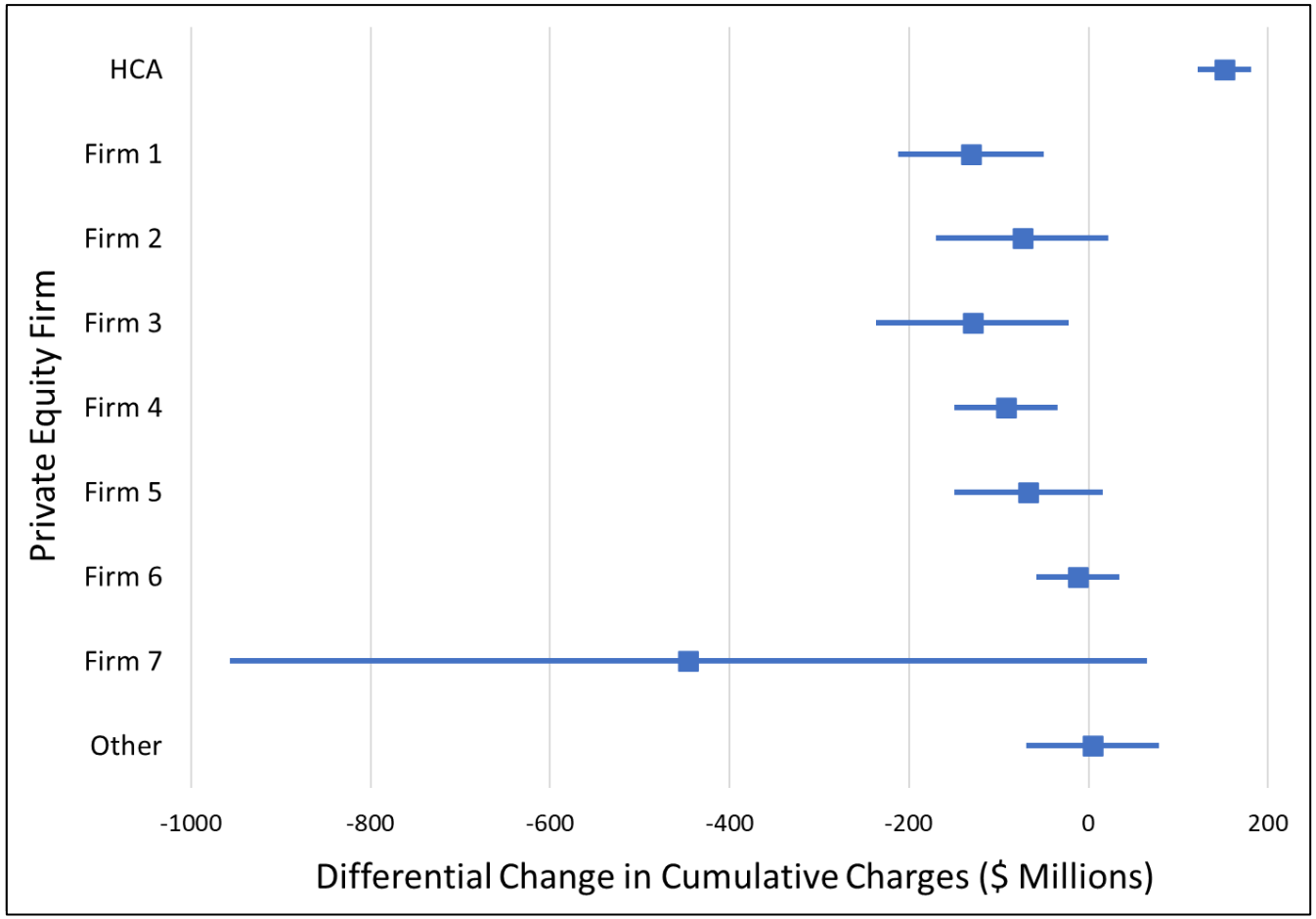


Kannan S, Song Z. Health Affairs (2025)

Policy Question 2: Do Private Equity Firms Differ in Strategy?

Changes in Cumulative Charges Billed (Reflects: Charges per service * Volume of services)





Kannan S, Song Z. Health Affairs (2025)

Private Equity Acquisitions of Physicians

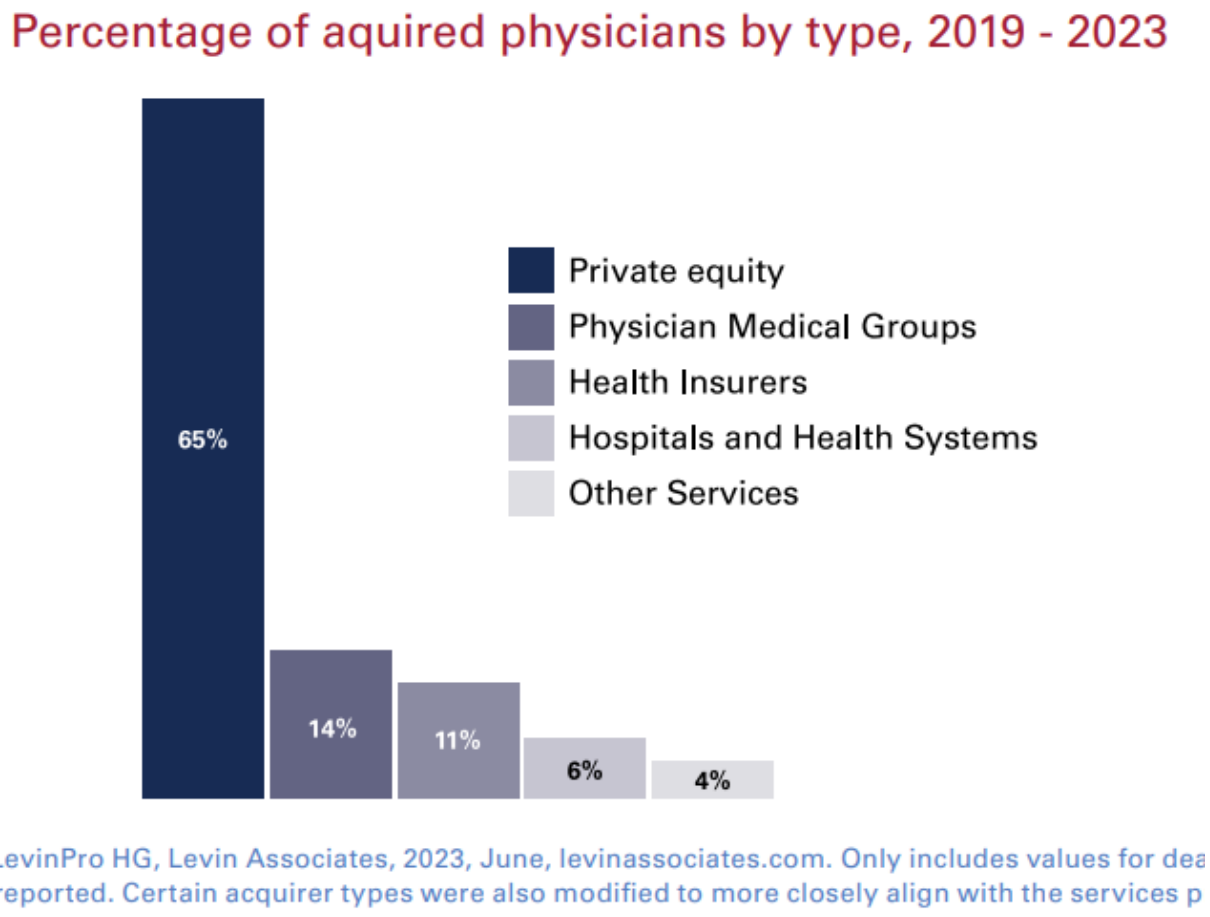
Geographic Variation in Private Equity Penetration Across Select Office-Based Physician Specialties in the US

Yashaswini Singh, MPA; Jane M. Zhu, MD, MPP, MSHP; Daniel Polsky, PhD, MPP; Zirui Song, MD, PhD

JAMA Health Forum (2022)

Specialty	Count of physicians identified in PE-acquired practices	Count of physicians in office-based settings	Estimated PE penetration (%)
Gastroenterology	845	6,147	13.7
Urology	492	4,758	10.3
Dermatology	851	8,565	9.9
Women's Health	1,352	15,360	8.8
Ophthalmology	741	11,398	6.5
Orthopedics	460	15,588	3.0
Total	4,738	61,752	7.7

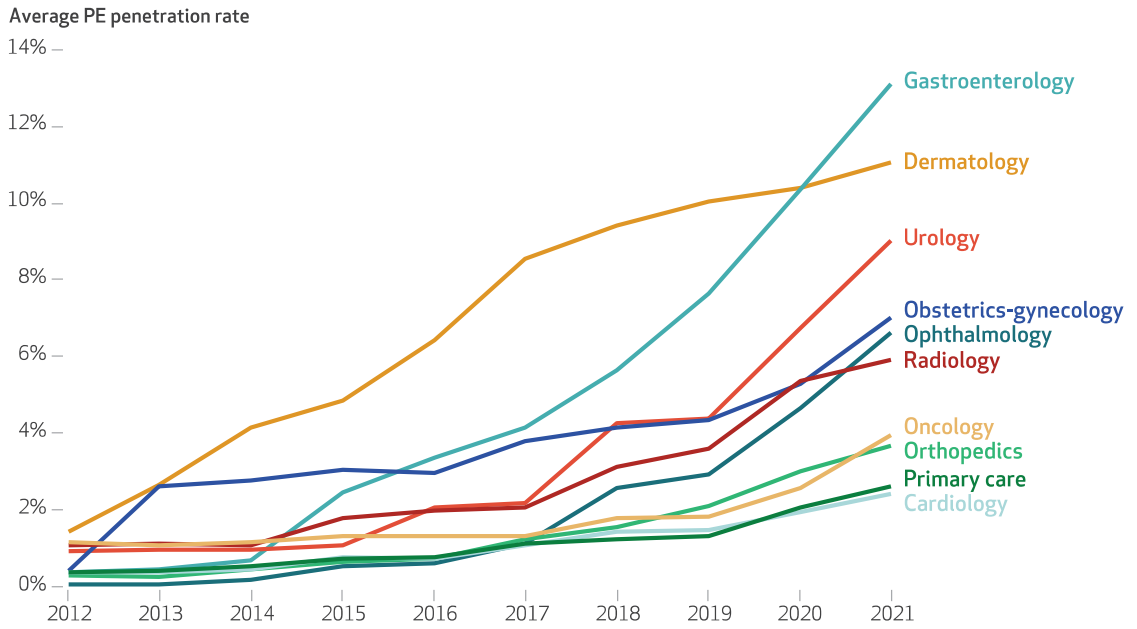
Private Equity Physician Practices



LevinPro HG, Levin Associates, 2023, June, levinassociates.com. Only includes values for dea
s reported. Certain acquirer types were also modified to more closely align with the services p

EXHIBIT 2

Trends in private equity (PE) penetration at the physician level in the US among 10 physician specialties, 2012–21



SOURCE Authors' analysis of data from the Irving Levin Associates Healthcare M&A Database, PitchBook private equity and merger and acquisition database, and OneKey Database provided by IQVIA (2020–21) and SK&A Office Based Physicians Database provided by IMS Health (now IQVIA) (2012–19). The PitchBook data presented here have not been reviewed by PitchBook analysts. The PitchBook database is dynamic; data for this figure are as of June 15, 2022. **NOTE** Average PE penetration rates at the physician level in each year by specialty were calculated by weighting each Metropolitan Statistical Area (MSA)-level market share by the number of full-time-equivalent physicians in that MSA by specialty, equivalent to the US penetration rate.

From 816 practices in 2012 to 5,779 practices in 2021 across 307 Metropolitan Statistical Areas (MSAs)
1/3 of MSAs: single PE firm has >30% market share

Levin Associates (2023)

Abdelhadi O, Fulton BD, Alexander L, Scheffler RM. Health Affairs (2024)

Acquisitions of MD Practices → ↑ Spending, Charges, Prices, Volume

Original Investigation

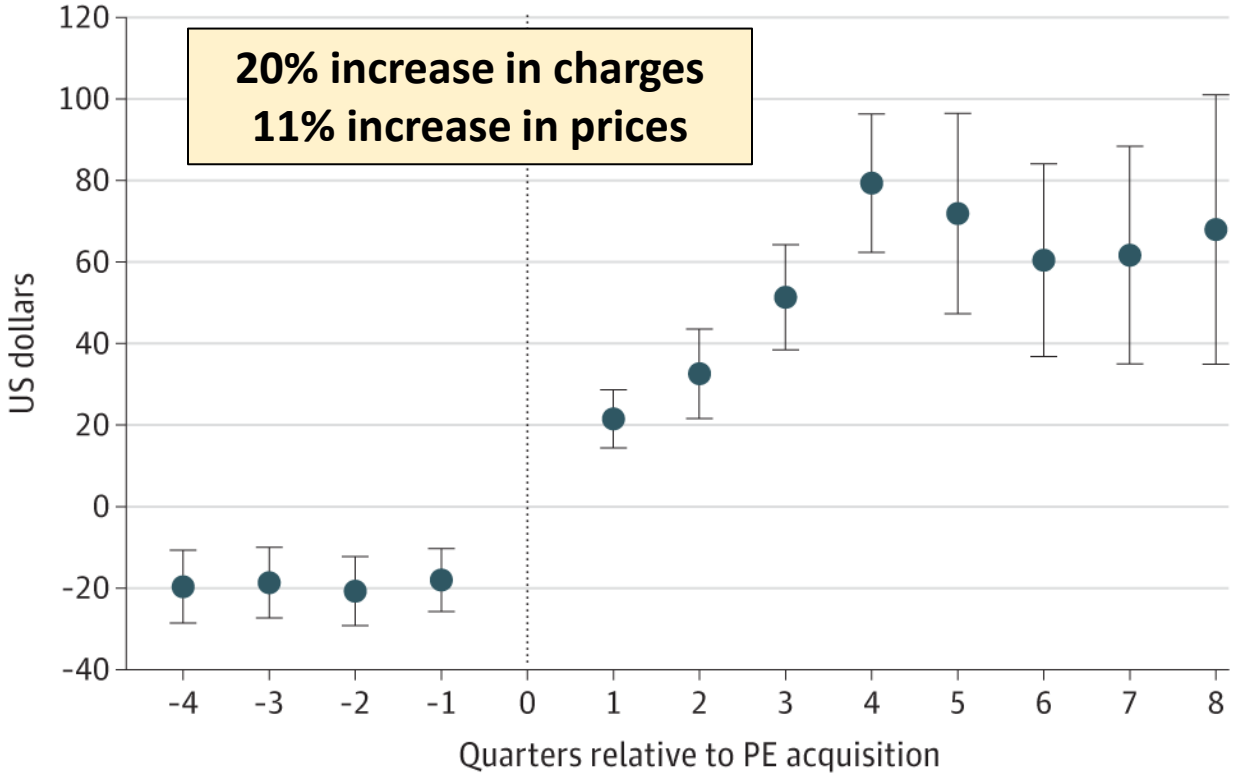
Association of Private Equity Acquisition of Physician Practices With Changes in Health Care Spending and Utilization

JAMA Health Forum (2022)

Yashaswini Singh, MPA; Zirui Song, MD, PhD; Daniel Polsky, PhD, MPP; Joseph D. Bruch, PhD; Jane M. Zhu, MD, MPP, MSHP

Table 1. Characteristics of PE- and Non–PE-Acquired Physician Practices at Baseline, 2015

Characteristic	Mean (SD)	
	PE-acquired	Non–PE-acquired[a]
Physician practices, No.	578	2874
Charge/claim, mean $	322 (258)	332 (326)
Allowed amount/claim, mean $	187 (136)	178 (136)
Total No.		
Unique patients	94 (182)	88 (172)
New patients	72 (136)	67 (132)
Encounters	124 (237)	118 (224)
E&M visits	75 (188)	72 (180)
Share of E&M visits >30 min		
New patients	0.26 (0.15)	0.26 (0.21)
Established patients	0.19 (0.17)	0.18 (0.22)
Patient HCC score, median	1.21 (1.05)	1.28 (1.10)



Relative to control, PE acquisitions led to:

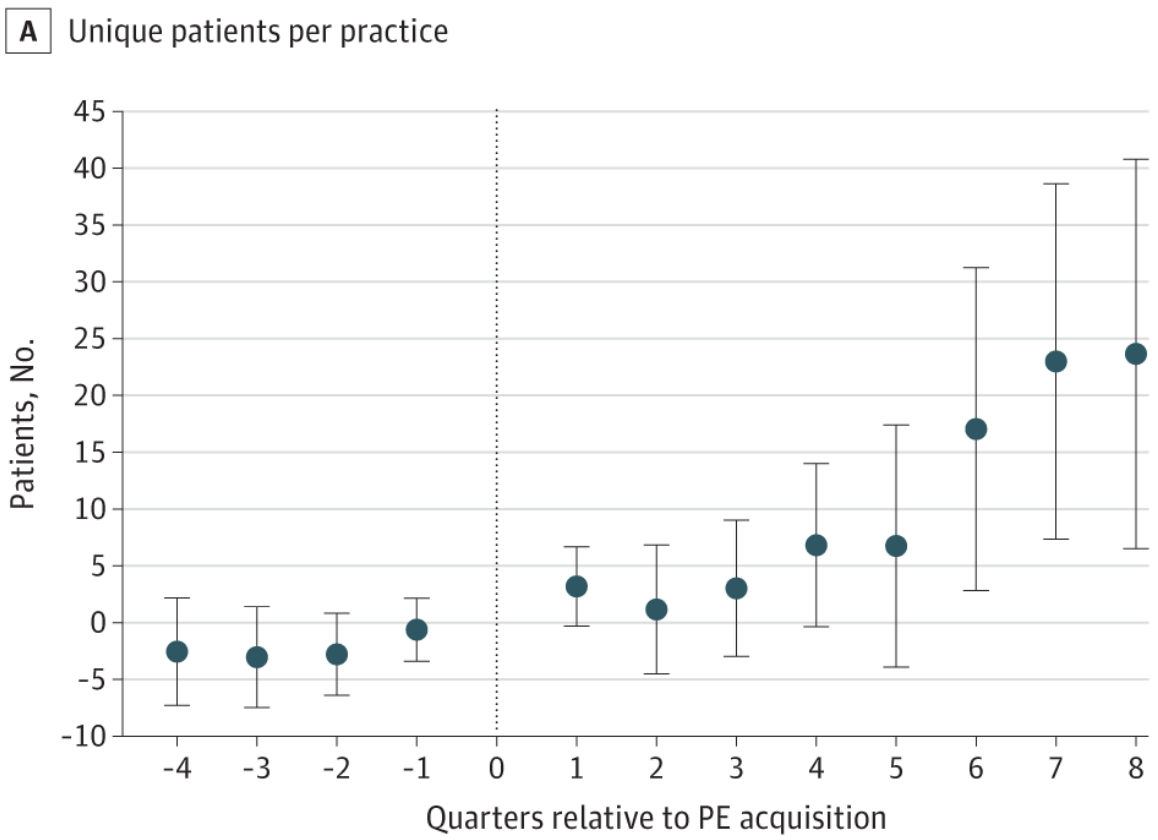
16% increase in aggregate volume

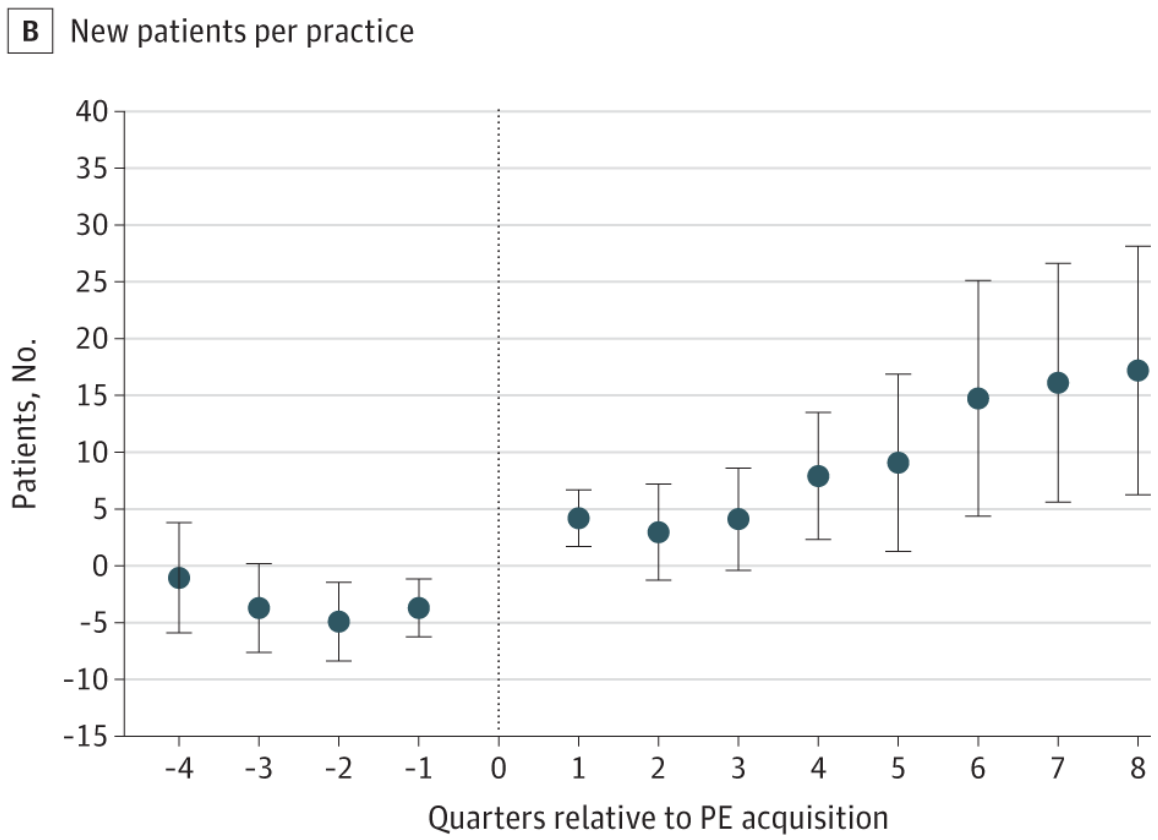
26% increase in unique patients

38% increase in new patient visits

9% increase in long (>30 min) visits

JAMA Health Forum





Singh Y, Song Z, Polsky D, Bruch JD, Zhu JM. JAMA Health Forum (2022)

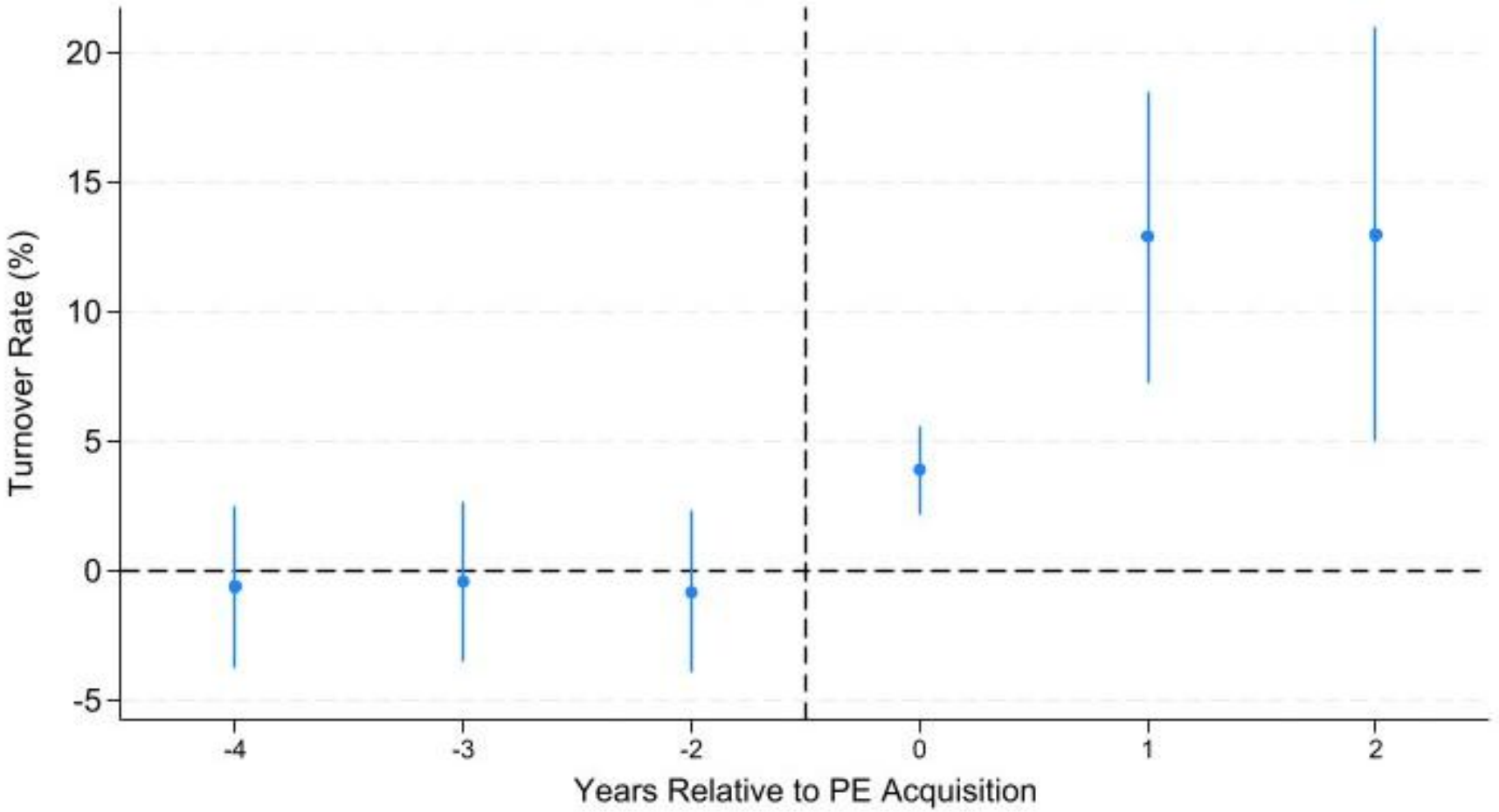
By Joseph Dov Bruch, Canyon Foot, Yashaswini Singh, Zirui Song, Daniel Polsky, and Jane M. Zhu

Workforce Composition In Private Equity–Acquired Versus Non–Private Equity–Acquired Physician Practices

Health Affairs

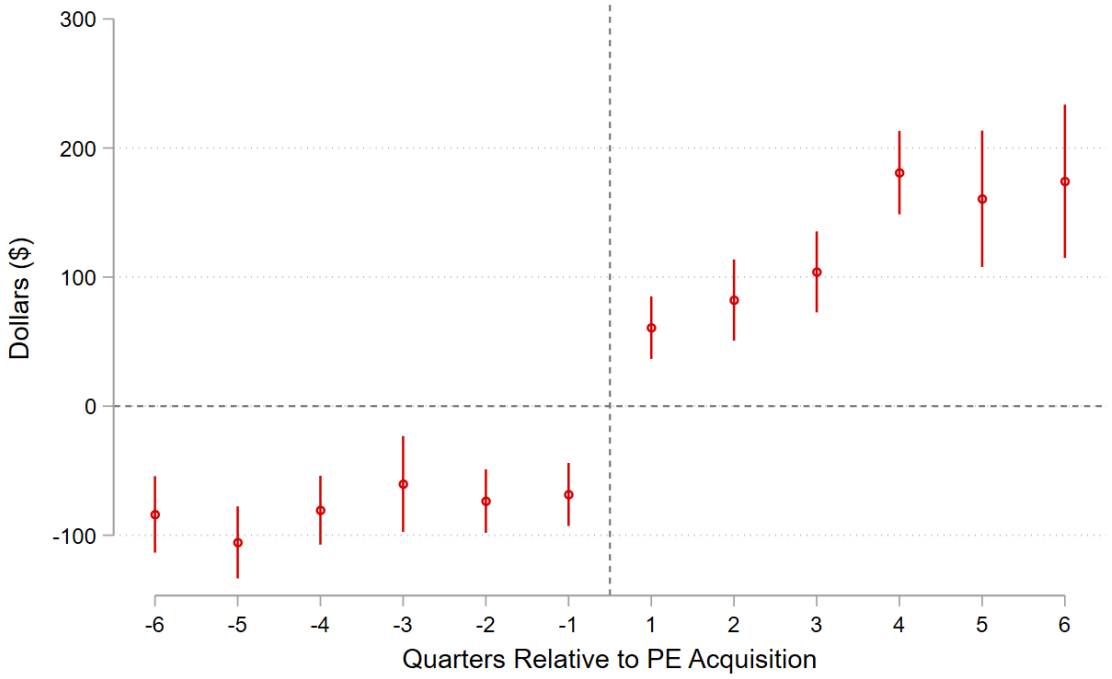
Relative to control, PE increases APP hiring.

PE acquisitions raised physician turnover rate by 13 percentage points (265% over baseline)



Additional Evidence on Acquisitions of Physician Practices

Private Equity GI vs. Health System GI

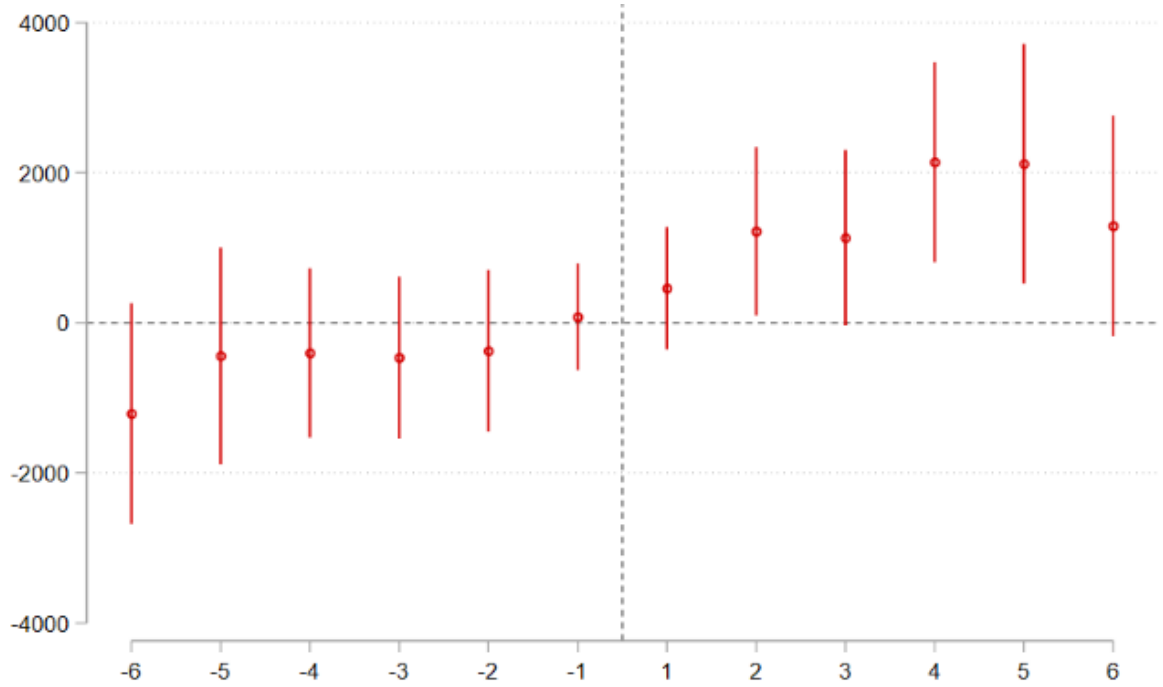


28% increase in prices
78% increase in professional fees
23% increase in patient volume

Singh Y, Song Z, Polsky D, Zhu JM. Under Revision

Private Equity Retina Practices vs. Control

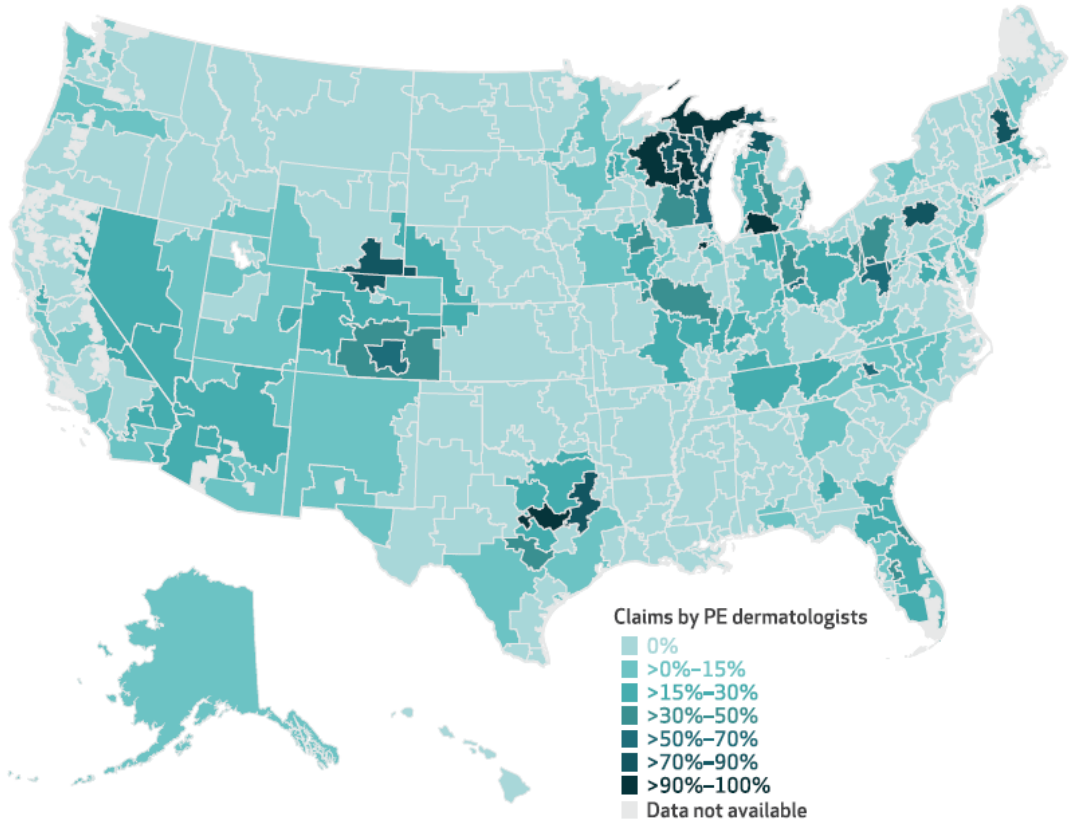
21% increase in Medicare spending
22% increase in expensive agents (Eylea)



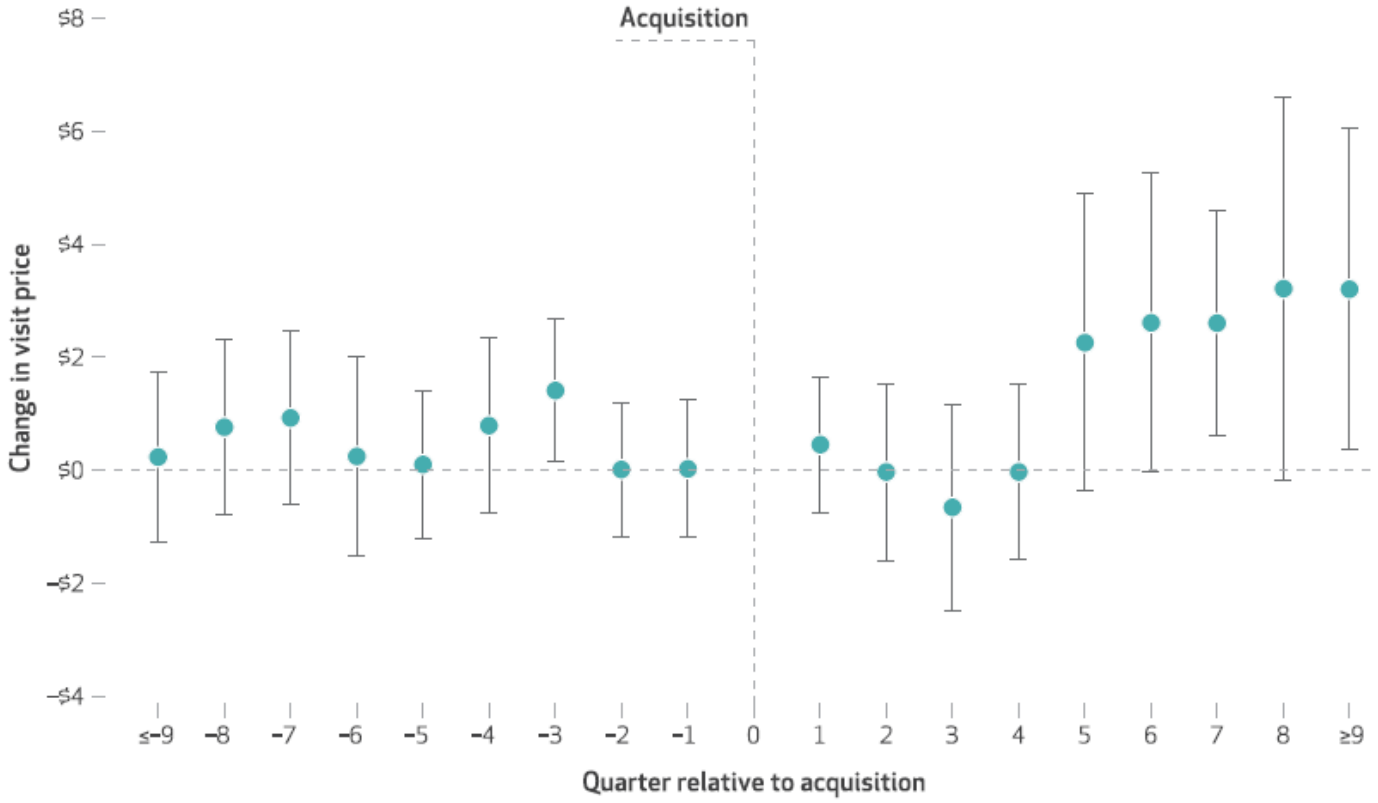
Singh Y, Aderman CM, Song Z, Polsky D, Zhu JM. Ophthalmology (2024)

Additional Evidence on Acquisitions of Physician Practices

Percent of dermatologist claims made by private equity (PE) dermatologists, by hospital referral region, 2017



Effect of private equity acquisition on the price of a routine dermatology office visit, by quarter, 2012–17



"At 1.5 years after acquisition, prices paid to private equity dermatologists for routine medical visits were 3-5 percent higher than those paid to non-private equity dermatologists. There was no significant consistent impact on dermatology spending or use of biopsies, lesion destruction, or Mohs surgery."

Braun RT, Bond AM, Qian Y, Zhang M, Casalino LP. Health Affairs. 2021.

Additional Evidence on Acquisitions of Physician Practices

JAMA Internal Medicine | Original Investigation

Association of Physician Management Companies and Private Equity Investment With Commercial Health Care Prices Paid to Anesthesia Practitioners

Ambar La Forgia, PhD; Amelia M. Bond, PhD; Robert Tyler Braun, PhD; Leah Z. Yao, BS; Klaus Kjaer, MD, MBA; Manyao Zhang, MA; Lawrence P. Casalino, MD, PhD

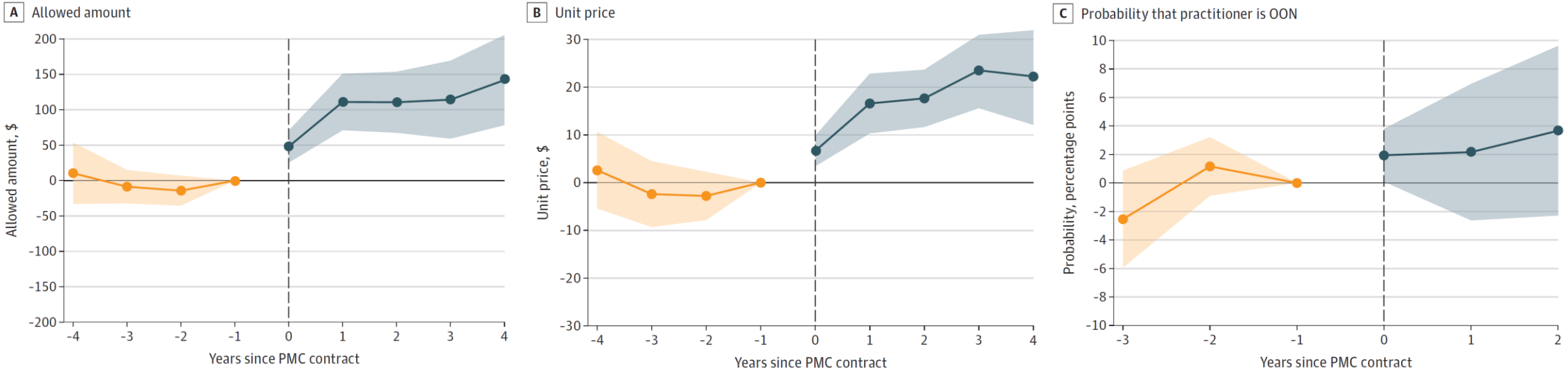
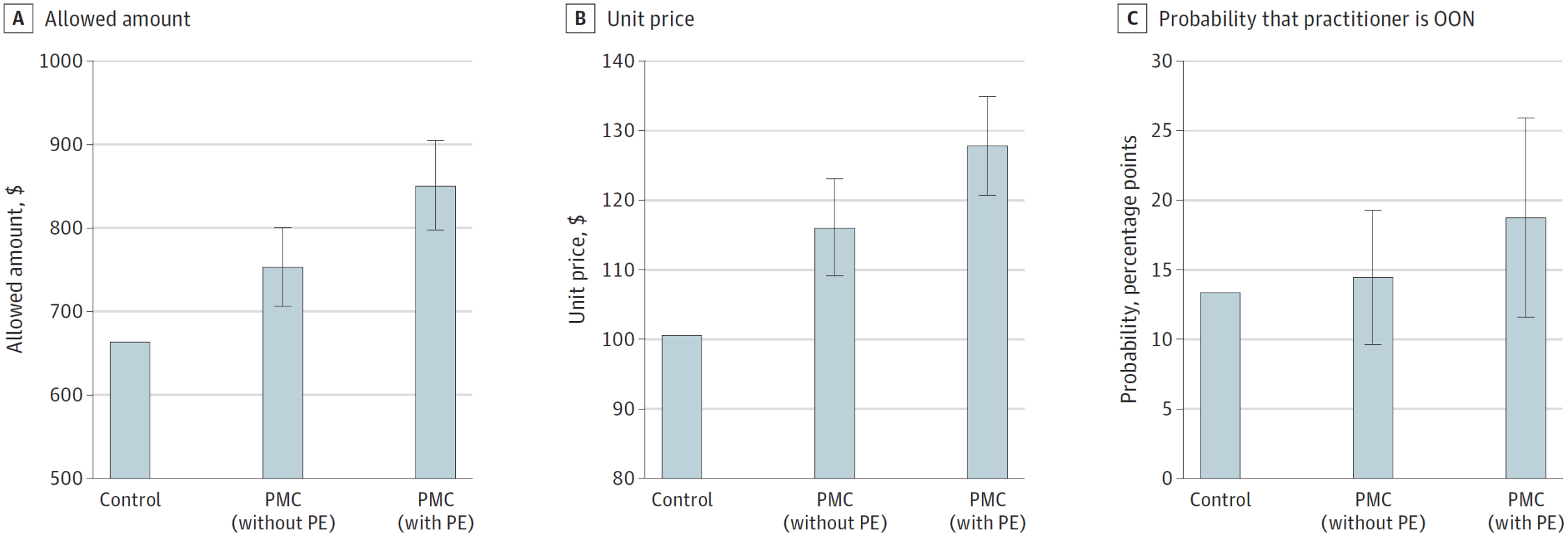


Figure 2. Adjusted Differential Changes in Outcomes Associated With Physician Management Company (PMC) Contract With and Without Private Equity (PE) Investment

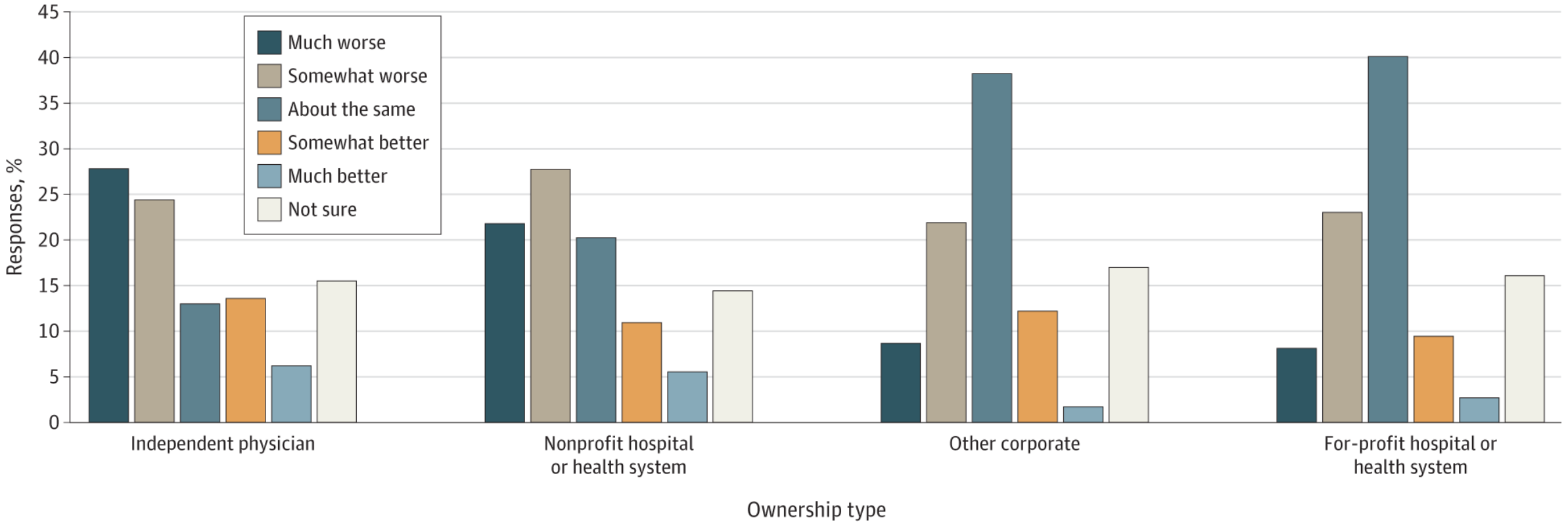


Adjusted difference-in-differences estimates from the specification interacting the post-PMC contract indicator with an indicator for whether the PMC received PE investment, relative to the regression-adjusted mean value of the control facilities, are shown. Therefore, the difference between the height of the PMC bars and the control bar represents the differential change in each outcome relative to control facilities, with the corresponding 95% CIs (error bars). The regression-adjusted difference (95% CI) between PMCs with PE relative to without PE is as follows: +$97.18 ($35.38 to $158.97) for allowed amounts, +$11.71 ($4.46to $18.95) for unit prices, and +4.34 percentage points (−2.11 to 10.79) for the probability that a practitioner is out-of-network (OON). See eTable 9 in the Supplement for the regression output.

La Forgia A, Bond AM, Braun RT, Yao LZ, Kjaer K, Zhang M, Casalino LP. JAMA Internal Medicine. 2022

Physician Perceptions of Private Equity

Favorability of Private Equity Ownership Compared With Other Types of Ownership

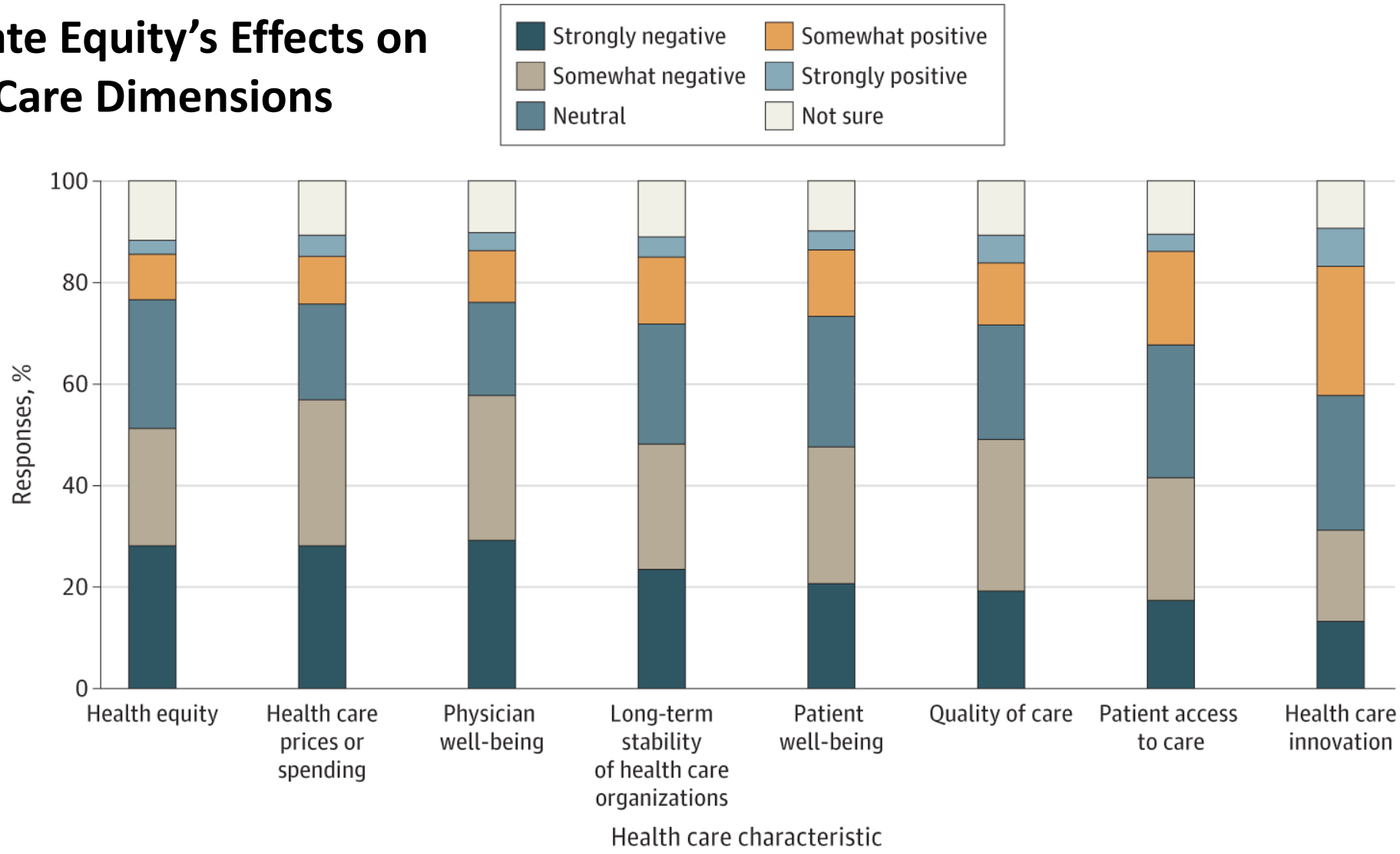


N=1397 MDs

Zhu JM, Zeveney A, Read S, Crowley R. JAMA Intern Med (2024)

Physician Perceptions of Private Equity

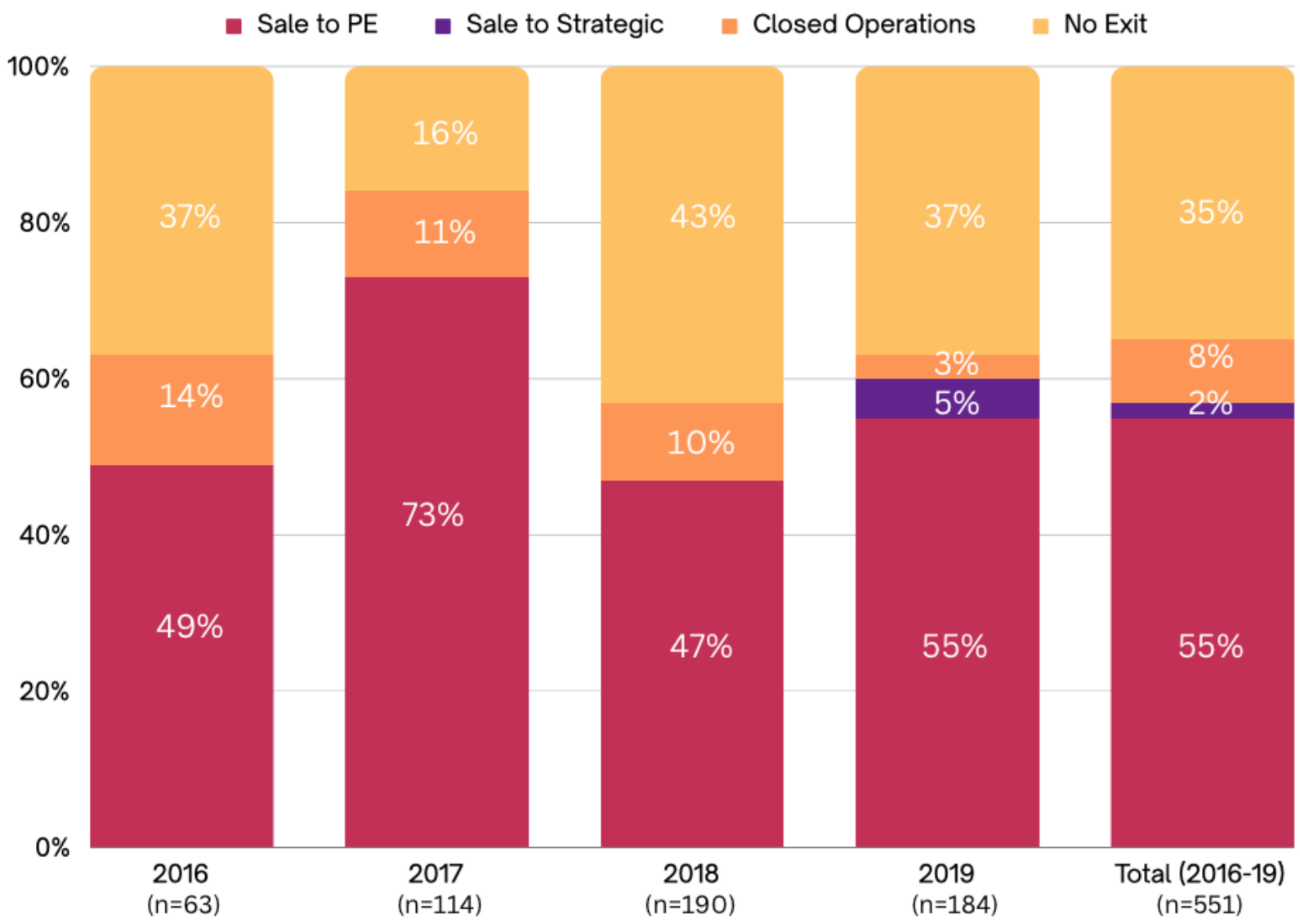
Perspectives of Private Equity's Effects on Various Health Care Dimensions



N=1397 MDs

Zhu JM, Zeveney A, Read S, Crowley R. JAMA Intern Med (2024)

Exit Strategies of Private Equity Firms



551 PE-acquired physician practices from 2016-2019:

55% resold to second PE owner within 3 years

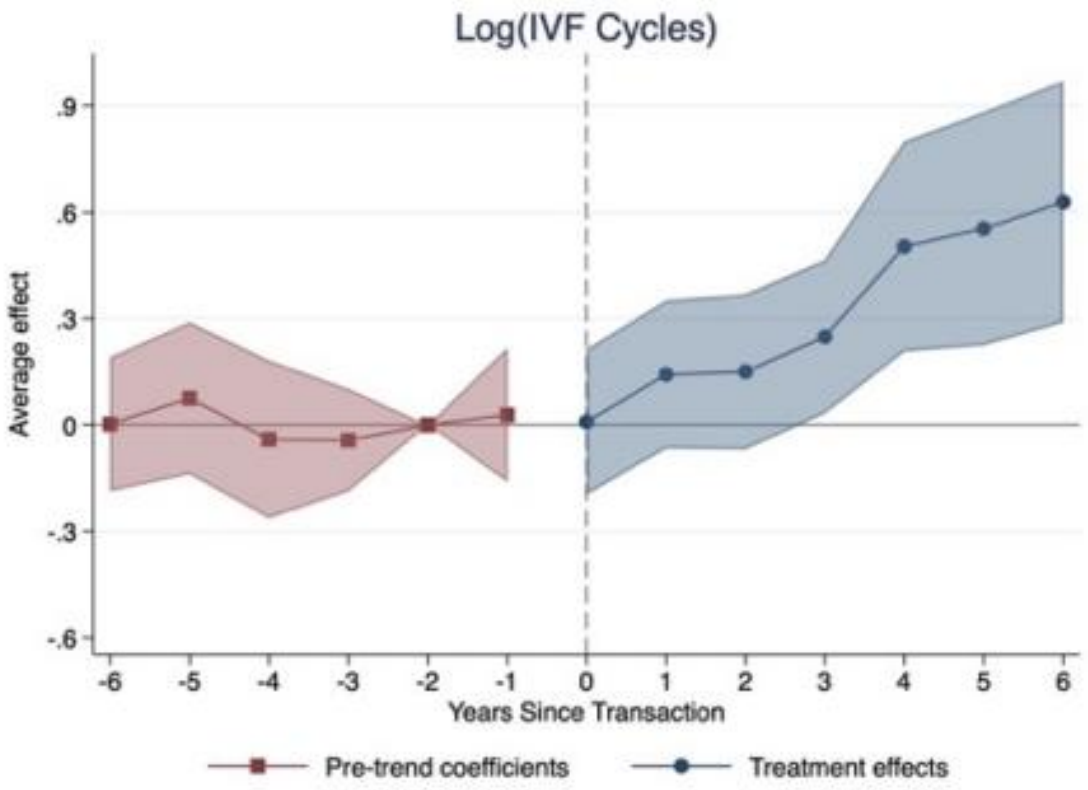
2% resold to strategic buyer

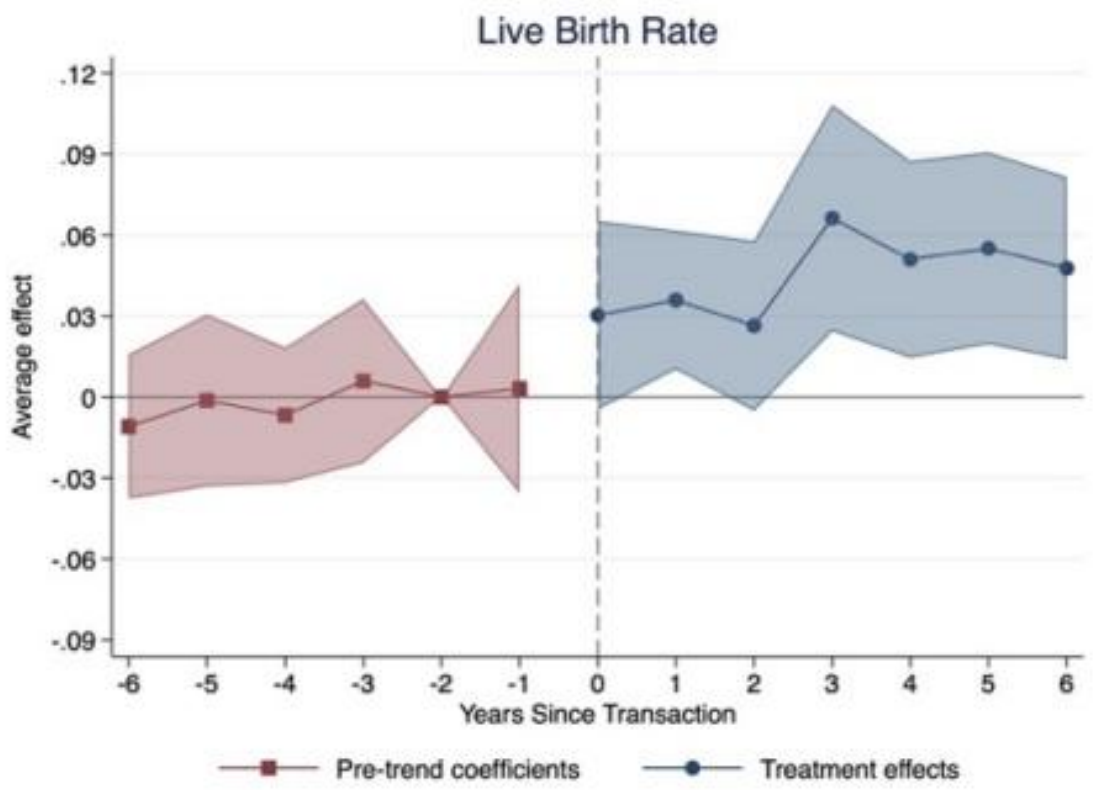
8% closed operations

Health Affairs Scholar

Singh, Y., Reddy, M., Zhu, J. M. (2024).

From the Beginning of Life – Fertility Clinics

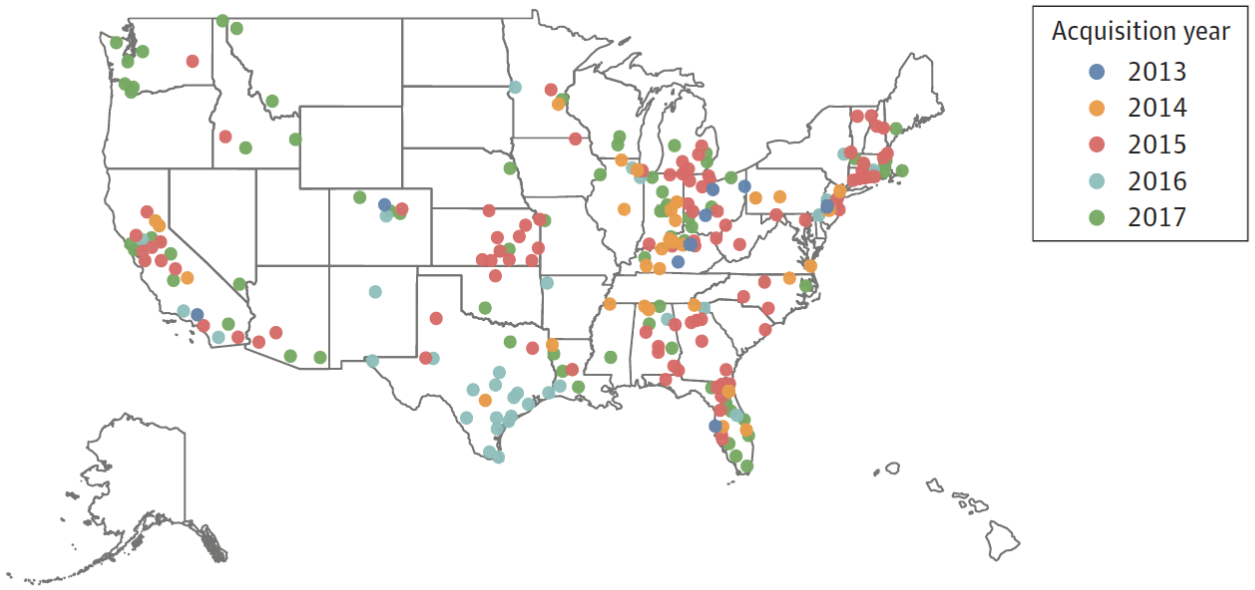


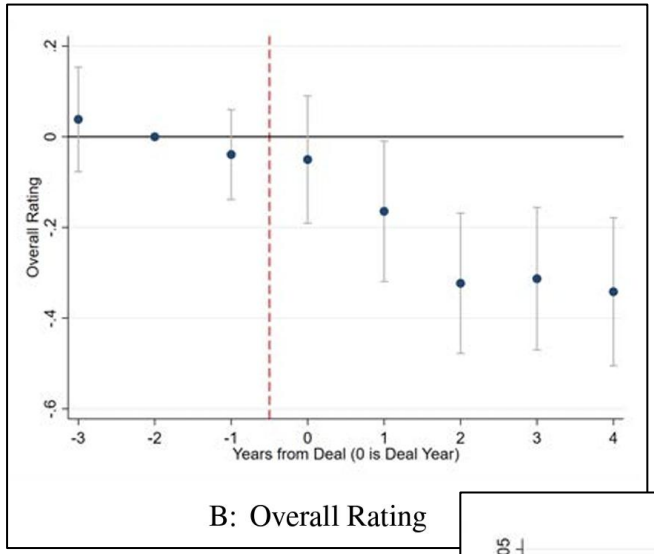


Private equity invests in 8 of 11 fertility chains. Total IVF price = $40-60K.
Acquisition → 27% ↑ in volume, 14% ↑ in IVF success rate.
No evidence of patient selection.

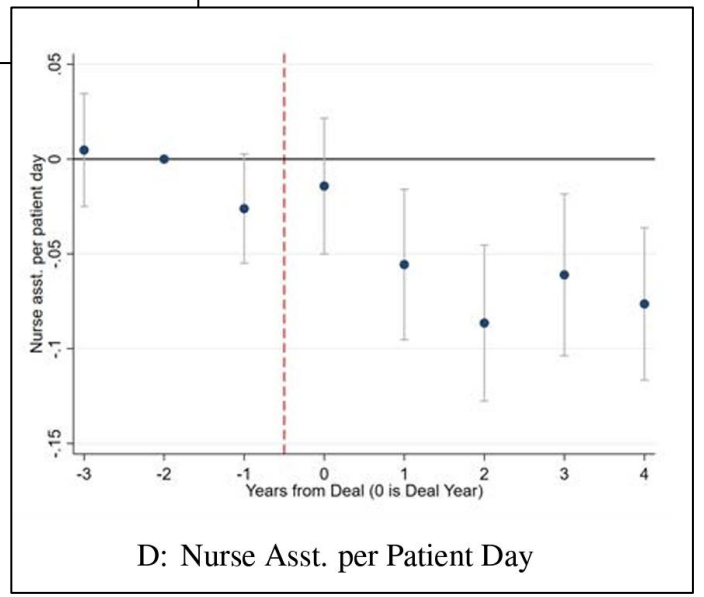
La Forgia and Bodner (Management Science, 2025)

To Older Age – Nursing Homes





B: Overall Rating



D: Nurse Asst. per Patient Day

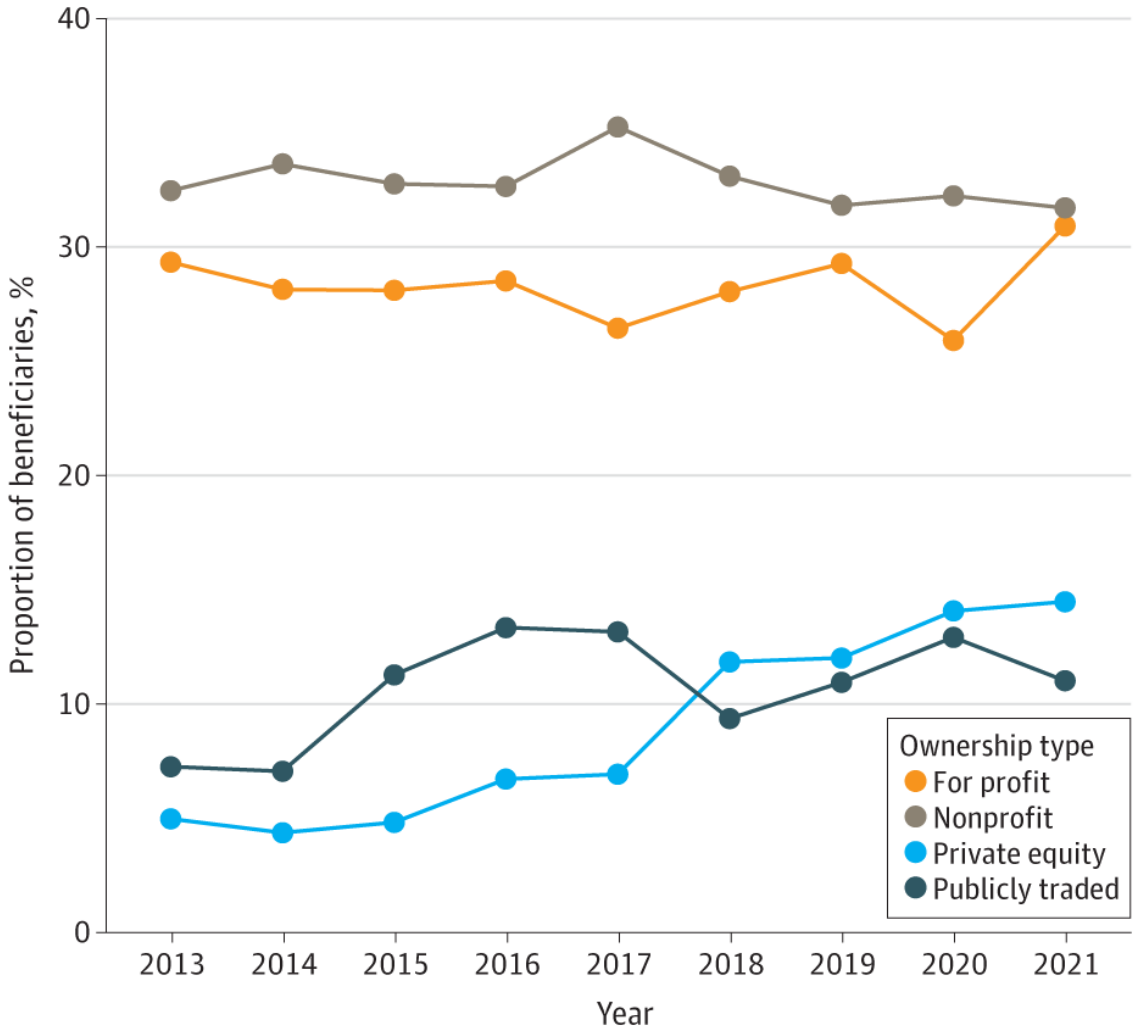
PE acquisitions increased:

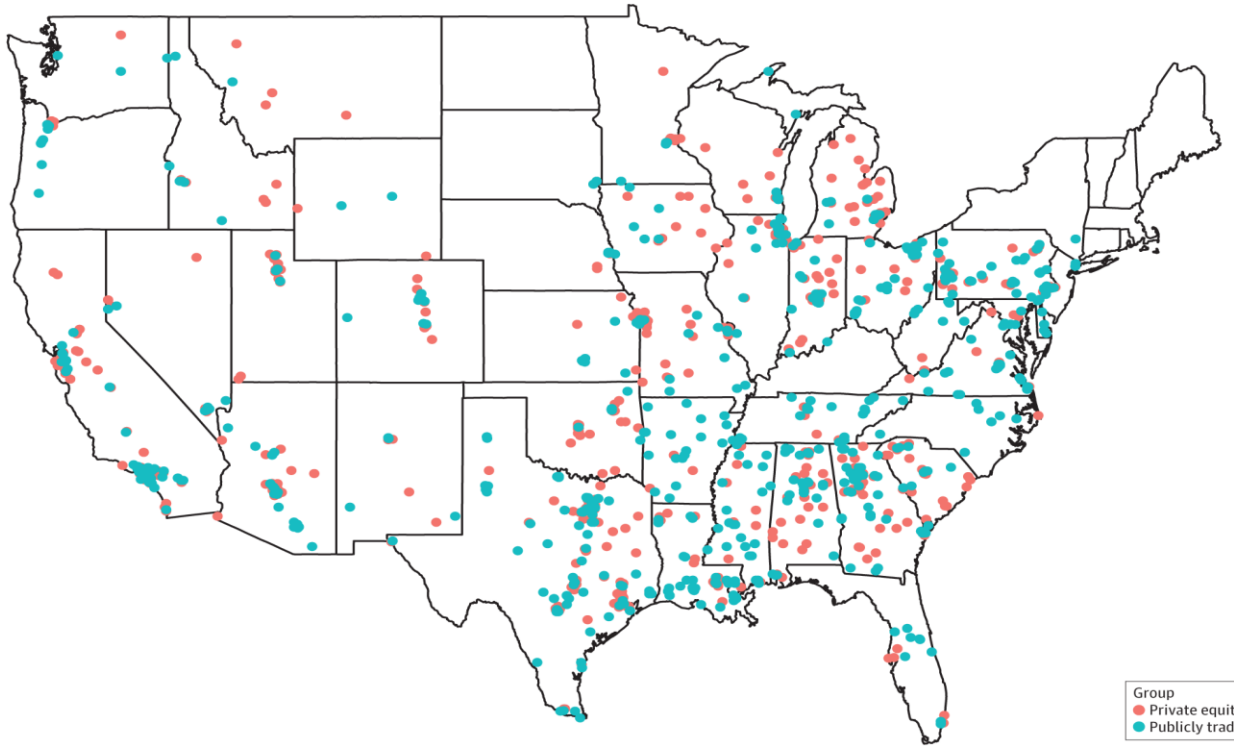
ED visits	11%
Hospitalizations	9%
Medicare spending	4%
Mortality	10%

Braun R, Jung HY, Casalino L, Myslinksi L, Unruh M. JAMA Health Forum (2021)

Gupta A, Howell S, Yannelis C, Gupta A. Review of Financial Studies (2023)

To the End of Life – Hospice

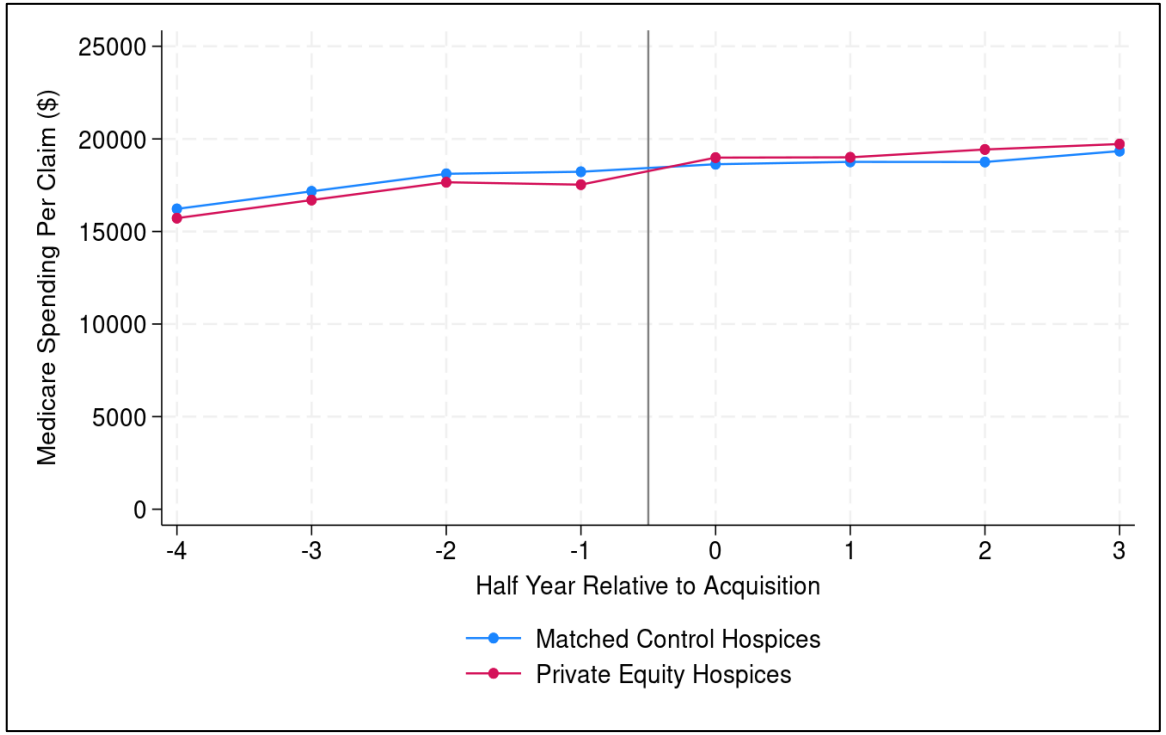




Braun RT, Unruh MA, Stevenson DG, Prigerson HG, Fernandez R, Yao LZ, Casalino LP. JAMA Network Open (2023)

To the End of Life – Hospice

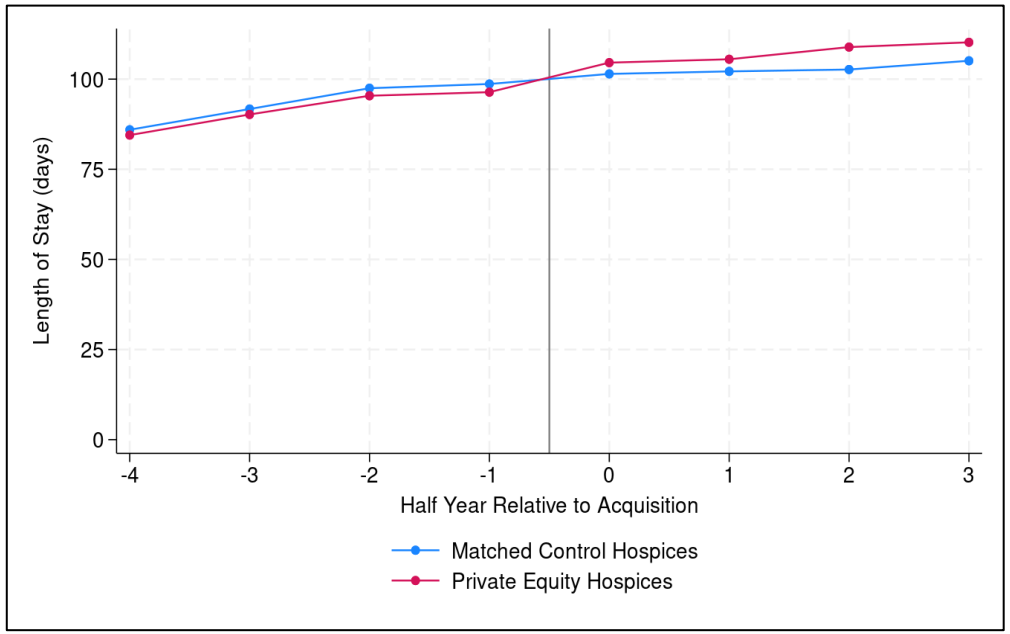
Hospice Characteristics	Private Equity (N = 187)	Control (N = 1,273)
Ownership		
For-profit	187 (100.0)	1273 (100.0)
Region		
Northeast	10 (5.3)	77 (6.0)
South	81 (43.3)	578 (45.4)
Midwest	44 (23.5)	264 (20.7)
West	52 (27.8)	354 (27.8)
Average Daily Census	86.3	84.6
Average Risk Score	2.5	2.5
Medicare Beneficiary Characteristics	**Private Equity (N = 28,329)**	**Control (N = 157,989)**
Age (mean (S.D.))	82.3 (10.6)	82.3 (10.6)
Sex (% Female)	58.2	57.4
Dual Eligible (%)	30.5	33.9
Race (%)		
Asian	714 (0.4)	4,516 (0.3)
Black	5,691 (9.1)	37,022 (9.0)
Hispanic	1,252 (2.0)	9,969 (2.4)
Native American	397 (0.6)	2,174 (0.5)
Other/Unknown	900 (1.4)	6,110 (1.5)
Non-Hispanic White	53,608 (85.7)	352,163 (85.5)

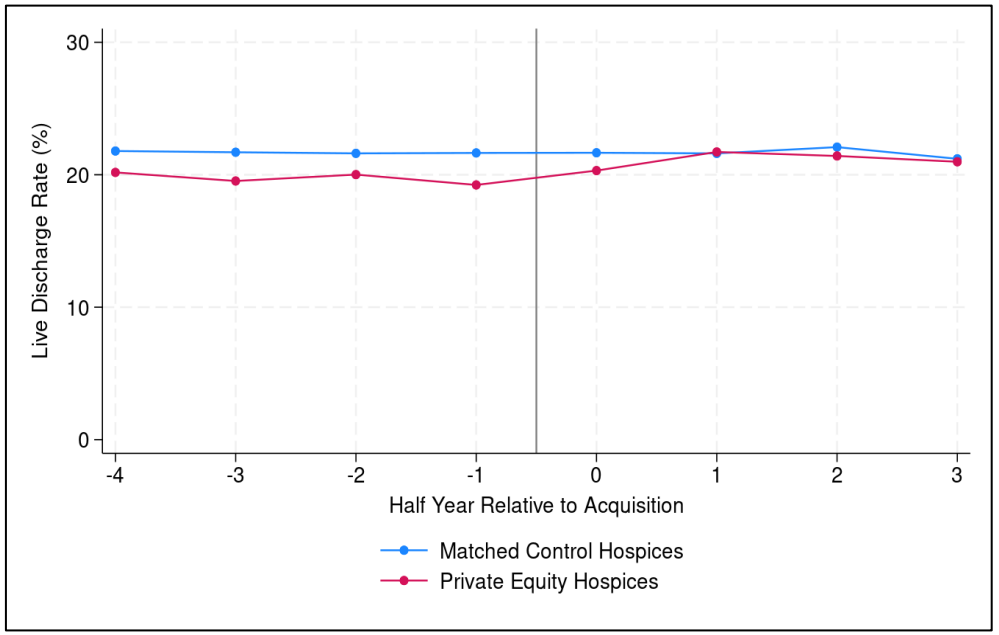


4.8% ↑ in Medicare spending on hospice, driven by a 5.5% ↑ in length of stay, relative to control

Kannan S, Driessen J, Kahn JM, Mankiw C, Song Z. Under review

	Private Equity Hospices (N=206,568)		Control For-Profit Hospices (N=1,202,821)		Unadjusted Difference-in-Differences†	Adjusted Difference-in-Differences‡ (%) [95% CI]	p-value
	Pre	Post	Pre	Post			
Spending and Utilization							
Claim Payment Amount ($)	16,924	19,306	17,462	18,968	876.50	806.80 (4.8) [274.32 to 1,339.27]	0.003
Claim Length of Stay (days)	91.8	107.9	93.6	103.3	6.49	5.08 (5.5) [1.96 to 8.20]	0.001
Visits per Day	4.5	3.9	6.1	5.7	-0.13	0.04 (0.8) [-0.20 to 0.27]	0.76
Visits in the Last Week of Life	21.8	19.1	33.6	31.7	-0.82	0.01 (0.1) [-1.50 to 1.52]	0.99
Discharge Outcomes							
Short Stay (<7 days, %)	24.0	22.4	24.1	24.7	-2.25	-1.15 (-4.8) [-1.82 to -0.49]	<0.001
Long Stay (>180 days, %)	16.4	18.8	16.8	17.6	1.64	0.80 (4.9) [0.10 to 1.50]	0.02
Live Discharge (%)	19.7	20.9	21.7	21.2	1.71	2.19 (11.1) [1.40 to 2.97]	<0.001
Patient Mix (Primary Dx)							
Dementia (%)	22.6	23.8	20.3	20.3	1.22	0.86 (3.8) [0.06 to 1.66]	0.03
Cancer (%)	22.3	21.3	22.2	21.3	-0.09	0.14 (0.6) [-0.51 to 0.78]	0.68





Kannan S, Driessen J, Kahn JM, Mankiw C, Song Z. Under review

Policy Framework for Private Equity

VIEWPOINT

A Policy Framework for the Growing Influence of Private Equity in Health Care Delivery

JAMA

F	Fraud & abuse	Enforce federal statutes including Anti-Kickback, Stark Laws
A	Antitrust	A) Federal: improve staffing and bandwidth for oversight at FTC B) State: state AGs, "corporate practice of medicine" laws
M	Moral hazard	A) Affiliation rule that ties acquired entities to the parent PE firm B) Limit the % debt used to make an acquisition C) Closure of the 20% carried interest “loophole”
P	Patients & prices	A) No Surprises Act prohibiting surprise billing in certain situations B) Price regulation to mitigate arbitrage incentive of consolidation
T	Transparency	Lower the threshold ($111.4 million) for mandatory reporting of PE acquisitions and the % debt used in the acquisition.

Cai C, Song Z. JAMA (2023)

VIEWPOINT

A Policy Framework for the Growing Influence of Private Equity in Health Care Delivery

1	Fraud & Abuse	Enforcement of federal statutes: e.g. Anti-Kickback, Stark Laws
2	Antitrust	A) Federal: staffing and oversight at the Federal Trade Commission B) States: Attorneys General, "corporate practice of medicine" laws
3	Risky Behaviors	A) Affiliation rule: boost PE accountability to their acquired entities B) Lower the % debt placed on the acquired entity (financial risk) C) Reform the 20% tax rate for PE profits (carried interest "loophole")
4	Patients & Prices	A) No Surprises Act: prohibiting surprise billing in certain situations B) Slow price growth to protect patients, employers, and taxpayers
5	Transparency	A) Lower the threshold ($119 million) for reporting of acquisitions B) Public reporting of owners and investors (MA, IN, other states)

Cai C, Song Z. JAMA (2023)

JAMA Forum

The New Role of Private Investment in Health Care Delivery

David M. Cutler, PhD; Zirui Song, MD, PhD (2024)

Disruptive innovation as a business philosophy has brought benefits to many parts of the economy. But in health care delivery, evidence increasingly suggests that not all disruption creates value for patients. A central issue for policy is how to encourage truly value-adding innovation for patients and payers without hurting patients or bankrupting society.

OWNERSHIP

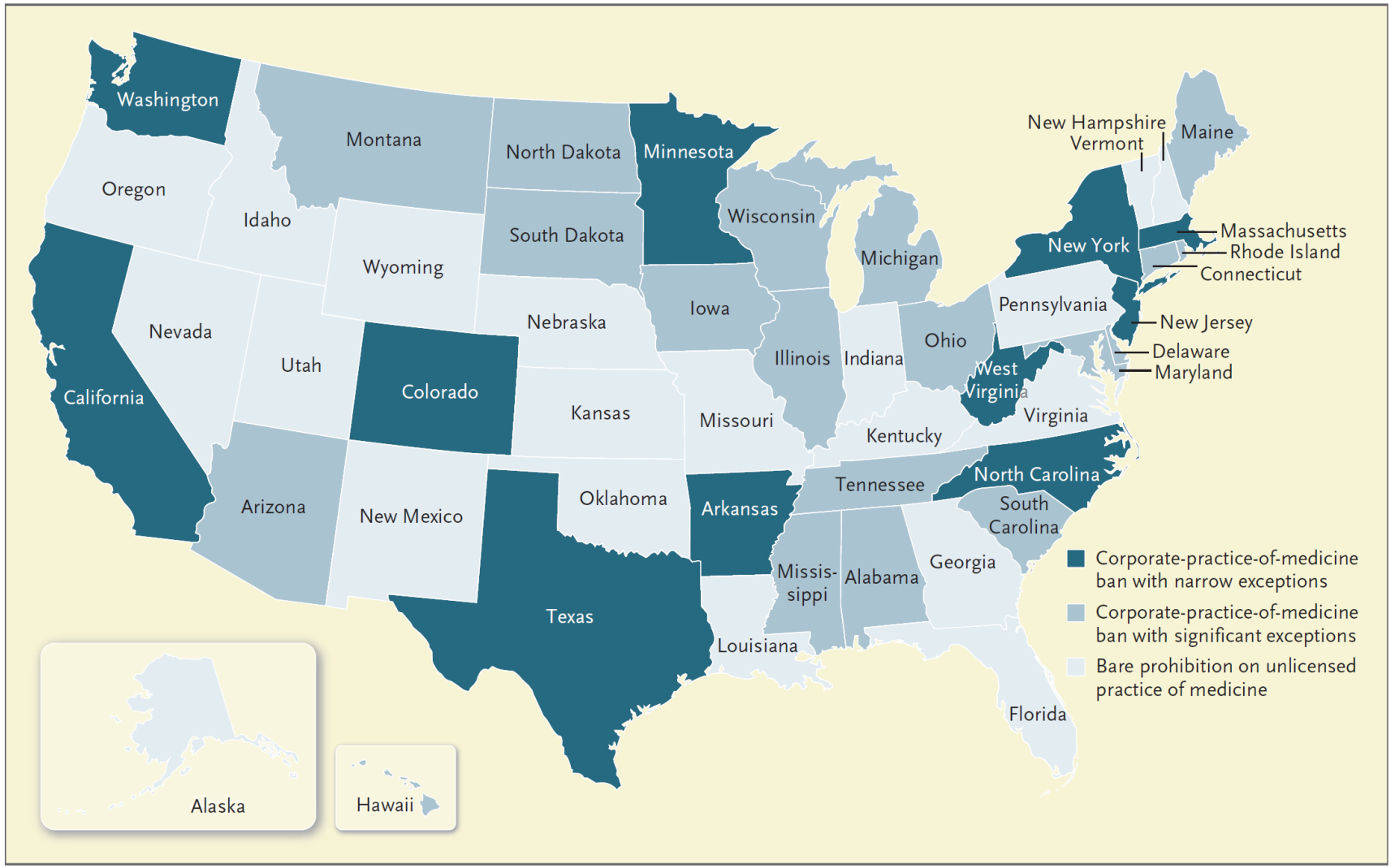
By Christopher Cai and Zirui Song (2024)

POLICY INSIGHT

Protecting Patients And Society In An Era Of Private Equity Provider Ownership: Challenges And Opportunities For Policy

ABSTRACT **Private equity (PE) acquisitions in health care delivery nearly tripled from 2010 to 2020. Despite concerns around clinical and economic implications, policy responses have remained limited. We discuss the US policy landscape around PE ownership, using policies in the European Union for comparison. We present four domains in which policy can be strengthened. First, to improve oversight of acquisitions, policy makers should lower reporting thresholds, review sequential acquisitions that together affect market power, automate reviews with potential denials based on market concentration effects, consider new regulatory mechanisms such as attorney general veto, and increase funding for this work. Second, policy makers should increase the longer-run transparency of PE ownership, including the health care prices garnered by acquired entities. Third, policy makers should protect patients and providers by establishing minimum staffing ratios, spending floors for direct patient care, and limits on layoffs and the sale of real estate after acquisition (forms of "asset stripping"). Finally, policy makers should mitigate risky financial behavior by limiting the amount or proportion of debt used to finance PE acquisitions in health care.**

Corporate Practice of Medicine Laws at the State Level



Scope of State Corporate-Practice-of-Medicine Laws in the United States.

Information is based on the authors' analysis of primary documents and summaries of legal texts as of April 2023.

Zhu JM, Rooke-Ley H, Fuse-Brown E. NEJM (2023)

“The Body Was Not Even Cold”

To

Subject

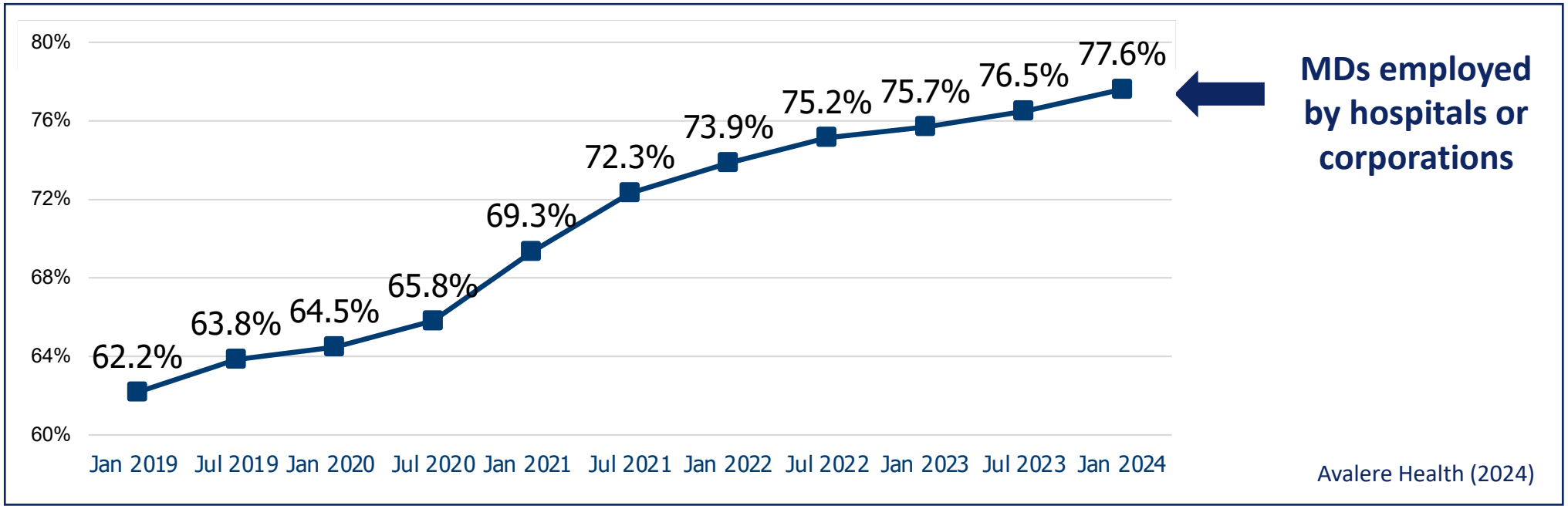
Dear Dr. [redacted]

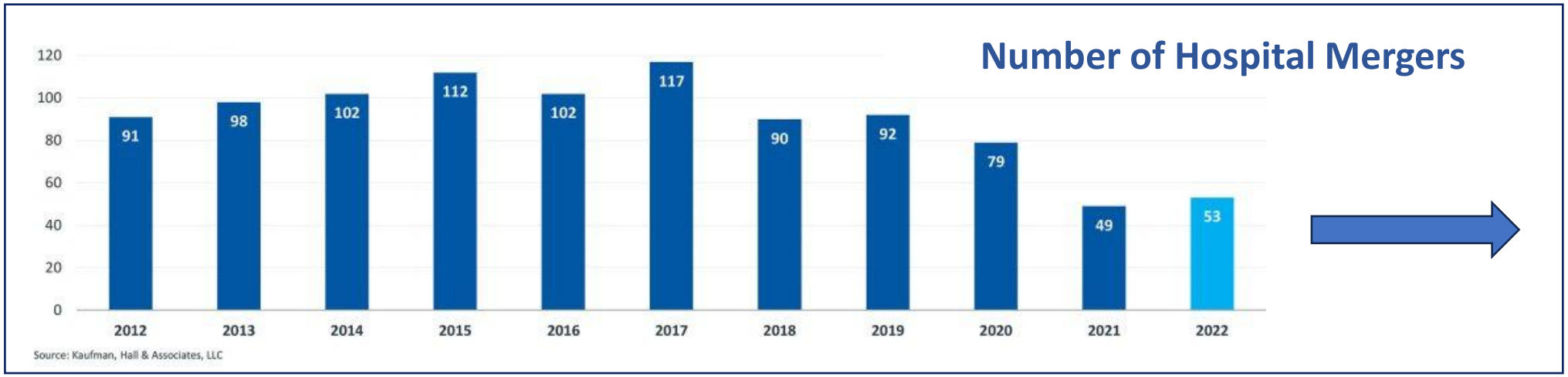
Our sincere condolences for the loss of your patient.

The Clinical Documentation Integrity (CDI) team reviews the charts of all deceased patients to make sure that the documentation captures the full complexity of the case. Having performed this review, we would appreciate your thoughtful attention to the Clinical Documentation query below.

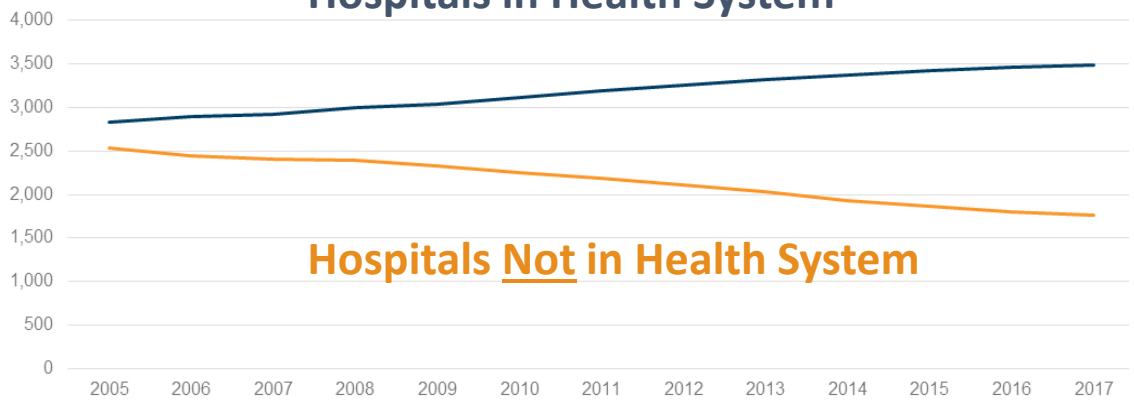
There are 3 CDI queries for you in Epic. Access the drop down options by using F2 when completing the query. If needed, further instructions are at the bottom of this email.

Current Era of Consolidation & Corporatization in Health Care

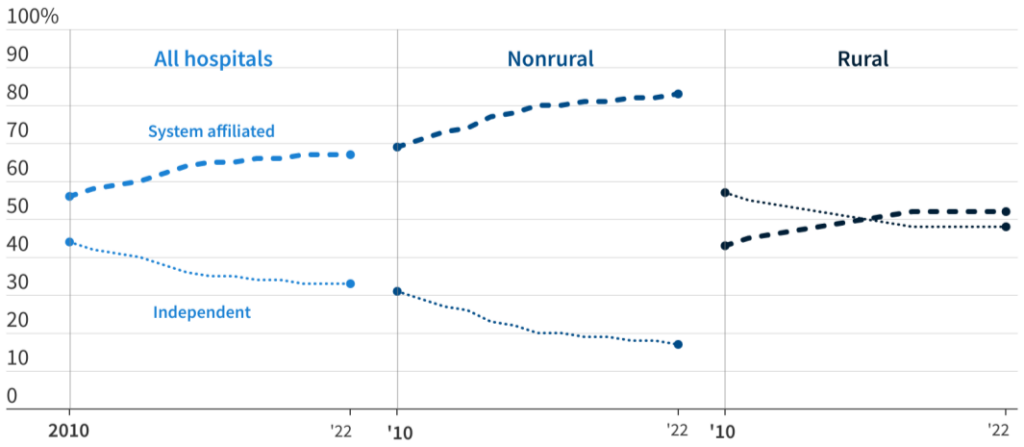




Current Era of Consolidation & Corporatization in Health Care



The share of hospitals affiliated with health systems increased from 56% in 2010 to 67% in 2022, with the share growing in both rural and nonrural areas



Note: Sample limited to non-federal general medical and surgical hospitals, excluding those in US territories.
Source: KFF analysis of AHA Annual Survey Database 2010-2022. • Get the data

KFF

Examples of Cross-Market Mergers Announced Since June 2021 With Combined Operating Revenues of at Least $5 Billion

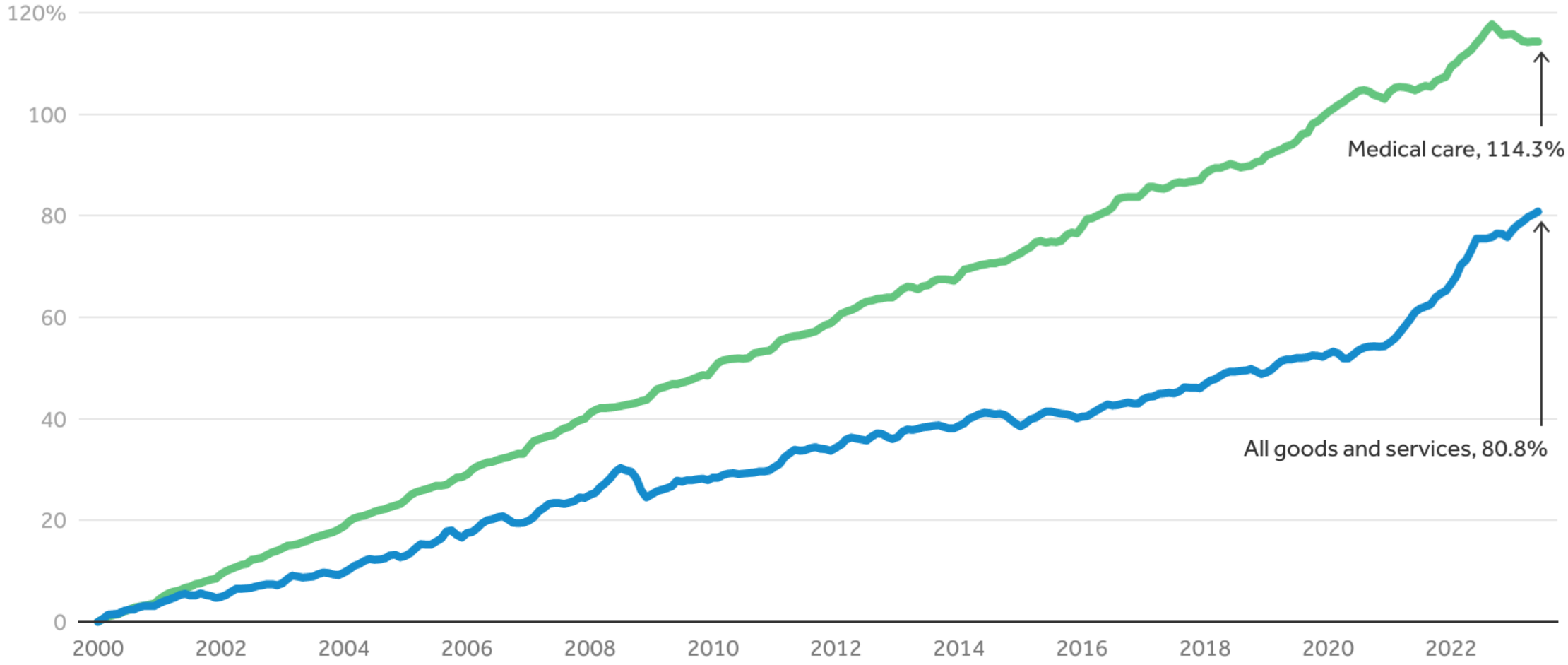
Year Announced	Larger system	Operating Revenues ($B)	Smaller system	Operating Revenues ($B)	Combined revenues ($B)
2023	BJC Healthcare (MO)	$6.3	St. Luke's Health System (MO)	$2.4	$8.7
2023	Kaiser Permanente (CA)*	$95.4	Geisinger (PA)*	$6.9	$102.3
2023	Presbyterian Healthcare Services (NM)	$5.5	UnityPoint Health (IA)	$4.3	$9.8
2022	University Of Michigan Health (MI)**	$5.6	Sparrow Health System (MI)	$1.5	$7.1
2022	Marshfield Clinic Health System (MI)	$2.8	Essentia Health (MN)	$2.6	$5.4
2022	Sanford Health (SD)***	$7.1	Fairview Health Services (MN)***	$6.4	$13.5
2022	Advocate Aurora Health (IL)	$14.1	Atrium Health (NC)	$9.0	$23.1
2021	Intermountain (UT)	$7.7	SCL Health (CO)	$2.9	$10.6
2021	Spectrum Health (MI)	$8.3	Beaumont Health (MI)	$4.6	$12.9

NOTE: Operating revenues come from audited financial statements covering the fiscal year prior to the merger announcement. State abbreviations reflect the corporate headquarters of a given health system. *Kaiser Permanente and Geisinger are both integrated health systems that include both insurance plans and health care providers. Revenues reflect all sources of operating income. **Reflects patient care revenues only. The University of Michigan does not separate out additional operating revenues related to its health system. ***Fairview Health Services and Sanford Health abandoned their plans to merge in July 2023.
SOURCE: KFF analysis of news releases and audited financial statements.

KFF

Kaiser Family Foundation (2023, 2024)

Prices of Medical Care vs. Prices of Everything Else – Last 23 Years

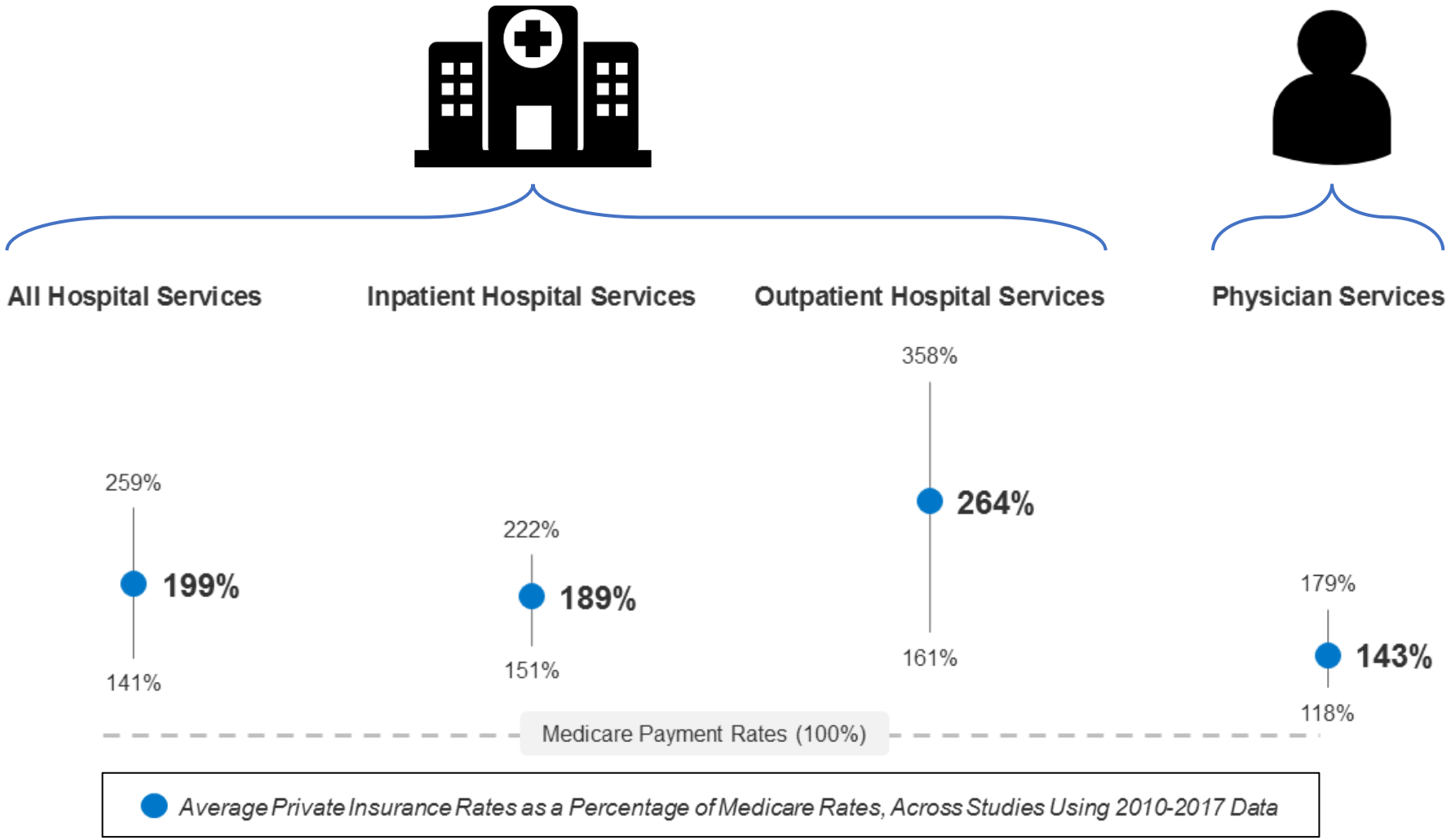


Note: Medical care includes medical services as well as commodities such as equipment and drugs.

Source: KFF analysis of Bureau of Labor Statistics (BLS) Consumer Price Index (CPI) data

Peterson-KFF
Health System Tracker

Consolidation → Higher Commercial Insurer Prices than Medicare



SOURCE: KFF analysis of 19 published studies comparing private insurance and Medicare payments to providers. Because some studies analyze payments to providers in multiple service categories, the number of studies across all categories is greater than 19.

KFF
HENRY J KAISER FAMILY FOUNDATION

Two Wrinkles to Commercial Prices: (1) Out-of-Network is Higher

	Medicare Price	Commercial Insurer Price			
		In-Network		Out-of-Network	
		Price	Ratio	Price	Ratio
Office Visit	$73	$80	1.1	$100	1.4
Hernia Repair	$540	$771	1.4	$1523	2.8
ECG	$9	$17	1.9	$28	3.3

No differences
in vs. out of network

Song Z. JAMA (2019)

(2) Geography Matters – Rural Commercial Prices Are Higher

Selected Commercial Prices as a Percentage of Traditional Medicare Fee-for-Service Prices, 2015.*

Service Code	Metropolitan Statistical Areas in the United States by Quartile of Population Size (Average Population in 2015)				Medicare Fee-for-Service Price
	Smallest Quartile (112,452)	Second Quartile (188,239)	Third Quartile (408,414)	Largest Quartile (2,022,512)	
	Rural	*percent*		**Urban**	*$*
Hospitalizations (DRG code)					
Major hip replacement (470)	228	180	159	132	21,977
Sepsis (871)	218	210	213	157	19,515
Digestive disorder (392)	242	183	154	140	8,297

Song Z. N Engl J Med (2017)