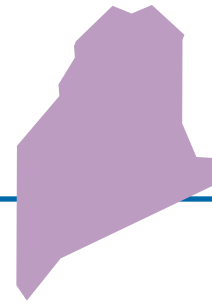


Spotlight on Maine

January 2018

This brief highlights the major strategies, lessons learned, and outcomes from Maine's experience from February 2010 to February 2016 with the quality demonstration funded by the Centers for Medicare & Medicaid Services (CMS) through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). For this demonstration, CMS awarded 10 grants that supported efforts in 18 States to identify effective, replicable strategies for enhancing the quality of health care for children. With funding from CMS, the Agency for Healthcare Research and Quality (AHRQ) led the evaluation of the program.

Maine's Goals: Improve the quality of care for children by—

- Increasing State-level reporting and use of child-focused quality measures.
- Helping practices implement quality improvement projects.
- Developing a secure electronic method for primary care providers to access health information for children in foster care.

Partner States: Maine and Vermont implemented similar projects and met regularly to discuss shared lessons.

Maine expanded State-level reporting and use of child-focused quality measures

Maine worked with a variety of stakeholders to increase State-level reporting and use of pediatric quality measures, including CMS's Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set).[1] Using demonstration funds, Maine—

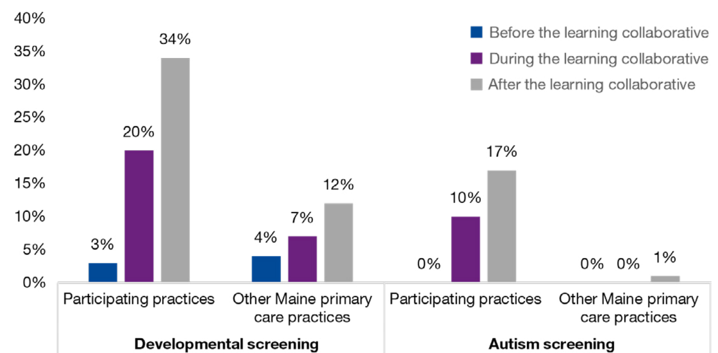
- **Reported 15 child-focused quality measures to CMS by the end of the grant period, up from 11 in 2010.** The State added a new billing code modifier to distinguish between global developmental and autism screenings, thereby permitting the State to report on the rates separately. The State also identified ways to use health information exchange (HIE) data to calculate measures. However, the State was unable to report on all 26 measures, in part, because of incomplete administrative data, limited technical staff to prepare data files and calculate measures, and difficulties in linking data across data systems.
- **Formed the Maine Child Health Improvement Partnership focused on quality improvement (QI).** The workgroup brought together representatives from practices, child advocacy organizations, professional associations, payers, and the public health system.[2] The partnership worked to: (1) develop a master list of pediatric quality measures (the final list included the Child Core Set and additional measures deemed important for QI), (2) align quality measures across initiatives in Maine, and (3) help design and gain provider buy-in for QI activities. Maine indicated that, even though broad stakeholder involvement helped the State gain support for its quality reporting and improvement efforts, it sometimes experienced difficulty in gaining consensus given the wide range of viewpoints represented.
- **Disseminated annual reports on statewide performance on 21 measures**. Following the above efforts, Maine Medicaid and the State's large employer coalition's public reporting program started monitoring additional Child Core Set measures. The State also implemented strategies to improve measure performance. For example, the State included several child-focused measures in its value-based purchasing arrangements with providers. As another example, to increase access to preventive oral health care, Maine began allowing primary care providers to bill for oral health evaluations conducted in their offices for any child under age 3 who had not previously visited a dentist.

Maine helped practices increase the delivery of preventive services

Maine provided practices with comparative quality data and technical assistance to help them increase the delivery of preventive services. Under the CHIPRA quality demonstration, Maine—

- **Improved a system that allows practices to generate real-time reports on immunization measures from the State's immunization registry**. Following the improvements, Maine reported that at least 40 out of 156 pediatric and family practices surveyed in the State used the registry as their data source for reporting immunization rates to the State.
- **Improved practice-level reports**. Maine added five Child Core Set measures to existing claims-based reports available to practices twice a year and encouraged practices to use the reports to track their performance. In a 2014 Statewide survey of pediatric and family practices (N=156), 80 percent of practices reported the use of pediatric-focused quality measures to monitor their performance. Practices reported most frequently using measures related to immunizations, well-child visits, and healthy weight. Although practices found the reports useful for targeting improvement strategies, long delays in claims processing and infrequent reporting created barriers to the reports' use in tracking performance. The State helped interested practices participating in the learning collaboratives run reports from their electronic health records or conduct chart reviews, enabling the practices to obtain more timely information between reporting periods.
- **Hosted learning collaboratives focused on immunizations, developmental screening, oral health, and healthy weight**. The Maine Child Health Improvement Partnership worked with the State to select the topic for each 9-month learning collaborative. The collaboratives involved a mix of activities, including in-person meetings, monthly Webinars, individualized technical assistance from a practice coach, and opportunities for clinicians to receive Maintenance of Certification credit. The collaboratives engaged a total of 48 practices that collectively served approximately 45 percent of all children in Medicaid and CHIP in the State. A given collaborative engaged anywhere from 12 to 34 practices, with practices most likely to participate in collaboratives that aligned with non-demonstration initiatives offering payment incentives for improved performance.
- **Fostered improved performance on quality measures**. Practices implemented various new strategies, including using the State registry to identify patients due for immunizations and embedding reminders in electronic health records to counsel patients about oral health and healthy eating. In State-reported data, practices participating in the first wave of the developmental screening learning collaborative increased rates of developmental and autism screening at a faster pace than did other practices in the State (Figure 1). Maine also reported that practices participating in other learning collaboratives improved performance on quality measures (such as immunization rates), although the changes were similar to improvements made by other Maine practices, or comparison data were not available.

Figure 1. Increases in developmental and autism screening rates for practices participating in Maine's developmental screening learning collaborative and other Maine practices



Note: Data were reported by Maine and not independently validated. The State analyzed Medicaid claims data for participating practices and for other Maine primary care practices. The period before the learning collaborative covered May 2011 through April 2012; the period during the learning collaborative covered May 2012 through April 2013; and the period after the learning collaborative covered May 2013 through April 2014.

Maine piloted an electronic process to share health information for children in foster care

During the demonstration, children entering the State's foster care system in six of Maine's 16 counties received a Comprehensive Health Assessment (CHA) from a contracted provider. Going beyond the standard assessment completed for all children in foster care, the CHA incorporates information from a physical examination, behavioral health evaluation, and health and other social service records. The State used demonstration funds to ease use of the CHA and conduct a pilot test using the State's HIE to store and share the CHA records. Maine—

- **Developed a process for CHA documents to be securely uploaded and retrieved from the State's HIE**. The State engaged several clinical consultants and pediatric primary care practices in planning and developing the information-sharing process and then pilot tested it with one State-contracted CHA provider. Maine reported that efforts to surmount legal barriers to sharing behavioral health data electronically were time- and resource-intensive. The State also found that educating providers about the content of the CHA documents helped overcome practices' resistance to incorporating a review of the CHA into their workflow. The State did not expand the pilot under the demonstration because of the time required for the State to resolve technical and legislative barriers associated with the State HIE.

Key demonstration takeaways

- Engaging stakeholders in the identification of quality measures to be tracked and topics to be addressed in learning collaboratives helped Maine improve consistency in measure reporting and encouraged practices to participate in QI activities.
- Learning collaboratives, clarified billing guidance, and enhanced reporting functions within the State's immunization registry helped practices build capacity and improve performance on quality measures, particularly developmental screening rates.
- Maine's efforts to report quality measures at the State level and share CHA information through the HIE were limited by incomplete administrative data, complexities related to sharing behavioral health information, variations in connectivity, and child health providers' use of the HIE. Nonetheless, the State was able to produce quality reports and piloted electronic sharing of CHA information.

Continuing Efforts in Maine

After Maine's CHIPRA quality demonstration grant ended in February 2016, the State planned to—

- Continue generating quality measure reports showing performance at the State and practice levels.
- Continue efforts to align pediatric quality measures used by different child-serving agencies and initiatives in the State.
- Provide ongoing support for the The Maine Child Health Improvement Partnership, which will continue advising the State and providers on improving quality reporting and implementing QI initiatives.

Endnotes

1. For more information on the Child Core Set, visit https://www.medicaid.gov/medicaid/quality-of-care/downloads/2016-child-core-set.pdf.
2. Maine published several reports on its CHIPRA quality demonstration Web site, including its master list of quality measures, an issue brief describing how the measures were selected, and evaluation reports from the State's learning collaboratives. To view the reports, visit http://www.maine.gov/dhhs/oms/provider/ihoc.shtml.

LEARN MORE

Maine's CHIPRA quality demonstration experiences are described in more detail on the national evaluation Website available at **http://www.ahrq.gov/policymakers/chipra/demoeval/demostates/me.html.**

The following products highlight Maine's experiences—

- *Evaluation Highlight No. 1:* How are CHIPRA demonstration States approaching practice-level quality measurement and what are they learning?
- *Evaluation Highlight No. 2:* How are States and evaluators measuring medical homeness in the CHIPRA Quality Demonstration Grant Program?
- *Evaluation Highlight No. 4:* How the CHIPRA quality demonstration elevated children on State health policy agendas.
- *Evaluation Highlight No. 6:* How are the CHIPRA quality demonstration States working together to improve the quality of health care for children?
- *Evaluation Highlight No. 11:* How are CHIPRA quality demonstration States using quality reports to drive health care improvements for children?
- *Evaluation Highlight No. 13:* How did CHIPRA quality demonstration States employ learning collaboratives to improve children's health care quality?
- *Article*: Devers K, Foster L, Brach C. Nine states' use of collaboratives to improve children's health care quality in Medicaid and CHIP. *Acad Pediatr* 2013; 13 (6): S95-102. PMID: 24268093.

The information in this brief draws on interviews conducted with staff in Maine agencies and participating practices and a review of project reports submitted by Maine to CMS.

The following staff from Mathematica Policy Research and the Urban Institute contributed to data collection or the development of this summary: Grace Anglin, Kelly Devers, Rachel Burton, Amanda Napoles, and Emily Lawton.