2014 ANNUAL REPORT

Test Year One

October 1, 2013 -September 30, 2014

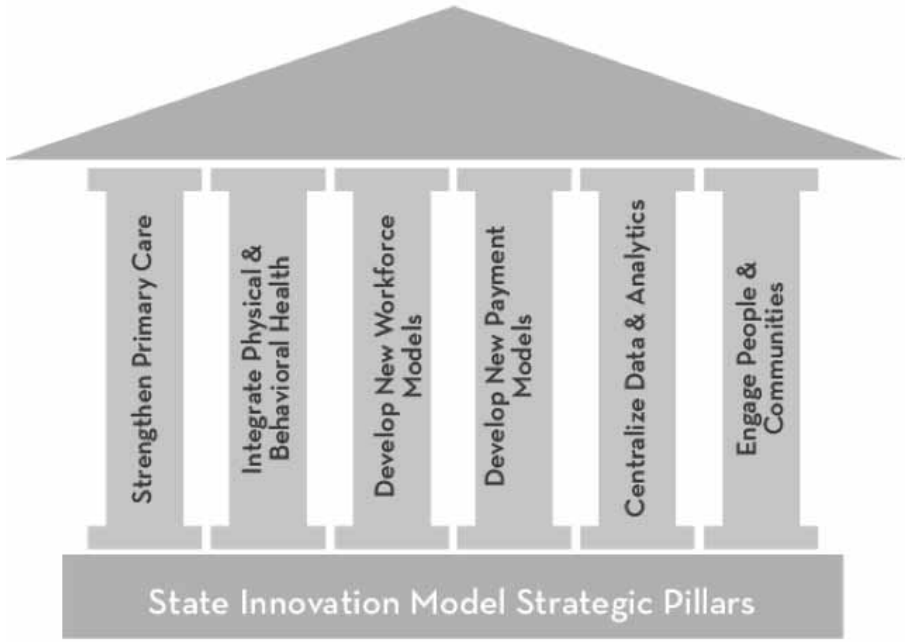
SIM
Healthcare System Transformation
A Collaborative Partnership led by Maine DHHS

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

EXECUTIVE SUMMARY

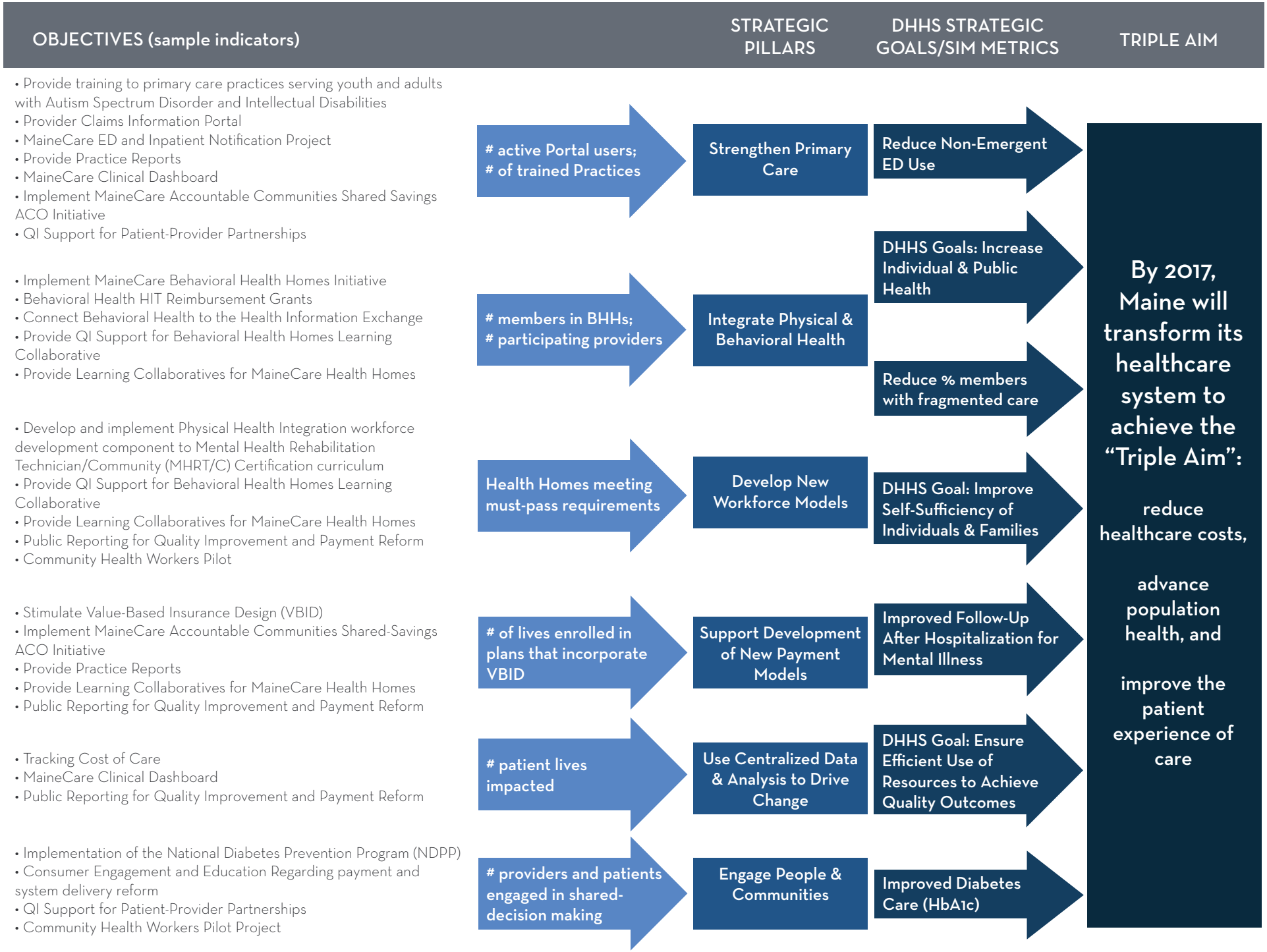
Healthcare Reform in Maine funded by the Maine State Innovation Model is based upon six key strategies which Maine believes will lead toward the achievement of the triple aim. All of the SIM objectives funded by the grant are aligned to at least one, if not several, of the Maine SIM Strategies. In the first full test year of the SIM grant, the SIM Program team prioritized the utilization of these six strategies to develop the Maine SIM Strategic Framework, providing the organizing structure for integration and alignment of all of the SIM objectives toward the intended outcomes. Before a society can work together to pull a wagon in the same direction toward an end goal, it must first understand what the wagon looks like, and the final destination. The Maine SIM Strategic Framework strives to achieve both the vision and the final direction in a simplified manner, enabling stakeholders to begin to move forward in a unified direction in a theater as complicated as healthcare reform.

For SIM test year one, the SIM Operational plan was adjusted to better articulate these strategies, and to describe how the SIM objectives are expected to contribute to strategy attainment, and ultimately contribute toward attainment of the Triple Aim. The 'driver diagram' on page 3 describes the relationships of the SIM objectives to these ultimate goals.



Year One saw great progress in every SIM objective, and largely every SIM objective is progressing according to the SIM Program Plan, also known as the Single-Source of Truth (SST). The SST is used substantially to monitor SIM progress, determine and monitor integration points, and adjust the SIM program accordingly.

The diagram on page 4 is a one page view of the status of every SIM objective through SIM Test Year One, each colored square representing the objective status in the associated quarter , with green indicating that goals are being met, yellow that goals are at risk of not being met ,and red that goals for that particular quarter were not met.


OBJECTIVES (sample indicators)
STRATEGIC PILLARS
DHHS STRATEGIC GOALS/SIM METRICS
TRIPLE AIM
• Provide training to primary care practices serving youth and adults with Autism Spectrum Disorder and Intellectual Disabilities
• Provider Claims Information Portal
• MaineCare ED and Inpatient Notification Project
• Provide Practice Reports
• MaineCare Clinical Dashboard
• Implement MaineCare Accountable Communities Shared Savings ACO Initiative
• QI Support for Patient-Provider Partnerships
active Portal users; # of trained Practices
Strengthen Primary Care
Reduce Non-Emergent ED Use
• Implement MaineCare Behavioral Health Homes Initiative
• Behavioral Health HIT Reimbursement Grants
• Connect Behavioral Health to the Health Information Exchange
• Provide QI Support for Behavioral Health Homes Learning Collaborative
• Provide Learning Collaboratives for MaineCare Health Homes
members in BHHs; # participating providers
Integrate Physical & Behavioral Health
DHHS Goals: Increase Individual & Public Health
Reduce % members with fragmented care
• Develop and implement Physical Health Integration workforce development component to Mental Health Rehabilitation Technician/Community (MHRT/C) Certification curriculum
• Provide QI Support for Behavioral Health Homes Learning Collaborative
• Provide Learning Collaboratives for MaineCare Health Homes
• Public Reporting for Quality Improvement and Payment Reform
• Community Health Workers Pilot
Health Homes meeting must-pass requirements
Develop New Workforce Models
DHHS Goal: Improve Self-Sufficiency of Individuals & Families
• Stimulate Value-Based Insurance Design (VBID)
• Implement MaineCare Accountable Communities Shared-Savings ACO Initiative
• Provide Practice Reports
• Provide Learning Collaboratives for MaineCare Health Homes
• Public Reporting for Quality Improvement and Payment Reform
# of lives enrolled in plans that incorporate VBID
Support Development of New Payment Models
Improved Follow-Up After Hospitalization for Mental Illness
• Tracking Cost of Care
• MaineCare Clinical Dashboard
• Public Reporting for Quality Improvement and Payment Reform
patient lives impacted
Use Centralized Data & Analysis to Drive Change
DHHS Goal: Ensure Efficient Use of Resources to Achieve Quality Outcomes
• Implementation of the National Diabetes Prevention Program (NDPP)
• Consumer Engagement and Education Regarding payment and system delivery reform
• QI Support for Patient-Provider Partnerships
• Community Health Workers Pilot Project
providers and patients engaged in shared-decision making
Engage People & Communities
Improved Diabetes Care (HbA1c)
By 2017, Maine will transform its healthcare system to achieve the "Triple Aim":
reduce healthcare costs,
advance population health, and
improve the patient experience of care

STRENGTHEN PRIMARY CARE	WEIGHT	INTEGRATE PHYSICAL & BEHAVIORAL HEALTH	WEIGHT	DEVELOP NEW WORKFORCE MODELS	WEIGHT	DEVELOP NEW PAYMENT MODELS	WEIGHT	CENTRALIZE DATA & ANALYSIS	WEIGHT	ENGAGE PEOPLE & COMMUNITIES	WEIGHT
MaineCare Objective 1	5	**MaineCare Objective 2**	5	**MHMC Objective 3**	5	**MHMC Objective 3**	5	**MHMC Objective 1**	5	**Maine CDC Objective 1**	3
Implement MaineCare Accountable Communities Shared Savings ACO Initiative		Implementation and ongoing support of MaineCare Behavioral Health Homes Initiative		Public reporting for quality improvement and payment reform		Public reporting for quality improvement and payment reform		Track healthcare costs to influence market forces and inform policy		Implementation of the National Diabetes Prevention Program (NDPP)	
QC Objective 1	4	**HIN Objective 2**	4	**QC Objective 1**	4	**MaineCare Objective 1**	5	**MHMC Objective 3**	5	**Maine CDC Objective 2**	2
Provide learning collaborative for MaineCare Health Homes		HIN will select 20 qualified Behavioral Health Organizations to provide $70,000 each towards their EHR investments including their ability to measure quality		Provide learning collaborative for MaineCare Health Homes		Implement MaineCare Accountable Communities Shared Savings ACO Initiative		Public reporting for quality improvement and payment reform		Community Health Workers Pilot Project	
HIN Objective 1	3	**HIN Objective 3**	4	**QC Objective 3**	4	**MHMC Objective 2**	4	**HIN Objective 1**	3	**MHMC Objective 6**	2
HIN's Health Information Exchange (HIE) data will support both MaineCare and provider care management of ED and inpatient utilization by sending automated emails to care managers to notify them of a patient's visit along with associated medical record documents		Connect behavioral health providers to HIN's Health Information Exchange		N/A Provide QI support for Behavioral Health Homes Learning Collaborative		Stimulate Value Based Insurance Design		HIN's Health Information Exchange (HIE) data will support both MaineCare and provider care management of ED and inpatient utilization by sending automated emails to care managers to notify them of a patient's visit along with associated medical record documents		Consumer engagement and education regarding payment and system delivery reform	
MHMC Objective 4	3	**QC Objective 3**	3	**MaineCare Objective 3**	3	**MHMC Objective 5**	3	**HIN Objective 4**	2	**HIN Objective 5**	1
Provide primary care providers access to claims data for their patient panels (portals)		N/A Provide QI support for Behavioral Health Homes Learning Collaborative		N/A Develop and implement physical health integration workforce development component to Mental Health Rehabilitation Technician/Community (MHRT/C) Certification curriculum		Provide practice reports reflecting practice performance on outcome measures		HIN will provide MaineCare with a web-based analytics tool referred to as a "dashboard." The dashboard will combine current real-time clinical HIE data with MaineCare's claims data. This is the first test of Maine's HIE to support a "payer" using clinical EHR data.		HIN will provide patients with access to their HIE medical record by connecting a provider's "patient portal" to the HIE. The patient will access the HIE record via a "blue button" in their local patient portal environment.	
MHMC Objective 5	3	**QC Objective 1**	3	**Maine CDC Objective 2**	2	**QC Objective 1**	4			**QC Objective 4**	1
Provide practice reports reflecting practice performance on outcome measures		Provide learning collaborative for MaineCare Health Homes		Community Health Workers Pilot Project		Provide learning collaboratives for MaineCare Health Homes				N/A Provide QI support for Patient-Provider Partnership Pilots (P3 Pilots)	
MaineCare Objective 4	2					**Maine CDC Objective 1**	3				
N/A Provide training to primary care practices on serving youth and adults with Autism Spectrum Disorder and intellectual disabilities						Implementation of the National Diabetes Prevention Program (NDPP)					
QC Objective 4	1										
N/A Provide QI support for Patient-Provider Partnership Pilots (P3)											

- MaineCare
- Quality Counts
- HealthInfoNet
- Maine Health Management Coalition
- Maine CDC

The self-evaluation also began in SIM Test Year One. However, due to substantial delays in the contracting process, SIM outcomes did not begin to be measured in that year. Still, substantial progress was made in the development of the self-evaluation plan and the foundation was developed to provide to the Lewin Group the data that will be needed for the self-evaluation, effectively setting the stage for outcome measurement beginning early in SIM test year two.

There were many challenges faced over the course of the first full testing year of the SIM grant. The nature of these challenges were varied, and many a result of the the very nature of this grant, which is the integration of efforts across many different organizations. While it is the power of the combination of these innovations that each organization is delivering that provides Maine with the unique opportunity that SIM provides to transform healthcare, the coordination of these innovations is an extremely challenging endeavor. The need for substantial governance, communication, and coordination are paramount to aligning efforts for maximum achievement, and doing so on a consistent and effective basis was a major focus in Year One, and will continue to be for the remainder of the grant.

In the remainder of this narrative, the major accomplishments within each SIM strategy are summarized, along with the key challenges that exist. Summaries are included in the SIM Governance and Program administration domains as well, as those are key factors in SIMs success.

SIM GOVERNANCE AND PROGRAM ADMINISTRATION

SIM Governance

The SIM Governance process matured significantly during Test Year One, as all the SIM governance committees and subcommittees transitioned from a learning mode to a decision making mode. The State of Maine serves as the lead convener of the SIM governance process, which includes the Maine Leadership Team, the SIM Steering Committee, and three subcommittees: Payment Reform, Delivery System Reform, and Data Infrastructure subcommittees, which are facilitated by the Maine Health Management Coalition, Quality Counts, and HealthInfoNet respectively. The Evaluation subcommittee, with the DHHS office of Continuous Quality Improvement in the lead, will begin work in the first quarter of year two. In addition, multiple workgroups were formed or enhanced as a result of SIM, including but not limited to, the Accountable Care Implementation subcommittee, the Measure

Alignment workgroup, HealthCare Cost workgroup, and the Value Based Insurance Design workgroup, among others. The overwhelming majority of the SIM governance meetings were held as scheduled, and the risk identification and mitigation process was developed and matured, facilitating communication between the stakeholder groups who are represented on each committee, subcommittee, and workgroup. Some highlights of the governance decisions made during SIM's first year include the collaboration toward a care coordination strategy, the focus on alignment of a core measure set, the initial review of methods to accelerate primary care payment reform, and the finalization of a healthcare transformation leadership development program. Engagement of the stakeholders on SIM governance structure remained robust throughout the year.

Keeping the work of all of these workgroups, committees, and subcommittees organized has been a major challenge, and one that can create confusion for even the most engaged stakeholders. Yet, progress was made during the year in organizing and making accessible the meeting documents, outputs, and sharing those outputs between groups. Ongoing progress in this area will remain a focus of the SIM Program.

SIM Program Administration

The SIM Program operationalization matured and solidified over the course of the year, as the SIM Program Plan was enhanced to include process that tied together project goals and reporting, invoicing, contracting, and overall integration. The SIM Program Plan, and the associated process, has become known as the 'Single Source of Truth', due to the degree to which it serves as SIM Command Central, integrating and relating all of the dozens of SIM activities that occur simultaneously and need to remain integrated and coordinated. The process developed to manage Maine's SIM grant has served as a best practice and has been emulated and adapted for use throughout the State of Maine's Department of Health and Human Services.

The SIM Program completed hiring as planned during the first year, hiring a SIM Budget and Contract coordinator in the first quarter, followed by Project Managers focused on the risk mitigation process and self- evaluation.

SIM Self-Evaluation

The state's SIM Self Evaluation began in July 2014 after a complicated contracting process that delayed work by nearly a year. The

evaluation team from the Lewin Group is responsible for measuring and reporting on the outcomes of the initiatives under the SIM grant which are focused on lower costs, improved quality, and improved patient experience of care. The Lewin Group is developing rapid cycle evaluations, with the intent to enable the SIM governance bodies to determine the impacts of the SIM innovations on a regular basis, and consider adjustments to improve results as needed.

Accomplishments from the first 90 days of the evaluation include an orientation, kick off meetings with staff from the State and the SIM partners, the hiring of a Quality Improvement Program Manager, drafting of logic models for the project as a whole and each initiative individually, and the development of a plan for the evaluation subcommittee and draft an outline for the evaluation plan.

STRENGTHEN PRIMARY CARE

A strong primary care system is foundational to improving the quality and lowering the cost of healthcare in our state. Primary care doctors play a leading role in managing patients' health and coordinating their care with hospitals and specialists. When primary care doctors have the tools and resources to do their job effectively they are able to keep patients healthy and reduce the need for costly emergency care down the road.

SIM test year one saw many capabilities developed that will strengthen primary care practices across the State of Maine, more effectively enabling these practices to deliver the proactive care to their patient populations that will help Maine to achieve the triple aim. Some of the capabilities that were developed as a result of SIM are as follows:

Health Home Learning Collaboratives

The Patient Centered Medical Home/Health Home Learning Collaborative continues to progress with success. In year one, 1,211 providers were included, along with 6 payers, impacting more than 700,000 beneficiaries across the State. Among the accomplishments in SIM Year One are: 1) rolling in 102 new single payer (Medicaid) primary care practices to the Learning Collaborative, including performing on-site practice assessments, focused support and tracking for achieving NCQA Medical Home recognition, and orientation sessions for them on the HH requirements and 10 Core Expectations; 2) convening several large

face-to-face Learning Session with all the PCMH and HH practices, now totaling about 177 primary care practices, to explore their transformation with national experts and network with their colleagues on best practices. 3) succeeding in collecting deliverables and reporting requirements from the practices as defined in their participation expectations; and 4) meeting and in many cases surpassing our Health Home Learning Collaborative quarterly accountability targets.

We are pleased with the results from year one of the SIM grant, and have successfully expanded the medical home movement in Maine by supporting the HH Initiative, and by January 2015 project that we will have nearly tripled the size of the PCMH/HH Learning Collaborative to include well over 200 primary care practices. We are also learning important lessons about how best to support the single payer HH practices in accomplishing their requirements and transforming care in the delivery system while they are still working primarily in the challenging environment of a fee-for-service model. By maximizing the positive, supportive relationships and technical assistance provided through the Learning Collaborative, we can use the discipline of quality improvement to hone in on the most difficult areas for the practices to 'move the needle' and provide customized approaches to facilitate their ability to provide high quality, patient centered primary care.

Emergency Room and Inpatient Notifications

HealthInfoNet completed the capability to send secure email notifications for selected events of care for the 1,800 MaineCare members identified by MaineCare's Care Management team to reduce unnecessary ED utilization. The secure emails contain personal health information and are sent to the MaineCare Care Management team for follow up intervention and planning in partnership with the hospitals across the state. During SIM test year one, more than 2,000 emails were produced from this project. Both unique events of care and a daily summary of all events of care in a 24 hour period have been tested and validated. Development work to produce emails containing clinical documents from events of care began during the 4th quarter.

Active clinical usage of the HIE and notifications has grown positively over the last year, and HIN exceeded its 3rd quarter goal for number of weekly unique user accesses to the HIE Clinical Portal tool. This means that the opportunity to leverage the notification service continued to grow throughout SIM test year one.

Primary Care Practice Access to Claims Data through Portals

By the end of SIM Test year one, there were more than 300 individual claims portals in existence deployed in practices across the state. Throughout the year, the Maine Health Management Coalition worked to promote and disseminate the patient portals, as well as explore new ways to leverage existing work across other payer data. As work continues into SIM Year Two on AC attribution methodology, SIM will be exploring ways to unify attribution processes where possible for use in future portals.

Primary Care Practice Reports

The distribution of Primary Care practice reports was substantially increased in over the course of SIM Year one, with nearly three quarters of all primary care practices across the State receiving these reports which included information on Commercial populations. In test year two, the practice reports will be developed to include MaineCare and Medicare populations, and attempts will be ongoing to reach every practice and practice group for report distribution.

Some of the major challenges included the delay in obtaining accurate data from the MHDO which did create a delay in our ability to update practice reports. We expect those delays to be mitigated moving forward.

Primary Care Practice Training in Intellectual and Developmental Disabilities

The process of refining the number and type of providers receiving the I/DD training will continue into SIM Test Year Two. A contract for services was developed and awarded at the end SIM Year One with Maine's Developmental Disabilities Council, an organization experienced with working with workforce training for the I/DD population. .

INTEGRATE PHYSICAL AND BEHAVIORAL HEALTH

Behavioral health is increasingly being recognized as a vital piece of high quality primary care. Healthcare providers understand that in order to keep patients healthy, equal attention needs to be given to both body and mind. The following SIM activities are being undertaken to strengthen the ties between physical and behavioral health in order to provide Maine patients with comprehensive care:

Behavioral Health Homes

Behavioral Health Homes were implemented on April 1, 2014, an unprecedented arrangement in the State of Maine, with the goal of integrating physical and behavioral health care for adults with Serious Mental Illness and Children with Serious Emotional Disturbance. In Maine, 24 community-based mental health agencies at 60 sites partnered with primary care practices in order to integrate care for complex populations to achieve improved physical and mental health outcomes. Behavioral Health Home Organizations (BHHOs) incorporated two new roles to their team-based approach to care to provide this service: the nurse care manager and the peer/family support coordinator. BHHOs also used an electronic portal developed by MaineCare which provided claims based data to guide teams in population management and risk stratification. In the portal, BHHOs were able to see aggregate quality metrics on their population served as well as drill down to data individual data. For example, one BHHO client had 69 emergency department visits prior to BHHO services and one visit post BHHO services, which was shown through portal data.

Although the State Plan Amendment was not approved during SIM's first year, the approval was received on December 17th 2014. Behavioral Health Home (BHH) enrollment has fluctuated, but appears to be trending upward. However, the enrollment goal in test year one of 8,500 people served was not attained. Just under 2000 people are enrolled in BHHO services. Approximately 70% of those receiving BHHO services are adults BHH leadership is developing strategies to increase the number enrolled in BHH. A key goal in the second year is to increase the number of enrolled lives in the behavioral health homes.

Behavioral Health Homes Learning Collaborative

The BHH Learning Collaborative continues to expand its outreach to and interaction with BHHOs in order to help the 24 BHHOs achieve the 10 core expectations and meet Learning Collaborative participation requirements of Learning Session attendance and participation in monthly webinars. Key concepts addressed this year by the Learning Collaborative include population management and risk stratification; the role of the nurse care manager and the peer/family support specialist on the BHHO team; and strategies for integrating physical and mental health as well as enhancing the involvement of families and peers BHH LC staff also conducted site assessments for each BHHO and provided this information to the BHHOs for practice improvement and action planning and to the Office of MaineCare Services.

Rich discussion from cross-sector stakeholders continues to inform Learning Collaborative work. Two groups advise Learning Collaborative efforts: The Behavioral Health Home Working Group and the Quality Counts Behavioral Health Committee. An Ad Hoc Committee: the Consumer/Family Peer Group advises the BHH Working Group on strategies to incorporate consumer and family perspective into BHH LC activities and educational content. In addition, a team of consultant psychiatrists and a consultant behavioral health organization and two consultant consumer organizations advise the BHH LC on its outreach, activities, quality improvement, and educational content.

Key BHH LC accomplishments of 2014:

- 96 percent of Behavioral Health Home Teams participated in three Learning Sessions held in 2014.
- BHH LC webinars exceeded the 50% participation goal set at the launch of the BHH LC, with an average participation rate for the 8 webinars held in 2014 of 71%. Total webinar participation for 2014 254 people.

In January 2015, the BHH LC will welcome three new BHHOs: Evergreen Behavioral Health, Motivational Services, and Sequel Services.

Behavioral Health Homes Electronic Health Records

In May of 2014 the Behavioral Health Information Technology Reimbursement Initiative was launched with the initial 20 BH. organizations from across the state of Maine. Of the participating organizations all regions of the state are represented: South, East/North, and Central/West. Approximately 90,000 patients are served annually by the participating organizations. Milestone One payments were paid out by the end of the 4th quarter, September 30th, 2014, in the total amount of $375,000, which is substantially short of goal and a result of the lack of readiness of BHHs and their her vendor's readiness for HL7 interoperability. The initiative holds required monthly webinar's and weekly technical calls to provide milestone information and education towards achieving the milestones. We expect these required meetings to assist in closing the gap between the goal of BHH EHRs and the current position.

Behavioral Health Homes to Health Information Exchange

HIN has seven active BH HIE connections in place. The first BH EHR vendor has completed bidirectional HIE testing and is scheduled to complete production validation in the 2nd quarter of year 2 to go-live with BH data sharing for the first time in Maine. As the sites participating in the Reimbursement Initiative are connected and begin to share data via a bidirectional VPN connection, the accountability targets of 15 BHH connected to the HIE will be accomplished in SIM test year 2.

DEVELOP NEW WORKFORCE MODELS

One of the primary drivers of high costs and poor patient outcomes in our healthcare system is the absence of coordinated preventative care. All too often we are treating health problems as they arise instead of dealing with them before they become an issue. To address this problem, SIM work focuses significant resources on expanding the ability of w providers to reach and serve patients. It will bolster efforts like Maine Quality Counts' Health Homes initiatives (pillar 2), the Maine Health Management Coalition's transparency initiatives (pillar 4), and Maine CDC's Community Health Workers (CHWs) Project:

Physical and Behavioral Health Integration Curriculum Development

In Year One, the contract for the development of the Physical and Behavioral Health Integration Curriculum was encumbered, and the work plan was drafted and refined. Current SIM goals associated with this initiative are out of alignment with current work plan and expectations, and the SST will be adjusted early in Year Two. Work on the curriculum development is on target and will provide a consistent method to provide high quality training to providers.

DEVELOP NEW PAYMENT MODELS

In today's fee-for-service payment system, doctors and hospitals are paid based on the amount of services they provide, not for making patients healthier. As part of the SIM initiative, the State is seeking to change this model to align payment with improved patient outcomes. The following describes work being undertaken to promote alternative payment systems:

Public Reporting

In SIM Year one, 1,933 providers and 228 provider organizations were represented in public reporting activities, and a major accomplishment of the SIM Year one was gaining a recommendation from both the MHMC Physicians and Systems Pathways To Excellence committees to publicly report on the proposed Total Cost of Care/Resource Use index measures. This is an important step forward in terms of enhancing transparency at both the practice and practice group level in Maine. The work of the Healthcare Cost work group also proceeded smoothly with the group identifying its top three priorities to focus on during its first phase of study: price, infrastructure and patient engagement. The Pathways To Excellence Behavioral Health group, newly formed in SIM year one, was also established and make great progress through the first year; displaying enthusiasm and drive to get quickly develop its first measures for public reporting.

Similarly, the Standard Measures Alignment subgroup continued to progress in its work and picked up the pace throughout the year. Additionally, we have observed a growing publicly shared view on the part of Maine payers regarding their interest in aligning their own metrics with those publicly reported by the Coalition, and we had been "saving" the conversation around a cost measure for later in this workgroup process. The recent recommendation of publication of the Total Cost and Resource Use Indices by the PTE groups now provide the basis for a much easier conversation about this within the context of the measure alignment workgroup, and is considered a major breakthrough during year one for public reporting and perhaps, payment reform as a whole.

Work in support of MaineCare's Accountable Communities initiative progressed throughout the year, with MHMC able to replicating Deloitte's attribution methodology enabling the provision of analytic support that MaineCare requires for this effort.

The ultimate goal for this objective is to, through public reporting, influence market forces and move a total of 67% of Maine's population to an alternative payment arrangement. In 2013, we reported 85,000 lives covered under alternative payment arrangements. A survey conducted at the end of Year One indicates a minimum of 215,000 such lives. This count does not include enrollees in two of the major health plans operating in the Maine market, nor any MaineCare enrollees.

Accountable Communities

Significant progress has been made in implementing the Accountable Communities (AC) program. MaineCare expected Round 1 participation of 5 ACs covering 25,000 lives; instead participation is 4 ACs covering 30,000. The contracting process took longer than expected, with the contracts not being signed during SIM Year 1, but with the contracts' start date being August 1, 2014. The Department has provided ACs with all required monthly data reports since August and has received extremely positive feedback from the ACs. Delays in the contracting process should not be a problem for Round II, because – unlike Round 1, for which the contract was developed after the RFA – the finalized contract will be part of the Round 2 RFA.

Stimulate Value Based Insurance Design

The Value Based Insurance Design initiative included 9 payers representing more than 600,000 beneficiaries with a goal of 100,000 enrolled lives by the end of the SIM grant. In year one, the VBID workgroup reviewed and recommended adoption of a strategy for rating health plans with regard to their use of value based design approaches; and these ratings have been published on the MHMC website (www.mehmc.org).

National Diabetes Prevention Program

The goal by the end of year one was for 5 provider organizations to participate in the NDPP, with an ultimate goal of 15 by the end of the grant. SIM did achieve the NDPP goal for year one. To support the organizations, training was held with the outcome of twenty new lifestyle coaches trained to support NDPP. Planning for a November NDPP forum to share information about NDPP with employers, providers, and payers also occurred. The forum included a partnership with the Maine Health Management Coalition, US Centers for Disease Control and Prevention, and American Medical Association. Partnering with the other SIM grant partners (MaineCare, MHMC, MQC, and HIN) provided opportunities to meet with work groups and their subcommittees. These work groups/subcommittees and their members have provided guidance on design and approach with payer/purchasers regarding NDPP and how to establish a sustainable structure for payment within VBID/ACO plan designs. Maine CDC is pleased with the opportunity that SIM has provided to the public health community in support of population health and strong community and clinical linkages well into the future. Being invited to participate in the various SIM work groups and subcommittees provides a unique opportunity to leverage the work of SIM for both the NDPP and CHW initiatives of Maine CDC. Important for sustainability is

consideration of how future payment and delivery system reform initiatives will support these strategies and the affiliated workforces.

CENTRALIZE DATA & ANALYTICS

Data and analytics are an integral piece of the SIM work currently underway around the state. Robust data holds not only the potential to tell us how costs, utilization and quality vary around the state, but it can also help break down barriers between doctors and the patients they care for. Nearly every SIM objective has a foundation in data and analytics because we know that what gets measured gets improved. The following SIM activities are being undertaken to strengthen data and analytics in the state:

All Payer Claims Database

The important work of maintaining and refining the claims database and warehouse continued throughout the project year. Previously reported issues with the commercial data from the MHDO's APCD were resolved through focused efforts on the part of MHMC data staff. This effort resulted in providing the MHDO vendor with critical fixes so that the data might be useful to any and all users of the APCD, not just to the Coalition in its SIM activities. The data issues, however, did take considerable time to resolve and thus generated delays in production timelines for deliverables that rely on commercial data (e.g. practice reports). MaineCare and Medicare data sets are now both residing with the Coalition's data vendor; MaineCare data is refreshed on a regular basis. The Coalition has encountered some difficulty in identifying the appropriate DUAs required to share Medicare data with the SIM "local" evaluation team (Lewin) and for using the Medicare data in all the ways contemplated under our SIM proposal. Working through these issues has required a substantial investment of time on the part of the Coalition, Department and CMS. An appropriate path forward was identified in Year Two, Q1 and is now being pursued, but as of this writing, the DUA is still pending with RESDAC.

Over the course of the year, in addition to continually refining the provider atlas, MHMC also began to add behavioral health providers to the atlas. This represents a substantial provider population, but is a necessary step in preparing to publicly report on behavioral health quality measures.

Healthcare Cost Workgroup

All meetings are publicized on the Maine Health Management Coalition website, on the SIM website, and are also shared with the SIM Steering Committee, the Payment Reform Subcommittee, and the Accountable Care Implementation (ACI) Steering Committee. In addition, email invites are routinely sent to all persons on the workgroup's interested parties list, which numbers approximately 125 individuals. At its April meeting, the group had identified price, infrastructure, and consumer engagement as their initial areas of focus, and at the May meeting participants began reviewing and discussing various price options for reducing healthcare costs, including transparency, reference pricing, bundled payments, and narrow networks. Working from this list of consensus-based priorities, the group – with the help of an expert facilitator (Bailit) – developed a recommendation for a voluntary cap on year over year growth in risk based contracts, tracking to Medical CPI. This recommendation was presented to a group of 52 attendees at the October 2014 CEO Summit. Informal feedback from this meeting indicated the intention of certain "pairs" of purchasers and ACOs to implement this recommendation. Other, more formal feedback has been a bit more equivocal. Because the lead time on contracting is so long (businesses were already well into the process of negotiating coverage arrangements by the time of the Summit), adoption of this tactic will only be able to be documented in 2016.

The Healthcare Cost workgroup has now begun to explore the issue of health care infrastructure, identifying potential areas where excess capacity might exist, as well as possible data needs.

Healthcare Cost Data Book

The Healthcare Cost Data Book was compiled and produced, with dissemination beginning in Year One, Q4 and continuing into Q1 of Year Two. The book has been well received. It is available in electronic form on the Coalition's website. Hard copies of the book were distributed to key stakeholders, including all SIM governance members, key members of the Administration, key members of the Maine Legislature and representatives of CMMI. The book will be updated on a regular basis, with subsequent "editions" released every six months.

CEO Summit

In Q3, staff worked to develop topics and recruitment strategies for the CEO Summit and advanced efforts to find a keynote speaker

and facilitator. The key note speaker for this event was Alan Gilbert, of GE's healthimagination initiative. More than 52 individuals participated in the Summit; as evidenced by participant feedback, the event was well-received.

Accountable Community Work With MaineCare

Over the course of the year, the Coalition worked closely with MaineCare staff and the Department's consultants (Deloitte) to discuss and refine the Accountable Community methodology. This has necessarily been a very long and very detailed process, so as to ensure that the Department is entirely comfortable that the approach reflects its policy decisions. As this process unfolded, new issues of policy presented themselves. This required time for the Department to resolve, but leads to a better end product. Because of the time taken to work through this process, though, the time line for the Coalition's work on AC's was delayed. Similarly, as issues crop up in the future, the Coalition's work will necessarily be impacted as the Department works to resolve new questions. The Coalition is now producing monthly reports for AC practices as required.

Clinical Dashboard

In order to produce the Analytics Dashboard to MaineCare, HIN devoted year 1 to completing the design and build of the technical environments to store and integrate all MaineCare claims files with the clinical data in the HIE. HIN has received all claims files from the fall of 2010 thru the current month and will continue to integrate current data throughout the project. The first "Analytics Dashboard" views were demonstrated to MaineCare in November of 2014. The first user access and training implementation sessions for the project will begin in the 1st quarter of year 2. The phase of the project that was successfully completed in year 1 was to integrate MaineCare's prescription history within the HIE's clinical portal to support Clinicians across the state managing medication reconciliation for patient treatment.

ENGAGE PEOPLE & COMMUNITIES

Whether the State Innovation Model work underway focuses on creating a new database or an Accountable Care Organization, the purpose is ultimately to provide higher quality, more affordable healthcare to Maine's people and communities. As the end-users of the work being done, it is important that Maine people are being involved and that they understand the reasons for the changes

taking place in the healthcare system. To that end, the State Innovation Model puts a strong emphasis on engaging people and communities.

Health Information Exchange - Patient Portal 'Blue Button' Pilot

The 12 month pilot between HIN and Eastern Maine Health System was launched in June. The initial implementation work for the pilot has begun with a selected leadership team focused on patient portal implementation and patient engagement. The pilot work will begin with an ideal set of primary care practices with strong patient engagement activities already in place during the 4th quarter and year 2 1st quarter. EMHS has approximately 17,000 registered, active users of their Patient Portal system. HIN will measure the unique users that access the "blue button" functionality that is being tested once the pilot sites are live. Go-Live is scheduled for January of 2015.

Community Health Workers Pilot

Community health workers can be an important bridge between providers and individuals to promote health, reduce disparities, and improve service delivery. Q3 of 2014 for the CHW Initiative was focused on readying activities for "CHW Pilot Site contract approval". Following the release of the CHWPP RFP were a number of preparatory activities that occurred and led up to the review of proposals for the CHW Pilot Projects, they included: a bidder's Conference (04/01/14), Publishing Questions and Answers specific to the CHWPP RFP (4/25/14), accepting Letters of Intent (05/02/14) and full proposal submissions (06/02/14). Review of the CHWPP proposals was completed during the week of June 16th by staff from Maine CDC and MaineCare. Contracts were completed with four organizations.

As part of building the infrastructure and sustainability of CHWs, a CHW Stakeholder Group was convened to inform the CHW Initiative and has met nine times since its inception in October of 2013. The group informs the CHW Initiative in the infrastructure and systems development work that parallels and complements the implementation of CHW Pilot Projects. Shared learning, development of guidance, networking and a focus on sustainability anchor the group in its work. Close to 100 individuals receive information regularly from the project and 30 members regularly participate in monthly meetings. The CHW Stakeholder Group has completed the following: CHW core roles and responsibilities, cross-walk of roles and responsibilities to skills and attributes of

CHWs, and recommendations for recruitment of CHWs

Community Education Regarding Regarding Payment and DSR

The Coalition has engaged in outreach efforts to inform the public about efforts around payment reform, public reporting, and so on. A video explaining VBID was produced and is now available on the Coalition's website. The Data Book served as a vehicle for outreach to a broad swath of the Maine public. The Coalition's annual conference served as a venue to spotlight issues central to SIM and generated a number of press pieces and interviews.

The MHMC also supports the Payment Reform Subcommittee, which is one of three subcommittees supporting SIM governance. This Committee chose to meet once every two months, alternating with meetings of the Coalition's ACI group, as many people serve on or are interested in the work of both committees. All efforts were made to ensure that members of the PRSC were kept up to date about and welcomed their participation in all relevant SIM activities.

Only recently has the PRSC been asked to weigh in on issues directly related to SIM governance (e.g. risk resolution), but it is anticipated that the level of their activity will increase over the coming months. It has been challenging to maintain members' level of interest, and the subcommittee has a number of open seats.

Patient Provider Partnership Training for Primary Care Practices

The Patient-Provider Partnership (P3) Pilot provides quality improvement support to 10 practice sites across the state to promote more effective communication between patients and their health care providers and more active engagement of patients in their health care decisions. P3 Pilot sites focus on three priority areas which include the American Board of Internal Medicine Foundation's Choosing Wisely health decision areas, Shared Decision Making involving lower back pain and Shared Decision Making involving medication in behavioral health. In year one P3 pilot sites participated in a P3 Learning Collaborative which has included two day-long Learning Sessions focused on strategies for implementing Choosing Wisely or Shared Decision Making in their practices to better engage patients, monthly educational webinars that have built upon each other to guide the practices through the stages of implementation, a quarterly newsletter of information, and toolkits for each area of focus. Keeping busy clinical practices actively

engaged is an ongoing challenge which the P3 Pilot has addressed by providing hands-on technical assistance from P3 Physician Consultants through site visits and conference calls to address practice-specific challenges to implementation.