Maine State Innovation Model Objectives and Targets

Legend: OMS | QC | HIN | CDC | MHMC

Secondary Driver	Objective:	Year 1 10/1/13-9/30/14 (Q1 / Q2 / Q3 / Q4)	Year 2 10/1/14-9/30/15 (Q1 / Q2 / Q3 / Q4)	Year 3 10/1/15-9/30/16 (Q1 / Q2 / Q3 / Q4)
Data-Informed Policy, Practice and Payment Decisions	Provide real-time notifications from the HIE to MaineCare and Health System Care Managers when MaineCare members are admitted or discharged from impatient and emergency room settings across all provider organizations connected to the HIE	**Go Live Target:** October 1, 2013: Notifications available to 1,6001 Medicaid Providers & Care Managers across the state. **Year 1 Target:** Increase weekly average from 4502 to 5500 unique provider organization users either accessing the ED notifications or the HIE portal	**Year 2 Targets:** 1) Increase making notifications available to 1,800 Medicaid Provider and Care Managers/Care Coordinators. 2) Increase to average of 600 unique provider organization users either accessing the ED notifications or the HIE portal per week.	**Year 3 Targets:** 1) Increase making notifications available to 2,000 Medicaid Provider & Care Managers/Care Coordinators. 2) Increase to an average of 800 unique provider organization users either accessing the ED notifications or the HIE portal per week.
	Objective:			
	Provide HIT and HIE adoption incentives to up to 20 Behavioral Health provider sites/organizations	**Go Live Target:** RFP requirements prepared for presentation to DIS. **Year 1 Targets:** 20 Behavioral health organizations3 demonstrate live use	**Year 2 Targets:** 20 organizations have access to the HIE portal and notifications and milestone 2 incentive delivered.	**Year 3 Targets:** All 20 organization's participating in e-quality measurement using the data submitted to the HIE and milestone 3 incentive delivered.
	Objective:			
	Provide Health Information Exchange access to Behavioral Health providers	**Go Live Target:** RFP requirements prepared for presentation to DIS. **Year 1 Targets:** Up to 5 sites go live with bi-directional HIE participation.	**Year 2 Targets:** Up to 7 sites go live with bi-directional HIE participation.	**Year 3 Targets:** Up to 10 sites go live with bi-directional HIE participation.
	Objective:			
	Provide a clinical dashboard to MaineCare from the HIE enabling MaineCare to clinically monitor MaineCare members' health care utilization and outcomes at the population and individual level. Develop and deploy real-time discrete data feeds for MaineCare Prescription data to HIN.	**Go Live Target:** Provide MaineCare BAA and DUA for AAG review and approval. **Year 1 Targets:** 1. Consistent meeting with MaineCare established for MaineCare IT staff to facilitate discrete medication feeds and roles for the dashboard access. 2. DIS approval of data access strategy. 3. Go-Live with real-time medication feeds 4. Establishment of VPNs for MaineCare to access dashboard. 5. Provide training for MaineCare staff in Dashboard use. 6. Make 291,000+ population data available in HIN Dashboard.	**Year 2 Targets:** 1. Continued provision of Dashboard to MaineCare. 2. Consistent data flow for MaineCare medication information into the HIE.	**Year 3 Targets:** 1. Continued provision of Dashboard to MaineCare. 2. Consistent data flow for MaineCare medication information into the HIE.

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		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Secondary Driver	**Objective:**												
Data-Informed Policy, Practice and Payment Decisions	Provide Maine patients with access to their statewide HIE record leveraging the "Blue Button" standards promoted by the Office of the National Coordinator for HIT (ONC). HIN will conduct a twelve month pilot with a provider organization to make the patient chart available via a certified EHR portal administered by the pilot site.	**Go Live** Target**:** As of October 1, 2013, criteria for PHR pilot prepared and finalized for presentation to the DIS in October. **Year 1 targets:** Establishment of contract with pilot site, establish project management process for implementation, implementation of PHR CCD export by month 6. Demonstrated download of CCD by 5%5 of the pilot sites active PHR users w/in go-live period of project.											
	Ensure effective management of SIM Payment Reform Subcommittee to promote sustainability of reform developed through SIM.	**Go Live Target:** Identify membership for Payment Reform Subcommittee . **Year 1 Target:** Provide support for Subcommittee in manner that supports active participation of membership.				**Year 2 Targets:** Provide support for Subcommittee in manner that supports active participation of membership.				**Year 3 Targets:** Provide support for Subcommittee in manner that supports active participation of membership.			
	Health information to influence market forces and inform policy: track health care costs	**Year 1 Target:** Build claims database that spans Medicare, MaineCare and commercial populations of Maine. This will represent approximately 900k covered lives who are eligible to receive services from Maine's provider community. Providers include all 39 Maine hospitals and all other non-hopsital providers in the state who contract with one or more commercial carriers, Medicare and/or MaineCare. (2) Develop/refine appropriate metrics and approach to measuring and tracking cost of care over time. (3) Publish initial edition of Healthcare Cost Fact Book and convene CEO Roundtable.				**Year 2 Targets:** (1) Maintain access to broadbased dataset. (2) Publish two updated editions of Fact Book. (3) Convene 2 additional CEO Roundtables, increasing attendance from 20 to 30 opinion leaders.				**Year 3 Targets:** (1) Maintain access to broadbased dataset. (2) Issue two additional updates of Fact book. (3) Convene two additional CEO Roundtables, increasing attendance from 30 to 50 CEOs.			

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Secondary Driver	**Objective:**												
Data-Informed Policy, Practice and Payment Decisions	Health information to influence market forces and inform policy: value based benefit design.	**Year 1 Targets:** (1) Adoption of core set of metrics against which plan designs may be benchmarked.				**Year 2 Targets:** (1) Refined metrics, as appropriate, based on trends and on market experience (2) increase in number of covered lives enrolled in plans incorporating narrowly constructed VBID , to include alignment of copays/deducitbles, utilization of high value providers as determinded by MHMC Get Better				**Year 3 Targets:** (1) Refined metrics, as appropriate, based on trends and on market experience			
	Health information to influency market forces and inform policy: Identify common metrics across payers for public reporting and alignment with payment through the work of the PTE Workgroups.	**Go Live Target:** Group will come into Testing Phase ready to work, having established ground rules Identified candidates for PTE BH workgroup. **Year 1 Target:** Identification of core metrics for reporting, vetted and approved through PTE and Board. Publish initial benchmarked rankings. Percent of Maine residents covered by alternative payment arrangement grows to 219,982 or 17%. Identification of core metric set for Behavioral Health (integration and quality) Identify core metrics for Adv Primary Care Recognition				**Year 2 Targets:** Learning collaborative tracking metrics identified not only for public reporting, but a separate set of metrics identified for use in learning. Number of Maine residents covered by an alternative payment arrangement grows to almost 462k, or 35.5% of population Finalization of metrics for BH; publish first set of metrics All metrics updated as appropriate				**Year 3 Targets:** Percent of Maine residents covered by alternative payment arrangements grows to 789,936 or 61%. This puts on a trajectory to reach 80% coverage at the end of 5 years from start of test year. All metrics updated as appropriate			

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Data-Informed Policy, Practice and Payment Decisions	Ensure effective management of SIM Payment Reform Subcommittee to promote sustainability of reform developed through SIM	**Go Live Target:** Identify membership for Payment Reform Subcommittee . **Year 1 Target:** Provide support for Subcommittee in manner that supports active participation of membership.				**Year 2 Targets:** Provide support for Subcommittee in manner that supports active participation of membership.				**Year 3 Targets:** Provide support for Subcommittee in manner that supports active participation of membership.			
Health Information for Consumers/Improved Continuum of Care	Provide Health Information Exchange access to Behavioral Health providers.	**Go Live Target:** RFP requirements prepared for presentation to DIS. **Year 1 Targets:**				**Year 2 Targets:** Up to 7 sites go live with bi-directional HIE participation.				**Year 3 Targets:** Up to 10 sites go live with bi-directional HIE participation.			
	Provide Maine patients with access to their statewide HIE record leveraging the "Blue Button" standards promoted by the Office of the National Coordinator for HIT (ONC). HIN will conduct a twelve month pilot with a provider organization to make the patient chart available via a certified EHR portal administered by the pilot site.	**Go Live Target:** As of October 1, 2013, criteria for PHR pilot prepared and finalized for presentation to the DIS in October. **Year 1 targets:** Establishment of contract with pilot site, establish project management process for implementation, implementation of PHR CCD export by month 6. Demonstrated download of CCD by 5% of the pilot sites active PHR users w/in go-live period of											

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		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Secondary Driver	**Objective:**												
Health Information for Consumers/Improved Continuum of Care	Provide Learning Collaborative for MaineCare Health Homes	**Go Live Target:** Launch Learning Collaborative to 82 new HH primary care practices, for a total of 157 participating HH practices; determine final NCQA status of 10 high risk practices (may not meet participation requirements by 12/31/13). Addition of 82 HH only practices reaches approximately 257,000 additional active (seen in past 2 years) patients with the medical home model **Year 1 Target:** Implement PCMH/HH Learning Collaborative, offering supporting for 100% of participating practices; provide QI support to ensure that ≥75% of the new 82 HH practices reach Must-Pass elements; and ≥75% practices implement Year 2 MaineCare screening requirements. Total combined active (seen in the past 2 years) patients reached with				**Year 2 Targets:** Clarify status of Maine enhanced payment for primary care practices, facilitating Learning Collaborative accordingly; Sustain PCMH/HH Learning Collaborative offering support for 100% of Year 2 participating primary care practices; Total combined active (seen in the past 2 years) patients reached with the medical/health				**Year 3 Targets:** Facilitate the Learning Collaborative offering support for 100% of Year 3 particpating practices; Total combined active (seen in the past 2 years) patients reached with the medical/health home Learning Collaborative approximates 432,000 individuals.			
	Ensure effective management of SIM Delivery System Reform Subcommittee to promote sustainabilty of reform through SIM	**Go Live Target:** Identify membership for Delivery System Reform Subcommittee . **Year 1 Target:** Provide support for Subcommittee in manner that supports active participation of membership.				**Year 2 Targets:** Provide support for Subcommittee in manner that supports active participation of membership.				**Year 3 Targets:** Provide support for Subcommittee in manner that supports active participation of membership.			

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		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Secondary Driver	**Objective:**												
Health Information for Consumers/Improved Continuum of Care	Provide Primary Care providers access to claims data for their patient panels (portals).	**Year 1 Target:** Complete design of portal and required analytics; data for MaineCare, Medicare and commercial populaionts will first be segregated with separate access due to challenges associated with the fundamental differences between the populations and the different risk profiles of the populations. Adoption by providers is voluntary, but it is estimated that 50 practices10will adopt the				**Year 2 Targets:** Deliver portal functionality to all requesting providers. Estimated additional uptake: est. 20%, bearing in mind that adoption is voluntary.				**Year 3 Targets:** Deliver portal functionality to all requesting providers. Estimated additional uptake: est. 20%, bearing in mind that adoption is voluntary.			
	Consumer engagement and education regarding payment and system delivery reform	**Year 1 Target:** Educate brokers, patient advocates, HR Specialists, union leaders on merits of VBID. Outreach to 200 people.				**Year 2 Targets:** Continue education and outreach efforts, reaching for all major payer organizations and MaineCare.				**Year 3 Targets:** Continued outreach and education; reaching an additional 200 providers and indivduals.			
	Implementation of the National Diabetes Prevention Program (NDPP).	**Go Live Target:** NDPP delivery reimbursement for contracted NDPP provider sites to MaineCare beneficiaries. **Year 1 Target:** 5 out of 15 NDPP provider sites have written agreements and are delivering NDPP to MaineCare beneficiaries.				**Year 2 Targets:** 1) Policy developed by MaineCare and Maine CDC to support the sustainable structure for NDPP reimbursement. 2) PCMH/ACO care delivery structures are utilizing pre-diabetes/diabetes algorithm to				**Year 3 Targets:** 1) Over 15 NDPP provider sites have written agreements and are delivering NDPP to MaineCare beneficiaries. 2) 300 out of 29,312 NDPP eligible beneficiaries have completed program over 3 years of SIM			

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		Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Secondary Driver	**Objective:**												
Health Information for Consumers/Improved Continuum of Care	CHW Pilot Project	**Go Live Target:** Transformed healthcare system integrates community health workers through a pilot that demonstrates CHWs as an effective, sustainable element. **Year 1 Target:** 1. Contracts for 5 CHW Pilot sites in place. 2. The 5 CHW pilot sites will have formal referral mechanisms with at least one and up to 3 providers.				**Year 2 Targets:** 1. CHW clients identified with a caseload of 15-20 clients for intensive service, and 30-50 clients for less				**Year 3 Targets:** 1. CHW clients identified with a caseload of 15-20 clients for intensive service, and 30-50 clients for			
	Implement MaineCare Behavioral Health Homes Initiative	**Year 1 Target:** Successfully recruit 15 Behavioral Health Home organizations (BHHOs) with 7000 enrolled members with SMI/ SED. There are 75 Behavioral Health Organizations that currently provide services beingtransformed through Behavioral Health Homes, and about 24,000 members with SMI/SED.				**Year 2 Targets:** Increase enrolled members to 7700. 3 in-person learning sessions annually, monthly working group, monthly phone and webinar support for 15 BHHOs and partnering practices. There are 75 Behavioral Health Organizations that currently provide services beingtransformed through Behavioral Health Homes, and about 24,000 members with SMI/SED.				**Year 3 Targets:** Increase enrolled members to 8500 total. 3 in-person learning sessions annually, monthly working group, monthly phone and webinar support for 15 BHHOs and partnering practices. There are 75 Behavioral Health Organizations that currently provide services beingtransformed through Behavioral Health Homes, and about 24,000 members with SMI/SED.			
	Develop and implement Physical Health Integration workforce development component to Mental Health Rehabilitation Technician/Community (MHRT/C) Certification curriculum.	**Year 1 Target:** Curriculum and training plan developed for Physical Health Integration ocmponent to Mental Health Rehabilitation Technician/Community Training.				**Year 2 Targets:** 500 direct service behavioral health individual providers trained in physical health integration.							

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Secondary Driver	**Objective:**												
Health Information for Consumers	Provide training to Primary Care Practices on serving youth and adults with Autism Spectrum Disorder and Intellectual Disabilities.	**Year 1 Target:** Curriculum and training plan developed for Adult Practice Sites Curriculum piloted at 5 Adult Practice Sites Training conducted at 15 pediatric sites				**Year 2 Targets:** Training conducted at 30 pediatric sites Training conducted at 55 adult practice sites				**Year 3 Targets:** Training conducted at 15 pediatric sites Training conducted at 60 adult practice sites			
Consumer Engagement	Provide Maine patients with access to their statewide HIE record leveraging the "Blue Button" standards promoted by the Office of the National Coordinator for HIT (ONC). HIN will conduct a twelve month pilot with a provider organization to make the patient chart available via a certified EHR portal administered by the pilot site.	**Go Live Target:** As of October 1, 2013, criteria for PHR pilot prepared and finalized for presentation to the DIS in October. **Year 1 targets:** Establishment of contract with pilot site, establish project management process for implementation, implementation of PHR CCD export by month 6. Demonstrated download of CCD by 5% of the pilot sites active PHR users w/in go-live											
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Secondary Driver	**Objective:**												
Health Information for Providers	Provide Primary Care providers access to claims data for their patient panels (portals).	**Year 1 Target:** Complete design of portal and required analytics; data for MaineCare, Medicare and commercial populaionts will first be segregated with separate access due to challenges associated with the fundamental differences between the populations and the different risk profiles of the				**Year 2 Targets:**				**Year 3 Targets:**			
	Provide practice reports reflecting practice performance on outcomes measures	**Year 1 Target:** Produce practice reports for all primary care practices indicating their interest in receiving them. While we will be able to produce reports for any primary care practice that serve a critical mass of patients, practices themselves must make the decision to actively request, review and use the reports. PCMH practices represent approximately 25% of primary care practices; all receive the reports. We estimated 10% of non-PCMH practices will choose to receive reports in Year One. Each new practice will receive an outreach visit.				**Year 2 Target:** Produce practice reports for all primary care practices indicating their interest in receiving them. We estimate that there will be an incremental increase of 10% in take up of reports in Year Two. Each new practice will receive an outreach visit.				**Year 3 Target:** Produce practice reports for all primary care practices indicating their interest in receiving them. Estimated new uptake is 15%, bringing "coverage" with practice reports to approx 50% of PC practices. Each new practice will receive an outreach visit.			

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Secondary Driver	**Objective:**												
Health Information for Providers	Implementation of the National Diabetes Prevention Program (NDPP).	**Go Live Target:** NDPP delivery reimbursement for contracted NDPP provider sites to MaineCare beneficiaries.				**Year 2 Targets:** 1) Policy developed by MaineCare and Maine CDC to support the sustainable structure for NDPP reimbursement.				**Year 3 Targets:** 1) Over 15 NDPP provider sites have written agreements and are delivering NDPP to			
	CHW Pilot Project	**Go Live Target:** Transformed healthcare system integrates community health workers through a pilot that demonstrates CHWs as an effective, sustainable element. **Year 1 Target:** 1. Contracts for 5 CHW Pilot sites in place. 2. The 5 CHW pilot sites will have formal referral mechanisms with at least one and up to 3 providers.				**Year 2 Targets:** 1. CHW clients identified with a caseload of 15-20 clients for intensive service, and 30-50 clients for less intensive service.				**Year 3 Targets:** 1. CHW clients identified with a caseload of 15-20 clients for intensive service, and 30-50 clients for less intensive service.			
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Secondary Driver(s)	**Objective:**												
Health Information for Providers	Provide training to Primary Care Practices on serving youth and adults with Autism Spectrum Disorder and Intellectual Disabilities	**Year 1 Target:** Curriculum and training plan developed for Adult Practice Sites Curriculum piloted at 5 Adult Practice Sites Training conducted at 15 pediatric sites There are over 400 primary care practice sites in Maine.				**Year 2 Targets:** Training conducted at 30 pediatric sites Training conducted at 55 adult practice sites				**Year 3 Targets:** Training conducted at 15 pediatric sites Training conducted at 60 adult practice sites			
Aligned Payment Models	Ensure effective management of SIM Payment Reform Subcommittee to promote sustainability of reform developed through SIM.	**Go Live Target:** Identify membership for Payment Reform Subcommittee . **Year 1 Target:** Provide support for Subcommittee in manner that supports active participation of membership.				**Year 2 Targets:** Provide support for Subcommittee in manner that supports active participation of membership.				**Year 3 Targets:** Provide support for Subcommittee in manner that supports active participation of membership.			
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Secondary Driver(s)	**Objective:**												
Improved Continuum of Care/Aligned Payment Models	CHW Pilot Project	**Go Live Target:** Transformed healthcare system integrates community health workers through a pilot that demonstrates CHWs as an effective, sustainable element. **Year 1 Target:** 1. Contracts for 5 CHW Pilot sites in place. 2. The 5 CHW pilot sites will have formal referral mechanisms with at least one and up to 3 providers.				**Year 2 Targets:** 1. CHW clients identified with a caseload of 15-20 clients for intensive service, and 30-50 clients for less intensive service.				**Year 3 Targets:** 1. CHW clients identified with a caseload of 15-20 clients for intensive service, and 30-50 clients for less intensive service.			
	Implement MaineCare Accountable Communities Shared Savings ACO Initiative	**Go Live Target:** Issue RFA **Year 1 Target:** Implement Accountable Communities that impact 50,000 patient lives above and beyond those impacted through Medical Homes, 3.8% of Maine's 1.3M population. Patients are not limited to MaineCare members attributed under Accountable Communities, since all patients, regardless of attribution status and payer, should be impacted through improved care coordination incented under model. Achieve participation from 6 Accountable Communities, including providers under current Medicare and commercial ACOs within the State (all 4 major health systems plus group of FQHC's). Achieve 25,000 MaineCare lives to Accountable Communities, 8.9% of the 281,000 MaineCare population.				**Year 2 Targets:** Provide all Accountable Communities with monthly utilization reports drilled down to the Primary Care practice level, and quarterly reports on actual TCOC to date and quality benchmark achievement. Achieve participation by all MaineCare Accountable Communities in 90% of bimonthly ACI learning collaborative meetings. Implement Accountable Communities that impact an additional 5,000 patient lives above and beyond those impacted through Medical Homes, reaching 4.2% of Maine's population. Achieve participation from 2 additional Accountable Communities. Achieve attribution of additional 2,700 MaineCare lives to Accountable Communities, 9.8% of the MaineCare				**Year 3 Targets:** Provide all Accountable Communities with monthly utilization reports drilled down to the Primary Care practice level, and quarterly reports on actual TCOC to date and quality benchmark achievement. Achieve participation by all MaineCare Accountable Communities in 90% of bimonthly ACI learning collaborative meetings. Implement Accountable Communities that impact an additional 5,500 patient lives above and beyond those impacted through Medical Homes, reaching 4.6% of Maine's population. Achieve participation from 2 additional Accountable Communities. Achieve attribution of additional 2,000 MaineCare lives to Accountable Communities, 10.5% of the MaineCare			

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Secondary Driver(s)	**Objective:**												
Aligned Payment Models	Implement MaineCare Behavioral Health Homes Initiative	**Year 1 Target:** Successfully recruit 15 Behavioral Health Home organizations (BHHOs) with 7000 enrolled members with SMI/ SED. There are 75 Behavioral Health Organizations that currently provide services beingtransformed through Behavioral Health Homes, and about 24,000 members with SMI/SED.				**Year 2 Targets:** Increase enrolled members to 7700. 3 in-person learning sessions annually, monthly working group, monthly phone and webinar support for 15 BHHOs and partnering practices. There are 75 Behavioral Health Organizations that currently provide services beingtransformed through Behavioral Health Homes, and about 24,000 members with SMI/SED.				**Year 3 Targets:** Increase enrolled members to 8500 total. 3 in-person learning sessions annually, monthly working group, monthly phone and webinar support for 15 BHHOs and partnering practices. There are 75 Behavioral Health Organizations that currently provide services beingtransformed through Behavioral Health Homes, and about 24,000 members with SMI/SED.			
Health Information for Consumers	Patient Engagement Communication Project	**Go Live Target:** Public supported with health communication messages that promote appropriate use of healthcare services and value of CHWs.				**Year 2 Targets:**				**Year 3 Targets:**			