Maine SIM Grant SST - Executive Level Project Plan with Accountability Targets

SIM Partner Organization: SIM Program Management **Lead/Point for Organization:** Randy Chenard

Secondary Driver	Subcommittee PR	Subcommittee DSR	Subcommittee DI	Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Year 1 10/1/13-9/30/2014 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	Known Risks	Dependency and Link to ID#	ID#
								10/1/2013															
N/A	X	X	X	**Objective 1: Manage SIM Governance Process/Structure**																			
						PG 1	Develop and facilitate Steering Committee meetings and process		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
						PG 2	Develop and Facilitate Leadership meetings and process		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
						PG 3	Develop and oversee Subcommittee meetings and process		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
						PG 4	Execute Risk/Issue escalation and mitigation process		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
				Objective 1: Accountability Targets				Planning Period Target: Establish all governance groups including membership, accountabilities,	Go Live Target: Governance structure developed and operational at beginning of test Year 1 Target: Manage governance structure and facilitate collaboration across stakeholder groups				Year 2 Targets: Manage governance structure and facilitate collaboration across stakeholder groups				Year 3 Targets: Manage governance structure and facilitate collaboration across stakeholder groups						
				Objective 1: Annual Cost (Aligns with annual budget total's submitted with contract)				$ 12,750.00	$ 72,684.00				$ 72,684.00				$ 72,684.00						

Secondary Driver	Subcommittee PR	Subcommittee DSR	Subcommittee DI	Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Year 1 10/1/13-9/30/2014 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	Known Risks	Dependency and Link to ID#	ID#
								10/1/2013															
N/A	X	X	X	**Objective 2: Develop, Manage, and adjust SIM Operational Plan**																			
						PG 6	Develop Operational Plan	✓	✓															
						PG 7	Adjust Operational plan		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
						PG 8	Begin SIM Communication Plan Development		✓														
						PG 9	Execute SIM Communications Plan			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
						PG 10	Begin and Execute Risk/Issue Management Process		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
						PG 11	Begin and execute SIM status reporting process		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
				Objective 2 Accountability Targets:				**Planning Period Target** Develop Operational Plan and gain CMMI approval	**Go Live Target:** Operational Plan Approved **Year 1 Target:** Manage Operational Plan				**Year 2 Targets:** Manage Operational Plan				**Year 3 Targets:** Manage Operational Plan						
				Objective 2: Annual Cost				$ 17,000.00	$ 135,172.00				$ 96,912.00				$ 96,912.00						
N/A	X	X	X	**Objective 3: Manage SIM Project Plans and Overall Budget**																			
						PG 12	Developed required SIM Contracts	✓	✓	✓	●	●											
						PG 13	Require and facilitate the development project plan for all SIM partners	✓	✓														
						PG 14	Manage project plans, adjust and report as required		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
				Objective 3: Accountability Targets				**Planning Period Target** Develop integrated project plan	**Go Live Target:** Project Plan Developed **Year 1 Target:** Manage project plan				**Year 2 Targets:** Manage Project Plan				**Year 3 Targets:** Manage Project Plan						
				Objective 3: Annual Cost (Aligns with annual budget total's submitted with contract)				$ 12,750.00	$ 72,684.00				$ 72,684.00				$ 72,684.00						

Maine SIM Grant - Executive Level Project Plan with Accountability Targets

SIM Partner Organization: HealthInfoNet **Lead/Point for Organization:** Shaun Alfreds, Katie Sendze

Secondary Driver	Subcommittee			Key Objective	Link to DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Milestone Timeline: Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Risks & Dependencies: Known Risks	Dependency and Link to ID#	
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			ID#
Data informed policy, practice, and payment decisions		**X**	**X**	**Objective 1: Provide real-time notifications from the HIE to MaineCare and health system Care Managers when MaineCare members are admitted or discharged from inpatient and emergency room settings across all provider organizations connected to the HIE.**																			
				VI.A VIII. G V XI.A	HIN 1	Obtain PHI 'Data Release Authorization' with HIE participating Providers	✓	✓													Provider site (38 hospitals) could deny release of PHI	Current provider participants in HIE	
					HIN 2	Establish DAA with MaineCare for PHI access	✓	●	●														
					HIN 3	Convene MaineCare partners to build data feeds		✓	✓												Delay in contract process or agreement	MaineCare contract process and rules	1,2
					HIN 4	Build and test production of notifications technology and workflow		✓	✓												Delay in ability for MaineCare to provide eligibility data	Dependent on MaineCare resources and participation	3
					HIN 5	Implement use of notifications. Work with MaineCare stakeholders and provider participants to provide content and process improvements related to notifications that supports SIM initiatives. This includes education about and related to notifications process and workflow.				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Care manager and provider engagement in workflow	MC and provider org. leadership engagement to implement new workflows	4
Quarterly Accountability Target						# of Active users of the Clinical portal				500	550	555	575	585	600	650	700	750	800				
Objective 1: Accountability Targets							Planning Period Target 1) Establishment of a new user class of the HIE (originally provider based) as a Payors - Starting with Medicaid. 2) Create Data Use Argent (DUA) for MaineCare, Request Permissions for Sharing of PHI with New HIE Participant Class.	Go Live Target: As of October 1, 2013, make notifications available to 1,600[1] Medicaid Providers and Care Managers across the state. Year 1 Target: Increase from 450[2] to an average of 550 unique provider organization users either accessing the ED notifications or the HIE portal per week.				Year 2 Targets: 1) Increase making notifications available to 1,800 Medicaid Provider and Care Managers/Care Coordinators. 2) Increase to an 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 and 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 1: Annual Cost (Aligns with annual budget total's submitted with contract)							**$45,616.90**	**$164,863.60**				**$195,813.51**				**$186,674.93**						

Secondary Driver	Subcommittee			Key Objective	Link to DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#	
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			ID#
Data informed policy, practice, and payment decisions		**X**	**X**	**Objective 2: Provide HIT and HIE adoption incentives to up to 20 Behavioral Health provider sites/organizations.**																			
					V.A VI.A X.A	HIN 6	Develop RFP for HIT and HIE adoption incentives	✓															Subcommittee start dates and process		
						HIN 7	Release the RFP		✓	●														6
						HIN 8	Announce awardees		✓	✓	●													7
						HIN 9	Support Quality Measure development and reporting via the HIE for awardees; Participate in ensuring quality reporting measures are defined with feedback from BH providers to include EHR capacity for submitting discrete data that supports specific quality measures as determined by the SIM Steering and Sub Committees through the statewide HIE.			■	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Variable and complex technical and process barriers to enable data for quality reporting	Stakeholder participation/consensus, technology	11
						HIN 10	RFP Milestone 1: EHR purchase, implementation, optimization, and/or upgrade - $35,000 per awardee			■	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
						HIN 11	RFP Milestone 2: Active interfaces with the statewide HIE- $10,000 per awardee			■	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Legal risks: 1) 42 CFR-Part 2 limitations as it relates to MH integration, provider side patient education to opt-in to their MH data 2) Contract timelines and delays for participation	Provider technology resources beyond the grant, patient education to opt-in	
						HIN 12	RFP Milestone 3: Quality Reporting/eMeasurement with the HIE- $25,000 per awardee										✓	✓	✓	✓	Barriers to data integration and interoperability	Bidirectional data integration, provider participation, patient's opting-in	12
	Quarterly Accountability Target						Amount of money of milestones paid out					$700,000				$200,000				$500,000			
	Quarterly Accountability Target						Number of participating Organization				20	20	20	20	20	20	20	20	20	20			
Objective 2 Accountability Targets:								Planning Period Target Establishment of Data Infrastructure Subcommittee (DIS) charge and membership. Determine parameters for behavioral health participation in the incentive program based on expectations of EHR adoption and capability to participate in data activities in years 2 and 3. Draft RFP for presentation to the DIS in October.	Go Live Target: RFP requirements prepared for presentation to DIS. Year 1 Targets: 20 Behavioral health organizations[3] demonstrate live use of EHR and milestone 1 incentive delivered.				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 2: Annual Cost (Aligns with annual budget total's submitted with contract)								**$46,764.58**	**$957,058.30**				**$632,670.05**				**$478,837.61**						

Secondary Driver	Subcommittee			Key Objective	Link to DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#	
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			ID#
Data informed policy, practice, and payment decisions; Improved continuum of care		X	X	**Objective 3: Provide Health Information Exchange access to Behavioral Health providers**																			
					V.A VI.A X.A XI.A	HIN 13	HIN will create access to the HIE Year 1: HIE access, up to 10 year 1		■	✓	✓	✓										Legal risks: 1) 42 CFR-Part 2 limitations as it relates to Mental Health integration, provider side patient education to opt-in to their MH data 2) Contract timelines and delays for participation	Provider technology resources beyond the grant, patient education to opt-in	
						HIN 14	Year 2: HIE access, up to 15 year 2						✓	✓	✓	✓								
						HIN 15	Year 3: HIE access, up to 15 year 3										✓	✓	✓	✓				
						HIN 16	HIN will bi-directionally connect up to 10 organizations to the HIE over three years: Year 1: Connect up to 5 bi-directional HIE sites		■	✓	✓	✓												13
						HIN 17	Year 2: Connect up to 7 bi-directional HIE sites						✓	✓	✓	✓								16
						HIN 18	Year 3: Connect up to 10 bi-directional HIE sites										✓	✓	✓	✓				17
						HIN 19	Provide Clinical Quality Measurement as developed in Objective 2 to participating sites through HIE tools.										✓	✓	✓	✓				12,16,17,18
	Quarterly Accountability Target						Number of sites			1	3	5	5	5	6	7	7	8	9	10				
Objective 3: Accountability Targets								Planning Period Target Establish HIE participant agreement parameters for new BH HIE participants. Determine RFP requirements for presentation to DIS in October for approval.		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 3: Annual Cost (Aligns with annual budget total's submitted with contract)								**$ 64,968.90**	**$ 478,771.70**				**$ 569,067.85**				**$ 590,673.41**						

Secondary Driver	Subcommittee			Key Objective	Link to DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#	
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			ID#
Data informed policy, practice, and payment decisions			X	**Objective 4: 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.**																		
					V.A VI.A	HIN 20	Collaborate with MaineCare to develop and define specific "Use Case" for MaineCare staff to access PHI through the HIN dashboard.		✓	✓	✓	●											
						HIN 21	Send letters to all HIN provider participants informing them of the project and requesting approval for sharing PHI with MaineCare; confirm approval from each participant for this "use Case" PHI release.		■	■	■	●									Provider participants of the HIE could deny their authorization to support the Use Case for PHI release to MaineCare.	Communication support with MaineCare as a partner.	
						HIN 22	Clinical Dashboard: Meet with stakeholders during the pre-testing period to demonstrate current functionality and identify and confirm specific analytic needs that might be met by HIN's data warehouse.	✓	✓														Current unknown data requirements and questions associated are undetermined at this time	**1,2, 3**
						HIN 23	Develop recurring meetings (quarterly) with appropriate SIM teams to evaluate measures, address data deficiencies, adjust metrics etc.			■	■	■	✓	✓	✓	✓	✓	✓	✓	✓			
						HIN 24	Develop and deploy the Dashboard:			■	■	■	✓	✓	✓	✓	✓	✓	✓	✓		The dashboard will be dependent upon the monthly submission of the MaineCare eligibility file as described in objective 1.	20
						HIN 25	Review the capability of HIN's HIE data warehouse to calculate and define quality measures that support MaineCare's Health Homes program. Establish criteria and specifications for warehouse enhancements as needed and within budget.			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		Partnership with MaineCare leadership related to quality measures work, definitions, and implementation within SIM.	
						HIN 26	MaineCare Discrete Medication Data Capture: During pre-testing phase, meet with MaineCare MMIS and Goold staff and develop project plan for deploying real-time discrete medication data feeds from MaineCare. *[Note- this activity will be necessary to support analytics for MaineCare patients on prescription use.]*	✓	✓													Medicaid and state vendor, Molina HealthCare, resources available to the project and timeline of those resources	Dependent on ID 41 and the work around state requirements and support available to make this happen	26, 3
						HIN 27	Begin technical implementation of discrete medication feeds in October 2013 with go-live targeted for no later than March 2014. *[Note: this timeline is dependent on the availability of resources at MaineCare to support this activity]*			✓	✓	✓									Medicaid and state vendor, Molina HealthCare, resources available to the project and timeline of those resources	Dependent on ID 41 and 48 the work around state requirements and support available to make this happen	20
Objective 4: Accountability Targets								Planning Period Target Build, test and establish HIE dashboard and data warehouse in secure data center (shared by HIE). Work with legal team to develop HIPAA Business Associate Agreements (BAA) and Data Use Agreement (DUA) with MaineCare.	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.						
Objective 4: Annual Cost (Aligns with annual budget total's submitted with contract)								**$ 319,276.10**	**$ 607,204.40**				**$ 620,833.53**				**$ 605,171.54**						

Secondary Driver	Subcommittee			Key Objective	Link to DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#	
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			ID#
Data informed policy, practice, and payment decisions; Improved continuum of care; Consumer Engagement; Patient and Family Centered Care		X	X	**Objective 5: 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.**																		
					V.A VIII.G	HIN 28	During pre-testing phase, identify criteria for community pilot site for "Blue-Button" deployment.	✓	✓	✓			**n/a**									Provider participant that can meet the required criteria for implementation must be willing to volunteer to the pilot.	
						HIN 29	Submit project criteria to the DIS and proceed to select pilot site volunteer.		✓														
						HIN 30	Confirm agreement with Pilot Partner		✓	✓												Provider volunteer could not be able to prioritize this project	Provider volunteer	24
						HIN30.1	conduct the 12-month pilot to test and modify technical requirements for PHR-HIE access using national standards		■	■	✓	✓	✓	✓	✓								
						HIN 31	Engage health care delivery communications and administration teams at pilot site on educating patients on the new PHR "Blue Button" technology.		■	■	✓	✓	●	●	●							Provider volunteer could not be able to prioritize this project	Site engagement	
						HIN 32	Engage Care Managers/health care delivery staff of pilot site on educating patients on how to access and use their record.		■	■	✓	✓	●	●	●							Provider volunteer could not be able to prioritize this project	Site engagement	
						HIN 33	Determine specifications that would support future statewide PHR roll out using best practice learning's from the pilot		■	■	■	■	■	■	●	●								26,27,28
	Quarterly Accountability Target						% of active portal users access of the HIN CCD at pilot sites				1%	5%												
Objective 5: Accountability Targets								Planning Period Target: 1. Testing of CCD export by HIN (using green CCD established by Mitre/ONC under previous contract), 2. Finalize licensing costs/contracts for IT vendor partners and establish audit and authorization profiles at HIN for end users. 3. Establishment of criteria for choosing PHR CCD export pilot site for presentation to the DIS in October.	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.														
Objective 5: Annual Cost (Aligns with annual budget total's submitted with contract)								**$ 387,410.51**	**$ 416,642.05**				**$ -**				**$ -**						

Secondary Driver	Subcommittee			Key Objective	Link to DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#	
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			ID#
Data informed policy, practice and payment decisions/Multi-Stakeholder Coalition Building and Support			✓	**Objective 6: Ensure effective management of SIM Data Infrastructure Subcommittee to promote sustainability of reform developed through SIM**																			
					A, T	HIN 34	Identify and finalize Subcommittee membership		✓															
						HIN 35	Convene Subcommittee		✓															
						HIN 36	Ensure participation and process according to established protocols			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Objective 6 Accountability Targets:								Planning Period Target: establish infrastructure, membership for Data Infrastructure Subcommittee	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						
Objective 6: Annual Cost								**$0.00**	**$100,706.00**				**$109,425.00**				**$103,744.00**						

Commitments from HIN/MHMC during Plan Synchronization: • Insuring a synergistic and integrative approach to the work of PTE- BH and the HIN BH RFP Quality work.
• Clearly outlining and communicating the process for a collaboration between HIN, health care provider(s) (Covered Entity(is)) and MHMC in integrating clinical and administrative claims data for a possible proof of concept.

Maine SIM Grant - Executive Level Project Plan with Accountability Targets

SIM Partner Organization: Maine CDC **Lead/Point for Organization:** Deb Wigand

Secondary Driver	*Subcommittee*			Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Milestone Timeline: Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Risks & Dependencies: Known Risks	Dependency and Link to ID#	
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			ID#
Aligned payment models, Patient-family centeredness of care, Consumer engagement, Improved continuum of care	x	x		**Objective 1: NDPP: Implementation of the National Diabetes Prevention Program (NDPP).**																			
					VA IIIC XIIIA IIIA IIIB VB	CDC 1	State capacity assessment of payers/ purchasers of health plans. Track barriers to capacity throughout payment test.		✓	●	●	●	●	●	●	●	●	●	●	●	Health Plan payers/ purchasers may have barriers to adoption of NDPP health plan benefits		
						CDC 2	Develop with health plan payers/ purchasers NDPP health benefit payment structure for identified health plans				✓	✓	✓	✓	✓	✓	✓	✓	✓				Health Plan payers/ purchasers may have benefit plan constraints to adoption of new payment structure		
						CDC 3	Trained supported Lifestyle Coach Workforce.			♦	✓	●	●	●	✓	●	●	●	●	✓			Delay in contract process or agreement to release SIM funds	DHHS releases funds for NDPP Lifestyle Coach Trainings	MC 1,2
						CDC 4	CDC-Recognized NDPP providers complete annual written agreement with Maine CDC to provide NDPP to qualified MaineCare beneficiaries.			✓	●	●	●	✓	●	●	●	●	✓				Can not limit to just MaineCare beneficiaries.	Multiple payer involvement in SIM.	MC
						CDC 5	Work with partners to assess/address barriers to a sustainable NDPP reimbursement through payer/ purchasers policy/ statutes.			♦	♦	♦	♦	♦	♦	✓	✓	✓	✓	✓	✓		Needed for Maine CDC to accomplish the SIM accountability target of "Sustainable NDPP payment structure recognized by all payers in Maine".	Future policy change options post SIM demonstration on sustainable NDPP payment structure.	
						CDC 5.1	NDPP payment tests developed with SIM partners (MaineCare, MHMC, MQC) guidance/support and TA from U.S. CDC.			✓	✓	●	●	●	●	●	●	●				NDPP payment reform tests must demonstrate value to payers.	Inclusion in VBID development, tests, payer engagement. ACI committee engagement.	MHMC 16, 17, 18, 19, 22, 37
						CDC 5.2	NDPP payment tests evaluation developed with SIM partners (MaineCare, MHMC, MQC, HIN) guidance/support and TA from U.S. CDC.			✓	✓	●	●	●	●	●	●	●				MaineCare direct support/assistance needed to help shape and redirect NDPP payment tests to align with new/emerging trends with public and private payers (VBID, HH, PCMH/ACO, etc.) involved in SIM & other MaineCare activities.	MaineCare provides guidance/support/input at key milestones over the 3 years of SIM grant.	MC 1,2
	Quarterly Accountability Target						# of written agreements issued to providers			1	3	5	5	7	8	10	10	12	13	15			
				Objective 1: Accountability Targets				Planning Period Target 1) MaineCare completed research on feasibility of retired S-Code assignment for NDPP Core & Post Core. 2) MaineCare will reimburse for NDPP delivery to beneficiaries 18 y/o and older who are at high risk or with pre-diabetes according to U.S. CDC DPRP standards.	Go Live Target: NDPP delivery reimbursement for contracted NDPP provider sites to MaineCare beneficiaries. NDPP payment tests RFP released. 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 support/enhance patient care.				Year 3 Targets: 1) Over 15 NDPP provider sites have written agreements and are delivering NDPP to MaineCare beneficiaries. Multiple payers are engaged in payment test demonstration linked to program outcomes. 2) 300 out of 29,312 NDPP eligible beneficiaries have completed program over 3 years of SIM Grant.						
				Objective 1: Annual Cost (Aligns with annual budget total's submitted with contract)								**$12,635**				**$114,000**				**$112,000**			

	PR	DSR	DI				10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			ID#
Aligned payment models, Patient-family centeredness of care, Consumer engagement, Improved continuum of care	x	x		**Objective 2: CHW Pilot Project**																		
				III.B, IV.A, V.B,V.C, VII.A, VII.B, XI.A,B,C,X III.A, XV.A,	CDC 6	RFP issued for CHW Pilot Sites			✓														
					CDC 7	CHW Pilot Site contract approval				✓	■												
					CDC 8	3 CHWs hired at pilot sites.					✓										CHW effectiveness on interdisciplinary teams is dependent on providers' familiarity with CHW model and best practices for integration.	Successful integration of CHWs into HH/PCMH/CCTs relies on providers having knowledge and awareness (i.e. education) on how to best integrate, utilize and support CHWs (i.e. Inclusion as key learning within QC/MC Collaboratives)	QC1/MC 1 MC19
					CDC 9	CHW clients identified					✓	✓	●	●	●	●	●	●	●				
					CDC 10	CHW services will commence						✓	✓	✓	✓	✓	✓	✓	✓				
					CDC 11	Recommendations for sustainability and use of CHW model in Maine		♦	♦	♦	♦	♦	♦	♦	♦	♦	✓	✓	✓	Future sustainability dependent on payment models other than self-funding	1.MC modeling of total cost of care should be inclusive of CHW services as part of bundled payments 2. Healthcare Cost Workgroup metrics should include costs/savings related to integration of CHW services into health care teams.	MC 5 MHMC 12
		Quarterly Accountability Target				Number of Clients served through the pilot						15	20	30	50	50	50	50	50			
Objective 2: Accountability Targets							Planning Period Target 1. Vendor selected for Project Management, Workgroup meting to define scope and approach.	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. [9]				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.						
Objective 2: Annual Cost (Aligns with annual budget total's submitted with contract)							**$ 26,350.00**			**$284,290**				**$808,552**				**$808,554**			

Maine SIM Grant - Executive Level Project Plan with Accountability Targets

SIM Partner Organization: Maine Quality Counts **Lead/Point for Organization:** Lisa Letourneau; Lisa Tuttle

Secondary Driver	*Subcommittee*			Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Milestone Timeline: Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Risks & Dependencies: Known Risks	Dependency and Link to ID#	
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			ID#
Improved Continuum of Care	✓	✓		**Objective 1: Provide Learning Collaborative for MaineCare Health Homes**																			
					XIV	QC 1	Establish organizational infrastructure for HH Learning Collaborative	✓	✓												Maine workforce shortage of QI professionals	Gap in connecting HH primary care practices to the HIE and functions	VI.A, VIII.G, V, XI.A
						QC 2	Launch and manage HH Communication Plan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			Clarification of HH Screening Tool requirements required for 2014	
						QC 3	Launch and Manage HH Education Plan; support PCMH/HH Learning Collab	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Maine workforce shortage of QI professionals	Clarification of HH Screening Tool requirements required for 2014	
						QC 4	Launch and Manage HH Data Management Plan	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	State infrastructure may not support automated collection of clinical measures		
						QC 5	Assess NCQA status of HH practices	✓	✓											HH practices may not meet NCQA PCMH requirements		
						QC 6	Assess baseline Core Expectation status; Assess HH practices onsite	✓	✓													
						QC 7	Clarify MaineCare requirements for HH quality measure reporting	✓	✓	✓	●	●								Lack of clarity on approach may delay	Dependent upon State ability to collect HH quality measures	
						QC 8	Establish HH participation requirements	✓	✓	●	●											
						QC 9	Finalize HH practice participation based on requirements		✓											Practice may not be able to accomplish requirements of NCQA and meet Must Pass elements		
						QC9.1	Provide Quality Improvement support to HH practices, supporting and monitoring their transformation to implement the HH model		♦		✓	✓	✓	✓	✓	✓	✓	✓	✓			
						QC 10	Ensure connection to CCT structure	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Potential confusion between CCT, CHW, Care Mgt and Case Mgt functions - clarity in functional appropriateness essential for success	Critical to ensure Medicaid enhance payment structure in order to sustain HH model	
						QC 11	Prepare for Sustainability of HH/CCT model			♦	♦	♦	✓	✓	✓	✓	✓	✓	✓	Enhanced payment model required to sustain	Critical to ensure Medicaid enhance payment structure in order to sustain HH model	
	Quarterly Accountability Target						Active, participating HH single payer practices supported by LC		75	80	90	102											
	Quarterly Accountability Target						Active, participating HH single payer practices supported by LC by percentage		75	75	100	100	100	100	100	100	100	100	100	100			
	Quarterly Accountability Target						Active, participating HH single payer practices meeting must-pass requirements by %		0	20	20	50	75	75	75	75	75	75	75	75			
	Quarterly Accountability Target						Active, participating HH single payer practices meeting screening requirements by %		0	0	0	40	75	75	75	75	75	75	75	75			
Objective 1: Accountability Targets								Planning Period Target Establish organizational infrastructure to support and staff Learning Collaborative; Establish baseline assessments on status of HH practices; Perform onsite assessments on up to 80 new HH Practices; Develop HH Communications Plan; Develop HH Education Plan; Develop HH Data Management Plan.	Go Live Target: Launch enrollment of up to 80 new HH practices in PCMH/HH Learning Collaborative to provide QI support for current 75 PCMH & new HH primary care practices, with total of up to 150 participating practices; determine final NCQA status of high risk practices (may not meet participation requirements by 12/31/13). Year 1 Target: Support PCMH/HH Learning Collaborative, offering supporting for 100% of participating practices; provide QI support to ensure that ≥75% of the new HH practices reach Must-Pass elements; and ≥75% practices implement HH Year 2 MaineCare screening requirements. [Note: PCMH & HH practices est'd to provide care for approx. 432,000 patients]				Year 2 Targets: Facilitate Learning Collaborative for HH practices; sustain PCMH/HH Learning Collaborative offering support for 100% of Year 2 participating primary care practices.				Year 3 Targets: Sustain PCMH/HH Learning Collaborative offering support for 100% of Year 3 participating practices.						
Objective 1: Annual Cost (Aligns with annual budget total's submitted with contract)								**$171,671**	**$938,933**				**$968,356**				**$983,607**				Obj. subtotal	$3,062,567	

Secondary Driver	Subcommittee			Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#	
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			ID#
Improved Continuum of Care		✓		**Objective 2: Provide support for SIM Delivery System Reform Subcommittee**																			
					XIV	QC 12	Identify and finalize Subcommittee membership		✓															
						QC 13	Convene Delivery System Reform Subcommittee			✓														
						QC 14	Ensure participation and process according to established protocols			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
Objective 2 Accountability Targets:								Planning Period Target: establish infrastructure, membership for Delivery System Reform Subcommittee	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						
Objective 2: Annual Cost												**$29,689**				**$29,731**				**$41,440**	Obj. subtotal	$100,860	

Secondary Driver	*Subcommittee*			Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#	
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			ID#
Improved Continuum of Care		✓		**Objective 3: Provide QI Support for Behavioral Health Homes Learning Collaborative**																			
						QC 15	Identify & support BHHs multi-stakeholder advisory committee (e.g. QC Behavioral Health Comm)			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
						QC 16	Launch and manage BHH Communication Plan			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
						QC 17	Establish organizational infrastructure for BHH Learning Collaborative; hire BHH Program Manager & contract with BH consultant			✓											Maine workforce shortage of QI professionals		
						QC 18	Identify & manage plan for integrating peer support into BHH curriculum & Learning Collab				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Financial resources for peer support		
						QC 19	Launch and Manage BHH Education Plan, including BH & PCMH/HH curriculum; support BHHs Learning Collaborative				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Maine workforce shortage of QI professionals		
						QC 20	Identify & manage plan for integrating BHH Education Plan with PCMH/HHs Education Plan				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Number of potential new HH practices unknown; learning needs will vary	Dependent on coord with PCMH/HHs	
						QC 21	Launch and Manage BHH Data Management Plan				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	State infrastructure may not support automated collection of clinical measures		
						QC 22	Assess baseline status of BHHs on Core Expectation				✓	✓											
						QC 23	Clarify MaineCare requirements for BHH quality measure reporting			✓	●										Lack of clarity on approach may delay	Dependent upon State ability to collect BHH clinical quality measures	
						QC 24	Establish BHH participation requirements			✓	●										Lack of clarity on approach may delay		
						QC 25	Ensure connection to CCT structure			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Potential confusion between CCT, CHW, Care Mgt and Case Mgt functions - clarity in functional appropriateness essential for success		
	Quarterly Accountability Target						% of BHHO's supported by BHH Learning collaborative				100	100	100	100	100	100	100	100	100	100			
	Quarterly Accountability Target						% of BHHO teams participating in monthly webinars				75	75	75	75	75	75	75	75	75	75			
	Quarterly Accountability Target						% of BHHO teams participating in Learning Sessions				75	75	75	75	75	75	75	75	75	75			
	Quarterly Accountability Target						Number of Multi-Stakeholder Advisory Groups (BHH Working Grp) Held				2	2	2	2	2	2	2	2	2	2			
	Quarterly Accountability Target						% of Advisory (BHH Working Grp) meetings with representation from state, provider and consumer organizations				100	100	100	100	100	100	100	100	100	100			
Objective 3 Accountability Targets:									Year 1 Target: Launch enrollment of up to 35 new BHHs into BHH Learning Collaborative to provide QI support for BHH organizations.				Year 2 Targets: Facilitate BHH Learning Collaborative for up to 35 BHHs; sustain BHH Learning Collaborative offering support for 100% of Year 2 participating BHH organizations				Year 3 Targets: Sustain BHH Learning Collaborative for up to 35 BHHs; sustain BHH Learning Collaborative offering support for 100% of Year 3 participating BHH organizations						
Objective 3: Annual Cost								**$0**				**$317,560**				**$387,088**				**$323,460**	Obj. subtotal	$1,028,108	

Secondary Driver	*Subcommittee*			Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#	
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			ID#
Improved Continuum of Care		✓		**Objective 4: Provide QI Support for Patient-Provider Partnership Pilots (P3 Pilots)**																			
						QC 26	Identify priorities for focus of P3 Pilots		✓	✓	●										Need direction from DSR Subcomm, SIM Steering Comm	Coordinate with VBID efforts	
						QC 27	Identify & support P3 multi-stakeholder advisory committee (e.g. ME Choosing Wisely Leadership Grp)			✓	✓	✓	✓	✓									
						QC 28	Launch and manage P3 Communication Plan			✓	✓	✓	✓	✓									
						QC 29	Establish organizational infrastructure for P3 Pilots; contract with P3 Program Manager & hire staff			✓											Maine workforce shortage of QI professionals		
						QC 30	Establish & manage process for selecting provider sites for participation in P3 Pilots			✓	✓										Sufficient interest from provider grps		
						QC 31	Identify & secure formal SDM tools			✓	●										Must be able to support costs of formal SDM tool	Coordinate with VBID efforts	
						QC 32	Establish & manage process for providing technical assistance & facilitating collaborative learning across provider Pilot sites			✓	✓	✓	✓	✓									
						QC 33	Launch & manage 1st P3 Pilot (e.g. Choosing Wisely) with 3 provider sites				✓	✓	✓	✓									
						QC 34	Launch & manage 2nd P3 Pilot (e.g. SDM) with 3 provider sites				✓	✓	✓	✓									
						QC 35	Launch & manage 3rd P3 Pilot (TBD) with 3 provider sites				✓	✓	✓	✓									
						Quarterly Accountability Target	# of provider pilots participating with at least 25 members attending, learning sessions				9	9	9	9									
						Quarterly Accountability Target	# of members attending the P3 leadership group				15	15	15	15									
						Quarterly Accountability Target	# of provider pilots participating with at least 25 members attending, Webinars				9	9	9	9									
						Quarterly Accountability Target	# of newsletters disseminated				1	1	1	1									
Objective 4 Accountability Targets:									Year 1 Target: Launch 3 Patient Provider Partnership (P3) Pilots with 9 provider sites.				Year 2 Targets: Support and facilitate learning across 9 provider sites in P3 Pilots; sustain support for 100% of participating provider organizations										
Objective 4: Annual Cost								**$0**			**$336,003**				**$178,630**				**$0**		Obj. subtotal	$514,633	
Totals								**$171,671**			**$1,622,185**				**$1,563,805**				**$1,348,507**		**$4,706,169**		

Maine SIM Grant - Executive Level Project Plan with Accountability Targets

SIM Partner Organization: MaineCare **Lead/Point for Organization:** Michelle Probert

Secondary Driver	Subcommittee			Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Milestone Timeline: Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Risks & Dependencies: Known Risks	Dependency and Link to ID#	
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			ID#
Aligned Payment Models	X	X		**Objective 1: Implement MaineCare Accountable Communities Shared Savings ACO Initiative**																			
					B.7, C.9, G.15. G.17, H.22, H.23, S.46	MC 1	Conduct provider outreach and education, including regional forums on proposed model	✓	✓															
						MC1.1	Provide ongoing provider outreach and education			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
						MC 2	Work with Accountable Care Implementation (ACI) workgroup to educate and recruit providers, provide learning collaborative support, and achieve multi-payer alignment on quality measures and value-based payment models.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
						MC 3	Develop and finalize quality framework	✓	✓	●														
						MC 4	Issue provider Request for Applications (RFA) and select eligible applicants		✓															
						MC 5	Conduct AC attribution and develop benchmark Total Cost of Care (TCOC) amounts	✓	✓	✓	●											Potential for problems with claims data	Timeliness of TCOC calculations by Accountable Community; replication of analysis for data analytics reports to providers	**4**
						MC 6	Develop Analytics Support For Accountable Communities	✓	✓	✓	●											Ability to replicate actuaries' analysis	Replication of TCOC, attribution for analytic reports	5
						MC 7	Obtain CMS approval for State Plan Amendment		✓	✓	●											Plan SPA submission for 11/1. SPA approval timeline dependent on CMS. CMS has been difficult to connect with.	Timely SPA approval	
						MC 8	Draft and adopt MaineCare rule for Accountable Communities		✓	✓	●													7
						MC 9	Finalization of Accountable Communities contracts, Implementation				✓													6, 7, 8
						MC 10	Provide Accountable Communities with analytic reports				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			6, 7
						MC 11	Open Accountable Communities RFA for additional rounds of applications					■	✓			■	✓							
	Quarterly Accountability Target						Total MaineCare Patient Lives Impacted					50000				55000				60500				
	Quarterly Accountability Target						Additional Maine Lives Impacted					25000				27700				29700				
	Quarterly Accountability Target						# of AC's Provided with monthly Utilization reports					5	0	5	5	7	7	7	7	9				
	Quarterly Accountability Target						AC's attended ACI Meeting by percent		90	90	90	90	90	90	90	90	90	90	90	90				
	Quarterly Accountability Target						Annual applications of ACO's					5	5	5	5	7	7	7	7	9				
Objective 1: Accountability Targets								Planning Period Target	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 population.				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 population.					
Objective 1: Annual Cost (Aligns with annual budget total's submitted with contract)																							

Secondary Driver	Subcommittee			Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#	
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			ID#
Aligned Payment Models Improved Continuum of Care	X	X	X	**Objective 2: Implement MaineCare Behavioral Health Homes Initiative**																			
					B.7, C.9, G.15. G.17, H.22, H.23	MC 12	Conduct provider outreach and education, including regional forums on proposed model	✓																
						MC 13	Issue provider Request for Applications (RFA) and select eligible applicants		✓															
						MC 14	Obtain CMS approval for State Plan Amendment	✓	✓	✓	●											Plan to submit SPA on 11/15 with retroactive approval to 1/15. State would be at risk while SPA not approved. 90-day approval dependent on CMS comfort with draft SPA.		
						MC 15	Draft and adopt MaineCare rule for Behavioral Health Homes	✓	✓	✓	●											Aggressive timeline. Challenging new area for AAG Office review.	Implementation of rule, initiative	9
						MC 16	Development of Behavioral Health Homes Enrollment System provider portal	✓	✓	●	●													
						MC 17	Eligible member identification and enrollment		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
						MC 18	Contract with entity to implement Behavioral Health Home Learning Collaborative		✓													Lengthy, burdensome State contracting process	Effective date of contract.	8
						MC 19	Development and implementation of Behavioral Health Home Learning Collaborative		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
						MC 20	Implementation			✓	●													
						MC 21	Provide Behavioral Health Homes with utilization and quality reports			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			
	Quarterly Accountability Target						Recruit BHHO's				15	15											
	Quarterly Accountability Target						members enrolled in BHHO			5000	6000	7000	7175	7350	7525	7700	7900	8100	8300	8500			
	Quarterly Accountability Target						percent of representation by stakeholders at monthly meetings						80	80	80	80	80	80	80	80			
Objective 2 Accountability Targets:								Planning Period Target Complete draft SPA and draft rule Initiate consultations with SAMHSA, CMS	Go Live Target: 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 being transformed 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 being transformed 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 being transformed through Behavioral Health Homes, and about 24,000 members with SMI/SED.					
Objective 2: Annual Cost												**$163,636**				**$218,182**				**$218,182**			

Secondary Driver	Subcommittee			Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#	
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			ID#
Improved Continuum of Care Patient/Family Centeredness of Care		X		**Objective 3: Develop and implement Physical Health Integration workforce development component to Mental Health Rehabilitation Technician/Community (MHRT/C) Certification curriculum.**[6]																			
					L.32	MC 22	Finalize contract with selected vendor			✓	●													
						MC 23	Development of curriculum			■	■	✓	✓	✓										
						MC 24	Implementation of trainings/ curriculum						■	■	✓	✓	✓	✓						
				Quarterly Accountability Target			percent of curriculum developed					50	75	100										
				Quarterly Accountability Target			percent of training plan developed					50	75	100										
				Quarterly Accountability Target			number of providers trained							25	100	200	300	500						
				Objective 3: Accountability Targets				Planning Period Target	Go Live Target: Year 1 Target: Curriculum and training plan developed for Physical Health Integration component to Mental Health Rehabilitation Technician/Community Training				Year 2 Targets: 500 direct service behavioral health individual providers trained in physical health integration.				Year 3 Targets:						
				Objective 3: Annual Cost (Aligns with annual budget total's submitted with contract)								**$219,357**				**$342,342**							

Secondary Driver	Subcommittee			Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#	
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4			ID#
Improved Continuum of Care Patient/Family Centeredness of Care		X		**Objective 4: Provide training to Primary Care Practices on serving youth and adults with Autism Spectrum Disorder and Intellectual Disabilities.**[7]																			
					L.32	MC 25	Finalize contract with selected vendor			✓	●													
						MC 26	Provide training to pediatric sites				✓	✓	✓	✓	✓	✓	✓	✓						
						MC 27	Develop training for adult practice sites				✓													
						MC 28	Implement Adult training at 5 pilot sites					✓												
						MC 29	Provide training to adult practice sites						✓	✓	✓	✓	✓	✓	✓	✓				
				Quarterly Accountability Target			Curriculum development						50	75	100									
				Quarterly Accountability Target			Training plan development						50	75	100									
				Quarterly Accountability Target			Targeted Case Managers providers Trained								10	20	30	40	50	60				
				Quarterly Accountability Target			Develop HH LC Training for PCP's					75	100											
				Quarterly Accountability Target			Number of HH PCP's Trained						15	25	50	75	100	125	150	175				
				Objective 4: Accountability Targets				Planning Period Target	Go Live Target: 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 There are over 400 primary care practice sites in Maine.				Year 3 Targets: Training conducted at 15 pediatric sites Training conducted at 60 adult practice sites There are over 400 primary care practice sites in Maine.						
				Objective 4: Annual Cost (Aligns with annual budget total's submitted with contract)								**$42,239**				**$88,489**				**$65,738**			

Maine SIM Grant - Executive Level Project Plan with Accountability Targets

✓ Milestone ● Ongoing work in preparation of completing Milestone

SIM Partner Organization: Maine Health Management Coalition Foundation | **Lead/Point for Organization:** Ellen Schneiter

Secondary Driver	Subcommittee			Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period 7/1/13- 9/30/13	Milestone Timeline: Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Risks & Dependencies: Known Risks	Dependency and Link to ID#
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
Data informed policy, practice and payment decisions	✓			**Objective 1: Health information to influence market forces and inform policy: track health care costs**																		
					1	MHMC 1	Execute DUAs with CMS to ensure availability of Medicare data	✓	✓	●	●											Precedent security audits of data vendor by CMS	Provider participants in HIE
						MHMC 2	Execute BAA with MEDHHS to ensure access to MaineCare data. DUA is incorporated into SIM sub recipient contract between MHMC and MEDHHS.	✓															
						MHMC 3	Execute/renew agreement with MHDO for receiving commercial claims on an ongoing basis			✓				✓					✓			Denial of access to claims data (highly unlikely)	
						MHMC 4	Establish/execute necessary BAAs and DUAs with participating commercial plans to access commercial claims data	✓															
						MHMC 5	Execute new scope of work between MHMC and data vendor, HDMS		✓													Delays in processing agreements	Timely execution of SIM contract with DHHS
						MHMC 6	Onboard additional staff to support data program activities and cost of care activities	✓	✓	✓												Ability to identify appropriate candidates to fill positions; timely execution of state contract	
						MHMC 7	Update statewide commercial claims on an ongoing, quarterly basis	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			Timeliness of availability of datasets. MHDO is transitioning to a new data vendor, which could delay processing. Compliance of commercial claims submitters.	3, 6
						MHMC 8	Obtain initial Medicare claims data feed; FTP directly to HDMS, implement and QC Medicare data				✓											Delay in execution of DUA with CMS. Delay in transmission of data from CMS.	1
						MHMC 9	Obtain subsequent Medicare claims data feeds to update database; FTP directly to HDMS, implement and QC Medicare data					✓		✓		✓		✓				Delay in execution of DUA with CMS. Delay in transmission of data from CMS.	1
						MHMC 10	Update MaineCare data on a continuing basis; data feeds will be received monthly, but processing to occur on a quarterly basis		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			Delays in transmission of data from Molina to HDMS	2, 5
						MHMC 11	Reconvene Healthcare Cost Workgroup and convene new Behavioral Healthcare Cost Workgroup - hold first meetings		✓													Inability to schedule meetings during month of December	
						MHMC 12	Convene regular meetings of Healthcare Cost Workgroups. Work to identify metrics to track cost of care, refining algorithm used in original grant proposal. Must ensure that metrics chosen complement payment reform strategies and benefit design strategies developing in Maine's health are environment.			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓			Ability to hold successful monthly meetings will hinge on participants' level of stamina for the task and their availability. Timely availability of claims data impacts ability to carry out work for these groups.	6,09,10,11
						MHMC 13	Publication of Healthcare Cost Fact Book			●	●	✓	●	✓	●	✓	●	✓	●	✓			12
						MHMC 14	CEO Roundtables convened to inform business and opinion leaders re: cost of care in Maine, trends			●	●	✓	●	✓	●	✓	●	✓	●	✓			12
				Quarterly Accountability Target			Increase in the number of participants in CEO roundtable					20		25		30		40		50			
				Objective 1: Accountability Targets				Planning Targets: Development and, when feasible, execution of necessary legal agreements required to gain access to claims datasets	Year One 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-hospital 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 broad-based 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 broad-based dataset. (2) Issue two additional updates of Fact book. (3) Convene two additional CEO Roundtables, increasing attendance from 30 to 50 CEOs.					
				Objective 1: Annual Cost (Aligns with annual budget total's submitted with contract)					**$1,537,917.00**				**$1,367,203.00**				**$1,371,468.00**					

Secondary Driver	Subcommittee			Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
Data informed policy, practice and payment	✓						**Objective 2: Health information to influence market forces and inform policy: value based benefit design**															
						MHMC 15	Onboard VBID staff person			✓				✓				✓			Implementation contract with DHHS not signed timely, may delay hire	
						MHMC 16	Survey plans to document current or planned activity for payment based on quality performance and cost effectiveness.				✓											1
						MHMC 17	Identify and develop key elements of value based design, based on the work of the ACI and Healthcare Cost Workgroups. Specify measures of quality performance and cost effectiveness, giving special consideration to alignment with those measures being used by payers - including Medicare and MaineCare.				✓											1, 2
						MHMC 18	Convene VBID workgroup and explore opportunities to align patients' out of pocket costs such as copays and deductibles with the value of services provided, as well as opportunities identified by the Healthcare Cost Workgroups and the ACI workgroup focusing on patient incentives as well as provider incentives. Learning from the experiences of payers and provider communities to date.				✓		✓		✓		✓		✓			1, 2
						MHMC 19	Evaluate and test the operability of alternative designs with regard to legal constraints including confidentiality statues, the ability of provider systems to implement and align with features of desired designs and the ability of paymers to implement such designs. Adopt set of core measures				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		4
						MHMC 20	Rank plans according to adopted VBID metrics; update on at least an annual basis					✓				✓						✓		4, 5
						MHMC 21	Publicly report VBID rankings, updating at least annually					✓				✓						✓		6
						MHMC 22	Advance change across payers by working with the ACI Workgroup, engaging consumers and employees around the issue of VBID and by engaging CEO decision makers around the potential of this type of benefit design.					✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		1-7
						MHMC 22.1	MHMC will introduce the NDPP at the ACI workgroup. ACI may serve as a venue for the NDPP pilot to showcase its work, educate purchasers regarding the program, building familiarity with the NDPP across a broad community. One aspect of this effort will be to work with the purchasers in ACI to identify candidate measures that may be used to gauge the relative impact/success of the introduction of the NDPP in a pilot workplace. The MHMC will help the DCD recruit commercial plan sponsors to participate in the CDC's NDPP pilot.			✓												Although the MHMC will provide the CDC with an opportunity to recruit ACI employer participants into the NDPP pilot and although the MHMC will work to encourage such participation, there is the risk that no participating employers will choose to enroll in the initiative. The MHMC cannot guarantee such participation.	The CDC is responsible for conduct of the NDPP pilot. If the pilot does not get off the ground, there will be no need for this discussion to occur at the ACI. Participation of the NDPP/CDC staff in the educational session(s).
						MHMC 22.2	MHMC will provide the already compiled methodology and results of State of Maine TDES program evaluation.		✓														
						MHMC 22.3	Using data and information generated by the Maine CDC regarding the outcomes or performance of the NDPP in the pilot worksites, the MHMC will work with ACI participants to help identify possible alternate, sustainable payment models for the National Diabetes Prevention Program (NDPP) program. This work will be informed by the relative success of the pilot project - as marked against performance measures and anticipated outcomes.			●	●	●	●	●	●	●	●	●	✓	✓	✓	The NDPP pilot effort may fail to collect data and information germane to the measures of success important to purchasers and payers participating in the ACI. Alternatively, outcomes may not be persuasive enough to encourage widespread adoption of the program in the workplace. The short time frame within which the grant occurs may not provide sufficient time to collect such convincing evidence. This will compromise the likelihood that participants will endorse or adopt any recommended funding strategies.	Successful conduct of the NDPP pilot in a timely manner, including collection of valid, reliable outcomes measures.
						MHMC 22.4	MHMC will introduce the NDPP to the VBID workgroup, in an effort to recommend elements of value based insurance design that can be used to reinforce the tenets of the NDPP.					✓											
						MHMC 22.5	The Maine Health Management Coalition will introduce CDC's Community Health Worker (CHW) pilots to ACI steering committee, as well as seek input on the pilots from the Payment Reform Subcommittee, to inform and educate these participants on the CHW initiative being conducted by the Maine CDC. The pilot is slated to begin in the spring of 2014. If the CHW pilot proves successful, ACI participants will explore strategies to develop and implement sustainable funding mechanisms to support this service on an on-going basis. Due to the timing of the pilot and the need to allow it to run for some substantial period of time in order to prove itself, this discussion will not occur before the latter half of Year Three of the project.				✓										The CHW pilot is a project of the Maine CDC. As such, the CDC is wholly responsible for the pilot getting off the ground in a timely fashion and running smoothly. The CDC is also responsible for collecting valid, reliable data regarding the outcomes of the pilot. Purchasers, payers and providers will need to be provided good outcomes data in order to move the issue of sustainable funding forward in these MHMC workgroups. The risk of not having such data within the short timeframe of the SIM grant appears to be relatively high.	The CDC is responsible for conduct of the CHW pilot. If the pilot does not get off the ground, there will be no need for this discussion to occur at the ACI. Participation by the CHW/CDC staff in these work sessions.
	Quarterly Accountability Target						number of covered lives enrolled in plans that incorporate value based design						0	0	0	10000	0	0	0	30000		
Objective 2 Accountability Targets:								**Planning Period Target**	Year 1 Targets: (1) Adoption of core set of metrics against which plan designs may be benchmarked (2) Publication of initial rankings of benefit designs				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/deductibles, utilization of high value providers as determined by MHMC Get Better Maine rankings or ACI metrics, and use of shared decision making of all preference sensitive services. Enrollment in plans with such designs will grow from 0 to 10k in Year 1.				Year 3 Targets: (1) Refined metrics, as appropriate, based on trends and on market experience (2) increase in number of covered lives enrolled in plans incorporating VBID from 10k to 30k.				
Objective 2: Annual Cost									**$351,107.00**				**$555,130.00**				**$380,333.00**					

Secondary Driver	Subcommittee			Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
Data informed policy, practice and payment	✓	✓					**Objective 3: Health information to influence market forces and inform policy: Identify common metrics across payers for public reporting and alignment with payment through the work of the PTE Workgroups**															
					Sub objective 3.1: PTE Physician	MHMC 23	Data Collection/Evaluation: **Practice Clinical and Office System Evaluation Data**. Physician, Practice Data - aggregation of data re: provider ratings for clinical recognition. Providers submit data to NCQA or BTE for selected metrics, or submit data directly to MHMCF	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Providers fail to submit data	
						MHMC 24	MHMCF downloads recognitions, or data for recognitions, from -- Bridges to Excellence (RDE file) -- CMS (meaningful use) -- IMPACT (pediatitec immunization) -- Practices (pediatric asthma data)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Providers fail to submit data	1
						MHMC 25	Update Provider Database on a real time basis of the MHMC provider hierarchy. This includes tracking providers, their site(s) of practice, specialty, health plan affiliation(s), ACO affiliation, and so on.	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
						MHMC 26	Publically Report Physician Practice Ratings - Reporting across practices	✓		●	●	✓	●	●	●	✓	●	●	●	✓		2
					Sub objective 3.2	MHMC 27	PTE Physicians group to identify core metrics for APC recognition			✓												
						MHMC 28	Testing of identified metrics for feasibility			✓	✓										PTE Workgroup fails to reach consensus re: metrics/reporting or Board fails to approve	
						MHMC 29	PTE adoption of APC metrics including value assignment; board approval			●	●	✓										
						MHMC 30	Publication of APC metrics						✓									7
						MHMC 31	Updating of published metrics						✓		✓			✓		✓		Updated data is not submitted timely	8
					Sub Objective 3.3	MHMC 32	Data Collection/Evaluation, **Hospitals and Systems** - aggregation of data re: hospital and System ratings/recognition program. Obtain data for hospital evaluations from: -- CMS (appropriate care, patient experience) -- Onpoint (Medication Safety) -- Leapfrog (patient safety, early deliverables) -- MHDO (Care transitions, falls with injury)	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Providers fail to submit data	
						MHMC 33	Compute, assignment of ratings, hospital review, governance review and update website - public reporting	✓		●	●	✓	●	●	●	✓	●	●	●	✓	PTE Workgroup fails to reach consensus re: metrics/reporting or Board fails to approve	11
						MHMC 34	Publically Report Hospital Ratings - Reporting across hospitals	✓		●	●	✓	●	●	●	✓	●	●	●	✓		12
					Sub objective 3.4: ACI Metrics	MHMC 35	ACI Workgroup Meetings	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Group operates by consensus; may decide to meet every other month	
						MHMC 36	Define and adopt ACO standards, predicated on accepted principles of the group; vet reporting metrics up through PTE Systems to MHMC Board.		✓	●	●	●									Group fails to reach consensus on core set of metrics for public benchmarking	
						MHMC 37	Identify performance targets and measure performance against targets			✓	●	●									Group fails to reach consensus on core set of metrics for public benchmarking	This work depends on the data management tasks outlined under Objective 1 above
						MHMC 38	Assess any change in readmission rates; care management of high cost/high utilizing patients; e-visits; and pharmacy management. Consideration of findings of the Healthcare Cost Workgroups (including BH cost group) and implications for ACO arrangements in Maine.				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		This work depends on the data management tasks outlined under Objective 1 above
						MHMC 39	Identify additional metrics to be used for learning and contracting purposes, as opposed to public reporting and benchmarking.; these metrics may be used to inform and measure risk contracting arrangements with regard to both quality and cost. Track metrics over time.			✓		✓				✓			✓		Group fails to reach consensus on set of metrics to be used for learning collaborative purposes	
						MHMC 40	Document progress toward alignment demonstrated by systems and practice-based initiatives through biannual reports vetted through the ACI Workgroup.				✓		✓		✓		✓		✓			14-18
					Sub objective 3.5: Behavioral Health PTE	MHMC 41	Outreach to potentially interested persons regarding participation in new PTE BH Workgroup	✓														
						MHMC 42	Identify behavioral health clinical consultant; on board BH PTE staff		✓													
						MHMC 43	Convene PTE BH Workgroup. At initial meeting provide orientation to PTE process, establish ground rules that will guide the work of the group.		✓	✓	✓	✓		✓		✓		✓		✓	A critical mass of interested parties fails to be identified	20, 21
						MHMC 44	Identification of Viable Performance Measures - candidate measures proposed by Committee members, staff		✓	✓											Group fails to reach consensus	22
						MHMC 45	Candidate measures assessed against specification review criteria (importance, scientific acceptability, usability, feasibility, addresses gaps in performance)			✓	✓										Identified metrics prove inappropriate due to lack of availability of valid data	22
						MHMC 46	Clinical review of candidate measures that satisfy specification review criteria			✓	✓											22
						MHMC 47	Surviving candidate measures to PTE Committee for value assignment (identify breakpoints for assignment of good/better/best ratings)				✓	✓									Identified metrics prove inappropriate due to lack of availability of valid data	24, 25
						MHMC 48	Surviving candidate measures adopted by PTE BH workgroup and Board for review; ensures purchaser buy in					✓									Full group/board fail to adopt	26
						MHMC 49	Approved metrics incorporated into rankings and published						✓									26
						MHMC 50	Update measures/rankings as appropriate								✓		✓				Data must be received from payers in timely manner	28

Sub objective 3.6: Reporting on Patient Experience of Care	MHMC 51	MHMCF obtains survey data from CMS-CG-CAHPS re: overall patient experience of care; data analyzed by Onpoint		✓												Data must be received from vendors in a timely manner	
	MHMC 52	CG-CAHPS data incorporated into existing reporting database		✓												Data must be received from vendors in a timely manner	30
	MHMC 53	Develop methods for updating CG-CAHPs for practices alternative the annual cycle of updates.		✓												Data set must contain valid observations to allow reporting	31
	MHMC 54	Develop reporting processes for CG-CAHPs			✓											Data set must contain valid observations to allow reporting	32
	MHMC 55	Develop plan to continue CG-CAHPS survey past the first year.			✓											Viability of plan will need to consider available resources; no budget for this activity. Continued MQF funding required.	
Sub Objective 3.7	MHMC91	Obtain initial clinical data feed; FTP directly to HDMS, implement and QC clinical data				✓											
	MHMC92	Clinical data first included in production data and available for reporting.					✓										
	MHMC93	Measure development, testing, and implementation using clinically enhanced claims data.					✓	✓									
	MHMC94	Submit application to HIN to request access to the clinical data.						✓									
	MHMC95	Application approval and execution of any necessary DUAs.						✓									
	MHMC96	Enhance reports to include measures derived from clinically enhanced claims data.							✓								
	MHMC97	Update clinical data on a continuing basis; data feeds will be received monthly, but processing to occur on a quarterly basis.								✓	✓	✓	✓	✓	✓		
Sub objective 3.8 Accountable Communities and Related Initiatives	MHMC98	Participate in MaineCare Accountable Community measurement methodology discussions			✓	✓											
	MHMC99	Replicate AC member attribution using the methodology specified by the Department's consultant (Deloitte) and approved by the Department. The Department's consultant (Deloitte) will work with the contractor in implementing the methodology the consultant develops, resolving any issues with the methodology. The Contractor will not carry out				✓										Consultant fails to complete work on methodology; errors or needed changes are identified during replication process	MC5
	MHMC100	Replicate AC benchmark PMPMs using the methodology specified by the Department's consultant (Deloitte) and approved by the Department. The Department's consultant (Deloitte) will work with the contractor in implementing the methodology the consultant develops, resolving any issues with the methodology. The Contractor will not carry out the calculation of PMPM benchmarks until the Department's consultant and the				✓										Consultant fails to complete work on methodology; errors or needed changes are identified during replication process	MC5
	MHMC101	Provide monthly utilization reports for ACs					✓	✓	✓	✓	✓	✓	✓	✓	✓	Consultants fail to complete work on methodology; data required for calculations not available; CMS fails to approve the DHHS State Plan Amendment; no providers participate in AC initiative.	The timeline for this activity is dependent upon the actual launch date by the Department of the AC initiative. MHMC88, 89, MC9
	MHMC102	Provide quarterly quality, attribution, and TCOC reports for ACs					✓	✓	✓	✓	✓	✓	✓	✓	✓	Consultants fail to complete work on methodology; data required for calculations not available; CMS fails to approve the DHHS State Plan Amendment; no providers participate in AC initiative.	The timeline for this activity is dependent upon the actual launch date by the Department of the AC initiative. MHMC88, 89, MC9
	MHMC103	Measure and report final Year 1 Accountable Community scorecard and final savings or recoupment payments for each participant in the Department's Accountable Communities initiative using the methodology specified by the Department's consultant (Deloitte) and approved by the Department. Detailed requirements of quarterly attribution reconciliation,										✓				Consultants fail to complete work on methodology, data required for calculations not available; CMS fails to approve the DHHS State Plan Amendment; no providers participate in AC initiative.	The timeline for this activity is dependent upon the actual launch date by the Department of the AC initiative. MHMC88, 89, MC9
	MHMC104	Conduct AC member attribution based on consultant methodology for Year Two of the initiative						✓	✓							Consultant fails to complete work on methodology	MHMC99
	MHMC105	Calculate AC benchmark PMPMs based on consultant methodology for Year Two of the initiative						✓	✓							Consultant fails to complete work on methodology	MHMC100
	MHMC106	Provide monthly utilization reports for HHs					✓	✓	✓	✓	✓	✓	✓	✓	✓	Data required to run reports is not available	
	MHMC107	Provide monthly utilization reports for BHHs					✓	✓	✓	✓	✓	✓	✓	✓	✓	Data required to run reports is not available; CMS fails to approve DHHS' State Plan Amendment; no providers enroll in BHH initiative	Actual timing of this activity is dependent upon the Department's ability to launch the BHH initiative. MC20
	MHMC108	Provide quarterly quality reports for HHs					✓	✓	✓	✓	✓	✓	✓	✓	✓	Data required to run reports is not available	
	MHMC109	Provide quarterly quality reports for BHHs					✓	✓	✓	✓	✓	✓	✓	✓	✓	Data required to run reports is not available; CMS fails to approve DHHS' State Plan Amendment; no providers enroll in BHH initiative	Actual timing of this activity is dependent upon the Department's ability to launch the BHH initiative. MC20
Quarterly Accountability Target		percent of Maine residents covered by alternative payment arrangements					17	20	25	30	35.5	40	45	50	61		

Objective 3: Accountability Targets	**Planning Period Target.** Convene ACI group and discuss relationship of ACI Workgroup to SIM project, SIM governance subcommittee and PTE Systems. Set ground rules that will guide the consensus process the group will work with. Identification of interested parties who wish to participate in new PTE BH Workgroup	**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). Identification of 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
Objective 3: Annual Cost (Aligns with annual budget total's submitted with contract)	$ 25,084.00	$ 1,224,396.00	$ 1,071,942.00	$ 1,031,855.00

Secondary Driver	Subcommittee			Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
Health Information to manage care, plan provider and patient-level interventions		✓		**Objective 4: Provide Primary Care providers access to claims data for their patient panels (portals)**																		
						MHMC 56	Identify primary care practices desiring claims portals. Prioritize implementation roll out with those practices participating in ACO arrangements having highest priority.		✓													Practices fail to sign up for portal access	
						MHMC 57	Refine mechanics of portal	✓															
						MHMC 58	Data analysis required to produce practice reports			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	Data must be received from payers in timely manner	1, 2
						MHMC 59	Roll out portal starting with highest priority practices			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		3
	Quarterly Accountability Target						# of practices that have adopted claims portals			30	40	50	52	54	56	60	62	64	66	72		
Objective 4: Accountability Targets								**Planning Period Target** Build out portal	**Year 1 Target:** Complete design of portal and required analytics; data for MaineCare, Medicare and commercial populations 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 practices will adopt the portals in the first year.				**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					
Objective 4: Annual Cost (Aligns with annual budget total's submitted with contract)									**$409,007.00**				**$337,600.00**				**$338,713.00**					

Secondary Driver	Subcommittee			Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
Health Information to manage care, plan provider and patient-level interventions		✓		**Objective 5: Provide practice reports reflecting practice performance on outcomes measures**																		
						MHMC 60	Extend offer of provider specific reports on risk adjusted cost and use metrics for benchmarking against peers by service category and clinical condition to all interested PCPs		✓													Practices decide not to sign up to receive practice reports	
						MHMC 61	Data analysis required for new practice reports			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		1
						MHMC 62	Roll out practice reports			✓		✓		✓		✓		✓		✓			2
						MHMC 63	Outreach to practices (working in conjunction with Quality Counts) to assist practices in gaining proficiency in reading and understanding reports and how to use the information they contain			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		3
	Quarterly Accountability Target						percent of Primary Care Practices receiving reports			15	20	25	27	29	32	35	40	44	47	50		
Objective 5 Accountability Targets:								**Planning Period Target** Continue production of practice reports for currently enrolled practices	**Go Live Target: 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.					
Objective 5: Annual Cost									**$457,385.00**				**$406,718.00**				**$408,061.00**					

Secondary Driver	Subcommittee			Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period 7/1/13-9/30/13	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
Health information for consumers	✓			**Objective 6: Consumer engagement and education regarding payment and system delivery reform**																		
						MHMC 64	Develop and implement media campaign around benefits of value based insurance design as well as broader topic of payment reform		✓	✓	✓	✓	✓	✓	✓	✓						
						MHMC 65	Develop a VBID curriculum eligible for continuing end credits for brokers and HR specialists	✓														
						MHMC 66	Provide free training for advocates, AAA advisors, navigators, free care providers, brokers and HR specialists regarding benefits of VBID and other forms of payment reform				✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
						MHMC 67	Develop a video for payers and purchasers (including MaineCare) to use that explains how VBID plans work.				✓												
						MHMC 68	Provide training for payers' staff members, MaineCare employees regarding characteristics and merits of VBID and other forms of payment reform						✓	✓	✓	✓							
						MHMC 69	Develop and make available a VBID implementation tool kit						✓										
						MHMC 70	Provide CME credits and curriculum around VBID for providers							✓	✓	✓	✓	✓	✓	✓	✓		
	Quarterly Accountability Target						number people who received payment reform education				100	200	250	300	350	400	450	500	550	600		
Objective 6: Accountability Targets								**Planning Period Target**	**Go Live Target:** **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. Reach an additional 200 individuals.				**Year 3 Targets:** Continued outreach and education; reaching an additional 200 providers and individuals					
Objective 6: Annual Cost (Aligns with annual budget total's submitted with contract)									**$102,734.00**				**$94,271.00**				**$94,484.00**					

Secondary Driver	Subcommittee			Key Objective	Associated DRR Section	ID#	Key Milestones	Planning Period	Year 1 10/1/13-9/30/2014				Year 2 10/1/14-9/30/15				Year 3 10/1/15-9/30/16				Known Risks	Dependency and Link to ID#
	PR	DSR	DI					10/1/2013	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
Data informed policy, practice and payment decisions/Aligned Payment Models/Multi-Stakeholder Coalition Building and Support		✓		**Objective 7: Ensure effective management of SIM Payment Reform Subcommittee to promote sustainability of reform developed through SIM**																		
					A, T	MHMC 71	Identify and finalize Subcommittee membership		✓														
						MHMC 72	Convene Subcommittee			✓													
						MHMC 73	Ensure participation and process according to established protocols			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
						MHMC74	Develop a SIM communications Plan		✓														
						MHMC75	Create and Maintain Listserv for general SIM correspondence			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
						MHMC76	Develop web portal for centralized communications (Rackspace)			✓													
						MHMC77	Schedule/ host bi-annual webinars			✓	✓		✓		✓		✓		✓				
						MHMC78	REMOVED																
						MHMC79	REMOVED																
						MHMC80	Develop and implement website enhancements		✓														
						MHMC81	Update and maintain SIM website			✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓		
						MHMC82	Develop/implement public information/relation strategy		✓														
						MHMC83	Create branding materials (slide decks, logos, descriptions)			✓													
						MHMC84	Create SIM Overview flier				✓												
						MHMC85	Create and disseminate SIM Fact sheet specifically for the legislature				✓												
						MHMC86	Create and disseminate SIM Fact sheet specifically for employers				✓												
						MHMC87	Create and disseminate SIM Fact sheet specifically for consumers					✓											
						MHMC88	Create and disseminate SIM Fact sheet specifically for providers					✓											
						MHMC89	Craft and disseminate media pitches, focused on SIM data and results					✓	✓		✓		✓		✓				
Objective 7 Accountability Targets:								Planning Period Target: establish infrastructure, membership for Payment Reform Subcommittee	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					
Objective 7: Annual Cost									**$ 4,800**				**$ 4,800**				**$ 4,800**					

Commitments from HIN/MHMC during Plan Synchronization: • Insuring a synergistic and integrative approach to the work of PTE- BH and the HIN BH RFP Quality work.
• Clearly outlining and communicating the process for a collaboration between HIN, health care provider(s) (Covered Entity(is)) and MHMC in integrating clinical and administrative claims data for a possible proof of concept.

Legend

Codes	Definition
✓	Original entry in the SST
●	Additional Ongoing work that wasn't originally scheduled. Work towards semi-annual and annual milestones is reflected with this.
■	Delayed or rescheduled start to task. Delay was caused by factors out of the control of the partner.
♦	Early start to task. Started work on task ahead of original scheduled time.