Maine State Innovation Model: The Operations Plan for Sustainable Health Care Reform

August 2014 Year Two

www.maine.gov/sim

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

Randal Chenard, Maine SIM Program Director

Maine Department of Health and Human Services

221 State Street, State House Station 11

Augusta, Maine 04333-0011

Randal.Chenard@maine.gov

(207) 287-3707

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Maine State Innovation Model (SIM) Hypothesis

By providing a cohesive, streamlined framework for health care reform and innovation which includes fostering engaged consumers and communities, transforming delivery systems to support accountable and integrated patient-centered primary care, and aligning public and private payment, accountability, quality and data infrastructure, Maine will realize improved quality of care and service while positively impacting health outcomes, population health, and cost.

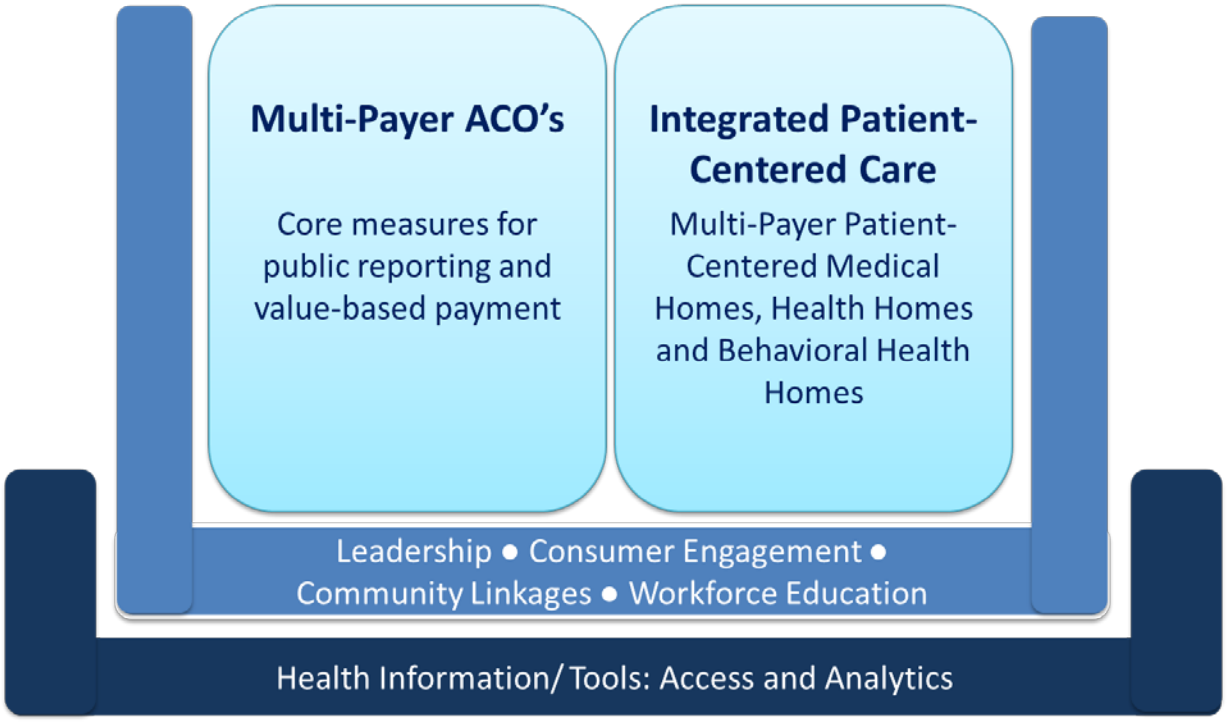

Figure 1 Maine SIM Hypothesis Linking Multi-Payer Accountable Care Organizations (ACOs) with Integrated Patient-Centered Care

The Maine State Innovation Model leverages the work of existing health care initiatives and structures and includes additional innovations to maximize the impact of interventions through a coordinated strategy.

The guiding principles of Maine's model are derived from the Triple Aim[1] goals and will be realized through the pursuit of six strategies, or Strategic Pillars, each of which include

[1] The IHI Triple Aim is a framework developed by the Institute for Healthcare Improvement that describes an approach to optimizing health system performance by 1) Improving the patient experience of care (including quality and satisfaction); 2) Improving the health of populations; and 3) Reducing the per capita cost of health care. Taken from the Institute for Healthcare Improvement website: http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

integrated objectives. The association between the Strategic Pillars and the aligned, integrated objectives are illustrated in Figure 2, the Maine SIM Strategic Framework.

Strategic Pillar #1: Strengthen Primary Care

Implement MaineCare Accountable Communities - Through the MaineCare Accountable Communities Initiative, the Department will engage in shared savings arrangements with provider organizations that commit to coordinating the care of all patients who rely on those organizations as their point of access to healthcare services. Accountable Communities that demonstrate cost savings and meet quality performance benchmarks will share in savings generated under the model.

Six Accountable Communities applied to participate in the first round of the initiative. The Department is working on rulemaking with the Attorney General's Office. An estimated 50,000 members will be attributed through these Accountable Communities in 2014. An additional 25,000 members, while not directly attributed, receive some of their care through these Accountable Communities and will also benefit from improved systems of care coordination. In whole, almost 30% of the MaineCare population will benefit from the Accountable Communities Initiative in this first round.
Accountable Communities will result in such improvements as:

- Reductions in inpatient readmissions
- Less non-emergent Emergency Department use
- More effective use of Electronic Medical Records and real-time data through Maine's Health Information Exchange
- Increased investment in care management for members with chronic conditions, and
- More emphasis on preventive care

MaineCare Notification Project - Currently, MaineCare Care Managers receive Emergency Department (ED) and inpatient discharge summary reports for their members from the treating hospital via fax as requested. HealthInfoNet (HIN) will automate this process between the hospitals and MaineCare, on the hospitals' behalf, using the Health Information Exchange. HIN will provide MaineCare Care Managers real-time electronic "notifications" using secure email of these events of care. The new electronic process aims to create a more efficient workflow for both the hospital and MaineCare staff while supporting MaineCare member's best possible care.

MaineCare Clinical Dashboard - HealthInfoNet (HIN) will provide a "Clinical Dashboard" to MaineCare using their members' information available in the Health Information Exchange (HIE). The goal is to make the HIE clinical data available to MaineCare as a payer to support program and policy development related to population health efforts.

Provider Portal- One of the benefits of having an all-payer claims database in Maine is the ability to offer healthcare providers an in-depth look at the makeup of their patient

populations. Under the Maine SIM award, the Maine Health Management Coalition has been contracted to build secure portals for providers to log in and examine claims data. This data will allow providers to allocate resources at their practice appropriately, and to target struggling patients that may need additional support.

Provider Practice Reports - Practice reports, like the provider portal, offer healthcare providers valuable insight into how well their practice is performing on key cost and quality metrics. The reports give providers insight into which areas they are performing well in, and which areas are in need of improvement.

Patient Portal Pilot - HealthInfoNet will partner with one Health Information Exchange (HIE) health care organization to provide their patients with access to their statewide Health Information Exchange (HIE) record. The pilot site must be able to connect their current "Patient Portal" to the HIE to allow patients to download a medical record summary document from the HIE known as the "Continuity of Care Document" (CCD).

Strategic Pillar #2: Integrate Physical and Behavioral Health

This strategy will assist behavioral health providers to transition into integrated Behavioral Health Homes.

Implement MaineCare Behavioral Health Homes Initiative - Through the MaineCare Behavioral Health Homes Initiative, the Department provides monthly reimbursement to community mental health agencies qualified as Behavioral Health Home Organizations (BHHO's) to support MaineCare members with Serious and Persistent Mental Illness (SPMI) and children with Serious Emotional Disturbance (SED). Members enrolled in this service receive integrated, intensive care management of mental and physical health needs; assistance with transitions of care between residential, community-based, and/or hospital settings; peer supports; and other services. Each BHH organization partners with one or more primary care Health Home practices to achieve the relationships and systems necessary for truly integrated care provision.

Behavioral Health Homes began implementation on April 1, 2014. 24 BHHOs with about 80 individual sites will be participating. The Department is targeting 5,000 enrollees for this first year. While a small population, the members represent some of the highest-need MaineCare members. Individuals with SPMI die, on average, 25 years earlier than the rest of the population. They often suffer from poor physical health in addition to their mental health and substance abuse issues, and account for a disproportionate share of MaineCare costs.

Behavioral Health Homes will result in such improvements as:

- Vastly improved coordination between mental health and physical health providers, including BHH organization use of Electronic Health Records and the Health Information Exchange;
- Reductions in inpatient readmissions;
- Less non-emergent Emergency Department use;

- Improved self-management of diabetes and other chronic conditions;
- Provision of peer and family supports.

Behavioral Health HIT Reimbursement Grant - HealthInfoNet (HIN) will use SIM funding to support behavioral health organizations with reimbursements towards improving Electronic Health Records technology and participation in health information exchange (HIE). HIN will also support behavioral health organizations in their measurement of quality of care using their interoperable data. The goal is to add up to 20 new behavioral health organizations to HIN's HIE by 2016.

Provide QI Support for Behavioral Health Homes Learning Collaborative - MaineCare Behavioral Health Homes Initiative Behavioral Health Homes Learning Collaborative: Maine Quality Counts will support a Learning Collaborative for 27 Behavioral Health Home organizations. The Learning Collaborative will offer practitioners the opportunity to come together in a structured way to learn from national, state, and local experts and from each other to improve the quality of services they provide. The BHH Learning Collaborative will focus on evidence-based best practices to improve the integration of behavioral and physical health services to improve care for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED). Additionally, the Collaborative will seek to identify best practices that can help BHHOs enhance coordination of care and bring about improvements and efficiencies that will help to decrease costs. The Learning Collaborative will incorporate provider and consumer perspectives and will present evidence-based and emerging best practices to participants for shared learning. Participants will be involved in a series of meetings to learn about best practices in chosen areas, quality improvement methods, and change ideas, and to engage in peer learning where participants share experiences on what has worked in their settings. Quality Counts will offer three day-long Learning Sessions per year as well as conduct site visits to assess baseline; hold webinars to share best practices and innovative approaches; and provide technical assistance as needed.

Provide Learning Collaborative for MaineCare Health Homes - Maine Quality Counts (QC) will be providing quality improvement support to 80 primary care practices participating in the MaineCare Health Homes (HH) initiative by providing direct outreach and support, as well as bringing these HH practices into the PCMH Learning Collaborative. This support includes conducting a baseline onsite assessment of each HH practice to assess the degree to which they have implemented the PCMH Core Expectations, as well as ongoing support provided by a QC Quality Improvement Specialist. The PCMH/HH Learning Collaborative also includes two to three day-long central Learning Sessions, as well as two regional meetings annually that bring practice teams together to learn from national and local experts and to share best practices on implementing the PCMH/HHs model of care.

Connect Behavioral Health organizations to the Health Information Exchange - HealthInfoNet aims to connect up to ten Behavioral Health organization's medical records systems to begin to collect data to incorporate into the current HIE which has been limited to non-behavioral health data.

Strategic Pillar #3: Develop New Workforce Models

The Maine State Innovation Model award is funding the following efforts to develop new workforce models:

Community Health Workers Pilot - Maine's Community Health Worker (CHW) initiative will develop a system of CHWs as part of Maine's transformed healthcare system. CHWs engage underserved populations by:

- providing culturally appropriate health education and outreach;
- linking individuals, communities, healthcare providers and social services;
- assuring people can access the services they need.

Research demonstrates that CHWs help improve health outcomes and reduce costs. Five SIM-funded CHW pilots will:

- Demonstrate the value of integrating CHWs into the local health care team;
- Provide models for state-wide replication;
- Build a core group of experienced CHWs who can provide leadership for ongoing development of the system.

Provide QI Support for Behavioral Health Homes Learning Collaborative – As noted in Strategic Pillar #2, Maine Quality Counts will support a Learning Collaborative for 27 Behavioral Health Home organizations. The Learning Collaborative will offer practitioners the opportunity to come together in a structured way to learn from national, state, and local experts and from each other to improve the quality of services they provide. The BHH Learning Collaborative will focus on evidence-based best practices to improve the integration of behavioral and physical health services to improve care for adults with Serious Mental Illness (SMI) and children with Serious Emotional Disturbance (SED). Additionally, the Collaborative will seek to identify best practices that can help BHH organizations enhance coordination of care and bring about improvements and efficiencies that will help to decrease costs. The Learning Collaborative will incorporate provider and consumer perspectives and will present evidence-based and emerging best practices to participants for shared learning. Participants will be involved in a series of meetings to learn about best practices in chosen areas, quality improvement methods, and change ideas, and to engage in peer learning where participants share experiences on what has worked in their settings. Quality Counts will offer three day-long Learning Sessions per year as well as conduct site visits to assess baseline; hold webinars to share best practices and innovative approaches; and provide technical assistance as needed.

Public Reporting for Quality Improvement & Payment Reform - We know that what gets measured gets improved, so in an effort to strengthen the quality and lower the cost of healthcare in Maine, the State Innovation Model award will provide additional funding to develop new quality and cost metrics that will be publicly reported on the Maine Health Management Coalition's website, www.getbettermaine.org. Patients will be encouraged to use the information to find top performing doctors and hospitals, and employers will be encouraged to use the information in their benefit designs.

Strategic Pillar #4: Support Development of New Payment Models

Implement MaineCare Accountable Communities – As noted in Strategic Pillar #1, through the MaineCare Accountable Communities Initiative, the Department will engage in shared savings arrangements with provider organizations that commit to coordinating the care of all patients who rely on those organizations as their point of access to healthcare services. Accountable Communities that demonstrate cost savings and meet quality performance benchmarks will share in savings generated under the model.

Six Accountable Communities have applied to participate in the first round of the initiative. The Department is working on rulemaking with the Attorney General's Office. An estimated 50,000 members will be attributed through these Accountable Communities in 2014. An additional 25,000 members, while not directly attributed, receive some of their care through these Accountable Communities and will also benefit from improved systems of care coordination. In whole, almost 30% of the MaineCare population will benefit from the Accountable Communities Initiative in this first round.
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- Increased investment in care management for members with chronic conditions, and
- More emphasis on preventive care

Provide Learning Collaborative for MaineCare Health Homes – Strategic Pillar #2 outlined how Maine Quality Counts (QC) will be providing quality improvement support to 80 primary care practices participating in the MaineCare Health Homes (HH) initiative by providing direct outreach and support, as well as bringing these HH practices into the PCMH Learning Collaborative. This support includes conducting a baseline onsite assessment of each HH practice to assess the degree to which they have implemented the PCMH Core Expectations, as well as ongoing support provided by a QC Quality Improvement Specialist. The PCMH/HH Learning Collaborative also includes two to three day-long central Learning Sessions, as well as two regional meetings annually that bring practice teams together to learn from national and local experts and to share best practices on implementing the PCMH/HHs model of care.

Provider Practice Reports - Provider Practice Reports, as described in Strategic Pillar #1, offer healthcare providers valuable insight into how well their practice is performing on key cost and quality metrics. The reports give providers insight into which areas they are performing well in, and which areas are in need of improvement.

Public Reporting for Quality Improvement & Payment Reform - We know that what gets measured gets improved, so in an effort to strengthen the quality and lower the cost of healthcare in Maine, the State Innovation Model award will provide additional funding to

develop new quality and cost metrics that will be publicly reported on the Maine Health Management Coalition's website, www.getbettermaine.org. Patients will be encouraged to use the information to find top performing doctors and hospitals, and employers will be encouraged to use the information in their benefit designs.

Stimulate Value-Based Insurance Design (VBID) - One of the reasons the US healthcare system is the most expensive in the world is because our current "fee-for-service" system incentivizes high volume, high cost care. At most hospitals and medical practices around the country, doctors are paid based on the number of services provided, not for making patients healthy. One way the State hopes to impact high healthcare costs is by changing the incentives in the market and aligning costs with the relative value of healthcare services. Value-Based Insurance Design is a form of health benefit design that provides incentives to consumers/patients that opt for care that is both high quality and low cost. It also incentivizes healthcare providers to choose lower cost care options when a range of equally effective approaches to care are available for a given patient.

To explore VBID in more detail and assess its potential for increasing healthcare value in Maine, the Maine Health Management Coalition (MHMC) convenes the VBID Workgroup. Facilitated by the MHMC's VBID Manager, the workgroup is charged with examining VBID examples around the country and identifying best practices in a value-based insurance design. They are also responsible for creating a means to rank insurance plans according to adopted VBID metrics, and encouraging Maine businesses to adopt the new benefit model.

Diabetes Prevention - The National Diabetes Prevention Program (NDPP), an evidence-based lifestyle change program focused on the prevention of Type 2 diabetes, has been proven to help people at high risk for type 2 diabetes prevent or significantly delay the disease by making modest lifestyle changes. Maine CDC and SIM grant partners are working with payers to test how this program can improve health outcomes and reduce healthcare costs when applied to Value Based Insurance Design (VBID), Patient Centered Medical Home (PCMH), and Accountable Care Organizations (ACO). If successful, this project will demonstrate the value of integrating NDPP into Maine's transformed healthcare system.

Strategic Pillar #5: Use Centralized Data and Analysis to Drive Change

The Maine State Innovation Model award is funding the following efforts to centralize data and analytics (see also Strategic Pillars #2 and #4):

Public Reporting for Quality Improvement & Payment Reform - We know that what gets measured gets improved, so in an effort to strengthen the quality and lower the cost of healthcare in Maine, the State Innovation Model award will provide additional funding to develop new quality and cost metrics that will be publicly reported on the Maine Health Management Coalition's website, www.getbettermaine.org. Patients will be encouraged to use the information to find top performing doctors and hospitals, and employers will be encouraged to use the information in their benefit designs.

Provider Practice Reports – Strategic Pillars #1 and #4 have described how practice reports offer healthcare providers valuable insight into how well their practice is performing on key cost and quality metrics. The reports give providers insight into which areas they are performing well in, and which areas are in need of improvement.

MaineCare Notification Project - Currently, MaineCare Care Managers receive Emergency Department (ED) and inpatient discharge summary reports for their members from the treating hospital via fax as requested. HealthInfoNet (HIN) will automate this process between the hospitals and MaineCare, on the hospitals behalf, using the Health Information Exchange. HIN will provide MaineCare Care Managers real-time electronic "notifications" using secure email of these events of care. The new electronic process aims to create a more efficient workflow for both the hospital and MaineCare staff while supporting MaineCare member's best possible care.

Tracking Cost of Care - We know that there is significant variation in the cost of healthcare services around the state of Maine, but without transparent pricing information it is impossible for consumers and businesses to know which practices and hospitals are offering the most competitive rates. This lack of transparency, and thus lack of competition, is one of the primary drivers behind Maine's high healthcare costs.

To address the high costs and lack of transparency, the Maine Health Management Coalition will convene the Cost of Care Work Group. The Cost of Care Work Group is a multi-stakeholder group that will analyze health care cost drivers in Maine and identify actionable strategies to reduce health care costs while preserving or improving quality. The group will include purchasers, providers, health plans, and consumers, and will meet monthly.

Additionally, the Maine Health Management Coalition will produce a Healthcare Cost "Fact Book" that will be made available to the general public. The fact book will provide information regarding the cost of care in Maine and identify those areas of highest costs.

While this work is being carried out, the Coalition will hold periodic summit meetings of Chief Executive Officers from Maine's business community to brief them on the findings of the Cost of Care Work Group and Healthcare Cost Fact Book

Strategic Pillar #6: Engage People and Communities

Patient Portal Pilot – While critical to strengthening primary care, the patient portal pilot will allow one Health Information Exchange (HIE) health care organization to provide their patients with access to their statewide Health Information Exchange (HIE) record in partnership with HIN. The pilot site must be able to connect their current "Patient Portal" to the HIE to allow patients to download a medical record summary document from the HIE known as the "Continuity of Care Document" (CCD).

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Research demonstrates that CHWs help improve health outcomes and reduce costs. Five SIM-funded CHW pilots will:

- Demonstrate the value of integrating CHWs into the health care team;
- Provide models for state-wide replication;
- Build a core group of experienced CHWs who can provide leadership for ongoing development of the system.

Consumer Engagement & Education Around Payment and System Delivery Reform – Engaging patients in payment and delivery system reform is crucial. As the end users of our healthcare system, patients will be the ones that ultimately accept or deny the changes taking place. Because some of the reforms might be construed as negative by patients, like the use of narrow networks in Value-Based Insurance Designs, the Maine Health Management Coalition will be spearheading a consumer engagement campaign in inform the public of what is changing and why it is important. They will produce videos, print materials, and will engage consumer advocates, Area Agency on Aging advisors, navigators, free care providers, brokers, human resource specialists, and Maine payer staff in trainings so that they better understand the changes taking place.

Figure 2: SIM Strategic Framework

Maine SIM Strategic Framework

Strengthen Primary Care	Weight	Integrate Physical and Behavioral Health	Weight	Develop New Workforce Models	Weight	Develop New Payment Models	Weight	Centralize Data & Analysis	Weight	Engage People & Communities	Weight
MaineCare Objective 1:	5	**MaineCare Objective 2:**	5	**MHMC Objective 3:**	5	**MHMC Objective 3:**	5	**MHMC Objective 1:**	5	**Maine CDC Objective 1:**	3
Implement MaineCare Accountable Communities Shared Savings ACO Initiative		Implement MaineCare Behavioral Health Homes Initiative		Public Reporting for Quality Improvement and Payment Reform		Public Reporting for Quality Improvement and Payment Reform		Track Healthcare Costs to influence market forces and inform policy		NDPP: Implementation of the National Diabetes Prevention Program (NDPP)	
QC Objective 1:	4	**HIN Objective 2:**	4	**QC Objective 1:**	4	**MaineCare Objective 1:**	5	**MHMC Objective 3:**	5	**Maine CDC Objective 2:**	2
Provide learning collaborative for MaineCare Health Homes		Through a RFP process, HIN will select 20 qualified Behavioral Health organizations to provide $70,000 each towards their EHR investments including their ability to measure quality.		Provide learning collaborative for MaineCare Health Homes		Implement MaineCare Accountable Communities Shared Savings ACO Initiative		Public Reporting for Quality Improvement and Payment Reform		Community Health Workers Pilot Project	
HIN Objective 1:	3	**HIN Objective 3:**	4	**QC Objective 3:**	4	**MHMC Objective 2:**	4	**HIN Objective 1:**	3	**MHMC Objective 6:**	2
HIN's Health Information Exchange (HIE) data will support both MaineCare and provider Care Management of ED and Inpatient utilization by sending automated email's to Care Managers to notify them of a patient's visit along with associated medical record documents.		Connect Behavioral Health providers to HIN's Health Information Exchange		Provide QI Support for Behavioral Health Homes Learning Collaborative		Stimulate Value Based Insurance Design		HIN's Health Information Exchange (HIE) data will support both MaineCare and provider Care Management of ED and Inpatient utilization by sending automated email's to Care Managers to notify them of a patient's visit along with associated medical record documents.		Consumer engagement and education regarding payment and system delivery reform	
MHMC Objective 4:	3	**QC Objective 3:**	3	**MaineCare Objective 3:**	3	**MHMC Objective 5:**	3	**HIN Objective 4:**	2	**HIN Objective 5:**	1
Provide Primary Care Providers access to claims data for their patient panels (portals)		Provide QI Support for Behavioral Health Homes Learning Collaborative		Develop and implement Physical Health Integration workforce development component to Mental Health Rehabilitation Technician/Community (MHRT/C) Certification curriculum.6		Provide practice reports reflecting practice performance on outcomes measures		HIN will provide MaineCare with a web-based analytics tool referred to as a "Dashboard". The Dashboard will combine the current real-time clinical HIE data with MaineCare's claim's data. This is the first test of Maine's HIE to support a "payer" using clinical EHR data.		HIN will provide patients with access to their HIE medical record by connecting a Provider's "Patient Portal" to the HIE. The patient will access the HIE record via a "blue button" in their local patient portal environment.	
MHMC Objective 5:	3	**QC Objective 1:**	5	**Maine CDC Objective 2:**	2	**QC Objective 1:**	4			**QC Objective 4:**	1
Provide practice reports reflecting practice performance on outcomes measures		Provide learning collaborative for MaineCare Health Homes		Community Health Workers Pilot Project		Provide learning collaborative for MaineCare Health Homes				Provide QI Support for Patient-Provider Partnership Pilots (P3 Pilots)	
MaineCare Objective 4:	2	**QC Objective 4:**	1			**Maine CDC Objective 1:**	3				
Provide training to Primary Care Practices on serving youth and adults with Autism Spectrum Disorder and Intellectual Disabilities.		Provide QI Support for Patient-Provider Partnership Pilots (P3 Pilots)				NDPP: Implementation of the National Diabetes Prevention Program (NDPP)					
QC Objective 4:	1										
Provide QI Support for Patient-Provider Partnership Pilots (P3 Pilots)											

Legend	Maine Care	Maine CDC	Maine Health Management Coalition	HealthInfoNet	Quality Counts

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Project Drivers: A Diagram of Health Care Innovations

Maine is forging new paths in health and social systems that are steeped in tradition and self-preservation. Advancing a reform agenda in this environment requires clear explanations of what we're doing and what difference it can make in our lives; we need to guide current thinking of "cause and effect" with a new hypothesis for sustainable change that is readily understood. Using the visual model of a *Driver Diagram*, Maine has organized its SIM Health Care Reform Efforts into logical sequences and groupings of actions that show how strategies move the drivers to achieve the Triple Aim goals.

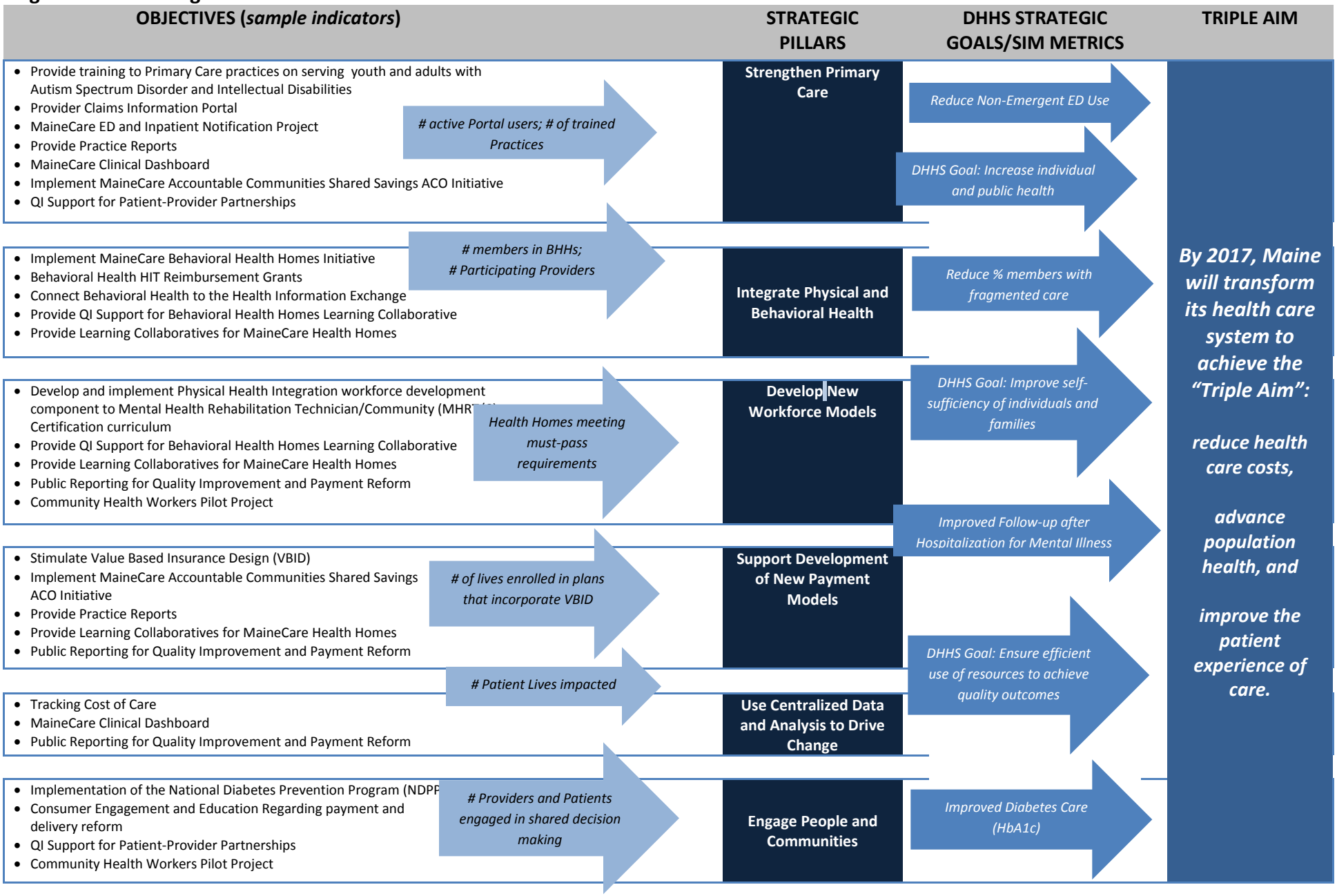
Constructing a driver diagram at the start of an initiative, especially one as multi-levered as Maine's Health Care Innovation Model, provides all partners with the scope of the work, where to focus monitoring of interventions, and which metrics to use for measuring change. Aims and driver diagrams are concrete ways to keep all partners focused on the work, and offer points of reference for improvement and course corrections as data is analyzed.

Aims are ambitious, yet attainable goals that focus the improvement efforts. As the Center for Medicare and Medicaid Innovation (CMMI) notes, an aim should be "specific, measurable, and time-bound."[2] Primary drivers are those system components or factors which contribute directly to achieving the measurable aims. They are the congregate movers resulting from the interventions and actions, or secondary drivers, taken by partners with a shared agenda. Secondary drivers often provide useful short-term measures that move the needle for longer-lasting, sustainable change. Finally, a useful driver diagram must also illustrate the causal connections between drivers and interventions; *relationship arrows* indicate how interventions can influence multiple drivers.

The driver diagram that follows (Figure 3) provides an overarching representation of the actions and the primary drivers they influence; it is the foundation for Maine's Innovation Model and visually demonstrate how Maine will transform its state's health care to achieve the "Triple Aim" goal: reduce health care costs, advance population health, and improve the experience of care.

[2] Center for Medicare and Medicaid Innovation, 2013.

Figure 3: Driver Diagram



A. Governance

***Refer to DRR Section A: Governance, Management Structure and Decision-making Authority Supporting Documentation Available*:**

Appendices A1- A11 can be found in Year One Plan Submission on this website: http://www.maine.gov/dhhs/sim/documents/SIM%20docs/plan%20docs/ops%20plan/MaineSIMOperationsPlanAppendicesA-B-C.pdf

1. Governor's Office

Governor Paul LePage is committed to reforming health care in Maine and has dedicated staffing at the Executive level and Cabinet level reporting directly to him with specific and significant involvement in the Maine SIM project. Within his office at the State Capitol, Holly Lusk, Senior Health Policy Advisor, serves as the conduit for project operations, assuring the alignment of the project goals with the policy objectives of the Executive Branch. Ms. Lusk functions to communicate constituency concerns or suggestions regarding health care that are addressed to the Governor's office. In addition, Ms. Lusk chairs the grant's Maine Leadership Team, which holds responsibility for policies, changes to the work plan, major shifts in resource allocation, and decisions requiring senior authority. The Maine Leadership Team is described in greater detail in Section 2 Governance/Management Structure.

In the fall of 2012, Governor LePage designated Mary Mayhew, Commissioner of the Maine Department of Health & Human Services, as the Principal Contact for the project. Ms. Mayhew is responsible for overall project oversight and implementation. As a member of the Governor's Cabinet, Commissioner Mayhew translates the Administration's strategic objectives into concrete personnel, financial, and regulatory operations of the Health and Human Services department. In turn, she keeps the Governor apprised of progress and opportunities. Finally, the Governor has granted Ms. Mayhew appointing authority for Steering Committee and Leadership Team membership.

2. Governance/Management Structure

The Maine SIM governance structure was constructed to designate clear roles and functions among state and stakeholder partners, maximize stakeholder involvement, and optimize communication and collaboration. This structure is grouped into three levels of checks and balances among program, participant, and regulatory representatives, each of which is a checkpoint for project accountability. At the helm of the Maine Innovation Model project is the Maine Leadership Team. Reporting to the Leadership Team is Program Director, Randal Chenard, and the Steering Committee, all of whom were appointed by Commissioner Mayhew. Reporting to the Steering Committee are three subcommittees and the evaluation consortium, each of which is focused on one of the primary drivers for the Triple Aim goals. Figure 4 shows the reporting and communication lines of these bodies.

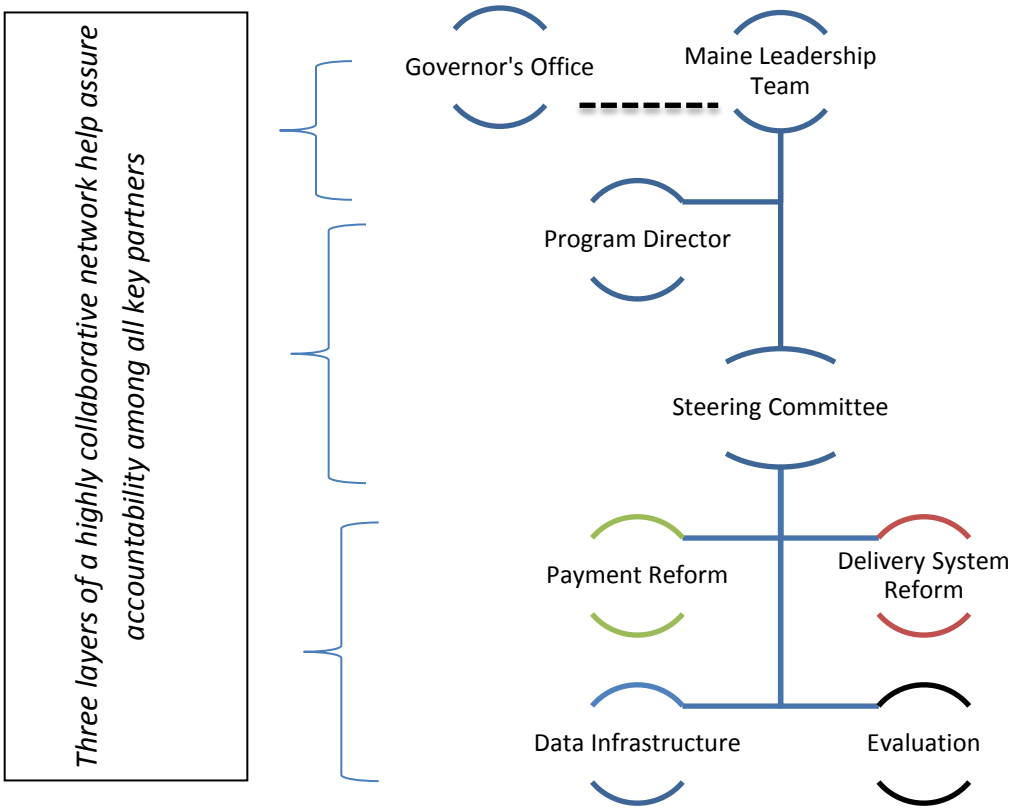


Figure 4: Maine SIM Governance Structure

SIM Grant Maine Leadership Team

The Maine Leadership Team has responsibility for policies, changes to the work plan, major shifts in resource allocation, and decisions requiring senior authority. Chaired by the Governor's Office, this group has the ultimate authority to make project changes and decisions. The Program Director reports directly to the Leadership Team at regularly scheduled meetings. The Maine Leadership Team receives reports from the Steering Committee and provides actions or guidance as necessary as a third level of accountability.

Members of the Grant Maine Leadership Team have been appointed by Commissioner Mayhew. Members include: Representative Terry Hayes (Legislator); Senator Michael Thibodeau (Legislator); Commissioner Anne Head (Dept. of Professional & Financial Regulations); Deputy Director James Leonard (Office of MaineCare Services); Commissioner Mary Mayhew (Dept. of Health & Human Services); Director Stefanie Nadeau (Office of MaineCare Services); Commissioner Richard Rosen (Dept. of Administrative and Financial Services); David Simsarian (Dept. of Health & Human Services); Tribal Representation (Pending Appointment); and MaineCare Medical Director Dr. Kevin Flanigan (Steering Committee Chair).

Maine SIM Steering Committee

The Steering Committee includes representation from a broad range of stakeholders, ranging from the state's Insurance regulatory body to Medicaid membership. The project's Steering Committee Chair reports bi-annual basis to the Governor and his Cabinet on the status of the SIM work and expectations for the next six months.

Steering Committee Appointments and Sectors Represented are:

- **Legislators**: Representatives Richard Malaby and Matthew Petersen
- **Tribal Nations:** Lisa Sockabasin (DHHS, Maine CDC Office of Health Equity)
- **Medicaid:** Stefanie Nadeau, Director, Office of MaineCare Services (OMS), Maine DHHS; Dr. Kevin Flanigan, MD, Medical Director, OMS; Rose Strout, MaineCare Member
- **Hospitals:** Katie Fullam-Harris, Vice President, Govt. & Emp. Relations, MaineHealth; Rebecca Arsenault, President and CEO, Franklin Community Health Network
- **Primary Care:** Dr. Noah Nesin, MD, FAAFP, Chief Quality Officer, Penobscot Community Health Center; Rhonda Selvin, APRN, C-NP, President, Maine Nurse Practitioner Association, Wiscasset Family Medicine
- **Behavioral Health:** Dale Hamilton, Executive Director, Community Health and Counseling Services, representing Maine Assoc. for Mental Health Services; Lynn Duby, CEO, Crisis and Counseling Centers
- **Commercial Payer:** Kristine Ossenfort, Anthem
- **Self-Insured Employer:** Penny Townsend, Wellness Manager, Cianbro
- **Long Term Care:** Sara Sylvester, Administrator, Genesis Healthcare Oak Grove Center
- **Health Information Exchange:** Shaun Alfreds, COO, HealthInfoNet
- **Insurance Regulator:** Eric Cioppa, Superintendent, Bureau of Insurance
- **Quality Monitoring:** Dr. Lisa Letourneau, MD, Maine Quality Counts; Jay Yoe, PhD, DHHS – Continuous Quality Improvement
- **Employers:** Andy Webber, CEO, Maine Health Management Coalition
- **CMS/CMMI:** Dr. Fran Jensen, MD, Centers for Medicare & Medicaid Service (Maryland)
- **Maine CDC**: Deb Wigand, Director, Division of Population Health, DHHS, Maine CDC
- **Patient Advocacy**: Jack Comart, Litigation Director, Maine Equal Justice Partners
- **SIM Program**: Randy Chenard, SIM Program Director, DHHS – SIM Program

The Steering Committee will oversee three permanent subcommittees and at least one ad hoc subcommittee, including:

- Payment Reform, coordinated by project partner, Maine Health Management Coalition;
- Delivery System Reform, coordinated by project partner, Quality Counts;
- Data Infrastructure, coordinated by project partner, HealthInfoNet; and
- Project Evaluation, supported by DHHS's Quality Improvement Director, Dr. Jay Yoe

Contractual Support

The state will provide the mechanisms for oversight of the contractual relationships supporting SIM work. Program oversight is the responsibility of the Program Director and contract management falls under the realm of the Division of Contract Management within the DHHS. The three key partners – Maine Health Management Coalition, Quality Counts, and HealthInfoNet - have key deliverables and work responsibilities written into their respective contracts. All other vendors will be selected through a Request for Proposal (RFP) process and be held to similar standard quarterly deliverable and financial reporting requirements.

3. Private/public Coordination of Efforts

Maine's Innovation Model was constructed to be a public/private venture. Coordination of efforts is facilitated by clear plans for communication, governance, management and decision making authority; it is further enhanced by sharing those plans.

The implementation phase was heralded by state press releases and publishing of the grant application on the state's website. State DHHS employees were notified as part of regular correspondence from the Commissioner, which linked the value added from the project to ongoing state improvement efforts in related public health, substance use, and social services offices. Following the selection of the Program Director, four forums were held in locations across the state to explain the state's Innovation Model to both the public and the broader health care community, including providers and payers. Two forums were accessible through webinars. The forums provided information about the SIM grant, current and future MaineCare initiatives that are part of SIM, the deliverables for key partners, and the project governance model.

Stakeholders are engaged in governance at the decision-making level through representation on the Steering Committee and participation in the subcommittees and workgroups. The kind of coordination needed by SIM has been modeled in part already by Maine's multi-payer Patient Centered Medical Home (PCMH) Pilot which involves primary care providers, Medicare (through the Centers for Medicaid and Medicare Services (CMS) Multi-payer Advanced Patient Care Practice (MAPCP) Demonstration), MaineCare (Maine's Medicaid program), and private insurers, and is being led by Quality Counts, one of the state's key SIM partners.

Included in our model is a close working relationship to the state health agency, the Maine Center for Disease Control (Maine CDC), located within DHHS, which houses several federally funded programs, including those from the Centers for Disease Control, Health Resources and Services Administration (HRSA), and the Office of Minority Health found in the Office of Health

Equity, the Office of Rural Health and Primary Care, and the Division of Population Health. Dr. Sheila Pinette, Maine CDC Director, has committed the Maine CDC to coordinate across all public health offices directly through Debra Wigand, Division Director of Population Health. Ms. Wigand, as a member of the Steering Committee and core member of the SIM team, assures the integration of appropriate public health programs.

Maine SIM work explicitly includes public health integration through the Maine CDC Division of Chronic Disease through workforce development and testing of prevention interventions and outreach via the National Diabetes Prevention Program (NDPP) and the Community Health Worker Pilot. . As this program evolves and becomes more visible, Maine anticipates additional connections with health promotion initiatives related to early childhood, nutrition, physical activity, obesity, cardiovascular, and cancer interventions as well as connections to the nine public health districts and various geographic areas of the state.

Semi-annual presentations by the Steering Committee Chairman at Governor Cabinet meetings provide the opportunity to report on progress as well as to present areas of potential engagement or projects for the other governmental departments to pursue.

Since its inception in Maine, SIM has already helped to drive changes within state government to pursue a more systemic approach to coordination, resource maximization, and alignment among programs that have historically operated independently. SIM now has the benefit of a Strategic Reform Coordinator (SRC), whose primary function is the execution of government strategies for complex and/or cross-functional agency-wide initiatives. Housed in the Office of the Commissioner, the SRC partners with the operational areas within the Maine DHHS to understand challenges with strategy and capability, and identify potential synergies across projects, programs, and initiatives. In the first year, the coordination capabilities developed by SIM have become tools embedded in the Department's grant approval process, procurement process improvements, and contract process redesigns.

4. Integration and Alignment

Within Maine DHHS, resources and expertise were reallocated for SIM support as Department directors recognized the interrelationships among existing efforts and the need for congruent and consistent messaging and funding. This offers state members on the Leadership Team and the Steering Committee greater access to governance expertise and improved ability to gauge the impact of critical federal policy priorities during the project period.

Past experience has helped anticipate barriers for service delivery as well. As noted earlier, the Maine Innovation Model builds off of the expansion of the Patient Centered Medical Home (PCMH) Pilot. This foundation facilitates the provision of learning collaboratives, technical assistance and eventual multi-payer enhanced payments for the 85 Health Home practices that currently receive financial reimbursement from MaineCare outside of the multi-payer. This existing model will also aid more global adoption of well-established and accepted quality measures. Using the multi-stakeholder process known as Pathway to Excellence (PTE), Maine

will have a standardized means by which to inform providers and members of the quality of the services delivered.

The SRC works closely with the SIM Program Director to link SIM and department-wide strategies, goals, and objectives; partner with senior management and leadership to propose solutions and standards to address evolving public needs, and ensure that new initiatives are clearly articulated to help agencies see their roles, maximize and leverage existing social, financial, and intellectual resources, and align department priorities. Figure 3 (Driver Diagram) shows the correlations made between the SIM objectives and DHHS strategic priorities.

B. Coordination Among Initiatives

***Refer to DRR Section B: Coordination with Other CMS, HHS, and Federal or Local Initiatives Supporting Documentation Available*:**
Appendices B1- B8 can be found in Year One Plan Submission on this website:
http://www.maine.gov/dhhs/sim/documents/SIM%20docs/plan%20docs/ops%20plan/MaineSIMOperationsPlanAppendicesA-B-C.pdf

Maine's Context for Coordination
Maine's current health system represents a patchwork of hospitals, local health systems, and provider groups, with most primarily reimbursed under a fee for service system that rewards volume rather than value. Maine has 37 acute care hospitals, 16 of which are Critical Access Hospitals in rural areas of the state. Of the 37 acute care hospitals, 19 belong to one of the four major hospital-based health systems that collectively provide care for more than 75% of the population, with each health system led by a flagship teaching hospital (one of which, Maine Medical Center, is university-affiliated). In 2012**,** Maine's physician workforce numbered approximately 4,000 active, licensed physicians; of that total, approximately 40% of which are primary care and 60% specialist physicians.[3] Maine has seen a dramatic movement to hospital-based practice both for primary care and specialist physicians over the past 5-10 years, with an estimated 80 % of physicians now employed by hospitals or health systems. In addition, Maine has a 22 Federally Qualified Health Centers with over 50 practice sites that provide a substantial proportion of primary care services in the state.

Coordination Strategy
Within the context of the patchwork system described above, the Maine State Innovation Model leverages the work of existing health care initiatives and structures to maximize the impact of interventions. The guiding principles of our model are derived from the Triple Aim goals and include six strategic pillars that are reflected throughout the driver diagrams: a comprehensive and strengthened primary care system; integration of behavioral health with primary care; development of new workforce models; value-based payment models; data-informed care and performance feedback; and engaged patients and communities. These strategic pillars and the objectives that support them will be coordinated with the many Federal and local initiatives within the Maine health care environment, including such projects as the Community Transformation Grants (CTGs); the Maine Maternal, Infant, and Early Childhood Home Visiting program (MIECHV), through the Health Resources and Services Administration (HRSA); and Project LAUNCH through the federal Substance Abuse and Mental Health Services Administration (SAMHSA).

Our governance structure assures multi-stakeholder input and engagement through the subcommittees that report up to the Steering Committee. The chairs of the subcommittees

[3] 2013 State Physician Workforce Data Book. American Association of Medical Colleges, Center for Workforce Studies. November 2013. Accessed online July 10, 2014 at https://members.aamc.org/eweb/upload/State%20Physician%20Workforce%20Data%20Book%202013%20(PDF).pdf

(delivery system reform, payment system reform, and data infrastructure) are bringing together leaders from across the health care system to address the reform activities. New connection points will be identified through these subcommittees.

5. Coordination with CMS/HHS/Federal and other CMMI Initiatives

Coordination with CMS/CMMI Accountable Care Organizations (ACOs)

The Accountable Care Implementation (ACI) Committee of the Maine Health Management Coalition is a coordination point for the work being done in SIM around ACOs. This group functions as a learning collaborative for organizations transitioning to multi-stakeholder ACO status. This group has active participation by Maine's largest self-insured employers and payers. Delivery systems participating in shared savings or shared risk arrangements use the ACI Committee to develop solutions, and gain understanding of strategies that work in various parts of Maine with different populations. The group expanded under SIM to incorporate behavioral health and other community organizations that MaineCare sees as key partners in its Accountable Communities Medicaid shared savings model.

The ACI workgroup is much more than a learning collaborative. This multi-stakeholder group of providers, payers and purchasers, is focused on identifying opportunities for improving quality of care and outcomes while reducing cost, and developing and implementing strategies to realize those objectives. This dynamic process considers the problem of quality and cost in a comprehensive manner; it is about much more than simply what providers "do." Payers are at the table in an effort to align their payment strategies in a way that supports providers' efforts to improve quality and reduce cost. Similarly, purchasers are at the table to encourage the alignment of the design of employee benefits to complement the efforts of payers and providers, by building incentives for those they insure to seek out high value, lower cost care. Working through a consensus-based process, ACI is developing a core measure set that the providers and payers agree upon to utilize for specific components of provider accountability and payment. This core measure set will also be vetted through the SIM Payment Reform subcommittee and Steering Committee. Upon approval, ACI will also nominate these same metrics to the PTE Systems workgroup for public reporting. Even if a measure fails to be endorsed by the MHMC Board, it may still be published on the SIM website. The purpose of these metrics is to measure the performance of Maine's health care delivery system with regard to quality and cost of care in a transparent manner. The PTE process tests nominated metrics against a set of basic criteria:

- Measures must be important to measure and report, both from the providers' and the purchasers' perspectives, and must relate to an actionable opportunity to improve quality and/or reduce cost;
- Measures must be reliable and valid; and
- Measures must be able to be implemented via reliance on available data that is retrievable without undue burden.

Maine's SIM model will make every effort to reduce the burden of reporting data for measurement activities. Most measures rely on data that may be obtained from payers; others rely on the reporting requirements that are aligned with Medicare or the State of Maine. Only

when there is no other source of data and when the group decides through its consensus-based process that a measure is critically important, is data collected directly from a provider. The ACI workgroup will coordinate efforts around the public reporting of adopted ACI/systems metrics; the group is also the connection with the VBID workgroup and alignment of desirable benefit designs, with a core set of ACO metrics and aligned payment approaches. Ultimately, the ACI workgroup will be in a position to endorse different payment methodologies, promoting innovation and, simultaneously, a set of practices that have been tested and which meet the consensus standards of the group. Its objective is to create movement in the marketplace from limited shared savings arrangements to more sophisticated and impactful models of payment, supporting purchasers as they leverage their sway with payers to adopt VBID. The ACI workgroup will track the performance of payers and systems as these innovations are adopted and implemented.

The ACI Committee is continually soliciting active involvement of all delivery systems in Maine that are participating in shared savings or shared risk arrangements. It has participation by EMHS, MaineHealth, Central Maine Health Care, and various FQHCs. These providers are also involved with Medicare's Shared Savings and Pioneer ACO Initiatives. Coordinated with the ACI Committee is another Management Coalition group, the Health Care Cost Workgroup and its subcomponent, the Behavioral Health Cost Workgroup. The Health Care Cost Workgroup identifies actionable strategies to reduce health care costs. The ACI Committee, the Health Care Cost Workgroup and the Behavioral Health Cost Workgroup will work together to inform costs and effective care interventions in ACO's statewide.

Coordination with MAPCP, Health Homes, and CMS Advanced Primary Care FQHC Demonstration Initiative

In the medical home model, health care is actively coordinated with and linked to community-based health promotion, behavioral health, and social services. For more than four years, public private efforts have used the medical home model to build a system that recognizes and rewards comprehensive coordinated health care. MaineCare and the Dirigo Health Agency joined Quality Counts and the Maine Health Management Coalition as conveners of the patient centered medical home collaborative. Leadership from these organizations developed and organized strategies to build a foundation for growing the advanced primary care infrastructure in the state.

Maine's enhanced primary care model is supported by technical assistance to PCMH practices, Health Homes, and many FQHC advanced primary care practices. Many of these practices are part of the systems that deliver care through ACO models and are using these practices to achieve better management and outcomes with the populations they are responsible for. Quality Counts has reached out directly to health care systems, associations, practice managers, and practitioners to encourage participation of practices to participate in the advanced primary care learning community via webinars, meetings, and workshops to advance high quality primary care.

A majority of practices in Maine delivering care through the medical home model are participating in Quality Counts meetings and webinars. Coordination of the CMS Multi-payer Advanced Primary Care Practice Demonstration (MAPCP) and MaineCare Health Homes initiatives occurs through monthly "Conveners' Meetings" between Quality Counts, the Maine Health Management Coalition, Dirigo Health, and MaineCare, focused on challenges experienced in the MAPCP and Health Home Initiatives. Medical homes do not exist in a vacuum; they are integral to ACOs, whether they are part of a larger system or they comprise their own system. Maine SIM envisions coordination of the medical home work with ACI efforts related to aligning payment approaches and measuring and tracking performance to capitalize on the momentum gained from the SIM initiative.

6. Coordination with Local Initiatives

Maine's SIM governance structure provides a formal avenue for assuring coordination of our SIM plan with related initiatives in the state. At the state level, the Program Director is key and meets regularly with the three subcommittee chairs.

The Delivery System Reform subcommittee is being led by the Lisa Tuttle, Project Manager, Maine Quality Counts, under the direction of the CEO of Maine Quality Counts, Lisa Letourneau, M.D., MPH. Formed in 2003 and incorporated in 2006, Maine Quality Counts is a Regional Health Improvement Collaborative (RHIC) that is committed to working with state agencies and other key stakeholders in Maine to improve quality and to promote public reporting of performance, consumer engagement and information sharing.

Maine has municipal health departments; one in Bangor and the other in Portland. The Maine CDC is connected to these two local public departments in addition to a statewide network of nine public health districts. Inclusion of Maine CDC as the connection to public health provides the most effective and efficient use of resources, assuring both inclusion of appropriate resources while avoiding duplication of services. SIM is a standing agenda item at the weekly Maine CDC Senior Management Team meeting. The Program Director will assure coordination with the Maine CDC and the Maine Hospital Association to include acute care institutions related to community benefit programs in conjunction with delivery system reform activities in both the subcommittee and Steering Committee of SIM.

The state partnership with the Maine Health Management Coalition Foundation (MHMC/F) provides an effective pathway to working with employers and health systems, as the larger employers and all health systems actively participate in MHMC activities, including the PTE process and the ACI process. Similarly, these constituents will be important participants in the Health Care Cost workgroups. SIM is a standing agenda item of the MHMC and the organization has been working with its members on strategic linkages to various health care related initiatives to assure efficient resource use and coordination.

There are currently some gaps that exist to connect with local initiatives, particularly the smaller, but powerful demonstration projects that are poised for potential acceleration of SIM values or are yielding impressive results. The Strategic Reform Coordinator will help assure that

these efforts inform and are informed by SIM. As an example, Quality Counts began working with the Maine Early Childhood Comprehensive Systems Initiative, a HRSA Maternal and Child Health-funded effort, to craft a proposal and workplan to integrate developmental screening for children birth to age three. The plan includes many of the same kinds of drivers employed by SIM: workforce development, data to drive consumer and practice improvements, and enhanced payments. While not part of the original proposal submitted by the state in Fall 2012, this effort will supplement the work of SIM as a micro-system focused on children with application for the broader reform movement.

Another local initiative, Maine's Project LAUNCH, located in Washington County, has had a rigorous evaluation of its innovative efforts to bridge health promotion professionals and the clinical health workforce. Final year evaluation results indicated dramatic reduction in length of NICU stay for vulnerable newborns and the near-elimination of hospital re-admissions for those same families. The cost benefit analysis from that project included an in-depth review of the impact of local community collaboration and can be an important component of the SIM quality improvement process.

The SIM Strategic Framework, as described and illustrated in the Maine SIM Hypothesis section of this plan, purposefully aligns current initiatives and assesses future initiatives for strategic alignment.

7. Integration with Existing Authorities

Maine's SIM test involves MaineCare's Behavioral Health Homes and Accountable Communities Initiatives in four principal ways:

1. Analytic Supports: The provision of analytic supports and reports for participating providers under these initiatives that are integrated and aligned with supports and reports developed for other payers under SIM.
2. Learning Collaboratives: The establishment of learning collaboratives to support payment reform and delivery system transformation for multi-payer ACOs and practice transformation efforts, including Accountable Communities and Behavioral Health Homes
3. Alignment of Measures: The multi-payer alignment of quality and cost measures for purposes of public reporting and value-based payment design.
4. Behavioral Health EHR Incentive: For Behavioral Health Homes, the identification of the Behavioral Health Home Organizations that will receive prioritization under the EHR Incentive Program RFP.

MaineCare received approval from CMS through a State Plan Amendment, effective 1/1/2013 for its Stage A Health Homes initiative. The state has finalized its Stage B Behavioral Health Homes State Plan Amendment and submitted a draft version to CMS in August 2013 with an anticipated final submission in September 2013. The Stage B Health Home Initiative was implemented in April 2014. Please refer to Appendix B7 in Year One Plan for this documentation.

The Accountable Communities Initiative is anticipated to launch in August of 2014. An actuarial analysis to determine the per member per month projected costs and attribution of members to providers has been in progress for over 12 months by Deloitte, and will be concluding by the end of summer, 2014. A concept paper, CMS Integrated Care Model (ICM)"toolkit" and draft shared savings methodology for the Accountable Care Communities Initiative have been shared with CMS and meetings are ongoing to discuss the process and approach the state will take with requesting an amendment to our state plan to launch the initiative.

Aside from these two initiatives, Health Homes Stage B and Accountable Communities, there are no other anticipated modifications to the State Plan. In the absence of indications of problems with the SPAs as formally submitted, the State plans to implement in accordance with its planned timelines even if the SPAs are not yet officially approved. Accordingly, a delay in the approval of the SPA that was significant enough to cause the State to delay implementation would impact the SIM test in the following ways:

1. Analytic Supports: analytic supports and reports for Accountable Communities and Behavioral Health Homes will not be delivered prior to implementation of these initiatives. Delay in implementation would also, therefore, delay the issuance of these reports. Work on the development and refinement of critical AC methodologies related to member attribution and baseline Per Member Per Month figures was necessarily begun months before the planned implementation date. This work is very resource intensive and must be deliberately and carefully thought through and subject to rigorous replication testing. This fundamental work is intended to ensure that reporting to participating providers and subsequent calculations of pmpm costs are reliable. In addition, for many providers, the reports and functionality for Accountable Communities and Behavioral Health Homes will be largely additive in function to reports they will already be receiving under the Stage A Health Homes and multi-payer PCMH pilot. In other words, the reports for Accountable Communities and Behavioral Health Homes will build off the infrastructure, metrics, portal and formatting utilized for the Health Homes/ PCMH reports. The differences will lie in the potential addition of certain measures, the specific population being reported on, and, for Behavioral Health Homes, the inclusion of Behavioral Health Home Organizations (in addition to the partnering Health Home practices that will largely be the same as those in Stage A) in the receipt of the reports.
2. Learning Collaboratives: The Accountable Care Implementation (ACI) workgroup receiving support under SIM to continue under expanded scope will be a powerful tool for the Accountable Communities Initiative both leading up to and after implementation. The group is an important sounding board as the State finalizes its Accountable Communities model in order to further that alignment, and will provide valuable input to the SIM Payment Reform Subcommittee and Steering Committee discussions. Once Accountable Communities applicants are selected (currently projected for December), the group also plays a role in education and capacity building for the Accountable Communities prior to implementation. Accountable Communities will be required to participate in the ACI workgroup; as such, the State anticipated that the constituency of the ACI workgroup will expand both in numbers and scope of services.

While this will occur to a degree prior to implementation of Accountable Communities, the largest impact will be evident post-implementation.
The Behavioral Health Homes Learning Collaborative provider plays an important role in provider readiness in the two months' prior to implementation, as Maine Quality Counts did under Health Homes Stage A. A delay in Behavioral Health Homes implementation would also impact pre-implementation readiness activities as well as post-implementation learning under the Collaborative.

3. Alignment of Measures: As stated in regards to ACI, there is on-going work to develop a set of standard core ACO metrics that stakeholders agree will serve as the "master list" from which measures used for ACO contracting will be drawn. Obviously, certain payers – most notably MaineCare – serve populations with special characteristics that will drive the use of special measures that will not be particularly relevant for others. This is expected, but efforts will be made to minimize the proliferation of payer-specific measures to maximize ability to compare performance across ACOs. The work of achieving alignment with MaineCare Accountable Communities quality metrics will largely occur pre-implementation. However, operational alignment will not be attained until all payers, including MaineCare, have implemented value-based payment efforts linked to the achievement of quality metrics. MaineCare would not stall this alignment on its own due to any few-month delay in Accountable Communities Implementation, as commercial payers will continue to work on alignment throughout this period.
4. Behavioral Health EHR Incentive: The State prioritized the involvement of qualified Behavioral Health Home Organizations in its Behavioral Health Homes EHR Incentive Program. Behavioral Health Homes do not need to be implemented prior to the selection of providers for the EHR Program; however, Behavioral Health Home Organizations should be selected prior to issuance of the EHR Program RFP.

8. Approval Status of Waivers

N/A

C. Beneficiary Outreach and Recruitment

Refer to DRR Section C: Outreach and Recruitment

Supporting Documentation Available:

Appendices C1- C18 can be found in Year One Plan Submission on this website: http://www.maine.gov/dhhs/sim/documents/SIM%20docs/plan%20docs/ops%20plan/MaineSIMOperationsPlanAppendicesA-B-C.pdf

9. Outreach and Recruitment Program

Maine's SIM stakeholder engagement process employs both direct and indirect approaches to reach critical stakeholders. The State began in earnest meeting with stakeholders statewide through a series of three-hour meetings in Spring 2013 in Northern, Central, and Southern Maine. The SIM Leadership team made multiple presentations to the Commissioner of DHHS and senior leadership about how SIM could be used to benefit the Department's strategic vision (see DHHS mission/strategic vision at http://www.maine.gov/dhhs/aboutus.shtml).

The Partners in Maine's SIM initiative have begun to implement an outreach and recruitment effort. In many ways, Maine's model differs from that being used in other SIM test states. Many aspects of our model are designed to test the power of collaboration and a consensus-building process to realize the goals of the Triple Aim. This approach relies on process more than it does on external regulation or statutes to compel participation. One of the primary processes being employed in Maine is the MHMC Pathways to Excellence, which involves the formation of specific work groups organized around the development of quality metrics focused on physician care and on care provided by health care systems. Under SIM, this work is being substantially extended. The ACI work group is identifying a set of core metrics to benchmark the quality of ACO arrangements developing in the State. A new PTE Behavioral Health work group has been convened to focus on the identification/development of key measures of behavioral health integration and the quality of BH care provided. Finally, two other work groups are focusing on tracking the cost of health care in Maine.

Community Stakeholder Engagement

As mentioned above, building off from provider outreach sessions to obtain support for Maine's SIM application in late summer of 2012, the State of Maine then conducted a series of four regional forums in June 2013 to provide an overview of the SIM model, partners and governance. These forums were well attended by a wide variety of stakeholders, including health systems, behavioral health providers, primary care providers, payers, advocacy organizations, state staff, and purchasers. In addition to these forums, Maine DHHS educated and engaged the state legislature, DHHS leadership and Offices regarding the SIM model, while the state's partners conducted parallel activities with their Boards and other workgroups. DHHS Commissioner Mary Mayhew reached out to professional societies and other stakeholder groups to name representatives to the SIM Steering Committee. As a result of these efforts, Maine has obtained commitment from the following community stakeholders, who have been participating in the Maine SIM Leadership Team and SIM Steering Committee:

- Public health: Maine CDC
- Long Term Services & Support (LTSS): long term care facility provider
- Behavioral Health: two behavioral health providers
- Consumer/ advocacy organizations: Maine Equal Justice Partners, MaineCare member representation
- Community-based organizations: HealthInfoNet, Maine Health Management Coalition, Maine Quality Counts

In addition, the Payment Reform, Delivery System Reform, and Health Information & Analytics Infrastructure Subcommittees include representation from these and other stakeholder groups, including: developmental disabilities, local health departments and additional consumer and community-based organizations. A broad range of providers and purchasers already participate in the MHMC PTE Physician, Systems and ACI work groups. Efforts are currently underway to expand participation in those groups to engage additional purchasers, and to attract consumers to participate in the process in a meaningful way. The chairs manage participation in the subcommittees to ensure appropriate representation from stakeholder groups in alignment with meeting agendas and initiative deliverables under discussion.

For instance, SIM leadership met with the Directors and Management of the Office of Aging and Disability Services (OADS) to coordinate existing OADS plans and developing SIM plans, and in September 2013, named the Director of OADS to the Healthcare Delivery Reform workgroup, The Long Term care Ombudsman has also been added to the Health Care Delivery Reform workgroup. These additions to the governance structure assure input into the course and direction that SIM takes and will influence how LTSS strategies and SIM interact. Additional statewide meetings were held in the Fall of 2013 to provide an update to stakeholders. MHMC has reached out to several mental health provider associations to elicit interest in participation in the new behavioral health PTE work group, convened for its first meeting during the first quarter of the testing grant. It is anticipated that the interest in this effort will be high, likely attracting a core group of more than 25 participants. Demands on participants in these processes are not insignificant; there will be frequent meetings and the work is detailed and complicated, which may erode participation over time. On-going efforts to re-examine and re-tool the PTE process are underway, to ensure the process remains vital and relevant to stakeholders; this is also intended to result in sustained participation in the multiple strands of work over time.

The SIM Project Plan includes accountability targets that address the question of the numbers of providers expected to participate in alternative payment arrangements over the course of the testing period; it also provides counts of providers expected to participate in other aspects of the SIM test, including but not limited to the uptake of provider administrative claims portals, practices adopting the use of practice reports, and the number of participants choosing to adopt EMR as part of HealthInfoNet's behavioral health initiative. The work plan also addresses the number of practices anticipated to apply for status as a MaineCare Behavioral Health Home.

Analysis of Target Population

A number of studies have been conducted over the past few years by Maine DHHS and collaborating entities in order to understand the utilization, cost, and geographic "hot spots" with a focus on Maine's Medicaid population. These include a 2010 study of emergency department use across multiple insurance groups by the Muskie School of Public Service at the University of Southern Maine, a FY09-FY10 **High Utilizer Analysis** for Cumberland, Kennebec, and Penobscot Counties by the Camden Coalition of Healthcare Providers, and an analysis of MaineCare's top 5% highest users done. These studies have informed the Department's work:

- outreaching to high utilizers in collaboration with hospital Emergency Departments;
- collaborating within the Department to better address barriers faced by MaineCare's most expensive patients;
- determining appropriate quality metrics for Maine's Health Homes Initiative and reformed Primary Care Provider Incentive Program; and
- structuring the Health Homes Initiative to mirror the Maine PCMH Pilot's partnership between primary care practices and Community Care Teams to serve high utilizers.

Maine's Delivery System Reform Subcommittee will continue to use these studies to help direct geographic focus of its Community Health Worker Pilot and Community Care Teams, to inform the selection of core metrics, and to determine focus areas for payment reform efforts.

Beneficiary Outreach and Recruitment

The Maine SIM uses a multi-payer care delivery strategy for both advanced primary care practices and ACOs. Beneficiary outreach and recruitment strategies vary by initiative focus and structure, and were largely underway prior to award of the SIM grant. MaineCare identified members eligible for Health Home Stage A services through a claims analysis and attributed these members to existing primary care practices whenever possible. Any eligible member assigned to a Health Home Primary Care Case Management (PCCM) practice or receiving the plurality of their care from a Health Home practice was notified of the Health Homes Initiative and their ability to "opt-out," then auto assigned after a 28 day period absent an indication of their wish to opt out. Members who could not be assigned to a practice receive a letter informing them of the Health Homes Initiative and their eligibility, along with a brochure for the program

Similarly, for MaineCare's Behavioral Health Homes, MaineCare identified members who were both eligible for Behavioral Health Home services and receiving Community Integration or Targeted Case Management at a participating Behavioral Health Home provider through claims analysis. These members were notified of the Behavioral Health Homes Initiative and their ability to "opt-out," then automatically assigned after a 28 day period absent an indication of their wish to opt out. Members who could not be assigned to a practice will receive a letter informing them of the Health Homes Initiative and their eligibility, along with a brochure for the program.

Under MaineCare's Accountable Communities Initiative, the Department notifies members of their attribution to an AC through an annual mailing. The notification will state:

- The basis for the member's attribution to an AC and general purposes of the AC program;

- Provider payment incentives under the AC program;
- That the Department may provide the AC Lead Entity Personal Health Information about the member for purposes of the AC Lead Entity's care coordination and quality improvement work; and
- That the member's Personal Health Information may be shared between the AC Lead Entity and other providers who provide services to the member while a member us attributed to an AC in order to coordinate care and provide quality services to that member.

Maine SIM anticipates that at the end of a five year period, beginning with the start date of the testing grant, at least 80% of Maine's population will be covered by an alternative payment arrangement as a result of SIM. These arrangements include the participation of the state's leading health care systems, which encompass the vast majority of primary care practices in Maine. For instance, within the coming year, it is expected that all of Anthem Maine's primary care coverage will be delivered through Patient Centered Medical Home arrangements with quality thresholds that trigger gain sharing. Anthem's network is extensive and includes approximately 95% of primary care practices in the state.

New ACO contracts put into place in Fall 2013 with the assistance of the MHMC include the Beacon provider network, MaineGeneral's network and MaineHealth's network. Although there is overlap with the Anthem primary care network, these arrangements involve many primary care practices.

Maine is a small state and most providers participate in most payer networks, although there is an emerging trend toward narrowing of networks in recent months. Still, we anticipate that a majority of the 500 or so primary care practices will be involved in the delivery of care within the context of an alternative payment arrangement before SIM testing concludes.

D. Information Systems and Data Collection

Refer to DRR Section D: Information Systems and Data Collection Setup

Supporting Documentation Available:

Appendices D1- D4 can be found in Year One Plan Submission on this website:
http://www.maine.gov/dhhs/sim/documents/SIM%20docs/plan%20docs/ops%20plan/MaineSIMOperationsPlanAppendicesD-E-G1-11.pdf

10. Underlying IT infrastructure

State Agencies Use of HIT and HIE

While most often used for enrollment or payment purpose, some State agencies do collect and/or maintain administrative data for health care outcomes and utilization. Within the Maine Department of Human Services, those offices collecting and maintaining data are MaineCare, Maine CDC, Aging and Disability Services, Family Independence, Child & Family Services, Substance Abuse and Mental Health Services, and Continuous Quality Improvement. Additionally, the Department of Public Safety–Emergency Medical Services collects data related to EMS runs. Within State government, the Maine Health Data Organization (MHDO) maintains health care utilization data on patients receiving services in inpatient, outpatient, ambulatory surgical facilities and ED settings. MHDO maintains the statewide all payer all settings claims database for all services rendered in Maine, as well as quality metrics and financial information for Maine hospitals.

In 2014, in an effort to improve transparency for consumers, the MHDO launched the "Maine HealthCost" webpage, which may be accessed through the MHDO site (*www.mhdo.maine.gov)*. This site provides consumers with the average cost of the 50 most frequent medical procedures in Maine, by health care facility. Although the cost (total and out of pocket) may vary based on a number of factors, the website is intended to facilitate consumers' cost comparisons, to help them make more informed choices about where to seek and receive care.

In addition to administrative data, some State agencies are electronically collecting and/or maintaining patient specific clinical data (with or without identification). This technology and the written commitment of the Maine Office of the State Coordinator for HIT provide the basic Infrastructure to support the enhancement of a wide range of health care data essential to SIM.

Administrative Claims Data

Health care data is critical to the grant's objective of achieving the Triple Aim. Many larger health systems have made investments to develop their own capacity to analyze data to support their ACO and population health efforts. Smaller systems, though, often lack the resources to engage in similar activities on their own. Under the SIM grant, the Maine Health Management Coalition (MHMC) will enable the development of data analytics capability for population health management for those organizations that may not otherwise have adequate access. In addition, MHMC will take a statewide, cross-system approach to aggregate analytics

to assist in our collective, public objective of understanding and improving the quality and cost of care across Maine.

The Maine Health Management Coalition will aggregate claims data covering all Maine beneficiaries of commercial, Medicare, and Medicaid health plans. MHMC will have access to Medicare and Medicaid data, identifiable at the person level, for all Maine beneficiaries. MHMC has person identifiable claims data from 2009 through current on about a third of the commercially insured Maine population though its database serving Coalition member plan sponsors. It also has complete claims data on the entire commercially insured Maine population from 2007 forward, from the MHDO All Payer Claims Database.

These baseline data sources provide historical and current data throughout the project:

a. *reporting to CMMI*: comprehensive longitudinal cost and utilization data across all insured members, providers, and payers – private and public;
b. *supports reporting of SIM activities*: tracking of progress and impacts by identified plans, purchasers, and providers participating in payment reform; and
c. *monitoring of a multi-payer system*: since Maine has all payer data, it will be able to track-multi payer systems. A relevant example is the MAPCP pilot sites which are supported by multiple commercial payers and Medicare.

A key feature of Maine data infrastructure is having historical claims data from all payers:

a. **Commercial.** The MHMC will process person-identifiable commercial claims for MHMC members, providers and emerging ACO systems that choose to take advantage of MHMC's capacity. These data are currently used for reporting on population cost, utilization and quality to purchasers, payers, providers, and emerging commercial ACO systems. Raw claims data are received quarterly directly from carriers and TPAs, various algorithms and groupers are applied, and an analytic data warehouse is created for multi-dimensional reporting across or within purchasers, providers, and geography. Additionally, the MHMC receives de-identified, statewide commercial claims from the Maine Health Data Organization (MHDO) for statewide reporting on drivers of population cost and utilization, in addition to profiling and benchmarking provider performance.
b. **Medicare**. The MHMC is one of thirteen national entities designated as a Qualified Entity by CMS and, beginning in the summer of 2014, will receive from CMS for calendar year 2009 to present, complete, person identified fee-for-service Medicare data for all Maine beneficiaries. Per the requirements of the QE program, these data will only support public reporting of Medicare data. In order to use these data for the full range of SIM activities, MHMC has a state DUA with DHHS.
c. **Medicaid**. The MHMC receives personally-identifiable Medicaid data. These data are updated via monthly feeds to MHMC's data vendor from MaineCare's data vendor. This new relationship was developed during the early months of the SIM initiative and is now fully implemented MHMC supports reporting to all MaineCare Accountable Communities, Primary Care Medical Homes, Health Homes and Behavioral Health Homes with patients assigned to practices based on the Department's attribution criteria *Timelines and Milestones* – Please see Appendix D1 in Year One Operations Plan for a detailed IT infrastructure work plan with timeline and milestones.

Patient Survey Data
While practice sites may engage in the collection of patient experience data independently, there is a statewide, publicly subsidized initiative to support the standardized collection of comparable data across Maine primary and specialty care practices. The Dirigo Health Agency's Maine Quality Forum, in collaboration with the Maine Department of Health and Human Services, Maine Quality Counts, the Maine Health Management Coalition, and Aligning Forces for Quality, sponsors this effort. This program is designed to minimize disruption to and complement on-going practice-sponsored efforts to conduct Clinician & Group Survey Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS) survey data, but allows for the collection and subsequent public reporting of comparable patient experience measures *across* Maine practices, in order to assist consumers in making informed decisions regarding where they seek care.

The target population for this initiative are adult patients (18 years of age or older) of primary care and specialty care practices, and parents/guardians of children (under 18 years of age) who are patients of pediatric sites. The results of the first round of this survey effort were published in March 2014 at www.mainepatientexperiencematters.org, a public website administered by the Maine Quality Forum. Additionally, ranked survey results (with good/better/best value assignments) will be published to the Maine Health Management Coalition's consumer website, www.getbettermaine.org. in 2014.

The second round of the subsidized survey initiative is being launched in late summer of 2014; the survey will be fielded beginning in the fall of 2014, with data submitted to the CAHPS database in March 2015. It is anticipated that second round survey results will be publicly reported to the MHMC consumer site in July 2015 and on the Maine Quality Forum site in August 2015.
Timelines and Milestones – Please see Appendix D1 in Year One Operations Plan for a detailed IT infrastructure work plan with timeline and milestones.

Clinical Data – Health Information Exchange (HIE) Scope and Infrastructure
Maine has had an operational health information exchange (HIE) since 2008 managed by HealthInfoNet (HIN), one of three implementation partners in the Maine SIM project. HealthInfoNet, a not-for-profit stakeholder organization, has been successful over the last seven years in building a community-based strategy for exchanging and collecting clinical data from provider-based electronic health records. Some highlights of this infrastructure and its use SIM activities include the following:

- **Health Information Exchange (HIE) Scope and Infrastructure** - The strength of provider participation in the statewide HIE allows HIN to support the statewide intake of clinical data for the delivery systems. This data can be used in multiple ways to support delivery reform.
- **HIE participation** includes - (1) 100% of Maine's 37 hospitals are under contract with 35 currently connected; (2) 34 FQHC sites and 386 ambulatory sites including physician practices, behavioral health, and long term care facilities are currently connected and

participating in the HIE; (3) 1,174,795 Maine residents have clinical data in the exchange (88% of Maine's resident population).

- **HIE Messaging** – Having access to real-time notifications when patients arrive at the Emergency Department or Inpatient settings is an essential tool for care management. To support MaineCare in better identifying and impacting high-risk and high-cost populations, HIN will provide real-time notifications to care managers (employed by both MaineCare and provider systems) when MaineCare patients are admitted to these settings. This activity leverages the HIE architecture and builds upon it by creating a MaineCare specific profile for specific use in notifications and data analytics in the data warehouse.
- **HIE Data Warehouse Tool** - Evaluation of clinical data using established and evolving quality measures is critical to payment reform. HIN's robust data warehouse will be tested as a key tool to support MaineCare with clinical data highlighting their high-risk populations with utilization and outcome trends. The data warehouse tool's primary focus is clinical data analytics to support provider organizations and MaineCare in improving their understanding of population-level real-time utilization and clinical outcomes. HIN recently tested the demonstration of combining statewide claims data with statewide clinical data successfully demonstrating that the individual data can be matched across clinical and administrative databases. HIN's data tools allow the state's health care providers to monitor and measure their clinical care in real time providing direct impact to the delivery of care, patient experience, as well as improve the satisfaction of care delivery professionals who are challenged with depending on outdated claims data to improve their care delivery.
- **HIE Personal Health Record Project** - Through SIM, HIN leverages the HIE's recent work in federal initiatives (Beacon, REC, SAMHSA) to further evolve the use of real-time clinical data to advance care plan management processes. Specifically, HIN engages the most important and underutilized member of the care management and planning team, the patient and their family, by providing the patient access to their statewide HIE record. HIN will test and pilot providing the patient community 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 make the patient chart available via a certified EHR portal administered by a health system and/or provider organization. The most underutilized member of the health care community is the patient, their family, and caregivers. The Blue Button concept will be tested and measured against improving the ability for a patient to participate and have access to a more complete clinical record that ever before. This project is developed to test the impact and the choices that patients/consumers make when they engage the health system with open and transparent access to their full medical record.
- **HIN Behavioral Health Projects** - Through SIM, HIN supports the inclusion of up to 25 behavioral health agencies in the HIE. In addition a meaningful use-like incentive program will be available to up to 20 behavioral health organizations to assist them in adopting EHRs, connecting to the HIE, and actively participating in quality measurement programs promoted by SIM. These activities vastly improve MaineCare's understanding of health care utilization and outcomes for persons with a behavioral health disorder. They also

allow for behavioral health providers to be more active members of the Health Homes and PCMHs.

Timelines and Milestones – Please see Appendix D1 in Year One Operations Plan for a detailed IT infrastructure work plan with timeline and milestones.

11. Process/Mechanisms for Data Collection

Administrative Claims Data - Overview of Data Sources and Uses
Complete claims information is collected including person, subscriber, and eligibility information, plan identifiers, coverage, payment, provider information, type of service, diagnoses, and procedures. Claims are processed, service categories created, clinical groupings, conditions, episodes of care are created, person level risk scores calculated, and other member characteristics created and assigned including treating provider, enrolled and attributed. Figure 5 below cross-references the data source by payer with the SIM objectives.

Figure 5: Data Source by Payer and SIM Activity

	Data Source			
Feature	Commercial		Medicare	MaineCare
Source	MHDO	Plan Sponsors	QECP	Molina
Agreements	Contract	BAA, DUA	DUA	Contract
Update	Quarterly, 3 month lag	Quarterly, no lag	Quarterly, 6 month lag	Monthly, 1 month lag
Complete Population Coverage	Y	N	Y	Y
Purchaser Analytics (e.g., Benefit Design)	N	Y	Y*	Y
Public Reporting	Y	N	Y	Y
Cost Workgroup Analysis	Y	Y	Y*	Y
Population Mgmt. Care Management High Utilizers, etc.	N	Y	Y*	Y
Support Health Homes as required for PMPM payments (CMS req)	----	----	----	Y
Tranparency to providers on their measurement**	N	Y	Y	Y
Mental Health included	Inconsistent	Inconsistent	N	Y
Pharmacy Claims	Inconsistent	Y	Y	Y
Able to construct accurate longitudinal records and easily match to other data sources.	N	Y	Y	Y

Data from the MHDO and MHMC are complementary. The MHDO can compel all commercial payers to submit healthcare claims on Maine residents, yielding a complete commercial claims database. The MHMC (and others) needs access to these data when data on the complete commercially insured population is required. These data are used for high level summary reporting.

Alternatively, data across commercial, Medicare, and MaineCare collected by the MHMC is at a level of detail, including PHI, which can yield specific actionable information not obtainable from the MHDO data. These data at MHMC often contain sensitive information that cannot be included in a publicly available database, such as names of patients, identity of employer groups, and information about the benefit design of specific members. These are the very fields needed to understand the effect of different benefit designs on member choices, or build lists of specific high utilization members in need of outreach, etc.

* Functions which require an additional state DUA beyond the QE DUA.

** Why CMS releases person identified data to QECPs. Fairness to providers.

Workflow Processes
Data are submitted via secure FTP directly to the MHMC data vendor. Once processed an analytic warehouse is built, information is made available through secure portals, standard reports, and custom analyses are produced to the specifications of defined users and applications. Providers that choose to have a certain level of access may see patient-level, identified information for members of their panels with whom they have a treatment relationship. Providers may access complete population or member level information for their practice panels; this information is derived from claims and includes summarized cost, utilization, service category and clinical condition metrics. Although not directly part of the SIM testing grant, plan sponsors have access to de-identified information on their insured populations through a secure portal as well as a rich set of custom and standard reports analyzing the cost and utilization of health care services analyzing benchmarked plan performance. Information is made available according to role-based authorization.

Agreements
MHMC has Business Associate Agreements (BAA) and Data Use Agreements (DUA) in place with all commercial Covered Entities submitting person identified data. It has a contract in place with the MHDO for statewide data, and the QE DUA in place with CMS for receipt and use of Medicare data. MHMC and MaineCare have an executed contract.

Physician/Practice Data
MHMC receives data on provider ratings monthly and public reports are updated quarterly.

- **Clinical Recognitions**:
    - **Adult primary care:** MHMC receives data on provider ratings monthly and public reports are updated quarterly. Providers submit clinical data to the National Committee for Quality Assurance (NCQA) or Bridges to Excellence which is then scored to represent levels or ratings of achievement for treating clinical conditions. Measures are: (a) diabetes: blood pressure control, LDL control, HbA1c control, eye exam, smoking status and advice and treatment, nephropathy assessment, and podiatry exam; (b) cardiac care: blood pressure control, LDL control, lipid profile, use of aspirin/antithrombotic, smoking status and advice and treatment; (c) CAD: blood pressure control, LDL control, lipid profile, activity and angina symptoms, LDL therapy, use of aspirin/antithrombotic, ACE/ARB therapy, smoking status and advice and treatment, beta blocker treatment; and (d) hypertension: blood pressure control, LDL control, lipid profile, use of aspirin, urine protein test, serum creatinine test, smoking status, diabetes screening, diet and physical activity counseling.
    - Pediatric primary care: MHDO receives data from pediatricians on the treatment of asthma and rates of pediatric immunizations. Pediatric practices extract clinical data on their patients and score it against targets for measurement as developed by the Improving Health Outcomes for Children program (a Children's Health Insurance Program Reauthorization Act funded grant).

- **Office Systems**: Physician office system recognition by either achieving NCQA Patient Centered Medical Home recognition or having a CMS Meaningful Use certified electronic medical record system.

Hospital Data

Hospital and System performance data for public reporting continues to evolve as measures and data sources continue to develop. Most hospital data is updated quarterly and is currently from the following sources:

(a) Hospital Compare: analyzed by Northeast Healthcare Quality Foundation (Medicare QIO) for Heart Failure Care, Pneumonia, Preventing Surgical Infections (Surgical Care Improvement Project or SCIP);
(b) MHMC-F Medication Spotlight Survey: Systems Addressing Medication Safety (by hospital pharmacists), analyzed by Onpoint Health Data (semi-annually updated);
(c) Leapfrog: National Safe Practice Score based on selected measures from the LF Hospital Quality Ratings, analyzed by MHMC-F (semi-annually updated);
(d) Leapfrog: Maternity Care: Early Elective Delivery, Episiotomy Rate, and Maternity Care Processes (Newborn Bilirubin Screening and Appropriate Deep Vein Thrombosis Prophylaxis in Women Undergoing Cesareans),
(e) MHDO: Falls with Injury, analyzed by MHMC-F;
(f) CMS Hospital Consumer Assessment of Healthcare Providers and Systems (H-CAHPS): Overall Patient Experience, analyzed by Onpoint Health Data;
(g) MHDO: Care Transition Measures, patient experience of preparation for transition, analyzed by MHMC-F.

HIE Clinical Data Collection and Processes

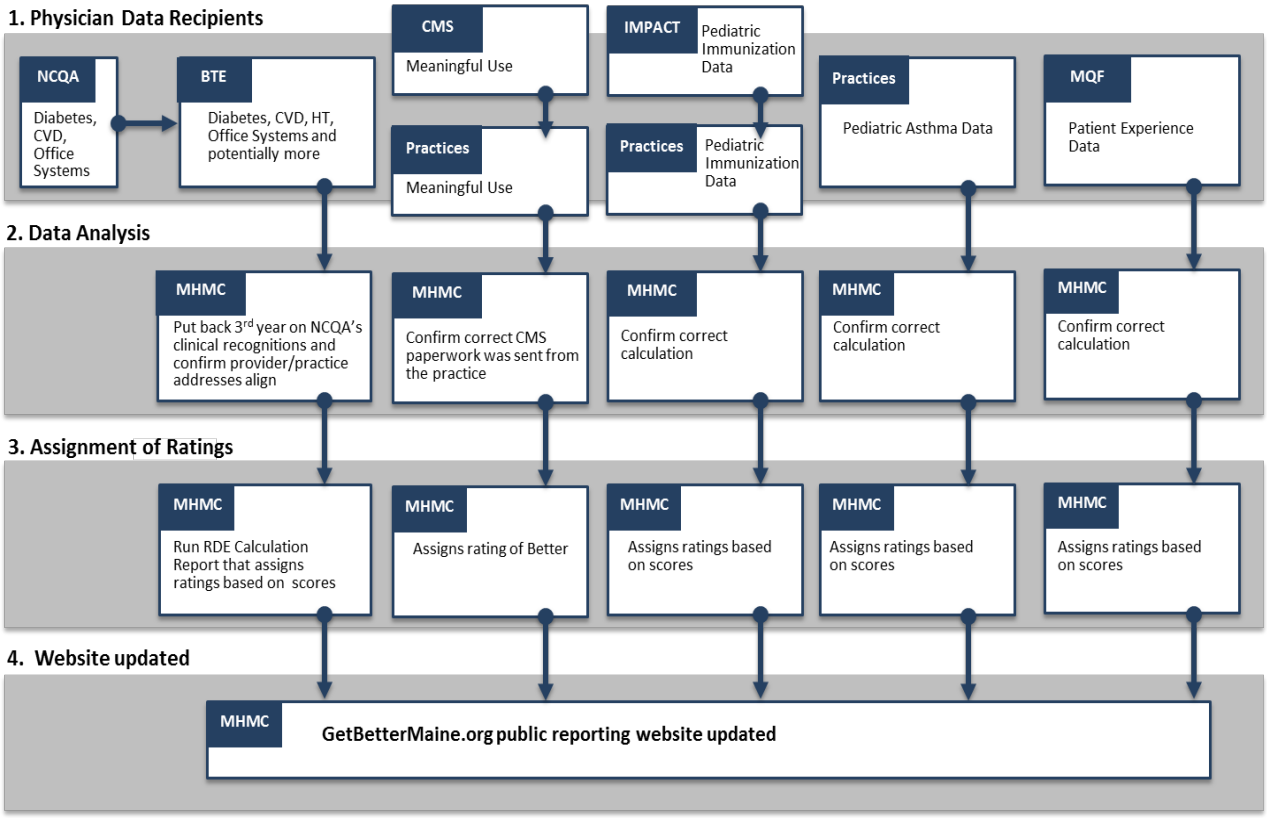
- HealthInfoNet uses HL-7 standards to promote real-time data collection from provider sites around the state.
- HIN standardizes all data collected according to national guidelines: CCD/CCR; ICD-9/10; CPT-4; RxBROM/NCPDP; LOINC; SNOMED-CT.
- Notifications functions that are being delivered for MaineCare patients use this same architecture to support the real-time notification of events as they happen.
- Currently HIN receives over 13.5 million messages per week.
- HIE data is processed into a reporting data warehouse on a weekly basis.

12. Reporting Mechanism across Payers and Providers

Reporting Across Practices

Data is updated monthly and the and publicly reported measures on the website www.getbettermaine.org are updated quarterly. Measures, processes, and displays are developed through a multi-stakeholder process with feedback from providers, plans/plan sponsors, payers and consumers. Figure 6 shows the current data sources and processes used by MHMC for public reporting of practice ratings for effective and safe care.

Figure 6: GetBetterMaine.org Physician Data Recipients Reporting Flow

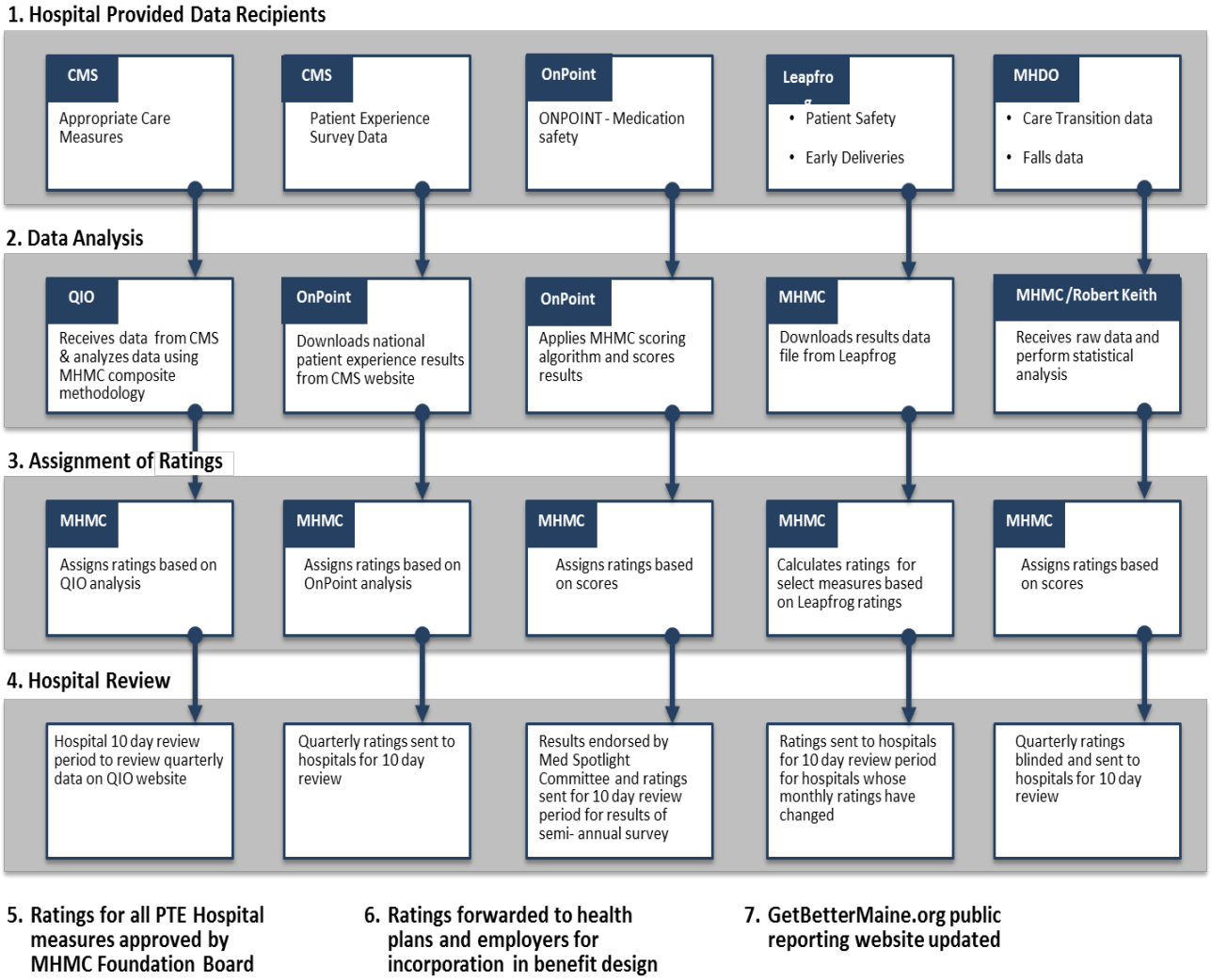


Website: www.getbettermaine.org

Reporting Across Hospitals

Data is updated quarterly or semi-annually and the publicly reported measures on GetBetterMaine.org are updated quarterly. Measures, processes, and displays are developed through a multi-stakeholder process with feedback from providers, plans/plan sponsors, and payers. Figure 7 shows the current data sources and processes MHMC uses for public reporting on practice ratings for effect care, safe care, and patient experience.

Figure 7: Hospital Provided Data Recipients Reporting Flow

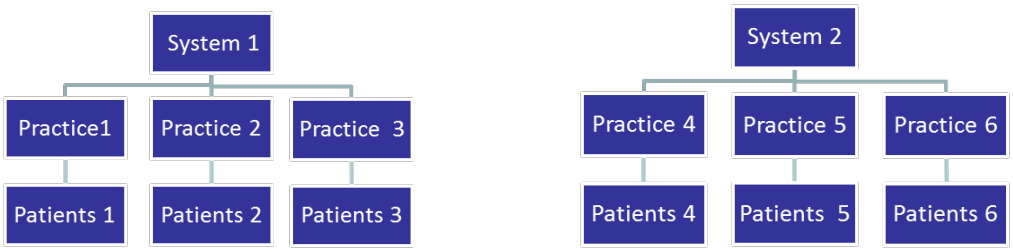


Reporting Across Practice Groups

Measures are being developed for Practice Group reporting. With the emergence of local and regional accountable care organizations the Maine Health Management Coalition Foundation (MHMC-F) made the conscious decision to develop a measure set for "practice group" performance. A multi-stakeholder forum and process has been established as part of the MHMC Pathways to Excellence (PTE) program. This committee is composed of physician groups, hospital clinical leaders, health plans, and purchasers - including Maine's Medicaid program, MaineCare. The PTE Systems committee has oversight on measure selection, measure testing, and performance benchmarking and public reporting.

Practice Groups - Practice groups are defined to establish *populations* for measurement and accountability. Practice groups are based on primary care panel populations, and a practice group is a group of primary care practices organized by single administering entity. The key is that for accountability, there needs to be influence with authority on how care is delivered. A

practice group may be hospital owned, but this is not a requirement. Patient panels may be attributed or enrolled, but most commonly are attributed as in the CMS ACO pilots. Examples of two practice groups:



Practice groups Measures - Practice groups measures are evolving and are selected for alignment with nationally endorsed measures, especially for CMS ACO pilots and emerging commercial ACO arrangements. In order to avoid the internal development of measures and to prevent duplication of reporting requirements, the MHMC-F seeks to adopt nationally-endorsed measures unless there is a compelling reason not to approve. As a result, the PTE Systems Committee and the MHMC-F have followed a path of substantial – but not total - alignment with CMS-required measures for reporting and National Quality Forum (NQF)-endorsed measures. NQF-endorsed measures have been fully vetted for fairness and reliability and reduce the need for extensive primary research. In the first year of the SIM project, MHMC conducted an inventory of all ACO measures being used in contracts in the State; there were 163 such measures identified. Only a small subset (approximately 50) of those measures was used by more than one payer (including Medicare).

As part of its Accountable Communities initiative, the MaineCare program has adopted an initial set of ACO measures to mark the performance of Accountable Care entities contracted with the state. While there is a degree of overlap between this set of measures and those used by commercial entities and by Medicare, there are unique characteristics of the Medicaid population that demand the use of special, population-specific measures. The inclusion of these measures contributes to divergence in the measure sets of the various payers.

As part of the SIM initiative, MHMC is working with payers and providers to identify a defined, core set of ACO measures intended to serve as the pool of measures that all payers agree to limit themselves to for ACO contracting; this effort complements a similar initiative at the national level.

Measures are sought and continue to be added through the PTE process. In addition to CMS and NQF, there are various resources for candidate measures, such as the HHS Measure Policy Council short list. These largely overlap with current PTE measures but can be used as a source for additional candidate measures. Besides the measures noted above in this document, measures being evaluated include:

- **Total Cost of Care and Relative Resource Use** (NQF #1604) - The Total Cost of Care and Resource Use measures were developed by Health Partners and includes all costs associated with treating patients including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services. Initial

implementation will include medical services only because of data limitations on complete pharmacy and behavioral health data across all patients and payers. Relative Resource Use measures weighted resource utilization by applying standardized prices across all payers and providers.

- **CG-CAHPS** - Clinician & Group Survey Consumer Assessment of Healthcare Providers and Systems (NQF #0005).
- **Care Transitions** (NQF #0228) - The 3-Item Care Transition Measure (CTM-3) set measuring patients' perspectives on coordination of hospital discharge care using the CMS/HCAHPS version survey questions.
- **Hospital Admissions for Ambulatory Care Sensitive Conditions (Inpatient ACSCs), and ED Utilization for Ambulatory Care Sensitive Conditions (ED ACSCs)** - The Inpatient ACS conditions measures are the AHRQ Prevention Quality Indicators (PQIs) and are used in their Healthcare Cost and Utilization Project (HCUP), their National Healthcare Disparities Report State Snapshots, and are endorsed by the NQF. Some are also required by CMS ACO/Shared Savings program. They represent conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease. Even though these indicators are based on hospital inpatient data, they provide insight into the quality of the health care system beyond the hospital to the primary care setting. With high-quality, community-based primary care, hospitalization for these illnesses often can be avoided.
  ED Utilization for ACS conditions measures are based on the same methodology as the Inpatient ACS conditions but for visits to the Emergency Department that do not result in an inpatient stay.
- **All Cause Readmissions Measure** (NQF #1768) - The National Committee for Quality Assurance (NCQA), the developer of the Healthcare Effectiveness Data and Information Set (HEDIS) for measuring health-plan quality, created this measure to assess readmissions by health insurance plans. It is NQF endorsed and will be used by Dartmouth Brookings ACO pilots. It looks at all readmissions, regardless of the cause and measures how well the system is managing the patients and coordinating their care.

Reporting to Practices

The mechanism for internal reporting to primary care practices will be through the MHMC Practice Reports. Additionally, practices have the option of accessing a portal for drill down to service and claims level information on all components of the reports.

Report Content - Content will include, benchmarked to peers: Total Cost of Care and Relative Resources Use overall and by service category with trends; inpatient admissions analysis cost and utilization by categories and trends; outpatient analysis by service, cost and trends; primary care and specialist utilization and cost, pharmacy cost and utilization analysis; cost and utilization of services by clinical conditions; high cost claimants analysis; care management compliance; and quality metrics for diabetes care, cardiovascular conditions, musculoskeletal conditions, respiratory conditions, prevention and screening, pediatric care, behavioral health, and medication management. These reports undergo refinement and improvement over time, resulting in data and information that is responsive to the needs of practices.

Measurement using Clinical Data

- The HIE data warehouse will be used to support dashboards for MaineCare patients, informing quality results for MaineCare Accountable Communities, generating quality metrics that will be determined for Behavioral Health, and linking clinical and claims data for cost/outcomes analysis.
    - Measures are being reviewed across the SIM project to assure alignment with federally funded programs and Health Home/PMCH pilots

Reporting timeframes will be determined by the SIM Steering Committee.

E. HIT Infrastructure Alignment

Refer to DRR Section E: Alignment with State HIT Plans and Existing HIT Infrastructure

***Supporting Documentation Available*:**
Appendices E1- E4 can be found in Year One Plan Submission on this website:
http://www.maine.gov/dhhs/sim/documents/SIM%20docs/plan%20docs/ops%20plan/MaineSIMOperationsPlanAppendicesD-E-G1-11.pdf

13. HIT Investments

Maine has made great strides in the use and adoption of Health Information Technology (HIT). Spearheading many of the coordination efforts for HIT are the Office of the State Coordinator for Health Information Technology (OSC), the MaineCare Meaningful Use HIT Program and HealthInfoNet (HIN) – the not-for-profit statewide health information exchange (HIE) organization. The Maine OSC is currently the recipient of the State HIE Cooperative Agreement from the Office of the National Coordinator for HIT (ONC). The OSC supports and convenes the statewide HIT Steering Committee (HITSC) and a number of governance committees for HIT efforts across the state. The OSC, in partnership with Maine's health care and consumer stakeholder community, released the first draft of its HIT Strategic and Operational Plan and received ONC approval of those activities in October of 2010. This plan represents the framework from which the State has continued its successful strategies to support the adoption of electronic health records (EHRs) and HIE.

HealthInfoNet, the designated statewide HIE and the recipient of the Regional Extension Center Cooperative Agreement from ONC, is a non-profit organization with a community Board of Directors that has been operationally exchanging clinical health data since 2008 to support care coordination across the State. These and other HIT efforts around the state serve as the foundation for achieving the goals of the SIM Grant and expanding the breadth and capability of HIT to improve health care effectiveness statewide.

Maine's HIT History and Current Strategies to Continued Success through SIM
The success of HIT adoption in Maine has been predicated on the perspective that HIT is not an end but a means to support the advancement of higher quality health care while maintaining a fair and appropriate cost structure. As such, the strategies taken to support adoption of technology have and continue to focus on the needs of the stakeholders and a market-driven approach to build buy-in.

Since 2010 the HIT Steering Committee (HITSC) has been meeting monthly. This group includes representation from all health care stakeholders including the behavioral health care community. HITSC minutes and activities can be found at http://www.maine.gov/hit. The HITSC provides direction to the OSC on policy and work plan decisions as well as feedback to all other stakeholders as strategies to support HIT adoption and use are explored. The HITSC and OSC are also advised by subcommittees for specific issues like statewide health care data planning and inclusion of sensitive health information in the health information exchange.

For example, a subcommittee – called the Legal Workgroup - comprised of health care lawyers, state agency representatives, advocacy groups including the Maine Civil Liberties Union, and behavioral health care providers advised the OSC on a bill to include mental health and HIV information in the HIE brought forward to the legislature in 2011 and passed into law June of 2011. This group continues to meet to discuss pressing legal issues in the state such as the legal requirements for the All Payer Claims Database, data use and the regulation responsibilities of the State of Maine over the State Designated HIE. The OSC works closely with HIN (see http://www.hinfonet.org). HIN has developed and manages the HIE technical and governance activities, including its Community Board of Directors, the Consumer Advisory Committee and the Technical and Provider Practice Committees. HIN also serves as the Maine Regional Extension Center (MEREC) and was the technology partner to the Bangor Beacon Community also funded by the ONC.

Since 2004 Maine has moved forward to promote the adoption of EMRs, establish one of the nation's first operational statewide electronic HIEs, and bring an ever-widening array of providers into the exchange to improve the coordination, integration and quality of patient care. Central to this strategy has been a longstanding priority to support the collaborative engagement of providers from the behavioral and physical health sector, and consumers, so the use and level of deployment of HIT enhances care at the patient and provider level. This integrated vision has guided the development of HIN since its inception. HIN has rapidly expanded, and today its secure database includes records for approximately 1.2 million (~88%) of Maine's 1.3 million residents. The HITECH Act and subsequent award of the HIE Cooperative Agreement to the State of Maine, the Regional Extension Center to HIN, and the Beacon Community Grant to Eastern Maine HealthCare Systems have also accelerated HIE activities.

A board of directors and several standing committees governs HIN. From the beginning, the organization has received strong support from the provider community. The Technical Provider and Practice Advisory Committee (TPPAC) comprised of hospital and practice IT professionals, clinicians, and health plans has worked closely with HIN to design an exchange that meets the needs of all of Maine – Integrated Delivery Networks, independent providers, urban and rural areas, and all levels of technology capacity. This technical design – a centralized repository model – fits the needs of the state in having aggregated standardized data to support its health care improvement initiatives such as the SIM grant.

Using the HIE network, providers share standardized data such as demographics, visit history and encounters, allergies, immunizations, prescriptions, medical conditions/diagnoses, procedures, lab and test results, operative reports, radiology results, and other documents. In an emergency, this information helps providers quickly and more accurately diagnose and treat patients. In non-emergency situations it supports decreased ordering of redundant tests and gives providers a more complete picture of their patients' care including medications and treatment provided in other settings. From a population health perspective, database serves as a tool for authorized users to look at population health, trends, and health system efficiencies. As part of the SIM project, HIN is working with Medicaid to deliver a Medicaid "dashboard" that can show health care utilization, distribution of patients, chronic disease and co-morbid

conditions for MaineCare to have a better understanding of their population. This activity began in October of 2013 and will continue throughout the project. The dashboard will be populated by clinical data from EHRs for patients who receive Medicaid benefits. The dashboard will include population-based views of the Medicaid population with specific capabilities to analyze the data through population, demographic, disease state, risk and other filters.

To support the current the statewide ED Care Management Initiative Pilot, HIN in partnership with MaineCare and the participants of the HIE , have deployed near real-time notifications to payer and provider care managers when identified residents receive services at Maine EDs and IP settings. HIN currently has real-time connections to 34 Maine hospitals, with the goal to have all hospitals connected to the HIE by the end of 2014. This will allow for accurate and timely identification of emergency department use that can be used for active intervention by care management staff. This strategy is widely supported by MaineCare, the ACOs, and private insurers, and represents a true value-add that only the HIE can perform effectively statewide.

Data Elements Collected by Maine's HIE and Participation in the HIE

HealthInfoNet currently collects data elements that form the basis of a national standard for transitions of care - the Continuity of Care Record (CCR) and Continuity of Care Document (CCD). Data elements include patient demographics, encounter/visit history, diagnoses, conditions, problem list, procedures, allergies, radiology reports, transcribed documents, laboratory results, immunizations, vital signs, and medication information (commercial, Medicare and Medicaid). Over time the data collected by HIN has expanded to represent the needs of the health care stakeholders in the State. In 2010, with the Bangor Beacon Project and to support Meaningful Use, HIN began collecting immunization information and all secondary diagnoses. More recently HIN has begun to collect insurer information and other data elements to support ACO and other activities. HIE tools operated by HIN were purposely chosen to be flexible, allowing all healthcare stakeholders to participate and be amenable to an array of messaging standards – such as HL7, CCR, CCD, REST, Direct.

As noted, in mid-2013, 34 Maine hospitals sent data to the HIE, and the remaining four (there are 38 Acute care hospitals in Maine) are finalizing interfaces. The HIE currently charges $1,000 per bed for hospitals and between$200 and $600 per prescribing prescriber per year for access to the exchange. As adoption has increased and the Maine Regional Extension Center (described below) has worked with individual practices, it has been found that while the HIE adds value, due to the low payment rates for behavioral health providers, cost remains an issue. To help to defray this for behavioral health providers, Maine is using the SIM funds to cover the interface and annual connection costs for up to 25 behavioral health organizations statewide.

HIE Use for Public and Population Health

Use of information in the HIE by providers promotes stronger coordination of care across all settings, reduces unnecessary and/or duplicative medical testing, lowers costs and provides greater quality care for Maine's population. The exchange also incorporates automated

laboratory result reporting to the Maine CDC (Maine's public health authority) for 30 of the 72 diseases mandated for reporting by the State. Moreover, HIN is able to leverage its laboratory reporting activities and a relationship with the statewide Immunization Registry (Impact II) to support participating providers in meeting the public health requirements of the CMS Meaningful Use of HIT incentive program. These functions form the basis for an evolving public health information infrastructure that will inform population health and emergency planning efforts in Maine into the future.

Recently, HIN has also been working with the federal CDC in a demonstration initiative to validate that population health reporting can be achieved using a statewide HIE and an ONC-funded population health tool - popHealth. To date, the demonstration effort has successfully populated fourteen of the Stage 1 Meaningful Use quality measures. This work with the popHealth analytical tool has expanded HIN's experience in managing large databases to support analytical reporting and served as a foundation for the development of a HIE data warehouse.

As part of the SIM activities, HIN will make this data warehouse available to MaineCare as a "dashboard" to understand the clinical and utilization statistics related to the Medicaid population. In addition, these tools will be used to support the clinical quality measures that are developed as part of the SIM Data and Analytics Subcommittee. The initial dashboard project began in October of 2013 with the expectation that by fall of 2014 the dashboard will be made available to MaineCare staff.

Medicaid, Meaningful Use EHR Incentives, and HIE

Maine has defined a coordinated and workable plan for incorporating prior investments in HIT and improving its deployment and use. Maine recognized the integral relationships fostered by the HITECH Act and continuing as a theme for emerging initiatives such as the SIM and Health Homes.

Maine's Meaningful Use Program was implemented in October 2011. In the first eighteen months of the program, over 2,636 payments totaling $71,259,575 have been paid to Maine Medicaid eligible professionals (EPs) and eligible hospitals (EHs). Maine was recognized as the first state in the nation to have all of its EHs participate in the Meaningful Use Program, and Maine had the highest percentage of EPs in the nation who received their first year payment. This success was due in large part to the collaboration and recognition of the benefits of having a coordinated statewide HIT effort that spans across all programs.

Maine's OMS HIT program is overseen by the State's Director of the Office of State Coordinator for HIT (OSC) housed in Maine's Medicaid agency. The OSC reports directly to the Deputy Director of the Medicaid Agency. Having the OSC and Meaningful Use functions in the same office enhances coordination of HIT efforts across program and agency lines. The OSC has an approved State HIT Plan with a multi-stakeholder steering committee that provides input and feedback. This framework has resulted in a collaborative partnership for all of the State's HIT initiatives.

The State used this foundation to formulate Goals, Objectives and Needs reflective of the federal and State-wide HIT/HIE efforts, including SIM:

Goal 1. HIT Initiative Integration Benefits

Recognizing the needs and benefits that a multi-dimensional approach to HIT affords to improve quality and health outcomes, payment reforms, ensure accurate program costs and efficiencies, and which the HITECH Act and/or Stage 2 and future stages of Meaningful Use (as defined by CMS) promotes and/or requires, the State will institute system improvements and enhance frameworks and governance of HIT programs including provider participation, exchange, and reporting of clinical, claims, and Meaningful Use data.

Key Objective: By 2016, all HITECH Act, State and DHHS-specific health care programs that use Health Information Technology, will be intrinsically linked through State alignment, coordination, and oversight of clinical, claims, and quality measures reporting and use to improve health outcomes, costs and quality.

Key Needs:

- Continue to use the collaborative efforts between CMS, ONC, MaineCare, the Maine Health Data Organization and its All Payer/All Claims Database, the OSC, Maine REC, HealthInfoNet, DHHS, Maine's Office of Information Technology, Maine's CDC, Maine's HIE, and private stakeholders for multi-stakeholder input for priority-setting and coordinating operation processes supporting the MaineCare EHR Incentive Program;
- Continue the work that the State has begun to institute system improvements and enhance frameworks and governance of HIT programs including provider participation, exchange, and reporting of clinical, claims, and Meaningful Use data to meet Goal 1 and Goal 1 Key Objective.
- Coordinate all HIT initiatives between health care settings to avoid duplication of efforts and to allow federal and State resources and lessons learned to be used to improve health outcomes;
- Partner with existing EHR adoption and implementation efforts currently underway by providers to coordinate State HIT initiatives, including the administration of the EHR MU Incentive Program;
- Undertake efforts to collaborate with new and emerging Maine Medicaid programs such as Health Homes and Maine's SIM and IHOC grants to expand use of HIT and Meaningful Use measures, and the use of the State's HIE and APCD clinical and claims data to improve quality, costs, and health outcomes.
- Efficiently use funding to optimize the benefits of HIT by coordinating and aligning health and quality data assurance programs.

Goal 2. Privacy and Security Benefits

MaineCare will build public trust and enhance participation in HIT and electronic exchange of protected health information by incorporating privacy and security solutions and appropriate legislation, regulations, and processes in every phase of its development, adoption and use data, including claims and clinical health care data.

Key Objective: By 2016, MaineCare will facilitate electronic exchange, access, and use of electronic protected health information, while maintaining the privacy and security of patient, provider and clearinghouse health information through the advancement of privacy and

security legislation, policies, principles, procedures and protections for protected health information that is created, maintained, received or transmitted.

Key Needs

- Update the State's inventory of existing privacy and security standards and practices including HIPAA and other Federal and State-specific laws within MaineCare to develop a comprehensive HIPAA and HITECH compliant program.
- Establish administrative, physical and technical privacy and security protections in accordance with industry business best-practices for all protected health information within MaineCare's HIT systems, the State's HIE, and other State systems.
- Continue collaboration with the OSC, which allows the State's HIE to participate in new and emerging MaineCare and HIT initiatives using practices and safeguards that ensure that health care discrimination does not occur while using health care data to improve all patient care, cost, quality and outcomes.

Goal 3. Communication, Education and Outreach Benefits

MaineCare will aid in transforming the current health care delivery system into a high performing health information exchange system by establishing and implementing robust communication, education, and outreach plans to promote wide-spread EHR, Meaningful Use, and exchange among MaineCare providers and inform Members about the benefits of health information technology.

Key Objective: By 2016, MaineCare will have highly promoted the national and State HIT efforts to improve health outcomes through the use of electronic health information tools by developing and implementing comprehensive communication and training programs for State decision makers, staff, providers, citizens of Maine and stakeholders.

Key Needs:

- Continue communication strategies to assist providers in understanding the HITECH Act and Meaningful Use requirements so that the benefits of HIT may be realized by coordination with existing Hospital and Provider Association communication channels.
- Continue outreach and training programs for DHHS decision makers, MaineCare management, State staff, and the Maine Regional Extension Center so that they may educate providers and Members about the benefits of HIT and provide Member education on HIT to empower them to effectively make decisions about health information in an informed manner.

Goal 4. Infrastructure and Systems Integration Benefits

The MaineCare MU program will advance the provision of services that are client-centered to improve health outcomes, quality, patient safety, engagement, care coordination, and efficiency and reduce operating costs by eliminating duplication of data costs through the promotion of adoption and Meaningful Use of HIT.

Key Objective: By 2016, all MaineCare Members will be managed by DHHS and providers who have secure access to health related information within a connected health care system using data and technology standards that enable movement, exchange, and use of electronic health care claims, clinical, and other information to support patient and population-oriented health care needs and which meet Meaningful Use requirements and promote future Stages of MU as defined and implemented by CMS.

Key Needs:

- Continue with efforts for a single point of entry for providers and use of a common identifier to improve access to health information in State systems for the purposes of research, determining patterns of care, improving quality and patient experience, ensuring accuracy of costs and claims information, and other efficiencies. Any solution to the single point of entry project must result in an inter-operable system or solution that can connect to the State designated HIE, CDC, and APCD as determined by the OSC, MaineCare program, and in accord with CMS rules and regulations. The solution must consider the feasibility of creating a two-way data flow between provider and State systems including, but not limited to, the MIHMS Claims Database; the IMMPACT 2- Web- based Immunization Information System; CDC Special Registries; the State's Meaningful Use system; and the State's designated HIE - HealthInfoNet.
- Develop and implement rules, policies and procedures, and system enhancements where needed, to the State's registration, attestation and payment systems for Eligible Professionals and Hospitals (if Medicaid only) for Meaningful Use reporting (as defined by CMS); quality and cost improvement measures, including the exchange, use, and reporting of health care data under MaineCare initiatives.
- Continue to work collaboratively with the State's CDC and EHs to conduct the necessary tests and interfaces to allow EHs to meet ELR MU reporting; and with EPs and EHs to meet Stage 2 requirements for reporting of CDC health population reports for immunization, cancer, lead, and other special registries.
- Provide outreach and education, stakeholder forums, and other efforts to educate MaineCare Members of their ability to obtain their personal health records electronically, and how to use this information to improve health outcomes and quality of care.
- Continue to build common individual identifier (e.g., Master Client Index) technology tools in an integrated manner to allow for continuity of care for individual MaineCare Members and to aid in better understanding population health including linking Member information across Maine Departments such as Corrections and Education.
- Remove data silos in State systems for program offices to have access to data collected and managed commonly across DHHS to better serve clients, through continued communications among agencies with a coordinated focus on using existing systems and infrastructure rather than building redundant or less efficient systems.
- Coordinate the clinical quality measures gathered by DHHS to ensure that CHIPRA, Meaningful Use, and all other clinical quality measures are coordinated to appropriately address populations with unique needs, such as children.
- Continue efforts to collect and disburse data in a standardized manner to promote the use of evidence-based protocols for clinical decisions.
- Participate in new Medicaid programs such as Health Homes and Maine's SIM and IHOC grants to establish HIT and MU measures requirements, including use of the State's HIE and APCD clinical and claims data, to improve quality, costs, and outcomes.

Much of the success of the MaineCare Meaningful Use Program can be attributed to our federal CMS partners who approved funding for the development and implementation of Maine's Program. Recently CMS has approved administrative funding for new and emerging initiatives such as electronic lab reporting from hospitals to MECDC, system upgrades to meet Stage 2 Meaningful Use requirements, collaborative efforts with the State's broadband authority for provider surveys and identification of potential funding opportunities, and other valuable projects.

Other OMS HIT Program projects that are being planned to complement the SIM grant to include:

- A request under the Meaningful Use Program for an appropriate allocation of funding for specialty registry reporting to the CDC required under Stage 2 Meaningful Use which will provide analytic tools for diseases such as cancer and diabetes, which will further increase the use of the HIE statewide;
- A request for an allocation of funding under the Meaningful Use Program for enhancing the Statewide HIE, which will dovetail well with the SIM goals and will enable Maine providers to meet important programmatic standards that will help inform mechanisms to reduce costs and improve quality of care;
- In conjunction with the State's broadband agency (see below), use the Meaningful Use program provider survey conducted in early 2013 to determine the use of EHRs and Internet capacity as a baseline to identify gaps and potential funding for providers to meet Stage 2 Meaningful Use requirements and participate in emerging tele-health initiatives.

Support for Behavioral Health Integration with HIT Efforts in Maine

State agencies serving those with behavioral and substance abuse problems support HIT integration and are involved in the work of HIN. The Office of Adult Mental Health is engaged in several initiatives related to the integration behavioral health and primary care. Statewide exchange of relevant information is especially critical for persons with serious and persistent mental illness (SPMI). Those with SPMI die on average 25 years prior to their age peers, due primarily to unmet physical health conditions. Maine has been on the cutting edge of tracking and analyzing these data and developing programs to reverse this trend.

Shared EHRs are key to successful interventions. The Maine Office of Substance Abuse and Mental Health Services (SAMHS) works with its contract agencies to improve the efficiencies and effectiveness of patient-centered substance abuse care. In 2011, SAMHS representatives were part of a statewide stakeholder process that generated a work plan and tools to support the integration of behavioral health information into the statewide HIE. SAMHS is also engaged in several initiatives related to the integration and exchange of health information as a tool to improve quality access to coordinated care for persons needing substance abuse services. SAMHS's value-based contracting principles encourage providers to coordinate care with mental health and physical health services and EHRs and HIE are critical to this successful coordination.

In addition to these activities in 2012, HIN was awarded, on behalf of the State of Maine, the SAMHSA/HRSA funded Center for Integrated Health Solutions (CIHS) cooperative agreement. Maine's project represents three major collaborators: The Office of the State Coordinator for Health Information Technology, HealthInfoNet, and The Hanley Center for Health Leadership. It also represents a wide range of private and public partners – including SAMHS - who over the project period have been and continue to be engaged in integrating behavioral health and primary care health information technology with providers statewide, through the HIE. This

project continues the efforts of Maine's health care stakeholders to make behavioral health and primary care integration the norm rather than the exception.

SIM is going to continue these important behavioral health integration activities to promote technology access across all behavioral health providers, while the State has the capacity to continuously work with consumers to help them understand the value and risks of these technologies. This work will assure that successful convening efforts of the behavioral health and primary care communities continues to break down both perceived and real barriers to integration and serve as a national model for dissemination.

Twenty Behavioral Health Organizations' HIE costs will be subsidized by the SIM grant. The HIE costs of twenty behavioral health organizations will be subsidized by the SIM grant chosen through an RFP process to be eligible for up to $70,000 as they implement/ upgrade their EHR, connect to the HIE, and participate in electronic quality measurement programs. Organizations have been chosen for program participation through an RFP released by HIN in the fall of 2013. SAMHS and HIN, working under another SAMHSA grant, are creating a single-sign-on link between the HIE and the Prescription Drug Monitoring Program (PDMP). The goal of the project is to promote a population-based focus on appropriate prescription drug use, while promoting higher quality care and reduced costs statewide. Using HIN as a means for providers to access the PDMP provides the opportunity to improve the use of both the PDMP and the HIE. Currently providers and pharmacists who use the PDMP must log onto a separate web-portal provided by the PDMP Vendor. With access to the PDMP included in HIN, the data will be available to providers in a workflow that is currently being promoted by the Federal Government through the CMS Meaningful Use of HIT Incentive programs, the State (through the Office of the State Coordinator for HIT and MaineCare), and provider organizations in Maine to improve the quality and effectiveness of care.
In addition, PDMP information will be available to providers and other authorized users in-context with the patient's clinical information – from all sources. In this way, providers, pharmacists and others authorized to access the PDMP through HIN will be able to quickly identify drug-shopping behavior and the appropriateness of the prescription medications being used based on the current medical history of the patient. This partnership will result in increased utilization of the PDMP program and the statewide HIE. Moreover, this integrated strategy will serve to support a comprehensive strategy by the State to leverage a secure, private, HIT structure, paid for by public and private stakeholders, to address the prescription drug problem in Maine, drive down overall health care costs and drive up quality and efficiency across the system.

14. Consumer Involvement in HIE and HIT

In addition to strong involvement by the provider community, HIN made a decision early on in its development to have a high level of participation by consumers. This level of consumer involvement is different than many other HIEs, but is an approach strongly supported by the HIN Board. The Consumer Advisory Committee is a HIN standing committee with representation from various organizations involved with consumers. The current membership

of the HIN Consumer Advisory Committee includes citizens, consumer advocates, consumer organizations, legal experts, health educators, privacy officers, public health professionals, and interested parties with experience and expertise in consumer participation and privacy protection in health information technology systems. Some of the organizations represented include the Family Planning Association of Maine, Legal Services for the Elderly, Maine Center for Public Health, Maine Civil Liberties Union, Maine Disability Rights Center, Maine Health Management Coalition, Maine Network for Health, National Alliance For the Mentally Ill and the University of New England Health Literacy Center. The Committee, which is chaired by a member of the HIN Board, has been responsible for reviewing and advising on all policies and procedures related to the confidentiality of the HIN clinical data and the privacy protection for patients. It has addressed HIPAA and State law requirements, as well as other federal and State guidelines and initiatives, and public health data laws. This committee has been instrumental in the development of the opt-out provision for patient participation in HIN for general medical information and the opt-in provision, passed into state law in 2011, for mental health and HIV information.

It has been HIN's goal since inception to allow consumers to both view and communicate information to the HIE. This has become even more important as health reform initiatives are implemented. Building on its long standing commitment to the involvement of patients in the development of the HIE and provision for patient access to the Statewide HIE, HIN is working closely with consumers and providers to expand patient participation and management of their own health care by implementing consumer-facing technologies. To assess the successful deployment of a comprehensive personal health record built upon a HIE model; HIN has met with health care providers, payers, government, and consumer stakeholders throughout 2012. In addition, a critical review of the proposed and now final rule for Meaningful Use Stage 2 was required. *The findings of this review pointed to six critical observations that have a significant impact on the statewide deployment of a HIE-based PHR:*

1) Meaningful Use requirements for Stage 2 have pushed health care providers and health care systems to a need for a tightly integrated patient portal solution with their EHR. The requirements for scheduling, messaging, and medication refill options for patients have focused most Maine providers' attention on their EHR vendors and integrated portals to meet Meaningful Use.
2) Many EMR-based portals are viewed by provider and consumer stakeholders as rudimentary in their ability to support all needs of patients. (a) They only include limited information; (b) The viewing portal is sometimes difficult to use and navigate through; (3) Access management presents difficulties.
3) EMRs have limited ability to accept discrete clinical data from other EMRs (CCDs are exchanged but as documents only) and therefore discrete data from other providers is not currently available in PHRs. This prevents consumers from having a true "community view" of their care between the hospital, their primary care provider and specialists.
4) EMR portals have limited ability to help the patient navigate other health care activities such as insurance eligibility, communications etc.
5) There have been identified needs for asynchronous communications from patients for care management purposes. Integrated EHR patient portals, while they do well for meeting the

needs of individual practice and hospitals they are not conducive to the patient centered medical home care management model of care coordination.

6) There has been an identified need in the Maine community to support more transparency in both quality and cost for patients. While there are some options available today, patients would prefer a single place to access their health care information, communicate with providers, and make health care purchasing decisions.

As a result of these findings, HIN and the State have found that a longitudinal, patient-centric, payer and provider agnostic personal health record platform is needed to help engage patients in all of their health care needs. *As a part of the SIM activities, HealthInfoNet will make the statewide HIE record available to patients/consumers through their provider-based patient portals that are being implemented as a result of Meaningful-Use Stage 2.* HIN is using the "blue-button" standards to deploy these tools – beginning a pilot with Eastern Maine Healthcare Systems. These tools will allow for information sharing with patients that supports real-time patient access to **all** of their clinical health information no matter where it is generated (PHR populated by the statewide HIE data).

HIT and HIE to Support ACO Efforts

In addition to managing the exchange, HIN has developed a clinical data warehouse environment to support data access and use. Exporting the HIE data to an analytic data warehouse will provide real time, high quality clinical data to assist in projecting health care utilization, treatment outcomes, and cost of identified patient cohorts – a necessary analysis for value-based purchasing, ACOs, and other health reform efforts. In 2012, HIN was awarded a grant by the Maine Health Access Foundation (MeHAF) to develop plans for the implementation of the data warehouse and to test the feasibility of linking the clinical data with Maine's All Payer Claims Database (APCD). This work provided the State and the Maine Health Data Organization (MHDO) – an independent State Government entity charged with oversight over the statewide APCD and rules and regulations regarding data collection, use, and release - with a detailed analysis of how the APCD data elements compare to the clinical data set including content and coding. The linkage feasibility study also provided HIN and the State with information on the strength of the identifying information in supporting valid linkages between the two databases. This study sets the foundation for the continued review and use of linked clinical and claims data to support the goals of the SIM grant.

The clinical data warehouse will also provide a statewide, shared resource for value-based purchasing initiatives and ACOs to use to meet the requirements to predict and measure the care provided to patients under this new model, including health outcomes, patient care treatment trends, and cost per patient. In addition the real-time nature of the HIE will allow the exchange to serve as a critical messaging engine to initiate care management processes that stakeholders need in order to promote better patient outcomes. *This work will complement the planned SIM work for payment and delivery system reform.* It has been recommended by the Commonwealth Commission that CMS should support: "Timely Monitoring, Data Feedback, and Technical Support for Improvement". This recommendation includes the development of robust information exchanges and standardized reports to provide ACOs with timely feedback on comparative results, support rapid-cycle improvements in quality and cost performance, and

develop new knowledge on effective and efficient clinical practices. The HIE in partnership with the State will support the use of clinical data matched with claims data to support these initiatives.

Maine Regional Extension Center and EMR/Meaningful Use Adoption Supports

HealthInfoNet oversees the Maine Regional Extension Center (MEREC), which provides education and technical assistance to help providers select, implement, and achieve meaningful use of certified EMRs. The MEREC is made up of a team of experienced local HIT professionals with intimate knowledge of the Maine health care community, and is part of a national network with access to a wealth of key information. It offers participating practices a wide range of services. Core services include: (1) EMR selection and implementation support; (2) Discounted pricing from pre-screened vendors; (3) HIE connection; (4) Low-interest loans offered in partnership with the Maine Health Access Foundation; (5) Quality improvement support in partnership with *Maine Quality Counts*; and (6) HIT & HIE Privacy and security best practices. In partnership with *Maine Quality Counts*, the MEREC has developed a quality and HIT coaching curriculum that is being deployed across the independent provider practices statewide (Approximately 145 practices). This curriculum is a model that is also being used for technical assistance to be delivered to provide similar QI support to BH providers in Maine. The goal is to provide both general EHR coaching activities *and* new topics related to behavioral health. Topics include: Using the HIE in the development of integrated health care plans for patients; Understanding how to use HIT to coordinate care for a Behavioral Health Home; Communicating with patients re: consent to include mental health information in the HIE; Using the HIE in behavioral health workflow; and Understanding State and Federal (42 CFR Part2) laws and policies concerning patient confidentiality and privacy related to sharing behavioral health information.

The MEREC and HIN have also been working with providers around the state to assess and collect information on the need for streamlined processes and HIT services. Many hospital, primary care and specialty (including behavioral health) providers have requested opportunities for shared services and shared learning opportunities to reduce their costs and administrative burden for complex HIT and HIE systems. Over the past 12 months, HIN has convened the hospital systems around the state and through an RFP process identified two vendors to serve as a vendor neutral shared electronic imaging archive managed by the HIE. In October 2012 HIN began a statewide pilot to demonstrate shared savings for use of a statewide archive rather than individual archives within each of the hospitals.

Similar efforts are underway in the behavioral health community. A number of Northern Maine community mental health providers, developed and are currently deploying a comprehensive EHR for five agencies – Day One, Charlotte White Center, Aroostook Mental Health Services, Opportunity Housing Inc., and Crisis and Counseling Centers. Their goal is to demonstrate how bringing unaffiliated organizations together to select and agree upon a common and limited set of reporting forms can result in cost saving through administrative streamlining. HIT integration is also proceeding in Southern Maine, where MaineHealth (Maine's largest integrated health care system), and the MaineHealth affiliated Maine Mental Health Partners (MMHP) are working to identify a single technology solution and an associated shared medical record across

their agencies. The MMHP network consists of Spring Harbor Hospital (a psychiatric facility), and three community mental health centers.

A subcommittee of the SAMHSA/HRSA project is currently charged with developing recommendations on addressing current and future barriers to EHR and HIT adoption by provider groups like behavioral health and long-term care (groups from which little funding from the CMS Meaningful Use program has been made available). SIM Grant Activates will be sought to continue these important convening efforts and to support these "un-incented" providers in adopting EHRs and HIT technologies that meet their needs.

Bangor Beacon HIE/HIT Efforts

HealthInfoNet and the OSC are currently working very closely with the federally funded Beacon Community project in the Bangor area. This project is focused on building a community based information exchange across many providers to support a more comprehensive approach to coordination of care and community involvement in providing high quality care while controlling cost. HIN is the exchange and data source. The work in building the capacity to serve as the data source for this initiative is very applicable to the broader efforts of establishing a statewide value-based data source. The Beacon Community's sustainability model is a true community-based ACO model, and the strategy to put technology in front has and will continue to serve as a model of data driven health care reform in the state.

Improving Health Outcomes for Children in Maine and Vermont (IHOC)

In February 2010, Maine and Vermont were awarded a five-year child health quality improvement grant by CMS which focuses on using quality measures and HIT to improve health outcomes for children. The goal, to improve timely access to quality care for children who are insured by Medicaid or CHIP, is being accomplished by working to:

- Collect clinical and administrative data, test, and align child health measures across programs.
- Share quality data with payers, providers, consumers and the Centers for Medicaid and Medicare Services (CMS).
- Align the IHOC quality measures with those of private payers, professional groups, and MaineCare.
- Set up secure computer systems to collect well-child data from electronic medical records, the statewide HIE and from state government.
- Develop new, secure ways for health providers to access health assessments for children in foster care.
- Provide the American Academy of Pediatrics' *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, Third Edition, Tool and Resource Kit.
- Conduct quality improvement training with the Patient Centered Medical Home Pilot and other medical practices. The goal is to improve rates of preventive services.
- Build a child health quality improvement partnership that will continue after the grant ends.

The IHOC grant has entered its fourth year, a key period of implementation of HIT to include continued utilization of the HIE to build on the tremendous efforts to provide a lasting framework for quality health care and measurement of children's health. Particularly when coupled with HRSA's Early Childhood Comprehensive Systems (ECCS) grant that builds on the work of IHOC for integrated developmental screening, the SIM grant provides an opportunity for further activities incorporating lessons learned and developing a long-term strategy for meeting the Triple Aim goals and objectives for this population. The IHOC grant principals have been active participants in the OSC Steering Committee (HITSC) supporting the coordination of children's HIT efforts, and will continue to complement and help inform the SIM grant and other HIT initiatives.

HIT Work Force Initiatives

Federal funding under the HITECH Act, provided opportunities for Maine's Community College system to provide HIT Certificate Programs for students entering the work force. Maine's Community College system successfully graduated 230 students with HIT Certification. These graduates are entering the job market with the skills and ability to help the State and the nation transform the Health Information Technology work force.

Maine's OSC and MaineCare Meaningful Use Program, with federal funding under the OSC program, recently began a cooperative agreement to hire six graduates of the Kennebec Valley Community College. As a new program, despite the success that Maine has seen from its streamlined reporting processes, Maine's providers are challenged by exporting data from EHRs for Meaningful Use purposes. The graduates have been hired to assist up to 900 eligible professionals to meet attestation and reporting requirements under the Meaningful Use Program.

Providers who are assisted with meeting Meaningful Use, but not yet participants in the HIE, will be referred to the HIE for education on the benefits of the exchange of health care data and assistance in participating in the HIE. These projects will enhance State HIT efforts, including the SIM grant goals and objectives, of having real-time data to improve health care delivery and patient experience.

ConnectME Authority—Broadband Capacity and Use

In 2006, Maine established the ConnectME Authority, an independent State agency governed by a public-private Board, to expand broadband capacity and use, particularly in unserved or under-served areas. Each year the Authority awards grants for projects that expand capacity to increase economic development, tele-health services, educational opportunities and improved health care. To date the Authority has awarded more than $9 million dollars for projects totaling in excess $17 million. The Authority administers a federal grant for mapping, planning, capacity building, and technical assistance.

The ConnectME Authority participates in the HITSC. As mentioned above, earlier this year, the OSC and the Authority engaged a vendor that conducts regular ongoing broadband mapping and surveys, to include 22 questions related to HIT, such as the use of EHRs, HIE, tele-health, broadband capacity for medical services requiring high-speed internet, etc. The survey results

will provide baseline data that will be used to identify areas for broadband projects and mechanisms to improve the use of EHRs and meet Meaningful Use requirements. The results will also be shared with the quality and evaluation group under the SIM grant for further efforts to improve HIT and health care delivery.

The Federal Communications Commission (FCC) recently announced that it will provide up to $60 million nationwide for grants to improve tele-health for Long Term Care providers, home health, and hospice organizations. The OSC and representatives of the HITSC and HIE plan to develop three grant proposals to be submitted later this year:

1) An EHR project with the Long Term Care organizations in the State (including the Beacon program), to develop a transition of care electronic application to be used for patients discharged from hospitals or LTC facilities to promote a higher quality of care and experience for the patient, and an integration of care between providers. This project will also seek funding for infrastructure and subsidized internet rates.
2) A project in rural Maine to provide funding for paramedics who are often the first responders at an accident or incident at home; and
3) A tele-health project that will enable providers, particularly home health workers, to communicate electronically with hospitals and physicians; utilize electronic systems that enable health care systems to provide at-home care, such as ICU or surgery follow-up, care management and nursing services; and appropriate tele-health mental health or counseling services.

These three projects complement the SIM grant model to develop community service responses to health care that enable the elderly and others to remain in their homes or if long term care is needed, allow health care providers to have access to accurate and timely information through the use of the HIE and new technologies.

As this Section demonstrates, the State of Maine takes a long-term integrated approach to Health Information Technology for today and the future. These efforts will benefit the SIM model by providing timely health care data--at the clinical, claims, and exchange and Meaningful Use levels--that enhance the State's ability to test and develop quality and efficient health care service delivery systems for payers, providers and patients.

G. Model Interventions

Refer to DRR Section G: Model Intervention, Implementation and Delivery
Supporting Documentation Available:
Appendices G1- G14 can be found in Year One Plan Submission on this website:
http://www.maine.gov/dhhs/sim/documents/SIM%20docs/plan%20docs/ops%20plan/MaineSIMOperationsPlanAppendicesD-E-G1-11.pdf
G15) Behavioral Health Home Rule
Website: http://www.maine.gov/sos/cec/rules/10/144/ch101/c2s092.docx

15. State Policy and Regulatory Levers

MaineCare's Health Homes Initiative and multi-payer Primary Care Medical Home (PCMH) Pilot provide the foundation for the State's emphasis on Delivery System Reform under its SIM Grant proposal. The State of Maine has an approved State Plan Amendment (effective January 1, 2013) and operational state policy for its Health Homes Initiative (Section 2703 of the Affordable Care Act) targeting MaineCare members with chronic conditions. 75 of the 171 total Health Home primary care practice sites, together with the 10 Community Care Teams with which they partner to serve the highest need patients, also receive support from commercial payers (Anthem, Aetna, and Harvard Pilgrim) and Medicare through Maine's Patient Centered Medical Home pilot, which is part of Medicare's Multi-payer Advanced Primary Care. Maine received approval in July 2013 for an amendment to its approved SPA in order to delete the reference to a June 30 deadline for primary care practice achievement of the National Committee for Quality Assurance (NCQA) PCMH certification. The State extended the deadline to December 31, 2013 and deleted reference to a specific date in the amended SPA.

The State has submitted its State Plan Amendment to CMS for the second stage of its Health Homes Initiative, Behavioral Health Homes to serve adults with Serious Mental Illness and children with Serious Emotional Disturbance. The State is currently working with CMS to respond to an issue raised in its Request for Additional Information. State rule for Behavioral Health Homes went into effect on April 1, 2014 to coincide with implementation of the initiative. See attached Behavioral Health Homes SPA as submitted and the approved Section 93 rule for Behavioral Health Homes.

The State received approval for its Accountable Communities SPA in May of 2014. The state submitted a minor amendment to its approved SPA in June necessary to implement Accountable Communities through contractual relationships with the AC Lead Entities. The State is working on approving contracts for the Accountable Communities in order to implement by August 1, 2014.

In regards to SIM, there are two main processes that exist to ensure any need for amendments or new legislation.

1) The Office of MaineCare Services currently has a process by which policy change concerns are discussed, developed, and driven through the regular agenda of Senior Management at MaineCare.
    - The Senior Management Team (SMT) at MaineCare has a standing weekly meeting to discuss the need for new legislation, review proposed legislation, and monitor enacted legislation to ensure the needs of MaineCare and the Department's Value-Based Purchasing Strategy are met.
    - New initiatives are also vetted at SMT. Once vetted; MaineCare's Policy Director assigns a policy writer to work with a programmatic lead to take the initiative through the requisite federal regulatory pathway and rulemaking process.
2) SIM's governance model, involves broad stakeholder engagement with representation throughout the healthcare industry and community (including members from the legislature). The governance structure itself serves as a vehicle to discuss, analyze, and promote amendments or new legislation. Maine's belief is that this governance structure will enable the healthcare community to speak with a unified voice to more effectively influence healthcare reform through policy.

State Policy to facilitate sharing individual mental health information
With support from DHHS, the Governor enacted into law H.P. 353 - L.D. 534, An Act To Improve Care Coordination for Persons with Mental Illness, which expands Maine state law 22 M.R.S.A. § 1711-C to allow for mental health information sharing for the purposes of care coordination and care management in addition to treatment and payment, the purposes currently covered be the law. This will enable providers to better identify gaps in care and improve care coordination and care management, especially under the models to be implemented through ACO arrangements and Behavioral Health Homes.

16. Other Policy and Regulatory Levers

Continued Support of Health Homes and the PCMH model, as Appropriate
Maine's SIM Leadership Team and Steering Committee will be engaging and educating the legislature regarding the outcomes and evaluations of Maine's multi-payer PCMH Pilot and Health Homes Initiative. The Department is working to procure support to extend funding for the Health Home Initiatives beyond the eight quarters of enhanced federal match. In tandem with this effort, the State and its SIM partners are leveraging relationships with employers and commercial payers in order to maintain and grow the PCMH model with enhanced payment support.

Coordinated Approach to Medicaid Primary Care Provider Incentive Program (PCPIP)
The State currently provides incentive payments to Primary Care Case Management (PCCM) office-based practice sites under its PCPIP program in order to 1) Increase access of MaineCare members to providers; 2) Reduce unnecessary/inappropriate ER utilization; and 3) Increase utilization of preventive/quality services. The state is evaluating the effectiveness of the program and plans to utilize these results to inform the selection of quality metrics for the SIM Initiative that will be reported on across payers. In addition, this evaluation will help the state to ensure that the PCPIP appropriately complements SIM and other MaineCare initiatives. The

State anticipates it will file an amendment to its PCCM SPA and pursue the requisite rulemaking in order to achieve these goals.

Consideration of New Pathways for Medicaid Cost-Sharing
VBID is an important component of Maine's SIM model. Maine already planned to work within Medicaid constraints to implement VBID principles to the extent possible with MaineCare's population absent a federal waiver. With the release of CMS-2334-F and its expanded flexibility for states to implement cost sharing with its Medicaid enrollees, Maine will be exploring the potential benefits of pursuit of this authority and how this opportunity may align with its VBID work for commercially insured populations.

Consideration of Future Federal Waiver
The State is interested in the pursuit of a global payment, or capitated, model that would build upon and rely on its relationship with providers and their community-based care coordination and management of high need individuals. Maine would like to work with CMMI to explore the potential use of an 1115 waiver in order to pursue this goal, as it does not want to construct such a model with all the Managed Care regulations pursuant with a 1915(b) waiver.

Potential Utilization and/or Amendment of 22 MRSA 1841 et seq., the Hospital and Health Care Provider Cooperation Act (2005)
Maine's Hospital and Health Care Provider Cooperation Act extends protection to horizontal relationships between hospitals and physicians by Creation of a Certificate of Public Advantage (COPA) that exempts the state from federal antitrust liability for conduct actively supervised by the state. Maine does not anticipate that providers will face antitrust issues accompanying the State's implementation of multi-payer ACOs. The State's four MSSP ACOs and one Pioneer ACOs are protected by the Medicare Fraud and Abuse waivers. In addition, providers will put in place appropriate contracts with each other to collaborate to coordinate care for patients. Providers that join together outside of a common health system are unlikely to have any significant market share. However, as payment reform models progress toward capitation, if providers do appear likely to face antitrust challenges, the State is exploring the feasibility and implications of amending the Cooperation Act to cover vertical relationships between hospitals, physicians, and other community-based and health providers.

17. Alignment of Current Policy Positions and Planned Actions with Federal Initiatives/ Direction

Maine's currently operational Health Homes SPA serving Medicaid members with chronic conditions and Behavioral Health Homes Initiative reflect the model put forth in Section 2703 of the Affordable Care Act. The Health Homes Initiative builds off the foundation of Maine's multi-payer Patient-Centered Medical Home Pilot, which welcomed Medicare as a payer through the Multi-Payer Advanced Primary Care Practice (MAPCP) initiative in January, 2012. Medicare's involvement in the PCMH Pilot enabled the addition of Community Care Teams to the model, which provide wrap around supports to the practice's highest need patients, as well as

expansion of the multi-payer Pilot practice sites from 26 to 75. MaineCare's participation in the Pilot is now through its Health Homes Initiative. In addition to its support of Maine's multi-payer PCMH Pilot, Medicare also provides support through CMS and HRSA's FQHC Advanced Primary Care (APC) Demonstration to 14 FQHC sites across the state. Six of the 14 APC sites also participate in the Health Homes Initiative. Overall:

- 75 practices and 10 Community Care Teams receive support from Medicare, MaineCare and commercial payers under the PCMH Pilot
- Six FQHC sites receive support from MaineCare and Medicare through Health Homes and the APC Demonstration
- 16 practice sites participate in Health Homes with Medicaid as the single- payer
- 80 practice sites participate in Health Homes and also receive support for practice transformation from Anthem and/or Maine Community Health Options outside of the MAPCP Demonstration.
- Eight FQHC sites participate in the APC Demonstration with single-payer support from Medicare.

Maine was an active participant in the federal MAC Value-Based Purchasing Learning Collaborative for Fee for Service states. This group was instrumental in aiding CMCS to formulate its guidance to states to create Integrated Care Models (ICM) under State Plan Authority. MaineCare's planned Accountable Communities Initiative will operate as a shared savings ACO model under this authority. Maine has also worked to align many of the features of its Accountable Communities model with Medicare's Shared Savings Program (MSSP) and Pioneer ACO Initiatives in terms of provider requirements, attribution, shared savings methodology, quality metrics and other features. This will facilitate Maine's five current Medicare ACOs to participate in MaineCare's Accountable Communities.

MaineCare has worked collaboratively with its Improving Health Outcomes for Children (IHOC) Project, a recipient of the federal CHIPRA Quality Demonstration grant, in order to align measures and priorities with its Health Homes Initiatives and Primary Care Provider Incentive Program (PCPIP). Maine's SIM team will continue to work with IHOC to ensure alignment with Accountable Communities and the common measures selected for publicly reporting and value-based purchasing efforts under multi-payer ACO arrangements.

The Maine CDC is our state public health agency within the Department of Health and Human Services. Ms. Debra Wigand, Director for the Division of Population Health, serves on the steering committee for SIM as well as workgroups. Ms. Wigand oversees many program areas supported by US CDC related to the SIM, including; Addressing Asthma from a Public Health Perspective; Heart Disease, Diabetes, Obesity, and Related Risk Factors and School Health; Oral Health; Cancer Prevention and Control (Breast, Cervical and Colorectal); and Tobacco Control; Ms. Wigand's Division oversees HRSA funded programs such as Maternal and Child Health Block Grant and the Children with Special Health Needs program. Maine CDC staff from these program areas are actively engaged with the SIM work.

Maine CDC alignment with SIM activities can be found through the community-clinical linkage of the community health worker model and the promotion of the National Diabetes Prevention Program (NDPP) developed by the US CDC. Epidemiology is core to much of the Maine CDC data and surveillance activities and will be helpful in evaluation and alignment of public health metrics. The Maine CDC is home to the HRSA Early Childhood Comprehensive Systems Initiative (ECCS), the ACA Maternal, Infant, and Early Childhood Home Visiting Program (MIECHV), Refugee Health and Women's Health activities. Also within the Maine CDC are the community benefit programs of critical access hospitals through the Rural Health and Primary Care Program and the Immunization Program.

The Maine CDC is currently engaging a diverse group of stakeholders to implement its a State Health Improvement Plan (SHIP) as part of its national Public Health accreditation effort. Goals for the State Health Improvement plan (SHIP) were based on Healthy Maine 2020 goals, in turn derived from Healthy People 2020. The SHIP process was focused on identifying best practices, including use of the National Prevention Strategy. The SHIP is the foundation for the SIM Population Health Plan Roadmap that will be included in this SIM Operational Plan revision.

18. Formal Mechanisms for Engaging Payers and Providers

Maine's formal mechanisms for engaging payers and providers include its SIM Steering Committee and Payment Reform, Data Infrastructure, and Delivery System Reform subcommittees, all part of Maine's SIM governance structure. Representatives from MaineCare, Medicare and Anthem, the largest commercial payer in state insuring almost 1/3 of Maine's total population, are appointed to the Steering Committee. The Maine Hospital Association selected representatives from a large health system and small hospital, and the Maine Medical Association, Maine Osteopathic Association, Maine Primary Care Association, and Maine Nurse Practitioner's Association collectively agreed on representatives from two primary care practices.

In addition to the Steering Committee and subcommittees, payers and providers will be represented in many stakeholder workgroups convened by partners under or in collaboration with SIM's various initiatives. These workgroups include:

- Maine Health Management Coalition's Accountable Care Implementation (ACI) workgroup, Pathways to Excellence (PTE) public reporting, PTE Behavioral Health, Health Care Cost Workgroup, Behavioral Health Care Cost Workgroup, and Value-Based Insurance Design (VBID).
- HealthInfoNet's Board of Directors, Consumer Advisory Committee and Technical and Provider Practice Advisory Committee
- Maine Quality Counts' Board, PCMH Working Group and Behavioral Health Committee

Figure 8 below indicates organizations representing different stakeholder groups on the abovementioned SIM governance committees and partner workgroups; in cases where specific representatives have not yet been selected, stakeholder groups that will be represented are indicated with an "x."

Figure 8: SIM Partner Representation: Provider and Payer Stakeholders

PROVIDER & PAYER STAKEHOLDERS		Commercial Payers	Primary Care Providers			Small Hospital	Health System	Academic med. Center	Professional Society	Behavioral Health Provider	Long Term Care Provider	Develop. Disability Provider	Pharmacy
			FQHC	Independent	Other								
SIM Steering Committee		Anthem	Penobscot Community Health Ctr		Wiscasset Family Medicine	Franklin Memorial Hospital (FMH)	MaineHealth	MaineHealth (Maine Medical Center)	Maine Nurse Practitioner Association (MNPA)	Community Health & Counseling Services (CHCS); Crisis & Counseling , Inc. (C&C)	Oak Grove Center		
SIM Subcommittees	**Delivery System Reform**		X*		X*	York Hospital	Tbd	X*	X*	X*	X*	X*	
	Payment Reform	X*			X*		X*			X*			
	Data and Analytics Infra-structure	X			X*		X*			X*	X		
MaineHealth Management Coalition	**Accountable Care Implementation (ACI)**	X			X	X	X	X	X	X			
	Pathways to Excellence (PTE)-Systems	Aetna	Penobscot Community Health Ctr		Martin's Point Healthcare	FMH	MaineGeneral (MG)	Maine Medical Ctr. (MMC)		Spectrum			
	PTE- Physicians												
	PTE- Behavioral Health	X	X	X	X	X	X	X	X				
	Health Care Cost Workgroup	X	X	X	X	X	X	X	X	X			
	Behav. Health Care Cost Workgroup	X	X	X	X	X	X	X	X	X			
	VBID	X	X	X	X	X	X	X	X				
HealthInfoNet (HIN)	**HIN Board of Directors**	Martin's Point		Manchester Family Medicine			Maine Health, Eastern Maine Health System (EMHS), MG, Central Maine	MMC					

PROVIDER & PAYER STAKEHOLDERS		Commercial Payers	Primary Care Providers			Small Hospital	Health System	Academic med. Center	Professional Society	Behavioral Health Provider	Long Term Care Provider	Develop. Disability Provider	Pharmacy
			FQHC	Independent	Other								
							Health System (CMHS						
	HIN Consumer Advisory Cmte						EMHS						
	HIN Technical & Provider Practice Advisory Cmte			Rockland Free Clinic	Martin's Point	Inland, FMH, Cary Medical, St. Joseph's	Eastern Maine Medical Center (EMMC) CMHS	MMC	MHA, MMA				
Maine Quality Counts	**Maine Quality Counts Board**	Aetna, Anthem					MaineHealth, MG, EMHS, CMHS		Maine Hospital Association (MHA), Maine Medical Association (MMA)	C&C, Maine Mental Health Partners (MMHP)			
	PCMH Working Group	Maine Community Health Options	DFD Russell, Eastport Health Center	Greater Portland Medical Group, PCMH-Bangor	Martin's Point, EMMC for Family Medicine, Husson Pediatrics, MMC PHO	St. Mary's MMP Group			Maine Network for Health, Maine Primary Care Association (MPCA), MNPA	Behavioral Health Integration at MaineHealth			Community Pharmacy of Maine
	Behavioral Health Committee	Anthem, CIGNA	Sacopee Valley Health Center			MidCoast Mental Health, Acadia Hospital	MaineHealth, MMC Psychiatry, EMHS, MG, St. Mary's Health System, Northeast Occupational Exchange		Maine Assoc. of Psychiatric Physicians, Maine Network for Health	MMHP, Aroostook MH Center, C&C, Spurwink, Charlotte White Ctr, Acadia Hosp, Sweetser, Evergreen Behavioral Services	Charlotte White Ctr		

19. Mechanisms That Engage a Wide Range of Governmental Stakeholders

Maine's formal mechanisms for engaging government stakeholders include its Maine SIM Leadership Team, SIM Steering Committee, and Payment Reform, Data Infrastructure and Delivery System Reform subcommittees, all part of Maine's SIM governance structure. The Senior Health Policy Advisor to the Governor chairs the Maine Leadership team, which involves the Commissioners of the Department of Health & Human Services (DHHS) and the Department of Professional and Financial Regulation, bipartisan elected officials, and leadership from Maine Medicaid and the Office of Policy and Management. MaineCare's medical director chairs the SIM Steering Committee, which includes representation from the Maine Center for Disease Control (CDC), the Bureau of Insurance (BOI), and bipartisan legislators. SIM subcommittees include representation from additional Offices within DHHS including Substance Abuse and Mental Health Services, Aging and Disability Services, and Child and Family Services.

Maine CDC is the state public health agency, and is part of DHHS. Maine CDC has been engaged with the SIM process beginning with the initial application, and is assisting in aligning chronic disease prevention and care management best practices from the public health field with the SIM approach. Maine has two municipal health departments – Bangor and Portland. The health department in Bangor has been actively involved in the Beacon Society initiative and both Portland and Bangor are kept informed on the SIM initiative via the Statewide Coordinating Council for Public Health (SCC). The SCC meets quarterly and members have been fully engaged in the development of the State Health Improvement Plan. Maine does not have county health departments, but is organized into nine public health districts. These districts are also kept informed of SIM progress via the SCC.

In addition to the Steering Committee and subcommittees, the State of Maine will be represented in many stakeholder workgroups convened by partners under or in collaboration with SIM's various initiatives. These workgroups include:

- Maine Health Management Coalition's Accountable Care Implementation (ACI) workgroup, Pathways to Excellence (PTE, public reporting) Physician, Systems and Behavioral Health groups, Health Care and Behavioral Health Care Cost Workgroups, and Vale-Based Insurance Design (VBID).
- HealthInfoNet's Board of Directors, Consumer Advisory Committee and Technical and Provider Practice Advisory Committee
- Maine Quality Counts' Board, PCMH Working Group and Behavioral Health Committee

Figure 9 below indicates titles of individuals representing different government offices on the abovementioned SIM governance committees and partner workgroups; in cases where specific representatives have not yet been selected, government entities that will be represented are indicated with an "X."

Figure 9: SIM Partner Representation: Government Stakeholders

GOVERNMENT STAKEHOLDERS		Federal CMS	Governor's Office	Department of Health and Human Services								City-level health dept.	State elected officials	Dept. of Prof & Finance Regs	Office of Policy & Mgmt	Tribal Nations	Maine Quality Forum	MHDO
				Commissioner's Office	MaineCare	Office of the State Coordinator	Maine Center for Disease Control	Substance Abuse & Mental Health	Office of Aging & Disability Services	Office of Child & Family Services	Office Of Cont. Qual. Improvement							
Maine Leadership Team			Senior Health Policy Advisor (Chair)	Commissioner	Director, Deputy Director, Medical Director													
SIM Steering Committee				Medical Director (Chair)	Director of Population Health								Bipartisan Representative, Senator	Commissioner	Director	X		
SIM Subcommittees	Delivery System Reform			X*	X*		X*	X*	X*	X*	X	X	X				X	
	Payment Reform	X	X		X*		X						X	Bureau of Insurance Sup't				
	Data and Analytics Infra-structure				X*	X*	X*	X*		X	X*		X				X*	X*
MaineHealth Management Coalition	**ACI**		X		Director of Strategic Initiatives		X											
	PTE-Systems				Director of Strategic Initiatives		X											
	PTE-Physicians				Medical Director													
	PTE-Behavioral Health				X			X										

GOVERNMENT STAKEHOLDERS		Federal CMS	Governor's Office	Department of Health and Human Services								City-level health dept.	State elected officials	Dept. of Prof & Finance Regs	Office of Policy & Mgmt	Tribal Nations	Maine Quality Forum	MHDO
				Commissioner's Office	MaineCare	Office of the State Coordinator	Maine Center for Disease Control	Substance Abuse & Mental Health	Office of Aging & Disability Services	Office of Child & Family Services	Office Of Cont. Qual. Improvement							
	Health Care Cost Workgroup		X		Director of Strategic Initiatives			X	X						X			
	Behav. Health Care Cost Workgroup		X		X			X	X						X			
	VBID				X			X	X						X			
Maine Quality Counts	Maine Quality Counts Board				Director of Strategic Initiatives		Director, Division of Population Health											
	PCMH Working Group				Director of Strategic Initiatives, Medical Director, Health Homes staff, Special Population												Exec. Director	
	Behavioral Health Committee				Value-Based Purchasing Project Manager			Assoc. Director									Executive Director	
HealthInfoNet (HIN)	**HIN Board of Directors**			Commissioner		HIT Director	State Epidemiology-gist											
	HIN Consumer Advisory Cmte					HIT Director												

GOVERNMENT STAKEHOLDERS		Federal CMS	Governor's Office	Department of Health and Human Services								City-level health dept.	State elected officials	Dept. of Prof & Finance Regs	Office of Policy & Mgmt	Tribal Nations	Maine Quality Forum	MHDO
				Commissioner's Office	MaineCare	Office of the State Coordinator	Maine Center for Disease Control	Substance Abuse & Mental Health	Office of Aging & Disability Services	Office of Child & Family Services	Office Of Cont. Qual. Improvement							
	HIN Technical & Provider Practice Advisory Cmte					HIT Director												

20. Mechanisms That Engage a Wide Range of Community/Patient Stakeholders

Maine's formal mechanisms for engaging a wide range of community/patient stakeholders include its SIM Steering Committee and Payment Reform, Data Infrastructure and Delivery System Reform subcommittees, all part of Maine's SIM governance structure. The Steering Committee includes a MaineCare member and Maine Equal Justice Partners, an advocacy organization, and all subcommittees include consumer representation as well. In the Spring of 2014, SIM consumer representation articulated a risk of insufficient consumer engagement in the SIM governance process, and developed a plan to mitigate that risk. That plan is in the process of being reviewed through SIM governance and recommendations with the objective to ensure robust consumer engagement will emerge and be implemented as directed by SIM governance will result.

In addition to the Steering Committee and subcommittees, the community and patient stakeholders will be represented in many stakeholder workgroups convened by partners under or in collaboration with SIM's various initiatives. These workgroups include:

- Maine Health Management Coalition's Accountable Care Implementation (ACI) workgroup, Pathways to Excellence (PTE, public reporting) Physician, Systems and Behavioral Health groups, Health Care and Behavioral Health Care Cost Workgroups, and Value-Based Insurance Design (VBID).
- HealthInfoNet's Consumer Advisory Committee
- Maine Quality Counts' Board, PCMH Working Group and Behavioral Health Committee

Long Term Care, behavioral health and developmental disability providers are also represented in Figure 8, Section 18 above as part of the Provider Category.

Figure 10 below indicates the names of employer, advocacy, community-based organizations and foundations. Consumer representation and cases where specific stakeholders have not yet been selected be represented are indicated with an "X."

Figure 10: SIM Partner Representation: Consumers

COMMUNITY/ PATIENT STAKEHOLDERS		Purchasers (not restricted to MHMC Members)	Community-based non-medical organizations	Foundations	Patient Advocacy Groups	Consumers	Tribal Nations	Quality Improvement Organization	Health Information Exchange	Regional Health Improvement Collaborative
Maine Leadership Team							X			
Steering Committee		Cianbro			Maine Equal Justice Partners	X	X	Maine Quality Counts (QC)	Health InfoNet (HIN)	Maine Health Management Coalition (MHMC)
Subcommittees	**Delivery System Reform**	X*	X*	Maine Health Access Foundation (MeHAF)	X	X		QC	HIN	MHMC
	Payment Reform	X* (must include non-Coalition purchaser)	X			X*		QC	HIN	MHMC
	Data and Analytics	X*	X			X*		QC	HIN	MHMC*
MaineHealth Management Coalition	**ACI**	X				X		QC	HIN	MHMC
	PTE-Systems	University of Maine System (UMS), Jackson Labs, State of Maine, Bath Iron Works, Maine Education Association Benefits Trust (MeABT), Employee Benefits Solutions				X		QC		
	PTE-Physicians	X		MeHAF		X		QC		
	PTE- Behav Health	X	X			X		QC	HIN	Network for Regional Health Improvement
	Health Care Cost Workgrp	X	X	MeHAF		X		QC	HIN	

COMMUNITY/ PATIENT STAKEHOLDERS		Purchasers (not restricted to MHMC Members)	Community-based non-medical organizations	Foundations	Patient Advocacy Groups	Consumers	Tribal Nations	Quality Improvement Organization	Health Information Exchange	Regional Health Improvement Collaborative
	Behav Health Care Cost Workgrp	X	X			X		QC		
Maine Quality Counts	**Maine Quality Counts Board**	Mt. Desert Island Imported Care Services, Inc.				X				
	PCMH Working Group	UMS		Medical Care Development	Consumers for Affordable Health Care	X				MHMC
	Behav Health Committee				NAMI Maine	X				
	Maine Quality Counts Board	X			Maine Parent Federation, Maine Children's Alliance, NAMI Maine	X				
	Maine Quality Counts Consumer Advisory Council				Lanie Abbott, Eastern Maine Health Systems Poppy Arford, Consumer Diane Boas, Consumer Cathy Bustin, Disability Rights Center Richard Chaucer, Consumer Kathy Day, Consumer					

COMMUNITY/ PATIENT STAKEHOLDERS		Purchasers (not restricted to MHMC Members)	Community-based non-medical organizations	Foundations	Patient Advocacy Groups	Consumers	Tribal Nations	Quality Improvement Organization	Health Information Exchange	Regional Health Improvement Collaborative
					Marianne Heinrick Perry, Consumer Arthur Hill, University of Maine Christine Holler, Consumer Kim Humphrey, Maine Primary Care Assoc. Daniel L'Heureux, Maine Quality Counts Board Lydia Richard, Consumer Jenny Rottmann, Maine Quality Counts Board Rose Strout, Consumer Judy Ward, Maine Quality Counts David White, Maine Quality Counts Board Kellie Slate Vitcavage, Maine Quality Counts					

COMMUNITY/ PATIENT STAKEHOLDERS		Purchasers (not restricted to MHMC Members)	Community-based non-medical organizations	Foundations	Patient Advocacy Groups	Consumers	Tribal Nations	Quality Improvement Organization	Health Information Exchange	Regional Health Improvement Collaborative
HealthInfoNet (HIN)	**HIN Consumer Advisory Committee**		AARP, Fran Peabody Center, Maine Civil Liberties Union, Planned Parenthood, Family Planning Association of Maine, Maine Center for Public Health		HIN Consumer Advisory Committee, Maine HIV Aids Advisory Committee, Advocacy Initiative Network	X			HIN	

21. Implementation of Public Health Integration

Dr. Sheila Pinette, Director of the Maine CDC, has committed the organization to coordinate with the Office of MaineCare Services and the SIM grant. Dr. Pinette has actively engaged senior staff, convening meetings of leadership from the two offices to discuss mutual goals. The Maine CDC commits to working with the Office of MaineCare Services to further this work. Examples of work already coordinated includes: Meaningful Use, State Health Improvement Plan priorities, messaging for MaineCare members, and a pilot for high cost utilizers that supports cross-office problem solving to support improved assistance to MaineCare members. The SIM grant provides the opportunity to broaden and further this work. SIM is a standing agenda item at the weekly Maine CDC Senior Management Team meeting, providing the impetus to keep the SIM model connected to the work of Maine CDC. Maine CDC also connects SIM to the Statewide Public Health Coordinating Council, which includes all nine public health districts with representatives from municipal and county governments, hospitals, community coalitions, educational institutions, agencies serving elders, tribal health, and health care systems. Both agencies will continue to look for ways to make the necessary connections to ensure that the SIM grant demonstrates authentic collaboration and gains from the support of public health efforts to impact Maine people where they live, learn, work, and play. Inclusion of Maine CDC as the connection to public health provides the most effective and efficient use of resources, assuring both inclusion of appropriate resources while avoiding duplication of services.

Shared planning and data is an important goal for this collaboration. Maine CDC released a State Health Assessment in 2012. This assessment was developed with engagement from hospitals, public health, educational institutions, and other state and community partners. The data has been made available to community partners and the public via the Internet. Since 2012, Maine CDC has been part of a collaboration to develop a shared health needs assessment and planning process to developed a set of common population health indicators and a shared community engagement process, satisfying public health needs and non-profit hospitals' IRS community health needs assessment requirements. A timeline for implementation has been developed by the workgroup. These activities will support SIM model implementation by providing a shared framework for population level data between health care and public health.

H. Participant Retention

Refer to DRR Section H: Participant Retention Process

Supporting Documentation Available:

Appendices H1- H10 can be found in Year One Plan Submission on this website: http://www.maine.gov/dhhs/sim/documents/SIM%20docs/plan%20docs/ops%20plan/MaineSIMOperationsPlanAppendices%20H-I-J-K-L.pdf

The Maine State Implementation Model primarily relies on cooperation and collaboration of payers and providers, augmented through the alignment and activation of market forces, to move the test model forward over the duration of the grant period. Collaboration is one of the major threads of the Maine SIM test. No commercial payer faces regulatory requirements that compel their involvement in SIM initiative activities. Similarly, providers are not influenced by statutory or regulatory dictates to participate in the SIM test.

MaineCare is subject to the direction of the Commissioner of the Department of Health and Human Services and the Governor of the State. The program's budget is proposed by the Governor and reviewed and finally enacted by the Legislature. While much policy direction for the program is set by state government's administration and/or the federal government, the Legislature does also provide direction in the form of enabling legislation. Recommendations from a Legislative taskforce on MaineCare Redesign recommended that the MaineCare program implement its Value-Based Purchasing program, including Health Homes and Accountable Communities. Stage A Health Homes are now codified in statute and Stage B Behavioral Health Homes and Accountable Communities will also be in statute once implemented. From this perspective, then, MaineCare is subject to certain statutory, regulatory, and budgetary “requirements” that governs the program's involvement in SIM.

The Maine Department of Health and Human Services chose to convene its strategic partners (Maine Health Management Coalition, HealthInfoNet and Maine Quality Counts) and drove the development of the SIM grant proposal. It did so without any formal external requirement to do so. The Department now acts as the lead Partner in the Maine SIM initiative, remaining the driving force of the initiative. Holly Lusk, health policy advisor to Governor Paul LePage, chairs the Maine Leadership Team, which is at the helm of the Maine SIM governance structure (see Section A of this Operations Plan).

CMS faces its own set of external, formal regulatory and statutory requirements that may contribute to its participation in certain aspects of the test model – e.g. alternative payment arrangements. Further, CMS' involvement in SIM is itself a creature of statute. Maine presumes that CMS' willingness to remain at the table will continue throughout the duration of the grant period.

22. Requirements for Participating Payers

Maine payers and providers have long demonstrated an aptitude and willingness to collaborate on their own accord to advance innovative ideas aimed at reforming our health care system. Like any innovative endeavor, not all of them have been successful, but that has not been because of a lack of collaboration and participation. Maine has consistently been a leader in health reform and those initiatives have always benefited from broad based involvement of all interested parties and the Maine SIM grant is no exception. The letters of commitment from Maine's major payers were included in the original proposal as well as the Operational Plan submitted in July 2013. Although there is no regulation or statute compelling their participation, their support of the proposal continues, as evidenced by their level of involvement since the early weeks of the planning phase of the project and their continued participation on the SIM Steering Committee and the subcommittees.

System Delivery

The Maine SIM model relies on alignment of delivery system reform efforts, public reporting, and, to the extent possible, value-based payment structures across payers. The platform for transformation of system delivery under SIM is Maine's PCMH Pilot and Health Homes Initiatives. The payers in the PCMH Pilot include MaineCare, Medicare, Anthem, Aetna, and Harvard Pilgrim Health Care. Each of the commercial payers all have contracts with the PCMH practices and Community Care Teams to provide monthly per member per month enhanced payments. Medicare has an agreement with the State's Maine Quality Forum/ Dirigo Health Agency under the Multi-payer Advanced Primary Care Practice Demonstration. In addition, Medicare provides support to six FQHC Health Home sites that are outside the MAPCP Demonstration and PCMH Pilot in accordance with CMMI requirements. MaineCare is required to provide support for qualified Health Homes through State rule, Section 91 of MaineCare policy, which is based on Section 2703 of the Affordable Care Act. With the implementation of Behavioral Health Homes, MaineCare will be bound by state rule developed to implement that initiative as well.

Payment Reform

Much of the alignment in public reporting and payment reform will be achieved through coordination across formally distinct payer initiatives. Medicare is bound to the quality reporting, shared savings payments and risk arrangements set forth as part of the Medicare Shared Savings Program and Pioneer ACO Initiative. MaineCare is working to achieve the maximum amount of alignment between its planned Accountable Communities shared savings ACO model and the Medicare ACO models that is feasible and desirable given differences in the target population and federal pathways for authority. Maine will be implementing Accountable communities as an Integrated Care Model under Primary care Case Management (PCCM) State Plan Authority. MaineCare's participation in this model will be codified under MaineCare policy. Maine's SIM Model takes advantage of market forces through the alignment of Medicare and Medicaid and employer/purchaser demand for accountable care arrangements and other value-based payment models in order to incent commercial payers to participate in the SIM model. The Maine Health Management Coalition's activities have been an ideal venue to

achieve this alignment through the establishment of a common understanding regarding current issues, challenges, and the vision for system delivery and payment reform moving forward. Commercial ACO arrangements currently fall into two categories: large self-insured plan sponsors and health plan directed agreements for fully-insured clients. In the case of large self-insured payers, there are direct contractual relationships between the plan sponsor and the provider organization. For fully-insured purchasers, the agreements are executed between the health plan and the provider organization.

Payer Letters of Support

Maine also received letters of support to its SIM application from the state's largest commercial payers, Anthem and Aetna, which together comprise 64% of the commercial market share in the state, as well as Maine Community Health Options (MCHO), Maine's Health CO-OP participating in the federal Health Insurance Marketplace. All three payers commit to participating in SIM project governance and working with the State to achieve alignment of quality measures and value-based payment strategies. In addition, Anthem and MCHO stated their intent to address the data needs of their providers and plan sponsors. See attached letters of support From Anthem, Aetna and MCHO in Appendix H5 in Year One Operations Plan.

23. Requirements for Participating Providers

Maine providers (as well as payers, purchasers, and consumers) are engaged in many of the workgroups that support important aspects of the SIM grant; these include the MHMC PTE Physicians and Systems Steering Groups, the ACI Steering Group, and the PTE Behavioral Health (Measures) Workgroup; the Maine PCMH Pilot Working Group; the BHHs Working Group; and the P3 Leadership Group. MHMC is also closely examining the PTE process to ensure it remains vital, engaging and relevant for Maine providers, purchasers, consumers and payers. Additionally, QC is planning to convene a Clinical Advisory Council to gain input from practicing clinicians on current and future quality improvement initiatives. Together, these efforts combine to create an environment that engages providers and supports continued collaboration around SIM.

System Delivery

The platform for transformation of system delivery is Maine's PCMH Pilot and Health Homes Initiatives. The 159 practice sites must follow Health Home requirements per Section 91 of MaineCare policy. The 75 sites of the 159 that are part of the multi-payer PCMH Pilot also have contracts with the commercial payers and memoranda of understanding with Maine Quality Counts under the MAPCP Demonstration. In addition, six FQHC Health Home sites that are outside of the PCMH Pilot follow Medicare requirements as part of CMMI's FQHC Advanced Primary Care Practice Demonstration. The Behavioral Health Homes will similarly face requirements under MaineCare policy developed to implement that initiative.

These advanced primary care models encourage provider participation through the provision of monthly fees to support practice transformation, technical assistance and learning collaboratives.

Payment Reform

Maine's three MSSP ACOs and one Pioneer ACO must subscribe to CMS and CMMI requirements. MaineCare anticipates that it will hold contracts with a "lead provider" within each Accountable Community. The lead provider will be responsible for agreements with other providers within the Accountable Community or with which it collaborates on locating, coordinating, and monitoring services for MaineCare members. In addition, Accountable Community providers will need to subscribe to the PCCM section of policy which will be amended to incorporate the Accountable Communities Integrated Care Model.

Maine's SIM Model takes advantage of the same market forces with providers as it does with payers on the commercial side. Large self-insured payers have direct contractual relationships between the plan sponsor and the provider organization. These agreements generally include provisions related to population attribution, PMPM target development, risk corridors, surplus/deficit sharing, quality measures/ incentives, and reconciliation methodology. There are instances where self-insured plan sponsors modify existing fully-insured arrangements and in those cases the contractual relationship still exists between the purchaser and provider organization. For fully-insured purchasers, the agreements are executed between the health plan and the provider organization.

Under SIM, relationships will evolve to include shared savings, bundled payments, and capitation. The general framework of the business relationships is likely to be the same but there may be prospects for collective agreements where multiple purchasers agree to similar terms with specific risk sharing arrangements for their populations.

As examples, the Maine State Employee Health Commission (which oversees the administration of the state employees' health plan) and three Systems – MaineHealth, MaineGeneral Health and Beacon – are completing ACO agreements. Additionally, the State Employee Health Commission has two risk agreements in place with specific hospital providers – Cary Medical Center and York Hospital. Aetna, Anthem and Cigna have each entered into ACO risk-sharing arrangements with selected systems on behalf of their fully-insured clients.

Primary Care Providers / Hospitals & Health Systems Letters of Support

The 159 current PCMH/ Health Home practices, future Behavioral Health Homes, Accountable Communities and providers engaged in other ACO arrangements will all benefit from the Maine SIM model initiatives and are bound by Payer requirements and contractual agreements. Many of these providers also submitted letters of support to coincide with Maine's SIM application. A table of PCP, hospital and health system providers who submitted letters of support, along with a list of initiatives in which they are involved, follows:

Provider Organization/ Health System	SIM-related Initiative Participation
Central Maine Healthcare	MSSP, Health Homes, PCMH
DFD Russell Centers	Health Homes, PCMH
DownEast Community Hospital	
Eastport Health Care Inc.	MSSP Maine Community ACO, Health Homes,

Provider Organization/ Health System	SIM-related Initiative Participation
	PCMH
Harrington Family Health Ctr	MSSP Maine Community ACO , Health Home
Health Access Network	FQHC APC Demonstration
MaineGeneral Health	SEHC ACO, Health Homes, PCMH
Martin's Point HealthCare	Health Homes, PCMH
Mercy Health System of Maine	Health Homes, PCMH
Mid Coast Hospital	Health Homes, PCMH
Northern Maine Medical Center	
Penobscot Community Health Care	Health Homes, PCMH, Beacon, Collaboration with Pioneer ACO
Pines Health Services	MSSP Maine Community ACO , Health Homes
Sacopee Valley Health Center	MSSP Maine Community ACO , Health Home, PCMH
St. Joseph Healthcare	Health Homes, Beacon, Collaboration with Pioneer ACO
York County Community Hlth Care	MSSP Maine Community ACO

The above-mentioned providers made the following commitments:

1. Engaging primary care practices in the enhanced primary care model endorsed by the project, either through participation in a recognized patient centered medical home/ health home pilot or through commitment to achieve Advanced Primary Care designations through Pathways to Excellence.
2. Committing to publicly reporting on a common set of measures, including total cost of care and patient experience. Additional measures will be determined through the Pathways to Excellence multi-stakeholder process.
3. Committing to the MHDO All Payer Database as a common claims data source and to a single source of analysis for the purposes of statewide public reporting on the measures determined in **#2,** and comparative statewide variation analysis necessary to gauge progress on and advance payment and delivery system reform.
4. Engaging in alternative reimbursement models which tie payment to accountability for cost and quality outcomes, moving toward greater accountability over time.
5. Participating in the learning collaborative(s) on medical home practice transformation and Accountable Care Organizations.
6. Engaging in activities to promote patient accountability, including the integration of shared decision making (SDM) at the practice level, exploration of patient incentives and benefit design, and partnerships to promote improved population health.
7. Participating in a statewide, multi-payer evaluation of the Maine Innovations Model.

In addition, while MaineHealth and Franklin Health Systems did not submit letters of support initially, they are now are active participants in SIM through their seats on the SIM Steering Committee. Both Health Systems have practices participating in Health Homes and PCMH, and MaineHealth is one of Maine's three MSSP ACOs. St. Mary's Health System, a Health Homes

and PCMH participant with 11 sites, has also since indicated its intent to support SIM. The State of Maine continues conversation with Eastern Maine Health Systems with the intention of garnering their active support for Maine SIM. EMHS actively participates in Health Homes, PCMH, Beacon, and is Maine's Pioneer ACO.

Behavioral Health Provider Letters of Support

Maine also received letters of support from numerous behavioral health providers, many of which have been actively participating in Behavioral Health Homes planning processes:

Behavioral Health Provider	SIM-related Initiative participation
Community Care	
Community Health & Counseling Svcs	Maine SIM Steering Committee, Beacon
ESM –Augusta	
Harbor Family Services	
Health Affiliates Maine	
Kennebec Behavioral Health	
MaineGeneral Health	
Spurwink	
Sweetser	
Tri-County Mental Health Services	
Umbrella Mental Health Services	

These providers agreed to:

1. Supporting and engaging in the behavioral health integration movement of the enhanced primary care model and MaineCare's Health Homes Initiative (the patient centered medical home with integration of physical and behavioral health, and community care teams for high risk/ high cost patients), with the expectation that participating behavioral health providers will apply to become Health Homes to serve individuals with serious mental illness.
2. Implementing Health Information Technology to promote care coordination and integration with physical health.
3. Participating in the Behavioral Health Cost Work Group (a sub group of the ongoing Health Care Cost Work Group initiative of Maine Health Management Coalition)
4. Committing to reporting on a common set of Behavioral Health measures, which will be publicly reported. These measures will be developed in cooperation with Pathways to Excellence (Maine Health Management Coalition).
5. Participating in the Behavioral Health learning collaborative to be developed as part of the continuous quality improvement efforts of the Innovation Model.

In addition to this list, Crisis and Counseling is also participating in SIM through its seat on the SIM Steering Committee.

I. Performance Measurement of Quality, Cost, and Health Goals

Refer to DRR Section I: Quality, Financial and Health Goals and Performance Measurement Plan

Supporting Documentation Available:

Appendices I1- I3 can be found in Year One Plan Submission on this website: http://www.maine.gov/dhhs/sim/documents/SIM%20docs/plan%20docs/ops%20plan/MaineSIMOperationsPlanAppendices%20H-I-J-K-L.pdf

24. State Performance Measures

In addition to the consensus-based selection of a set of core measures on which SIM partners will publicly report and utilize in value-based purchasing efforts, the Maine SIM initiative will employ a broader range of recognized performance metrics in support of the project objectives – strengthening primary care, improving transparency and understanding of health care cost and quality, and developing an aligned approach to payment reform. Although not precisely aligned with the metrics presented in the CMMI Core Measures guidance (dated April 2013), the metrics to be used in the Maine SIM project cover the same domains of structure, process, outcome, experience of care, and cost/resource use.

Many of the metrics identified for use in Maine are either NQF-endorsed or are in an NQF endorsement maintenance phase. For instance, the Total Cost of Care metric developed by HealthPartners will be used to measure risk adjusted PMPM cost. This metric is endorsed by the National Quality Forum; it is referenced as NQF 1604. This metric will be used to measure cost of care and resource use at the practice level (there will likely be too few patients at the individual provider level to allow for valid measurement) and, perhaps, at the practice group or system, as well. MHMC also relies on a range of care recognition measures developed by Bridges to Excellence, LeapFrog, Prometheus and Health Partners, many of which are not NQF-endorsed, but are nationally accepted, widely used, and have been adopted as a result of the consensus of the stakeholders involved in the Coalition's PTE process to facilitate benchmarking local performance against national standards.

Importantly, the Maine SIM project contemplates the identification and adoption of additional measures: these new metrics growing out of the consensus-based work of the SIM stakeholders and participants will be aligned, to the greatest extent possible, with national measures. In any case, metrics used or adopted for use must meet key, fundamental criteria that align with NQF principles. Specifically, all metrics must be important to measure, and must be scientifically acceptable (that is, they must be demonstrated to be reliable and valid). Additionally, metrics must be both understandable and useful in their support of stakeholder decision making. They must address gaps in performance and must be feasible to implement (data required must be readily available and retrievable without undue burden).

There are many other measures collected by various stakeholders that may be used to support the SIM effort. These include data from the Behavioral Risk Factor Surveillance Survey (BRFSS),

which is conducted by the Maine CDC. The Maine Health Data Organization (MHDO) is an independent executive agency responsible for collecting clinical and financial health care data and information. The MHDO administers Maine's all payer claims database, one of the first such databases in the nation. The agency also collects hospital and ambulatory surgical facility quality metrics for care related to patients with a principle diagnosis of acute myocardial infarction, heart failure and pneumonia; patients who receive one of a set of selected surgical procedures; health care associated infection rates and compliance with evidence-based interventions for reducing risk of infection; nursing-sensitive patient centered health care outcome measures and related nursing system-centered health care quality metrics; care transition measures (based on the 3-Item CTM survey); and nurse perceptions of the culture of patient safety in their health care organization. Some of these measures are routinely used in the work of the MHMC and will be incorporated into SIM-related work. Other data are available for use by the SIM project, if the need arises.

MaineCare data will be provided by the state through its data vendor. Similarly, Medicare data use and business agreements between CMS and MHMC have been put into place. Clinical data is currently collected by HealthInfoNet (HIN), Maine's HIE. Under SIM, HIN will build and provide a clinical dashboard for the Department, specific to MaineCare members. The dashboard will enable MaineCare to clinically monitor its members' health care utilization and outcomes at the population and individual level. HIN will also collaborate with the state and SIM stakeholders to assist in the development of appropriate behavioral health metrics, incentivizing behavioral health providers to participate in clinical quality reporting around agreed upon measures.

Data related to CG-CAHPS surveying will initially be provided by the Maine Quality Forum of the Dirigo Health Agency, which is sponsoring the fielding of the survey. The first round of data from that effort has been publicly reported; the Agency is sponsoring a second round of CG-CAHPS surveying, as well, and data from the new round is to be submitted by March 2015, with publication following completion of analytics. Not all Maine practices have chosen to participate in the Quality Forum's initiative. The MHMC will be constructing an alternative method for those practices to submit patient experience survey data, as these data are a requirement for meeting practice recognition status.

25. Alignment across Payers for the Endorsed Performance Measures

The Maine SIM project will rely on the work of the ACI workgroup and the MHMC Pathways to Excellence (PTE) process to ensure buy-in for metrics used to drive improvements in quality, outcomes and cost of care. Working through a consensus-based process, ACI will develop a core measure set that the providers and payers agree upon to utilize for specific components of provider accountability and payment. This core measure set will also be vetted through the SIM Payment Reform subcommittee and Steering Committee. Upon approval, ACI will also nominate these same metrics or a subset of the metrics to the PTE Systems Committee for public reporting. The MHMC PTE workgroup will make a recommendation to the Foundation

Board regarding the advisability of publicly reporting these measures on the MHMC website. Additionally, the SIM Steering Committee – taking into consideration recommendations regarding publication provided by the SIM Payment Reform Subcommittee – will decide to publicly report the measures on an alternative website (or not) or to simply follow the Foundation Board decision regarding publication on the MHMC site. Therefore, measures may end up being published on one or two sites, or not published. The PTE process is one with which Maine stakeholders are very familiar; it has served as the foundation for quality improvement work in the state for many years. The MHMC supports a Provider committee (primarily physicians) and a Systems committee.[4]

The PTE Systems Committee comprises 15 members who occupy "slots" for a range of constituencies. There are six employer/purchaser seats; six seats for providers (systems); one seat for a payer; and two seats for consumers. Only seated members of the Committee may vote in the Systems PTE process. The Committee engages in a four-part process as it develops a measure set. Measure identification may originate with the Systems Committee itself, or with MHMC staff. Most importantly, the ACI workgroup will play a pivotal role in the nomination of systems measures, identifying potential measures to the PTE workgroup through its consensus-based process, and advocating for those measures through the PTE vetting process. Involvement in the ACI workgroup will be sought from a wide range of stakeholders and participation will be open to any person interested in furthering this consensus based work. Measure specifications are evaluated for validity and appropriateness, and tested by calculation using available data. Results of testing are taken back to the PTE committees for review and approval. Measures surviving this process are assigned for public reporting.

The Systems Committee is charged with selection of specific measures and the evaluation of specifications for those measures. The Committee must assign value ("good"/"better"/"best") and determine how measured performance be reported. The Committee performs a review of results before they are posted publicly on the MCMH website (www.getbettermaine.org.). Additionally, reporting is made back to practices, hospitals and systems; in those reports, actual measured values are provided. The Physician PTE Committee operates with a more open structure – any interested stakeholder may participate in the process. In contrast to the Systems Committee, the Physician Committee operates on a consensus rather than on a formal voting basis.

Proposals for metrics may be raised in a variety of ways: staff may raise a proposal or any PTE participant may raise a proposal. Through this structure, representatives from the SIM Steering Committee will nominate metrics. Once a metric is proposed, it is assigned a "Coalition Measure Champion" who assumes responsibility for shepherding the measure through the PTE process. MHMC staff review the proposed metric against the criteria required for any measure used by MHMC – reliability, validity, endorsement status, availability of data, and so on (see

[4] The Systems Committee replaced the hospital committee. With the emergence of local and regional accountable care organizations, a conscious decision was made to develop a set of metrics that may be used to measure system performance, as that is now the unit of observation of most interest and import.

discussion regarding criteria for metrics, above). Metrics found to meet basic criteria are sent to the MHMC Communications group who conduct testing with consumers (both informed consumers and uninformed consumers) for feedback and input, to ensure any metric chosen for use carries an appropriate consumer perspective.

Each metric is also subject to review by MHMC clinical advisors who may or may not provide endorsement from a clinical perspective. History has shown this step to be critical to ensuring practitioner buy in. Any metric that fails to gain clinical endorsement will not move forward. Metrics are tested using claims and other administrative data from Maine's all payer database, maintained by the Maine Health Data Organization. Providers have been submitting data to that database for decades; it was one of the first all payer databases in the nation and data garnered from it are generally acceptable to all stakeholders.

Once all of the process vetting is completed, the MHMC Foundation Board is asked to sign off on the measure. If approved, the measure may be publicly reported on the MHMC website. In the SIM project, if a measure fails to be endorsed by the MHMC Board, it may still be published on the SIM website.

As noted above, all of the State's major commercial payers are familiar with and participate in the PTE process, as does MaineCare. By virtue of the process itself, all measures are either accepted by consensus or by vote, ensuring alignment of major payers with the consensus of providers and payers on the adopted metrics. A set of behavioral health metrics to be used as part of the SIM grant have not yet been vetted or accepted. As called for in the grant proposal, a new Behavioral Health PTE Committee will be formed and will operate in the same open and consensual manner as does the Physician PTE Committee.

It is important to bear in mind that the MHMC PTE process is driven by the interests of purchasers. MHMC is a purchaser-led partnership among a broad range of stakeholders who work collaboratively to maximize improvement in the value of health care services being delivered to patients. Over the past twenty years, the MHMC has worked to develop and foster consensus around strategies that will help transform Maine's health care system. This work has resulted in agreement in large measure, on the metrics we can use to benchmark and track our progress. Because this work has involved many of the state's largest purchasers – in the private and in the public sector – it has proven its ability to move the market for health care in Maine. As the number of physicians and practices gain PTE recognition status and as purchasers move to incorporate preference for highly ranked providers in their benefit designs, the incentive for not-yet-ranked providers to "get on board" has grown. Although ACO development is still in its infancy in this state, awareness of the fact that purchasers are paying attention to rankings as they seek higher value has brought systems to the PTE process, as well. This phenomenon supports the notion that an alignment of interests – coalescing around the PTE measures – does, in fact, exist.

Additionally, the Health and Human Services' (HHS) Measure Policy Council (MPC) works across its federal agencies to align quality improvement objectives at all levels of care--including

community, practice, and individual physician settings. Traditionally, there has been a proliferation of measures used by HHS agencies for numerous programs and initiatives that have resulted in some redundancies and overlaps in measures and reporting. Ultimately, these redundancies and overlaps pose a burden for providers collecting and reporting data, and also result in conflicting results, inefficient use of resources, and lost opportunities to achieve improvement through reinforcing program use of key measures. Until now, no formal systematic mechanism had been established to align, coordinate, review, and retire measures across HHS programs. With the formation and charter of the MPC in spring 2012 as a sub-workgroup of the HHS National Quality Strategy Group, the ability to align development and implementation of measures across HHS programs is now a very near reality. Through its recent work, the MPC has shortlisted several measures which are summarized and listed out in the second and third tabs of this file, respectively. Like the criteria used for the Maine SIM project, these measures have been shortlisted for their alignment to the following activities and policies:

- They support MU, National Quality Strategy and Triple Aim initiatives, and health are transformation and payment reform initiatives.
- They are applicable to a broad spectrum of reporting entities (ambulatory providers, hospitals, payers, other facilities).
- They remove the high-burden for reporting entities yet have a low impact on cost for agencies to measure or change.
- They enable reporting that can demonstrate real results.

During the implementation phase and first testing year of Maine's project, SIM governance processes have been developed and refined. One aspect of SIM oversight relates to decision making by SIM governance bodies regarding public reporting on a SIM website of measures recommended for adoption by MHMC PTE steering committees.

The process adopted requires review of recommended measures first by the SIM Payment Reform Subcommittee. Importantly, this is not a technical review of the measure; technical details have already been addressed over the course of months (or sometimes years) of work at the PTE group level. Work on the measure – including relevant value assignment – occurs as part of the PTE process; measures will not be refined through the SIM review process. Instead, the Payment Reform Subcommittee will consider making recommendations to the full SIM Steering Committee regarding publication of the measure – complete with value assignments as developed at the PTE level – on a website other than www.getbettermaine.org. The alternative site may be the SIM webpage or the DHHS website, but it would be a site independent of the MHMC. The Subcommittee may also opt to recommend that the measure not be published independently at all, relying instead, on publication to the MHMC consumer site.

The SIM Steering Committee will consider the recommendations of the Payment Reform Subcommittee and make a final decision regarding independent publication of the measure. This implies that a measure finally recommended for public reporting by a MHMC PTE committee may have one of several fates: it may or may not be approved for publication on

www.getbettermaine.org. by the MHMC-F Board of Directors and it may or may not be approved for publication on an independent SIM-site. Conceivably, a measure may ultimately be published in none, one, or two places.

26. Provider, Consumer and Payer Buy-In of Selecting SIM Performance Measures

As described earlier, the process of developing and adopting performance measures is a collaborative one which relies heavily on consensus. The Physician PTE Committee develops physician metrics; this group is open to any interested provider. Care is taken to cultivate feedback and input from the purchaser and consumer communities, as well. Membership on the Systems PTE Committee is assigned, rather than open. This is done to ensure a more balanced set of voices in the process, rather than engendering a dynamic where Systems or hospitals alone drive the process. Decisions are made via a voting process to ensure that all perspectives may be expressed. This Committee comprises representatives of Systems and hospitals, payers/purchasers and consumers.

The PTE process is an iterative one. Review of each proposed metric unfolds over a series of months, with suggestions and input from the respective Committees raised along the way being used to improve the process and outcome of the effort. *As noted, the SIM initiative involves the development of a Behavioral Health PTE Committee*. MHMC has solicited the participation of behavioral health providers – physicians and non-physicians – as well as purchasers and payers for this new committee, which began work early in calendar year 2014. Additionally, MHMC has retained qualified clinical advisors to support the identification of appropriate behavioral health metrics for use in this effort. As always, the MHMC Foundation Board of Trustees will have final review of any and all metrics that will be publicly reported on the MHMC website. This Board comprises members from the provider, consumer, payer, hospital and System communities. Metrics endorsed through the PTE process but not endorsed by the Board may be publicly reported on a separate website that is exclusively SIM-related, if approved through the SIM governance structure (see governance discussion above).

As anticipated, measuring performance against the cost of care metric presented certain challenges. Importantly, the cost of care was discussed and documented in great detail in Maine's SIM proposal. That proposal enjoyed the support and endorsement of a wide range of stakeholders, including hospitals and health care systems. That said, the issue of cost of care is a politically sensitive and one that requires constant attention, particularly in a time when ACO development/contracting activities are vigorously underway. As of June 2014, both the PTE Physicians and PTE Systems groups have recommended public reporting of the Total Cost of Care and Resource Use measures on www.getbettermaine.org.The MHMC-F Board will consider these recommendations and make a final decision regarding publication and the timing of such.

27. Plan for Quality Performance Target-Setting

The more detailed-level MHMC metrics described above are updated on a regular basis, with updated information publicly reported on at least a quarterly basis by MHMC. MHMC quality and utilization metrics are compared to national benchmarks, when available. Selected metrics related to patient safety, though, are benchmarked at the state level. Total cost of care will be benchmarked regionally and nationally. Premiums for coverage will be benchmarked using Kaiser Family Foundation data.

J. Privacy and Confidentiality

Refer to DRR Section J: Appropriate Consideration for Privacy and Confidentiality
Supporting Documentation Available:
Appendices J1- J4 can be found in Year One Plan Submission on this website:
http://www.maine.gov/dhhs/sim/documents/SIM%20docs/plan%20docs/ops%20plan/MaineSIMOperationsPlanAppendices%20H-I-J-K-L.pdf

28. Special Privacy and Confidentiality Protections

Maine's Global Approach to Privacy and Confidentiality
Maine has taken a global approach to ensuring privacy, confidentiality, and security of health care data and information. Using this global approach enables the State to develop and implement policies and requirements that govern the broad range of health care privacy and confidentiality and security laws and policies, which is a critical component of integration of health care data. The "siloed" approach where patient care was provided by separate and distinct types of providers, does not lend itself to integrated care. Privacy and confidentiality requirements must be dealt with at the systemic level. To implement this global approach as the foundation of the State's privacy and confidentiality and security plan, Maine embarked on a thorough and thoughtful review of all privacy laws and policies. The Office of the State Coordinator for HIT convened a Legal Work Group (LWG) in 2010 and again in 2012 to help inform the State on privacy issues. The LWG has approximately 12 members, comprised of lawyers and other professionals from the State, health care organizations, consumers, and others. The LWG met approximately 20 times over the course of this period to conduct a thorough review of federal and State laws pertaining to personal health care data.

The initial LWG produced consensus based modifications to Maine law that were enacted by the Maine legislature to allow the exchange of health care information while protecting privacy and consumer choice. The second LWG project included an effort that tracked and identified cites to HIPAA, Substance Abuse Part 2 laws, Mental Health protections under federal and Maine-specific laws, HIV regulations, and Maine laws that provide protections for patient information.

In August 2012, the LWG produced and presented its final report to decision makers, health care providers, consumers, and stakeholders, a report that has been shared nationally and which is the cornerstone of tools used for State privacy, confidentiality, and security measures. The LWG report information is being used by the State to build, in a systemic manner, safeguards for the integration of health care using appropriate protections. The information will also be used to conduct risk assessments and safeguards for the protection of personal or protected health information. Specifically, the LWG report includes information on Maine's state-wide HIE as a mechanism of submitting and sharing clinical data, Maine's APCD, and other sources of data, all of which will be used under the SIM grant.

An explanation of the Grids found in Appendix J4 in Year One Operations Plan follows:

(1) **Graphic and Detailed Grids (Spreadsheets).** The graphic and spreadsheets are grouped into four categories of PHI: General Health (termed non-sensitive PHI); and Mental Health, Substance and Alcohol Abuse, and HIV (these three are termed sensitive PHI). The reason the LWG chose these categories is because for the most part, federal and state laws and rules treat PHI differently based on which one of these categories the PHI falls under. Then, the four categories of PHI are further delineated by the category of use: Informed Authorization, Treatment, Payment and Operations (TPO); Public health; Fundraising; Research; and Marketing, because federal and state laws and rules treat PHI differently based on use.

(2) **Inverted Pyramids**. This high level graphic that displays each of the four categories of information (columns) and the six basic uses of information (rows). "Allowed" disclosure of PHI is at the top of the inverted pyramid, moving down to the "restricted" disclosure and finally the bottom of the pyramid which is "prohibited" without patient authorization. (This document is intended as the general rule.)

(3) **Detailed Grid**. This spreadsheet builds on the inverted pyramid document. The spreadsheet has two tabs: 1) Detailed (General Health, SA, and HIE) and MHDO and HIN/HIE; and 2) Detailed MH (Shown under separate tab because Maine law differentiates between MH agencies and professionals who may provide MH services as part of their practices).
Each "drills down" to show the federal and State laws and rules governing each category of information (General Health, Mental Health, Substance and Alcohol Abuse, HIV), and within the category, the laws governing each of the six types of information. It provides a brief summary of the applicability and a citation to the law. There is also is column color coded to show "allowed" disclosure as green; "restricted disclosure" as yellow; and "prohibited without authorization" as red, as a general rule. Exceptions to the rule are noted in the detailed full grid.

Protecting Privacy and Confidentiality—Patient Consent

General Health Information Opt-Out and Opt Back In Consent Process

Maine complies with federal and State laws governing PHI. HIPAA and Maine State law permits providers to share information when necessary to support the Triple Aim. These laws allow providers to share patient information with what HIPAA defines as "business associates". In Maine, the statewide HIE is operated by HealthInfoNet a private company which has Business Associate Agreements (BAAs) with providers to protect the confidentiality, security and integrity of patient information in the same way as the providers themselves. Maine law, under title 22 MRS Section 1711-C, gives patients the right to opt-out of having their general health information in the HIE. When a patient opts out, their medical information is deleted from the HIE. Demographic information is retained to ensure no additional medical information is included.

There are three options for opting out: (1) by mail; (2) by phone; or (3) online. The quickest method of opting out is online, by going to www.hinfonet.org/optout or filling out an opt-out form, available at a participating provider or from HIN. Maine State law requires that participating providers inform every patient about the HIE and the patient's ability to opt-out when they first visit that provider. HIN instructs all participating providers to include

information about HIN, and the ability for consumers to opt-out of the exchange in the Notice of Privacy Practices that every patient is provided and must acknowledge receipt of prior to receiving treatment. HealthInfoNet also gives participating providers the opt-out form and additional educational materials to help providers educate patients about the HIE and authorization options.

Patients can choose to participate again or opt back in. When they opt back in, their medical information is collected from the day the opt-in is processed forward. No past medical information will be available. There are two options for opting back in: online or over the phone: (1) Visit www.hinfonet.org/optin; (2) Call HIN at 207-541-9250 or Toll Free at 866-592-4352. HIN manages the opt-out/opt back in process centrally. Patients only have to make their consent decision once to cover information collected from all participating provider organizations.

Mental Health and HIV Consent Process

Under HIPAA and Maine law, providers can legally share a patient's medical information with other providers also treating the patient. However there are additional protections placed on some mental health and HIV related information. For this information to be visible in the HIE, patients need to give their provider permission to see it. They do not have to give permission to anyone if they don't want to, and they can choose to make available mental health only, HIV only or both. The one exception to this is in a medical emergency, when the law allows providers to access this information to prevent harm to the patient or others during that emergency. To access the patient's information, the provider must record in the system that the patient has given authorization and to what type of information.

Information covered by this authorization process includes: (1) Information created by a licensed mental health facility or a licensed mental health provider like a counselor, psychiatrist or psychiatric hospitals; (2) HIV/AIDS diagnoses and results of HIV/AIDS lab tests. Mental health and HIV information is only available in the HIE if the patient has NOT elected to opt-out. If the patient has opted out of participation in the HIE, none of their medical information will be available, even in an emergency.

Patients can authorize their providers to access this information in one of two ways.

(1) They can fill out an authorization form available from their participating provider or HIN. This form is available for download at HIN's website. The patient's identity must be verified and the authorization form witnessed and sent to HIN by a staff member of a participating provider, in person by a HIN staff member, or signed by a Notary Public using a separate form. Once the form is processed, a patient's mental health and/or HIV data will be available to all their participating providers. Patients can revoke their previous authorization using the same form. When they revoke their authorization, information is hidden, but not deleted, and will still be available in emergency situations.
(2) During their visit, the patient can give an individual user permission to access their mental health, HIV/AIDS information or both. This information will be available to that individual provider for that visit only. The patient will need to give permission each time they want this individual to have access in the future.

Substance Abuse Information
The State complies with federal substance abuse privacy and confidentiality laws. Due to the very restrictive provisions of Part 2, Maine's HIE does not accept data related to substance abuse. Maine is working with the federal government in its efforts to develop an authorization system which would afford patients the ability to have this information included in the HIE and available for appropriate health care use. Until the federal government issues specific guidelines and policies, Maine will continue its policy of neither accepting nor storing substance abuse information as that term is defined by federal and state law.

Confidentiality of Genetic, Communicable Diseases, and Newborns
Maine has specific laws regarding the confidentiality of sensitive health information. (Title 22 MRS Section 1532, et sec.) Records that contain personally identifying medical information that are created or obtained in connection with the department's public health activities or programs are confidential. These records include, but are not limited to, information on genetic, communicable, occupational or environmental disease entities, and information gathered from public health nurse activities, or any program for which the department collects personally identifying medical information.

State Policies for Claims and Clinical Data
Maine DHHS has privacy, confidentiality and security policies and protections in place. The Department, as a component of acceptance and approval of Maine's MMIS system, conducted necessary privacy and security risk assessments and security plans. In addition, the Department has developed and implemented privacy and security policies that cover federal HIPAA and other privacy, confidential and security laws, and Maine-specific protections. In 2013, the Department hired a Director of Healthcare Privacy, in an effort to coordinate privacy and security initiatives. Those initiatives include, among other things, the implementation of a Privacy/Security Liaison program, new and updated policies, procedures and forms, an online education presences, update Department-wide training and coordination with the state's Office of Information Technology to implement ongoing security safeguards, such as email and portable device encryption.

Maine's APCD, housed in an independent State agency, the Maine Health Data Organization (MHDO), has over the past two years, embarked in a transformation process that further strengthens privacy, security and confidentiality policies while allowing for the appropriate use of claims data to help meet the Triple Aim. This transformation provides a framework for the coordination and governance of the linking of claims and clinical data, an important component of the SIM grant objectives for improving health care and outcomes. Maine's statewide HIE, operated by HIN, has also developed privacy and security measures for the HIE.

K. Project Personnel Recruitment and Training

Refer to DRR Section K: Staff/Contractor Recruitment and Training

Supporting Documentation Available:

Appendices K1 can be found in Year One Plan Submission on this website:
http://www.maine.gov/dhhs/sim/documents/SIM%20docs/plan%20docs/ops%20plan/MaineSIMOperationsPlanAppendices%20H-I-J-K-L.pdf

29. Roles and Responsibilities for Existing and New Staff or Contractors

State Staff

For State staff who are contributing to SIM work as a percentage allocation of their overall work duties, their specific roles have been outlined more informally through general description of roles/responsibilities.

Contractor Staff

Roles and responsibilities in support of the SIM Grant are clearly defined as part of the executed contract between the State and the contractor.

30. Recruiting New/Additional Staff and/or Contractors

State Staff are hired through standard State recruitment protocols (internally through job postings and externally through standard recruitment processes). Contractor Staff are identified through a procurement process. The three major SIM Grant partners referenced in the State's original Grant Application (Maine Health Management Coalition, HealthInfoNet and Quality Counts) were procured through a Sole Source model based on their unique qualifications to execute on critical SIM deliverables in the necessary timeframes.

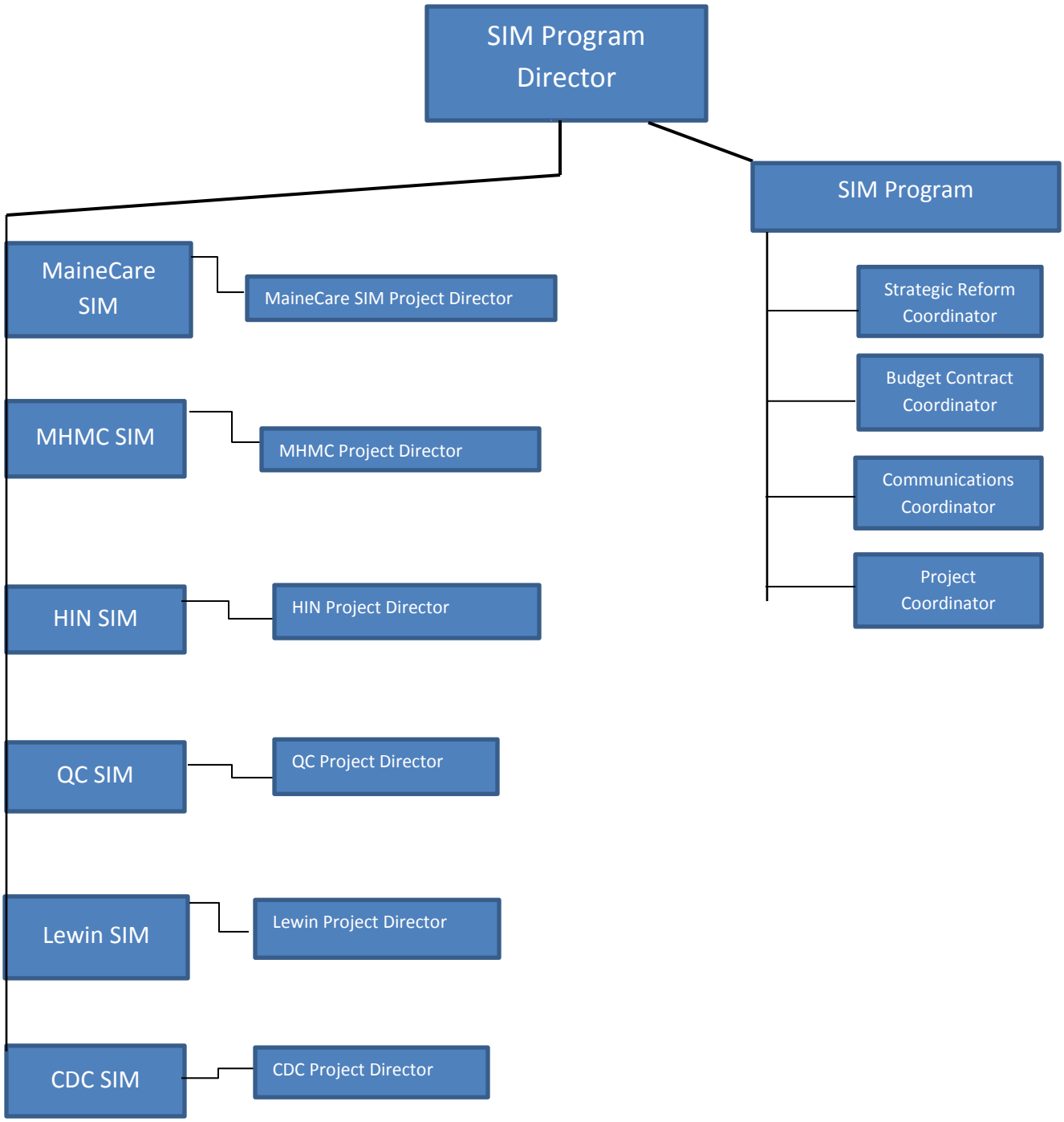
- For the SIM Program Director, the State utilized a Sole Source procurement model.
- For the remaining envisioned contracted partners, the State utilizes competitive procurement models in alignment with State guidelines.

31. Training of New and Existing Staff or Contractors

The training and support model is a blend of the following approaches:

- Self-study via documents shared on our active State SIM website;
- One-on-one or group level walkthroughs of high-level SIM presentations;
- Link to CMMI SIM website for self-study; and
- Access to State Core Team members for ad-hoc inquiries and orientation.

Maine SIM Program Organization Chart



The following show Key State and Contractor staffing for Maine SIM:

Key State Personnel **State and Non-SIM funded contract staff assigned to SIM**				
Name	**Email**	**SIM Role**	**Qualifications**	**Supervisor**
Mary Mayhew	Mary.Mayhew@maine.gov	State of Maine SIM Lead	DHHS Commissioner	Governor
Holly Lusk	Holly.E.Lusk@maine.gov	Maine Leadership Team Chair	Senior Health Policy Advisor to the Governor	Governor
Kevin Flanigan, MD	Kevin.Flanigan@maine.gov	SIM Steering Committee Chair	MaineCare Medical Director	MaineCare Director
David Simsarian	David.Simsarian@maine.gov	Maine Leadership Team	Director, Business Technology Solutions	DHHS Chief Operating Officer
Stefanie Nadeau	Stefanie.Nadeau@maine.gov	Maine Leadership Team, SIM Steering Committee	Director, Office of MaineCare Services	DHHS Commissioner
Jay Yoe	Jay.Yoe@maine.gov	Evaluation Plan lead	Director, Office of Continuous Quality Improvement	DHHS Chief Operating Officer
James Leonard	James.F.Leonard@maine.gov	MaineCare Leadership	Deputy Medicaid Director, former Office of the State Controller for HIT	MaineCare Director
Peter Kraut	Peter.Kraut@maine.gov	MaineCare lead	Comprehensive Health Planner II	Deputy MaineCare Director
Debra Wigand	Debra.A.Wigand@maine.gov	CDC Leadership	CDC – Director, Division of Population Health	CDC, Deputy Director
Sam Adolphsen	Sam.Adolphsen@maine.gov	DHHS Leadership	DHHS, Chief Operating Officer	DHHS Commissioner
John Martins	John.A.Martins@maine.gov	DHHS Communications Lead	DHHS, Director of Communications	DHHS Commissioner
Sheryl Peavey	Sheryl.Peavey@maine.gov	Strategic Reform Coordinator	DHHS, Strategic Development	DHHS Commissioner
Alan Henry	Alan.Henry@maine.gov	SIM Finance Manager	Finance, Budget and Contract Coordinator	DHHS Budget Director
Sybil Mazerolle	sybil.mazerolle@maine.gov	Program Associate		MaineCare Director of Strategic Initiatives
Nate Morse	Nathan.morse@maine.gov	NDPP Coordinator	Comprehensive Health Planner	CDC Division Director
Kitty Purington	Kitty.Purington@maine.gov	Project Manager VBPI	Contracted Value-Based Purchasing Manager	Deputy MaineCare Dir.
Amy Wagner	amy.wagner@maine.gov	Project Coordinator	DHHS – Office of Continuous Quality Improvement	Dir. of Continuous Quality Improvement

Key Contractors Please list the contractors funded through SIM					
Name	**Email**	**Organization**	**SIM Role**	**State Supervisor**	**Contract Status as of September, 2014**
Randal Chenard	Randal.Chenard@maine.gov	Independent	Project Director	MaineCare Director	Complete
Maine Health Management Coalition (CEO Andy Webber; SIM Project Director Ellen Schneiter)	AWebber@mehmc.org eschneiter@mehmc.org	Maine Health Management Coalition	Testing Partner	Deputy Medicaid Director	Complete
HealthInfoNet (COO Shaun Alfreds, SIM Project Director Katie Sendze)	salfreds@hinfonet.org ksendze@hinfonet.org	HealthInfoNet	Testing Partner	Deputy Medicaid Director	Complete
Maine Quality Counts (CEO Dr. Lisa Letourneau, SIM lead Lisa Tuttle)	lletourneau@mainequalitycounts.org ltuttle@mainequalitycounts.org	Maine Quality Counts	Testing Partner	Deputy Medicaid Director	Complete
Sue Bembers	Sue.bembers@Lewin.com	The Lewin Group	Evaluation	Dir. of Continuous Quality Improvement	Complete
Gloria Aponte Clarke	gaclarke@hinfonet.org	HealthInfoNet	Project Manager	DHHS- Strategic Development	Complete
Trevor Putnoky	tputnoky@mhmc.org	Maine Health Management Coalition	Communication Director	DHHS, Director of Communications	Complete
Barbara Ginley	bginley@mainemigrant.org	Medical Care Development	Community Health Worker Pilot Project Manager	CDC, Director of Population Health	Complete

L. Workforce Capacity Monitoring

Refer to DRR Section L: Workforce Capacity Monitoring
Supporting Documentation Available
Appendices L1- L2 can be found in Year One Plan Submission on this website:
http://www.maine.gov/dhhs/sim/documents/SIM%20docs/plan%20docs/ops%20plan/MaineSIMOperationsPlanAppendices%20H-I-J-K-L.pdf

32. Program to Address the Future Health Care Workforce

Workforce Development in Maine
The Maine Health Workforce Forum was established in 2004 to coordinate the information and stakeholders needed to assess current and projected shortages in a number of health occupations and to make policy recommendations. The Forum meets at least annually. Participants include representatives of health professional associations, licensing boards, employers, education programs, Maine Department of Health and Human Services, Center for Disease Control and Prevention and the Maine Department of Labor. Maine CDC Rural Health and Primary Care has funded the Forum for five years through a grant that ended in June 2013. The report from the forum is on the DHHS website as part of a legislative mandate:
http://www.maine.gov/dhhs/mecdc/local-public-health/orhpc/hwf/index.shtml
The Workforce Forum partners with the Department of Labor and is actively looking for opportunities to implement the recommendations of the Forum and further the work.

Of note from the Health Workforce Forum Reports

Essential to meeting the growing demand for health care services statewide is ensuring that Maine has a sufficient number of workers with the appropriate mix of occupations, in the required locations. The state faces a number of unique, long-term challenges with respect to these issues: there are indications of worker shortages in some occupations and in the state's rural areas; the resident population is aging and consuming increasing amounts of health care services; the health care workforce is nearing retirement age. With regard to some of these challenges, the economic downturn has issued a short-term reprieve: - hiring demand for health care workers has subsided, and with individuals remaining in their jobs for longer periods, the supply of health care workers has increased. Registered nurses (RNs), nursing aides, medical assistants and physical therapists are the four occupations with the highest number of vacant positions.

Training to PCMH, HH Practices
The Maine SIM project will support a key aspect of workforce development and training - the provision of quality improvement (QI) training and support to primary care practice teams participating in the Maine Patient Centered Medical Home (PCMH) and Health Homes (HH) initiatives. Through efforts led by Maine Quality Counts, Maine will offer structured learning using the Learning Collaborative model to work with teams from the 75 practices in the multi-

payer PCMH Pilot and an additional 96 practices in the MaineCare HHS initiative to transform practice to a PCMH model of care. [Described in Section M - Care Transformation Plans].

While not training, *per se*, the MHMC will be supporting practices in developing their understanding of the data used in developing practice rankings and of the information included in the practice reports. This effort will provide additional foundation for the work Maine Quality Counts undertakes with the practices as they seek to improve the delivery of care.

Training on Shared Decision Making (SDM) – Type tools

Through the SIM initiative, Maine will also provide training to the primary care workforce on shared decision making models and tools, with the goal of incorporating them into the practice workflow. The approach is informally referred to as P3, Patient-Provider Partnerships, and focuses on three major health issues, including back pain and substance use.

New Workforce Models

Maine will work with key partners to develop several new workforce models to support the SIM, including:

- **Community Paramedicine -** We will build on early efforts to develop an innovative new workforce model utilizing community-based paramedics to address unmet community health needs. This effort will build off an initial project authorizing the development of 12 community paramedicine pilot projects authorized by the Maine Legislature (LD 1837) to assist those receiving care at home. Under this pilot, community paramedics will make home visits to patients who are homebound or who do not have or cannot reach a physician, and who might otherwise seek care in the ED. The program will specifically seek to reach out and provide home-based interventions to individuals with chronic illnesses who are at high risk for hospital readmission, and those with recurring intensive health care needs.
- **Community Health Workers (CHWs) -** An important component of Maine's SIM grant is to develop a statewide system for training and certifying CHWs. The training/ certification system will rely on a partnership between state government and Maine's public and private academic institutions to ensure that the academic and field training components are accessible and available statewide, and are able produce a corps of skilled CHWs with a consistent body of knowledge and skill set. Once established, this training / certification system will generate a dependable CHW workforce - an asset to the health care system that has never existed in Maine, other than in isolated pockets of locally-driven innovations. The state recognizes the value of developing CHW's as an integral part of the health care delivery team to maximize use of health care professionals' skills and strengthen the ability to connect to patients.

  A long term goal of the CHW project is to develop a new and recognized allied health care profession in Maine. In year three of the SIM project, the CHW Project Manager will develop recommendations to help shape that outcome. Maine CDC, MaineCare and the CHW Project Manager will engage Maine's colleges and universities that offer health care course content to identify potential sites for formal CHW coursework.

  Maine SIM CHW initiative has selected five pilot sites that will: (1) demonstrate the value of integrating CHWs into the health care team; (2) provide models that can be replicated and emulated across the state; (3) build a core group of experienced CHWs

who can provide leadership and community engagement to drive the ongoing development of the system**.**

It will also intersect with the payment reform component of the SIM grant to ensure that payment reform efforts incorporate efficient funding mechanisms to sustain the role of Community Health Workers as an effective element within the "transformed" health system in Maine for the long term.

Curricula Development and Training on Integrated Coordination of Care

- **Case management workforce for individuals with Intellectual and Developmental Disability (I/DD):** As high cost utilizers of the health care system, addressing gaps in the care of individuals with I/DD is essential to achieving SIM's Triple Aim. Building on existing service systems and expertise within community ID/DD Targeted Case Management (TCM) providers, this initiative will have a focus on enhancing their care model to incorporate an integrated physical health approach. The project will provide integrated healthcare training for TCM providers for individuals with I/DD, addressing the specific gaps faced by this population relating to their physical healthcare needs. This project will also fund a Technical Assistance RN that will be available in order to ensure that training takes hold and has an opportunity to be effective with the TCM providers. Lastly, this initiative will leverage the Health Homes Learning Collaborative, in order to reach and train primary care providers on the treatment and coordination of care for patients with I/DD in their practices. MaineCare is currently finalizing project parameters and plans to implement a contract for curriculum development in Q1 of Year 2 of SIM. MaineCare also plans on working with Quality Counts to have a breakout session in their spring all-day learning session for Health Homes, Q2 of Year 2 of SIM.
- **Case management workforce for individuals with SMI and SED:** Physical Health integration funding for Behavioral Health Home training and work force development allows MaineCare to leverage existing training processes and expertise within community mental health to incorporate the new expectations anticipated for an integrated behavioral health work force. This funding supports development of a curriculum and training strategy for community mental health direct service staff which aligns with current requirements for Mental Health Rehabilitation Technician and TCM providers. The work has been added to an existing contract with the organization that currently oversees the MHRT training and curriculum. This contract has been reviewed within DHHS and is awaiting allotment of funds; the project will begin as soon as these funds have been awarded.

National Diabetes Prevention Program (NDPP)

The NDPP will support population health management strategies as a preventative health care initiative within the SIM. It can be applied to the PCMH & ACO care delivery systems and supports SIM efforts to reduce PMPY costs by delaying or preventing MaineCare members with pre-diabetes or at high risk for diabetes from progressing into Type 2 diabetes (where they will consume 2.3 times more health care dollars). The Maine CDC will contract with the national provider of NDPP Lifestyle Coaches Training. NDPP Lifestyle Coaches Training will be held May each year of SIM; contract with Emory University DTTAC for Master Trainer, Training Materials, Event Planning/Facilitation to deliver this evidence-based program to providers in Maine. This

will support the infrastructure growth and enhance health system capacity to support the sustainable delivery of the NDPP in communities across Maine.

Partnerships to support new workforce models for the transformed system
Maine partners will work with an array of institutions receiving funds for medical education to collaboratively develop changes over time to the clinical and business models; including Univ. of New England, Maine Medical Center/Tufts University collaboration and universities, colleges, community colleges, and hospital based allied professions training.

M. Care Transformation

Refer to DRR Section M: Care Transformation Plans

Supporting Documentation Available:

M1) Quality Counts (QC) website:
www.mainequalitycounts.org;

M2) QC Learning Community web link:
www.mainequalitycounts.org/page/896-679/qc-learning-community

M3) QC annual conference, 2014:
http://www.mainequalitycounts.org/page/887-984/qc-2014

M4) QC support for Maine PCMH Pilot practices web link:
www.mainequalitycounts.org/page/896-659/patient-centered-medical-home

M5) QC PCMH Learning Session Regional Forum, and webinar dates and content of past sessions and events are available at www.mainequalitycounts.org/page/2-714/pcmh-learning-sessions-and-webinars

M6) QC Initial information/ resources available for Health Homes practices web link:
www.mainequalitycounts.org/page/2-851/mainecare-health-homes-information

33. Quality Improvement Supports for Providers

Maine has both strong leadership and a wide array of Continuous Quality Improvement (CQI) resources and trainings for providers and physician practice teams. Leadership and support for CQI has come from key stakeholders including Maine provider groups and major health systems; FQHCs and the Maine Primary Care Association; the Maine Practice Improvement Network, a network of Quality Improvement (QI) coaches and facilitators; and Maine Quality Counts (QC), a regional health care collaborative and a SIM partner contracted to provide CQI support services to Health Home (HH) practices. QC is an independent, multi-stakeholder alliance working to transform health and health care in Maine by leading, collaborating, and aligning quality improvement efforts in the state. QC supports a statewide "QC Learning Community" (QCLC) which offers a network to identify and promote the spread of CQI best practices throughout the state using multiple channels (see www.mainequalitycounts.org/page/896-679/qc-learning-community).

The QCLC offers opportunities for providers and practice staff to learn from each other and from national experts through monthly QI webinars; quarterly e-newsletters; a web-based repository of QI tools hosted on the QC website (see www.mainequalitycounts.org); periodic regional improvement meetings for providers and practice staff; and opportunities for direct practice-to-practice networking to observe the implementation of best practices. As part of this Learning Community, QC sponsors an annual conference, or QI "best practice college", as one of its hallmark activities to promote CQI efforts and the transformation changes needed to improve health and health care in Maine which this year focused on moving from health care innovation to transformation and attracted more than 700 individuals from around the state

including providers, practice team members, consumers, and other stakeholders (see http://www.mainequalitycounts.org/page/887-984/qc-2014).
As a contracted SIM partner, QC is providing QI support to HH practices specifically to support the process of practice transformation (see more detail in question #34 below).

34. Practice Transformation Training and Care Process Redesign Activities

Maine supports CQI efforts and training of provider practices on practice transformation and care process redesign through several efforts that leverage existing statewide learning and action networks. Over the past four years, Maine has made critical investments in the development and diffusion of the Patient Centered Medical Home (PCMH), a model that shows great promise in improving care and controlling costs, including the development of a multi-payer PCMH Pilot that includes Medicare (MAPCP demo), Medicaid (MaineCare), and several of the major commercial payers.

Maine Quality Counts (QC) has provided QI support for practice transformation to the 75 practices selected to participate in the multi-payer Pilot over the past four years, sponsoring the Maine PCMH Learning Collaborative which includes three day-long Learning Sessions each year; Regional Forums in five regions of the State in spring and fall; monthly webinars for Pilot teams; access to QI tools and resources; and direct QI assistance through a network of QI coaches and staff. QC supports practice transformation efforts for the Pilot practices with a focus on the "10 Core Expectations" of the Maine PCMH Pilot, a set of key changes for PCMH transformation that include an expectation to implement the widely accepted PCMH "Joint Principles", as well as additional changes such as integrating behavioral health into primary care, engaging consumers in improving care, effectively using HIT to improve care, and reducing waste to help control health care costs.

Information on QC support for Maine PCMH Pilot practices is available at www.mainequalitycounts.org/page/896-659/patient-centered-medical-home.
Information on PCMH Learning Session Regional Forum and webinar dates and content of past sessions and events are available at www.mainequalitycounts.org/page/2-714/pcmh-learning-sessions-and-webinars.

MaineCare has leveraged its investment in the PCMH Pilot by developing and aligning its Health Homes (HH) initiative as the next step in building a comprehensive and coordinated primary care infrastructure to address the needs of people with chronic conditions. *Under the SIM initiative*, QC is contracted to provide QI support services and build CQI capacity within the 102 current HH practices that met HH eligibility requirements, joining the 75 practices currently in the multi-payer PCMH Pilot. QC staff provide this QI support for the additional HH practices by expanding the PCMH Learning Collaborative to include ongoing statewide in-person Learning Sessions 2-3X/year; regional meetings in up to five regions of the state 2-3X/year; monthly webinars with PCMH and HH teams; web-based learning resources including access to the

American College of Physicians' Medical Home Builder tool; and access to other tools and resources through the QC website. Initial information and resources available for HH practices at www.mainequalitycounts.org/page/2-851/mainecare-health-homes-information.
The State has taken steps to ensure alignment of these efforts with other improvement efforts in Maine, including working closely with the Maine Regional Extension Center (MEREC), led by HIN. Through these efforts, all but one of the 177 practices in the PCMH Pilot and HH initiative have a fully implemented EMR, and receive regular information and support for use of the HIE to improve care processes. Additionally, through SIM the State expanded these efforts to include training for HH practice teams on best practices for providing and integrating care for patients with developmental delays and autism, intellectual and physical disabilities, and to improve substance abuse screening for adults and teens.

Through SIM, the State contracted with QC to provide QI support to the five Behavioral Health Home (BHH) organizations participating in the Health Homes "Stage B" initiative designed to improve care and coordination for individuals with Serious Mental Illness (SMI) and children with a diagnosis of Serious Emotional Disturbance. QC will provide QI support by conducting a learning collaborative with BHHs that provides CQI training and support for these organizations to improve systems of care for individuals with SMI and children with SED, including systems to ensure the delivery and integration of high quality primary care services for these individuals. Launched on April 1, 2014, the BHH Learning Collaborative has held two Learning Sessions and begun a series of monthly webinars and a newsletter. Through Learning Sessions and webinars, BHH organizations will be able to access state, regional, and national content experts. QC staff are also conducting baseline assessments of BHHOs through site visits that will result in BHHOs identifying areas of improvement. In October of 2014, the Behavioral Health Homes will join with the Health Homes and Patient-Centered Medical Homes in a joint Learning Session with opportunities to align delivery models and strengthen provider communication.

In addition, the Maine SIM effort will contract with organizations to provide additional services that will support CQI efforts, including the launch of the Patient Provider Partnership (P3) Pilot Initiative, a program in ten primary care and behavioral health practices with the goal to improve health care quality and reduce avoidable costs by engaging patients more actively in decisions about their health care. The P3 Pilot Initiative will address three priority areas of high strategic importance to the state. The first set of pilots will use the American Board of Internal Medicine (ABIM) Foundation's "Choosing Wisely®" initiative as the basis for promoting more productive patient-provider conversations and engaging patients in shared decision making about their care. The second set will focus on shared decision making for low back pain treatment. The third will focus on medication decisions in behavioral health.

N. Sustainability Plans

Refer to DRR Section N: Sustainability Plans

Supporting Documentation Available:

Appendices N1 can be found in Year One Plan Submission on this website: http://www.maine.gov/dhhs/sim/documents/SIM%20docs/plan%20docs/ops%20plan/MaineSIMOperationsPlanAppendicesM-N-O-P.pdf

35. Financial Model for Sustaining New Payment and Service Delivery Models

Maine has engaged employers and commercial payers to actively participate in the Maine SIM. They have, in fact, been major drivers of health care and payment reform statewide, and are fully engaged participants in initiatives like the Multi-Payer PCMH Pilot and the CMS Maine MAPPC Demonstration based on the PCMH Pilot. Maine is unique in its focus on the development of multi-stakeholder, shared risk ACOs for the more diverse, real life health care environment. In this multi-stakeholder, shared risk model, providers become accountable for population health and costs through a redesign of the health care delivery system and the use of alternative payment models. This focus is currently being piloted on the commercial side at MaineGeneral Health, a medium-sized health system similar to rural health systems in much of the country. Mid Coast Health Services (Mid Coast) has partnered with Bath Iron Works (BIW) to develop a primary care based ACO pilot for the Mid Coast region. Mid Coast is also using their own employees as an incubator for their ACO, with pilot projects currently focused on behavioral health integration and on reducing the high utilization of musculoskeletal services – i.e. improving treatment for low back pain. Other multi-stakeholder, primary care based ACOs are also emerging, each of which has different risk arrangements.

Maine's major payers participate with Maine Health Management Coalition (MHMC) in ACO development, including: Anthem Blue Cross Blue Shield; Harvard Pilgrim; Aetna; Cigna; new players like Martin's Point Health Care (which has a Medicare Advantage Plan); and MaineCare. As noted elsewhere, MaineCare is moving to provider-centric care management approach designed to include an ACO model by 2014. As new approaches to care prove effective in reducing costs while improving the quality of care, the expectation is that payers will work collaboratively with ACO partners to change reimbursement to reflect those new approaches, thus creating sustainability.

The Maine Department of Health and Human Services has included funding for its Health Homes Initiative for members with chronic conditions in the state's budget for Fiscal Years 2015 and 2016, to continue funding of the models once enhanced funding expires as of December 31, 2014. The experiences / lessons learned through SIM will help us to inform legislative recommendations for MaineCare rates, based on performance outcomes. These results will also inform continued justification for future amendments to the State Plan. Data from the Health Home initiatives will begin to be presented to the 126th Legislature in the second session of 2014. Updates on the impact of Health Homes from Stage A implementation will be provided

to the Health and Human Services Committee and to Appropriations during the session. It is the intent to provide the legislature with enough evidence over the course of the SIM initiative to support transitioning Health Home payments and performance structures from the 90/10 federal share under the Affordable Care Act to the standard FMAP rate for MaineCare to become a standard part of state Medicaid program. The alignment of the Medicaid Accountable Communities Initiative with other ACO's in the state in terms of public reporting on core quality measures, and a commitment to progressive value-based payment, is a long term commitment from the State of Maine that will sustain beyond the SIM grant.

In addition to financial sustainability, components of the Model will build organizational capacity that currently does not exist. Learning collaboratives will create a base of knowledge that will help create a permanent culture shift. Supporting the acquisition of electronic health records (EHRs) for Behavioral Health organizations will create a permanent HIT infrastructure that will help them better grow and sustain their work. Much of the Maine Innovation Model will support foundational change, rather than the one-time use of funding to solve an immediate problem. Maine's Office of the State Coordinator along with the MaineCare HIT program will work with HealthInfoNet (HIN) to compile data and substantiate a rationale for attaining 90/10 HIT infrastructure funding to support ongoing development of health information technology to benefit the MaineCare populations beyond the SIM project. HIN has developed and implemented a sustainability plan of its own that is supported by a range of services, including subscription fees to provide stable funding to core health information exchange services.

O. Administrative Systems and Reporting

Refer to DRR Section O: Administrative Systems and Reporting

Supporting Documentation Available:

Appendices O1- O2 can be found in Year One Plan Submission on this website:
http://www.maine.gov/dhhs/sim/documents/SIM%20docs/plan%20docs/ops%20plan/MaineSIMOperationsPlanAppendicesM-N-O-P.pdf

36. Programmatic and Financial Oversight

The Budget and Contract Coordinator (Finance Manager) provides contractual oversight of the agreements including contract language and budget development for the SIM Program. The Budget and Contract Coordinator shepherds the contracts through the Department and external procurement processes. The Maine DHHS Division of Contract Management supports the SIM work in review, approval and tracking of related contracts. This division coordinates with the Project Director and the Budget and Contract Coordinator, both housed at the Commissioner's Office, as well as the Office of MaineCare Services, and the Maine Centers for Disease Control, where program expertise resides.

The Agreement Administrator and the Budget and Contract Coordinator monitor the provider's compliance with the terms of the agreement, including but not limited to timeliness, completeness and accuracy of all fiscal expenditure reports, service delivery reports, performance based contracting reports and all other reports required under the Agreement. The provider shall deliver all compliance documentation, including reports required by the agreement, for the Administrator's and Coordinator's review. The Department may require the provider to take corrective action if, in the Department's determination, corrective action is required for compliance.

Regarding financial oversight, the coordinator reviews the invoices, and garners approval from program administration. The division processes invoices and tracks payments against all agreements. The DHHS Financial Service Center has the lead for financial oversight of the grant dollar spending and the Accounts Payable process. The Budget and Contract Coordinator monitors expenditures and confers with the Service Center to assure accuracy of the funds.

The Budget and Contract Coordinator reviews all monthly partner reports to provide agreement with the report requirements, objective milestones and accountability targets, cross referencing the Accountability Template, affectionately known as the Single Source of Truth (SST). The coordinator tracks the tasks worked on as stated in the SST and reported in the prior month goals to ensure compliance with the contract requirements and overall SIM activities. The program team conducts a review of quarterly reports in association with the Program Manager before submittal to CMS.

P. Implementation Timeline

Refer to DRR Section P: Implementation Timeline for Achieving Participation and Other Metrics

Supporting Documentation Available:

P1) Strategic Framework (Figure 11)
P2) SIM Monthly Status Report (Figure 12)
P3) SIM Quarterly Report Template (Figure 13)
P4) SIM Program Plan website:
https://mainesimgrant.atrackspace.com/Governance

The SIM Program Director oversees the overarching Maine SIM Program Plan. The Strategic view of the program plan is a key component of the Operational Plan, and is the major framework which organizes all of SIM activities. This Strategic Framework of the SIM Program plan includes the six key strategies, and each individual SIM objective, all of which align to one or more of the strategies. (See Figure 11)

Figure 11: Strategic Framework

Strengthen Primary Care	Weight	Integrate Physical and Behavioral Health	Weight	Develop New Workforce Models	Weight	Develop New Payment Models	Weight	Centralize Data & Analysis	Weight	Engage People & Communities	Weight
MaineCare Objective 1:	5	**MaineCare Objective 2:**	5	**MHMC Objective 3:**	5	**MHMC Objective 3:**	5	**MHMC Objective 1:**	5	**Maine CDC Objective 1:**	3
Implement MaineCare Accountable Communities Shared Savings ACO Initiative		Implement MaineCare Behavioral Health Homes Initiative		Public Reporting for Quality Improvement and Payment Reform		Public Reporting for Quality Improvement and Payment Reform		Track Healthcare Costs to influence market forces and inform policy		NDPP: Implementation of the National Diabetes Prevention Program (NDPP)	
QC Objective 1:	4	**HIN Objective 2:**	4	**QC Objective 1:**	4	**MaineCare Objective 1:**	5	**MHMC Objective 3:**	5	**Maine CDC Objective 2:**	2
Provide learning collaborative for MaineCare Health Homes		Through a RFP process, HIN will select 20 qualified Behavioral Health organizations to provide $70,000 each towards their EHR investments including their ability to measure quality.		Provide learning collaborative for MaineCare Health Homes		Implement MaineCare Accountable Communities Shared Savings ACO Initiative		Public Reporting for Quality Improvement and Payment Reform		Community Health Workers Pilot Project	
HIN Objective 1:	3	**HIN Objective 3:**	4	**QC Objective 3:**	4	**MHMC Objective 2:**	4	**HIN Objective 1:**	3	**MHMC Objective 6:**	2

HIN's Health Information Exchange (HIE) data will support both MaineCare and provider Care Management of ED and Inpatient utilization by sending automated email's to Care Managers to notify them of a patient's visit along with associated medical record documents.		Connect Behavioral Health providers to HIN's Health Information Exchange		Provide QI Support for Behavioral Health Homes Learning Collaborative		Stimulate Value Based Insurance Design		HIN's Health Information Exchange (HIE) data will support both MaineCare and provider Care Management of ED and Inpatient utilization by sending automated email's to Care Managers to notify them of a patient's visit along with associated medical record documents.		Consumer engagement and education regarding payment and system delivery reform	
MHMC Objective 4:	**3**	**QC Objective 3:**	**3**	**MaineCare Objective 3:**	**3**	**MHMC Objective 5:**	**3**	**HIN Objective 4:**	**2**	**HIN Objective 5:**	**1**
Provide Primary Care Providers access to claims data for their patient panels (portals)		Provide QI Support for Behavioral Health Homes Learning Collaborative		Develop and implement Physical Health Integration workforce development component to Mental Health Rehabilitation Technician/Community (MHRT/C) Certification curriculum.6		Provide practice reports reflecting practice performance on outcomes measures		HIN will provide MaineCare with a web-based analytics tool referred to as a "Dashboard". The Dashboard will combine the current real-time clinical HIE data with MaineCare's claim's data. This is the first test of Maine's HIE to support a "payer" using clinical EHR data.		HIN will provide patients with access to their HIE medical record by connecting a Provider's "Patient Portal" to the HIE. The patient will access the HIE record via a "blue button" in their local patient portal environment.	
MHMC Objective 5:	**3**	**QC Objective 1:**	**5**	**Maine CDC Objective 2:**	2	**QC Objective 1:**	**4**			**QC Objective 4:**	**1**
Provide practice reports reflecting practice performance on outcomes measures		Provide learning collaborative for MaineCare Health Homes		Community Health Workers Pilot Project		Provide learning collaborative for MaineCare Health Homes				Provide QI Support for Patient-Provider Partnership Pilots (P3 Pilots)	
MaineCare Objective 4:	**2**	**QC Objective 4:**	**1**			**Maine CDC Objective 1:**	**3**				
Provide training to Primary Care Practices on serving youth and adults with Autism Spectrum Disorder and Intellectual Disabilities.		Provide QI Support for Patient-Provider Partnership Pilots (P3 Pilots)				NDPP: Implementation of the National Diabetes Prevention Program (NDPP)					
QC Objective 4:	**1**										
Provide QI Support for Patient-Provider Partnership Pilots (P3 Pilots)											

Legend	Maine Care	Maine CDC	Maine Health Management Coalition	HealthInfoNet	Quality Counts

Each SIM objective, as outlined in the SIM Strategic Framework, includes (1) High level milestones and goals, or Accountability Targets, and (2) Mid and lower level tasks and dependencies, which align to individual project plans managed by each Maine SIM Partner. This integrated SIM Program Plan has become known as the 'Single Source of Truth' or SST, and is managed by the SIM Program Team.

Additional project plans will become a part of the overall SST as additional contracts are awarded through RFP procurement processes.
The SIM Program Plan is monitored and updated regularly by the SIM Program Team as required and indicated by SIM required reporting. Monthly Status reports are provided by each partner to the SIM Program directly. Additional reports on SIM objectives, stakeholder perspectives, and stakeholder identified risks and issues are reported through the subcommittees per the Governance structure as outlined in Section A. (See Figure 12 and Figure 13)

Figure 12: Monthly Report Template

SAMPLE **Maine SIM Monthly Status Report**

Submitter Name	
Organization	
Month/Year of Reporting Period	
Date of Report Submission	

Section I: Current Month Status

Section for Quarterly Accountability Targets

OBJ #	Narrative	Quarterly Target Number	Actual number reached	Percentage of completion
1	Help people out	100 people	75 people	75%

Task #	Brief Narrative of the Task	Status of Task*	Current Task Explanation	Number of Meetings	Meeting Attendees	# of Reports	Copies Issued	Trainings Held	Training Attendees	Projection Narrative	Outlook Green Yellow Red
ADM1	Crossing the Street	In Progress	Crossing Guard Meeting	1	25					Monthly Meeting	Green
ADM2	New Crosswalk	Completed	Installed New Crosswalk							N/A	

New Numeric Section for Accountability Targets

OBJ #	Narrative	Quarterly Target Number	Actual number reached	Percentage of completion
2	Good works reward program	50 people	1 person	2%

Task #	Brief Narrative of the Task	Status of Task*	Current Task Explanation	Number of Meetings	Meeting Attendees	# of Reports	Copies Issued	Trainings Held	Training Attendees	Projection Narrative	Outlook Green Yellow Red
ADM17	RFP development	No Progress	Meeting cancelled due to snow							Rescheduled for next month	Yellow
ADM21	Criteria mapping	N/A	New for next month							Gather information	Green

***Status Notes: Completed: the task has been completed and no additional work is needed. In Progress: Ongoing work toward milestone/Accountability Target**
No Progress: No work done on scheduled task, provide reason why

Section II: Narrative Status of Work

Area to provide more detail regarding the work on objectives and tasks listed in section I

Section III: Key Risks/ Issues (Narrative) **Entered into Risk Log (YES / NO)**

List the key risks and issues as related to the tasks. Make sure to enter the risks on the risk log as well.

Section IV: Lessons Learned

Description of what worked well and what did not work well and how the approach was adapted to meet the task needs.

Section III: Key Risks/ Issues (Narrative) **Entered into Risk Log (YES / NO)**

List the key risks and issues as related to the tasks. Make sure to enter the risks on the risk log as well.

Section IV: Lessons Learned

Description of what worked well and what did not work well and how the approach was adapted to meet the task needs.

Figure 13: Quarterly Report Template

SIM Partner Status

Partner Name

FFY Q3, 2014

Overall SIM Partner Status:	

Status Summary

Risks/Issues

STATUS

Objective	Status Description

QUARTERLY ACCOUNTABILITY TARGETS

Objective #	Target Measure Description	Target Number	Actual Number	Percentage of Completion	Status

Status codes for accountability targets: Green 90% to 100%, Yellow 75% to 89%, **Red 0% to 74%**

QUANTITATIVE MEASURES

Frequency	Meetings	Meeting Attendees	Trainings Held	Training Attendees	Reports/ Publications	Copies Issued
Month One						
Month Two						
Month Three						
Quarterly Total						

Status Outlook for FFY Q4, 2014

Objective	Status Outlook (Green, Yellow, Red)	Associated Narrative (include information on expected Milestones or Accountability Targets)

Non-SIM Health Care Reform Innovations –
Please provide other examples of Health Care Reform that are not being driven by SIM, but are related to the overall initiative.

Status reporting is required to be reported to the SIM Program Team on a monthly and quarterly basis, with issues and risks to be reported on a monthly basis to ensure early detection/discussion and to identify the need for escalation through the Governance structure. Any changes to project scope, resource requirements, or time requirements will be summarized and provided escalated through the SIM Governance process. Attached are sample status reports, issue logs, and risk logs that will be used for this purpose. The status will include a summary assessment from each subcommittee that will indicate the subcommittee status as green (project tasks on target), yellow (components of project plans at risk for not meeting goals), or red (project plan components not meeting objectives). Each summary assessment will include accompanying narrative to adequately describe the reason for selecting the assessment level. The Status reports, along with summarized issues and risks will be used to provide required reporting to CMS at the frequency and in the format required. The Program Director will be accountable for this reporting.

Reporting content is outlined in Section R, which describes the Maine SIM evaluation plan, and frequency is addressed in Sections Q and R respectively. This information will be provided to CMS/CMMI as required in the terms and conditions. Ensuring that CMS/CMMI receives this reporting information as required will be the accountability of the SIM Program Director.

37. Project Plan for Completing Model Testing and 38. Sequenced Project Activities

The SST provides the framework and guidance for the program to proceed by establishing tasks within a time frame as well as targeted milestones and targets to be completed. The imbedded document below is a copy of that plan.

Maine SIM SSTv11 with QAT 072414.xls

39. Measurable Project Activities

The quarterly accountability targets as defined by the objectives listed in the strategic framework and well as defined in the SST have been broken down even further by SIM Program Management in collaboration with the partners. Figure 14 below lists the Year 2 targets.

Figure 14: Quarterly Accountability Targets

YEAR 2					No quarterly activity, so no target to be met.	
Objective #	Narrative	Measurement Basis	Y2Q1	Y2Q2	Y2Q3	Y2Q4
HIN1	HIE Notifications	# of active users of the Clinical Portal	555	575	585	600
HIN2	HIE Incentives	amount money of milestone paid out				$200,000
HIN2	HIE Incentives	# of organizations participating	20	20	20	20
HIN3	HIE to BHH	Sites Connections	10	11	11	12
HIN3	HIE to BHH	BHH Bidirectional Connections	5	5	6	7
CDC1	NDPP	written agreements issued to providers	5	7	8	10
CDC2	CHW Pilot	number of Clients served through the pilot	15	20	30	50
QC1	LC for HH	Active, participating HH single payer practices meeting supported by Learning Collaborative	100%	100%	100%	100%
QC1	LC for HH	Active, participating HH single payer practices meeting must-pass requirements	75%	75%	75%	75%
QC1	LC for HH	Active, participating HH single payer practices meeting screening requirements	75%	75%	75%	75%
QC3	LC for BHH	% of BHHO's supported by BHH Learning collaborative	100%	100%	100%	100%
QC3	LC for BHH	% of BHHO teams participating in monthly webinars	50%	50%	75%	75%
QC3	LC for BHH	% of BHHO teams participating in Learning Sessions	50%	50%	75%	75%
QC3	LC for BHH	Number of Multi-Stakeholder Advisory Groups (BHH Working Grp) Held	2	2	2	2
QC3	LC for BHH	% of Advisory (BHH Working Grp) meetings with representation from state, provider and consumer organizations	100%	100%	100%	100%
QC4	P3 Pilots	# of provider pilots participating with at least 25 members attending, learning sessions	9	9		

QC4	P3 Pilots	# of members attending the P3 leadership group	15	15		
QC4	P3 Pilots	# of provider pilots participating with at least 25 members attending, Webinars	9	9		
QC4	P3 Pilots	# of newsletters disseminated	1	1		
MC1	ACO	Total Patient Lives Impacted				55000
MC1	ACO	Additional Maine Lives Impacted				27700
MC1	ACO	# of AC provided with monthly Utilization reports	0	5	5	7
MC1	ACO	AC's attended ACI meeting	90%	90%	90%	90%
MC1	ACO	Annual applications of ACO's	5	5	5	7
MC2	BHH	members enrolled in BHHO	7175	7350	7525	7700
MC2	BHH	percent of representation by stakeholders at monthly meetings	80%	80%	80%	80%
MC3	MHRT/C Certification	Curriculum development	75%	100%		
MC3	MHRT/C Certification	Training plan development	75%	100%		
MC3	MHRT/C Certification	providers		25	100	200
MC4	ID/DD TCM Providers	Curriculum development	50%	75%	100%	
MC4	ID/DD TCM Providers	Training plan development	50%	75%	100%	
MC4	ID/DD TCM Providers	Targeted Case Managers providers Trained			10	20
MC4	ID/DD PCP Training	Develop HH LC Training for PCP's	100%			
MC4	ID/DD PCP Training	Number of HH PCP's Trained	15	25	50	75
MHMC1	CEO Roundtable	Increase in number of Members / Participants		25		30
MHMC2	VBID	Number of covered lives enrolled in plans that incorporate value based design	0	0	0	10000
MHMC3	Alternative payor coverage	Percent of Maine residents covered by alternative payment arrangements	20%	25%	30%	35.50%
MHMC4	Patient portals	# of practices that have adopted claims portals	52	54	56	60
MHMC5	Practice reports	Percentage of Primary Care Practices receiving reports	27%	29%	32%	35%
MHMC6	Payment Reform education	people	250	300	350	400

Q. Communications and Management Plan

Refer to DRR Section Q: Communications and Management Plan

Supporting Documentation Available:

Q1) Maine SIM Initiative website: www.maine.gov/sim

Q2) Communications Matrix (Figure 16)

40. Communication Plan to Reach Stakeholders

SIM Communications Plan

The SIM grant recognizes the importance of communications and the use of all avenues of communications to reach a variety of stakeholders. While the SIM State Plan requires the development of a communications plan for the length of the grant, it is critical to allow the plan to evolve, based on the needs of targeted audiences. The Maine SIM Team learned in early interactions with stakeholders of their communications preferences and have taken those into consideration in developing this plan, which spans the remainder of calendar year 2014 and extends through 2015. It is hoped that this plan, guided by feedback from external audiences and stakeholders, will meet the needs of funders, the State, and the grant's partners. The SIM Team intent is to assure consistent communication of all types of information including achievement of key milestones, barriers to success, areas of focus and pressing needs through the end of the grant and beyond. The team anticipates the need to adjust communications strategies as time moves forward, and intends to formally revise the plan in July 2015. The following plan outlines the tools that will be used to reach all of the identified audiences, their purpose and anticipated timelines for updates. Also included is a communications matrix to offer a visual representation of the communications plan, targeted audiences and a timeline of planned activities.

Short Term Needs That Have Been Met

Early on in this process, anticipating the need for a web-based communications portal, DHHS created the SIM web site, www.maine.gov/sim. It is believe this site will evolve to one that stands alone and features all of the information associated with the SIM grant. From the onset, community forums were used to introduce the grant to all stakeholders and the public. A news release was published to announce the forums, and webinars were offered in the two largest geographic regions. The slide presentation and webinar can be accessed at the SIM Web site. Staff asked forum participants to share their preferences regarding the receipt of communications. The majority asked to be placed on an e-mail listserv for SIM and noted that the SIM web site would be effective as a centralized information base.

Long-Term Communications Strategies and Needs

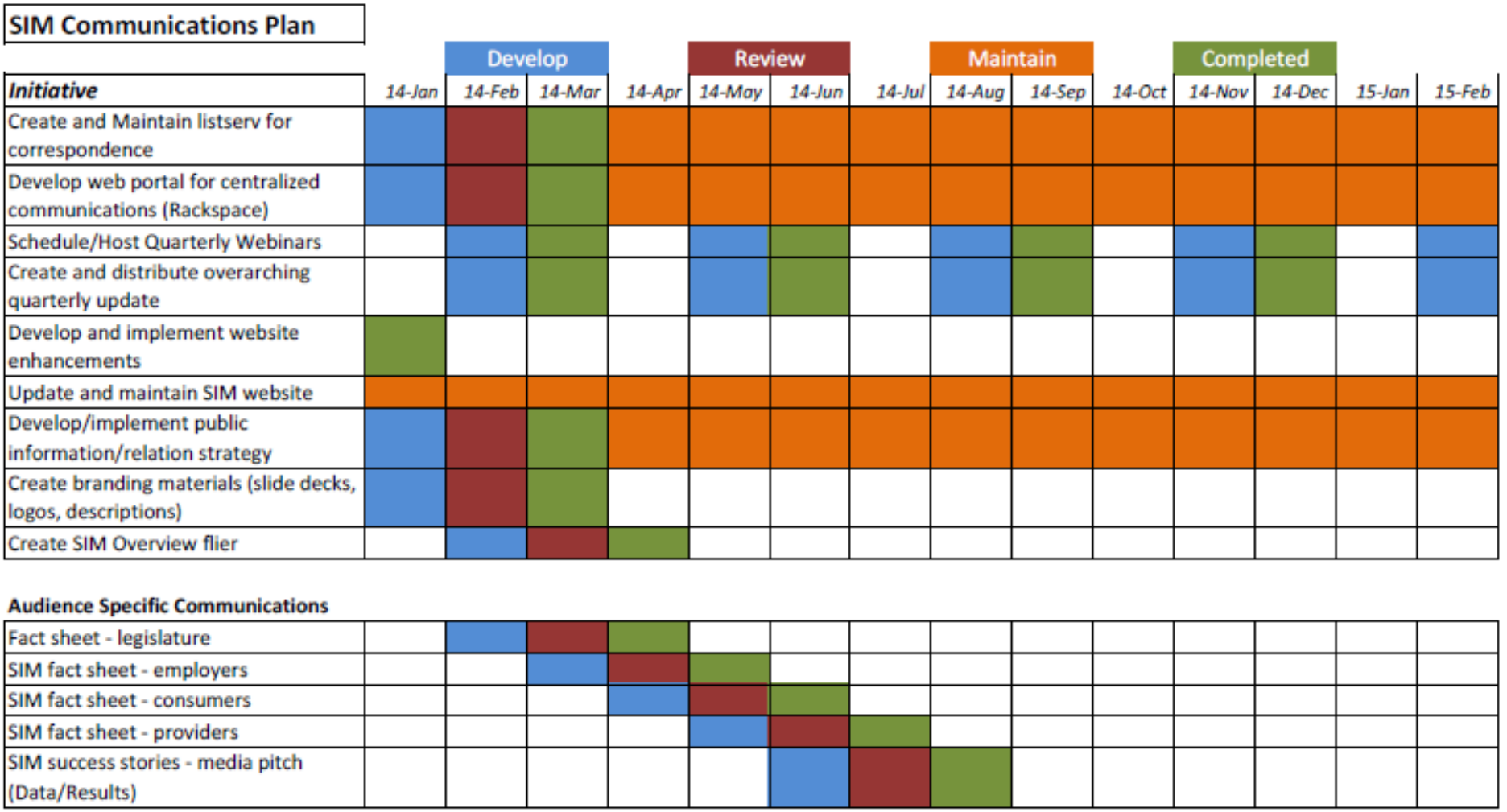
Establishing a long-term communication plan is a bit more difficult than the short term, immediate needs of SIM messaging. It is clear that frequent communication is critical to this process and that while over-arching communication is necessary, efficient and preferred, other

efforts may require a more audience-specific approach. Some of the long-term strategies planned are:
(1) Quarterly Update Report – targeted to partners and interested parties. It includes updates on each strategic objective status and includes an outlook for the next six months.
(2) Web site enhancement and development - This vehicle is centric to communications success. Elements of the web site include: Meeting minutes from all committees; all presentations; news releases and announcements; upcoming deadlines; collateral materials such as fact sheets and brochures that are available for download and localized printing; frequently asked questions and their answers; and a 'contact us' section where anyone can freely share ideas or concerns;
(3) Web Portal for Stakeholders – A secure online portal where stakeholders can share and edit documents, access meeting minutes, templates and other resources, and view a calendar of key meeting dates and information. A 'Keep it Simple' approach to the portal will be employed to ensure its usability;
(4) Branding Consistency – To create a unified SIM brand under DHHS, templates for presentations, logo use and other public facing materials have been developed and distributed among stakeholders.
(5) Media Engagement – There are stories to tell around patient outcome improvement and reduced savings. The SIM plan includes making 'pitches' to the Maine media on a periodic basis, hoping to localize and regionalize the story where appropriate;
(6) Collateral materials - While Maine SIM team has created an initial 'one sheet' flyer as an overarching document to briefly describe SIM, it is anticipated that there will be a need for additional collateral materials, including brochures and fact sheets. A production schedule has been tentatively included in the attached matrix;
(7) Open Web Forums/Semi-Annual Meetings - The SIM Program Director will conduct open forums each quarter that allow anyone to ask questions, share ideas or express concerns. In addition, a more formalized meeting will be held twice yearly to educate, inform, celebrate and promote achievements, while re-establishing direction for the coming six months;
(10) Public information – Maine SIM will cultivate a strategy to communicate with the public at-large which may include news releases, media engagement and public forums.

41. External Communications with Stakeholders

See Figure 15 (SIM Communication Plan)

Figure 15


SIM Communications Plan
Develop
Review
Maintain
Completed
Initiative
14-Jan
14-Feb
14-Mar
14-Apr
14-May
14-Jun
14-Jul
14-Aug
14-Sep
14-Oct
14-Nov
14-Dec
15-Jan
15-Feb
Create and Maintain listserv for correspondence
Develop web portal for centralized communications (Rackspace)
Schedule/Host Quarterly Webinars
Create and distribute overarching quarterly update
Develop and implement website enhancements
Update and maintain SIM website
Develop/implement public information/relation strategy
Create branding materials (slide decks, logos, descriptions)
Create SIM Overview flier
Audience Specific Communications
Fact sheet - legislature
SIM fact sheet - employers
SIM fact sheet - consumers
SIM fact sheet - providers
SIM success stories - media pitch (Data/Results)

SIM Communications Plan

Initiative	*15-Mar*	*15-Apr*	*15-May*	*15-Jun*	*15-Jul*	*15-Aug*	*15-Sep*	*15-Oct*	*15-Nov*	*15-Dec*
Create and Maintain listserv for correspondence										
Develop web portal for centralized communications (Rackspace)										
Schedule/Host Quarterly Webinars										
Create and distribute overarching quarterly update										
Develop and implement website enhancements										
Update and maintain SIM website										
Develop/implement public information/relation strategy										
Create branding materials (slide decks, logos, descriptions)										
Create SIM Overview flier										

Audience Specific Communications

Fact sheet - legislature										
SIM fact sheet - employers										
SIM fact sheet - consumers										
SIM fact sheet - providers										
SIM success stories - media pitch (Data/Results)										

42. Communications Oversight Entity

DHHS will be overseeing all communications, and ensuring effective SIM communication coordination where partners are involved.

R. Evaluation Plan

Refer to DRR Section R: Evaluation

Supporting Documentation Available:

Appendices R2- R5 can be found in Year One Plan Submission on this website:
http://www.maine.gov/dhhs/sim/documents/SIM%20docs/plan%20docs/ops%20plan/MaineSIMOperationsPlanAppendicesQ-R-S-T.pdf

R1) Self- Evaluation Contract – The Lewin Group (Attachment R1)

43. Entity Responsible For Managing Data Collection and Reporting Processes

As a key component of the Maine Self Evaluation effort, the State has competitively procured the services of an external evaluation entity, The Lewin Group, to perform the required SIM data collection, reporting, and self-evaluation functions and effectively monitor the implementation and impact of the State Innovation Model initiative.

As evaluator, The Lewin Group is responsible for the development and implementation of a comprehensive evaluation agenda and evaluation plan; the development and coordination of a sustainable research infrastructure and research collaborative; the development of data collection protocols and methods; all project related data collection activities; supporting CMMI and RTI with the Cross-Site evaluation design and data collection activities; data analytics; the design and implementation of focused studies to test specific model components; and working with our Innovation partners to develop a robust Continuous Quality Improvement (CQI) and reporting infrastructure to support and drive system change efforts.

After a protracted competitive procurement process, a contract has been executed with The Lewin Group starting July 1, 2014. The Lewin Group has extensive knowledge and experience in the design and implementation of large-scale health care evaluations, performance metrics, advanced analytics, and National experience in guiding healthcare transformation initiatives (See Self-Evaluation Contract in Attachment R1.)

Evaluation Infrastructure and Support

The scope and complexity of evaluation of the Maine SIM necessitates the participation and support from all Innovation project partner organizations and will require extensive engagement of project stakeholders. The proposed organizational structure for the evaluation is as follows:

The Maine DHHS will serve as the lead agency for the State and will provide overall direction, oversight and facilitation of all Evaluation Contract activities. Maine DHHS has established processes and procedures and extensive experience working with CMS and will work cooperatively with the CMMI/RTI evaluators on all aspects of the project.

Dr. James Yoe, Director of the ME-DHHS Office of Continuous Quality Improvement. Dr. Yoe has extensive experience in the design and implementation of complex service system evaluations and has led a number of large scale grant funded evaluation projects for the state, including: the CMS funded State Profile Tool for Long-Term Services and Supports, the evaluation of the Thrive Trauma Informed System of Care for children and youth with serious behavioral and emotional challenges funded by SAMHSA and is currently Principal Investigator for the SAMHSA funded Mental Health Data Infrastructure Grant.

Dr. Yoe and the Office of Continuous Quality Improvement have led evaluation and system change efforts related to the integration of physical and behavioral health care for persons with serious mental illness (SMI). This work included a multi-year health claims study funded by AHRQ of individuals with multiple complex conditions with a focus on those individuals with SMI and diabetes as well as a system transformation initiative, funded by the Maine Health Access Foundation (MeHAF) focused on increasing awareness and implementing strategies within selected behavioral health provider organizations to better identify and address the physical health concerns of adults with SMI. This work provided the foundation for and has served as guide to the design and implementation of Behavioral Health Homes initiative and focused work on the integration of behavioral and physical health in primary care practices and behavioral health organizations planned as a core innovation component of the Maine SIM Project.

The Maine SIM Project intends to establish an Evaluation and Performance Reporting Committee. This committee will be co-chaired by the State evaluation lead, Dr. James Yoe and the Self-Evaluation Contractor (Lewin Group) and include representatives from the State Office of MaineCare Services and other DHHS Program Offices, SIM partner organizations, including: the Maine Health Management Coalition, Health InfoNet, and Quality Counts. This committee will be responsible for providing strategic oversight and project direction to the design and implementation of the project evaluation, performance reporting, CQI, and evaluation dissemination and translation activities.

44. Design and Implementation of an Evidence Based Evaluation Framework

45. Design/ Implementation of a Meaningful Self-Evaluation and Continuous Improvement

Overview/Specific Aims

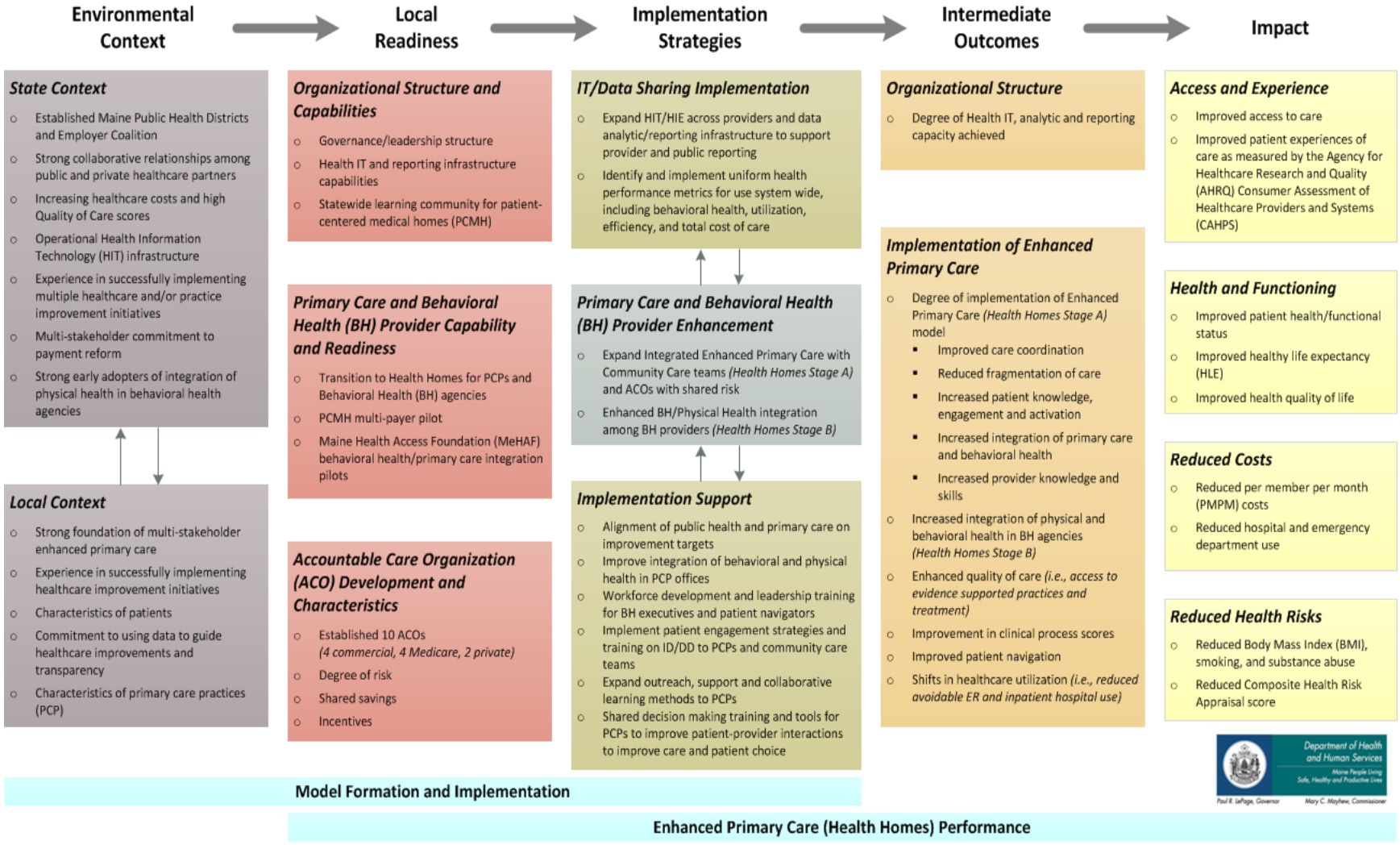
Maine's overarching quality and evaluation framework is based on the Triple Aim goals of improving quality, reducing costs, and enhancing patient experience of care. The core objective of the evaluation approach is to provide a coherent and coordinated quality improvement and measurement framework to support and guide the development and implementation of the innovation reforms as well as a robust and sustainable evaluation strategy that will document and assess the unique and combined effects of different innovation strategies and initiatives. Maine's goals for quality reporting, continuous quality improvement and evaluation are to:

1. Establish a common set of quality/performance metrics that cover population health, practice/provider, and individual client-level measures) for use by both primary care and behavioral health providers;
2. Provide continuous feedback on performance to providers and other key project stakeholders that allows for timely review of the data, supports data driven decision making, continuous improvement, and dissemination and translation of lesson's learned and best practices;
3. Develop data sets for use in describing and documenting model interventions, changes in care processes and practices, and assessing the impact/effectiveness of the innovation model and key service and practice level reforms;
4. Build a local research an evaluation infrastructure to support a sustainable research collaborative to build evidence for the effectiveness of the State Innovation models in improving the quality of care, reducing health risks, improving health outcomes for members and reducing the health care costs.

Self-Evaluation Strategy and Approach

An initial step in Maine's process of developing the Maine SIM Self-Evaluation was the development of an evaluation logic model. The model provides a schematic of how we anticipate that the State's Innovation Model approach to payment and delivery system reform will achieve the intended Triple Aim outcomes, what those outcomes might be, and the contextual factors, such as local and state influences and degree of readiness of communities and primary care practices that might influence the implementation and success of the project. The SIM Evaluation Logic Model is presented in Figure 16 (below).

Figure 16: Draft Evaluation Logic Model



It is anticipated that implementation of the SIM will result in multiple practice and client-level impacts, including: reduced costs of care, improved quality of services and improved client experiences and outcomes. The logic model then outlines a number of factors that may potentially influence the effectiveness of the planned implementation strategies and resulting outcomes, including: the state and local context in which the innovation model interventions are launched; the organizational capacity and readiness of communities, primary care and behavioral health providers, and health care systems to adopt the model innovations; the specific implementation strategies and activities that the SIM project pursues; and the intermediate service delivery and person-specific outcomes that result from those activities.

This evaluation logic model is intended as a starting place in mapping out the pathways by which the Innovation model interventions will lead to expected outcomes and the complex interplay of multiple influencing factors that may mediate those outcomes. The model is intended to serve as guide for the design and implementation of self-evaluation studies and will be revised and updated accordingly throughout the implementation of the project.

One of the initial start-up activities of the Self-Evaluation Contractor will be, in collaboration with ME-DHHS OCQI, ME-SIM leadership, and ME-SIM partners, to update and refine the initial evaluation logic model with a focus on aligning the evaluation plan to the SIM strategic pillars and mapping the SIM operational measures and targets to the Triple Aim outcomes.

Based on the logic model and consistent with the CMMI/RTI Cross-Site evaluation focus, the evaluation of Maine SIM will focus on following key research questions:
(1) Does the model implementation lead to changes in service utilization patterns and reduced per member per month, total, medical, and behavioral health care costs?
(2) Does the model lead to improvements in care coordination and less fragmentation of care and for what populations?
(3) Does the model lead to improvements in quality and process of care?
(4) To what extent does the model improve the level of integration of physical and behavioral health across Maine's health care system?
(5) Does the model lead to improvements in member health, wellbeing and functioning and in reduced of health risk behaviors?
(6) Does the model lead to improved member experiences of care, engagement, and perception of services?
(7) What factors influence the adoption and spread of model enhancements? To what extent are model components implemented consistently and with fidelity?
(8) What system, practice, and person-level factors are associated with the model outcomes?

Self-Evaluation Infrastructure and Study Components

The overall approach to the project evaluation will incorporate mixed method, qualitative and quantitative designs that utilize multiple data collection methods and data sources and captures data from multiple sources at different levels of the health care delivery system (i.e., state, regional and local practice) and on different member population groups. A key

component of the evaluation approach will be the development of a sustainable research infrastructure and collaborative of health care researchers both within and outside of Maine. The purpose of this collaborative is to incubate and stimulate research ideas, enhance in-state research expertise, increase access to specialized research methodology and analytic expertise, launch focused and innovative studies to test the effectiveness of various components of the State Innovation Model and provide dissemination/translation of research results broadly across the state. The Lewin Group, in collaboration with the ME-DHHS Office of Continuous Quality Improvement and our Innovation partners will be responsible for the design and implementation of the local infrastructure required to support the proposed Self-Evaluation and RTI/CMMI cross-site evaluation efforts and the development of a sustainable research collaborative.

In addition to the research infrastructure development, the Self-Evaluation design will include three core study components, including:

- ***Implementation/Process Study***:

  Study Objective: To conduct a comprehensive implementation study that will comprehensively describe the characteristics of communities and health care settings which are impacted by the Maine SIM innovations. This study will be implemented to gather qualitative and quantitative data from providers, consumers, and health systems to assess perceptions, identify challenges and develop strategies for success.

  Key Research Question(s) to be addressed:

  - What factors influence the adoption and spread of SIM model innovations?
  - To what extent are SIM model components implemented consistently and with fidelity?
  - What system, practice, and beneficiary level factors are associated with SIM outcomes?

  The primary intent of this study component will be to describe the variability and richness of the community contexts and health care settings in which the planned interventions will be implemented. This information will be critical in understanding the impact and outcomes of the SIM Innovations and will provide ongoing information on implementation progress, challenges encountered, and unintended consequences of the planned model interventions. This study will be qualitative and descriptive in nature and will build on the CMMI Rapid Cycle Evaluation of State Models. This study component will involve a combination of provider/practice site visits; focus groups and individual interviews with key project stakeholders, including: community partners, primary care and behavioral health practices, Community Care Teams (CCT), and service recipients. Data will be obtained from multiple sources, including: stakeholder and participant surveys and interviews; Project Steering Committee and project work group minutes, project plans and other program documentation; analysis of policy changes; analysis of the roll out and implementation of the planned innovation model interventions; and challenges encountered and how they were resolved. In order to document progress and provide data to inform and guide the implementation process, multiple rounds of data collection are planned.

  This study will build on the evaluation of the PCMH Pilot project, Multi-Payer Advanced Primary Care Practice Demonstration Project (MAPCP), and the AHRQ funded Multiple Complex

Conditions Project, data will also be collected from participating primary care and behavioral health practices to assess the degree of change in practice/provider culture, team orientation, leadership and workplace stress; the degree to which practices are meeting health home practice requirements; and level of integration of physical and behavioral health achieved. A full study design and proposal for this evaluation component will be developed by the Self-Evaluation contractor within the first three months of contract initiations (September 2014). Key deliverables and timelines related to this study component are outlined in the Self-Evaluation Contract in Attachment R1.

- ***Economic/Cost Study***:

Study Objective: The focus of this study component is to assess changes in health care utilization trends and associated expenditures by analyzing changes in health care service utilization, service costs and return on investment linked to Maine SIM initiatives, including planned primary care and behavioral health practice innovations.

Key Research Question(s) to be addressed:

- Does the Maine SIM model implementation result in changes in service utilization patterns and reduced cost of care? If so, to what extent?

This study component will involve a comprehensive cost effectiveness study that is designed to evaluate changes in service utilization trends and associated costs, and an analysis of cost savings and return on investment (ROI) linked to the planned primary care and behavioral health practice innovations.

The study design will involve a longitudinal approach in order to assess utilization and cost trends over the SIM testing period and will compare innovator sites (i.e., communities and primary care/behavioral health practices that have implemented the model enhancements) with in-state comparison communities and practices that have not yet implemented the model/practice enhancements or are at early stages of implementation. A full study design and proposal will be developed by the Lewin Group within the first three months of the initiation of the contract (September 2014). Key deliverables and timelines related to this study component are outlined in the Self- Evaluation Contract in Attachment R1.

- ***Impact/Effectiveness Studies***:

Objectives: Design and implement an overall effectiveness study and facilitate multiple targeted studies aimed at testing the impact and effectiveness of SIM interventions.

Key Research Question(s) to be addressed:

- Does the model lead to improvements in care coordination and less fragmentation of care and, if so, for what populations and to what extent?
- Does the model lead to improvements in quality and processes of care and, if so, to what extent?
- To what extent does the model improve the level of integration of physical and behavioral health across Maine's health care system?

- Does the model lead to improvements in beneficiary health, well-being, function, and reduced health risk behaviors, and if so, to what extent?

The Lewin Group will design and execute an Impact/Effectiveness Evaluation in order to assess the overall effects of SIM innovations on processes of care, clinical quality outcomes and member experiences of care. The measures and data collection methods utilized for this study component will be aligned with the CMMI/RTI Impact evaluation effort and will build on the National evaluation by incorporating Maine SIM specific measures of interest. This design of this study component will be guided by the Maine SIM strategic priorities/pillars and the evaluation logic model (see above – Figure 16) that outlines the theory of change proposed by the Maine SIM. The Impact/Effectiveness Study uses a longitudinal, multi-method study design and will build upon previous and current evaluation work related to Patient Centered Medical Homes (PCMH) and Multi-payer Advanced Primary Care Practice Demonstration (MAPCP) evaluations conducted by the University Of Southern Maine, Cutler Institute for Health Policy as well as the AHRQ Multiple Chronic Conditions Project.

In addition, the Lewin Group will coordinate with ME-DHHS OCQI and other research partners associated with the planned Research Collaborative in the design and implementation of one or two targeted investigations during the SIM testing period aimed at testing the effectiveness of various Maine SIM interventions and reforms. The Lewin Group will coordinate with and integrate other research/evaluation studies currently underway on key components of the SIM test, including the evaluations of Health Homes and Behavioral Health Homes.

Since 2010, the PCMH and Multiple Chronic Conditions research and evaluation projects have provided a fertile testing ground for identifying and testing both process of care and clinical quality/outcome measures appropriate for assessing the effectiveness of key components of the planned Innovation model as well as the testing and refining of data collection approaches, measurement tools, CQI and dissemination and translation strategies, and analytic methodologies. Please refer to Appendices R1, R2, and R3, as found in Year One Plan Submission, for the PCMH Evaluation Report, AHRQ Multiple Chronic Conditions Project and a Summary of Planned Health Home Evaluation Plan.

Another important line of research inquiry to be undertaken by the Research Collaborative will focus on the effects of primary care and mental health integration on process and outcomes of care for people with mental illness and other chronic health conditions. Maine DHHS has been recognized nationally for its evaluation work and system change initiatives promoting the integration of physical and mental health care. A recently completed, multi-year, research study on the health service outcomes of adults with serious mental illness and diabetes (MCC Project) funded by AHRQ provides a research and methodological framework for further research inquiry in this area.

Data Sources

The Maine SIM evaluation framework uses a mixed methods approach incorporating both qualitative and quantitative data and information that will be obtained from multiple data sources, including: (1) Tracking/monitoring of project and program implementation; (2) Focus groups and Individual Interviews with project stakeholders; (3) Practice and provider surveys; (4) Member perception of care and wellness surveys; (5) Member focus groups; (6) Clinical data

from EHRs and chart reviews and patient functional status surveys; (7) All payer claims data – health service utilization and expenditures; (8) Vital statistics data – mortality; (9) Clinical process of care and quality of care measures via PTE and all-payer claims data. Quantitative and qualitative data will be collected on a quarterly, semi-annually and annual basis throughout the SIM testing period and coordinated with the CMMI Cross-site evaluation data collection schedule.

Support of Data Collection Efforts for CMMI Cross-Site Evaluation

The State Self-Evaluation Team is committed to working with the CMMI/RTI Cross-Site Evaluation team on the three part evaluation strategy including: 1) the overall design and data collection strategy, 2) rapid cycle evaluation of state models; and 3) longitudinal impact evaluation. The State Evaluation Team will assist CMMI/RTI in the following planned Cross-Site evaluation activities:

- Design and implementation of core cross-site performance measures;
- Development and implementation of standardized data collection, reporting, and data quality control protocols;
- Facilitate preparation and transmission of analytic data sets for use by the CMMI/RTI Evaluators;
- The design and monitoring of rapid cycle continuous improvement processes to promote real time improvements.
- Coordinate and facilitate onsite data collection (stakeholder and beneficiary interviews and focus groups) for the implementation and impact evaluation components;
- Align/coordinate cross-site evaluation activities with Self-Evaluation plans;
- Transmit evaluation data to CMMI Evaluation Team.

Performance Measurement, Reporting and Continuous Improvement Monitoring (Reference Sect I).

Quality data, useful reports and timely feedback of performance information is essential to the successful design and implementation of the innovation strategies, targeting and delivery of services, focusing continuous improvement initiatives, and to drive change across the health care system.

The selection of core quality metrics for use in quality reporting will use and build on existing quality metrics in use with PCPs, ACO's commercial payers as well as measures established for the MaineCare Health Home, Behavioral Health Home and Accountable Community initiatives. Substantial work on metric development has been completed in Maine through the Multi-payer patient centered medical home pilot, the MaineCare health home initiatives, and the AHRQ Multiple Complex Conditions Project. This metrics development work has involved extensive engagement of stakeholders in the selection process and incorporated multiple measure sets including: the PTE Practice and clinical quality measures, Commercial ACO measures, PCMH Pilot measures, Health Home measures, Behavioral Health Home measures, and Accountable Community measures as well as population health measures collected via the Maine CDC. Together, these efforts provide a robust foundation from which to build on for the metrics development for the SIM Project.

Maine is committed to a robust and practical quality measurement and reporting system. The proposed measurement and reporting system to support the Maine SIM is designed to enhance an already established and tested infrastructure for health care measure development and practice reporting and includes two measurement tiers: 1) Practice level reporting - core health quality measures for ongoing use for multi-payer practice level reporting; and 2) SIM Effectiveness Reporting – Core system and practice level measures for assessing the effectiveness of Maine SIM innovations.

Practice Level Reporting: Measurement development for practice level reporting includes the development and implementation of a common set of evidence supported quality measures for use for practice level reporting with primary care and behavioral health providers across multiple payer systems. The selection process for these core practice measures is currently underway through a multi-stakeholder process coordinated by the SIM project partner, the Maine Health Management Coalition (MHMC) and the SIM Payment Reform Sub-Committee.

SIM Implementation and Effectiveness Reporting: The focus of this measurement and reporting tier is to provide ongoing, targeted information to SIM leadership, partners and stakeholders on SIM innovation implementation progress and fidelity and the extent to which these implementation strategies are effective in moving the bar on key Triple Aim outcomes. This data will be used to guide and inform SIM program planning, to focus SIM interventions, identify and resolve implementation challenges and inform and prioritize continuous improvement strategies.

An essential component of this work was the development of a set of core metrics for use in measuring the effectiveness of the SIM project. To this end, the Maine SIM team has worked to develop a set of targeted measures to monitor the effectiveness of the Maine SIM Innovations in achieving the Triple Aim goals of improved health outcomes, quality, patient experience, and lower costs. A multi-stakeholder, ad hoc Core Metrics Committee was established to assist in this measure review and selection process. This committee included representation from ME-SIM Management Team, SIM Partner Organizations, Hospital Systems, and Primary Care Practices. This measure review and evaluation process was supported by the NORC and RTI technical assistance teams.

The initial step in developing a set of core metrics for the Maine SIM initiative was to compile measures that are currently tracked and reported across Maine's major SIM models (Health Homes, Behavioral Health Homes, Patient Centered Medical Homes, Commercial Accountable Care Organizations, and Accountable Communities). Stakeholders emphasized the importance of drawing on existing measurement efforts in the development of the core measure sets to minimize any additional reporting burdens on providers.

The Core Metrics Committee evaluated this broad set of metrics against the following criteria:

- Aligns across multiple model measure sets
- Aligns with SIM strategic pillars and Triple Aim goals

- Addresses priority domains of measurement recommended by Commissioner Mary Mayhew, including emergency department use, readmissions, imaging, and care coordination.
- Reflects a mix of process and outcomes and short and long term impacts
- Addresses populations prevalent in Medicaid (children, behavioral health, disabilities)
- Safeguards against restrictive patient/client selection practices (i.e., creaming, skimping, and premature discharge of patients)
- Addresses the Center for Medicare and Medicaid Innovation (CMMI's) core measurement areas related to population health (diabetes, obesity, and tobacco control).

The measures recommended by the Core Metrics Committee are displayed in Figure 17. The table provides information about which SIM initiatives are currently reporting on the measure, which of the Triple Aim outcomes and SIM Strategic Pillars the measure maps to, and a brief description of the Committee's rationale for including the measure.

The core metric set was not intended to include all of the measures that will be used to evaluate the Maine SIM initiative, so some gaps inherently exist. Although the measures recommended for the core metric set (Figure 17) collectively represent all of the Triple Aim outcomes and SIM strategic pillars, representation is weaker for several pillars and outcomes. Some of these gaps are due to data limitations and others are a result of selecting a limited number of core measures for the SIM dashboard.

The recommended core measures were reviewed and discussed by the SIM Steering Committee in May 2014 and work is underway to incorporate the Committee's recommendations and finalize the measure set.

The MHMC Foundation (MHMC-F) will serve as the lead agency for reporting of quality information for the initiative. The MHMC-F data system includes an inclusive all claims database and the analytic tools required to transform health claims data into actionable information to inform decision making and drive continuous system improvement. The MHMC-F will produce a variety of performance reports targeting multiple audiences, including: (1) Monthly performance monitoring reports on primary care and behavioral health practices participating in the State Innovation Model Testing Project, detailing performance trends on selected quality metric, and highlighting emergent issues or quality concerns; (2) Predictive modeling reports to assist providers and project stakeholders in determining the risk levels of clients presenting for services and predicting future service use and potential gaps in care; (3) Web-based Quarterly dashboards using the core set of quality/performance measures (to be determined) that include benchmarks and comparisons with peers. Once established, a selection of metrics from these dashboards will be publically reported and shared with project partners and stakeholders.

Approach to Continuous Quality Improvement, Adoption of Promising Practices and Continuous Learning

- The state will foster the development of learning collaboratives among providers, members, community care organizations, and other stakeholders to promote continuous learning, support Innovation Model reforms and drive health care improvements.

- Continuous improvement will be supported through the use of multiple methods, including: learning collaboratives; data forums; targeted technical assistance and coaching; targeted quality improvement strategies and the implementation of rapid assessment and improvement methods.
- Quality Counts will provide Innovation Model CQI services through an expansion of a current contract with MaineCare. Continuous improvement services include: (1) IHI model learning collaboratives for providers transitioning to Person Centered Medical Home status;
- Patient Engagement learning opportunities through its Better Health, Better Maine campaign, which offers both patients and primary care providers the tools, guidance and resources needed to initiate necessary and effective provider/patient conversation.

Figure 17: Maine SIM Core Metrics Draft 5/21/2014

Measure	SIM Initiatives Using Measure	Strategic Pillars*	Triple Aim Outcomes**	Rationale
ED Utilization				
Non-emergent ED use: Based on Maine list of 14 diagnoses identified as preventable in A Maine ED study, including: sore throat; viral infection; anxiety; conjunctivitis; external and middle ear infections; upper respiratory infections; bronchitis; asthma; dermatitis and rash; joint pain; lower and unspecified back pain; muscle and soft tissue limb pain; fatigue; headache	ME Health Homes, ME Behavioral Health Homes, PCMH, Accountable Communities	1, 2, 3, 4, 6	2, 4	Commissioner recommendation and major cost driver
Readmissions				
All-cause readmissions	ME Health Homes, ME Behavioral Health Homes, PCMH, Accountable Communities	1, 2, 3, 4	2, 3, 4	Commissioner recommendation and major cost driver
Imaging				
Use of imaging studies for low back pain: The percentage of members with a primary diagnosis of low back pain who had an imaging study within 28 days of the diagnosis.	ME Health Homes, 1 of 4 ACI Commercial Payers, Accountable Communities	1	2, 4	Commissioner recommendation and important measure of potential overuse
Fragmented Care				
Percent of members with fragmented care: This measure uses Liu's fragmented care index (FCI) is based on Bice and Boserman's continuity of care index (CCI) that considers the number of different providers visited, the proportion of attended visits to each provider and the total number of visits.	ME Health Homes, ME Behavioral Health Homes	1, 2, 3, 4, 6	1, 4	Commissioner recommendation and key measure of overarching SIM goal to improve care coordination
Total Cost of Care Index				

Population based, case-mix (risk) adjusted, per capital total medical and pharmacy cost paid to providers with high cost claimants capped at 100K.	To be used across all SIM Initiatives	1, 4	2, 4	CMMI/CMS recommendation

Table 1: Recommended Measures (cont.)

Measure	SIM Initiatives Using Measure	Strategic Pillars*	Triple Aim Outcomes**	Rationale
Pediatric/Adolescent Care				
Well-child Visits (ages 3-6 and 7-11)	ME Health Homes; ME Behavioral Health Homes; 2 of 4 ACI Commercial Payers; Accountable Communities	1	2, 3	Well visits in younger ages strong impact on preventable diseases
Developmental Screenings in the First 3 Years of Life	ME Health Homes; Accountable Communities	1	2, 3	Key measure of early childhood
Mental Health				
Follow-Up After Hospitalization for Mental Illness	ME Health Homes; ME Behavioral Health Homes; Accountable Communities	1, 2, 5, 6	2, 3	Important mental health measure
Screening for Clinical Depression and Follow-up Plan	ME Health Homes; ME Behavioral Health Homes	1, 2, 5, 6	2, 3	Important mental health measure
Patient Experience/Engagement				
Providers support you in taking care of your own health, CAHPS PCMH		1, 6	1	Captures patient experience & engagement
Willingness to Recommend Provider (Definitely Yes/Somewhat Yes/No), CAHPS	Accountable Communities	1, 6	1	Captures patient experience
Obesity				
Adult BMI Assessment	ME Health Homes; ME Behavioral Health Homes	1	2, 3	Addresses CMMI core population

				health priorities
Weight Assessment and BMI Classification (ages 3-17)	ME Behavioral Health Homes	1,2	2, 3	Addresses CMMI core population health priorities
Adults Meeting Physical Activity Guidelines: ≥150 minutes per week of moderate-intensity aerobic activity, or ≥75 minutes of vigorous-intensity aerobic activity, or an equivalent combination of moderate- and vigorous-intensity aerobic activity [where vigorous-intensity minutes are multiplied by 2] totaling ≥150 minutes per week).	None, available from BRFSS	1,2	2, 3	Addresses CMMI core population health priorities
Diabetes Care				
Diabetic Care HbA1c (ages 18-75)	All Models, 2 of 4 ACI Commercial Payers	1, 2, 5	2, 3	Addresses CMMI core population health priorities

*** Strategic Pillars:** 1 – Strengthen Primary Care; 2 – Integrate Physical and Behavioral Health; 3 – Develop New Workforce Models; 4 – Develop New Payment Models; 5 – Centralize Data & Analysis; 6 – Engage People & Communities
**** Triple Aim Outcomes:** 1 – Improved Patient Experience; 2 – Improved Quality of Care; 3 – Improved Population Health; 4 – Reduced Health Care Costs

S. Fraud and Abuse Prevention, Detection, and Correction

Refer to DRR Section S: Fraud and Abuse Prevention, Detection and Correction
Supporting Documentation Available:
S1) Website for regulations cited:
http://www.gpo.gov/fdsys/pkg/CFR-2009-title42-vol4

46. Protections Integrated into the Planned Transformation to Guard against New Fraud and Abuse Exposures

Currently under the existing MaineCare fee for service model, the State has an approved and accepted Program Integrity Unit guarding against fraud, abuse, and overpayments, and has a recovery audit contract to perform similar functions. Medicare has a similar program in place to address fraud, abuse, and overpayments. Initial model changes are handled through the existing fee for service model in Maine Medicaid.

Shared Savings
With a shared savings model under a fee for service system, payers must balance the accurate calculation of shared savings taking into account a claims run-out period with the need to avoid a prolonged delay in the payment of shared savings to an ACO. Medicaid analytics staff have a methodology to accurately project total spend after 3 months' of claims run-out. MaineCare will collaborate with other payers regarding this methodology, as appropriate. In addition, MaineCare will monitor claim submission trends to ensure no "bump" in claims from Accountable Communities providers once the 3-month claims run-out period has passed.

Health Homes
MaineCare tracks the enrollment of its members in the Health Homes Initiative in its MIS system, MIHMS. This enables the state to ensure that there is no duplication of payment or service for an individual MaineCare member. In addition, Health Home providers refer additional members through a Health Home Enrollment System developed for this purpose, and must attest to the provision of a minimum billable activity for all enrolled Health Home members on a monthly basis in order to receive payment. MaineCare cross references attested members for Medicare enrollment at practices that are also part of Medicare's MAPCP demonstration. The State does not pay for dually –eligible members who receive payment through Medicare at these 75 practices.

Ongoing Payment Reform
The project manager monitors changes and/ or amendments in the SIM for the following: new payment methodologies (shared savings payments, incentive payments, capitation payments, etc.); new classes, and/or types of providers, and services provided through contractors (MCOs, ACOs etc.). Prior to implementation of a model change or amendment; a review will be performed. The review will evaluate each of the regulation's listed below and describe how the change or amendment is addressed in our current approach or identify what changes need to occur and how those changes address the regulation prior to implementation.

The SIM steering committee will evaluate the benefits of creating a fraud, abuse, and overpayment working group under the Payment Reform subcommittee comprised of Maine Medicaid, Medicare and private payer representatives to develop a cross payer plan for identification of fraud, abuse, and overpayment. Applicable Regulations:

- 42 CFR §431.54
- 42 CFR §433.116
- 42 CFR §438.600 through .610
- 42 CFR §447.45
- 42 CFR §455 and 456 All subsections
- 42 CFR §460
- 42 CFR §1002 all subsections

47. Plan for Existing Fraud and Abuse Protections that May Pose barriers

Anti-Trust

As stated in Section G, Maine does not anticipate providers to face anti-trust issues accompanying the State's implementation of multi-payer ACOs. The State's four MSSP ACOs and one Pioneer ACO are protected by the Medicare Fraud and Abuse waivers. In addition, providers will put in place appropriate contracts with each other to collaborate to coordinate care for patients. Providers that join together outside of a common health system are unlikely to have any significant market share within Maine. However, as payment reform models progress toward capitation, if providers do appear likely to face anti-trust challenges, the State is exploring the feasibility and implications of amending 22 MRSA 1841 et seq., the Hospital and Health Care Provider Cooperation Act (2005) to cover vertical relationships between hospitals, physicians, and other community-based and health providers.

T. Risk Mitigation Strategies

Refer to DRR Section T: Risk Mitigation Strategies

Supporting Documentation Available:
T1) Weighted Criteria (Figure 18)
T2) SIM Risk Log Template (Figure 19)
T3) Risk and Issue Log – Attachment T1
Website: https://mainesimgrant.atrackspace.com/Governance/Forms/AllItems.aspx

48. Success and the Potential Risk Factors

The symbiotic mitigation of risk and the collaborative approach to finding solutions to issues and other challenges that arise during the transformative testing that is funded under the SIM grant is a key accountability of the SIM Governance structure. As stated earlier, Maine believes that transformative, sustainable change will come from a broad-based, highly-credible, **collaborative** network of private, not-for profit, and public sector representatives that are passionate, engaged and empowered to influence effective health care reform action. Risk mitigation and issue resolution are key accountabilities of the members of the SIM governance, and recommendations for studies, strategies, executive orders, task force formation, or legislation will be an expectation of those members serving. The process to do so is managed by the State through the SIM Program Director and SIM Program Manager. It is important to accentuate that, while the expectation is that risks and issues will be identified, mitigated and resolved at the subcommittee and steering committee levels, the SIM Maine Leadership Team is comprised of high-level State executives, with the ultimate accountability to resolve any escalated risks or issues. The Risk and issue mitigation plan in Attachment T1, illustrates in detail the process and tools in the Maine risk and issue mitigation plan.

Quantifying potential risks in a timely and precise manner is central to the risk mitigation process. Identifying potential risks as soon as possible enables the SIM partners time to effectively mitigate risks. Clear guidance has been given to the SIM Governance structure as to the process for reporting potential risks. Risks to the project have been reported on an ongoing basis to ensure early detection, discussion and identification of the need for escalation through the Governance structure, as appropriate.. In year two, each level of the Governance structure, (leadership team, steering committee, sub committees) meetings will include a standing agenda item titled: risks/issues. The weekly telephonic partner meeting will also include a standing agenda item titled: risks/issues. Time will be taken during meetings to explicitly request, discuss and document potential risks. Liberal and early risk identification is highly encouraged amongst all levels of the governance structure.

Figure 19 contains a risk log template that is used to record and quantify identified risks. Each risk is assessed a calculated risk score (including weighted priority, probability, and impact) which provides guidance as to the level of risk to the success of the State Innovation Model test, enabling high risk items to be immediately addressed through the Governance structure which is comprised of leaders throughout the stakeholder communities. The weighted priority

criteria (Figure 18) outlines the objective weight assignment of numbers one through five and the guiding criteria for assigning the risk as addressing a "limited scope" or affecting a "foundational objective". The probability and potential impact of a risk taking place is assigned a number from one to three reflecting if the probability is low, medium or high.

The risk score allows the risks to be ranked in an objective manner. An additional tool to assess which risks are immediately actionable is the "waterline". Items above the waterline are flagged for immediate action.

In year one there was a process for adding items to the risk log and development of risk plans. As a further development, year two will include clear steps for updating, closing risks and reporting on risks. The act of updating a risk offers an opportunity to re-calculate a risk score and re- designate the risk as either above or below the proverbial "water" line. The SIM Project recognizes that risk mitigation strategies must be responsive to changes in priority, probability and impact.

Figure 18: Weighting Criteria for Maine SIM Objectives

Definitions:

Strategic Pillar Objective	The Strategic level objective that the identified SIM objective aligns to, i.e. – the objective of 'Strengthening Primary Care'
SIM Objective	The SIM objectives that are aligned to the appropriate SIM Strategic Pillar, i.e., MaineCare Objective 1: Implement MaineCare Accountable Communities Shared Savings ACO Initiative

Objective Weight Assignment	Objective Category	Guiding Criteria
5	Foundational Objective	1. The objective is foundational to SIM Grant's ability to achieve the Strategic level objectives represented by the Strategic Pillar,
4	Critical Objective	1. A SIM objective that is critical to the Strategic level objective, and failure to achieve this objective would hamper the effectiveness of any foundational objective, aligned to the Strategic Pillar, or 2. The objective is integrated with other objectives within the Strategic Pillar, meaning failure to achieve it would impact other objectives and challenge significantly the ability to achieve the Strategic Pillar objective
3	Supportive Objective	1. The objective provides substantial support to a foundational or critical objective aligned in the Strategic Pillar, or 2. Failure to achieve a supportive objective would have a moderate impact on the ability to achieve the strategic objective
2	Contributory Objective	1. The SIM objective contributes to the Strategic objectives for targeted populations

		2. Limited integration exists with other SIM objectives in the Strategic Pillars

Figure 19: SIM Risk Log Template

Maine State Innovation Model Risk and Issue Mitigation Plan

Field to Complete	Relevant Information
Risk/Issue Identified (narrative to match Risk/issue log)	
Risk ID Number (from Risk/Issue Log)	
SIM Objectives Impacted (from the SST, or outlined in SIM Strategic Framework document)	
Accountability Targets Impacted (from SST)	
Associated Strategic Pillar(s)	
Lead Contact	
Relevant Subcommittees/Workgroups	

Risk/Issue Mitigation Plan

Risk/Issue Mitigation Plan Timeline

Summary of Impact if Risk not mitigated or issue not resolved

Attachment T1: Risk Mitigation Log

Maine SIM Risk Log for OPS plan.xlsx