Introduction

Maine believes its health care system can improve the health of Maine people, improve the quality and experiences of health care, and reduce health care costs by 2016. During the next three years, an unprecedented partnership among physical and behavioral health providers, public and private insurers, data and system analysts, workforce developers, economists, and Maine consumers will put this belief to the test through the ***Maine State Innovation Model (SIM).*** Federal partners are confident in its potential and have funded Maine as well as five other states to implement their state level health care innovation reform plans.

The ***Maine SIM*** intends to achieve the Triple Aim goals: improve the health of Maine’s population, improve the experience Maine patients have with their health care, and reduce the total costs of care. The model has a foundation in emerging health care initiatives, promising community-based demonstration projects, and evidence-based strategies that empower consumers with long-term health conditions. The power of the innovation, however, comes from the concurrent application of existing efforts with enhanced investments, all within a shared commitment to accountability, transparency, and quality.

Advancing health care reform in Maine is a complex and complicated endeavor that engages a public-private governance body, three multi-disciplinary workgroups, and policymakers, patients, and providers in all sixteen counties. The Steering Committee is comprised of state-level leaders in health, public health, health technology, finance, and service delivery. The three workgroups focus their activities to develop the physical and behavioral health workforce, apply social and financial incentives, leverage existing resources and initiatives, and collect and use cost and quality outcome data to inform practice, policy, and payment. Success, however, will be measured only when all partners, including patients and providers, demonstrate a shared ownership of this reform.

The Operations Plan for the Maine Health Care Innovation Model is the guidebook to help Maine achieve its Triple Aim objectives and transform health care. This Plan outlines the vision for reform, illustrates the drivers for change, and documents the components demonstrating Maine's state and local partner readiness to test the Innovation Model.

The Operations Plan is a working document. It is intended both to facilitate adherence to project work plans as well as to encourage flexibility and adaption as activities and evaluation reveal unforeseen opportunities or results. Maine has a proven history of innovation; following the Operations Plan should foster new collaborations, make better use of Maine’s social and financial capital, and offer other states a roadmap to advance sustainable and meaningful health care reform.

**Summary of Maine SIM Initiatives**

TheMaine State Innovation Model leverages the work of existing healthcare initiatives and structures and includes additional innovations to maximize the impact of interventions through a coordinated strategy.

The guiding principles of our model are derived from the Triple Aim goals and will be realized through inter-connected approach using six strategies.

**Component #1: Strengthen Primary Care**

1. Expand the enhanced primary care model supported by the Innovation Plan – the PCMH with Community Care Team (CCT) support for high risk/high cost chronically ill patients. The current PCMH Pilot will expand in January, 2013, from 26 to 76 practices. Approximately 57 additional practices are eligible for MaineCare Health Homes status during 2013-2015, under the Stage A SPA (Section 2703, ACA). Health Homes are based on the PCMH Pilot model (enhanced primary care with CCTs) to offer more intensive management support services to the highest needs MaineCare patients.
2. Support targeted efforts to improve care transitions to reduce avoidable readmissions and ED use
3. Support new workforce models to support the transformed health system and the inter-relationship between the broad health system and PCMH practices. This activity includes supporting the training of workers for the Maine CDC implementation of the National Diabetes Prevention Program, and other CDC identified trainings. Shared decision-making is included here.
4. Practice Reports
5. Provide access to providers to data for their patients
6. Aligning incentives across payers

**Component #2: Integrate primary care and behavioral health**

Assist in transitioning behavioral health providers to Health Home status

1. Participation in HealthInfoNet (the state’s HIE) electronic health information exchange and planned incentive program for EHR adoption similar to the meaningful use program for PCPs.
2. MaineCare will solicit behavioral health providers to participate in Stage B Health Homes, centered on patients with SPMI – anticipated date of RFP, early 2013.
3. Provide a learning collaborative focused specifically on the integration of primary care and behavioral health (BH) – to include (a) technical assistance (TA) on integrating care as part of practice transformation; patient engagement; policy development; and mini-grants to expansion sites to participate in TA activities. The State will develop an RFP within the 6 month planning period for provision of the collaborative.
4. Maine Health Management Coalition will work with behavioral health providers to develop behavioral health quality measures for public reporting, through the PTE process.

**Component #3: Link to Public Health & Special Populations**

1. Increase patient engagement within the MaineCare population.
2. Align long-term care with the enhanced primary care model. We will develop a sub-group to assess issues related to transitions to and from long-term care facilities; regulatory issues surrounding eligibility; access to long-term care; HIT needs; and workforce needs. These efforts will be aligned with the Balancing Incentive Program in the Office of Aging and Disability Services.
3. HealthInfoNet to provide a clinical dashboard that allows MaineCare to look at population health, utilization and clinical outcomes for Medicaid patients.
4. Develop and test across five pilot sites, a new workforce model employing “Community Health Workers”, focusing on underserved populations, to support them in a broad set of activities from transportation, language translations services, identifying appropriate providers, and engaging in their health.
5. Diabetes prevention program

**Component #4 – Support Development of New Payment Models**

1. Implementation of MaineCare Shared Savings Accountable Communities
2. Transparent data reporting of cost and outcomes
3. The MHMC will continue its Health Care Cost Work Group initiative to identify actionable strategies to reduce healthcare costs. To identify strategies to reduce costs around Behavioral Health care (a significant cost driver for the MaineCare population) MHMC will add a dedicated Behavioral Health Cost Subgroup.
4. Develop strategies to drive the implementation of new payment models In the absence nationally of a roadmap for organizations wishing to transition to ACO status, MHMC has developed a replicable and supportive pathway to provide this support including:

* Aligning incentives. Sustain the momentum of cost analysis and reduction efforts currently underway.
* Exploration of State (Governor/Insurance Commissioner) policy levers to incent commercial payers to align with MaineCare/SIM – and alignment with the Federal/State Health Insurance Exchange
* Sustained PCMH and Health Homes across all public and private payers

1. Sustaining expanded allied health workforce

**Component #5 – Use Centralized Data and Analysis to Drive Change**

1. Support the use of a common measure set and public reporting, and analysis and feedback to providers and other stakeholders. The Innovation Model requires participating providers to commit to a common set of measures, a common claims data source (Maine Health Data Organization all payer database), and a single source of analysis for public reporting and statewide variation.
2. Through the established Pathways to Excellence, MHMC will work with providers to develop a common set of measures, including working with Behavioral Health providers to develop a common set of BH measures, to be publicly reported. (These are in addition to Total Cost of Care and Patient Experience measures, which MHMC will also report). MHMC will utilize the all claims data base (MHDO) to provide analysis of these common measures, to provide system-wide analysis of healthcare trends, and to track where the state is moving as a whole.
3. MHMC will also offer drill-down services of data to individual members for the purpose of care management (although this piece is NOT a requirement of participation in the Innovation Model). MHMC will use Prometheus to examine resources used to treat a unique episode of care, which will allow partitioning services into standard and potentially avoidable categories and use the information as a quality and efficiency measure for specialists.
4. HealthInfoNet will provide a clinical dashboard that allows MaineCare to look at population health, utilization and clinical outcomes for Medicaid patients.

**Component #6 – Increase Patient Engagement**

1. Increase the knowledge base of consumers concerning the cost of care and the need for system transformation. Provide special emphasis on reaching and engaging the MaineCare population. MHMC will broaden the MHMC Employee Activation Group and other consumer education initiatives to include additional consumers/purchasers/ payer opportunities. During the planning period, MHMC will model an outreach initiative in which MHMC will partner with cultural leaders in rural communities to develop pathways for local engagement with MaineCare members in trusted venues.
2. Increase patient/provider interactions to improve care. The Innovation Model will provide shared decision making (SDM) training and tools to participating PCPs, with the goal of incorporating SDM into the practice workflow. We are currently considering the Choosing Wisely program, but will issue an RFP during the planning period for provision of either this or another SDM program.
3. Measure patient experience of care. As part of the local evaluation process, patient experience of care will be measured using the CG-CAHPS survey. The Maine Quality Forum is currently conducting CG-CAHPS surveying statewide, which will establish a baseline for comparison. Participating sites will complete additional surveys in each of the three years of the project.
4. Add community health workers
5. HIN will engage Maine patients by providing them access to their statewide HIE record leveraging the “Blue Button” standards promoted by the Office of the National Coordinator for HIT (ONC). HIN will conduct a twelve month pilot with a provider organization to make the patient chart available via a certified EHR portal administered by the pilot site.