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| Maine Innovation Model: The Operations Plan for Sustainable Health Care Reform  |
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| www.maine.gov/sim |



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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 Innovation Model.*** 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 Innovation Model*** 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 workplans 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.

Project Drivers: Diagrams of Health Care Innovations

Maine has organized its Health Care Reform Efforts into logical sequences and groupings of actions that lead to the intended outcome.

Clearly defining an aim and its drivers enables a team to have a shared view of the theory of change in a system. A driver diagram represents the team members’ current theories of “cause and effect” in the system – what changes will likely cause the desired effects. It sets the stage for defining the “how” elements of a project – the specific changes or interventions that will lead to the desired outcome.

Creating a driver diagram is most useful in the initial planning of a performance improvement project or initiative, and serves as a tool that should be updated regularly as the team refines the theories of improvement. It also helps in defining which aspects of the system should be measured and monitored**,** to see if the changes/interventions are effective, and if the underlying causal theories are correct. Aims and driver diagrams assist teams in staying focused and on course when they are used as regular references for the improvement work.

**What is an aim?**

An aim is a clearly articulated goal or objective of the work. It describes the desired outcome, and often includes sub-aims. An aim should be specific, measurable, and time-bound, and should answer the question “How much improvement, to what, for whom, and by when?”

**What are drivers?**

The primary drivers, sometimes referred to as “key drivers,” are system components or factors which contribute directly to achieving the aim. Secondary drivers are actions, interventions, or lower-level components necessary to achieve the primary drivers. Secondary drivers should be used to identify changes that can be tested in order to affect the primary drivers. Each driver should be able to be measured, and most drivers should align with specific process measures.

One way to organize and display drivers is through creating a driver diagram. A driver diagram should indicate the causal relationship between the secondary drivers, primary drivers, and the aim.

SP Provide "how to read the driver diagrams that follow" narrative. and how this relates to the original six components from the original narrative

Overarching Model Driver Diagram

## MAINE HEALTH CARE INNOVATION MODEL: Overarching Project Driver Diagram

## Payment Reform

## Systems Reform

## Consumer Engagement

Governance

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

## 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. 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, responsible for project oversight and implementation. Commissioner Mayhew ‘s office issued a press release announcing the grant award, which sparked coverage in state and regional media. The Commissioner installed a Project Manager, who reports directly to the Maine Leadership Team, chaired by Holly Lusk, Health Policy Advisor for Governor LePage.

As described in the SIM application, members of the Grant Maine Leadership Team have been appointed by the Commissioner.

**Grant Maine Leadership Team Appointments are**: Rep. Terry Hayes (Legislator); Sen. 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); Director Richard Rosen (Office of Policy & Management); David Simsarian (Dept. Of Health & Human Services); Pending appointment (Tribal Representation); Dr. Kevin Flanigan (Steering Committee Chair).

The Maine Leadership Team will receive reports from the Steering Committee, whose members are also appointed by Commissioner Mayhew. The Steering Committee includes representation from a broad range of stakeholders, ranging from the state’s Bureau of Insurance to a Medicaid member. The project’s Steering Committee Chair will report on a 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 Malaby and Petersen
* **Tribal Nations:** (pending)
* **Medicaid:** Stephanie Nadeau, Director; Dr. Kevin Flanigan, MD; Rose Strout, MaineCare Member
* **Hospitals:** Katie Fullam-Harris from MaineHealth; Rebecca Ryder, CEO of Franklin Community Health Network
* **Primary Care:** Dr. Noah Nesin and Rhonda Selvin, APRN
* **Behavioral Health:** Dale Hamilton, Executive Director, Community Health and Counseling Services; Lynn Duby, CEO of Crisis and Counseling Centers
* **Commercial Payer:** Kristine Ossenfort, Anthem
* **Self-Insured Employer:** Penny Townsend, Cianbro
* **Long Term Care:** Sara Sylvester, NH
* **Health Information Exchange:** Shaun Alfreds, COO HealthInfoNet
* **Insurance Regulator:** Eric Cioppa, Insurance Superintendent
* **Quality Monitoring:** Dr. Lisa Letourneau, Quality Counts; Jay Yoe, DHHS Quality Improvement
* **Employers:** Michael DeLorenzo, Interim CEO Maine Health Management Coalition
* **CMS/CMMI:** Dr. Fran Jensen
* **Maine CDC**: Debra Wigand
* **Patient Advocacy**: Jack Comart, Maine Equal Justice Partners

Within DHHS the Maine CDC will be responsible for implementing three SIM Public Health initiatives (Community Health Worker Pilot, National Diabetes Prevention Program, and Patient Engagement Campaign).

**Documentation Available:** ▪ Governor’s 9/19/2012 letter of support, ▪ Press release on 2/22/2013 ▪ Announcement of Project Manager; (OK)

## 2. Governance/Management Structure

Governance, management and oversight authorities, structures, processes and finances are in place or sufficiently enabled by regulation and/or contractual arrangements to be effective. A graphic representing the project governance structure appears below.

The Maine Leadership Team has responsibility for policies, changes to the work plan, major shifts in resource allocation, and decisions requiring senior authority. The Project Manager reports directly to the Leadership Team at regularly scheduled meetings. The Maine Leadership Team has the ultimate authority to make project changes and decisions. The Maine Leadership Team will receive reports from the Steering Committee.

The Steering Committee will oversee three permanent and at least one ad hoc workgroup. These workgroups are: (1) System Delivery (coordinated by project partner, Quality Counts); (2) Transparency (coordinated by project partner, HealthInfoNet); (3) Payment Reform (coordinated by project partner, Maine Health Management Coalition); (4) Project Evaluation (supported by DHHS’s Quality Improvement Director, Jay Yoe).

**Contractual Support**

Two different levels of contracts will be awarded. (1) The three key partners – Maine Health Management Coalition, Quality Counts, HealthInfoNet - have key deliverables and work responsibilities written into the grant and governance. Each will have a contract with the State of Maine and will report directly to the Program Manager. (2) All other vendors will be selected through an RFP process.

## 3. Private/public coordination of efforts around key test model elements

The state is implementing a plan to communicate and coordinate accountability for project governance, management, decision making and results across public and private stakeholders. The Stakeholder Engagement Plan is included as ATTACHMENT \_\_\_. (OK)

The state has taken a two-pronged approach to communicating with stakeholders. (1) In June, 2013, four forums were held to inform both the public and the broader health care community, including providers and payers. Two were accessible through webinar. These forums provided information about the SIM grant, current and future MaineCare initiatives that are part of SIM, the deliverables for the three key partners, and the project governance model. (2) A communication strategy has also been developed (See: Section Q – Communications and Management Plan). Stakeholders are engaged in governance at the decision-making level through representation on the Steering Committee and participation in the workgroups. At the primary care level the transformative model already in place is a multi-payer patient centered medical home model involving CMS, MaineCare (Maine’s Medicaid program) and private insurers. This effort, the CMS Multi-payer Patient Centered Medical Home (which is overseen by a governance workgroup chaired by Quality Counts, one of the key SIM partners), will be expanded.

**Documentation Available:** ▪ Agenda and presentation from state Forums (OK)

## 4. Integration and Alignment

The state has analyzed existing legislative and executive authorities to determine the limits and governance requirements of the planned transformation and any misalignment is being adequately addressed. As noted above, part of the Maine SIM is an expansion of a previous model - the Patient Centered Medical Home (PCMH). This model is expanding, with additional sites being added to the multi-payer component, and with the addition of Health Homes (a recognized model under the ACA). Past experience with establishing the original PCMH pilot project allows for significant growth under the SIM grant. Furthermore, we will be able to expand well-established and accepted quality measures more globally. These measures, developed through the multi-stakeholder process known as Pathway to Excellence (PTE) will be used in this grant as a standardized means by which to inform providers and members of the level of quality delivered. Under SIM, an open process will be conducted to allow interested persons to nominate new quality and utilization measures to the PTE workgroups. The Accountable Care Implementation (ACI) workgroup – also open to all interested persons – will recommend appropriate, relevant systems-related metrics to the PTE process. The PTE Systems workgroup will vet nominated metrics and, for those metrics that survive the PTE process, the workgroup will determine how best to publicly report those measures, depending on the particular audience being addressed.

**Documentation Available:** ▪ Health & Human Services Committee presentation 3/13/2013, and ACI Committee minutes (OK)

Coordination Among Initiatives

***Refer to DRR Section B: Coordination with Other CMS, HHS, and Federal or Local Initiatives***

## 5. Coordination with CMS/HHS/federal and other CMMI initiatives

**Coordination Strategy**

TheMaine State Innovation Model leverages the work of existing healthcare initiatives and structures 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; a comprehensive primary care system, integration of behavioral health into primary care, linkage of public health and special populations, data informed care and performance feedback, and engaged patients. These principles and the strategies that support them will be coordinated with the many Federal and local initiatives within the Maine healthcare environment. The Maine model was developed with an understanding of the drivers of cost and inefficiency and informed by a multi-disciplinary perspective underscoring the value of coordinated care and lessons learned from the many innovative pilots that have run in the state. To that end we developed our operations model.

**Data Informed Model**

Several studies and experiences in Maine influenced the decisions we made to put forward the six components of Maine’s SIM. One of the critical pieces of information that informed our model design was an understanding of cost drivers within Maine’s healthcare environment. In 2009 the Maine Quality Forum, within the Dirigo Health Agency (an agency within Maine Government) contracted with Health Dialog Analytic Services (HDAS) analyzed the claims in the all-payer database constructed by the Maine Health Data Organization and the Maine Health Information Center. The database includes commercial, Medicare and MaineCare (Medicaid) claims. HDAS grouped claims into Acute Inpatient, Outpatient, Emergency Room, and Other (such as long term care) types of healthcare, then looked for the main drivers of cost for inpatient and outpatient care. Key findings from the analysis include:

* Total cost is a function of volume of services (utilization) and price per service. Of these two variables, utilization, or service volume, was found to be the more powerful determinant of total cost.
* Significant variation in per-capita spending exists across Health Service Areas (HSAs) for both inpatient and outpatient care.
* A significant portion of inpatient care (>30%) is “potentially avoidable” (PA). This does ***not*** mean preventable or that 30% of inpatient spending can be eliminated; rather, that through analysis and interventions, it can be reduced.
* While some HSAs exhibit more potentially avoidable inpatient costs than others, PA admissions and costs are observed in all communities in Maine with different HSAs exhibiting high costs in different clinical areas.
* On the outpatient side, spending is dispersed among several specific categories, with lab tests accounting for the highest percentage of all outpatient spending (6.8%), followed by advanced imaging (MR and CT) (5.1%). Over 30 additional categories account for less than 5% of total outpatient spending, with many accounting for less than 1%.
* Outpatient spending on high cost categories (*i.e.* lab tests, advanced imaging, specialist visits) varies significantly by geography suggesting the possibility of both overuse (avoidable) and underuse.
* While no single clinical group or type of service on both the inpatient (IP) and outpatient (OP) side drive the majority of healthcare spending, certain population cohorts do drive high percentages of the spending:
* Chronic disease patients exhibit significantly higher rates of potentially avoidable and preference-sensitive care admissions.
* Approx. 10% of the MaineCare and Commercial populations have a chronic disease, and drive approx. 30% of total spending, and 40% of IP spending.
* Approx. 30% of the Maine Medicare population has a chronic disease, and drives approx. 65% of total spending and 70% of IP spending.

Through reductions in potentially avoidable hospital admissions and in high variation-high cost outpatient services, this study identified potential savings of over $350 million in annual health care expenditures in Maine. The specific types of IP and OP geographic variation observed in the analysis provide a guide to begin analyzing reasons for the variation and the development of community specific strategies to address the variation. However, the analysis at the Healthcare Service Area (HSA) level does ***not*** allow for provider and/or hospital specific accountability for the variation. Additional analysis is required for that level of conclusion. This variation and the statewide high prevalence of potentially avoidable admissions indicate the presence of probable overuse in every area of the State, allowing for a discussion of statewide and targeted community-specific strategies and interventions.

**Background History to Using Multi-Stakeholder Groups in SIM**

The importance of the HDAS analysis to our SIM can be understood from how the findings of the study and subsequent public meetings generated action within the healthcare environment. In the spring of 2009, the Maine Hospital Association outlined a strategic plan that was, in part, shaped by the results of the HDAS cost driver study. The Hospital Association and state medical associations were invited to public forums where the results and findings of the HDAS study were revealed. These meetings highlighted unwarranted variation in Maine’s healthcare delivery system and generated attention on the necessity of lowering variation of potentially avoidable admissions. The actions taken by the state in this effort, using data to inform the public on performance of the healthcare system, resulted in hospitals and providers committing to lowering admissions of ambulatory care sensitive conditions. The state actively engaged in a collaborative and coordinated effort with the Maine Health Management Coalition on both the findings and subsequent follow-up strategies in an effort to maximize the impact of using data driven findings to influence healthcare system change.

The foundation of a transformed Maine healthcare delivery system is based on the medical home model, where healthcare is actively coordinated and a linkage to community services, including behavioral health and social services is integrated into care delivery. Over the past four years there has been a concerted effort through a public private partnership to truly build a system that recognizes and rewards comprehensive coordinated healthcare using a medical home model. The State of Maine joined Quality Counts and the Maine Health Management Coalition as a convener of the patient centered medical home collaborative. Two agencies, MaineCare and the Dirigo Health Agency lead this work on behalf of the State. Leadership from these organizations developed and organized strategies to build a foundation for growing the advanced primary care infrastructure in the state. Today there are more than 150 advanced primary care practices or about 1 in 4 in the state.

**Collaborative Environment**

Our State Innovation Model narrative noted the many initiatives occurring in Maine.The healthcare environment here has a rich history of innovation and commitment to high quality care. There is good evidence to support a collaborative environment through examining the various initiatives the state is engaged in. Many are identified in the SIM application and the Maine State Healthcare Innovation Plan. What is clear in each of these initiatives is the involvement and inclusion of various sectors of the healthcare system in various committees, workgroups, and governance bodies. Leveraging and coordinating ongoing work across the state healthcare environment to avoid duplication and overlap is critical to attaining success from our efforts to achieve the goals of the SIM plan. A key principle to our operational plan is the efficient and effective use of resources to achieve our objectives. Efficiency is best realized when resources are coordinated and maximized toward contributing to realization of objectives with minimal duplication and overlap when possible.

**Collaboration Strategies and Tools**

Our coordination strategy is based on using and expanding existing organizational activities and infrastructure directed toward coordinated approaches to achieve the six objectives of our model. We have identified critical key partnerships and coordination points to organize interaction between initiatives that are directly and indirectly included in the SIM plan (Stakeholder Engagement Plan). Our governance structure is our primary locus of control for assuring coordination between initiatives that impact the six objectives. We will be coordinating strategy and workplans through the workgroups that report up to the Steering Committee. The leaders of the workgroups (delivery system reform, payment system reform, and informed consumer engagement) are bringing together leaders from across the healthcare system responsible for various aspects of achieving the six objectives and those specific objectives most closely aligned to the workgroup focus. Secondary and tertiary connection points will be identified through these workgroups, and a functional coordination eco-map will be developed and managed by the SIM project manager. The eco-map will be used throughout the project to assure that the maximum efficient use of total resources is coordinated where possible. The eco-map is a project management tool that is used to identify, catalog, and document existing activities and resources associated with various health and healthcare related initiatives in Maine’s health and healthcare environments. We distinguish between health and healthcare to establish boundaries around public health as in primary and secondary prevention initiatives and healthcare delivery interventions, with an understanding and recognition of overlap in areas where public health is part of a healthcare delivery intervention as is the case for evidence based primary and secondary prevention activities such as those in cardiovascular health and diabetes management.

A **GRAPHIC** entitled Initiative Coordination & Workplan Monitoring Process is included as ATTACHMENT \_\_\_\_. (OK).

**Coordination with CMS/CMMI Accountable Care Organizations**

We are using facilitated stakeholder groups made up of representatives from across the healthcare environment. These groups have various combinations of employers, payers, government, consumers, providers, and systems that are represented. Each stakeholder group is focused on specific parts of the healthcare system and each has a relationship to the workgroups in our governance model and to the six objectives of the model we are testing.

A **GRAPHIC** entitled Model to be Tested is included asATTACHMENT **\_\_\_\_. (**OK)The Accountable Care Implementation (ACI) Committee (Model to be Tested GRAPHIC - component #4 (1) ) of the Maine Health Management Coalition will be used as a coordination point for the work being done in SIM around ACOs. The function of this group is to serve 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 ACI workgroup, though, is much more than a learning collaborative. Working through a consensus-based process, this group is responsible for recommending/nominating metrics to the PTE Systems workgroup, and advocating for those metrics. 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 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 FQHC’s. Coordinated with the ACI Committee is another Management Coalition group, the Health Care Cost Workgroup (Model to be Tested GRAPHIC - component #4 (2)). The Health Care Cost Workgroup identifies actionable strategies to reduce healthcare 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**

Our enhanced primary care model (Model to be Tested GRAPHIC - Component 1 (#1)) is supported by various forms of technical assistance to practices (Model to be Tested GRAPHIC - Components 1 (#2, #3,)). These technical assistance components are being made available to PCMH practices, health homes, and 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 healthcare 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 caret. 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 MAPCP and MaineCare Health Homes initiatives occurs through monthly “the Conveners’ Meeting” between Quality Counts, the Maine Health Management Coalition, Dirigo Health, and MaineCare focused on challenges experienced in the MAPCP and Health Home Initiatives. Importantly, 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. We expect the work around medical homes will coordinate with ACI efforts related to aligning payment approaches, and measuring and tracking performance to capitalize on the momentum we gain from the SIM initiative.

**Documentation Available** - PCMH Conveners Meeting Minutes.

A **GRAPHIC** entitled Overlap of Fed & State Initiatives in Maine is included as ATTACHMENT \_\_\_. (OK)

**Documentation Available:** ACI Committee agendas and minutes, Executive Summit documents, e-mails supporting cooperation

## 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. The coordination point for tracking and managing this aspect of our strategy is the SIM Program manager who is meeting regularly with the three workgroup leaders focused on the themes of transparency, payment and delivery reform. We’ve spoken earlier about using a matrix type tool we term a coordination eco-map. Delivery system reform is being led by Lisa Letourneau, M.D., MPH. Lisa is the CEO of Maine Quality Counts. 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. Included in our model is a close working relationship to the Maine Center for Disease Control (MECDC). Debra Wigand, Division Director of Population Health, is a member of the Steering Committee and core member of the SIM team. The MECDC Office of Rural Health and Primary Care has HRSA funded initiatives and reporting of community benefit programs of critical access hospitals. The Program Manager will assure coordination with the MECDC 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 workgroup and Steering Committee of SIM. Dr. Sheila Pinette, Director of the MECDC has committed that organization to coordinate across all public health offices directly through Debra Wigand, Division Director of Population Health. Ms Wigand, as a core member of the SIM team, will assure the integration of appropriate public health programs. Currently public health is integrated through the Chronic Disease division along workforce development and testing of prevention interventions via the National Diabetes Prevention Program (NDPP), Community Health Worker Pilot, and Patient Engagement Campaign. Additional public health integration will be assessed and connections supported by Ms Wigand for population health prevention related to 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.

Maine has municipal health departments; one in Bangor the other in Portland. MECDC is connected to these two local public departments in addition to a statewide network of nine public health districts. Inclusion of MECDC 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 MeCDC Senior Management Team meeting. Our partnership with the Maine Health Management Coalition (MHMC) 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 healthcare related initiatives to assure efficient resource use and coordination.

## 7. Integration with Existing Authorities

MaineCare has received approval from CMS through a State Plan Amendment, effective 1/1/2013 (Evidence is located in the document grid - NEED) for its Stage A Health Home initiative. The state is finishing up on its Stage B health Home SPA which is planned for draft submission to CMS by end of July, 2013 and anticipated to be ready for final submission September,2013 . The Stage B Health Home Initiative would be implemented January 2014 (Evidence is located in the document grid - NEED).

The Accountable Care Communities Initiative is anticipated to launch in the first quarter of 2014. An actuarial analysis to determine the pm/pm costs and attribution of members to providers has been in progress for over 12 months by Deloitte. Anticipated conclusion of that work is expected this quarter. A concept paper of the Accountable Care Communities Initiative has been shared with CMS and a meeting with CMS is scheduled for 7/23 to discuss the process and approach the state will take with requesting an amendment to our state plan to launch our Accountable Care Communities Initiative.

Aside from these two initiatives, Health Homes Stage B and Accountable Care Communities we do not anticipate a need for modifications to our MaineCare state plan amendment.

## 8. Approval Status of Waivers (for Track 2 States only)

**N/A**

# Beneficiary Outreach and Recruitment

***Refer to DRR Section C: Outreach and Recruitment***

## 9. Outreach and recruitment program

**Beneficiary Outreach and Recruitment**

The Maine SIM uses a multi-payer care delivery strategy for both advanced primary care practices and ACOs. There are distinct beneficiary outreach and recruitment strategies supporting each initiative. All of the initiatives described in our application were underway prior to award of the SIM grant. We include descriptions of the outreach and recruitment efforts for your review. Two initiatives that require CMS Authority (Accountable Communities and Health Homes Stage B) are in the process of defining their outreach and recruitment plan - however, both plans will likely be very similar to the thorough approach used by MaineCare when it implemented the first stage of its Health Home initiative. We have attached documentation from Stage A Health Homes in the Appendix for your review.

**Documentation Available:** MaineCare Health Homes Member Services TCM Letter (OK); MaineCare Advisory Committee Meeting Notes , 2012-2013 (OK); Plan submitted and approved by CMS. **(**this is the HH SPA**)**

Information Systems and Data Collection

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

## 10. Underlying IT infrastructure

Infrastructure to support the intake of a wide range of healthcare data exists and continues to be enhanced.

**Administrative Claims Data**

The Maine Health Management Coalition (MHMC) will be aggregating claims data covering all Maine beneficiaries of commercial, Medicare, and Medicaid health plans. Maine Health Management Coalition will have 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 has complete claims data on the entire commercially insured Maine population from 2007 forward.

These data will be the foundation for the following since we will have 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 for self-evaluation of SIM activities: tracking of progress and impacts by identified plans, purchasers, and providers participating in payment reform;

(c) monitoring of a multi-payer system: since we will have all payer data, we will be able to track-multi payer systems. A small but current and relevant example is the MAPCP pilot sites which are supported by multiple commercial payers and Medicare.

A key feature of our data infrastructure is that we will have historical data from all payers.

* Commercial. The MHMC processes person identifiable commercial claims. 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 monthly 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 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.
* Medicare. The MHMC is one of 4 entities nationwide designated as a Qualified Entity by CMS and will receive complete person identified fee-for-service Medicare data for all Maine beneficiaries from CMS for calendar year 2009 to present.  These data will support reporting to the Multi-payer Advanced Primary Care Practice Demonstration (MAPCP) sites as well as on the statewide Medicare population. The MHMC’s data vendor has also implemented a DUA with CMS to receive personally identifiable Medicare data for practice reporting to the MAPCP practices.  These data are attributed to the MAPCP practices
* Medicaid. The MHMC will have Medicaid data, identifiable at the person level, for all Maine beneficiaries through agreements MaineCare. This relationship is being implemented.  Similarly MHMC will be supporting reporting to all Maine Medicaid Health Homes with patients assigned to practices based on the Health Home assignment criteria, as well as attribution.

*Timelines and Milestones* - Detailed IT infrastructure work plan with timeline and milestones **MIKE** – we’ll need this workplan for APPENDIX

**Patient Survey Data**

CG-CAHPS is collected via a vendor and processed through the University of Southern Maine and made available by the Maine Quality Forum.

*Timelines and Milestones* - Detailed IT infrastructure work plan with timeline and milestones

**Supplemental Data**

Purchasers are concerned with the total impact of health and healthcare on cost. MHMC has the infrastructure to receive and combine data supplemental to claims and clinical data, such as independently collected biometric, coaching, wellness, and absenteeism, which it is now starting to integrate.

**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 38 hospitals are under contract with 35 currently connected; (2) Over 300 ambulatory practices are participating and sending data to the HIE; (3)85% of Maine people are included in the exchange-1,100,000 out of 1,300,000
* 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 will leverage the HIE architecture and will build 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 will leverage 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 will engage 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 healthcare 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 will support 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 will vastly improve MaineCare’s understanding of health care utilization and outcomes for persons with a behavioral health disorder. They will also allow for behavioral health providers to be more active members of the Health Homes and PCMHs.

*Timelines and Milestones* - Detailed IT infrastructure work plan with timeline and milestones

## 11. Process/mechanisms for data collection

**Administrative Claims Data -** Overview of Data Sources and Uses:



**What is collected**

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.

**Workflow processes**

Data are submitted via secure FTP directly to the MHMC data vendor. Once processed and an analytic warehouse is built, information is made available through secure portals, standard reports, and custom analyses depending on the user and applications. Providers with treatment relationships may see patient level identified information on their panels. Providers may access complete population or member level information from claims including summarized cost, utilization, service category and clinical condition metrics on their panels. 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 healthcare services analyzing benchmarked plan performance. MHMC does not handle identified member data. Information is made available according to role based authorization.

**Agreements**

MHMC has Business Associate Agreements and Data Use Agreements in place with all commercial Covered Entities submitting person identified data. It has a DUA in place with the MHDO for statewide commercial data, is writing reporting and research DUAs with CMS for receipt and use of Medicare data. MHMC and MaineCare are executing a Business Associate Agreement and Data Use Agreement.

**Evaluation Data**

**Physician/Practice Data**

MHMC receives data on provider ratings monthly and public reports are updated quarterly.

* Clinical Recognitions: MHMC receives data on provider ratings monthly and public reports are updated quarterly. Providers submit data to NCQA or Bridges to Excellence which is then combined into ratings for treating clinical conditions. Measures are: (a) Diabetes: blood pressure control, LDL control, HbA1c, eye exam, smoking status and advice and treatment, nephropathy assessment, and podiatry exam. (b) Cardiac Care: blood pressure control, LDL control, lipid profile, antithrombotic, smoking status and control; (c) CAD: blood pressure control, LDL control, lipid profile, activity and angina symptoms, LDL therapy, aspirin/antiplatelet therapy, ACE/ARB therapy, smoking status, betablocker treatment; (d) Hypertension: blood pressure control, LDL control, lipid profile, use of aspirin, urine protein test, serum creatine test, smoking status, diabetes screening, diet and weight counseling.
* 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. 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, Surgical Infections, System to Prevent Medical Errors; (b) MHMC-F Medication Safety Survey: Medication Safety, analyzed by Onpoint Health Data; (c) Leapfrog: National Safe Practice Score, analyzed by MHMC-F; (d) MHDO: Falls with Injury, analyzed by MHMC-F; (e) CMS H-CAHPS: Overall Patient Experience, analyzed by Onpoint Health Data; (f) Maine Health Data Organization: Care Transitions, analyzed by MHMC-F

**Clinical Data -** The HIE Clinical Data Collection and Processes include the following:

* 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: (a) CCD/CCR; (b) ICD-9/10; (c) CPT-4; (d) RxNORM/NCPDP; (e) LOINC; (f) 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 3.2 million discrete messages per week
* HIE data is processed into a reporting data warehouse on a weekly basis.

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## 12. Reporting mechanism across payers and providers

**Measurement using Clinical Data**

Reporting Across Practices - Data is updated monthly and public reporting on GetBetterMaine.org is updated quarterly. Measures, processes, and displays are developed through a multi-stakeholder process with feedback from providers, plans/plan sponsors, and payers.

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Website: [www.getbettermaine.org](http://www.getbettermaine.org)

Reporting Across Hospitals - Data is updated quarterly and public reporting on GetBetterMaine.org is updated quarterly. Measures, processes, and displays are developed through a multi-stakeholder process with feedback from providers, plans/plan sponsors, and payers.

* The HIE data warehouse will be used to support dashboards for MaineCare patients, 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

# HIT Infrastructure Alignment

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

## 13. HIT Investments

Maine has made great strides in the use and adoption of HIT. At the spearhead of many of the coordination efforts for HIT are the Office of the State Coordinator for Health Information Technology (OSC), the MaineCare HIT Program and HealthInfoNet (HIN) – the not-for-profit statewide health information exchange (HIE) organization. The OSC is currently the recipient of the State HIE Cooperative Agreement, from the Office of the National Coordinator for HIT (ONC), for Maine. 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 healthcare while maintaining a fair and appropriate cost structure. To this end, 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 on a monthly basis. This group includes representation from all health care stakeholders including the behavioral health care community. HITSC minutes and activities can be seen at http://[www.maine.gov/hit](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 sub-committees for specific issues like statewide healthcare data planning and inclusion of sensitive health information in the health information exchange. For example, a sub-committee – called the Legal Workgroup - comprised of healthcare lawyers, state agency representatives, advocacy groups including the Maine Civil Liberty Union, and behavioral healthcare 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 (~84%) 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 HINto 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 will work 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 will begin in October of 2013 and 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. In addition HIN will deliver real-time notifications to MaineCare care management staff and care management staff at Hospital and PCMH organizations when someone with MaineCare coverage is admitted or discharged from an ED or IP setting. This activity will begin in the Summer of 2013. MaineCare will submit to HIN on a monthly basis an eligibility file that HIN will upload into the HIE architecture. This will allow for automated triggering of email alerts and the inclusion of Medicaid members into the HIN dashboard.

To support the current the statewide ED Care Management Initiative Pilot, HIN in partnership with MaineCare and the participants of the HIE , will deploy 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 2013. 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 – HL7, CCR, CCD, REST, Direct etc.

As noted, in mid-2013, 34 Maine hospitals are sending data to the HIE, and the remaining 4 (there are 38 Acute care hospitals in Maine) are in the process of setting up their interfaces, with an anticipated go-live on the HIE before the end of 2013. 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, *we are using the SIM to cover the interface and annual connection costs for up to 25 behavioral health organizations statewide beginning in January 2014.*

**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 (Immpact 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 has served as a foundation for the development of a HIE data warehouse in 2013. 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 Transparency and Data workgroup. The initial dashboard (described above) will be made available to MaineCare in October of 2013.

**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.) 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.
* **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 then 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.

Maine understands that interaction with key stakeholders regarding the administration of the EHR Incentive Program and the HIT vision is not a one-time affair. The successful adoption and implementation of HIT hinges on buy-in and participation from all of the impacted stakeholders- from the Program Directors administering the program, OIT for technology planning and support, Maine’s CDC and APCD, the providers adopting the technology and receiving the payments, and the MaineCare Members that are ultimately receiving the benefits of coordination of care and lower health care costs. MaineCare is committed to continued and ongoing collaboration with these stakeholders to better meet the needs of its constituents and fully realize the benefits of HIT.

**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 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 healthcare 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-five Behavioral Health Organizations’ HIE costs will be subsidized by the SIM grant. The HIE costs of twenty-five behavioral health organizations will be subsidized by the SIM grant. Twenty will participate in 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 will be chosen for program participation through an RFP being 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), with go-live scheduled for the late fall of 2013. 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 healthcare costs and drive up quality and efficiency across the system.

**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 healthcare 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 healthcare 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.* We will be using the “blue-button” standards to deploy these tools – beginning as a pilot in October of 2013. 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 healthcare 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 healthcare 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 (42CFRPart2) 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.

Model Interventions

***Refer to DRR Section G: Model Intervention, Implementation and Delivery***

## 15. State policy and regulatory levers

**Federal and State levers to implement Maine’s Medicaid initiatives:**

MaineCare’s Health Homes Initiative and multi-payer Primary Care Medical Home (PCMH) Pilot provide the foundation for the State’s emphasis on System Delivery Reform under its SIM Grant proposal.  The State of Maine has an approved State Plan Amendment and operational state policy for it Health Homes Initiative (Section 2703 of the Affordable Care Act) targeting MaineCare members with chronic conditions.  75 of the 159 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, Harvard Pilgrim) and Medicare through Maine’s Patient Centered Medical Home pilot, which is part of Medicare’s Multi-payer Advanced Primary Care.  As of \_\_\_\_, Maine has submitted 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 has extended the deadline to December 31, 2013 and has deleted reference to a specific date in the amended SPA.

The State is also in the process \_\_\_\_\_ of amending the language to its Health Home Section of Policy in order to clarify the language that was originally enacted under emergency rule \_\_\_\_\_.  See attached documentation of SPA approval and applicable MaineCare rule.

 The State is currently crafting its draft State Plan Amendment for CMS and SAMHSA review for its 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 has been working with the Center for Health Care Strategies on its model and submitted a concept paper to CMS on \_\_\_. The State is targeting SPA submission for September 30, 2013, and is working on its rulemaking process in tandem with SPA submission in order to implement its Behavioral Health Homes Initiative as of January 1, 2014.

The State has been engaged with CMS on model and SPA development for its Accountable Communities Medicaid ACO initiative utilizing the toolkit that CMS developed for states pursuing Integrated Care Models.  To date, the state has submitted and engaged CMS in discussion around the requested concept paper, CMS ICM toolkit, and Maine’s shared savings payment methodology with sample calculations (see attached documents).  The state is awaiting feedback questions from CMS and anticipates SPA submission on October 31, 2013 for March 1, 2014 implementation.  The state is working on its rulemaking process for the Accountable Communities in tandem with its SPA.

**State Policy to facilitate sharing individual mental health information**

With support from DHHS, the Governor has 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](http://janus.state.me.us/legis/statutes/22/title22sec1711-C.html) 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**

Maine’s SIM Leadership Team and Steering Committee will be engaging and educating the legislature in order to procure support to extend funding for the Health Home Initiatives beyond the eight quarters of enhanced federal match.  The state is actively working on its evaluation of the model in order to present its case regarding the critical role of Health Homes in systems delivery reform and the reduction of costs and improvement in quality for the Medicaid population.  In tandem with this effort , the State and its SIM partners will be 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 in order to achieve these goals and pursue the requisite rulemaking as well.

**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](http://r20.rs6.net/tn.jsp?e=001soqgFbuqdZ0LEdyg94wdPgUbkTfB4Bo65G7yyM9I0-AuEu1zz2vn9-XC_VzR8zJhs4OUGSbDMmcI339RIZi8CeBoe83uwVhgGT5crmz0mBS9oxqRT0BTgYI_86_DjTqix1-a2xl44ePpt1pBwg_bF3tPqRJddyEWE5gLVu_fsr4=) 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 of Maine 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 Mnaged 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 physiciansby 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 providers to face anti-trust 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 anti-trust 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.

**Documentation Available:** Accountable Care Communities doc. (OK). VBID Workgroup minutes (OK). MaineCare Health Homes SPA (2012)

## 17. Current policy positions and planned actions

Maine’s currently operational Health Homes SPA serving Medicaid members with chronic conditions and its planned Behavioral Health Homes SPA 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 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 the 75 practices and 10 Community Care Teams that receive multi-payer support, 84 other practice sites participate in Health Homes with Medicaid as the single- payer.

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. Need info from Jim/ Shaun/ Dawn re HIT; Sheryl/ Deb re CDC, HRSA.

## 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, Health Information and Health System Delivery Reform Workgroups, all part of Maine’s SIM governance structures.  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 \_\_\_\_\_ selected representatives from two primary care practices MICHELLE - How were Dr. Nesin and Rhonda Selvin selected (PCMH? MPCA?  MMA?.

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

* Maine Health Management Coalition’s Accountable Care Implementation (ACI) workgroup, Pathways to Excellence public reporting, Pathways to Excellence Behavioral Health, Health Care Cost Workgroup, Behavioral Health Care Cost Workgroup, and Vale-Based Insurance Design.
* 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

The table 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.” MICHELLE – is sending this table.

## 19. Mechanisms that engage a wide range of governmental stakeholders

**MICHELLE –** NEED info

## 20. Mechanisms that engage a wide range of community/patient stakeholders

**MICHELLE –** NEED info

## 21. Implementation of public health integration

**MICHELLE –** NEED info

Participant Retention

***Refer to DRR Section H: Participant Retention Process***

## 22. Requirements for Participating Payers

The Model intervention being used in Maine is multi-payer and value based and leverages the existing initiatives being tested by commercial insurers and employers, Medicare, and MaineCare. Two components of the Model are now being finalized and we will be requesting federal authority to operationalize the behavioral health centric Health Home model and Accountable Communities, Maine’s Medicaid Accountable Care Organization. Through the Maine Health Management Coalition, several large employers have entered into agreements with providers and systems to provide population health care via a shared savings model. For the Medicare shared savings programs CMS has contractual arrangements with the systems and entities delivering care to Medicare recipients in Maine for the duration of the SIM project MaineCare has developed provider agreements that are referenced in the approved Health Home SPA and that encourage continued participation in the Health Home initiative and provide incentives to practices with technical assistance and learning community involvement to promote continued participation. Health home practices are provided additional fees that acknowledge the added value of comprehensive care that is delivered through these NCQA certified practices. Our Health Home Stage B model has all of the same retention methods, configured to benefit behavioral health providers and incent multi-disciplinary collaboration of care for people with severe mental illness and children with severe emotional disturbance. (Include a copy of the draft or concept paper of stage b health homes). MaineCare has been developing its Medicaid ACO and has outlined its expectations on provider participation.

**Documentation Available** - Business Assoc Agreement MHMC & MaineCare; Business Assoc Agreement MQF & MaineCare; copy of the MaineCare Health Homes SPA –draft

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 currently nearing completion of 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.

## 22. Requirements for Participating Providers

SEE Response to NUMBER 22: NO> NOTE: THIS SHOULD BE ANSWERED DIRECTLY

Performance Measurement of Quality, Cost, and Health Goals

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

**24. State Performance Measures**

The Maine SIM initiative will employ a broad 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 a NQF endorsement maintenance phase. 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, 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 useful in their support of stakeholder decision making and understandable. They must address gaps in performance and must be feasible to implement (data required must be readily available and retrievable without undue burden).

**Documentation Available**: Hospital Ratings Methodology – March, 2013 (OK)

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 Department of Human Services Center for Disease Control. 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; healthcare 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 are in the process of being 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. Not all Maine practices, though, 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. 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 two PTE committees: a provider committee (primarily physicians) and a Systems committee.[[1]](#footnote-1)

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](http://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. 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 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 provide (or not) 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 data base, 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 is MaineCare. It is the same process used to measure performance of Primary Care Medical Homes in Maine.All of the State’s commercial payers and the MaineCare program (Maine’s Medicaid program) are members of the MHMC and participate in the PTE process. 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 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.

Finally, 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, in many cases, 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.

## 26. Provider, consumer and payer buy-in of selecting SIM performance measures

As described above, the process of developing and adopting performance measures is a collaborative one which depends in large measure 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 again, 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 will involve the development of a Behavioral Health PTE Committee*. MHMC will solicit the participation of behavioral health providers – physicians and non-physicians – as well as purchasers and payers for this new committee, which will be formed by the October 1st launch date. Additionally, MHMC is in the process of identifying appropriate 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.

Measuring performance against the cost of care metric may present 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.

## 27. Plan for quality performance target-setting

The more detail-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 ordinarily compared to national benchmarks, with local targets pegged to performance falling into the top percentiles. 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.

ELLEN – believes this section needs more work

Privacy and Confidentiality

***Refer to DRR Section J: Appropriate Consideration for Privacy and Confidentiality***

## 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, healthcare 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.

[Please see ATTACHMENTS \_\_\_\_, \_\_\_\_ - Legal Workgroup PHI Pyramid and LWG Detailed Grid] (OK ). An explanation of the attached grids is as 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 Consent, 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 consent. (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 consent” 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 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](http://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 consent 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](http://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 (go live date, summer 2013)**

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 consent and to what type of information.

Information covered by this consent 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 consent for their providers to access this information in one of two ways. (1) They can fill out a consent form available from their participating provider or HIN. This form is available for download at HIN’s [website](http://www.hinfonet.org/resources/for-patients). The patient’s identity must be verified and the consent 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 consent using the same form. When they revoke their consent, 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 a consent 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 not 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. *The Department recently hired a Department-wide privacy, confidentiality and security officer to lead a coordinated effort for initiatives, such as the SIM grant.*

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 state-wide HIE, operated by HIN, has also developed privacy and security measures for the HIE.

Project Personnel Recruitment and Training

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

## 29. Roles and responsibilities for existing and new staff or contractors

## 30. Recruiting new/additional staff and/or contractors

## 31. Training of new and existing staff or contractors

Please see ATTACHMENT \_\_\_\_ (Staff & Contractor Recruitment & Training), PowerPoint presentation with detail responding to NUMBERS 29, 30, and 31. (OK) The contract for the CHW Project Manager has been awarded via competitive bid to a highly qualified and experienced organization. The Project Manager is expected to begin work full time on August 1, 2013. The CHW pilot projects must be identified via a competitive RFP, which is expected to be issued in January 2014, with a projected start date of May 1, 2014 for the contracts for the pilot sites.

Workforce Capacity Monitoring

***Refer to DRR Section L: Workforce Capacity Monitoring***

## 32. Program to address the future healthcare 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 5 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> We are uncertain about the future of the Workforce Forum, as there is minimal funding to support the activities.  The Forum has more recently suggested that businesses infuse funds in to the Forum with no success, to date.

Of note from the Health Workforce Forum Reports - Essential to meeting the growing demand for healthcare 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 healthcare services; the healthcare workforce is nearing retirement age. With regard to some of these challenges, the economic downturn has issued a short-term reprieve - hiring demand for healthcare workers has subsided, and with individuals remaining in their jobs for longer periods, the supply of healthcare 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, a state contracted SIM partner, we 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 80 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)** Through the SIM initiative, we will also provide training to the primary care workforce on SDM models and tools, with the goal of incorporating SDM into the practice workflow. We are considering focusing these efforts on the ABIM’s “Choosing Wisely” initiative, but will issue an RFP during the planning period for provision of either this or another SDM program.

**New Workforce Models**

We 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 healthcare 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.We recognize 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 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.
* Our SIM CHW initiative will also include a series of 5 pilots that will: (1) demonstrate the value of integrating CHWs into the healthcare 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 Community Health Workers as an effective element within the “transformed” health system in Maine for the long term.

**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 it supports SIM efforts to reduce cost PMPY 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**

We 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.

Care Transformation

***Refer to DRR Section M: Care Transformation Plans***

## 33. Quality improvement supports for providers

Maine has both strong leadership and a wide array of 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 QI coaches and facilitators; and Maine Quality Counts (QC), a regional healthcare 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 healthcare 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](http://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](http://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 healthcare in Maine which this year focused on achieving the Triple Aim and attracted over 800 individuals from around the state including providers, practice team members, consumers, and other stakeholders (see [www.mainequalitycounts.org/page/887-852/qc-2013](http://www.mainequalitycounts.org/page/887-852/qc-2013)).

As a contracted SIM partner, QC will be 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; 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](http://www.mainequalitycounts.org/page/896-659/patient-centered-medical-home).

Information on PCMH Learning Session and webinar dates and content of past sessions are available at [www.mainequalitycounts.org/page/2-714/pcmh-learning-sessions-and-webinars](http://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 will be contracted to provide QI support services and build CQI capacity within the 80 HH practices that met HH eligibility requirements, joining the 75 practices currently in the multi-payer PCMH Pilot. QC staff will 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](http://www.mainequalitycounts.org/page/2-851/mainecare-health-homes-information) (Note: these resources will be expanded under SIM).

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 155 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 will expand 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 will also contract with an organization to provide QI support to Behavioral Health Home (BHH) organizations participating in the Health Homes “Stage B” initiative* designed to improve care and coordination for individuals with Serious Mental Ill ness (SMI). This contractor is expected to support a learning collaborative with BHHs that provides CQI training and support for these organizations to improve systems of care for individuals with SMI, including systems to ensure the delivery and integration of high quality primary care services for these individuals. In addition, the *Maine SIM effort will contract with organizations to provide additional services that will support CQI efforts,* including supporting the physician leadership development, and supporting an effort to introduce Shared Decision Making into primary care practices. These efforts will be aligned and integrated with the current PCMH and HH QI supports and services.

# Sustainability Plans

***Refer to DRR Section N: Sustainability Plans***

## 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 healthcare 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 healthcare environment. In this multi-stakeholder, shared risk model, providers become accountable for population health and costs through a redesign of the healthcare delivery system and the use of alternative payment models. This focus is currently being piloted 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 recently developed an insurance product); and MaineCare. Health insurance coverage among Maine’s 1.3 million people is as follows: Private Health Insurance (47.5%); MaineCare (18.5%); Medicare (18.4%); Military (6.0%); and Uninsured (9.6%).[[2]](#endnote-1) As noted elsewhere, MaineCare is moving to a managed care approach designed to include an ACO model by 2012. 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.

If the MaineCare Health Homes and Accountable Communities are successful in lowering costs and increasing quality, we plan to present to the Legislature a request for continued funding of the models after enhanced funding expires. The experiences / lessons learned through the Innovations Model initiative 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 126 Legislature in the second session of 2014. Updates on the impact of health homes from our 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.

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.

Administrative Systems and Reporting

***Refer to DRR Section O: Administrative Systems and Reporting***

## 36. Programmatic and Financial Oversight

Identified office/entity responsible for the programmatic and financial oversight of the cooperative agreement

KAREN KALKA **– NEED this info**

Implementation Timeline

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

*let's add an intro to the detail here.show the linking of the categories of actions in the project plans*

## 37. Project plan for completing Model Testing

The SIM Program Director (formerly described as the Project Manager) will oversee the development and maintenance of an overarching Maine SIM Program Plan. This first iteration of this plan is a key component of the Operational Plan, and will evolve and improve as the Program progresses - however, all the major components of the plan will be included within the first iteration.

The first iteration Program Plan will include two levels of information: (1) High level milestones and goals – aka a ‘Course grained’ Program Plan; (2) Mid and lower level tasks and dependencies – aka a ‘Fine grained’ project plan, composed of several individual project plans. The first level Program plan will be informed by the second level plan.

The second level project plan will actually be composed of plans that will be managed by Project Managers from several entities, including State entities (CDC, MaineCare, etc), and the three major partners, the Maine Health Management Coalition, HealthInfoNet, and Quality Counts. Additional project plans will become a part of the overall Program Plan as additional contracts are awarded through RFP processes.

The first level Program Plan will be monitored and updated regularly by the Program Director as required by changes in the second level project plans, as reported to the Program Director by the Project Managers through the status reporting process. Status reports will be provided through the workgroups per the Governance structure as outlined in Section A. These workgroups have the following accountabilities as related to project plan development, management, and reporting: (1) The SIM Workgroups; (2) Provide working group level project plan to the Program Manager to support the development and management of an overall integrated Program Plan; (3) Identify and create awareness of dependencies and cross work group collaboration needs; support the same as identified by other work groups; (4) Maintain an issue and risk log to feed to Program Manager to roll up to an overall Grant issue and risk log; (5) Escalation issues will brought to the Steering Committee as required through the Program Manager and must have clarity on what the issue definition, options to address & a recommended options to address; (6) Support Program Manager in preparing regular overall Program status reports

Status reports will be required to be reported to the Program Manager on a bi-weekly basis, with issues and risks to be reported on a weekly 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 to the Steering Committee. 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 workgroup that will indicate the workgroup 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.

**Available Documentation:** SIM Status Report,; SIM Issue Log,; SIM Risk Log

## 38. Sequenced Project activities

**SEE: Response to NUMBER 37**

## 39. Measurable Project Activities

Project activities specified / planned in a way that they can complete and produce measurable results during the project’s period of performance

**SEE: Response to NUMBER 37**

Communications and Management Plan

***Refer to DRR Section Q: Communications and Management Plan***

## 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, we believe that it is critical to allow the plan to evolve, based on the needs of targeted audiences. We have learned in our early interactions with stakeholders of their communications preferences and have taken those into consideration in developing this initial plan, which spans the remainder of calendar year 2013 and extends through 2014. It is our hope that this plan, guided by the early feedback from external audiences and stakeholders, will meet the needs of our funders, the State and the grant’s partners. Our desire 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. As we fully anticipate the need to adjust communications strategies as time moves forward, we believe it is in our best interest of the grant to formally revise the plan in January 2015. This plan that you are reviewing outlines the tools that will be used to reach all of the identified audiences, their purpose and anticipated timelines for updates. We have also included 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](http://www.maine.gov/sim). We believe this site will evolve to one that stands alone and features all of the information associated with the SIM grant. On June 11, the SIM Team completed its fourth community forum to introduce the grant to all stakeholders and members of the general 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. 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 we plan to employ are: (1) Monthly updates - limited to one sheet, front and back, presented at a high level, designed for all audiences; (2) Project Manager’s Report – targeted to partners and interested parties. It may be more technical in nature and frequency is to be determined. The report would include separate reports from the work group areas of transparency, payment reform, and delivery system model development; (3) Web site enhancement and development - This vehicle is centric to communications success. Elements of the web site must 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; (4) Data Dashboard - A dashboard that begins with the definition of the measures to which the grant will be held accountable supports transparency. Over time, these fields will be populated with actual figures representing progress and provide indicators on cost savings and quality improvement. A ‘Keep it Simple’ approach to the dashboard will be employed to ensure its usability; (5) Annual Report – Contingent on available resources, an annual report that shares data and personal success stories to help reinforce key messages and leverage support for the SIM initiatives will be produced; (6) Media Engagement – We clearly will have some stories to tell around patient outcome improvement and reduced savings. We plan to make ‘pitches’ to the Maine media on a periodic basis, hoping to localize and regionalize the story where appropriate; (7) Creating Champions/Identifying Detractors – Our long-range plan must include a strategy of building community champions for the SIM Grant and plans for how to equip our champions with messages that may derail those who are not in favor of the approach. The Healthy Maine Partnership model has worked to a degree in the development of local infrastructure and a similar approach may be effective for the SIM grant; (8) Collateral materials - While we have created an initial ‘one sheet’ flyer as an overarching document to briefly describe SIM, we anticipate the need for additional collateral materials, including brochures and fact sheets. A production schedule has been tentatively included in the attached matrix; (9) Open Web Forums/Semi-Annual Meetings - The SIM Project 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 - We will cultivate a strategy to communicate with the public at-large which may include news releases, media engagement and public forums.

**Key Questions that Remain Unanswered That Impact Communications**

 (1) **Communications support** – will there be staff support within the grant to spearhead communications efforts? (2) **Funding** – Does the grant have an established funding mechanism for communications? (3) **Communications Expectations, Goals, Challenges and Obstacles -** How are each of these defined and how do they impact our work? (4) **Key messages** – While they will change over time, what are the three core messages that carry forward through all of our initiatives?

**Communications Matrix**

[ATTACHMENT \_\_\_] (OK). Attached is a document that lists desired communications activities, current status, targeted completion dates and defined audiences. Where the word ‘all’ is used to describe the audience, we are defining this population as: Public and private payers; providers and caregivers, including hospitals; community-based practices; behavioral health providers; specialists; long-term care providers; social service providers; state staff; legislators; patients and their families. Once again, we cannot understate that this is a work in progress that will be informed by the targeted audiences as they evolve. The matrix, as it stands today, is an anticipated work plan that is subject to change.

## 41. Demonstration of external communications with stakeholders

Please see response to NUMBER 40.

## 42. Communications Oversight Entity

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

Evaluation Plan

Refer to DRR Section P: Evaluation

## 43. Entity responsible for managing data collection and reporting processes

## 44. Design and implementation of an evidence based evaluation framework

## 45. Design/ implementation of a meaningful self-evaluation and continuous improvement

**Overview/Specific Aims**

**Mai**ne’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 healthcare costs.

**Evaluation Strategy and Approach -** State Innovation Grant Evaluation Framework - An important first step in Maine’s process of developing the Innovation Model project 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 service delivery 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 1 (below).



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 healthcare 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 will serve as guide for the design and implementation local evaluation studies and will be revised and updated accordingly throughout the implementation of the project.

Based on the logic model and consistent with the CMMI Cross-Site evaluation focus, the evaluation of the State Innovation Model 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 healthcare 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 healthcare 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?

**Evaluation Approach -** 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 healthcare delivery system (i.e., state, regional and local practice) and on different member population groups. The proposed evaluation approach will develop a sustainable research infrastructure and collaborative of healthcare researchers both in-state and out-of-state 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 local evaluation contractor 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 local and CMMI cross-site evaluation efforts and the development of a sustainable research collaborative.

In addition to the research infrastructure development, the local evaluation design will include three core study components, including:

* Implementation Study: This study will describe the variability and richness of the community contexts and healthcare settings in which the planned interventions will be implemented. This information will be critical in understanding the impact and outcomes of the Innovation model 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. Building 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 will be developed by the evaluation contractor within the first three months of the initiation of project implementation.
* Economic/Cost Study: 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 36 month model 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 evaluation contractor within the first three months of the initiation of project implementation.
* Impact/Effectiveness Studies:The local evaluation contractor in collaboration with other research partners associated with the Research Collaborative and with input from a broad variety of provider and member stakeholders will design multiple investigations aimed at testing the effectiveness of various Innovation Model interventions and reforms. Guided by the underlying logic of the proposed model innovation, a local impact study will be designed and implemented to assess the effects of the planned Innovation Model interventions on process of care, clinical quality outcomes and member experiences of care. This study will incorporate the CMMI Impact evaluation measures and data collection methods and supplement the CMMI evaluation with site-specific measures of interest. The longitudinal study design and methodology will draw from and expand upon the work of the 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. The proposed Research Collaborative will also coordinate with other planned research/evaluation studies, for example the CMS driven evaluation of 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. [See ATTACHMENT \_\_\_\_ for a summary of the PCMH Evaluation Report, AHRQ Multiple Chronic Conditions Project and a Summary of Planned Health Home Evaluation Plan]. **JAY** – I NEED this summary.

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 proposed 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 36 month model innovation 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 Evaluation Team is committed to working with the CMMI 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 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;
	+ Development and preparation of analytic data sets for use by the CMMI Evaluators;
	+ The design and monitoring of rapid cycle continuous improvement processes to promote real time improvements.
	+ Coordinate and perform data collection for the model implementation and impact evaluations;
	+ Align cross-site evaluation activities with local evaluation plans;
	+ Transmit evaluation data to CMMI Evaluation Team.

**Evaluation Infrastructure and Support –**

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

* The ME-DHHS will serve as the lead agency for the State for the cooperative agreement. Maine DHHS has established processes and procedures and extensive experience working with CMS and will work cooperatively with the CMMI evaluators on all aspects of the project. The Department lead for the evaluation will be Dr. James Yoe, Director of the ME-DHHS Office of Continuous Quality Improvement Services. 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 has 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 serves as a strong foundation and springboard for the integration of behavioral and physical health in primary care practices and behavioral health organizations planned as a component of the SIM Project.
* As a key component of the planned evaluation infrastructure, the State will issue a Request For Proposals (RFP) to identify a local evaluator for the project. The evaluator will be 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 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. We have identified two major university-based research groups that are likely to respond to the RFP solicitation, both of which have extensive knowledge and experience with Maine’s healthcare system, including involvement in recent statewide healthcare transformation initiatives. These Maine-based evaluators, include: the University of Southern Maine, Muskie School of Public Service, and the University of New England, Center for Health Policy, Planning and Research. Both have extensive experience coordinating and conducting large scale system evaluation and QI related projects and experience working with national teams on CMS, AHRQ, NIH, and US-CDC demonstrations and initiatives.
* The Innovation Model Project will establish an Evaluation and Performance Reporting Committee. This committee will be co-chaired by the State evaluation lead, Dr. James Yoe and the contract evaluator (to be determined) and include representatives from the State Office of MaineCare Services and other DHHS Program Offices, from our Innovation Model 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.

In addition we will establish a state-wide advisory committee, co-led by Dr. Yoe and our local evaluation contractor. This committee will provide expert and stakeholder consultation and guidance to the SIM Evaluation project. Committee membership will include representatives from key stakeholder groups, including adult, youth and family member service recipients; primary care and mental health providers; health innovation leadership such as MeHAF, Maine Health Management Coalition, HealthInfoNet and Quality Counts; research collaborative partners; and other Maine DHHS Offices. This group will meet quarterly throughout the SIM model testing phase to coordinate with ME DHHS and the SIM Evaluators on the design and implementation of the SIM Local Evaluation. Their contributions may include recommendations for focused QI initiatives, outcome measure selection, identification and design of additional studies, and feedback about potential burden and threats to fidelity for participant sites, and site selection.

**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 healthcare system.
* Maine is committed to a robust and practical quality measurement system. A common set of evidence supported quality measures for use by primary care and behavioral health providers will be identified through the established Pathways to Excellence (PTE) process of the project’s implementation partner, the Maine Health Management Coalition (MHMC). The selection of core performance metrics will be guided by the State Innovation model evaluation logic model and will incorporate and build on existing quality metrics in use with PCP’s as well as metric development work that is currently in process. 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 incorporated multiple measure sets including: the AHRQ Adult and Children’s Core Measure, PTE Practice and clinical quality measures, PCMH Pilot measures, CMS required Health Home measures, and population health measures collected via the Maine CDC. This initial development work has involved extensive engagement of stakeholders in the selection process. A core set of quality measures specific to behavioral health is also currently being developed. This work provides a strong foundation from which to build on for the metrics development for the State Innovation Model Project [See ATTACHMENT \_\_\_\_ for MHMC metrics). (OK)
* 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 healthcare 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 conversations.

Fraud and Abuse Prevention, Detection, and Correction

***Refer to DRR Section R: Fraud and Abuse Prevention, Detection and Correction***

## 46. Protections integrated into the planned transformation to guard against new fraud and abuse exposures

Currently under the existing 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. The project manager will monitor changes and or amendments in the SIM for the following: new payment methodologies (capitation payments, incentive payments, shared savings 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 project committee should evaluate the benefits of creating a fraud, abuse, and overpayment group 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

The issue of anti-trust as it relates to payment reform remains top of mind, and efforts are underway to ensure that the alignment work undertaken under the SIM initiative remains sensitive to that challenge.

## 47. Plan for existing fraud and abuse protections that may pose barriers

See response to NUMBER 46, above.

# Risk Mitigation Strategies

***Refer to DRR Section T: Risk Mitigation Strategies***

## 48. Success and the potential risk factors

Risks to the project will be reported on a weekly basis to ensure early detection/discussion and to identify the need for escalation through the Governance structure. Attached is a risk log template that will be used for this purpose. Each risk will be assessed a calculated risk score that will provide guidance as to the level of risk to expected 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 Governance Structure is outlined in Section A. **Available Documentation** - SIM Risk Log.

Appendices and Supporting Documentation

| APPENDIXNUMBER | CORRESPONDINGSECTION | Item  | **Pg****TO BE ADDED** |
| --- | --- | --- | --- |
| AVAIL  | A (Governance) | ACO Initial Report Library |  |
| AVAIL | A | ACO Initial Report Library [PPT Presentation] |  |
| AVAIL | A | Bylaws |  |
| AVAIL | A | Forum presentation |  |
| AVAIL | A | Gov Program Mgr Announce |  |
| AVAIL | A | Governor’s 09192012 Letter of Support for SIM Project |  |
| AVAIL | A | Legislative Presentation |  |
| AVAIL | A | Media Coverage |  |
| AVAIL | A | Press release |  |
| AVAIL | A | Steering Meeting Minutes 6.19.13 |  |
| ADDING # | A | Stakeholder Engagement Plan (Planning Period) |  |
| AVAIL | B (Coordination w/other initiatives) | ACI Agenda Apr 22 |  |
| AVAIL | B | ACI Agenda Jan 15 |  |
| AVAIL | B | ACI Agenda Jul 16 |  |
| AVAIL | B | ACI Agenda May 21 |  |
| AVAIL | B | ACI Agenda Nov 20 |  |
| AVAIL | B | ACI Agenda Oct 10 |  |
| AVAIL | B | ACI Final Agenda 7.12 |  |
| AVAIL | B | ACI Minutes 2.15 |  |
| AVAIL | B | ACI Minutes 7.21 |  |
| AVAIL | B | ACI Minutes Nov 20 |  |
| AVAIL | B | ACI Mtg Attendance |  |
| AVAIL | B | AF4Q PCMH Conveners Mtg Agenda 7.13.13 |  |
| AVAIL | B | Evidence of Coord (2 emails 062813) (JIM) |  |
| AVAIL | B | Evidence of Coordination 2 emails |  |
| AVAIL | B | Exec Summit 2nd ex sum draft agenda |  |
| AVAIL | B | Exec Summit Attendees |  |
| AVAIL  | B | Exec Summit pathstopayment |  |
| AVAIL | B | Exec Summit pointsof agreement |  |
| AVAIL  | B | Exec Summit revised draft |  |
| AVAIL | B | PCMH Convener Mtg 3.20 |  |
| AVAIL | B | PCMH Convener Mtg 5.15 |  |
| AVAIL | B | PCMH Convener Mtg 6.19 |  |
| AVAIL  | B | PCMH Convener Mtg Agenda 2.20.13 |  |
| ADDING # | B | **GRAPHIC** – Coordination & Workplan Monitoring Process |  |
| ADDING # | B | **GRAPHIC** – Figure 1 Model to be Tested |  |
| ADDING # | B | **GRAPHIC** - Overlap of Fed & State Initiatives in Maine |  |
| AVAIL  | C (Beneficiary Outreach/Recruitment) | MaineCare Advisory Mtg Notes 011513 |  |
| AVAIL | C | MaineCare Advisory Mtg Notes 03052013 |  |
| AVAIL | C | MaineCare Advisory Mtg Notes 09042012 |  |
| AVAIL | C | MaineCare Advisory Mtg Notes 1.15.13 |  |
| AVAIL | C | MaineCare Advisory Mtg Notes 10022012 |  |
| AVAIL | C | MaineCare Advisory Mtg Notes 12.4.12 |  |
| AVAIL | C | MaineCare Advisory Mtg Notes 12042012 |  |
| AVAIL | C | MaineCare Advisory Mtg Notes 3.5.13 |  |
| AVAIL | C | MaineCare Advisory Mtg Notes 7.9.13 |  |
| AVAIL | C | MaineCare Advisory Mtg Notes 9.4.12 |  |
| AVAIL  | C | MaineCare Health Homes Lett TCM Devel Svces Care Mgrs 060413 |  |
| AVAIL | C | MaineCare Health Homes Member Svces TCM Lett  |  |
| AVAIL | C | MaineCare Health Homes SPA Draft as of Oct 19 2012 |  |
| AVAIL | C | MaineCare Internal VB Purchasing Mtg 07032013 |  |
| AVAIL  | C | MaineCare Internal VB Purchasing Mtg 7.3.13 |  |
| AVAIL | C | Members Standing Comm (MSC) member info 08242012 |  |
| AVAIL | C | Members Standing Comm (MSC) minutes 02032012 |  |
| AVAIL  | C | Members Standing Comm (MSC) minutes 04062012 |  |
| AVAIL | C | Members Standing Comm (MSC) minutes 05172012 |  |
| AVAIL | C | Members Standing Comm (MSC) minutes 08252012 |  |
| AVAIL | C | Members Standing Comm (MSC) notes 11182011 |  |
| AVAIL | C | Members Standing Comm (MSC) questions 08242012 |  |
| AVAIL  | C | MUSKIE – MaineCare Health Homes Brochure |  |
| AVAIL | C | MUSKIE – MaineCare Health Homes Brochure 2 |  |
| AVAIL | C | MUSKIE – MaineCare Health Homes Brochure 3 |  |
| AVAIL | C | Template Health Homes Opt Out Letter |  |
| AVAIL | C | Template Health Homes Transfer Opt Out Letter |  |
| AVAIL | C | Value Based Purch collegecurriculum-outline 120511  |  |
| AVAIL | C | Value Based Purchasing 4 Public Forums notes & questions |  |
| NEED THIS | D (IT Systems / Data Collection) | Detailed IT infrastructure work plan with timeline and milestones  |  |
|  | E (Alignment w/State IT Plans) | Nothing listed in the narrative as an attachment |  |
| N/A | F (Enrollment Eligibility / Disenrollment) | Section No Longer Required |  |
| AVAIL | G (Intervention/Implement/Delivery) | Accountable Care Communities doc |  |
| AVAIL | G | MaineCare Health Homes SPA Draft as of Oct 19 2012 |  |
| AVAIL | G | VBID Workgroup minutes 10.12.12 |  |
| AVAIL | G | VBID Workgrp minutes 101212 (JIM) |  |
| AVAIL | H (Participant Retention) | Bus Assoc Agree MQC&MaineCare 070813 |  |
| AVAIL | H | Bus Assoc Agree MQF&MaineCare |  |
| AVAIL | H | MaineCare Health Homes SPA Draft as of Oct 19 2012 |  |
| AVAIL | I (Qual/Fin/Hlth Goals & Perf Measure) | Hospital Ratings Methodology Mar 2013 |  |
| ADDING # | J (Privacy & Confidentiality) | Legal Workgroup PHI Pyramid |  |
| ADDING # | J | LWG Detailed Grid |  |
| ADDING # | K (Staff/Contractor Recruitment/Training) | Staff Contractor Recruitment & Training |  |
|  | L (Workforce Capacity Monitoring) | Nothing listed in the narrative as an attachment |  |
| AVAIL | M (Care Transformation Plans) | Several web links embedded in narrative |  |
|  | N (Sustainability) | Nothing listed in the narrative as an attachment |  |
|  | O (Admin Systems & Reporting) | Nothing listed in the narrative as an attachment |  |
| AVAIL | P (Implement Timeline) | SIM issue log template |  |
| AVAIL | P | SIM Risk Log Template |  |
| AVAIL | P | SIM status report |  |
| ADDING # | Q (Communications/ Management Plan) | Communications Plan Matrix |  |
| AVAIL | R (Evaluation) | MHMC Measure Library – copy of (MHMC measure set) |  |
| NEED THIS | R | Summary of PCMH Evaluation Report, AHRQ Multiple Chronic Conditions Project and a Summary of Planned HH Evaluation Plan |  |
| N/A | S (Fraud & Abuse) | References to applicable laws are in the narrative |  |
| AVAIL | T (Risk Mitigation) | SIM Risk Log Template |  |
|  |  |  |  |
|  |  |  |  |
| AVAIL | Where does this belong? | MHMC-MDO-chg-Comp with survey (JIM) |  |
| AVAIL | Where does this belong? | MHMC-MHDO Chge comp with summary (JIM) |  |
|  |  |  |  |
|  |  |  |  |

Other Deliverables for the NCC:

Budget and Narrative

1. 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. [↑](#footnote-ref-1)
2. [↑](#endnote-ref-1)