DRAFT CONTENT GRID

(Based on Ops Plan GUIDANCE Document from CMMI on June 30)

AS of July 9 – Tuesday – 3:00 p.m.

This document in progress shows the information being requested by CMMI, and the order in which that information is being requested. Sections are headed A-T, with 48 questions to be answered across all Sections.

At it arrives, the actual CONTENT is being added, with a preliminary edit and insertion of notes concerning APPENDIX Attachments. Some of the CONTENT is not yet plugged in – either because it hasn't arrived yet, or (in several cases) because I'm still working with it.

I've also included an APPENDIX grid at the end, which is also in progress.

Operational Plan

DRAFT CONTENT GRID

(Based on Ops Plan GUIDANCE Document from CMMI on June 30)

SECTION A - Governance, Management Structure and Decision-making Authority - *In your Application Project Narrative Section A.17, you were asked to describe elements of your organizational capacity, including the model staffing resources and roles, and project management and governance structure for operationalizing the plan. This section should include information regarding the following:*

CONTENT for SECTION A assigned to Kevin Flanigan as lead with Dave Simsarian

NUMBER 1. Governor's Office engagement in overseeing the project and implementing the proposed state innovation model
Examples of items to include: • Updated Stakeholder Engagement Plan • Description of specific examples of the Governor's or Governor's Office participation in the project in state's Operational Plan for Model Testing; evidence of participation of cabinet-level representatives from other state agencies should also be provided • Legislation, Executive Orders(s) or regulatory language related to the Governor's participation, including authority of the Governor to appoint individuals to project-related governance entities • A schematic of the organizational structure and a detailed description of the roles of the participants Also – The form on Page 7 of the C MMI Ops Plan Guidance Document should be completed and included]
RESPONSE to NUMBER 1
The Governor and/or staff reporting directly to him have specific and significant involvement in the proposed project. Governor Paul LePage provided a key letter of support for Maine's grant proposal. In his 9/19/2012 letter, he designates Mary Mayhew, Commissioner of the Maine Department of Health & Human Services, as the principal contact for the project. The Commissioner reports directly to the Governor. Commissioner Mayhew has been, and will be actively engaged in overseeing and implementing the Maine State Innovation Model (SIM). The Commissioner's Office issued a press release announcing the grant award, which sparked coverage in state and regional media. Maine's public radio network ran the story, as did two of the state's major daily newspapers and the Boston Globe. Copies of the media coverage are included. The Commissioner installed a Project Manager, who will report directly to the Grant Maine Leadership Team, an Executive Committee. As described in the grant proposal, members of the Grant Maine Leadership Team have been appointed by the Commissioner. Holly Lusk, Health Policy Advisor for Governor LePage, will serve as the Chairperson for this Committee.

TABLE I: Grant Maine Leadership Team Appointments

Position	**Appointee**
Legislator	Rep. Terry Hayes
Legislator	Sen. Michael Thibodeau
Dept. of Professional & Financial Regulations	Commissioner Anne Head
Office of MaineCare Services	Deputy Director James Leonard
Dept. of Health & Human Services	Commissioner Mary Mayhew
Office of MaineCare Services	Director Stefanie Nadeau
Office of Policy & Management	Director Richard Rosen
Dept. Of Health & Human Services	David Simsarian
Tribal Representation	Pending acceptance of appointment
Steering Committee Chairman	Dr. Kevin Flanigan

In addition to the Governor's direction and support noted above, the Steering Committee Chairman will report on a bi-annual basis to the Governor and his Cabinet on the status of the SIM grant work and expectations for the next six months. Finally - within the Department of Health & Human Services the Maine CDC will be responsible for two large Public Health initiatives as part of this grant work – (1) Tobacco cessation; and (2) Diabetes Prevention.

Documentation available: [These Attachments are indicated above, and are listed in the APPENDIX – I need all of them]]

- Governor's 9/19/2012 letter of support
- Press release on 2/22/2013
- Media coverage of grant award: Maine Public Broadcasting Network (2/22/2013) WCSH television news (2/22/2013); Boston Globe (2/23/2013); Bangor Daily News (2/21/2013); NECN.com (2/22/2013); Portland Press Herald (2/21/2013)
- Announcement of Project Manager

Other support. . .

- Activities involving other state agencies
- Organizational structure for project

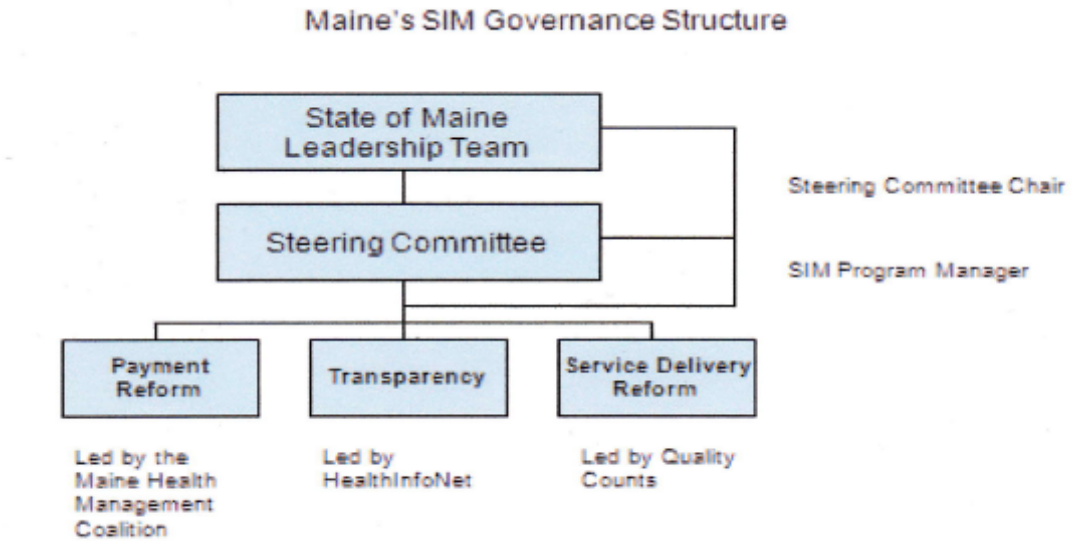
NUMBER 2. Governance and management structure, decision making authority, and the stakeholder representation and contractual and/or regulatory arrangements which are accountable for implementation of the proposed innovation model

Examples of items to include:

- Description of project governance structure and processes in state's Operational Plan for Model Testing, including a schematic of the organizational structure and a detailed description of the roles of the participants
- Legislation, Executive Order(s) or regulatory language related to project governance, with specific language related to decision making process and authority
- Contracts and budgets related to governance and management

RESPONSE to NUMBER 2

Governance, management and oversight authorities, structures, processes and finances are in place or sufficiently enabled by regulation and/or contractual arrangements to be effective.



The Grant Maine Leadership Team, an Executive Committee, appointed by DHHS Commissioner Mayhew, has responsibility for policies, changes to the work plan, major shifts in resource allocation, and decisions requiring senior authority. [See **Table I:** Grant Maine Leadership Team Appointments.] The Project Manager reports directly to the Maine 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, 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. [See Table II: Steering Committee Appointments.] The Steering Committee will oversee three permanent and at least one ad hoc workgroup:

- System Delivery (coordinated by project partner, Quality Counts)
- Transparency (coordinated by project partner, HealthInfoNet)
- Payment Reform (coordinated by lead vendor, Maine Health Management Coalition)
- Project Evaluation (supported by DHHS's Quality Improvement Director, Jay Yoe)

Table II: Steering Committee Appointments

Sector	Appointee
Legislators	Rep. Malaby and Rep. Petersen
Indian Tribes	Pending
Medicaid	Director, Stefanie Nadeau; Medical Director, Kevin Flanigan, M.D.; and MaineCare Member Rose Strout
Hospital	MaineHealth, Katie Fullam-Harris, and Farmington Hospital CEO, Rebecca Ryder
Primary Care	Dr. Noah Nesin and Rhonda Selvin, APRN
Behavioral health	Dale Hamilton, Exec Director, and Lynn Duby, CEO
Commercial payer	Anthem, Kristine Ossenfort
Self-insured employer	Cianbro, Penny Townsend
Long term care	NH, Sara Sylvester
Health Information Exchange (HIE)	HIN, Shaun Alfreds, COO
Insurance regulator	Insurance Superintendent, Eric Cioppa
Quality monitoring	Quality Counts, Dr. Letourneau, and DHHS Quality Improvement, Jay Yoe
Employers	Maine Health Management Coalition, Michael Delorenzo, interim CEO
CMS/CMMI	Dr. Fran Jensen
MaineCDC	Deb Wigand
Patient Advocate	Maine Equal Justice Partners, Jack Comart
Tribal Representative	Pending

Documentation available: [Will these be Attachments for Appendix? If so, need these]

- Governance model from 3/15 strategy meeting
- By-Laws

Other support . . .
Two different levels of contracts will be awarded. One level of contract will be with the three key partners; HelathInfoNet, QualityCounts and Maine Health Management Coalition. These three partners have key deliverables and work responsibilities within the grant and the governance. Each of these three will have a contract with the State of Maine and will report directly to the Program Manager. All other vendors will be selected through an RFP process.

NUMBER 3. Mechanisms to coordinate private and public efforts around key test model elements

Examples of items to include:

- Description of communication and coordination mechanisms that reflect broad audience in state's Operational Plan for Model Testing
- Legislation, Executive Order(s) or regulatory language /policies related to public-private governance, communication and reporting/transparency
- Website, webinars, town halls, list serves, and other communication mechanism

RESPONSE to NUMBER 3

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 _____

The state has taken a two pronged approach to communicating with stakeholders. In June, 2013, four forums were held across the state to inform both the public and the health care community, including providers and payers. Two of these forums were conducted live locally, and accessible through webinar for those who could not attend in person. These forums provided information around the SIM grant, the current and future MaineCare initiatives that are part of the SIM grant, the deliverables for the three key partners, and the governance model that will be used to oversee the grant work. In addition to these forums a communication strategy has been developed that is noted and described in detail elsewhere in this report (Section Q).

Governance is another area of key collaboration towards making this a system-wide approach to improving the care delivery model for all Main-

ers who need to access healthcare in Maine. As described above, all stakeholders are engaged at the decision-making level through representation in the Steering Committee as well as working in the Workgroups that will oversee and contribute to the work being performed as defined by the grant deliverables.

Finally - at the primary care level the transformative model already in place is one that is a multi-payer model involving CMS, MaineCare [Maine's Medicaid program] and private insurers. This effort , the Multi-payer Patient Centered Medical Home, will be expanded. It is overseen by a governance workgroup chaired by one of the key partners, QualityCounts.

Web page dedicated to the project [Web page dedicated to the SIM, or to the PCMH Pilot? In either case, putting the web address here would be good]

NUMBER 4. Integration or alignment of planned transformation with existing legislative and executive authority

Examples of items to include:

- Research, analysis or studies conducted to determine alignment of the planned transformation with existing authorities
- Legislation summaries
- Regulatory citations

RESPONSE to NUMBER 4

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.

Documentation available [Will documentation be included as ATTACHMENTS? For Section A I also have an ACO Reports Library PowerPoint presentation. Should this be included as an ATTACHMENT?]

As noted above, part of the test model 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 that are 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, known as the 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.

SECTION B. Coordination with Other CMS, HHS, and Federal or Local Initiatives – *In your Application Project Narrative Section A.7, you were asked to describe other federal initiatives operating in the state and how your model would coordinate or integrate with initiatives such as but not limited to: Medicare Share Savings Program, Pioneer ACOs, Bundled Payment for Care Improvement initiative, Comprehensive Primary Care Initiative, Aging and Disability Resource Centers, Medicaid health homes, the Money Follows the Person Demonstration Program, etc.*

CONTENT for SECTION B assigned to Jim Leonard

NUMBER 5. Coordination between SIM and CMS/HHS/federal and other CMMI initiatives including, but not limited to: (a) 1115a Medicaid Demonstrations; (b) Medicaid-led transformation efforts, such as Health Homes, ACOs, and Patient Centered Medical Homes; (c) Comprehensive Primary Care initiative; (d) Duals integration; (e) Medicare Advanced Primary Care; (f) initiatives from related agencies like CDC, HRSA, and AHRQ
Examples of items to include: • Description of coordination sufficient to support (a)-(f) above (or other federal initiatives such as those noted in Appendix A of the Demonstration Readiness Review tool) in state's Operational Plan for Model Testing • Visual schematic and/or mapping of how these initiatives fit together programmatically and operationally (e.g. elements of alignment between initiatives, work plans with coordinated activities, etc.) and how accountability for SIM activities is shared across entities
RESPONSE to NUMBER 5
Initiative Coordination Strategy The Maine 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. Maine's State Innovation 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 the state influenced the decisions we made to put forward the six components of Maine's State Innovation Model. 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 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). Potentially avoidable does ***not*** mean preventable or that 30% of inpatient spending can be eliminated; rather, that through analysis and interventions, it can be reduced. See full report for further definition.
    - 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 and outpatient 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.
    - Approximately 10% of the MaineCare and Commercial populations have a chronic disease, and drive approximately 30% of total spending, and 40% of inpatient spending.
    - Approximately 30% of the Maine Medicare population has a chronic disease, and drives approximately 65% of total spending and 70% of inpatient spending.

Through reductions in potentially avoidable hospital admissions and in high variation-high cost outpatient services, this study identifies savings of over $350 million in annual health care expenditures in Maine.

The specific types of inpatient and outpatient 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 state-wide 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 model 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 as well as 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. Much work has been done to build an environment where coordinated healthcare, including connections to social services occurs. 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 outlined the many initiatives occurring in the state.

The healthcare environment in Maine 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 of these initiatives are identified in the State Innovation Model narrative 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. One 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 initiative coordination strategy is based on using and expanding existing organizational activities and infrastructure directed toward coordinated approaches to achieving 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 State Innovation Model plan (Stakeholder engagement plan). Our governance structure is our primary locus of control for assuring coordination between initiatives that impact the six objectives of the model. We will be coordinating strategy and workplans through the three workgroups that report up to the Steering Committee. The leaders of the three workgroups; delivery system reform, payment system reform, and transparency are each bringing together key organizational leadership from across the healthcare system responsible for various aspects of achieving the six objectives of the model 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 SIM coordination eco-map will be used throughout the project period to assure that the maximum efficient use of total resources is coordinated where possible. The coordination 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 the Maine 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.

GRAPHIC entitled Coordination & Workplan Monitoring Process is included as ATTACHMENT _____ (OK – I have this from JIM.

Coordination with CMS/CMMI Accountable Care Organizations

In our Innovation Model 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, ands systems that are represented. Each stakeholder group is focused on specific parts of the healthcare system and each has a relationship to the three workgroups in our governance model and six objectives of the model we are testing.

The Accountable Care Implementation (ACI) Committee (Figure 1: Model to be Tested, component #4 (1)) of the Maine Health Management Coalition will be used as a coordination point for the work being done in SIM around accountable care organizations. The function of this group has become a learning collaborative for organizations transitioning to multi-stakeholder ACO status. This group has active participation by the

state's largest self-insured employers and payers in Maine. Delivery systems that are participating in shared savings or shared risk arrangements use this group to develop solutions, gain understanding of strategies that work in various parts of the state with different populations. The ACI is soliciting active involvement of all delivery systems in Maine that are participating in shared savings or shared risk arrangements. The ACI workgroup has participation by EMHS, MaineHealth, Central Maine Health Care, and various FQHC's. Coordinated with the ACI workgroup is another Management Coalition group, the Health Care Cost Workgroup (Figure 1: Model to be Tested, component #4 (2)). The function of the Health Care Cost Workgroup is to identify actionable strategies to reduce healthcare costs. The workgroups 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

GRAPHIC (Figure 1) entitled (Figure 1 - Model to be Tested is included as ATTACHMENT _____ (OK – I have this from Jim)

Our enhanced primary care model (Figure 1: Component 1 (#1)) is supported by various forms of technical assistance to practices (Figure 1: 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 (Rita, can you ask Lisa L. to get documentation on the attendance to the annual QC meeting and the monthly webinars to insert as "evidence for CMMI in the Appendix?).

Coordination of of MAPCP and MaineCare Health Homes occurs through "the Conveners' Meeting". The Conveners' Meeting" is a monthly meeting between Quality Counts, the Maine Health Management Coalition, Dirigo Health, and MaineCare focused on challenges experienced in the MAPCP and Health Home Initiatives. Agendas and notes of the most recent meetings can be found in the Appendix (Rita, can you ask Lisa L. to get documentation on the Conveners' meetings to insert as "evidence for CMMI in the Appendix?).

GRAPHIC entitled Overlap of Fed & State Initiatives in Maine is included as ATTACHMENT _____ (OK – I have this from JIM)

NUMBER 6. How the state will coordinate its SIM activities with related state-specific non-federally funded local initiatives including, but not limited to: (a) Regional health improvement collaboratives; (b) Community benefit programs sponsored by non-profit hospitals/businesses; (c) Local public health department activities; (d) Local health education activities; (e) Community needs assessment completed by not-for-profit hospitals and health systems; (f) Other key local initiatives sponsored by city, county or regional public health commissions/agencies, foundations, large employers, academic institutions, community organizations, etc.

Examples of items to include: • Description of coordination sufficient to support examples above (or other local non-federally funded initiatives) in state's Operational Plan for Model Testing • Mapping of how these initiatives fit together programmatically and operationally (e.g. elements of alignment between initiatives, work plans with coordinated activities, etc.)
RESPONSE to NUMBER 6
NUMBER 7. For Track 1 States, how the planned transformation is integrated with existing State Plan Amendment and waiver authorities
Examples of items to include: • Incorporation of 1115a Medicaid demonstration waiver and SPA authority analysis, planning and discussion in state's Operational Plan for Model Testing • Existing SPA & waiver documents • Research, analysis or studies conducted to determine alignment of planned transformation with existing SPA & waiver authorities • Documentation of conversations with CMCS confirming these conclusions
RESPONSE to NUMBER 7
NUMBER 8. For Track 2 States, whether Medicaid waiver andf/or new Medicare payment model requests and/or Title XI waivers been approved, or if CMS determined that the state's request can be accomplished through authorities other than Medicaid waiver authority

Examples of items to include: • Documentation of CMS approval or dismissal of special authority requirements • Documentation of status of approval actions, if ongoing and expected timeline for approval
RESPONSE to NUMBER 8

SECTION C. Outreach and Recruitment – *In your Application Project Narrative Section E, you were asked to describe the state's plan to actively engage and obtain commitment from community stakeholders, such as: relevant public agencies such as public health, long-term services and support, behavioral health, mental health, substance abuse, developmental disabilities, and local health (city, county, or state-level), consumer organizations, and/or community based organizations. This section of the Operational Plan should include information regarding the following:*

CONTENT FOR SECTION C assigned to Jim Leonard

NUMBER 9. Outreach and recruitment program (per its Stakeholder Engagement Plan) consistent with the features of the innovation model
Examples of items to include: • Updated Stakeholder Engagement plan with demonstrated execution of components of the plan including engagement of beneficiaries • Description of Outreach Plan in state's Operational Plan for Model Testing with documentation of initiated implementation • Recent studies or other evidence of understanding beneficiary or target population behavior
RESPONSE to NUMBER 9
Beneficiary Outreach and Recruitment The Maine Innovation Model uses a multi-payer care delivery strategy for both advanced primary care practices and accountable care organizations. As such, there are distinct beneficiary outreach and recruitment strategies supporting each initiative. All of the initiatives described in our

application have been underway prior to award of the State Innovation Model 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 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.

See the following Appendix Items
ATTACHMENT _____ (MaineCare Health Homes Member Services TCM Letter) OK (Rita)
ATTACHMENT _____ (MaineCare Advisory Committee Meeting Notes , 2012-2013) OK (Rita)
ATTACHMENT _____ (Plan submitted and approved by CMS) JIM**, I NEED this document**

NOTE from JIM - Here is what I think we need to complete this section:

- MaineCare – shown above. I have asked Loretta to locate this info.
- MHMC – Commercial ACO outreach and recruitment notifications, i.e. BIW, UMaine, SEHC
- Medicare – Pioneer and shared savings programs. I looked online and struck out on the CMMI website trying to locate the outreach and recruitment plan that had to be filed with CMMI for the Pioneer. CMS must have similar documents for the shared savings initiatives in Maine.

SECTION D. Information Systems and Data Collection Setup - *In your Application Narrative Section A.17 you were asked to describe the processes to support the implementation and testing of the model, including: data collection and reporting; provider payment systems; model enrollment or assignment processes; contracting and administrative processes, and continuous improvement analysis and performance optimization process. This section of the Operational Plan should also include information regarding the following:*

CONTENT for SECTION D assigned to Mike Delorenzo/Ellen Jane Schneiter (lead), Shaun Alfreds , Dawn Gallagher

NUMBER 10. Description of the underlying IT infrastructure to support intake of data for delivery system and payment reform efforts

Examples of items to include:

- Description of IT infrastructure sufficient to support reporting to CMMI, self-evaluation of SIM activities, and monitoring of a multi-payer system
- Detailed IT infrastructure work plan with timeline & milestones

- Evidence supporting the completion of early milestones identified in the work plan and consistent with requirements described in the terms and conditions, including submitting Medicaid data in TMSIS format, and complying with federal standards for privacy safeguards

RESPONSE to NUMBER 10

Activities of HealthInfoNet (HIN), one of three implementation partners in the SIM project

[HIN will be adding to these once they have a sense of context for the rest of the section] :

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 efforts.

HIE participation:

- 100% of 38 hospitals are under contract with 35 currently connected
- Over 300 ambulatory practices are participating and sending data to the HIE
- 85% of Maine people are included in the exchange-1,100,000 out of 1,300,000

HIN's 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.

HIN's 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.

HIN's 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. HIN will partner with MaineCare to achieve this objective. 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's Behavioral Health Projects:
Through SIM, HIN will support the inclusion of up to 30 behavioral health agencies in the HIE. This activity will vastly improve MaineCare's understanding of health care utilization and outcomes for persons with a behavioral health disorder. This will also allow for behavioral health providers to be more active members of the Health Homes and PCMHs. [More to be added]

NUMBER 11. Description of the process(es)/mechanisms for data collection on a regularly defined basis to support the state's delivery system and payment reform efforts

Examples of items to include:

- Detailed depiction of IT infrastructure sufficient to support the frequency of data collection, which measures will be collected, how and when data will be submitted, &reports in state's Operational Plan for Model Testing
- Reference to State HIT Plan which includes above features
- Info on an All Payer Claims database, including work flow processes & description of key data contributors
- Execution of contract for TA involving data collecti &utilization
- Data Use/sharing Agreements & MOUs regarding data collection, analysis, and sharing
- Description of use of TMSIS formats for Medicaid data

RESPONSE to NUMBER 11

HIE Clinical Data Collection and Processes

- HealthInfoNet uses Hl-7 standards to promote real-time data collection from provider sites around the state
- HIN standardizes all data collected according to national guidelines
    - CCD/CCR
    - ICD-9/10
    - CPT-4
    - RxNORM/NCPDP
    - LOINC
    - SNOMED-CT

- Notifications functions that are being delivered for MaineCare patients use this same architecture to support the real-time notification of events as they happen
- Currently HIN receives over 3.2 million discrete messages per week
- HIE data is processed into a reporting data warehouse on a weekly basis.

NUMBER 12. Description of the formal measurement reporting mechanism across payers and providers

Examples of items to include:

- Description of process for collecting measurements/data from participating stakeholders including providers and payers
- Reporting requirements including frequency and mechanisms

RESPONSE to NUMBER 12

Measurement using Clinical Data

- 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 all federally funded programs and Health Home/PMCH pilots
- Reporting timeframes will be determined by the SIM Steering Committee

SECTION E. Alignment with State HIT Plans and Existing HIT Infrastructure - *Federal programs and state governments have made significant investments in promoting information technology for more efficient health care delivery in recent years. Those investments must be recognized and leveraged by SIM initiatives in a coordinated and economic fashion. This section of the Operational Plan should include information regarding the following:*

CONTENT for SECTION E assigned to Shaun Alfreds (lead), Dawn Gallagher, Jim Leonard

NUMBER 13. How Health Information Technology (HIT) investment as part of the model is aligned with and leverages prior federal investments in health information exchange (HIE), and meaningful use of electronic health record technologies by various provider

categories.

Examples of items to include:

- Mapping/flow chart demonstrating connections within proposed HIT that supports communication across entities/activities
- Description of HIT alignment, coordination and reuse/leverage as noted above
- Documentation of specific reuse of previous federally-funded State HIT programs
- Legislative, regulatory or contractual language requiring the use of previously implemented federally-funded HIT in State programs and/or by participants in the proposed innovation model
- Description of coordination with CMCS through IAPD requests for MMIS, HITECH funding requests

RESPONSE to NUMBER 13

State Health Care Innovation Grant: Operational Plan

Section VI: Alignment with State HIT Plans and Existing HIT Infrastructure

Outline of information in this section:

- Maine's HIT History and Current Strategies to Continued Success Through SIM
- Data Elements Collected by Maine's HIE and Participation in the HIE
- HIE Use for Public and Population Health
- Medicaid, Meaningful Use EHR Incentives, and HIE
- Support for Behavioral Health Integration with HIT Efforts in Maine
- Consumer Involvement in HIE and HIT
- HIT and HIE to Support ACO Efforts
- Bangor Beacon HIE/HIT Efforts

The State of Maine has made great strides in the use and adoption of Health Information Technology. At the spearhead of many of the coordination efforts for HIT in Maine are the Office of the State Coordinator for Health Information Technology (OSC), the MaineCare HIT Program and HealthInfoNet – 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 it's 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 the State of Maine has been predicated on the perspective that HIT is not an end but a means to support the advancement of higher quality health care while maintaining a fair and appropriate cost structure. To this end, the strategies taken in the State 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 Health Information Technology 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. 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 Health Information Exchange.

The OSC works closely with HealthInfoNet, the State Designated HIE Organization (see http://www.hinfonet.org). HealthInfoNet has developed and manages the health information exchange technical activities and the governance activities for the HIE, including its Community Board of Directors, the Consumer Advisory Committee and the Technical and Provider Practice Committees. HealthInfoNet also serves as the Maine Regional Extension Center and was the technology partner to the Bangor Beacon Community also funded by the ONC.

Since 2004 Maine has moved forward on an ambitious plan to promote the adoption of electronic medical records, 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 HealthInfoNet – the only HIE in the State - since its inception. HealthInfoNet 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 the subsequent award of the HIE Cooperative Agreement to the State of Maine, the Regional Extension Center to HealthIn-

foNet, and the Beacon Community Grant to Eastern Maine HealthCare Systems have also accelerated HIE activities.

HealthInfoNet began as a project called the Maine Health Information Network Technology Project (MHINT) in 2004. Four groups, including the Maine Health Access Foundation, the Maine CDC (Department of Public Health), the Maine Quality Forum and the Maine Health Information Center, came together to study the feasibility of developing a statewide electronic health information exchange or HIE. By 2005, the MHINT project organized a process for bringing together a larger group of stakeholders to explore what it would take to create an HIE in Maine. This process resulted in the signing of a memorandum of understanding (MOU) by Maine's four largest health systems that stated among other things, "we will no longer compete on data" and ultimately the establishment of HealthInfoNet as a new, independent nonprofit (501c3) organization by early 2006.

A board of directors and several standing committees governs HealthInfoNet. The organization is a collaborative organization that is working with all geographical areas in Maine to build and manage a HIE that includes all patients regardless of insured status. From the beginning, HealthInfoNet 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 HealthInfoNet to design an exchange that meets the needs of all of Maine – Integrated Delivery Networks, small and large independent providers, urban and rural areas, and all levels of technology capacity. This technical design – a centralized repository model – fit and continues to fit the needs of the state in having aggregated standardized data to support its health care improvement initiatives such as the State Innovation Model Testing 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, this robust and growing database serves as a tool for authorized users to look at population health, trends, and health system efficiencies. As part of the SIM project, HealthInfoNet will be working with Medicaid to deliver a Medicaid "dashboard" that can show health care utilization, distribution of patients, chronic disease and co-morbid conditions for MaineCare to have a better understanding of their population. This activity will begin in October of 2013 and continue throughout the project. The dashboard will be populated by clinical data from EHRs that for patients that 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 HealthInfoNet will be delivering real-time notifications to MaineCare care management staff as well as care management staff at Hospital and PCMH organizations around the state when a person with MaineCare coverage is admitted or discharged from an emergency room or inpatient setting. This activity will begin in the Summer of 2013. MaineCare will submit to HealthInfoNet 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 HealthInfoNet dashboard.

To support the current the statewide Emergency Department Care Management Initiative Pilot, HealthInfoNet 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 emergency departments and inpatient settings. HealthInfoNet currently has real-time connections to 34 hospitals across Maine with the goal to have all hospitals connected to the exchange 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 as well as private insurers alike 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). The 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 HealthInfoNet 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, HealthInfoNet began collecting immunization information and all secondary diagnoses. More recently HealthInfoNet has begun to collect insurer information and other data elements to support ACO and other activities. The HIE tools operated by HealthInfoNet were purposely chosen to be flexible allowing all health care stakeholders to participate and be amenable to an array of messaging standards – HL7, CCR, CCD, REST, Direct etc.

By the mid-2013, 34 hospitals in Maine are actively sending data to the HIE and the remaining 4 (there are 38 Acute care hospitals in the state) are in the process of setting up their interfaces with an anticipated go-live on the HIE before the end of 2013. The Exchange 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 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 around the state, 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 (this may be best aligned with the Objectives in other sections)

Use of the information in the exchange 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 Center for Disease Control (Maine's public health authority) for 30 of the 72 diseases mandated for reporting by the State of Maine. Moreover, HealthInfoNet 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.

HealthInfoNet recently has been working with the federal Center for Disease Control (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 HealthInfoNet'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.

Excerpts from the HITECH Act- Mission, Goals, and Objectives demonstrate the flexible and long-term efforts and steps that Maine has taken to ensure integrated and high-quality HIT efforts:

The integration of HIT initiatives traces back to 2009 with the development of a State Medicaid HIT Plan that involved a multi-stakeholder process to design an HIT foundation. This foundation was based on the HITECH Act that provides the framework for improving health information technology. The structure of the programs established by the HITECH Act recognizes a federal/state partnership to build the HIT vision and to plan and implement that vision: *A Nation in which the health and well-being of individuals and communities are improved by health information technology.*

The State of Maine strives to continually improve the health of its residents. The State has aligned its strategic HIT/HIE vision and goals with those of the Office of the National Coordinator by adopting a vision anchored in providing or facilitating a system of person-centered, integrated, efficient, and evidence-based health care delivery for all Maine citizens: ***Preserving and improving the health of Maine people requires a transformed patient centered health system that uses highly secure, integrated electronic health information systems to advance access, safety, quality, and cost efficiency in the care of individual patients and populations.***

The Medicaid HIT program used these two essential building blocks as a foundation for its vision to improve the use of HIT/HIE to have all Eligible Professionals and Eligible Hospitals achieve Meaningful Use: ***A Medicaid Health Information Technology (HIT) program that promotes the goals of the Federal HITECH Act, including the Office of the National coordinator and the Office of the State Coordinator, and leads Maine's efforts for providers to achieve "Meaningful Use" and to provide truly integrated, efficient, secure, and high quality health care to MaineCare Members that improves health outcomes.***

The State used this foundation to formulate Goals, Objectives and Needs are reflective of the federal and State-wide HIT/HIE efforts, including the 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 program 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 their 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 they are 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.

<u>Support for Behavioral Health Integration with HIT Efforts in Maine</u>

State of Maine agencies serving those with behavioral and substance abuse problems support HIT integration and are involved in the work of HealthInfoNet. 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 (OSA) works with its contract agencies to improve the efficiencies and effectiveness of patient-centered substance abuse care. In 2011 OSA 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. OSA 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. OSA'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 January 2012 HealthInfoNet was awarded, on behalf of the State of Maine, the SAMHSA/Health Resources and Services Administration (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 (the statewide HIE organization), and The Hanley Center for Health Leadership. It also represents a wide range of private and public partners – including OSA - 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.

As was discussed above, 25 Behavioral Health Organizations' HIE costs will be subsidized by the SIM grant. In addition up to $70,000 will be available to each of 20 behavioral health organizations as they implement/upgrade their EHR, connect to the HIE, and participate in electronic quality measurement programs across the state. Organizations will be chosen for participation in this program through a Request for Proposals (RFP) being released by HealthInfoNet in the Fall of 2013.

Further building upon the electronic partnership with the State of Maine CDC for electronic laboratory reporting, partnership with OSA and the Office of the State Coordinator for HIT, and the broadening relationship with providers statewide, OSA and HealthInfoNet working under another SAMHSA grant are creating a singles-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 HealthInfoNet 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. It has been stated in recent media reports that this system is often not used because it represents yet one more place health care practitioners need to go to look for information, in an already cumbersome and time-consuming workflow. With access to the PDMP included in HealthInfoNet, 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 Health Information Technology Incentive programs, the State (through the Office of the State Coordinator for HIT and MaineCare), and provider organizations across the state 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 HealthInfoNet 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 both the PDMP program and the statewide HIE. Moreover, this integrated strategy will serve to support a comprehensive strategy by the State of Maine to leverage a secure, private, health information technology structure, paid for by public and private stakeholders, to address the prescription drug problem in the State, drive down overall health care 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, HealthInfoNet made a decision early on in its development to have a high level of participation by the consumer community. This level of consumer involvement is different than many HIE's throughout the country but an approach that was strongly supported by the HealthInfoNet Board. The Consumer Advisory Committee is a HealthInfoNet 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, HealthInfoNet is working closely with consumers and the provider community to expand patient participation and management of their own health care by implementing consumer-facing technologies. To assess the successful deployment of a comprehensive personal health record built upon a HIE model, HealthInfoNet has been meeting with health care providers, health care 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
   c. 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, HealthInfoNet and the State of Maine 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).

<u>HIT and HIE to Support ACO Efforts</u>
In addition to managing the exchange, HealthInfoNet has developed a clinical data warehouse environment to support data access and use. Exporting the exchange data to an analytic data warehouse will provide real time, high quality clinical data to assist in projecting healthcare utiliza-

tion, treatment outcomes, and cost of identified patient cohorts – a necessary analysis for value-based purchasing, Accountable Care Organizations (ACOs), and other health reform efforts. In 2012 HealthInfoNet was awarded a grant by the Maine Health Access Foundation (MeHAF) to develop the 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 of Maine 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 HealthInfoNet 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 health information exchange 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 state innovation 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.

<u>Maine Regional Extension Center and EMR/Meaningful Use Adoption Supports</u>
HealthInfoNet oversees the Maine Regional Extension Center (MEREC). The MEREC provides education and technical assistance to help providers select, implement, and achieve meaningful use of certified EMRs. The MEREC is made up of a team of experienced local HIT professionals with intimate knowledge of the Maine health care community, and is part of a national network with access to a wealth of key information. It offers participating practices a wide range of services. Core services include: (1) EMR selection and implementation support; (2) Discounted pricing from pre-screened vendors; (3) HIE connection; (4) Low-interest loans offered in partnership with the Maine Health Access Foundation; (5) Quality improvement support in partnership with *Maine Quality Counts*; and (6) HIT & HIE Privacy and security best practices.

The MEREC, in partnership with *Maine Quality Counts*, 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
- Understanding State and Federal (42CFRPart2) laws and policies concerning patient confidentiality and privacy related to sharing behavioral health information.

The MEREC and HealthInfoNet 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 HealthInfoNet 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 HealthInfoNet 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. [Need to discuss the specific workgroups that will be focusing on this]

<u>Bangor Beacon HIE/HIT Efforts</u>

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. HealthInfoNet is the exchange and data source for the development of this community based initiative. 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.

SECTION F. Enrollment Eligibility and Disenrollment Processes – *CMMI Overview* *- Clearly documented rules and effective processes must be in place at the beginning of the planned transformation for determining who is eligible for programs related to the innovation model, along with well-understood instructions for how individuals can actively enroll, with their consent, and how they can withdraw, dis-enroll or be deemed ineligible if their circumstances change, if the program is not determined to be effective for them or as the program is changed as part of continuous improvement of the innovation model.*

CONTENT for SECTION F – no longer required

NUMBER 14. No longer required to submit anything here (per CMMI)
RESPONSE to NUMBER 14
This section is no longer required / applicable, per CMMI

SECTION G. Model Intervention, Implementation and Delivery – I*n your Application Narrative Section A: Description of the State Health Care Innovation Plan Testing Strategy and specifically Sections A.1 – A.3, you were asked to describe the models' purpose, the scope of the models and phase-in scheduled, and the delivery system or payment model(s) to be tested. This section of the Operational Plan should include information regarding the following:*

CONTENT for SECTION G assigned to Randy Chenard (lead), Commissioner Mayhew, Commissioner Head, Holly Lusk

NUMBER 15. Identification and assessment of the state policy and regulatory levers available to accelerate the implementation of the proposed innovation model
Examples of items to include for **15,** 16, 17:

- Incorporation of federal and state policy and regulatory analysis and documentation of necessary authorities or authority-granting actions for Model Testing
- Description of recent studies or analysis of policy and regulatory authorities
- Description of enabling policy, legislative or regulatory actions

RESPONSE to NUMBER 15

NUMBER 16. Incorporation of a broad array of policy and regulatory levers that are consistent across multiple areas of state influence to advance the innovation model

Examples of items to include See # 15, above

RESPONSE to NUMBER 16

NUMBER 17. How current policy positions and planned actions are aligned with or reflective of federal positions and stated direction

Examples of items to include See # 15, above

RESPONSE to NUMBER 17

NUMBER 18. Formal mechanisms (e.g. implementation workgroups, stakeholder meetings, public comment processes) for engaging payers and providers with communication, input, and shared decision making. (a) Payers – multi-payer reforms including major com-

mercial payers adopting value based payment strategies and agreed to aligned quality measures. (b) <u>Providers</u> – including hospitals and health systems, large academic medical centers, independent providers, and professional societies and organizations such as the state medical societies and hospital associations.
<u>Examples of items to include for **18**, 19, 20:</u> • Updated stakeholder engagement plan • Description of engagement activities sufficient to support SIM model implementation • Detailed work plan and timeline (within testing timeframe) for each phase of participant/stakeholder engagement
RESPONSE to NUMBER 18
NUMBER 19. Mechanisms that engage a wide range of <u>governmental stakeholders,</u> which can include the following: (a) Dept of Social Services; (b) Public health department; (c) Mental health agency; (d) Substance abuse agency; (e) Developmental disabilities agency; (f) Aging agency; (g) City-level local health department; (h) County-level local health department; (i) State-level elected officials
<u>Examples of items to include</u> See # 18, above
RESPONSE to NUMBER 19
NUMBER 20. Mechanisms that engage a wide range of <u>community/patient stakeholders</u>, which can include the following: (a) Community-based non medical organizations; (b) Faith-based organizations; (c) Foundations; (d) Patient advocacy groups; (e) School districts; (f) Multi-purpose social service organizations; (g) Senior and Adult day centers; (h) Housing programs
<u>Examples of items to include</u> See # 18, above

RESPONSE to NUMBER 20
NUMBER 21. Implementation of public health integration
Examples of items to include: • Detailed work plan and timeline (within testing timeframe) • Evidence of completion of early key milestones towards public health integration • Evidence of public health integration including: o Development of a shared vision for improving population health o Community engagement in defining population needs o Leadership alignment o Establishment of a shared infrastructure (e.g., coordinated services, data exchange, workforce) o Sharing and collaborative use of data
RESPONSE to NUMBER 20

SECTION H. Participant Retention Process – In your Application Narrative Section A.10, you were asked to describe the geographic areas or communities that will be the focus of model test, and how the program will be gradually rolled out to the state population, and in Section B and C you were asked to describe the expected transformation of the major provider entities within the state, the rationale for their transformation and include evidence that these groups have committed to making the specified changes, and to describe the roles of other payers and stake-holders participating in the model. The objective of the SIM transformation effort is that the preponderance of the states population's health care delivery is financed through value based payment systems. Reaching the preponderance of care can be accomplished through the models

that will be tested by the State's Innovation Model in addition to the existing transformation initiatives currently operating across the state. For the SIM initiative to succeed and be sustainable over its planned duration and beyond the grant timeframe, participants – especially private payers and providers – must be bound to their commitment to the initiative, either contractually or through the use of regulatory mandates, incentives, penalties or a mix. This section of the Operational Plan should include information regarding the following:

CONTENT for SECTION H assigned to Stephanie Nadeau (lead), Mike Delorenzo, Ellen Jane Schneiter

NUMBER 22. How participating payers are required to implement key features of the proposed model
Examples of items to include for **22**, 23: Description of payer retention methods, including: • State contracts with payers/providers • Legislative or regulatory language related to participation requirements, incentives and penalties • Contract amendments • Participant letters or other statements of commitment
RESPONSE for NUMBER 22
NUMBER 23. How participating providers are required to implement key features of the proposed model
Examples of items to include See # 22, above
RESPONSE to NUMBER 23

SECTION I . Quality, Financial and Health Goals and Performance Measurement Plan - *In your Application Narrative Section A.12 and A.13, you were asked to describe current clinical quality and experience outcomes as well as population health status by target population and the target outcomes that are expected from the model. This section of the Operational Plan should use the templates on the following pages to provide information about the state's self-evaluation, and include other additional information regarding the following:*

CONTENT FOR SECTION I. assigned to Mike Delorenzo/Ellen Jane Schneiter (lead), Jim Leonard, Michelle Probert

NUMBER 24. The state's set of performance measures, consistent with endorsed measures (e.g. NQF, Meaningful Use, CMMI Core measure set), including quality, patient satisfaction, financial and health outcomes
DIRECTIONS for this number appear below as a long text explanation, including explanation of required FORMS.
RESPONSE to NUMBER 24
NUMBER 25. Description of alignment across payers for the endorsed performance measures, including quality, patient satisfaction, financial and health outcomes
DIRECTIONS for this number appear below as a long text explanation, including explanation of required FORMS.
RESPONSE to NUMBER 25
NUMBER 26. Description of provider, consumer and payer but-in during process of selecting SIM performance measures

DIRECTIONS for this number appear below as a long text explanation, including explanation of required FORMS.
RESPONSE to NUMBER 26
NUMBER 27. A plan for quality performance target-setting with a schedule for routinely assessing current performance against targets/ benchmarks
DIRECTIONS for this number appear below as a long text explanation, including explanation of required FORMS.
RESPONSE to NUMBER 27

FROM CMMI -

One key feature of self-monitoring is collecting data on your processes and outcomes for your own model. You will be asked to submit reports using an agreed-upon set of metrics that are integral to your self-monitoring strategy. The metrics set will consist of both core measures that are required of all awardees and/or other measures specific to each awardee or type of awardee.

*In an effort to establish a consistent framework for performance measurement and quality improvement, the CMMI Rapid Cycle Evaluation Group developed the **CMMI Core Measures** document (Appendix B) which aims to align indicators used for evaluations across the Innovation Center. Measurement alignment is necessary for the Innovation Center to examine the overall impact of its programs on the health of populations, quality, and efficiency of care, and to compare the effectiveness of different models. As a way to coordinate with other movements both external and internal to CMS, the list includes, but is not limited to, measures recommended by the Measure Applications Partnership, Patient-Centered Medical Home Collaborative, National Committee for Quality Assurance, CMS quality reporting programs, and AHRQ standards. In addition, measures identified in this core list were compared against a scan of monitoring and evaluation measures that CMS have used or considered in the past.*

*A majority of the indicators found in this document have been endorsed by the National Quality Forum (NQF). Because NQF employs a consensus-based approach to assess the feasibility, reliability, validity, and usability of quality performance measures, and is the premier organization for evaluating and endorsing health care performance measures1, **we encourage the use of NQF endorsed measures to the extent possible**. In the absence of an NQF endorsed standard, we have identified indicators or recommendations from other sources that we believe are appropriate for use.*

*Due to a multitude of diverse programs, unique intervention approaches, and varying availability of data, no parsimonious set will adequately serve as indicators for any of our programs. This core list is intended to identify a minimum set of meaningful measures for CMMI evaluations and other analysis. We acknowledge that there are many measurement gaps and that not all measures are applicable to all models . **We ask our grantees to align with the indicators in the core list conceptually, and to align with the indicators operationally when possible.** In other words, these measures should be used as they are specified when applicable and broadened and modified as appropriate to the population being studied.*

***Your measures should align strongly with the aim(s) and drivers in the driver diagram**. Aims are generally based on outcome goals and drivers typically reflect the key processes or sets of processes predicted as necessary to achieve the aim. Therefore, the primary and many of the secondary drivers should align with the process measures identified in the plan and vice versa. You may have a few drivers that are not measured initially as well as additional measures beyond those associated with drivers. Check for alignment after developing your list of measures. If there are drivers that do not align with measures, consider how you will monitor progress towards that driver or whether it should be in the driver diagram; if there are measures that do not align with the driver diagram, consider why the measure will be tracked. Strong alignment, not necessarily complete, is highly recommended. Your list of self-monitoring measures will be reviewed and refined in consultation with your Project Officer, the SIM technical assistance team, and the CMS Evaluation contractor, and may require revision over time.*

REQUIRED FORMS to be attached

CMS Forms to be included from the GUIDANCE DOCUMENT:

1.1 Describe how self-measurements will be used
1.2 Programmatic and Operational Domains
1.3 Outcome Measure Selection from suggested CMS Core Measures
1.4 Custom Outcome Measures Selection (Not from CMMI Core Measures)

SECTION J . Appropriate consideration for Privacy and Confidentiality - *IF APPLICABLE TO ACTIVITIES FUNDED BY THE STATE INNOVATION MODEL AWARD, this section of the Operational Plan should include information regarding the following:*

CONTENT for SECTION J assigned to Dawn Gallagher (lead), Mike Delorenzo/Ellen Jane Schneiter, Shaun Alfreds

NUMBER 28. Special protections related to diagnoses, conditions, and populations with privacy and confidentiality concerns
Examples of items to include: • Incorporation of regular HIPAA and special privacy and confidentiality protections • Documented recognition of SAHMSA and other advanced privacy regulations, guidelines, and protections • State regs and State-based actions on privacy protection
RESPONSE to NUMBER 28
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 which 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 re-

port that has been shared nationally and which is the cornerstone of tools used for State privacy, confidentiality, and security measures. [ATTACHMENT _____]

An explanation of the 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 is a very 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. (Note: 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).

For each of the four pyramids, it "drills down" to show the federal and the State laws and rules that govern each categories of information (General Health, Mental Health, Substance and Alcohol Abuse, and 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 cite to the law. In addition, there is a column that is color coded to show "allowed" disclosure as green; "restricted disclosure" as yellow; and "prohibited without consent" as red, as the general rule. Exceptions to the rule are also noted in the detailed full grid.

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.

Protecting Privacy and Confidentiality—Patient Consent

1. 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 state-wide 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: by mail, by phone or online. The quickest method of opting out is online by going to www.hinfonet.org/optout or filling out an opt-out form, available at a participating provider or from HealthInfoNet.

Maine State law requires participating providers inform every patient about the HIE and the patient's ability to opt-out when they first visit that provider. HealthInfoNet instructs all participating providers to include information about HealthInfoNet 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 all 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
2. Call HealthInfoNet at 207-541-9250 or Toll Free at 866-592-4352

HealthInfoNet 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.

2. Mental Health and HIV Consent Process

Under HIPAA and Maine law, providers can legally share a patient's medical information with other providers also treating the patient. However there are additional protections placed on some mental health and HIV related information. For this information to be visible in the HIE, patients need to give their provider permission to see it. They do not have to give permission to anyone if they don't want to, and they can choose to

make available mental health only, HIV only or both. The one exception to this is in a medical emergency, when the law allows providers to access this information to prevent harm to the patient or others during that emergency. To access the patient's information, the provider must record in the system that the patient has given 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 HealthInfoNet. This form is available for download at HealthInfoNet's website. The patient's identity must be verified and the consent form witnessed and sent to HealthInfoNet by a staff member of a participating provider, in person by a HealthInfoNet 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.

3. 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.

4. Confidentiality of Genetic, Communicable Diseases, and New-Borns

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. [ATTACHMENT _____]

Corrections

[Insert Appropriate Laws]

State Policies for Claims and Clinical Data

The State's Department of Health and Human Services (Department) 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. These policies can be found at [NEED THIS INFORMAITON]

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. [ATTACHMENT____]

Maine's state-wide HIE, operated by HIN, has developed privacy and security measures for the HIE. [Insert HIN privacy policies here]

SECTION K. Staff/Contractor Recruitment and Training – *This section of the Ops Plan should include information regarding the following:*

CONTENT for SECTION K assigned to David Simsarian (lead), Jim Leonard, Randy Chenard

NUMBER 29. How state has clearly delineated roles and responsibilities for existing and new staff or contractors to support SIM activities
Ex of items to include for **29**, 30, 31: • Staff job descriptions that support SIM activities with delineation of specific responsibilities and their accountability for specific SIM activities • Staffing plan and staffing/contractors budgets included in the Operational Plan • Comprehensive org chart • Recruitment strategy/activity • Training curriculum • Method for recurring feedback and monitoring of performance
RESPONSE to NUMBER 29
I have the PowerPoint presentation w/information for this section. (Rita Molloy)
NUMBER 30. How the state has or will recruit new/additional staff and/or contractors (as budgeted in SIM application) to adequately support SIM activities
Ex of items to include See #29
RESPONSE to NUMBER 30
NUMBER 31. How the state has trained all new and existing staff or contractors to fulfill their roles and defined supports for ongoing workforce development to ensure support of SIM activities throughout the grant period

Ex of items to include See #29
RESPONSE to NUMBER 31

REQUIRED FORMS to be attached

CMS Forms to be included from the GUIDANCE DOCUMENT:

1. Key State Personnel (p 21 of Guidance Doc)
2. Key Contractors (p 22 of Guidance Doc)
3. Positions to be Filed (p 22 of Guidance Doc)

SECTION L. Workforce Capacity and Monitoring – ***This section of the Operational Plan should include information regarding:***

CONTENT for SECTION L assigned to Deb Wigand (lead), Lisa Latourneau

NUMBER 31. How the State has designed, planned and begun to implement a program to address the future healthcare workforce requirements of its proposed innovation model
Examples of items to include: • Updated Stakeholder Engagement Plan demonstrating participation of academic medical centers • References to workforce capacity building and coordination • Studies or other documentation of current workforce capacity issues and future trends and gaps • Legislative, regulatory or executive actions related to studying, developing recommendations or taking action on healthcare workforce issues, including scope of practice changes

- Documentation of workforce capacity programs / curricula in:
  - State employment training programs
  - Community colleges and universities
  - Medical schools and other graduate education programs

RESPONSE to NUMBER 31

Workforce development in Maine

The Health Workforce Forum was established in 2004 by Maine statute 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 ends June 2013. The report from the forum is on the DHHS website as part of a legislative mandate.
Found at: 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

An essential component 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. Maine 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 higher and higher amounts of healthcare services, the healthcare workforce is nearing the age of retirement. 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 were the four occupations with the highest number of vacant positions.

Training to PCMH, HH practices

One key aspect of workforce development and training that will be supported by the Maine SIM initiative is 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) initiative. Through efforts led by Maine Quality Counts, a state contracted SIM partner, we will be offering 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. More information on these efforts is described in section XIV. Care Transformation Plans.

Training on Shared Decision Making

Through the Maine SIM initiative, we will also provide training to the primary care workforce on shared decision making (SDM) models and tools, with the goal of incorporating SDM into the practice workflow. We are currently 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

Within the Maine SIM initiative, we will be working with key partners to develop several new workforce models to support our Innovation Plan. These include the following:

- *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 and 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 throughout the state, and are able produce a corps of skilled CHWs with a consistent body of knowledge and skillset. Once established, this training and 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.

There are pockets of community health workers in Maine, but we are lacking a statewide system at this time. 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 the third year of the 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.

Maine's SIM CHW initiative will also include a series of 5 pilots that will:

- demonstrate the value of integrating CHWs into the healthcare team
- provide models that can be replicated and emulated across the state
- build a core group of experienced CHWs who can provide leadership and community engagement to drive the ongoing development of the system

Maine's CHW initiative 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*

The National Diabetes Prevention (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.

<u>Partnerships to support new workforce models for the transformed system</u>

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. *(from page 34 of narrative in application)*

SECTION M. Care Transformation Plans – *This section of the Operational Plan should include information re: the following:*

CONTENT for SECTION M assigned to Lisa Letourneau

NUMBER 33. Identified quality improvement supports for providers, including training on continuous quality improvement methodology Or participation in learning collaboratives

RESPONSE to NUMBER 33

Maine is fortunate to have both strong leadership and a wide array of Continuous Quality improvement 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, a regional healthcare collaborative and a SIM partner contracted to provide CQI support services to Health Home (HH) practices.

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

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).

NUMBER 34. Activities related to practice transformation training and care process redesign supports that leverage existing statewide learning and action networks (e.g. PCMH, Health Home, regional extension centers) and other communication vehicles engaging providers

Examples of items to include

A detailed strategy, with goals and timeline, to ensure that continuous quality improvement is a fundamental component of the care transformational model. More information may include:

- Curriculum to be provided in training programs for providers and other stakeholders
- Schedule of webinars/ collaborative/training sessions offered to providers (within SIM testing timeframe)
- Deployment of professionals trained in quality improvement directly into practices located in healthcare organizations and in the community
- Funding opportunities beyond SIM for this type of training
- Mechanism to monitor if providers are utilizing this method for transformation (are they attending the trainings, are they participating in QI activities in their practices and incorporating their lessons learned into their work)

RESPONSE to NUMBER 34

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. 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.

MaineCare, Maine's Medicaid program, 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 (note: these resources will be expanded under SIM).

The State has taken steps to ensure alignment of these efforts with other improvement efforts in the state, including working closely with the Maine Regional Extension Center which has been led by HealthInfoNet, Maine's Health Information Exchange and contracted SIM partner. 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.

SECTION N. Sustainability Plans – *This section of the Operational Plan should include information re: the following:*

CONTENT for SECTION N assigned to Jim Leonard (lead), Michelle Probert, Mike Delorenzo/Ellen Jane Schneiter

NUMBER 35. An evidence-based financial model for sustaining new payment and service delivery model(s) after the testing phase is complete, based on leveraging a comprehensive set of funding sources
Examples of items to include o Evidence-based analysis of how the models will continue to be financially viable after SIM funding is expended, including potential funding sources are currently or will become available o Mechanism for measuring total cost of care for the delivery of the transformative care and what funding will be necessary to ensure the model's success o Plans and necessary laws/regulations/levers for reinvesting the savings from the implementation of the model, both from the private and public providers/organizations o Identification of incentives for providers, patients and other stakeholders to sustain the care delivery model, including community based and population health interventions
RESPONSE to NUMBER 35

SECTION O. Administrative Systems and Reporting – *This section of the Operational Plan should include information re: the following:*

CONTENT for SECTION O assigned to Karen Kalka

NUMBER 36. Identified office/entity responsible for the programmatic and financial oversight of the cooperative agreement
Examples of items to include • Defined responsibilities of the accountable office or entity to accurately inform and report on financial and programmatic SIM activities and progress to CMMI/CMS and state leadership • Mechanism for tracking agreements and relevant issues with their execution
RESPONSE to NUMBER 36

SECTION P. Implementation Timeline for Achieving Participation and Metrics – *This section of the Operational Plan should include information re: the following:*

CONTENT for SECTION P assigned to Randy Chenard

NUMBER 37. Project plan for completing Model Testing and implementing the proposed innovation model that is actionable by the project team (with assignments of responsibility) and provides detailed project tracking and reporting by the project oversight entity and CMS
Examples of items to include for **37,** 38, 39: o A project plan with milestones, logical timelines and phasing schedules for participants/providers and payers o A mechanism to track the achievement of milestones and measureable outcomes o Details about data submission and reporting to CMS (when, how, who is responsible) o A strategy to revise the expenditures, staffing, activities and schedule, utilizing the analysis of measures developed to track the activities
RESPONSE to NUMBER 37

NUMBER 38. Project activities specified / planned / structured appropriately in terms of sequencing and conducting activities in parallel to achieve results
Examples of items to include – See #37
RESPONSE to NUMBER 38
NUMBER 39. Project activities specified / planned in a way that they can complete and produce measurable results during the project's period of performance
Examples of items to include – See #37
RESPONSE to NUMBER 39

SECTION Q. Communications Management Plans – *This section of the Operational Plan should include information re: the following:*

CONTENT for SECTION Q assigned to Sara Cairns, John Martins (lead)

NUMBER 40. A communication plan to reach the following stakeholders throughout the length of the project: (a) payers (public & private); (b) Providers and caregivers (including academic medical centers, hospitals, community-based practices, specialists/ behavioral health, long-term care); (c) Public health organizations (DOH, CDC, etc): (d) Social services (transportation, education, nutrition, housing); (e) Patients and their families

Ex of items to include for **40,** 41, 42:

- Communication plans for each stakeholder group with timelines and milestones that support state's SIM activities; this plan should be multi-modal (e.g.,website, listserves, press releases, listening sessions, conferences etc) and provide a timeline and milestones for the implementation of these models
- Communication techniques/vehicles including tracked participation in webinars, collaborative, in-person meetings, visits to website, etc.
- A stakeholder engagement plan that is continuously updated throughout the testing period; it should contain specific contact information of the individual stakeholders, their organization and the justification for including them on the list
- Assigned accountabilities and responsibilities for the communications plan

RESPONSE to NUMBER 40

SIM Communications Plan

The State Innovations Model 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 time-lines for updates. We have also included a communications matrix to offer a visual representation of the communications plan, targeted audi-ences and a timeline of planned activities.

Short Term Needs That Have Been Met

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 (see Attachments _____) and webinars were offered in the two largest geographic regions.

The slide presentation and webinar can also be accessed at the SIM Web Page on the Office of MaineCare Services web site [Must add Web link] Staff asked those who participated in these forums 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.

Early on in this process, anticipating the need for a web-based communications portal, DHHS created the SIM web site, 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.

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 and presented at a high level. This document will be 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 de-termined. 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 _____]

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 the fact 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.

NUMBER 41. Demonstration that the state has initiated external communications with each group of relevant stakeholders including: (a)

payers (public & private); (b) Providers and caregivers (including academic medical centers, hospitals, community-based practices, specialists/ behavioral health, long-term care); (c) Public health organizations (DOH, CDC, etc): (d) Social services (transportation, education, nutrition, housing); (e) Patients and their families
Ex of items to include – See # 40
RESPONSE to NUMBER 41
[Please see response to Number 40]
NUMBER 42. If applicable, the entity overseeing and executing all components of the communications plan across the entire grant period
Ex of items to include – See # 40
RESPONSE to NUMBER 42
Is this applicable? If so, need information.

SECTION R. Evaluation Plan – *This section of the Operational Plan should include information re: the following*

CONTENT for SECTION R assigned to Dr Jay Yoe

NUMBER 43. Entity responsible for managing data collection and reporting processes (self-evaluation, reporting to CMMI, and financial data for multi-payer systems)
NUMBER 44. Design and implementation of an evidence
NUMBER 45. Design and implementation of a meaningful self-evaluation and continuous improvement monitoring for the planned transformation

Examples of items to include (**43,44,45**)

- Mechanisms/reporting tools to facilitate tracking
- Responsibilities for data collection and reporting
- A well-designed strategy to work with the CMS eval contractor

RESPONSE to NUMBERS 43, 44, and 45

SIM Evaluation Framework & Plan (Draft: 6/27/2013) JAY – do you want the AHRQ Final Report (Integration of Health Care in Maine) included in APPENDIX as an ATTACHMENT? (Rita Molloy)

Overview/Specific Aims

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

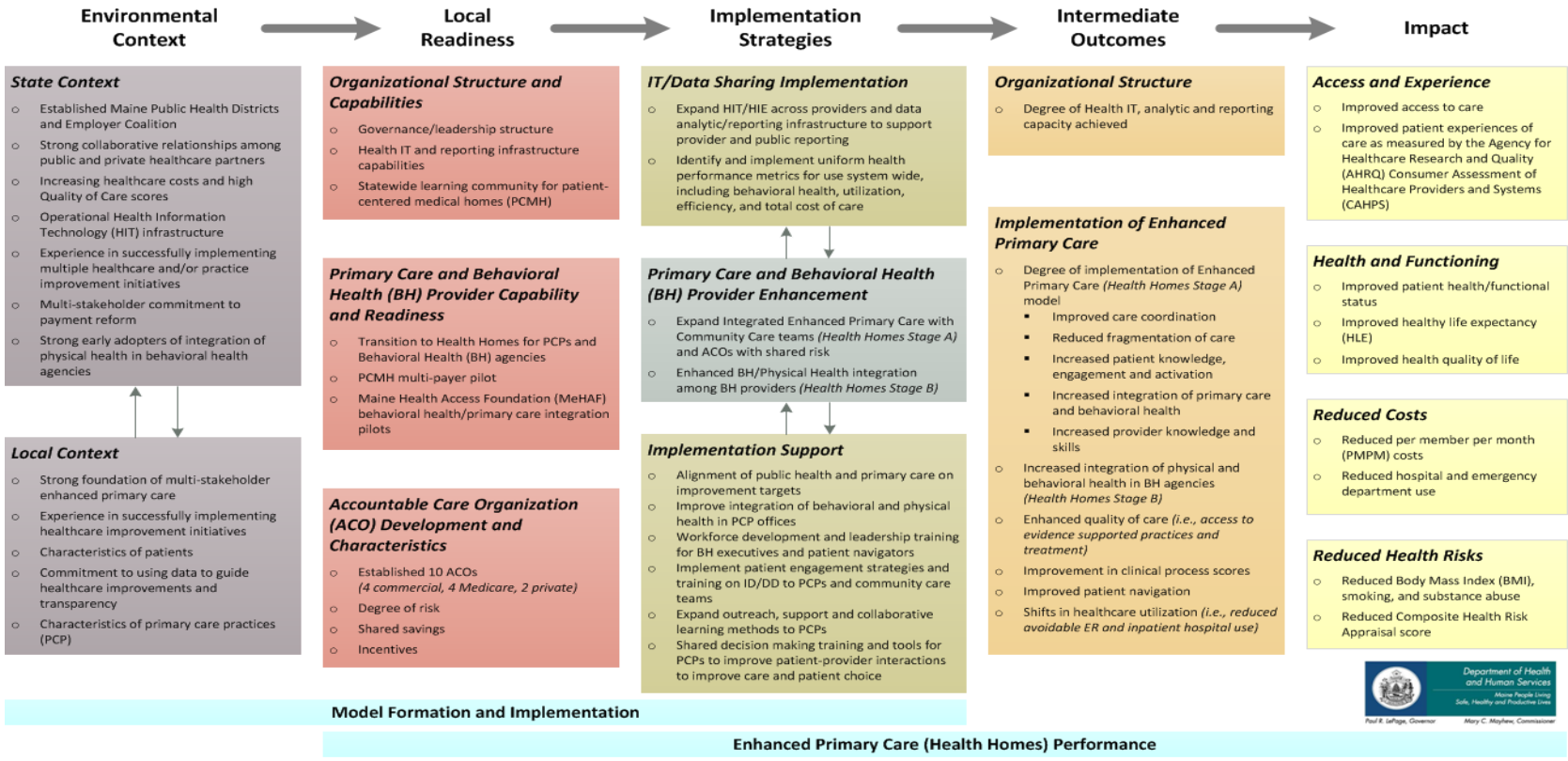
1. Establish a common set of quality/performance metrics that cover population health, practice/provider, and individual client-level measures) for use by both primary care and behavioral health providers;
2. Provide continuous feedback on performance to providers and other key project stakeholders that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



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:

- Does the model implementation lead to changes in service utilization patterns and reduced per member per month, total, medical, and behavioral healthcare costs?
- Does the model lead to improvements in care coordination and less fragmentation of care and for what populations?
- Does the model lead to improvements in quality and process of care?
- To what extent does the model improve the level of integration of physical and behavioral health across Maine's healthcare system?
- Does the model lead to improvements in member health, wellbeing and functioning and in reduced of health risk behaviors?
- Does the model lead to improved member experiences of care, engagement, and perception of services?
- What factors influence the adoption and spread of model enhancements? To what extent are model components implemented consistently and with fidelity?
- 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 inter-

ventions 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].

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:

- Tracking/monitoring of project and program implementation;
- Focus groups and Individual Interviews with project stakeholders;
- Practice and provider surveys;
- Member perception of care and wellness surveys;
- Member focus groups;
- Clinical data from EHRs and chart reviews and patient functional status surveys;
- All payer claims data – health service utilization and expenditures;

- Vital statistics data – mortality;
- 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 State Innovation Model 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 Innovation Models 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 and both have extensive experience coordinating and conducting large scale system evaluation and quality improvement 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 quality improvement 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 Section 10).

- 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 description of initial measures).

- 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:
    - 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;
    - 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;
    - 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:
    - IHI model learning collaboratives for providers transitioning to Person Centered Medical Home status;

o 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.

SECTION S. Fraud and Abuse Prevention, Detection and Correction – *This section of the Operational Plan should include information re: the following*

CONTENT for SECTION S assigned to Herb Downs/Greg Nadeau

NUMBER 46. Protections integrated into the planned transformation to guard against new fraud and abuse exposures introduced under new payment models
Examples of items to include: • A transparent strategy to work with Federal partners from OIG/OGC/Medicare and others to seek waivers or other guidance whenever potential barriers to successful implementation and execution arise • Mechanisms to prevent fraud and abuse and a process to identify, monitor and address all potential fraud and abuse issues that may develop as a result of the grantee's model(s) • Fraud & abuse protections, penalties or detection measures in contract terms &conditions • State regulations and State-based actions related to fraud and abuse • Recent studies or analysis of fraud and abuse barriers to implementation • Evidence that necessary waivers have been obtained
RESPONSE to NUMBER 46
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 model 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: [Do you want to list Web addresses for finding these?]

- 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

NUMBER 47. Plan for existing fraud and abuse protections that may pose barriers to implementing the proposed innovation model and obtaining necessary waivers from OIG/Medicare

Examples of items to include – See #46

RESPONSE to NUMBER 47

Does the response to question #46 answer this question as well? If mot, need information.

SECTION T. Risk Mitigation Strategy – This section of the Operational Plan should include information re: the following

CONTENT for SECTION T assigned to Herb Downs/Greg Nadeau

NUMBER 48. A thorough study of the likelihood of success and the potential risk factors that must be addressed to increase the probability of success of the proposed innovation model, including recommendations for mitigating identified risks
Examples of items to include: • A consistent and continuous process to identify, analyze and monitor risks for the successful implementation and execution of the model in multiple dimensions, relating to: o Project timelines and milestones o Budget adherence o Provider and beneficiary participation o Sustainability o Patient safety o Stakeholder engagement o Cost of h/care transformation
RESPONSE to NUMBER 48

APPENDIX

CONTENTS

APPENDIX NUMBER	SECTION	Item	**Pg**	**My Notes**
	?	Bus Assoc Agree MHMC&DHHS 070813		RECV'd
	?	Bus Assoc Agree MQC&MaineCare 070813		RECV'd
	?	Evidence of Coord (2 emails 062813) (JIM)		RECV'd
	?	MHMC-MDO-chg-Comp with survey (JIM)		RECV'd
	?	VBID Workgrp minutes 101212 (JIM)		RECV'd
	A	ACO Initial Report Library [PPT Presentation]		ask Kevin to resend
	A	Bylaws		NEED (Kevin
	A	Governance Model from Strategy Mtg of 03152013		NEED (Kevin)
	A	Governor's 09192012 Letter of Support for SIM Project		NEED (Kevin)
	A	Press Releases on 02222013 • Maine Coverage of Award on MPBN 02222013 • Maine Coverage of Award on WCHS 02222013 • Maine Coverage of Award – Boston Globe 02232013 • Maine Coverage of Award – Bangor Daily News 02222013 • Maine Coverage of Award on NECN 02222013 • Maine Coverage of Award – Portland Press Herald 02132013		NEED (Kevin)
	A	Stakeholder Engagement Plan (Planning Period)		RECV'd
	B	**GRAPHIC** – Coordination & Workplan Monitoring Process		
	B	**GRAPHIC** – Figure 1 Model to be Tested		
	B	GRAPHIC - Overlap of Fed & State Initiatives in Maine		RECV'd
	C	MaineCare Advisory Mtg Notes 011513		RECV'd
	C	MaineCare Advisory Mtg Notes 03052013		RECV'd
	C	MaineCare Advisory Mtg Notes 09042012		RECV'd
	C	MaineCare Advisory Mtg Notes 10022012		RECV'd
	C	MaineCare Advisory Mtg Notes 12042012		RECV'd
	C	MaineCare Health Homes Lett TCM Devel Svces Care Mgrs 060413		RECV'd
	C	MaineCare Health Homes Member Svces TCM Lett		RECV'd

APPENDIX NUMBER	SECTION	Item	Pg	My Notes
	C	MaineCare Internal VB Purchasing Mtg 07032013		RECV'd
	C	Members Standing Comm (MSC) member info 08242012		RECV'd
	C	Members Standing Comm (MSC) minutes 02032012		RECV'd
	C	Members Standing Comm (MSC) minutes 04062012		RECV'd
	C	Members Standing Comm (MSC) minutes 05172012		RECV'd
	C	Members Standing Comm (MSC) minutes 08252012		RECV'd
	C	Members Standing Comm (MSC) notes 11182011		RECV'd
	C	Members Standing Comm (MSC) questions 08242012		RECV'd
	C	MUSKIE – MaineCare Health Homes Brochure		RECV'd
	C	MUSKIE – MaineCare Health Homes Brochure 2		RECV'd
	C	MUSKIE – MaineCare Health Homes Brochure 3		RECV'd
	C	Template Health Homes Opt Out Letter		RECV'd
	C	Template Health Homes Transfer Opt Out Letter		RECV'd
	C	Value Based Purch collegecurriculum-outline 120511		RECV'd
	C	Value Based Purchasing 4 Public Forums notes & questions		RECV'd
	I	Hospital Ratings Methodology March 2013		RECV'd
	I	**REQUIRED FORMS to be attached** **CMS Forms to be included from the GUIDANCE DOCUMENT:** 1.5 Describe how self-measurements will be used 1.6 Programmatic and Operational Domains 1.7 Outcome Measure Selection from suggested CMS Core Measures 1.8 Custom Outcome Measures Selection (Not from CMMI Core Measures)		NEED ALL
	K	**REQUIRED FORMS to be attached** **CMS Forms to be included from the GUIDANCE DOCUMENT:** 4. Key State Personnel (p 21 of Guidance Doc) 5. Key Contractors (p 22 of Guidance Doc) 6. Positions to be Filed (p 22 of Guidance Doc)		NEED ALL

APPENDIX NUMBER	SECTION	Item	**Pg**	**My Notes**
	Q	Communications Plan Matrix		RECV'd