

Maine Comprehensive Community Care Initiative (Maine CCCi) Concept Paper

(Note: plain text indicates recommended elements from CMS Guidance document;
italicized text indicates Maine-specific additions)

I. Introduction

Maine seeks to leverage federal Medicare funds to create further alignment with Primary Care investments to the State to continue and further accelerate the redesign of primary care as foundational to larger health system transformation efforts. The next step to advance an innovative, multi-payer primary care alternative payment model that supports patient-centered, community health-oriented, and high-value care is critical. We propose the creation of the Maine Comprehensive Community Care initiative (CCCi), a multi-stakeholder, community-oriented approach that builds on the significant work to date of the Patient Centered Medical Home (PCMH), Health Home (HH) and State Innovation Model (SIM) efforts, which advances further innovations in care delivery and payment to achieve better care, better health, and lower cost.

a. History of PCMH/HH/MAPCP efforts in Maine

The state of Maine has been a leader in efforts to redesign primary care, initially launching the multi-payer Maine PCMH Pilot in 2010. Convened by the Dirigo Health Agency's Maine Quality Forum, Maine Quality Counts, and the Maine Health Management Coalition, the Maine PCMH Pilot was developed as a multi-stakeholder effort to implement and evaluate the PCMH model and the first step in achieving statewide adoption of an advanced primary care model. The Pilot was initially launched with 26 primary care practices selected from around the state for their demonstrated leadership and commitment to redesigning primary care, with a goal of delivering effective, efficient and accessible health care and delivering sustainable value to patients, providers, purchasers and payers. Additionally, in January 2013, Maine's Medicaid program (MaineCare) established a Health Homes (Stage A) program under federal authority pursuant to Section 2703 of the Affordable Care Act, with the goal of improving care coordination for MaineCare members with chronic conditions. MaineCare then implemented a Behavioral Health Home (BHH) program in early 2014, which focuses on persons with severe and persistent mental health conditions and children with serious emotional disturbances. The Stage A demonstration builds off the State's existing Maine multi-payer Patient Centered Medical Home (PCMH) Pilot project and Maine's Medicare Advanced Primary Care Practice (MAPCP) Demonstration by providing add-on payments to primary care practices and strengthening the community care team (CCT) model to provide care management and social support services to high-need MaineCare patients. To date, there are 177 Health Home practices, 29 Behavioral Health Home Organizations with a total of 72 Behavioral Health Homes sites.

b. Relationship to Maine SIM efforts

Building on the initial efforts of the Maine PCMH, HH efforts, Maine state leadership obtained one of the original State Innovation Model (SIM) awards with five other states in 2013 to further improve the health of Maine people, advance the quality and experience of health care, and reduce health care costs. The Maine SIM initiative has been built on six "pillars" of innovation, including strengthening primary care; integrating physical and behavioral health; developing new workforce and payment models; centralizing data and analysis; and engaging people and communities. Maine SIM innovations to date include advancing primary care innovation through support for the HHs and BHHs initiatives; workforce development through a Community Health Worker Pilot; the development of primary care practice reports that highlight

opportunities for improvements in cost and utilization; public reporting on quality improvement; and advances in payment reform and value-based insurance design.

The Maine SIM effort has fueled an unprecedented partnership among physical and behavioral health providers, public and private insurers, data and system analysts, purchasers, workforce developers, and consumers. The power of the innovation comes from the concurrent application of existing efforts with enhanced investments, all within a shared commitment to accountability, transparency, and quality. The Maine CCCi seeks to leverage SIM investments to further strengthen and advance a community-based primary care model that engages patients and communities in improving both health and health care.

c. Results from PCMH & HH efforts to date

An independent evaluation of the original three-year experience of the Maine PCMH Pilot showed important improvements in care and utilization: total costs were significantly lower in Maine PCMH Pilot practices vs. usual care (\$279 vs. \$302 per member per month) for commercial patients (p value <0.05); ED costs were lower than usual care for Medicare patients (\$6.16 vs. \$6.76) (p value <0.05)ⁱ. Additionally, the state of Maine's independent evaluation of the first year of the MaineCare HHs initiative has similarly shown positive results: HH practices showed a 14% decrease in non-emergent ED use compared to 2.6% decrease in the comparison group (p value <0.05); and HHs showed 17.9% reduction in claims-based cost avoidance, or \$110 in per member per month costs, relative to a control group.ⁱⁱ

Results from similar advanced primary care models in other states are also showing promising results: evaluation of Year 1 results of the CMS Comprehensive Primary Care initiative (CPCi) showed reductions in key utilization and/or cost measures in five of the seven CPCi communities.ⁱⁱⁱ Results of the Vermont Blueprint/PCMH initiative have shown lower healthcare expenditures for Blueprint participants at a level that has offset the payments that insurers made for medical homes and community health teams: in 2013, when comparing Blueprint participants to non-PCMH primary care practices, the total expenditures per capita were \$101 less per Blueprint participant for Medicaid, and \$565 less per Blueprint participant for commercial payers.^{iv}

Results from these and other efforts suggest that it typically takes 3-5 years of multi-payer investment in primary care redesign before results are seen; given the number of primary care practices in Maine that have already been making these investments, it is reasonable to expect significant demonstrable results within the proposed five-year timeframe of the Maine CCCi demonstration.

Based on these results, as well as qualitative reports from PCMH, HH, and CCT providers and patients, Maine is well-positioned to take the next step forward to advance primary care redesign supported using an aligned, multi-payer alternative payment model that builds on the prior work of the PCMH, HH, and SIM efforts in the state. We expect that implementation of the proposed CCCi model will result in demonstrable improvements in key targeted areas of clinical quality (e.g. hypertension control); patient experience of care; as well as decreases in utilization and costs (e.g. reduced ED visits; avoidable readmissions; and inappropriate use of high-cost medications). As noted in the CMS Guidance document, we plan to conduct an actuarial assessment of projected savings linked to key areas of focus for reducing utilization and cost savings for our full proposal.

d. Governance provided through existing SIM Governance Model

The state of Maine is well-positioned to leverage the existing Maine SIM governance structure to lead and support the Maine CCCi. Maine's SIM effort is led by the Maine Leadership Team with support of the Governor's office, and a multi-stakeholder Steering Committee, along with subcommittees that provide input and direction on Payment Reform, Delivery System Reform, Data Infrastructure, and Evaluation. This multi-stakeholder governance structure and participants have the relationships and experience to provide ongoing leadership for the Maine CCCi.

II. Maine CCCi Proposal - Overview of Proposed Model

The Maine Comprehensive Community Care initiative (CCCi) will build from the extensive investments and learnings of Maine's progressive PCMH, HHs and SIM experience to take the next step to a broader, more comprehensive community-based approach that continues to advance primary care redesign and links primary care practices with community partners to advance both health care and social service needs. We will also build from the national experience of the CMS Comprehensive Primary Care initiative (CPCi) communities to leverage the learnings from that effort, and link that with Maine's SIM efforts to further advance our three-part goals of improving care, improving health, and lowering costs.

III. Payment Methodology

The proposed Maine CCCi payment model is comprised of three components for primary care practices, and one new payment for innovative use of high-value specialty services. Primary care payments will include (1) *ongoing fee-for-service (FFS) payments* for service delivery; supplemented by (2) *risk-adjusted care management PMPM payments* that enable practices to implement and sustain the infrastructure to deliver comprehensive services to high-risk populations and to provide community care team and specifically support practice-based care management, as well as payments to Community Care Teams (CCTs) for the most high-needs, high-cost patients, as well as payments for Community Health Worker (CHW) staff to assess and provide navigation to help identify and address patients' social service needs ; and (3) *accountability payments* that directly incent providers and practice teams to improve outcomes. The proposed fourth payment element (4) is a new payment for specialty cognitive consultation services, described in more detail below.

The first two primary care payment elements (i.e. FFS + care management PMPM) are currently being paid by commercial and public payers only to practices participating in the MAPCP demonstration, and by Medicaid to practices in the Health Homes initiative. The proposed CCCi would bring multi-payer alignment to all eligible and participating primary care practices in the state, and would add the third, element – i.e. accountability payment as a mechanism for incenting and holding practices accountable for the desired outcomes. In order to advance the principles of value-based payment, the third (new) component of accountability payments is designed to provide performance-based incentives to reward practices for performance improvement.

Additionally, we feel it is critical that primary care practices be allowed to participate in the Maine CCCi model even if they are also participating Accountable Care Organization (ACO) models. While many Maine provider groups participate in ACO contracts with both commercial and public payers, these ACO contracts generally do not provide substantial changes to FFS-based primary care payments other than the possibility of participating in shared savings distributions; given that the majority of Medicare ACO pilots in the state have not reached a

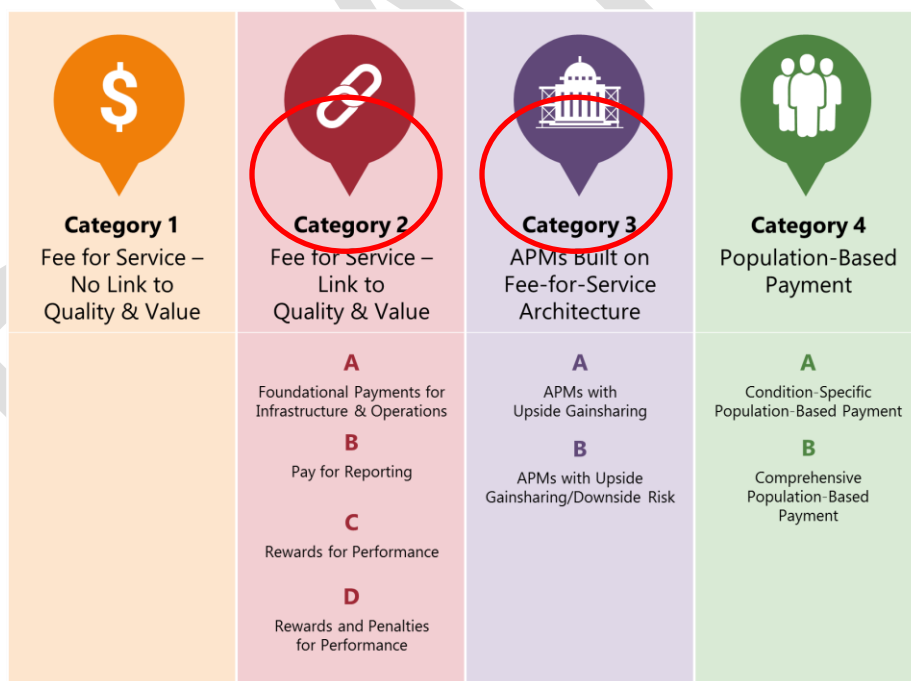
level of savings needed to distribute shared savings in most years, this has meant that primary care payments have been limited almost solely to FFS payments. This has significantly limited the ability of primary care practices to invest in the staffing and system changes needed to meaningfully change practice, even within ACO contracts .

It is important to note that the proposed new payment model for primary care follows the trajectory established by CMS in their Health Care Payment Learning and Action Network’s (HCPLAN) Alternative Payment Model (APM) framework that will be an essential element of the upcoming implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) – i.e. fee-for-service (FFS) payments linked to quality and value (Category 2); providing the foundation to transition to use of Alternative Payment Models (APMs) that build on FFS architecture with upside (Category 3a) and downside (Category 3b) risk; and eventually moving to population-based payment (Category 4) – as illustrated in the CMS HCP-LAN graphic, below:



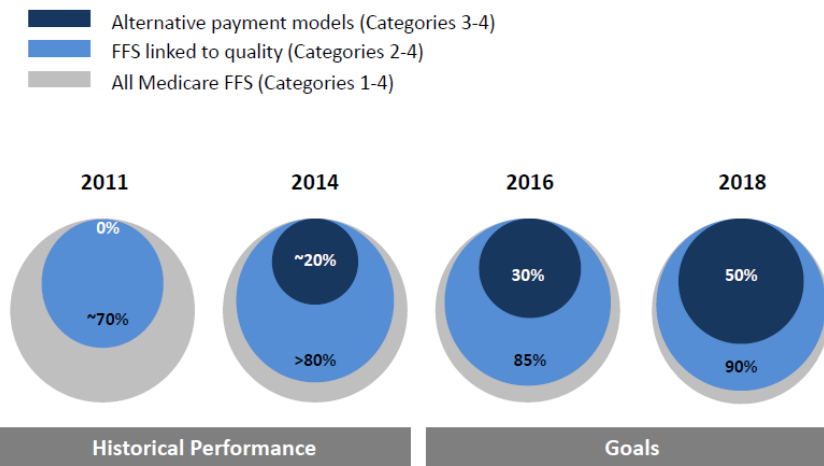
Alternative Payment Model (APM) Framework At-A-Glance

The framework situates existing and potential APMs into a series of categories:



This effort to implement a new primary care payment model in Maine also aligns with the “bold goals” proposed by DHHS Secretary Burwell in January 2015 which set a goal that 30% of Medicare payments would be linked to quality and value through Alternative Payment Models by 2016, and 50% by 2018; and 85% of Medicare FFS payments will be linked to quality by 2016, and 90% by 2018, as illustrated below:

Target percentage of payments in 'FFS linked to quality' and 'alternative payment models' by 2016 and 2018



The proposed new Maine CCCi primary care payment model is consistent with the CMS HCP-LAN framework, and, as noted above, is comprised of three components: (1) ongoing FFS payments supplemented by (2) risk-adjusted care management PMPM payments that enable practices to implement and sustain the infrastructure to deliver comprehensive services to high-risk populations and to provide payment by practices to Community Care Teams (HCP-LAN Category 2A); and (3) accountability payments in the form of performance incentives designed to promote accountability for impacting Total Costs of Care (HCP-LAN Category 3). Of note, the proposed Maine CCCi payment model is also consistent with recommendations that emerged from previous Maine SIM efforts (i.e. SIM Payment Reform Subcommittee) which used a three tiered model for describing payment change, as outlined below:

Primary Care Payment Models	Key Elements	Current Alternative Primary Care Payment Models
Tier 1	Fixed PMPM payment as initial investment in primary care	Maine PCMH Pilot MaineCare Health Homes (HHs) Sev commercial payers
Tier 2	Risk-adjusted PMPM + accountability-based payments	<ul style="list-style-type: none"> • MaineCare HHs that participate in Accountable Communities initiative • Anthem Enhanced Personal Health Care (EPHC) program • Medicare CPCi • PROPOSED Maine CCCi
Tier 3	Comprehensive primary care payment	Medicare Advantage plans Capitated primary care payments

In summary, the proposed Maine CCCi leverages and significantly expands current work in Maine to advance multi-payer value-based primary care models and aligns with both previous recommendations from Maine stakeholders and the direction of CMS through the HCP-LAN.

To help promote planning and accountability for using new funding to support innovative models of care, practices participating in the Maine CCCi would be required to develop an annual budget designed to articulate how the PMPM payments will be invested; practices will be asked specifically to budget for how new CCCi payments will support their efforts to deliver care management for high-risk patients; implement 24/7 patient access; improve patient experience, use data to guide performance improvement; enhance EHR and HIE capacity; ensure care coordination across medical neighborhood; and improve patients' shared decision-making.

In order to advance the principles of value-based payment, the third component of the proposed Maine CCCi model, the accountability payment, adds performance-based incentives to reward practices for their performance and performance improvement. Baseline practice performance targets will be established for meaningful use, performance on a set of quality/quality improvement measures (see [Appendix](#)), and total cost of care and public reporting/transparency. Payers will establish annual practice performance targets which may identify performance improvement based on past experience and/or absolute performance targets based on expectations. To ensure that practices are credited for overall performance improvement, incentive payments may be determined by assigning each target a specific value with the accumulation of target achievement determining the total incentive reward. Initially, performance improvement will be measured against each practice's performance. As measurement tools becomes more robust and transformation more widespread, practice performance can be measured with regional or statewide performance.

To facilitate payer flexibility, the model enables each payer to determine the relative weight and value each payer assigns for performance incentives. Incentives will be based upon specific performance related to meaningful use, quality/quality improvement, total cost of care, and transparency/public reporting. While it would be encouraged that all of the payers apply performance in the four domains each payer would determine the relative value of specific performance indicators for purposes of calculating performance and/or shared savings payments.

Further, each payer can base payment on either a monthly PMPM for infrastructure or strictly on performance incentives or both. MaineCare for example could determine that sufficient infrastructure payments have already been invested. Therefore, incentive performance would be the exclusive factor determining additional payments. Initially, failure to achieve established performance measures would result in no additional payments. In subsequent years, risk could be shared by both the payer and provider and ultimately the practice would assume full risk.

The merits of this approach are threefold. First, both high-performing and modestly-performing practices can achieve incentive payments through performance improvement as the incentive payments are predicated on continuous improvement. A variation on this approach is to require improved performance compared with an established best practice benchmark. Second, the incentives can be determined by a range of performance indicators reflecting quality, utilization, HIT, transparency and total cost of care. Since practices cannot control many facets of total cost and there is considerable variation in total cost performance, payers would be encouraged to base cost performance on benchmarks of prior practice experience and/or targets adjusted to reflect regional variation.

Finally, adoption of the Category 2 model (i.e. FFS tied to quality/value) followed by the Category 3 framework (i.e. move to use of Alternative Payment Models (APMs)) will position practices to meet the APM provisions of MACRA, with the potential to benefit from financial rewards and avoid the risk of experiencing substantial upcoming payment penalties under the Merit-based Incentive Payments System (MIPS) introduced by MACRA. The transition from the current payment practices to more meaningful adoption of APMs linked to quality and assuming gradual risk will provide a pathway to MACRA requirements.

The fourth new component of the CCCi payment model is the introduction of new specialty “e-consult” payments to improve access to specialty physicians, behavioral health providers, and pharmacists for providing high-value, “cognitive consultation” services to primary care clinicians to improve quality of care and increase efficiency of the consultation process. Electronic consultation systems between primary practices and specialty providers have been implemented and tested in numerous markets. Early experience with these models has demonstrated the potential for significant cost savings if more widely adopted.^v Savings are achieved through lower unit cost of services for specialty services, as well as important decreases in downstream costs (e.g. avoiding unnecessary or repeated diagnostic testing). As part of this effort, we will identify an appropriate financing model for implementation in the Maine market.

IV. Primary Care Functions

The Maine CCCi model of care will build on the existing PCMH, HH, CCT, and CPCi models, and will expand the model further to take an initial step toward identifying the health-related social needs that often create barriers to the ability to manage chronic conditions, increase health care costs, and lead to avoidable health care utilization. Key components of the Maine CCCi model will include the following:

- a. *Leadership for advanced primary care*
- b. *Team-based care*
- c. *Access and continuity*
 - i. *Promote access to telehealth services to improve access to primary & specialty care*
- d. *Risk-stratified care management*
 - i. *Practice-based care management*
 - ii. *Community-based complex care management (Community Care Teams)*
- e. *Planned care for population health*
- f. *Patient and family caregiver engagement*
- g. *Comprehensiveness and coordination*
- h. *Behavioral health integration*
- i. *Assessing and addressing health-related social needs*
- j. *Using data to drive improvement*

V. Primary Care Expectations for Implementing Enhanced Functions – CCCi Milestones

As part of its commitment to promoting accountability within this new model, the Maine CCCi will ask participating primary care practices to report on set of milestones that set clear expectations for implementing the changes in primary care processes, including the following:

1. Create a budget forecast using a standard template that outlines where CCCi money is being reinvested.
2. Ensure that payment changes from payers are reflected in provider and team compensation models.
3. Develop system for providing case management for high risk patients with metrics, plan, and implementation methodology.

4. Develop system that ensures access to the care team 24/7, and providers can access patient data after standard office hours so they can continue to participate in care decisions with their patients.
5. Develop system for using one or more methods for assessing patient experience in care (e.g. completion of CAHPS survey) and for using patient input to guide improvements in care (e.g. patient/family advisory council).
6. Develop systems to use data to guide patient care at provider/team level through the use of data-driven rapid cycle improvement efforts.
7. Actively build relationships and provider engagement across the medical neighborhood.
8. Implement systems that support improved patient shared decision making capacity.
9. Participate in CCCi statewide learning collaborative to share best practices and lessons learned.
10. Meet requirements for Meaningful Use Stage 2 (1?).
11. Develop systems to routinely assessing health-related social needs of patients and assisting with navigation to community-based resources to address those needs.

VI. Multi-payer and Provider Participation

Capitalizing on the experience of the MAPCP, the commercial health plans will be recruited to participate in the multi-payer proposal. Based on past experience it is anticipated that each of the five major commercial payers will participate in the initiative. Payers will be expected to commit to broad alignment on the key components of performance measures, provider enrollment, attribution, and payment methodology.

VII. Data Sharing Between Payers and Practices

Maine's SIM experience has significantly advanced the state's data, analytic, and reporting resources and capabilities. During the three years of SIM testing, Maine advanced its usage and coordination of data to inform the direction and detail of its healthcare delivery and payment transformations. Maine has leveraged four unique data resources in its SIM experience that position the state for success in advancing the next phase of healthcare transformation: (1) the Maine Health Data Organization's (MHDOS) All-Payer Claims Database (APCD) is used to provide data for analyses that inform decisions on direction and adjustment of healthcare transformation through performance measurement at the practice and population levels.

Data from the state's largest employer coalition supplemented by Medicare and APCD data is analyzed and reported on a practice level with detail that provides comparative performance on quality and efficiency. (2) Through SIM, the State developed a 'Core Measure Dashboard', which compares results across the three populations, MaineCare, Medicare, and Commercial, on measures determined by consensus. (3) MaineCare, the state's Medicaid agency, is providing a portal based view of its attributed data for participating health homes and accountable community organizations. Additionally, HealthInfoNet is a statewide health information exchange with a centralized model for data management. (4) HealthInfoNet has introduced clinical and claims-based analytic functionality that supports providers statewide and through SIM is piloting care management functions with MaineCare, having developed near-real-time prospective predictive modeling tools for the Medicaid program.

These tools, leverage both clinical and claims data to accurately identify patients that are likely to be high utilizers, high cost, to be readmitted and to develop significant chronic illnesses (diabetes, CHF, stroke, acute myocardial infarction (AMI), etc.), before these events happen. In addition, HealthInfoNet has incorporated MaineCare prescription claims information into the HIE to allow for more comprehensive care management and medication reconciliation for

providers statewide. SIM has enabled the state to invest in a data analytics and reporting structure that is providing actionable information for quality improvement, program adjustments, and accountability.

Maine has also advanced its use of certified electronic health record systems as a core expectation in a transformed healthcare delivery system. All health home and patient centered medical homes are required to meaningfully use electronic health records and a very high percentage of these practices participate in the health information exchange. Through SIM, the health information exchange has on-boarded twenty behavioral health organizations and is exchanging data to facilitate coordination of care across physical and behavioral medicine. The health information exchange provides transition of care notifications to facilitate care coordination. As a result of our recent three-year SIM experience, Maine is well positioned to provide the advanced data support needed for successful clinical and administrative management of the CCCi model.

This effort will build on these SIM-supported data advances, and will enhance the use of current databases and reporting techniques to support the data needs and reporting of the Maine CCCi model. The Maine Health Management Coalition (MHMC) has considerable experience using the APCD to produce practice reports to individual primary care practices. Until 2016 these reports have focused exclusively on the commercial sector but the MHMC will begin producing reports based on Medicaid and Medicare claims data this year with direct feeds from MaineCare and CMS through its Qualified Entity status. These reports will provide practices with a retrospective analysis of their patients' claims experience, including reporting on Total Cost of Care (TCoC).

The MaineCare Health Home provider portal will continue to serve as a valuable tool for practices participating in the Health Homes initiative. MaineCare and HealthInfoNet (HIN) are also collaborating on a model to test sharing of selected clinical data related to diabetes.

The introduction of accountability measures for determining performance-based payments that include clinical outcomes will require additional and far greater collaboration of data sharing among payers, providers, and health data organizations. Partners will seek the most efficient, timely, and least disruptive techniques to collect and report clinical data at the individual and aggregate level. Access to clinical outcome data will be highly dependent upon individual practice EHR capabilities and the designation of reporting entities.

VIII. Shared Learning & Practice Transformation Support

a. History of PCMH/HH/CCT Learning Collaborative

Both the Maine PCMH/HH and SIM initiatives have recognized shared learning across practices as a critical element of advancing practice redesign with enhanced care delivery models to improve outcomes. To support that effort, Maine Quality Counts (QC) has offered education and quality improvement support to PCMH Pilot practices and CCTs, initially through a PCMH Learning Collaborative which was then expanded with state support under SIM to include HH practices. The collaborative is based on the successful "Breakthrough Series Collaborative" (BTS) model developed by the Institute for Healthcare Improvement, with the overall objective of providing opportunities for shared learning and rapid cycle improvement. PCMH and HH practices, along with CCTs, participate in the Collaborative. Support for PCMH/HH practice transformation also includes a team of Quality Improvement (QI) Specialists who partner directly with practices on change and improvement strategies within a QI framework.

Under the Maine CCCi, the systems for shared learning and practice transformation support will focus on providing assistance to practices in key areas for improvement that are needed to directly impact the key outcomes of focus for clinical quality, patient experience, and utilization/cost outcomes. These include developing strong leadership for change; building a team-based approach to care; ensuring patient empanelment and delivering enhanced access to care; identifying practice systems to support population risk stratification and effective care management; supporting effective models for behavioral-physical health integration; effectively engaging patients and families; optimizing use of health information technology; and strengthening connections to community resources and social support services. The combination of these key changes have been shown in other effective advanced primary care models (e.g. CPCi, VT Blueprint) to be directly linked to improved outcomes in quality and costs of care.

b. Improving patient experience & opportunity for alignment

Through the efforts of the Maine PCMH Pilot and the leadership of the Maine Quality Forum (MQF), one of the Pilot Conveners, Maine primary care practices have made considerable strides in measuring and improving patient experience of care, another key opportunity to align state efforts with the goals of the proposed Maine CCCi. The MQF has supported two rounds of statewide surveying of physician practices using the nationally validated CG-CAHPS survey for ambulatory practices, and providing significant subsidies to help defray the costs of conducting these surveys. In exchange for this support, participating practices have agreed to public reporting of survey results at the practice level on the MQF website, Patient Experience Matters. The MQF has also provided practices with quality improvement resources for improving patient experience in practice settings. We are confident that this experience assessing and improving patient experience of care will offer an important opportunity to improve patient experience in the Maine CCCi.

b. NNE-PTN & opportunity for alignment

Maine has additionally stepped forward to offer support for practice transformation under the CMS Transforming Clinical Practices Initiative (TCPI), with Maine Quality Counts leading a three-state effort to launch the Northern New England Practice Transformation Network (NNE-PTN). The NNE-PTN, launched in late 2015, will provide technical assistance and QI support to primary care and specialty clinicians and practices through on-site QI support, in-person educational sessions, and web-based distance learning methods to support needed improvements in care. We anticipate that the NNE-PTN structure and resources could potentially be leveraged to provide QI support to CCCi practices in the state.

IX. Quality & Accountability strategy

The SIM grant enabled stakeholders to develop a recommended core measure set to be used for both payment and monitoring purposes for ACO contracts. The core measure set was endorsed by the commercial plans and MaineCare with the recognition that the core set would not be the exclusive indicators of performance but would constitute the foundation of an aligned measure set. The measure set was configured with the goal of broad adoption of payers and alignment with CMS. The measures are predominantly NQF-endorsed and are deemed to have wide acceptance.

The PCMH Conveners have compared the Maine core measure set with recently published CMS-AHIP consensus core measures for PCMH, and identified significant alignment with the SIM recommended core measure set, with 11 ambulatory care measures included in both the Maine SIM core measure set and the CMS-AHIP consensus measures. We propose that those 11

measures be used as the core set of accountability measures for the CCCi performance incentive payments, supplemented by four additional measures. The four additional measures include: (1) Follow-Up for Hospitalization for Mental Illness (in order provide a claims-based measure for behavioral health); (2) Plan All-Cause Readmissions recognizing the local emphasis on reducing hospital readmissions; (3) & (4) two indicators related to public reporting and submission of data to the organization designated to collect and report on practice performance in an effort to advance transparency.

There were several measures that were embraced for future adoption with the recognition that there are current challenges to report selected measures requiring clinical reporting. It is intended that a revised payment methodology linked to reporting components will provide adequate incentives to encourage greater reporting of key clinical outcome measures. Further, there is an interest in expanding the core set to ultimately include patient-reported outcome (PRO) data in subsequent years.

DRAFT

Appendix: Proposed Quality and Accountability Measures

<u>Measure Domain/Name</u>	<u>NQF #</u>	<u>Steward</u>	<u>Process/ Outcome</u>	<u>Care Setting</u>	<u>Data Source</u>
Chronic Illness – Diabetes					
1. Comprehensive Diabetes Care Medical Attention for Nephropathy	0062	NCQA	Process	Ambulatory	Claims
2. Comprehensive Diabetes Care Eye Exam	0055	NCQA	Process	Ambulatory	Claims
3. Comprehensive Diabetes Care HbA1c Poor Control (<9.0%)	0059	NCQA	Outcome	Ambulatory	Claims & Clinical
Chronic Illness – Cardiovascular Care					
4. Controlling High Blood Pressure (<140/90 mm Hg)	0018	NCQA	Outcome	Ambulatory	Claims & Clinical
Chronic Illness – Pulmonary					
5. Avoidance of Antibiotic Treatment in Adults w/Acute Bronchitis	0058	NCQA	Process	Ambulatory	Claims
Preventive Care					
6. Colorectal Screening	0034	NCQA	Process	Ambulatory	Claims & Clinical
7. Tobacco Use: Screening and Cessation Intervention	0028	AMA-PCPI	Process	Ambulatory	Claims & Clinical
8. Adult BMI Assessment	N/A	NCQA	Process	Ambulatory	Claims & Clinical
Behavioral Health					
9. Follow-Up after Hospitalization for Mental Illness	0576	NCQA	Process	Ambulatory	Claims

<u>Measure Domain/Name</u>	<u>NQF #</u>	<u>Steward</u>	<u>Process/ Outcome</u>	<u>Care Setting</u>	<u>Data Source</u>
Utilization					
10. Use of Imaging Studies for Low Back Pain	0052	NCQA	Process	Ambulatory	Claims
11. Plan All-Cause Readmissions	1768	NCQA	Outcome	Ambulatory	Claims
Patient Experience					
12. CG-CAHPS	0005	AHRQ	Survey	Ambulatory	Survey
Cost					
13. Total Cost of Care Population-Based PMPM Index (TCI)	1604	Health Partners	Cost	Setting Free	Claims
Transparency					
14. Submits performance data to PCMH Conveners or designated organization at prescribed intervals	N/A	TBD		Ambulatory	Claims, Clinical, Survey
15. Submits performance data to MHMC as prescribed by Pathways to Excellence Steering Committee for public reporting on GetBetterMaine	N/A	TBD		Ambulatory	Claims, Clinical, Survey

ⁱ Maine PCMH Pilot Evaluation – USM Muskie Evaluation Team presentation, 2015

ⁱⁱ Maine SIM Evaluation – <http://www.maine.gov/dhhs/sim/evaluation/reports.shtml>

ⁱⁱⁱ Evaluation of the Comprehensive Primary Care Initiative: First Annual Report, <https://innovation.cms.gov/files/reports/cpci-evalrpt1.pdf>

^{iv} Vermont Blueprint for Health Annual report (January 2015), <http://legislature.vermont.gov/assets/Legislative-Reports/VTBlueprintforHealthAnnualReport2014-Final.2015.01.26.pdf>

^v N. Olayiwola, et al, Electronic Consultations to Improve the Primary Care - Specialty Care Interface for Cardiology in the Medically Underserved, *Ann Fam Med*, 14 (2), March 2016.