

Maine

ME Quality Forum, Quality Counts & ME Health Management Coalition

<http://www.mainequalitycounts.org/patient-centered-medical-home/main/>

Statutory authority: N

- Pilot result of Legislative Commission; recognized in state health plan; Medicaid participation supported by legislative appropriation

Multi-payer database: Y

Status:

- Practices have been selected & have submitted NCQA apps; completing agreements; payments 1/10

Payers:

- Anthem BCBS of Maine; Aetna; CIGNA; Harvard Pilgrim Health Care; Medicaid

Scope # practices/physicians/covered lives:

- 26/221/ 75,000

Practice qualification:

- NCQA PPC-PCMH

Community integration:

- Pilot “Core Expectations” include commitment from practices to improve connections to local community & community resources

Integration with wellness/disease prevention:

- “Core Expectations” includes commitment from participating practices to connect with their local “Healthy Maine Partnership” (i.e. state-supported community coalition promoting disease prevention)

Evaluation: Independent

- Aligned with 6 aims of IOM’s quality of care including assessment of changes in clinical outcomes, cost/ resource use, patient experience, & practice teams / systems

Administrative entity/ongoing management:

- Quality Counts manages day-to-day operations

Attribution:

- Plans & providers agreed to methodology (commercial: claims based - anyone with last visit to site in 2 year time period & member at end of period)

Quality measurement

- Practices commit to submitting clinical quality measures quarterly; claims data used to create quality & resource use feedback reports for practices

Payment model:

- Prospective PMPM care coordination fee

Support to practices:

- 1:1 Quality improvement coaches using Microsystems
- Learning collaborative 3/year
- T/A from contracted experts for targeted key areas (e.g. HIT, involving patients in redesign efforts)
- Feedback reports every 6 months



“Core Expectations” for Pilot Practices

1. Demonstrated physician leadership
2. Team-based approach
3. Population risk-stratification and management
4. Practice-integrated care management
5. Same-day access
6. Behavioral-physical health integration
7. Inclusion of patients & families
8. Connection to community / local HMP
9. Commitment to waste reduction
10. Patient-centered HIT

Support for Practice Transformation

- PCMH Learning Collaborative
- 1:1 practice coaching from QI coaches
- Technical assistance for specific improvement areas (e.g. working with patients & families, BH integration, HIT)
- Ongoing data feedback:
 - Clinical quality measures
 - Claims-based practice reporting of costs & resource use