Goal 10:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Service Based Measures

Service

☐ Comprehensive Care Management

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Care Coordination

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Health Promotion

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Individual and Family Support Services (including authorized representatives)

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Referral to Community and Social Support Services

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - A: Categorically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

ix. Evaluations

A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):

i. Hospital admissions

Description

HEDIS Claims based measure Inpatient Utilization – general hospital/acute care (IPU) and inpatient alcohol and other drug services (IAD)

Data Source

HEDIS claims-based measure

Frequency of Data Collection

This measure will be reported quarterly on the Health Homes quality measures report.

ii. Emergency room visits

Description

HEDIS and non-emergent ED use measures described more fully in Quality measures section.

Data Source

Claims

Frequency of Data Collection

This measure will be reported quarterly on the Health Homes quality measures report.

iii. Skilled Nursing Facility admissions

Description

Skilled Nursing Facility Admission rate per 1000 member months, all SNF admissions.

Data Source

Claims and other administrative data

Frequency of Data Collection

Annually

i.

B. Describe how the State will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program, as it pertains to the following:

Hospital admission rates

ii. Chronic

Maine's Health Homes Program is strategically aligned with and built on the foundation of the state's multi-payer Patient Centered Medical Home (PCMH) Pilot. The Maine multi-payer PCMH Pilot is also participating in the Medicare Advanced Primary Care Practice (MAPCP) Demonstration. We expect all of the practices in the multi-payer PCMH Pilot to become Health Home practices. Some Health Home practices will not be part of the multi-payer PCMH Pilot due to limits on the number of practices in the Maine PCMH Pilot.

The evaluation of the Health Homes Program will build on the evaluation of the Maine multi-payer PCMH Pilot that is being conducted by the Muskie School of Public Service School at the University of Southern Maine with funding from MaineCare and Maine-based foundations. This evaluation is examining over the 3 years of the Pilot (2010-2013 with 2008 as baseline) the cost-efficiency (i.e. cost and utilization/resource use) and quality outcomes for patients in the multi-payer PCMH Pilot practices compared with patients in two other groups of practices (chosen through propensity score matching): (1) practices that are NCQA-recognized as PCMHs, and (2) practices that are not NCQA recognized (usual care). The Health Homes evaluation will use a pre-post, comparison group design that follows patients over a 2-year period starting in 2013, with 2012 as baseline. A comparison group of patients will be selected based on a propensity matching algorithm that includes health home disease criteria, other chronic conditions, age, gender and geography. These patients will be assigned to a usual source of care practice based on a claims algorithm. Practice and member characteristics that are available through MaineCare administrative data will be considered in modeling. A final evaluation plan will be developed and coordinated with any national Health Homes evaluation.

The evaluation will also collect practice-level data to monitor program implementation, processes and lessons learned. This will include review of quarterly reports prepared by the Community Care Teams (CCTs) and Health Home practices, interviews with CCT leaders, and review of meeting notes and interviews with the Steering Committee and Learning Collaborative members. To the extent additional funding can be secured to support such activities, we will develop a strategy to assess consumer experience with the Health Homes using a combination of methods including interviews with advocacy and consumer groups, focus groups, and consumer surveys.

Hospital Admission rates: Maine's Medicaid claims data will be used to compute hospital admission rates for individuals in the Health Homes. To the extent possible, Medicaid cross-over claims will be used for calculation of rates for members who are dually eligible. To the extent cross-over claims are not complete or inadequate for measure construction, Maine will work with CMS to obtain the necessary data use agreements to obtain Medicare data. Maine is already getting Medicare data from CMS for the Medicare Advanced Primary Care Demonstration but would need a separate agreement and data for the evaluation of the Health Homes.

See list of hospital admission and ER use rates above (i.e. hospital admissions, potential avoidable hospital admissions, hospital readmissions, ED use, non-emergent ED use).

disease management

A combination of claims, administrative and qualitative data will be used to monitor chronic disease management processes and outcomes. We will compute the chronic disease measures listed above under Goal 2 and compare the rates for those in the Health Homes with those in a comparison group. We will examine the frequency and characteristics of those who are referred to CCTs and variations in referral patterns across practices. We will leverage information gathered from existing initiatives (e.g. Maine Quality Counts Learning Collaboratives, the PCMH evaluation, and PCMH Working Group (steering committee)meetings) supplemented by additional key informant interviews, as necessary, to identify other process or structural elements of chronic disease management that the Health Homes use to assess needs, coordinate services, triage referrals to CCTs, and communicate with other specialty or community based providers. For members who are referred to the Community Care Teams, we will analyze the Health Monitoring Outcome Reports submitted by each team and examine trends over time. These reports include individual level data on blood pressure monitoring and control (all CCT patients); tobacco use and counseling services (all CCT patient), diabetes monitoring and control (CCT patients with diabetes); and depression screening (CCT patients with diabetes or CVD). This information may be supplemented with chart reviews or audits of some of the Health Home practices.

iii. Coordination of care for individuals with chronic conditions

Claims data will be used to examine two claims based care coordination measures identified above: (1) fragmentation of care and (2) follow-up care after mental health hospitalization for people in Health homes and in a comparison group. Structural measures of care coordination will be examined using a monitoring tool that examines the extent to which the core expectations of the Health Home Practices are being met and progress in meeting those goals. Other qualitative data and case record reviews will be used to illustrate and assess the processes and protocols used by the Health Homes and the CCTs to coordinate care for people with chronic conditions (e.g. during or after a hospitalization; for people with multiple conditions and providers). This may include case record reviews of the Practices and CCTs to assess other components of care coordination including items such as date of comprehensive assessment and care plan development; contacts during and after a hospitalization; and frequency and intensity of care management for hi-risk patients.

Each quarter the CCTs will identify at least one patient story that illustrates the work of the CCT and provide the story of this individual. These reports will be used to inform the implementation of the CCTs and will inform lessons learned. We will regularly communicate and work with the Health Homes and CCTs to identify the challenges and strategies used to implement the care coordination and care management processes within and across organizations.

iv. Assessment of program implementation

Qualified practices and CCTs will be required to submit quarterly reports on their progress in meeting the PCMH core expectations. (e.g. Leadership and Governance, Team-based Approach to Care; Risk Stratification etc). These expectations are outlined in the MOU with the practices and CCTs. Practices and CCTs will report on the degree of progress in each of these areas (e.g. no progress, early progress, moderate progress, and fully implemented). The criteria for making progress in each of these areas are defined in the reporting tool.

v. Processes and lessons learned

Maine DHHS will work with Maine Quality Counts to assess and monitor lessons learned through reports and discussions with the PCMH Working Group, the PCMH Pilot Learning Collaborative for the PCMHs. Maine will also work with the Health Home practices that are not part of the multi-payer PCMH Pilot to monitor and obtain feedback on the lessons learned by these practices. Quarterly reports on the structures of care and processes of care (as outlined in the CCT MOU) and the biannual Health Monitoring and Outcome Reports (also outlined in the CCT MOU) will inform the discussions of the Working Group and the PCMH Learning Collaborative.

vi. Assessment of quality improvements and clinical outcomes

The quality and clinical outcome measures, including those discussed in the Quality Measures section above as well as the CMS core Health Homes measures, will be calculated at the patient level. Where appropriate, models will be risk adjusted and change over time will be examined for health home and comparison patients for the pre/post period.

vii. Estimates of cost savings

Medicaid and Medicare data will be used to compute cost savings in the pre/post period. Maine will calculate baseline Medicaid and Medicare (if applicable) cost per person in the base year (2012) and three years of implementation. The cost savings estimates will be risk adjusted. The final method for computing cost savings will be determined as part of a final evaluation plan and will be coordinated with the national evaluation plan.

Page

3.1 - B: Medically Needy View

Attachment 3.1-H

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

- [ ] Health Home Services

i. Geographic Limitations

Statewide Basis

If Targeted Geographic Basis,

ii. Population Criteria

The State elects to offer Health Home Services to individuals with:

- [x] Two chronic conditions
- [x] One chronic condition and the risk of developing another
- [ ] One serious mental illness

from the list of conditions below:

- [x] Mental Health Condition
- [x] Substance Use Disorder
- [x] Asthma
- [x] Diabetes
- [x] Heart Disease
- [ ] BMI Over 25

☑ Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

Maine will be using two or more chronic conditions or one chronic condition and being at risk for another.

The targeted chronic conditions include: a mental health condition (excluding SPMI or SED); a substance use disorder; asthma; tobacco use; diabetes; heart disease; being overweight or obese as evidenced by a body mass index over 25; Chronic Obstructive Pulmonary Disease (COPD); hypertension; hyperlipidemia; developmental disorders; acquired brain injury; andseizure disorders and cardiac and circulatory congenital abnormalities.

Members with any of the following chronic conditions are considered, by definition, to be at risk for another condition because of strong evidence in the medical literature (cited below) that having one of these conditions is strongly associated with high risk of developing another chronic condition: mental health conditions; substance abuse; diabetes; heart disease; obesity; COPD; hypertension; hyperlipidemia; tobacco use; developmental and intellectual disabilities; and cardiac and circulatory congenital abnormalities.

Primary Condition: Mental Health Conditions (e.g. depression)
Secondary Condition:Heart Disease
Citations:

Scherrer JF, Xian H, Franz CD, Lyons MJ, Jacobson KC. Eisen SA, Kremen WS. Depression is a risk factor for incident heart disease in a genetically informative twin design. Presented at the Annual Meeting of the American Psychosomatic Society, March 4-7, 2009: Chicago, Il.

Primary: Substance Abuse
Secondary: Depression
Citation:

Brook DW, Brook JS, Zhang C, Cohen P, Whiteman M. Drug use and the risk of major depressive disorder, alcohol dependence, and substance use disorders. Arch Gen Psy-chiatry. 2002 Nov; 59(11):1039-44.

Primary: Diabetes
Secondary:Heart Disease
Citation(s)
Stratton IM, Adler AI, Neil HA, et al. Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. BMJ 2000;321: 405–412

Primary:Heart Disease
secondary: Depression
Citation: Musselman DL, Evans DL, Nemeroff CB. The relationship of depression to cardiovascular disease, Eepidemiology, biology and treatment. Arch Gen Psychiatry 1998; 55:580–592

Primary: Obesity
Secondary: Diabetes, Heart Disease
Citations: Centers for Disease Control and Prevention. Third National Health and Nutrition Examination Sur-vey, 1988–94. Analysis by the Lewin Group, Falls Church, Va.1999

Robert H. Eckel, MD, Nutrition Committee. Obesity & Heart Disease. Circulation. 1997;96:3248-3250
COPD Heart Disease Don D. Sin and S. F. Paul Man Chronic Obstructive Pulmonary Disease as a Risk Factor for Cardiovascular Morbidity and Mortality. Proc Am Thorac Soc Vol 2. pp 8–11, 2005.

Primary: Hypertension
Secondary: Heart Disease
Citation: Castelli WP. Epidemiology of coronary heart disease. The Framingham Study. American journal of medicine, 1984, 76:4-12.

Primary:Hyperlipidemia
Secondary: Heart Disease
Citation: Castelli WP. Epidemiology of coronary heart disease. The Framingham Study. American journal of medicine, 1984, 76:4-12.

Prmary: Tobacco Use
Secondary: Heart Disease
Citation: Castelli WP. Epidemiology of coronary heart disease. The Framingham Study. American journal of medicine, 1984, 76:4-12.

Primary: Developmental & Intellectual Disabilities
Secondary: Obesity
Citation: Centers for Disease Control and Prevention (CDC) National Center on Birth Defects and Developmental Disabilities (NCBDDD), Health Surveillance of People With Intellectual Disabilities , Results of a Working Meeting, April 2010.

Primary: Cardiac & Circu-latory Congenital Abnormalities (e.g. Tetralogy of Fallot, pulmo-nary atresia)

Secondary: Pulmonary Hypertension
Citation: Granton JT, Rabinovitch M. Pulmonary arterial hypertension in congenital heart disease. Cardiol Clin. 2002. 20:441-457.

Members with other Health Home -identified conditions (e.g. ABI, seizure disorder, asthma) may also be identified as "at risk" of a second condition if their Health Home provider identifies through their clinical assessment that they are at significant risk of developing a second condition and documents this in the EHR – e.g. a clinician seeing a patient with asthma who is a former smoker may identify that the patient is at very high risk of developing additional chronic conditions when he learns that she has recently lost her housing and moved in with her boyfriend who is a smoker, and is now exposed to second-hand smoke (exten-sive evidence from the literature shows that exposure to second-hand smoke is a risk for developing cancer and other chronic conditions – see U.S. Department of Health and Human Services, U.S. Surgeon Generals Office, The Health Consequences of Involuntary Expo-sure to Tobacco Smoke: A Report of the Surgeon General, 2006, http://www.surgeongeneral.gov/library/secondhandsmoke)

For all members, there will be a two-step process for identifying chronic condition / Health Home eligibility. (1) MaineCare will conduct an analysis of claims data in order to identify members meeting Health Home eligibility criteria. (2) Practices will be able to notify MaineCare of any additional members not identified in the claims data for whom the practice has clinical EHR docu-mentation of the member's eligibility

(1) state analysis of claims for diagnoses and service use, as follows: (1) ICD-9 code list developed from various reference sources, including AHRQ CCS, AHRQ MCC, and others; and (2) any mention of the diagnosis on any claim form type. Claim form types include UB-04 institutional claims and 1500 professional claims. All MaineCare (Medicaid) services are billed on one of these claim forms. Service use as indicated by claims will also be used to identify members with a developmental disability (HCBS for individuals with Developmental Disabilities Waiver Service Use -§ 26, ICFMR Service Use -§ 40), Acquired Brain Injury (ABI) (Rehabilitative Service Use -§102), and diabetes (use of insulin). Members with other (non SPMI or SED) mental health or substance abuse conditions are included in the model.

(2) PCP identification of members not otherwise identified through the claims analysis. Because claims data only reflect past history, the PCP will also use screening and assessment tools to identify other eligible adults and children, and based on individ-ual patient results, make discretionary requests to the State for inclusion of additional eligible adults and children in the Health Homes program. These screening tools include Audit and BASRR for adults, CRAFFT for children, PHQ9 s for depression, and oth-ers. Using additional assessment tools, the PCP can make further discretionary request to the State, based on individual patient measures. The Health Home provider will need to provide documentation evidencing the member's eligibility (e.g. EHR docu-mentation supporting additional diagnoses).

iii. Provider Infrastructure

☐ Designated Providers as described in §ection 1945(h)(5)

☑ Team of Health Care Professionals as described in §ection 1945(h)(6)

☐ Health Team as described in §ection 1945(h)(7), via reference to §ection 3502

iv. Service Definitions

Comprehensive Care Management

Service Definition

Ways Health IT Will Link

Care Coordination

Service Definition

Ways Health IT Will Link

Health Promotion

Service Definition

Ways Health IT Will Link

Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Service Definition

Ways Health IT Will Link

Individual and Family Support Services (including authorized representatives)

Service Definition

Ways Health IT Will Link

Referral to Community and Social Support Services

Service Definition

Ways Health IT Will Link

v.Provider Standards

vi. Assurances

☐ A. The State assures that hospitals participating under the State plan or a waiver of such plan will establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated providers.

☐ B. The State has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.

☐ C. The State will report to CMS information submitted by health home providers to inform the evaluation and Reports to Congress as described in section 2703(b) of the Affordable Care Act, and as described by CMS.

vii. Monitoring

A. Describe the State's methodology for tracking avoidable hospital readmissions, to include data sources and measure specifications.

B. Describe the State's methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measure specifications.

C. Describe the State's proposal for using health information technology in providing health home services under this program and improving service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Measure

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Goal Based Quality Measures

Please describe a measureable goal of the health home model that will be operationalized utilizing measures within the domains listed below. The measures may or may not be tied to the services depending on the goal. If the measure is tied to a service, please complete the service-based quality measure section. If the measure is tied to a goal, please complete the goal-based measure section.

Goal 1:

Clinical Outcomes

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 2:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 3:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 4:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 5:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 6:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 7:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 8:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 9:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Goal 10:

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

viii. Quality Measures: Service Based Measures

Service

☐ Comprehensive Care Management

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Care Coordination

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Health Promotion

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Comprehensive Transitional Care (including appropriate follow-up, from inpatient to other settings)

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Individual and Family Support Services (including authorized representatives)

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Service

☐ Referral to Community and Social Support Services

Clinical Outcomes

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Experience of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

Quality of Care

Measure

Data Source

Measure Specification

How Health IT will be Utilized

3.1 - B: Medically Needy View

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Services: Medically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

ix. Evaluations

A. Describe how the State will collect information from health home providers for purposes of determining the effect of this program on reducing the following (include the data source and frequency of data collection):

i. Hospital admissions

Description

Data Source

Frequency of Data Collection

ii. Emergency room visits

Description

Data Source

Frequency of Data Collection

iii. Skilled Nursing Facility admissions

Description

Data Source

Frequency of Data Collection

B. Describe how the State will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program, as it pertains to the following:

i. Hospital admission rates

ii. Chronic disease management

iii. Coordination of care for individuals with chronic conditions

iv. Assessment of program implementation

v. Processes and lessons learned

vi. Assessment of quality improvements and clinical outcomes

vii. Estimates of cost savings

4.19 – B: Payment Methodology View

Attachment 4.19-B

Page

Health Homes for Individuals with Chronic Conditions
Amount, Duration, and Scope of Medical and Remedial Care Services: Categorically Needy

Notwithstanding anything else in this State Plan provision, the coverage will be subject to such other requirements that are promulgated by CMS through interpretive issuance or final regulation

Payment Methodology

Payment Type: Per Member Per Month

Provider Type

Team of Health Care Professionals: The Health Home operates through a cohesive Team of Health Care Professionals. Payment to the team incorporates both base monthly per member per month (PMPM) payments and add-on payments that support specialized care management supports for special health needs. All specialized care management programs are coordinated by the Community Care Teams working with the Health Home practices.

Description

The Health Home per member per month (PMPM) is distributed to the member of the Team of Healthcare Professionals using the methodologies described below.

The Health Home practice payment component is determined by calculating care management and care coordination costs that are incurred in the individual practice. The Community Care Team payment is an add-on payment supporting care management services for individuals with special health needs. The state will provide add-on payments for no more than 5% of the total number of Health Home enrollees associated with Health Home practices.

All payments are contingent on the Team of Health Care Professionals meeting the requirements set forth in this SPA and the resulting MaineCare rule, as determined by the State of Maine. Failure to meet such requirements is grounds for revocation of Health Home status and termination of payments. The payment methodology for Health Homes is in addition to the existing fee-for-service payments for direct services, and is structured as follows:

Practice PMPM care management payment:

Maine will pay for reimbursement of the cost of staff associated with the delivery of Health Home services to Health Homes-eligible members not covered by other reimbursement under MaineCare.

CCT PMPM add-on payment:

Maine will pay for reimbursement of the cost of staff associated with the delivery of care management supports for individuals with special health needs served by the Health Home practices, not covered by other reimbursement under MaineCare. The state will provide add-on payments for no more than 5% of the total number of Health Home enrollees associated with Health Home practices.

The State will review rates annually to ensure that rates are economic and efficient based on analysis of care management costs conducted by the Team of Health Care Professionals and its components. We will continue to base payments on the costs of staff to provide the care management services.

Minimum criteria for receipt of Health Home payments: The criteria required for receiving a monthly PMPM payment are:

- The person is identified as meeting Health Home eligibility criteria through the state MMIS system and/or through documentation of eligibility from Health Home EHRs;
- The person is enrolled as a Health Home member;
- The minimum Health Home service required to merit PMPM payment to the Health Home practice is that the person has received monitoring for treatment gaps and/or patient engagement and outreach activities.
- The minimum Health Home service required to merit PMPM payment to the Community Care Team is that the person has been the recipient of patient engagement and outreach activities to receive enhanced services by the Community Care Team, and/or the person has received another core Health Home service from the Community Care Team in alignment with the person's plan of care.
- The Health Home will report that the minimal service required for the PMPM payment occurred on a monthly Health Home report. The record will include the provider number, beneficiary number, and date of service.

Cost Considerations: The following outlines the principal salary, FTE, and other cost considerations included in the PMPM rate methodologies for the Health Home Practice PMPM and CCT add-on PMPM payments.

Practice PMPM care management payment:
FTE Staffing per 3,250 Health Home Enrollees:
0.7 primary care provider - salary $159,000
1.4 Clinical Staff - salary $60,278
1.2 non-clinical support staff - salary $35,464
1.0 data manager %67,246
Total PMPM = $12.00

CCT PMPM Add-on Payment
Team member FTEs per 488 health home enrollees with special health care needs (5% highest need)
.03 Medical Director - salary $159,307
1.00 CCT Manager - salary $59,280
1.00 CCT Clinical lead - Salary $53,581
3.00 Nurse Care managers - salary $60,278
4.50 Non-clinical care Coordinators - salary $41,558
total PMPM = $129.50

Health Home Practices

Given that the activities supported through PCCM (referenced in Provider Standards) also constitute baseline foundational activities required of the Health Home practice for all Health Homes-eligible members, PCCM practices qualified as Health Home practices will not receive PCCM care management payments for members enrolled in both PCCM and Health Homes, so as not to duplicate payment for services. The Health Home practice will receive a $12.00 PMPM payment for Health Home services delivered to all members enrolled in the Health Home, regardless of whether the member is enrolled in PCCM.

In order to avoid duplication of services or payments, members currently receiving targeted case management (TCM) will have the choice to either continue receiving TCM or to receive this care through their health home.

There will be no duplication of services and payments for similar services provided under other Medicaid authorities.

Health Home service payments will not duplicate any other payment either through the State Plan or waiver of the State Plan. The Office of MaineCare Services will prevent duplication of payments and of roles and responsibilities on an ongoing basis.

☐ Tiered?

Payment Type: Alternate Payment Methodology

Provider Type

n/a

Description

n/a

☐ Tiered?