MEDICAID MODEL DATA LAB

Id: MAINE
State: Maine
Health Home Services Forms (ACA 2703)
Page: 1-10

TN#: ME-12-0002 | Supersedes TN#: ME-12-0001 | Effective Date: 01/01/2013 | Approved Date: 01/17/2013

Transmital Numbers (TN) and Effective Date

Please enter the numerical part of the Transmital Numbers (TN) in the format YY-0000 where YY = the last two digits of the year for which the document relates to, and 0000 = a four digit number with leading zeros. The dashes must also be entered. State abbreviation will be added automatically.

Supersedes Transmital Number (TN)

12-0001

Transmital Number (TN)

12-0002

Please enter the Effective Date with the format MM/dd/yyyy where MM = two digit month number, dd = the two digit day of the month, and yyyy = the four digit year. Please also include the slashes (/).

Effective Date

01/01/2013

3.1 - A: Categorically Needy View

Attachment 3.1-H

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

☑ Health Home Services

How are Health Home Services Provided to the Medically Needy?

Same way as Categorically Needy

i. Geographic Limitations

Statewide Basis

If Targeted Geographic Basis,

ii. Population Criteria

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

☑ Two chronic conditions
☑ One chronic condition and the risk of developing another
☐ One serious mental illness

from the list of conditions below:

☑ Mental Health Condition
☑ Substance Use Disorder
☑ Asthma
☑ Diabetes
☑ Heart Disease
☑ BMI Over 25
☑ Other Chronic Conditions Covered?

Description of Other Chronic Conditions Covered.

Maine has also developed the following list of qualifying chronic conditions: tobacco use; Chronic Obstructive Pulmonary Disease (COPD); hypertension; hyperlipidemia; developmental disabilities or autism spectrum disorders; acquired brain injury; seizure 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 disabilities and autism spectrum disorders; 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. Aquired Brain Injury, seizure disorder, or 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 (extensive 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 others. 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).

Individuals will be enrolled in a Health Home as follows: (1) Health Home eligible members who currently are either enrolled with or who have a plurality of PCP visits with a Primary Care Case Management (PCCM) practice that applies for and meets Health Home eligibility criteria will receive written notification that their current practice is becoming a Health Home for MaineCare members with chronic conditions. The Member will receive information about the benefits of participating in a Health Home and be notified of their ability to opt out of the initiative. If the Member does not opt out of Health Homes services within 28 days, they will automatically be enrolled into Health Homes on either the 1st or the 15th of the month. They will receive a confirmation letter once they are officially assigned a Health Home.; (2) Health Home eligible MaineCare members who are not enrolled with or who do not have a plurality of PCP visits with PCCM practices that apply for and meet Health

Home eligibility criteria will receive written notification on the benefits of participating in a MaineCare Health Home as well as a list of Health Homes in their area that they can choose from. These members will be encouraged to respond within 28 days of receiving the letter, though they will also be able to enroll at a later date if they so choose and remain eligible. (3) Health Home eligible members currently receiving targeted case management (TCM) services will receive written notification of their choice to either continue receiving TCM or to receive this care through a Health Home. There will be no duplication of services and payments for similar services provided under other Medicaid authorities. The notification will include an explanation of the benefits of participating in a MaineCare Health Home as well as a list of Health Homes in their area that they can choose from.
The state will carry out this notification through the development of written materials to send directly to identified members, to distribute to Health Home practices, and to include in new member welcome packets. These materials will also be available on the MaineCare website.

In cases in which an individual chooses to transfer to a new Health Home provider, the HH team is responsible for providing cop-ies of all appropriate medical documentation (i.e. medical record, care plans) to the new provider.

The Health Home will serve all categorically eligible Medicaid recipients including dually eligible individuals and those enrolled in 1915 (c) waivers.

Maine elects to exclude individuals with SMI/SED from both the categorically as well as medically needy populations.

iii. Provider Infrastructure

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

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

The Health Home team of health care professionals centers on the primary care Health Home practice. Each Health Home enrol-lee is linked to a primary care provider to serve as a medical home that provides acute and preventive care, manages chronic illnesses, coordinates specialty care and referrals to social, community, and long-term care supports, provides comprehensive care management, and provides access to 24/7 coverage. Providers are paid a per member per month (PMPM) fee for medical home services, separate from Medicaid fee-for-service payments. Maine's current PCCM providers ensure access to preventive care for enrolled MaineCare members. by: (1) Providing comprehensive primary care; (2) Authorizing medically necessary referrals; (3) Providing or arranging 24 hour coverage, 7 days a week; and (4) Educating patients about MaineCare PCCM rules, seeking appropriate regular care and following practice rules. To qualify as Health Home practices, PCCM provider practices must significantly exceed these baseline PCCM requirements by offering a more patient-centered, proactive, and highly coordinated set of Health Home services. Health Home practices are required to have NCQA PCMH recognition, have a fully implemented EHR, and fully implement the following ten "Core Expectations" that align with Maine's multi-payer Patient Centered Medical Home Pilot:

o Demonstrated leadership
o Team-based approach to care
o Population risk stratification and management
o Practice-integrated care management
o Enhanced access to care
o Behavioral-physical health integration
o Inclusion of patients & families in implementation of PCMH model
o Connection to community
o Commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of healthcare services
o Integration of health information technology (HIT)

The HH Team of Health Care Professionals must certify as part of the HH application process that it will provide each of the services delineated under the CMS Health Home definition. The Health Home contracts with each participating practice will further define service and staffing expectations for participation in the MaineCare Health Homes Initiative.

Maine's Health Homes Initiative incorporates a component of wraparound clinical services provided by a Community Care Team (CCT). The Health Home Practices are required to contract with CCTs in order to deliver services as a Health Home Team. These contracts may vary given the particular arrangements of the individual Health Home Teams, but all member of the Health Home Team will be subject to the core expectations. The CCT complements the care management provided directly by PCPs and their care teams. The CCT care managers work in concert with the Health Home practice to identify and manage care for high-cost, high-risk patients (e.g. typically, the top 5% of high utilizing/high cost patients), as required in an agreement between the CCT and the Office of MaineCare Services. CCTs are locally-based and serve multiple roles. CCT care managers visit patient homes, when appropriate, to perform medication reconciliation and assessments. They work with the Health Home practice to plan and coordinate referrals for community and social supports and assist with referrals, as needed.

CCTs support the Health Home practices in managing the highest risk and cost patients by working with an interdisciplinary team that is led by the PCP to jointly develop individual care plans. The CCT will ensure effective coordination and communication across a patient's full healthcare team and community supports, which helps the patient to achieve better health outcomes. The role of the CCT a complementary to and coordinated with existing services, so as not to duplicate or offer redundant services within the Health Home team. The Health Home team member that takes the lead on providing each service, the Health Home practice or the CCT, depends on whether the beneficiary is experiencing a period of high needs. All beneficiaries will receive care and Health Home services from their Health Home practice team, while a smaller number (generally approximately 5% of beneficiaries) will be offered additional, more intensive care coordination services from the partnering CCT. CCTs are expected to work with the Health Home practice to identify these patients in order to identify priority status and develop appropriate care planning and interventions. CCTs must consider a minimum set of criteria for risk stratification to identify these patients, as follows:

Criteria for CCT Risk Stratification of Eligible Members

(1) CCTs will review available data from a variety of sources, including electronic health records, claims data, and E.D. or admission reports from hospitals. Real-time data from hospitals for inpatient and emergency department admissions and discharges are ideal to identify patients who may need robust care management to prevent further need for emergent and acute care. The CCT will strive to have agreements with all local hospitals to obtain this data on a regular (preferably daily) basis, whether by electronic access, fax, or on-site access to admissions and E.D. logs. The CCT may embed care managers in the hospital, who work directly with the discharge planning staff and often begin the discharge process on the day of admission. Patients who meet any of the following criteria are considered priority patients for the CCT:

1.1 Hospital Admissions
• 3 or more admissions in past 6 months, or
• 5 or more admissions in past 12 months

1.2 Emergency Department Utilization
• 3 or more E.D. visits in past 6 months, or
• 5 or more E.D. visits in past 12 months

1.3 Payer identification of high-risk or high-cost members.

(2) In addition to patients identified using above criteria, the CCT may identify patients for intensive care management services based on Health Home practice referral. In making referrals to the CCT, Health Home practices are encouraged to consider pa-tients with the following criteria:
• Chronic Conditions: especially patients with 3 or more chronic conditions, and/or failure to meet multiple treatment goals
• Polypharmacy: Patients using 15 or more chronic medications, and/or on multiple high-risk medications (e.g. insulin, warfarin, etc.)
• High social service needs interfering with care: Patients with one or more of the above conditions who also have high levels of social service needs that result in high rates of avoidable utilization of medical services.

(3) Additional criteria - CCTs may add criteria to their risk stratification plan as appropriate for their Health Home, patient popu-lation and ability to obtain reliable data. Health Home practices and CCTs will need to assess the complete picture for each patient, taking a number of additional factors into account. These factors might include payer identification as utilizing the E.D. for non-emergent/avoidable causes,

discharged following psychiatric admission or residential treatment and social barriers such as advanced age, lives alone, no family/social network support, no transportation or limited transportation, and financial difficulty.

The organizations selected to provide CCT services have appropriate medical, clinical, and administrative leadership and infrastructure to perform health home functions as part of a cohesive "Team of Health Care Professionals." Entities that provide CCT services may include hospitals, health systems, home health agencies, Federally Qualified Health Centers, Rural Health Centers, primary care practices or groups of primary care practices, behavioral health organizations, social service organizations, and/or other community-based entities. As part of the Health Home team, CCTs may be situated in free-standing community organizations, or they may be part of physician practices or health care systems.

CCT staff consists of a multidisciplinary group of health care professionals under the leadership of a CCT manager and designated care management and clinical/medical directors. Each CCT hires care management staff based on its own quality and improvement and care management strategy. Most CCTs employ a mix of care managers who are nurses and social workers, including behavioral health social workers with master's degrees. Additional CCT staff may consist of a care coordinator; nutritionist; case manager; pharmacist; chronic care assistant; community health worker; care navigator; health coach; and/or other staff approved by the state. Identification of the 'lead coordinator' or 'touch point' CCT member for patients receiving intensive care management services from the CCT is largely dependent on the individual needs of each patient. Each CCT will have a process to identify the patient's needs and identify the lead coordinator CCT member, matching the needs of the patient to the clinician/CCT member whose area of expertise is best coordinated to those needs. The flexibility of the matching process (patient to lead coordinator) is critical, particularly since the clinical focus of a patient's situation may change to such an extent that a change in lead coordinator is necessary in order to 'match' the patient with the most appropriate care.

Policies, Procedures and Accountabilities: Health Home practices and CCTs - CCTs are required to establish processes and proce-dures for communication and coordination with the Health Home practices they serve, including expectations for regular meetings with practice teams and methods for regular communication with those teams. At a minimum, the CCT will meet monthly with the practice team to identify and coordinate care for high-needs beneficiaries. CCTs and Health Home practices are required to submit quarterly reports on their adherence to and progress with core expectations, participation in Health Home learning collaborative and evaluation activities, and communications and interaction with each other. The State will monitor the implementation of these communication and coordination policies through these quarterly reports to ensure they are consistent with minimum expectations.

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

iv. Service Definitions

Comprehensive Care Management

Service Definition

The Health Home team has a clear process for providing care management services, and has identified specific individuals to work closely with the practice team to provide care management for patients at risk for experiencing adverse outcomes, including patients with chronic illness who are complex or fail to meet multiple treatment goals; patients identified as at risk for avoidable hospitalization or emer-gency department use; and patients at risk for developing avoidable conditions or complications of ill-ness. The Health Home practice will coordinate and provide access to comprehensive care manage-ment, care coordination, and transitional care across settings for these individuals.

Levels of care management change according to member needs over time. As in the multi-payer PCMH Pilot model, the CCT will provide wraparound services for those with the highest needs; otherwise, care management will be provided by the Health Home practice.

Outlined below are the Health Home practice and CCT relationships to members (1) with baseline needs (receives all care from Health Home practice), and (2) during periods of high need (receives highly co-ordinated care between Health Home practice and CCT until high need is resolved).

Health Home Practice Care for Health Home Members with Baseline Needs:
The Health Home practice team, ideally including an RN or social worker located in and/or closely integrated with the PCP practice, provides care management services for specific individuals within the practice who have one or more chronic conditions and are at risk for experiencing adverse outcomes.

These services include; (1) Prospective identification of at-risk patients; (2) Conducting clinical assessments, monitoring & follow up of clinical and social service needs; (3) Conducting medication review & reconciliation; (4) Communicating and coordinating care with treating providers.

Health Home practice Care for Health Home Members During Period(s) of Very High Needs:
When a patient is identified as having a particularly intense or complex set of needs (e.g. multiple hospitalizations, ED visits, multiple/complicated service needs), Health Home practice identifies the patient for CCT care management during the period of time for which the patient experiences a high level of need.

CCT Care for Health Home Members During Period(s) of Very High Needs:
The CCT, including an RN and social worker, working closely with the PCP practice, provides care management services for very high-needs individuals within the practice who have been identified for more intensive services when they have particularly intense or complex set of needs (e.g. multiple hospitalizations, ED visits, multiple/complicated service needs).

Services to be provided by the CCT during this period of high needs include: (1) Medical assessments and complete community/social service needs assessments; (2) Nurse care management (including patient visits prior to hospital discharge, in the primary care practice, group visits or at home);(3) Case/panel management (screening, patient identification, scheduling appointments, referrals to care managers and other team members); (4) Behavioral health (brief intervention, cognitive behavioral therapy, motivational interviewing, and referral); (5) Substance abuse services (screening, brief treatment and referral);(6) Psychiatric prescribing consultation for providers (provided by psychiatrist);
Medication review and reconciliation

Following resolution or stabilization of members' high/ complex needs, CCT "hands back" the patient to the Health Home practice for basic care management support as needed.

The Care Plan:
The primary care provider within the HH practice team (i.e. physician or nurse practitioner) will develop a patient centered care plan that will identify the patient's health goals, identified in partnership with the patient, and identify all services necessary to meet the health goals of care management for the enrollee, such as prevention, wellness, medical treatment by specialists and be-havioral health providers, transition of care from provider to provider, and social and community-based services where appropriate.. The care plan will be recorded in the EHR. Other members of the practice team including nurses and medical assistants may contribute as appropriate (e.g. may cite patient-established goals, record pertinent clinical data, note medication changes, etc.).

The CCT will contribute to the care plan by communicating its interactions and recommendations to the Health Home practice care provider: The CCT will stay informed about the beneficiary's care from the Health Home practice care provider through regular communications with the Health Home practice team.

The Health Home practice and CCT, where appropriate, will work together to ensure that the patient (and/or their guardian) plays a central and active part in the development and execution of the care plan, and that they are in agreement with the care plan's goals, interventions and timeframes. Family members and other supports involved in the patient's care should be identified and included in the plan, as requested by the patient. As appropriate, the care plan will be shared with beneficiaries at the time of each visit as a "visit summary" generated out of the EHR.

Ways Health IT Will Link

Health homes will use EHR technology to provide individual and population healthcare to the MaineCare population being served. Provider EHR's will capture discrete clinical data that will be used in generating performance reports.

Maine's statewide health information exchange (HIE), HealthInfoNet, has live connections to over 80% of Maine hospitals, with an additional 15% of hospitals that are either contracted or verbally committed Almost half of primary care practices are connected, with an additional 30% contracted. On-boarding of ambulatory care practices is proceeding rapidly, with priority being given to medical home practices by the HIE vendor. Health Homes will be added to the prioritization list of ambulatory practices.

In addition to the statewide HIE, secure messaging using NHIN/Direct Project standards is also available to CCTs for secure exchange of patient information between known entities, i.e. the CCT and the Health Home practice. HIN secure messaging provides a secure transport for patient care summaries, transition of care documents, and free form text. Direct is "a simple, secure, scalable, standards-based way to send authenticated, encrypted health information directly to known, trusted recipients over the Internet." More information about Direct and the Direct Project can be found at:
http://www.directproject.org

Subject to the receipt of grant funding, the HIE is also developing and implementing a patient portal, which would be operational in the second half of 2013. The patient portal would allow MaineCare members to view their healthcare information online.

Health Home teams will participate in a provider learning collaborative whose focus will be evidence based practice, including incorporating HIT into patient care (e.g. the use of registries for those diagnosed with chronic illness).

CCT access to the EHR varies by community. In some communities, the CCT and Health Home practice Careshare a common EHR, and the CCT can fully access and document care in directly in the EHR. In other communities, the CCT does not have access to the EHR; in those communities, the CCT providers will communicate with the PCMH practice through use of HIN Direct secure messaging standards; the Health Home practice will then enter that communication into the EMR. Wherever possible, we will also encourage Health Home practice teams and CCTs to access patient information using HealthInfoNet (our HIE).

Care Coordination

Service Definition

A comprehensive set of services provided by the Health Home practice team to assure patients receive timely, quality care. The Health Home will: (1) Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines; (2) Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders; (3) Coordinate and provide access to mental health and substance abuse services; (4) Develop a care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services as appropriate.

Health Home Practice Care for all Health Home Members:
The Health Home practice team provides all patients with a comprehensive set of high quality health care services informed by evidence-based guidelines, and coordinates care across providers to assure that patients receive timely, safe, and high-quality care.

These services include the following: (1) Delivery of health promotion and preventive health services, including prevention of mental illness and substance abuse disorders; (2) Delivery and coordination of acute and chronic care services, and integration of physical and mental health care; and (3) Coordination with care provided by other specialty providers, including mental health and substance abuse services.

CCT care for Health Home Members During Period(s) of Very High Needs:
The CCT provides "wrap-around" care management support to address the complex needs of CCT patients and/or to help CCT patients overcome barriers to care, while coordinating care with the Health Home Practice.

The Health Home practice will be accountable for the following for their patient population: engaging and retaining Health Home enrollees in care; coordinating and arranging for the provision of services; supporting adherence to treatment recommendations; and monitoring and evaluating the enrollee's needs. When the Health Home practice identifies patients with very high needs, they will refer the patient to their partnering Health Homes CCT for wraparound support services, as outlined above.

The Health Home practice will be required to develop and have policies, procedures and accountabilities (contractual agreements) in place with their CCT to support and define roles and responsibilities for effective collaboration among the practice, CCT; primary care, specialist, long term care, behavioral health providers; and community-based organizations. For patients receiving home-based long-term care services and supports, the Health Home team will communicate with and conduct outreach to providers of these services, and will work actively to incorporate these services into the patient's care plan. These policies and procedures will direct and incorporate successful collaboration through the use of evidence-based referrals, follow-up consultations, and regularly, scheduled case review meetings with all members of the interdisciplinary care team. To support care management/coordination activities, the Health Home practice and the CCT will have the option of utilizing technology conferencing tools including audio, video and/or web deployed solutions when security protocols and precautions are in place to protect patient health information.

The Health Home practice, in collaboration with the CCT will develop and utilize a system to track and share patient information and care needs across providers, monitor patient outcomes, and initiate changes in care as necessary to address patient need.

Ways Health IT Will Link

HIT will play a central role in care coordination, from sharing of care documents, to the availability of continuity of care documents in the HIE between ambulatory and hospital based providers. All health home practices will have certified EHR systems that allow integration of HIN secure messaging into the EHR. Direct will be the method used for coordination of information between CCTs and health home practices.

Availability of secure communication in an accessible location reduces a barrier to communication across different points of care. The HIN secure messaging protocol provides a method for providers who are not part of an integrated system to communicate, which is a special challenge for providers in the behavioral health, long term care, and home health sectors. Use of Direct in other settings across the nation has demonstrated its value in care coordination.

Health Promotion

Service Definition

For eligible Health Home enrollees, health promotion will begin with patient engagement and outreach by the Health Home team. The Health Home practice will then promote patient education and chronic illness self-management for eligible patients in the Health Home, beginning with practice-based screening for tobacco and alcohol use, as primary causes of chronic illness, and proceeding to the CCT for the highest need members for follow-up education with the patient and family, and patient/family referrals to community-based prevention programs and resources.

Maine's Health Home plan for outreach and engagement will require Health Home practices to confirm eligible Health Home patients' involvement with the practice, actively seek to engage patients in care by phone, letter, HIT and/or community outreach. Community Care Teams' outreach and engagement activities will seek to engage the highest five percent of Health Home-eligible patients who have been referred to the CCT and/or have been identified as high needs patients based on their history of ED use, admissions, etc. Outreach and engagement functions will include aspects of comprehensive care management, care coordination, and linkages to care that address all of a patient's clinical and non-clinical care needs, including health promotion. The Health Home practice will support continuity of care through coordination with the interdisciplinary CCT, and will promote evidence-based care for tobacco cessation, diabetes, asthma, hypertension, chronic obstructive pulmonary disease (COPD), hyperlipidemia, developmental and intellectual disorders, acquired brain injury, seizure disorders, and cardiac and circulatory congenital abnormalities, self-help recovery resources, and other services based on individual needs and preferences.

Ways Health IT Will Link

Maine has an established network of public health programs, diabetes education programs, cardiovascular health programs, and other chronic illness programs. Many are accessible through the state's Healthy Maine Partnerships (enhanced community coalitions) and 211 system. Web sites concerning health promotion and chronic disease self-management programs will be made available to health home enrollees, along with referral services.

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

Service Definition

Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care.

Health Home Practice Care for Health Home Members with Baseline Needs:
The Health Home practice team supports the coordination of care for all patients transitioning between care settings, including the following:

(1) Acute Inpatient Hospital, Skilled Nursing, and Long-Term Care Facilities: The Health Home practice team establishes processes with the major acute care hospital(s), SNFs, and LTC facilities in their community to ensure that the practice is notified in a timely manner when patients from the practice are discharged. The Practice Team conducts follow up call to discharged patients and ensures that medication reconciliation and timely post-discharge follow up are completed.

(2) Pediatric patients: The Health Home practice team facilitates transition to an adult system of care, and supports communication with and referral to appropriate providers.

Health Home Practice Care for Health Home Members During Period(s) of Very High Needs:
For HH members who have been referred to CCT for higher-level care management, the Health Home practice team supports the coordination of care during transitions of care by ensuring that the member is seen in the practice for a timely follow up visit.

CCT care for Health Home Members During Period(s) of Very High Needs:
The CCT provides "wrap-around" care management support to address the complex needs of CCT patients and/or to help CCT patients overcome barriers to care, while coordinating care with the Health Home practice team.

The CCT will establish processes with the major acute care hospital(s), SNFs, LTC and residential facilities in their community to ensure that they are notified in a timely manner when CCT patients discharged. The CCT conducts follow up call to discharged patients and ensures that medication reconciliation and timely post-discharge follow up are completed, and may conduct a home visit if indicated.

The CCT will also ensure that a timely follow-up visit with the Health Home practice is scheduled, and will help to address barriers such as transportation needs to ensure that the visit occurs.

Comprehensive transitional care will be provided to prevent avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing or treatment facility), and to ensure proper and timely follow-up care. To accomplish this, the Team of Health Care Professionals will be expected to establish processes with the major acute care hospital(s), SNFs, LTC and other residential facilities in their community to:
• provide prompt notification of an enrollee's admission and/or discharge to/from an emergency room, or an inpatient or residential/rehabilitation setting.
• assure timely access to post discharge follow-up care that includes, at a minimum, receipt of a summary care record from the discharging entity, medication reconciliation, and a plan for timely scheduled appointments at recommended outpatient providers.

The CCT component of the Health Home team will be a leader in all phases of care transition for members receiving intensive care management services from the CCT, including discharge planning and follow up to assure that enrollees receive follow-up care and services, and re-engagement of patients who have become lost to care.

The State will work closely with the Health Home team to identify and resolve any issues with coordinating care. The State will reach out to those providers as needed to facilitate resolution of any issues related to unwillingness to coordinate care. Through the MOAs established between CCTs and MaineCare, and the MOAs between CCTs and their partnering Health Home practices, clear expectations are established that the Team of Health Care Professionals will provide support for transitional care for the patients they serve. As a payer of health care services, MaineCare will hold the Health Home practices and CCTs accountable for the care they provide by monitoring their performance on quality benchmarks as well as their adherence to and progress with core expectations, participation in Health Home learning collaborative and evaluation activities, and communications and interaction with each other through their required quarterly reports.

Ways Health IT Will Link

Use of the HIN secure messaging system has been used nationally to provide an organized handoff of care plans during transitions. We will emphasize this strategy as both a best practice through learning collaborative sessions (SEE Provider Standards section of this document), and by promotion of HIN secure messaging with CCTs.

Sharing of care plans at point of transition will be accomplished either through the exchange of documents via Direct, or through care summary information shared between EHRs. The specific strategy will be dependent upon system capabilities, but because of the availability of a low cost alternative to EHR through HIN secure messaging, we are certain that all providers will have access to a method that will allow for exchange of documents to ensure successful transitions of care.

Systems that have a fully certified EHR and are connected to the HIE will have access to care summary records within their system. Those that do not will be exchanging information through a method like Direct.

In addition, Maine's HIE has developed the capability to notify care managers when their assigned patients visit the ED or are admitted to or discharged from the hospital. MaineCare is working to provide this capability to Health Home teams. This functionality has great potential to help Health Home teams reduce ED use and hospital readmissions.

Individual and Family Support Services (including authorized representatives)

Service Definition

Health Home Practice Care for Health Home Members with Baseline Needs:
The Health Home practice team provides self-management support to patients - i.e. (1) Health coaching for nutrition, physical activity, tobacco cessation, diabetes, asthma, other chronic disease; (2) Chronic disease self-management education and skill-building, such as linking to Living Well programs.

Health Home Practice Care for Health Home Members During Period(s) of Very High Needs:
For HH members who have been referred to CCT for higher-level care management, the Health Home practice team supports the coordination of care during transitions of care by ensuring that the member is seen in the practice for a timely follow up visit.

CCT care for Health Home Members During Period(s) of Very High Needs:
The CCT provides "wrap-around" care management support to address the complex needs of CCT patients and/or to help CCT patients overcome barriers to care, while coordinating care with the Health Home practice team.

The CCT will establish processes with the major acute care hospital(s), SNFs, LTC and residential facilities in their community to ensure that they are notified in a timely manner when CCT patients discharged. The CCT conducts follow up calls to discharged patients and ensures that medication reconciliation and timely post-discharge follow up are completed, and may conduct a home visit if indicated.

The Health Home will use peer supports, support groups, and self-care programs to increase patient and caregiver knowledge about an individual's chronic illness(es), promote the enrollee's engagement and self-management capabilities, and help the enrollee improve adherence to their prescribed treatment. The Health Home will also discuss and provide information on advance directives, in order to allow the enrollee, the enrollee's family and care givers to make informed end-of-life decisions ahead of time.

The Health Home will ensure that all communication and information shared with the patient, the patient's family and care givers meets health literacy standards and is culturally appropriate, and the plan of care will reflect and incorporate member and/or family preferences, education and support for self -management, self -recovery and other resources as appropriate.

Ways Health IT Will Link

Use of the HIN secure messaging system has been used nationally to provide an organized handoff of care plans during transitions. We will emphasize this strategy as both a best practice through learning collaborative sessions (SEE Provider Standards section of this document), and by promotion of HIN secure messaging with CCTs.

Sharing of care plans at point of transition will be accomplished either through the exchange of documents via Direct, or through care summary information shared between EHRs. The specific strategy will be dependent upon system capabilities, but because of the availability of a low cost alternative to EHR through HIN secure messaging, we are certain that all providers will have access to a method that will allow for exchange of documents to ensure successful transitions of care.

Systems that have a fully certified EHR and are connected to the HIE will have access to care summary records within their system. Those that do not will be exchanging information through a method like Direct.

In addition, Maine's HIE has developed the capability to notify care managers when their assigned patients visit the ED or are admitted to or discharged from the hospital. MaineCare is working to provide this capability to Health Home teams. This functionality has great potential to help Health Home teams reduce ED use and hospital readmissions.

Referral to Community and Social Support Services

Service Definition

Health Home Practice Care for Health Home Members with Baseline Needs:
The Health Home practice team provides referrals to community and social support services as relevant to patient needs - i.e.
(1) Actively connects patients to community organizations that offer supports for self-management and healthy living, and routine social service needs

Health Home Practice Care for Health Home Members During Period(s) of Very High Needs:
The Health Home practice team provides clinical guidance and oversight to the CCT.

CCT Care for Health Home Members During Period(s) of Very High Needs:
The CCT provides referrals to community, social support and recovery services to high-needs patients while they are in a high-needs period– i.e. (1) Actively connects patients to community and social service support organizations that offer supports for self-management and healthy living, as well as social service needs such as transportation assistance, housing, literacy, economic and other assistance to meet basic needs.

The plan of care will include community-based and other social support services, and appropriate and ancillary healthcare services that address and respond to the patient's needs and preferences, and contribute to achieving the patient's goals.

Ways Health IT Will Link

Visit summary notes and patient care summaries from certified EHRs will contain contact information to community resources that have been identified to benefit the patient. CCTs will communicate to the provider through HIN secure messaging or other means, and have the capacity to coordinate referrals to community-based support and other social services.

v.Provider Standards

Under Maine's approach to health home implementation, the Health Home (i.e., the qualified practice and CCT) is the central point for directing patient-centered care, and is accountable for reducing avoidable health care costs, specifically: reducing preventable hospital admissions/readmissions and avoidable emergency room visits; providing timely post-discharge follow up; and improving patient outcomes by addressing primary medical, specialist and behavioral health care (by direct provision, or contractual arrangements with appropriate service providers)in a comprehensive, integrated service model.

The Health Home Team of Health Care Professionals need to meet the following criteria:

• Enrollment in the MaineCare program, (i.e. must sign or be a party to a MaineCare Provider/Supplier Agreement if appropriate to that MaineCare practice or managed care Primary Care Provider (PCP) practice);

• Commitment to meeting the following ten "Core Expectations" that align with Maine's multi-payer Patient Centered Medical Home Pilot:
o Demonstrated leadership
o Team-based approach to care
o Population risk stratification and management
o Practice-integrated care management
o Enhanced access to care
o Behavioral-physical health integration
o Inclusion of patients & families in implementation of PCMH model
o Connection to community
o Commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost- effective use of healthcare services
o Integration of health information technology (HIT)

Health Homes must perform each of the following eleven CMS Health Home core functional components:
o Provide quality driven, cost-effective, culturally appropriate, and patient- and family- centered Health Home services;
o Coordinate and provide access to high-quality health care services informed by evidence based clinical practice guidelines;
o Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
o Coordinate and provide access to treatment for mental health and substance abuse disorders;
o Coordinate and provide access to comprehensive care management, care coordination, and transitional care across care settings. Transitional includes appropriate follow up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from pediatric to an adult system of health care;
o Coordinate and provide access to chronic disease management, including self-management support to patients and their families;
o Coordinate and provide access to patient and family supports, including referral to community-based social support, and recovery services;
o Coordinate and provide access to long-term care supports and services;
o Develop a patient-centered care plan that coordinates and integrates all of a patient's clinical data and non-clinical health care related needs and services;
o Demonstrate the capacity to use HIT to link services, and facilitate communication among CCT members, and between the CCT and patient , and family care givers, and to provide feedback to practices, as feasible and appropriate; and
o Establish a continuous quality improvement (CQI) program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality care outcomes at the population level.

The Health Home must also have the capability to share information with other providers and for collecting reporting and reporting quality measures, and it must have a system in place with hospitals and residential facilities to provide health home prompt notification of individual's admission and/or discharge and systematic follow-up protocols to assure timely access to follow-up care.

The PCMH Learning Collaborative. The Team of Health Care Professionals must participate in Maine multi-payer Patient Centered Medical Home (PCMH) Learning Collaborative activities, a statewide effort to provide support for practice transformation and Community Care Teams to move to a PCMH model of care, as state resources are available. The Learning Collaborative is based on the Institute for Healthcare Improvement's "Breakthrough Series Collaborative" (BTS) model, a model with proven success in supporting health care providers working to transform systems of care. The Learning Collaborative is led by faculty and staff experienced in delivery system transformation to work with clinician and patient teams from each Health Home. Participating Health Homes are expected to designate a leadership team (physician leader, administrative leader, and an additional clinical member) to attend day-long "learning sessions" (3/year) that bring teams together with faculty and content experts to promote collaborative learning and rapid cycle improvement methods. The Collaborative also includes support between Learning Sessions through coaching and regular outreach. Learning Session topics are organized around the ten "Core Expectations" of the Maine multi-payer PCMH Pilot and are focused on key changes required by the PCMH model of care. The Learning Collaborative will extend through the two years of the Health Home initiative, with Learning Sessions scheduled every 4 months throughout that period.

Additional Criteria for the Health Home practice component are:

•Health Home practices must sign or be party to a MaineCare Primary Care Case Management Rider to the MaineCare Provider/Supplier Agreement. In order to participate in the Primary Care Case Management program a Primary Care Practice must: (a) provide or arrange twenty-four (24) hour a day, seven (7) day a week coverage; (b) be a Prevention, Health Promotion and Optional Treatment Services' provider if treating children age twenty (20) and under; (c) assist the Department in educating members enrolled in Primary Care Case Management; (d) keep a member who is enrolled in Primary Care Case Management on his/her panel until another PCP is selected if it is necessary for a member to change his/her PCP; (e) submit all provider developed material about Primary Care Case Management to the Department for review and approval prior to using such materials; (f) review member utilization reports and advise the Department of any errors, omissions or discrepancies of which the PCP is aware; (g) oversee and manage a care plan for patients who have chronic conditions including but not limited to: chronic obstructive pulmonary disease (COPD), asthma, cardiovascular disease (CVD), depression and/or diabetes

• Health Home practices must have achieved Patient Centered Medical Home (PCMH) recognition by the National Committee for Quality Assurance (NCQA) by June 30, 2013;

• Health Home practices must have a fully implemented electronic health record (EHR);

• Each Health Home practice must partner with a Health Home-eligible Community Care Team in order to qualify together as a Health Home.

Additional Criteria for the Community Care Team component are:

• A CCT must have a CCT Manager, Director or Coordinator that provides leadership and oversight to ensure the CCT meets goals

• A CCT must have a Medical Director (at least 4 hours/month) that works with all providers in partnering Health Home practice practices to select and rollout evidenced-based clinical initiatives, lead quality improvement efforts, evaluate progress, and convene provider clinical quality improvement meetings;

• A clinical leader that directs care management activities across the CCT, but does not duplicate care management that is already in place in the partnering Health Home practices,

• A CCT must partner with a Health Home practice.

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.

Using claims data, Maine will track admissions for the same diagnosis within 30 days of discharge /1000: (# of readmissions with a primary diagnosis matching the primary diagnosis for the original admission/member months) x 12,000.

MaineCare claims data will be used to calculate the percent of hospital discharges that result in a readmission to the hospital within 30 days. Inpatient admissions of any type will be considered in the measure. Admissions to Institutes for Mental Diseases (IMDs) will not be considered in this measure. Crossover-claims will be used for calculation for members who are dually eligible for Medicare and Medicaid. This measure will be calculated for all members attributed to the practice.

Numerator: Subsequent admission to hospital within 30 days of discharge date from initial hospitalization within the referent period

Denominator: Initial admission during referent period to general acute and critical access hospitals.

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.

For program monitoring, Medicaid claims information will be used to trend unadjusted PMPM payments (total and by selected sub-totals, including hospital inpatient, outpatient, physician, pharmacy, behavioral health and other) for health home sites on an annual basis. This information will be tracked by service date and use 2011-2012 a two-year base period for comparison purposes. Trends will be calculated in total and separately for Medicaid-only and dual eligible members. High cost outlier cases will be removed. Additionally, cost saving estimates will be developed from the changes in the utilization measures identified in Quality Measures Goal #1 below. The findings for the valuation described below will provide a more rigorous cost impact analysis.

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).

The State of Maine requires all Health Homes to use EHR technology. Many of the providers are participating in the MaineCare HIT incentive program. 100% of the state's FQHC's that are becoming health homes are enrolled in the MaineCare HIT incentive program. As a result, these practices have the capacity and experience to use technology in a meaningful way. Maine also has telehealth laws that provide some incentives for the use of remote monitoring and other technologies that improve care at reduced costs.
The state has an advanced HIE (HealthInfoNet) has live connections to over 80% of Maine hospitals, with an additional 15% of hospitals that are either contracted or verbally committed. Almost half of primary care practices are connected, with an additional 30% contracted. The on-boarding schedule to add new providers will be adjusted to provide preference for Health Homes. Though it is essentially only a couple of years old, the HIE already shows significant advancement in information sharing:

- 96.5% of pharmacies statewide participate in e-prescribing;
- 32.6% of hospitals share electronic care summaries with providers outside of their system;
- 57% of hospitals share laboratory results electronically with providers compared to 43% nationally;
- 52% of hospitals share laboratory results electronically with ambulatory providers outside their system compared to 39% nationally;
- 67% of office-based physicians are able to view lab results electronically; and
- 41% of ambulatory care physicians are able to provide patients with clinical summaries for each visit compared to 38% nationally.

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: 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:

Reduce Inefficient Healthcare Spending

Clinical Outcomes

Measure

Measure 1) Ambulatory Care-Sensitive Condition Admission: Ambulatory care sensitive conditions: age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital, per 100,000 population under age 75 years.

Measure 2) Plan- All Cause Readmission: For members 18 years of age and older, the number of acute inpatient stays during the measurement year that were followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.

Measure 3)ED Utilization (Utilization): Number of ED visits per 1000 member months

Measure 4)Non-Emergent ED visits: Maine ED study developed list of 14 diagnoses identified as preventable. The criteria for selection of the included conditions were: 1) matching diagnostic codes of conditions seen frequently both in hospital emergency departments and in primary care settings; 2) eliminating any diagnoses that, when seen in an emergency department, result in the patient being admitted more than 5 percent of the time; 3) a review of the list of diagnoses generated through this process by clinicians with emergency department experience and selection by the clinicians of a sub-set of conditions that, based on their clinical judgment, met the criterion of usually being an avoidable ED visit. Commercial and Medicaid claims used as source for identification of ICD-9 codes.

Measure 5)Use of Imaging Studies for low back pain (LBP): The percentage of members with a primary diagnosis of low back pain who had an imaging study within 28 days of the diagnosis.

Measure 6)Percent of Members with fragmented primary care: Measure developed based on Liu methodology

Data Source

Measure 1) Claims/ NQMC
Measure 1) Claims/ NCQA
Measure 3) HEDIS Claims-based measure
Measure 4) Claims
Measure 5) HEDIS Claims-based measure
Measure 6) Claims

Measure Specification

Measure 1)
Numerator Description
Total number of acute care hospitalizations for ambulatory care sensitive conditions under age 75 years

Denominator Description
Total mid-year population under age 75

Measure 2)
Numerator Description
Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination
Denominator Description
Count the number of Index Hospital Stays for each age, gender, and total combination

Measure 3)
Emergency Department (ED) visits were identified using standard coding systems for hospital billing: Uniform Billing (UB) Revenue Codes or CPT Codes (Current Procedural Terminology).

Both of these systems include multiple codes that refer to emergency department care. The comprehensive list of codes applied was developed by the National Committee for Quality Assurance (NCQA) Health Effectiveness Data Information Set (HEDIS).
Numerator: Number of ED visits not resulting in an inpatient stay. Excludes visits with a primary diagnosis of mental illness (ICD-9 code 290-316)

Denominator: Member months
Measure is shown as a rate per 1000 member months.

Measure 4)
ED visits identified by HEDIS coding and with the following primary diagnosis:
- Sore throat (Strep) 034.0
- Viral Infection (unspecified) 079.99
- Anxiety (unspecified or generalized) 300.00, 300.02
- Conjunctivitis (acute or unspecified) 372.00, 372.30

• External and middle ear infections (acute or unspecified) 380.10, 381.00, 381.01, 381.4, 382.00, 382.9
• Upper respiratory infections (acute or unspecified) 461.9, 473.9, 462, 465.9
• Bronchitis (acute or unspecified) or cough 466.0, 786.2, 490
• Asthma (unspecified) 493.90
• Dermatitis and rash 691.0, 691.8, 692.6, 692.9, 782.1
• Joint pain 719.40, 719.41, 719.42, 719.43, 719.44, 719.45, 719.46, 719.47, 719.48, 719.49
• Lower and unspecified back pain 724.2, 724.5
• Muscle and soft tissue limb pain 729.1, 729.5
• Fatigue 780.79
• Headache 784.0
Numerator: Non-Emergent ED Visits
Denominator: Members
Measure is expressed as a rate per 1000 member months.

Measure 5)
Numerator: Members with an imaging study (plain x-ray, MRI, CT scan) within 28 days of low back pain diagnosis
Denominator: All members with an outpatient or ED visits with a primary diagnosis of low back pain (with qualifications)

Measure 6)
This measure uses Liu's fragmented care index (FCI) is based on Bice and Boserman's continuity of care index (CCI) that considers the number of different providers visited, the proportion of attended visits to each provider and the total number of visits. The CCI runs from "0" continuous care to "1" fragmented care.

Measure Specs: Numerator: Number of members above the 75th percentile on FCI index
Denominator: Number of members

How Health IT will be Utilized

These measure will be included on the Health Homes quality measures report.

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:

Improve Chronic Disease 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

Measure 1) Diabetic Care HbA1c: Percentage of members 18-75 years of age with diabetes (type 1 or type 2) who had a Hemoglobin A1c test in the measurement year, average number of tests received and the distribution of number of tests members received.

Measure 2) Diabetic Care HbA1c: Percentage of members 5-17 years of age with diabetes (type 1 or type 2) who had a Hemoglobin A1c test in the measurement year, average number of tests received and the distribution of number of tests members received. Annual hemoglobin A1C testing (all children and adolescents diagnosed with diabetes)

Measure 3)Diabetic Eye Care Exams: Percentage of members 18-75 years of age with diabetes (type 1 or type 2) who had a retinal eye exam performed.

Measure 4)Diabetic LDL measured within previous 12 months: Percentage of members 18-75 years of age with diabetes (type 1 or type 2) who had a LDL-C screening performed.

Measure 5) Diabetic Nephropathy Screening: Percentage of patients with diabetes with nephropathy screening.

Measure 6) Use of Spirometry Testing in the Assessment and Diagnosis of Chronic Pulmonary Disease (COPD): Adults with a new (within the measurement year) diagnosis or newly active COPD who received Spirometry testing to confirm the diagnosis. Spirometry testing must occur 730 days (2 years) prior to or 180 days after the diagnosing event. Age 42 and older.

Measure 7)Cholesterol Management for Patients with Cardiovascular Conditions

Measure 8)Follow-Up After Hospitalization for Mental Illness HEDIS Claims: Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.

Measure 9)Initiation and Engagement of Alcohol and Other Drug Dependence Treatment: Percentage of adolescents and adults members with a new episode of alcohol or other drug (AOD) dependence who received the following:
- Initiation of AOD treatment.
- Engagement of AOD treatment.

Data Source

Measure 1) HEDIS Claims-based measure
Measure 2) IHOC (Maine Improving Health Outcomes for Children Program)
Measure 3) HEDIS Claims-based measure
Measure 4) HEDIS Claims-based measure
Measure 5) HEDIS Claims-based measure
Measure 6) HEDIS Claims-based measure
Measure 7) HEDIS Claims-based measure
Measure 8) Claims NCQA
Measure 9) Claims NCQA

Measure Specification

Measure 1)
Numerator: Number of patients age 18-75 years with diabetes with at least one HbA1c tests within 12 month referent period
Denominator: Total number of patients age 18-75 with diabetes identified in 12 month referent period

Measure 2)
Numerator: The number of patients in the denominator sample who have documentation of date and result for the most recent HbA1c test during the 12-month reporting period

Denominator: A systematic sample of patients, ages 5-17, with a diagnosis of diabetes and/or notation of prescribed insulin/oral hypoglycemics/ antihyperglycemics for at least 12 months. This is defined by documentation of a face-to-face visit for diabetes care between the physician and patient that predates the most recent visit by at least 12 months.

Measure 3)
Numerator: Number of patients age 18-75 years with diabetes with at least one retinal eye exam performed within previous 24 months, or within previous 12 months for those previously diagnosed with retinopathy.
Denominator: Total number of patients age 18-75 with diabetes identified in 12 month referent period

Measure 4)
Numerator: Number of patients age 18-75 years with diabetes with at least one LDL-C screening tests performed within 12 month referent period
Denominator: Total number of patients age 18-75 with diabetes identified in 12 month referent period

Measure 5)
Numerator: Number of patients age 18-75 years with diabetes with at least one nephropathy screening tests performed within 12 month referent period.

Denominator: Total number of patients age 18-75 with diabetes identified in 12 month referent period

Measure 6)
Numerator: Members with new COPD diagnosis that received a Spirometry test within the 2 years prior or 180 days after the diagnosing event.
Denominator: All members 42 and older identified with a diagnosis of COPD on an outpatient, ED or acute inpatient visit and were continuously enrolled for 2 years.

Measure 7)
The percentage of members 18-75 years of age who from January 1 through November 1 of the year prior to the measurement year were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous transluminal coronary angioplasty (PTCA), or who had a diagnosis of ischemic vascular disease (IVD) during the measure year or year prior to the measurement year, who received an LDL-C screening.
Numerator: Members identified that had an LDL-c screening during the measurement year and the year prior to the measurement year.

Denominator: Members are identified by either an event of AMI, CABG or PTCA or by a diagnosis of IVD on an outpatient or inpatient stay.

Measure 8)
Numerator Description
An outpatient visit, intensive outpatient encounter, or partial hospitalization (refer to Table FUH-C in the original measure documentation for codes to identify visits) with a mental health practitioner within 7 days after discharge. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.
Denominator Description
Members 6 years of age and older discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with a principal mental health diagnosis on or between January 1 and December of the measurement year

Measure 9)
Numerator Description
Initiation of Alcohol and other Drug (AOD) Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis.
Engagement of Alcohol and other Drug (AOD) Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.

Denominator Description
Members 13 years of age and older as of December 31 of the measurement year with a new episode of alcohol or other drug (AOD) during the intake period, reported in two age stratifications (13-17 years, 18+ years) and a total rate. The total rate is the sum of the two numerators divided by the sum of the two denominators.

How Health IT will be Utilized

These measures will be included on the Health Homes quality measures report.

Measure

Goal 3:

Improve Preventive Care for Children (Pediatric)

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

Measure 1) Well Child Visits in First 15 Months of life:
Average number of visits and percentage of members who turned 15 months of age during the measurement year that had at least one well-child visit and percentage for each number of well-child visits for these children.

Measure 2) Well-Child Visits Between 15 Months and 3 Years of Age: Percentage of children who received who received 0, 1, 2, or 3 well-child care visits with a PCP from the 15 months of age to their 3rd year birth date.

Measure 3)Well-Child Visits ages 3-6 and 7-11: Percentage of members who were three to eleven years of age who received one or more well -child visits with a PCP during the measurement year

Measure 4)Adolescent Well-Care Visit (12-20): Percentage of members who were 12-20 years of age and who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year

Measure 5)Developmental Screenings in the first 3 years of Life: The percentage of children screened for risk of developmental, behavioral and social delays using a standardized screening tool in the first three years of life. This is a measure of screening in the first three years of life that includes three, age-specific indicators assessing whether children are screened by 12 months of age, by 24 months of age and by 36 months of age.

Data Source

Measure 1) HEDIS Claims-based measure
Measure 2) Maine CHIPRA Claims-based Measure
Measure 3) HEDIS Claims-based measure
Measure 4) HEDIS Claims-based measure
Measure 5) Maine CHIPRA Claims-based Measure

Measure Specification

Measure 1)
Numerator: Eight numerators are calculated to correspond to the number of children who received 0,1,2,3,4,5,6 and a summary for any well child visit (1-6) with a PCP.
Denominator: Children 15 months of age during the referent period.

Measure 2)
Numerator: Five numerators are calculated to correspond to the number of children who received 0, 1, 2, or 3 and a summary for any visit (1 -6) with a PCP.
Denominator: Children between 15 months and 3 years of age during the referent period.

Measure 3)
Numerator: Children who received one or more well child visits with a PCP
Denominator: Children between the ages of 3 and 6 during the measurement year.

Numerator: Children who received one or more well child visits with a PCP
Denominator: Children between the ages of 7 and 11 during the measurement year.

Measure 4)
Numerator: Children between 12-20 years of age and who had at least one comprehensive well-care visit with a PCP or OB/GYN during the measurement year
Denominator: Children between 12-20 years of age during the measurement year

Measure 5)
Numerator:
The numerator identifies children who were screened for risk of developmental, behavioral and social delays using a standardized tool. National recommendations call for children to be screened at the 9, 18, and 24- OR 30-month well visits to ensure periodic screening over the first three years. The measure is based on three, age-specific indicators.

Indicator 1: Children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by 12 months of age

Indicator 2: Children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by 24 months of age

Indicator 3: Children who screening for risk of developmental, behavioral and social delays using a standardized screening tool that was documented by 36 months of age.
Denominator: Children ages 12 to 36 month in the measurement year.

How Health IT will be Utilized

These measure will be included on the Health Homes quality measures report.

Goal 4:

Ensure Evidence-Based Prescribing

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

Measure 1)Use of Appropriate Medications for People with Asthma / Pediatric Measures. Medication Therapy: Percentage of patients 2-75 who were identified as having persistent asthma and were appropriately prescribed controller medication (report separately for patients 2-<19 yo, 19-75 yo, and total)

Measure 2)Non evidence-based Antipsychotic Prescribing

Measure 3) Use of High-Risk Medications in the Elderly(DAE): The percentage of members 65 years of age and older who received at least one high-risk medication (High risk medications are based on the HEDIS Technical Specifications, http://www.ncqa.org/tabid/1442/Default.aspx); The percentage of members 65 years of age and older who received at least two different high-risk medications.

Data Source

Measure 1) IHOC (Maine Improving Health Outcomes for Children Program), Claims
Measure 2) Claims measure based on MEDNET project with Rutgers
Measure 3) HEDIS Claims-based measure Claims

Measure Specification

Measure 1)
Numerator: Total number of patients age 2-75 during the measurement year identified with persistent asthma who were appropriately prescribed controller medication during the measurement year.

Denominator: Total number of patients age 2-75 during the measurement year identified with persistent asthma

(a) Numerator: Number of patients age 2-<19 during the measurement year identified with persistent asthma who were appropriately prescribed controller medication during the measurement year

Denominator: Total number of patients age 2-<19 during the measurement year identified with persistent asthma

(b) Numerator: Total number of patients age 19-75 during the measurement year identified with persistent asthma who were appropriately prescribed controller medication during the measurement year

Denominator: Total number of patients age 19-75 during the measurement year identified with persistent asthma

Measure 2)
Numerator: Members on Antipsychotic with no or weak indication for use.
Denominator: Members with selected mental health conditions as identified by claims.

Measure 3)
Two numerators' calculated:

Numerator: at least one high-risk medication: At least one prescription dispensed for any high-risk medication during the measurement year.

Numerator: at least one high-risk medication: At least one prescription dispensed for any high-risk medication during the measurement year.

Denominator: Members 65 years and older at the end of the measurement year.

How Health IT will be Utilized

These measures will be included on the Health Homes quality measures report.

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