U.S. Department of Health and Human Services
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MEDICAID HEALTH HOMES IN MAINE:

REVIEW OF PRE-EXISTING INITIATIVES AND STATE PLAN AMENDMENT FOR THE STATE'S FIRST HEALTH HOMES UNDER SECTION 2703 OF THE AFFORDABLE CARE ACT

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Maine's Health Home Program at a Glance	
Health Home Eligibility Criteria	2 chronic conditions, 1 chronic condition and at risk of another
Qualifying Conditions	• Mental health condition • Substance use disorder • Asthma • Diabetes • Heart disease • Body mass index over 25 • Tobacco use • Chronic obstructive pulmonary disease • Hypertension • Hyperlipidemia • Developmental disabilities or autism • Seizure disorder • Congenital cardiovascular abnormalities • Other conditions as identified by providers
Enrollment*	42,958
Designated Providers	Community Care Teams (CCTs), Medicaid-enrolled primary care providers (PCPs)
Administrative/ Service Framework	The health homes program is implemented statewide, as part of an expansion of the state's pre-existing Patient-Centered Medical Home (PCMH) Pilot. The program also incorporates wraparound care management by regional CCTs, which contract with multiple practices to assist them in managing the needs of high-cost, high-risk patients.
Required Care Team Members	• CCT manager, director or coordinator • Medical director (at least 4 hours/month) • Clinical care management leader • An established partnership with a health home practice
Payment System	Per member per month (PMPM) care management fee
Payment Level	CCT: $129.50 PCP: $12.00
Health Information Technology (HIT) Requirements	All health homes are required to have a fully implemented electronic health record, though the level of HIT use varies among communities. The state's health information exchange, HealthInfoNet, connects to more than 80% of Maine hospitals and more than half of primary care practices.
* January 2014 data provided to the Centers for Medicare and Medicaid Services' Health Home Information Resource Center.	

Introduction

Maine's Section 2703 Health Homes State Plan Amendment (SPA) was approved by the Centers for Medicare and Medicaid Services (CMS) on January 22, 2013 with a retroactive effective date of January 1, 2013. The state offers health home services to beneficiaries with two chronic conditions, or one chronic condition and who are at risk of another chronic condition. Qualifying conditions are a mental health condition (excluding serious persistent mental illness [SPMI] and serious emotional disturbance [SED]), substance use disorder, asthma, diabetes, heart disease, body mass index (BMI) over 25, 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. Any beneficiary with one of these conditions, except asthma, acquired brain injury, or seizure disorders, is automatically considered to be at-risk for developing another chronic condition. Beneficiaries with asthma, acquired brain injury, or seizure disorders also may enroll if a health home provider determines and documents in the electronic health record (EHR) that the beneficiary is at risk of another chronic condition. The health homes program is implemented statewide, as part of an expansion of the state's pre-existing Patient-Centered Medical Home (PCMH) Pilot.

Maine's health home program also incorporates wraparound care management by regional Community Care Teams (CCTs), which assist practices in managing the needs of high-cost, high-risk patients. CCTs contract with multiple practices to identify and provide care management services for this segment of population. As of January 2014, there were over 150 PCMH and health home practices, as well as ten CCTs.[1] The state has submitted a request to expand health homes to beneficiaries with SPMI or SED in a subsequent SPA, which is currently being reviewed by the CMS.

Implementation Context

Maine's health home Initiative is an extension of its multi-payer PCMH Pilot, which began in 2009. Both programs build on the state's existing primary care case management program (PCCM), in which over 400 MaineCare primary care physicians participate.[2] The PCMH/health homes initiative is an integral part of the state's Value-Based Purchasing Strategy, which aims to strengthen primary care, improve care transitions, and implement a shared savings model of Accountable Care Organization across the state.[3] The state is pursuing these three goals through multiple state and federal initiatives, many of which have implications for both the implementation and evaluation of the health homes program.

Patient-Centered Medical Home Implementation

In 2007-2008, the Maine legislature created the bipartisan Commission to Study Primary Care Medical Practice. The Commission recommended the development of a

PCMH pilot,[4] and in 2009 the legislature appropriated $500,000 for that purpose. The Maine PCMH Pilot is a five-year multi-payer initiative aimed at transforming primary practice and payment in the state, and is jointly led by the Maine Quality Forum (part of the state's Dirigo Health Agency [DHA][5]), Quality Counts (a nonprofit regional health improvement collaborative of health care delivery organizations, payers, employers, providers, associations and individuals[6]), and the Maine Health Management Coalition (an employer-led coalition). Fifty practices applied for participation; 22 adult practices and four pediatric practices were selected.

Enhanced per member per month (PMPM) payments to practices began in January 2010. Two years later, Medicare joined the pilot as part of the broader CMS Multipayer Advanced Primary Care Practice (MAPCP) demonstration.[7] Participating payers are MaineCare, Medicare, and private insurers, Aetna, Anthem BlueCross BlueShield, and Harvard Pilgrim Health Care. Private insurers are paying approximately $3 PMPM to cover care management services, while Medicare is paying $7 PMPM.[8] (MaineCare's payment structure is described in the Payment Structure section below.)

In early 2012, the pilot program added a wraparound care management service component to the model, known as Community Care Teams (CCTs). Eight regional CCTs were formed to support participating providers in managing their highest-risk, highest-cost patients (e.g., the top 5% of high utilizing/high-cost patients). Two additional CCTs were formed in January 2013 when 50 practices were added to the multi-payer pilot and the state SPA went into effect. In addition to receiving enhanced payments from the participating payers, the practices and CCTs in the PCMH pilot receive a variety of transformation supports, including a learning collaborative, practice coaching, and consultation with key experts.[4]

As part of its statewide implementation of the SPA, MaineCare also designated 84 additional health home practices in January 2013.[9] These practices do not participate in the multi-payer pilot, and thus only receive enhanced payment from MaineCare. Due to funding constraints, these practices did not receive technical assistance from the state's primary quality improvement contractor, Quality Counts, until July 2013 through implementation of the State Innovation Model (SIM) grant, described below. Six of these practices, however, began receiving technical assistance--as well as enhanced payments from Medicare--in September 2011 through their participation in the Federally Qualified Health Center (FQHC) MAPCP Demonstration. This demonstration is separate from MAPCP, but like MAPCP is intended to support the implementation of the advanced primary care practice model and test its effects on selected outcomes.[10] Fourteen FQHCs in Maine were selected to participate in the demonstration, which will end in August 2014.

Maine is also participating in the five-year CHIPRA Quality Demonstration Grant, which aims to identify promising practices for improving child health care quality.[11] Maine's project, known as Improving Health Outcomes for Children, is pursuing three interrelated efforts: (1) to include child health measures in the state's existing quality measurement and performance payment system; (2) to collect and report these

measures, as well as other health data, electronically; and (3) to support the four pediatric practices participating in the PCMH pilot, which will track and report selected pediatric measures through their EHRs.

Improving Care Transitions

In 2010, MaineCare partnered with Maine General (a large hospital system) to pilot a targeted care management program for 35 beneficiaries with high rates of emergency department use. Over one year, the pilot achieved a 33% reduction in emergency department visits.[12] Over the course of 2011, MaineCare expanded the pilot, known as the Emergency Department Collaborative Care Management Project, to all 36 hospitals in the state.[11] The Collaborative involves partnerships between participating hospitals, primary care practices, behavioral health providers, state agencies, and other care managers. The goal of the care management process is to connect high service utilizers to a primary care provider (PCP) and a community-based care manager. Where community-based care management resources are not available, MaineCare care managers work directly with the identified members. To date, the program has targeted approximately 1,692 MaineCare beneficiaries, generating an estimated $8.6 million in savings.[13]

One of the state's Area Agencies on Aging is also a recipient of a CMS Center for Medicare and Medicaid Innovation Community-based Care Transitions Program (CCTP) grant.[14] These grants provide funding to test care transition models for high-risk Medicare beneficiaries. The goals of the CCTP are to improve transitions from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk Medicare beneficiaries, and to document measurable savings to the Medicare program. In Maine, the CCTP grant builds on previous care transition improvement efforts undertaken by the Maine Medical Center's (MMC's) Physician Hospital Organization (PHO). From a small pilot involving one MMC hospital, the project has expanded to include four hospitals owned by MaineHealth, another hospital system. The Southern Maine Agency on Aging began partnering with the MMC PHO to provide social work and community resource development in 2010, and the project currently targets 5,700 Medicare beneficiaries with multiple chronic conditions. Efforts are also underway to expand the model to additional MaineHealth hospitals.

Accountable Care Organizations and Payment Reform

In February 2013, Maine received a $33 million SIM grant from CMS, which will be used to implement the SIM.[15] In addition to supporting the state's ongoing efforts to leverage and align the various initiatives already underway in the state, it will also support the formation of multi-payer Accountable Care Organizations (ACOs). MaineCare has also established a Medicaid shared saving ACO initiative, known as Maine's Accountable Communities Medicaid AC0.[16] Accountable Communities are driven by three overarching strategies: (1) *Transformation of Care*: Accountable Communities must align with and build on the ten core expectations of Maine's PCMH/heath home initiative; (2) *Community-Led Innovation*: ACOs must meet baseline

provider qualifications and reporting requirements, but will be granted some measure of flexibility to structure services in a way that reflects the local context; and (3) *Shared Savings*: the state will phase in risk-sharing payment structures, and may test a range of different models beyond shared savings, including shared savings with no downside risk, shared savings with some level of risk, partial capitation and global capitation.[17]

SIM grant funding will also support a range of additional project components, including the data analytic structure needed for multi-payer claims analysis, public reporting, and secure information sharing; quality improvement support and other forms of technical assistance; and development of new workforce models to support the transformed system. Health homes are considered to be a fundamental component in the transformation of primary care across the state, but they are not required to participate in Accountable Communities at this time.

Implications for the Maine Section 2703 Medicaid Health Homes Evaluation

Like many states, Maine is participating in a broad range of reform initiatives, many of which are designed to overlap or align closely with each other. Analyses of health home effects will need to take into account that 75 health home practices have been receiving both technical assistance and enhanced payment from multiple sources in the PCMH pilot, while about 80 others are receiving only MaineCare payments and, at least at the outset, less technical assistance. To date, six entities have applied to be ACOs, and almost all primary care sites within the ACOs are also health homes.

Both CCTs and health home practices will have very differing levels of experience --as well as capabilities--in providing care management and coordination services, and will be starting from different places in terms of the staffing, technical assistance, and health information technology (HIT) infrastructure available to them. Many of the structures and processes that underpin the identification, management, and transition of the highest-need patients between CCT and practice are still being refined. These, as well as other program details, will continue to evolve. It will be necessary to understand baseline characteristics and any significant changes made over the course of the evaluation period. It will also be necessary to control for participant and provider time in the program, as well as enrollee participation in other care management prior to health home enrollment when assessing program outcomes.

Population Criteria and Provider Infrastructure

Maine offers health home services to categorically and medically needy beneficiaries with two or more chronic conditions, or one chronic condition and the risk of developing another. Qualifying conditions are a mental health condition, substance use disorder, asthma, diabetes, heart disease, BMI over 25, tobacco use, COPD, hypertension, hyperlipidemia, developmental disabilities or autism spectrum disorders,

acquired brain injury, seizure disorders, and cardiac and circulatory congenital abnormalities. Any beneficiary with one of these conditions--except asthma, acquired brain injury, or seizure disorders--is automatically considered to be at-risk for developing another chronic condition. Beneficiaries with asthma, acquired brain injury, or seizure disorders also may enroll if a health home provider determines and documents in the EHR that the beneficiary is at risk of another chronic condition (see Table 1). Beneficiaries with serious and persistent mental illness or serious emotional disturbance are excluded from this phase of health home implementation, as the state plans to target this population under a separate SPA (referred to as Behavioral "Stage B" health homes), which is currently being reviewed by CMS.

Health home providers are primary care practices that meet the state's established medical home criteria (see next section). They are required to contract with a state CCT that provides wraparound clinical care management services for high-risk, high-cost patients within a geographic region in order to deliver services as a health home team. The state estimates that roughly 5% of a practice's patient panel will need this higher level of care management at any one time. Entities that provide CCT services currently include hospitals, health systems, home health agencies, FQHCs, rural health centers (RHCs), primary care practices or groups of primary care practices, behavioral health organization, social service agencies, and/or other community-based entities.

CCT staff are multidisciplinary, and are typically led by a CCT manager and designated care management and clinical/medical directors. Most CCTs include a mix of nurses and social workers including behavioral health social workers, and may also include 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. Each CCT must establish a process for identifying a patient's needs and linking them to a lead coordinator whose expertise matches those needs. This process is flexible, as patient needs may shift and require the designation of a different lead coordinator.

Health home practices and CCTs share accountability for reducing avoidable health care costs, with a specific focus on reducing inpatient and emergency department utilization, providing timely post-discharge follow-up, and improving patient outcomes. As part of their care management process, CCTs are required to establish communication and coordination procedures with the health home practices they serve, and must meet with the practice team at least monthly in order to identify and coordinate care for high-needs beneficiaries. CCTs and health home practices are also required to submit quarterly reports on their activities.

Enrollment and Patient Risk Stratification

Eligible beneficiaries are identified through both claims data analysis and provider identification. Once a practice obtains health home status, eligible beneficiaries who are either enrolled with or who regularly visit that practice receive written notification that their current practice is becoming a health home. They also receive information about

the initiative and are notified of their ability to opt-out. Beneficiaries who do not opt-out within 28 days will automatically be enrolled on either the 1st or the 15th of the month, and will also maintain the right to opt-out any time after the 28 day period. Eligible beneficiaries who are not already enrolled with a practice receive written notification from the state outlining the benefits of participating in the MaineCare health home initiative, as well as a list of health homes in their area from which they can choose. These members are encouraged to respond within 28 days of receiving the letter, but may enroll at a later date if they choose. Finally, health home-eligible members currently receiving targeted case management (TCM) services receive written notification of their choice to either continue receiving TCM or to receive care management through a health home.[18]

Once enrolled, members with baseline needs receive care management services from the health home practice, including assessment, monitoring, and follow-up on clinical and social service needs; medication review; and coordination with other providers. Health homes patients with more complex needs are referred to the CCT for enhanced care management services, such as comprehensive needs assessments, case management, behavioral health intervention, substance abuse services, and medication review and reconciliation. Following the resolution or stabilization of that member's needs, the health home practice resumes responsibility for care management.

Patients who meet any of the following criteria are considered priority patients and thus eligible for referral to the CCT:

1. Hospital admissions:
   - Three or more admissions in the past six months, or
   - Five or more admissions in the past 12 months.

2. Emergency department utilization:
   - Three or more emergency department visits in the past six months, or
   - Five or more emergency department visits in the past 12 months.

3. Payer identification of high-risk or high-cost utilizers.

4. Provider identification of high utilizers.

Health home are encouraged to identify and target patients who would benefit from CCT services, particularly those with three or more conditions, who are failing to meet treatment goals, who are using multiple drugs for their chronic condition, and patients with social service needs that interfere with care. CCTs may add criteria to the risk stratification plan as deemed appropriate for their health home partner practices, patient population, and the health home's ability to obtain reliable patient data.

Service Definitions and Provider Standards

Service definitions as provided in the SPA are adapted in Table 2. In order to qualify as a health home, practices must be enrolled as MaineCare PCCM providers (see Table 3 for a list of PCCM standards), achieve PCMH recognition by the National Committee for Quality Assurance (NCQA) within the timeframe given by the state, and have an EHR. The SPA does not list staffing requirements for practices.

Each CCT must be led by a CCT manager or director, and must include a medical director and a clinical leader. The medical director (who must be provide at least four hours per month) is responsible for clinical quality improvement efforts, while the clinical leader directs care management activities across the entire CCT.

Both practices and CCTs are required to: (1) enroll in the MaineCare program; (2) participate in the PCMH Pilot Learning Collaborative; (3) have the capacity to share patient data, collect and report quality measures, and ensure notification of admission or discharge as well as timely follow-up; and (4) commit to meeting the ten Core Expectations of Maine's multi-payer PCMH Pilot (see Table 2).

Use of Health Information Technology

Maine requires all health homes to have a "fully implemented" EHR, but the SPA does not specify what full implementation entails. Many of the providers are participating in the MaineCare HIT incentive program and, as a result, practices have the capacity and experience to use technology in a meaningful way. Maine also has tele-health laws that provide some incentives for the use of remote monitoring and other technologies that improve care at reduced costs. The HIT infrastructure underpinning the exchange of enrollee information varies across communities. In some cases, the CCT and practice share an EHR, or have negotiated agreements that allow CCTs to document--or at least access--the practice’s EHR. In other cases, the two must rely on direct secure messaging through the state’s health information exchange, HealthInfoNet (HIN). This exchange connects to more than 80% of Maine hospitals, and as of January 2013 an additional 15% of the state’s hospitals have either contracted or verbally committed to joining. Almost half of primary care practices are also connected, with an additional 30% under contract. HIN will eventually include an enrollee portal, which the state anticipated to be operational by fall 2013. HIN has also developed a notification system to alert care managers when an assigned enrollee has visited the emergency department or been admitted. The state is currently working to make this system available to health home providers.

Payment Structure

Both health home practices and CCTs receive a separate per member per month (PMPM) payment for the provision of care management services. The PMPM rate paid

to the practice is $12 per health home enrollee and is based on estimates of the staffing costs associated with providing health home services not otherwise reimbursable under MaineCare. At a minimum, the practice must monitor a health home enrollee for treatment gaps or provide some form of outreach and engagement each month to receive the payment. Case management payments for all other patients not enrolled in health homes remain at the current $3.50 PMPM under the state's PCCM program.

The Community Care Team payment is described as an "add-on" payment to support care management services for the high-need individuals referred to them, and is set at $129.50. The state provides those add-on payments for no more than 5% of the total number of health home enrollees associated with a given health home practice. At a minimum, the CCT must conduct engagement and outreach with the identified enrollees, or must provide a core health home service in order to receive payment.

Quality Improvement Goals and Measures

The state has selected 23 goal-based quality measures, all of which will come from claims data, and most of which align with the reporting requirements of other initiatives or organizations (e.g., the Improving Health Outcomes for Children initiative and the Healthcare Effectiveness Data and Information Set [HEDIS]). These are listed in Table 4.

Evaluation Measures and Methods

The evaluation measures and methodology described in the SPA are reproduced in Table 5. As the health home initiative is aligned with the PCMH pilot and the MAPCP demonstration, the evaluation of the program will build on a study already being conducted by the Muskie School of Public Service School at the University of Southern Maine. This PCMH Pilot evaluation will include three years of data from the pilot (2010-2013, with 2008 as baseline), and will examine cost-efficiency and quality outcomes for PCMH Pilot practices compared with two groups of comparison practices: other NCQA-recognized practices, and practices that do not have NCQA recognition. These practices will be matched using propensity scoring.

The health home evaluation will have a pre/post design with a matched comparison group, using 2012 as a baseline. Patients will be tracked over the two years of the enhanced match. The comparison group will be matched by health home disease criteria, other chronic conditions, age, gender, and geography, then assigned to a nonhealth home practice based on a historical claims. The study may control for other practice and member characteristics that may be obtained through administrative data. A final evaluation plan will be developed and coordinated with any national health homes evaluation.

The evaluation will also collect qualitative data at the practice level data, including data from quarterly health home reports, other key project documents, and interviews. The state may also assess consumer experience through interviews, focus groups, and surveys.

TABLE 1. Target Population and Designated Providers--Maine	
SPA Approval (Effective Date)	January 22, 2013 (January 01, 2013)
Designated Provider(s)	Primary care practices working in partnership with Community Care Teams (CCTs)
Health Home Team Composition	A CCT must have: • CCT manager, director or coordinator • Medical director (at least 4 hours/month) • Clinical care management leader • Established partnership with a health home practice
Target Population	MaineCare beneficiaries with 2 chronic conditions, or 1 chronic condition and the risk of developing another.
Qualifying Chronic Conditions	• Mental illness (excluding SPMI and SED) • Substance use disorder • Asthma • Diabetes • Heart disease • BMI over 25 • Tobacco use • COPD • Hypertension • Hyperlipidemia • Developmental disabilities or autism spectrum disorders • Seizure disorder • Cardiac and circulatory congenital abnormalities

TABLE 2. Health Home Service Definitions--Maine	
Care Coordination	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 substance abuse services; (4) develop a care plan for each individual that coordinates and integrates all of his or her clinical and nonclinical health care related needs and services as appropriate. **Health Home Practice Care for all Health Home Members**: The health home practice team provides all enrollees with a comprehensive set of high-quality health care services informed by evidence-based guidelines, and coordinates care across providers to assure that enrollees receive timely, safe, and high-quality care. These services include: (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. **For Health Home Members During Period(s) of Very High Needs**: The CCT provides "wraparound" care management support to address the complex needs of CCT enrollees and/or to help CCT enrollees overcome barriers to care, while coordinating care with the health home practice. The health home practice will be accountable for 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 enrollees with very high needs, they will refer the enrollee to their partnering CCT. The health home practice will be required to develop policies, procedures and accountabilities with their CCT to support and define roles and responsibilities for effective collaboration. For enrollees receiving home-based long-term 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 enrollee's care plan. These policies and procedures will direct referrals, follow-up consultations, and regularly scheduled case review meetings with all members of the inter-disciplinary care team. The health home practice and the CCT will have the option of using technology conferencing tools including audio, video and/or web deployed solutions when security protocols and precautions are in place to protect enrollee health information. The health home practice, in collaboration with the CCT will develop and use a system to track and share enrollee information and care needs across providers, monitor enrollee outcomes, and initiate changes in care as necessary to address enrollee need.

TABLE 2 (*continued*)	
Comprehensive Care Management	**Health Home Practice Care for all Health Home Members**: The health home practice provides care management services for individuals who have one or more chronic conditions and are at a risk for experiencing adverse outcomes. These services include: prospective identification of enrollees; conducting clinical assessments; monitoring and follow-up of clinical and social service needs; conducting medication review and reconciliation; communicating and coordinating care with other providers. **For Health Home Members During Period(s) of Very High Needs**: Health home enrollees with high/complex needs will be referred to the CCT. Services provided by the CCT include medical assessments and community/social service needs assessments; nurse care management, case/panel management; behavioral health; substance abuse services; psychiatric prescribing consultation; and medication review and reconciliation. Following the resolution or stabilization of the members' high/complex needs, CCT "hands back" the enrollee to the health home practice for basic care management support. The PCP will develop a care plan that, in consultation with the enrollee, identifies the enrollee's health goals, and will identify all services necessary to meet the enrollee's care management goals, including prevention, wellness, medical treatment by specialists and behavioral health providers, transition of care form provider to provider, and social and community-based services. The care plan will be recorded in the enrollee's EHR. The CCT will contribute to the care plan by communicating its interactions and recommendation to the health home practice care providers. The CCT communicates regularly with the health home practice team to stay informed about the beneficiaries care. The health home practice and CCT, where appropriate, will work together to ensure that the enrollee (and/or guardian) plays a central and active part in the development and execution of the care plan, and that there is agreement with the plans' goals, interventions, and timeframes. Family members and other support involved in the enrollee's care should be identified and included in the plan, as requested by the patient. The care plan will be shared with the enrollee at each visit, generated as a summary from the EHR.
Health Promotion	Health promotion will begin with enrollee engagement and outreach by the health home team. The health home practice will promote enrollee education and chronic illness self-management for eligible enrollees 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 enrollee and family, and enrollee/family referrals to community-based prevention programs and resources. Maine's plan for outreach and engagement will require health home practices to confirm eligible enrollees' involvement with the practice; actively seek to engage enrollees in care by phone, letter, HIT and/or community outreach. CCTs outreach and engagement activities will seek to engage the highest 5% of HH-eligible enrollees who have been referred to CCT and/or have been identified as high needs enrollees based on their emergency department use and hospital admissions. Outreach and engagement functions will include aspects of comprehensive care management, care coordination, and linkages to care that address all of an enrollee's clinical and nonclinical care needs, including health promotion. The health home practice will support continuity of care through coordination with the inter-disciplinary CCT, and will promote evidence-based care for tobacco cessation, diabetes, asthma, hypertension, 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.

TABLE 2 (*continued*)	
Comprehensive Transitional Care	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, long-term care and other residential facilities in their community to: provide prompt notification of an enrollee's admission and/or discharge to/from an emergency department, 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. **For Health Home Members with Baseline Needs**: The health home practice team supports the coordination of care for all enrollees 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 long-term care facilities in their community to ensure that the practice is notified in a timely manner when enrollees from the practice are discharged. The Practice Team conducts follow-up call to discharged enrollees and ensures that medication reconciliation and timely post-discharge follow-up are completed. (2) Pediatric enrollees: The health home practice team facilitates transition to an adult system of care, and supports communication with and referral to appropriate providers. **For Health Home Members During Period(s) of Very High Needs**: The CCT will establish processes with the major acute care hospital(s), SNF/long-term care and residential facilities in their community to ensure that they are notified in a timely manner when CCT enrollees are discharged. The CCT conducts follow-up calls to discharged enrollees 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. 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 enrollees who have become lost to care.
Individual and Family Support Services	The health home will provide: (1) self-management support to enrollees, such as health coaching; and (2) chronic disease management education and skill building. It will also ensure that a member receives timely follow-up care following a discharge or other care transition. The health home will use peer supports, support groups, and self-care programs to increase enrollee and caregiver knowledge about the enrollee'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 for end-of-life decisions. The health home will ensure that all communication with the enrollee and their caregivers 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.

TABLE 2 (*continued*)	
Referral to Community and Social Supports	**For Health Home Members with Baseline Needs**: The health home practice team provides referrals to community and social support services as relevant to enrollee needs, including actively connecting enrollees to community organizations that offer supports for self-management and healthy living, and routine social service needs. **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 enrollees while they are in a high-needs period, including but not limited to actively connecting enrollees 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 health care services that address and respond to the enrollee's needs and preferences, and contribute to achieving the enrollee's goals.

TABLE 3. Standards for MaineCare PCCM and Maine PCMH Pilot Practices	
Maine Primary Care Management Standards	• Provide or arrange for 24/7 coverage • Be a Prevention, Health Promotion, and Optional Treatment Services Provider for enrollees age 20 and younger • Provide enrollee education on the MaineCare PCCM program, and submit all material developed to support that education for approval by the state • Maintain a member on his/her panel until and unless another PCP is selected • Review and correct member utilization reports provided by the state • Develop and manage a care plan for MaineCare beneficiaries with chronic conditions
Maine PCMH Pilot Core Expectations	• Demonstrated leadership • Team-based approach to care • Population risk stratification and management • Practice-integrated care management • Enhanced access to care • Behavioral-physical health integration • Inclusion of enrollees and families in implementation of PCMH model • Connection to the community • Commitment to reducing unnecessary health care spending, reducing waste and improving cost-effective use of health care services • Integration of HIT

TABLE 4. Health Home Goals and Quality Measures--Maine	
Reduce Inefficient Health Care Spending	Clinical outcome measures: • Ambulatory care-sensitive admission • Plan all-cause readmission • Emergency department utilization • Nonemergent emergency department visits • Use of imaging studies for low back pain • Percent of members with fragmented primary care
Improve Chronic Disease Management	Quality of care measures: • Diabetic care adult (18-75 years of age) HbA1c testing • Diabetic care pediatric/adolescent (5-17 years of age) HbA1c test • Diabetic eye care exams (18-75 years of age) • Diabetic LDL measured within previous 12 months • Diabetic nephropathy screening • Use of spirometry testing in the assessment and diagnosis of COPD • Cholesterol management for patients with cardiovascular conditions • Follow-up after hospitalization for mental illness HEDIS claims • Initiation and engagement of alcohol and other drug dependence treatment
Improve Preventive Care for Children	Quality of care measures: • Well-child visits in first 15 months of life • Well-child visits between 15 months and 3 years of age • Well-child visits ages 3-6 and 7-11 • Adolescent well-care visit (12-20) • Developmental screenings in the first 3 years of life
Ensure Evidence-Based Prescribing	Quality of care measures: • Use of appropriate medications for people with asthma/pediatric measures medication therapy • Non evidence-based antipsychotic prescribing • Use of high-risk medications in the elderly

TABLE 5. Evaluation Methodology--Maine	
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.
Chronic Disease Management	The state will use a combination of claims, administrative and qualitative data to monitor chronic disease management processes and outcomes. The state will examine the frequency and characteristics of patients who are referred to CCTs and variations in referral patterns across practices. Information will be gathered from existing initiatives (e.g., Maine Quality Counts Learning Collaboratives, the PCMH evaluation and PCMH Working Group steering committee meetings), and 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 CCTs, the state 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.
Coordination of Care for Individuals with Chronic Conditions	Claims data will be used to examine 2 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. 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 high-risk patients. Each quarter the CCTs will identify at least 1 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. The state 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.
Assessment of Program Implementation	Qualified practices and CCTs will be required to submit quarterly reports on their progress in meeting the PCMH core expectations. These expectations are outlined in the Memorandum of Understanding (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.
Processes and Lessons Learned	Maine Department of Health and Human Services 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 bi-annual Health Monitoring and Outcome Reports (also outlined in the CCT MOU) will inform the discussions of the Working Group and the PCMH Learning Collaborative.

TABLE 5 (*continued*)	
Assessment of Quality Improvements and Clinical Outcomes	The quality and clinical outcome 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.
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 cost per person in the base year 2012, and 3 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 conducted with the national evaluation plan.

APPENDIX: Pre-Existing Initiatives in Maine						
	Maine PCMH Pilot[2,5,6]	**FQHC MAPCP Demonstration[7,19,20]**	**CHIPRA Quality Demonstration (IHOC)[8]**	**CCTP[11,21]**	**Emergency Department Collaborative Care Management Program[10]**	**State Innovation Model Testing Grant[13]**
Timeline	• **January 2010**--26 practices selected for the initial pilot (1 later dissolved) • **January 2012**--Medicare joins as a payer (MAPCP) • **Early 2012**--8 CCTs formed • **January 2013**--Pilot expanded to include 50 practices and 2 CCTs	The demonstration began in September 2011, and will run through August 2014	The demonstration began in February 2010, and will run through January 2015	• The demonstration will run from 2011-2015 • Grants were awarded on a rolling basis until September 2012 • Awardees receive grants for 2 years, which may be extended annually thereafter	• **September 2010**--MaineGeneral Hospital initiated a care management program for the 35 highest emergency department utilizers • **Summer 2011**--Program was expanded statewide	The grant period runs from 2013-2016
Geographic Area	Statewide	Statewide	Statewide	5 counties in southern Maine	Statewide	Statewide
Sponsors	MaineCare, CMS, Anthem BlueCross BlueShield, Aetna, Harvard Pilgrim Health Care, Maine Health Management Coalition, Quality Counts	CMS, HRSA, National Association of Community Health Centers	CMS, MaineCare	CMMI	State hospitals, MaineCare	CMS, MaineCare, Maine Health Management Coalition
Scope	75 practices, covering roughly 25% of the state population	14 FQHCs and their attributed Medicare FFS patients	4 pediatric practices involved in the PCMH pilot	5 hospitals serving 5,700 Medicare beneficiaries with multiple chronic conditions	• 36 hospitals • Primary care, care management, and behavioral health providers • 1,600 patients	The grant will support implementation of the Maine Innovation Model, which targets the state's entire health system

APPENDIX (*continued*)						
	Maine PCMH Pilot[2,5,6]	**FQHC MAPCP Demonstration[7,19,20]**	**CHIPRA Quality Demonstration (IHOC)[8]**	**CCTP[11,21]**	**Emergency Department Collaborative Care Management Program[10]**	**State Innovation Model Testing Grant[13]**
Goals	• Enhance primary care across the state • Improve health outcomes • Reduce overall health care costs	Evaluate the effect of the advanced primary care practice model on care quality, health outcomes, and the cost of care provided to Medicare beneficiaries served by FQHCs	• Collect and report child health quality measures through electronic clinical records, and integrate them into the state reporting system • Implement an electronic health assessment for children in the foster care system • Support TA to the 4 pediatric practices in the PCMH pilot	• Establish or enhance partnerships between hospitals and community-based organizations (CBOs) • Implement transitional care models to improve quality of care and reduce readmissions	• Reduce avoidable emergency department use • Improve care management and health outcomes for high-needs individuals • Contain costs	• Implement payment reform across public and private payers • Transform the primary care system through the PCMH model • Build the data infrastructure to support performance measurement, quality improvement, and public reporting of quality and cost data
Payment Approach	• Medicare pays $7 PMPM to the practices and $3 PMPM to CCTs • Private insurers pay approximately $3 PMPM to practices and $0.30 PMPM to CCTs • MaineCare pays $12 PMPM to practices and $129.50 PMPM to CCTs for HH patients only	$6 PMPM care management fee, paid in addition to the "all-inclusive per visit payment" that FQHCs receive for providing Medicare services	• PMPM care management fee • Approximately $3 PMPM from MaineCare and private payers	• CBOs are paid an all-inclusive rate per discharge of an eligible Medicare beneficiary • CBOs will be paid only once within a 180-day timeframe for a given beneficiary	No information found	The state will test a range of payment models: • Shared savings • Shared savings plus risk-sharing • Partial capitation models • Global capitation

APPENDIX (*continued*)						
	Maine PCMH Pilot[2,5,6]	**FQHC MAPCP Demonstration[7,19,20]**	**CHIPRA Quality Demonstration (IHOC)[8]**	**CCTP[11,21]**	**Emergency Department Collaborative Care Management Program[10]**	**State Innovation Model Testing Grant[13]**
Technical Assistance (TA)	Maine Quality Counts and CMS are offering TA through a variety of mechanisms	TA will support practices in medical home transformation and achieving NCQA recognition	CHIPRA funds are being used to support pediatric-specific TA to the 4 practices	CBOs are encouraged to contact their Medicaid Quality Improvement Organization for technical support, and have contracted with the Lewin Group to provide TA for all awardees	No information found	Grant funding will support a range of TA to providers
HIT Use	Practices and CCTs are expected to achieve 10 core expectations, among which is HIT integration	Practices are not required to have an EHR, but are encouraged to adopt tools such as registries and schedulers	Practices are testing methods for collecting and reporting data electronically	No information found	No information found	Grant funding will support HIT infrastructure development and enhancement at multiple levels, from statewide data collection and reporting to provider-level EHR implementation and use
Evaluation Methods	The Muskie School at the University of Southern Maine will evaluate both the implementation process and impact on selected outcomes, using a pre/post comparison group design	CMS will conduct bi-annual NCQA recognition readiness assessments, and an independent evaluator will assess impact on access, quality and cost outcomes	Agency for Healthcare Research and Quality and CMS have contracted with an independent evaluator to assess the impact of CHIPRA demonstration activities on child health outcomes across the 18 states participating in the demonstration	CMS will contract with an independent evaluator to assess program performance. Outcomes of interest include 30-day, 90-day, and 180-day readmission, mortality, and emergency department visits	Initial evaluation of the pilot at Maine General found a 33% reduction in emergency department visits. Cost savings are projected to reach 9.75 million by the end of 2013	The state will contract with a third party evaluator to develop and implement an evaluation plan

Endnotes

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This paper is an attachment to the U.S. Department of Health and Human Services (HHS), Office of the Assistant Secretary for Planning and Evaluation (ASPE) report "***Evaluation of the Medicaid Health Home Option for Beneficiaries with Chronic Conditions: Annual Report - Year Two***". The full report is available at: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm.

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EVALUATION OF THE MEDICAID HEALTH HOME OPTION FOR BENEFICIARIES WITH CHRONIC CONDITIONS: Annual Report - Year Two

Files Available for This Report

Full Report (including state appendices)
- Executive Summary: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2es.cfm
- HTML: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm
- PDF: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.pdf

Alabama appendix only
- HTML: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2.cfm#AL
- PDF: http://aspe.hhs.gov/daltcp/reports/2014/HHOption2-AL.pdf

Idaho appendix only
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