



Exploring Medicaid Health Homes:
**Leveraging an All-Payer Medical Home
Program for Medicaid Health Homes**

March 21, 2013; 3:00 – 4:00PM (ET)



Exploring Medicaid Health Homes

*Dianne Hasselman
Director of Quality and Equality
Center for Health Care Strategies*

Health Home Information Resource Center

Technical Assistance for State Health Home Development

- Established by CMS to help states develop health home models for beneficiaries with complex needs
- Technical assistance led by Mathematica Policy Research and the Center for Health Care Strategies includes:
 - One-on-one technical support
 - Peer-learning collaboratives
 - Webinars open to all states
 - Online library of hands-on tools and resources, including:
 - Matrix of Approved Health Home SPAs
 - Map of State Health Home Activity
 - New draft SPA template

Exploring Medicaid Health Homes

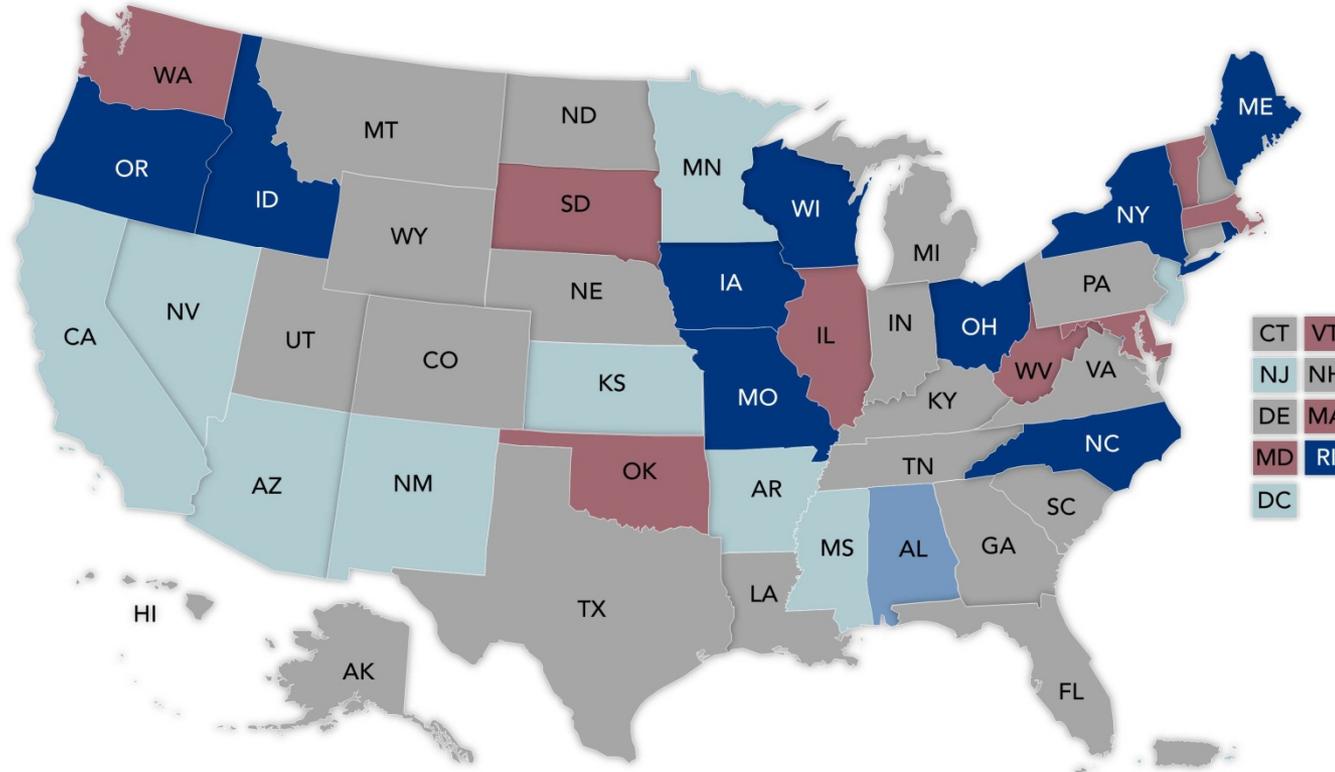
Webinar Series

- Provides a forum for states to share models, elements of their SPAs, and successes or challenges in their development process
- Creates an opportunity for CMS to engage in conversation with states considering and/or designing health home programs
- Disseminates existing knowledge useful to health home planning
- Open to any state considering or pursuing health homes

National Landscape to Date

- 12 approved State Plan Amendments in 10 states: IA, ID, ME, MO, NC, NY, OH, OR, RI and WI
- Number of states in discussions with CMS
- Many other states exploring the opportunity to develop health homes

State Health Home Activity



Approved Health Home State Plan Amendment (SPA)	Idaho, Iowa, Maine, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, Wisconsin
Health Home SPA "On the Clock" (officially submitted to CMS)	Alabama
Draft Health Home SPA Under CMS Review	Illinois, Iowa (2 nd SPA), Maryland, Massachusetts, Oklahoma, Rhode Island (3 rd SPA), South Dakota, Vermont, West Virginia, Washington
Approved Health Home Planning Request	Alabama, Arizona, Arkansas, California, District of Columbia, Idaho, Kansas, Maine, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, West Virginia, Wisconsin
No Activity	Alaska, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Indiana, Kentucky, Louisiana, Michigan, Montana, Nebraska, New Hampshire, North Dakota, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Wyoming

Context for Maine

- Quality Counts – an independent regional quality improvement collaborative
 - Focus on improving health care in Maine
 - Plays leadership role in administering Maine’s all-payer medical home program
- Maine Medicaid – saw an opportunity to leverage the existing building block of Maine’s all-payer medical home program
- Eastern Maine HomeCare – one of Medicaid’s health home providers

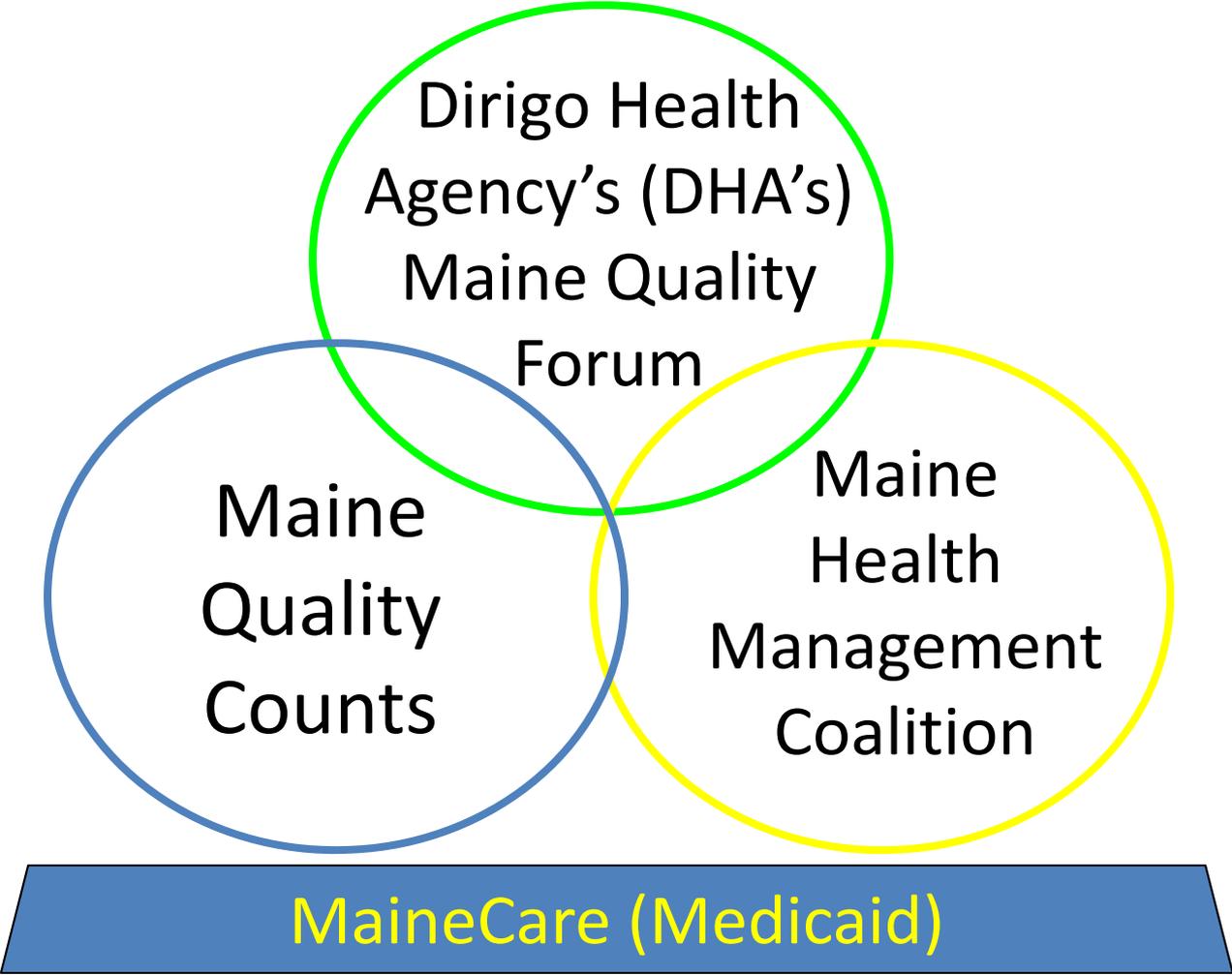
Today's Presenters

- Quality Counts: Helena Peterson
- Maine Medicaid: Michelle Probert
- Eastern Maine HomeCare:
 - Jaime Boyington
 - Kathleen Bates, RN
 - Molly Stevens, RN

**MaineCare Health Homes,
the Maine PCMH Pilot &
Community Care Teams (CCTs)**

March 2013

Maine PCMH Pilot Leadership

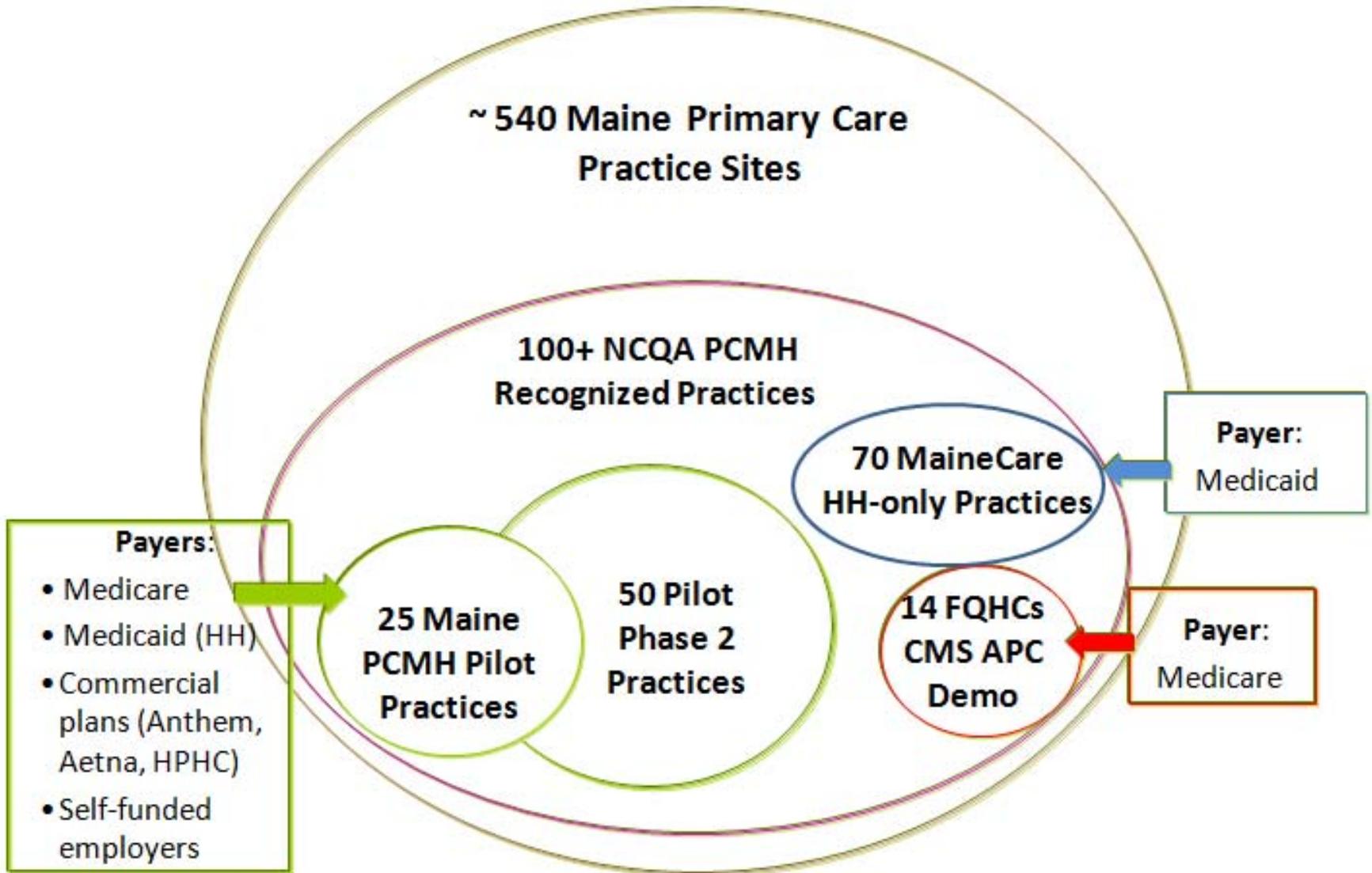


Maine PCMH Pilot

Key elements:

- Originally, 3-year multi-payer PCMH pilot
- Collaborative effort of key stakeholders, major payers
- Adopted common mission & vision, guiding principles for Maine PCMH model
- Initially 22 adult / 4 pedi PCP practices across state
- Supporting practice transformation & shared learnings beyond pilot practices
- Committed to engaging consumers/ patients at all levels
- Conducting rigorous outcomes evaluation (clinical, cost, patient experience of care)

Maine's Medical Home Movement



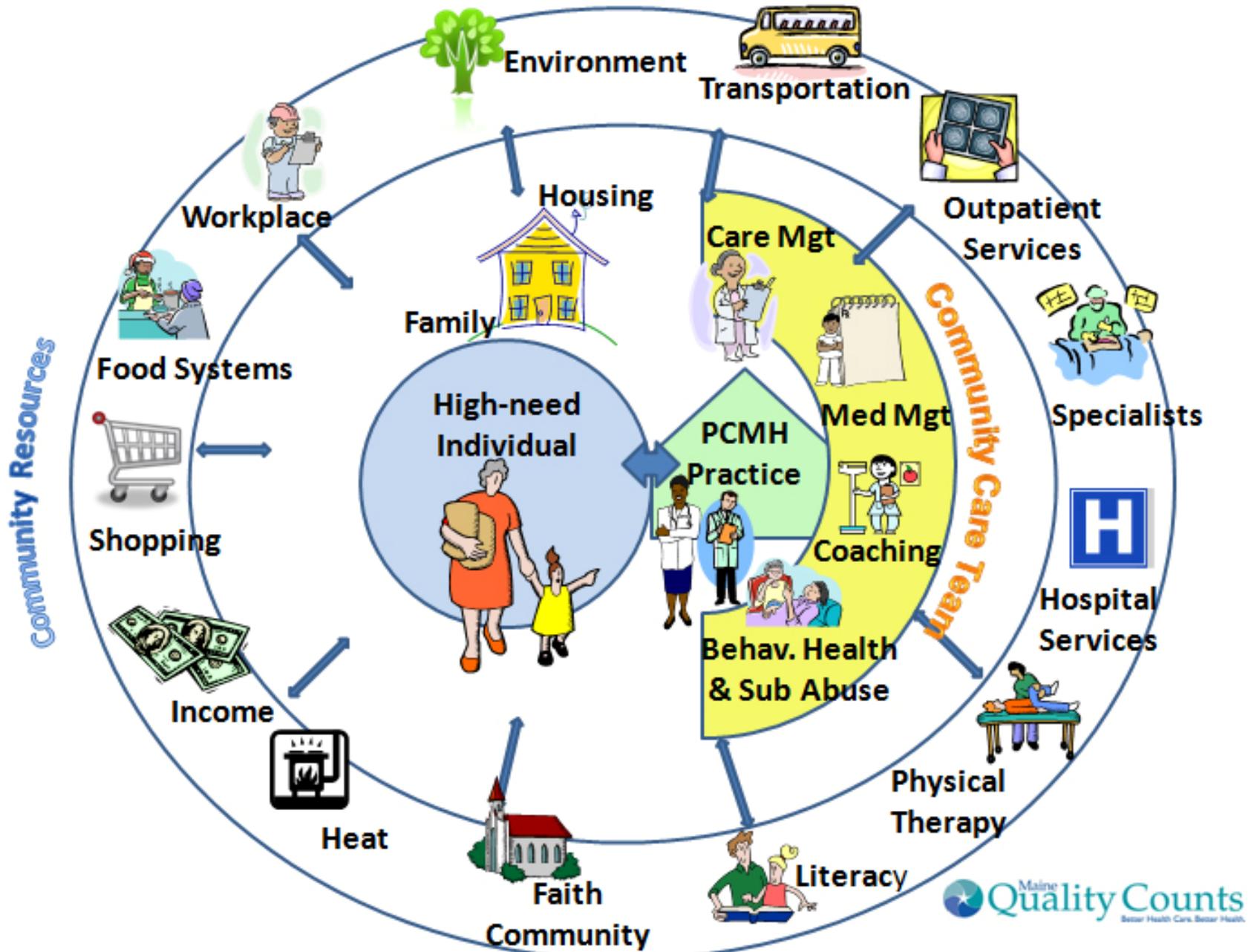
Implications of CMS MAPCP Demo

- Medicare joined as payer in Pilot (Jan 2012)
- Stronger focus on reducing waste & avoidable costs – particularly readmissions
- Introduction of Community Care Teams
- Ability to access Medicare data for reporting, identifying pts at risk
- Opportunity for 50 additional practices to join “Phase 2” of Pilot (Jan 2013)

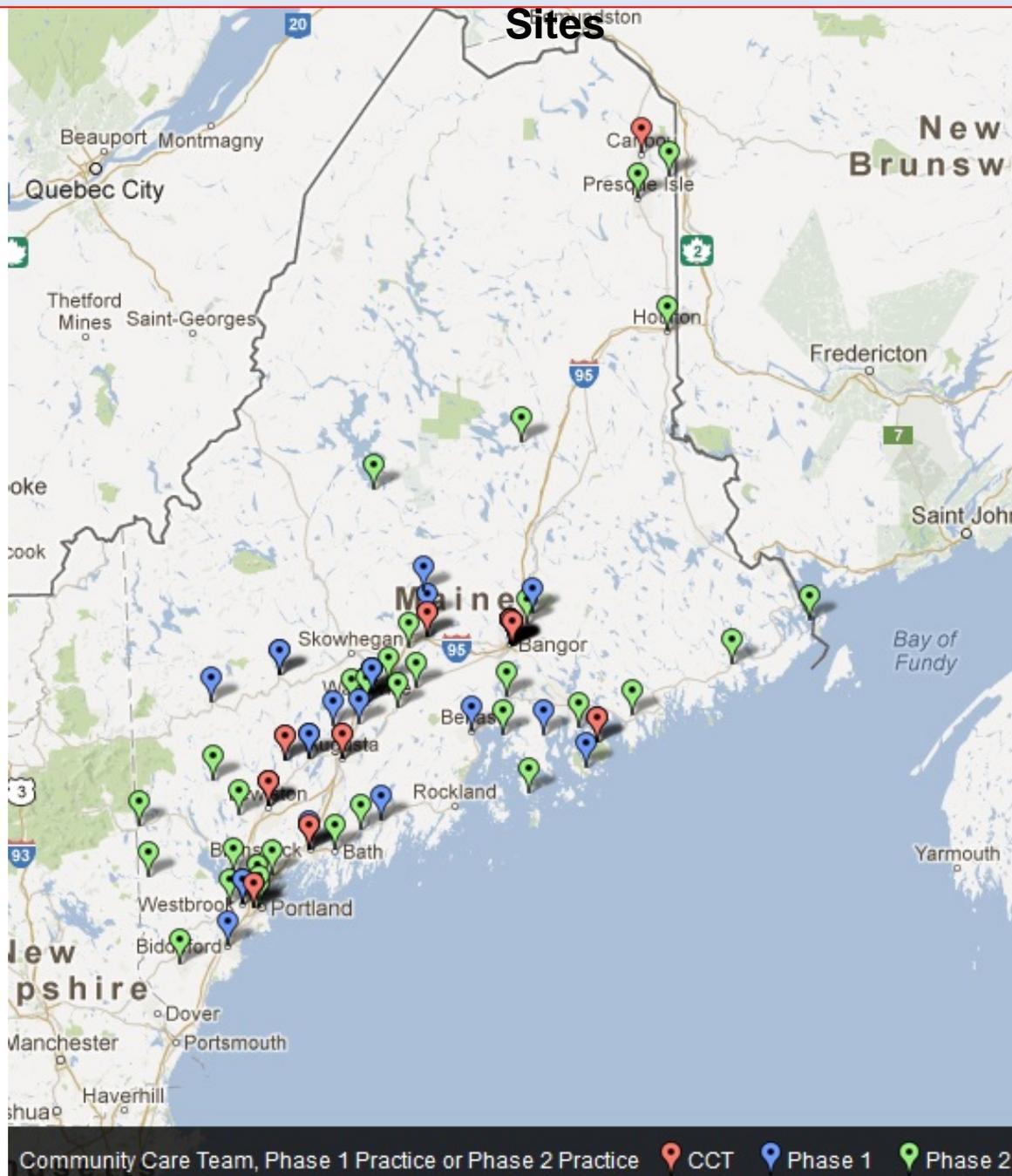
Community Care Teams

- Multi-disciplinary, community-based, practice-integrated care teams
- Build on successful models (NC, VT, NJ)
- Support patients & practices in Pilot sites, help **most high-needs** patients overcome barriers – esp. *social needs* - to care, improve outcomes
- Key element of cost-reduction strategy, targeting high-needs, high-cost patients to reduce avoidable costs (ED use, admits)

Maine PCMH Pilot Community Care Teams



Maine PCMH Pilot Community Care Teams, Phase 1 and Phase 2 Practice



MaineCare Perspective

MaineCare- Maine's Medicaid Program

- Approximately 340,000, one in four, Mainers are enrolled in MaineCare
- MaineCare accounts for about 1/3 of Maine's overall budget
- Maine is a wholly fee for service state.
- MaineCare has over 400 PCPs participating in Primary Care Case Management (PCCM). Enrollment is mandatory for TANF populations, children, pregnant women and childless adults below 100% FPL
- Rated 8th healthiest state in the nation
- Oldest median age in the nation

CMS Health Homes – ACA Section 2703: Stage A

Chronic conditions

(per CMS):

- Mental health
- Substance abuse
- Asthma
- Diabetes
- Heart disease
- Overweight (BMI > 25) & Obesity

Maine-specific

- Chronic Obstructive Pulmonary Disease (COPD)
- Hypertension
- Hyperlipidemia
- Tobacco use
- Developmental Disabilities & Autism Spectrum
- Acquired brain injury
- Cardiac & circulatory congenital abnormalities
- Seizure disorder

Maine Medicaid (MaineCare)

Health Homes Initiative

Stage A:

- Health Home = PCMH primary care practice + CCT
- Payment weighted toward medical home
- Eligible Members:
 - Two or more chronic conditions
 - One chronic condition and at risk for another

Stage B:

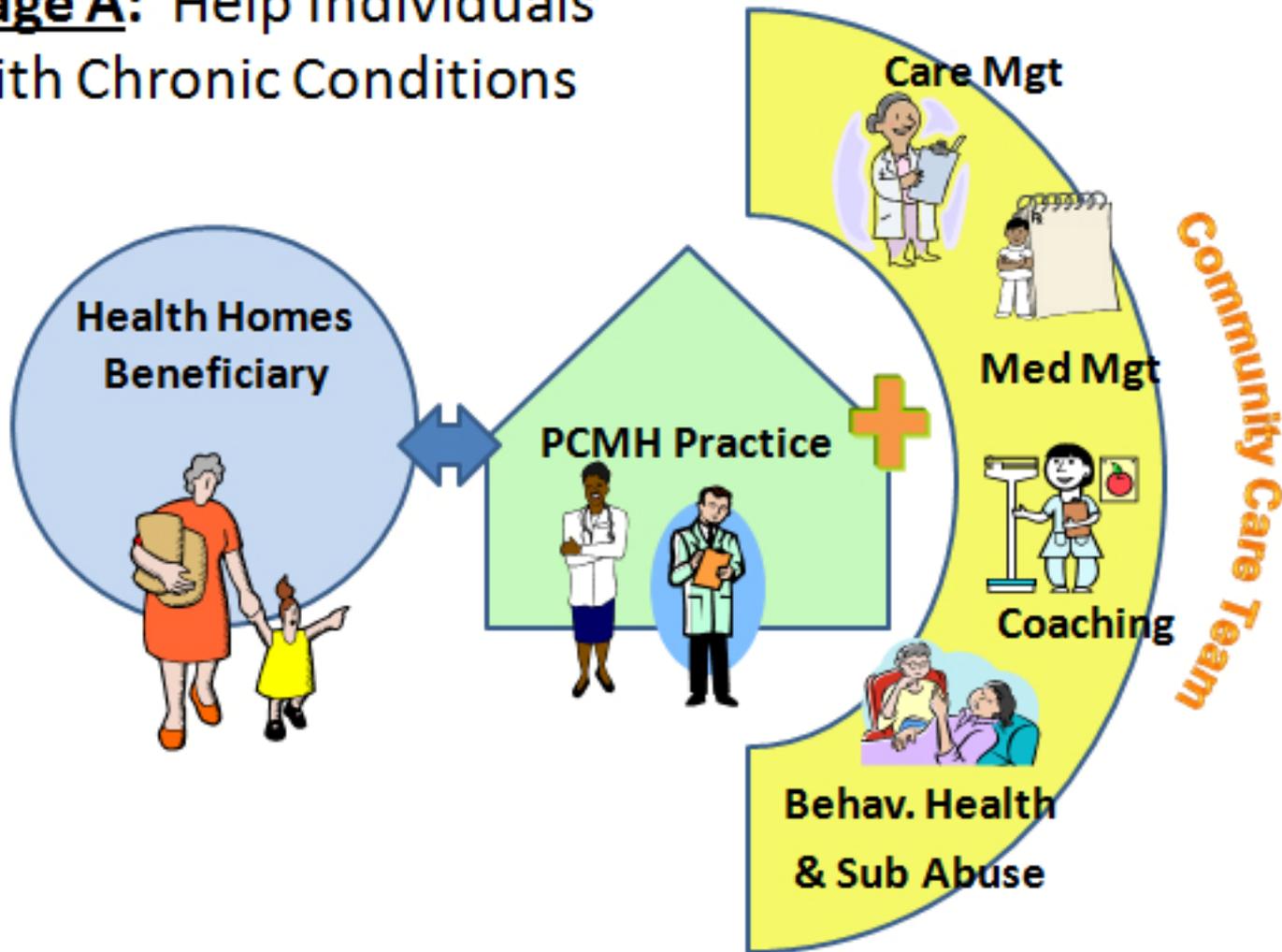
- Health Home = CCT with behavioral health expertise + PCMH primary care practice
- Payment weighted toward CCT
- Eligible Members:
 - Adults with Serious Mental Illness
 - Children with Serious Emotional Disturbance

Alignment of Pilot with MaineCare Health Homes Initiative

- Affordable Care Act (ACA) Sect 2703 - opportunity to develop Medicaid “Health Homes” initiative
- MaineCare elected to align HH initiative with current multi-payer Pilot – part of VBP initiative
- Defined MaineCare “Health Home”(HH):
 - HH = PCMH practice + CCT**
- Provided opportunity to leverage multi-payer PCMH model, practice transformation support infrastructure

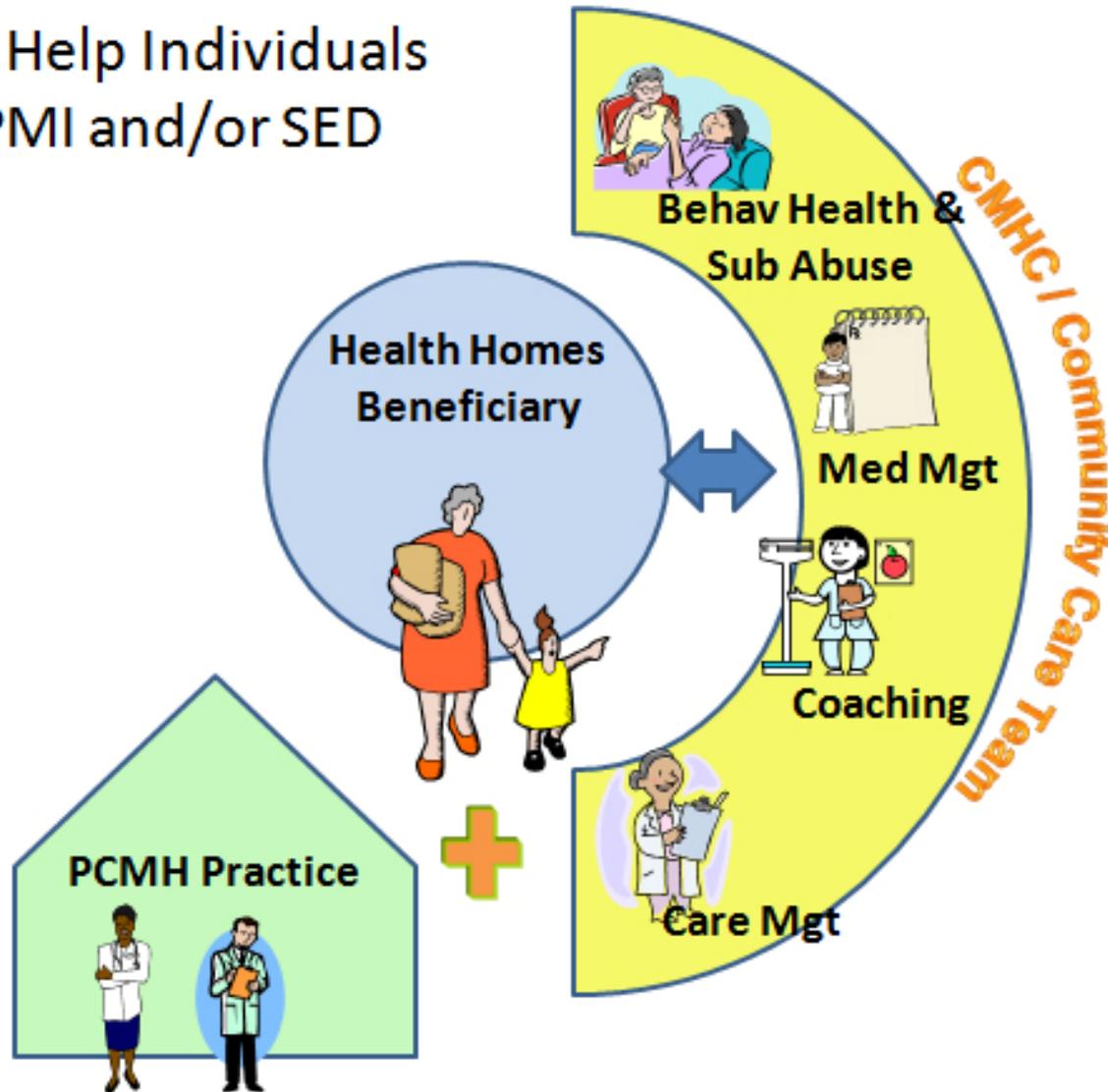
MaineCare Health Homes

Stage A: Help Individuals with Chronic Conditions



MaineCare Health Homes

Stage B: Help Individuals with SPMI and/or SED



MaineCare Services

An Office of the Maine Department of Health and Human Services

Current Projects

Health Information Technology (HIT)

HIPAA 5010

NEW! Improving Health Outcomes for Children (IHOC)

Value Based Purchasing

PNMI Initiative

Transportation Initiative

News & Groups

Headline News

Stakeholder Groups

Provider Updates



Social Services Help

Value-Based Purchasing (VBP) Strategy

All documents and materials on the MaineCare web pages reflect MaineCare's current thinking and are subject to change. No materials on the web page, distributed and discussed at meetings, or sent in emails or mailings are binding in any way concerning the future procurement process.

- [Design Management Committee](#)
- [Member Standing Committee](#)
- Quality Counts presentation 11/22/2011 ([.pdf](#) | [.ppt](#))
- [Request For Information \(RFI\)](#)
- [Resources page](#)
- [Specialized Services/ Stakeholder Advisory Committee](#)
- [Tribal Consultation](#)
- Value-Based Purchasing Strategy Announcement: Commissioner memo ([.pdf](#)) Fact Sheet ([.pdf](#))

Design Management Committee

- Presentation January 9, 2012 ([.pdf](#) | [.ppt](#))

Member Standing Committee

Future Meetings

February 3, 2012

- Agenda ([.doc](#))

Past Meetings

November 18, 2011

- Agenda ([.doc](#))
- Presentation ([.ppt](#))
- Meeting Notes ([.doc](#))



Provider Perspective



EMHC Community Care Team Overview March 2013

Jaime Boyington, LCSW
Community Care Team Coordinator
Eastern Maine HomeCare

TOGETHER We're Stronger

Community Care Teams

- The primary goal of the CCT is to provide support for the most complex, high risk, high need and/or high cost patients served by the PCMH & Health Home Sites
- Who have we seen?
 - 235 referrals from 20 (of 31) practices to date
 - 38 referrals from CCT supported non-EMHS member practices in 2013
 - 48 (20.4%) Pediatric referrals
 - Primary Insurance Status = 49.8% Medicare, 23.4% MaineCare 8% self-pay

Referral Reasons

Top 5 Reasons

- Frequent ED use
- Family Circumstances
- Behavioral health
- Home Safety
- Medication Adherence/Reconciliation

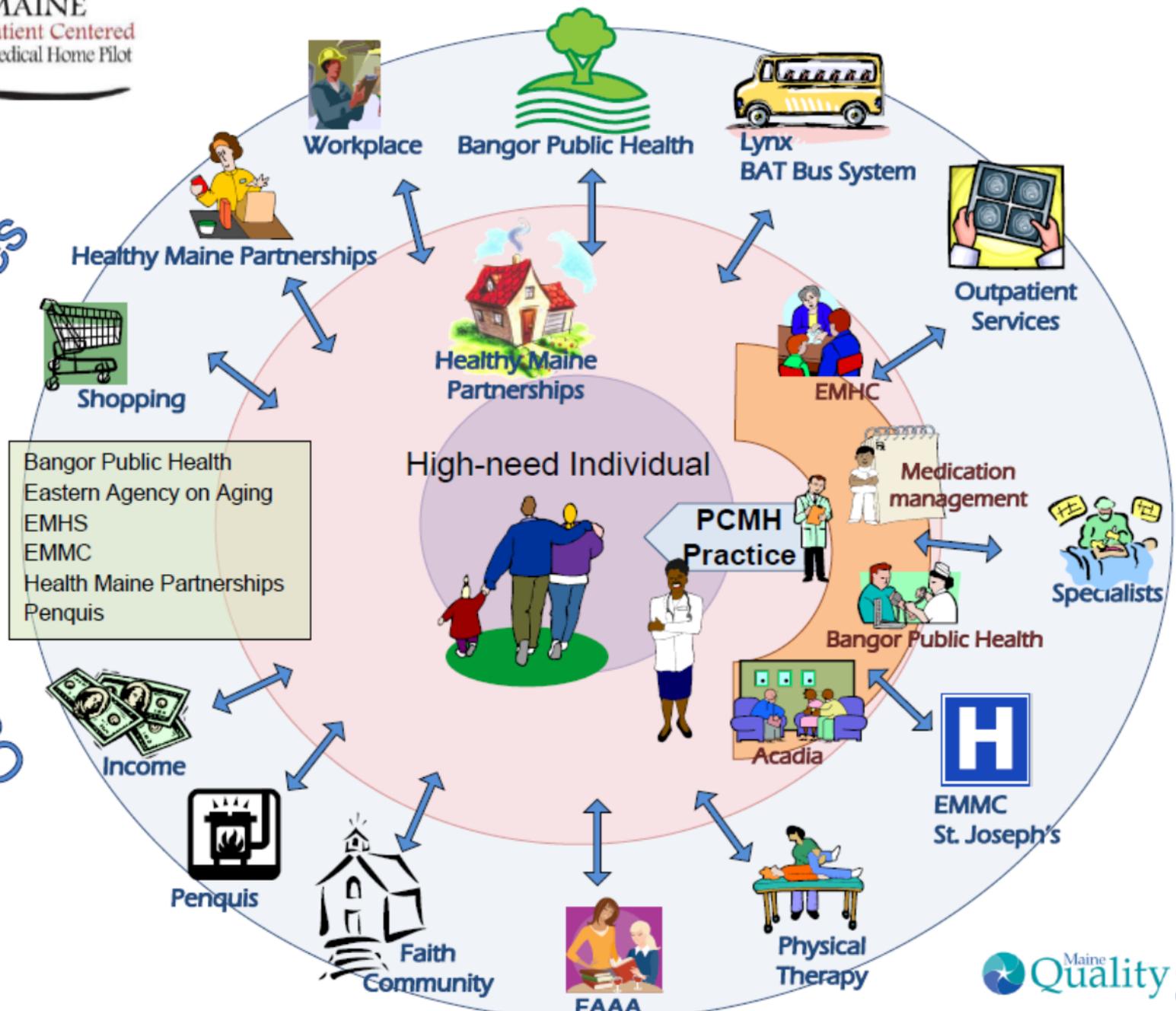
Other reasons

- Transportation
- Nutrition
- Diabetes Management
- Other Chronic Disease Management
- New diagnosis
- Financial
- Dementia
- Multiple Medical Co-Morbidities

Maine PCMH Pilot Community Care Teams



Community Resources



Patient “EKG”

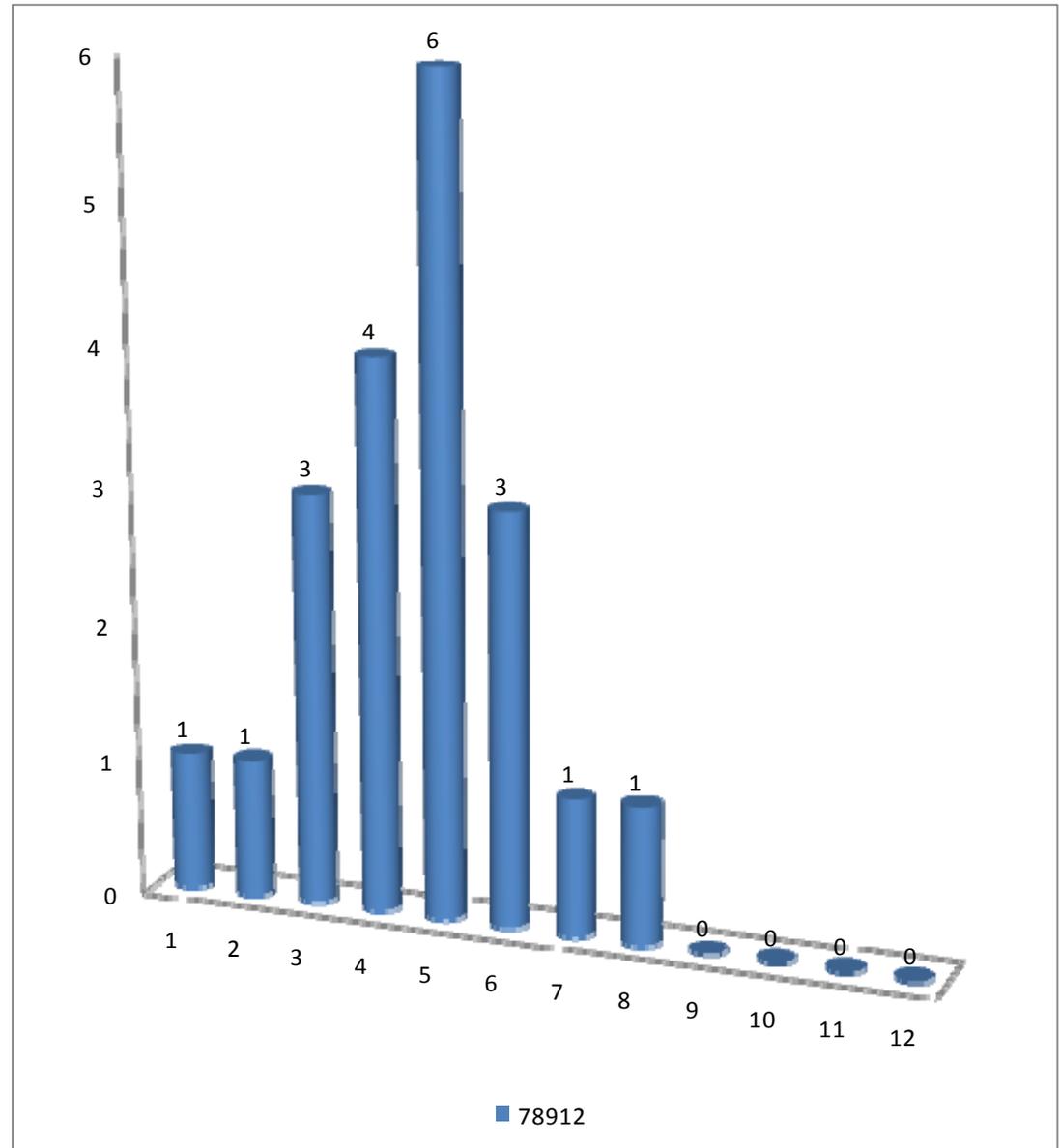
50 yr old, Substance Abuse w/o detox

255 active days – 8 home visits, 4 visits w/ patient @ PCP office & Hospital, 2 visits in Community setting, & 34 phone calls/collateral contacts

Cost Est < \$2400

1- 6 = Hospital ED visits each month for the 6 months during CCT intervention (total 18)

7-12 = hospital ED visits each month for the 6 months following CCT intervention (total 2)

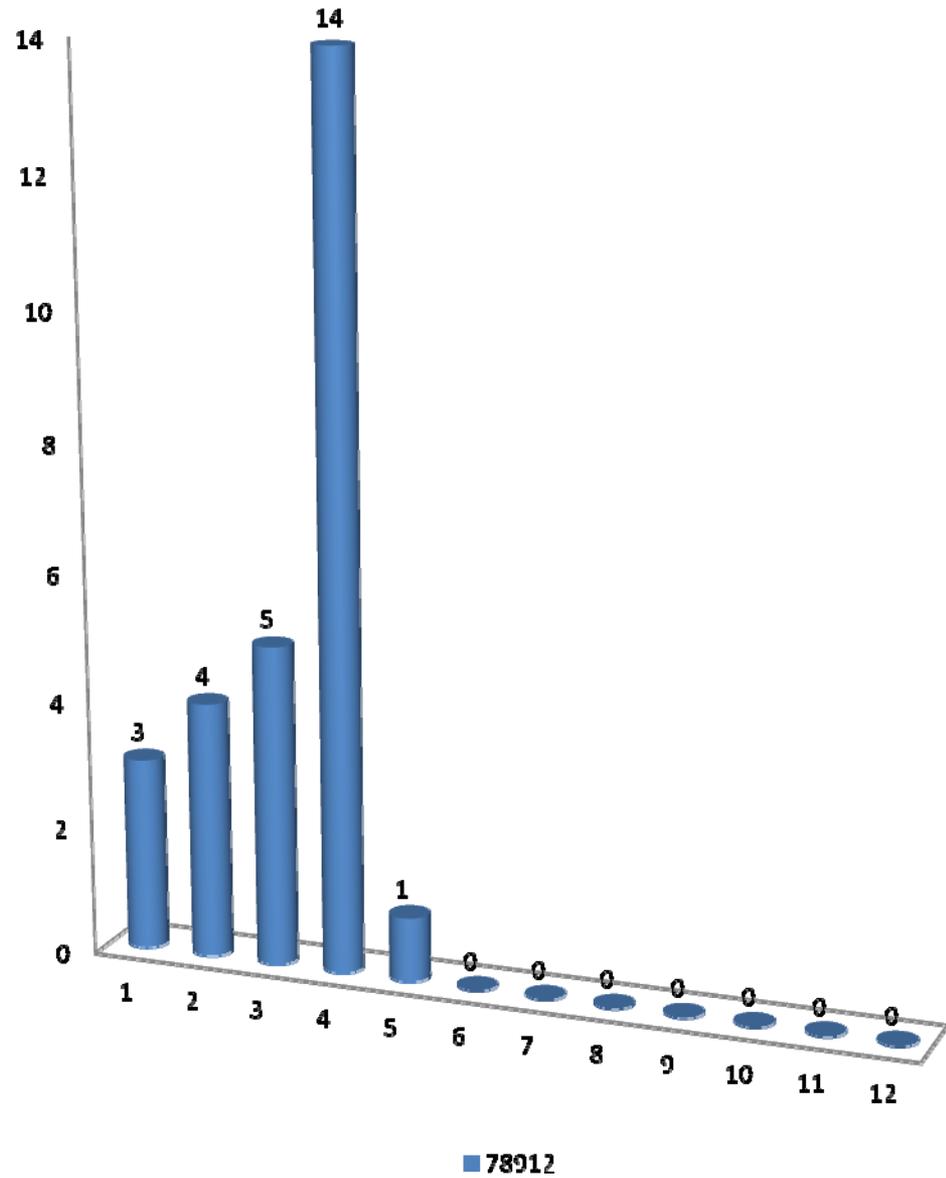


Patient "EKG"

Same patient

1-6 = # of hospital days spent inpatient during 6 months of CCT intervention (total 27)

7-12 = # of hospital days spent 6 months following CCT intervention





Why CCT?

- Community Based & Highly Integrated with practice
- Documentation in EMR = real time
 - HealthInfo Net = broad reach
 - High degree of coordination & communication with all other service providers
 - Patient Centered
 - Lowers cost

Questions for Health Home Providers

- How do you – as a CCT and part of a health home team – help Medicaid patients address the complex medical, behavioral health, and social issues they face?
- In what setting do you typically work with Medicaid patients?

Contact Info / Questions

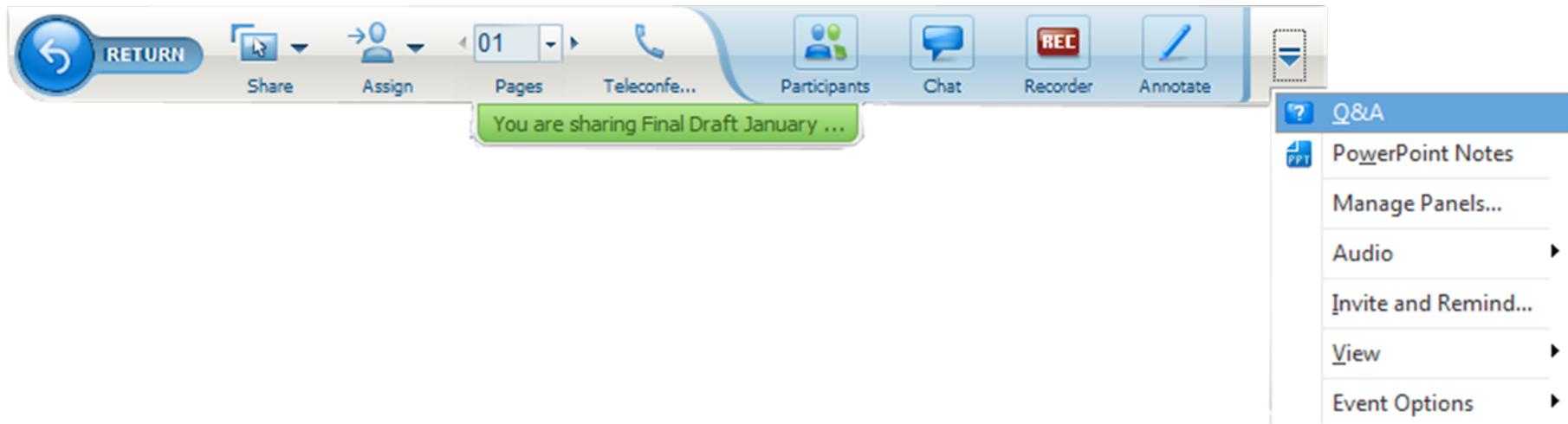
- MaineCare: Michelle Probert, Kitty Purington
 - Michelle.probert@maine.gov
 - Kitty.purington@maine.gov
- Maine Quality Counts: Lisa Letourneau MD, MPH
 - LLetourneau@mainequalitycounts.org, 207.415.4043
- Community Care Teams: Helena Peterson RN, MPH
 - Hpeterson@mainequalitycounts.org, 207.266.7211
- Maine PCMH Pilot
 - www.mainequalitycounts.org

Questions?

To submit a question please click the question mark icon located in the toolbar at the top of your screen.

Your questions will be viewable only to Health Home Information Resource Center staff and the panelists.

Answers to questions that cannot be addressed due to time constraints will be posted online after the webinar.



For More Information

- Download practical resources to improve the quality and cost-effectiveness of Medicaid services.
- Subscribe to e-mail Updates to learn about new programs and resources.
- Learn about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost beneficiaries.

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