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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

CENTERS FOR MEDICARE & MEDICAID SERVICES

Division of Medicaid and Children's Health Operations / Boston Regional Office

July 12, 2013

Mary Mayhew, Commissioner
Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011

RE: Maine 13-012

Dear Commissioner Mayhew:

We are now ready to approve State Plan Amendment (SPA) No. 13-012; attached you will find an approved copy of the SPA. As requested, this SPA is effective April 1, 2013.

The purpose of this SPA is to amend the State's approved Title XIX State Plan to update the deadline by which a Health Home must achieve Patient Centered Medical Home certification. This SPA is budget neutral.

If you have any questions regarding this SPA, please contact Kathryn Holt, Maine State Lead, at 617/565-1246, or at kathryn.holt@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

cc: Stefanie Nadeau, Director, Office of Maine Care Services

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL FOR: HEALTH CARE FINANCING ADMINISTRATION	1. TRANSMITTAL NUMBER: 13-012	2. STATE: MAINE
	3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE(S) APRIL 1, 2013	

5. TYPE OF PLAN MATERIAL *(CHECK ONE)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION: 42 U.S.C. 1396w-4	7. FEDERAL BUDGET IMPACT: Budget neutral
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: ATTACHMENT 3.1-H PAGE 8	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*: ATTACHMENT 3.1-H PAGE 8

SUBJECT OF AMENDMENT: HEALTH HOME NCQA CERTIFICATION

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
COMMISSIONER, DEPT. OF HUMAN SERVICES

12. SIGNATURE OF STATE AGENCY OFFICIAL: /s/ [redacted]	16. RETURN TO: STEFANIE NADEAU Director, MaineCare Services #11 State House Station 221 STATE HOUSE STATION Augusta, ME 04333-0011
13. TYPED NAME: STEFANIE NADEAU FOR THE COMMISSIONER	
14. TITLE: Director, MaineCare Services	
15. DATE SUBMITTED: JUNE 28, 2013	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 28, 2013	18. DATE APPROVED: July 8, 2013
PLAN APPROVED - ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL: 04/01/2013	20. SIGNATURE OF REGIONAL OFFICIAL: /s/ [redacted]
21. TYPED NAME: Richard McGreal	22. T[redacted] Associate Regional Administrator

23. REMARKS

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

th Home practices must have achieved Patient Centered Medical Home (PCMH) recognition by the National Committee for Quality Assurance (NCQA) by the date ted on the MaineCare Value-Based purchasing website located at www.maine.gov/dhhs/oms/vbp.

- 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 erence for Health Homes. Though it is essentially only a couple of years old, the HIE already shows significant advancement in information sharing.