MAINE
Patient Centered
Medical Home Pilot

Maine PCMH Pilot & Community Care Teams: A Targeted Strategy to Improve Care & Control Costs for High-Needs Patients

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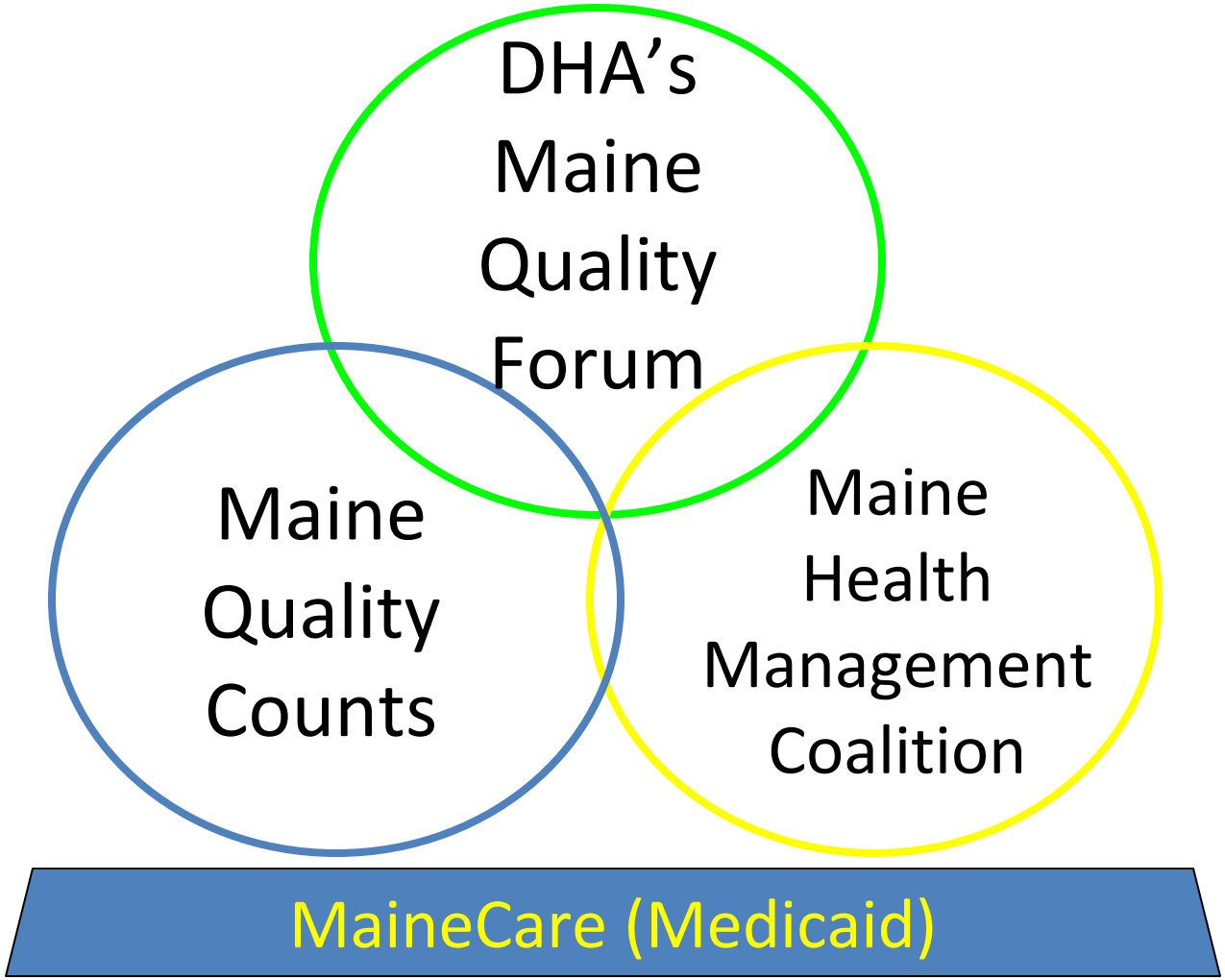
Maine PCMH Pilot & CCT Leadership



Maine PCMH Pilot
Practice "Core Expectations"

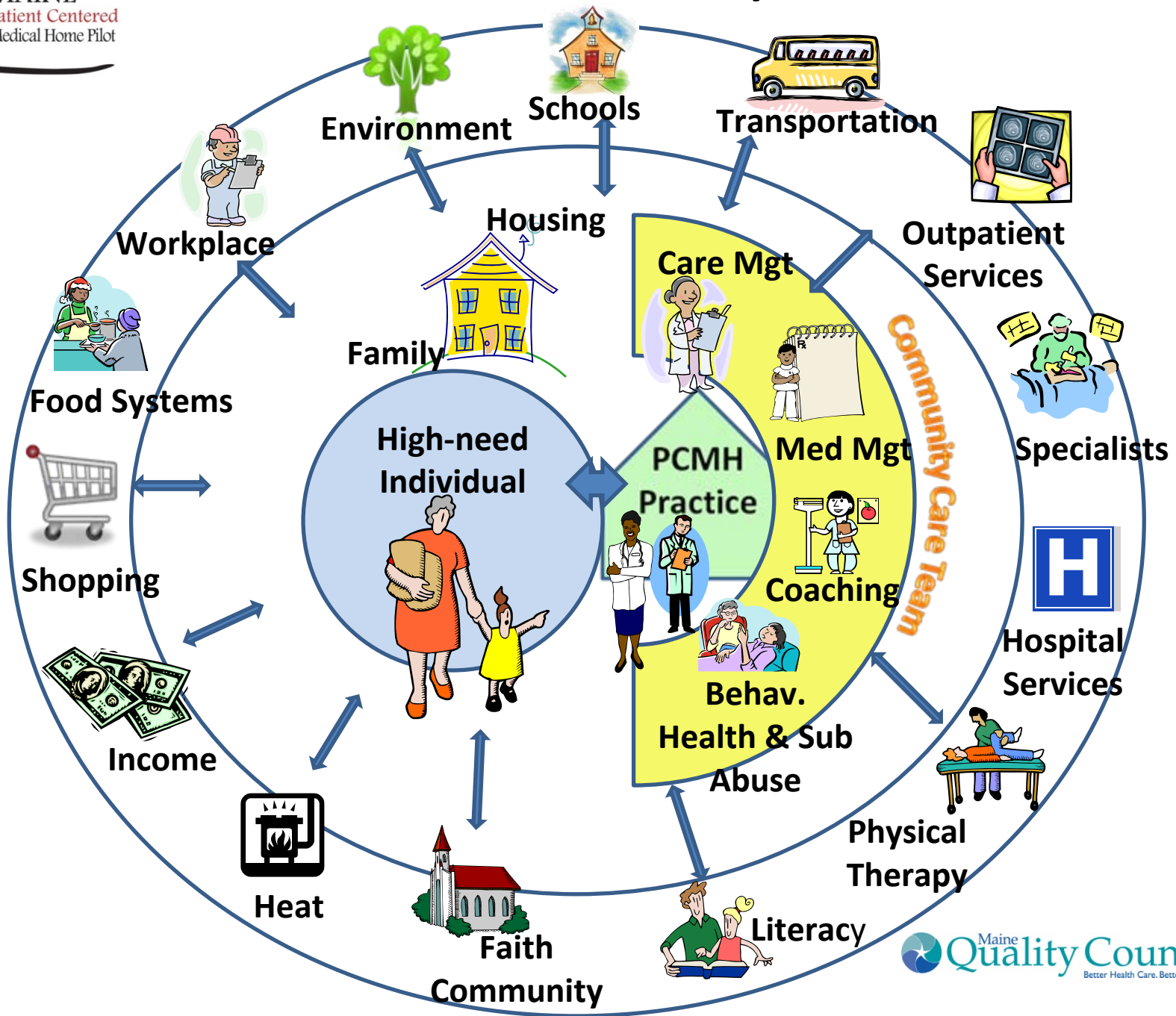
1. Demonstrated physician leadership
2. Team-based approach
3. Population risk-stratification and management
4. Practice-integrated care management
5. Same-day access
6. Behavioral-physical health integration
7. Inclusion of patients & families
8. Connection to community / local HMP
9. Commitment to waste reduction
10. Patient-centered HIT

Maine Community Care Teams

- Multi-disciplinary, community-based, practice-integrated care teams (RN, BH, social services, etc)
- Support **most high-needs** patients from ME PCMH Pilot practices statewide
- Hosted in various org's (home care, hosps, practices)
- Treatment goal: overcome barriers to care, esp. *social needs,* to improve outcomes
- Key element of PCMH/MAPCP cost-reduction strategy, targeting high-needs, high-cost patients to reduce avoidable costs (ED use, admits)

Maine PCMH Pilot Community Care Teams

MAINE Patient Centered Medical Home Pilot



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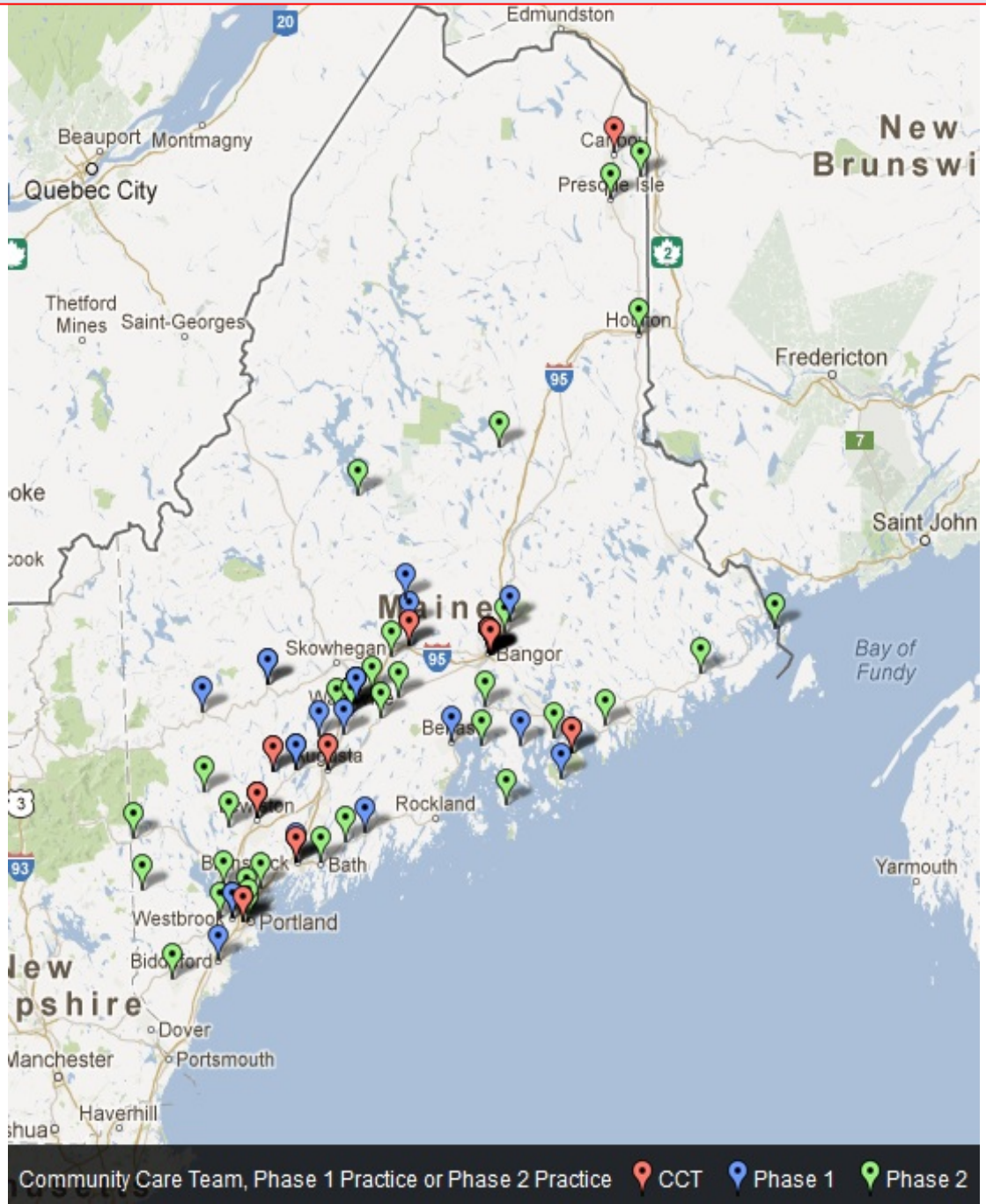
Maine PCMH Pilot Community Care Teams, Phase 1 and Phase 2 Practice Sites



ME PCMH Pilot CCTs

- AMHC
- Androscoggin Home Health
- Coastal Care Team (Blue Hill FP, Community Health Center/MDI, Seaport FP)
- CHANS Home Health (MidCoast area)
- Community Health Partners (Newport FP, Dexter FP)
- DFD Russell (FQHC)
- Eastern Maine Homecare
- Kennebec Valley CCT (MaineGeneral Health)
- Maine Medical Center PHO
- Penobscot Community Health Care (FQHC)

Identifying Potential CCT Patients

- Encourage practices, CCTs to use standard “high-needs” criteria – i.e.
- Frequent hospital admissions: 3+ admits past 6 mos, or 5+ admits past 12 mos
- Frequent ED visits: 3+ visits past 6 mos, or 5+ admits past 12 mos
- Payer ID of patients as high risk or high cost
- Provider referral – multiple complex chronic conditions; polypharmacy; high social svc needs

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

Maine Medicaid (MaineCare) Health Homes Initiative

Stage A:

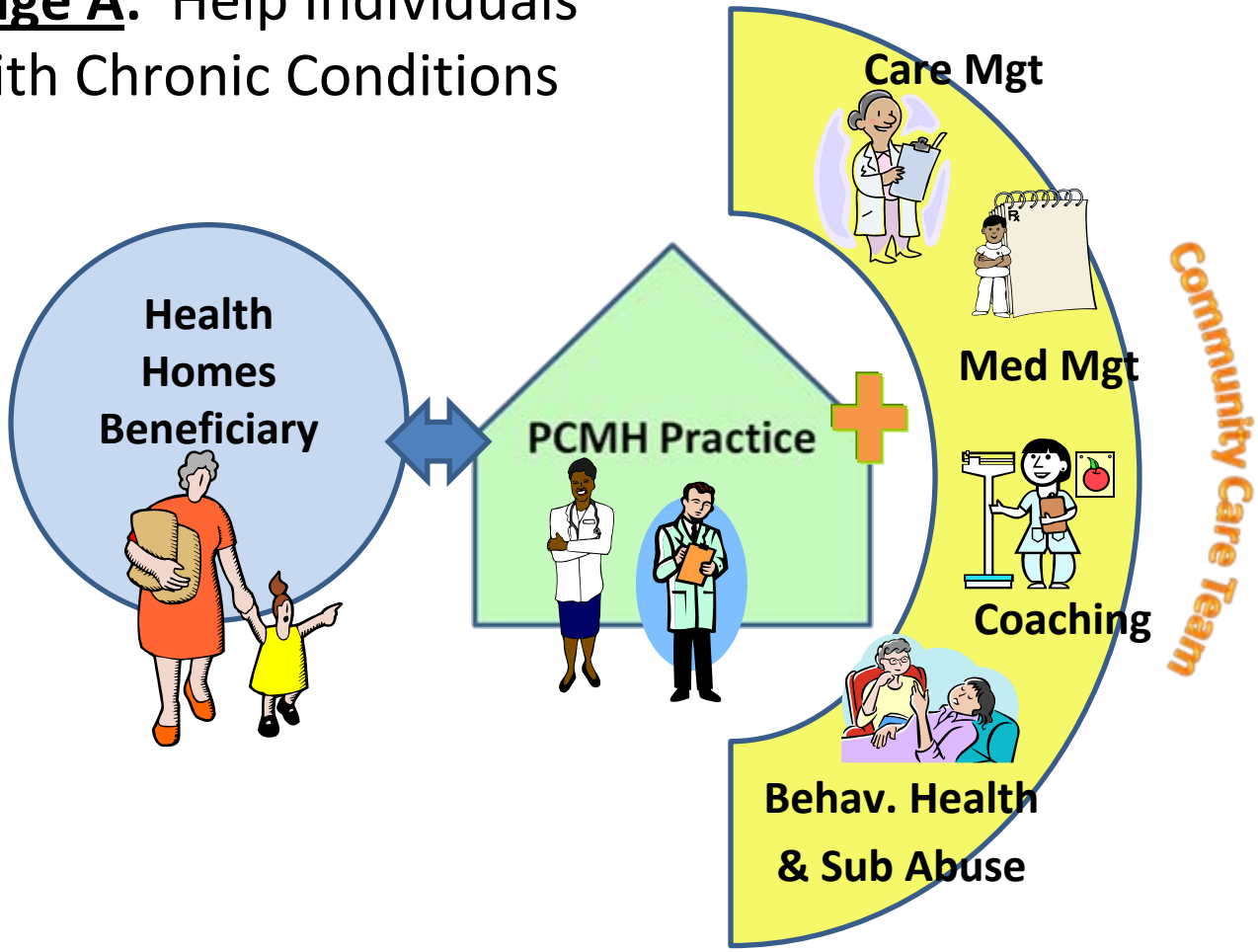
- Health Home = PCMH primary care practice + CCT
- Payment weighted toward medical home
- Eligible Members:
  - Two or more chronic conditions
  - One chronic condition and at risk for another

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

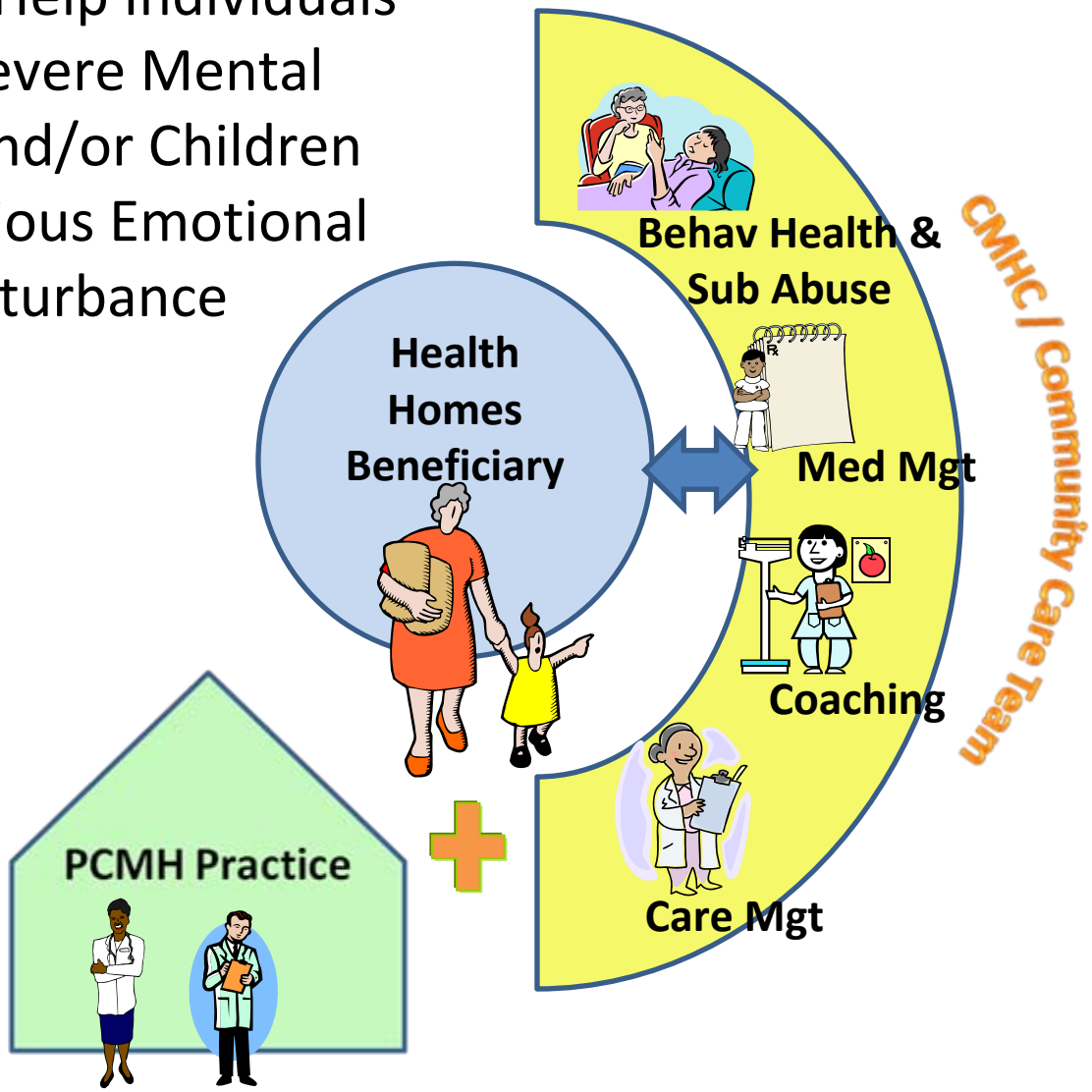
MaineCare Health Homes

<u>Stage A</u>: Help Individuals with Chronic Conditions

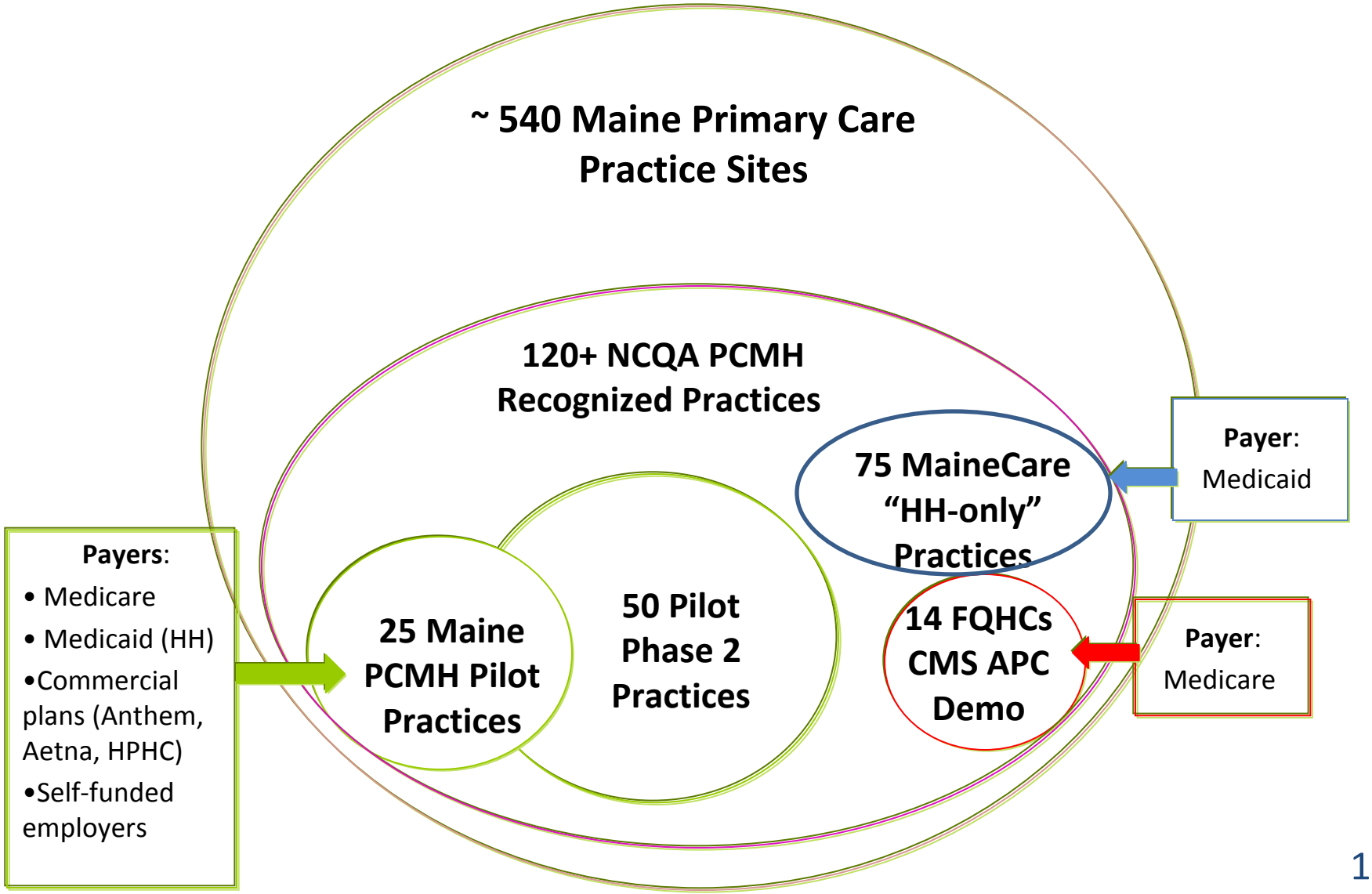


MaineCare Health Homes Proposal

<u>Stage B</u>: Help Individuals with Severe Mental Illness and/or Children with Serious Emotional Disturbance



Maine's Medical Home Movement



PCMH + CCTs: Hub of Wider Delivery & Payment Reform Models (ACOs!)

ACO

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Unique Features of Maine Approach

- Defining “Health Home” as PCMH + CCT
- Adding CCT services to specifically support high-needs, high-cost members (recognizing these mbrs can often outstrip capacity of most primary care practices – even PCMHs!)
- Recognizing differences between “routine”/chronic disease care management & CCT multi-disciplinary team approach for most high-needs mbrs

Financing CCTs: Maine Approach

- Linked CCT model, payment to multi-payer PCMH model
- Leveraged public, private payers agreement to provide pmpm payment
- Participation in CMS MAPCP demo brought in Medicare as payer
- Alignment of ACA Health Homes with multi-payer Pilot provided opportunity to leverage federal 90:10 match for CCT services

Reflections

- Key barriers
  - Data
  - Standard, timely identification of patients
- Surprises!
  - Positive: degree of community need
  - Negative: challenges of developing “standard” model in way that respects local differences
- Creative tools

Communicating Value of CCTs

- Recognize universal nature of "80/20 rule" – i.e.
  - 20% individuals account for 80% of costs
- Even more pronounced in Medicaid populations! (90/10, 95/5!)
- Recognize likely differences in short-term impact of chronic disease management vs. focused support for high-needs individuals
- Recognize CCTs as key strategic component of state VBP programs


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