MaineCare Community Care Teams (CCT)

May 21, 2021

Agenda

Community Care Team (CCT) Overview

- How to become a CCT
- CCT requirements, service expectations, and member eligibility
- How to partner with a CCT
- Upcoming Proposed Change: Permanent Supportive Housing (PSH) CCT

Primary Care 2.0

- Overview of program and practice characteristics
- Impact on CCT

CCT Provider Discussion

- Beacon Health

Next Steps

Community Care Teams (CCT)

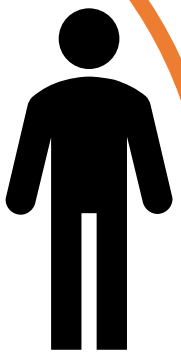
Eligibility: Two chronic conditions/one chronic condition and at risk for another

AND

Recent high utilization, polypharmacy, transitioning from incarceration, or high-risk as identified through a risk score.

Community Care Team

A **Community Care Team** is a community-based care management team. CCTs address housing, food insecurity, transportation, literacy, etc.



Partnership

A **primary care practice** to serve as the medical home

Community Care Teams (CCTs)

Purpose: CCTs support complex, high-risk, high-need, and/or high-cost members needing a higher level of care than is available through primary care by coordinating patients' medical and social service needs with the health care team and community supports.

Staffing Requirements:
CCT Manager
Clinical Leader
Medical Director

Additional CCT staff may consist of a peer support specialist, peer recovery coach, case worker, care manager, housing navigator, outreach worker, social worker, behavioral health professional, community health worker, care navigator, health coach and/or other staff approved by the state.

CCT Requirements

Execute a MaineCare Provider Agreement, complete a Community Care Team application, and be approved as a Community Care Team by MaineCare

Execute a contract with one or more primary care practices to provide a higher level of coordinated care to its members

Electronic Health Record (EHR)

Submit CCT core standard status reports and staff listings quarterly for the first year, then annually

Participate in available Value-Based Purchasing technical assistance

What are CCT Services?

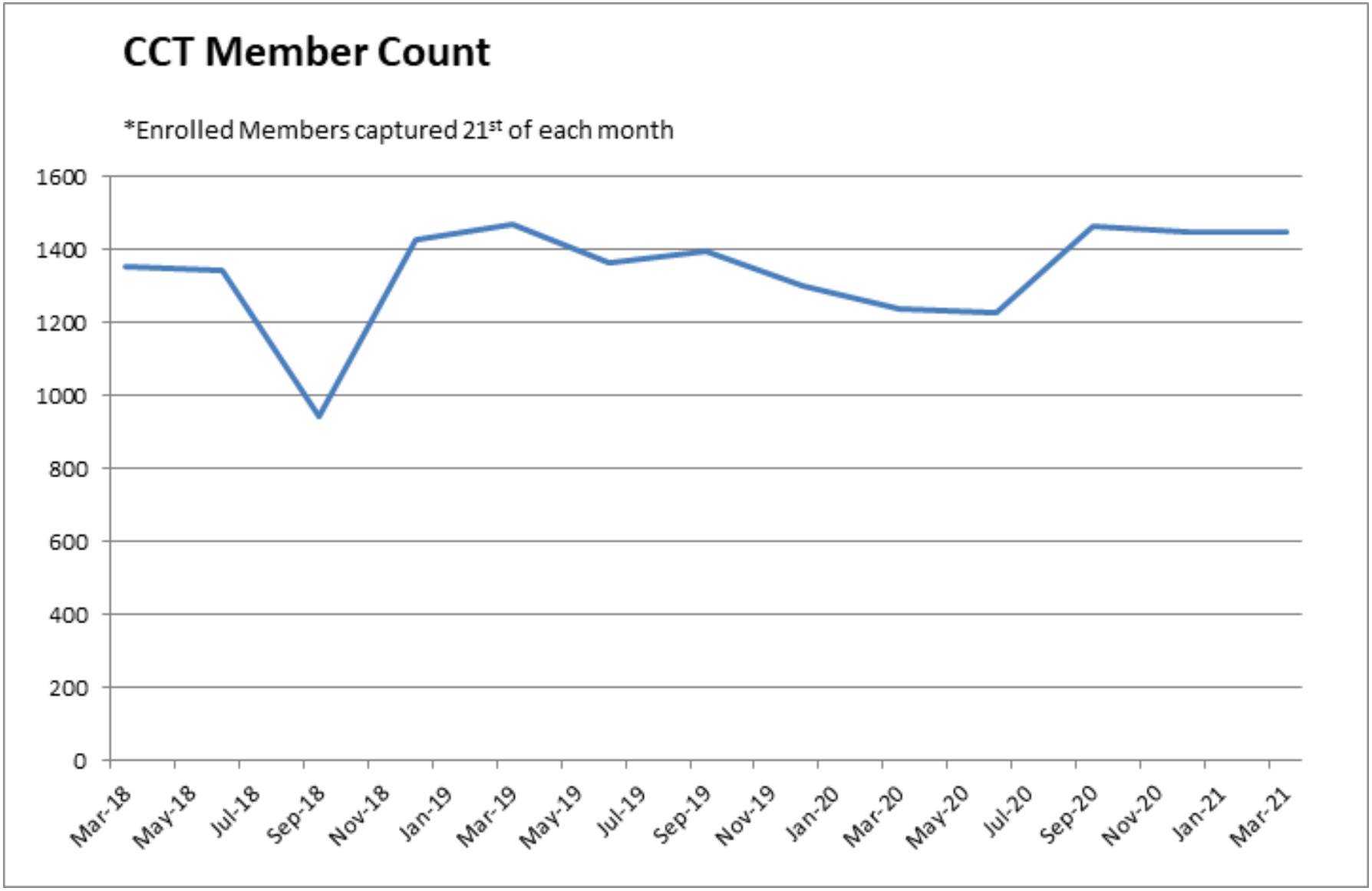
Service Category	CCT Service Examples
Comprehensive Care Management	Targeted Outreach & Engagement
	Comprehensive Medical/Psychosocial Assessments
	Plan of Care Development & Care Management
Care Coordination	Care Coordination for Health Management, Promotion, & Preventive Services
Health Promotion	Member Education and Follow-up
	Chronic Illness & Healthy Living Self-Management
	Referral to Community-Based Prevention Resources
Comprehensive Transitional Care	Inpatient/Insitutional Discharge Transition Services
Individual & Family Support	Self-Care and Management Supports
	Health Coaching for Adherence to Prescribed Treatment
	Chronic Disease Education & Skill-Building
Referral to Community & Social Support Services	Recovery Services Referral
	Community & Social Support Services Referral

Community Care Teams (CCTs) Listing

Current Listing of CCTs:

- Androscoggin Home Healthcare and Hospice
- Aroostook Mental Health Services
- DFD Russell Medical Center
- Fish River Rural Health Center
- Maine Medical Center
- MaineGeneral Medical Center- Kennebec Valley
- Mid Coast Hospital
- Mount Desert Island- Coastal Care Team
- Northern Light - Beacon Health
- Penobscot Community Health Center

CCT Member Utilization



Permanent Supportive Housing (PSH) Community Care Teams (CCT)

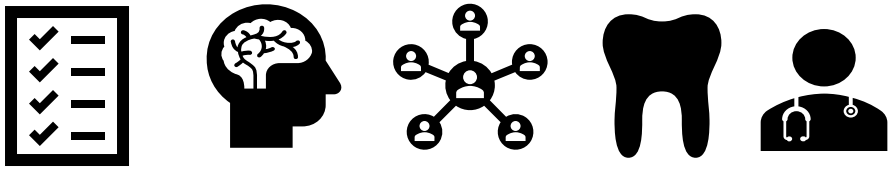
Permanent Supportive Housing CCT

A team of specialized providers that support members with eligible chronic conditions in accessing and sustaining housing and meeting other needs through whole-person care coordination and health promotion.

Eligibility: Two chronic conditions/one chronic condition and at risk for another

AND

Experiencing long-term homelessness



The Need for Permanent Supportive Housing Services in Maine

- **Innovation Accelerator Program (IAP)**
  - A State Medicaid-Housing Agency Partnerships with technical assistance from the Corporation for Supportive Housing and the Center for Health Care Strategies.

- **LD 1318**: *Resolve, To Increase Access to Housing-related Support Services*
  - "The Department shall examine opportunities…to provide housing-related services to persons experiencing chronic homelessness who have mental health or substance use disorders and other vulnerable populations, including, but not limited to, individuals with disabilities and older adults needing long-term services.

Permanent Supportive Housing (PSH) Benefit Development

Goals:

- Improve wellbeing for MaineCare members with disabilities and chronic health conditions, including substance use disorder (SUD), who are experiencing homelessness
- Develop a Medicaid benefit to support housing sustainability, improved health outcomes, and reduce overall costs of care.

Target Population: Approximately 250 individuals experiencing homelessness that have complex medical, social, and behavioral health care needs that require intensive Health Home services to achieve and sustain care coordination and housing.

What are PSH CCT Services?

Service Category	PSH Service
Comprehensive Care Management	Targeted Outreach & Engagement
	Comprehensive Psychosocial Assessments
	Plan of Care Development & Care Management
Care Coordination	Care Coordination
	Housing & Tenancy Coordination Services
Health Promotion	Behavioral Health Services Support
	Therapeutic Habilitative & Rehabilitative Skills Development
Comprehensive Transitional Care	Housing Transition Services
Individual & Family Support	Peer Supports & Tenant Support Group
	Income, Employment, Education, & Vocational Supports
	Crisis Management Plan Implementation Supports
Referral to Community & Social Support Services	Crisis Services Referral
	Community & Social Support Services Referral

PSH CCT Tiers

Intensive	Stabilization	Maintenance
• Be diagnosed with two (2) or more chronic conditions, OR one (1) chronic condition AND be at risk for another chronic condition. and • Be homeless currently and • Have long-term homelessness	• Be diagnosed with two (2) or more chronic conditions, OR one (1) chronic condition AND be at risk for another chronic condition. and • Be housed or have been housed; and • Have a SPDAT or Y-SPDAT score of 20 to 60.	• Be diagnosed with two (2) or more chronic conditions, OR one (1) chronic condition AND be at risk for another chronic condition. and • Be housed and • Have a SPDAT or Y-SPDAT score of 4 to 19.

PSH CCT Model: Flexibility to Meet Complex Needs

- Member referrals from all points of contact in healthcare and community service settings
- Team approach to the delivery of intensive core services
- Three tiers of service intensity: Intensive, Stabilization, Maintenance
- Per member per month (PMPM) reimbursement rate for each tier
- TBD: Performance measures aligned with PC 2.0 to reward member-centered care and primary care integration

Primary Care 2.0

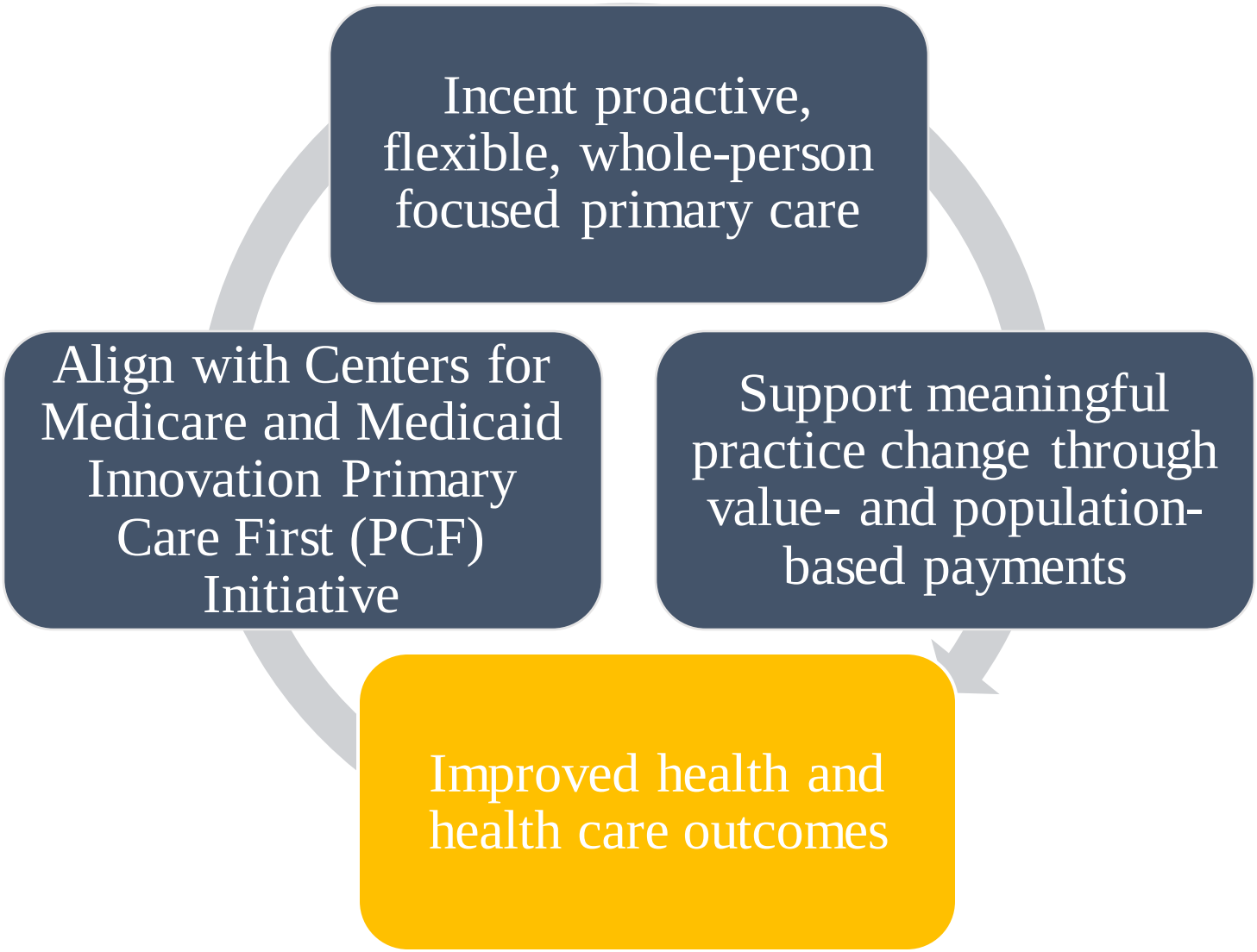
A value-based payment model designed to simplify, integrate and improve MaineCare's current primary care programs:

- Primary Care Case Management (PCCM)
- Primary Care Health Homes (HHs)
- Primary Care Provider Incentive Payment (PCPIP)

One program for all primary care providers participating in MaineCare. One program for eligible MaineCare members.

Implementation Goal: October 2021

MaineCare Primary Care Evolution Goals



Primary Care 2.0 Practice Characteristics

Base Level	Intermediate	Advanced
• Has 24/7 coverage, including access to records • Has a certified Electronic Health Record (2015 edition) • Participates in technical assistance	**Tier 1 AND** • PCMH accreditation or is a Primary Care First participating practice • HealthInfoNet connection • Collects and track social health needs • Holds a practice agreement with at least one Behavioral Health Home • Refers to a Community Care Team • Offers telehealth • Offers MAT services or has a cooperative referral and co-management process with an MAT provider • Includes MaineCare members and/or their families as advisors in practice improvement efforts • Offers evidence-based community health worker services directly or through partnerships (e.g., CBOs)	**Tier 2 AND** • Bi-directional HIN connection with data elements that would allow for clinical quality measurement of PC 2.0 measures • Participates in MaineCare's Ac countable Communities (AC) • Has a Joint Care Management and Population Health Strategy with AC and any contracted CCT

2.0 CCT Impacts

Member eligibility criteria

Delivery of core Health Home services:

Comprehensive care management

Care Coordination

Health promotion

Comprehensive transitional care

Individual and family support

Referral to community and social support services

Use of VMS portal for panel management and attestation

2.0 CCT Impacts

End of primary care “Health Homes”

VMS portal process of member attribution

Addition of quality measure(s) - TBD

Coordination with MaineCare Accountable Communities for an aligned health strategy

CCT Provider Discussion

Northern Light - Beacon Health: Jaime Rogers

What would be the incentive/value for a primary care provider to coordinate CCT services?

Please provide an example of a CCT success story, starting with the referral.

Next Steps

- If interested in becoming a CCT or connecting with an existing CCT, contact the VBP unit

- Questions/Additional Information - General Email Box: HH-BHH-Services.DHHS@maine.gov

Questions?

MaineCare Value-Based Purchasing Unit

HH-BHH-Services.DHHS@maine.gov