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91.02 DEFINITIONS

91.02-1 Community Care Team (CCT) – A CCT is a multi-disciplinary, community-based, practice-integrated care management team that has completed an application and been approved by MaineCare to provide Community Care Team services.

91.02-2 Electronic Health Record (EHR) – An Electronic Health Record means a systematic collection of electronic health information about individual MaineCare members. It is a record in digital format that is capable of being shared across different health care settings, for example by way of network-connected enterprise-wide information systems and other information networks or exchanges.

91.02-3 Health Home – The Health Home consists of an Health Home Practice and CCT working together to provide Health Home Services to eligible MaineCare members.

91.02-4 Health Home Practice (HHP) – A Health Home Practice is a primary care practice that has completed an application and been approved by MaineCare to provide Health Home Services.

91.02-5 Plan of Care – The Plan of Care is a patient-centered plan that describes, coordinates and integrates all of a member's clinical data, and clinical and non-clinical health care-related needs and services. The Plan of Care shall include member health care data, member health goals, and the services and supports necessary to achieve those goals. This may include, but not be limited to, prevention, wellness, specialty care, behavioral health, transitional care and coordination, and social and community services.

91.03 PROVIDER REQUIREMENTS

The HHP and CCT must meet requirements as set forth in this Section.

91.03-1 Health Home Practice (HHP)

1. The HHP must execute a MaineCare Provider Agreement.

2. The HHP must be a primary care practice site that provides care to adult or children members, is located in the state of Maine, and has at least one full-time primary care physician or nurse practitioner.

3. The HHP must sign or be a party to a MaineCare Provider/Supplier Agreement.

4. The HHP must complete a Health Home Practice application and be approved as a Health Home Practice by MaineCare.

91.03 PROVIDER REQUIREMENTS (cont.)

5. The HHP has fully implemented an Electronic Health Record (EHR).

6. The HHP has received National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PPC-PCMH) Recognition.

7. The HHP has an executed contract with a CCT.

8. The HHP has established member referral protocols with area hospitals.

9. Within one year of a practice's participation as a MaineCare HHP, the HHP certifies that it has fully implemented the following Core Health Home Standards:

   a. **Demonstrated Leadership** – The HHP identifies at least one primary care physician or nurse practitioner as a leader within the practice who champions the implementation and continued maintenance of Core Health Home Standards.

      The primary care leader(s) work with other providers and staff in the HHP to build a team-based approach to care, continually examine processes and structures to improve care, and review data on the performance of the practice.

      The primary care leader participates as a member of the practice Leadership Team and participates in Health Home learning opportunities regarding Health Home implementation offered by the Department.

   b. **Team-Based Approach to Care** – The HHP has implemented a team-based approach to care delivery that includes expanding the roles of non-physician providers (e.g. nurse practitioners, physician assistants, nurses, medical assistants) to improve clinical workflows.

      The HHP utilizes non-physician staff to improve access and efficiency of the practice team in specific ways, including one or more of the following:

      - through greater use of planned visits;
      - integrating care management into clinical practice;
      - delegating some types of patient testing or exams (e.g., ordering of routine screening tests, diabetic foot exams) to non-physicians;
      - expanding patient education; and,
      - providing greater data support to physicians to enhance the quality and cost-effectiveness of their clinical work.

91.03 PROVIDER REQUIREMENTS (cont.)

c. **Population Risk Stratification and Management** – The HHP has adopted processes to identify and stratify patients across their population who are at risk for adverse outcomes, and adopted procedures that direct resources or care processes to reduce those risks.

"Adverse outcomes" means a negative clinical outcome and/or avoidable use of healthcare services such as hospital admissions, emergency department visits, or non-evidence based use of diagnostic testing or procedures.

d. **Enhanced Access** – The practice enhances access to services for their population of patients, including:

- The HHP has a system in place that allows patients to have same-day access to their healthcare provider using some form of care that meets their needs – e.g. open-access scheduling for same-day appointments, telephonic support, and/or secure messaging.

- The HHP has processes in place to monitor and ensure access to care, e.g., tracks wait time to third next available appointment.

e. **Practice Integrated Care Management** – The HHP has processes in place to provide care management services, and identifies specific individuals to work with the practice team to provide care management for patients at high risk of experiencing adverse outcomes.

Care management staff have clear roles and responsibilities, are integrated into the practice team, and receive explicit training to provide care management services.

Care management staff have processes for tracking outcomes for patients receiving care management services.

f. **Behavioral Physical Health Integration** – HHP has completed a baseline assessment of their behavioral-physical health integration capacity during the first year of MaineCare Health Home participation.

Using results from this baseline assessment, HHP has implemented one or more specific improvements to integrate behavioral and physical health care, including one or more of the following:

- Implemented processes to routinely conduct a standard assessment for depression in patients with chronic illness;

- Hired a behavioralist into the practice to assist with chronic condition management; and,

91.03 **PROVIDER REQUIREMENTS** (cont.)

- Co-locate behavioral health services within in the practice.

g. **Inclusion of Patients and Families** – HHP includes members and family members as documented and regular participants at leadership meetings, and/or practice has in place a member and family advisory process to identify patient-centered needs and solutions for improving care in the practice.

HHP has processes in place to support members and families to participate in these leadership and/or advisory activities (e.g., after hours events, transportation, stipends, etc.).

HHP has implemented systems to gather member and family input at least annually (e.g. via mail survey, phone survey, point of care questionnaires, focus groups, etc.). HHP has processes in place to design and implement changes that address needs and gaps in care identified via member and family input.

h. **Connection to Community Resources and Social Support Services** – HHP has processes in place to identify local community resources and social support services.

HHP has processes in place to routinely refer patients and families to local community resources and social support services, including those that provide self-management support to assist members in overcoming barriers to care and meeting health goals.

i. **Commitment to Reducing Waste, Unnecessary Healthcare Spending, and Improving Cost-effective Use of Healthcare Services** – The HHP has processes in place to reduce wasteful spending of healthcare resources and improving the cost-effective use of healthcare services as evidenced by at least one initiative that targets waste reduction, including one or more of the following:

- Reducing avoidable hospitalizations;
- Reducing avoidable emergency department visits;
- Reducing non-evidence-based use of expensive imaging, such as MRI for low back pain or headache;
- Working with specialists to develop new models of specialty consultation that improve patient experience and quality of care, while reducing unnecessary use of services; and,
- Directing referrals to specialists who consistently demonstrate high quality and cost efficient use of resources.

9**1.03 PROVIDER REQUIREMENTS** (cont.)

j. **Integration of Health Information Technology** – HHP uses an electronic data system that includes identifiers and utilization data about patients. Member data is used for monitoring, tracking and indicating levels of care complexity for the purpose of improving patient care.

The system is used to support member care, including one or more of the following:

- The documentation of need and monitoring clinical care;
- Supporting implementation and use of evidence-based practice guidelines;
- Developing plans of care and related coordination; and,
- Determining outcomes (e.g., clinical, functional, satisfaction, and cost outcomes).

91.03-2 Community Care Team (CCT)

1. The CCT must execute a MaineCare Provider Agreement;

2. The CCT must complete a Community Care Team application and be approved as a Community Care Team by MaineCare;

5. The CCT must have executed a contract with one or more HHPs to provide Health Home services; and,

6. CCT staff shall consist of a multidisciplinary group of health care professionals under the leadership of a CCT Manager, a Medical Director, and a Clinical Leader. Their responsibilities are:

a. A CCT Manager provides leadership and oversight to ensure the CCT meets goals;

b. A Medical Director (at least 4 hours/month) collaborates with the HHP to select and implement evidenced-based clinical initiatives, lead quality improvement efforts, evaluate progress, and convene provider clinical quality improvement meetings; and,

c. A Clinical Leader directs care management activities across the CCT, and does not duplicate care management that is already in place in the HHP.

Additional CCT staff may consist of a nurse care coordinator, nutritionist, social worker, behavioral health professional, case manager, pharmacist, care manager or chronic care assistant, community health worker, care navigator, health coach and/or other staff approved by the state.

91.04 MEMBER ELIGIBILITY

In order to be eligible for Health Home Services, the member must be diagnosed with two (2) or more chronic conditions, OR one (1) chronic condition AND be at risk for another chronic condition. All diagnoses must be documented in the member's Plan of Care.

91.04-1 Chronic Conditions

1. a mental health condition (excluding Serious and Persistent Mental Illness and Serious Emotional disturbance, as defined in Section 13 and Section 17 of this Manual);
2. a substance use disorder;
3. tobacco use;
4. diabetes;
5. heart disease;
6. overweight or obese as evidenced by a body mass index over 25;
7. Chronic Obstructive Pulmonary Disease (COPD);
8. hypertension;
9. hyperlipidemia;
10. developmental and intellectual disorders;
11. circulatory congenital abnormalities;
12. asthma;
13. acquired brain injury; and
14. seizure disorders.

91.04-2 At Risk for Another Chronic Condition

1. A member is deemed to be at risk for another chronic condition if the member has been diagnosed with any of the following:

    a. a mental health condition (excluding Serious and Persistent Mental Illness and Serious Emotional disturbance, as defined in Section 13 and Section 17 of this Manual);
    b. a substance use disorder;
    c. tobacco use;
    d. diabetes;
    e. heart disease;
    f. overweight or obese as evidenced by a body mass index over 25;
    g. chronic obstructive pulmonary disease (COPD);
    h. hypertension;
    i. hyperlipidemia;
    j. developmental and intellectual disorders; or,
    k. circulatory congenital abnormalities

91.04 MEMBER ELIGIBILITY (cont.)

2. A member with a diagnosis of asthma, acquired brain injury or seizure disorder, is eligible for Health Home Services if it is documented in the member's Plan of Care that the member is at risk for another chronic condition.

91.04-3 Additional Requirements for Eligibility for Community Care Team Services

Members who are eligible for Section 91 services, with more intense health care needs may be eligible for CCT services, in addition to HHP services.

The HHP assesses Section 91 members for eligibility for CCT services.

The members referred to CCT by the HHP shall not exceed 5% of the HHP's total assigned members.

To be eligible for CCT services, a member must meet one of the following criteria:

1. Hospital Admissions

   a. 5 or more admissions in past 12 months
   b. 3 or more admissions in past 6 months, or

2. Emergency Department Utilization

   a. 3 or more E.D. visits in past 6 months, or
   b. 5 or more E.D. visits in past 12 months

3. Members identified by the Department as high-risk or high-cost

4. Polypharmacy: members using 15 or more chronic medications, and/or on multiple high-risk medications (e.g. insulin, warfarin, etc)

5. High social service needs that interfere with care: Eligible members who also have significant social service needs that result in high rates of avoidable utilization of medical services (e.g. members who are homeless, have an intellectual disability, substance abuse).

Following resolution or stabilization of members' high/ complex needs, the CCT will end services for the member and refer the member back to the HHP for Health Home services, pursuant to their Plan of Care.

91.04-4 Member Assignment

1. The Department shall assign members to a Health Home.

91.04 MEMBER ELIGIBILITY (cont.)

a. Members who meet Section 91 eligibility criteria, and who were receiving Health Home Services under Chapter VI, Section 1 of this manual, Primary Care Case Management, will receive written notification from the Department that their provider has become a Health Home provider. If their PCCM provider becomes a Section 91 provider, members will receive information about the benefits of participating in a Health Home and be notified of their ability to opt out of enrollment in these services. If the member does not opt out within twenty-eight (28) days of the letter, the member will be automatically enrolled by the Department in Health Home services on either the 1st or 15th of the month.

b. Members who meet Section 91 eligibility requirements, but who did not receive services under Chapter VI, Section 1, Primary Care Case Management, will receive written notification of the benefits of participating in a MaineCare Health Home and a list of Health Homes in their area. Members will be encouraged to respond within twenty-eight (28) days of receiving the letter, but may also enroll at a later date.

c. Health Home Services are optional services. A member may opt out of Health Home Services. Members who elect to receive Health Home services may choose to receive the service from any qualified Health Home (consisting of one HHP and one CCT).

91.05 COVERED SERVICES

91.05-1 Comprehensive Care Management

The HHP and/or the CCT will coordinate and provide access to comprehensive care management, care coordination and transitional care across settings for Health Home-eligible individuals. Levels of care management may change according to member needs over time.

The HHP shall develop a Plan of Care with each Health Home member. The Plan of Care shall be recorded in the member's record, and in the HHP's electronic health record (EHR) and include the member's health goals, and the services and supports necessary to achieve those goals (including prevention, wellness, specialty care, behavioral health, transitional care and coordination, and social and community services as needed). HHP services shall also include:

1. Prospective identification of at-risk patients;

2. Clinical assessments, monitoring & follow up of clinical and social service needs;

3. Medication review & reconciliation; and,

4. Communicating and coordinating care with treating providers

91.05 COVERED SERVICES (cont.)

As part of care management, HHPs shall conduct the following screenings and assessments for all of their assigned Health Home members:

1. Measurement of BMI in all adult patients at baseline and at least every two years, and BMI percent-for-age at least annually in all children.

2. During the second year of MaineCare participation as a Health Home practice and annually thereafter:

    a. Depression and substance abuse screening (PHQ9 and AUDIT, DAST) for all adults with chronic illness, and substance abuse screening (CRAFFT) for adolescents.

    b. ASQ or PEDS developmental screening for all children age one to three, and the MCHAT 1 for at least one screening between ages 16-30 months with a follow-up MCHAT 2 if a child does not pass the screening test.

Comprehensive Care Management for Members Referred to CCTs

HHP Services

The HHP shall identify the member referred to the CCT for Comprehensive Care Management.

CCT Services

The CCTs shall have access and contribute to the Plan of Care for Members with high needs, either directly through the EHR, or through secure messaging. The CCT shall also provide:

a. Medical assessments and complete community/social service needs assessments;
b. Nurse care management (including patient visits prior to hospital discharge, in the primary care practice, group visits or at home);
c. Case/panel management (screening, patient identification, scheduling appointments, referrals to care managers and other team members);
d. Behavioral health (brief intervention, cognitive behavioral therapy, motivational interviewing, and referral);
e. Substance abuse services (screening, brief treatment and referral);
f. Psychiatric prescribing consultation for providers (provided by psychiatrist); and,
g. Medication review and reconciliation.

91.05 COVERED SERVICES (cont.)

91.05-2 Care Coordination

The HHP will provide care coordination services that:

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 and substance abuse services; and,

4. Develop a Plan of Care for each member that coordinates and integrates all clinical and non-clinical health-care related needs and services, as appropriate.

Care Coordination for Members Referred to CCTs

HHP Services

The HHP shall identify the member referred to the CCT for Care Coordination. The HHP shall provide the same care coordination to members that have been referred to CCTs as those that have not been referred.

CCT Services

The CCT shall provide intensive and comprehensive care coordination to address the complex needs of CCT patients and/or to help CCT patients overcome barriers to care. The CCT's efforts shall be performed in coordination with, and not duplicate services delivered by, the HHP.

91.05-3 Health Promotion

The HHP shall promote member education and chronic illness self-management beginning with screening for tobacco and alcohol use, as primary causes of chronic illness. Health Promotion shall include follow-up education with the member and family, and referrals to community-based prevention programs and resources.

Health Promotion for Members Referred to CCTs

HHP Services

The HHP shall identify the member referred to the CCT for Health Promotion. The HHP will support continuity of care through coordination with the CCT, and will

91.05 COVERED SERVICES (cont.)

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, integrated behavioral health and other services based on individual needs and preferences.

CCT Services

The CCT will provide additional health promotion services for the highest need members through community-based outreach and care management sessions with the patient. Outreach and engagement functions will include aspects of comprehensive care management, care coordination, and linkages to care that address all of a member's clinical and non-clinical care needs, including health promotion.

91.05-4 Comprehensive Transitional Care

The HHP will provide Comprehensive Transitional Care 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. This service include conducting follow-up calls to discharged Members and ensuring that medication reconciliation and timely post-discharge follow-up are completed, and facilitating transition to adult systems of care for pediatric patients.

Comprehensive Transitional Care for Members Referred to CCTs

HHP Services

The HHP shall identify the member referred to the CCT for Comprehensive Transitional Care. The HHP will support the coordination of care during transitions of care by ensuring that the member is seen in the practice for a timely follow-up visit.

CCT Services

The CCT will provide the following Comprehensive Transitional Care services:

1. Intensive and comprehensive care management support to address member's complex needs and/or help members overcome barriers to care, while coordinating care with the Health Home practice team;

2. Conduct follow-up calls to discharged members and ensure that medication reconciliation and timely post-discharge follow-up are completed, and may conduct a home visit if indicated; and,

91.05 COVERED SERVICES (cont.)

3. Ensure that a timely follow-up visit with the HHP is scheduled, and help address barriers such as transportation needs to ensure that the visit occurs.

91.05-5 Individual and Family Support Services

The Health Home Team shall employ approaches which may include but are not limited to peer supports, support groups, and self-care programs to increase member and caregiver knowledge about an individual's chronic illness(es), promote the member's engagement and self-management capabilities, and help the member improve adherence to their prescribed treatment. Individual and Family Support Services shall include, but not be limited to:

1. Health coaching for nutrition, physical activity, tobacco cessation, diabetes, asthma, and other chronic diseases;
2. Chronic Disease self-management;
3. Use of Peer Supports, support groups, and self-care programs; and,
4. Information on Advance Directives.

Individual and Family Support Services for Members Referred to CCTs

HHP Services

The HHP shall identify the member referred to the CCT for Individual and Family Support.

CCT Services

The CCT provides self-management support to members, i.e. (1) health coaching for nutrition, physical activity, tobacco cessation, diabetes, asthma, other chronic disease; (2) chronic disease self-management education and skill-building, such as linking to Living Well programs.

91.05-6 Referral to Community and Social Support Services

The Health Home practice team provides referrals to community and social support services relevant member needs, actively connecting members to community organizations that offer supports for self-management and healthy living, and routine social service needs.

91.05 COVERED SERVICES (cont.)

Referral to Community and Social Support Services for Members Referred to CCTs

CCT Services

The CCT shall provide referrals to community, social support and recovery services to members, connect members 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.

91.06 NON-COVERED SERVICES

A member may only receive Health Home services from one CCT and one HHP. Health Home Services do not preclude a member from receiving other medically necessary services. Members may not receive Health Home Services that duplicate services from other sections of this manual.

91.07 REPORTING REQUIREMENTS

In addition to the documentation and reporting requirements of the *MaineCare Benefits Manual*, Chapter I, Section I, the CCT and the HHP shall report quarterly, in the format determined by the Department, on activity and improvement in the following domains:

1. Leadership
2. Team-based approach to care
3. Population risk stratification and management
4. Practice-integrated care management
5. Enhanced access to care
6. Behavioral-physical health integration
7. Inclusion of patients & families in implementation of PCMH model
8. Connection to community resources and social support services
9. Commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost-effective use of healthcare services
10. Integration of health information technology (HIT)

91.08 REIMBURSEMENT

1. Reimbursement is specified in Chapter III, Section 91.

2. Minimum Requirement for an HHP to receive the per member per month (PMPM) reimbursement: In order to be eligible for a PMPM, for each member for each calendar month, the HHP is required to provide at least one Section 91 Covered Services to a member eligible for Section 91 services, and in accordance with the member's Plan of Care.

3. Minimum Requirement for a CCT to receive the per member per month (PMPM) reimbursement: In order to be eligible for a PMPM, for each member for each calendar month, the CCT is required to provide at least one Section 91 Covered Service to a member eligible for Section 91 services, and in accordance with the member's Plan of Care.

4. Payment will be made as specified above, so long as the service provided is not a duplicative service which is reimbursed under another section of the *MaineCare Benefits Manual*.