This Section is Dependent Upon Approval by the Centers for Medicare and Medicaid Services (CMS)

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92.01 DEFINITIONS

92.01-1 Behavioral Health Home Organization (BHHO) – A BHHO is a community-based mental health organization, that is licensed in the state of Maine, has been approved by MaineCare to provide Section 92 services for members (both adults and children) eligible for such services, and that satisfies the additional provider requirements and standards set forth herein.

92.01-2 Behavioral Health Home Learning Collaborative - A statewide effort to provide support for service system transformation.

92.01-3 Electronic Health Record (EHR) – An Electronic Health Record is 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 by a Department-designated health information exchange(s) (HIE), a Department-designated network connected enterprise-wide information system(s), and other information networks or exchanges. An EHR supports Clinical EHR functions, such as intake, clinical care, task management, and case management where appropriate, and has HL7 interoperability capabilities to support the electronic sharing of portions of the patient's record.

92.01-4 Health Home Practice (HHP) – A Health Home Practice is a primary care practice that has been approved by MaineCare to provide Section 92 services for members (both adults and children) eligible for such services, and satisfies the additional provider requirements and standards set forth herein.

92.01-5 National Committee for Quality Assurance (NCQA) - a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality.

92.01-6 Patient Centered Medical Home (PCMH) Learning Collaborative – a statewide effort to provide support for practice transformation and move to a PCMH model of care.

92.01-7 Plan of Care – The Plan of Care is a person-centered plan that describes, coordinates and integrates all of a member's clinical and non-clinical health care-related needs and services. The Plan of Care shall include the member's physical health and behavioral health goals (including recovery oriented goals), and the services and supports necessary to achieve those goals.

92.02 PROVIDER REQUIREMENTS

The BHHO and HHP must meet the following requirements:

92.02-1 Behavioral Health Home Organization (BHHO)

A. The BHHO must execute a MaineCare Provider Agreement.

B. The BHHO must be a community-based mental health organization, licensed to provide services in the state of Maine, that provides care to adult and/or children members, is located in the state of Maine, and delivers services through a team-based model of care that includes at least the following personnel:

(1) Psychiatric Consultant – shall be a psychiatrist who has current and valid licensure as a physician from the Maine Board of Licensure in Medicine, and who is certified by the American Board of Psychiatry and Neurology Psychiatric medication management or is eligible for examination by that Board as documented by written evidence from the Board, or has completed three years of post-graduate training in psychiatry approved by the Education Council of the American Medical Association and submits written evidence of the training; OR an advanced practice psychiatric and mental health registered nurse who is licensed as a nurse practitioner or clinical nurse specialist by the state of Maine, has graduated from a child and adolescent or adult psychiatric and mental health nurse practitioner, or clinical nurse specialist program, and is certified by the appropriate national certifying body; OR an organization licensed by the Department to provide medication management services pursuant to Chapter II, Section 65 of the *MaineCare Benefits Manual*.

The Psychiatric Consultant shall consult with other BHHO and HHP professionals and with the member as necessary, to provide expertise on the development of evidence-based practices and protocols to the BHHO organization.

Under Section 92, the Psychiatric Consultant shall not duplicate any other psychiatric services that may be necessary and provided through other sections of the *MaineCare Benefits Manual*.

(2) Nurse Care Manager – shall be a registered nurse, a psychiatric nurse licensed as a registered professional nurse by the state or province where services are provided and certified by the American Nurses Credentialing Center (ANCC) as a psychiatric and mental health nurse; an advanced practice psychiatric and mental health registered nurse licensed as a nurse practitioner or clinical nurse

92.02 PROVIDER REQUIREMENTS (cont.)

specialist by the state or province where services are provided, who has graduated from a child and adolescent or adult psychiatric and mental health nurse practitioner or clinical nurse specialist program, and is certified by the appropriate national certifying body; a nurse practitioner, or advance practice nurse, as defined by the Maine State Board of Nursing.

The Nurse Care Manager shall provide primary care consultation, psychiatric care consultation, and work with the BHHO, the HHP and the member to provide other Section 92 services as necessary, pursuant to the Plan of Care.

(3) Clinical Team Leader – shall be an independently licensed mental health professional, who may be a physician, physician's assistant, psychologist, a Licensed Clinical Social Worker, Licensed Master Social Worker, or Licensed Master Social Worker Conditional II Licensed Clinical Professional Counselor, Licensed Marriage and Family Therapist, Registered Nurse, Psychiatric Nurse, Advanced Practice Registered Nurse, or an Advanced Practice Psychiatric Nurse; OR, for children's BHH services, a person who was employed on August 1, 2009 as a case management supervisor under the former Section 13 of Chapter II of the *MaineCare Benefits Manual*. Such staff shall be considered qualified to serve as a Clinical Team Leader for purposes of this rule.

The Clinical Team Leader shall oversee the development of the Plan of Care and direct care management activities across the BHHO, provide supervision of Health Home Coordinators and Certified Intentional Peer Support Specialists, and ensure that the BHHO meets its requirements as a whole.

(4) Certified Intentional Peer Support Specialist (CIPSS) – is an individual who has completed the Maine Office of Substance Abuse and Mental Health Services (SAHMS) curriculum for CIPSS, and receives and maintains that certification.

The CIPSS is an individual who is receiving or has received services and supports related to the diagnosis of a mental illness, is in recovery from that illness, and who is willing to self-identify on this basis with BHH members.

Peer support staff may function as a CIPSS without CIPSS certification for the first nine months of functioning as a CIPSS, but may not continue functioning as a CIPSS beyond nine months: (a) without having received provisional certification by completion of the Core training, and (b) without continuing pursuit of full certification as a CIPSS and maintaining certification as an Intentional Peer Support Specialist according to requirements as defined by SAMHS.

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92.02 PROVIDER REQUIREMENTS (cont.)

(5) Family or Youth Support Specialist –for children's services is an individual who has completed a designated Maine Office of Child and Family Services curriculum for peer supports and receives and maintains that certification.

The Youth Support Specialist is an individual who is receiving or has received services and supports related to the diagnosis of a mental illness, is in recovery from that illness, and who is willing to self-identify on this basis with BHH members.

The Family Support Specialist is an individual who has a family member who is receiving or has received services and supports related to the diagnosis of a mental illness, and who is willing to self-identify on this basis with BHH members.

Peer support staff may function as a Family/Youth Support Specialist for children's services without certification for the first nine months of functioning as a Family/Youth Support Specialist, but may not continue functioning as a Family/Youth Support Specialist for children's services beyond nine months: (a) without having received provisional certification by completion of the Core training, and (b) without continuing pursuit of full certification as a Family/Youth Support Specialist for children's services and maintaining certification as a Family/Youth Support Specialist according to requirements as defined by the Maine Office of Child and Family Services.

(6) Health Home Coordinator for Members with Serious Emotional Disturbance (SED) – shall be an individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR a who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school; OR who has been employed since August 1, 2009 as a case manager providing services under Chapter II, Section 13 of the *MaineCare Benefits Manual.*

The SED Health Home Coordinator shall draft the Plan of Care for each SED member, implement that Plan of Care and the coordination of services, and

92.02 PROVIDER REQUIREMENTS (cont.)

support and encourage members in actively participating in reaching the goals set forth in their Plan of Care.

(7) Health Home Coordinator for Members with Serious and Persistent Mental Illness (SPMI) – shall be an individual who is certified by the Department as a Mental Health Rehabilitation Technician/Community (MHRT/C).

The BHH Health Home Coordinator shall draft the Plan of Care for each member, oversee that Plan of Care and the coordination of services, and support and encourage members in actively participating in reaching the goals set forth in their Plan of Care.

(8) Medical Consultant – shall be a physician licensed by the State of Maine to practice medicine or osteopathy, a Physician's Assistant licensed as such by the State of Maine, or a Certified Nurse Practitioner who is a registered nurse who meets all of the requirements of the licensing authority of the State of Maine to practice as a Certified Nurse Practitioner.

The Medical Consultant shall collaborate with other providers of BHHO services and the HHP (at least 4 hours/month per 200 members or pro-rated for agencies that serve fewer than 200 clients) to select and implement evidence-based clinical initiatives, lead quality improvement efforts, evaluate progress, and convene provider clinical quality improvement meetings.

C. The BHHO must be co-occurring capable, meaning that the organization is structured to welcome, identify, engage and serve individuals with co-occurring substance abuse and mental health disorders and to incorporate attention to these issues into program content.

D. The BHHO must adhere to licensing standards in documentation of all its BHHO providers' qualifications in their personnel files. Pursuant to applicable licensing standards, the BHHO must have a review process to ensure that employees providing BHHO services possess the minimum qualifications set forth above.

E. The BHHO must be approved as a BHHO by MaineCare through the BHHO application process.

F. The BHHO must have an executed contract or Memorandum of Agreement with at least one HHP in its area that describes procedures and protocols for regular and systematized communication and collaboration across the two agencies, the roles and responsibilities of each organization in service delivery, and other information necessary to effectively deliver all BHH services to all shared members without duplication. This may include

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92.02 PROVIDER REQUIREMENTS (cont.)

names and contact information of key staff at BHHO and HHP, acceptable mode(s) of electronic communication to ensure effective and privacy-protected exchange of health information, frequency of communication at both leadership and practice levels (e.g., weekly, monthly, quarterly), procedures for bi-directional access to member plan of care and other health information, referral protocols for new members, collaboration on treatment plans and member goals and, as needed, Business Associate Agreement/Qualified Service Organization addenda.

G. Within twenty-four (24) months of the BHHO's participation, the BHHO must create and implement an EHR system and an EHR for each member.

H. The BHHO must participate in the Behavioral Health Home Learning Collaborative, and designate a leadership team to attend Learning Collaborative sessions at least two (2) times per year, which year shall run following the first day of the BHHO's participation. The leadership team shall consist of: the BHHO's Clinical Team Leader, and an additional Clinical Member. Within the first six (6) months following the start of the BHHO's participation, the BHHO shall obtain a written site assessment from the Department or its authorized agent, to establish a baseline status in meeting the Core Standards (below) and identify the BHHO's training and educational needs.

I. The BHHO must establish member referral protocols with area hospitals and child/adult residential facilities. The protocols must include coordination and communication on enrolled or potentially eligible members, The BHHO shall have systematic follow-up protocols to assure timely access to follow-up care.

J. Within one year of the BHHO's participation, the BHHO must fully implement the following Core Standards:

(1) Demonstrated Leadership – the BHHO identifies at least one Clinical Team Leader within the BHHO who implements and oversees the Core Standards.

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

The Clinical Team Leader participates as a member of the practice Leadership Team and participates in Behavioral Health Home learning opportunities regarding implementation offered by the Department.

92.02 PROVIDER REQUIREMENTS (cont.)

(2) Team-Based Approach to Care – the BHHO has implemented a team-based approach to care delivery that includes expanding the roles of non-licensed team professionals and includes Certified Intentional Peer Support Specialists as leaders and partners in the provision of care.

The BHHO utilizes non-licensed staff to improve access, efficiency, and member engagement in specific ways, including one or more of the following:

a. Through clear identification of roles and responsibilities;

b. Training on and integration of Certified Intentional Peer Support Specialists as meaningful partners in service delivery;

c. Regular team meetings.

(3) Population Risk Stratification and Management – the BHHO has adopted processes to identify and stratify members across their population who are at risk of adverse outcomes, and adopted procedures that direct resources or care processes to reduce those risks.

For purposes of this provision, "adverse outcomes" means hospitalization, institutionalization, involvement with law enforcement, job loss or home loss, which occur as a result of the member's Serious and Persistent Mental Illness or Serious Emotional Disturbance.

(4) Enhanced Access – the BHHO enhances access to services for their members, including:

a. The BHHO has a system in place that allows members to have same-day access to their 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.

b. The BHHO has processes in place to monitor and ensure this enhanced access to care.

(5) Comprehensive Consumer/Family Directed Care Planning – the BHHO has processes in place to ensure that consumer voice and choice is reflected in Plan of Care development. These processes include:

a. Wraparound principles for children with SED and their families.

b. Practice guidelines for recovery-oriented care.

92.02 PROVIDER REQUIREMENTS (cont.)

(6) Behavioral-Physical Health Integration – the BHHO has completed a baseline assessment of its behavioral-physical health integration capacity during its first year of participation as a BHHO. Using results from this baseline assessment, the BHHO has implemented one or more specific improvements to integrate behavioral and physical health care.

(7) Inclusion of Members and Families – the BHHO includes members and their family as documented and regular participants at leadership meetings, and/or the BHHO has in place a member-driven process to identify needs and solutions for improving services.

a. The BHHO has processes in place to support members and families to participate in these leadership and/or advisory activities (e.g., on the agency's Board of Directors, involvement in internal advisory committees that solicit and support the engagement of consumers and families in identifying needs and solutions, etc.);

b. The BHHO has implemented systems to gather member and family input at least annually (through mail surveys, phone surveys, point of care questionnaires, focus groups, or other methods); and

c. The BHHO has processes in place to design and implement changes that address needs and gaps in care identified via member and family input.

(8) Connection to Community Resources and Social Support Services – the BHHO has processes in place to identify and make referrals to local community resources and social support service, including those that provide support in self-management, to assist members in overcoming barriers to care and meeting health and recovery goals.

(9) Commitment to Reducing Waste, Unnecessary Healthcare Spending, and Improving Cost-Effective Use of Healthcare Services – the BHHO 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, such as:

a. Reducing avoidable hospitalizations;

b. Reducing avoidable emergency department visits;

92.02 PROVIDER REQUIREMENTS (cont.)

c. Working with specialists to develop new models of specialty consultation that improve member experience and quality of care, while reducing unnecessary use of services; and

d. Directing referrals to specialists who consistently demonstrate high quality and cost efficient use of resources.

(10) Integration of Health Information Technology – the BHHO uses an electronic data system that includes identifiers and utilization data about members. Member data is used for monitoring, tracking and indicating levels of care complexity for the purpose of improving member care.

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

a. The documentation of need and monitoring clinical care;

b. Supporting implementation and use of evidence-based practice guidelines;

c. Developing Plans of Care and related coordination; and

d. Determining outcomes (e.g., clinical, functional, recovery, satisfaction, and cost outcomes).

92.02-2 Health Home Practice (HHP)

A. The HHP must execute a MaineCare Provider Agreement.

B. The HHP must have received National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PPC-PCMH) Recognition within one (1) year from the date of enrollment and is located in the state of Maine.

C. The HHP must be approved as an HHP by the Department through the HHP application process.

D. The HHP must have a fully implemented EHR.

E. The HHP must have an executed contract or memorandum of agreement with at least one BHHO in its area that describes procedures and protocols for regular and systematized communication and collaboration across the two agencies, the roles and responsibilities of each organization in service delivery, and other information necessary to effectively deliver all BHH services to all shared members without duplication. This may include names and contact information of key staff at BHHO and HHP, acceptable mode(s) of electronic communication to ensure effective and

92.02 PROVIDER REQUIREMENTS (cont.)

privacy-protected exchange of health information, frequency of communication at both leadership and practice levels (e.g., weekly, monthly, quarterly), procedures for bi-directional access to member plan of care and other health information, referral protocols for new members, collaboration on treatment plans and member goals and, as needed, Business Associate Agreement/Qualified Service Organization addenda.

F. The HHP must have established member referral protocols with area hospitals and child/adult residential facilities. The protocols must include coordination and communication on enrolled or potentially eligible members. The HHP must have systematic follow-up protocols to assure timely access to follow-up care.

G. The HHP must provide comply with *MaineCare Benefits Manual*, Ch. VI, Section 1-Primary Care Case Management, Section 1.08-5-Twenty-Four Hour Coverage.

H. The HHP must participate in Maine's multi-payer Patient Centered Medical Home (PCMH) Learning Collaborative. The HHP shall designate a leadership team to attend day-long Learning Collaborative sessions at least two (2) times per year. The leadership team shall consist of: the HHP's physician leader, an administrative leader, and an additional clinical member.

I. Within one year of participation, the HHP must fully implement the following Core Standards:

1. **Demonstrated Leadership** – The HHP identifies at least one primary care physician or nurse practitioner as a leader within the practice who implements and oversees the Core 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.

2. **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.

92.02 PROVIDER REQUIREMENTS (cont.)

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.

3. **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," for purposes of this provision, 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.

4. **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 (i.e., the organization leaves some percentage of its appointment open for same-day/next 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.

5. **Practice Integrated Care Management** – The HHP has processes in place to provide care management services, and identifies specific

92.02 PROVIDER REQUIREMENTS (cont.)

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.

6. Behavioral Physical Health Integration – HHP has obtained a written site assessment of its behavioral-physical health integration capacity from the Department or its authorized agent 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;
- Included a behavioral health professional as part of the practice to assist with chronic condition management; and,
- Co-locate behavioral health services within in the practice.

7. 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.

92.02 PROVIDER REQUIREMENTS (cont.)

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.

8. **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.

9. **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.

10. **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

92.02 PROVIDER REQUIREMENTS (cont.)

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).

92.03 MEMBER ELIGIBILITY

Members must meet the eligibility requirements set forth in this section.

92.03-1 General Eligibility. Members must meet the eligibility criteria as set forth in the *MaineCare Eligibility Manual*, Chapter 1, Section 1.

92.03-2 Specific Requirements

A. **Serious and Persistent Mental Illness**. Adult members must meet the following criteria. Eligibility must be supported by written diagnosis(es), rendered by a physician, a physician assistant, or an independently licensed clinician, within the scope of the professional's license, and the diagnosis(es) shall be documented in the member's record.

1. Members must have a primary diagnosis on Axis I or Axis II of the multi-axial assessment system of the *Diagnostic and Statistical Manual of Mental Disorders IV*, or a mental health diagnosis under the *Diagnostic and Statistical Manual of Mental Disorders 5*, **except that** the following diagnoses may not be primary diagnoses for purposes of this eligibility requirement:

(a) Delirium, dementia, amnestic, and other cognitive disorders;

92.03 MEMBER ELIGIBILITY (cont.)

(b) Mental disorders due to a general medical condition, including neurological conditions and brain injuries;
(c) Substance abuse or dependence;
(d) Mental retardation;
(e) Adjustment disorders;
(f) V-codes; or
(g) Antisocial personality disorders.

AND

2. Has a LOCUS score, as determined by staff certified for LOCUS assessment by DHHS upon successful completion of prescribed LOCU S training, of seventeen (17) (Level III) or greater. The LOCUS assessment must be administered annually and documented in the member's record.

B. **Serious Emotional Disturbance**. Children members must meet the following criteria. Eligibility must be supported by written diagnosis(es), rendered by a physician, a physician assistant, or an independently licensed clinician, within the scope of the professional's license, and the diagnosis(es) shall be documented in the member's record.

1. Members must have received an Axis I or Axis II mental health diagnosis(es) as described in the *Diagnostic and Statistical Manual of Mental Disorders IV,* or a mental health diagnosis under the *Diagnostic and Statistical Manual of Mental Disorders V,* or a diagnosis described in the current version of the *Diagnostic Classification of Mental Health and Developmental Disabilities of Infancy and Early Childhood* (DC:0-3), except that the following diagnoses are not eligible for services in this section:

(a) Learning Disabilities in reading, mathematics, written expression;

(b) Motor Skills Disorder;

(c) Learning Disabilities Not Otherwise Specified;

(d) Communication Disorders (Expressive Language Disorders, Mixed Receptive Expressive Language Disorder, Phonological Disorder, Stuttering, and Communication Disorder Not Otherwise Specified;

92.03 MEMBER ELIGIBILITY (cont.)

AND

Members must also have a significant impairment or limitation in adaptive behavior or functioning according to a standardized tool:

a. CAFAS: if the eight (8) scale composite CAFAS score is at least fifty-one (51)

b. CANS: if assessment scores indicate a 2 or higher in both of the following sections: "Child Behavioral/Emotional Needs" AND "Life Domain Functioning".

c. The PECFAS and/or ASQ: SE: if indicating possible functional impairment(s) and together with other clinical information a comprehensive view of the child is developed and the need for case management services is identified.

C. **Eligibility Verification.** Member eligibility is determined by the Department or its agent, which must provide pre-authorization for services. Each member's eligibility must be based on a diagnosis rendered within the past year, as documented by an appropriately licensed professional. Reassessments shall occur at least annually in order to ensure ongoing eligibility for services provided herein. Eligibility verification shall be included in the member's record.

92.03-3 Ineligibility for Services. If members are eligible for services under Section 13 (Targeted Case Management), Section 17 (Community Integration Services), and/or Section 91 (Health Home Services), they may not receive those services at the same time that they receive Section 92 services herein. Members must choose among the different types of MaineCare services for which they are eligible, and such choice must be clearly documented in the member's record.

92.04 POLICIES AND PROCEDURES FOR MEMBER IDENTIFICATION AND ENROLLMENT

A. **Member Identification.** The Department or its agent shall identify certain members as potentially eligible for BHH services through claims and encounter data analyses, and shall assess the eligibility of other members upon request. The Department or its agent shall pre-authorize services before they are rendered, and members shall be assigned to or enrolled with Behavioral Health Home providers as follows:

92.04 POLICIES AND PROCEDURES FOR MEMBER IDENTIFICATION AND ENROLLMENT (cont.)

1. **Automatic Enrollment and Notice Requirements.** The Department or its agent shall identify members who meet Section 92 eligibility criteria, and who have received prior authorization for Section 17 Community Integration Services (CIS) or Section 13 Targeted Case Management (TCM) Services from that MaineCare provider that has been approved as a BHHO. These members will receive written notification from the Department that their provider has been approved to become a BHHO, and that they are eligible for BHH services. The notice shall provide information about the benefits of participating in a Health Home, and shall list all of the Health Home providers in the member's area. The notice shall clearly inform members that they will be automatically enrolled for BHH services with their current TCM/CIS provider (now a BHHO), and about their ability to opt out of enrollment for BHH services. The notice shall clearly explain that members must choose between the BHH services provided through Section 92, or to continue receiving services via Sections 13 or 17, but that they may not receive both services at the same time. The notice shall inform the member that, in the event he/she does not opt out, the member's Section 13 or 17 services shall be terminated. The notice shall set forth the requirements for opting out (i.e., – by returning a written notice, or making a phone call to the Department), and shall contain contact information for MaineCare Member Services to provide assistance to members in making this choice. If the member does not opt out within twenty-eight (28) days of receipt of the auto-enrollment notification, the member will be automatically enrolled by the Department in BHH services on either the 1st or the 15th of the month.

2. **Newly Eligible Members**. Members who meet Section 92 eligibility criteria but who do not receive CIS or TCM services will receive written notification of the benefits of participating in a Health Home, and a list of all Health Home providers in their area. Members will be encouraged to respond within twenty-eight (28) days of receiving the notification, but they may enroll for BHH services at any time.

3. **Requests and Referrals**. Members may request BHH services or be referred for BHH services by another MaineCare provider. The Department or its agent shall approve or deny the enrollment of such members within three (3) business days of a request for services.

92.04 POLICIES AND PROCEDURES FOR MEMBER IDENTIFICATION AND ENROLLMENT (cont.)

4. **Selection of an HHP**. Within six months following their enrollment with a BHHO, members must identify an HHP from among the HHPs that partner with the member's BHHO. If the member does not select an HHP within six months, the member shall cease to receive services from the BHHO, and shall receive a notice of termination of services.

B. Enrollment and Freedom of Choice

1. Enrollment in BHH services will be prospective only. The BHHO and HHP selection or enrollment is effective on the 1st or 15th of the month following the date that the member's enrollment is entered by the Department or its agent.

2. BHH services are optional. Any member may opt out of BHH services at any time, and may choose to receive services from any qualified BHHO and partnering HHP, by providing notice to the BHH provider and/or the Department. The choice to opt out or switch providers shall be effective on the first day of the following month, or five calendar days from the date of the opt out or change notice, whichever comes later, or as determined by the Department. Members who opt out of the service or switch providers shall be removed from the member list for that provider. BHH providers must transfer all the member's clinical documentation to the appropriate provider(s) within ten (10) business days of notification that a member shall transfer to a new BHH provider.

92.05 COVERED SERVICES

BHH services may be delivered face to face, via phone or other media, in any community location where confidentiality can be maintained, and are provided by the BHHO and HHP as follows:

92.05-1 Comprehensive Care Management

Comprehensive Care Management are services provided to assure that members receive timely and coordinated services and supports that address physical and behavioral health needs, and promote community and home-based recovery.

A. **Comprehensive Care Management Services – BHHO**: Within the first thirty (30) days following a member's enrollment for BHH services, the Health Home Coordinator, in consultation with other providers, as necessary, shall provide each member with a face to face meeting and a comprehensive assessment that identifies the medical, behavioral, mental health, social, residential, educational, vocational, and other related needs, strengths, and

92.05 COVERED SERVICES (cont.)

goals of the member (and the family/caretaker if the member is a minor), including utilization of screening tools for co-occurring disorders. The comprehensive review shall include a psychosocial assessment, including history of trauma and abuse, substance abuse, general health and capabilities, medication needs, member strengths and how they can be optimized to promote goals, available support systems, living situation, employment and/or educational status, and other relevant information. A reassessment must occur as change in the member's needs warrants or at a minimum on an annual basis.

C. **Plan of Care**. Based on the comprehensive assessment, within the first thirty (30) calendar days following a member's enrollment, the Health Home Coordinator in partnership with the member, shall draft a comprehensive, individualized, and member-driven Plan of Care, that shall identify and integrate behavioral and physical health needs and goals. The Plan of Care must be consented to by the member, as reflected by the member's signature on the Plan of Care, documented in the member's record, and accessible to the member, the BHHO and HHP. The Plan of Care may include, but not be limited to, information on prevention, wellness, peer supports, health promotion and education, crisis planning, and identifying other social, residential, educational, vocational, and community services and supports that enable a member to achieve physical and behavioral health goals. The member (or parent/guardian) plays a central and active role in the development of the Plan of Care, which shall clearly identify the goals and timeframes for improving the member's health and health care status, and the interventions that will produce this effect. The Plan of Care shall identify member strengths and how these strengths can be optimized to promote goals, The Plan of Care shall clearly identify providers involved in the member's care, such as the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), Health Home Coordinator, and other providers directly involved in the member's care.

All identified clinical services indicated in the Plan of Care must be approved by a medical or mental health professional working within the scope of his/her license. The Plan of Care must be reviewed and approved in writing by a medical or mental health professional within the first thirty (30) calendar days following acceptance of the Plan by the member, and every ninety (90) calendar days thereafter, or more frequently if indicated in the Plan of Care.

D. During the first three months after a member's enrollment, the BHHO shall provide individualized outreach, education and support to the member (and family, if the member is a minor) regarding BHH services and benefits, including information on sharing personal health information, and coordination with primary care services provided by HHPs. These services may be provided via in person meetings, follow up phone calls, development of written materials or presentations, assistance from Peer Support

92.05 COVERED SERVICES (cont.)

providers, and other strategies to ensure that the BHHO's members are fully educated and engaged with the needs and goals set forth in the Plan of Care.

E. The BHHO shall obtain written consent for services and authorization for release and sharing of information from each member.

F. During the first six months days after a member's enrollment, the BHHO shall provide information to members who do not have a treating relationship with a participating HHP to assist in establishing this relationship.

G. The Health Home Coordinator shall review the Plan of Care as change in the member's need occurs, or at least every ninety (90) days, to determine the efficacy of the services and supports, and formulate changes in the Plan as necessary. The BHHO shall consult with the HHP and the member as necessary, and update the Plan accordingly to ensure that it remains current. The BHHO shall be responsible for the management, oversight and implementation of the Plan of Care, including ensuring active member participation and that measurable progress is being made on the goals identified in the Plan of Care. The member may decline to receive services identified in the Plan of Care, in which case the BHHO must document such declination in the member's record.

H. The BHHO shall scan for gaps in each member's care by reviewing utilization reports for data across the following domains, and communicate any gaps in care to the member and the HHP:

1. Hospitalizations in the last quarter as well as the last year;
2. Emergency Department visits in the last quarter as well as the last year;
3. Patients with total paid claims greater than $10,000;
4. Patients with eleven (11) or more medications;
5. Patients with no PCP visits in the last year;
6. Patients with no HbA1c test (diabetes) in the last quarter;
7. Patients with no LDL panel (diabetes) in the last year; and
8. Patients with no LDL panel in the last year (CVD).

I. **Comprehensive Care Management Services – HHP**: The HHP shall coordinate with the member and the BHHO in the development of the Plan of Care and ensure that current medical information regarding all physical health conditions, including lab tests/results, and medications, are shared and incorporated in the Plan of Care.

J. The HHP shall conduct clinical assessment, monitoring and follow up of physical and behavioral health care needs, conduct medication review and reconciliation, monitor chronic conditions, weight/BMI, tobacco and other substance use, and communicate regularly with

92.05 COVERED SERVICES (cont.)

the BHHO and other treatment providers, as necessary, to identify and coordinate a member's emerging care management needs.

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

a. 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.

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

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

d. 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.

L. The HHP shall scan for gaps in each member's care by reviewing utilization reports for data across the following domains, and communicate any gaps in care to the member and the BHHO:

1. Hospitalizations in the last quarter as well as the last year;
2. Emergency Department visits in the last quarter as well as the last year;
3. Patients with total paid claims greater than $10,000;
4. Patients with eleven (11) or more medications;
5. Patients with no PCP visits in the last year;
6. Patients with no HbA1c test (diabetes) in the last quarter;
7. Patients with no LDL panel (diabetes) in the last year; and
8. Patients with no LDL panel in the last year (CVD).

92.05-2 Care Coordination

Care Coordination is a set of services designed to support the member (and family/guardian if the member is a minor) in the implementation of the Plan of Care.

A. **Care Coordination Services – BHHO**: For each member, the BHHO shall identify specific resources and the amount, duration, and scope of services necessary to achieve the goals identified in the Plan of Care.

92.05 COVERED SERVICES (cont.)

B. The BHHO shall provide referrals to other services and supports, as identified in each member's Plan of Care, and shall follow up with each member to ensure that the member takes action in regard to each referral. The BHHO shall have an organizational understanding and provide systematic identification of local medical, community, and social services and resources that may be needed by the member.

C. The BHHO shall assign to each member a Health Home Coordinator, who shall be responsible for overall management of the Plan of Care, and coordinate and provide access to other providers, including the HHP, as set forth in the Plan of Care.

Members shall have only one Health Home Coordinator, and cannot be enrolled in more than one care management program funded by Medicaid.

D. The BHHO shall ensure that it has policies and procedures in place to ensure that the Health Home Coordinator can communicate with treating clinicians on an as needed basis, changes in patient condition that may necessitate treatment change.

E. The BHHO shall follow up with each member following a hospitalization, use of crisis service, or out of home placement.

F. The BHHO shall ensure that members have access to crisis intervention and resolution services, coordinate follow up services to ensure that a crisis is resolved, and assist in the development and implementation of crisis management plans. Unless other resources are preferred by the member, crisis services are DHHS-funded crisis providers in the community.

G. The BHHO shall coordinate and facilitate access to psychiatric consultation and/or medication management.

H. **Care Coordination Services – HHP**: For each member, the HHP shall coordinate and provide access to high quality physical health and treatment services identified in the Plan of Care, including the identification and referral to physical health care specialty providers. The HHP shall consult and coordinate with the BHHO to facilitate successful referral to all necessary services and supports identified in the Plan of Care.

92.05-3 Health Promotion

Health Promotion is a set of services that emphasize self-management of physical and behavioral health conditions, in an effort to assist the member in the implementation of the Plan of Care.

A. **Health Promotion Services – BHHO:** The BHHO shall provide education, information, training and assistance to members in developing self-monitoring and management skills.

92.05 COVERED SERVICES (cont.)

C. The BHHO shall promote healthy lifestyle and wellness strategies, including but not limited to: substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activities.

D. The BHHO shall coordinate and provide access to self-help/self-management and advocacy groups, and shall implement population-based strategies that engage members about services necessary for both preventative and chronic care. For members who are minors, the BHHO shall provide training to the member's parent/guardian in regard to behavioral management and guidance on at-risk behavior.

E. **Health Promotion Services – HHP**: The HHP shall coordinate with the member and the BHHO to identify and provide access to necessary Health Promotion Services, based on each member's needs, as set forth in the Plan of Care, including providing education about the management of chronic physical conditions.

F. The HHP shall review all discharge plans, monitor and review medication and lab results, and regularly communicate about these efforts with the BHHO.

92.05-4 Comprehensive Transitional Care

Comprehensive Transitional Care services are designed to ensure continuity of care and prevent the unnecessary use of emergency rooms, hospitals, and/or out of the home placement of members.

A. **Comprehensive Transitional Care Services – BHHO**: The BHHO shall have in place processes and procedures with local inpatient facilities, emergency departments, residential facilities, crisis services, and corrections for prompt notification of an individual's admission and/or planned discharge to/from one of these facilities.

B. The BHHO shall collaborate with facility discharge planners, the member and the member's family or other support system, as appropriate, to ensure a coordinated, safe transition to the home/community setting, and to prevent avoidable readmission after discharge. The BHHO shall assist the member with the discharge process, including outreach in order to assist the member with returning to the home/community.

C. The BHHO shall collaborate with members, their families, and facilities to ensure a coordinated, safe transition between different sites of care, or transfer from the home/community setting into a facility. The BHHO shall assist the member in exploration of less restrictive alternatives to hospitalization/institutionalization.

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92.05 COVERED SERVICES (cont.)

D. The BHHO shall ensure a continuity of care and the coordination of services for members in transitional care. The BHHO shall provide timely and appropriate follow up communications on behalf of transitioning members, which includes a clinical hand off, timely transmission and receipt of the transition/discharge plan, review of the discharge records, and coordination of medication reconciliation.

E. The BHHO shall facilitate, coordinate, and plan for the transition of members from children's services to the adult system.

F. **Comprehensive Transitional Care Services – HHP**: The HHP shall review any and all discharge plans and timely follow up with the member regarding physical health needs, including medication reconciliation, consult with the BHHO regarding same, and update the member's Plan of Care accordingly.

92.05-5 Individual and Family Support Services

Individual and family support services include assistance and support to the member and/or the member's family in implementing the Plan of Care.

A. **Individual and Family Support Services – BHHO**: The BHHO shall provide assistance with health-system navigation, and training on self-advocacy techniques.

B. In accordance with the members Plan of Care, the BHHO shall provide information, consultation, and problem-solving supports, if desired by a member, to the member, and his or her family or other support system, in order to assist the member in managing symptoms or impairments of his or her illness.

C. The CIPSS shall coordinate and provide access to Peer Support Services, Peer advocacy groups, and other Peer-run or Peer-centered services, maintain updated information on area Peer services, and shall assist the member with identifying and developing natural support systems.

D. The BHHO shall document in the Plan of Care the member's family or caregiver support systems and preferences. If authorized by the member, the Plan of Care shall be accessible to the member's family or other caregivers.

E. The BHHO shall discuss advance directives with members and their family or caregivers, as appropriate.

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92.05 COVERED SERVICES (cont.)

F. The BHHO shall assist the member in developing communication skills necessary to request assistance or clarification from supervisors and co-workers when needed and in developing skills to enable the individual to maintain employment.

G. **Individual and Family Support Services – HHP**: The HHP shall assist the member with medication and treatment management and adherence, and shall document such efforts in the member's EHR.

92.06 NON-COVERED SERVICES AND LIMITATIONS

A. A member may receive Section 92 services from only one BHHO and one HHP. BHH services do not preclude a member from receiving other medically necessary services.

B. Only the Covered Services set forth herein shall be reimbursable through Section 92.

C. Payment for BHH services must not duplicate payments made by public agencies or private agencies under other program authorities for health home, case management, or service coordination services.

D. Adult members who are provided Section 92 services shall not also receive services under Sections 17.04-1 (Community Integration Services), 17.04-2 (Community Rehabilitation Services), 17.04-3 (Intensive Case Management Services), 17.04-4 (Assertive Community Treatment), or Section 13 (Targeted Case Management) of the *MaineCare Benefits Manual*.

E. Children who are provided Section 92 services shall not also receive services under Section 13 (Targeted Case Management).

It is the duty and obligation of the BHHO and the HHP to review the entirety of each member's services and ensure that the Section 92 services do not duplicate similar services that may be provided.

F. Only one Behavioral Health Home Team shall be allowed for each member receiving Section 92 services.

92.07 REPORTING REQUIREMENTS

In addition to the documentation and reporting requirements of the *MaineCare Benefits Manual*, Chapter I, Section I, and other reports that may be required by the Department, the BHHO and the HHP shall report quarterly, in the format designated by the Department, on activities and improvement upon the following. Providers that fail to timely or adequately file reports or satisfy

92.07 REPORTING REQUIREMENTS (cont.)

the benchmarks defined by the Department may be terminated from providing Section 92 services.

A. **The Core Standards:** BHHOs and HHPs shall report on the Core Standards in 92.02-1(J) (BHHOs) and 92.02-2(I) (HHPs).

B. **The Health Home Provider Functional Requirements**. The BHHO shall fully satisfy the Functional Requirements within 18 months of being approved as a BHHO, and shall report upon each of the Functional Requirements, showing progress towards full implementation of the Requirements:

1. Provide quality-driven, cost-effective, culturally appropriate, and consumer and family-centered health home services;
2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
3. Coordinate and provide access to preventative and health promotion services, including prevention of mental illness and substance abuse disorders;
4. Coordinate and provide access to treatment for mental health and substance abuse services;
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient or other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
8. Coordinate and provide access to long term care supports and services;
9. Develop a person-centered Plan of Care for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the providers and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

92.07 REPORTING REQUIREMENTS (cont.)

C. **Health Home Quality Measures** – The BHHO and HHP shall submit data necessary to compile and report on Behavioral Health Home Quality Measures as identified by the Department and posted to the Behavioral Health Home webpage. Data sources may include but are not limited to claims, clinical data, the DHHS Enterprise Information System, APS submissions, and surveys.

92.08 DOCUMENTATION AND CONFIDENTIALITY

In addition to the requirements, above, and set forth in Chapter I, Section I, the BHHO and the HHP must maintain a specific record and documentation of services for each member receiving covered services.

A. **Records.** The member's record must minimally include:

1. Name, address, birthdate, and MaineCare identification number;
2. Diagnosis(es) that support eligibility for services herein, including the most recent documentation of diagnoses that substantiate ongoing eligibility for services;
3. The comprehensive assessment that must occur within the first thirty (30) days of initiating of services, and any reassessments that occur;
4. The Plan of Care;
5. Correspondence to and from other providers;
6. Release of information statements as necessary, signed by the member or
7. Documentation/record entries (i.e. progress notes) for each service provided, including the date of service, the type of service, the place of the service or method of delivery (ie, phone contact), the goal to which the service relates, the duration of the service, the progress the member has made towards goal attainment, the signature and credentials of the individual performing the service, whether the individual has declined services in the Plan of Care, and timelines for obtaining needed services.

B. **Confidentiality and Disclosure of Confidential Documents/Information**. Providers shall maintain the confidentiality of information regarding these members in accordance with Chapter I, Section I of the *MaineCare Benefits Manual*, 42 C.F.R. §§ 431.301-306, 22 M.R.S.A. §1711-C, and with all other applicable sections of state and federal law and regulation.

92.09 MINIMUM REQUIREMENTS FOR REIMBURSEMENT

Reimbursement for Section 92 services shall be as follows:

A. Minimum Requirements for BHHO Reimbursement. In order for the BHHO to be eligible for the per member per month (PMPM) payment, for each member for each calendar month, the BHHO shall:

1. In collaboration with the member and the HHP, develop a Plan of Care pursuant to the requirements herein, or review and update the Plan of Care within the last ninety (90) days;
2. Submit cost and utilization reports upon request by the Department, in a format determined by the Department; AND

3. Deliver at least one hour of at least one Section 92 Covered Service to a member eligible for Section 92 services, pursuant to the member's Plan of Care.

The BHHO must document each service provided to each member, for each calendar month, in order to be eligible to receive the PMPM reimbursement.

B. **Minimum Requirements for HHP Reimbursement.** In order for the HHP to be eligible for a PMPM, for each member for each calendar month, the HHP shall scan for gaps in care, pursuant to the requirements set forth herein.

The HHP must document this scan for care in order to be eligible to receive the PMPM reimbursement.

C. **Duplication of Services Will Not Be Reimbursed**. The Department shall not reimburse BHH providers for members receiving Section 92 services if:

1. **For adults:** The member is also receiving Sections 17.04-1 (Community Integration Services), 17.04-2 (Community Rehabilitation Services), 17.04-3 (Intensive Case Management Services), 17.04-4 (Assertive Community Treatment, Section 13 (Targeted Case Management), or Section 91 (Health Home Services) of the *MaineCare Benefits Manual*.
2. **For children**: The member is also receiving services pursuant to Section 13 (Targeted Case Management), or Section 91 (Health Home Services) of the *MaineCare Benefits Manual*.
3. Similar services provided through the home and community-based waiver services authorized by Section 1915(c) of the Social Security Act that are described elsewhere in the *MaineCare Benefits Manual*, including, but not limited to, the services described in Sections 12, 21, 22 and 29.