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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. The BHHO is the lead Behavioral Health Home entity.

**92.01-2 Electronic Health Record (EHR)** – An EHR 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.

**92.01-3 Health Home Practice (HHP)** – A HHP is an enhanced 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.

**92.01-4 National Committee for Quality Assurance** **(NCQA)** - a private, 501(c)(3) not-for-profit organization dedicated to improving health care quality.

**92.01-5 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. Provider must maintain documentation of all processes and procedures described below that is available upon request, for review by the Department.

**92.02-1 Behavioral Health Home Organization (BHHO)**

A. The BHHO must execute a MaineCare Provider Agreement.

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

C. The BHHO must be a community-based mental health organization, licensed to provide services in the state of Maine, that provides case management to adult and/or

**92.02 PROVIDER REQUIREMENTS** (cont.)

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. **The Department shall seek and anticipates receiving CMS approval for this Section.** Pending approval, each role must be filled by a different individual. If there is a lapse in fulfillment of team member roles of greater than thirty (30) continuous days, the BHHO must notify the Department in writing and maintain records of active recruitment to fill the position(s).

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 (3) 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 a psychiatric and mental health advanced practice registered nurse (PMH-APRN) 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.

The Psychiatric Consultant shall consult with other BHHO and primary care 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 where services are provided and certified by the American Nurses Credentialing Center (ANCC) as a psychiatric and mental health nurse; a PMH-APRN who is licensed as a nurse practitioner or clinical nurse specialist by the state 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; or an advanced 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 primary care practice and the member to provide other Section 92 services as necessary, pursuant to the Plan of Care.

**92.02 PROVIDER REQUIREMENTS** (cont.)

**(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 conditional II licensed clinical professional counselor, licensed marriage and family therapist, advanced practice registered nurse such as a PMH-APRN; 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)** – (for adult services) is an individual who has completed the Maine Office of Behavioral Health (OBH) 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 (9) months of functioning as a CIPSS, but may not continue functioning as a CIPSS beyond nine (9) months without: (a) having received provisional certification by completion of the Core training, and (b) continuing pursuit of full certification as a CIPSS and maintaining certification as an Intentional Peer Support Specialist according to requirements as defined by SAMHS.

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.

**(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 (OCFS) 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.

**92.02 PROVIDER REQUIREMENTS** (cont.)

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 (9) 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 OCFS.

**(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 (4) 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 (4) year educational institution

in an unrelated field and at least one (1) 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 utilizing a Child and Adolescent Needs and Strengths assessment tool (CANS) information, implement 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.

Each member shall have only one Health Home Coordinator and cannot be enrolled in more than one case management program funded by Medicaid.

**(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 SPMI Health Home Coordinator shall draft the Plan of Care for each member, oversee that Plan of Care and the coordination of services, and support

**92.02 PROVIDER REQUIREMENTS** (cont.)

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

Each member shall have only one Health Home Coordinator and cannot be enrolled in more than one case management program funded by Medicaid.

**(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 meets all of the requirements of the licensing authority of the State of Maine.

The Medical Consultant shall collaborate with other providers of BHHO and primary care services (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.

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

F. The BHHO must have an executed contract or Memorandum of Agreement with at least one (1) 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, pay and receive reimbursement for all BHH services to all shared members without duplication. This may include names and contact information of key staff at the 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. The BHHO must have an EHR system and an EHR for each member.

H. The BHHO shall have in place processes, and procedures, and member referral protocols with local inpatient facilities, Emergency Departments (ED), child/adult

**92.02 PROVIDER REQUIREMENTS** (cont.)

residential facilities, crisis services, and corrections for prompt notification of an individual’s admission and/or planned discharge to/from one of these facilities or services. 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.

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

J. The BHHO must participate in BHH technical assistance opportunities, as determined by the Department. At least one (1) member of the care team described in 92.02-1(C) must engage in these opportunities.

1. 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 entity, to establish a baseline status in meeting the Core Standards (92.02-1 (L)) and identify the BHHO’s training and educational needs.

L. For the first year of participation, the BHHO must submit quarterly reports on progress towards implementing the Core Standards. Within one year of the BHHO’s participation, the BHHO must fully implement the Core Standards.

Once Core Standards are fully implemented, the BHHO may request the Department’s approval to submit the Core Standard progress report annually instead of quarterly.

The Core Standards are:

1. **Demonstrated Leadership** – The BHHO identifies at least one (1) 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.

1. **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 CIPSS 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:

1. Through clear identification of roles and responsibilities;

**92.02 PROVIDER REQUIREMENTS** (cont.)

1. Training on and integration of CIPSS as meaningful partners in service delivery;
2. 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 SPMI or SED.

1. **Enhanced Access** – The BHHO enhances access to services for their members, including:
2. The BHHO has a system in place, such as an on call or answering service, for BHH members to reach a member of the organization or an authorized entity twenty-four (24) hours a day, seven (7) days a week to address and triage the members’ needs.
3. The BHHO has processes in place to ensure twenty-four (24) hours a day, seven (7) days a week access to BHH member records.
4. 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:
6. Wraparound principles for children with SED and their families.
7. Practice guidelines for recovery-oriented care.
8. **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.
9. **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.

**92.02 PROVIDER REQUIREMENTS** (cont.)

1. 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.);
2. 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
3. The BHHO has processes in place to design and implement changes that address needs and gaps in care identified via member and family input.
4. **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.
5. **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:
6. Reducing avoidable hospitalizations;
7. Reducing avoidable ED visits;
8. 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
9. 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:

1. The documentation of need and monitoring clinical care
2. Supporting implementation and use of evidence-based practice guidelines;
3. Developing Plans of Care and related coordination; and

**92.02 PROVIDER REQUIREMENTS** (cont.)

1. Determining outcomes (e.g., clinical, functional, recovery, satisfaction, and cost outcomes).
	* 1. **Health Home Practice (HHP)**
2. The HHP must execute a MaineCare Provider Agreement.
3. 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 be located in the state of Maine.
4. The HHP must be approved as an HHP by the Department through the HHP application process.
5. The HHP must have a fully implemented EHR.
6. 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, pay, and receive reimbursement for all BHH services to all shared members without duplication. This may include names and contact information of key staff at the 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.
7. 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.
8. The HHP must comply with *MaineCare Benefits Manual*, Ch. VI, Section 1-Primary Care Case Management, Section 1.08-5-Twenty-Four Hour Coverage.
9. The HHP must participate in Health Home technical assistance opportunities, as determined by the Department, and as described in Section 91, Health Homes. (10-144 C.M.R. Ch. 101, Ch. II, Sec. 91.03-1(9)(a))
10. Within one (1) year of participation, the HHP must fully implement the following Core Standards, as described in Section 91, Health Home Services.

**92.02 PROVIDER REQUIREMENTS (cont.)**

**92.02-3** **Protections for Adults with Serious and Persistent Mental Illness**

If the member is an Adult with a Serious and Persistent Mental Illness (*i.e.,* the member meets eligibility criteria in 92.03-2(A)) and is receiving Behavioral Health Home Services reimbursed under Section 92, as identified in the member’s Plan of Care, then the provider must:

* + - 1. Obtain written approval from the Director of the Office of Behavioral Health (OBH) (or designee) prior to terminating services to that member;
				1. Written approval is not required in cases where the terminating provider has successfully facilitated a member’s transfer, with the member’s consent, to a new provider;
			2. If approved by OBH, issue a thirty (30) day advanced written termination notice to the member prior to termination of member’s services. In cases where the member poses a threat of imminent harm to persons employed or served by the provider, the Director of the Office of Behavioral Health (or designee) may approve a shorter notification for termination of services;
			3. Assist the member in obtaining clinically necessary services from another provider prior to discharge or termination;
			4. Accept referrals through the Department-defined referral process within seven (7) calendar days. Only in cases where providers have received written approval of declination from OBH, may a referral be declined.

**92.02-4 Timeliness and Duration of Care**

For Behavioral Health Homes serving Adults with Serious and Persistent Mental Illness (*i.e*., the member meets eligibility criteria in 92.03-2(A)), providers must conduct an initial face-to-face intake or initial assessment visit within seven (7) calendar days of referral, regardless of source of referral. In the event a provider receives a referral and does not have capacity to initiate services, the provider must offer the option of placing the member on a hold for service.

A. **Hold for Service**

Members have the option to be placed on hold for service if the agency, upon receipt of a referral from any source, has determined that it does not have the capacity to conduct an intake or initial assessment within seven (7) calendar days as required in Sec. 92.02-4. To be placed on hold for

service, providers must offer the member alternatives to being placed on hold for service, including but not limited to giving information on other service providers within a 25-mile radius servicing the area. This

**92.02 PROVIDER REQUIREMENTS** (cont.)

information shall be provided in writing. Should members wish to be on hold for service with an agency, the provider will document the member choice and the offering of alternatives in the member’s referral record. At this time, the seven (7) calendar day face-to-face requirement will be suspended. Agencies must follow up with members no more than thirty (30) calendar days after being placed on hold to reevaluate their desire to remain on hold for service, which will be documented in the member record. Agencies must continue to follow up with members in successive thirty (30) day increments to reevaluate the member’s desire to remain on hold. When the agency has determined it has the capacity to serve the member, it will contact the member immediately and have seven (7) calendar days to conduct the intake or initial assessment.

**92.03 MEMBER ELIGIBILITY**

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

* + 1. **General Eligibility**. Members must meet the eligibility criteria as set forth in the *MaineCare Eligibility Manual*, Chapter 1, Section 1.
		2. **Specific Requirements**
1. **Serious and Persistent Mental Illness (SPMI)**. 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.
2. Members must have a primary mental health diagnosis under the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders*, **except that** the following diagnoses may not be primary diagnoses for purposes of this eligibility requirement:
	* 1. Delirium, dementia, amnestic, and other cognitive disorders;
		2. Mental disorders due to a general medical condition, including neurological conditions and brain injuries;
		3. Substance use or dependence;
		4. Intellectual disability;
		5. Adjustment disorders;
		6. Z-codes; or
		7. Antisocial personality disorder.

AND

**92.03 MEMBER ELIGIBILITY** (cont.)

* 1. Has a LOCUS score, as determined by staff certified for LOCUS assessment by DHHS upon successful completion of prescribed LOCUS training, of seventeen (17) (Level III) or greater. The LOCUS assessment must be administered annually and documented in the member’s record.
1. **Serious Emotional Disturbance (SED)**. 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.

Members must have a mental health diagnosis under the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders,* or a diagnosis described in the current version of the *Diagnostic Classification of Mental Health and Developmental Disabilities of Infancy and Early Childhood*, except that the following diagnoses are not eligible for services in this section:

1. Learning Disabilities in reading, mathematics, written expression;
2. Motor Skills Disorder;
3. Learning Disabilities Not Otherwise Specified;
4. Communication Disorders (Expressive Language Disorders, Mixed Receptive Expressive Language Disorder, Phonological Disorder, Stuttering, and Communication Disorder Not Otherwise Specified;

AND

1. After the initial month of BHH enrollment, members must also have a significant impairment or limitation in adaptive behavior or functioning as evidenced by a CANS score of a two (2) or higher in both of the following sections: “Child Behavioral/Emotional Needs” and “Life Functioning Domain.” The CANS must be reviewed and updated by the BHH a minimum of every one hundred and eighty days (180) days or sooner when major changes occur. The CANS, including all age relevant domains, must be entered into the Maine ASO database, or approved equivalent data system, for tracking and reporting purposes. Information gathered via the CANS must be used to inform and guide the development of the Plan of Care, described in 92.05-1.
2. **Eligibility Verification.** Member eligibility is determined by the Department or its authorized entity, 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.

* 1. **POLICIES AND PROCEDURES FOR MEMBER IDENTIFICATION AND ENROLLMENT**

**92.04-1 Member Identification**

 **The Department shall seek and anticipates receiving approval of this Section.** Pending approval, the BHH provider shall identify members who are potentially eligible for BHH services based on the eligibility criteria for BHH Services. The BHH provider will submit potentially eligible members through a certification process to approve services.

**92.04-2 Enrollment and Freedom of Choice**

**A. Enrollment.** **The Department shall seek and anticipates receiving CMS approval of this Section.** Pending approval, the BHH Provider will identify members for BHH based on the BHH eligibility criteria. Potentially eligible members will be given information about the benefits of participating in a BHH. The member can choose to be part of BHH once confirmed eligible. They must be approved through a certification process, with the certification effective the earliest date without risk of duplicative services. The member can choose to not participate at any time by notifying their BHH provider or the Department’s authorized entity.

1. **Requests and Referrals**. Members may request BHH services or be referred for BHH services by another MaineCare provider. The Department or its authorized entity shall approve or deny the enrollment of such members within three (3) business days of a request for services.
2. **Selection of a primary care practice**. Upon entry of enrollment with a BHHO, the BHHO will work with the member to identify an HHP or other primary care provider.
3. **Duplication and Freedom of Choice.** A member may not receive services under this Section at the same time the member is receiving services under Section 13, Targeted Case Management Services; Section17, Community Support Services; Section 91, Health Home Services; or, Section 93, Opioid Health Home Services. If, through the certification process, the member is determined to be receiving a duplicative service, the member must choose which service they want to receive, and such choice must be clearly documented in the member’s record.

A member may opt out of BHH services at any time, and may choose to receive services from any qualified BHHO, by providing notice to the BHHO provider. The choice to switch providers shall be effective on the 21st day of the following month,

or the first available date when a duplication of service does not exist. Members who switch providers shall be removed from the member list for that provider. BHHO 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 BHHO provider.

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

Providers that offer Section 13, Section 17, Section 91, and/or Section 93 services and also Section 92 services must be able to demonstrate that members are provided with information regarding choice of Section 13, Section 17, Section 91, Section 93 and Section 92 services for which the member is eligible and which the provider offers.

**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. Not all aspects of BHH covered services require direct member involvement; however, all covered services require that provider activities are directly related to an individual member, are member-informed, and pursuant to the member’s Plan of Care. BHH covered services are services 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.

1. **Comprehensive Care Management Services – BHHO**:
2. **Comprehensive Assessment**. 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 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 use, 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.
3. **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 BHHO shall be responsible for the management, oversight, and implementation of the Plan of Care,

**92.05 COVERED SERVICES** (cont.)

including ensuring active member participation and that measurable progress is being made on the goals identified in the Plan of Care.

1. 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, HHP and other providers, as appropriate.
2. The BHHO shall obtain written consent for services and authorization for release and sharing of information from each member.
3. 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.
4. The member (or parent/guardian) plays a central and active role in the development and maintenance 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.
5. If authorized by the member, the BHHO shall document in the Plan of Care the member’s family, guardian(s), or caregiver support systems and preferences. If authorized by the member, the Plan of Care shall be accessible to the member’s family, guardian(s), or other caregivers.
6. The Plan of Care shall identify member strengths and how these strengths can be optimized to promote goals.
7. 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.
8. 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.
9. 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. The Health Home Coordinator with other care team members, as appropriate, shall review the Plan of Care as changes in the member’s needs occur, or at least

every ninety (90) days, to determine the efficacy of the services and supports, and formulate changes in the Plan as necessary, with member consultation.

1. The BHHO shall consult with care team members and the member as necessary, and update the Plan accordingly to ensure that it remains current.
2. 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.

**92.05 COVERED SERVICES** (cont.)

* 1. **Integration with Primary Care.** During the first three (3) 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 BHHO services and benefits, including information on sharing personal health information, and coordination with primary care services. These services may be provided via in-person meetings, follow up phone calls, development of written materials or presentations, assistance from Peer Support 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.

The BHHO shall scan for gaps in each member’s care by reviewing, at a minimum, utilization reports for data across the following domains, and work with the member and appropriate providers to address any gaps in care:

1. Hospitalizations in the last quarter as well as the last year;
2. ED 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).

B. **Comprehensive Care Management Services – HHP**:

1. 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.

**(2)** 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 the BHHO and other treatment providers, as necessary, to identify and coordinate a member’s emerging care management needs.

Specifically, HHPs shall have processes in place to conduct the following screenings and assessments for all of their assigned BHH 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:

**92.05 COVERED SERVICES** (cont.)

* 1. Depression and substance use screening (PHQ9 and AUDIT, DAST) for all adults with chronic illness, and substance use screening (CRAFFT) for adolescents.
	2. 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.

**(3)** The HHP shall scan for gaps in each member’s care by, at a minimum, reviewing utilization reports for data across the following domains, and work with the BHHO and the member to address any gaps in care:

1. Hospitalizations in the last quarter as well as the last year;
2. ED 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.

1. **Care Coordination Services – BHHO**
2. 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. 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.
3. 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.
4. 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.
5. 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

**92.05 COVERED SERVICES** (cont.)

plans. Unless other resources are preferred by the member, crisis services are DHHS-funded crisis providers in the community.

1. The BHHO shall coordinate and facilitate access to psychiatric consultation and/or medication management.
2. **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.

1. **Health Promotion Services – BHHO**
2. The BHHO shall provide education, information, training and assistance to members in developing self-monitoring and management skills.
3. 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.
4. 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.
5. **Health Promotion Services – HHP**
6. 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.
7. 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 COVERED SERVICES** (cont.)

**92.05-4 Comprehensive Transitional Care**

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

1. **Comprehensive Transitional Care Services – BHHO**
2. 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.
3. The BHHO shall assist the member with the discharge process, including outreach in order to assist the member with returning to the home/community.
4. The BHHO shall follow up with each member following a hospitalization, use of crisis service, or out of home placement.
5. 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.
6. The BHHO shall assist the member in exploration of less restrictive alternatives to hospitalization/ institutionalization.
7. 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.
8. The BHHO shall facilitate, coordinate, and plan for the transition of members from children’s services to the adult system.
9. **Comprehensive Transitional Care Services – HHP**
10. 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.

**92.05 COVERED SERVICES** (cont.)

1. **Individual and Family Support Services – BHHO**
2. The BHHO shall provide assistance with health-system navigation, and training on self-advocacy techniques.
3. 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.
4. The CIPSS shall coordinate and provide access to Peer Support Services, Peer advocacy groups, and other Peer-run or Peer-centered services, and shall assist the member with identifying and developing natural support systems.
5. The BHHO shall discuss advance directives with members and their family, guardian(s), or caregivers, as appropriate.
6. 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.
7. **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.

**92.05-6 Referral to Community and Social Support Services**

Referral to Community and Social Support Services involves providing assistance to members to obtain and maintain diverse services and supports as identified in their Plan of Care. Referral to community and social services involves an organizational understanding and systematic identification of area resources, services and supports

1. **Referral to Community and Social Support Services - BHHO**
	1. Services may include outreach and coordination by providers, as needed to ensure a successful referral, and may include reminders and scheduling appointments.
	2. The BHHO will also provide linkages to services, including linkages to long-term care services and home and community supports.
2. **Referral to Community and Social Support Services – HHP.** Clinical staff at the HHP may provide referrals to community and social supports.

**92.06 NON-COVERED SERVICES AND LIMITATIONS**

1. 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.
2. Only the Covered Services set forth herein shall be reimbursable through Section 92.
3. 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 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 the benchmarks defined by the Department may be terminated from providing Section 92 services.

1. **The Core Standards:** BHHOs and HHPs shall report on the Core Standards in 92.02-1(L) (BHHOs) and 92.02-2(I) (HHPs).
2. **Health Home Quality Measures:** The BHHO and HHP shall submit data necessary to compile and report on Behavioral Health Home Performance 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, certification 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.

1. **Records.** The member’s record must minimally include:
2. Name, address, birthdate, and MaineCare identification number;
3. Diagnosis(es) that support eligibility for services herein, including the most recent documentation of diagnoses that substantiate ongoing eligibility for services;
4. The comprehensive assessment that must occur within the first thirty (30) days of initiating of services, and any reassessments that occur;
5. The Plan of Care;

**92.08 DOCUMENTATION AND CONFIDENTIALITY** (cont.)

1. Correspondence to and from other providers;
2. Release of information statements as necessary, signed by the member or guardian;
3. 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 (i.e., 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.

1. **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:

1. **Minimum Requirements for BHHO Reimbursement. The Department shall seek and anticipates receiving CMS approval for this Section. Pending approval,** 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:
2. In collaboration with the member and other appropriate providers, including but not limited to the primary care practice, and in accordance with 92.05-1(A)( 2) develop and/or update the Plan of Care with pertinent information from monthly activities or developments;
3. Submit cost and utilization reports upon request by the Department, in a format determined by the Department;
4. Scan the utilization data, as identified by MaineCare, for its assigned population;
5. Deliver at least one (1) Section 92.05 Covered Service to an enrolled member within the reporting month, pursuant to the member’s Plan of Care. At least one (1) of the services must include a member encounter (including encounters with a member’s family, guardian(s), or caregiver, if appropriate and pursuant to the Plan of Care) except that the BHH may attest to a member for a single month if a Section 92 service was delivered and a member encounter was attempted, but not achieved. This exception is allowable only for one month during a twelve-month period.

**92.09 MINIMUM REQUIREMENTS FOR REIMBURSEMENT (cont.)**

1. Make payment to affiliated HHPs for their members enrolled as a BHH member in those affiliated practices.

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

1. **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, at a minimum:
	1. Scan the utilization data, as identified by MaineCare, for its assigned population.

AND

* 1. Monitor and respond to treatment gaps on the individual level and/or provide patient engagement, outreach or other 92.05 Covered Services and in coordination with the Plan of Care and appropriate members of the care team.

The HHP must attest to meeting this requirement in order to be eligible to receive the PMPM reimbursement. The HHP shall be reimbursed for services from the affiliated BHHO with whom that member is enrolled.

1. **Duplication of Services Will Not Be Reimbursed**. Payment for BHHO 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. The Department shall not reimburse BHH providers for members receiving Section 92 services if:
2. **For adults:** The member is also receiving Sections 17.04-1 (Community Integration Services), 17.04-2 (Community Rehabilitation Services), 17.04-3

(Assertive Community Treatment, Section 13 (Targeted Case Management), Section 91 (Health Home Services) or Section 93 (Opioid Health Home Services) of the *MaineCare Benefits Manual*.

1. **For children**: The member is also receiving services pursuant to Section 13 (Targeted Case Management), Section 91 (Health Home Services), or Section 93 (Opioid Health Home Services) of the *MaineCare Benefits Manual*.
2. 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*.

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.

**92.09 MINIMUM REQUIREMENTS FOR REIMBURSEMENT** (cont.)

1. **Failure to Meet Program Requirements.** The Department may terminate a provider from the BHH program based on failure to meet program requirements. Termination from the BHH program will be in accordance with the provisions of Ch. I, Sec. 1.03-4.