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MAINE DEPARTMENT OF HEALTH AND HUMAN SERVICES
Office of MaineCare Services

Request for Applications (RFA)

MaineCare Behavioral Homes Initiative

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Deadline for Written Questions: Friday, October 25, 2013, 5:00 PM EST

Completed Applications Due: Friday December 6, 2013 5:00 PM EST

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I. Purpose of the Request for Applications (RFA)

The objective of this document is to identify qualified and interested behavioral health providers to deliver Behavioral Health Home services in partnership with Health Home primary care practices as set forth in this RFA. It is anticipated that Behavioral Health Home services will have a start date of April 2014. A separate application process will identify qualified primary care practices interested in becoming a Behavioral Health Home Primary Care Practice.

Applications must be submitted by December 6, 2013. This RFA does not obligate the Department or any provider to enter into a contract or to deliver or pay for any services.

All information in this RFA is subject to change pending final approval from the Center for Medicare and Medicaid (CMS) of Maine's State Plan Amendment for Behavioral Health Homes.

II. Overview of Maine's Behavioral Health Home Initiative

Section 2703 of the Affordable Care Act permits states to provide Health Home services as a Medicaid State Plan Option to members with identified chronic conditions. Health Home services - comprehensive care coordination, care management, health promotion, assistance with transitions, referral, and individual and family support - provide a mechanism through which MaineCare can manage both the physical and behavioral health needs of its members within a unified system of care.

MaineCare implemented Stage A of its Health Home initiative in January 2013. Based on Maine's multi-payer Patient-Centered Medical Home (PCMH) pilot, Stage A Health Homes focuses on the needs of individuals with chronic conditions. In Stage A, a Health Home primary care practice partners with a Community Care Team (CCT) to deliver comprehensive and well-managed care to individuals with two or more chronic conditions, or members with one chronic condition and at risk for another. Members receive services from the Health Home Primary Care Practice. Members in need of intensive Health Home services are referred to the CCT for additional care coordination.

Health Homes, grounded in Maine's experience with the Maine multi-payer PCMH pilot, have a number of features that make them different from typical case management services:

- Data-driven: data is used in Health Homes to identify members who need additional support in order to manage their care, and is also used to provide feedback to providers on both utilization and key quality benchmarks.
- Population-based: tools, such as patient registries, are used to identify needs across the member panel.
- Integrated: physical and behavioral health needs must be included in the person's plan of care.
- Outcomes-oriented: Health Homes are measured in a variety of ways to determine the impact they are having on members receiving the service.

MaineCare currently has 159 Health Home practice sites across the state that deliver Health Home services to MaineCare members through Stage A.

Stage B of MaineCare's Health Home initiative focuses on the development of Behavioral Health Homes (BHH), a partnership between a licensed community mental health provider (the "Behavioral Health Home Organization" or BHHO) and one or more Health Home primary care practices (the HHP) to manage the physical and behavioral health needs of individuals with significant behavioral health needs. Both organizations will receive a per member, per month payment for Health Home services provided to the eligible and enrolled member. Behavioral Health Homes build on some of the key features of Stage A, with some important differences:

Key Features	**Stage A**		**Stage B**	
Eligibility	Adults and children with chronic health care needs		Adults with serious mental illness and children with serious emotional disturbance	
Enrollment	Members are enrolled via the participating Health Home primary care practice (the HHP) with whom they have a treatment relationship; members are referred to a CCT as needed		Members are enrolled via the community mental health provider (the BHHO) with whom they have a treatment relationship; the BHHO assists the member in identifying a partnering PCP	
Payment	PCP: $12.00/PMPM	CCT: $128.50 PMPM	PCP: $15.00 PMPM	BHHO $330.00 PMPM adults $290.00 PMPM children
Providers	Approved Health Home Primary Care Practices Approved Community Care Teams		Approved Health Home Primary Care Practices Approved Behavioral Health Home Organizations	

Behavioral Health Homes will build on the existing care coordination and behavioral health expertise of community mental health providers for adults and children. Services currently delivered through Targeted Case Management (TCM) for children with serious emotional disturbance and through

Community Integration (CI) for adults will be built into the Behavioral Health Homes model. Building these services and service providers into the Behavioral Health Home model allows MaineCare to avoid duplication while leveraging existing expertise and systems of care.

Participation in Behavioral Health Home services is entirely voluntary. Members may choose to receive BHH services, or may remain with their current services. If members choose to participate in the service, they may opt out of the service at any time.

Providers may deliver both BHH and CI/TCM services, although not to the same individual at the same time. Providers may choose to start their BHH program at a single location rather than organization-wide. Within the given location, all eligible MaineCare members must be given the opportunity to enroll in the service.

All information in this RFA is subject to change pending final approval from CMS of Maine's State Plan Amendment for Behavioral Health Homes.

III. Stakeholder Engagement

The Department released a Request for Information (RFI) on its overall Value-Based Purchasing (VBP) strategy in November 2011 and held three regional forums in the spring of 2012. The Department engaged with a designated Member Standing Committee (MSC) regarding its VBP Strategy from October 2011 through August 2012, and has reported regularly to the Medicaid Advisory Committee on design and development.

Since November 2012, the Department has participated in the Behavioral Health Homes Advisory Committee, facilitated through the Maine Health Access Foundation. That group brought together providers and consumer representation in discussion around development of the model. In April 2013, the Department released another RFI specifically to elicit feedback and information on Stage B Behavioral Health Home design. Following release of the RFI, the Department held meetings with consumer organizations to gather additional feedback. The Department has convened a State Plan Amendment work group that includes provider and consumer representation to assist MaineCare in development of the model. In September, 2013, the Department again held regional forums on its VBP strategy to elicit feedback and questions.

The Department will continue to engage providers, consumers and others in the design, development, and implementation of the model. As we develop a new model of care, the Department anticipates many opportunities for continued input and collaboration.

Additional Information

- The Department's Value-Based Purchasing Strategy: www.maine.gov/dhhs/oms/vbp
- Health Homes information: http://www.maine.gov/dhhs/oms/vbp/health-homes/index.html

- Information on Maine Quality Counts multi-payer PCMH Pilot and MaineCare Health Homes Initiative: http://www.mainequalitycounts.org/page/896-659/patient-centered-medical-home
- SAMHSA website on Health Homes and integrated care: http://www.integration.samhsa.gov

IV. MaineCare Member Eligibility

Individuals with serious mental illness and serious emotional disturbance shall be eligible for Behavioral Health Homes. Members will be identified based on claims analysis and/or assessment that indicates diagnostic and functional criteria for the service. Eligibility criteria will be further defined and specified in the MaineCare Benefits Manual.

Serious and Persistent Mental Illness (SPMI):

1) The member meets the following criteria:
   a) has a primary diagnosis on Axis I or Axis II of the multi-axial assessment system of the current version 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:
      i) Delirium, dementia, amnestic, and other cognitive disorders;
      ii) Mental disorders due to a general medical condition, including neurological conditions and brain injuries;
      iii) Substance abuse or dependence;
      iv) Developmental Disability/Intellectual Disability;
      v) Adjustment disorders;
      vi) V-codes; or
      vii) Antisocial personality disorders;

AND

2) The member 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 or other tool and scoring as specified by the Department.

Serious Emotional Disturbance (SED):

1) an Axis I or Axis II mental health diagnosis(es) as described in the most recent version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or a diagnosis described in the most recent version of the Diagnostic Classification of Mental Health and Developmental Disabilities of Infancy and Early Childhood (DC: 0-3). Axis I mental health diagnoses do not include the following: Learning Disabilities (LD) in reading, mathematics, written expression, Motor Skills Disorder, and LD NOS (Learning Disabilities Not Otherwise Specified); Communication Disorders (Expressive Language Disorders, Mixed Receptive Expressive Language Disorder, Phonological Disorder, Stuttering, and Communication Disorder NOS); and
2) Significant impairment or limitation in adaptive behavior or functioning as evidenced by eight (8) scale composite CAFAS score of at least fifty-one (51), or other tool, such as the CANS, with scoring as specified by the Department.

V. Behavioral Health Home Services

Behavioral Health Home services shall be delivered by a Behavioral Health Home Organization (BHHO) that partners with one or more Health Home Primary Care Practices (HHP) to deliver services in a coordinated and comprehensive way. Each entity, the BBHO and HHP, has its own requirements and service obligations.

Members eligible to receive the service shall be enrolled with the BHHO of their choice. That provider shall partner with approved Health Home practices to deliver services. Both the BHHO and the HHP shall receive a per member per month (PMPM) payment to manage care collaboratively. If the member is no longer in need of the BHHO level of service, the member may receive services solely from the HHP. In those instances, only the HHP receives a PMPM payment. Behavioral Health Home services shall be further defined in the Maine Health Home State Plan Amendment and in MaineCare regulation.

The Behavioral Health Home Organization and the Health Home Practice shall deliver BHH services to enrolled individuals in order to receive a PMPM payment. Services may be delivered in an office, home, or community setting. Services may be delivered face-to-face, via phone, secure email or other means, or in a group setting. Services include collateral contact with members of the treatment team or other providers/supports. Unless otherwise noted, specific services and how they are delivered (and by whom) shall depend on the needs identified in the member's plan of care. Services shall be documented in the member's record.

Comprehensive Care Management

The Behavioral Health Home Organization shall ensure that all members receive the following:

- Comprehensive assessment that identifies the medical, behavioral, social, residential, educational, vocational, and other related strengths and needs of the member (and family/caretaker if the member is a child);
- Development and periodic review of a comprehensive person-centered plan of care with the member (and family as appropriate) to build on strengths and address identified physical and behavioral health and recovery needs. The plan shall include resources, services, and supports that assist the member in meeting identified goals. The plan may include wellness and prevention, peer supports, health promotion and education, crisis planning, and other social, residential, educational, vocational, and community services and supports.
- Management and oversight of the implementation of the plan of care, including periodic review and adjustment.
- During the first six months after enrollment in the BHH, in addition to other Health Home services, the BHHO shall provide intensive and individualized outreach, education, and support to the member (and family, as appropriate) regarding BHH services and benefits, including information on sharing protected health information (Protected Health Information) and coordination with and selection/identification of primary care services. This work may involve face to face meetings in the home, community setting or office, follow up phone calls,

development of written materials or presentations, assistance from peer supports/navigators, and multiple strategies to ensure full education and engagement of the member.

- The BHHO shall obtain written consent for the service and authorization for release and sharing of information from each member.
- The BHHO shall provide information and supports to members who do not have a treatment relationship with a participating Health Home Practice to assist in establishing this relationship within the first six months of their enrollment in the BHH.

Care Coordination

Care Coordination is a set of services designed to support the member (and family, as appropriate) with the implementation of the comprehensive and person-centered plan of care. Services include:

- Outreach and engagement with the member and/or family
- Identification of specific resources cited in the plan of care
- Facilitation of referrals
- Advocacy in accessing necessary services and supports
- Exploration of least restrictive, most inclusive alternatives and services
- Coordination with other providers and supports
- Follow up after hospitalization, use of crisis services, or out of home placement
- Information, consultation, and problem-solving supports to the individual (and/or family, as appropriate).

Health Promotion

Health Promotion assists the member (and family as appropriate) with implementation of the plan of care. Health promotion services emphasize self-management of physical and behavioral health conditions. Services include:

- Delivery of education, training and assistance in developing self-monitoring and management skills;
- Promotion of healthy lifestyle and wellness tools and resources including but not limited to substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention and increasing physical activity;
- Connecting members with self-help/self-management and advocacy groups; and
- Population-based strategies (such as the use of disease registries) that enable systematic engagement and outreach to members about services needed for both preventive and chronic care.

Comprehensive Transitional Care Services

Comprehensive transitional care services ensure continuity of care and prevent the unnecessary use of emergency departments, hospitals and/or out of home placement. Services include:

- Development of processes and procedures with area inpatient facilities, Emergency Departments, residential facilities, and crisis services for prompt notification of an individual's admission and/or planned discharge to/from one of these facilities;
- Collaboration with facility discharge planners to ensure a seamless transition to the home/community setting;
- Timely and appropriate follow up for transitioning members that includes clinical hand off, timely transmission and receipt of transition/discharge plan, and medication reconciliation;
- Assistance with the discharge process, including outreach to the member and assistance with returning to the home/community;
- Review of discharge records including after-care plan, medications, and crisis plans;
- Update of care plan; and
- Facilitation, coordination, and planning for transition from different service systems, e.g., child to adult system; community to nursing facility or long term care setting; corrections to community, etc.

Individual and family support services include assistance and support to the member and/or family in implementing the plan of care. Services include:

- Assistance with system navigation;
- Advocacy and/or training in self-advocacy techniques;
- Provision of and linkage to peer support services;
- Identifying and accessing natural support systems;
- Assistance in identifying and developing social support networks;
- Connection to peer advocacy groups, family support networks, wellness centers, and other peer-run or peer-centered services; and
- Maintaining updated information on area peer 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 includes:

- "Warm hand-off' as needed to ensure a successful referral;
- Outreach, reminders, and scheduling assistance;
- Follow up as needed with the member and other providers;
- With the member, identifying and troubleshooting barriers to successful referral; and
- Organizational understanding and systematic identification of area the resources, services and supports likely needed by the BHH member.

VI. Reimbursement

Behavioral Health Homes manage both physical and behavioral health care for individuals with significant behavioral health needs within a unified plan of care. The PMPM payment will allow providers with expertise in the needs of this population to move away from volume-driven care and focus on the development of services and systems that support specified quality outcomes. Members

who no longer need a BHHO level of care may receive Health Home services through the Health Home primary Care practice (HHP). Once this transition has occurred, only the HHP receives a PMPM payment.

Provider	**Minimum Service Criteria in order to receive PMPM payment**	**PMPM**
BHHO – Adult	The BHHO has performed the following functions: • The member is identified as meeting BHH eligibility criteria through claims analysis or assessment; • The member is enrolled as a BHH member at that location; • The BHHO, in collaboration with the member and the HHP, has developed a comprehensive, person-centered plan of care or has updated this plan of care within the last 90 days; • The BHHO has delivered and documented at least one hour of BHH services in accordance with the plan of care.	$330.00
BHHO - Child	The BHHO has performed the following functions: • The member is identified as meeting BHH eligibility criteria through claims analysis or assessment; • The member is enrolled as a BHH member at that location; • The BHHO, in collaboration with the member and the HHP, has developed a comprehensive, person-centered plan of care or has updated this plan of care within the last 90 days; • The BHHO has delivered and documented at least one hour of Behavioral Health Home services in accordance with the plan of care.	$290.00
Health Home Primary Care Practice	The person is identified as meeting Behavioral Health Home eligibility criteria through claims analysis or assessment; The person is enrolled as a Behavioral Health Home member at that location; The minimum Behavioral Health Home service required for PMPM payment to the Health Home Practice is that the practice has scanned for gaps in care for the enrolled member.	$15.00

During the first six months of BHH implementation, the state proposes to pay an enhanced PMPM payment to the BHHO for each assigned BHH member to cover the cost of additional staff time anticipated for intensive outreach, education, and enrollment efforts. This additional staff time is will be reimbursed via a $35.00 add-on PMPM rate during this timeframe only.

The State will review rates to ensure that rates are economic and efficient. MaineCare will continue to base payments on the costs of staff to provide the BHH services to eligible MaineCare members.

VII. Quality and Reporting Framework

Maine's Quality Framework for Behavioral Health Homes is still in development and will be finalized prior to April 2014 implementation. Measures will be calculated across the entire Behavioral Health Home initiative, and are not tied to reimbursement.

In an effort to align with existing state and national initiatives and minimize the reporting burden on providers, Mainecare will prioritize the use of nationally recognized, claims-based measures. However, few nationally recognized claims-based measures pertain to community mental health or recovery. For this reason, existing Maine-based data (via SAMHS, OCFS, APS, the Mental Health and Wellness survey tool) may also be used in the development of Behavioral Health Home measures. In addition, certain measures required by CMS as part of state Health Home implementation[1] call for clinical information; MaineCare will work with BHH providers and Maine HealthInfoNet to identify technical solutions in gathering clinical data. The following is a draft list of measures currently under review:

Goal 1: Reduce Inefficient Healthcare Spending

Ambulatory Care-Sensitive Condition Admission

Plan- All Cause Readmission

ED Utilization

Non-Emergent ED visits

Percentage of Members with Fragmented Primary Care

Out of Home Placement Days for Children

Goal 2: Effectively Manage Behavioral Health Conditions/Promote Recovery

Follow-Up After Hospitalization for Mental Illness

Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Reduce Non Evidence-based Antipsychotic Prescribing

SPMI/SED Care – Antipsychotic medications; access and adherence

Improvement in Housing Stability

[1] See information on CMS Health Home Core measures here.

Improvement in Employment Status

Goal 3: Improve Chronic Disease Management

Adult/Pediatric Diabetes Care: HbA1c monitoring

Adult Diabetes Care: Eye Exam

Adult Diabetes Care: Lipid Monitoring

Adult Diabetes Care: Nephropathy Screening

Adult Diabetes Care: Appropriate Use of Medications

Appropriate Medication Therapy Asthma

Controlling High Blood Pressure

Spirometry Testing in Chronic Obstructive Pulmonary Disease (COPD):

Lipid Management

Goal 4: Promotion of Wellness and Prevention

Well-child visits

Adolescent well-care visits

Healthy weight/Body Mass Index

Diabetes/CVD Prevention When Using Atypical Anti-psychotic Medications

Goal 5: Improve Experience of Care for Consumers/ Families

% of members reporting improved overall satisfaction with treatment and services
% of members reporting positive experience with access to services
% of members reporting improved outcome as a result of treatment and services
% of members reporting improved level of functioning as a result of treatment and services
% of members reporting social connectedness with the community
% of members reporting satisfaction with person-centered planning

VIII. Reporting

The BHHO will continue to participate in any current reporting required by either OCFS or SAMHS, including consent decree and APS reporting requirements.

The BHHO will also submit quarterly Quality Improvement reports that focus on progress toward and achievement of Behavioral Health Home Core Expectations. These expectations build on the Core Expectations for Maine's multi-payer Patient Centered Medical Home pilot and shall be further outlined in MaineCare rule:

1. Demonstrated Leadership
2. Team-based approach to care
3. Enhanced access to care
4. Population risk stratification and management
5. Comprehensive consumer/family directed care planning
6. Inclusion of patients & families in implementation of BHH model
7. Behavioral-Physical Health Integration
8. Connection to community resources and social support services
9. Commitment to reducing waste and unnecessary health care spending
10. Integration of Health Information technology

IX. Data and Health Information Technology

Behavioral Health Home providers will have access to the following data supports:

MaineCare Health Home Enrollment System Web-Based Portal

- MaineCare will provide HHPs and BHHOs with online access to member panel and utilization data, referral, and payment information.

MaineCare Utilization Reports

Three months of rolling MaineCare claims data supporting the following initial measures:

- Count of hospitalizations paid in the last quarter[2]
- Count of hospitalizations paid in the last year[3]
- Count of Emergency Department visits paid in the last quarter

[2] Hospital data excludes detail regarding IMDs and psychiatric specialty hospitals, and excludes substance abuse-related detail from hospitals with specialty substance abuse services.

[3] Hospital data excludes detail regarding IMDs and psychiatric specialty hospitals, and excludes substance abuse-related detail from hospitals with specialty substance abuse services.

- Count of Emergency Department visits paid in the last year
- Total MaineCare payments (medical and prescriptions) for patients that exceed $10,000
- Patients with 11 or more different Prescription NDC codes paid by MaineCare in the last year[4]
- Patients with no Primary Care visit paid in the last year
- Patients with Diabetes identified through claims analysis without a HbA1c test claim paid in the last quarter
- Patients with Diabetes identified through claims analysis without an LDL panel claim paid in the last year
- Patients with Cardiovascular Disease identified through claims analysis without an LDL panel claim paid in the last year

X. Service Supports

MaineCare will develop BHH infrastructure through the following initiatives funded under the state's State Innovation Model (SIM) test:

- BHHO Health Information Technology: Via the SIM, MaineCare will fund the development and adoption of electronic health records for a limited number of behavioral health providers. Community BHHO providers will be prioritized in this process.
- Behavioral Health Home Learning Collaborative: MaineCare will fund a BHH Learning Collaborative to provide technical assistance and support to participating providers in implementing the BHH model.
- Workforce development: Mainecare will fund the development of a Behavioral Health Home curriculum to align with current training resources and expectations.

XI. Requirements for Behavioral Health Home Organizations

1. Maine Community Mental Health License: All Behavioral Health Home Organizations must have a current and valid license to provide Community Support services. BHHOs that serve adults must be able to meet all mandated consent decree requirements as described in Rider A and Rider E of the DHHS adult mental health contract. BHHOs that serve children must be able to meet all requirements of Rider A and Rider E of the DHHS children's behavioral health contract.
2. BHHO provider must deliver psychiatric medication management services or have a memorandum of agreement with a psychiatric provider that ensures access to psychiatric consultation for BHH members.
3. Expertise in co-occurring disorders as defined in current DHHS contract standards.
4. Commitment to full adoption and implementation of an Electronic Health Record within 24 months of Health Home implementation.

[4] Excludes detail on substance abuse and HIV medication.

5. Commitment to implementation of the Core BHH Expectations within one year of initial participation in MaineCare Behavioral Health Homes. Core Expectations will be further defined by MaineCare rule. All Organizations will be required to provide a quarterly report on Core Expectations benchmarks, as further defined by MaineCare. Providers that do not meet benchmarks may be terminated from the program.

    - Demonstrated Leadership
    - Team-based approach to care
    - Enhanced access to care
    - Population risk stratification and management
    - Comprehensive consumer/family directed care planning
    - Inclusion of patients & families in implementation of BHH model
    - Behavioral-Physical Health Integration
    - Connection to community resources and social support services
    - Commitment to reducing waste and unnecessary health care spending
    - Integration of Health Information technology

6. Ability to perform each of the following CMS Health Home core functional components:

    A. Provide quality driven, cost-effective, culturally appropriate, and patient- and family-centered Health Home services;
    B. Coordinate and provide access to high-quality health care services informed by evidence based clinical practice guidelines;
    C. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
    D. Coordinate and provide access to treatment for mental health and substance abuse disorders;
    E. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across care settings. Transitional includes appropriate follow up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from pediatric to an adult system of health care;
    F. Coordinate and provide access to chronic disease management, including self-management support to patients and their families;
    G. Coordinate and provide access to patient and family supports, including referral to community-based social support, and recovery services;
    H. Coordinate and provide access to long-term care supports and services;
    I. Develop a patient-centered care plan that coordinates and integrates all of a patient's clinical data and non-clinical health care related needs and services;
    J. Demonstrate the capacity to use Health Information technology to link services, and facilitate communication among members, and between the BHHO and member , and family members as appropriate, and to provide feedback to practices, as feasible and appropriate; and
    K. Establish a continuous quality improvement (CQI) 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 care outcomes at the population level.

7. Participation in the Behavioral Health Home Learning Collaborative: The BHHO must participate in Maine Behavioral Health Homes Learning Collaborative activities, a statewide effort to provide support for service system transformation, as state resources are available. Participating Behavioral Health Homes Organizations are expected to designate a leadership team to attend learning sessions that bring teams together with faculty and content experts to promote collaborative learning and rapid cycle improvement methods. The Collaborative also includes support between learning sessions through coaching and regular outreach.

8. Partnership with at least one Health Home Primary Care Practice: As of the BHH service start date, this partnership must be formalized in a memorandum of understanding/agreement that details how the organizations will provide integrated and coordinated BHH services, including the method for regular and systematic provider to provider communications, sharing patient information securely across organizations; and timely collaboration in comprehensive person-centered care management and plan development.

9. Ability to deliver a team-based service that includes, at minimum, the following components:
   - Clinical Team leader (independently licensed mental health professional, including an Licensed Clinical Social Worker, Licensed Clinical Professional Counselor, Licensed Marriage and Family Therapist, psychologist, psychiatrist)
   - Health Home Coordinator (Qualified TCM case management providers for children and Mental Health Rehabilitation Technician/C certified providers for adults)
   - Peer Support Specialist (Certified Intentional Support Specialist and/or other training as may be described by the Department)
   - Nurse Care Manager (Licensed Practical Nurse, Registered Nurse, Nurse Practitioner)
   - Primary Care Consultation
   - Psychiatric Consultation

XII. Application Requirements

Applicants must complete the application at:
https://www.surveymonkey.com/s/BehavioralHealthHomes

Through their response, applicants must demonstrate that they currently meet, or commit to meet, all requirements under Section XI of this proposal. MaineCare may request additional documentation as needed to support application materials prior to implementation of the program.

XIII. RFA Process

A. Timeline

Activity	Date
RFA posted	Friday, October 11, 2013

Written Questions Due	Friday, October 25, 2013
Informational Webinars/information sessions	October 28, 2013: Augusta Civic Center, 9:00-10:30 October 29, 2013: Webinar, 2:00- 3:00 October 30: Webinar, 11:00- 12:00
Notice of Intent (optional)	Friday, November 15, 2013
Summary of Questions and Answers	Friday, November 15, 2013
Applications Due	Friday, December 6, 2013
Provider approval and commitment letter	Friday, January 10, 2014
Notice to members	March 3, 2014
Implementation	April 1, 2014

B. Written Questions

Written questions must be received no later than 5:00 p.m. local time on October 25th, 2013. No questions will be accepted after the Written Question due date.

Send written questions to:

RFA Coordinator: Kitty Purington, kitty.purington@maine.gov

Responses to questions will be compiled in writing and posted to the Behavioral Health Homes website. The Department will make every effort to provide answers to the questions on or before Friday, November 15.

C. Notice of Interest and/or Intent

The Department encourages behavioral health organizations and primary care practices interested in or intending to partner to form a Behavioral Health Home to submit a non-binding Notice of Interest and/or Intent. Notices of Interest/ Intent will be accepted until November 15. Providers should indicate their interest and/or intent to apply by filling out the survey at:

https://www.surveymonkey.com/s/MaineCareBHHInterest

With provider permission, the Department will use this information to assist BHHOs and HHPs in identifying potential partners in their area who are similarly interested in providing BHH services.

D. Changes/ Additional Requirements

The State may change requirements or impose additional requirements for participation as a Behavioral Health Home as identified through the federal approval process with CMS.

E. Application Review & Eligibility Notification

The Department will review all applications received by the deadline. The Department will notify all applicants that meet the Behavioral Health Home requirements in writing of their approval to provide the service. In order to deliver the service as of April, 2014 MaineCare must receive and have on file a Commitment Letter signed by the authorized representative of the approved organization.