DATE: December 17, 2013

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: Proposed Rule: MaineCare Benefits Manual, Chapters II & III, Section 92, Behavioral Health Home

This letter gives notice of a proposed rule: MaineCare Benefits Manual, Chapters II, Section 92, Behavioral Health Homes.

This proposed rulemaking seeks to create Behavioral Health Homes, effective April 1, 2014, which will provide comprehensive system of care coordination for members with Serious Emotional Disorders (SED), and Serious and Persistent Mental Illness (SPMI). Members eligible for Section 92 services may also be eligible for services under Section 13 (Targeted Case Management), Section 17 (Community Integration Services) and/or Section 91 (Health Home Services); such members may not receive those services at the same time that they receive Section 92 services, and must choose among the different types of services for which they are eligible.

Section 92 services shall be provided to eligible members by a Behavioral Health Home Organization (BHDO) that partners with one or more Health Home Practices (HHPs). BHDOs and HHPs shall integrate and coordinate all primary, acute, behavioral health and long term services and supports for eligible members. BHDOs shall develop and implement a comprehensive Plan of Care for each member. Section 92 services are expected to result in improved physical and behavioral health outcomes for members, reduced hospital admissions and emergency room use, better transitional care, improved communication between health care providers, and the increased use of preventive services, community supports, and self-management tools.

Section 92 Behavioral Health Homes are implemented pursuant to section 2703 of the Affordable Care Act, 42 U.S.C. § 1396w-4. The Department is seeking approval of a State Plan Amendment from the Centers for Medicare and Medicaid Services. Section 2703 provides an enhanced federal matching rate of 90% for the first eight (8) quarters following the effective date of the program.

Rules and related rulemaking documents may be reviewed at, or printed from, the MaineCare Services website at http://www.main.gov/dhhs/oms/rules/index.shtml or, for a fee, interested parties may request a paper copy of rules by calling (207) 287-9368 or 624-4050. For those who are deaf or hard of hearing and have a TTY machine, the TTY number is 711.

A concise summary of the proposed rule is provided in the Notice of Agency Rule-making Proposal, which can be found at http://www.main.gov/sos/cec/rules/notices.html. This notice also provides information regarding the rule-making process. Please address all comments to the agency contact person identified in the Notice of Agency Rule-making Proposal.
Notice of Agency Rule-making Proposal

AGENCY: Department of Health and Human Services, Office of MaineCare Services

CHAPTER NUMBER AND TITLE: Chapter 101, MaineCare Benefits Manual, Chapters II & III, Section 92, Title: Behavioral Health Homes

PROPOSED RULE NUMBER:

CONCISE SUMMARY: This proposed rulemaking seeks to create Behavioral Health Homes, effective April 1, 2014, which will provide comprehensive system of care coordination for members with Serious Emotional Disorders (SED), and Serious and Persistent Mental Illness (SPMI). Members eligible for Section 92 services may also be eligible for services under Section 13 (Targeted Case Management), Section 17 (Community Integration Services) and/or Section 91 (Health Home Services); such members may not receive those services at the same time that they receive Section 92 services, and must choose among the different types of services for which they are eligible.

Section 92 services shall be provided to eligible members by a Behavioral Health Home Organization (BHHO) that partners with one or more Health Home Practices (HHPs). BHHOs and HHPs shall integrate and coordinate all primary, acute, behavioral health and long term services and supports for eligible members. BHHOs shall develop and implement a comprehensive Plan of Care for each member. Section 92 services are expected to result in improved physical and behavioral health outcomes for members, reduced hospital admissions and emergency room use, better transitional care, improved communication between health care providers, and the increased use of preventive services, community supports, and self-management tools.

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PUBLIC HEARING:
Date: January 14, 2014
Time: 1:30 pm
Location: 19 Union St, Room 110, Augusta, Maine 04333

The Department requests that any interested party requiring special arrangements to attend the hearing contact the agency person listed above before January 3, 2014.

DEADLINE FOR COMMENTS: Comments must be received by midnight January 24, 2014

AGENCY CONTACT PERSON: Peter Kraut, Comprehensive Health Planner II
AGENCY NAME: MaineCare Services
ADDRESS: 242 State St.
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Augusta, Maine 04333-0011
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TELEPHONE: 207-624-4041 FAX: (207) 287-9369
TTY: 711 (Deaf or Hard of Hearing)
IMPACT ON MUNICIPALITIES OR COUNTIES (if any): The Department does not anticipate that this rulemaking will have any impact on municipalities or counties.

CONTACT PERSON FOR SMALL BUSINESS INFORMATION (if different):
N/A

STATUTORY AUTHORITY FOR THIS RULE:
22 M.R.S.A §§42, 3173

SUBSTANTIVE STATE OR FEDERAL LAW BEING IMPLEMENTED (if different): 42 U.S.C. § 1396w-4

E-MAIL FOR OVERALL AGENCY RULE-MAKING LIAISON: kevin.wells@maine.gov
This Section is Dependent Upon Approval by the Centers for Medicare and Medicaid Services (CMS)

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92.01 DEFINITIONS

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

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

92.01-3 Electronic Health Record (EHR) – An Electronic Health Record is a systematic collection of electronic health information about individual MaineCare members. It is a record in digital format that is capable of being shared across different health care settings by a Department-designated health information exchange(s) (HIE), a Department-designated network connected enterprise-wide information system(s), and other information networks or exchanges.

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

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

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

92.01-7 Plan of Care – The Plan of Care is a person-centered plan that describes, coordinates and integrates all of a member’s clinical data and 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 BHBO and HHP must meet the following requirements:
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92.02 PROVIDER REQUIREMENTS (cont.)

92.02-1 Behavioral Health Home Organization (BHHO)

A. The BHHO must execute a MaineCare Provider Agreement.

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

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

The Psychiatric Consultant shall consult with other BHHO and HHP professionals and with the member as necessary, to provide coordination of each member’s psychiatric service and medication needs, and 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, nurse practitioner, licensed practical nurse, or advance practice nurse, as defined by the Maine State Board of Nursing.
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**92.02 PROVIDER REQUIREMENTS (cont.)**

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

(3) **Clinical Team Leader** – shall be an independently licensed mental health professional, who may be a physician, physician’s assistant, psychologist, licensed clinical social worker, licensed clinical professional counselor, licensed marriage and family therapist, registered nurse, psychiatric nurse, advanced practice registered nurse, or an advanced practice psychiatric nurse; OR 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 BHIO, provide supervision of Health Home Coordinators and Certified Intentional Peer Support Specialists, and ensure that the BHIO meets its requirements as a whole.

**Certified Intentional Peer Support Specialist (CIPSS)** – is an individual who has completed the Maine Office of Substance Abuse and Mental Health Services 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. CIPSS for children’s services is an individual who has completed the designated Maine Office of Child and Family Services curriculum for peer supports and receives and maintains that certification.

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

The SED Health Home Coordinator shall draft the Plan of Care for each SED member, implement that Plan of Care and the coordination of services, and ensure that members are actively participating in reaching the goals set forth in their Plan of Care.

(5) 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 SPMI member, oversee that Plan of Care and the coordination of services, and ensure that members are actively participating in reaching the goals set forth in their Plan of Care.

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

The Medical Consultant shall collaborate with other providers of BHHQ services and the HHIP (at least 4 hours/month) to select and implement evidence-based clinical initiatives, lead quality improvement efforts, evaluate progress, and convene provider clinical quality improvement meetings.

A. At least one of the BHHQ's professionals (listed above) must have expertise in co-occurring substance use and mental health disorders.
92.02 PROVIDER REQUIREMENTS (cont.)

B. The BHDO must maintain documentation of all its BHDO providers’ qualifications in their personnel files, including transcripts, licenses, and certificates. The BHDO must have a review process to ensure that employees providing BHDO services possess the minimum qualifications set forth above. The review process must occur upon hiring new employees and on an annual basis to assure that credentials remain valid. The BHDO must also maintain documentation of all staff education, participation in Learning Collaborative sessions, staff development, and other training in staff personnel files.

C. The BHDO must be approved as a BHDO by MaineCare through the BHDO application process.

D. The BHDO must have an executed contract with at least one HHP in its area.

E. Within twenty-four (24) months of the BHDO’s participation, the BHDO must create and implement an EHR system and an EHR for each member, and agree to allow clinical health care data in the EHR to be shared for purposes of providing services herein.

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

G. The BHDO has 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, and must require prompt notification to the BHDO
of a member’s admission and discharge. The BHHO shall have systematic follow-up protocols to assure timely access to follow-up care.

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

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

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

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

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

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

a. Through clear identification of roles and responsibilities;
b. Training on and integration of Certified Intentional Peer Support Specialists as meaningful partners in service delivery;
c. Expansion of member education; and
d. Adequate supervision and team meetings.

(3) **Population Risk Stratification and Management** – the BHHO has adopted processes to identify and stratify members across their population
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92.02 PROVIDER REQUIREMENTS (cont.)

who are at risk of adverse outcomes, and adopted procedures that direct resources or care processes to reduce those risks.

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

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

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

b. The BHHO ensures 24 hours/seven days a week availability to a Health Home Coordinator to provide information and emergency consultation services.

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

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

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

b. Practice guidelines for recovery-oriented care.

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

(7) Inclusion of Members and Families – the BHHO includes members and their family as documented and regular participants at leadership
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92.02 PROVIDER REQUIREMENTS (cont.)

meetings, and/or the BHHO has in place a member-driven process to identify needs and solutions for improving services.

a. The BHHO has processes in place to support members and families to participate in these leadership and/or advisory activities;
b. The BHHO has implemented systems to gather member and family input at least annually (through mail surveys, phone surveys, point of care questionnaires, focus groups, or other methods); and
c. The BHHO has processes in place to design and implement changes that address needs and gaps in care identified via member and family input.

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

(9) Commitment to Reducing Waste, Unnecessary Healthcare Spending, and Improving Cost-Effective Use of Healthcare Services – the BHHO has processes in place and will be held accountable for the reduction of wasteful spending of healthcare resources and improving the cost-effective use of healthcare services, as evidenced by at least one initiative that targets waste reduction, such as:

a. Reducing avoidable hospitalizations;
b. Reducing avoidable emergency department visits;
c. Reducing non-evidence-based use of expensive imaging, such as MRI for low back pain or headache;
d. 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
e. Directing referrals to specialists who consistently demonstrate high quality and cost efficient use of resources.


92.02 PROVIDER REQUIREMENTS (cont.)

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

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

a. The documentation of need and monitoring clinical care;
b. Supporting implementation and use of evidence-based practice guidelines;
c. Developing Plans of Care and related coordination; and
d. Determining outcomes (e.g., clinical, functional, recovery, satisfaction, and cost outcomes).

92.02-2 Health Home Practice (HHP)

A. The HHP must execute a MaineCare Provider Agreement.

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

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

D. The HHP must have a fully implemented EHR and agree to allow clinical health care data in the EHR to be shared for purposes of providing services herein.

E. The HHP must have a contract with at least one BHHO in its area.

F. The HHP has 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, and must require prompt notification to the HHP of a member’s admission and discharge. The
This Section is Dependent Upon Approval by the Centers for Medicare and Medicaid Services (CMS)

92.02 PROVIDER REQUIREMENTS (cont.)

HHP shall have systematic follow-up protocols to assure timely access to follow-up care.

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

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

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

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

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

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

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

   The HHP utilizes non-physician staff to improve access and efficiency of the practice team in specific ways, including one or more of the following:
92.02 PROVIDER REQUIREMENTS (cont.)

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

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

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

4. Enhanced Access — The practice enhances access to services for their population of patients, including:

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

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

5. Practice Integrated Care Management — The HHP has processes in place to provide care management services, and identifies specific individuals to work with the practice team to provide care management for patients at high risk of experiencing adverse outcomes.
92.02 PROVIDER REQUIREMENTS (cont.)

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

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

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

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

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

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

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

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

HHP has processes in place to support members and families to participate in these leadership and/or advisory activities.

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

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

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

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

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

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

    The system is used to support member care, including one or more
    of the following:
92.02 PROVIDER REQUIREMENTS (cont.)

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

92.03 MEMBER ELIGIBILITY

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

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

92.03-2 Specific Requirements.

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

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

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

AND

2. 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 and Plan of Care.

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

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

   (a) Learning Disabilities in reading, mathematics, written expression;
   (b) Motor Skills Disorder;
   (c) Learning Disabilities Not Otherwise Specified;
   (d) Communication Disorders (Expressive Language Disorders, Mixed Receptive Expressive Language Disorder, Phonological Disorder, Stuttering, and Communication Disorder Not Otherwise Specified;

   AND

2. Members must also have a significant impairment or limitation in adaptive behavior or functioning according to a standardized tool:
   a. CAFAS: if the eight (8) scale composite CAFAS score is at least fifty-one (51)
92.03 MEMBER ELIGIBILITY (cont.)

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

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

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

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

92.04 POLICIES AND PROCEDURES FOR MEMBER IDENTIFICATION AND ENROLLMENT

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

1. Automatic Enrollment and Notice Requirements. The Department or its agent shall identify members who meet Section 92 eligibility criteria, and who, within the past twelve (12) months, have received prior authorization for Section 17 Community Integration Services (CIS) or Section 13 Targeted Case Management (TCM) Services from a MaineCare provider that has been approved as a BHHO. These members will receive written notification from the Department that their provider has been
approved to become a BHBO, and that they are eligible for BHH services. The notice shall provide information about the benefits of participating in a Health Home, and shall list all of the Health Home providers in the member’s area. The notice shall clearly inform members that they will be automatically enrolled for BHH services with their current TCM/CIS provider (now a BHBO), and about their ability to opt out of enrollment for BHH services. The notice shall clearly explain that members must choose between the BHH services provided through Section 92, or to continue receiving services via Sections 13 or 17, but that they may not receive both services at the same time. The notice shall inform the member that, in the event he/she does not opt out, the member’s Section 13 or 17 services shall be terminated. The notice shall set forth the requirements for opting out (ie – by returning a written notice, or making a phone call to the Department), and shall contain contact information for MaineCare Member Services to provide assistance to members in making this choice. If the member does not opt out within twenty-eight (28) days of receipt of the auto-enrollment notification, the member will be automatically enrolled by the Department in BHH services on either the 1st or the 15th of the month.

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

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

4. Selection of an HHP. Within 180 days following their enrollment with a BHBO, members must identify an HHP from among the HHPs that contract with the member’s BHBO. If the member does not select an HHP within 180 days, the member shall cease to receive services from the BHBO, and shall receive a notice of termination of services.
92.04 POLICIES AND PROCEDURES FOR MEMBER IDENTIFICATION AND ENROLLMENT (cont.)

B. Enrollment and Freedom of Choice

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

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

92.05 COVERED SERVICES

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

92.05-1 Comprehensive Care Management

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

A. Comprehensive Care Management Services – BHHO: Within the first thirty (30) days following a member’s enrollment for BHH services, the Health Home Coordinator, in consultation with other providers, as necessary, shall provide each member with a face to face meeting and a comprehensive assessment that identifies the medical, behavioral, mental health, social, residential, educational, vocational, and other related needs, strengths, and goals of the member (and the family/caretaker if the member is a minor), including utilization of screening tools for co-occurring
disorders. The comprehensive review shall include a psychosocial assessment, including history of trauma and abuse, substance abuse, general health and capabilities, medication needs, self-care potential, 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.

B. 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 include all the member’s clinical data, diagnoses, and non-clinical health and behavioral health-related information, to identify and integrate behavioral and physical health needs and goals. The Plan of Care must be consented to by the member, as reflected by the member’s signature on the Plan of Care, documented in the member’s record, and accessible to the member, the BHHO and HHP. The Plan of Care may include, but not be limited to, information on prevention, wellness, peer supports, health promotion and education, crisis planning, and identifying other social, residential, educational, vocational, and community services and supports that enable a member to achieve physical and behavioral health goals. The member (or parent/guardian) plays a central and active role in the development of the Plan of Care, which shall clearly identify the goals and timeframes for improving the member’s health and health care status, and the interventions that will produce this effect. The Plan of Care shall clearly identify the primary care physician/nurse practitioner, specialist(s), behavioral health care provider(s), Health Home Coordinator, and other providers directly involved in the member’s care.

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

C. During the first three months after a member’s enrollment, the BHHO shall provide individualized outreach, education and support to the member (and family, if the member is a minor) regarding BHH services and benefits, including information on sharing personal health information, and coordination with primary care services.
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92.05 COVERED SERVICES (cont.)

provided by HHPs. These services may be provided via in person meetings, follow up phone calls, development of written materials or presentations, assistance from Peer Support providers, and other strategies to ensure that the BHJO’s members are fully educated and engaged with the needs and goals set forth in the Plan of Care.

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

E. During the first 180 days after a member’s enrollment, the BHJO shall provide information to members who do not have a treating relationship with a participating HHP to assist in establishing this relationship.

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

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

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

H. Comprehensive Care Management Services – HHP: The HHP shall coordinate with the member and the BHJO 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.

I. 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.

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

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

92.05-2 Care Coordination

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

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

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

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

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

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

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

F. The BHHO shall ensure that members have access to crisis intervention and
   resolution services, coordinate follow up services to ensure that a crisis is resolved,
   and assist in the development and implementation of crisis management plans.

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

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

92.05-3 Health Promotion

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

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

**B.** The BHBO 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.

**C.** The BHBO 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 BHBO shall provide training to the member’s parent/guardian in regard to behavioral management and guidance on at-risk behavior.

**D. Health Promotion Services – HHP:** The HHP shall coordinate with the member and the BHBO 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.

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

**92.05-4 Comprehensive Transitional Care**

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

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

**B.** The BHBO shall collaborate with facility discharge planners, the member and the member’s family or other support system, as appropriate, to ensure a coordinated, safe transition to the home/community setting, and to prevent avoidable readmission after discharge. The BHBO shall assist the member with the discharge process, including outreach in order to assist the member with returning to the home/community.
92.05 COVERED SERVICES (cont.)

C. The BHHO shall collaborate with members, their families, and facilities to ensure a coordinated, safe transition between different sites of care, or transfer from the home/community setting into a facility.

D. The BHHO shall assist the member in exploration of less restrictive alternatives to hospitalization/institutionalization.

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

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

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

92.05-5 Individual and Family Support Services

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

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

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

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

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

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

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

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

92.06 NON-COVERED SERVICES AND LIMITATIONS

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

B. Only the Covered Services set forth herein shall be reimbursable through Section 92; these services do not include the direct delivery of an underlying medical, educational, social or other service to which a member may have been referred.

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

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

E. Children who are provided Section 92 services shall not also receive services under Section 13 (Targeted Case Management).
92.06 NON-COVERED SERVICES AND LIMITATIONS (cont.)

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

F. Only one Health Home Coordinator, who functions as a comprehensive case manager, shall be allowed for each member receiving Section 92 services.

92.07 REPORTING REQUIREMENTS

In addition to the documentation and reporting requirements of the MaineCare Benefits Manual, Chapter I, Section I, and other reports that may be required by the Department, the BHHO and the HHP shall report quarterly, in the format designated by the Department, on activities and improvement upon the following. Providers that fail to timely or adequately file reports or satisfy the benchmarks defined by the Department may be terminated from providing Section 92 services.

A. The Core Standards: BHHOs and HHPs shall report on the Core Standards (above).

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

1. Provide quality-driven, cost-effective, culturally appropriate, and consumer and family-centered health home services;

2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;

3. Coordinate and provide access to preventative and health promotion services, including prevention of mental illness and substance abuse disorders;

4. Coordinate and provide access to treatment for mental health and substance abuse services;

5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient or other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care;
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92.07 REPORTING REQUIREMENTS (cont.)

6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families;
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services;
8. Coordinate and provide access to long-term care supports and services;
9. Develop a person-centered Plan of Care for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services;
10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the providers and individual and family caregivers, and provide feedback to practices, as feasible and appropriate; and
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

C. Health Home Quality Measures – The BHCO and HHP shall participate and support reporting on the following Health Home Quality measures as defined below, using claims-based, clinical data, and other information, as necessary:

1. Ambulatory Care-Sensitive Condition Admission;
2. Plan- All Cause Readmission;
3. Non-Emergent ED visits;
4. Percent of Members with fragmented primary care
5. Care Transition: Transition Record Transmitted to Health care Professional;
6. Out of Home Placement Days for Children
7. All readmissions All readmissions for behavioral health diagnoses (including IMD, as data is available)
8. Adult Diabetes Care
9. Pediatric Diabetes Care: HbA1c monitoring
10. Adult Diabetes Care: Eye Exam
11. Adult Diabetes Care: Lipid Monitoring
12. Adult Diabetes Care: Nephropathy Screening
13. Controlling high blood pressure
14. Appropriate Medication Therapy, Adult & Pediatric Asthma Care:
15. Spirometry Testing in Chronic Obstructive Pulmonary Disease (COPD)
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92.07 REPORTING REQUIREMENTS (cont.)

16. Lipid Management
17. Well-Child Visits ages 3-6 and 7-11:
18. Adolescent Well-Care Visit (12-20):
19. Healthy Weight:
20. Adult Body Mass Index (BMI) Assessment
21. Metabolic Screening for adults and children who are prescribed antipsychotic medications
22. Screening for Clinical Depression and Follow-up Plan
23. Follow-Up After Hospitalization for Mental Illness
24. Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
25. Non evidence-based Antipsychotic Prescribing
26. SMI/SED Care – Antipsychotic medications
27. Employment Status (adults)
28. Residential stability
29. Functional improvement, Adults
30. Functional improvement, Children
31. SMI/SED Experience of Care Measures:
   a. Overall satisfaction with treatment and services
   b. Access to services
   c. Improved outcome as a result of treatment and services
   d. Improved level of functioning as a result of treatment and services
   e. Social connectedness with the community
   f. Positive experience in their participation in treatment planning.

92.08 DOCUMENTATION AND CONFIDENTIALITY

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

A. Records. The member’s record must minimally include:

1. Name, address, birthdate, and MaineCare identification number:
92.08 DOCUMENTATION AND CONFIDENTIALITY (cont.)

2. Diagnosis(es) that support eligibility for services herein, including the most recent documentation of diagnoses that substantiate ongoing eligibility for services;
3. The comprehensive assessment that must occur within the first thirty (30) days of initiating services, and any reassessments that occur;
4. The Plan of Care;
5. Correspondence to and from other providers;
6. Release of information statements as necessary, signed by the member or parent/guardian; and
7. Documentation/record entries (i.e. progress notes) for each service provided, including the date of service, the type of service, the place of the service or method of delivery (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.

B. Record Retention. Members’ records compiled under this Section shall be kept current. Records shall be retained for a period of not less than five (5) years from the date of service provision. If an audit is initiated within five (5) year retention period, the records must be retained until the audit is completed and a cost settlement has been made.

C. Confidentiality and Disclosure of Confidential Documents/Information. The disclosure of information regarding members receiving services herein is strictly limited to purposes directly connected with the administration of the MaineCare program. 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:
92.09 MINIMUM REQUIREMENTS FOR REIMBURSEMENT (cont.)

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

1. In collaboration with the member and the HHP, develop a Plan of Care pursuant to the requirements herein, or review and update the Plan of Care within the last ninety (90) days;
2. Submit a monthly Care Plan report that summarizes the services delivered for the month in support of the Plan of Care and as further documented in the member’s record; AND
3. Deliver at least one hour of at least one Section 92 Covered Service to a member eligible for Section 92 services, pursuant to the member’s Plan of Care.

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

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

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

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

1. For adults: The member is also receiving Sections 17.04-1 (Community Integration Services), 17.04-2 (Community Rehabilitation Services), 17.04-3 (Intensive Case Management Services), 17.04-4 (Assertive Community Treatment, Section 13 (Targeted Case Management), or Section 91 (Health Home Services) of the MaineCare Benefits Manual.
2. For children: The member is also receiving services pursuant to Section 13 (Targeted Case Management), or Section 91 (Health Home Services) of the MaineCare Benefits Manual.
3. Similar services provided through the home and community-based waiver services authorized by Section 1915(c) of the Social Security Act that are
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92.09 MINIMUM REQUIREMENTS FOR REIMBURSEMENT (cont.)

described elsewhere in the MaineCare Benefits Manual, including, but not limited to, the services described in Sections 12, 21, 22 and 29.
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So long as the requirements of Chapter II, Section 92 are met, reimbursement shall be as follows:

Behavioral Health Home Organizations

For adults, Behavioral Health Home Organizations will be reimbursed at a rate of $365.00 per member per month from April 1, 2014 through June 30, 2014 and $330.00 per member per month thereafter.

For children, Behavioral Health Home Organizations will be reimbursed at a rate of $325.00 per member per month from April 1, 2014 through June 30, 2014 and $290.00 per member per month thereafter.

Health Home Practices

Health Home practices will be reimbursed at a rate of $15.00 per member per month.