MaineCare Services
An Office of the Department of Health and Human Services
Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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DATE: April 11, 2017

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

SUBJECT: **Emergency Adoption**: Chapter 101, MaineCare Benefits Manual, Chapters II & III, Section 93, Opioid Health Home Services

This letter gives notice of an emergency rule: MaineCare Benefits Manual, Section 93, Opioid Health Home Services

The Maine 128th Legislature passed legislation, P.L. 2017, Chapter 2, *An Act To Make Supplemental Appropriations and Allocations for the Expenditures of State Government and To Change Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Year Ending June 30, 2017.* Part P (the "Supplemental Budget") granted the Department emergency rulemaking authority to establish the Opioid Health Home program without the necessity of demonstrating that immediate adoption is necessary to avoid a threat to public health, safety, or general welfare under 5 M.R.S. § 8054.

The rule establishes the MaineCare OHH program for addressing the opioid crisis in Maine. The OHH initiative is an innovative model providing comprehensive, coordinated care focused on serving the MaineCare population. In addition to expanding primary care access to treatment for an individual's substance abuse dependency, the OHH integrates physical, social, and emotional supports to provide holistic care. The model provides a community-based support system focused on team-based clinical care. The OHH team model involves a range of qualified staff, including a Clinical Team Lead, Medication Assisted Therapy (MAT) prescriber, Nurse Consultant, Licensed Alcohol and Drug Counselor, Certified Clinical Supervisor, and Peer Recovery Coach. It is expected that this newly established OHH program will not only result in more individuals receiving the substance abuse treatment they need, but will also lead to improvements in the quality of care they are receiving. OHH services are optional, and members can choose to receive the services from any OHH.

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

If you have any questions regarding the policy, please contact Provider Services at 1-866-690-5585 or TTY users call Maine relay 711.

Notice of Agency Rule-making Emergency Adoption

AGENCY: Department of Health and Human Services, MaineCare Services

CHAPTER NUMBER AND TITLE: 10-144 C.M.R., Chapter 101, MaineCare Benefits Manual, Chapters II & III, Section 93, Opioid Health Home Services

ADOPTED RULE NUMBER:

CONCISE SUMMARY: The Emergency adopted rule establishes the MaineCare Opioid Health Home (OHH) Services program for addressing the opioid crisis in Maine. The OHH initiative is an innovative model providing comprehensive, coordinated care focused on serving the MaineCare population. In addition to expanding primary care access to treatment for an individual's substance abuse dependency, the OHH integrates physical, social, and emotional supports to provide holistic care. The model provides a community-based support system focused on team-based clinical care. The OHH team model involves a range of qualified staff, including a Clinical Team Lead, Medication Assisted Therapy (MAT) prescriber, Nurse Consultant, Licensed Alcohol and Drug Counselor, Certified Clinical Supervisor, and Peer Recovery Coach. It is expected that this newly established OHH program will not only result in more individuals receiving the substance abuse treatment they need, but will also lead to improvements in the quality of care they are receiving. OHH services are optional, and members can choose to receive the services from any OHH.

See http://www.maine.gov/dhhs/oms/rules/index.shtml for rules and related rulemaking documents.
See: https://www.surveymonkey.com/r/OHHApplication for the Opioid Health Homes Application.

EFFECTIVE DATE: April 11, 2017

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Section 93 OPIOID HEALTH HOME SERVICES

Established: Emergency Rule 4/11/17

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

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Section 93 OPIOID HEALTH HOME SERVICES

Established: Emergency Rule 4/11/17

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

3.01 DEFINITIONS

93.01-1 Electronic Health Record (EHR) – An EHR means a systematic collection of electronic health information about individual MaineCare members. It is a record in digital format that is capable of being shared across different health care settings by a Department-designated health information exchange(s) (HIE), a Department-designated network connected enterprise-wide information system(s), and other information networks or exchanges. An EHR supports Clinical EHR functions, such as intake, clinical care, task management, and case management where appropriate, and has HL7 interoperability capabilities to support the electronic sharing of portions of the patient's record.

93.01-2 Opioid Health Home (OHH) – A group of providers that furnishes services based on an integrated care delivery model focused on whole-person treatment including, but not limited to, counseling, care coordination, medication-assisted treatment, peer support, and medical consultation for individuals who have been diagnosed with an opioid dependency. An OHH is a team of providers that have completed an application and been approved by the Department to provide OHH services.

93.01-3 Plan of Care/Individual Treatment Plan (ITP) – The Plan of Care/ITP is a care 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/ITP shall include member health care data, member health goals, and the services and supports necessary to achieve those goals, with particular regard to the member's opioid dependency.

93.01-4 Dosage Plan – An individualized medication-related plan developed by the Medication Assisted Treatment prescriber specifically for the member based on the results of the Comprehensive Biopsychosocial Assessment, diagnosis, level of care required, and treatment priorities. To provide comprehensive and maximally effective opioid substance use disorder care, the Dosage Plan is included in the Plan of Care/ITP and modified as medically indicated based on the member's response to treatment.

93.02 PROVIDER REQUIREMENTS

The OHH must meet the following requirements. OHH providers must maintain documentation of all processes and procedures described below in an operating manual that is available for review by the Department upon request.

93.02-1 Opioid Health Home (OHH) Requirements

A. The OHH must execute a MaineCare Provider Agreement.

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.02 PROVIDER REQUIREMENTS (cont.)

B. The OHH must be approved as an OHH by the Department through the OHH application process.

C. The OHH must utilize an EHR system and create an EHR for each member.

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

E. The OHH must be a community-based provider licensed to provide substance use disorder services in the state of Maine that provides care to MaineCare members, and is located within the state of Maine. The OHH delivers a team-based model of care through a team of employed or contracted personnel. The team must include at least the personnel identified in this sub-section. Each role must be filled by a different individual. If there is a lapse in fulfillment of team member roles of greater than thirty (30) continuous days, the OHH must notify the Department in writing and maintain records of active recruitment to fill the position(s).

1. **Clinical Team Lead** – A licensed clinical professional with opioid addiction treatment expertise, who may be a physician, physician's assistant, psychologist, a licensed clinical social worker, a licensed clinical professional counselor, or advanced practice registered nurse.

   The Clinical Team Lead shall oversee the development of the Plan of Care/ITP and direct care management activities across the OHH, and ensure that the OHH meets its requirements as a whole with regard to each member served.

2. **Medication Assisted Treatment (MAT) prescriber** – A licensed health care professional with authority to prescribe buprenorphine.

   The OHH MAT prescribers provide services for the chronic condition of opioid dependence through an office-based opioid treatment setting and shall be trained and authorized to prescribe buprenorphine, buprenorphine derivatives, and naltrexone for opioid dependence.

   The OHH MAT prescribers must have completed the federally required training and hold the appropriate X-DEA license to prescribe buprenorphine in an office-based setting. They are required to adhere to Maine's Office of Substance Abuse and Mental Health Services, 14-118 C.M.R. Chapter 11, Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications.

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.02 PROVIDER REQUIREMENTS (cont.)

3. **Nurse Care Manager** – A registered nurse with expertise in addiction treatment, a psychiatric nurse licensed as a registered professional nurse by the state or province where services are provided and certified by the American Nurses Credentialing Center (ANCC) as a psychiatric and mental health nurse (PMHN), a Psychiatric Mental Health Advanced Practice Registered Nurse (PMH-APRN) who is licensed as a nurse practitioner or clinical nurse specialist by the state or province where services are provided, who has graduated from a child and adolescent or adult psychiatric and mental health nurse practitioner or clinical nurse specialist program, and is certified by the appropriate national certifying body, or an advance practice nurse, as defined by the Maine State Board of Nursing.

   The Nurse Care Manager shall provide primary care consultation, psychiatric care consultation, and work with the primary care practice and the member to provide other Section 93 services as necessary, pursuant to the Plan of Care/ITP.

   The Nurse Care Manager shall have primary responsibility for the implementation of OHH services and specific care plans. The Nurse Care Managers assist the physician in the monitoring of routine health screens, they conduct regular face-to-face assessments of clients, screen BMI and blood pressure, make referrals, monitor medications and assist in the coordination with outside providers, including hospitals. The Nurse Care Manager shall be involved in providing all aspects of OHH services, including comprehensive care management, care coordination, health promotion, transitions of care, individual and family supports, and referrals to community and social support services.

4. **Certified Clinical Supervisor (CCS) –** A clinician who is credentialed by the Maine State Board of Alcohol and Drug Counselors, 02-384 C.M.R. Chapter 6, and must conduct supervision as defined in the Regulations for Licensing and Certifying of Substance Abuse Treatment Programs, 14-118 C.M.R. Chapter 5, Section 11, in the State of Maine.

   The CCS provides clinical supervision of the Licensed Alcohol and Drug Counselor.

5. **Licensed Alcohol and Drug Counselor (LADC)** – Licensed Alcohol and Drug Counselor means a clinician who is credentialed by the Maine State Board of Alcohol and Drug Counselors, 02-384 C.M.R. Chapter 5, who provides individual or group substance abuse outpatient therapy, is supervised by the CCS, and meets the criteria established in M.R.S. Title 32, § 6214-D.

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.02 PROVIDER REQUIREMENTS (cont.)

The LADC shall provide supervision of the Peer Recovery Coach. The LADC also provides counseling related to opioid dependency and support in other OHH services.

6. **Peer Recovery Coach** – An individual who is in recovery from substance use disorder and who is willing to self-identify on this basis with OHH members. Their life experiences and recovery allow them to provide recovery support in such way that others can benefit from their experiences.

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

G. The OHH must establish and maintain a relationship with a primary care provider, authorized and evidenced by a signed medical release, for each OHH member served.

H. The OHH shall ensure that it has policies and procedures in place to ensure that the Clinical Team Lead can communicate any changes in patient condition with treating clinicians that may necessitate treatment change.

I. The OHH shall have in place processes, procedures, and member referral protocols 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 or services. The protocols must include coordination and communication on enrolled or potentially eligible members. The OHH shall have systematic follow-up protocols to assure timely access to follow-up care.

J. The OHH must participate in Department-approved OHH technical assistance and educational opportunities. At least one (1) member of the care team must engage in these opportunities. Within the first six (6) months following the start of the OHH's participation, the OHH shall obtain a written site assessment from the Department or its authorized entity, to establish a baseline status in meeting the Core Standards (93.02-3) and identify the OHH's training and educational needs.

93-02-2 Requirements for Option A and Option B

Each OHH shall select whether it intends to be an "Option A" OHH or an "Option B" OHH. The minimum services required for reimbursement of the OHH Option A (includes medication) or Option B (includes prescription) are as follows.

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.02 PROVIDER REQUIREMENTS (cont.)

A. **Option A Minimum Services**

1. One (1) Section 93.05-7 office visit with the MAT prescriber and member each month; AND

2. The OHH must provide adequate counseling to address opioid substance use disorder. Section 93.05-8 counseling must be provided to each member at a minimum of one (1) counseling session per month; AND

3. Provision of a maximum of a thirty (30) day supply of medication (Section 93.05-9); AND

4. Delivery of at least one additional covered service described in Sections 93.05-1 through 93.05-6, to an enrolled member within the reporting month, pursuant to the member's Plan of Care/ITP.

B. **Option B Minimum Services**

1. One (1) Section 93.05-7 office visit with the MAT prescriber and member each month; AND

2. The OHH must provide adequate counseling to address opioid substance use disorder. Section 93.05-8 counseling must be provided to each member at a minimum of one (1) counseling session per month; AND

3. Delivery of at least one additional covered service described in Sections 93.05-1 through 93.05-6, to an enrolled member within the reporting month, pursuant to the member's Plan of Care/ITP.

93.02-3 Core Standards

The OHH must meet the following Core Standards. For the first year of participation, the OHH must submit quarterly reports on sustained implementation of the Core Standards. Once Core Standards are fully implemented, the OHH may request the Department's approval to submit the Core Standard progress report annually instead of quarterly.

The Core Standards are:

A. **Demonstrated Leadership** – The Clinical Team Lead of the OHH implements and oversees the Core Standards.

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.02 PROVIDER REQUIREMENTS (cont.)

The Clinical Team Lead shall work with other providers and staff in the OHH 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 Clinical Team Lead participates in OHH technical assistance and educational opportunities regarding OHH implementation offered by the Department or its authorized entity.

B. **Team-Based Approach to Care** – The OHH shall implement 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) and non-licensed staff (e.g. peer recovery coach) to improve clinical workflows.

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

1. through clear identification of roles and responsibilities;
2. integrating care management into clinical practice;
3. expanding patient education; and
4. providing greater data support to physicians to enhance the quality and cost-effectiveness of their clinical work.

C. **Population Risk Stratification and Management** – The OHH shall adopt 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.

D. **Enhanced Access** – The OHH shall enhance access to services for their population of patients, including:

1. The OHH shall have a system in place that allows patients to have same-day access to their healthcare provider using some form of care that meets

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.02 PROVIDER REQUIREMENTS (cont.)

their needs – e.g. open-availability for same day access to an OHH team member, telephonic support, and/or secure messaging.

2. The OHH shall have processes in place to monitor and ensure access to care.

E. **Practice Integrated Care Management** – The OHH shall have processes in place to provide care management services and identify specific individuals to work with the practice team to provide care management for patients at high risk of experiencing adverse outcomes.

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

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

F. **Behavioral Physical Health Integration** – The OHH shall complete a baseline assessment of its behavioral-physical health integration capacity during its first year of participation as an OHH. Using results from this baseline assessment, the OHH shall implement one or more specific improvements to integrate behavioral and physical health care.

G. **Inclusion of Patients and Families** – The OHH shall include members and family members as documented and regular participants at leadership meetings. The OHH shall have in place a member and family advisory process to identify patient-centered needs and solutions for improving care in the practice.

1. The OHH shall have processes in place to support members and families to participate in these leadership and/or advisory activities.

2. The OHH shall have 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.).

3. The OHH shall have processes in place to design and implement changes that address needs and gaps in care identified via member and family input.

H. **Connection to Community Resources and Social Support Services –** The OHH shall have processes in place to identify local community resources and social support services.

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.02 PROVIDER REQUIREMENTS (cont.)

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

I. **Commitment to Reducing Waste, Unnecessary Healthcare Spending, and Improving Cost-effective Use of Healthcare Services** – The OHH shall have 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:

1. Reducing avoidable hospitalizations;

2. Reducing avoidable emergency department visits; and

3. Working with the team to develop new processes and procedures that improve patient experience and quality of care, while reducing unnecessary use of services.

J. **Integration of Health Information Technology** – The OHH shall use an electronic data system that includes identifiers and utilization data about members. Member data is used for monitoring, tracking and indicating levels of care complexity for the purpose of improving member care.

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

1. The documentation of need and monitoring clinical care;

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

3. Developing Plans of Care/ITPs and related coordination; and

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

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.03 MEMBER ELIGIBILITY

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

93.03-1 General Eligibility

Members must meet the eligibility criteria as set for in the *MaineCare Eligibility Manual*, Chapter 1, Section 1.

93.03-2 Specific Requirements

All diagnoses and qualifying risk factors must be documented in the member's Plan of Care/ITP.

A. Members must be diagnosed with Substance Use Disorder, Opioid (as set forth in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. *DSM–5*)); AND have a second chronic condition OR be at risk of having a second chronic condition.

B. Eligible Chronic Conditions as Second Chronic Condition

1. a mental health condition;
2. a substance use disorder;
3. tobacco use;
4. diabetes;
5. heart disease;
6. overweight or obese as evidenced by a body mass index over 25;
7. Chronic Obstructive Pulmonary Disease (COPD);
8. hypertension;
9. hyperlipidemia;
10. developmental and intellectual disorders;
11. circulatory congenital abnormalities;
12. asthma;
13. acquired brain injury; and
14. seizure disorders.

C. Definition of at Risk of another Chronic Condition

Members shall be assessed by the OHH providers for high risk behaviors and other risk factors that may contribute to chronic conditions such as, but not limited to: smoking; obesity; poor nutrition; childhood trauma; risky sex practices; intravenous drug use; history of or current abuse of substances other than opioids; and family health issues.

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.03 MEMBER ELIGIBILITY (cont.)

93.03-3 Eligibility Certification

Member eligibility is determined by the Department or its authorized entity, which must provide certification for services within the first thirty (30) days of service. Providers must submit certification requests to the Department or its authorized entity within thirty (30) days of the start of service. Each member's eligibility must be based on a diagnosis rendered within the past year from the date of the certification request, as documented by an appropriately licensed professional. Reassessments shall occur at least annually in order to ensure ongoing eligibility for services provided herein. Providers shall maintain a member's eligibility verification in the member's record.

93.04 POLICIES AND PROCEDURES FOR MEMBER IDENTIFICATION AND ENROLLMENT

93.04-1 Member Identification

The OHH provider shall identify members who are potentially eligible for OHH services based on the eligibility criteria for OHH Services. The OHH provider will submit potentially eligible members through a certification process to approve services.

93.04-2 Enrollment and Freedom of Choice

A. **Enrollment.** The OHH Provider shall identify members for OHH based on the OHH eligibility criteria. Potentially eligible members will be given information about the benefits of participating in an Opioid Health Home. The member can choose to be part of OHH once confirmed eligible. They must be approved through a certification process. Once approved, the member will be placed on the provider OHH panel effective as of the 21st of the month, unless the member qualifies at an earlier or later date, without risk of duplicative services. The member can choose to not participate at any time by notifying their OHH provider.

B. **Duplication and Freedom of Choice.** A member may not receive services under this Section at the same time the member is receiving services under Section 13, Targeted Case Management Services; Section17, Community Support Services; Section 65, Behavioral Health Services; Section 91, Health Home Services; or Section 92, Behavioral Health Home Services, (as defined by Section 93.08 (D)). If, through the certification process, the member is determined to be receiving a duplicative service (as defined by Section 93.08 (D)), the member must choose which service they want to receive.

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

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

Providers that offer Section 13, Section 17, Section 65, Section 91, Section 92, and/or Section 93 services must be able to document that members are provided with information regarding choice of Section 13, Section 17, Section 65, Section 91, Section 92 and Section 93 services for which the member is eligible and which the provider offers.

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

93.05 COVERED SERVICES

OHH services may be delivered, face-to-face, via phone or other media, in any community location where confidentiality can be maintained, as clinically appropriate. Not all aspects of OHH covered services require direct member involvement; however, all covered services require that provider activities are directly related to an individual member, are member-informed, and pursuant to the member's Plan of Care/ITP. OHH covered services are services provided by the OHH as follows.

93.05-1 Comprehensive Care Management

The OHH will coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings for OHH eligible individuals. Levels of care management may change according to member needs over time. Care management is provided for members, with the involvement of his or her family or other support system, if desired by the member, in order to assist the member to develop and implement a whole-person care plan and monitor the member's success in achieving goals. The OHH shall review all discharge plans, monitor and review medication and lab results, and regularly communicate about these efforts with the multi-disciplinary team.

The OHH will establish and maintain relationships with the multidisciplinary team through outreach, planning, and communication in formulating and facilitating treatment recommendations.

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.05 COVERED SERVICES (cont.)

A. **Comprehensive Biopsychosocial Assessment**

The OHH shall conduct a clinical comprehensive biopsychosocial assessment including issues regarding: addiction-focused history, patterns, durations, periods of sobriety, successful strategies used, physical and mental health (to include depression and anxiety), family history, education, legal, medications, social supports, allergies, housing, financial, nutritional , military, vocational, spirituality/religion, and leisure/recreational activities. Sufficient biopsychosocial screening assessments must be conducted to determine diagnosis, the level of care in which the member should be placed, and to identify treatment priorities for the Plan of Care/ITP. A comprehensive assessment report and evidence of the member having had an annual physical exam must be documented in the medical record for each OHH member.

B. **Plan of Care/Individual Treatment Plan (ITP)**

A goal-oriented Plan of Care/ITP shall be developed and implemented by the multi-disciplinary team, which includes the member.

The following provisions apply to the Plan of Care/ITP:

1. The Plan of Care/ITP shall be recorded in the member's record and in the OHH's electronic health record (EHR).

2. The Plan of Care/ITP shall include the member's health goals, and the services and supports necessary to achieve those goals (including prevention, wellness, specialty care, behavioral health, transitional care and coordination, and social and community services as needed).

3. The Plan of Care/ITP shall include measurable treatment objectives and activities designed to meet those objectives.

4. The Plan of Care/ITP shall be developed within a maximum of thirty (30) days following the member's enrollment and updated every ninety (90) days thereafter.

5. The Plan of Care/ITP must be reviewed if clinically indicated when a member's needs or circumstances change. The member's needs may be reassessed and the Plan of Care/ITP reviewed and amended more frequently than every ninety (90) days.

6. The Plan of Care/ITP shall specify the services and supports that are to be furnished to meet the preferences, choices, abilities, and needs of the member.

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.05 COVERED SERVICES (cont.)

The plan must include measurable goals that are developed following clinical assessment of the member.

7. The Plan of Care/ITP must include a dosage plan as documented by the OHH in the member's record.

8. The Plan of Care/ITP must meet the requirements of Section 93.07, Documentation and Confidentiality.

93.05-2 Care Coordination

The OHH shall provide intensive and comprehensive care coordination to address the complex needs of OHH members and help OHH members overcome any barriers to care by providing access to all clinical and non-clinical health-care related needs and services as appropriate to meet the individual member's treatment needs.

Forms of care coordination as may include but, are not limited to the following, if medically indicated:

1. Assistance in accessing health care and follow-up care;

2. Assessing housing needs, providing assistance to access and maintain safe/affordable housing;

3. Assessing employment needs and providing assistance to access and maintaining employment;

4. Conducting outreach to family members and others to support connections to services and expand social networks;

5. Assistance in locating community services in social, legal, medical, behavioral healthcare areas; and

6. Maintaining frequent communication with other team providers to monitor health status, medical conditions, medications, and medication side effects.

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.05 COVERED SERVICES (cont.)

93.05-3 Health Promotion

The OHH shall provide health promotion services to encourage and support healthy behaviors and encourage self-management of health. OHH health promotion activities may include but are not limited to, the following:

1. Health education specific to opioid dependence and treatment;
2. Relapse prevention plans;
3. Health education regarding a member's other chronic conditions;
4. Development of self-management plans;
5. Behavioral techniques to promote healthy lifestyles;
6. Supports for managing chronic pain;
7. Smoking cessation and reduction in use of alcohol and other drugs
8. Nutritional counseling; and
9. Promotion of increased physical activity

93.05-4 Comprehensive Transitional Care

Comprehensive Transitional care services are designed to ensure continuity and coordination of care, and prevent the unnecessary use of emergency rooms and hospitals.

A. The OHH shall collaborate with hospital ERs, discharge planners, long-term care, corrections, probation and parole staff, residential treatment programs, primary care and specialty mental health and substance abuse treatment services to provide comprehensive transitional services. The OHH shall work with discharge planners to schedule follow-up appointments with primary or specialty care providers within seven (7) days of discharge and work with members to ensure attendance at scheduled appointments.

B. The OHH shall collaborate with facility discharge planners, the member, and other support systems, as appropriate, to ensure a coordinated, safe transition to the home/community setting, and to prevent avoidable readmission after discharge.

C. The OHH shall assist the member with the discharge process, including outreach in order to assist the member with returning to the home/community.

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.05 COVERED SERVICES (cont.)

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

E. The OHH 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.

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

G. The OHH 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.

93.05-5 Individual and Family Support Services

Individual and family support services promote recovery by supporting participation in treatment, allowing members to maintain independence and improve the quality of their lives. Support may involve families, communities, and other individuals or entities identified by the member as an integral to their recovery process.

The OHH shall employ approaches which may include but are not limited to peer supports, support groups, and self-care programs. These approaches shall be designed to increase member and caregiver knowledge about an individual's chronic condition(s), promote member engagement and self-management capabilities, and help the member improve adherence to their prescribed treatment.

The OHH shall provide assessment of individual and family strengths and needs, provide information about services and education about health conditions, assistance with navigating the health and human services systems, opioid substance use disorder supports and outreach to key caregivers, and assistance with adhering to treatment plans.

93.05-6 Referral to Community and Social Support Services

The OHH shall provide referrals based on the assessment and member's care plan as appropriate. Referrals will be made through telephone or in person and may include electronic transmission of requested data. The OHH shall follow through on referrals to insure that the member is connecting with the services.

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.05 COVERED SERVICES (cont.)

The OHH shall provide referrals to community, social support and recovery services to members, connect members to community and social service support organizations that offer supports for self-management and healthy living, as well as social service needs such as transportation assistance, housing, literacy, employment, economic and other assistance to meet basic needs.

93.05-7 Office Visit with the MAT Prescriber

The OHH MAT prescriber must meet with the member at least one time per month. The office visit shall focus on the identified treatment priorities on the most up-to-date Plan of Care/ITP for the member, including, but not limited to, the member's physical health, behavioral health, recovery-oriented goals, and the services and supports necessary to achieve those goals.

93.05-8 Counseling Addressing Opioid Dependency

The OHH must provide adequate counseling to address substance use disorder. Counseling must be provided by a professional who is licensed to provide counseling for individuals with substance use disorder. All OHH members must engage in individual or group counseling sessions at a minimum of one hour weekly during the induction phase (minimum of forty-five (45) days), bi-weekly in the stabilization stage (the period after which a person has discontinued or greatly reduced their drug use, no longer has cravings, and has few or no side effects), and at a minimum of once per month in the maintenance phase. Group sessions must be provided with direct oversight by a professional who is licensed to provide counseling for individuals with substance use disorder. Group counseling sessions must be related to opioid dependency and may include, but are not limited to, the following: psychoeducational groups, skill development groups, cognitive behavioral therapy groups, or substance use disorder support groups.

93.05-9 Medication

The OHH MAT prescribers shall provide buprenorphine, buprenorphine derivatives, and naltrexone for opioid substance use disorder. The medication can be provided either directly on site or by providing the member with a prescription. A thirty (30) day supply is the maximum amount that can be provided.

All prescriptions for buprenorphine, buprenorphine derivatives, and naltrexone must be reported to the Maine Prescription Monitoring Program (PMP) pursuant to the rules established at 14-118 C.M.R. Chapter 11, Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications.

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.05 COVERED SERVICES (cont.)

These rules require that opioid containing drugs directly administered in a setting other than an emergency room, an inpatient hospital, a long-term care facility or a residential care facility be reported to the PMP. Because reporting to the PMP may be done only by a pharmacist, buprenorphine, buprenorphine derivatives, and naltrexone may only be directly administered in an office setting if there is a dispensing pharmacist on site who is able to submit the required information to the PMP. If a pharmacist is not available on site, a prescription must be written for the buprenorphine, buprenorphine derivatives, or naltrexone and filled at an outside pharmacy.

93.06 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 OHH shall report in the format designated and frequency determined by the Department including:

A. **The Core Standards:** OHHs shall report on the Core Standards in Section 93.02-3.

B. **Opioid Health Home Quality Measures** – OHH shall submit data necessary to compile and report on Opioid Health Home Quality Measures as identified by the Department. Data sources may include but are not limited to claims, clinical data, the DHHS Enterprise Information System, APS submissions, and surveys.

Providers that fail to timely or adequately file reports or satisfy the benchmarks defined by the Department may be terminated from providing Section 93 services.

93.07 DOCUMENTATION AND CONFIDENTIALITY

In addition to the requirements, above and set forth in Chapter I, Section 1, of the *MaineCare Benefits Manual*, the OHH must maintain a specific record and documentation of services for each member receiving covered services.

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

1. Name, address, birthdate, and MaineCare identification number;

2. Diagnoses that support eligibility for services herein, including the most recent documentation of diagnoses that substantiate ongoing eligibility for services;

3. The comprehensive assessment that must occur within the first thirty (30) days of initiating of services, and any reassessments that occur;

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.07 DOCUMENTATION AND CONFIDENTIALITY (cont.)

4. The Plan of Care/ITP and any updates that occur;

5. Correspondence to and from other providers;

6. Release of information statements as necessary, signed by the member, including right notification, rules and regulations, confidentiality statement and release of information;

7. Documentation/record entries (i.e. progress notes) that clearly reflect implementation of the treatment plan and the member's response to treatment, as well as subsequent amendments to the plan. 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 to, 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/ITP, and timelines for obtaining needed services; and

8. A record of discharge/transfer planning, beginning at admission and any referrals made.

B. **Confidentiality and Disclosure of Confidential Documents/Information**. Providers shall maintain the confidentiality of information regarding these members in accordance with Chapter I, Section 1 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.

93.08 REIMBURSEMENT

Reimbursement for Section 93 services shall be as follows:

A. **Minimum Requirements for OHH Reimbursement**

In order for the OHH to be eligible for the Per Member Per Month (PMPM) payment, for each member for each calendar month, the OHH shall:

1. In collaboration with the member and other appropriate providers, develop and/or update the Plan of Care/ITP with pertinent information from monthly activities or developments in accordance with the provisions of this policy;

2. Submit cost and utilization reports upon request by the Department, in a format determined by the Department;

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.08 REIMBURSEMENT (cont.)

3. Scan the utilization data, as identified by the Department, for its assigned population;

4. The OHH must attest to meeting these requirements in order to be eligible to receive the PMPM reimbursement.

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

B. **Minimum Requirements for OHH Option A**

In addition to the requirements of 93.08 (A), the minimum services required for billing under Section 93, Chapter III, for OHH Option A include all of the following :

1. One (1) Section 93.05-7 office visit with the MAT prescriber and member each month; AND

2. The OHH must provide adequate counseling to address opioid substance use disorder. Section 93.05-8 counseling must be provided to each member at a minimum of one (1) counseling session per month; AND

3. Provision of a maximum of a thirty (30) day supply of medication (Section 93.05-9); AND

4. Delivery of at least one additional covered service described in Sections 93.05-1 through 93.05-6, to an enrolled member within the reporting month, pursuant to the member's Plan of Care/ITP.

C. **Minimum Requirements for OHH Option B**

In addition to the requirements of 93.08 (A), the minimum services required for billing under Section 93, Chapter III, for OHH Option B include all of the following:

1. One (1) Section 93.05-7 office visit with the MAT prescriber and member each month; AND

2. The OHH must provide adequate counseling to address opioid substance use disorder. Section 93.05-8 counseling must be provided to each member at a minimum of one (1) counseling session per month; AND

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

93.08 REIMBURSEMENT (cont.)

3. Delivery of at least one additional covered service described in Sections 93.05-1 through 93.05-6, to an enrolled member within the reporting month, pursuant to the member's Plan of Care/ITP.

D. **Duplication of Services Will Not Be Reimbursed**

The Department shall not reimburse OHH providers for members receiving Section 93 services if:

1. Members also receive services under Sections 17.04-1 (Community Integration Services), 17.04-2 (Community Rehabilitation Services), 17.04-3 (Intensive Case Management Services), Section 13 (Targeted Case Management), Section 91 (Health Home Services), or Section 92 (Behavioral Health Home Services) of the *MaineCare Benefits Manual*.

2. Members receive similar opioid dependency counseling provided through *MaineCare Benefits Manual*, Section 65, Behavioral Health Services.

93.09 BILLING INSTRUCTIONS

OHH organizations must register as a user on the Department Portal. The OHH's authorized users attest that the OHH has performed the necessary "minimum billable activity" (Section 93.08) each month to receive payment for Section 93 members.

Section 93 REIMBURSEMENT FOR OPIOID HEALTH HOME SERVICES

Established: Emergency Rule 4/11/17

The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

If the requirements of Chapter II, Section 93 are met, reimbursement shall be as follows:

Option A:

Opioid Health Homes **directly administering** buprenorphine, buprenorphine derivatives, and naltrexone in an office setting will be reimbursed at a rate of $1,000.00 per member per month.

Option B:

Opioid Health Homes **providing a prescription** for buprenorphine, buprenorphine derivatives, and naltrexone, to be filled at an outside pharmacy will be reimbursed at a rate of $496.00 per member per month.