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BETHANY L. HAMM
ACTING COMMISSIONER

DATE: November 27, 2018

TO: Interested Parties

FROM: Stefanie Nadeau, Director, MaineCare Services

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

This letter gives notice of emergency rules: 10-144 C.M.R. Ch. 101, Section 93, Opioid Health Home Services, Chapters II & III.

The Department of Health and Human Services ("Department") adopts changes to Chapters II and III, Section 93, Opioid Health Home Services of the *MaineCare Benefits Manual* on an emergency basis pursuant to P.L. 2017, ch. 460, Part G, *An Act Making Certain Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government* (emergency, effective July 9, 2018) (the "Act") and pursuant to the Department's emergency rulemaking authority under 5 M.R.S. § 8054.

Part G of the Act amends the Maine Substance Abuse and Treatment Act, 5 M.R.S. §§ 20001-20078-A, by implementing new definitions and creating a "hub-and-spoke" model of treatment. The Act provides funding to hubs and spokes to cover costs of intensive, intermediate and long-term treatment, including, but not limited to the cost of medication, screening, behavioral health treatment, urine drug screens, office visits and recovery support services for individuals with Opioid Use Disorder (OUD), including those who are uninsured. Among other directives, the Act requires the Department by October 1, 2018 to "ensure a continuum of evidence-based treatment and recovery support services for OUD is accessible to all people in the State through contracts with hubs and spokes." The Department is also tasked with assessing federal funding opportunities, developing grant funding for education, providing treatment to uninsured individuals seeking treatment, developing assessment measures for the performance evaluation of the hub-and-spoke model, developing a plan to create a statewide resource and referral center for substance use disorder treatment and recovery resources, and reporting back to the Legislature on its progress by February 1, 2019. The Act became law on an emergency basis on July 9, 2018, following findings by the Legislature that it was "immediately necessary for the preservation of public peace, health and safety."

As a result of the Act, the Department is reviewing all of its programs that provide substance use disorder treatment options for both MaineCare members and uninsured individuals. This includes Opioid Health Homes (OHH). OHH services were established by the Legislature in 2017 to provide an integrated care delivery model focused on whole-person treatment of opioid use disorder for the uninsured, MaineCare members, and the uninsured but MaineCare-eligible populations. *See* P.L. 2017, ch. 2, Part P (emergency, effective March 15, 2017). The Department currently provides OHH services to MaineCare members through Section 93 of the MaineCare Benefits Manual and to the uninsured through OHH contracts that mirror these rules.

The Department believes this current service delivery OHH model largely abides by the hub-and-spoke model envisioned under the Act. Many current OHH providers function as hubs or spokes by providing treatment to individuals, some of whom carry multiple diagnoses, and by referring individuals to different levels of care depending on clinical need. However, to more closely align with the Legislature's directive, the Department is implementing the following emergency rule changes: adding a definition of Integrated Medication Assisted Treatment (IMAT) to describe OHH service expectations; adding urine drug screening as an integral part of IMAT services; establishing levels of care (intensive, intermediate/stabilization, and maintenance) that correspond to the member's needs; and creating a tiered reimbursement rate structure corresponding to these levels of care. Given the emergency nature of the Act, the Department does not need to make additional emergency findings to support these portions of the emergency rulemaking.

In conjunction with these changes, the Department believes additional changes are needed on an emergency basis pursuant to 5 M.R.S. § 8054 to improve the Section 93 rules by making it easier for current and new providers to deliver IMAT services through the OHH model. In turn, this will increase accessibility to services for all individuals with opioid use disorder as envisioned under the Act. The State is currently in the midst of an opioid epidemic which claimed approximately one life per day in 2017. Funding and service-delivery requirements supporting IMAT are critical to providing MaineCare members and uninsured individuals high-quality treatment options. The Department is therefore making emergency changes to Section 93 that: alter the current staffing requirements and add a new patient navigator to the OHH team to ensure flexibility for provider organizations and expertise to meet members' needs; create an allowance for members who meet eligibility for MaineCare Benefits Manual, Section 92, Behavioral Health Home Services, Section 91, Health Home Services, certain Section 13, Targeted Case Management Services, or Section 17, Community Support Services to receive these services in coordination with OHH services; ease requirements regarding the Electronic Health Record to allow provider flexibility in meeting OHH program requirements; provide clarification to covered services; and make minor and technical changes to the operation of OHH. These emergency changes are the result of Departmental review and stakeholder feedback. Both providers and members alike will benefit from these changes.

With the emergency adoption of the above changes, the reimbursement of OHH services at a Per Member Per Month (PMPM) rate will now be based on the level of care of services provided to the member and whether the OHH provides coordinated case management to the member. Urine drug screening will be part of the OHH bundled reimbursement. Medication costs will be excluded from the PMPM bundle and billed separately. This change in reimbursement structure allows for provider organizations to receive reimbursement commensurate with the needs of their patient population(s) and with the organization's service delivery model. Providers will benefit as these rate changes are all reimbursement increases from the current structure.

Additionally, in order to continue to ensure that all individuals with OUD have access to OHH services, the Department will make the majority of the appropriation included in Part G of the Act available to providers through contracts to deliver these services to uninsured individuals. The Department will align both current and new contracts, when possible, with the Section 93 rules to maintain service expectations regardless of funding source and to avoid any administrative burden that would arise from operating two different models of service delivery.

These emergency rule changes will be contingent upon approval from the Centers for Medicare and Medicaid Services (CMS). CMS approved the State Plan Amendment on October 13, 2017, for the original OHH model with the effective date of October 1, 2017. The methodology notice for the current changes was published on September 27, 2018, and the Department will be submitting the State Plan Amendment to CMS for approval by December 31, 2018.

These emergency rule changes will take effect upon adoption and will be in effect for ninety days. 5 M.R.S. § 8054. To prevent a lapse in the Section 93 rules and these services following the expiration of the emergency period, the Department is concurrently engaging in the routine technical rulemaking process for Section 93.

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.

Emergency Notice of Agency Rule-making Adoption

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

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

ADOPTED RULE NUMBER:

CONCISE SUMMARY:

The Department of Health and Human Services ("Department") adopts changes to Chapters II and III, Section 93, Opioid Health Home Services of the *MaineCare Benefits Manual* on an emergency basis pursuant to P.L. 2017, ch. 460, Part G, *An Act Making Certain Appropriations and Allocations and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government* (emergency, effective July 9, 2018) (the "Act") and pursuant to the Department's emergency rulemaking authority under 5 M.R.S. § 8054.

The Act requires the Department to ensure that a continuum of evidence-based treatment and recovery support services for opioid use disorder is accessible to the people of Maine. The Department is implementing the following emergency rule changes: adding a definition of Integrated Medication Assisted Treatment (IMAT) to describe OHH service expectations; adding urine drug screening as an integral part of IMAT services; establishing levels of care (intensive, intermediate/stabilization, and maintenance) that correspond to the member's needs; and creating a tiered reimbursement rate structure corresponding to these levels of care. Given the emergency nature of the Act, the Department does not need to make additional emergency findings to support these portions of the emergency rulemaking.

In conjunction with these changes, the Department believes in order to address the current opioid epidemic additional changes are needed on an emergency basis pursuant to 5 M.R.S. § 8054 to improve the Section 93 rules by making it easier for current and new providers to deliver IMAT services through the OHH model. In turn, this will increase accessibility to services for all individuals with opioid use disorder as envisioned under the Act. The State is currently in the midst of an opioid epidemic which claimed approximately one life per day in 2017. Funding and service-delivery requirements supporting IMAT are critical to providing MaineCare members and uninsured individuals high-quality treatment options. The Department is therefore making emergency changes to Section 93 that: alter the current staffing requirements and add a new patient navigator to the OHH team to ensure flexibility for provider organizations and expertise to meet members' needs; create an allowance for members who meet eligibility for MaineCare Benefits Manual, Section 92, Behavioral Health Home Services, Section 91, Health Home Services, certain Section 13, Targeted Case Management Services, or Section 17, Community Support Services to receive these services in coordination with OHH services; ease requirements regarding the Electronic Health Record to allow provider flexibility in meeting OHH program requirements; provide clarification to covered services; and make minor and technical changes to the operation of OHH. These emergency changes are the result of Departmental review and stakeholder feedback. Both providers and members alike will benefit from these changes.

http://www.maine.gov/dhhs/oms/rules/index.shtml for rules and related rulemaking documents.

EFFECTIVE DATE:	November 27, 2018
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Section 93 OPIOID HEALTH HOME SERVICES

Established: 4/11/17
Last Updated: Emergency Rule 11/27/18

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

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Last Updated: Emergency Rule 11/27/18

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.

93.01 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 Integrated Medication Assisted Treatment (IMAT) – A combination of medication approved by the federal Food and Drug Administration for the treatment of substance use disorder with counseling, urine drug screening, and behavioral therapy that has proven effective in treating substance use disorder.

93.01-3 Intensive Outpatient Services (IOP) Level of Care – This level of care includes Opioid Health Home sites that operate an IOP in accordance with MaineCare Benefits Manual, Section 65.06-5. This level of care only includes coverage for members in the induction phase of treatment.

93.01-4 Intermediate/Stabilization Level of Care – This level of care includes: (a) members in the stabilization phase of treatment and, (b) members in the induction phase of treatment in a setting that does not operate at the IOP Level of Care or the member is not receiving IOP Level of Care.

93.01-5 Maintenance Level of Care – This level of care includes members in the maintenance phase of treatment.

93.01-6 Opioid Health Home (OHH) – A group of providers that furnishes Integrated Medication Assisted Treatment (IMAT) 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, urine drug screening, and medical consultation for individuals who have been diagnosed with an opioid dependency. An OHH is a team of providers that has completed an application and been approved by the Department to provide OHH services.

93.01-7 Plan of Care/Individual Treatment Plan (ITP) – The Plan of Care/ITP is a care plan that describes, coordinates and integrates a member's clinical data, as well as clinical and non-clinical health care-related needs and services. The Plan of Care/ITP shall also include member health goals, and the services and supports necessary to achieve those goals, with particular focus on the member's opioid dependency. The Plan of Care/ITP may exist within the member's Electronic Health Record (EHR).

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.

93.01 DEFINITIONS (cont.)

93.01-8 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.

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

C. The OHH is encouraged to utilize an EHR system and create an EHR for each member. Lack of an EHR system will not be a determining factor in approving an OHH provider application.

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 use and mental health disorders and to incorporate attention to these issues into member services.

E. The OHH must be a community-based provider located within the state of Maine, preferably licensed to provide substance use disorder services in the state of Maine. Lack of a substance abuse license will not be a determining factor in approving an OHH provider application. 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. Unless otherwise specified, each role must be filled by a different individual; the Department reserves the right to waive this requirement based on team member professional experience and training. 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).

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.)

All team members shall contribute to delivery of integrated and coordinated, whole-person care through a team-based approach.

1. **Clinical Team Lead** – A licensed clinical professional with significant experience treating individuals with substance use disorders, 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 coordinate the care management activities across the OHH, ensure that there is a current Plan of Care/ITP for each member, and ensure that there is appropriate supervision of the Peer Recovery Coach.

   The Clinical Team Lead role may be filled by an individual also serving in one of the other roles below, as long as the individual also meets the qualifications described above.

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

   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.

   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*.

3. **Nurse Care Manager** –The Nurse Care Manager may be either:

   a. A registered nurse who completes the Substance Abuse and Mental Health Services Administration (SAMHSA) required training for an X-DEA license (i.e. SAMHSA approved eight-hour training for Buprenorphine prescribing by physicians) within six (6) months of initiating service delivery for OHH members. Registered nurses may not continue functioning as a Nurse Care Manager beyond six (6) months if the appropriate training has not been completed or

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. A psychiatric nurse licensed as a registered professional nurse and certified by the American Nurses Credentialing Center (ANCC) as a psychiatric and mental health nurse (PMHN), or
c. An advanced practice nurse, as defined by the Maine State Board of Nursing.

The Nurse Care Manager shall have primary responsibility for the implementation, coordination, and oversight of each OHH member's Plan of Care/ITP, assist in the coordination of care with outside providers, and communicate barriers to adherence as appropriate to the team, including the Clinical Team Lead. The Nurse Care Manager shall be involved in overseeing and/or participating in all aspects of OHH services.

4. **Clinical Counselor who supports individuals with Opioid Use Disorder (OUD)** – The Clinical Counselor must be:
    a. A clinical professional with a minimum certification as a Certified Alcohol and Drug Counselor (CADC) or, Licensed Alcohol and Drug Counselor (LADC), OR
    b. A Licensed Clinical Social Worker (LCSW), Licensed Master Social Worker – Conditional Clinical (LMSW-CC), Licensed Clinical Professional Counselor (LCPC), Licensed Clinical Professional Counselor – Conditional (LCPC-C), or Licensed Marriage and Family Therapist (LMFT) or Licensed Marriage and Family Therapist – Conditional (LMFT-C):
        i. Who has completed a minimum of sixty (60) hours of alcohol and drug education within the last five (5) years, **or**
        ii. Who, within a maximum of five (5) years of initiating service delivery for OHH services, has completed sixty (60) hours of alcohol and drug education.

    The Clinical Counselor training must be documented and records must be kept on file for review by the Department upon request.

The Clinical Counselor provides counseling related to opioid dependency, individual or group substance use disorder outpatient therapy.

5. **Patient Navigator** – The Patient Navigator must:
    a. Have at least one (1) year of job experience in a health/social services or behavioral health setting and hold an Associate's degree; **or,**
    b. Have a Bachelor's degree from an accredited four-year institution of higher learning; **or**
    c. Be a medical assistant, **or**
    d. Be a licensed practical nurse, **or**

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.)

e. Be a registered nurse, **or**
f. Be the Nurse Care Manager described in 93.02-1(E)(3), **or**
g. Be the Clinical Counselor described in 93.02-1(E)(4).

The Patient Navigator shall work with the member to collaborate with other health care, mental health, social service, and community providers to guide the member in accessing additional services and supports that will help the member in their recovery.

For OHH members who are receiving coordinated case management services, the Patient Navigator shall be the primary provider of care coordination, health promotion, individual and family support services, and referral to community and social support 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. Such a release is not required when the member's primary care provider is also the member's provider within the OHH.

H. The OHH shall ensure that it has policies and procedures in place to ensure that the Clinical Team Lead and other team members, as appropriate, can communicate any changes in patient condition that may necessitate treatment change with the member's treating clinicians. This includes the requirement for establishing policies and procedures around coordination, including but not limited to, a signed medical release with the entities listed in 93.08(C) when applicable.

I. The OHH shall have in place processes, procedures, and member referral protocols with local inpatient facilities, Emergency Departments (EDs), 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.

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.)

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.

93.02-2 Core Standards

The OHH must demonstrate how it will meet the following Core Standards prior to approval to provide services. Within the first three (3) months following the start of the OHH's participation, the OHH shall participate in an on-site assessment initiated by the Department, or its authorized agent, to establish a baseline in meeting the Core Standards and identify the OHH's training and educational needs. For the first year of participation, the OHH must submit quarterly reports on sustained implementation of the Core Standards. After the first year, 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 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 assist with the review of data on the quality performance of the practice.

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 enhance the quality and cost-effectiveness of their clinical work.

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.)

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, ED 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 members to have same-day access to a healthcare provider using a form of care that meets the members' 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, be 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** – Upon approval as an OHH, the OHH shall complete a baseline assessment of its behavioral-physical health integration capacity. 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.

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.)

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 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 organizational 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 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 improve 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 ED visits; or

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 must be used to support member care, including one or more of the following:

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.)

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; or

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

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 described in Chapter I, Section 1 of the *MaineCare Benefits Manual* and in the *MaineCare Eligibility Manual*, 10-144 Chapter 332.

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. an additional substance use disorder (other than opioid 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;

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.)

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 substance use other than opioids; and family health issues.

93.03-3 Eligibility Certification

Providers must submit certification requests to the Department or its authorized entity. 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 a professional whose scope of practice includes the ability to diagnose. 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 Duplication of Services

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 with the certification effective the earliest date without risk of duplicative services. The member can choose to not participate at any time by notifying their OHH provider or the Department's authorized entity for certifications of OHH 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.

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

B. **Duplication of Services.** The Department will not reimburse for duplicative services for members as set forth in the Reimbursement provision of this rule. If, through the certification process, the member is determined to be receiving a duplicative service, the member must choose which service they want to receive.

Providers of OHH services will provide members with notice that the members cannot receive duplicative services, and will keep a record of written documentation signed by the member as to their choice of service.

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 be 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 shall ensure comprehensive care management is provided by the OHH to members who are not receiving coordinated case management services under other Sections of the *MaineCare Benefits Manual* (as described in 93.08(C)). When a member is receiving the services outlined in 93.08(C), comprehensive care management is considered duplicative; however, the OHH shall request access to the member Plan of Care and contribute to successful implementation of the Plan of Care through are Coordination services (see 93.05-2).

Comprehensive care management is provided for members, with the involvement of the member's family or other support system, if desired by the member, in order to assist the member to 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. Levels of care management may change according to member needs over time.

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

93.05-2 Care Coordination

Care Coordination is a required service for all OHH members. Care coordination is primarily the responsibility of the patient navigator, but may also be provided by any member of the multi-disciplinary OHH team.

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 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 and 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 social, legal, medical, behavioral healthcare and transportation services; and

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

93.05-3 Health Promotion

Health promotion is a required service for all OHH members. Health promotion may be provided by any member of the multi-disciplinary OHH team.

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 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

The OHH shall provide comprehensive transitional care, as needed, for members who are not receiving coordinated case management services under other Sections of the *MaineCare Benefits Manual* (as described in 93.08(C)). When a member is receiving coordinated case management services as outlined in 93.08(C), this service is considered duplicative; however, the OHH shall still contribute to successful care transitions through care coordination services (see 93.05-2).

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

A. When possible, the OHH shall collaborate with hospital EDs, discharge planners, long-term care, corrections, probation and parole staff, residential treatment programs, primary care and specialty mental health and substance use disorder treatment services to provide transitional services. As clinically appropriate, the OHH shall work with the member to ensure that the member remains engaged or re-engages in an appropriate level of care for Opioid Use Disorder (OUD) following an absence in treatment from the OHH. As clinically appropriate, 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.

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.)

B. The OHH shall assist the member and family, guardian(s), or caregivers, as appropriate, with the discharge process, including outreach in order to assist the member with returning to treatment for OUD in the community, transition planning, and work to prevent avoidable readmissions after discharge.

C. The OHH shall attempt to follow-up with each member following an inpatient hospitalization, use of crisis service, incarceration or out-of-home placement.

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

E. As allowed by law, 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 related to the member's OHH treatment.

93.05-5 Individual and Family Support Services

Individual and Family Support Services is a required service for all OHH members. This service may be provided by any member of the multi-disciplinary OHH team. For members receiving coordinated case management, the patient navigator is tasked with this primary responsibility.

Individual and family support services promote recovery by supporting participation in treatment. 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 family/support knowledge about an individual's chronic condition(s), promote member engagement and self-management capabilities, and help the member maintain their recovery.

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.

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.)

93.05-6 Referral to Community and Social Support Services

Referral to Community and Social Support Services is a required service for all OHH members; however, all referrals should be shared and documented in the Plan of Care/ITP through Care Coordination, when able through the acquisition of appropriate releases.

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 encourage the member to connect with the services.

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 Comprehensive Assessment

A. Comprehensive Biopsychosocial Assessment

At intake, qualified OHH staff must conduct a comprehensive biopsychosocial assessment to include the following components:

1. Addiction-focused history, including patterns of use, durations or periods of sobriety, and successful strategies used;
2. Physical and mental health (to include any history of depression or anxiety);
3. Medications;
4. Allergies;
5. Family history;
6. Social supports;
7. Housing status;
8. Financial status;
9. Nutritional status;
10. Education;
11. Military service, if applicable;
12. Legal issues;
13. Vocational background;
14. Spirituality and religious preferences; and
15. Leisure and recreational activities.

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.)

Qualified OHH staff must conduct sufficient biopsychosocial screening assessments 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. The OHH shall place and maintain a comprehensive assessment report and evidence of the member having had an annual physical exam in the medical record for each OHH member.

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

The multi-disciplinary OHH team, which must include the member, shall develop and implement a goal-oriented Plan of Care/ITP.

The Plan of Care/ITP must:

1. Be included in the member's record.

2. 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. Include measurable treatment objectives and activities designed to meet those objectives.

4. Be developed within a maximum of thirty (30) days following the member's enrollment and updated every ninety (90) days thereafter.

5. Be reviewed 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. Specify the services and supports that are to be furnished to meet the member's preferences, choices, abilities, and needs.

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

8. Include a Dosage Plan as documented by the OHH in the member's record.

9. Meet the requirements of Section 93.07, "Documentation and Confidentiality."

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.)

93.05-8 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.

93.05-9 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 (expected to last no more than sixty (60) days per induction and may not exceed six (6) months in a twelve (12)-month period), 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.

93.05-10 Medication

The OHH MAT prescribers shall provide members with a prescription for medication to assist in the member's recovery. Covered medications shall include buprenorphine, buprenorphine derivatives, and naltrexone for opioid substance use disorder. The medication can be provided either directly on site at the OHH or by an outside pharmacy. A thirty (30) day supply is the maximum amount that can be reimbursed per billing period

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*. Please refer to MBM, Chapter II, Section 80, Pharmacy Services and MaineCare's Preferred Drug List at www.mainecarepdl.org for the most current and accurate prescribing criteria for these 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.)

Due to reporting requirements of the PMP, buprenorphine, buprenorphine derivatives, and naltrexone may only be directly administered in an office setting if there is a dispensing pharmacist responsible for the site who is able to submit the required information to the PMP. If a pharmacist is not available to serve this function, a prescription must be written for the buprenorphine, buprenorphine derivatives, or naltrexone and filled at an outside pharmacy.

93.05-11 Urine Drug Screening

The OHH shall provide, as part of the OHH bundled reimbursement, all appropriate point of care and confirmatory urine drug screening/testing related to OUD treatment. Screenings must be in compliance with Section 55, Laboratory Services and Section 80, Pharmacy Services of the *MaineCare Benefits Manual*.

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

B. **Opioid Health Home Quality Measures** – The 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, certification submissions, and surveys.

Providers who 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;

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.)

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;

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.

9. Adequate clinical documentation to support the phrase of treatment for which the provider is attesting.

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**

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.)

In order for the OHH to be eligible for the Per Member Per Month (PMPM) payment, for each member for each billing 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;

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

4. Attest to meeting these requirements in order to be eligible to receive the PMPM reimbursement.

5. Document each service provided to each member, for each calendar month, in order to be eligible to receive the PMPM reimbursement.

In addition, the minimum services required for billing include all of the following:

6. At least one (1) Section 93.05-8 office visit with the MAT prescriber and member each month; AND

7. Provision of adequate counseling to address opioid use disorder as described in Section 93.05-9; AND

8. Provision of (through dispensing on site or prescription to an outside pharmacy) a maximum of a thirty (30) day supply of medication as described in Section 93.05-10; AND

9. 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; AND

10. Provision of urine drug screening in accordance with Section 93.05-11.

B. **Duplicative Services Will Not Be Reimbursed**

The Department will not reimburse OHH providers for a member receiving Section 93 services if:

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.)

1. The member receives Section 13, Targeted Case Management for adults with substance use disorder.

2. The member receives opioid dependency counseling provided through *MaineCare Benefits Manual*, Section 65, "Behavioral Health Services".

3. The member receives Medication Assisted Treatment with Methadone provided through *MaineCare Benefits Manual*, Section 65, "Behavioral Health Services".

4. The member receives medication management for opioid dependency treatment through *MaineCare Benefits Manual*, Section 65, "Behavioral Health Services".

5. The member receives urine drug screening from the same service location under which a member is receiving OHH services.

Mental health counseling and medication management not related to opioid dependency treatment through Section 65, "Behavioral Health Services", are not considered duplicative services.

C. **Coordinated Case Management**

Members who elect to receive coordinated case management outside of the OHH shall not receive comprehensive care management, as described in 93.05-1, and comprehensive transitional care, as described in 93.05-4 from the OHH provider. Coordinated case management services may include the following *MaineCare Benefits Manual* services to be delivered in coordination with all other OHH services: Sections 17.04-1 ("Community Integration Services"), 17.04-2 ("Community Rehabilitation Services"), 17.04-3 ("Intensive Case Management Services"); Section 13 services for children with developmental disabilities, children with behavioral health disorders, children with chronic medical care needs, adults with developmental disabilities, or adults with HIV; Section 91 ("Health Home Services"); or Section 92 ("Behavioral Health Home Services") of the *MaineCare Benefits Manual.*

For these members, only the lower "coordinated case management" tier of reimbursement will be provided, regardless of phase of treatment.

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.

93.09 BILLING INSTRUCTIONS

OHH organizations must register as users 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.

Billing for medications (93.05-10), shall be as follows:

1. When a prescription for medication is written, but not dispensed at the OHH, the dispensing pharmacy shall bill for the medication in accordance with *MaineCare Benefits Manual*, Section 80, Pharmacy Services.

2. When a prescription for medication is dispensed by the OHH, the OHH shall include the billing for the medication on the applicable UB or 1500 claim form.

Section 93 REIMBURSEMENT FOR OPIOID HEALTH HOME SERVICES

Established: 4/11/17
Last Updated: Emergency Rule 11/27/18

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:

Opioid Health Homes that provide comprehensive care management services, as described in Chapter II, Section 93.05-1, and comprehensive transitional care, as described in Chapter II, Section 93.05-4, will be reimbursed at the following rates:

Intensive Outpatient Services (IOP) Level of Care: $2,217.76 per member per month

Intermediate/Stabilization Level of Care: $1,045.01 per member per month

Maintenance Level of Care: $662.68 per member per month.

Opioid Health Homes that do not provide comprehensive care management, as described in Chapter II, Section 93.05-1, and comprehensive transitional care, as described in Chapter II, Section 93.05-4, because the member is receiving coordinated case management services under other Sections of the *MaineCare Benefits Manual* as described in Section 93.08(C) will be reimbursed at the following rates:

Intensive Outpatient Services (IOP) Level of Care: $1,963.45 per member per month

Intermediate/Stabilization Level of Care: $790.70 per member per month

Maintenance Level of Care: $408.37 per member per month.