Table of Contents

State/Territory Name: Maine

State Plan Amendment (SPA) #: 22-0033-CCT

This file contains the following documents in the order listed:

ME - Submission Package - ME2022MS0007O - (ME-22-0033-CCT) - Health Homes

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Medicaid and CHIP Operations Group
601 E. 12th Street
Room 355
Kansas City, MO 64106

Center for Medicaid & CHIP Services

July 13, 2023

Michelle Probert
Director
Office of MaineCare Services
109 Capitol Street
11 State House Station
Augusta, ME 04330-0011

Re: Approval of State Plan Amendment ME 22-0033

Dear Michelle Probert,

On June 30, 2022, the Centers for Medicare and Medicaid Services (CMS) received Maine State Plan Amendment (SPA) ME 22-0033 to implement Community Care Teams (CCTs) to deliver health home services designed to address the whole-person needs to include assessment of the level of care coordination needs based on risk factors of adults and children with chronic conditions and polypharmacy and high emergency department utilization.

We approve Maine State Plan Amendment (SPA) ME 22-0033 with an effective date of July 01, 2022.

If you have any questions regarding this amendment, please contact Gilson DaSilva at Gilson.DaSilva@cms.hhs.gov.

Sincerely,

Ruth A. Hughes

Acting Director, Division of Program Operations

Center for Medicaid & CHIP Services

ME - Submission Package - ME2022MS0007O - (ME-22-0033-CCT) - Health Homes

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

CMS-10434 OMB 0938-1188

Package Header

Package ID ME2022MS0007O

SPA ID ME-22-0033-CCT

Submission Type Official

Initial Submission Date 6/30/2022

Approval Date 07/13/2023

Effective Date N/A

Superseded SPA ID N/A

State Information

State/Territory Name: Maine

Medicaid Agency Name: Office of MaineCare Services

Submission Component

- (●) State Plan Amendment
- (●) Medicaid
- ( ) CHIP

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

Package Header

Package ID ME2022MS0007O

SPA ID ME-22-0033-CCT

Submission Type Official

Initial Submission Date 6/30/2022

Approval Date 07/13/2023

Effective Date N/A

Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID ME-22-0033-CCT

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	7/1/2022	ME-12-004-X
Health Homes Geographic Limitations	7/1/2022	ME-12-004-X
Health Homes Population and Enrollment Criteria	7/1/2022	ME-12-004-X
Health Homes Providers	7/1/2022	ME-12-004-X
Health Homes Service Delivery Systems	7/1/2022	ME-12-004-X
Health Homes Payment Methodologies	7/1/2022	ME-12-004-X
Health Homes Services	7/1/2022	ME-12-004-X
Health Homes Monitoring, Quality Measurement and Evaluation	7/1/2022	ME-12-004-X

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

Package Header

Package ID ME2022MS0007O
SPA ID ME-22-0033-CCT
Submission Type Official
Initial Submission Date 6/30/2022
Approval Date 07/13/2023
Effective Date N/A
Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives

Community Care Teams (CCTs) deliver health home services designed to address the whole-person needs of adults and children with chronic conditions and polypharmacy, high emergency department utilization, an assessment of high-risk or high-cost utilization and/or health-related social needs (HRSNs) requiring intensive community coordination. Community Care Teams will collaboratively deliver health home services at an intensity level as required by the severity of the member's needs. Community Care Teams deliver health home services to achieve the following goals:

1. Reduce Inefficient Healthcare Spending

2. Improve Chronic Disease Management

3. Promote and the Resolution of HRSNs

4. Promote Wellness and Prevention

5. Promote Recovery and Effective Management of Chronic Health Conditions

6. Promote Improved Experience of Care for Consumers

7. Promote and Improve Health Equity

Members may opt out of Health Home services at any time. Maine's first Health Home Program was implemented in January 2013 and is updated with this SPA to align with MaineCare's Primary Care Plus (PCPlus) model and to make CCT service delivery improvements. This Health Home SPA also adds CCT II for the delivery of health home services to members with chronic conditions and HRNs, including but not limited to homelessness, requiring intensive community coordination to:

1.Build and improve networks of care management, coordination and supports across the State for those members with chronic conditions and HRSNs requiring intensive community coordination to improve health equity, health outcomes and continuity of care for eligible members.
2.Maintain the gains of beneficiaries through the improvement of the members' self-management abilities and the delivery of enhanced integration and coordination of primary, acute, behavioral health and long-term services and supports.
3.Reduce unnecessary or avoidable health care costs.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2022	$593838
Second	2023	$1715073

Federal Statute / Regulation Citation

1945 of the Social Security Act

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
fiscal	6/29/2022 4:25 PM EDT	
Copy of Section 91 Fiscal	6/29/2022 4:25 PM EDT	

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

Package Header

Package ID ME2022MS0007O

SPA ID ME-22-0033-CCT

Submission Type Official

Initial Submission Date 6/30/2022

Approval Date 07/13/2023

Effective Date N/A

Superseded SPA ID N/A

Governor's Office Review

- ○ No comment
- ○ Comments received
- ○ No response within 45 days
- ◉ Other

Describe N/A

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 7/28/2023 6:47 PM EDT

ME - Submission Package - ME2022MS0007O - (ME-22-0033-CCT) - Health Homes

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

CMS-10434 OMB 0938-1188

Package Header

Package ID	ME2022MS0007O	**SPA ID**	ME-22-0033-CCT
Submission Type	Official	**Initial Submission Date**	6/30/2022
Approval Date	07/13/2023	**Effective Date**	7/1/2022
Superseded SPA ID	ME-12-004-X		
	System-Derived		

Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

MIGRATED_HH.CONVERTED Maine Health Homes Services

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Community Care Teams (CCTs) deliver health home services designed to address the whole-person needs of adults and children with chronic conditions and polypharmacy, high emergency department utilization, an assessment of high-risk or high-cost utilization, and/or health-related social needs (HRSNs) requiring intensive community coordination. Community Care Teams will collaboratively deliver health home services at an intensity level as required by the severity of the member's needs. Community Care Teams deliver health home services to achieve the following goals:
1. Reduce Inefficient Healthcare Spending
2. Improve Chronic Disease Management
3. Promote and Support the Resolution of HRSNs
4. Promote Wellness and Prevention
5. Promote Recovery and Effective Management of Chronic Health Conditions
6. Promote Improved Experience of Care for Consumers
7. Promote and Improve Health Equity

Members may opt out of Health Home services at any time. Maine's first Health Home Program was implemented in January 2013 and is updated with this SPA to align with MaineCare's Primary Care Plus (PCPlus) model and to make CCT service delivery improvements. This Health Home SPA also adds CCT II for the delivery of health home services to members with chronic conditions and HRSNs, including but not limited to homelessness, requiring intensive community coordination to:
1.Build and improve networks of care management, coordination and connections to community supports across the State for those members with chronic conditions and HRSNs requiring intensive community coordination to improve health equity, health outcomes and continuity of care for eligible members.
2.Maintain the gains of beneficiaries through the improvement of the members' self-management abilities and the delivery of enhanced integration and coordination of primary, acute, behavioral health and long-term services and supports.
3.Reduce unnecessary or avoidable health care costs.

General Assurances

- [x] The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- [x] The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.
- [x] The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.
- [x] The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.
- [x] The state provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each health homes enrollee will be claimed.
- [x] The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 7/28/2023 6:48 PM EDT

ME - Submission Package - ME2022MS0007O - (ME-22-0033-CCT) - Health Homes

Health Homes Geographic Limitations

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

CMS-10434 OMB 0938-1188

Package Header

Package ID	ME2022MS0007O	**SPA ID**	ME-22-0033-CCT
Submission Type	Official	**Initial Submission Date**	6/30/2022
Approval Date	07/13/2023	**Effective Date**	7/1/2022
Superseded SPA ID	ME-12-004-X		
	System-Derived		

- (●) Health Homes services will be available statewide
- ( ) Health Homes services will be limited to the following geographic areas
- ( ) Health Homes services will be provided in a geographic phased-in approach

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 7/28/2023 6:50 PM EDT

ME - Submission Package - ME2022MS0007O - (ME-22-0033-CCT) - Health Homes

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

CMS-10434 OMB 0938-1188

Package Header

Package ID ME2022MS0007O

SPA ID ME-22-0033-CCT

Submission Type Official

Initial Submission Date 6/30/2022

Approval Date 07/13/2023

Effective Date 7/1/2022

Superseded SPA ID ME-12-004-X

System-Derived

Categories of Individuals and Populations Provided Health Home Services

The state will make Health Home services available to the following categories of Medicaid participants

☑ Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups

☑ Medically Needy Eligibility Groups

Mandatory Medically Needy

☑ Medically Needy Pregnant Women

☑ Medically Needy Children under Age 18

Optional Medically Needy (select the groups included in the population)

Families and Adults

☐ Medically Needy Children Age 18 through 20

☐ Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

☐ Medically Needy Aged, Blind or Disabled

☐ Medically Needy Blind or Disabled Individuals Eligible in 1973

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

Package Header

Package ID ME2022MS0007O
SPA ID ME-22-0033-CCT
Submission Type Official
Initial Submission Date 6/30/2022
Approval Date 07/13/2023
Effective Date 7/1/2022
Superseded SPA ID ME-12-004-X
System-Derived

Population Criteria

The state elects to offer Health Homes services to individuals with:

☑ Two or more chronic conditions

Specify the conditions included:

☑ Mental Health Condition
☑ Substance Use Disorder
☑ Asthma
☑ Diabetes
☑ Heart Disease
☑ BMI over 25
☑ Other (specify):

Name	Description
cardiac and circulatory congenital abnormalities	See 'Specify the criteria for at risk of developing another chronic condition'
Chronic Obstructive Pulmonary Disease (COPD)	See 'Specify the criteria for at risk of developing another chronic condition'
developmental disabilities or autism spectrum disorders;	See 'Specify the criteria for at risk of developing another chronic condition'
Hyperlipidemia	See 'Specify the criteria for at risk of developing another chronic condition'
Hypertension	See 'Specify the criteria for at risk of developing another chronic condition'
seizure disorders	See 'Specify the criteria for at risk of developing another chronic condition'
Tobacco use	See 'Specify the criteria for at risk of developing another chronic condition'
Acquired brain injury	See 'Specify the criteria for at risk of developing another chronic condition'
HIV/AIDS	See 'Specify the criteria for at risk of developing another chronic condition'

☑ One chronic condition and the risk of developing another

Specify the conditions included:

☑ Mental Health Condition
☑ Substance Use Disorder
☐ Asthma
☑ Diabetes

- [x] Heart Disease
- [x] BMI over 25
- [x] Other (specify):

Name	Description
childhood trauma	See 'Specify the criteria for at risk of developing another chronic condition'
HIV/AIDS	See 'Specify the criteria for at risk of developing another chronic condition'
risky sex practices	See 'Specify the criteria for at risk of developing another chronic condition'
intravenous drug use	See 'Specify the criteria for at risk of developing another chronic condition'
history of incarceration	See 'Specify the criteria for at risk of developing another chronic condition'
family history of genetic predisposition for developing a chronic condition	See 'Specify the criteria for at risk of developing another chronic condition'
cardiac and circulatory congenital abnormalities.	See 'Specify the criteria for at risk of developing another chronic condition'
COPD	See 'Specify the criteria for at risk of developing another chronic condition'
developmental disabilities and autism spectrum disorders	See 'Specify the criteria for at risk of developing another chronic condition'
hyperlipidemia	See 'Specify the criteria for at risk of developing another chronic condition'
hypertension	See 'Specify the criteria for at risk of developing another chronic condition'
tobacco use	See 'Specify the criteria for at risk of developing another chronic condition'
Poor nutrition	See 'Specify the criteria for at risk of developing another chronic condition'

Specify the criteria for at risk of developing another chronic condition:

Targeting Eligibility Criteria for MaineCare CCT Health Home Services

A member must also meet one of the following eligibility criteria:

Hospital Admissions: Two or more admissions in the past three months or three or more admissions in the past twelve months.

Emergency Department (ED) Utilization: Two or more ED visits in the past three months or three or more ED visits in the past twelve months.

The member is identified by the Department as high-risk through Department-provided risk stratification and population health management data or by direct referral from the Department or its authorized agent.

Member is transitioning from institutional settings and at increased risk of poor outcomes.

Member is identified by CCT risk-stratification as:

a. at risk for deteriorating health status, as defined by a validated risk prediction score; and/or

b. high-risk or high cost by severity of illness, high social service needs that interfere with care, and service utilization; and/or

c. having higher hospital costs, ED use, readmissions, utilization and/or escalation of services than what is expected for their clinical risk group.

References for chronic condition, risk factors, and targeting criteria for eligibility included in MaineCare's Health Home services benefit model:

Scherrer JF, Xian H, Franz CD, Lyons MJ, Jacobson KC. Eisen SA, Kremen WS. Depression is a risk factor for incident heart disease in a genetically informative twin design. Presented at the Annual Meeting of the American Psychosomatic Society, March 4-7, 2009: Chicago, Il.

Brook DW, Brook JS, Zhang C, Cohen P, Whiteman M. Drug use and the risk of major depressive disorder, alcohol dependence, and substance use disorders. Arch Gen Psychiatry. 2002 Nov; 59(11):1039-44.

Stratton IM, Adler AI, Neil HA, et al. Association of glycaemia with macrovascular and microvascular complications of type 2 diabetes (UKPDS 35): prospective observational study. BMJ 2000;321: 405-412.

Musselman DL, Evans DL, Nemeroff CB. The relationship of depression to cardiovascular disease, Epidemiology, biology and treatment. Arch Gen Psychiatry 1998; 55:580-592

Analysis by the Lewin Group, Falls Church, Va.1999 Robert H. Eckel, MD, Nutrition Committee. Obesity & Heart Disease. Circulation. 1997;96:3248-3250 COPD Heart Disease.

Don D. Sin and S. F. Paul Man Chronic Obstructive Pulmonary Disease as a Risk Factor for Cardiovascular Morbidity and Mortality. Proc Am Thorac Soc Vol 2. pp 8-11, 2005.

Centers for Disease Control and Prevention (CDC) National Center on Birth Defects and Developmental Disabilities (NCBDDD), Health Surveillance of People with Intellectual Disabilities, Results of a Working Meeting, April 2010.

Granton JT, Rabinovitch M. Pulmonary Arterial Hypertension in Congenital Heart Disease. Cardiol Clin. 2002. 20:441-457.

US Burden of Disease Collaborators. The state of US health, 1990–2010: burden of diseases, injuries, and risk factors. JAMA. 2013; 310:591–608.

CASA Columbia. 2012. Addiction medicine: Closing the gap between science and practice. - Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults. Felitti, Vincent J et al. AJPM, 14:4:245 - 258.

Castelli WP. Epidemiology of coronary heart disease. The Framingham Study. American Journal of Medicine. 1984, 76L4-12.

Centers for Disease Control and Prevention. Third National Health and Nutrition Examination Survey, 1988-94. Analysis by the Lewin Group, Falls Church, VA 1999.

National Academies of Sciences, Engineering, and Medicine. 2018. Permanent Supportive Housing: Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness. Washington, DC: The National Academies Press.

Institute of Medicine, Committee on Health Care for Homeless People.1988. Homelessness, Health, and Human Needs. Washington, DC: The National Academies Press.

Centers for Medicare and Medicaid. (2021, January 7). Opportunities in Medicaid and CHIP to Address Social Determinants of Health. State Health Official Letter 21-001. p 22.

☐ One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

Package Header

Package ID ME2022MS0007O

SPA ID ME-22-0033-CCT

Submission Type Official

Initial Submission Date 6/30/2022

Approval Date 07/13/2023

Effective Date 7/1/2022

Superseded SPA ID ME-12-004-X

System-Derived

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the state will use to enroll eligible Medicaid individuals into a Health Home:

- (•) Opt-In to Health Homes provider
- ( ) Referral and assignment to Health Homes provider with opt-out
- ( ) Other (describe)

Describe the process used:

There are four methods by which members may be identified and determined eligible for CCT services:

MaineCare identifies members meeting eligibility criteria utilization patterns, social determinants of health (SDOH) risk factors (when available), and other risk eligibility and/or severity criteria for services.; or

Providers may notify MaineCare of any members not identified in retrospective claims data for whom their is appropriate documentation of the member's eligibility and must submit this documentation as requested by the Department. Providers are required to retain in the members record documentation of the member's qualifying diagnoses; or

Members may request services or be referred for services from any point-of-care at which the members' need for services are identified; or

Providers shall accept referrals and assess members who are potentially eligible for covered services based on the established health home eligibility and severity criteria. Providers shall enroll qualifying members for services when the member opts in and consents to receive health home services.

A member may only receive services from one CCT Provider at any given time. The Department, or it's authorized entity, reviews the CCT Provider attestation against current authorizations or claims data for duplicative services to ensure that there is no duplication in services. If there is duplication, the Member shall choose which service they want to receive. CCTs Providers shall provide Members with notice that the Members cannot receive duplicative services. The Member's choice of services will be retained in the Member's EHR. CCT Provider services do not preclude a Member from receiving other medically necessary services. There will be no duplication of services and payments for similar services provided under other Medicaid authorities.

This view was generated on 7/28/2023 6:51 PM EDT

ME - Submission Package - ME2022MS0007O - (ME-22-0033-CCT) - Health Homes

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

CMS-10434 OMB 0938-1188

Package Header

Package ID ME2022MS0007O

Submission Type Official

Approval Date 07/13/2023

Superseded SPA ID ME-12-004-X

System-Derived

SPA ID ME-22-0033-CCT

Initial Submission Date 6/30/2022

Effective Date 7/1/2022

Types of Health Homes Providers

- [ ] Designated Providers
- [x] Teams of Health Care Professionals

Indicate the composition of the Health Homes Teams of Health Care Professionals the state includes in its program. For each type of provider indicate the required qualifications and standards

- [ ] Physicians
- [ ] Nurse Practitioners
- [ ] Nurse Care Coordinators
- [ ] Nutritionists
- [ ] Social Workers
- [ ] Behavioral Health Professionals
- [x] Other (Specify)

Provider Type	Description
CCT of Health Care Professionals Staff Requirements	The CCT shall have a documented relationship (e.g. Memorandum of Understanding or practice agreement) with one or more primary care practices to provide CCT services to patients of the practice; and CCT staff shall consist of a multidisciplinary group of a minimum of three health care professionals and shall cover the roles of a CCT Manager, a Medical Director, and a Clinical Leader. Their responsibilities are: a. A CCT Manager provides leadership and oversight to ensure the CCT meets Core Standards; b. A Medical Director collaborates with primary care practices, identify and implement evidenced-based clinical initiatives,

Provider Type	Description
	lead quality improvement efforts, evaluate progress, and convene clinical quality improvement meetings. The Medical Director shall be a physician (Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO)) or Advanced Practice Registered Nurse (APRN); and c. A Clinical Leader is a clinician who directs care management activities across the CCT and does not duplicate care management that is already in place through primary care providers. The following clinician types may serve as Clinical Leaders: Licensed Clinical Professional Counselor (LCPC); Licensed Clinical Professional Counselor-conditional (LCPC-Conditional); Licensed Clinical Social Worker (LCSW); Licensed Master Social Worker conditional clinical (LMSW-conditional clinical); Licensed Marriage and Family Counselor (LMFT); Licensed Marriage and Family Counselor-conditional (LMFT-conditional); Licensed Alcohol and Drug Counselors (LADC), physician; psychiatrist; APRN; Physician Assistant (PA); registered nurse; licensed clinical psychologist; Certified Clinical Supervisor (CCS); and physician (MD/DO). The Clinical Leader and Medical Director may be the same individual, but to maintain the minimum of three health care professionals, another team member will need to be included as part of the leadership team. Additional CCT staff may consist of, but is not limited to, the following: a nurse care coordinator, nutritionist, social worker, behavioral health professional, case manager, pharmacist, care manager or chronic care assistant, CHW (through contracting with a community-based organization (preferred) or employing a CHW directly), care navigator, and/or health coach. 3. The CCT shall maintain a Participant Agreement for data sharing with Maine's statewide state-designated Health Information Exchange (HIE).
CCT II Program Provider Team of Health Care Professionals Staff Requirements	The CCT II Provider shall implement processes, procedures, and member referral protocols with local primary care providers, behavioral health providers, inpatient facilities, Emergency Departments (EDs), residential facilities, crisis services, and correctional facilities for prompt

	Provider Type	Description
		notification of an individual's admission and/or planned discharge to/from one of these facilities or services. 2. The CCT II Provider shall establish and maintain referral and service coordination relationships with community resource providers to support timely access to follow-up to community resources and supports to address health-related social needs (HRSNs). The CCT II Provider shall have a system in place, such as an on-call staff or answering service, for members to reach a member of the organization or an authorized entity twenty-four (24) hours a day, seven (7) days a week to triage and address the members' needs; 4. The CCT II Provider shall be a community-based provider with expertise in addressing homelessness. The CCT II Provider shall deliver a team-based model of care through a multi-disciplinary team of employed or contracted personnel. The team shall include at least the personnel identified in this sub-section. Unless otherwise specified, each role shall 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 CCT II Provider shall notify the Department in writing and maintain records of active recruitment to fill the position(s). All team members shall contribute to delivery of integrated and coordinated, whole-person care through a team-based approach. A CCT II Provider Manager is a professional with at minimum a bachelor's degree that provides leadership and oversight to ensure the CCT II Provider meets the Core Standards and may be filled by an individual also serving as the Clinical Leader. A Clinical Leader is a clinician who is appropriately licensed or certified, practicing within the scope of that licensure or certification, and qualified to complete and direct the comprehensive assessment and Plan of Care requirements of this Section and directs the care management and coordination activities across the CCT II Provider. A clinician includes the following:

Provider Type	Description
	LCPC; LCPC-conditional; LCSW; LMSW-conditional clinical; LMFT; LMFT-conditional; LADC, physician; psychiatrist; APRN; PA; registered nurse or licensed clinical psychologist; CCS; MD/DO. The Case Manager is a professional who works with the Clinical Leader to implement care management, coordination, and supports to assist the member gain and maintain access to services to meet the goals of the Plan of Care. The Case Manager shall meet, at minimum, one of the following criteria: Has a minimum of a bachelor's degree in social work, sociology, public health, or nursing from an accredited four (4) year institution of higher learning; Has a combined five (5) years of education and experience in providing direct services in social, health, or behavior health fields; or Has a current Mental Health Rehabilitation Technician/Community (MHRT/C) Certification. A Community Health Worker or Peer Support Staff is an individual who provides health home services has completed one or more of the following: Maine Office of Behavioral Health (OBH) curriculum for Certified Intentional Peer Support Specialist (CIPSS) and receives and maintains that certification. The CIPSS is an individual who is receiving or has received services and supports related to the diagnosis of a mental illness, is in recovery from that illness, and who is willing to self-identify on this basis with CCT II Provider members. Peer Support Staff may function as a CIPSS without CIPSS certification for the first nine (9) months of functioning as a CIPSS, but may not continue functi

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

Package Header

Package ID ME2022MS0007O

SPA ID ME-22-0033-CCT

Submission Type Official

Initial Submission Date 6/30/2022

Approval Date 07/13/2023

Effective Date 7/1/2022

Superseded SPA ID ME-12-004-X

System-Derived

☐ Health Teams

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

Package Header

Package ID	ME2022MS0007O	**SPA ID**	ME-22-0033-CCT
Submission Type	Official	**Initial Submission Date**	6/30/2022
Approval Date	07/13/2023	**Effective Date**	7/1/2022
Superseded SPA ID	ME-12-004-X		
	System-Derived		

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

MaineCare Health Home Core Standards and Infrastructure

Requirements and Core Standards for CCT I and CCT II Providers of Health Home Services:

Both CCT I and CCT II Providers shall:

Execute a MaineCare Provider Agreement;

Complete a CCT application and be approved as a CCT by MaineCare;

Have an operational electronic health record (EHR);

Participate in Department-required CCT I and CCT II Provider technical assistance and educational opportunities on an annual basis. At least one (1) person in each CCT I and CCT II Provider must engage in these opportunities;

Meet Core Standards. CCT I and CCT II Providers shall demonstrate how they intend to meet the following Core Standards prior to approval to provide services.

a. Demonstrated Leadership

b. Team-Based Approach to Care

c. Population Risk Stratification and Management

d. Enhanced Access

e. Integrated Care Management

f. Behavioral and Physical Health

g. Inclusion of Members and Families

h. Connection to Community Resources and Social Support Services

i. Commitment to Reducing Waste, Unnecessary Healthcare Spending, and Improving Cost-effective Use of Healthcare Services

Integration of Health Information Technology

Policies, Procedures and Accountabilities: Maine's CCT I and CCT II programs include multi-disciplinary teams of professionals that partner with members (and their families/caregivers) to develop and implement a comprehensive and integrated plan of care for all members receiving CCT I and CCT II services. The plan of care will serve as the centralized, member-driven care management document for the member's behavioral and physical health care needs. CCT I and CCT II Providers will have a documented collaboration with each primary care practice delivering primary care services to the members they serve to support the delivery of services without duplication and the implementation of the member's comprehensive plan of care and care coordination across providers to improve effectiveness and efficiency, while reducing fragmentation, emergency and acute care utilization.

Supports for Health Homes Providers

Describe the methods by which the state will support providers of Health Homes services in addressing the following components

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family- centered Health Homes services
2. Coordinate and provide access to high quality health care services informed by evidence-based clinical practice guidelines
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders
4. Coordinate and provide access to mental health and substance abuse services
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care
6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families
7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services
8. Coordinate and provide access to long-term care supports and services
9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services

10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate
11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level

Description

MaineCare provides a comprehensive CCT I and CCT II Provider services support strategy. Components may include but are not limited to site visits, facilitated peer-to-peer learning opportunities, sharing of quality and utilization measures through an online portal to support care management, sharing of educational/training materials (e.g. workforce training), regional forums, HIT support and development resources, training opportunities and data sharing to support quality improvement efforts and other opportunities designed to support core health home standards and functions. Providers shall participate in a site assessment to establish baseline status in meeting Core Standards and identify training and educational needs. Throughout the program CCT I and CCT II Providers shall participate in technical assistance activities as required by the Department to further program objectives.

Please also see the “Provider Infrastructure” Section for the description of the core standards that address 1-11 specifically.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

In addition to the previously identified “Provider Infrastructure” requirements and core standards CCT I and CCT II Providers must also:

1. Enrollment. CCT I and CCT II Providers shall give potentially eligible members information about the benefits of receiving CCT I and CCT II services. The member can choose to be part of a CCT I and CCT II Provider once confirmed eligible. The member shall be approved for services effective the earliest date without risk of duplicative services. The member can choose to not participate at any time by notifying their CCT I and CCT II Provider or the Department.

2. Duplication of Services. The Department will not reimburse for duplicative services for members. A member may only receive services from one CCT I and CCT II Provider at any given time. If, through the enrollment process, the member is determined to be receiving a duplicative service, the member shall choose which service they want to receive. CCT I and CCT II Providers shall provide members with notice that the members cannot receive duplicative services and will retain a record of the member’s service choice in the member’s record.

CCT I and CCT II Provider services do not preclude a member from receiving other medically necessary services.

3. Consent Forms: CCT I and CCT II Providers shall retain a signed consent form for all CCT I and CCT II Provider members in the member record. For children receiving services, CCT I and CCT II Providers shall retain a signed informed consent form from a parent or legal guardian. Consent documentation must, at a minimum:

Indicate that the member or parent or legal guardian has received information in writing, and verbally as appropriate, explaining the CCT I and CCT II Provider purpose and the services provided; and

Indicate that the member or parent or legal guardian has consented in writing, and verbally as appropriate, to receive the CCT I and CCT II services and understand their right to choose, change, or disenroll from their CCT I and CCT II Provider at any time;

Name	Date Created	
No items available		

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 7/28/2023 6:52 PM EDT

ME - Submission Package - ME2022MS0007O - (ME-22-0033-CCT) - Health Homes

Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

CMS-10434 OMB 0938-1188

Package Header

Package ID	ME2022MS0007O	**SPA ID**	ME-22-0033-CCT
Submission Type	Official	**Initial Submission Date**	6/30/2022
Approval Date	07/13/2023	**Effective Date**	7/1/2022
Superseded SPA ID	ME-12-004-X		
	System-Derived		

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services

- [x] Fee for Service
- [ ] PCCM
- [ ] Risk Based Managed Care
- [ ] Other Service Delivery System

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 7/28/2023 6:53 PM EDT

ME - Submission Package - ME2022MS0007O - (ME-22-0033-CCT) - Health Homes

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

CMS-10434 OMB 0938-1188

Package Header

Package ID ME2022MS0007O
SPA ID ME-22-0033-CCT
Submission Type Official
Initial Submission Date 6/30/2022
Approval Date 07/13/2023
Effective Date 7/1/2022
Superseded SPA ID ME-12-004-X
System-Derived

Payment Methodology

The State's Health Homes payment methodology will contain the following features

☑ Fee for Service

☐ Individual Rates Per Service

☑ Per Member, Per Month Rates

☑ Fee for Service Rates based on

- ☑ Severity of each individual's chronic conditions
- ☑ Capabilities of the team of health care professionals, designated provider, or health team
- ☑ Other

Describe below

There are three tiers, each based on acuity level and how the Team addresses individual's needs.

☐ Comprehensive Methodology Included in the Plan

☐ Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided

CCT I reimbursement continues to be a single PMPM for qualifying individuals.

There are three tiers of CCT II Provider payment rates, each based on the acuity level of the member's qualifying eligibility criteria and the intensity level of the community coordination required, as measured by a clinical assessment tool approved by the State, to effectively deliver the health home services required to meet the goals identified in the member's Plan of Care.

Tier One: Chronic condition(s) and/or risk for chronic condition(s) and health-related social needs (HRSNs) requiring intensive community coordination inclusive of, but not limited to homelessness.

Tier Two: Chronic condition(s) and/or risk for chronic condition(s) and health-related social needs (HRSNs) requiring moderate community coordination.

Tier Three: Chronic condition(s) and/or risk for chronic condition(s) and health-related social needs (HRSNs) requiring a reduced level community coordination.

CCT II Services Tier Movement: Once eligible for services, the member may move through the tiers from greater to lesser and lesser to greater intensity based upon the member's status as it is reassessed in relationship to the tier criteria. If a member opts out of CCT II Provider services they may opt back in at any point in the future and their tier eligibility will be based on their current assessment.

☐ PCCM (description included in Service Delivery section)

- [ ] Risk Based Managed Care (description included in Service Delivery section)
- [ ] Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

Package Header

Package ID ME2022MS0007O

SPA ID ME-22-0033-CCT

Submission Type Official

Initial Submission Date 6/30/2022

Approval Date 07/13/2023

Effective Date 7/1/2022

Superseded SPA ID ME-12-004-X

System-Derived

Agency Rates

Describe the rates used

- (•) FFS Rates included in plan
- ( ) Comprehensive methodology included in plan
- ( ) The agency rates are set as of the following date and are effective for services provided on or after that date

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

Package Header

Package ID	ME2022MS0007O	**SPA ID**	ME-22-0033-CCT
Submission Type	Official	**Initial Submission Date**	6/30/2022
Approval Date	07/13/2023	**Effective Date**	7/1/2022
Superseded SPA ID	ME-12-004-X		
	System-Derived		

Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. In the SPA please provide the cost data and assumptions that were used to develop each of the rates;
2. Please identify the reimbursable unit(s) of service;
3. Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit;
4. Please describe the state's standards and process required for service documentation, and;
5. Please describe in the SPA the procedures for reviewing and rebasing the rates, including:
    - the frequency with which the state will review the rates, and
    - the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.

Comprehensive Description

To be eligible for CCT II Provider services the member must meet tier eligibility criteria and have two chronic conditions or one chronic condition and be at risk for a second chronic condition as indicated below:

Chronic Conditions

1. a mental health condition (excluding Serious and Persistent Mental Illness and Serious Emotional disturbance, as defined in MBM, Section 92, Behavioral Health Homes;
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 for an adult or the 85th percentile for a child;
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;
14. seizure disorders; and
15. HIV/AIDS.

A Member is deemed to be at risk for another chronic condition if the Member has been diagnosed with or has any of the following:

1. a mental health condition (excluding Serious and Persistent Mental Illness and Serious Emotional disturbance, as defined in MBM, Section 92, Behavioral Health Homes);
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 for an adult or the 85th percentile for a child;
7. COPD;
8. hypertension;
9. hyperlipidemia;
10. developmental and intellectual disorders;
11. congenital or acquired circulatory abnormalities;
12. HIV/AIDs;
13. poor nutrition;
14. childhood trauma;
15. risky sex practices;
16. intravenous drug use;
17. history of incarceration;
18. history of or current substance use; or
19. family history or genetic predisposition for developing a chronic condition.

CCT II Provider Service Tier Eligibility:

There are three tiers of CCT II Provider payment rates, each based on the acuity level of the member's qualifying eligibility criteria and the intensity level of the community coordination required, as measured by a clinical assessment tool approved by the State, to effectively deliver the health home services required to meet the goals identified in the member's

Plan of Care.
Tier One: Chronic condition(s) and/or risk for chronic condition(s) and health-related social needs (HRSNs) requiring intensive community coordination inclusive of, but not limited to homelessness.
Tier Two: Chronic condition(s) and/or risk for chronic condition(s) and health-related social needs (HRSNs) requiring moderate community coordination.
Tier Three: Chronic condition(s) and/or risk for chronic condition(s) and health-related social needs (HRSNs) requiring a reduced level community coordination.

For individuals receiving Tier One: Intensive Services, inclusive of the 6 section 2703 health home services, the full Per Member Per Month (PMPM) payment is $835.53. For individuals receiving Tier Two: Stabilization Services, inclusive of the 6 section 2703 health home services, the full PMPM payment is $484.30. For individuals receiving Tier Three: Maintenance Services, inclusive of the 6 section 2703 health home services, the full PMPM payment is $260.11.

The PMPM amounts were established based on the independent rate study used for the State's Behavioral Health Home services. The State believes that required staff time differs between the tiers, and adjusted accordingly, the cost data assumptions, contributions and caseload to reflect the higher-level of support provided by the CCT II Provider. This rate was developed by determining the monthly cost per case of each team Member, applicable administrative support cost per case, and operating overhead rates. The costs were informed by provider reported costs and national standards.

CCT II Providers are a team of providers supported by a PMPM payment. Payment will be made monthly.

General/Overall Requirements: In order for the CCT II Provider to be eligible for the PMPM, for each member for each calendar month, the CCT II Provider shall:

In collaboration with the member and other appropriate providers, complete and/or update a comprehensive, whole-person assessment and develop and/or update the Plan of Care with pertinent information from monthly activities or developments in accordance with the provisions of this policy;

Submit Health Home Core Standards implementation progress reports to the Department quarterly for the first year of participation and then quarterly or annually thereafter;

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

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

The CCT II Provider must attest to meeting these requirements in order to be eligible to receive the PMPM reimbursement;

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

In addition to the requirements above, the minimum services required for billing under CCT II Provider Teams include all of the following:

Regular minimum monthly contact to deliver and/or assess the member's need for each of the 6 core Health Home services pursuant to the member's Plan of Care;

CCT II Providers must deliver adequate care management, coordination, and supports to provide transitional continuity of care and to address the health conditions and social determinants of health that destabilize housing status.

Provision of housing navigation services to ensure timely connection with housing resources.

In addition to the requirements above and set forth in Chapter I, Section I, of the MaineCare Benefits Manual (MBM), the CCT II Provider must maintain a specific record and documentation of services for each member receiving covered services. The member's record must minimally include:

Name, address, birthdate, and MaineCare identification number

Signed, informed consent form for CCT II Provider services;

Documentation of diagnoses, SPDAT score, and homelessness status that substantiate initial and ongoing eligibility;

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

The Plan of Care and any updates that occur;

Correspondence to and from other providers;

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

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 services provided, including the date, type, and place of service and method of delivery (i.e. in person, telehealth), the goal to which the service relates, the duration of the service, the progress the member has made towards goal attainment, the signature and credentials of the staff member delivering the service, whether the individual has declined services in the Plan of Care, and timelines for obtaining needed services;

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

Providers shall maintain the confidentiality of information regarding these members in accordance with Chapter I, Section I of the MBM, 42 C.F.R. 431.301-306, 22 M.R.S.A. 1711-C, and with all other applicable sections of state and federal regulation.

Payment will be made via MMIS after a transition period; MaineCare is currently using an external portal. CCT II Provider organizations must register as a user on the Department Portal. The CCT II Provider's authorized users attest that the CCT II Provider organization has performed the necessary "minimum billable activity" each month to receive payment for members receiving CCT II Provider services.

The State will review service utilization and rates annually to ensure that rates are economic and efficient based on analysis of costs and services provided by the Team of Health Care professional. MaineCare will continue to base payments on the costs of staff to provide health home services to the target populations. Rates are the same for government and private providers.

CCT I PMPM reimbursement effective through June 2023 is 135.90.

Each July 1, CCT and CCT II services will receive an annual cost of living adjustment (COLA) equal to the percentage increase in the state minimum wage as set by using the Department of Labor, which is equal to the increase identified by the Consumer Price Index for Urban Wage Earners and Clerical Workers, CPI-W, for the Northeast Region, or its successor index, as published by the United States Department of Labor, Bureau of Labor Statistics or its successor agency and rounded to the nearest $0.05. Annual updates will be posted on the Department's website at: https://mainecare.maine.gov/Provider%20Fee%20Schedules/Forms/Publication.aspx?RootFolder=%2FProvider%20Fee%20Schedules%2FRate%20Setting%2FSection%20091%20%2D%20Health%20Home%20Services&FolderCTID=0x012000264D1FBA0C2BB247BF40A2C571600E81&View=%7B69CEE1D4%2DA5CC%2D4DAE%2D93B6%2D72A66DE366E0%7D

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

Package Header

Package ID	ME2022MS0007O	**SPA ID**	ME-22-0033-CCT
Submission Type	Official	**Initial Submission Date**	6/30/2022
Approval Date	07/13/2023	**Effective Date**	7/1/2022
Superseded SPA ID	ME-12-004-X System-Derived		

Assurances

- [x] The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.

Describe below how non-duplication of payment will be achieved In order to avoid duplication of services or reimbursement, members currently receiving services identified as duplications of health home services will have the choice to either continue receiving the service or to receive services through their chosen CCT or CCT II Provider.

- [x] The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).
- [x] The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.
- [x] The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
No items available		

This view was generated on 7/28/2023 6:54 PM EDT

ME - Submission Package - ME2022MS0007O - (ME-22-0033-CCT) - Health Homes

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

CMS-10434 OMB 0938-1188

Package Header

Package ID	ME2022MS0007O	**SPA ID**	ME-22-0033-CCT
Submission Type	Official	**Initial Submission Date**	6/30/2022
Approval Date	07/13/2023	**Effective Date**	7/1/2022
Superseded SPA ID	ME-12-004-X		
	System-Derived		

Service Definitions

Provide the state's definitions of the following Health Homes services and the specific activities performed under each service

Comprehensive Care Management

Definition

CCT II Provider Comprehensive Care Management Services:

Whole-person Comprehensive Assessment: Within the first thirty (30) days following a member's enrollment for CCT II services, the CCT II Provider shall conduct a face-to-face comprehensive assessment which shall include the identification of primary, behavioral, and acute health care coordination needs and:

Person-centered health-related Social Needs (HRSNs) Assessment including housing status;

A SPDAT or Y-SPDAT assessment or other State approved clinical assessment tool to measure community coordination needs;

A psychosocial assessment, which shall include, at minimum, a history of trauma and abuse; HRSNs; housing instability; substance use; general health and capabilities; behavioral health and capabilities; and medication needs. The psychosocial assessment shall also identify member strengths and how they can be optimized to promote:

Medical and behavioral health goals;

HRSNs goals;

Available support systems;

Community integration;

Employment and/or educational status; and

Self-management and self-advocacy.

Assessment shall be repeated every 90 days or more often when indicated by a significant change in the member's circumstances or needs. Comprehensive reassessment must reoccur as changes in the member's needs warrants or, at a minimum, on an annual basis.

Plan of Care: Based on the comprehensive assessment, within the first thirty (30) calendar days following a member's enrollment, the CCT II Provider in partnership with the member, shall draft a comprehensive, individualized, and member-driven Plan of Care that shall identify and integrate housing needs and goals. The CCT II Provider shall be responsible for the management, oversight, and implementation of the Plan of Care, including ensuring active member participation and that measurable progress is made on these goals.

The Plan of Care must be reviewed and approved in writing by an appropriately licensed medical or mental health professional within the first thirty (30) calendar days following acceptance of the Plan by the member or the member's parent or legal guardian, as appropriate, and every ninety (90) calendar days thereafter or more frequently if indicated in the Plan of Care. The Clinical Leader with other care team members, as appropriate, shall review the Plan of Care as changes in the member's needs occur, or at least every ninety (90) days, to determine the efficacy of the services and supports and formulate changes in the Plan as necessary with member consultation;

The member or the member's parent or legal guardian, as appropriate, shall consent to the Plan of Care which shall be:

Reflected by the appropriate signature on the Plan of Care; and

Documented in the member's record; and

Accessible to the member, the member's legal guardian, the CCT II Provider, primary care provider, and other providers, as appropriate.

The CCT II Provider shall consult with care team members, the member, and the member's parent or legal guardian, as appropriate, when changes in the Member's situation or needs occur and update the Plan of Care accordingly to ensure that it remains current;

The member may decline services identified in the Plan of Care, the CCT II Provider shall document the declination in the member's record;

The Plan of Care shall clearly identify providers involved in the member's care, such as the primary care provider, specialist(s), behavioral health care provider(s), and other providers directly involved in the member's care;

If authorized by the member or the member's parent or legal guardian, as appropriate, the CCT II Provider shall document in the Plan of Care the member's preferred family supports, or other support systems and preferences. If authorized by the member or the member's parent or legal guardian, as appropriate, the Plan of Care shall be accessible to the member's family, guardian(s), or other caregivers;

The Plan of Care shall address for the purpose of care coordination and linkages to the service areas of housing, prevention, wellness, harm reduction, peer supports, health promotion and education, crisis planning, and identifying the social, residential, educational, vocational, and community services and supports that enable a member to achieve physical, social, and behavioral health goals;

When identified in the comprehensive assessment, the Plan of Care shall include the development of an individualized housing support plan that addresses identified barriers, including short and long-term measurable goals for each need, establishes the member's approach to meeting the goals, and identifies when community supports and services may be required to meet the goals;

As part of the Plan of Care, the CCT II Provider shall develop with the member a crisis management plan based upon the comprehensive assessment to develop crisis prevention and early resolution strategies. The member plays a central and active role in the development and maintenance of the crisis management plan, which shall clearly identify the known pre-cursors to crisis and the strategies and techniques to be utilized to stabilize each situation. The crisis management plan shall identify goals and interventions to produce effective crisis prevention, de-escalation, and resolution; and

The Plan of Care shall identify member strengths and how these strengths can be optimized to promote goals. The member shall play a central and active role in the development and maintenance of the Plan of Care, which shall clearly identify the goals and timeframes for improving the member's health and health care status, and the interventions that will produce this outcome.

Integration with Primary Care. During the first three (3) months after a member's enrollment, the CCT II Provider shall provide individualized outreach, education, monitoring, evaluation, health promotion, and care coordination to assist the member with the establishment of a primary care provider and services.

The CCT II Provider shall work with members and appropriate providers to scan for gaps in the member's care by reviewing member feedback, referral completion records, or, at a minimum, Department provided utilization reports.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

HIT plays a central role in CCT and CCT II Provider service delivery. Through MaineCare's web-based portal, providers can access information regarding eligible and pending members and information on key quality and utilization measures. Online utilization reports supply CCT and CCT II Providers with monthly utilization data from MaineCare claims to assist providers with identifying members with high needs/high-cost and as a tool to scan for and act upon any gaps in care. All CCT and CCT II Providers must have EHR systems that allow integration of secure messaging into the EHR. CCT and CCT II Providers should be able to share health information, including care planning documents, to and from other treating providers/organizations and across the team of professionals. CCT and CCT II Providers will also be expected to use population-based management tools, such as disease registries and other tracking techniques in order to engage members in care. MaineCare requires or prioritizes connection with Maine's state designated healthcare information exchange (HIE). Utilizing this tool supports comprehensive transitional supports and enhanced care management and coordination. In addition, Maine's HIE has the ability to notify care managers when their assigned patients visit the ED or are admitted to or discharged from the hospital. This functionality supports CCT and CCT II Provider teams reduce ED use and hospital readmissions.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic

- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Clinical Leader	CCT II: A Clinical Leader is a clinician who is appropriately licensed or certified, practicing within the scope of that licensure or certification, and qualified to complete and direct the comprehensive assessment and Plan of Care requirements of this Section and directs the care management and coordination activities across the CCT II Provider. A clinician includes the following: LCPC; LCPC-conditional; LCSW; LMSW-conditional clinical; LMFT; LMFT-conditional; LADC, physician; psychiatrist; APRN; PA; registered nurse or licensed clinical psychologist; CCS; MD/DO. CCT: A Clinical Leader is a clinician who directs care management activities across the CCT and does not duplicate care management that is already in place through primary care providers. The following clinician types may serve as Clinical Leaders: Licensed Clinical Professional Counselor (LCPC); Licensed Clinical Professional Counselor-conditional (LCPC-Conditional); Licensed Clinical Social Worker (LCSW); Licensed Master Social Worker conditional clinical (LMSW-conditional clinical); Licensed Marriage and Family Counselor (LMFT); Licensed Marriage and Family Counselor-conditional (LMFT-conditional); Licensed Alcohol and Drug Counselors (LADC), physician; psychiatrist; APRN; Physician Assistant (PA); registered nurse; licensed clinical psychologist; Certified Clinical Supervisor (CCS); and physician (MD/DO)
Case Manager	CCT II only: The Case Manager is a professional who works with the Clinical Leader to implement care management, coordination, and supports to assist the Member gain and maintain access to services to meet the goals of the Plan of Care. The Case Manager shall meet, at minimum, one of the following criteria: Has a minimum of a bachelor's degree in social work, sociology, public health, or nursing from an accredited four (4) year institution of higher learning; Has a combined five (5) years of education and experience in providing direct services in social, health, or behavior health fields; or Has a current Mental Health Rehabilitation Technician/Community (MHRT/C) Certification.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

Package Header

Package ID	ME2022MS0007O	**SPA ID**	ME-22-0033-CCT
Submission Type	Official	**Initial Submission Date**	6/30/2022
Approval Date	07/13/2023	**Effective Date**	7/1/2022
Superseded SPA ID	ME-12-004-X System-Derived		

Care Coordination

Definition

Care Coordination is a comprehensive set of services provided by the CCT and CCT II Provider team to assure members receive timely and quality care with continuity.

CCT Care Coordination Services:

The CCT shall provide intensive and comprehensive care coordination services to address the complex needs of CCT patients and/or to help CCT patients overcome barriers to care:

1. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;
2. Coordinate and provide access to preventive, health promotion, treatment, and recovery services, including those related to mental health and substance use;
3. Develop a Plan of Care for each member that coordinates and integrates all clinical and non-clinical health related needs and services, as appropriate; and
4. The CCTs' efforts shall be performed in coordination with, and not duplicate services delivered by, the member's primary care provider.

CCT II Provider Care Coordination Services:

The CCT II Provider shall provide care coordination to address the members' complex needs and to overcome barriers to care by facilitating access to all medically necessary clinical and non-clinical health-related social needs. Care coordination includes but is not limited to the following:

Assistance in establishing a primary care provider and accessing health care and follow-up care;

Assessing housing needs and providing care coordination for tenancy support services to help the member access and maintain safe/affordable housing when as identified as a plan of care goal;

Assessing employment needs and providing assistance to access and maintain employment;

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

Assistance in locating and accessing community social, legal, medical, behavioral healthcare, and transportation services;

Ensuring that members have access to crisis intervention and resolution services, coordinate follow up services to ensure that a crisis is resolved, and assist in the development and monitoring of crisis management plans; and

Maintaining frequent communication with other team providers to monitor health status and to ensure that the Plan of Care is effectively implemented and adequately addresses the member's needs.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

HIT plays a central role in CCT and CCT II Provider service delivery. Through MaineCare's web-based portal, providers can access information regarding eligible and pending members and information on key quality and utilization measures. Online utilization reports supply CCT and CCT II Providers with monthly utilization data from MaineCare claims to assist providers with identifying members with high needs/high-cost and as a tool to scan for and act upon any gaps in care. All CCT and CCT II must have EHR systems that allow integration of secure messaging into the EHR. CCT and CCT II Providers should be able to share health information, including care planning documents, to and from other treating providers/organizations and across the team of professionals. CCT and CCT II Providers will also be expected to use population-based management tools, such as disease registries and other tracking techniques in order to engage members in care. MaineCare requires or prioritizes connection with Maine's state designated healthcare information exchange (HIE). Utilizing this tool supports comprehensive transitional supports and enhanced care management and coordination. In addition, Maine's HIE has the ability to notify care managers when their assigned patients visit the ED or are admitted to or discharged from the hospital. This functionality supports CCT and CCT II Provider teams reduce ED use and hospital readmissions

Scope of service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists

- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Clinical Leader	CCT II: A Clinical Leader is a clinician who is appropriately licensed or certified, practicing within the scope of that licensure or certification, and qualified to complete and direct the comprehensive assessment and Plan of Care requirements of this Section and directs the care management and coordination activities across the CCT II Provider. A clinician includes the following: LCPC; LCPC-conditional; LCSW; LMSW-conditional clinical; LMFT; LMFT-conditional; LADC, physician; psychiatrist; APRN; PA; registered nurse or licensed clinical psychologist; CCS; MD/DO. CCT: A Clinical Leader is a clinician who directs care management activities across the CCT and does not duplicate care management that is already in place through primary care providers. The following clinician types may serve as Clinical Leaders: Licensed Clinical Professional Counselor (LCPC); Licensed Clinical Professional Counselor-conditional (LCPC-Conditional); Licensed Clinical Social Worker (LCSW); Licensed Master Social Worker conditional clinical (LMSW-conditional clinical); Licensed Marriage and Family Counselor (LMFT); Licensed Marriage and Family Counselor-conditional (LMFT-conditional); Licensed Alcohol and Drug Counselors (LADC), physician; psychiatrist; APRN; Physician Assistant (PA); registered nurse; licensed clinical psychologist; Certified Clinical Supervisor (CCS); and physician (MD/DO)
Case Manager	CCT II only: The Case Manager is a professional who works with the Clinical Leader to implement care management, coordination, and supports to assist the Member gain and maintain access to services to meet the goals of the Plan of Care. The Case Manager shall meet, at minimum, one of the following criteria: Has a minimum of a bachelor's degree in social work, sociology, public health, or nursing from an accredited four (4) year institution of higher learning; Has a combined five (5) years of education and experience in providing direct services in social, health, or behavior health fields; or Has a current Mental Health Rehabilitation Technician/Community (MHRT/C) Certification.
Community Resource Navigator	CCT II: Community Resource Navigator is an individual who has completed a State approved training like the Maine State Housing Authority's Housing Navigator training and serves to provide assistance and linkages to the member to access the needed community resources and services to address health-related social needs (HRSNs) as identified in the memebrs's comprehensive assessment and Plan of Care. The Community Resource Navigator role may be filled by an individual also serving in one of the other roles, as long as the individual meets necessary training requirements.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

Package Header

Package ID	ME2022MS0007O	**SPA ID**	ME-22-0033-CCT
Submission Type	Official	**Initial Submission Date**	6/30/2022
Approval Date	07/13/2023	**Effective Date**	7/1/2022
Superseded SPA ID	ME-12-004-X System-Derived		

Health Promotion

Definition

Health Promotion is a set of services that emphasize self-management of physical and behavioral health conditions.

CCT Health Promotion Services:
To perform Health Promotion, CCTs shall promote mmember education and chronic illness self-management for members, in accordance with the United States Preventative Services Task Force recommendations and other evidence-based guidelines for primary, secondary, and tertiary prevention of developing or mitigating the condition(s). This may include, but is not limited to, periodic screening and treatment of tobacco and substance use, diabetes, heart disease, obesity, arthritis, HIV, and depression. Health Promotion may also include education on preventing injuries and acute traumatic events, such as interpersonal violence and abuse; the appropriate use and storage of medications; prevention of sexually transmitted infections; regular use of seat belts, car seats, and motorcycle and bicycle helmets; gun and weapon safety measures; functional smoke and carbon monoxide alarms; benefits of consistent exercise and sleep; and other strategies to support a members' quality of life and wellbeing. Health Promotion shall include identification of risk factors based with targeted follow-up education with the member, family, and other caregivers and referrals to community-based prevention Providers and resources as indicated with periodic updates to ensure ongoing follow-up.

CCT II Provider Health Promotion Services:

Health Promotion is a set of services that emphasize self-management of physical and behavioral health conditions. The CCT II Provider shall:

Provide education, information, training, and assistance to members for the development of self-monitoring and management skills to support members in attaining the goals of the Plan of Care;

Promote healthy lifestyle, psychosocial health, and wellness strategies including, but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, harm reduction, conflict resolution, problem solving, risk avoidance, and increasing physical activities; and

Coordinate and provide access to self-help/self-management and advocacy groups and shall implement population-based strategies that engage members with services necessary for both preventative and chronic care.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

Maine has an established network of public health programs, diabetes education programs, cardiovascular health programs, and other chronic illness programs. Many are accessible through the state's Healthy Maine Partnerships (enhanced community coalitions) and Maine's 211 service directory system. The Value-Based provider portal provides member diagnosis and utilization data to support providers in the identification of opportunities for referrals for clinical services and community supports and services to promote member health.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Community Health Worker/Peer Support Staff	CCT II: A Community Health Worker or Peer Support Staff is an individual who provides Health Home services and has completed one or more of the following: 1.Maine Office of Behavioral Health (OBH) curriculum for Certified Intentional Peer Support Specialist (CIPSS) and receives and maintains that certification. The CIPSS is an individual who is receiving or has received services and supports related to the diagnosis of a mental illness, is in recovery from that illness, and who is willing to self-identify on this basis with CCT II Provider Members. Peer Support Staff may function as a CIPSS without CIPSS certification for the first nine (9) months of functioning as a CIPSS, but may not continue functioning as a CIPSS beyond nine (9) months without: (a) having received provisional certification by completion of the Core training, and (b) continuing pursuit of full certification as a CIPSS and maintaining certification as an Intentional Peer Support Specialist according to requirements as defined by OBH; 2. Connecticut Community for Addiction Recovery (CCAR), or other recovery coach curriculum with certification approved by the Department or their designee in the first six (6) months following their employment start-date with the CCT II Provider; 3.CCT II Provider organization training to deliver peer support services that includes competencies and training elements focused on supportive housing services and at least one (1) year of full-time equivalent practical work experience related to providing direct support services in the community or behavioral health fields; or 4. CHW training program with relevant CHW core competencies or evidenced by a Maine CHW certification or registration (effective the date such a designation becomes active in the State of Maine). Lived experience related to housing insecurity and/or homelessness is preferred for any Peer Support Staff or CHW team members.
Case Manager	CCT II only: The Case Manager is a professional who works with the Clinical Leader to implement care management, coordination, and supports to assist the Member gain and maintain access to services to meet the goals of the Plan of Care. The Case Manager shall meet, at minimum, one of the following criteria: Has a minimum of a bachelor's degree in social work, sociology, public health, or nursing from an accredited four (4) year institution of higher learning; Has a combined five (5) years of education and experience in providing direct services in social, health, or behavior health fields; or Has a current Mental Health Rehabilitation Technician/Community (MHRT/C) Certification.
Clinical Leader	CCT II: A Clinical Leader is a clinician who is appropriately licensed or certified, practicing within the scope of that licensure or certification, and qualified to complete and direct the comprehensive assessment and Plan of Care requirements of this Section and directs the care management and coordination activities across the CCT II Provider. A clinician includes the following: LCPC; LCPC-conditional; LCSW; LMSW-conditional clinical; LMFT; LMFT-conditional; LADC, physician; psychiatrist; APRN; PA; registered nurse or licensed clinical psychologist; CCS; MD/DO. CCT: A Clinical Leader is a clinician who directs care management activities across the CCT and does not duplicate care management that is already in place through primary care providers. The following clinician types may serve as Clinical Leaders: Licensed Clinical Professional Counselor (LCPC); Licensed Clinical Professional Counselor-conditional (LCPC-Conditional); Licensed Clinical Social Worker (LCSW); Licensed Master Social Worker conditional clinical (LMSW-conditional clinical); Licensed Marriage and Family Counselor (LMFT); Licensed Marriage and Family Counselor-conditional (LMFT-conditional); Licensed Alcohol and Drug Counselors (LADC), physician;

Provider Type	Description
	psychiatrist; APRN; Physician Assistant (PA); registered nurse; licensed clinical psychologist; Certified Clinical Supervisor (CCS); and physician (MD/DO)

Health Homes Services

Package Header

Package ID	ME2022MS0007O	**SPA ID**	ME-22-0033-CCT
Submission Type	Official	**Initial Submission Date**	6/30/2022
Approval Date	07/13/2023	**Effective Date**	7/1/2022
Superseded SPA ID	ME-12-004-X		
	System-Derived		

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

The CCT shall provide Comprehensive Transitional Care to prevent avoidable readmission after discharge from an inpatient facility (hospital, rehabilitative, psychiatric, skilled nursing, or treatment facility), reduce avoidable morbidity and mortality related to uncoordinated transitions of care, ensure safe transitions upon release of incarceration, and ensure proper and timely follow-up care from primary care, behavioral health, and/or specialty providers. This service includes:

Ensuring that medication reconciliation is completed after transitions of care and conducting a home visit if indicated;

Ensuring that timely follow-up visits with all appropriate behavioral and physical health providers are scheduled. The CCT is expected to follow-up to confirm follow-up appointments occurred and help address barriers such as transportation needs to ensure that the visit occurs;

Assessing and responding to social service needs identified through discharge planning and follow-up, such as access to food and housing; and

Providing care transition support to other levels of care.

CCT II Provider Comprehensive Transitional Care Services:

Comprehensive Transitional Care services are designed to ensure continuity and coordination of care, prevent the unnecessary use of the ED and hospitals, ensure safe and effective discharges or releases (including from incarceration), and/or prevent loss of housing and health gains acquired through CCT II services. To provide Comprehensive Transitional Care, the CCT II Provider shall:

Collaborate with shelter staff, facility discharge planners, incarceration officials, other community setting managers, the Member, the Member's parent or legal guardian when appropriate, and, with the Member's consent, the Member's family or other support system to ensure a coordinated, safe transition to housing in the community;

Provide Members with care coordination and transitional care services to support improved health outcomes during transitions between healthcare, post-incarceration, community-based settings and the member's residence;

Follow-up with Members following a hospitalization, use of crisis service, out-of-home placement, or post-incarceration;

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;

Assist the Member explore less restrictive alternatives to hospitalization/ institutionalization; and

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 the transition to housing.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

MaineCare requires or prioritizes connection with Maine's state designated healthcare information exchange (HIE). Utilizing this tool will better support comprehensive transitional supports as well as building health information interoperability across sites of care for enhanced care management and coordination. Maine's HIE has the ability to notify care managers when their assigned patients visit the ED or are admitted to or discharged from the hospital. This functionality will help CCT and CCT II Provider teams reduce ED use and hospital readmissions.

Scope of service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
- ☐ Nurses
- ☐ Medical Specialists

- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Case Manager	CCT II only: The Case Manager is a professional who works with the Clinical Leader to implement care management, coordination, and supports to assist the Member gain and maintain access to services to meet the goals of the Plan of Care. The Case Manager shall meet, at minimum, one of the following criteria: Has a minimum of a bachelor's degree in social work, sociology, public health, or nursing from an accredited four (4) year institution of higher learning; Has a combined five (5) years of education and experience in providing direct services in social, health, or behavior health fields; or Has a current Mental Health Rehabilitation Technician/Community (MHRT/C) Certification.
Medical Director	CCT: A Medical Director (at least 4 hours/month) will collaborate with primary care practices, identify and implement evidenced-based clinical initiatives, lead quality improvement efforts, evaluate progress, and convene clinical quality improvement meetings. The Medical Director shall be a physician (Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO)), Advanced Practice Registered Nurse (APRN), or physician assistant
Clinical Leader	CCT II: A Clinical Leader is a clinician who is appropriately licensed or certified, practicing within the scope of that licensure or certification, and qualified to complete and direct the comprehensive assessment and Plan of Care requirements of this Section and directs the care management and coordination activities across the CCT II Provider. A clinician includes the following: LCPC; LCPC-conditional; LCSW; LMSW-conditional clinical; LMFT; LMFT-conditional; LADC, physician; psychiatrist; APRN; PA; registered nurse or licensed clinical psychologist; CCS; MD/DO. CCT: A Clinical Leader is a clinician who directs care management activities across the CCT and does not duplicate care management that is already in place through primary care providers. The following clinician types may serve as Clinical Leaders: Licensed Clinical Professional Counselor (LCPC); Licensed Clinical Professional Counselor-conditional (LCPC-Conditional); Licensed Clinical Social Worker (LCSW); Licensed Master Social Worker conditional clinical (LMSW-conditional clinical); Licensed Marriage and Family Counselor (LMFT); Licensed Marriage and Family Counselor-conditional (LMFT-conditional); Licensed Alcohol and Drug Counselors (LADC), physician; psychiatrist; APRN; Physician Assistant (PA); registered nurse; licensed clinical psychologist; Certified Clinical Supervisor (CCS); and physician (MD/DO)

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

Package Header

Package ID	ME2022MS0007O	**SPA ID**	ME-22-0033-CCT
Submission Type	Official	**Initial Submission Date**	6/30/2022
Approval Date	07/13/2023	**Effective Date**	7/1/2022
Superseded SPA ID	ME-12-004-X		
	System-Derived		

Individual and Family Support (which includes authorized representatives)

Definition

The CCT shall employ approaches to increase member and caregiver knowledge about an individual's chronic illness(es), promote the member's engagement and self-management capabilities, and help the member improve adherence to their prescribed treatment and Plan of Care. Individual and Family Support Services shall include, but not be limited to:

Health coaching for nutrition, physical activity, tobacco cessation, diabetes, asthma, and other chronic diseases;

Chronic disease self-management, education, and skill-building;

Connection to community-based organizations;

Connection to peer support staff, CHWs, support groups, and self-care programs; and

Discussing advance directives with members and their families, guardian(s), or caregivers, as appropriate.

CCT II Provider Individual and Family Support Services:

Individual and family support services include assistance and support to the member and/or the member's family in implementing the Plan of Care. The CCT IIProvider shall:

Provide assistance with housing and health-system navigation and training on self-advocacy skills;

Provide information, consultation, and problem-solving guidance to the member, and his or her family or other support system, to educate the member in the use of self-management skills and supports to reduce avoidable emergency service utilization and maintain health quality improvement and the resolution of health-related social needs (HRSNs);

Provide education and guidance the member to support engagement in employment, education, vocational, and housing support services to establishing and maintain community-integration, health-and independence-sustaining skills;

Assist the member, according to the needs and goals identified in the comprehensive assessment and Plan of Care, to develop communication skills necessary to obtain and maintain housing and employment and request assistance or clarification from landlords, neighbors, supervisors, and co-workers when needed;

Support the member to implement his/her crisis management plan to prevent crises and implement early resolution strategies. The member shall play a central and active role in the implementation of the crisis management plan to attain effective crisis prevention, de-escalation, and resolution;

Provide coordination and guidance to members in linking, acquiring and retaining peer support services, peer advocacy groups, and other peer-run or peer-centered services and help the member identify natural support systems; and

Discuss advance directives with members and their family, guardian(s), or caregivers, as appropriate.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

HIT plays a central role in CCT and CCT II Provider service delivery. Through MaineCare's web-based portal, providers can access information regarding eligible and pending members and information on key quality and utilization measures. Online utilization reports supply CCT and CCT II Providers with monthly utilization data from MaineCare claims to assist providers with identifying members with high needs/high-cost and as a tool to scan for and act upon any gaps in care. All CCT and CCT II Providers must have EHR systems that allow integration of secure messaging into the EHR. CCT and CCT II Providers should be able to share health information, including care planning documents, to and from other treating providers/organizations and across the team of professionals. CCT and CCT II Providers will also be expected to use population-based management tools, such as disease registries and other tracking techniques in order to engage members in care. MaineCare requires or prioritizes connection with Maine's state designated healthcare information exchange (HIE). Utilizing this tool supports comprehensive transitional supports and enhanced care management and coordination. In addition, Maine's HIE has the ability to notify care managers when their assigned patients visit the ED or are admitted to or discharged from the hospital. This functionality supports CCT and CCT II Provider teams reduce ED use and hospital readmissions.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner

- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Community Health Worker/Peer Support Staff	CCT II: A Community Health Worker or Peer Support Staff is an individual who provides Health Home services and has completed one or more of the following: 1.Maine Office of Behavioral Health (OBH) curriculum for Certified Intentional Peer Support Specialist (CIPSS) and receives and maintains that certification. The CIPSS is an individual who is receiving or has received services and supports related to the diagnosis of a mental illness, is in recovery from that illness, and who is willing to self-identify on this basis with CCT II Provider Members. Peer Support Staff may function as a CIPSS without CIPSS certification for the first nine (9) months of functioning as a CIPSS, but may not continue functioning as a CIPSS beyond nine (9) months without: (a) having received provisional certification by completion of the Core training, and (b) continuing pursuit of full certification as a CIPSS and maintaining certification as an Intentional Peer Support Specialist according to requirements as defined by OBH; 2. Connecticut Community for Addiction Recovery (CCAR), or other recovery coach curriculum with certification approved by the Department or their designee in the first six (6) months following their employment start-date with the CCT II Provider; 3.CCT II Provider organization training to deliver peer support services that includes competencies and training elements focused on supportive housing services and at least one (1) year of full-time equivalent practical work experience related to providing direct support services in the community or behavioral health fields; or 4. CHW training program with relevant CHW core competencies or evidenced by a Maine CHW certification or registration (effective the date such a designation becomes active in the State of Maine). Lived experience related to housing insecurity and/or homelessness is preferred for any Peer Support Staff or CHW team members.
Case Manager	CCT II only: The Case Manager is a professional who works with the Clinical Leader to implement care management, coordination, and supports to assist the Member gain and maintain access to services to meet the goals of the Plan of Care. The Case Manager shall meet, at minimum, one of the following criteria: Has a minimum of a bachelor's degree in social work, sociology, public health, or nursing from an accredited four (4) year institution of higher learning; Has a combined five (5) years of education and experience in providing direct services in social, health, or behavior health fields; or

Provider Type	Description
	Has a current Mental Health Rehabilitation Technician/Community (MHRT/C) Certification.
Clinical Leader	CCT II: A Clinical Leader is a clinician who is appropriately licensed or certified, practicing within the scope of that licensure or certification, and qualified to complete and direct the comprehensive assessment and Plan of Care requirements of this Section and directs the care management and coordination activities across the CCT II Provider. A clinician includes the following: LCPC; LCPC-conditional; LCSW; LMSW-conditional clinical; LMFT; LMFT-conditional; LADC, physician; psychiatrist; APRN; PA; registered nurse or licensed clinical psychologist; CCS; MD/DO. CCT: A Clinical Leader is a clinician who directs care management activities across the CCT and does not duplicate care management that is already in place through primary care providers. The following clinician types may serve as Clinical Leaders: Licensed Clinical Professional Counselor (LCPC); Licensed Clinical Professional Counselor-conditional (LCPC-Conditional); Licensed Clinical Social Worker (LCSW); Licensed Master Social Worker conditional clinical (LMSW-conditional clinical); Licensed Marriage and Family Counselor (LMFT); Licensed Marriage and Family Counselor-conditional (LMFT-conditional); Licensed Alcohol and Drug Counselors (LADC), physician; psychiatrist; APRN; Physician Assistant (PA); registered nurse; licensed clinical psychologist; Certified Clinical Supervisor (CCS); and physician (MD/DO)

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

Package Header

Package ID	ME2022MS0007O	**SPA ID**	ME-22-0033-CCT
Submission Type	Official	**Initial Submission Date**	6/30/2022
Approval Date	07/13/2023	**Effective Date**	7/1/2022
Superseded SPA ID	ME-12-004-X		
	System-Derived		

Referral to Community and Social Support Services

Definition

CCT Referral to Community and Social Support Services: The CCT shall provide and follow-up on referrals for members to community, social support, and recovery services. The CCT shall connect members to community and social service organizations that offer supports for self-management, healthy living, and basic social service needs such as transportation assistance, housing, literacy, economic, and other assistance.

CCT II Provider Referral to Community and Social Support Services:

The CCT II Provider 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 CCT II Provider shall follow through on referrals to encourage the member to connect with the services.

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

When able through the acquisition of appropriate releases, all referrals should be shared and documented in the Plan of Care through Care Coordination.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

HIT plays a central role in CCT and CCT II Provider service delivery. Through MaineCare's web-based portal, providers can access information regarding eligible and pending members and information on key quality and utilization measures. Online utilization reports supply CCT and CCT II Providers with monthly utilization data from MaineCare claims to assist providers with identifying members with high needs/high-cost and as a tool to scan for and act upon any gaps in care. All CCT and CCT II Providers must have EHR systems that allow integration of secure messaging into the EHR. CCT and CCT II Providers should be able to share health information, including care planning documents, to and from other treating providers/organizations and across the team of professionals. CCT and CCT II Providers will also be expected to use population-based management tools, such as disease registries and other tracking techniques in order to engage members in care. MaineCare requires or prioritizes connection with Maine's state designated healthcare information exchange (HIE). Utilizing this tool supports comprehensive transitional supports and enhanced care management and coordination. In addition, Maine's HIE has the ability to notify care managers when their assigned patients visit the ED or are admitted to or discharged from the hospital. This functionality supports CCT and CCT II Provider teams reduce ED use and hospital readmissions.

Scope of service

The service can be provided by the following provider types

- [ ] Behavioral Health Professionals or Specialists
- [ ] Nurse Practitioner
- [ ] Nurse Care Coordinators
- [ ] Nurses
- [ ] Medical Specialists
- [ ] Physicians
- [ ] Physician's Assistants
- [ ] Pharmacists
- [ ] Social Workers
- [ ] Doctors of Chiropractic
- [ ] Licensed Complementary and alternative Medicine Practitioners
- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Clinical Leader	CCT II: A Clinical Leader is a clinician who is appropriately licensed or certified, practicing within the scope of that licensure or certification, and qualified to complete and direct the comprehensive assessment and Plan of Care requirements of this Section and directs the care management and coordination activities across the CCT II Provider. A clinician includes the following: LCPC; LCPC-conditional; LCSW; LMSW-conditional clinical; LMFT; LMFT-conditional; LADC, physician; psychiatrist; APRN; PA; registered nurse or licensed clinical psychologist; CCS; MD/DO. CCT: A Clinical Leader is a clinician who directs care management activities across the CCT and does not duplicate care management that is already in place through primary care providers. The following clinician types may serve as Clinical Leaders: Licensed Clinical Professional Counselor (LCPC); Licensed Clinical Professional Counselor-conditional (LCPC-Conditional); Licensed Clinical Social Worker (LCSW); Licensed Master Social Worker conditional clinical (LMSW-conditional clinical); Licensed Marriage and Family Counselor (LMFT); Licensed Marriage and Family Counselor-conditional (LMFT-conditional); Licensed Alcohol and Drug Counselors (LADC), physician; psychiatrist; APRN; Physician Assistant (PA); registered nurse; licensed clinical psychologist; Certified Clinical Supervisor (CCS); and physician (MD/DO)
Medical Director	CCT: A Medical Director (at least 4 hours/month) will collaborate with primary care practices, identify and implement evidenced-based clinical initiatives, lead quality improvement efforts, evaluate progress, and convene clinical quality improvement meetings. The Medical Director shall be a physician (Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO)), Advanced Practice Registered Nurse (APRN), or physician assistant
Case Manager	CCT II only: The Case Manager is a professional who works with the Clinical Leader to implement care management, coordination, and supports to assist the Member gain and maintain access to services to meet the goals of the Plan of Care. The Case Manager shall meet, at minimum, one of the following criteria: Has a minimum of a bachelor's degree in social work, sociology, public health, or nursing from an accredited four (4) year institution of higher learning; Has a combined five (5) years of education and experience in providing direct services in social, health, or behavior health fields; or Has a current Mental Health Rehabilitation Technician/Community (MHRT/C) Certification.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

Package Header

Package ID ME2022MS0007O

SPA ID ME-22-0033-CCT

Submission Type Official

Initial Submission Date 6/30/2022

Approval Date 07/13/2023

Effective Date 7/1/2022

Superseded SPA ID ME-12-004-X

System-Derived

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-charts of the typical process a Health Homes individual would encounter

described in attachment

Name	Date Created	
CMS_SPA_ Member Flow Chart_Section 91_05.03.2022	6/30/2022 1:31 PM EDT	

PRA Disclosure Statement: Centers for Medicare & Medicaid Services (CMS) collects this mandatory information in accordance with (42 U.S.C. 1396a) and (42 CFR 430.12); which sets forth the authority for the submittal and collection of state plans and plan amendment information in a format defined by CMS for the purpose of improving the state application and federal review processes, improve federal program management of Medicaid programs and Children's Health Insurance Program, and to standardize Medicaid program data which covers basic requirements, and individualized content that reflects the characteristics of the particular state's program. The information will be used to monitor and analyze performance metrics related to the Medicaid and Children's Health Insurance Program in efforts to boost program integrity efforts, improve performance and accountability across the programs. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1188. The time required to complete this information collection is estimated to range from 1 hour to 80 hours per response (see below), including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

This view was generated on 7/28/2023 6:55 PM EDT

ME - Submission Package - ME2022MS0007O - (ME-22-0033-CCT) - Health Homes

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

CMS-10434 OMB 0938-1188

Package Header

Package ID	ME2022MS0007O	**SPA ID**	ME-22-0033-CCT
Submission Type	Official	**Initial Submission Date**	6/30/2022
Approval Date	07/13/2023	**Effective Date**	7/1/2022
Superseded SPA ID	ME-12-004-X		
	System-Derived		

Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

MaineCare complies with Health Homes core set reporting and will be reevaluating the methodology for calculating cost savings for the CCT and CCT II Provider service, based on utilization following the change in this State Plan Amendment. This Health Home SPA is now exclusively focused on high-risk/high-need members and the cost saving methodology will be adjusted to look for impacts such as hospitalizations, ambulance, and other high-acuity services. Additional cost impacts may be seen through increased chronic care and wellness service utilization such as primary care, behavioral health, and prescription drugs. These impacts will be monitored and reported in required reporting.

Describe how the state will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider)

HIT plays a central role in CCT and CCT II Provider service delivery. Through MaineCare's web-based portal, providers can access information regarding eligible and pending members and information on key quality and utilization measures. Online utilization reports supply CCT and CCT II Providers with monthly utilization data from MaineCare claims to assist providers with identifying members with high needs/high-cost and as a tool to scan for and act upon any gaps in care. All CCT and CCT II Providers must have EHR systems that allow integration of secure messaging into the EHR. CCT and CCT II Providers should be able to share health information, including care planning documents, to and from other treating providers/organizations and across the team of professionals. CCT and CCT II Providers will also be expected to use population-based management tools, such as disease registries and other tracking techniques in order to engage members in care. MaineCare requires or prioritizes connection with Maine's state designated healthcare information exchange (HIE). Utilizing this tool supports comprehensive transitional supports and enhanced care management and coordination. In addition, Maine's HIE has the ability to notify care managers when their assigned patients visit the ED or are admitted to or discharged from the hospital. This functionality supports CCT and CCT II Provider teams reduce ED use and hospital readmissions.

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | ME2022MS0007O | ME-22-0033-CCT | MIGRATED_HH.CONVERTED Maine Health Homes Services

Package Header

Package ID	ME2022MS0007O	**SPA ID**	ME-22-0033-CCT
Submission Type	Official	**Initial Submission Date**	6/30/2022
Approval Date	07/13/2023	**Effective Date**	7/1/2022
Superseded SPA ID	ME-12-004-X		
	System-Derived		

Quality Measurement and Evaluation

- [x] The state provides assurance that all Health Homes providers report to the state on all applicable quality measures as a condition of receiving payment from the state
- [x] The state provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals
- [x] The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS
- [x] The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report

This view was generated on 7/28/2023 6:56 PM EDT