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State/Territory Name: Maine

State Plan Amendment (SPA) #:15-005

This file contains the following documents in the order listed:

1) Approval Letter

2) CMS 179 Form

3) Approved SPA Pages

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

April 21, 2015

Mary Mayhew, Commissioner
Department of Health and Human Services
11 State House Station
Augusta, Maine 04333-0011

RE: Maine ME 15-005

Dear Commissioner Mayhew:

We are now ready to approve State Plan Amendment (SPA) No. ME 15-005 Attached you will find an approved copy of the SPA. This SPA is effective January 1, 2015.

The purpose of this SPA is to amend the State's approved Title XIX State Plan to revise the reimbursement methodology for comprehensive Health Home services provided to adults and children with significant mental health and co-occurring diagnoses. This SPA is estimated to have a Federal budget impact of $524,556 in Federal Fiscal year 2015 and $593,215 in Federal Fiscal year 2016.

If you have any questions regarding this SPA, please contact Aimee Campbell-O'Connor, Maine State Lead, at 617-565-1642, or at Aimee.Campbell-O'Connor@cms.hhs.gov.

Sincerely,

/s/

Richard R. McGreal
Associate Regional Administrator

cc: Stefanie Nadeau, Director, Office of Maine Care Services

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 15-005

2. STATE: Maine

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE AND MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE(S)
1/1/2015

5. TYPE OF PLAN MATERIAL *(CHECK ONE)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
SECTION 1902(A) (30)(A)M OF THE SOCIAL SECURITY ACT; 42 CFR 447.201

7. FEDERAL BUDGET IMPACT:
FFY 15 ~~$58,284~~ $524,556
FFY 16 ~~$183,905~~ $593,215

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 3.1H, pages 32-88.

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 3.1H, pages 32-74.

SUBJECT OF AMENDMENT: BEHAVIORAL HEALTH HOME SERVICES

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED
COMMISSIONER, DEPT. OF HUMAN SERVICES

12. SIGNATURE OF STATE AGENCY OFFICIAL:
/s/

13. TYPED NAME:
STEFANIE NADEAU

14. TITLE:
Director, Office of MaineCare Services

15. DATE SUBMITTED:
3/9/2015

16. RETURN TO:
Stefanie Nadeau, Director
Office of MaineCare Services
#11 State House Station
442 CIVIC CENTER DRIVE
Augusta, ME 04333-0011

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
3/9/2015

18. DATE APPROVED:
4/21/15

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1/1/2015

20. SIGNATURE OF REGIONAL OFFICIAL:
/s/

21. TYPED NAME:
Richard McGreal

22. TITLE
Associate Regional Administrator

23. REMARKS
State submitted request for pen and ink changes to 179 for Boxes 8 and 9 on 4/1/15. State submitted unsigned revised 179 for Box 7 on 4/9/2015 with new calculations of Fiscal Impact.

OFFICIAL

Health Home State Plan Amendment

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Transmittal Number: 15-005 Supersedes Transmittal Number: 14-001 Approved Effective Date: Jan 1, 2015 Approval Date: Apr 21, 2015 Attachment 3.1-H Page Number: 32

Submission Summary

Transmittal Number:
Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

15-005

Supersedes Transmittal Number:
Please enter the Supersedes Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

14-001

☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.**

Name of Health Homes Program:

ME Behavioral Health Homes

State Information

State/Territory name:	**Maine**
Medicaid agency:	Office of MaineCare Services

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

Name:	Stefanie Nadeau
Title:	Director, Office of MaineCare Service
Telephone number:	(207) 287-2093
Email:	stefanie.nadeau@maine.gov

The primary contact for this submission package.

Name:	Kitty Purington

Title:	Project Manager, Value-Based Purchasing
Telephone number:	(207) 624-6821
Email:	kitty.purington@maine.gov

The secondary contact for this submission package.

Name:	James Leonard
Title:	Deputy Director, MaineCare
Telephone number:	(207) 287-4532
Email:	James.F.Leonard@maine.gov

The tertiary contact for this submission package.

Name:	Elizabeth Bradshaw
Title:	Comprehensive Health Planner II
Telephone number:	(207) 624-4054
Email:	Elizabeth.S.Bradshaw@maine.gov

Proposed Effective Date

01/01/2015 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
MaineCare has one Health Home State Plan amendment currently in operation. That SPA ("Stage A") was implemented in January, 2013 and is designed to provide comprehensive Health Home services to adults and children with chronic health conditions. Maine's second Health Home SPA, Behavioral Health Homes, builds on this existing Health Home infrastructure, with some key differences designed to address the needs of adults and children with significant mental health and co-occurring diagnoses. Through this SPA, Maine will work toward the following goals:
1. Reduce Inefficient Healthcare Spending
2.Improve Chronic Disease Management
3. Promotion of Wellness and Prevention
4. Recovery and Effective Management of Behavioral Health Conditions
5. Promote Improved Experience of Care for Consumers/ Families

In Maine's Behavioral Health Home model, licensed Behavioral Health Home Organizations partner with enhanced primary care practices. Members are assigned through the BHHO. Operating as a team, provider organizations will collaboratively serve eligible MaineCare members with significant behavioral health needs. Members who choose to participate in Behavioral Health Home services will first choose the BHHO, and then identify a partnering enhanced primary care practice to serve as their primary care provider. The team will coordinate services through an integrated and comprehensive plan of care. Members may opt out of the service at any time.

Behavioral Health Homes will integrate with and not duplicate services currently offered to MaineCare members. MaineCare will work with new and existing qualified providers to develop more integrated, more coordinated, and more comprehensive service systems across the state.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2015	$ 524556.00
Second Year	2016	$ 593215.00

Federal Statute/Regulation Citation

42 U.S.C. 1396w-4

Governor's Office Review

- (●) **No comment.**
- ( ) **Comments received.**
  Describe:
- ( ) **No response within 45 days.**
- ( ) **Other.**
  Describe:

Transmittal Number: 15-005 ***Supersedes Transmittal Number: 14-001 Approved Effective Date: Jan 1, 2015 Approval Date: Apr 21, 2015***

Transmittal Number: 15-005 Supersedes Transmittal Number: 14-001 Approved Effective Date: Jan 1, 2015 Approval Date: Apr 21, 2015 Attachment 3.1-H Page Number:

Submission - Public Notice

Indicate whether public notice was solicited with respect to this submission.

- ( ) **Public notice was not required and comment was not solicited**

○ **Public notice was not required, but comment was solicited**

◉ **Public notice was required, and comment was solicited**

Indicate how public notice was solicited:

☑ **Newspaper Announcement**

Newspaper	
Name: Bangor daily news Date of Publication: 12/31/2014 (mm/dd/yyyy) Locations Covered: Northern Maine	
Name: Kennebec Journal Date of Publication: 12/31/2014 (mm/dd/yyyy) Locations Covered: Central Maine	
Name: Portland Press Herald Date of Publication: 12/31/2014 (mm/dd/yyyy) Locations Covered: Southern Maine	
Name: Sun Journal Date of Publication: 12/31/2014 (mm/dd/yyyy) Locations Covered: Central Maine	

☐ **Publication in State's administrative record, in accordance with the administrative procedures requirements.**

Date of Publication: (mm/dd/yyyy)

☐ **Email to Electronic Mailing List or Similar Mechanism.**

Date of Email or other electronic notification: (mm/dd/yyyy)

Description:

☐ **Website Notice**

Select the type of website:

☐ Website of the State Medicaid Agency or Responsible Agency

Date of Posting:

(mm/dd/yyyy)

Website URL:

☐ Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

☐ Other

☐ **Public Hearing or Meeting**

☐ **Other method**

Indicate the key issues raised during the public notice period:(This information is optional)

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: 15-005 Supersedes Transmittal Number: 14-001 Approved Effective Date: Jan 1, 2015 Approval Date: Apr 21, 2015 Attachment 3.1-H Page Number:

Submission - Tribal Input

☑ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☑ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☑ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner:

☑ **Indian Tribes**

Indian Tribes	
Name of Indian Tribe: Houlton band of Maliseets et al., Date of consultation: 01/06/2015 (mm/dd/yyyy) Method/Location of consultation: regularly scheduled call with tribes. Also includes representatives from the following: Aroostook Band of Micmacs Houlton Band of Maliseets Passamaquoddy Tribe at Indian Township Passamaquoddy Tribe at Pleasant Point Aroostook Band of Micmacs Passamaquoddy Health Care Passamaquoddy at Pleasant Point Penobscot Nation No substantive issues raised in consultation with the tribes.	

☐ **Indian Health Programs**

☐ **Urban Indian Organization**

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☑ **Other Issue**

Issues	
Issue Name:	
Summarize Comments no other issues were raised as a result of the consultative activities. **Summarize Response**	

Submission - SAMHSA Consultation

☑ **The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.**

Date of Consultation	
Date of consultation: 09/12/2013 (mm/dd/yyyy)	

Transmittal Number: 15-005 Supersedes Transmittal Number: 14-001 Approved Effective Date: Jan 1, 2015 Approval Date: Apr 21, 2015 Attachment 3.1-H Page Number:

Health Homes Population Criteria and Enrollment

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 Abuse Disorder**
☐ **Asthma**
☐ **Diabetes**
☐ **Heart Disease**
☐ **BMI over 25**

Other Chronic Conditions	

☐ **One chronic condition and the risk of developing another**

Specify the conditions included:

☐ **Mental Health Condition**
☐ **Substance Abuse Disorder**
☐ **Asthma**
☐ **Diabetes**
☐ **Heart Disease**
☐ **BMI over 25**

Other Chronic Conditions	

Other Chronic Conditions	

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

☑ **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:
Adults:
1. Members must have a primary diagnosis on Axis I or Axis II of the multi-axial assessment system of the DSM IV, or comparable mental health diagnosis under the DSM V. The following diagnoses may not be primary diagnoses for purposes of this eligibility requirement:

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

2. Has a LOCUS score of seventeen (17) (Level III) or greater.

Serious Emotional Disturbance (children):
1. Members must have received an Axis I or Axis II mental health diagnosis(es) as described in the DSM IV, or a mental health diagnosis under the DSM V, or a diagnosis described in the current version of the DC:0-3, except that the following diagnoses are not eligible for services in this section:

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

AND

2. After the first month, members must also have a significant impairment or limitation in adaptive behavior or functioning according to a standardized tool:
a. CAFAS: if the eight (8) scale composite CAFAS score is at least fifty-one (51)
b. CANS: if assessment scores indicate a 2 or higher in both of the following sections: “Child Behavioral/Emotional Needs” AND “Life Domain Functioning”.
c. The PECFAS and/or ASQ: SE: if these tools indicate possible functional impairment(s) and together with other clinical information a comprehensive view of the child is developed and the need for case management services is identified.

Geographic Limitations

☑ **Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.

If no, specify the geographic limitations:

By county

Specify which counties:

By region

Specify which regions and the make-up of each region:

By city/municipality

Specify which cities/municipalities:

Other geographic area

Describe the area(s):

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

Describe the process used:

Automatic Assignment with Opt-Out of Health Homes provider

Describe the process used:
Members will initially be identified via claims/PA data. MaineCare shall assess eligibility of other members upon request. The Department or its agent shall identify members who meet eligibility criteria and who have received a PA for Community Integration Services or TCM from a MaineCare provider that has been approved as a BHHO. These members will receive written notification from the Department that their provider has been approved to become a BHHO, and that they are eligible for BHH services. Members may opt out at any time. Members opting out will be not be enrolled in BHH. Members must choose between the Health Home services for which they are eligible and may not be enrolled in more than one Health Home service at the same time. The notice shall explain the benefits of the Health Home, and inform members that they must choose between BHH services and TCM or Community Integration Services (adults), and that they may not receive both services at the same time. The notice shall inform the member that, in the event he/she does not opt out, the member's Section 13 or 17 services shall end and be replaced instead with the BHH services. The notice shall set forth the requirements for opting out, and shall contain contact information for MaineCare Member Services to provide assistance to members in making this choice. If the member does not opt out within twenty-eight (28) days of receipt of the auto-enrollment notification, the member will be automatically enrolled by the Department in BHH services. The member shall agree to be in the behavioral health homes via a consent form.

Members may identify an enhanced primary care practice from among those practices that partner with the member's BHHO.

Members no longer eligible for BHH will receive notice and may be enrolled in the MaineCare Stage A health Home for members with chronic conditions.

The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.

Other

Describe:

The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.

The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.

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.

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. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes

Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.

☑ **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

Transmittal Number: 15-005 Supersedes Transmittal Number: 14-001 Approved Effective Date: Jan 1, 2015 Approval Date: Apr 21, 2015 Attachment 3.1-H Page Number:

Health Homes Providers

Types of Health Homes Providers

☐ **Designated Providers**

Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

☐ **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

☐ **Community Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☐ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

☐ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☑ **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**

Describe the Provider Qualifications and Standards:

☐ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

☑ **Other (Specify)**

Provider	
Name: Behavioral Health Home Organization Provider Qualifications and Standards: BHHOs are licensed MH providers that meet BHHO Qualifications and Standards as specified in SPA and as defined in MaineCare rule. The BHHO shall include the following staff/qualifications: 1. Nurse Care Manager 2. Clinical Team Leader who is an independently licensed mental health professional 3. Peer Support Specialist (adults): has completed the Maine SAMHS curriculum for Certified Intentional Peer Support Services and receives and maintains that certification. The CIPSS is an individual who is receiving or has received services and supports related to the diagnosis of a mental illness, is in recovery from that illness, and who is willing to self-identify on this basis with BHH members. Children: Peer Support for children's services is an individual who has completed the designated Maine Office of Child and Family Services curriculum for peer supports and receives and maintains that certification. 4. Health Home Coordinator (SED): has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience;	

Provider	
OR has a Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school; OR has been employed since August 1, 2009 as a case manager providing services under Chapter II, Section 13 of the MaineCare Benefits Manual. 5. Health Home Coordinator (SPMI): has certification from DHHS as a Mental Health Rehabilitation Technician/Community or similar qualification as determined by DHHS. 6. Medical Consultant 7. Psychiatric Consultant	
Name: Enhanced Primary Care Practice Provider Qualifications and Standards: Enhanced Primary Care Practice (EPCP)have completed an application and have been approved by MaineCare to participate in Behavioral Health Homes. These practices must achieve National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PPC-PCMH) Recognition within a time specified by MaineCare regulation, must have a fully implemented EHR, have a memorandum of understanding with at least one BHHO in its area, and have established member referral protocols with area hospitals. Additional requirements are specified in the Provider Standards section, below. EPCPs typically have the following staff: • Primary care provider: Licensed physician, nurse practitioner, or physician assistant under supervision of a physician • Clinical Staff - Care manager: registered nurse (RN), licensed practical nurse (LPN), licensed social worker (LSW), or other appropriately licensed clinical staff • Support staff with experience or ability to provide administrative and/or clinical support to clinical team • Data manager with experience or ability to provide support for the collection and management of health data (e.g. implementation and use of electronic health record (EHR)	

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

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 will provide educational opportunities to participating providers, including learning collaboratives, work force training, HIT support and development resources, and other opportunities designed to support core health home expectations and functions.

MaineCare will leverage expertise and resources from existing initiatives to create a comprehensive BHH support strategy. Components include:

Expertise and curricula in Maine's PCMH Pilot and existing Health Homes SPA (implemented in 1/1/13)

Expertise and curricula from the MeHAF Behavioral Health Homes initiatives, which fund planning and development of BHH via grants to providers

Specialized learning opportunities and curricula available via Maine's State Innovation Model (SIM) for Behavioral Health Homes:

• The Behavioral Health Home Learning Collaborative will provide training, technical support and transformation supports to BHHOs and Enhanced primary care practices, with a focus on implementation of BHH Core Expectations. Participation in the learning collaborative is mandatory for BHH providers. Providers shall:

o Identify a clinical and administrative leadership team for learning collaborative activities;

o Participate in learning collaborative activities at minimum two times per year;

o Participate in a site assessment to establish baseline status in meeting Core Expectations and identify training and educational needs.

• Integrated BHHO work force training: SIM supports curriculum development and training to ensure that non-licensed mental health staff delivering BHH services will be trained to manage and provide integrated services that focus on key health concerns for the SPMI/SED population.

• Training and support for Enhanced primary care practices to better provide integrated care to the SPMI/SED population

• Training and resources to support the adoption and use of HIT for participating behavioral health home

providers
• Collaborative development of behavioral health measures.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

Maine's Behavioral Health Homes will be multi-disciplinary teams of Behavioral Health Home professionals that partner with members (and, for children, their families/caregivers) to develop and implement a comprehensive and integrated plan of care for all Behavioral Health Home members. The plan of care will serve as the centralized, member-driven care management document for the member's behavioral and physical health care needs. MaineCare's team of health care professionals will consist of two collaborating entities: the Behavioral Health Home Organization (the BHHO) and one or more enhanced primary care providers. Behavioral Health Homes may partner with more than one enhanced primary practice care practice in order to support consumer choice in primary care.

The BHHO will serve as the lead entity. The BHHO will have a memorandum of agreement with each partnering enhanced primary care practice that describes procedures and protocols for regular and systematized communication and collaboration across the two agencies, the roles and responsibilities of each organization in service delivery, and other information necessary to effectively deliver all BHH services to all shared members without duplication, such as:
• Names and contact information of key staff at BHHO and enhanced primary care practice
• Procedures for effective communication, such as
o Acceptable mode(s) of electronic communication to ensure effective and privacy-protected exchange of health information
o Frequency of communication at both leadership and practice levels (e.g., weekly, monthly, quarterly)
o Procedures for Bi-directional access to member plan of care and other health information;
o Referral protocols for new members;
o Collaboration on treatment plans and member goals;
• As needed, Business Associate Agreement/Qualified Service Organization addenda

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:

Behavioral Health Home Organization Requirements:
1. The BHHO must execute a MaineCare Provider Agreement.
2. The BHHO must be a community-based mental health organization, licensed to provide services in the state of Maine, that provides care to adult and/or children members, is located in the state of Maine, and delivers services through a team-based model of care that includes at least the following personnel:
a. Psychiatric Consultant – shall be a psychiatrist who has current and valid licensure as a physician from the Maine Board of Licensure in Medicine, and who is certified by the American Board of Psychiatry and Neurology Psychiatric medication management or is eligible for examination by that Board as documented by written evidence from the Board, or has completed three years of post-graduate training in psychiatry approved by the Education Council of the American Medical Association and submits written evidence of the training; OR an advanced practice psychiatric and mental health registered nurse who is licensed as a nurse practitioner or clinical nurse specialist by the state of Maine, has graduated from a child and adolescent or adult psychiatric and mental health nurse practitioner, or clinical nurse specialist program, and is certified by the appropriate national certifying body; OR an organization licensed by the Department to provide medication management services pursuant to Chapter II, Section 65 of the MaineCare Benefits Manual.
b. Nurse Care Manager – shall be a registered nurse, a psychiatric nurse licensed as a registered professional nurse by the state or province where services are provided and certified by the American Nurses Credentialing Center (ANCC) as a psychiatric and mental health nurse; an advanced practice psychiatric and mental health registered nurse licensed as a nurse practitioner or clinical nurse specialist by the state or province where services are provided, who has graduated from a child and adolescent or adult psychiatric and mental health nurse practitioner or clinical nurse specialist program, and is certified by the appropriate national certifying body; a nurse practitioner, or advance practice nurse, as defined by the Maine State Board of Nursing.
c. Clinical Team Leader – shall be an independently licensed mental health professional, who may be a physician, physician's assistant, psychologist, a licensed clinical social worker, licensed master social worker, or licensed master social worker conditional II licensed clinical professional counselor, licensed marriage and family therapist, registered nurse, psychiatric nurse, advanced practice registered nurse, or an advanced practice psychiatric nurse; OR, for children's BHH services, a person who was employed on August 1, 2009 as a case management supervisor under the former Section 13 of Chapter II of the MaineCare Benefits Manual. Such staff shall be considered qualified to serve as a Clinical Team Leader for purposes of this rule.

d. Certified Intentional Peer Support Specialist (CIPSS)Adults – is an individual who has completed the Maine Office of Substance Abuse and Mental Health Services curriculum for CIPSS, and receives and maintains that certification.

The CIPSS is an individual who is receiving or has received services and supports related to the diagnosis of a mental illness, is in recovery from that illness, and who is willing to self-identify on this basis with BHH members.

Peer support staff may function as a CIPSS without CIPSS certification for the first nine months of functioning as a CIPSS, but may not continue functioning as a CIPSS beyond nine months: (a) without having received provisional certification by completion of the Core training , and (b)without continuing pursuit of full certification as a CIPSS and maintaining certification as an Intentional Peer Support Specialist according to requirements as defined by SAMHS.

e. Family or Youth Support Specialist – for children's services is an individual who has completed a designated Maine Office of Child and Family Services curriculum for peer supports and receives and maintains that certification.

The Youth Support Specialist is an individual who is receiving or has received services and supports related to the diagnosis of a mental illness, is in recovery from that illness, and who is willing to self-identify on this basis with BHH members.

The Family Support Specialist is an individual who has a family member who is receiving or has received services and supports related to the diagnosis of a mental illness, and who is willing to self-identify on this basis with BHH members.

Peer support staff may function as a Family/Youth Support Specialist for children's services without certification for the first nine months of functioning as a Family/Youth Support Specialist, but may not continue functioning as a Family/Youth Support Specialist for children's services beyond nine months: (a) without having received provisional certification by completion of the Core training , and (b)without continuing pursuit of full certification as a Family/Youth Support Specialist for children's services and maintaining certification as a Family/Youth Support Specialist according to requirements as defined by the Maine Office of Child and Family Services.
e. Health Home Coordinator for Members with Serious Emotional Disturbance (SED) – shall be an individual who has a minimum of a Bachelor's Degree from an accredited four year institution of higher learning, with specialization in psychology, mental health and human services, behavioral health, behavioral sciences, social work, human development, special education, counseling, rehabilitation, sociology, nursing, or closely related field; OR who has a Bachelor's Degree from an accredited four year educational institution in an unrelated field and at least one year of full-time equivalent relevant human services experience; OR a who has Master's Degree in social work, education, psychology, counseling, nursing, or closely related field from an accredited graduate school; OR who has been employed since August 1, 2009 as a case manager providing services under Chapter II, Section 13 of the MaineCare Benefits Manual. The BHH Health Home Coordinator for children shall draft the Plan of Care for each member, implement that Plan of Care and the coordination of services, and support and encourage ensure the member in actively participating in reaching the goals set forth in their Plan of Care.
f. Health Home Coordinator for Members with Serious and Persistent Mental Illness (SPMI) – shall be an individual who is certified by the Department as a Mental Health Rehabilitation Technician/Community (MHRT/C). The BHH Health Home Coordinator shall draft the Plan of Care for each member, oversee that Plan of Care and the coordination of services, and ensure that members are actively participating in reaching the goals set forth in their Plan of Care.
g. Medical Consultant – shall be a physician licensed by the State of Maine to practice medicine or osteopathy, or a Certified Nurse Practitioner who is a registered nurse who meets all of the requirements of the licensing authority of the State of Maine to practice as a Certified Nurse Practitioner, or a Physician's Assistant meets all of the requirements of the licensing authority of the State of Maine to practice as a Physician's Assistant . The Medical Consultant shall collaborate with other providers of BHHO services and the enhanced primary care practice to select and implement evidence-based clinical initiatives, lead quality improvement efforts, evaluate progress, and convene provider clinical quality improvement meetings.

The BHHO must maintain documentation of all its BHHO providers' qualifications in their personnel files, including transcripts, licenses, and certificates, and other documentation as specified in MaineCare regulation.
3. The BHHO must be approved as a BHHO by MaineCare through the BHHO application process.
4. The BHHO must have an MOU or MOA with at least one enhanced primary care practice in its area.

5. Within twenty-four (24) months of the BHHO's participation, the BHHO must implement an EHR system and an EHR for each member.
6. The BHHO must participate in the Behavioral Health Home Learning Collaborative, and designate a leadership team to attend Learning Collaborative sessions at least two (2) times per year, which year shall run following the first day of the BHHO's participation. The leadership team shall consist of: the BHHO's Clinical Team Leader, and an additional Clinical Member or administrative leader. Within the first six (6) months following the start of the BHHO's participation, the BHHO shall obtain a written site assessment to establish a baseline status in meeting the Core Standards (below) and identify the BHHO's training and educational needs.
7. The BHHO has established member referral protocols with area hospitals and child/adult residential facilities.
8. Within one year of the BHHO's participation, the BHHO must fully implement the following Core Standards:
a. Demonstrated Leadership
b. Team-Based Approach to Care
c. Population Risk Stratification and Management
d. Enhanced Access
e. Comprehensive Consumer/Family Directed Care Planning
f. Behavioral-Physical Health Integration
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
j. Integration of Health Information Technology

The Core expectations will be further defined by MaineCare rule. Behavioral Health Home organizations will be required to provide a quarterly report on Core Expectations benchmarks, as further defined by MaineCare. Providers that do not meet benchmarks may be terminated from the program.

Commitment to addressing each of the following eleven CMS Health Home core functional components:

1. Provide quality driven, cost-effective, culturally appropriate, and patient- and family- centered Health Home services;
2. Coordinate and provide access to high-quality health care services informed by evidence based clinical practice guidelines;
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
4. Coordinate and provide access to treatment for mental health and substance abuse disorders;
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across care settings. Transitional includes appropriate follow up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from pediatric to an adult system of health care;
6. Coordinate and provide access to chronic disease management, including self-management support to patients and their families;
7. Coordinate and provide access to patient and family supports, including referral to community-based social support, and recovery services;
8. Coordinate and provide access to long-term care supports and services;
9. Develop a patient-centered care plan that coordinates and integrates all of a patient's clinical data and non-clinical health care related needs and services;
10. Demonstrate the capacity to use HIT to link services, and facilitate communication among BHHO members, and between the BHHO and member, and family care givers, and to provide feedback to practices, as feasible and appropriate; and
11. Establish a continuous quality improvement (CQI) program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality care outcomes at the population level.

Enhanced Primary Care Practice Requirements

Enhanced primary care providers must meet the following criteria via MaineCare application:

1. The practice must execute a MaineCare Provider Agreement.

2. The practice must have received National Committee for Quality Assurance (NCQA) Patient-Centered Medical Home (PPC-PCMH) Recognition within the time period specified within MaineCare rule.

3. The practice must be approved by the Department through an application process.
4. The practice must have a fully implemented EHR.
5. The practice must have a contract with at least one BHHO in its area.
6. The practice has established member referral protocols with area hospitals.
7. The practice must comply with MaineCare Benefits Manual, Ch. VI, Section 1-Primary Care Case Management, Section 1.08-5-Twenty-Four Hour Coverage.
8. The practice must participate in Maine's multi-payer Patient Centered Medical Home (PCMH) Learning Collaborative. The practice shall designate a leadership team to attend day-long Learning Collaborative sessions at least two (2) times per year. The leadership team shall consist of: the practice's physician leader, an administrative leader, and an additional member.
9. Within one year of the BHHO's participation, the practice must fully implement the following Core Standards:

a. Demonstrated leadership
b. Team-based approach to care
c. Population risk stratification and management
d. Practice-integrated care management
e. Enhanced access to care
f. Behavioral-physical health integration
g. Inclusion of patients & families in implementation of PCMH model
h. Connection to community
i. Commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost- effective use of healthcare services
j. Integration of health information technology (HIT)

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

1. Provide quality driven, cost-effective, culturally appropriate, and patient- and family- centered Health Home services;
2. Coordinate and provide access to high-quality health care services informed by evidence based clinical practice guidelines;
3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders;
4. Coordinate and provide access to treatment for mental health and substance abuse disorders;
5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across care settings. Transitional includes appropriate follow up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from pediatric to an adult system of health care;
6. Coordinate and provide access to chronic disease management, including self-management support to patients and their families;
7. Coordinate and provide access to patient and family supports, including referral to community-based social support, and recovery services;
8. Coordinate and provide access to long-term care supports and services;
9. Develop a patient-centered care plan that coordinates and integrates all of a patient's clinical data and non-clinical health care related needs and services;
10. Demonstrate the capacity to use HIT to link services, and facilitate communication among BHHO members, and between the BHHO and patient , and family care givers, and to provide feedback to practices, as feasible and appropriate; and
11. Establish a continuous quality improvement (CQI) program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality care outcomes at the population level.

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Health Homes Service Delivery Systems

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

☑ **Fee for Service**

☐ **PCCM**

○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☐ **Risk Based Managed Care**

○ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**

☐ **The current capitation rate will be reduced.**

☐ **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:

☐ **Other**

Describe:

○ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**

Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

○ **Yes**

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

○ **No**

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

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Health Homes Payment Methodologies

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

☑ **Fee for Service**

☐ **Fee for Service Rates based on:**

☐ **Severity of each individual's chronic conditions**

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

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

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

☐ **Other: Describe below.**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

☑ **Per Member, Per Month Rates**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

Individuals with SPMI and SED have significant and inter-related behavioral and physical health care costs. Recent studies in Maine indicate that this population incurs higher than average physical health care costs that could be avoided through more integrated and comprehensive care management of both behavioral and physical health care needs. MaineCare currently reimburses its behavioral health providers on a FFS basis. Relationships with primary care are generally informal, and service systems do not support close collaboration or coordination across service providers.

Behavioral Health Homes, a team of health care professionals supported by a PMPM payment, will facilitate achievement of key goals for this population by addressing both physical and behavioral health

care issues for individuals with significant behavioral health needs within a unified plan of care. The PMPM payment will allow providers with expertise in the needs of this population to move away from volume-driven care and focus on the development of services and systems that support specified quality outcomes. The PMPM payment leverages Maine's existing Health Home infrastructure, and provides resources for two disparate systems (Community Behavioral Health and Primary Care) to work collaboratively to reduce cost and unnecessary service utilization. The state will make tiered payments, based on distinct activities as outlined in the Covered Services section. Payment will be made to the BHHO with a pass-through payment to the enhanced primary care practice.
Payment Tiers as of January 1, 2015 (for cost assumptions, see below):

o Member with SED: $322.00 PMPM to BHHO
o Member with SMI: $365.00 PMPM to BHHO
o Member with SED and engaged with an enhanced primary care practice: $337.00 to BHHO with pass-through payment to practice;
o Member with SMI and engaged withenhanced primary are practice: $379.00 to BHHO with pass-through payment to practice.

During the first three months of BHH implementation, the state will pay an enhanced PMPM payment for each assigned BHH member for additional staff time anticiapted for intensive outreach, education, and enrollment efforts, particularly related to engaging members effectively in primary care practices. This additional staff time is estimated at approximately 10-15% above normal operations, which translates into a $35.00 add-on to the PMPM rate during this timeframe only.

All Health Home services are documented in the member record/EHR. This documentation is auditable.

Cost assumptions: BHHO
The BHHO payment is determined by calculating the cost of Behavioral Health Home services incurred within the BHH organization, based on claims data that indicate level of services required for eligible populations (SPMI, SED). MaineCare will pay for reimbursement of the cost of staff associated with the delivery of Behavioral Health Home services to Health Home-eligible members not covered by other reimbursement under MaineCare.

FTE and cost assumptions/BHH for SED (Children):

o From April 1, 2014 through June 30, 2014:
Staff FTE per 200 members
Clinical Team Leader 0.75
HH Coordinator 7
Peer Specialist 1
Nurse Care Manager 0.50
Medical Consultant 0.02
Psychiatrist 0.02
Total FTE/200 9.5
Total cost $290.00 PMPM

FTE and cost assumptions/BHHO for SMI(adults):

Staff FTE per 200 members
Clinical Team Leader 0.75
HH Coordinator 8
Peer Specialist 1
Nurse Care Manager 0.75
Medical Consultant 0.02
Psychiatrist 0.02
Total FTE/200 10.48
Total cost $330.00 PMPM

From July 1, 2014 through December 31, 2014:

FTE and cost assumptions/BHHO for SED (children):

Staff FTE per 185 members
Clinical Team Leader 0.75
HH Coordinator 7
Peer Specialist 1
Nurse Care Manager 0.50
Medical Consultant 0.02
Psychiatrist 0.02
Total FTE/185 9.5
Total cost $314.00 PMPM

FTE and cost assumptions/BHHO for SMI (adults):

Staff FTE per 185 members
Clinical Team Leader 0.75
HH Coordinator 8
Peer Specialist 1
Nurse Care Manager 0.75
Medical Consultant 0.02
Psychiatrist 0.02
Total FTE/185 10.8
Total cost $357.00 PMPM

As of January 1, 2015:
FTE and cost assumptions/BHHO for SED (children):
Staff FTE per 180 members
Clinical Team Leader 0.75
HH Coordinatitor 7
Peer Specialist 1
Nurse Care Manager 0.50
Medical Consultant 0.02
Psychiatrist 0.02
Total FTE/185 9.5
Total cost $322.00 PMPM

FTE and cost assumptions/BHHO for SMI (adults)
Staff FTE per 181 members
Clinical Team Leaders 0.75
HH Coordinator 8
Peer Specialist 1
Nurse Consultant 0.02
Psychiatrist 0.02
Total FTE/181 10.8
Total cost $365.00 PMPM

Minimum billable services
MBS requirements for the BHHO:

The member is identified as meeting Behavioral Health Home eligibility criteria through the state MMIS system or through the state/vendor prior authorization process;

Individual is enrolled as a Behavioral Health Home member at that location;

The BHHO has performed the following functions per member, per month:
• The BHHO, in collaboration with the member and the enhanced primary care practices, has developed a plan of care or has updated this plan of care within the last 90 days
• The BHHO has submitted required reports on cost/utilization

• The BHHO has delivered at least one hour of service in accordance with the plan of care.

Health Home services must be provided to each member for each month in order to be eligible for the PMPM payment.

Enhanced Primary Care: The enhanced primary care practice payment component is determined by calculating care management and care coordination costs that are incurred in the individual practice. MaineCare will pay for reimbursement of the cost of staff associated with the delivery of Health Home services to Health Home-eligible members not covered by other reimbursement under MaineCare.

FTE and Cost Assumptions: enhanced PCP
Staff FTE per 3000 members
PCP 0.7
clinical staff 1.63
support staff 1.2
data manager 1.00
Total FTE /3000 4.53
Total cost $15.00 PMPM

MBS requirements for the enhanced PCP:

The member is identified as meeting Behavioral Health Home eligibility criteria through the state MMIS system or through the state/vendor prior authorization process;

Individual is enrolled as a Behavioral Health Home member at that location;

The enhanced primary care provider has performed the following functions per member, per month:
• Scanned/monitored for gaps in care via monthly utilization report and/or patient engagement and outreach activities.

Standards and processes for documentation:
BHHO:
• Individual Care Plan
• Monthly utilization report and supporting documentation in the member record/EHR
• Web-based enrollment and tracking
• Utilization review and quality improvement oversight by DHHS/vendor

Enhanced primary care practice:
-MaineCare Monthly Utilization Report
-Web-based enrollment and tracking

The State will review service utilization and rates annually to ensure that rates are economic and efficient based on analysis of care management costs and services provided by the Team of Health Care Professionals and its components. Rates will be updated accordingly. MaineCare will continue to base payments on the costs of staff to provide the care management services to target populations.

Rates are the same for government and private providers.
Payment will be made monthly.

Payment will be made via MMIS after a transition period: Mainecare is currently using an external portal and designing the technical solution to incorporate both Health Homes SPAs into MMIS.

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to

receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (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 PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

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

☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.
Members must receive a prior authorization/certification for BHH services. Authorization for the service will include utilization review of other services, such as TCM and Community Support. Members receiving targeted case management (TCM)or Community Support will have the choice to either continue receiving TCM or to receive this care through their health home.

Given that the activities supported through PCCM (referenced in Provider Standards) also constitute baseline foundational activities required of the enahced primary care practice for all Health Homes-eligible members, PCCM practices qualified as enhanced primary care practices will not receive PCCM care management payments for members enrolled in both PCCM and Health Homes, so as not to duplicate payment for services. The emahanced primary care practice will receive a $15.00 PMPM payment for Health Home services delivered to all members enrolled in the Behavioral Health Home,

regardless of whether the member is enrolled in PCCM.

OPT OUT, continued: If a member enrolled in BHH stabilizes and no longer qualifies as having SPMI or SED, and qualifies for the Stage A HH SPA, that member could transition to the Stage A SPA. The member would stop receiving BHH services from the BHHO, but could remain with their same enhanced primary care practice.

As the lead entity, the BHHO will provides all BHH services to the member. This shall include extensive outreach, education, and support to the member on selecting and engaging with an enhanced primary care practice, collaboration with any identified physical health care providers to ensure all available physical health care information is incorporated into the member's plan of care, care coordination with any current providers on referral and/or change in health status, etc.

Mainecare's Stage A Health Home Initiative consists of Health Home practices that partner with CCTs around the state. Members enrolled in Stage A receive HH services from the practice, in times of more intense need, the member is referred to the CCT. Together, the HHP and the CCT manage the care of the population of members with two chronic conditions or one chronic condition and at risk for another. The BHH will engage these same HH practices. The enhanced primary care practice in Behavioral Health Homes will partner with a BHH organization (typically, a CMHC) to assist in managing the physical and behavioral health care of members with serious mental health needs. Members will be assessed regularly for their need for this high level of care management.

Members who no longer need a high level of care can be transitioned seamlessly to Stage A: eligible members will receive written notice that they are being discharged from the BHH and enrolled in the Stage A HH. Those members will stay with their enhanced primary care practice; the practice will then receive the PMPM payment for the member through the Stage A health home state plan option.
Members transitioned to Stage A will have access to the CCT: members can be served in a lower level of care while still having access to additional care management and support when/if needed.
MaineCare already has in place tracking systems to ensure that no member is enrolled in more than one HH SPA at a time, and is tracking HH service utilization across the two initiatives to ensure that no member receives more than 8 quarters of enhanced match through any combination of HH SPA options.

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

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Submission - Categories of Individuals and Populations Provided Health Homes Services

The State will make Health Homes services available to the following categories of Medicaid participants:

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

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:
The BHHO shall:
-assess of medical, behavioral, social, residential, educational, vocational, and other related needs, strengths, and goals of the member (and the family/caretaker if the member is a minor), including use of screening tools for co-occurring disorders. The member will have a periodic clinical reassessment of need and the Plan of care shall be updated accordingly.
-draft a comprehensive, individualized, and member-driven Plan of Care (Plan). Plan may include, but is not limited to, prevention, wellness, peer supports, health promotion/education, crisis planning, and other social, residential, educational, vocational, long term care, home and community-based services, and community services/supports that enable member to achieve physical/behavioral health goals.
-provide outreach, education and support to member (and family, if member is a minor) re: BHH services/benefits. Outreach may be provided in person, phone, written materials, via assistance from Peer providers, and other strategies to support BHHO members.
-obtain written consent for services and authorization for release and sharing of information from each member.
-provide information to members without an EPCP.
-review the Plan as change in the member's need occurs.
-scan for gaps in care by review of monthly utilization reports; communicate gaps to the member/EPCP.

EPCP shall:
-coordinate with member/BHHO in development of Plan and ensure that information regarding health conditions, including lab tests/results, medications, are incorporated in the Plan.

-assess, monitor and follow up of physical/behavioral health needs, conduct medication review/reconciliation, monitor chronic conditions, weight/BMI, tobacco/substance use, and communicate regularly with the BHHO and other providers as necessary to identify and coordinate a member's care.
-scan for gaps in member's care by reviewing monthly utilization reports, and communicate gaps in care to the member/BHHO.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
HIT will play a central role in BHH service delivery.

Organizations will be expected to electronically share care plans, and may also access continuity of care documents in the HIE.

Through MaineCare's web-based Health Home portal, providers can access information regarding eligible and pending members and refer members to an enhanced primary care practice. Online utilization reports will make available to BHH providers monthly utilization data from MaineCare claims to assist providers in the identification of high needs/high cost members and as a tool to scan for and act upon any gaps in care. MaineCare is also exploring the potential for real-time notification of hospital admissions and ED use with its statewide HIE, which could be added as another portal function.

All health home practices will have certified EHR systems that allow integration of secure messaging into the EHR.

BHHOs, community mental health providers, are at different stages in EHR implementation. Certain BHHOs that meet other specified criteria will be eligible to receive funding through Maine's state Innovation Model initiative for the development and implementation of EHRs.

Over the course of 24 months, all Behavioral Health Home Organizations will be expected to have implemented certified EHR systems.

As an initial expectation, BHHOs should be able to share health information, including care planning documents, to and from other treating providers/organizations and across the team of BHH professionals.

The BHHO 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.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

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☐ **Physicians' Assistants**

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☐ **Pharmacists**

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☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

BHHO and enhanced primary care practice

Description

• The BHHO Clinical Team Leader shall be responsible for clinical oversight, review, and management of the plan. Other Team members, including the Nurse Care Manager, and/or HH Coordinator and Peer Support Specialist (under the supervision of the Clinical Team Leader and within the scope of their license/credential), shall also provide comprehensive care management.

• Clinical Staff at the enhanced primary care practice, which may include a nurse or nurse care manager, shall provide comprehensive care management.

Care Coordination

Definition:
Care Coordination services, BHHO
BHHO shall:

-identify specific resources and the amount, duration, and scope of services necessary to achieve the goals identified in the Plan.
-provide referrals to other services and supports, as identified in each member's Plan, and shall follow up with each member to assist the member in taking action in regard to each referral. The BHHO shall have an organizational understanding and provide systematic identification of local medical, community, and social services and resources that may be needed by the member.
-assign to each member a Health Home Coordinator, who shall be responsible for overall management of the Plan of Care, and coordinate and provide access to other providers, including the EPCP, as set forth in the Plan. Members cannot be enrolled in more than one care management program funded by Medicaid.
-shall ensure that it has policies and procedures in place to ensure that the Health Home Coordinator can communicate with treating clinicians on an as needed basis, changes in patient condition that may necessitate treatment change.
-follow up with each member following a hospitalization, use of crisis service, or out of home placement.
-ensure that members have access to crisis intervention and resolution services, coordinate follow up services to ensure that a crisis is resolved, and assist in the development and implementation of crisis management plans.
-coordinate and provide access to psychiatric consultation and/or medication management.
Care Coordination Services –EPCP:
For each member, the enhanced primary care practice shall coordinate and provide access to high

quality physical health and treatment services identified in the Plan of Care, including the identification and referral to physical health care specialty providers. The EPCP shall consult and coordinate with the BHHO to ensure that the member is successfully referred to all necessary services and supports identified in the Plan of Care.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The team of BHH professionals will be expected to share and update health information across the team. The specific mode of transmission (via EHR, secure messaging, etc.) will be according to individual capacity and will be described in the BHHO and enhanced primary care practice MOAs.

All enhanced primary care practice will have certified EHR systems that allow integration of secure messaging into the EHR.

BHHOs, community mental health providers, are at different stages in EHR implementation. However, certain BHHOs that meet criteria will be eligible to receive funding through Maine's state Innovation Model initiative for the development and implementation of EHRs.

Over the course of 24 months, all Behavioral Health Home Organizations will be expected to have implemented certified EHR systems.

As an initial expectation, BHHOs should be able to share health information, including care planning documents, to and from other treating providers/organizations and across the team of BHH professionals.

MaineCare will also make available to BHH providers utilization data from MaineCare claims to assist providers in the identification of high needs/high cost members as a tool to scan for and act upon any gaps in care.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

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☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

BHHO and enhanced primary care practices

Description

The Behavioral Health Home Organization shall provide care coordination services. Services may be provided in the home, office, or other community setting. Services may be provided by the Clinical team leader, Nurse Care Manager, and/or HH Coordinator and Peer Support Specialist (under the supervision of the Clinical Team Leader and within the scope of their license/credential).

Clinical staff at the enhanced primary care practice, which may include a nurse or nurse care manager, shall support implementation of the plan of care through review of discharge plans, monitoring and review of medication and lab results, and regular and systematic communication of findings with the BHHO.

Health Promotion

Definition:

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

Health Promotion Services – BHHO: The BHHO shall provide education, information, training and

assistance to members in developing self-monitoring and management skills.

1. The BHHO shall promote healthy lifestyle and wellness strategies, including but not limited to: substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, and increasing physical activities.

2. The BHHO shall coordinate and provide access to self-help/self-management and advocacy groups, and shall implement population-based strategies that engage members about services necessary for both preventative and chronic care. For members who are minors, the BHHO shall provide training to the member's parent/guardian in regard to behavioral management and guidance on at-risk behavior.

Health Promotion Services – enhanced primary care practice
The enhanced primary care practice shall coordinate with the member and the BHHO to identify and provide access to necessary Health Promotion Services, based on each member's needs, as set forth in the Plan of Care, including providing education about the management of chronic physical conditions. The enhanced primary care practice shall review all discharge plans, monitor and review medication and lab results, and regularly communicate about these efforts with the BHHO.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The team of BHH professionals will be expected to share and update health information across the team. The specific mode of transmission (via EHR, secure messaging, etc.) will be according to individual capacity and will be described in the BHHO and enhanced primary care practice MOAs.

All enhanced primary care practices will have certified EHR systems that allow integration of secure messaging into the EHR.

BHHOs, community mental health providers, are at different stages in EHR implementation. However, certain BHHOs that meet specified criteria will be eligible to receive funding through Maine's state Innovation Model initiative for the development and implementation of EHRs.

Over the course of 24 months, all Behavioral Health Home Organizations will be expected to have implemented certified EHR systems.

As an initial expectation, BHHOs should be able to share health information, including care planning documents, to and from other treating providers/organizations and across the team of BHH professionals.

MaineCare will also make available to BHH providers utilization data from MaineCare claims to assist providers in the identification of high needs/high cost members as a tool to scan for and act upon any gaps in care.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

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☐ **Dieticians**

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☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

BHHO and enhanced primary care practice

Description

The Behavioral Health Home Organization shall provide Health Promotion services. Services may be provided in the home, office, or other community setting. Services may be provided by the Clinical team Leader, Nurse Care Manager, and/or HH Coordinator and Peer Support Specialist (under the supervision of the Clinical Team Leader and within the scope of their license/credential).

The enhanced primary care practice shall coordinate with the member and the BHHO to identify and provide access to necessary Health Promotion Services, based on each member's needs, as set forth in the Plan of Care, including providing education about the management of chronic physical conditions. Clinical staff at the enhanced primary care

practice, which may include a nurse or nurse care manager, shall identify Health Promotion needs through review of discharge plans, monitoring and review of medication and lab results, and regular and systematic communication of findings with the BHHO.

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

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

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

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

2. The BHHO shall collaborate with facility discharge planners, the member and the member's family or other support system, as appropriate, to ensure a coordinated, safe transition to the home/community setting, and to prevent avoidable readmission after discharge. The BHHO shall assist the member with the discharge process, including outreach in order to assist the member with returning to the home/community.

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

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

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

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

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

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Use of the secure messaging has been used to provide an organized handoff of care plans during transitions. We will
emphasize this strategy as both a best practice through learning collaborative sessions (SEE Provider

Standards section of this document), and by promotion of secure messaging with BHHOs.

Sharing of care plans at point of transition will be accomplished either through the exchange of documents via secure messaging, or through care summary information shared between EHRs. The specific strategy will depend upon system capabilities.

Systems that have a fully certified EHR and are connected to the HIE will have access to care summary records within their system. Those that
do not will be exchanging information through other methods, such as secure messaging.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

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☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

BHHO and enhanced primary care practice

Description

Transitional care Services may be delivered within the BHHO by the Clinical team Leader, the Nurse Care Manager, and/or by the HH Coordinator and the Peer Support Specialist (under the supervision of the Clinical Team leader and within the scope of their license/credential). Services may be provided in the home, office, or other community setting, including the discharging facility.

Clinical staff at the enhanced primary care practice, which may include a nurse or nurse care manager, shall support and coordinate with the member and the BHHO in transition services.

Individual and family support, which includes authorized representatives

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

Individual and Family Support Services – BHHO

1. The BHHO shall provide assistance with health-system navigation, and training on self-advocacy techniques.

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

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

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

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

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

Individual and Family Support Services – enhanced primary care practice: The enhanced primary care practice shall assist the member with medication and treatment management and adherence, and shall document such efforts in the member's EHR.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
In reaching out to members and their families, Teams of BHH providers will be encouraged to explore (via the Learning Collaborative and other resources) the potential for texting, web-based member portals, and other strategies.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

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Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

BHHO and enhanced primary care practice

Description

The Behavioral Health Home Organization shall provide Individual and family support services. Services may be provided in the home, office, or other community setting. Individual and family Supports shall be delivered by the Clinical team Leader, Nurse Care Manager, and/or the HH Coordinator and Peer Support Specialists (under the supervision of the Clinical Team Leader and within the scope of their license/credential).

Referral to community and social support services, if relevant

Definition:

Referral to community and social support services involves providing assistance to members to obtain and maintain diverse services and supports as identified in their plan of care. Referral may include a "warm hand-off" as needed to ensure a successful referral, and may include outreach, reminders, and scheduling appointments. Referral to community and social services involves an organizational understanding and systematic identification of area the resources, services and supports likely needed by the BHH member.

The BHH will also provide linkages to services, including linkages to long term care services and home and community supports.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.

Visit summary notes and patient care summaries from certified EHRs will contain contact information to community resources that have been
identified to benefit the member.

The team of BHH professionals will communicate to each other through secure messaging or other means, and identify methods to effectively coordinate referrals to community-based support and other social services e.g., encrypted email, electronically shared care plans.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

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Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

BHHO and enhanced primary care practice

Description

Referral to community and social support services shall be delivered by the BHHO by the Clinical team leader, the Nurse Care Manager, and/or by the HH Coordinator and Peer Support Specialist (under the supervision of the Clinical Team Leader).

Clinical staff at the enhanced primary care practice, which may include a nurse or nurse care manager, shall provide referral to community and social supports.

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:
1. MaineCare members enter the Behavioral health Home system through the Behavioral health Home Organization.
2. BHHO performs an initial eligibility assessment and requests authorization from MaineCare/its PA vendor
3. PA is approved/denied.
4. If approved, member receives comprehensive assessment and develops plan of care with BHHO within 30 days.
5. Plan of care is reviewed/revised with member every 90 days.
6. BHHO assists the member in identifying a enhanced primary care practice.
7. Member may opt out of the service at any time and revert to traditional case management.

☑ **Medically Needy eligibility groups**

◉ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**

○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**

○ **All Medically Needy receive the same services.**

○ **There is more than one benefit structure for Medically Needy eligibility groups.**

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
Using claims data, Maine will track admissions for the same diagnosis within 30 days of discharge /1000: (# of readmissions with a primary diagnosis matching the primary diagnosis for the original admission/member months) x 12,000.
MaineCare claims data will be used to calculate the percent of hospital discharges that result in a readmission to the hospital within 30 days.
Inpatient admissions of any type will be considered in the measure. Crossover-claims will be used for calculation for members who are dually eligible for Medicare and Medicaid. This measure will be calculated for

all members attributed to the practice.
Numerator: Subsequent admission to hospital within 30 days of discharge date from initial hospitalization within the referent period

Denominator: Initial admission during referent period to general acute and critical access hospitals.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
Medicaid claims information will be used to trend unadjusted PMPM payments (total and by selected sub-totals, including hospital inpatient, outpatient, physician, pharmacy, behavioral health and other) for health home sites on an annual basis. This information will be tracked by service date and use a two-year base period for comparison purposes. Trends will be calculated in total and separately for Medicaid-only and dual eligible members. High cost outlier cases will be removed.

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).
Maine requires all enhanced primary care practices to use EHRs. Most of these providers are participating in the MaineCare HIT incentive program. 100% of the state's FQHC's that are or are becoming enhanced primary care practices are enrolled in the MaineCare HIT incentive program. These practices have the capacity/experience to use technology in a meaningful way. Maine also has telehealth laws that provide some incentives for the use of remote monitoring and other technologies.

The state has an advanced HIE (HealthInfoNet) that has live connections to over 89% of Maine hospitals, with an additional 11% of hospitals that are under contract and are at various stages of connection. Almost half of primary care practices are connected, with an additional 30% contracted. The on-boarding schedule to add new providers will be adjusted to provide preference for Health Homes. Maine's HIE shows significant advancement in information sharing:
• 1,304,599 (97% of the state population) unique lives represented in the HIE as of the end of December 2013
• Over 1,700 active users per month with 13,500 patient access per month.
• Over 97% of pharmacies participating in electronic prescribing
• All hospitals have met Meaningful Use Stage 1
• Over 500K HIE transactions per quarter supporting ACO and Public Health efforts around the state

Maine, via its SIM model, has also committed to assisting its behavioral health providers in accessing HIT. Via SIM, Maine will provide resources/training to BH providers to enhance EHRs and connect to the HIE. Resource allocation will be weighted toward BHHOs in accessing this funding. Use of HIT will also be addressed and incorporated into the BHHO Learning Collaborative.

MaineCare will make available to both enhanced primary care practices and BHHOs a utilization report (UR) via a web portal. The UR will include claims data; MaineCare will explore how to link clinical data to the UR via the Health Home enrollment System Portal.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **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.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:

Identification of Alcohol and Other Drug Services

Measure Specification, including a description of the numerator and denominator.
This measure summarizes the number and percentage of members with an alcohol and other drug claim who received chemical dependency services during the measurement year: Any Service; Inpatient; intensive outpatient or partial hospitalization; outpatient or ED.
Data Sources:
claims
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ◉ **Continuously**
- ○ **Other**

Measure:

Inpatient Utilization – general hospital/acute care (IPU)

Measure Specification, including a description of the numerator and denominator.
Denominator Description
all member months for the measurement year, stratified by age.

Numerator Description
All days associated with the identified discharges for total inpatient, medicine, surgery and maternity
Data Sources:
claims
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ○ **Annually**
- ◉ **Continuously**
- ○ **Other**

Emergency Room Visits

Measure:

ED Utilization (Utilization): Number of ED visits per 1000 member months;

Measure Specification, including a description of the numerator and denominator.

Numerator: Number of ED visits not resulting in an inpatient stay. Excludes visits with a primary diagnosis of mental illness (ICD-9 code 290-316)
Denominator: Member months
Measure is shown as a rate per 1000 member months.
Data Sources:
claims
Frequency of Data Collection:

- **Monthly**
- **Quarterly**
- **Annually**
- **Continuously**
- **Other**

Measure:

Non-Emergent ED visits:

Measure Specification, including a description of the numerator and denominator.
ED visits identified by HEDIS coding and with the following primary diagnosis:
• Sore throat (Strep) 034.0
• Viral Infection (unspecified) 079.99
• Anxiety (unspecified or generalized) 300.00, 300.02
• Conjunctivitis (acute or unspecified) 372.00, 372.30
• External and middle ear infections (acute or unspecified) 380.10, 381.00, 381.01, 381.4, 382.00, 382.9
• Upper respiratory infections (acute or unspecified) 461.9, 473.9, 462, 465.9
• Bronchitis (acute or unspecified) or cough 466.0, 786.2, 490
• Asthma (unspecified) 493.90
• Dermatitis and rash 691.0, 691.8, 692.6, 692.9, 782.1
• Joint pain 719.40, 719.41, 719.42, 719.43, 719.44, 719.45, 719.46, 719.47, 719.48, 719.49
• Lower and unspecified back pain 724.2, 724.5
• Muscle and soft tissue limb pain 729.1, 729.5
• Fatigue 780.79
• Headache 784.0
Numerator: Non-Emergent ED Visits
Denominator: Members
Measure is expressed as a rate per 1000 member months.
Data Sources:
claims
Frequency of Data Collection:

- **Monthly**
- **Quarterly**
- **Annually**
- **Continuously**
- **Other**

Skilled Nursing Facility Admissions

Measure:

Skilled Nursing Facility Admission rate per 1000 member months, all SNF admissions.

Measure Specification, including a description of the numerator and denominator.
Skilled Nursing Facility Admission rate per 1000 member months, all SNF admissions.
Data Sources:
claims
Frequency of Data Collection:

- **Monthly**

- Quarterly
- Annually
- Continuously
- Other

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates
Medicaid claims data will be used to compute hospital admission rates for individuals in the Health Homes. To the extent possible, Medicaid cross-over claims will be used for calculation of rates for members who are dually eligible. To the extent cross-over claims are not complete or inadequate for measure construction, Maine will work with CMS to obtain the necessary data use agreements to obtain Medicare data. Maine is already getting Medicare data from CMS for the Medicare Advanced Primary Care Demonstration but would need a separate agreement and data for the evaluation of the Health Homes.

Chronic Disease Management
A combination of claims, administrative and qualitative data will be used to monitor behavioral health and chronic disease management processes and outcomes. Maine will compute certain chronic disease measures (see administrative attachment and measures) and compare the rates for those in Behavioral Health Homes with those in a comparison group. We will leverage information gathered from existing initiatives (e.g. Maine Quality Counts Learning Collaboratives, the PCMH evaluation, the Health Homes stage A evaluation), supplemented by additional key informant interviews, as necessary, to identify other process or structural elements of chronic disease management that the BHHs use to assess needs, coordinate services, engage members, and communicate with other specialty or community based providers.

Coordination of Care for Individuals with Chronic Conditions
Claims data will be used to examine two claims-based care coordination measures: (1) fragmentation of care and (2) follow-up care after mental health hospitalization for people in a BHH and in a comparison group. Structural measures of care coordination will be examined using a monitoring tool that examines the extent to which the core expectations of the BHHO and enhanced primary care practice are being met and progress in meeting those goals. Other qualitative data and case record reviews will be used to illustrate and assess the processes and protocols used by the team of BHH professionals to coordinate care for people with chronic conditions (e.g. during or after a hospitalization; for people with multiple conditions and providers). This may include case record reviews of the enhanced primary care practices and BHHOs to assess other components of care coordination including items such as date of comprehensive assessment and care plan development; contacts during and after a hospitalization; and frequency and intensity of care management for hi-risk patients.

Assessment of Program Implementation
Enhanced primary care practices and BHHOs will be required to submit quarterly reports on their progress in meeting the core expectations (e.g. Leadership and Governance, Team-based Approach to Care; etc.). Practices and BHHOs will report on the degree of progress in each of these areas (e.g. no progress, early progress, moderate progress, and fully implemented). The criteria for making progress in each of these areas shall be defined in the reporting tool.

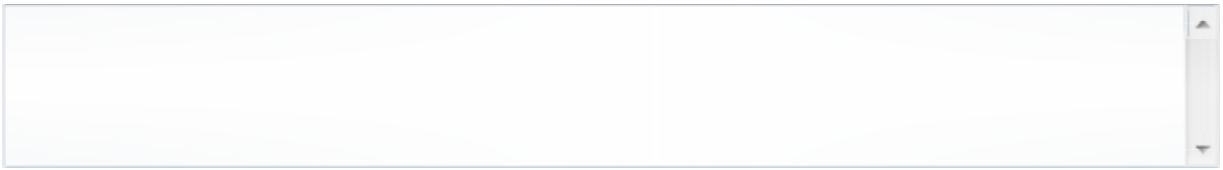
Processes and Lessons Learned
MaineCare (or contractor) will assess and monitor lessons learned through reports and discussions with provider and consumer groups, the BHH Learning Collaborative, and other stakeholders. Quarterly reports on the structures of care and processes of care will inform the discussions.

Assessment of Quality Improvements and Clinical Outcomes
Quality and clinical outcome measures, (see administrative attachment and measures), will be calculated at the patient level. Where appropriate, models will be risk adjusted and change over time will be examined for health home and comparison patients for the pre/post period.

Estimates of Cost Savings

- [x] **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.



PRA Disclosure Statement

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 0938-1148. The time required to complete this information collection is estimated to average 80 per response, 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.