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State/Territory Name: Maine

State Plan Amendment (SPA) #:18-0002

This file contains the following documents in the order listed:

1) Approval Letter

2) CMS Summary (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

January 15, 2019

Jeanne Lambrew, Acting Commissioner
Department of Health and Human Services
221 State Street
Augusta, Maine 04333-0011

Dear Commissioner Lambrew:

We are now ready to approve State Plan Amendment (SPA) No. ME 18-0002. The purpose of this SPA is to amend the State's approved Title XIX State Plan to update the state's Behavioral Health Home (BHH) program. The state plan pages for this SPA were submitted and approved through the Medicaid and CHIP Program System (MACPro).

The purpose of this SPA is to institute pay-for-performance in the BHH program by making one percent of Behavioral Health Home Organization (BHHO) total per member per month payments subject to recoupment if the BHHO does not achieve a minimum level of quality. This SPA also updates a number of operational aspects to the BHH program and further defines program and provider expectations.

We are approving this SPA with an effective date of April 21, 2018 and have included the approved state plan pages with this letter. This approval is based on the state's agreement to collect and report information required for the evaluation of the health home model. States are also encouraged to report on the CMS-recommended core set of quality measures in MACPro.

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

CMS-10434 OMB 0938-1188

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0012O | ME-18-0002 | Behavioral Health Homes

Package Header

Package ID ME2018MS0012O

SPA ID ME-18-0002

Submission Type Official

Initial Submission Date 6/29/2018

Approval Date 1/7/2019

Effective Date 4/21/18

Superseded SPA ID 15-005

State Information

State/Territory Name: Maine

Medicaid Agency Name: Office of MaineCare Services

Submission Component

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

Submission - Summary

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SPA ID and Effective Date

SPA ID ME-18-0002

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
No items available		

Submission - Summary

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SPA ID ME-18-0002
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Superseded SPA ID 15-005

Executive Summary

Summary Description Including Goals and Objectives

The Behavioral Health Home (BHH) program aims to achieve the following goals, through a multi-disciplinary team-based model of care with a focus on behavioral and physical health integration.

I. Reduce Inefficient Healthcare Spending
2. Improve Chronic Disease Management
3. Promote Wellness and Prevention
4. Promote Recovery and Effective Management of Behavioral Health Conditions
5. Promote Improved Experience of Care for Consumers/ Families

This SPA institutes pay-for-performance in the BHH program by making one percent of Behavioral Health Home Organization (BHHO) total Per Member Per Month (PMPM) payments subject to recoupment if the BHHO does not achieve a minimum level of quality, as defined by performance on a Department-defined quality measure related to chronic disease management. This SPA also updates a number of operational aspects to the BHH program and further defines program and provider expectations.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2018	$0
Second	2019	$-25396

Federal Statute / Regulation Citation

Section 2703 of the PPACA

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0012O | ME-18-0002 | Behavioral Health Homes

Package Header

Package ID ME2018MS0012O

SPA ID ME-18-0002

Submission Type Official

Initial Submission Date 6/29/2018

Approval Date 1/7/2019

Effective Date 4/21/18

Superseded SPA ID 15-005

Governor's Office Review

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

Describe Not required.

Submission - Public Comment

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0012O | ME-18-0002 | Behavioral Health Homes

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Submission Type Official
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Approval Date 1/7/2019
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Superseded SPA ID 15-005

Name of Health Homes Program

Behavioral Health Homes

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

- ○ Public notice was not federally required and comment was not solicited
- ○ Public notice was not federally required, but comment was solicited
- ◉ Public notice was federally required and comment was solicited

Indicate how public comment was solicited:

- ☐ Newspaper Announcement
- ☐ Publication in state's administrative record, in accordance with the administrative procedures requirements
- ☐ Email to Electronic Mailing List or Similar Mechanism
- ☑ Website Notice

Select the type of website

- ☑ Website of the State Medicaid Agency or Responsible Agency

Date of Posting: Apr 3, 2018

Website URL: http://www.maine.gov/dhhs/oms/rules/stateplan/index.shtml

- ☐ Website for State Regulations
- ☐ Other
- ☐ Public Hearing or Meeting
- ☐ Other method

Upload copies of public notices and other documents used

Name	Date Created	
BHH_P4P Method notice_ 4.3.18	4/30/2018 3:16 PM EDT	

Upload with this application a written summary of public comments received (optional)

Name	Date Created	
No items available		

Indicate the key issues raised during the public comment period (optional)

- ☐ Access
- ☐ Quality
- ☐ Cost
- ☐ Payment methodology
- ☐ Eligibility
- ☐ Benefits
- ☐ Service delivery
- ☐ Other issue

Submission - Tribal Input

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0012O | ME-18-0002 | Behavioral Health Homes

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SPA ID ME-18-0002
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Superseded SPA ID 15-005

Name of Health Homes Program

Behavioral Health Homes

One or more Indian health programs or Urban Indian Organizations furnish health care services in this state

- (•) Yes
- ( ) No

This state plan amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations

- (•) Yes
- ( ) No

[x] The state has solicited advice from Indian Health Programs and/or Urban Indian Organizations, as required by section 1902(a)(73) of the Social Security Act, prior to submission of this SPA

Complete the following information regarding any solicitation of advice and/or tribal consultation conducted with respect to this submission:

Solicitation of advice and/or Tribal consultation was conducted in the following manner:

[x] All Indian Health Programs

Date of solicitation/consultation:	Method of solicitation/consultation:
1/2/2018	Conference call followed by letter (1/23/2018)

[ ] All Urban Indian Organizations

States are not required to consult with Indian tribal governments, but if such consultation was conducted voluntarily, provide information about such consultation below:

[ ] All Indian Tribes

The state must upload copies of documents that support the solicitation of advice in accordance with statutory requirements, including any notices sent to Indian Health Programs and/or Urban Indian Organizations, as well as attendee lists if face-to-face meetings were held. Also upload documents with comments received from Indian Health Programs or Urban Indian Organizations and the state's responses to any issues raised. Alternatively indicate the key issues and summarize any comments received below and describe how the state incorporated them into the design of its program.

Name	Date Created	
Jan_2018_Tribal_call_notes	4/30/2018 3:20 PM EDT	
BHH_18_SPA	4/30/2018 3:57 PM EDT	

Indicate the key issues raised (optional)

- [ ] Access
- [ ] Quality
- [ ] Cost
- [ ] Payment methodology
- [ ] Eligibility
- [ ] Benefits
- [ ] Service delivery
- [ ] Other issue

Submission - Other Comment

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0012O | ME-18-0002 | Behavioral Health Homes

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SAMHSA Consultation

Name of Health Homes Program

Behavioral Health Homes

☑ 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
9/12/2013

This view was generated on 1/14/2019 12:10 PM EST

CMS-10434 OMB 0938-1188

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0012O | ME-18-0002 | Behavioral Health Homes

Package Header

Package ID	ME2018MS0012O	**SPA ID**	ME-18-0002
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Superseded SPA ID	N/A		

Program Authority

1945 of the Social Security Act

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

Name of Health Homes Program

Behavioral Health Homes

Executive Summary

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

Behavioral Health Homes (BHHs) are designed to address the needs of adults and children with significant mental health and co-occurring diagnoses. In Maine's Behavioral Health Home model, licensed Behavioral Health Home Organizations (BHHOs) partner with enhanced primary care practices. Operating as a team, provider organizations will collaboratively serve eligible MaineCare members with significant behavioral health needs. The team will coordinate services through an integrated and comprehensive plan of care. The Behavioral Health Home (BHH) program aims to achieve the following goals:

I. Reduce Inefficient Healthcare Spending
2 .Improve Chronic Disease Management
3. Promote Wellness and Prevention
4. Promote Recovery and Effective Management of Behavioral Health Conditions
5. Promote Improved Experience of Care for Consumers/ Families

Members may opt out of Health Home services 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, coordinated, and comprehensive service systems across the state.

Behavioral Health Homes are Maine's second Health Home program. The first Health Home Program 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.

General Assurances

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

Health Homes Geographic Limitations

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0012O | ME-18-0002 | Behavioral Health Homes

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

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0012O | ME-18-0002 | Behavioral Health Homes

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Superseded SPA ID	N/A		

Categories of Individuals and Populations Provided Health Homes Services

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

- [x] Categorically Needy (Mandatory and Options for Coverage) Eligibility Groups
- [x] Medically Needy Eligibility Groups

Mandatory Medically Needy

- [x] Medically Needy Pregnant Women
- [x] Medically Needy Children under Age 18

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

Families and Adults

- [ ] Medically Needy Children Age 18 through 20
- [ ] Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

- [ ] Medically Needy Aged, Blind or Disabled
- [ ] Medically Needy Blind or Disabled Individuals Eligible in 1973

Health Homes Population and Enrollment Criteria

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Population Criteria

The state elects to offer Health Homes services to individuals with

- ☐ Two or more chronic conditions
- ☐ One chronic condition and the risk of developing another
- ☑ One serious and persistent mental health condition

Specify the criteria for a serious and persistent mental health condition

Adults:
1. Members must have a primary mental health diagnosis under the most current edition of the Diagnostic and Statistical Manual of Mental Disorders. 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) Intellectual disability;
(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 a mental health diagnosis under the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, or a or a diagnosis described in the current version of the Diagnostic Classification of Mental Health and Developmental Disabilities of Infancy and Early Childhood, 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 as evidenced by a Child and Adolescent Needs and Strengths assessment tool (CANS) score of a 2 or higher in both of the following domain: Child Behavioral/Emotional Needs and Life Functioning Domain.

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0012O | ME-18-0002 | Behavioral Health Homes

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Enrollment of Participants

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

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

Describe the process used

The BHH provider shall identify members who are potentially eligible for BHH services based on eligibility criteria for BHH services. Potentially eligible members will be given information about what a BHH provides, potential benefits of participating in a BHH, other services for which they may be eligible but are considered duplicative of BHH, and their ability to select among any qualified provider. If a member elects to pursue BHH services, the BHH provider will submit potentially eligible members through a certification process to approve services.

Members may also request BHH services or be referred for BHH services by another MaineCare provider. The Department or its authorized entity shall approve or deny the enrollment of members.

Members will be able to select an EPCP from among those who have partnerships with the BHHO, or they may select a primary care practice that does not have an agreement with a BHHO.

BHH provides must maintain documentation indicating that the member has enrolled and given consent to participate in the Health Homes program. This documentation should, at a minimum, indicate that the individual has received required information explaining the Health Homes program and the date that the individual enrolled in the program. This consent form must be documented in the health record. BHH providers are required to follow all applicable state and federal laws governing the sharing of protected health information.

The member can opt out of services at any time, and may choose to receive services from any qualified BHH by notifying their BHH provider of the Department's authorized entity.

Members no longer eligible for BHH will receive notice and may be enrolled in the MaineCare Health Home for members with chronic conditions or other services for which they are eligible.

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0012O | ME-18-0002 | Behavioral Health Homes

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Types of Health Homes Providers

☐ Designated Providers

☑ 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

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.

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.

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.

☑ Nurse Practitioners

Describe the Provider Qualifications and Standards

Psychiatric Consultant – shall be 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.

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.

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.

☑ Nurse Care Coordinators

Describe the Provider Qualifications and Standards

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.

☐ Nutritionists

☑ Social Workers

Describe the Provider Qualifications and Standards

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.

☐ Behavioral Health Professionals

☑ Other (Specify)

Provider Type	Description

Provider Type	Description
Family or Youth Support Specialist	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.
Health Home Coordinator for Members with Serious and Persistent Mental Illness (SPMI)	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).

Provider Type	Description
Enhanced Primary Care Practice (EPCP)	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)

Provider Type	Description
Health Home Coordinator for Members with Serious Emotional Disturbance (SED)	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.
CIPSS	Certified Intentional Peer Support Specialist (CIPSS) for 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.

1 – 5 of 5

☐ Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

Maine's Behavioral Health Homes will be multi-disciplinary teams of Behavioral Health Home professionals that partner with members (and 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 provider. Members will be able to select an EPCP from among those who have partnerships with the BHHO, or they may select a primary care practice that does not have an agreement with a BHHO; in this case, the BHHO is still required to coordinate care for this individual.

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
  - Acceptable mode(s) of electronic communication to ensure effective and privacy-protected exchange of health information
  - Frequency of communication at both leadership and practice levels (e.g., weekly, monthly, quarterly)
  - Procedures for Bi-directional access to member plan of care and other health information;
  - Referral protocols for new members;
  - Collaboration on treatment plans and member goals;
- As needed, Business Associate Agreement/Qualified Service Organization addenda

Supports for Health Homes Providers

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

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

Description

MaineCare provides a comprehensive BHH support strategy. Components include site visits, facilitated peer-to-peer learning opportunities, sharing of quality and utilization measures through an online portal to support care management, sharing of educational/training materials (e.g. workforce training), regional forums, HIT support and development resources, training opportunities and data sharing to support quality improvement efforts (e.g. the Data-Focused Learning Collaborative and pay-for-performance), and other opportunities designed to support core health home expectations and functions.

Providers shall participate in a site assessment to establish baseline status in meeting Core Expectations and identify training and educational needs. Throughout the program BHHs shall participate in technical assistance activities as required by the Department to further program objectives.

Other Health Homes Provider Standards

The state's 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. 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. Each team member role must be filled by a different individual (though child and adult teams may overlap if all specified requirements are met). If there is a lapse in fulfillment of team member roles of greater than 30 continuous days, the BHHO must notify the Department in writing and maintain records of active recruitment.
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. The BHHO must have an EHR system and an EHR for each member.
6. The BHHO must participate in BHH technical assistance opportunities, as determined by the Department. At least one member of the care team must engage in these opportunities.
7. 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.
8. The BHHO must be co-occurring capable.
9. In accordance with state and federal law, the BHHO shall ensure that it has policies and procedures in place to ensure that the Health Home Coordinator can communicate changes in patient condition that may necessitate treatment change with treating clinicians, on as needed basis.
10. The BHHO shall have processes and procedures, and member referral protocols with local inpatient facilities, Emergency Departments (EDs), child/adult residential facilities, crisis services, etc. for prompt notification of an individual's admission and/or planned discharge to/from one of these facilities or services. The BHHO shall have systematic follow-up protocols to assure timely access to follow-up care.
11. 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 Standards will be further defined by MaineCare rule. Behavioral Health Home organizations will be required to provide periodic reports on compliance/successes/challenges in meeting the Core Standards, as further defined by MaineCare. Providers that do not meet Core Standards 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 or MOA with at least one BHHO in its area.
6. The practice has established member referral protocols with area hospitals and other facilities. The practice must have systematic follow-up protocols to ensure timely access to follow-up care.
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 technical assistance opportunities, as determined by the Department. At least one member of the care team must engage in these opportunities.
9. Within one year of the practice'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
h. Connection to community resources and social support services
i. Commitment to reducing unnecessary healthcare spending, reducing waste, and improving cost- effective use of healthcare services
j. Integration of health information technology (HIT)

Providers must have the 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.

Name	Date Created	
No items available		

Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0012O | ME-18-0002 | Behavioral Health Homes

Package Header

Package ID ME2018MS0012O **SPA ID** ME-18-0002

Submission Type Official **Initial Submission Date** 6/29/2018

Approval Date 1/7/2019 **Effective Date** 4/21/2018

Superseded SPA ID N/A

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

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

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0012O | ME-18-0002 | Behavioral Health Homes

Package Header

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Superseded SPA ID	N/A		

Payment Methodology

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

☑ Fee for Service

- ☐ Individual Rates Per Service
- ☑ Per Member, Per Month Rates
  - ☑ Fee for Service Rates based on
    - ☐ Severity of each individual's chronic conditions
    - ☑ Capabilities of the team of health care professionals, designated provider, or health team
    - ☐ Other
- ☐ Comprehensive Methodology Included in the Plan
- ☐ Incentive Payment Reimbursement

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

Pay-for- Performance Provisions: One percent of total BHHO PMPM payments are subject to recoupment based on the performance measure below. BHHO performance will be assessed every six (6) months, using twelve (12) months of claims data. Of the twelve (12) months of data used to measure performance, at least six (6) months of claims data will be drawn from a time period following the implementation of a new or adjusted performance measure or threshold.

The Department will provide interim performance data throughout the assessment period. Providers will have the opportunity to review and refute Department findings on their performance score before recoupment. Notice of recoupment and the right to appeal will be provided in accordance with 22 M.R.S. §1714-A and MBM, Section 1, Chapter 1, General Administrative Policies and Procedures. Recoupment will be pursuant to 22 M.R.S. §1714-A and recoupment shall not occur until any appeals have been exhausted.

Providers will receive at least one-hundred and eighty (180) days' notice prior to a change to pay-for-performance stipulations.

Recoupment under the pay-for-performance provision of this chapter shall not interfere with the ability of the Department to enforce compliance with any other requirements of the MaineCare Benefits Manual (MBM).

Performance Measure:

Numerator: MaineCare members assigned to the BHH who had two (2) or more prescriptions filled for an anti-psychotic medication (anti-psychotic medications are those included in the most recently published HEDIS Listing which is available at www.ncqa.org) AND who had an HbA1c or blood glucose test during the twelve (12)-month time period.

Denominator: MaineCare members assigned to the BHH who had two or more prescriptions filled for an anti-psychotic medication during the twelve (12)-month period.

Performance Threshold for Recoupment:

The current threshold for the BHH pay-for-performance will be listed on: http://www.maine.gov/dhhs/oms/vbp

The Department will set a performance threshold based on at least twelve (12) months of data from members in existing BHHOs. The performance threshold will be set so that at least 70% of eligible BHHOs are expected to be above the recoupment threshold based on the data available at the time of the calculation. The Department cannot anticipate the percent of providers that will, during the performance period, fail to meet the performance threshold.

Eligible Behavioral Health Homes Organizations are those in which at least ten percent (10%) of their member panel is clinically eligible for inclusion in the performance measure.

The State will consider reporting this measure annually to the Health Homes Quality Measure portal, as an additional measurement of program effectiveness and improvement.

☐ PCCM (description included in Service Delivery section)

☐ Risk Based Managed Care (description included in Service Delivery section)

☐ Alternative models of payment, other than Fee for Service or PMPM payments (describe below)

Health Homes Payment Methodologies

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Agency Rates

Describe the rates used

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

Health Homes Payment Methodologies

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Rate Development

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

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

Comprehensive Description

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, 2016 (for cost assumptions, see below):
• Member with SED or SMI: $394.40 PMPM to BHHO
• Member with SED/SPMI and engaged with an enhanced primary care practice: $409.40 to BHHO with
pass-through payment to practice
All Health Home services are documented in the member record/EHR. This documentation is auditable.
Rate Model: BHHO
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.
Health Home Coordinator
• Monthly Cost of Wages and Benefits: $4,306.75
• Number of Cases per Health Home Coordinator 24
• Monthly Health Home Coordinator Cost per Case $179.45
Clinical Team Leader
• Monthly Cost of Wages and Benefits: $6,892.51
• Number of Cases per Clinical Team Leader: 192
• Monthly Clinical Team Leader Cost per Case: $35.90
Nurse Care Manager
• Monthly Cost of Wages and Benefits: $6,185.09
• Number of Cases per Nurse Care Manager: 200
• Monthly Nurse Care Manager Cost per Case: $30.93
Peer Support Specialist/Family or Youth Support Specialist
• Monthly Cost of Wages and Benefits: $2,756.00
• Number of Cases per Peer/Family or Youth Support Specialist: 100
• Monthly Peer/Family or Youth Support Specialist Cost per Case: $27.56
Psychiatric Consultant
• Hourly Cost of Wages and Benefits: $101.29
• Annual Psychiatric Consultant Hours per 200 Cases: 42
• Monthly Psychiatric Consultant Cost per Case: $1.76
Medical Consultant
• Hourly Cost of Wages and Benefits: $91.20
• Annual Medical Consultant Hours per 200 Cases: 42
• Monthly Medical Consultant Cost per Case: $1.58
Administrative Support
• Monthly Cost of Wages and Benefits for Administrative Support: $3,723.18
• Number of Cases per Administrative Support Staff: 200
• Monthly Administrative/Support Cost per Case: $18.62
Operating/Overhead
• Monthly Operating/Overhead Cost per Case: $98.60
• Total Operating and Overhead Costs: $117.22
• Total Operating and Overhead Rate: 29.7%
Monthly Case Rate: $394.40

Minimum billable services

BHHO:
The member is identified as meeting Behavioral Health Home eligibility criteria 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 or more frequently (with monthly activities or developments, when appropriate);
• The BHHO has submitted required reports on cost/utilization;
• The BHHO has delivered at least one allowable health home service during the reporting month. At least one of the services must include a face-to-face or telehealth member encounter. While a covered health home service is always required for payment, there may be an exception to the requirement of a face-to-face or telehealth encounter for one month during a twelve-month period, to allow for covered services that were delivered but where there was not a face-to-face or telehealth encounter (e.g. telephone based covered health home services).

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

Minimum billable requirements for the enhanced PCP:
The member is identified as meeting Behavioral Health Home eligibility criteria 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;
- Monitor and respond to treatment gaps on the individual level by providing at least one covered health home service.

The State will review service utilization and rates 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 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 Health Home payments into MMIS.

Health Homes Payment Methodologies

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Assurances

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

Describe below how non-duplication of payment will be achieved

Members must receive a prior authorization/certification for BHH services. Authorization for the service will include utilization review of other services, such as Targeted Case Management (TCM) and Community Support. Members will have the choice to either continue receiving existing services 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 enhanced primary care practice for all Health Home-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.

As the lead entity, the BHHO will provide 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 first Health Home Initiative consists of Health Home practices that partner with CCTs around the state. Enrolled members receive 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. Members will be assessed regularly for their need for this high level of care management. When eligible, members who no longer need a high level of care can be transitioned seamlessly to HH: eligible members will receive written notice that they are being discharged from the BHH and enrolled in the HHH. Those members will stay with their enhanced primary care practice; the practice will then receive the PMPM payment for the member through the Health Home State Plan option. Members transitioned to HHs 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 three health home initiatives to ensure that no member receives more than eight quarters of enhanced match through any combination of HH SPA options.

☑ The state has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☑ The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.

☑ The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).

Optional Supporting Material Upload

Name	Date Created	
No items available		

Health Homes Services

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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 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, and including a comprehensive psychosocial assessment The member will have a periodic clinical reassessment of need and the Plan of Care shall be updated accordingly.
-draft and manage implementation of a comprehensive, individualized, and member-driven Plan of Care. 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.
- monitor and address gaps in care (including those identified via the Value-Based Purchasing portal).
- provide all health home services including the coordination/integration of the member's physical, behavioral, and long-term services needs.

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 address gaps in care.

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

HIT plays a central role in BHH service delivery. Through MaineCare's web-based Value-Based Purchasing portal, providers can access information regarding eligible and pending members and refer members to an enhanced primary care practice, and information on key quality and utilization measures. Online utilization reports supply BHH providers monthly utilization data from MaineCare claims to assist providers with identifying high needs/high cost members and as a tool to scan for and act upon any gaps in care.

All BHHOs and EPCP must have certified EHR systems that allow integration of secure messaging into the EHR.

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 service

The service can be provided by the following provider types

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

Provider Type	Description
BHHO and enhanced primary care practice	The Behavioral Health Home Organization shall provide comprehensive care management services. Services may be provided by the Clinical Team Leader, Nurse Care Manager, and/or HH Coordinator. Clinical staff (typically a nurse or care manager) at the enhanced primary care practice also may 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.
-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 of 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

HIT plays a central role in BHH service delivery. Through MaineCare's web-based Value-Based Purchasing portal, providers can access information regarding eligible and pending members and refer members to an enhanced primary care practice, and information on key quality and utilization measures. Online utilization reports supply BHH providers monthly utilization data from MaineCare claims to assist providers with identifying high needs/high cost members and as a tool to scan for and act upon any gaps in care.

All BHHOs and EPCP must have certified EHR systems that allow integration of secure messaging into the EHR.

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 service

The service can be provided by the following provider types

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

Provider Type	Description

Provider Type	Description
BHHO and enhanced primary care practices	The Behavioral Health Home Organization shall provide care coordination services. 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 (typically a nurse or care manager) at the enhanced primary care practice also may provide care coordination.

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

HIT plays a central role in BHH service delivery. Through MaineCare's web-based Value-Based Purchasing portal, providers can access information regarding eligible and pending members and refer members to an enhanced primary care practice, and information on key quality and utilization measures. Online utilization reports supply BHH providers monthly utilization data from MaineCare claims to assist providers with identifying high needs/high cost members and as a tool to scan for and act upon any gaps in care.

All BHHOs and EPCP must have certified EHR systems that allow integration of secure messaging into the EHR.

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 service

The service can be provided by the following provider types

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

Provider Type	Description

Provider Type	Description
BHHO and enhanced primary care practice	The Behavioral Health Home Organization shall provide Health Promotion services. 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, care manager, or primary care provider, 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.

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

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Scope of service

The service can be provided by the following provider types

- ☐ Behavioral Health Professionals or Specialists
- ☐ Nurse Practitioner
- ☐ Nurse Care Coordinators
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- ☐ Medical Specialists
- ☐ Physicians
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- ☐ Pharmacists
- ☐ Social Workers
- ☐ Doctors of Chiropractic
- ☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
BHHO and enhanced primary care practice	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). Clinical staff at the enhanced primary care practice, which may include a nurse, care manager or primary care provider, 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 member's 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 Peer Support 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 discuss advance directives with members and their family or caregivers, as appropriate.

5. 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

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Scope of service

The service can be provided by the following provider types

☐ Behavioral Health Professionals or Specialists

☐ Nurse Practitioner

☐ Nurse Care Coordinators

☐ Nurses

☐ Medical Specialists

☐ Physicians

☐ Physician's Assistants

☐ Pharmacists

☐ Social Workers

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
BHHO and enhanced primary care practice	The Behavioral Health Home Organization shall provide Individual and family support services. 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). Clinical staff (typically a nurse or care manager) at the enhanced primary care practice also may provide Individual and Family Support Services.

Referral to Community and Social Support Services

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 outreach and coordination by providers, reminders, and scheduling appointmets to ensure a successful referral. 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

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- ☐ Licensed Complementary and alternative Medicine Practitioners
- ☐ Dieticians
- ☐ Nutritionists
- ☑ Other (specify)

Provider Type	Description
BHHO and enhanced primary care practice	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, care manager, or primary care provider, shall provide referral to community and social supports.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0012O | ME-18-0002 | Behavioral Health Homes

Package Header

Package ID	ME2018MS0012O	**SPA ID**	ME-18-0002
Submission Type	Official	**Initial Submission Date**	6/29/2018
Approval Date	1/7/2019	**Effective Date**	4/21/2018
Superseded SPA ID	N/A		

Health Homes Patient Flow

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

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 or stop services entirely.

Name	Date Created	
BHHO PatientFlow	6/15/2018 4:14 PM EDT	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0012O | ME-18-0002 | Behavioral Health Homes

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Monitoring

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

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 BHHS to use EHRs. The state has an advanced HIE (HealthInfoNet). Maine has also committed to assisting its behavioral health providers in accessing HIT. Maine provides resources/training to BHH providers connect to the HIE.

MaineCare makes available to both enhanced primary care practices and BHHOs utilization and quality data via a web portal.

Health Homes Monitoring, Quality Measurement and Evaluation

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Quality Measurement and Evaluation

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

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