Table of Contents

State/Territory Name: Maine

State Plan Amendment (SPA) #:18-0032

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Boston Regional Office
JFK Federal Building, Government Center, Room 275
Boston, MA 02203

Division of Medicaid and Children's Health Operations

August 07, 2019

Michelle Probert
Director
Office of MaineCare Services
242 State St.
SHS 11
Augusta, ME 04330

Re: Approval of State Plan Amendment ME-18-0032 Opioid Health Home

Dear Michelle Probert:

On December 31, 2018, the Centers for Medicare and Medicaid Services (CMS) received Maine State Plan Amendment (SPA) ME-18-0032 for Opioid Health Home to (1) create a tiered rate structure to reflect varying levels of treatment required to provide Integrated Medication Assisted Treatment (IMAT) to members receiving OHH services; (2) alter the staffing requirements of the OHH team to ensure flexibility for provider organizations and expertise to meet members' needs..

We approve Maine State Plan Amendment (SPA) ME-18-0032 on August 07, 2019 with an effective date(s) of November 21, 2018.

Name	Date Created	
No items available		

If you have any questions regarding this amendment, please contact Aimee Campbell-O'Connor at 2074412788 or Aimee.Campbell-OConnor@cms.hhs.gov.

Sincerely,

Francis T. McCullough

Director
Division of Medicaid Field Operations East
Regional Operations Group

Division of Medicaid and Children's Health Operations

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0017O | ME-18-0032 | Opioid Health Home

Package Header

Package ID ME2018MS0017O
SPA ID ME-18-0032
Submission Type Official
Initial Submission Date 12/31/2018
Approval Date 8/7/2019
Effective Date N/A
Superseded SPA ID N/A

State Information

State/Territory Name: Maine
Medicaid Agency Name: Office of MaineCare Services

Submission Component

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

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0017O | ME-18-0032 | Opioid Health Home

Package Header

Package ID ME2018MS0017O
SPA ID ME-18-0032
Submission Type Official
Initial Submission Date 12/31/2018
Approval Date 8/7/2019
Effective Date N/A
Superseded SPA ID N/A

SPA ID and Effective Date

SPA ID ME-18-0032

Reviewable Unit	Proposed Effective Date	Superseded SPA ID
Health Homes Intro	11/21/2018	ME-17-0006
Health Homes Population and Enrollment Criteria	11/21/2018	ME-17-0006
Health Homes Providers	11/21/2018	ME-17-0006
Health Homes Payment Methodologies	11/21/2018	ME-17-0006
Health Homes Services	11/21/2018	ME-17-0006

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0017O | ME-18-0032 | Opioid Health Home

Package Header

Package ID ME2018MS0017O
SPA ID ME-18-0032
Submission Type Official
Initial Submission Date 12/31/2018
Approval Date 8/7/2019
Effective Date N/A
Superseded SPA ID N/A

Executive Summary

Summary Description Including Goals and Objectives

The OHH initiative is an innovative model providing comprehensive, coordinated care focused on serving MaineCare members with opioid dependency who are receiving Medication Assisted Treatment (MAT) in the form of buprenorphine, buprenorphine derivatives, and naltrexone. This model is based on a multidisciplinary team approach consisting of a clinical team lead, MAT prescriber, nurse care manager, clinical counselor, patient navigator, and peer recovery coach. The OHH must be a community-based provider in Maine, preferably licensed to provide substance use disorder services. In addition to expanding access to treatment for an individual's opioid dependency, the OHH integrates physical, social, and emotional supports to provide holistic care. It is expected that the OHH program will not only result in more individuals receiving the opioid use disorder treatment they need, but will also lead to improvements in the quality of care they are receiving.

The primary goals of this State Plan Amendment (SPA) are to: (1) create a tiered rate structure to reflect varying levels of treatment required to provide Integrated Medication Assisted Treatment (IMAT) to members receiving OHH services; (2) alter the staffing requirements of the OHH team to ensure flexibility for provider organizations and expertise to meet members' needs.

Maine has two other health home programs which use a similar model of service delivery; however, each program has different provider requirements, provider composition, goals, target populations, and methods of reimbursement.

Federal Budget Impact and Statute/Regulation Citation

Federal Budget Impact

	Federal Fiscal Year	Amount
First	2019	$2519842
Second	2020	$2376055

Federal Statute / Regulation Citation

1945 of SSA/Section 2703 of the ACA

Supporting documentation of budget impact is uploaded (optional).

Name	Date Created	
No items available		

Submission - Summary

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0017O | ME-18-0032 | Opioid Health Home

Package Header

Package ID	ME2018MS0017O	**SPA ID**	ME-18-0032
Submission Type	Official	**Initial Submission Date**	12/31/2018
Approval Date	8/7/2019	**Effective Date**	N/A
Superseded SPA ID	N/A		

Governor's Office Review

- (•) No comment
- ( ) Comments received
- ( ) No response within 45 days
- ( ) Other

Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0017O | ME-18-0032 | Opioid Health Home

Package Header

Package ID	ME2018MS0017O	**SPA ID**	ME-18-0032
Submission Type	Official	**Initial Submission Date**	12/31/2018
Approval Date	8/7/2019	**Effective Date**	11/21/2018
Superseded SPA ID	ME-17-0006		
	System-Derived		

Program Authority

1945 of the Social Security Act

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

Name of Health Homes Program

Opioid Health Home

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

This SPA establishes the MaineCare Opioid Health Home (OHH) program to address the opioid crisis in Maine. The OHH initiative is an innovative model providing comprehensive, coordinated care focused on serving MaineCare members with opioid dependency who are receiving Medication Assisted Treatment (MAT) in the form of buprenorphine, buprenorphine derivatives, and/or naltrexone. In addition to expanding access to treatment for an individual's opioid use disorder, the OHH integrates physical, social, and emotional supports to provide holistic care. This model is based on a multidisciplinary team approach consisting of a clinical team lead, MAT prescriber, nurse care manager, clinical counselor, patient navigator, and peer recovery coach. The OHH must be a community-based provider in Maine, preferably licensed to provide substance use disorder services. It is expected that the OHH program will not only result in more individuals receiving opioid use disorder treatment but will also lead to improvements in the quality of care they are receiving. OHH services are optional, and members can choose to receive the services from any OHH. In order to receive full reimbursement under this section, OHH providers must provide the six health home services outlined in this State Plan section and also three non-health home services that are integral to high-quality care for opioid dependency, including, opioid dependency counseling, at least one monthly office visit with the MAT provider. Providers must also provide (through dispensing on-site or prescription to an outside pharmacy) a monthly supply of buprenorphine, buprenorphine derivatives, and/or naltrexone for opioid dependence. OHH providers are not required to deliver other state plan services. Before the OHH option, individuals with substance use disorder were eligible for the Stage A Health Home model, but the team composition for OHH targets the specific needs of individuals with opioid use disorder. The OHH option provides additional support to the member in creating and supporting the implementation of a comprehensive plan of care with a team that has expertise in substance use disorders. The OHH also provides support to MAT prescribers, who may not have the resources to provide the robust level of coordinated care across all relevant providers and community resources. The State uses a certification process to check for and prevent any duplication of service. This process was updated to reflect the option of a higher-level intensity of OHH services to be made available to members for whom OHH services medically necessary. This process, completed by the Department's authorized entity, reviews the request for OHH services against existing service authorizations which are considered duplicative (including authorizations for the other Health Home programs). The OHH authorization is then either denied or issued at the higher-level of intensity. A member will not be approved for duplicative services. When a denial is issued, the authorized entity will notify the requesting provider and the provider is required to work with the member to determine whether they would like to switch to OHH services or remain in their existing service. This work involves communicating with the member's care team (including the provider of the duplicative services). Members have freedom to select the service of their choice for which they are eligible.

General Assurances

- ☑ The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.
- ☑ The states 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 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.
- ☑ 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.
- ☑ The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.

Health Homes Population and Enrollment Criteria

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0017O | ME-18-0032 | Opioid Health Home

Package Header

Package ID	ME2018MS0017O	**SPA ID**	ME-18-0032
Submission Type	Official	**Initial Submission Date**	12/31/2018
Approval Date	8/7/2019	**Effective Date**	11/21/2018
Superseded SPA ID	ME-17-0006		
	System-Derived		

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 (Mandatory and Options for Coverage) Eligibility Groups

☑ Medically Needy Eligibility Groups

Mandatory Medically Needy

☑ Medically Needy Pregnant Women

☑ Medically Needy Children under Age 18

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

Families and Adults

☑ Medically Needy Children Age 18 through 20

☑ Medically Needy Parents and Other Caretaker Relatives

Aged, Blind and Disabled

☑ Medically Needy Aged, Blind or Disabled

☐ Medically Needy Blind or Disabled Individuals Eligible in 1973

Health Homes Population and Enrollment Criteria

Package Header

Package ID ME2018MS0017O
SPA ID ME-18-0032
Submission Type Official
Initial Submission Date 12/31/2018
Approval Date 8/7/2019
Effective Date 11/21/2018
Superseded SPA ID ME-17-0006
System-Derived

Population Criteria

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

- [ ] Two or more chronic conditions
- [x] One chronic condition and the risk of developing another

Specify the conditions included:

- [ ] Mental Health Condition
- [ ] Substance Use Disorder
- [ ] Asthma
- [ ] Diabetes
- [ ] Heart Disease
- [ ] BMI over 25
- [x] Other (specify):

Name	Description
Substance Use Disorder, Opiod	As set forth in the Diagnostic and Statistical Manual of Mental Disorders (5th ed. DSM–5); AND have a second chronic condition OR be at risk of having a second chronic condition.

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

Eligible Chronic Conditions as Second Chronic Condition

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

Definition of at Risk of another Chronic Condition
High risk behaviors and other risk factors that may contribute to chronic conditions such as, but not limited to: smoking; obesity; poor nutrition; childhood trauma; risky sex practices; intravenous drug use; history of or current substance use other than opioids; and family health issues.

Citations to support the above "at risk conditions" include:
- US Burden of Disease Collaborators. The state of US health, 1990–2010: burden of diseases, injuries, and risk factors. JAMA. 2013;310:591–608.
- CASAColumbia. (2012). Addiction medicine: Closing the gap between science and practice.
- Relationship of Childhood Abuse and Household Dysfunction to Many of the Leading Causes of Death in Adults Felitti, Vincent J et al. AJPM, 14:4:245 - 258.
- Castelli WP. Epidemiology of coronary heart disease. The Framingham Study. American Journal of Medicine. 1984, 76L4-12.
- Centers for Disease Control and Prevention. Third National Health and Nutrition Examination Survey, 1988-94. Analysis by the Lewin Group, Falls Church, VA 1999.

☐ One serious and persistent mental health condition

Health Homes Population and Enrollment Criteria

Package Header

Package ID	ME2018MS0017O	**SPA ID**	ME-18-0032
Submission Type	Official	**Initial Submission Date**	12/31/2018
Approval Date	8/7/2019	**Effective Date**	11/21/2018
Superseded SPA ID	ME-17-0006		
	System-Derived		

Enrollment of Participants

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

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

Describe the process used:

The OHH Provider shall identify members for OHH based on the OHH eligibility criteria. For example, MAT prescribers or other providers may review their current panel of members to identify individuals who may benefit from this service; the provider may then make a referral or, if the are an OHH provider themselves, discuss this service option with the member. Additional providers may refer individuals to OHH providers, to determine clinical appropriateness and eligibility. A list of approved OHH providers is available on the State website to facilitate this process. Individuals may also use this list to find providers. Written materials include previously developed provider manuals as well as a Member handbook. Potentially eligible members will be given information about the benefits of participating in an OHH (in whatever format the provider elects to use). If the member elects to receive OHH services, the OHH provider will initiate the certification process to have the service approved and ensure non-duplication. The Department, or it's authorized entity, reviews the service request against current authorizations or claims data for duplicative services to ensure that there is no duplication in services. If there is duplication, OHH services will not be approved.

The member can choose to not participate at any time by notifying their OHH provider. Each member's eligibility must be based on a diagnosis rendered within the past year from the date of the certification request, as documented by an appropriately licensed professional. Reassessments shall occur at least annually in order to ensure ongoing eligibility for services provided herein. Providers shall maintain documentation on enrollment verification and consent to participate in the member's record.

As stated in the General Assurances subsection, 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. 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. The State will claim enhanced match through 9/30/19. A member may only be in one health home program at a time.

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0017O | ME-18-0032 | Opioid Health Home

Package Header

Package ID ME2018MS0017O
SPA ID ME-18-0032
Submission Type Official
Initial Submission Date 12/31/2018
Approval Date 8/7/2019
Effective Date 11/21/2018
Superseded SPA ID ME-17-0006
System-Derived

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

- A physician or physican's assistant, with significant experience treating individuals with substance use disorders may be the Clinical Team Lead.
- A physician or physician's assistant may also be the Medication Assisted Treatment (MAT) Provider, which is a licensed health care professional with authority to prescribe buprenorphine. This provider must have completed the federally required training and hold the appropriate X-DEA license to prescribe buprenorphine in an office-based setting. They must also follow state laws.
- Regarding physician's assistants: Authority to prescribe buprenorphine will be allowed only in accordance with federal law; as such, prescribing privileges will not extend beyond 2021 unless authorized by federal law.

☑ Nurse Practitioners

Describe the Provider Qualifications and Standards

- An advanced practice registered nurse (APRN) with significant experience treating individuals with substance use disorders may be the Clinical Team Lead.
- A psychiatric mental health advanced practice registered nurse or other advanced practice registered nurse may be the Nurse Care Manager.
- An APRN may also be the Medication Assisted Treatment (MAT) Provider, which is a licensed health care professional with authority to prescribe buprenorphine. This provider must have completed the federally required training and hold the appropriate X-DEA license to prescribe buprenorphine in an office-based setting. They must also follow state laws. Authority to prescribe buprenorphine will be allowed only in accordance with federal law; as such, prescribing privileges will not extend beyond 2021 unless authorized by federal law.

☑ Nurse Care Coordinators

Describe the Provider Qualifications and Standards

- A registered nurse who completes the SAMHSA required training for an X-DEA license (i.e. SAMHSA approved eight-hour training for Buprenorphine prescribing by physicians) within six months of intiating service delivery for OHH members. This training is for content purposes only and is not related to actual prescribing. This professional may be the Nurse Care Manager.
- A psychiatric and mental health nurse may be the Nurse Care Manager.
- A licensed practical nurse, registered nurse, or the registered nurse with the training described in the first bullet above, may by the Patient Navigator.

☐ Nutritionists

☑ Social Workers

Describe the Provider Qualifications and Standards

- A licensed clinical social worker (LCSW) with significant experience treating individuals with substance use disorders may be the Clinical Team Lead.
- A LCSW or licensed master social worker -conditional clinical: (a) who has completed sixty hours of alcohol and drug education within the last five years; or, (b) within a maximum of five years of initiating OHH services completes sixty hours of alcohol and drug educations, may be the Clinical Counselor and/or the Patient Navigator.

☑ Behavioral Health Professionals

Describe the Provider Qualifications and Standards

- A psychologist, licensed clinical professional counselor, with significant experience treating individuals with substance use disorders may be the Clinical Team Lead.
- A certified alcohol and drug counselor or higher licensure (LCSW, LMSW-cc, licensed clinical professional counselor (LCPC), LCPC-conditional, licensed marriage and family therapist: (a) who has completed sixty hours of alcohol and drug education within the last five years; or, (b) within a maximum of five years of initiating OHH services completes sixty hours of alcohol and drug educations, may be the Clinical Counselor.Counselor and/or the Patient Navigator.

☑ Other (Specify)

Provider Type	Description
Peer Recovery Coach	An individual who is in recovery from substance use disorder and who is willing to self-identify on this basis with OHH members. Their life experiences and recovery allow them to provide recovery support in such way that others can benefit from their experiences.
Patient Navigator	This may also be an individual with at least one year of job experience in a health/social services or behavioral health setting and hold an Associate's degree; or, an individual with a Bachelor's degree from an accredited four-year institution of higher learning; or, be a medical assistant.

☐ Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

OHH providers must meet provider requirements (described below). In general, the OHH must include the following team members: clinical team lead, MAT prescriber (must have completed the federally required training and hold the appropriate X-DEA license to prescribe buprenorphine in an office-based setting), clinical counselor, nurse care manager, patient navigator, and peer recovery coach. The OHH must be a community-providers and while a substance abuse service license is not required, it is preferred. The Department acknowledges that entities such a certain physician offices or federally qualified health centers may not have these licenses, but are well-equipped to deliver quality services under the OHH model. Provider arrangements may vary as long as program requirements are met.

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

The Department uses Core Standards to achieve the Health Home functional components. The Core Standards are Demonstrated Leadership, Team-based Approach to Care, Population Risk Stratification and Management, Enhanced Access, Practice Integrated Care Management, Behavioral Physical Health Integration, Inclusion of Patients and Families, Connection to Community Resources and Social Support Services, Commitment to Reducing Waste and Improving Cost-effective Use of Healthcare Services, Integration of Health Information Technology. Technical assistance opportunities are available to assist OHHs in achieving and maintaining excellence in the Core Standards. Technical assistance includes a combination of in-person collaborative meetings with OHH providers, on-site assistance with quality improvement staff, and other methods of sharing best practices between OHH providers.

For the first year of participation, the OHH must submit quarterly reports on sustained implementation of the Core Standards. Once Core Standards are fully implemented, the OHH may request the Department's approval to submit the Core Standard progress report annually instead of quarterly. The Department conducts an initial site assessment to go over program requirements and ensure providers understand expectations and resources available to them. Throughout program participation, the Department evaluates providers based on measures present in the claims-based dashboard.

Other Health Homes Provider Standards

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

The OHH must meet the following requirements. .
A. The OHH must execute a MaineCare Provider Agreement.
B. The OHH must be approved as an OHH by the Department through the OHH application process.
C. The OHH is encouraged to utilize an EHR system and create an EHR for each member. Lack of an EHR system will not be a determining factor in approving an OHH provider application.
D. The OHH must be co-occurring capable, meaning that the organization is structured to welcome, identify, engage, and serve individuals with co-occurring substance use and mental health disorders and to incorporate attention to these issues into member services.
E. The OHH must be a community-based provider located within the state of Maine, preferably licensed to provide substance use disorder services in the state of Maine. The OHH delivers a team-based model of care through a team of employed or contracted personnel. The team must include at least the personnel identified in this State Plan section. Unless otherwise specified, each role must be filled by a different individual; the Department reserves the right to waive this requirement based on team member professional experience and training. If there is a lapse in fulfillment of team member roles of greater than thirty (30) continuous days, the OHH must notify the Department in writing and maintain records of active recruitment to fill the position(s). All team members shall contribute to delivery of integrated and coordinated, whole-person care through a team-based approach.
F. The OHH must adhere to licensing standards regarding documentation of all OHH providers' qualifications in their personnel files. Pursuant to applicable licensing standards, the OHH must have a review process to ensure that employees providing OHH services possess the minimum qualifications set forth above.
G. The OHH must establish and maintain a relationship with a primary care provider, authorized and evidenced by a signed medical release, for each OHH member served. Such a release is not required when the member's primary care provider is also the member's provider within the OHH.
H. The OHH shall ensure that it has policies and procedures in place to ensure that the Clinical Team Lead and other team members, as appropriate, can communicate any changes in patient that may necessitate treatment change with the member's treating clinicians. This includes the requirement for establishing policies and procedures around coordination, including but not limited to, a signed medical release with the entities listed in 93.08(C) when applicable.
I. The OHH shall have in place processes, procedures, and member referral protocols with local inpatient facilities, Emergency Departments (EDs), residential facilities, crisis services, and corrections for prompt notification of an individual's admission and/or planned discharge to/from one of these facilities or services.The protocols must include coordination and communication on enrolled or potentially eligible members. The OHH shall have systematic follow-up protocols to assure timely access to follow-up care.
J. The OHH must participate in Department-approved OHH technical assistance and educational opportunities. At least one (1) member of the care team must engage in these opportunities.

Name	Date Created	
No items available		

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0017O | ME-18-0032 | Opioid Health Home

Package Header

Package ID ME2018MS0017O
SPA ID ME-18-0032
Submission Type Official
Initial Submission Date 12/31/2018
Approval Date 8/7/2019
Effective Date 11/21/2018
Superseded SPA ID ME-17-0006
System-Derived

Payment Methodology

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

☑ Fee for Service

☐ Individual Rates Per Service

☑ Per Member, Per Month Rates

☑ Fee for Service Rates based on

☑ Severity of each individual's chronic conditions

☑ Capabilities of the team of health care professionals, designated provider, or health team

☑ Other

Describe below

Payments are also tiered by clinical phase (intensity of service).

☐ 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	There are three tiers of OHH payment rates, each is based on acuity level and how the OHH team addresses the individual's needs.

☐ 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

Package Header

Package ID	ME2018MS0017O	**SPA ID**	ME-18-0032
Submission Type	Official	**Initial Submission Date**	12/31/2018
Approval Date	8/7/2019	**Effective Date**	11/21/2018
Superseded SPA ID	ME-17-0006		
	System-Derived		

Agency Rates

Describe the rates used

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

Health Homes Payment Methodologies

Package Header

Package ID	ME2018MS0017O	**SPA ID**	ME-18-0032
Submission Type	Official	**Initial Submission Date**	12/31/2018
Approval Date	8/7/2019	**Effective Date**	11/21/2018
Superseded SPA ID	ME-17-0006		
	System-Derived		

Rate Development

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

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

Comprehensive Description

There are three tiers of OHH payment rates, each is based on acuity level and how the OHH team addresses the individual's needs.

(1)To be eligible for Tier 1 services, members must have an opioid use disorder and have a second chronic condition or be at risk of a second chronic condition consistent with the Maine Opioid Health Home SPA approved Executive Summary and Population Criteria.

(2)To be eligible for Tier 2 services the member must meet the eligibility criteria for Tier 1 AND they must also be diagnosed with two (2) or more of the following chronic conditions, OR one (1) chronic condition AND be at risk for another chronic condition as indicated below:

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

At Risk for Another Chronic Condition:
1. A member is deemed to be at risk for another chronic condition if the member has been diagnosed with any of the following:

a. a mental health condition;
b. a substance use disorder;
c. tobacco use;
d. diabetes;
e. heart disease;
f. overweight or obese as evidenced by a body mass index over 25;
g. chronic obstructive pulmonary disease (COPD);
h. hypertension;
i. hyperlipidemia;
j. developmental and intellectual disorders; or,
k. circulatory congenital abnormalities

(3) To be eligible for Tier 3 services a member must have an opioid use disorder and have a second chronic condition or be at risk of a second chronic condition consistent with the Maine Opioid Health Home SPA approved Executive Summary and Population Criteria and must also be diagnosed with a Serious and Persistent Mental Illness (SPMI), Serious Emotional Disturbance (SED), HIV or experiencing homelessness.

For individuals receiving Tier 1 services, inclusive of the 6 section 2703 health home services, the full Per Member Per Month payment is $394.40. For individuals receiving Tier 2 services, inclusive of the 6 section 2703 health home services and chronic condition management, the full PMPM payment is $409.40. For individuals receiving Tier 3 services, inclusive of the 6 section 2703 health home services and acute community supports, the full PMPM payment is $534.49.1. The PMPM was established based on the independent rate study recently used for the State's Behavioral Health Home program. This rate was approved under Maine SPA 16-0001, which included a cost calculation. The State believes that while the staff members (and qualifications) differ between the tiers, that the cost data assumptions for the team members is similar. The

State adjusted the assumptions regarding team member contributions and caseload to reflect the higher-level of support provided by the OHH in this scenario. This rate was developed by determining the monthly cost per case of each team member, applicable administrative support cost per case, and operating and overhead rates. These costs were informed by provider reported costs and national standards 2. Opioid Health Homes are a team of providers supported by a PMPM payment. Payment will be made monthly. 3. General/Overall Requirements: In order for the OHH to be eligible for the Per Member Per Month (PMPM) payment, for each member for each calendar month, the OHH shall: (1) In collaboration with the member and other appropriate providers, develop and/or update the Plan of Care/ITP with pertinent information from monthly activities or developments in accordance with the provisions of this policy; (2) Submit cost and utilization reports upon request by the Department, in a format determined by the Department; (3) Scan the utilization data, as identified by the Department, for its assigned population; (4) The OHH must attest to meeting these requirements in order to be eligible to receive the PMPM reimbursement. (5) The OHH must document each service provided to each member, for each calendar month, in order to be eligible to receive the PMPM reimbursement. In addition to the requirements above, the minimum services required for billing under OHH include all of the following: (1) At least one office visit with the MAT prescriber and member each month; AND (2) The OHH must provide adequate counseling to address opioid substance use disorder. This counseling must be provided to each member at a minimum of one counseling session per month in the maintenance phase, twice monthly in the stabilization phase, and weekly in the induction phase; AND (3) Provision of (through dispensing on-site or a prescription to an outside pharmacy) a maximum of a thirty (30) day supply of medication; AND (4) Delivery of at least one health home services to an enrolled member within the reporting month, pursuant to the member's Plan of Care/Individual Treatment Plan (ITP). 4. In addition to the requirements, above and set forth in Chapter I, Section 1, of the MaineCare Benefits Manual, the OHH must maintain a specific record and documentation of services for each member receiving covered services. The member's record must minimally include: (1)Name, address, birthdate, and MaineCare identification number; (2) Diagnoses that support eligibility for services herein, including the most recent documentation of diagnoses that substantiate ongoing eligibility for services; (3) The comprehensive assessment that must occur within the first thirty (30) days of initiating of services, and any reassessments that occur; (4)The Plan of Care/ITP and any updates that occur; (5) Correspondence to and from other providers; (6) Release of information statements as necessary, signed by the member, including right notification, rules and regulations, confidentiality statement and release of information; (7) Documentation/record entries (i.e. progress notes) that clearly reflect implementation of the treatment plan and the member's response to treatment, as well as subsequent amendments to the plan. Progress notes for each service provided, including the date of service, the type of service, the place of the service or method of delivery (i.e., phone contact), the goal to which the service relates to, the duration of the service, the progress the member has made towards goal attainment, the signature and credentials of the individual performing the service, whether the individual has declined services in the Plan of Care/ITP, and timelines for obtaining needed services; and, (8) A record of discharge/transfer planning, beginning at admission and any referrals made. Providers shall maintain the confidentiality of information regarding these members in accordance with Chapter I, Section 1 of the MaineCare Benefits Manual, 42 C.F.R. §§ 431.301-306, 22 M.R.S.A. §1711-C, and with all other applicable sections of state and federal law and regulation. Payment will be made via MMIS after a transition period; MaineCare is currently using an external portal. OHH organizations must register as a user on the Department Portal. The OHH's authorized users attest that the OHH has performed the necessary "minimum billable activity" each month to receive payment for Section 93 members. 5. The State will review service utilization and rates annually to ensure that rates are economic and efficient based on analysis of costs and services provided by the Team of Health Care Professionals. MaineCare will continue to base payments on the costs of staff to provide health home services to the target populations. Rates are the same for government and private providers. Reimbursement for services that are not the 6 section 2703 Health Home services are reimbursed through other sections, see Supplement 1 to Attachment 4.19-B items 5 and 12, of the Maine Medicaid State Plan as applicable.

Health Homes Payment Methodologies

Package Header

Package ID	ME2018MS0017O	**SPA ID**	ME-18-0032
Submission Type	Official	**Initial Submission Date**	12/31/2018
Approval Date	8/7/2019	**Effective Date**	11/21/2018
Superseded SPA ID	ME-17-0006 System-Derived		

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 OHH providers must submit a certification request for authorization to Department or its authorized entity. During this authorization, the Department of its authorized entity ensures that the member is not receiving any duplicative services. Authorizations are denied or adjusted accordingly.

☑ 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

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0017O | ME-18-0032 | Opioid Health Home

Package Header

Package ID	ME2018MS0017O	**SPA ID**	ME-18-0032
Submission Type	Official	**Initial Submission Date**	12/31/2018
Approval Date	8/7/2019	**Effective Date**	11/21/2018
Superseded SPA ID	ME-17-0006		
	System-Derived		

Service Definitions

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

Comprehensive Care Management

Definition

The OHH will coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings for OHH eligible individuals. Levels of care management may change according to member needs over time. Care management is provided for members, with the involvement of the member's family or other support system, if desired by the member, in order to assist the member to implement a whole-person care plan and monitor the member's success in achieving goals. The OHH shall review all discharge plans, monitor and review medication and lab results, and regularly communicate about these efforts with the multi-disciplinary team. The OHH will establish and maintain relationships with the multidisciplinary team through outreach, planning, and communication in formulating and facilitating treatment recommendations. As part of care management, during intake, the OHH shall conduct a clinical comprehensive biopsychosocial assessment including issues regarding: addiction-focused history, patterns, durations, periods of sobriety, successful strategies used, physical and mental health (to include depression and anxiety), family history, education, legal, medications, social supports, allergies, housing, financial, nutritional , military, vocational, spirituality/religion, and leisure/recreational activities. Sufficient biopsychosocial screening assessments must be conducted to determine diagnosis, the level of care in which the member should be placed, and to identify treatment priorities for the Plan of Care/Individual Treatment Plan (ITP). A comprehensive assessment report and evidence of the member having had an annual physical exam must be documented in the medical record for each OHH member. Additionally, OHH providers shall develop a goal-oriented Plan of Care/ITP. This shall be implemented by the multi-disciplinary team, which includes the member. The Plan of Care/ITP shall be recorded in the member's record and in the OHH's electronic health record (EHR). The Plan of Care/ITP shall include the member's health goals, and the services and supports necessary to achieve those goals (including prevention, wellness, specialty care, behavioral health, transitional care and coordination, and social and community services as needed).The Plan of Care/ITP shall include measurable treatment objectives and activities designed to meet those objectives. The Plan of Care/ITP shall be developed within a maximum of thirty (30) days following the member's enrollment and updated every ninety (90) days thereafter. The Plan of Care/ITP must be reviewed if clinically indicated when a member's needs or circumstances change. The member's needs may be reassessed and the Plan of Care/ITP reviewed and amended more frequently than every ninety (90) days. The Plan of Care/ITP shall specify the services and supports that are to be furnished to meet the preferences, choices, abilities, and needs of the member. The plan must include measurable goals that are developed following clinical assessment of the member. The Plan of Care/ITP must include a dosage plan as documented by the OHH in the member's record.

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

Health Information Technology is used in a number of ways across the various services and as a core part of the OHH model. This includes the following requirements:
- All OHH providers must have access to and are required to complete a monthly review of utilization data for their member panel. This is a portal maintained by the Department and populated with timely claims data. The information in the portal is expected to assist providers in panel management by identifying gaps in care and high-risk individuals.
- OHH providers must comply with state laws regarding Maine's Prescription Monitoring Program (PMP). Compliance and engagement with the PMP is a key piece to managing the opioid epidemic in the State and in the delivery of the OHH model.
- OHH providers must utilize an electronic health record (EHR) system and create an EHR for each member that meets the interoperability standards set forth by the Department.
- OHH providers, as a core standard for participation, must demonstrate how they use an electronic data systems for monitoring, tracking and indicating levels of care complexity for the purposes of improving member care. The system must be used to support member care in one of more of the following ways: (1) The documentation of need and monitoring clinical care; (2) Supporting implementation and use of evidence-based practice guidelines; (3) Developing Plans of Care and related coordination; and (4) Determining outcomes.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

These providers may serve as the Clinical Team Lead, in which case these providers would oversee the development of the Plan of Care and direct care management activities across the OHH. This would include providing any necessary clinical oversight and input into the biophysical assessments. These providers may also oversee admissions and discharges from the program.

A behavioral health profession that is providing Clinical Counseling may provide care management by working with other care team members (including the member) and ensuring the comprehensive care plan is up to date.

☑ Nurse Practitioner

Description

These providers may serve as the Clinical Team Lead, in which case these providers would oversee the development of the Plan of Care and direct care management activities across the OHH. This would include providing any

necessary clinical oversight and input into the biophysical assessments. These providers may also oversee admissions and discharges from the program.

A Nurse practitioner that is the Nurse Care Manager has the primary responsibility for the implementation of OHH services and specific care plans. These providers are involved in overseeing all aspects of the OHH services.

The Medication Assisted Treatment provider may provide care management by working with other care team members (including the member) and ensuring the comprehensive care plan and the dosage plan are up to date.

- [x] Nurse Care Coordinators

Description

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

- [ ] Nurses
- [ ] Medical Specialists
- [x] Physicians

Description

These providers may serve as the Clinical Team Lead, in which case these providers would oversee the development of the Plan of Care and direct care management activities across the OHH. This would include providing any necessary clinical oversight and input into the biophysical assessments. These providers may also oversee admissions and discharges from the program.

The Medication Assisted Treatment provider may provide care management by working with other care team members (including the member) and ensuring the comprehensive care plan and the dosage plan are up to date.

- [x] Physician's Assistants

Description

These providers may serve as the Clinical Team Lead, in which case these providers would oversee the development of the Plan of Care and direct care management activities across the OHH. This would include providing any necessary clinical oversight and input into the biophysical assessments. These providers may also oversee admissions and discharges from the program.

The Medication Assisted Treatment provider may provide care management by working with other care team members (including the member) and ensuring the comprehensive care plan and the dosage plan are up to date.

- [ ] Pharmacists
- [x] Social Workers

Description

These providers may serve as the Clinical Team Lead, in which case these providers would oversee the development of the Plan of Care and direct care management activities across the OHH. This would include providing any necessary clinical oversight and input into the biophysical assessments. These providers may also oversee admissions and discharges from the program.

A licensed social worker that is the Clinical Counselor may provide care management by working with other care team members (including the member) and ensuring the comprehensive care plan is up to date.

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

Provider Type	Description
Peer Recovery Coach	The Peer Recovery Coach and Patient Navigator provides support to the patient across all services. This may include contacting the member to answer any questions and provide any support in navigating services.

Care Coordination

Definition

Care Coordination is a required service for all OHH members. Care coordination is primarily the responsibility of the patient navigator, but may also be provided by any member of the multi-disciplinary OHH team.
The OHH shall provide intensive and comprehensive care coordination to address the complex needs of OHH members and help OHH members overcome any

barriers to care by facilitating access to all clinical and non-clinical health-care related needs and services as appropriate to meet the individual member's treatment needs. Forms of care coordination may include but, are not limited to the following, if medically indicated:

1. Assistance in accessing health care and follow-up care, including long-term care services and supports;
2. Assessing housing needs; and providing assistance to access and maintain safe/affordable housing;
3. Assessing employment needs and providing assistance to access and maintaining employment;
4. Conducting outreach to family members and others to support connections to services and expand social networks;
5. Assistance in locating community social, legal, medical, behavioral healthcare and transportation services; and
6. Maintaining frequent communication with other team providers to monitor health status, medical conditions, medications, and medication side effects.

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

Health Information Technology is used in a number of ways across the various services and as a core part of the OHH model. This includes the following requirements:
- All OHH providers must have access to and are required to complete a monthly review of utilization data for their member panel. This is a portal maintained by the Department and populated with timely claims data. The information in the portal is expected to assist providers in panel management by identifying gaps in care and high-risk individuals.
- OHH providers must comply with state laws regarding Maine's Prescription Monitoring Program (PMP). Compliance and engagement with the PMP is a key piece to managing the opioid epidemic in the State and in the delivery of the OHH model.
- OHH providers must utilize an electronic health record (EHR) system and create an EHR for each member that meets the interoperability standards set forth by the Department.
- OHH providers, as a core standard for participation, must demonstrate how they use an electronic data systems for monitoring, tracking and indicating levels of care complexity for the purposes of improving member care. The system must be used to support member care in one of more of the following ways: (1) The documentation of need and monitoring clinical care; (2) Supporting implementation and use of evidence-based practice guidelines; (3) Developing Plans of Care and related coordination; and (4) Determining outcomes.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

These providers may serve as the Clinical Team Lead, in which case they would provide any assistance in assessing member needs and in facilitating access to health care or other resources.

These providers may also be Clinical Counselors or Patient Navigators in which case they would be responsible for maintaining frequent communication with other team providers to monitor health status, member goals, etc.

☑ Nurse Practitioner

Description

These providers may serve as the Clinical Team Lead, in which case they would provide any assistance in assessing member needs and in facilitating access to health care or other resources.

As the Nurse Care Manager or Patient Navigator, this provider would have the primary responsibility of care coordination, including items 1-6 in the service description. These providers address the complex needs of OHH members and help OHH members overcome any barriers to care by providing access to all clinical and non-clinical health-care related needs and services as appropriate to meet the individual member's treatment.

If a Nurse Practitioner were the Medication Assisted Treatment provider they would be responsible for maintaining frequent communication with other team providers to monitor health status, medications, etc.

☑ Nurse Care Coordinators

Description

The Nurse Care Manager or Patient Navigator has the primary responsibility of care coordination, including items 1-6 in the service description. These providers address the complex needs of OHH members and help OHH members overcome any barriers to care by providing access to all clinical and non-clinical health-care related needs and services as appropriate to meet the individual member's treatment.

☐ Nurses

☐ Medical Specialists

☑ Physicians

Description

These providers may serve as the Clinical Team Lead, in which case they would provide any assistance in assessing member needs and in facilitating access to health care or other resources.

The Medication Assisted Treatment provider is responsible for maintaining frequent communication with other team providers to monitor health status, medications, etc.

☑ Physician's Assistants

Description

These providers may serve as the Clinical Team Lead, in which case they would provide any assistance in assessing member needs and in facilitating

access to health care or other resources.

If a Physician's Assistant were the Medication Assisted Treatment provider they would be responsible for maintaining frequent communication with other team providers to monitor health status, medications, etc.

☐ Pharmacists

☑ Social Workers

Description

These providers may serve as the Clinical Team Lead, in which case they would provide any assistance in assessing member needs and in facilitating access to health care or other resources.

These providers may also be Clinical Counselors or Patient Navigators in which case they would be responsible for maintaining frequent communication with other team providers to monitor health status, member goals, etc.

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

☐ Dieticians

☐ Nutritionists

☑ Other (specify)

Provider Type	Description
Peer Recovery Coach or Patient Navigator	The Peer Recovery Coach or Patient Navigator provides support to the patient across all services. This may include contacting the member to answer any questions and provide any support in navigating services.

Health Promotion

Definition

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

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

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

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

Health Information Technology is used in a number of ways across the various services and as a core part of the OHH model. This includes the following requirements:
- All OHH providers must have access to and are required to complete a monthly review of utilization data for their member panel. This is a portal maintained by the Department and populated with timely claims data. The information in the portal is expected to assist providers in panel management by identifying gaps in care and high-risk individuals.
- OHH providers must comply with state laws regarding Maine's Prescription Monitoring Program (PMP). Compliance and engagement with the PMP is a key piece to managing the opioid epidemic in the State and in the delivery of the OHH model.
- OHH providers must utilize an electronic health record (EHR) system and create an EHR for each member that meets the interoperability standards set forth by the Department.
- OHH providers, as a core standard for participation, must demonstrate how they use an electronic data systems for monitoring, tracking and indicating levels of care complexity for the purposes of improving member care. The system must be used to support member care in one of more of the following ways: (1) The documentation of need and monitoring clinical care; (2) Supporting implementation and use of evidence-based practice guidelines; (3) Developing Plans of Care and related coordination; and (4) Determining outcomes.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

These providers may serve as the Clinical Team Lead, in which case they would assist in developing prevention, self-management, and other health promotion plans. These providers would be involved in establishing best practice in these areas.

These providers may also be Clinical Counselors or Patient Navigators in which case they would be responsible for providing one-on-one health

education, working on behavioral techniques, and implementing any health promotion plans.

- [x] Nurse Practitioner

Description

These providers may serve as the Clinical Team Lead, in which case they would assist in developing prevention, self-management, and other health promotion plans. These providers would be involved in establishing best practice in these areas.

As the Nurse Care Manager or Patient Navigator, these providers would be responsible for supporting and implementing any health promotion plans, including providing any one-on-one support between other formal appointments.

If this provider were the Medication Assisted Treatment provider they would be responsible for engaging with the OHH providers and coordinating health promotion activities and strategies.

- [x] Nurse Care Coordinators

Description

As the Nurse Care Manager or Patient Navigator, these providers would be responsible for supporting and implementing any health promotion plans, including providing any one-on-one support between other formal appointments.

- [ ] Nurses
- [ ] Medical Specialists
- [x] Physicians

Description

These providers may serve as the Clinical Team Lead, in which case they would assist in developing prevention, self-management, and other health promotion plans. These providers would be involved in establishing best practice in these areas.

If this provider were the Medication Assisted Treatment provider they would be responsible for engaging with the OHH providers and coordinating health promotion activities and strategies.

- [x] Physician's Assistants

Description

These providers may serve as the Clinical Team Lead, in which case they would assist in developing prevention, self-management, and other health promotion plans. These providers would be involved in establishing best practice in these areas.

If this provider were the Medication Assisted Treatment provider they would be responsible for engaging with the OHH providers and coordinating health promotion activities and strategies.

- [ ] Pharmacists
- [x] Social Workers

Description

These providers may serve as the Clinical Team Lead, in which case these providers would assist in developing prevention, self-management, and other health promotion plans. These providers would be involved in establishing best practice in these areas.

These providers may also be Clinical Counselors or Patient Navigators in which case they would be responsible for providing one-on-one health education, working on behavioral techniques, and implementation of the health promotion plan.

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

Provider Type	Description
Peer Recovery Coach	The Peer Recovery Coach provides support to the patient across all services. This may include contacting the member to answer any questions and provide any support in navigating services.

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

Definition

Comprehensive Transitional care services are designed to ensure continuity and coordination of care and prevent the unnecessary use of the ED and hospitals. A. When possible, the OHH shall collaborate with hospital EDs, discharge planners, long-term care, corrections, probation and parole staff, residential treatment programs, primary care and specialty mental health and substance use disorder treatment services to provide transitional services. As clinically appropriate, the OHH shall work with the member to ensure that the member remains engaged or re-engages in an appropriate level of care for opioid use disorder following an absence in treatment from the OHH. As clinically appropriate, the OHH shall work with discharge planners to schedule follow-up appointments with primary or specialty care providers within seven (7) calendar days of discharge and work with members to ensure attendance at scheduled appointments. B. The OHH shall assist the member and family, guardian(s), or caregivers, as appropriate, with the discharge process, including outreach in order to assist the member with returning to treatment for OUD in the community, transition planning, and work to prevent avoidable readmissions after discharge. C. The OHH shall attempt to follow up with each member following an inpatient hospitalization, use of crisis service, incarceration, or out -of -home placement. D. The OHH shall assist the member in exploration of less restrictive alternatives to hospitalization/ institutionalization. E. As allowed by law, the OHH shall provide timely and appropriate follow up communications on behalf of transitioning members, which includes a clinical hand off, timely transmission and receipt of the transition/discharge plan, review of the discharge records, and coordination of medication reconciliation. related to the member's OHH treatment. OHH providers must maintain documentation of all processes and procedures described below in an operating manual that is available for review by the Department upon request.

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

Health Information Technology is used in a number of ways across the various services and as a core part of the OHH model. This includes the following requirements:
- All OHH providers must have access to and are required to complete a monthly review of utilization data for their member panel. This is a portal maintained by the Department and populated with timely claims data. The information in the portal is expected to assist providers in panel management by identifying gaps in care and high-risk individuals.
- OHH providers must comply with state laws regarding Maine's Prescription Monitoring Program (PMP). Compliance and engagement with the PMP is a key piece to managing the opioid epidemic in the State and in the delivery of the OHH model.
- OHH providers must utilize an electronic health record (EHR) system and create an EHR for each member that meets the interoperability standards set forth by the Department.
- OHH providers, as a core standard for participation, must demonstrate how they use an electronic data systems for monitoring, tracking and indicating levels of care complexity for the purposes of improving member care. The system must be used to support member care in one of more of the following ways: (1) The documentation of need and monitoring clinical care; (2) Supporting implementation and use of evidence-based practice guidelines; (3) Developing Plans of Care and related coordination; and (4) Determining outcomes.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

These providers may serve as the Clinical Team Lead, in which case they would provide clinical guidance and consultation with other providers to assist in safe transitions between care settings.

These providers may also be Clinical Counselors or Patient Navigators in which case they would be part of the care team working to ensure continuity of care and services.

☑ Nurse Practitioner

Description

These providers may serve as the Clinical Team Lead or Medication Assisted Treatment Prescriber, in which case they would provide clinical guidance and consultation with other providers to assist in safe transitions between care settings.

As the Nurse Care Manager or Patient Navigator, these providers would have primary responsibility to work with facility discharge planners, the member, and other support systems, as appropriate and to follow-up with members after inpatient episodes. This provider will also oversee that all aspects of a safe transition are provided.

☑ Nurse Care Coordinators

Description

The Nurse Care Manager has primary responsibility to work with facility discharge planners, the member, and other support systems, as appropriate and to follow-up with members after inpatient episodes. This provider will also oversee that all aspects of a safe transition are provided.

☐ Nurses

☐ Medical Specialists

☑ Physicians

Description

These providers may serve as the Clinical Team Lead or Medication Assisted Treatment Prescriber, in which case these providers would provide clinical guidance and consultation with other providers to assist in safe transitions between care settings.

☑ Physician's Assistants

Description

These providers may serve as the Clinical Team Lead or Medication Assisted Treatment Prescriber, in which case these providers would provide clinical guidance and consultation with other providers to assist in safe transitions between care settings.

☐ Pharmacists

☑ Social Workers

Description

These providers may serve as the Clinical Team Lead, in which case these providers would provide clinical guidance and consultation with other providers to assist in safe transitions between care settings.

These providers may also be Clinical Counselors or Patient Navigators in which case they would be part of the care team working to ensure continuity of care and services.

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

Provider Type	Description
Peer Recovery Coach	The Peer Recovery Coach provides support to the patient across all services. This may include contacting the member to answer any questions and provide any support in navigating services.

Individual and Family Support (which includes authorized representatives)

Definition

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

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

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

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

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

Health Information Technology is used in a number of ways across the various services and as a core part of the OHH model. This includes the following requirements:
- All OHH providers must have access to and are required to complete a monthly review of utilization data for their member panel. This is a portal maintained by the Department and populated with timely claims data. The information in the portal is expected to assist providers in panel management by identifying gaps in care and high-risk individuals.
- OHH providers must comply with state laws regarding Maine's Prescription Monitoring Program (PMP). Compliance and engagement with the PMP is a key piece to managing the opioid epidemic in the State and in the delivery of the OHH model.
- OHH providers must utilize an electronic health record (EHR) system and create an EHR for each member that meets the interoperability standards set forth by the Department.
- OHH providers, as a core standard for participation, must demonstrate how they use an electronic data systems for monitoring, tracking and indicating levels of care complexity for the purposes of improving member care. The system must be used to support member care in one of more of the following ways: (1) The documentation of need and monitoring clinical care; (2) Supporting implementation and use of evidence-based practice guidelines; (3) Developing Plans of Care and related coordination; and (4) Determining outcomes.

Scope of service

The service can be provided by the following provider types

- [x] Behavioral Health Professionals or Specialists

Description

These providers may serve as the Clinical Team Lead, in which case these providers would participate in meetings with individual and family supports, as appropriate.

These providers may also be Clinical Counselors or Patient Navigators in which case they would ensure that the member is offered options to participate in support groups and that individuals that the member identifies, are engaged in the member's treatment, as appropriate.

- [x] Nurse Practitioner

Description

These providers may serve as the Clinical Team Lead, in which case these providers would participate in meetings with individual and family supports, as appropriate.

As Nurse Care Manager or Patient Navigator, this provider engages with the member and any identified individual and family supports on a regular basis and facilitates meetings with or feedback to other providers, as appropriate.

These providers may also be Medication Assisted Treatment Prescribers in which case they would ensure that individuals that the member identifies, are engaged in the member's treatment, as appropriate.

- [x] Nurse Care Coordinators

Description

As Nurse Care Manager or Patient Navigator, this provider engages with the member and any identified individual and family supports on a regular basis and facilitates meetings with or feedback to other providers, as appropriate.

- [ ] Nurses
- [ ] Medical Specialists
- [x] Physicians

Description

These providers may serve as the Clinical Team Lead, in which case these providers would participate in meetings with individual and family supports, as appropriate.

These providers may also be Medication Assisted Treatment Prescribers in which case they would ensure that individuals that the member identifies, are engaged in the member's treatment, as appropriate.

- [x] Physician's Assistants

Description

These providers may serve as the Clinical Team Lead, in which case these providers would participate in meetings with individual and family supports, as appropriate.

These providers may also be Medication Assisted Treatment Prescribers in which case they would ensure that individuals that the member identifies, are engaged in the member's treatment, as appropriate.

- [ ] Pharmacists
- [x] Social Workers

Description

These providers may serve as the Clinical Team Lead, in which case these providers would participate in meetings with individual and family supports, as appropriate.

These providers may also be Clinical Counselors or Patient Navigators in which case they would ensure that the member is offered options to participate in support groups and that individuals that the member identifies, are engaged in the member's treatment, as appropriate.

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

Provider Type	Description
Peer Recovery Coach	The Peer Recovery Coach provides support to the patient across all services. This may include contacting the member to answer any questions and provide any support in navigating services.

Referral to Community and Social Support Services

Definition

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

The OHH shall provide referrals based on the assessment and member's care plan as appropriate. Referrals will be made through telephone or in person and may include electronic transmission of requested data. The OHH shall follow through on referrals to encourage the member to connect with the services. The OHH shall provide referrals to community, social support and recovery services to members, connect members to community and social service support organizations that offer supports for self-management and healthy living, as well as social service needs such as transportation assistance, housing, literacy, employment, economic and other assistance to meet basic needs.

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

Health Information Technology is used in a number of ways across the various services and as a core part of the OHH model. This includes the following requirements:
- All OHH providers must have access to and are required to complete a monthly review of utilization data for their member panel. This is a portal maintained by the Department and populated with timely claims data. The information in the portal is expected to assist providers in panel management by identifying gaps in care and high-risk individuals.
- OHH providers must comply with state laws regarding Maine's Prescription Monitoring Program (PMP). Compliance and engagement with the PMP is a key piece to managing the opioid epidemic in the State and in the delivery of the OHH model.
- OHH providers must utilize an electronic health record (EHR) system and create an EHR for each member that meets the interoperability standards set forth by

the Department.
- OHH providers, as a core standard for participation, must demonstrate how they use an electronic data systems for monitoring, tracking and indicating levels of care complexity for the purposes of improving member care. The system must be used to support member care in one of more of the following ways: (1) The documentation of need and monitoring clinical care; (2) Supporting implementation and use of evidence-based practice guidelines; (3) Developing Plans of Care and related coordination; and (4) Determining outcomes.

Scope of service

The service can be provided by the following provider types

☑ Behavioral Health Professionals or Specialists

Description

As the Clinical Team Lead, this provider may be required to make certain referrals and collaborate with other treating providers, in coordination with the full care team.

As the Clinical Counselor, this provider is expected to make appropriate referrals to community and social service support organizations, as appropriate and in coordination with the full care team.

All members of the care team are to be engaged in following through with referrals.

☑ Nurse Practitioner

Description

As the Clinical Team Lead, this provider may be required to make certain referrals and collaborate with other treating providers.

As the Medication Assisted Treatment Prescriber, this provider would work with the full care team to make any appropriate referrals.

As Nurse Care Manager, this provider is primarily responsible for ensuring referrals are made for social services. This provider also assists in ensuring follow through of all other referrals through outreach to the member and other providers.

All members of the care team are to be engaged in following through with referrals.

☑ Nurse Care Coordinators

Description

As Nurse Care Manager, this provider is primarily responsible for ensuring referrals are made for social services. This provider also assists in ensuring follow through of all other referrals through outreach to the member and other providers.

☐ Nurses

☐ Medical Specialists

☑ Physicians

Description

As the Clinical Team Lead, this provider may be required to make certain referrals and collaborate with other treating providers.

As the Medication Assisted Treatment Prescriber, this provider would work with the full care team to make any appropriate referrals.

All members of the care team are to be engaged in following through with referrals.

☑ Physician's Assistants

Description

As the Clinical Team Lead, this provider may be required to make certain referrals and collaborate with other treating providers.

As the Medication Assisted Treatment Prescriber, this provider would work with the full care team to make any appropriate referrals.

All members of the care team are to be engaged in following through with referrals.

☐ Pharmacists

☑ Social Workers

Description

As the Clinical Team Lead, this provider may be required to make certain referrals and collaborate with other treating providers.

As the Clinical Counselor, this provider is expected to make appropriate referrals to community and social service support organizations, as appropriate and in coordination with the full care team.

☐ Doctors of Chiropractic

☐ Licensed Complementary and alternative Medicine Practitioners

- [ ] Dieticians
- [ ] Nutritionists
- [x] Other (specify)

Provider Type	Description
Peer Recovery Coach	The Peer Recovery Coach provides support to the patient across all services. This may include contacting the member to answer any questions and provide any support in navigating services.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | ME2018MS0017O | ME-18-0032 | Opioid Health Home

Package Header

Package ID	ME2018MS0017O	**SPA ID**	ME-18-0032
Submission Type	Official	**Initial Submission Date**	12/31/2018
Approval Date	8/7/2019	**Effective Date**	11/21/2018
Superseded SPA ID	ME-17-0006		
	System-Derived		

Health Homes Patient Flow

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

A member and provider will discuss options related to treatment of the member's opioid dependency. This will include discussing the different service delivery options (e.g. what is included, who is on the team, what is considered duplicative, etc.). If a member elects to receive OHH services, the provider will submit for authorization through the Department or its authorized agent. If approved, the member may begin services and the provider is eligible for reimbursement for OHH services. If duplication exists, the OHH services will be denied and this will need to be discussed with the member to determine how they would like to proceed. This is a conversation about treatment goals, duplication, services, etc. The member has freedom to choose between services for which they are eligible. If the member still would like to receive OHH services, the provider will work with the existing provider (from the duplicative service) on a transition plan.

Name	Date Created	
OHHPatientFlowIV	9/28/2017 10:15 AM EDT	

This view was generated on 8/13/2019 3:51 PM EDT