**TABLE OF CONTENTS**

93.01 **DEFINITIONS** 1

93.01-1 American Society of Addiction Medicine (ASAM) Criteria 1

93.01-2 Community Health Worker (CHW) 1

93.01-3 Medication Plan 1

93.01-4 Electronic Health Record (EHR) 1

93.01-5 Integrated Medication Assisted Treatment (IMAT) 1

93.01-6 Intensive Outpatient Services (IOP) Level of Care 1

93.01-7 Induction Level of Care 1

93.01-8 Maintenance Level of Care 2

93.01-9 Medication Plus Level of Care 2

93.01-10 Methadone Level of Care 2

93.01-11 Opioid Health Home (OHH) 2

93.01-12 Opioid Treatment Program 2

93.01-13 Plan of Care/Individual Treatment Plan (ITP) 2

93.01-14 Stabilization Level of Care 2

93.02 **PROVIDER REQUIREMENTS** 2

93-02-1 Opioid Health Home (OHH) Requirements 3

93.02-2 Core Standards 7

93.03 **MEMBER ELIGIBILITY** 10

93.03-1 General Eligibility 10

93.03-2 Specific Requirements 10

93.03-3 Eligibility Certification 11

93.04 **POLICIES AND PROCEDURES FOR MEMBER IDENTIFICATION**

**AND ENROLLMENT** 11

93.04-1 Member Identification 11

93.04-2 Enrollment and Duplication of Services 11

93.04-3 ASAM Criteria 12

93.05 **COVERED SERVICES** 12

93.05-1 Health Home Services 13

93.05-2 Comprehensive Assessment 16

93.05-3 Office Visit with MOUD Prescriber 18

93.05-4 Counseling Addressing Opioid Dependency 18

93.05-5 Medication 19

93.05-6 Urine Drug Screening 19

93.06 **REPORTING REQUIREMENTS** 19

93.07 **DOCUMENTATION AND CONFIDENTIALITY** 20

93.08 **REIMBURSEMENT** 21

93.08-1 Minimum Requirements for OHH Reimbursement 21

93.08-2 Minimum Requirements for Additional Provider Support 22

93.08-3 Pay-for-Performance 22

93.08-4 Duplicative Services will not be Reimbursed 22

93.09 **BILLING INSTRUCTIONS** 23

**93.01 DEFINITIONS**

**93.01-1** **American Society of Addiction Medicine (ASAM) Criteria** – Level of care criteria that establish what services are medically necessary for a member.

**93.01-2** **Community Health Worker (CHW) –** A trained (as described in 93.02-1(E)(5)) health worker who applies their unique understanding of the experience, socio-economic needs, language and/or culture to advocate for individual and community needs and acts as a bridge between providers and individuals to promote health, reduce disparities, and improve service delivery. CHWs are distinguished from other health professionals because they are hired primarily for their understanding of the populations and communities they serve, conduct outreach a significant portion of the time, and have experience providing services in community settings (adapted from the Maine State Innovation Model definition).

**93.01-3 Medication Plan –** An individualized medication-related treatment plan developed by the Medication for Opioid Use Disorder (MOUD) prescriber specifically for the member based on the results of the Comprehensive Biopsychosocial Assessment, diagnoses, level of care required, and treatment priorities.

**93.01-4 Electronic Health Record (EHR)** – An EHR means a systematic collection of electronic health information about individual MaineCare members. It is a record in digital format that is capable of being shared across different health care settings by a Department-designated health information exchange(s) (HIE), a Department-designated network connected enterprise-wide information system(s), and other information networks or exchanges. An EHR supports Clinical EHR functions, such as intake, clinical care, task management, and case management where appropriate, and has HL7 interoperability capabilities to support the electronic sharing of portions of the patient’s record.

**93.01-5 Integrated Medication Assisted Treatment (IMAT) –** Acombination of medication approved by the federal Food and Drug Administration for the treatment of substance use disorder with counseling, urine drug screening, and behavioral therapy that has proven effective in treating substance use disorder.

**93.01-6 Intensive Outpatient Services (IOP) Level of Care –** This level of care includes members in the induction phase of treatment who require OHH sites that operate an IOP in accordance with *MaineCare Benefits Manual (MBM), Ch. II, Section 65.06-5*. This Level of Care is expected to last no more than sixty (60) days per induction and shall not exceed six (6) months in a twelve (12)-month period.

**93.01-7 Induction Level of Care –** This level of care includes members in the induction phase of treatment who do not require the IOP Level of Care. This Level of Care is expected to last no more than sixty (60) days per induction and shall not exceed six (6) months in a twelve (12)-month period.

**93.01 DEFINITIONS** (cont.)

**93.01-8 Maintenance Level of Care –** This level of care includes members in the maintenance phase of treatment.

**93.01-9** **Medication Plus Level of Care –** This level of care includes members in any phase of clinical treatment who only receive the services described in 93.05-1, 93.05-2, 93.05-3, 93.05-5, and 93.05-6.

**93.01-10 Methadone Level of Care –** This level of care includes members who are receiving methadone treatment services under *MBM, Section 65* and who are also receiving the services described in 93.05-1, Health Home Services, from an OHH provider.

**93.01-11 Opioid Health Home (OHH)** – A group of providers that furnishes IMAT and MOUD services based on an integrated care delivery model focused on whole-person treatment which may include, but is not limited to, counseling, care coordination, MOUD, recovery coach support, urine drug screening, and medical consultation for individuals who have been diagnosed with an opioid dependency. An OHH is a team of providers that has completed an application and been approved by the Department to provide OHH services.

**93.01-12** **Opioid Treatment Program (OTP)** – An accredited treatment program with Substance Abuse and Mental Health Services Administration (SAMHSA) certification and Drug Enforcement Agency (DEA) registration to administer and dispense opioid agonist medications that are approved by Federal Drug Administration to treat opioid addiction.

**93.01-13 Plan of Care/Individual Treatment Plan (ITP)** – The Plan of Care/ITP is a care plan that describes, coordinates and integrates a member’s clinical data, as well as clinical and non-clinical health care-related needs and services. The Plan of Care/ITP shall also include member health goals, and the services and supports necessary to achieve those goals, with particular focus on the member’s opioid dependency. The Plan of Care/ITP may exist within the member’s Electronic Health Record (EHR).

**93.01-14** **Stabilization Level of Care –** This level of care includes members who have discontinued or greatly reduced their substance use, no longer have cravings, and have few or no side effects.

**93.02** **PROVIDER REQUIREMENTS**

The OHH must meet the following requirements. OHH providers must maintain documentation of all processes and procedures described below in an operating manual that is available for review by the Department upon request.

**93.02** **PROVIDER REQUIREMENTS** (cont.)

**93.02-1 Opioid Health Home (OHH) Requirements**

1. The OHH must execute a MaineCare Provider Agreement. The OHH is subject to applicable state and federal Medicaid law, including but not limited to the MBM, Chapter I, Section 1.
2. The OHH must be approved as an OHH by the Department through the OHH application process.
3. 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.
4. 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. The OHH delivers a team-based model of care through a team of employed or contracted personnel. The team must include at least the personnel identified in this sub-section. Unless otherwise specified, each role must be filled by a different individual; the Department reserves the right to waive this requirement based on team member professional experience and training. If there is a lapse in fulfillment of team member roles of greater than thirty (30) continuous days, the OHH must notify the Department in writing and maintain records of active recruitment to fill the position(s).

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

1. **Clinical Team Lead** – A licensed clinical professional with significant experience treating individuals with substance use disorders, who may be a physician, physician’s assistant, psychologist, Licensed Clinical Social Worker (LCSW), Licensed Clinical Professional Counselor (LCPC), Licensed Alcohol and Drug Counselor – Certified Clinical Supervisor (LADC-CCS) or Advanced Practice Registered Nurse (APRN).

The Clinical Team Lead shall coordinate the care management activities across the OHH, ensure that there is a current Plan of Care/ITP for each member, and ensure that there is appropriate supervision of the Recovery Coach.

**93.02** **PROVIDER REQUIREMENTS** (cont.)

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

1. **MOUD prescriber** – A licensed health care professional with authority to prescribe buprenorphine.

OHH MOUD prescribers provide services for the chronic condition of opioid dependence through an office-based opioid treatment setting and shall be trained and authorized to prescribe buprenorphine, buprenorphine derivatives, and naltrexone for opioid dependence.

OHH MOUD prescribers must have completed any applicable federally required training and hold the appropriate X-DEA license to prescribe buprenorphine in an office-based setting. They are required to adhere to Maine’s Office of Substance Abuse and Mental Health Services, 14-118 C.M.R. Chapter 11, *Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications*.

For members in the Methadone Level of Care who receive OHH services from an OTP, this role may be filled by a practitioner licensed under state and federal law to order, administer, or dispense opioid agonist treatment medications.

For members in the Methadone Level of Care who receive OHH services from a non-OTP OHH, the MOUD Prescriber must coordinate with the OTP.

All MOUD prescribers must be involved in the services described under Section 93.05-1. Activities may include, but are not limited to, participating in team meetings, assisting with the coordination of care across specialty and primary care providers, assessing risk of and discussing with the member potential medication interactions, and providing assistance and guidance in ensuring physical and behavioral health issues are addressed through screening, care coordination, and health promotion.

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

1. A registered nurse, psychiatric nurse licensed as a registered professional nurse and certified by the American Nurses Credentialing Center (ANCC) as a psychiatric and mental health nurse (PMHN), APRN (as defined by the Maine State Board of Nursing), or a Licensed Practical Nurse (LPN) 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 (6) months of initiating service delivery for OHH members. These providers may not

**93.02** **PROVIDER REQUIREMENTS** (cont.)

continue functioning as a Nurse Care Manager for more than six (6) months without completing the appropriate training; or

b. An APRN who holds their X-DEA license.

The Nurse Care Manager shall contribute to implementation, coordination, and oversight of each OHH member’s Plan of Care/ITP, assist in the coordination of care with outside providers, and communicate barriers to adherence as appropriate to the team, including the Clinical Team Lead.

The Nurse Care Manager position may be filled by another appropriate licensed medical professional on the OHH team, as long as the individual also meets the qualifications described above.

4. **Clinical Counselor who supports individuals with (OUD)** – The Clinical Counselor must be:

1. A clinical professional with a minimum certification as a Certified Alcohol and Drug Counselor (CADC) or LADC; or
2. A LCSW, Licensed Master Social Worker – Conditional Clinical (LMSW-CC), LCPC, Licensed Clinical Professional Counselor – Conditional (LCPC-C), or Licensed Marriage and Family Therapist (LMFT) or Licensed Marriage and Family Therapist – Conditional (LMFT-C):
   * 1. Who has completed a minimum of sixty (60) hours of alcohol and drug education within the last five (5) years; or
     2. Who, within a maximum of five (5) years of initiating service delivery for OHH services, has completed sixty (60) hours of alcohol and drug education.

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

The Clinical Counselor provides counseling related to opioid dependency and individual or group substance use disorder outpatient therapy for members receiving counseling. For all members, the Clinical Counselor provides behavioral health expertise and contributes to care planning, assessment of individual care needs, and identification of and connection to behavioral health services, as part of the services described in 93.05-1.

1. **Patient Navigator** – The Patient Navigator must:
   1. Have at least one (1) year of job experience in a health/social services or behavioral health setting and hold an Associate’s degree; or
   2. Be a Mental Health Rehabilitation Technician/Community (MHRT/C) with at least one (1) year of related work experience; or
   3. Have a Bachelor’s degree from an accredited four-year institution of higher learning; or

**93.02** **PROVIDER REQUIREMENTS** (cont.)

* 1. Be a medical assistant;or
  2. Be an LPN; or
  3. Be a registered nurse; or
  4. Be the Nurse Care Manager described in 93.02-1(E)(3); or
  5. Be the Clinical Counselor described in 93.02-1(E)(4); or
  6. Be a Community Health Worker (CHW) who has completed a training program with a curriculum approved by the Department, or their designee, that includes both relevant CHW core competencies and training specific to OUD treatment and recovery; or holds a Maine CHW certification or registration (effective the date such a designation becomes active in the State of Maine).

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

1. **Recovery Coach** – The Recovery Coach must:
2. Be an individual in long-term recovery or a recovery ally, and
3. Effective upon rule adoption, complete the 30-hour Connecticut Community for Addiction Recovery (CCAR) training, or other Department-approved Recovery Coach training, within six (6) months of the rule adoption date or within six (6) months of beginning to deliver OHH services, whichever is later.

Recovery Coaches who are themselves in long-term recovery are encouraged and preferred, as their life experiences and recovery allow them to provide recovery support in such a way that others can benefit from their experiences.

1. The OHH must adhere to applicable licensing standards regarding documentation of all OHH providers’ qualifications in their personnel files. Pursuant to applicable licensing standards, the OHH must have a review processto ensure that employees providing OHH services possess the minimum qualifications set forth above.
2. If an OHH member has a primary care provider, the OHH must establish a relationship with that primary care provider, authorized and evidenced by a signed medical release.\* Such a release is not required when the member’s primary care provider is also the member’s provider within the OHH.

\*The Department shall seek and anticipates receiving approval for this section from the Centers for Medicare and Medicaid Services (CMS). Pending approval, covered services will be provided as described in this policy.

**93.02** **PROVIDER REQUIREMENTS** (cont.)

1. The OHH shall ensure that it has policies and procedures in place to ensure that the Clinical Team Lead and other team members, as appropriate, can communicate any changes in patient condition that may necessitate treatment change with the member’s treating clinicians. This includes the requirement for establishing policies and procedures around coordination, including but not limited to, a signed medical release with the entities listed in 93.08(C) when applicable.
2. 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.

K. The OHH shall refer members to another OHH or appropriate provider when a member requires treatment or a level of care that the OHH does not offer.\*

\*The Department shall seek and anticipates receiving approval for this section from the CMS. Pending approval, covered services will be provided as described in this policy.

**93.02-2 Core Standards**

The OHH must demonstrate how it will meet the following Core Standards prior to approval to provide services. Within the first three (3) months following the start of the OHH’s participation, the OHH shall participate in an on-site assessment initiated by the Department, or its authorized agent, to establish a baseline in meeting the Core Standards and identify the OHH’s training and educational needs. For the remainder of the first year of participation, the OHH must submit quarterly reports on sustained implementation of the Core Standards. After the first year, the OHH may request the Department’s approval to submit the Core Standard progress report annually instead of quarterly.

The Core Standards are:

1. **Demonstrated Leadership** – The Clinical Team Lead of the OHH implements and oversees the Core Standards.

**93.02** **PROVIDER REQUIREMENTS** (cont.)

The Clinical Team Lead shall work with other providers and staff in the OHH to build a team-based approach to care, continually examine processes and structures to improve care, and assist with the review of data on the quality performance of the practice.

1. **Team-Based Approach to Care** – The OHH shall implement a team-based approach to care delivery that includes expanding the roles of non-physician providers (e.g. APRNs, physician assistants, nurses, medical assistants) and non-licensed staff (e.g. recovery coaches) to improve clinical workflows.

The OHH utilizes non-physician and non-licensed staff to improve access and efficiency of the practice team in specific ways, including one or more of the following:

1. Through clear identification of roles and responsibilities;
2. Integrating care management into clinical practice;
3. Expanding patient education; and
4. Providing greater data support to enhance the quality and cost-effectiveness of their clinical work.
5. **Population Risk Stratification and Management** – The OHH shall adopt processes to identify and stratify patients across their population who are at risk for adverse outcomes or are missing critical preventive services and/or other health screenings. The OHH shall also adopt procedures that direct resources or care processes to reduce those risks.

“Adverse outcomes,” for purposes of this provision, means a negative clinical outcome and/or avoidable use of healthcare services such as hospital admissions, ED visits, or non-evidence-based use of diagnostic testing or procedures.

1. **Enhanced Access** – The OHH shall enhance access to services for its population of patients, including:
2. The OHH shall have a system in place that allows members to have same-day access to an OHH team member using a form of care that meets the members’ needs – e.g. open-availability for same day access to an OHH team member, telephonic support, and/or secure messaging.

2. The OHH shall have processes in place to monitor and ensure access to care.

1. **Practice Integrated Care Management** – The OHH shall have processes in place to identify the need for and provide care management services.

**93.02** **PROVIDER REQUIREMENTS** (cont.)

Care management staff shall have clear roles and responsibilities, be integrated into the practice team, and receive explicit training to provide care management services.

Care management staff shall have processes for tracking outcomes for patients receiving care management services.

1. **Behavioral Physical Health Integration** – Upon approval as an OHH, the OHH shall complete a baseline assessment of its behavioral-physical health

integration capacity. Using results from this baseline assessment, the OHH shall implement one or more specific improvements to integrate behavioral and physical health care.

1. **Inclusion of Patients and Families** – The OHH shall include members and family members as documented and regular participants at leadership meetings. The OHH shall have in place a member and family advisory process to identify patient-centered needs and solutions for improving care in the practice.
2. The OHH shall have processes in place to support members and families to participate in these leadership and/or advisory activities.
3. The OHH shall have systems to gather member input, and family input when beneficial, at least annually (e.g. via mail survey, phone survey, point of care questionnaires, focus groups, etc.).
4. The OHH shall have processes in place to design and implement changes that address organizational needs and gaps in care identified via member and family input.
5. **Connection to Community Resources and Social Support Services –** The OHH shall have processes in place to identify local community resources and social support services.

The OHH shall have processes in place to routinely refer patients and families to local community resources and social support services, including those that provide self-management support to assist members in overcoming barriers to care and meeting health goals.

1. **Commitment to Reducing Waste, Unnecessary Healthcare Spending, and Improving Cost-effective Use of Healthcare Services** – The OHH shall have processes in place to reduce wasteful spending of healthcare resources and improve the cost-effective use of healthcare services as evidenced by at least one initiative that targets waste reduction, including one or more of the following:
2. Reducing avoidable hospitalizations;

**93.02** **PROVIDER REQUIREMENTS** (cont.)

1. Reducing avoidable ED visits; or
2. Working with the team to develop new processes and procedures that improve patient experience and quality of care, while reducing unnecessary use of services.

J. **Integration of Health Information Technology** – The OHH shall use an electronic data system that includes identifiers and utilization data about members. Member data is used for monitoring, tracking and indicating levels of care complexity for the purpose of improving member care.

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

1. The documentation of need and monitoring clinical care;
2. Supporting implementation and use of evidence-based practice guidelines;
3. Developing Plans of Care/ITPs and related coordination; or
4. Determining outcomes (e.g., clinical, functional, recovery, satisfaction, and cost outcomes).

**93.03 MEMBER ELIGIBILITY**

Members must meet the eligibility requirements set forth in this section.

**93.03-1 General Eligibility**

Members must meet the eligibility criteria described in Chapter I, Section 1 of the *MBM* and in the *MaineCare Eligibility Manual*, 10-144 Chapter 332.

**93.03-2 Specific Requirements**

All diagnoses and qualifying risk factors must be documented in the member’s Plan of Care/ITP.

Members must be diagnosed with Substance Use Disorder, Opioid (as set forth in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed. *DSM–5*)); AND have a second chronic condition OR be at risk of having a second chronic condition.

* 1. **Eligible Chronic Conditions as Second Chronic Condition**
  2. a mental health condition;
  3. an additional substance use disorder (other than OUD);
  4. tobacco use;

**93.03 MEMBER ELIGIBILITY** (cont.)

* 1. diabetes;
  2. heart disease;
  3. overweight or obese as evidenced by a body mass index over 25;
  4. Chronic Obstructive Pulmonary Disease (COPD);
  5. hypertension;
  6. hyperlipidemia;
  7. developmental and intellectual disorders;
  8. circulatory congenital abnormalities;
  9. asthma;
  10. acquired brain injury; and
  11. seizure disorders.
  12. **Definition of at Risk of another Chronic Condition**

Members shall be assessed by the OHH providers for high risk behaviors and other risk factors that may contribute to chronic conditions such as, but not limited to: smoking; obesity; poor nutrition; childhood trauma; risky sex practices; intravenous drug use; history of or current substance use other than opioids; and family health issues.

**93.03-3 Eligibility Certification**

Providers must submit certification requests to the Department or its authorized entity. Each member’s eligibility shall be based on a diagnosis rendered within the past year from the date of the certification request, as documented by a professional whose scope of practice includes the ability to diagnose. Reassessments shall occur at

least annually in order to ensure ongoing eligibility for services provided herein. Providers shall maintain a member’s eligibility verification in the member’s record.

**93.04 POLICIES AND PROCEDURES FOR MEMBER IDENTIFICATION AND ENROLLMENT**

**93.04-1 Member Identification**

The OHH provider shall identify members who are potentially eligible for OHH services based on the eligibility criteria for OHH Services. The OHH provider will submit potentially eligible members through a certification process to approve services.

**93.04-2 Enrollment and Duplication of Services**

A. **Enrollment.** The OHH Provider shall identify members for OHH based on the OHH eligibility criteria. Potentially eligible members shall be given information about the benefits of participating in an OHH. The member can choose to be part

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

of OHH once confirmed eligible. They must be approved through a certification process with the certification effective the earliest date without risk of duplicative services. The member can choose to not participate at any time by notifying their OHH provider or the Department’s authorized entity for certifications of OHH services.

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

The Department’s authorized entity will notify members that they cannot receive duplicative services and will keep a record of documentation as to the members’ choice of service.

C. **Requests and Referrals.** Members may request OHH services or be referred for OHH services by another MaineCare provider. The Department or its authorized entity shall approve or deny the enrollment of such members within three (3) business days of a request for services.

1. **Consent Forms.** OHH providers must retain a signed consent form for all OHH members in the member record. Consent documentation must, at a minimum:
   * 1. Indicate that the individual has received information in writing, and verbally as appropriate, explaining the OHH purpose and the services provided; and
     2. Indicate that the individual has consented in writing, and verbally as appropriate, to receive the OHH services and understand their right to choose, change, or disenroll from their OHH provider at any time.

**93.04-3 ASAM Criteria**

Members must be assessed for appropriateness of OHH services in alignment with the ASAM Criteria. Members must meet ASAM Level 0.5 or Level I for individual, family or group outpatient services. Members must meet ASAM Level II.1 or II.5 for Intensive Outpatient Services Level of Care.

**93.05 COVERED SERVICES**

OHHs shall provide the following six (6) covered services in accordance with the requirements in their respective subsections. For clarity, each member in the IOP, Induction, Stabilization, and Maintenance Levels of Care receives each covered service. For members in the Medication Plus Level of Care, which does not require counseling, OHHs shall provide each covered service

**93.03 COVERED SERVICES** (cont.)

except for 93.05-4, Counseling Addressing Opioid Dependency. For members in the Methadone Level of Care who receive methadone treatment services under *MBM, Section 65*, OHHs shall only provide 93.05-1, Health Home Services.

OHH services may be delivered, face-to-face, via phone or other media, in any community location where confidentiality can be maintained, as clinically appropriate. Not all aspects of OHH covered services require direct member involvement; however, all covered services require that provider activities be directly related to an individual member, are member-informed, and pursuant to the member’s Plan of Care/ITP.

**93.05-1 Health Home Services**

The OHH shall provide at least one of the following Health Home Services to each OHH member within the reporting month, pursuant to the member’s Plan of Care/ITP.

A. **Comprehensive Care Management**

Comprehensive care management is provided for members, with the involvement of the member’s family or other support system, if desired by the member, in order to assist the member to implement a whole-person care plan and monitor the member’s success in achieving goals. The OHH shall review all discharge plans, monitor and review medication and lab results, and regularly communicate about these efforts with the multi-disciplinary team. Levels of care management may change according to member needs over time.

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

B. **Care Coordination**

The OHH shall provide intensive and comprehensive care coordination to address the complex needs of OHH members and help OHH members overcome any barriers to care by providing access to all clinical and non-clinical health-related social 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;

**93.03 COVERED SERVICES** (cont.)

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

C. **Health Promotion**

The OHH shall provide health promotion services to encourage and support healthy behaviors and encourage self-management of health. OHH providers must provide and document efforts to connect each OHH member to a primary care provider. OHH health promotion activities may also include, but are not limited to the following:

1. Health education specific to opioid dependence and treatment;
2. Relapse prevention plans;
3. Health education and referral support regarding a member’s other chronic conditions or health-related risk factors (e.g. oral health, contraceptive counseling, screenings);
4. Development of self-management plans;
5. Behavioral techniques to promote healthy lifestyles;
6. Supports for managing chronic pain;
7. Smoking cessation and reduction in use of alcohol and other drugs
8. Nutritional counseling; and
9. Promotion of increased physical activity

**93.03 COVERED SERVICES** (cont.)

D. **Comprehensive Transitional Care**

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

1. When possible, the OHH shall collaborate with hospital EDs, discharge planners, long-term care facilities, corrections, probation and parole staff, residential treatment programs, primary care and specialty mental health and substance use disorder treatment services to provide transitional services. The OHH shall attempt to follow up with each member following an inpatient hospitalization, use of crisis services, incarceration, or out-of-home placement. 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 OUD following an absence in treatment from the OHH. As clinically appropriate, the OHH shall work with discharge planners to schedule follow-up appointments with primary or specialty care providers within seven (7) days of discharge and work with members to ensure attendance at scheduled appointments.
2. 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.
3. The OHH shall assist the member in exploration of less restrictive alternatives to hospitalization/ institutionalization.
4. 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.

E. **Individual and Family Support Services**

Individual and Family Support Services is a required service for all OHH members. This service may be provided by any member of the multi-disciplinary OHH team.

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.

**93.03 COVERED SERVICES** (cont.)

The OHH shall employ approaches which may include but are not limited to 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 use disorder supports and outreach to key caregivers, and assistance with adhering to treatment plans.

F. **Referral to Community and Social Support Services**

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 refer members to community, social support and recovery services including but not limited to resources and agencies that provide transportation, housing, and career planning/employment based upon individual needs identified through assessment and treatment planning processes.

**93.05-2 Comprehensive Assessment**

OHHs shall provide this covered service to each OHH member.

A. **Comprehensive Biopsychosocial Assessment**

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

1. Addiction-focused history, including patterns of use, durations or periods of sobriety, and successful strategies used;
2. Physical and mental health (to include any history of depression or anxiety);
3. Medications;
4. Allergies;
5. Family history;
6. Social supports;
7. Housing status;
8. Financial status;
9. Nutritional status;
10. Education;

**93.03 COVERED SERVICES** (cont.)

1. Military service, if applicable;
2. Legal issues;
3. Vocational background;
4. Spirituality and religious preferences; and
5. Leisure and recreational activities.

Qualified OHH staff shall conduct biopsychosocial screening and assessment to determine diagnosis, the level of care in which the member should be placed, and to identify treatment priorities for the Plan of Care/ITP. The OHH shall place and maintain a comprehensive assessment report and evidence of the member having had an annual physical exam in the medical record for each OHH member.

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

The multi-disciplinary OHH team, which must include the member, shall develop and implement a goal-oriented Plan of Care/ITP, which must be available for update and review by all OHH team members.

The Plan of Care/ITP must:

1. Be consented to by the member, as evidenced by the member’s signature on the Plan of Care/ITP, and included in the member’s record.
2. Include the member’s health goals and the services and supports necessary to achieve those goals (including prevention, wellness, specialty care, behavioral health, transitional care and coordination, and social and community services as needed).
3. Include measurable treatment objectives and activities designed to meet those objectives.
4. Be developed within a maximum of thirty (30) days following the member’s enrollment and updated every ninety (90) days thereafter.
5. Be reviewed when a member’s needs or circumstances change. The member’s needs may be reassessed and the Plan of Care/ITP reviewed and amended more frequently than every ninety (90) days.
6. Specify the services and supports that are to be furnished to meet the member’s preferences, choices, abilities, and needs.

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

**93.03 COVERED SERVICES** (cont.)

1. To provide comprehensive and maximally effective OUD care, include a Medication Plan which is documented by the OHH in the member’s record and modified as medically indicated by the member’s response to treatment.
2. Meet the requirements of Section 93.07, “Documentation and Confidentiality.”

**93.05-3 Office Visit with the MOUD Prescriber**

The OHH MOUD prescriber shall meet with each member, except for members in the Methadone Level of Care, at least one time per month. The office visit shall focus on the identified treatment priorities on the most up-to-date Plan of Care/ITP for the member, including, but not limited to, the member’s physical health, behavioral health, recovery-oriented goals, and the services and supports necessary to achieve those goals.

**93.05-4 Counseling Addressing Opioid Dependency**

A.The OHH shall provide adequate individual or group counseling sessions to address OUD to members in the IOP, Induction, Stabilization, and Maintenance Levels of Care. OHHs shall not provide this covered service to members in the Medication Plus or Methadone Levels of Care.

* + 1. Members in the IOP and Induction Levels of Care shall, at a minimum, engage in individual or group counseling for four billable hours per month\* (see note below).

* + 1. Members in the Stabilization Phase shall, at a minimum, engage in individual or group counseling for two billable hours monthly.
    2. Members in the Maintenance Level of Care shall, at a minimum, engage in individual or group counseling for one billable hour monthly.

\*NOTE: The expectation is that counseling will be one hour in duration for each required time period (weekly, biweekly, monthly), but this may be delivered in multiple member contacts, if clinically appropriate and documented in the member’s record.

B. Counseling must be provided by a professional who is licensed to provide counseling for individuals with substance use disorder.

C. Group sessions shall be provided with direct oversight by a professional who is licensed to provide counseling for individuals with substance use disorder. Group

**93.03 COVERED SERVICES** (cont.)

counseling sessions shall be related to opioid dependency treatment and recovery goals and may include, but are not limited to, the following: psychoeducational groups, skill development groups, cognitive behavioral therapy groups, or substance use disorder support groups.

**93.05-5 Medication**

The OHH MOUD prescribers shall provide members, except for members in the Methadone Level of Care, with a prescription for a maximum 30-day supply per billing period of medication to assist in the member’s recovery, as medically appropriate. Medications included in the OHH model are buprenorphine, buprenorphine derivatives, naltrexone for opioid use disorder, and methadone. The medication can be provided either directly on site at the OHH, by an outside pharmacy, or by the OTP when a member is receiving methadone.

All prescriptions for buprenorphine, buprenorphine derivatives, and naltrexone must be reported to the Maine Prescription Monitoring Program (PMP) pursuant to the rules established at 14-118 C.M.R. Chapter 11, *Rules Governing the Controlled Substances Prescription Monitoring Program and Prescription of Opioid Medications,* and other applicable state and federal laws. Please refer to *MBM, Chapter II, Section 80, Pharmacy Services* and MaineCare’s Preferred Drug List at [www.mainecarepdl.org](http://www.mainecarepdl.org) for the most current and accurate prescribing criteria for these medications.

OHHs are encouraged to co-prescribe naloxone to members at high-risk for an opioid overdose and/or as clinically appropriate.

**93.05-6 Urine Drug Screening**

For each member, except for members in the Methadone Level of Care, the OHH shall provide, as part of the OHH bundled reimbursement, all appropriate point of care and confirmatory urine drug screening/testing related to OUD treatment. Screenings must be in compliance with Section 55, Laboratory Services and Section 80, Pharmacy Services, of the *MBM*.

**93.06 REPORTING REQUIREMENTS**

In addition to the documentation and reporting requirements of the *MBM*, Chapter I, Section I, and other reports that may be required by the Department, the OHH shall report in the format designated and frequency determined by the Department, including:

**93.06 REPORTING REQUIREMENTS** (cont.)

1. **The Core Standards.** The OHH shall report on the Core Standards in Section 93.02-3.
2. **Opioid Health Home Quality Measures.** The OHH shall submit data necessary to compile and report on OHH Quality Measures as identified by the Department. Data sources may include but are not limited to claims, clinical data, the DHHS Enterprise Information System, certification submissions, and surveys.

Providers who fail to timely or adequately file reports or satisfy the benchmarks defined by the Department may be terminated from providing Section 93 services.

**93.07 DOCUMENTATION AND CONFIDENTIALITY**

In addition to the requirements, above and set forth in Chapter I, Section 1, of the *MBM,* the OHH must maintain a specific record and documentation of services for each member receiving covered services.

1. **Records.** The member’s record must minimally include:
2. Name, address, birthdate, and MaineCare identification number;
3. Diagnoses that support eligibility for services herein, including the most recent documentation of diagnoses that substantiate ongoing eligibility for services;
4. The comprehensive assessment that must occur within the first thirty (30) days of initiating of services, and with any reassessments that occur;
5. The Plan of Care/ITP and any updates that occur;
6. Correspondence to and from other providers;
7. Release of information statements as necessary, signed by the member, including right notification, rules and regulations, confidentiality statement and release of information;
8. 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;
9. A record of discharge/transfer planning, beginning at admission and any referrals made; and

**93.07 DOCUMENTATION AND CONFIDENTIALITY** (cont.)

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

B. **Confidentiality and Disclosure of Confidential Documents/Information.** Providers shall maintain the confidentiality of information regarding these members in accordance with Chapter I, Section 1 of the *MBM*, 42 C.F.R. §§ 431.301-306, 22 M.R.S.A. §1711-C, and with all other applicable sections of state and federal law and regulation.

**93.08 REIMBURSEMENT**

OHHs are reimbursed a Per Member Per Month (PMPM) payment for each OHH member, based on the member’s level of care at the end of the billing month. The PMPM payment amount for each level of care is based on the expected use of OHH covered services.

**93.08-1 Minimum Requirements for OHH Reimbursement**

In order for the OHH to be eligible for the PMPM payments for each billing month, the OHH shall:

1. Provide the covered services described in and in accordance with 93.05, Covered Services;
2. Submit cost and utilization reports upon request by the Department, in a format determined by the Department;
3. Scan panel data, as identified by the Department, for its assigned population;
4. Attest to meeting the following requirements:

1. Members in the IOP, Induction, Maintenance, and Stabilization Levels of Care must be enrolled for a minimum of fifteen (15) days in a service month for the OHH to attest for each member.

2. Members in the Medication Plus or Methadone Levels of Care must be enrolled for a minimum of one (1) day in a service month for the OHH to attest for each member.

1. Document each service provided to each member, for each billing month, as required by these rules, in order to be eligible to receive the PMPM reimbursement.
2. For members in the Methadone Level of Care, have them sign a release of information allowing coordination of care between the OTP and the OHH.

**93.08 REIMBURSEMENT** (cont.)

**93.08-2 Reimbursement for Additional Provider Support**

OHH members who have additional community support needs related to mental health, HIV, medical concerns and/or utilization, and/or homelessness, may receive Health Home Services, as described in 93.05-1, from providers in *MBM* Section 13, Targeted Case Management Services (excluding 13.03-4(B)); Section 17.04-1 and 17.04-2, Community Support Services; and Section 92, Behavioral Health Home Services. In these cases, the OHH will receive an increased PMPM payment based on the member’s level of care that includes a $394.40 pass-through payment which the OHH must give to the additional support provider. Additional provider support provided to eligible members shall be approved by the Department or its authorized entity, requires the member to sign an authorization to release confidential information between the OHH and the additional support provider, and requires a contractual agreement between the OHH and additional support provider.

**93.08-3** **Pay-for-Performance**

Four (4) percent of total OHH PMPM payments is withheld from regular payments and reimbursed based on performance on three performance measures. Thresholds for minimum and excellent performance determine reimbursement amount and are based on a composite score of the performance measures and will be set so that no less than 70% of eligible OHHs are expected to be above the minimum performance threshold and no less than 20% of OHHs are expected to be above the excellent performance threshold. OHHs who meet the minimum performance threshold receive the full four (4) percent back. The four (4) percent withholds that are not distributed to OHHs due to the OHHs’ failure to meet the minimum performance threshold will be distributed to the OHHs that meet the excellent performance threshold. Every six (6) months, OHHs will receive a report indicating whether they qualified for the four (4) percent withhold and the excellent performance threshold redistribution. For more information, see *MBM, Chapter III, Opioid Health Homes*.

**93.08-4 Duplicative Services Will Not Be Reimbursed**

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

1. Services through Section 13, Targeted Case Management Services, for adults with substance use disorder.
2. Services through Section 13, Targeted Case Management Services; Section 17, Community Support Services; or Section 92, Behavioral Health Homes, unless the Section 13, 17, or 92 provider has a contract with the OHH to provide Health Home Services, as described in 93.05-1.

**93.08 REIMBURSEMENT** (cont.)

1. Opioid dependency counseling provided through *MBM*, Section 65, Behavioral Health Services, unless the member is in the Medication Plus Level of Care.
2. MAT with Methadone provided through *MBM*, Section 65, Behavioral Health Services, unless the member is in the Methadone Level of Care.

E. Medication management for opioid dependency treatment through *MBM*, Section 65, Behavioral Health Services.

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

1. Urine drug screening from the same service location under which a member is receiving OHH services.
2. Section 97, Private Non-Medical Institution Services, Appendix B.

**93.09** **BILLING INSTRUCTIONS**

The OHH shall attest through a claims process that the OHH has performed the necessary “minimum billable activity” (Section 93.08) each month to receive payment for Section 93 members.

Billing for medications (93.05-5), shall be as follows:

1. When a prescription for medication is written, but not dispensed at the OHH, the dispensing pharmacy shall bill for the medication in accordance with *MBM,* Section 80, “Pharmacy Services”.
2. When a prescription for medication is dispensed by the OHH, the OHH shall include the billing for the medication on the applicable UB or 1500 claim form.