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**91.01 DEFINITIONS**

**91.01**-**1** **Behavioral and Physical Health Integration** means the care a Member experiences as a result of a team of primary care and behavioral health providers, working together with Members and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

**91.01-2 Billing Month** is from the 21st of a month to the 20th of the following month, e.g. March 21st to April 20th.

**91.01**-**3 Community Care Team (CCT)** means a multi-disciplinary, community-based and/or practice-integrated care management team that has completed an application and been approved by MaineCare to provide CCT covered services.

**91.01**-**4** **Community Health Worker (CHW)** means a trained health worker who applies their unique understanding of the community’s 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 in that 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.

 CHW training shall include CHW core competencies as defined by The Community Health Worker Core Consensus Project (see https://www.c3project.org/roles-competencies) or evidence of a Maine CHW certification or registration, if such a designation becomes active in the State of Maine.

**91.01**-**5** **Electronic Health Record (EHR)** is a systematic collection of electronic health information about individual patients, including Members. It is a record in digital format that is capable of being shared across different health care settings including via 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 it has HL7 interoperability capabilities to support the electronic sharing of portions of the patient’s record.

**91.01**-**6 Housed** means a Member’s status when they have either moved into an apartment, home, or other domicile or in a long-term placement in an assisted living or waiver home setting.

**91.01 DEFINITIONS** (cont.)

**91.01-7** **Housing Outreach and Member Engagement Provider (HOME Provider)** is a specialized CCT approved by MaineCare to provide housing outreach and Member engagement services for eligible Members with Long-term Homelessness.

**91.01**-**8** **Long-term Homelessness** means residing in a place not meant for human habitation, an emergency shelter, a temporary outdoor shelter, a homeless shelter, or a setting of institutional care or incarceration for a minimum total of 180 days out of either the last 365 days or two (2) out of the last three (3) 365-day periods. Stays in a setting of institutional care or incarceration may not account for more than 90 of the Member’s total homeless days in any one 365-day period. If Long-term Homelessness criteria was met, as defined above, prior to incarceration then the Member is considered to have Long-term Homelessness post incarceration.

**91.01-9 Member** means a MaineCare member.

**91.01**-**10 Plan of Care** is a patient-centered plan that describes, coordinates, and integrates all of a Member’s clinical information and clinical and non-clinical health care-related needs and services. The Plan of Care shall include Member health care data, Member health goals, and the services and supports necessary to achieve those goals. Services and supports may include, but not be limited to, prevention, wellness, specialty care, behavioral health, transitional care and coordination, and social and community services.

**91.02 GENERAL REQUIREMENTS FOR CCTs AND HOME PROVIDERS**

CCTs and HOME Providers shall meet the requirements set forth in this Section.

Both CCTs and HOME Providers shall:

1. Execute a MaineCare Provider Agreement;
2. Complete a CCT application and be approved as a CCT by MaineCare;
3. Have an operational EHR;
4. Participate in Department-required CCT or HOME Provider technical assistance and educational opportunities on an annual basis. At least one (1) person in each CCT and HOME Provider must engage in these opportunities;
5. **Meet Core Standards.** CCTs and HOME Providers shall demonstrate how they intend to meet the following Core Standards prior to approval to provide services. Within the first three (3) months from the start of the CCTs’ and HOME Providers’ participation, they shall

**91.02 GENERAL REQUIREMENTS FOR CCTs AND HOME PROVIDERS** (cont.)

participate in an on-site assessment initiated by the Department, or its authorized agent, to establish their baseline performance in regards to meeting the Core Standards, and to identify the CCTs’ and HOME Providers training and educational needs.

For the remainder of the first year of participation, the CCTs and HOME Providers shall submit quarterly reports on sustained implementation of the Core Standards. After the first year, the CCTs and HOME Providers may request the Department’s approval to submit the Core Standard progress report annually instead of quarterly. The progress report shall compare CCT and HOME Providers progress to the baseline.

a. **Demonstrated Leadership** – CCTs and HOME Providers shall identify at least one individual as a leader within the care team who champions the implementation and continued maintenance of the Core Standards.

b. **Team-Based Approach to Care** – CCTs and HOME Providers shall implement a team-based approach to comprehensive care management, coordination, and supports that includes expanding the roles of non-billable professionals (e.g. nurses, medical assistants, peer support staff, CHWs, and/or housing navigators). CCTs and HOME Providers shall review policies, procedures, data, and structures to improve care delivery, access, efficiency, and Member engagement in specific ways, including two or more of the following:

1. Identifying roles and responsibilities across care team members;
2. Training on and integration of non-licensed team professionals as meaningful partners in service delivery;
3. Holding regular team meetings;
4. Expanding Member education and support opportunities; and
5. Providing greater data support to enhance the quality and cost-effectiveness of CCT and HOME Providers services.

c. **Population Risk Stratification and Management** – CCTs and HOME Providers shall adopt processes internally and with external partners (e.g. primary care practices, behavioral health providers, social service agencies) to identify and stratify patients who are at risk for adverse outcomes and shall adopt procedures that direct resources or care processes to reduce those risks. CCTs and HOME Providers shall utilize predictive analytics and/or risk models based on clinical, demographic, social, and/or other model inputs. CCTs and HOME Providers shall retain risk assessment documentation in the Member’s record.

 “Adverse outcomes” includes, but is not limited to, loss of housing, incarceration, or a negative clinical outcome and/or avoidable use of healthcare services such as crisis services, hospital admissions, and/or emergency department visits.

**91.02 GENERAL REQUIREMENTS FOR CCTs AND HOME PROVIDERS** (cont.)

d. **Enhanced Access** –The CCTs and HOME Providers shall enhance access to services for their population by:

1. Ensuring access to Member records twenty-four (24) hours a day, seven (7) days a week;

ii. Implementing processes to monitor and ensure access to care, e.g. from referral to intake; and

iii. Following up on Member inquiries within one (1) business day of the Member’s inquiry.

e. **Integrated Care Management** – CCTs and HOME Providers shall have policies and procedures in place to provide care management services for patients at high risk of experiencing adverse outcomes. Care management staff shall have clear roles and responsibilities, receive explicit training to provide care management services, and have processes for tracking outcomes for patients receiving care management services. CCTs and HOME Providers shall contribute to health management strategies and planning processes with their clinical and community partners.

f. **Behavioral and Physical Health Integration** – Annually, CCTs and HOME Providers shall submit a completed assessment of their Behavioral and Physical Health Integration progress and identify an area of focus for the following twelve-(12) month period to improve Behavioral and Physical Health Integration. The assessment tool will be provided by the Department.

g. **Inclusion of Members and Families** –CCTs and HOME Providers shall

include and document Members and family members as regular participants at leadership meetings or in committees/meetings to advise leadership on patient-centered needs and solutions to improve services.

CCTs and HOME Providers shall implement systems to gather Member and family input at least annually (e.g. via mail survey, phone survey, point of care questionnaires, focus groups, etc.). CCTs and HOME Providers shall have a process in place to design and implement changes that address needs and gaps in care identified via Member and family input.

h. **Connection to Community Resources and Social Support Services** – CCTs and HOME Providers shall have processes in place to identify local community resources and social support services, including those that provide self-management support to assist Members overcome barriers to care and meet health goals and health-related social needs.

**91.02 GENERAL REQUIREMENTS FOR CCTs AND HOME PROVIDERS** (cont.)

i. **Commitment to Reducing Waste, Unnecessary Healthcare Spending, and Improving Cost-effective Use of Healthcare Services** – CCTs and HOME Providers shall implement processes to reduce wasteful spending on healthcare resources and to increase the cost-effective use of healthcare services as evidenced by at least one initiative that targets waste reduction from the following list:

1. Reducing avoidable hospitalizations;
2. Reducing avoidable emergency department visits;
3. Reducing avoidable escalation of service needs such as crisis, residential, and inpatient stays;
4. Directing referrals to medical and/or behavioral health specialists who consistently demonstrate and document high quality and cost-efficient use of resources.

j. **Integration of Health Information Technology** – CCTs and HOME Providers shall use an electronic data system that includes identifiers and utilization data about patients. Member data is used for monitoring, tracking, and indicating levels of care complexity for the purpose of improving patient care.

The system is used to support Member care, including one or more of the following:

1. The documentation of need and monitoring of clinical care;
2. Supporting implementation and use of evidence-based practice guidelines;
3. Developing plans of care and related coordination; or
4. Determining outcomes (e.g. clinical, functional, satisfaction, and cost outcomes); or
5. Assessing risk (e.g. predictive analytics, risk scores/models).

**91.02-1 Additional Requirements for Community Care Team Providers**

1. The CCT shall have a documented relationship (e.g. Memorandum of Understanding or practice agreement) with one or more primary care practices to provide CCT services to patients of the practice; and
2. CCT staff shall consist of a multidisciplinary group of a minimum of three health care professionals and shall cover the roles of a CCT Manager, a Medical Director, and a Clinical Leader. Their responsibilities are:

a. A CCT Manager provides leadership and oversight to ensure the CCT meets Core Standards;

**91.02 GENERAL REQUIREMENTS FOR CCTs AND HOME PROVIDERS** (cont.)

b. A Medical Director (at least 4 hours/month) will collaborate with primary care practices, identify and implement evidenced-based clinical initiatives, lead quality improvement efforts, evaluate progress, and convene clinical quality improvement meetings. The Medical Director shall be a physician (Doctor of Medicine (MD) or Doctor of Osteopathic Medicine (DO)), Advanced Practice Registered Nurse (APRN), or physician assistant; and

c. A Clinical Leader is a clinician who directs care management activities across the CCT and does not duplicate care management that is already in place through primary care providers. The following clinician types may serve as Clinical Leaders: Licensed Clinical Professional Counselor (LCPC); Licensed Clinical Professional Counselor-conditional (LCPC-Conditional); Licensed Clinical Social Worker (LCSW); Licensed Master Social Worker conditional clinical (LMSW-conditional clinical); Licensed Marriage and Family Counselor (LMFT); Licensed Marriage and Family Counselor-conditional (LMFT-conditional); Licensed Alcohol and Drug Counselors (LADC), physician; psychiatrist; APRN; Physician Assistant (PA); registered nurse; licensed clinical psychologist; Certified Clinical Supervisor (CCS); and physician (MD/DO).

The Clinical Leader and Medical Director may be the same individual, but to maintain the minimum of three health care professionals, another team member will need to be included as part of the leadership team.

Additional CCT staff may consist of, but is not limited to, the following: a nurse care coordinator, nutritionist, social worker, behavioral health professional, case manager, pharmacist, care manager or chronic care assistant, CHW (through contracting with a community-based organization (preferred) or employing a CHW directly), care navigator, and/or health coach.

If there is a lapse in staff fulfillment of team member roles of greater than thirty (30) continuous days, the CCT shall notify the Department in writing and maintain records of active recruitment to fill the position(s).

1. The CCT shall maintain a Participant Agreement for data sharing with Maine’s statewide state-designated Health Information Exchange (HIE). The minimum clinical data set the CCT shares must include: all patient demographic, encounter, and visit information (including coding) and must be shared via a Health Level – 7 (HL-7) Admission, Discharge & Transfer (ADT) interface

**91.02 GENERAL REQUIREMENTS FOR CCTs AND HOME PROVIDERS** (cont.)

 **91.02-2 Additional Requirements for HOME Providers**

1. The HOME Provider shall implement processes, procedures, and Member referral protocols with local primary care providers, behavioral health providers, inpatient facilities, Emergency Departments (EDs), residential facilities, crisis services, and correctional facilities for prompt notification of an individual’s admission and/or planned discharge to/from one of these facilities or services. The protocols shall include coordination and communication on enrolled or potentially eligible Members.
2. The HOME Provider shall establish and maintain relationships with shelter services and housing providers to support housing placement and have systematic follow-up protocols to ensure timely access to follow-up care.
3. The HOME Provider shall have a system in place, such as an on-call staff or answering service, for Members to reach a member of the organization or an authorized entity twenty-four (24) hours a day, seven (7) days a week to triage and address the Members’ needs.
4. The HOME Provider shall be a community-based or practice-integrated provider with expertise in addressing homelessness. The HOME Provider shall deliver a team-based model of care through a multi-disciplinary team of employed or contracted personnel. The team shall include at least the personnel identified in this sub-section. Unless otherwise specified, each role shall be filled by a different individual; the Department reserves the right to waive this requirement based on team member professional experience and training. If there is a lapse in fulfillment of team member roles of greater than thirty (30) continuous days, the HOME Provider shall notify the Department in writing and maintain records of active recruitment to fill the position(s). All team members shall contribute to delivery of integrated and coordinated, whole-person care through a team-based approach.
5. A HOME Provider Manager is a professional with at minimum a bachelor’s degree that provides leadership and oversight to ensure the HOME Provider meets the Core Standards and may be filled by an individual also serving as the Clinical Leader.
6. A Clinical Leader is a clinician who is appropriately licensed or certified, practicing within the scope of that licensure or certification, and qualified to complete and direct the comprehensive assessment and Plan of Care requirements of this Section and directs the care management and coordination activities across the HOME Provider. A clinician includes the following: LCPC; LCPC-conditional; LCSW; LMSW-conditional clinical; LMFT; LMFT-

**91.02 GENERAL REQUIREMENTS FOR CCTs AND HOME PROVIDERS** (cont.)

conditional; LADC, physician; psychiatrist; APRN; PA; registered nurse or licensed clinical psychologist; CCS; MD/DO.

1. The Case Manager is a professional who works with the Clinical Leader to implement care management, coordination, and supports to assist the Member gain and maintain access to services to meet the goals of the Plan of Care. The Case Manager shall meet, at minimum, one of the following criteria:
2. Has a minimum of a bachelor’s degree in social work, sociology, public health, or nursing from an accredited four (4) year institution of higher learning;
3. Has a combined five (5) years of education and experience in providing direct services in social, health, or behavior health fields; or
4. Has a current Mental Health Rehabilitation Technician/Community (MHRT/C) Certification.
5. A Community Health Worker or Peer Support Staffis an individual who has completed one or more of the following:
6. Maine Office of Behavioral Health (OBH) curriculum for Certified Intentional Peer Support Specialist (CIPSS) and receives and maintains that certification.

The CIPSS is an individual who is receiving or has received services and supports related to the diagnosis of a mental illness, is in recovery from that illness, and who is willing to self-identify on this basis with HOME Provider Members. Peer Support Staff may function as a CIPSS without CIPSS certification for the first nine (9) months of functioning as a CIPSS, but may not continue functioning as a CIPSS beyond nine (9) months without: (a) having received provisional certification by completion of the Core training, and (b) continuing pursuit of full certification as a CIPSS and maintaining certification as an Intentional Peer Support Specialist according to requirements as defined by OBH;

1. Connecticut Community for Addiction Recovery (CCAR), or other recovery coach curriculum with certification approved by the Department or their designee in the first six (6) months following their employment start-date with the Home Provider;
2. HOME Provider organization training to deliver peer support services that includes competencies and training elements focused on supportive housing services and at least one (1) year of full-time equivalent practical work experience related to providing direct support services in the community or behavioral health fields; or

**91.02 GENERAL REQUIREMENTS FOR CCTs AND HOME PROVIDERS** (cont.)

1. CHW training program with relevant CHW core competencies or evidenced by a Maine CHW certification or registration (effective the date such a designation becomes active in the State of Maine).

Lived experience related to housing insecurity and/or homelessness is preferred for any Peer Support Staff or CHW team members.

1. Housing Navigator is an individual who has completed the Maine State Housing Authority’s Housing Navigator training and serves to help the Member find and maintain stable, long-term housing. The Housing Navigator shall help the Member find housing resources, apply for vouchers, establish relationships with area landlords, and related tasks. The Housing Navigator role may be filled by an individual also serving in one of the other roles, as long as the individual also meets the qualifications described above.
2. Additional HOME Provider staff may consist of, but is not limited to, additional Peer Support Staff or CHWs, case workers, care managers, outreach workers, nutritionists, pharmacists, chronic care assistants, social workers, behavioral health professionals, care navigators, or health coaches.
3. The HOME Provider shall adhere to applicable licensing standards regarding keeping documentation of employees’ qualifications in their personnel files. Pursuant to applicable licensing standards, the HOME Provider shall have a review process to ensure that employees providing HOME services possess the minimum qualifications set forth above.
4. The HOME Provider shall obtain credential evaluations from a member of the National Association of Credential Evaluation Services (NACES) to ensure that degrees held by staff members and earned from institutions outside of the United States meet the staff qualifications set forth in this sub-section.
5. The HOME Provider shall establish and maintain a relationship with a primary care provider, authorized and evidenced by a signed medical release, for each HOME Provider Member served that has a primary care provider. Such a release is not required when the Member’s primary care provider is also the Member’s provider within the HOME Provider team. HOME Providers shall work with each Member to establish and/or strengthen primary care relationships.
6. The HOME Provider team shall participate in multi-disciplinary team meetings which include the Member’s primary care and behavioral health providers to inform on-going assessment and the Member’s Plan of Care, as appropriate.

**91.02 GENERAL REQUIREMENTS FOR CCTs AND HOME PROVIDERS** (cont.)

1. The HOME Provider shall adhere to mandated reporting standards pursuant to Title 22 M.R.S. §4011 (A).

**91.03 MEMBER ELIGIBILITY FOR COMMUNITY CARE TEAM SERVICES**

CCT services are for Members who are high-risk and/or high-cost and whose health care needs are more intense than can be managed solely by a primary care provider. CCTs will request qualifying Members be added to their panels.

To be eligible for CCT services, the Member must:

1. Be diagnosed with two (2) or more chronic conditions (91.03-1) and meet one of the general eligibility requirements (91.03-3); or

2. Be diagnosed with one (1) chronic condition (91.03-1), be at risk for another chronic condition (91.03-2), and meet one of the general eligibility requirements (91.03-3).

All diagnoses related to eligibility must be documented in the Member’s EHR.

**91.03-1 Chronic Conditions**

1. a mental health condition (excluding Serious and Persistent Mental Illness and Serious Emotional disturbance, as defined in MBM, Section 92, Behavioral Health Homes;

2. a substance use disorder;

3. tobacco use;

4. diabetes;

5. heart disease;

6. overweight or obese as evidenced by a body mass index over 25 for an adult or the 85th percentile for a child;

7. Chronic Obstructive Pulmonary Disease (COPD);

8. hypertension;

9. hyperlipidemia;

10. developmental and intellectual disorders;

11. circulatory congenital abnormalities;

12. asthma;

13. acquired brain injury;

14. seizure disorders; and

15. HIV/AIDS.

**91.03 MEMBER ELIGIBILITY FOR COMMUNITY CARE TEAM SERVICES** (cont.)

**91.03-2 At Risk for Another Chronic Condition**

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

1. a mental health condition (excluding Serious and Persistent Mental Illness and Serious Emotional disturbance, as defined in MBM, Section 92, Behavioral Health Homes);

2. a substance use disorder;

3. tobacco use;

4. diabetes;

5. heart disease;

6. overweight or obese as evidenced by a body mass index over 25 for an adult or the 85th percentile for a child;

7. COPD;

8. hypertension;

9. hyperlipidemia;

10. developmental and intellectual disorders;

11. congenital or acquired circulatory abnormalities;

12. HIV/AIDs;

13. poor nutrition;

14. childhood trauma;

15. risky sex practices;

16. intravenous drug use;

17. history of incarceration;

18. history of or current substance use; or

19. family history or genetic predisposition for developing a chronic condition.

**91.03-3** **General Eligibility Requirements**

Members shall also meet one of the following additional requirements for CCT eligibility and document the qualifying reason(s) for eligibility:

1. **Hospital Admissions**

a. Two or more admissions in past three months; or

b. Three or more admissions in past 12 months

2. **ED Utilization**

a. Two or more ED visits in past three months; or

b. Three or more ED visits in past 12 months

**91.03 GENERAL REQUIREMENTS FOR CCTs AND HOME PROVIDERS** (cont.)

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

4. Members transitioning from institutional settings and at increased risk of poor outcomes (e.g. release from incarceration).

5. Members identified by CCT risk-stratification as:

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

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

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

6. **Polypharmacy:** Members using 5 or more chronic medications and/or on multiple high-risk medications (e.g., insulin, warfarin, etc.), as defined by evidence-based or expert opinion.

**91.04 MEMBER ELIGIBILITY FOR HOME SERVICES**

There are three (3) HOME service tiers: Intensive, Stabilization, and Maintenance. Members shall first meet the Intensive Tier criteria to receive HOME covered services. Once Intensive Tier eligibility is established, the HOME Provider shall assess Members for meeting Stabilization and Maintenance Tier criteria to ensure appropriate reimbursement. The Member’s service tier may cycle back and forth between each tier, as indicated by the eligibility criteria.

Documentation of the Member’s criteria for movement between tiers shall be retained in the Member’s record. The expected intensity level of the covered services differs in each tier, but the covered services remain the same.

To be eligible for any HOME Provider service Tier, Members must meet the below eligibility criteria for one of the tiers and have at least two (2) chronic conditions or one (1) chronic condition and be at risk for a second chronic condition, in accordance with 91.03-1 and 93.03-2.

**91.04-1 Intensive** **Tier: Member Eligibility**

For HOME Provider Intensive Tier services, Members must:

1. Currently be homeless and have Long-term Homelessness; or
2. Currently be homeless and have previously been in the Intensive Tier.

**91.04 MEMBER ELIGIBILITY FOR HOME SERVICES** (cont.)

**91.04-2** **Stabilization Tier: Member Criteria**

 For HOME Provider Stabilization Tier services, Members must:

1. Be Housed; and
2. Have a Services Prioritization Decision Assistance Tool (SPDAT) or Youth Service Prioritization Decision Assistance Tool (Y-SPDAT) score of twenty (20) to sixty (60).

**91.04-3 Maintenance Tier: Member Criteria**

 For HOME Provider Maintenance Tier services, Members must:

1. Be Housed; and
2. Have a SPDAT or Y-SPDAT score of four (4) to nineteen (19).

**91.05 POLICIES AND PROCEDURES**

**91.05-1 Member Identification**

Members may request CCT or HOME services or be referred for CCT or HOME services from any point-of-care at which the Member’s needs for CCT or HOME services are identified.

CCTs and HOME Providers shall accept referrals and assess Members who are potentially eligible for covered services based on the eligibility criteria in 91.03 and 91.04. CCTs and HOME Providers shall enroll qualifying Members for CCT or HOME services.

**91.05-2 Enrollment and Duplication of Services**

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

**1.05 POLICIES AND PROCEDURES** (cont.)

2. **Duplication of Services.** The Department will not reimburse for duplicative services for Members. A Member may only receive services from one CCT or HOME

 Provider at any given time. If, through the enrollment process, the Member is determined to be receiving a duplicative service, the Member shall choose which service they want to receive. CCTs and HOME Providers shall provide Members with notice that the Members cannot receive duplicative services. The Member’s choice of services will be retained in the Member’s EHR. CCT or HOME Provider services do not preclude a Member from receiving other medically necessary services.

Members may not receive CCT or HOME services that duplicate services from other sections of the *MaineCare Benefits Manual*, including the following services:

1. Section 13: Targeted Case Management Services
2. Section 17.04-1: Community Integration Services
3. Section 17.04-2: Community Rehabilitation Services
4. Section 17.04-3: Assertive Community Treatment
5. Section 46: Psychiatric Hospital Services (except as described 91.08-2)
6. Section 67: Nursing Facility Services (except as described 91.08-2)
7. Section 92: Behavioral Health Home Services
8. Section 93: Opioid Health Home Services

MaineCare services that are covered concurrently with HOME services only for a thirty (30) day overlap from the date of admission or sixty (60) day overlap prior to the date of discharge to allow for comprehensive transitional care include:

1. Section 46: Psychiatric Hospital Services
2. Section 67: Nursing Facility Services

3. **Consent Forms:** CCTs and HOME Providers shall retain a signed consent form for all CCT and HOME Provider Members in the Member record. For children receiving services, CCTs and HOME Providers shall retain a signed consent form from a parent or legal guardian. Consent documentation must, at a minimum:

a. Indicate that the Member or parent or legal guardian has received information in writing, and verbally as appropriate, explaining the CCT or HOME Provider purpose and the services provided; and

b. Indicate that the Member or parent or legal guardian has consented in writing, and verbally as appropriate, to receive the CCT or HOME services and understand their right to choose, change, or disenroll from their CCT or HOME Provider at any time.

**91.06** **COMMUNITY CARE TEAM COVERED SERVICES**

**91.06-1 Comprehensive Care Management**

The CCT willcoordinate and provide access to culturally and linguistically appropriate comprehensive care management, care coordination, and transitional care across settings for eligible Members. Levels of care management may change according to Member needs over time.

The CCT shall develop a Plan of Care with each Member served. The Plan of Care shall be recorded in the Member’s record and in the CCT’s EHR and 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 CCT shall be responsible for the management, oversight, and implementation of the Plan of Care, including ensuring active Member participation and that measurable progress is made on the plan’s goals. Services shall also include:

1. A comprehensive biopsychosocial assessment, conducted face-to-face or via telehealth in accordance with Chapter I, Section 4, which includes the following components:
	1. Physical health, including oral health;
	2. Mental health, including any history of depression or anxiety;
	3. Substance use (including at a minimum, Screening Brief Intervention and Referral to Treatment (SBIRT) services);
	4. Medications;
	5. Allergies;
	6. Family history;
	7. Social supports;
	8. Housing status;
	9. Financial status;
	10. Nutritional status;
	11. Education;
	12. Military service, if applicable;
	13. Legal issues;
	14. Vocational background;
	15. Spirituality and religious preferences; and
	16. Leisure and recreational activities.
2. Clinical assessments, monitoring, and follow up of clinical and social service needs;

3. Medication review and reconciliation;

4. Communicating and coordinating care with treating providers;

**91.06 COMMUNITY CARE TEAM COVERED SERVICES** (cont.)

1. Nurse care management (including patient visits prior to hospital discharge, in the primary care practice, in group visits or at home); and
2. Case/panel management (screening, patient identification, scheduling appointments, referrals to care managers and other team members).

**91.06-2 Care Coordination**

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

1. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines;

2. Coordinate and provide access to preventive, health promotion, treatment, and recovery services, including those related to mental health and substance use;

3. Develop a Plan of Care for each Member that coordinates and integrates all clinical and non-clinical health related needs and services, as appropriate;

4. The CCTs’ efforts shall be performed in coordination with, and not duplicate services delivered by, the Member’s primary care provider.

**91.06-3 Health Promotion**

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

**91.06 COMMUNITY CARE TEAM COVERED SERVICES** (cont.)

**91.06-4 Comprehensive Transitional Care**

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

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

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

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

4. Providing care transition support to a lower level of care when the member no longer meets CCT eligibility requirements and is discharged from the CCT panel.

**91.06-5 Individual and Family Support Services**

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

1. Health coaching for nutrition, physical activity, tobacco cessation, diabetes, asthma, and other chronic diseases;
2. Chronic disease self-management, education, and skill-building;
3. Connection to community-based organizations;
4. Connection to peer support staff, CHWs, support groups, and self-care programs; and

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

**91.06 COMMUNITY CARE TEAM COVERED SERVICES** (cont.)

**91.06-6 Referral to Community and Social Support Services**

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

**91.07** **HOME COVERED SERVICES**

The HOME Provider shall conduct outreach to underserved Members with high emergency services utilization, chronic conditions, complex care coordination needs, and Long-term Homelessness in need of intensive HOME services. The HOME services tier in which the Member is enrolled will determine the intensity level required for each service.

**91.07-1 Comprehensive Care Management**

Comprehensive Care Management includes the following:

1. Within the first thirty (30) days following a Member’s enrollment for HOME services, the HOME Provider shall conduct a face-to-face comprehensive assessment which shall include:

1. An individual housing assessment;

1. A SPDAT or Y-SPDAT assessment;
2. A psychosocial assessment, which shall include, at minimum, a history of trauma and abuse; housing instability; substance use; general health and capabilities; behavioral health and capabilities; and medication needs. The psychosocial assessment shall also identify Member strengths and how they can be optimized to promote:
3. Medical and behavioral health goals;
4. Housing goals;
5. Available support systems;
6. Community integration;
7. Employment and/or educational status; and
8. Self-management and self-advocacy.

The SPDAT or Y-SPDAT assessment shall be repeated every 90 days or more often when indicated by a significant change in the Member’s circumstances or needs. Comprehensive reassessment must reoccur as changes in the Member’s needs warrants or, at a minimum, on an annual basis.

**91.07** **HOME COVERED SERVICES** (cont.)

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

1. The Member or the Member’s parent or legal guardian, as appropriate, shall consent to the Plan of Care which shall be:

1. Reflected by the appropriate signature on the Plan of Care; and
2. Documented in the Member’s record; and
3. Accessible to the Member, the Member’s legal guardian, the HOME Provider, primary care provider, and other providers, as appropriate.
4. The HOME Provider shall obtain written consent for services and authorization for the release and sharing of information from each Member or the Member’s parent or legal guardian, as appropriate;
5. If authorized by the Member or the Member’s parent or legal guardian, as appropriate, the HOME Provider shall document in the Plan of Care the Member’s preferred family supports, or other support systems and preferences. If authorized by the Member or the Member’s parent or legal guardian, as appropriate, the Plan of Care shall be accessible to the Member’s family, guardian(s), or other caregivers;
6. The Plan of Care shall address, but not be limited to, the areas of housing, prevention, wellness, harm reduction, peer supports, health promotion and education, crisis planning, and identifying other social, residential, educational, vocational, and community services and supports that enable a Member to achieve physical, social, and behavioral health goals;
7. The Plan of Care shall include the development of an individualized housing support plan based upon the comprehensive assessment that addresses identified barriers, including short and long-term measurable goals for each need, establishes the Member’s approach to meeting the goals, and identifies when community supports and services may be required to meet the goals;
8. As part of the Plan of Care, the HOME Provider shall develop with the Member a crisis management plan based upon the comprehensive assessment to develop crisis prevention and early resolution strategies.

**91.07** **HOME COVERED SERVICES** (cont.)

The Member plays a central and active role in the development and maintenance of the crisis management plan, which shall clearly identify the known pre-cursors to crisis and the strategies and techniques to be utilized to stabilize each situation. The crisis management plan shall identify goals and interventions to produce effective crisis prevention, de-escalation, and resolution;

1. The Plan of Care shall identify Member strengths and how these strengths can be optimized to promote goals. The Member shall play a central and active role in the development and maintenance of the Plan of Care, which shall clearly identify the goals and timeframes for improving the Member’s health and health care status, and the interventions that will produce this outcome;
2. The Plan of Care shall clearly identify providers involved in the Member’s care, such as the primary care provider, specialist(s), behavioral health care provider(s), and other providers directly involved in the Member’s care;
3. All identified clinical services indicated in the Plan of Care must be approved by a medical or behavioral health professional working within the scope of their license;
4. The Plan of Care must be reviewed and approved in writing by an appropriately licensed medical or mental health professional within the first thirty (30) calendar days following acceptance of the Plan by the Member or the Member’s parent or legal guardian, as appropriate, and every ninety (90) calendar days thereafter or more frequently if indicated in the Plan of Care. The Clinical Leader with other care team members, as appropriate, shall review the Plan of Care as changes in the Member’s needs occur, or at least every ninety (90) days, to determine the efficacy of the services and supports and formulate changes in the Plan as necessary with Member consultation;
5. The HOME Provider shall consult with care team members, the Member, and the Member’s parent or legal guardian, as appropriate, when changes in the Member’s situation or needs occur and update the Plan of Care accordingly to ensure that it remains current; and
6. The Member may decline services identified in the Plan of Care, the HOME Provider shall document the declination in the Member’s record.
7. Integration with Primary Care. During the first three (3) months after a Member’s enrollment, the HOME Provider shall provide ongoing individualized outreach, education, and support to the Member regarding HOME services and benefits, including information on sharing personal health information and coordination with primary care services.

**91.07** **HOME COVERED SERVICES** (cont.)

1. The HOME Provider shall work with Members and appropriate providers to scan for gaps in the Member’s care by reviewing Member feedback, referral completion records, or, at a minimum, Department provided utilization reports.

**91.07-2 Care Coordination**

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

* 1. Assistance in establishing a primary care provider and accessing health care and follow-up care;
	2. Assessing housing needs and providing coordination and tenancy support services to help the Member access and maintain safe/affordable housing;
	3. Assessing employment needs and providing assistance to access and maintain employment;
	4. Conducting outreach to family members and others to support connections to services and expand social networks;
	5. Assistance in locating and accessing community social, legal, medical, behavioral healthcare, and transportation services;
	6. Ensuring that Members have access to crisis intervention and resolution services, coordinate follow up services to ensure that a crisis is resolved, and assist in the development and implementation of crisis management plans; and
	7. Maintaining frequent communication with other team providers to monitor health status and to ensure that the Plan of Care is effectively implemented and adequately addresses the Member's needs.

**91.07-3 Health Promotion**

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

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

**91.07** **HOME COVERED SERVICES** (cont.)

1. Promote healthy lifestyle, psychosocial health, and wellness strategies including, but not limited to, substance use prevention, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, harm reduction, conflict resolution, problem solving, risk avoidance, and increasing physical activities; and
2. Coordinate and provide access to self-help/self-management and advocacy groups and shall implement population-based strategies that engage Members with services necessary for both preventative and chronic care.

**91.07-4 Comprehensive Transitional Care**

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

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

1. Provide Members with care coordination and support services, including, but not limited to, housing navigator services, peer support services, and psychosocial and care coordination supports to assist the Member attain and transition to housing;

1. Follow-up with Members following a hospitalization, use of crisis service, out-of-home placement, or incarceration;
2. Collaborate with Members, their families, and facilities to ensure a coordinated, safe transition between different sites of care or transfer from the home/community setting into a facility;
3. Assist the Member explore less restrictive alternatives to hospitalization/ institutionalization; and
4. Provide timely and appropriate follow-up communications on behalf of transitioning Members, which includes a clinical hand off, timely transmission, and receipt of the transition/discharge plan, review of the discharge records, and coordination of the transition to housing.

**91.07** **HOME COVERED SERVICES** (cont.)

**91.07-5 Individual and Family Support Services**

Individual and family support services include assistance and support to the Member and/or the Member’s family in implementing the Plan of Care. The HOME Provider shall:

1. Provide assistance with housing and health-system navigation and training on self-advocacy skills;
2. Provide information, consultation, and problem-solving support services to the Member, and his or her family or other support system, in order to assist the Member in the use of self-management skills to reduce emergency service utilization and maintain housing;
3. Support and assist the Member to engage in employment, education, vocational, and housing opportunities to establishing housing-, health-, and independence-sustaining skills;
4. Assist the Member to develop communication skills necessary to obtain and maintain housing and employment and request assistance or clarification from landlords, neighbors, supervisors, and co-workers when needed;
5. Support the Member to implement his/her crisis management plan to prevent crises and implement early resolution strategies. The Member shall play a central and active role in the implementation of the crisis management plan to attain effective crisis prevention, de-escalation, and resolution;
6. Coordinate and provide access to peer support services, Peer advocacy groups, and other Peer-run or Peer-centered services and help the Member identify and develop natural support systems; and
7. Discuss advance directives with Members and their family, guardian(s), or caregivers, as appropriate.

**91.07-6 Referral to Community and Social Support Services**

1. The HOME Provider shall provide referrals based on the assessment and Member’s care plan as appropriate. Referrals will be made through telephone or in person and may include electronic transmission of requested data. The HOME Provider shall follow through on referrals to encourage the Member to connect with the services.

**91.07** **HOME COVERED SERVICES** (cont.)

1. The HOME Provider shall provide referrals to community, social support, and recovery services. The HOME Provider shall connect Members to community and social service support organizations that offer supports for crisis intervention, management and resolution, self-management and healthy living, and basic social service needs such as transportation assistance, housing, literacy, employment, economic, and other assistance.
2. When able through the acquisition of appropriate releases, all referrals should be shared and documented in the Plan of Care through Care Coordination.

**91.08 REPORTING REQUIREMENTS**

In addition to the documentation and reporting requirements of the *MaineCare Benefits Manual*, Chapter I, Section I, and other reports that may be required by the Department, the CCTs and HOME Providers shall report in the format designated and frequency determined by the Department, including:

1. The Core Standards: The CCTs and HOME Providers shall report on the Core Standards in Section 91.02.
2. Performance Measures: The CCTs and HOME Providers shall submit data necessary to compile and report on performance measures as identified by the Department. Data sources may include, but are not limited to, claims, clinical data, surveys, risk scores, and administrative encounter data.

**91.09 REIMBURSEMENT**

1. Reimbursement is specified in Chapter III, Section 91.

2. CCTs and HOME Providers are eligible for reimbursement for each Member for each Billing Month if they provide at least one Section 91.06 or 91.07 Covered Service in accordance with the Member’s Plan of Care.

3. For Members receiving HOME services and residential or facility services concurrently, as allowable in 91.05, the HOME Provider shall attest to the Member at the next less intensive tier of services or remain attested at Maintenance Tier for the duration of the residential or facility services. When residential or facility services end, the HOME Provider shall attest to the Member at the most appropriate tier based on the Member’s current criteria.