

## Opportunity for Public Comment

Comments may be sent to Michele A. Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499; TTY:800-735-2258, or email to [dhmh.regs@maryland.gov](mailto:dhmh.regs@maryland.gov), or fax to 410-767-6483. Comments will be accepted through August 12, 2013. A public hearing has not been scheduled.

# Title 10

## DEPARTMENT OF HEALTH AND MENTAL HYGIENE

### Subtitle 09 MEDICAL CARE PROGRAMS

#### 10.09.33 Health Homes

Authority: Health General Article, §2-104(b), Annotated Code of Maryland

#### ALL NEW

##### .01 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

- (1) "Administrative Service Organization (ASO)" means the entity with which the Mental Hygiene Administration may contract to provide the services described in COMAR 10.09.70 for the public mental health system.
- (2) "Care management tool" means a system that helps accomplish administrative tasks of the health home, including maintaining a list of health home participants and scheduling and tracking participants' clinical appointments.
- (3) "Caregiver" means a family member, guardian, or other individual who is not paid to provide care to the participant and who helps the participant achieve and maintain wellness.
- (4) "Chesapeake Regional Information System for our Patients (CRISP)" means the electronic notification system health home providers are required to use in order to access participant hospital encounter data.
- (5) "Department" means the Department of Health and Mental Hygiene, the State agency designated to administer the Maryland Medical Assistance Program under Title XIX of the Social Security Act, 42 U.S.C §1396 et seq.
- (6) "eMedicaid" means the health information system in which a health home provider will input information regarding participants' services and health and social outcomes.
- (7) "Full-time equivalent (FTE)" means an employee who works 40 hours per week.
- (8) "Health home" means a provider designated to offer enhanced care coordination and management services to individuals affected by, or at risk for, chronic conditions, operating under the conditions of this chapter.
- (9) "HIT" means Health Information Technology.
- (10) "Individualized Treatment Plan (ITP)" means a written plan of action that is developed and modified to address a patient's specific service needs, which is maintained in the individual's medical record and satisfies the following conditions:
  - (a) Meets the requirements of COMAR 10.47.01.04C; or
  - (b) Meets the requirements of COMAR 10.21.21.06C
- (11) "Managed Care Organization (MCO)" has the meaning stated in Health-General Article, §15-101, Annotated Code of Maryland.
- (12) "Medical Assistance Program" has the meaning stated in COMAR 10.09.36.01.
- (13) "Mental health case management" means services covered under this chapter which assist participants in gaining access to the full range of mental health services, and necessary medical, social, financial assistance, counseling, educational, housing, and other support services.
- (14) "Minor" means an individual who is younger than 18 years old.
- (15) "Mobile Treatment (MT) program" means a program approved under COMAR 10.21.28.

(16) "Opioid Treatment Program (OTP)," formerly referred to as Opioid Maintenance Therapy (OMT) programs, means a program approved to provide opioid maintenance therapy under COMAR 10.47.02.11.

(17) "Participant" means an individual enrolled in a health home funded by the Medical Assistance Program.

(18) "Provider" means an individual, association, partnership, corporation, unincorporated group, or any other person authorized, licensed, or certified to provide health services.

(19) "Psychiatric Rehabilitation Program (PRP)" means a program approved under COMAR 10.21.21 for adults, COMAR 10.21.29 for minors, or both.

#### **.02 Licensing Requirements.**

A. A PRP serving adults and participating as a health home shall be licensed pursuant to COMAR 10.21.21.

B. A PRP serving minors and participating as a health home shall be licensed pursuant to COMAR 10.21.29.

C. A MT program participating as a health home shall be licensed pursuant to COMAR 10.21.19.

D. An OTP participating as a health home shall be licensed to provide opioid maintenance therapy pursuant to COMAR 10.47.02.11.

#### **.03 Participant Eligibility.**

A. An individual is eligible for health home services if the individual:

(1) Is a recipient of Maryland Medical Assistance; and

(2) Meets the following criteria:

(a) Receives outpatient mental health treatment with a PRP or MT program for a serious and persistent mental illness or serious emotional disturbance, and is not currently receiving:

(i) 1915(i) waiver services; or

(ii) Mental Health Case Management; or

(b) Receives treatment with an OTP for an opioid substance use disorder, and is at risk for additional chronic conditions based on:

(i) Current alcohol use, tobacco use, or other non-opioid use; or

(ii) A history of alcohol, tobacco, or other non-opioid substance dependence.

B. A health home participant that is no longer receiving services from their PRP, MT program, or OTP provider may continue to receive health home services for up to 6 months for the purposes of reengagement or transition to another level of care.

#### **.04 Conditions for Health Home Provider Participation.**

To be eligible as a health home, a provider shall:

A. Meet the conditions for provider participation in the Medical Assistance Program, as set forth in COMAR 10.09.36.03;

B. Meet the licensure requirements set forth in Regulation .02 of this chapter;

C. Be accredited by, or demonstrate evidence of having started the accreditation process from, an approved accrediting body as a health home;

D. For PRP and MT health homes serving minors, demonstrate a minimum of 3 years of experience serving minors, which may be achieved as an independent practice or as a member of a broader agency, with exceptions designated by the Department;

E. At the time of enrollment as a health home, be enrolled or be able to provide documentation of starting the process of enrollment with the following:

(1) CRISP in order to receive hospital encounter alerts; and

(2) The State's ASO in order to access real-time pharmacy data for participants;

F. At the time of enrollment as a health home, have an internal protocol for reviewing and responding to hospital encounter alerts and pharmacy use data;

G. Directly provide, or subcontract for the provision of, health home services to all participants;

H. Maintain an electronic database with the ability to, at minimum:

(1) Maintain an up-to-date list of all health home participants and their contact information; and

(2) Record and review clinical appointments;

I. Maintain a file for each participant that includes:

(1) A form signed by the participant consenting to participate in the health home, including the program's data-sharing elements;

(2) An initial assessment of the participant's health and social services needs, as described in Regulation

.06B(1)(a) of this chapter;

(3) An ITP, updated every 6 months, which includes, at a minimum:

(a) The participant's goals;

(b) Timeframes for meeting goals;

(c) Proposed interventions for meeting goals;

(d) Relevant community networks and supports;

(e) Optimal clinical outcomes for the participant; and

(f) Signatures of:

- (i) The participant or the participant's parent or guardian; and
  - (ii) The nurse care manager to whom the participant has been assigned in the health home;
- J. Safeguard the confidentiality of the participants' records in accordance with State and federal laws and regulations;
- K. Provide on-call and crisis intervention services by telephone 24 hours a day, 7 days a week to participants and, as appropriate, their caregivers, or if the participant is a minor, the minor's parent or guardian;
- L. Be responsible for meeting all health home service requirements, including services performed by a business or individual subcontracted to provide such services;
- M. Convene health home team meetings every 6 months, at minimum, to plan and implement goals and objectives of functioning as a health home;
- N. Collaborate with MCOs and the ASO to improve patient outcomes; and
- O. Agree to participate in federal and State-required evaluation activities, including:
- (1) Using eMedicaid or another Department-approved health information tool that feeds into eMedicaid to:
    - (a) Input information related to participants' services and health at least monthly;
    - (b) Generate monthly reports documenting:
      - (i) Health home service delivery; and
      - (ii) Participants' health and social outcomes; and
    - (c) Update participant diagnoses and outcomes every 6 months; and
  - (2) Completing and submitting to the Department a program assessment every 6 months to demonstrate that:
    - (a) All staffing and other regulatory requirements are being met; and
    - (b) A quality improvement plan is being implemented.

**.05 Health Home Provider Staff.**

- A. Health Home Staffing Requirements.
- (1) Nurse Care Manager.
    - (a) At minimum, the health home shall maintain nurse care manager staff at a ratio of .5 FTE per 125 participants.
    - (b) The nurse care manager shall be a:
      - (i) Nurse practitioner meeting the conditions of COMAR 10.27.07; or
      - (ii) Registered nurse licensed pursuant to COMAR 10.27.01 and meeting the conditions of COMAR 10.27.09.
  - (2) Health Home Director.
    - (a) At minimum, the health home shall maintain a health home director at a ratio of .5 FTE per 125 health home participants.
    - (b) A health home with less than 125 participants may employ 1 FTE individual to serve as both the nurse care manager and health home director, provided that individual meets the requirements for both positions.
    - (c) A health home with 375 or more participants, requiring more than 1 FTE health home director, may choose to designate a lead health home director and additional key management staff who meet the requirements of §A(2)(d)(i) or (ii) of this regulation.
    - (d) The health home director shall:
      - (i) Possess a Bachelor's degree from an accredited university and 2 years experience in health administration; or
      - (ii) Possess a Master's degree from an accredited university in a related field;
      - (iii) Be licensed as a Registered Nurse with the Maryland Board of Nursing; or
      - (iv) Be licensed as a Physician or be licensed as a Nurse Practitioner.
  - (3) Physician or Nurse Practitioner.
    - (a) At minimum, the health home shall maintain physician or nurse practitioner services at a ratio of one and one half (1.5) hours per health home participant per 12 month period.
    - (b) The physician shall meet the conditions of COMAR 10.32.01.
    - (c) The nurse practitioner shall meet the conditions of COMAR 10.27.07.
  - (4) Administrative Support Staff.
    - (a) The health home shall maintain administrative support at a level sufficient to meet the service provision and reporting requirements of the health home.
    - (b) Administrative support for the health home may be one or a combination of the following:
      - (i) Administrative support staff; or
      - (ii) An electronic care management tool that addresses the administrative health home tasks.
- B. A health home with fewer than 125 participants may form a consortium to share health home staff and costs, contingent upon geographic proximity and Department approval of a plan detailing the proposed collaboration.
- C. Should staffing levels drop below the levels required by this regulation for more than 60 days, the health home shall:
- (1) Report this to the Department; and
  - (2) Demonstrate that steps have been taken to reach the required staffing levels.

#### **.06 Covered Services.**

A. The Department covers the services in §§B—G of this regulation when these services have been documented, pursuant to the requirements in this chapter, as necessary.

B. Comprehensive Care Management. The health home shall collaborate to provide comprehensive care management services including:

- (1) An initial assessment performed prior to the patient's enrollment, which includes:
  - (a) A, comprehensive assessment of the participant's physical health, mental health, chemical dependency, and social service needs, conducted by a physician or nurse practitioner, if no such assessment has been performed in the preceding 6-month period; and
  - (b) Requesting records from the participant's primary care physician and other providers;
- (2) Development of an ITP within 30 days following enrollment, in accordance with Regulation .04I(3) of this chapter;
- (3) Delineation of roles, which includes:
  - (a) Assigning each team member clear roles and responsibilities; and
  - (b) Ensuring that participant ITPs identify providers and specialists involved in the participant's care; and
- (4) Monitoring and reassessment, which includes:
  - (a) Monitoring and documenting participant health status and progress toward ITP goals;
  - (b) Monitoring population health status and service use to determine adherence to or variance from treatment guidelines; and
  - (c) Outcomes evaluation and reporting, which includes using eMedicaid and other available HIT tools such as electronic health records.

C. Care Coordination and Health Promotion.

- (1) The health home shall coordinate and provide access to:
  - (a) High-quality health care services;
  - (b) Preventive and health promotion services, including education regarding:
    - (i) Mental illness;
    - (ii) Substance use disorders; and
    - (iii) Chronic physical health conditions;
  - (c) Mental health and substance abuse services;
  - (d) Chronic disease management services; and
  - (e) Long-term care supports and services.
- (2) The health home shall coordinate services and support, including:
  - (a) Appointment scheduling;
  - (b) Referrals and follow-up monitoring;
  - (c) Hospital discharge processes; and
  - (d) Communication with other providers and supports, including school service providers.
- (3) The health home shall assign each participant a nurse care manager who is responsible for coordinating the participant's care and ensuring implementation of the ITP.
- (4) The health home shall develop policies and procedures to facilitate collaboration between primary care, specialist, and behavioral health providers, community-based organizations and, for minors, school-based providers.
- (5) The health home shall follow security protocols to protect confidential health information.
- (6) The health home shall assist participants with the implementation of their ITP, including:
  - (a) Health education specific to a participant's chronic conditions;
  - (b) Development of a plan for self-management;
  - (c) Medication review and education; and
  - (d) Substance use prevention, smoking cessation, obesity reduction, improved nutrition, and increased physical activity.
- (7) A health home serving minors shall actively involve parents and families in providing services in accordance with §C(6) of this regulation, including:
  - (a) Identifying conditions for which the minor may be at risk due to family, physical, or social factors; and
  - (b) Working with the minor and parents and families to address the identified conditions.
- (8) The health home shall use eMedicaid to document, review, and report health promotion services delivered to each participant.

D. Comprehensive Transitional Care.

- (1) The health home shall provide services designed to:
  - (a) Streamline plans of care;
  - (b) Reduce hospital admissions;
  - (c) Ease the transition to long-term services;
  - (d) Interrupt patterns of frequent hospital emergency department use; and
  - (e) Ensure timely and proper follow-up care across settings, including from:
    - (i) An inpatient setting to other settings; and
    - (ii) A pediatric system of care to an adult system of care.

(2) The health home shall increase participants' and caregivers' ability to manage care and live safely in the community.

(3) The health home shall utilize CRISP to receive alerts of hospital admissions, discharges, or transfers among their health home participants.

(4) The health home shall follow up with participants within 2 business days of discharge with a home visit, phone call, or scheduling an on-site appointment.

E. Individual and Family Support Services.

(1) Services shall include, but are not limited to:

- (a) Advocating for individuals and families;
- (b) Obtaining and adhering to medications and other prescribed treatments;
- (c) Accessing resources that support participants, including providing referrals for:
  - (i) Community services;
  - (ii) Social support services;
  - (iii) Recovery services; and
  - (iv) Transportation to medically necessary services;

(d) Improving health literacy;

(e) Increasing the participant's ability to self-manage care;

(f) Facilitating participation in the ongoing revision of the treatment plan; and

(g) Providing information on advance directives and health care power of attorney.

(2) The health home shall utilize peer supports, support groups, and self-care programs to:

(a) Increase participants' and caregivers' knowledge of the participants' diseases;

(b) Increase caregivers' care-management capabilities;

(c) Promote participants' adherence to their treatment; and

(d) Increase participants' self-management capabilities.

(3) The health home shall ensure that all communication shared with the participant, the participant's family, and caregivers is language, literacy, and culturally appropriate.

F. Referral to Community and Social Support Services. The health home shall provide assistance in accessing, as appropriate:

(1) Medical assistance;

(2) Disability benefits;

(3) Subsidized or supported housing;

(4) Personal needs support;

(5) Peer support; or

(6) Legal services.

G. The health home shall assist in coordinating these services.

H. Use of HIT to Link Services. The provider shall use HIT including CRISP, eMedicaid and pharmacy data from the ASO to:

(1) Facilitate communication between health home team members, the participant, and their caregivers; and

(2) As appropriate, provide feedback to participants' other providers.

I. Health home services provided by PRP, MT, or OTP staff qualify as covered services.

**.07 Health Home Participant Flow.**

A. Enrollment.

(1) The health home shall enroll an individual only after the individual has been enrolled in the health Home provider's applicable PRP, MT, or OTP services.

(2) An OTP established as a health home shall identify eligible individuals under the OTP's care and report the qualifying risk factors diagnoses through eMedicaid during enrollment.

(3) The health home shall provide the individual with a brief description of health home services, including:

(a) Explaining the data sharing elements of the program; and

(b) Describing how individual may opt out if desired.

(4) Following the provision of information in accordance with §A(3) of this regulation, the health home shall obtain the individual's consent to participate in the health home.

(5) Following consent to participate in accordance with §A(4) of this regulation, the health home shall complete the individual's online eMedicaid intake report thereby enrolling the individual into the health home.

(6) The health home shall:

(a) Notify a participant's other treatment providers about health home services; and

(b) Encourage other providers' participation in care coordination efforts.

B. Participation.

(1) A health home participant shall receive a minimum of two health home services per month, as defined in eMedicaid and to be documented in eMedicaid.

(2) An assigned nurse care manager shall monitor the participant's care and health status, with the health home team providing health home services.

C. Discharge

(1) In the event of discharge, the health home shall create a discharge plan with referrals to appropriate services and providers.

(2) The health home shall report all discharges and completion of discharge plans in eMedicaid.

**.08 Limitations.**

A. An eligible individual may not receive services from a health home provider that is not the individual's PRP, MT, or OTP provider.

B. Health home services do not restrict or otherwise affect:

(1) Eligibility for Title XIX benefits or other available benefits or programs, except as limited by regulation §E of this chapter;

(2) The freedom of a participant to select from all available services for which the participant is found to be eligible; or

(3) A participant's free choice among providers in the Medical Assistance Program.

C. A health home may not bill the Department for:

(1) Activities that have already been billed to or counted towards a service requirement for another Medical Assistance Program or other program;

(2) Activities not consistent with the definition of health home services under this chapter;

(3) Activities delivered as part of institutional discharge planning; or

(4) A participant's health home per member per month rate more than once per month.

D. The Department may not reimburse for monthly health home services unless the individual receiving health home services:

(1) Is Medicaid eligible at the time of service delivery and engaged in treatment with either an OTP or PRP or MT services;

(2) Is enrolled as a health home member at the billing health home provider; and

(3) Has received a minimum of two health home services in the stated month that has been documented in eMedicaid.

E. Reimbursement will not be made for health home services if the participant is receiving a comparable service under another Medical Assistance Program or other program.

F. A participant's health home provider may not be the participant's family member.

**.10 Payment Procedures.**

A. The Department shall reimburse the health home according to the requirements in this chapter and the rate established in §C of this regulation.

B. Request for Payment.

(1) The health home provider is authorized to begin billing for a participant when:

(a) The participant is receiving PRP, MT, or OTP services; and

(b) The intake portion of the participant's eMedicaid file has been completed with the necessary demographic information, qualifying diagnosis baseline data, and consent form.

(2) After completing the required health home service provision reporting in eMedicaid, the health home provider shall, within 30 days from the end of the month during which health home services were provided, submit a request for payment for all participants who received two health home services during that month.

(3) A health home provider shall bill the Department for the appropriate rate specified in §C of this regulation.

C. Payment shall be made:

(1) To the health home provider for covered services rendered to a participant; and

(2) At a monthly rate per participant of \$98.87, on the condition that the requirements of this chapter are met.

**.11 Recovery and Reimbursement.**

Recovery and reimbursement shall be as set forth in COMAR 10.09.36.07.

**.12 Cause for Suspension or Removal and Imposition of Sanctions.**

A. Cause for suspension or removal from the Medical Assistance Program and imposition of sanctions shall be as set forth in COMAR 10.09.36.08.

B. If the Department determines that a health home provider has failed to comply with the provisions of this chapter, the Department may initiate one or more of the following actions against the health home provider:

(1) Recovery of overpayment made by the Department;

(2) Withholding of payment by the Department;

(3) Reduction in payment by the Department, including a 10 percent reduction in reimbursement for services that are not billed within the timeframe required by Regulation .10B(2) of this chapter;

(4) Suspension from being a health home provider;

(5) Removal from being a health home provider; or

(6) Disqualification from being a health home provider at any future time.

**.13 Appeal Procedures.**

Appeal procedures shall be as set forth in COMAR 10.09.36.09.

**.14 Interpretive Regulation.**

State regulations shall be interpreted as set forth in COMAR 10.09.36.10.

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**Secretary of Health and Mental Hygiene**

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