SUMMARY OF COMMENTS AND RESPONSES
AND LIST OF CHANGES TO FINAL RULE

10-144 C.M.R. Chapter 101, MaineCare Benefits Manual

Chapter II, Section 89, MaineMOM Services and Reimbursement

The Department of Health and Human Services held a virtual Public Hearing on July 24, 2023. Written and verbal comments were accepted through August 3, 2023. Comments were received from the following people:

Table of Commenters

1. Katie Fullam Harris, Chief Government Affairs Officer - MaineHealth, Portland, ME
2. Maura Graff, Vice President of Business Strategy, Planned Parenthood of Northern New England, Colchester, VT

Summary of Comments and Responses

1. **Comment:** Commenter 1 strongly recommended broadening the member eligibility criteria to be inclusive of any substance use disorders (SUD) for which there are evidence-based medical and behavioral interventions. The commenter noted that while providing care to pregnant and postpartum patients with opioid use disorder (OUD) is vitally important, OUD is not always present and/or the patient's primary SUD does not qualify for MaineMOM because they have a SUD that is not an OUD. The commenter concluded that expanding the inclusion criteria to include SUDs such as alcohol use disorder (AUD) and stimulant use disorder would allow providers to better care for patients and connect them to treatment.

   Response: The Department thanks the commenter for the comment. While the Department understands the merit of a service model that addresses all SUDs, at this time, MaineMOM services are specifically for members with OUD as they were funded as an extension of the federal Maternal Opioid Misuse model out of the Centers for Medicare and Medicaid Innovation (CMMI). The Department will continue to engage with stakeholders to consider expanding the model to all SUDs in the future. No changes were made to the rule because of this comment.

2. **Comment:** Commenter 1 stated upwards of 28% of members receiving MaineMOM services from its organization have duplicate services during at least part of their enrollment. The commenter noted enrollees into MaineMOM who have duplicative services may not understand which services cause the duplication. The commenter also stated these enrollees who have duplicative services may be difficult to assist, as they may not know which services are causing duplication, and it would be difficult to help the member decide which services to keep without more information about the other provider. The commenter recommended the Department reconsider which services are duplicative of MaineMOM services.

   Response: The Department thanks the commenter for their comment. The Department has accurately assessed which services are duplicative of MaineMOM services and will continue to work with its designated authorized entity Accentra, formerly known as Kepro, and providers to assist with duplicative service issues. No changes were made to the rule because of this comment.

3. **Comment:** Commenter 1 stated requiring enrollment into Kepro poses a barrier for practices, particularly medical practices. The commenter stated medical providers, unlike behavioral health

providers, have not used Kepro previously and are not well positioned to monitor Kepro to check the status of duplications. The commenter asserted that training should be provided by the Department, though using training would add an administrative burden to medical practices. The commenter stated that the overall administrative costs of complying with this requirement, including training in and continued use of Kepro, would add a burden to medical practices.

Response: The Department thanks the commenter for their comment. The Department's designated authorized entity Accentra, formerly known as Kepro, offers provider assistance, user guides, recordings of previous trainings, and ad hoc training. MaineMOM providers who began services through the CMMI pilot are already using Accentra successfully. Accentra will continue to be used for MaineMOM. No changes were made to the rule because of this comment.

4. **Comment:** Commenter 1 recommended that digital documentation of general consent to treat stored in an Electronic Health Record (EHR) meet the requirement to retain a consent form for all members in the member record.

   Response: The Department thanks the commenter for their comment. Member consent, as described in the rule, is a federally required component of any Health Home model. Providers must retain documentation of consent in the member's EHR. This documentation may be entirely digital but must still comply with Section 89.04-2(D)(1-2). To make this clear, the Department changed "a consent form" in Section 89.04-2(D) to "documentation of consent" and changed the section title from "Consent Form" to "Documentation of Consent."

5. **Comment:** Commenter 1 asked the Department to clarify whether documentation of a medical diagnosis of a SUD meets the American Society of Addiction Medicine (ASAM) Levels of Care (LOC) Level 0.5 or Level I. The commenter stated that not all locations providing MaineMOM services regularly perform a formal LOC assessment with the ASAM tool.

   Response: The Department thanks the commenter for their comment. The ASAM criteria, rather than basing treatment decision on the diagnosis alone, takes a multidimensional approach. The ASAM criteria evaluates various dimensions, risks, needs, strengths, and resources to standardize treatment planning and client placement. The Department's goal is to have the ASAM criteria implemented across the system of care for those with a SUD diagnosis. Recognizing this is a shift for some aspects of the system, the Department will look to provide technical support as needed. Members must minimally meet ASAM Level 0.5 or Level I for individual, family, or group outpatient services. While the Department does not specifically require the use of the ASAM CONTINUUM™ assessment tool, providers need to document how they determined the ASAM LOC based upon ASAM criteria. No changes were made to the rule because of this comment.

6. **Comment:** Commenter 1 stated that requiring a coordinated care plan could be challenging for MaineMOM providers in medical settings. The commenter stated that medical sites review plans of care on an as-needed basis and that following a standardized timeline for reviewing course of care is not routine for these sites. The commenter suggested that permitting some flexibility in the timing of the review and patient approval of the plan could be sufficient for provider compliance with this requirement.

   Response: The Department thanks the commenter for their comment. Developing and reviewing care plans is a standard of care that is required in all MaineCare Health Home policies as part of a whole-person, coordinated, and efficient model of care. No changes were made to the rule because of this comment.

7. **Comment:** Commenter 1 noted the proposed rule requires providers to create a Plan of Safe Care at least sixty (60) days after intake. Given that patients begin care at different times in their pregnancy date, the commenter suggested the Department change the timing requirement such that providers must create a Plan of Safe Care prior to the end of pregnancy.

   Response: The Department thanks the commenter for their comment. The Department agrees to change the language in Section 89.05-1(A)(3) to reflect how people enter into MaineMOM services under different circumstances and timing. The language is revised to require the creation of a Plan of Safe Care prior to the pregnancy due date for a member who enrolls in MaineMOM services at least thirty (30) days prior to the pregnancy due date. For a member who enrolls after thirty (30) days prior to the pregnancy due date, a Plan of Safe Care should be developed as soon as possible and appropriate, conditional on birth outcome.

8. **Comment:** Commenter 1 suggested that the Department remove coordination and communication with an established pediatric provider for the infant as a component of Comprehensive Transitional Care. The commenter asserted this function is standard practice already for inpatient pediatric teams.

   Response: The Department thanks the commenter for their comment. The Department agrees with the commenter that this requirement is standard practice, and, for that reason, will retain it as a component of Comprehensive Transitional Care. No changes were made to the rule because of this comment.

9. **Comment:** Commenter 1 recommended the Department add a medication-only level of care. The commenter believes this would align with changes to Section 93, Opioid Health Home Services. The commenter stated this addition could permit MaineMOM services recipients to receive OUD medication without electing to participate in OUD counseling.

   Response: The Department thanks the commenter for their comment. At this time, the Department is not proposing a medication-only level of care for MaineMOM members. MaineMOM services were designed over the course of several years with clinical and non-clinical stakeholders. During this process there was strong support for requiring a minimal level of counseling for this population. No changes were made to the rule because of this comment.

10. **Comment:** Commenter 1 recommended the Department align the SUD counseling requirement of one (1) hourly visit monthly with the Section 93, Opioid Home Health Services, counseling requirements. The commenter stated that, with certain integrated behavioral health providers, patients may attend multiple, shorter counseling sessions which equate to sixty (60) minutes. The commenter stated this method is in alignment with standard billing practices based on a billable month.

    Response: The Department thanks the commenter for their comment. The Department has revised the SUD Counseling requirement for MaineMOM in Section 89.05-3. The revision makes clear that while the counseling requirement will remain at a minimum as one billable hour monthly, this may be delivered in multiple member contacts, if clinically appropriate and documented in the member's record.

11. **Comment:** Commenter 1 recommended that the Department change the Recovery Coach requirement in Section 89.06 from "Be an individual in long-term recovery" to "Be a person in recovery" because there is no standard definition of "long-term recovery." The commenter stated that being in recovery for a certain length of time does not correlate to the level of support that an individual may need in their recovery.

Response: The Department thanks the commenter for their comment. The Department is comfortable removing "long-term" for the reasons cited and has removed two uses of this term from Section 89.06-1(F)(1)(g).

12. **Comment:** Commenter 1 suggested the Department remove "recovery ally" from eligible criteria for a Recovery Coach. The commenter stated this removal would align with the National Model Standards for Peer Support Certification by the Substance Abuse and Mental Health Services Administration (SAMHSA), which defines Substance Use Peers as those with lived experience involving a substance use condition. The commenter asserted this removal would better support peer recovery programs, as this would better align peer support roles with the population they are serving. The commenter suggested that "recovery ally" may, in aligning with SAMSHA guidance, be better integrated into a Family Peer role, which is distinct from a Recovery Coach.

    Response: The Department thanks the commenter for their comment. MaineMOM Recovery Coaches are required to complete Connecticut Community for Addiction Recovery (CCAR) training, which includes Recovery Allies, or a different Department-approved Recovery Coach training or certification. The Department appreciates the view that recovery coach roles should be limited to individuals in recovery from SUD. The Department declines to remove recovery ally from the requirements to be a Recovery Coach, as in 89.06-1(F)(1)(g)(i) at this time. No changes were made to the rule because of this comment.

13. **Comment:** Commenter 1 recommended that the Department make two additions to the required training for Recovery Coaches. The commenter recommended requiring the CCAR Ethical Considerations for Recovery Coaches course, in addition to the CCAR Recovery Coach Academy. The commenter also recommended requiring Certified Intentional Peer Support (CIPS) training within the first year of this role. The commenter believes the addition of these two training elements would provide comprehensive training, as well as connect Peer Coaches to quarterly co-reflections as part of the CIPS program.

    Response: The Department thanks the commenter for their comment. The CCAR Recovery Coach Academy is an extremely valuable resource, and the Department will continue to encourage MaineMOM providers to complete other CCAR and CIPS trainings. At this time, the Department declines to add to the minimum requirements for Recovery Coach training. No changes were made to the rule because of this comment.

14. **Comment:** Commenter 1 recommended that the Department include Licensed Marriage and Family Therapists (LMFTs) as eligible professionals who may fulfill the role of Clinical Team Lead.

    Response: The Department thanks the commenter for their comment. The Department declines to add LMFTs to the list of providers which may act as the Clinical Team Lead at this time but will consider reviewing this for future changes. No changes were made to the rule because of this comment.

15. **Comment:** Commenter 1 asked the Department to clarify whether MaineMOM team members can have a regional role, covering multiple practices or floating between practice sites.

    Response: The Department thanks the commenter for their response. MaineMOM care team members are not prohibited from serving in multiple locations. No changes were made the rule because of this comment.

16. **Comment:** Commenter 1 stated the requirement of MaineMOM providers to establish and maintain a relationship with a Primary Care Provider (PCP), authorized and evidenced by a signed medical release for each MaineMOM member served, except when the member's (PCP) is also the member's provider within the MaineMOM provider, would be a significant challenge to meet in practice. The commenter stated this would be challenging since many patients do not have a PCP outside of their prenatal care provider. The commenter suggested that the Department add language excluding patients without a PCP from this requirement.

    Response: The Department thanks the commenter for their comment. The Department has added "If a MaineMOM member has a primary care provider" to the beginning of Section 89.06-1(M). This change does not remove other requirements in Section 89 of the MaineMOM provider to engage in efforts to connect the member to a primary care provider.

17. **Comment:** Commenter 2 inquired whether the MaineMOM program is applicable to them as a family planning provider and asked if there would be any opportunity to participate. The commenter also asked, even if they cannot participate, is there a way they can partner with the Department and support the program.

    Response: The Department thanks the commenter for the comment. MaineCare enrolled providers that meet the eligibility criteria in Chapter II, Section 89, can enroll as Section 89 providers and deliver MaineMOM services. For opportunities to partner with MaineMOM providers or support the program, please visit https://www.mainemom.org/ or https://www.maine.gov/dhhs/oms/about-us/projects-initiatives/mainemom. No changes were made to the rule because of this comment.

List of Changes Made to Final Rule
Based on Comments Received and OAG Legal Review

1. As a result of comments, the Department changed the Section 89.04-2(D) title from "Consent Forms" to "Documentation of Consent" and changed "a consent form" to "documentation of consent" in the subsequent sentence.

2. As a result of comments, the Department changed Section 89.05-1(A)(3) from "Ensure a Plan of Safe Care is created at least sixty (60) days after intake" to "Ensure a Plan of Safe Care is created prior to the pregnancy due date for a member who enrolls in MaineMOM services at least thirty (30) days prior to the pregnancy due date. For a member who enrolls after thirty (30) days prior to the pregnancy due date, a Plan of Safe Care should be developed as soon as possible and appropriate, conditional on birth outcome."

3. As a result of comments, the Department made two changes under Section 89.05-3. The first change replaced "hourly visit" with "billable hour." The second change was adding a sentence to clarify that while the counseling requirements will be one hour in duration monthly, this may be delivered in multiple member contacts, as clinically appropriate, and documented in the member's record.

4. As a result of comments, the Department replaced "long-term recovery" with "recovery" in Section 89.06-1(F)(1)(g).

5. As a result of comments, the Department added "If a MaineMOM member has a primary care provider" to the beginning of Section 89.06-1(M).

6. As a result of final rule review, the Department eliminated Section 89.08(A)(9) "Adequate clinical documentation to support the phase of treatment to which the MaineMOM provider is attesting." MaineMOM services do not include phases of treatment and this was erroneously included in the proposed rule.