Cornerstone Behavioral Healthcare
Section 7. Eligibility and Access

Cornerstone Behavioral Healthcare (CBH) strives to provide high quality Trauma-Informed Care to individuals receiving Mental Health (MH)/Substance Use Disorder (SUD) care. CBH will base services in a trauma-informed approach and trauma-specific interventions to address the consequences of trauma in the individual and to promote recovery and facilitate healing. This approach will be used in all of its outpatient programs including Therapy, Testing, Medication Management and Case Management as outlined and defined below.

Trauma-Informed Approach:

- Realizes the widespread impact of trauma and understands potential paths for recovery;
- Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system;
- Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and
- Seeks to actively resist re-traumatization

CBH has adopted SAMHSA's six key principles of a trauma-informed approach and trauma-specific interventions based on the SAMHSA's perspective that "it is critical to promote the linkage to recovery and resilience for those individuals and families impacted by trauma." Consistent with SAMHSA's definition of recovery, services and supports that are trauma-informed build on the best evidence available and client and family engagement, empowerment, and collaboration.

SAMHSA's Six Key Principles of a Trauma-Informed Approach

- Safety
- Trustworthiness and Transparency
- Peer support
- Collaboration and mutuality
- Empowerment, voice and choice
- Cultural, Historical, and Gender Issues

CBH will utilize Trauma-Specific Interventions, which prescribe:

- All people need to be respected, informed, connected, and hopeful regarding their own recovery.
- The correlation between trauma and symptoms of trauma such as substance use, eating disorders, depression, and anxiety.
- The need to work in a collaborative way with clients, family and friends of the client, and other human services agencies in a manner that will empower clients.
- CBH also supports and utilizes the inclusion of Certified Intentional Peer Support Specialists (CIPSS).

With proper training and certification, CBH may utilize known Trauma-Specific Interventions which are based on psychosocial educational empowerment principles such as, but not limited to:

- "Addiction and Trauma Recovery Integration Model (ATRIUM)
- Essence of Being Real
- Risking Connection®
- Sanctuary Model®
- Seeking Safety
- Trauma, Addiction, Mental Health, and Recovery (TAMAR)
- Trauma Affect Regulation: Guide for Education and Therapy (TARGET)
- Trauma Recovery and Empowerment Model (TREM and M-TREM)"

Trauma-Informed Care (TIC) Plan:

- CBH will include TIC information upon hire and orientation of staff.
- CBH will offer training to support professional development of staff.
- CBH will maintain videos on Trauma Informed care for group supervision.
- CBH will include this topic within perspectives of clients living with MI.
- CBH will maintain its office environment with these principals to be welcoming and promote sense of safety.

- Clinical Staff will include screening for trauma in the AC-OK in the initial co-occurring assessment of individuals receiving MH/SUD services, using best practice assessment protocols, tools, and procedure.
- As it is identified, need for treatment will be identified in all plans of care.
- Annual screening of individuals receiving MH/SUD services will include screening for trauma and the identified needs will be incorporated in all plans of care.
- As indicated and consented to, individuals, receiving MH/SUD services will be referred to evidence-based trauma treatment as indicated.
- Crisis plans will identify trauma triggers and best ways to support and individual.
- In Adult Community Integration Service, clients will be offered to the opportunity to complete a psychiatric advanced directive to promote client choice, specific care directives to prevent re-traumatization by systems.
- Clients will be referred to TIC and peer support services, as indicated.

CBH will conform and maintain compliance with 10-144 CMR Ch. 101, MaineCare Benefits Manual and/or existing contracts with the Department of Health and Human Services (DHHS) in regards to requirements for eligibility and access to services, which include:

A. Access to Services: CBH will minimize barriers to a client's ability to access services, including, but not limited to, the following:

1. CBH will accommodate the written and oral communication needs of clients or applicants in accordance with, but not limited, to the following:
    a. CBH will provide or arrange for communication through assistive listening devices, telephone amplification, sign language services, or other communication methods for deaf or hearing-impaired persons;
    b. CBH will provide or arrange for communication assistance for clients with special needs who have difficulty making their service needs known, including but not limited to, the following:
        i. Providing or arranging for visible or tactile alarms for safety and privacy
        ii. Providing or arranging for communication assistance consistent with the client's literacy level
        iii. Providing or arranging interpreters for limited- or non-English speaking clients, or hearing-impaired clients who communicate in American Sign Language, referred for services. CBH will locate a language interpreter at no expense to the client. Should an interpreter not be located, CBH will contact DHHS for a recommendation. All services will be billed to third party payers within the established rules and procedures.
2. CBH will ensure that restrictions on access to services and treatment are limited to and based on eligibility or admission requirements, and that no person is denied access to services based solely on a co-occurring condition or on the person's refusal of any other service.
3. CBH strives to provide same day access for clients seeking case management services. If not possible, CBH will follow the Waiting List policy (Section 7E).
4. Clients wishing to access CBH services who do not have their own transportation may use community transportation services appropriate to their individual needs. The location of all CBH offices will take into consideration public transportation if it is available. If a client requests assistance with transportation, either the CBH staff person taking the initial referral or the clinician providing ongoing mental health services shall inform the client of transportation option(s) available. Case Managers may occasionally link clients to community-based services if these needs are identified in the Individualized Support Plan. Case Managers' primary function is not to provide "transportation."

B. Eligibility Criteria: CBH will develop, update, and maintain written policies and procedures regarding eligibility criteria for receiving services.

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1. Eligibility Policy
    a. Eligibility depends on screening of the client and the services they are seeking and desire. CBH matches the client with what is available within our system.
    b. The client must be in the state of Maine at the time of service.
    c. The client must identify as having a behavioral health issue (consider service specific regulations outlined above/below), and
    d. Be able to provide their own consent or legal representative consent.
    e. Everyone must have had an assessment or evaluation in the past 12 months.
2. Service Specific Eligibility
    a. Section 65 Outpatient Services:
        i. Medication Management:
            - Persons over the age of 5,
            - Who have a disorder that can be treated with medication, and
            - Are need of treatment and management of mental health disorders, substance use disorders, and/or co-occurring disorders.
        ii. Outpatient Therapy:
            - Have a diagnosed mental health disorder as specified in the DSM 5-TR
            - Person who are ages 3 and over.
        iii. Substance Use Disorder Outpatient Services:
            - Have a diagnosed substance use disorder as specified in the ASAM Criteria: Treatment Criteria for Addictive, Substance -Related and Co-Occurring Conditions.
        iv. MAT/MOUD:
            - Persons who are ages 14 and older, and
            - Are in need of opioid use disorder treatment as assessed by an MOUD provider.
    b. Section 17 Adult Community Support:
        i. Client must meet general MaineCare eligibility requirements and specific requirements as outlined below. Services must be coordinated, not duplicated.
        ii. Person age eighteen (18) or older, or an emancipated minor, and meets criteria for a Serious and Persistent Mental Illness as follows:
            - Has a primary diagnosis of Schizophrenia or Schizoaffective disorder, in accordance with the Diagnostic and Statistical Manual, 5th edition (DSM 5) criteria; or
            - Has another primary DSM 5 diagnosis with the exception of Neurocognitive Disorders, Neurodevelopmental Disorders, Antisocial Personality Disorder, and Substance Use Disorders who:
                ⇒ Has a written opinion from a clinician, based on documented or reported history, stating that they are likely to have future episodes, related to mental illness, with a non-excluded DSM 5 diagnosis, that would result in, or have significant risk factors of, homelessness or criminal justice involvement, or require a mental health inpatient treatment greater than seventy-two (72) hours, or residential treatment unless community support program services are provided; based on documented or reported history; for the purposes of this section, reported history shall mean an oral or written history obtained from the member, a provider, or a caregiver; or
            - Has received treatment in a state psychiatric hospital, within the past twenty-four (24) months, for a non-excluded DSM 5 diagnosis; or
            - Has been discharged from a mental health residential facility, within the past twenty-four (24) months, for a non-excluded DSM 5 diagnosis; or
            - Has had two or more episodes of inpatient treatment for mental illness, for greater than seventy-two (72) hours per episode, within the past twenty-four (24) months, for a non-excluded DSM 5 diagnosis; or

- Has been committed by a civil court for psychiatric treatment as an adult; or
- Until the age of twenty-one (21), was eligible as a child with severe emotional disturbance, and has a written opinion from a clinician, in the last twelve (12) months, stating that they had risk factors for mental health inpatient treatment or residential treatment, unless ongoing case management or community support services are provided: and

iii. Has significant impairment or limitation in adaptive behavior or functioning directly related to the primary diagnosis and defined by the Level of Care Utilization System (LOCUS) or other acceptable standardized assessment tools approved by the Department. If using the LOCUS, the member must have a LOCUS score, as determined by a LOCUS Certified Assessor, of seventeen (17) (Level III) or greater, except that to be eligible for Community Rehabilitation Services (17.04-2)

iv. Client who is age eighteen (18) to twenty-one (21) may elect to receive services as an adult or as a child. A client choosing services as an adult is eligible for services under this Section. A client choosing services as a child may be eligible for services under Chapter II, Section 65, Behavioral Health Services, or Section 13, Targeted Case Management, or both.

v. The LOCUS will be administered at intake, annually, and at time of discharge; or when a higher level of service is warranted.

vi. Determination of Eligibility. For each member seeking Community Support Services, a Community Support Provider will:

- Verify the member's eligibility for MaineCare; * If the individual is not currently receiving MaineCare, grant funds may be utilized if available.
- Determine the member's eligibility, initially and annually, for Community Support Services. The annual eligibility verification must include a recent diagnosis that is supported by evidence of symptoms as defined in the current version of the DSM, completed within the past year, as documented by an appropriately licensed clinician.
- Verify that a member meets specific Eligibility Requirements within thirty (30) days of the start date of services. If eligibility verification is not submitted by close of business on day thirty (30), MaineCare will cease payment for services under this section on day thirty-one (31).
- Requests for a waiver of Specific Requirements for eligibility must be made in accordance with MaineCare regulations.
- Provide CI Services only to individuals who meet the Eligibility for Care requirements according to the following priority list (in ranking order of priority):
  - ⇒ Individuals being discharged from Riverview Psychiatric Recovery Center (RPC) or Dorothea Dix Psychiatric Center (DDPC); or are leaving incarceration;
  - ⇒ All other clients being referred by Department personnel;
  - ⇒ Individuals being discharged from other psychiatric inpatient facilities
  - ⇒ Individuals who are within Medically Needy Deductible (MaineCare Spend Down) ineligibility periods, individuals with Limited MaineCare, and uninsured individuals

c. Section 92 Behavioral Health Home:

i. Eligibility Verification. Member eligibility is determined by the Department or its authorized entity, which must provide pre-authorization for services in Kepro. Each member's eligibility must be based on a diagnosis rendered within the past year, as documented by an appropriately licensed professional.

ii. Adult clients must meet general MaineCare eligibility requirements and specific requirements as outlined below.

- Members must meet the following criteria for Serious and Persistent Mental Illness. Eligibility must be supported by written diagnosis(es), rendered by a physician, a physician assistant, or an independently licensed clinician, within the scope of the professional's license, and the diagnosis(es) shall be documented in the member's record.

iii. Members must have a primary mental health diagnosis under the most current edition of the Diagnostic and Statistical Manual of Mental Disorders, except that the following diagnoses may not be primary diagnoses for purposes of this eligibility requirement:

1. Delirium, dementia, amnestic, and other cognitive disorders;
2. Mental disorders due to a general medical condition, including neurological conditions and brain injuries;
3. Substance use or dependence;
4. Intellectual disability;
5. Adjustment disorders;
6. Z-codes; or
7. Antisocial personality disorder; and

⇒ Has a LOCUS score, as determined by staff certified for LOCUS assessment by DHHS upon successful completion of prescribed LOCUS training, of seventeen (17) (Level III) or greater. The LOCUS assessment must be administered annually and documented in the member's record.

iv. Child clients must meet general MaineCare eligibility requirements and specific requirements as outlined below

- Children must meet the following criteria for Serious Emotional Disturbance (SED). Eligibility must be supported by written diagnosis(es), rendered by a physician, a physician assistant, or an independently licensed clinician, within the scope of the professional's license, and the diagnosis(es) shall be documented in the member's record.
- Members must have a mental health diagnosis under the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, or a diagnosis described in the current version of the Diagnostic Classification of Mental Health and Developmental Disabilities of Infancy and Early Childhood, except that the following diagnoses are not eligible for services in this section:
  - ⇒ Learning Disabilities in reading, mathematics, written expression;
  - ⇒ Motor Skills Disorder;
  - ⇒ Learning Disabilities Not Otherwise Specified;
  - ⇒ Communication Disorders (Expressive Language Disorders, Mixed Receptive Expressive Language Disorder, Phonological Disorder, Stuttering, and Communication Disorder Not Otherwise Specified; and
- After the initial month of BHH enrollment, members must also have a significant impairment or limitation in adaptive behavior or functioning, as evidenced by a CANS score of a two (2) or higher in both of the following sections: "Child Behavioral/Emotional Needs" and "Life Functioning Domain." The CANS must be reviewed and updated by the BHH a minimum of every one hundred and eighty days (180) days or sooner when major changes occur. The CANS, including all age relevant domains, must be entered into the Maine ASO database for tracking and reporting. Information gathered via the CANS must be used to inform and guide the development of the Individualized Service Plan (ISP).

d. Section 13 Targeted Children's Case Management:

i. Children age 4-20 with Behavioral Health Disorders,

ii. Have a qualified diagnosis included in the Targeted Case Management Eligibility Group. The diagnosis must be rendered, within the scope of the individual's license, by a physician, a physician assistant or an independently licensed clinician

iii. Functional limitations, as set forth below, must be identified, supported, and documented in assessments using accepted standardized instruments that are developmentally appropriate to the members being assessed.

- Functional Limitations mean:
  - ⇒ Functional Limitations quantified through DHHS/OBH approved standardized instruments for behavioral health. Currently, the Child and Adolescent Needs and Strength assessment (CANS) is the designated tool.
  - ⇒ Children must have assessment scores are 2 or higher for both the "Behavioral/Emotional needs" AND "Life domain functioning" sections of the CANS. Additionally, 2 CANS scores are required in different domains.

iv. Authorization

- Case management service is authorized initially for 30 days when a prior authorization is completed and they meet eligibility criteria. After the initial authorization period ends on the 20th day of the month, a CSR is submitted, which extends to 6 months. This depends on CANS Score, ISP, and medical necessity.
- Clinical information will be considered in addition to the CANS scores as the scores are not the sole criteria for eligibility.
- CBH is responsible for confirming the individual's eligibility for case management services.

C. Intake, Screening, Referral, and Admission Policies: CBH will update and maintain written policies and procedures for intake, screening, referral, and admission processes.

1. Intake Policy:
   a. Intake is a required component of the admission process. It involves meeting with the client/legal representative in person to review service options, preferences, required disclosures, rights of recipients, and to obtain informed consent and required signatures. Sending intake paperwork via mail or electronically prior to admission is permissible when in-person intake is not an option, but all intake paperwork must be reviewed by client and provider during intake appointment.
   b. Intakes may be facilitated and completed by administrative support staff. These will be sent to the clinical staff for review with the client.
   c. Intakes will be scheduled for eligible clients within program-specific time frames. This will follow basic screening for:
      i. eligibility for service being requested
      ii. having insurance or source of payment that pays for the service requested
      iii. sufficient program capacity to accommodate client needs
      iv. persons being discharged from a psychiatric hospital or crisis unit
2. Screening Policy:
   a. All potential clients will be screened upon referral to determine the need and urgency of need, appropriateness of the referral, basic eligibility, and need for additional services.
   b. Once the screening is complete and basic eligibility is established, the person will be scheduled for intake unless they need a service that falls outside the scope of services offered by CBH, or when CBH does not have the capacity to serve. In that case, CBH will follow policies for waitlist, referrals, and hold for service.
3. Referral Policy:
   a. Incoming referrals: CBH will accept referrals via walk-in, phone, email, electronically, and fax. CBH will maintain a CBH Referral Form on its website and will make it available to anyone who requests it. Referrals will be reviewed, screened, and triaged the same day to the appropriate department. All referrals will be dated and will be maintained in the EHR.

i. When CBH receives a referral that needs immediate attention, the Clinical Director and Program Managers will be notified and consulted to determine next steps to expedite intake based on the needs presented and to make appropriate referrals for emergency needs.

b. Outgoing referrals: CBH will make referrals to other organizations when a need is identified. Referrals may be indicated for many reasons including but not limited to: a service is needed that falls outside the scope of services offered by CBH, CBH does not have the capacity to serve, or a client requests a referral to a community service, care provider, or community resource.
   i. Referrals must be need-based. Clients must be consulted, have options presented, provide informed consent, and sign a release of information.
   ii. Referrals should include demographic information, contact information, need/reason for referral, who made referral, date of referral, contact information of the referred individual, and other information as required by the receiving entity.
   iii. Referrals will be documented on an "Outgoing Referral Form," to be retained in EHR.

4. Admission Policy:
   a. People seeking service will be fully admitted to CBH once screening is done, eligibility is determined, all intake disclosures and consents are signed, assessment is completed, and authorization is obtained, if applicable.

D. Screening Practices: CBH will screen potential clients upon referral. CBH strives to have new referrals screened and assigned in the same day. CBH will screen referrals to identify the need and urgency of services. Those considered urgent include individuals who are identified as meeting one or more of the following criteria:

1. Members identified as having SPMI who are hospitalized at the time of referral will be assigned a case manager within three days of application. If not hospitalized, the person will be assigned a case manager in one day.
2. All persons currently receiving active discharge planning while in state hospitals or who have been discharged in the last six months.
3. All persons with an SPMI receiving active discharge planning from other inpatient units or residential treatment centers, or who have been discharged in the last six months.
4. Persons with hospitalization or residential treatment care of at least six months duration in the last eighteen months.
5. Persons with two or more periods of hospitalization in the last twelve months.
6. Persons who are homeless and in a homeless shelter.
7. Persons who are in a current crisis stabilization unit or recently discharged.
8. Persons who are expressing risk and are likely to deteriorate clinically to a point of needing immediate institutionalization in the absence of prompt community support service intervention.
9. Children who have been expelled or are not attending school.
10. Medication Assisted Treatment/MOUD only: members in withdrawal and/or at risk of overdose or members who are pregnant.

E. Waiting Lists: CBH will develop, maintain, and review a written policy for managing waiting lists. Waiting lists for services will be utilized when CBH does not have the capacity to serve upon referral and when the individual declines a referral to other service providers. CBH will follow required DHHS regulations.

1. Service specific rules:
   a. Outpatient Services (Section 65)
      i. Perspective clients can be placed on a waiting list if immediate services are not available. First, they will be offered contact information about other service providers. If they choose the waiting list, they will be contacted by phone or mail once there is an opening. The waiting list will be managed by Medical Records, and openings will be prioritized based on severity of need and/or date referral was made.

ii. Required for SUD: current wait list of individuals who are awaiting admission into the program through an electronic treatment data system of the Department of Health and Human Services, Office of Behavioral Health (OBH) or its contractor.

b. Adult Community Integration (Section 17), Behavioral Health Homes (Section 92)
   i. CBH's policy is to serve people requesting Sec 17 and Sec 92 services with same-day access. If CBH is not able to provide same-day access for a referral, CBH will submit a "Hold for Service" (HFS) (aka waiting list), called a referral in DHHS's approved electronic data reporting and utilization management system. A chart will also be created in the EHR to document the referral. CBH will also offer alternatives to the waiting list by providing contact information of other service providers in a 25-mile radius.
   ii. Hold for Service is required when:
      - the agency is unable to provide same-day service
      - the member is not able to participate in a same-day service
      - a referral is received from a community provider and the agency is unable to reach the member
   iii. Hold for Service is not required when:
      - when a member is provided services on the day of referral
      - at the time of referral, the member is notified that they would need to be placed on HFS, and they decline to wait for services
   iv. Referral Refusal is required when:
      - the member declines to wait for services
      - agency is unable to reach member after several attempts
      - an intake has been scheduled and the member declines services
      - CBH is unable to accept the referral
      - the member was on HFS with CBH and has decided to go to another agency for services
   v. Hold for Service will require member's name, date of birth, and diagnosis. If there is not an eligible diagnosis available, enter R69 (Illness Unspecified). This will need to be changed upon submission of prior authorization.
   vi. CBH will manage the HFS list in DHHS's approved electronic data reporting and utilization management system and outreach all individuals every thirty (30) days to ensure circumstances have not changed and confirm they still want services, attempting at least three (3) times and documenting each attempt as a contact note. CBH will maintain and update this list to mirror the waiting list in its own EHR.
   vii. Clients will be selected from the waiting list based on the date of referral, first come first served basis, unless they meet the priority category per contractual requirements.
   viii. Once a member has been served, there is no need to discharge the HFS request. It will be removed once the prior authorization is submitted.

c. Targeted Children Case Management (Section 13.12) and Child Behavioral Health Home (Section 92)
   i. CBH's policy is to serve people requesting Sec 13.12 and Sec 92 services with same-day access. If CBH is not able to provide same-day access for a referral, CBH will submit a "Hold for Service" (HFS), called a "referral" in DHHS's approved electronic data reporting and utilization management system. A chart will also be created in the EHR to document the referral. CBH will also offer alternatives to the waiting list by providing contact information of other service providers in a 25-mile radius.
   ii. Staff will manage the list each month by:
      - Contacting each waiting client or their legal representative to determine if they want to continue to wait
      - Offering a list of other area providers with the client/legal representative

- Assisting the client/legal representative with a referral to an alternate provider if they no longer want to wait
- Documenting and retaining client/legal representative communication along with CBH's efforts and targeted date to provide the service
- Updating DHHS's approved tracking system with each client's waiting list status
- Monitoring and verifying the accuracy of CBH's waiting list

F. Referral Procedure: CBH will develop, review, and maintain a written policy for referral to other providers.

1. Referrals may be made as needed and consented for by applicants and/or their legal representatives, including but not limited to, the following circumstances:
    a. Services are denied or deemed inappropriate upon referral/screening:
        i. CBH will refer the applicant to other services for which they might be eligible.
        ii. CBH will provide the rationale to explain why CBH services are denied or deemed inappropriate to meet the level of care of the applicant.
        iii. CBH will offer the applicant recommendations regarding options to meet their needs.
        iv. CBH will provide assistance, as needed, to help the applicant obtain/access service(s) for which they are referred. **See Sec 7.c.**
    b. CBH is unable to meet the client's assessed needs after screening:
        i. If it is determined that the referred individual's needs are beyond the scope of services offered by CBH, the applicant will be referred to other services for which they might be eligible and might better meet their assessed needs.
        ii. CBH will provide the rationale for why CBH services are not appropriate to meet the needs of the applicant and will offer recommendations to meet their needs.
        iii. CBH will provide assistance, as needed, to help the applicant obtain/access service(s) for which they are referred.
    c. The client requests transfer to another organization: Transfer means a planned transition in care from one organization to another, or from one level of care to another within the same organization.
        i. Should a referred individual request to be transferred to another service at any point in the eligibility and access process, CBH will make the referral.
        ii. CBH may ask the client the reason(s) they are choosing to be transferred.
        iii. CBH may offer to address the issue(s) that may have caused concern for the client.
        iv. CBH will also help the client look for appropriate alternatives and make these referrals efficiently to enable clients to access needed services quickly.
    d. Client needs additional services
        i. CBH will refer the client to other services when a client asks, or CBH determines that the client needs another service and the client consents to referral.
2. Any referral made will need to have expressed consent of the client or their legal representative.
3. Referrals will be documented on the "Outgoing Referral Form", see Referral Policy Sec 7.C.3.b.

Sharon Jordan
_____ 05/11/2024
Clinical Director Date