

DEPARTMENT OF SOCIAL SERVICES

Notice of Proposed Medicaid State Plan Amendment

Behavioral Health Homes Pursuant to Section 1945 of the Social Security Act (SPA 15-014)

The State of Connecticut Department of Social Services (DSS) proposes to submit the following Medicaid State Plan Amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services.

Changes to the Medicaid State Plan

Pursuant to section 17b-8 of the Connecticut General Statutes, DSS provides notice that it intends to amend the Medicaid State Plan, effective on or after October 1, 2015, to establish behavioral health homes as a SPA option pursuant to section 1945 of the Social Security Act for specified Medicaid beneficiaries with a chronic serious mental illness. Those services will be offered statewide in a new Behavioral Health Home Medicaid SPA Option, which is a collaboration led by three partner state agencies: DSS, the Department of Mental Health and Addiction Services, and the Department of Children and Families.

SPA 15-014 amends the Medicaid State Plan by establishing new provisions that set forth the Behavioral Health Home SPA Option. Services available under Behavioral Health Homes include a variety of care management, care coordination, transitional care activities, individual and family support services, referrals to community and social support services, and other services as specified in the SPA. Designated providers are local mental health authorities (LMHAs) and LMHA affiliate providers.

Fiscal Information – Estimated Annual Change to Medicaid Expenditures

Based on the information that is available at this time, DSS estimates that this SPA will increase annual aggregate expenditures by approximately \$25.3 million in Federal Fiscal Year 2016 and approximately \$25.8 million in Federal Fiscal Year 2017.

Information on Obtaining SPA Language and Submitting Comments

In accordance with federal Medicaid requirements, upon request, DSS will provide copies of the proposed SPA. Copies of the proposed SPA may also be obtained at any DSS regional office and on the DSS web site: <http://www.ct.gov/dss>. Go to “Publications” and then “Updates.”

Written, telephone, and email requests should be sent to: Ginny Mahoney, Department of Social Services, Medical Policy Unit, 55 Farmington Avenue, 9th Floor, Hartford, CT 06105, Telephone: 860-424-5145, Email: ginny.mahoney@ct.gov. Please reference “SPA 15-014 – Behavioral Health Homes”. Written comments may be submitted in the same manner as requests no later than July 30, 2015.

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| Public Notice | |
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| Check which of the following applies to your specific state | |
| <p>Whether Comment is Solicited (Indicate whether public comment was solicited. Public Notice is required for new Health Homes programs and for changes to payment methodologies.)</p> | <ul style="list-style-type: none"> <input type="radio"/> Public notice was not required and comment was not solicited <input type="radio"/> Public notice was not required but comment was solicited <input checked="" type="radio"/> Public notice was required and comment was solicited |
| <p>Method of Public Comment (Indicate how public comment was solicited, such as newspaper, publication in state administrative record, website notice, and public hearing. For each method, indicate date and location of notice, URL, date of posting and/or the date, time and location of any public meetings. Adding additional detail around the key issues raised during this period is <i>optional</i>.)</p> | <p>Prior to the formal comment period, a draft State Plan Amendment (SPA) was shared with stakeholders to solicit comments. The Departments of Mental Health and Addiction Services (DMHAS), Children and Families (DCF), and Social Services (DSS) held a meeting with the Adult Quality, Access, and Policy Committee of the Connecticut Behavioral Health Oversight Council (CT BHPOC) on January 8, 2014 and the full CT BHPOC on January 15, 2014 to discuss comments and incorporate stakeholder input.</p> <p>Connecticut has complied with all CMS requirements related to posting notice of the draft Behavioral Health Home SPA and conducting a thirty-day public comment period.</p> <p>On June 30, 2015, notice was published in the Connecticut Law Journal, the state’s official register. The notice and also a copy of the draft State Plan Amendment were posted on the DSS website (http://www.ct.gov/dss) on _____, 2015 and on the DMHAS website (http://www.ct.gov/dmhas) on _____, 2015. The public comment period ran from June 30, 2015 through July 30, 2015.</p> |
| Tribal Input | |
| <p>Whether Input is Solicited (Indicate whether tribal input was solicited. Tribal input is required if the State Plan Amendment is likely to have a direct effect on Indians,</p> | <p>The Behavioral Health Home (BHH) SPA is not likely to have a direct effect on members of Connecticut’s Tribal Nations. However, in accordance with Connecticut’s approved SPA regarding tribal notifications, on xxxx, notice was sent to Connecticut’s two federally recognized Indian tribes,</p> |

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| Indian health programs or Urban Indian Organizations. | |
| Organization Consulted for Tribal Input (Indicate which organizations were consulted for tribal input) | Connecticut has two federally recognized Indian tribes: the Mashantucket Pequot Tribal Nation and the Mohegan Tribe. |
| Method of Tribal Input (For each organization consulted, indicate the date, method, and location of consultation. Indicate any key issues raised (Access, Quality, Cost, Payment Methodology, eligibility, benefits, service delivery and any other areas) raised during these consultations.) | See above. |
| SAMHSA Consultation | |
| SAMHSA Consultation (Add the date of the SAMHSA Consultation. mm/dd/yyyy format.) | <p>SAMHSA consultations occurred on 12/12/13 and 1/3/14</p> <p>On January 10, 2014, CT's BHH Team (DMHAS, DCF, DSS) received written comments from SAMHSA's Health Home Team summarizing telephone consultations which occurred on 12/12/13 and 1/3/14. The report includes a score given by SAMHSA HH Team members on the extent that the state has addressed elements in the SPA related to the six core BHH services. CT received a rating of 4 or 80% (on a 1-5 rating scale) on each of the elements related to adult services and an average rating of 3.3 (63%) for the extent to which children services were addressed.</p> <p>SAMHSA recommendations centered on:</p> <ul style="list-style-type: none"> • Services to children/youth • Substance use screening & assessment • Use of HIT <p>Improvements to the SPA result from SAMHSA's feedback. Changes include an expansion of the background and descriptions of each of these areas.</p> |
| Health Home Population Criteria and Enrollment | |
| Population Criteria (Indicate if State will be using | <input type="checkbox"/> Two chronic conditions <input type="checkbox"/> One chronic condition and the risk of developing another |

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| <p>2 or more chronic conditions, 1 chronic condition and at risk for another or 1 serious and persistent mental illness. Specify the targeted chronic conditions)</p> <p><i>Other Chronic Conditions Covered</i> (For other chronic conditions that go beyond what is written in Statute, states will need to provide justification as to why these conditions would need or benefit from health home services, e.g. intensive care coordination)</p> | <p>× One serious mental illness</p> <p><i>from the list of conditions below:</i></p> <p><input type="checkbox"/> Mental Health Condition</p> <p><input type="checkbox"/> Substance Use Disorder</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> BMI Over 25</p> <p><input type="checkbox"/> Other chronic conditions (please list)</p> |
| <p>Geographic Area (Describe whether statewide or if targeting geographic areas(e.g. county/city/region/ or other). Specify geographic areas (e.g. names of counties/city/regions).</p> | <p>Connecticut will build on the Department of Mental Health and Addiction Services’ existing statewide behavioral health services infrastructure to implement BHHs in a targeted manner using statewide Local Mental Health Authorities and their designated affiliates.</p> |
| <p>Enrollment of Participants (Describe how the individuals will be assigned to the health home, including whether eligible individuals can opt-in to a Health Home or are auto-assigned with an option to opt-out)</p> | <p>CT has identified the following criteria to determine eligibility for Behavioral Health Homes:</p> <ul style="list-style-type: none"> • SPMI: schizophrenia and psychotic disorders, mood disorders, anxiety disorders, obsessive compulsive disorder, post-traumatic stress disorder, borderline personality disorder • Medicaid eligible, but not a Qualified Medicare Beneficiary (QMB) • High Medicaid claims (≥ \$10,000/1year) <p>Eligible individuals presently receiving services at a BHH designated provider will receive written notification about their auto-enrollment for BHH services. The letter will include, but not be limited to, the following information: 1. The BHH to which they will be auto-enrolled (their existing BH provider for BHH services); 2. The option to choose another BHH provider; 3. The option to opt out completely with no changes to their present care; and 4. Examples of services they will receive via the BHH (health information, health screenings, help with care transitions, quitting smoking, others).</p> |

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| | <p>Eligible individuals presently not receiving services from BHH designated providers will receive a notification letter of their eligibility, which will include contact information to request participation in the BHH. Additionally, should non-enrolled, eligible individuals receive services from a hospital (Emergency Department or Inpatient), the Administrative Services Organization (ASO) will provide outreach to offer BHH services as an option as described above.</p> <p>Draft notification letters have been submitted as separate documents.</p> |
| <p>Assurances (Review and agree to the assurances)</p> | <ul style="list-style-type: none"> ○ The State provides assurance that eligible individuals will be given a free choice of Health Home providers. ○ The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Home services. ○ The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Home providers. ○ The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Behavioral Health Home enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Behavioral Health Home State Plan Amendment that makes Behavioral Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition. ○ The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities. |
| <p>Health Home Provider Requirements</p> | |
| <p>Types of Providers (Select the types of providers to be included, such as 1. Designated Providers; 2. Teams of Health Care Professionals; or 3. Health Teams. For each type, indicate provider qualifications and standards.)</p> | <p>Designated Providers: Connecticut Local Mental Health Authorities (LMHA) and designated LMHA affiliates will serve as Behavioral Health Home designated providers, thereby utilizing the existing statewide behavioral health infrastructure to implement BHH services. As designated providers of BHH services, LMHA staffing will be enhanced to support the provision of BHH services. All BHH designated providers will be required to meet state credentialing requirements; must have the demonstrated ability to provide the six core health home services; and must have a substantial percentage of individuals eligible for enrollment in behavioral health homes as determined by the state.</p> <p>At a minimum, each behavioral health home team will include a Director, Primary Care Nurse Care Manager, Primary Care Physician Consultant, Administrative Systems Specialist, Hospital Transition Coordinator, Licensed Behavioral Health Clinician, Care Coordinator (Behavioral Health Home Specialist), and Peer Recovery Specialist. The behavioral health home services will focus on “whole person” care by integrating primary care functions into a behavioral health and substance abuse setting, which will allow for greater coordination with primary care in the community.</p> <p>In addition to the standards and qualifications above, the providers must also follow the items described in the Provider Standards section below.</p> |
| <p>Supports for Health Homes Providers (Describe the</p> | <ol style="list-style-type: none"> 1. Provide quality-driven, cost effective, culturally appropriate, and person and family-centered Health Homes services; 2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines; 3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and |

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| <p>methods by which the State will support providers of Health Homes services in addressing the 11 components listed on the right and how these methods will be incorporated in the State’s provider standards.)</p> | <p>substance use disorders;</p> <ol style="list-style-type: none"> 4. Coordinate and provide access to mental health and substance abuse services; 5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care; 6. Coordinate and provide access to chronic disease management, including self-management supports to individuals and their families; 7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services; 8. Coordinate and provide access to long-term care supports and services; 9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services; 10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and the individual and his/her family caregivers, and provide feedback to practices, as feasible and appropriate; 11. Establish a continuous quality improvement program, and collect and report on data that permit an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level. <p>State Methods used to Support Providers: Providers will be supported in transforming service delivery by participating in a statewide BHH learning collaborative. The state will contract with an Administrative Services Organization to assess providers’ learning needs, as it is expected that there will be varying levels of experience with organizational change, transformation approaches, and knowledge of health home services. Behavioral health home providers will be required to participate in the learning collaborative specifically designed to aid in implementation. Support and learning will be provided to providers between Learning Collaborative sessions via provider-specific technical assistance both on-site and telephonically.</p> <p>The Learning Collaborative curriculum will include, at a minimum the following: acceptable evidence based clinical and substance abuse screening assessment instruments and intervention models (including SBIRT); orientation to the DCF system of care and community collaborative infrastructure and process; orientation to, and opportunity for trainer certification from the CT Department of Public Health on the Chronic Disease Management Model and the CT Department of Aging on the Transitional Care Model.</p> |
| <p>Provider Infrastructure (Describe the infrastructure of provider arrangements for Health Homes Services.)</p> | <p>The Department of Mental Health and Addiction Services (DMHAS) promotes and administers comprehensive, recovery-oriented services in the areas of mental health treatment and substance abuse prevention and treatment throughout Connecticut. DMHAS also provides collaborative programs for individuals with special needs, such as persons with HIV/AIDS infection, people in the criminal justice system, those with problem gambling disorders, substance abusing pregnant women, persons with traumatic brain injury or hearing impairment, those with co-occurring substance abuse and mental illness, and special populations transitioning out</p> |

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| | <p>of the Department of Children and Families.</p> <p>The foundation of DMHAS’ statewide treatment system is Local Mental Health Authorities (LMHA). LMHAs are both state-operated and private, non-profit agencies that provide treatment and support at the community level. LMHAs and contracted LMHA affiliate providers (Affiliates) will serve as designated providers of behavioral health home services. Each LMHA has the specific responsibility for one or more catchment areas assuring statewide coverage. Contract language will be added to the private, non-profit contracts explicitly defining Behavioral Health Home services, provider standards and performance outcome measures.</p> |
| <p>Provider Standards (Describe the State's minimum requirements and expectations for Health Homes providers)</p> | <p>In addition to being a state designated LMHA or Affiliate, all behavioral health homes will be required to meet the following credentialing requirements, which may be amended from time-to-time as necessary and appropriate:</p> <ol style="list-style-type: none"> 1. Meet all applicable state licensure requirements necessary to perform behavioral health home services; 2. Be accredited by either The Commission on Accreditation of Rehabilitation Facilities or The Joint Commission; 3. Be in the CT Medicaid Program as a mental health clinic or outpatient hospital; 4. Have capacity to serve individuals on Medicaid or are Medicare/Medicaid dually eligible and are eligible for behavioral health home services in the designated service area; 5. Meet staffing requirements to ensure behavioral health home team composition and roles; 6. Meet enhanced access requirements including enhanced enrollee access to the health home team and 24/7 access to crisis intervention and other needed services; 7. Have a strong, engaged leadership committed and capable of leading the provider through the transformation process as demonstrated by the agreement to participate in the learning collaborative and other technical assistance; 8. Conduct a standardized assessment and complete status reports to document enrollees’ living arrangement; employment, education; legal, entitlement, and custody status; etc.; 9. Develop and maintain a single person-centered care plan that coordinates and integrates all behavioral health, primary care, and other needed services and supports with documentation to demonstrate that behavioral health home services are being delivered in accordance with program guidelines and requirements; 10. Conduct wellness interventions, as indicated, based on enrollees’ level of risk; 11. Agree to convene regular documented behavioral health home team meetings for case consultation and implementation of practice transformation; 12. Within three months of implementation, become familiar with DCF System of Care Practice Standards that govern the delivery of care within the Children’s Behavioral Health Service system for all individuals under 18 years of age; 13. Within three months of implementation develop a contract or MOU with regional hospitals, DCF system of care community collaborative, Children’s Emergency Mobile Psychiatric Services (EMPS), primary care and other provider systems to ensure a formalized relationship for transitional care planning, to include communication of inpatient admissions as well as identification of individuals seeking Emergency Department (ED) services (for children, these MOUs should build upon those agreements executed between EDs and emergency mobile psychiatric service providers); 14. Within three months of implementation, develop and maintain referral agreements with regional primary care practices or federally qualified health centers, including pediatric resources; 15. Have a comprehensive data collection system capable of communicating with the state’s data system; 16. Have the capacity to collect and report data in the form and manner specified by the state on implementation progress, |

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| | <p>staffing, services, time/activities, outcomes, etc.;</p> <p>17. Agree to participate in CMS and state-required evaluation activities;</p> <p>18. Agree to site visits and auditing of records by the state, and develop quality improvement plans to address identified issues;</p> <p>19. Maintain compliance with all terms and conditions as a behavioral health home provider or face termination; and</p> <p>20. Implement a behavioral health home model that the state determines has a reasonable likelihood of being cost-effective. (Improvement on outcome measures will be used to determine cost effectiveness prior to the calculation of return on investment.)</p> |
| Health Home Service Delivery System | |
| <p>Type of Service Delivery System (Indicate whether services are provided Fee for Service, using Primary Care Case Management, using Risk-Based Managed Care, or another service delivery system)</p> | <p>CT’s Medicaid program is currently a managed Fee for Service delivery system with administrative service organizations. Behavioral Health Home will be paid at a per member per month rate.</p> |
| <p>PCCM Information (If applicable, indicate whether duplicate payments are provided to PCCM and health homes and, if so, describe the payment methodology for PCCM health homes)</p> | <p>N/A</p> |
| <p>Risk-Based Managed Care Information (If applicable, summarize contract language regarding health home services and indicate whether health homes are paid as part of the capitation rate. If not, describe the payment methodologies for health</p> | <p>N/A</p> |

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| homes in risk-based managed care.) | |
| Health Plans as a Designated Provider or part of a Team of Team of Health Care Professionals (Summarize contract language regarding health home services and indicate whether health homes are paid as part of the capitation rate. If not, describe the payment methodologies for health homes in risk-based managed care.) | N/A |
| Other Service Delivery System. (Describe if providers will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers.) | N/A |
| Payment Methodology | |
| Type of Payment Methodology (Indicate whether services are provided Fee for Service, using Primary Care Case Management, using Risk-Based Managed Care, or another model) | Fee for Service: <ul style="list-style-type: none"> • Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided • Provide description of rate-setting policies <p>The BHH funding methodology is based on the cost to employ key health and behavioral health staff/professionals (salaries and fringe benefits) to provide the BHH services and indirect costs. The payment is a statewide monthly bundled rate per client.</p> <p>The BHH services are eligible for reimbursement for a recipient when one or more services are rendered in the billing period and the recipient or their representative approves of such services. The billing period for BHH services is a calendar month. No more than one unit will be billed for each BHH eligible client in a month. BHH services claimed under Medicaid must be substantiated by documentation in the eligible client’s service record. This documentation must be auditable. The</p> |

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State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities. A payment for BHH services may not duplicate Medicaid payments made for other covered services.

The BHH teams include both public and private providers. BHH services are provided by DMHAS employees and private providers under contract with DMHAS. Providers submit BHH services to DMHAS each month. DMHAS submits BHH claims for processing in the MMIS for each Medicaid BHH member who receives at least one BHH service in the month.

Rates for BHH services shall be updated annually. The Department of Mental Health and Addiction Services (DMHAS) will be reimbursed at cost for BHH services provided by DMHAS employees and private providers under contract with DMHAS. BHH reimbursable cost is calculated utilizing the CMS approved cost report and CMS approved Random Moment Time Study (RMTS).

CMS approved random moment time studies are conducted with moments selected on a quarterly basis, but the Time Study is conducted continually. RMTS percentage efforts are calculated each quarter and the SFY quarter results are used for the allocation of direct costs. The Time Study participants include all staff reasonably expected to perform BHH Services during the time study period.

DMHAS annually will complete and certify a Cost Report for costs related to BHH services provided by DMHAS employees for the period from July 1 through June 30. Private providers under contract with DMHAS will annually submit to DMHAS a financial report for the period from July 1 through June 30 and DMHAS certifies the private provider Behavioral Health Home costs. Cost reports are due to the Department of Social Services no later than 10 months following the close of the state fiscal year during which the costs included in the Cost Report were incurred. The annual cost report shall include the certification of funds in accordance with the DMHAS-DSS MOU. Submitted cost reports are subject to desk review by the single state agency or its designee. Desk review will be completed in the 8 months following the receipt of the cost reports.

Private Provider Expenditures are calculated in accordance with the following:

- i. The total contract amount from DMHAS is compared to the total budget amount of the provider and a percentage is calculated.
- ii. Direct service costs of providing BHH services include salary, wage, and fringe benefits that can be directly charged to BHH services. Direct costs shall not include room and board charges.
- iii. Other direct costs including mileage reimbursement, translation and interpretation services, leasing of office equipment training, and necessary office supplies and direct service overhead cost which are directly attributable to support the delivery of BHH services. Mileage reimbursement will be supported with mileage logs documenting actual mileage specific to BHH services, individual receiving services and their Medicaid status at the

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| | <p>time of the services.</p> <ul style="list-style-type: none">iv. Total private provider costs are the sum of item ii. and item iii.v. Private provider service cost attributable to DMHAS is calculated by applying the DMHAS contract funding percentage identified in step i to item iv.vi. Private provider direct BHH services costs net of primary care physician consultant’s component is calculated by applying results of the RMTS to item v.vii. The Medicaid allowable costs for BHH services net of primary care physician consultant’s component are calculated by applying the Medicaid penetration rate to the BHH reimbursable costs (item vi). The Medicaid penetration rate is calculated by dividing the state fiscal year monthly average of the number of Medicaid BHH enrolled private provider clients as of the 5th day of each month during the cost period by the average total number of all private provider clients in the program as of the same day.viii. Primary care physician consultant’s Medicaid allowed cost is calculated by multiplying the hourly rate paid to the PCP consultant by the number of Medicaid billable BHH service hours as reported by BHH designated providers in the current service system utilized by the Department (DDaP.)ix. Total Medicaid allowable costs eligible for certification is determined by adding the total primary care physician consultant’s Medicaid allowable cost (viii.) to the Medicaid allowable costs (vii). <p><u>Payment at Cost for Public Providers</u> are calculated in accordance with the following:</p> <ul style="list-style-type: none">i. Direct service costs of providing BHH services include salary, wage and fringe benefits that can be directly charged to BHH services. Direct costs shall not include room and board charges.ii. Other direct costs including mileage reimbursement, translation and interpretation services, leasing of office equipment, training, and necessary office supplies which are directly attributable to support the delivery of BHH services. Mileage reimbursement will be supported with mileage logs documenting actual mileage specific to BHH services, individual receiving services and their Medicaid status at the time of the services.iii. Total direct costs net of primary care physician consultant’s component include the sum of item i. and item ii.iv. Direct BHH services cost net of primary care physician consultant’s component is calculated by applying results of the |
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| | <p>RMTS to item iii.</p> <ul style="list-style-type: none">v. Indirect costs are equal to the direct BHH services cost net of primary care physician consultants' component (iv.) multiplied by the indirect cost rate set by the Department of Health and Human Services for the Department of Mental Health and Addiction Services.vi. Total BHH reimbursable service cost is the sum of items iv and v.vii. The Medicaid allowable costs for BHH services are calculated by applying the Medicaid penetration rate to the BHH reimbursable costs (item vi).viii. The Medicaid penetration rate is calculated by dividing the state fiscal year monthly average of the number of Medicaid BHH receiving BHH services as of the 5th day of each month during the cost period by the average total number of all clients in the program as of the same day.x. Primary care physician consultant's Medicaid allowed cost is calculated by multiplying the hourly rate paid to the PCP consultant by the number of Medicaid billable BHH service hours as reported by BHH designated providers in the current service system utilized by the Department (WITS).ix. Total Medicaid allowable costs eligible for certification is determined by adding the total primary care physician consultant's Medicaid allowable cost (ix.) to the Medicaid allowable costs (vii). <p><u>Interim Rates</u></p> <p>The initial DMHAS BHH interim rate was set at \$300 as of 7/1/2015 and is effective for services on or after that date. The rate is a statewide bundled rate for both governmental and private providers.</p> <p>The PMPM rate for BHH services effective 7/1/2015 is based on staff full-time equivalents (FTEs) per 400 Medicaid beneficiaries:</p> <ul style="list-style-type: none">a. Director = 0.4b. Primary Care Nurse Manager / Nurse = 2.0c. Primary Care Physician Consultant = 0.2d. Administrative Systems Specialist = 0.5e. Hospital Transition Coordinator = 1.3f. Care Coordinator / Behavioral Health Home Specialists = 8.0g. Peer Recovery Specialist = 4.0 |
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| | <p>h. Total FTE = 16.4 i. Indirect = 10% j. Total cost = \$300.00 PMPM</p> <p>Interim rates for BHH services shall be updated annually. Interim rates are based on the most recent finalized replacement rates for BHH services provided to Medicaid clients by the Department of Mental Health and Addiction Services and private providers under contract with the Department of Mental Health and Addiction Services based upon the cost settlement, as determined in section XX below, rounded up to the nearest \$10. Interim rates are provisional in nature, pending the completion of cost reconciliation and cost settlement for that period.</p> <p><u>Monthly Rate</u></p> <p>The monthly rate for BHH services is calculated by dividing the total allowable BHH costs by the total number of recorded BHH service months for the same period. No more than one unit will be billed for each Medicaid eligible client in a month.</p> <p><u>Settlement</u></p> <p>DMHAS claims paid at the interim rate for BHH services delivered by DMHAS and private providers during the reporting period, as documented in the MMIS, will be compared to the total Medicaid allowable costs for BHH services based on the CMS approved Cost Report identified in section XX. The Department of Mental Health and Addiction Services interim rate claims for BHH services will be adjusted in aggregate. This results in cost reconciliation. Reconciliation will occur within 24 months of the end of the reporting period contained in the submitted cost report.</p> <p>If it has been determined that an overpayment has been made, the Department of Social Services will return the federal share of the overpayment. If the actual, certified Medicaid allowable costs of BHH services exceed the interim Medicaid rates, the Department of Social Services will submit claims to CMS for the underpayment. Cost settlement will occur within the timelines set forth in 42 CFR 433 Subpart F. Connecticut will not modify the CMS-approved scope of costs, time study methodology or the annual cost report methodology without CMS approval.</p> <p><u>Audit</u></p> <p>All supporting accounting records, statistical data and all other records related to the provision of BHH services delivered by the Department of Mental Health and Addiction Services’ and private providers may be subject to audit. If an audit discloses discrepancies in the accuracy and/or allowances of actual direct or indirect costs or statistical data as submitted for each fiscal year by the Department of Mental Health and Addiction Services and private providers, the Department of Social Services’ payment rate for the said period shall be subject to adjustment.</p> |
| <p>Will payment methodology be tiered? If yes, provide</p> | <p>No</p> |

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| methodology for tiering the payments, such as: severity of a person’s condition, provider capabilities, or use of incentive payments). | | | |
| Health Home Services | | | |
| Comprehensive Care Management (Provide the service definition and associated activities. Identify the primary provider types that will serve as the lead for this service). | Service Definition | Ways HIT Will Link | Provider Types Furnishing the Service |
| | <p>The goal of Comprehensive Care Management is the initial engagement of individuals, providing them with the needed information, education, and support necessary to make fully-informed decisions about their care options so they may actively participate in their care planning.</p> <p>Individuals and their identified supports work with their identified care manager(s) and behavioral health, primary care and other community providers to identify and obtain the necessary supports and services to assist individuals to achieve and maintain their highest level of health and success. To that end, a comprehensive needs assessment is completed with each individual to help identify their medical, behavioral health, pharmacological, housing and recovery and social support needs, as well as their current expectations, providers, benefits, preferences, choices, strengths, resources, motivation, and barriers.</p> <p>Based on the completed comprehensive needs assessment, individuals and their identified supports will develop a person-centered care plan which prioritizes goals, identifies optimal outcomes and determines the assignment of the roles and responsibilities of health team</p> | <p>CT plans to leverage existing technology and methodology to collect data from providers. Data will be aggregated and analyzed by the Department or its agent for the purpose of outcome reporting and provision to the health home network.</p> <p>This method will allow the input and sharing of information between the state and BHH providers, as well as, amongst the BHH team. At a minimum, the following information will be included:</p> <ul style="list-style-type: none"> - BHH Eligibility and Enrollment; -Medicaid service utilization, including admissions to EDs or in-patient hospitalizations; -Integrated needs assessments; -BHH person-centered care plan resulting from the integrated assessment; -BHH services received; and -Consumer satisfaction. <p>The state will utilize this information along with Medicaid claims data to create and share reports on</p> | <p>This service can be provided by the following provider types. Selected provider types are “bolded” below. Select all that apply:</p> <ul style="list-style-type: none"> ○ Behavioral Health Professionals or Specialists ○ Nurse Care Coordinators ○ Nurses ○ Medical Specialists ○ Physicians ○ Physicians’ Assistants ○ Pharmacists ○ Social Workers ○ Mental Health Workers/BHH Specialists ○ Recovery and Peer Support Specialists ○ Doctors of Chiropractic ○ Licensed Complementary and Alternative Medicine Practitioners ○ Dietitians ○ Nutritionists ○ Other (specify): <ul style="list-style-type: none"> ○ Director ○ Primary Care Nurse Manager / Nurse ○ Primary Care Physician Consultant ○ Administrative Systems |

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| | <p>members. Individuals and their identified supports will periodically reassess (no less than annually) the person-centered care plan by reviewing needs and goals, identifying progress made toward meeting those goals to achieve positive outcomes and determine the individuals’ satisfaction with services. Adjustments in the plan are made accordingly each time the plan is reassessed.</p> <p>Comprehensive Care Management services include outreach and engagement to support and promote continuity of care to individuals. Outcome reports that indicate progress toward meeting outcomes for individual satisfaction, health status, service delivery and costs will be developed and disseminated to all health home participants.</p> | <p>productivity, quality measures and outcomes which will aid in supporting performance improvement and improved consumer outcomes.</p> | <ul style="list-style-type: none"> ○ Specialist ○ Hospital ○ Coordinator ○ Care Coordinator / Behavioral Health Home Specialists ○ Peer Recovery Specialist |
| <p>Care Coordination and Health Promotion (Provide the service definition and list associated activities. Identify the primary provider type that will serve as the lead for this service).</p> | <p style="text-align: center;">Service Definition</p> <p>Care Coordination is the implementation and monitoring of the individualized person-centered care plan with active individual involvement through appropriate linkages, referrals, coordination, and follow-up to needed services and supports, including referral and linkages to long-term services and supports to achieve outcomes consistent with individual needs, strengths and preferences.</p> <p>Overarching activities of Care Coordination include the provision of case management services necessary to ensure individuals and their identified supports have access to medical, behavioral health, pharmacology and recovery support services (e.g. housing, access to benefits, vocational, social, and educational, etc.).</p> | <p style="text-align: center;">Ways HIT Will Link</p> <p>CT plans to leverage existing technology and methodology to collect data from providers. Data will be aggregated and analyzed by the Department or its agent for the purpose of outcome reporting and provision to the health home network.</p> <p>This method will allow the input and sharing of information between the state and BHH providers, as well as, amongst the BHH team. At a minimum, the following information will be included:</p> <ul style="list-style-type: none"> - BHH Eligibility and Enrollment; -Medicaid service utilization, including admissions to EDs or in- | <p style="text-align: center;">Provider Types Furnishing the Service</p> <p>This service can be provided by the following provider types. Selected provider types are “bolded” below. Select all that apply:</p> <ul style="list-style-type: none"> ○ Behavioral Health Professionals or Specialists ○ Nurse Care Coordinators ○ Nurses ○ Medical Specialists ○ Physicians ○ Physicians’ Assistants ○ Pharmacists ○ Social Workers ○ Mental Health Workers/BHH Specialists ○ Recovery and Peer Support Specialists ○ Doctors of Chiropractic |

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| | <p>Specific Care Coordination activities are conducted with individuals and their identified supports, medical, behavioral health and community providers, across and between care settings to ensure all services are coordinated. Specific activities include, but are not limited to:</p> <ul style="list-style-type: none"> ▪ Fostering communication with and amongst the individual, her/his providers and her/his identified supports ▪ Assistance in follow up care and follow through on recommendations ▪ Assistance with appointment scheduling and accessing and coordinating necessary health care and recovery support services as defined in the care plan, including transportation, ▪ Skill building and teaching/coaching to help individuals maximize independence in the community; ▪ Conducting referrals and follow-up monitoring ▪ Participating in hospital discharge processes and other care transition ▪ Outreach to engage, support and promote continuity of care to individual ▪ Ensuring linkage to medication monitoring if it is an identified need <p>Health Promotion Services encourage and support healthy living concepts to motivate individuals to adopt healthy behaviors and promote self-management of their health and wellness. Health Promotion Services place a strong emphasis on self-direction and skills development through health education and wellness interventions so individuals can</p> | <p>patient hospitalizations; -Integrated needs assessments; -BHH person-centered care plan resulting from the integrated assessment; -BHH services received; and -Consumer satisfaction.</p> <p>The state will utilize this information along with Medicaid claims data to create and share reports on productivity, quality measures and outcomes which will aid in supporting performance improvement and improved consumer outcomes.</p> | <ul style="list-style-type: none"> ○ Licensed Complementary and Alternative Medicine Practitioners ○ Dietitians ○ Nutritionists ○ Other (specify): ○ Director ○ Primary Care Nurse Manager / Nurse ○ Primary Care Physician Consultant ○ Administrative Systems Specialist ○ Hospital Transition Coordinator ○ Care Coordinator / Behavioral Health Home Specialists ○ Peer Recovery Specialist |
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| | <p>monitor and manage their chronic health conditions to improve health outcomes. SAMHSA has defined the eight dimensions of wellness as Financial, Social, Spiritual, Health, Environmental, Emotional, Occupational and Intellectual which provides a helpful framework for Health Promotion Services.</p> <p>Activities related to Health Promotion should look at individuals from holistic perspective and service shall include, but not be limited to:</p> <ul style="list-style-type: none"> • Health education and wellness interventions specific to individuals’ chronic condition(s); • Development of self-management with the individual; • Education regarding the importance of immunizations and promotion of health screenings; • Healthy lifestyle choices within one’s budget; • Health education about chronic conditions to family members and other natural supports; • Support for improving social networks; and • Wellness and health-promoting lifestyle interventions such as, but not limited to, substance use prevention/early intervention and harm reduction, HIV/AIDS prevention/early intervention, STD prevention/early intervention, family planning and pregnancy, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, increasing physical activity, and promoting independence and skill development related to self-administration | | |
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| | <p>of medications.</p> <ul style="list-style-type: none"> • Connection to Early and Periodic Screening, Diagnostic and Treatment Services Program (EPSDT). | | |
| <p>Comprehensive Transitional Care (Provide the service definition, including appropriate follow-up from inpatient and other facility-based settings, and list associated activities. Identify the primary provider type that will serve as the lead for this service).</p> | <p style="text-align: center;">Service Definition</p> <p>Comprehensive Transitional Care activities are specialized care coordination services that focus on the movement of individuals between or within different levels of care or settings (medical, behavioral health, long-term care, home, other community settings, e.g., shelter) while shifting from the use of reactive care and treatment to proactive care via health promotion and self-management. Services are designed to streamline plans of care and crisis management plans, reduce barriers to timely access, reduce inappropriate hospital and nursing home admissions, interrupt patterns of frequent emergency department use, and prevent gaps in services which could result in (re)admission to a higher level of care or longer lengths of stay at an unnecessary level of care.</p> <p>Collaboration and real time notification of admissions and discharges to and from acute and other care settings is crucial to facilitate interdisciplinary collaboration among providers (physicians, nurses, social workers, discharge planners, pharmacists, etc.). Therefore, the health home team must maintain collaborative relationships with hospital emergency departments, housing providers, psychiatric units of local hospitals, long-term care, detox providers and other applicable settings.</p> <p>The ensure seamless transitional care to the</p> | <p style="text-align: center;">Ways HIT Will Link</p> <p>CT plans to leverage existing technology and methodology to collect data from providers. Data will be aggregated and analyzed by the Department or its agent for the purpose of outcome reporting and provision to the health home network.</p> <p>This method will allow the input and sharing of information between the state and BHH providers, as well as, amongst the BHH team. At a minimum, the following information will be included:</p> <ul style="list-style-type: none"> - BHH Eligibility and Enrollment; -Medicaid service utilization, including admissions to EDs or in-patient hospitalizations; -Integrated needs assessments; -BHH person-centered care plan resulting from the integrated assessment; -BHH services received; and -Consumer satisfaction. <p>The state will utilize this information along with Medicaid claims data to create and share reports on productivity, quality measures and</p> | <p style="text-align: center;">Provider Types Furnishing the Service</p> <p>This service can be provided by the following provider types. Selected provider types are “bolded” below. Select all that apply:</p> <ul style="list-style-type: none"> ○ Behavioral Health Professionals or Specialists ○ Nurse Care Coordinators ○ Nurses ○ Medical Specialists ○ Physicians ○ Physicians’ Assistants ○ Pharmacists ○ Social Workers ○ Mental Health Workers/BHH Specialists ○ Recovery and Peer Support Specialists ○ Doctors of Chiropractic ○ Licensed Complementary and Alternative Medicine Practitioners ○ Dieticians ○ Nutritionists ○ Other (specify): ○ Director ○ Primary Care Nurse Manager / Nurse ○ Primary Care Physician Consultant ○ Administrative Systems Specialist |

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| | <p>least restrictive setting, the care coordinator will collaborate with the individual and appropriate facility staff to assist in the development and implementation of a discharge or transition plan. The care coordinator will also develop and implement a systematic follow-up protocol with individuals, as they change levels of care or providers within the same level of care, to ensure timely access to follow-up care, medication education and reconciliation, and other needed services/supports.</p> <p>DMHAS and DCF intersect at many points across CT’s behavioral health care service continuum. This is perhaps most prominent in the joint effort of the two agencies around the Young Adult population. The DMHAS Young Adult Services (YAS) program was developed to help young adults transition successfully from the Dept. of Children & Families system to the adult mental health system. In order to be considered for Young Adult Services, an individual must be between the ages of 18 and 25, have a history of DCF involvement and have a major mental health issue.</p> <p>To ensure the transition, Young Adult Services’ (YAS) programs have been developed at LMHAS throughout Connecticut. DMHAS LMHA YAS programs collaborate with DCF prior to an individual’s 18th birthday and develop a service plan together with the individual and involved caregivers. The active involvement of the client, their family, and the community in the development of the recovery plan is essential to success</p> | <p>outcomes which will aid in supporting performance improvement and improved consumer outcomes.</p> | <ul style="list-style-type: none"> ○ Hospital Transition Coordinator ○ Care Coordinator / Behavioral Health Home Specialists ○ Peer Recovery Specialist |
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| Individual and Family Support Services (Provide the service definition and list associated activities. Identify the primary provider type (see list to the right) that will serve as the lead for this service). | Service Definition | Ways HIT Will Link | Provider Types Furnishing the Service |
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| | <p>Individual and Family Support Services help individuals reduce barriers to achieving goals, increase health literacy and knowledge about chronic condition(s), increase self-management skills such as advocacy, and improve health outcomes. Care Coordinators must ensure that individual care plans accurately reflect the preferences, goals, resources, and optimal outcomes of the individual and her/his identified supports. All communication and information shared with individuals and their identified supports must be language, literacy, and culturally appropriate and executed in a location and time convenient to the individual and her/his identified supports.</p> <p>Services can include, but are not limited to:</p> <ul style="list-style-type: none"> • Assistance in accessing self-help, peer support services, technology such as smart phones, support groups, wellness centers, and other self-care programs; • Teaching and coaching self-advocacy for individuals and families; • Health education, wellness promotion, and prevention and early intervention services; • Assistance in identifying and developing social support networks; • Assistance with obtaining and adhering to prescribed medication and treatments; and • Helping to identify new resources to aid in reduction of barriers to help support individuals attain their highest level of health and functioning within their families and community, including non-medical recovery supports such as transportation and housing. | <p>CT plans to leverage existing technology and methodology to collect data from providers. Data will be aggregated and analyzed by the Department or its agent for the purpose of outcome reporting and provision to the health home network.</p> <p>This method will allow the input and sharing of information between the state and BHH providers, as well as, amongst the BHH team. At a minimum, the following information will be included:</p> <ul style="list-style-type: none"> - BHH Eligibility and Enrollment; -Medicaid service utilization, including admissions to EDs or in-patient hospitalizations; -Integrated needs assessments; -BHH person-centered care plan resulting from the integrated assessment; -BHH services received; and -Consumer satisfaction. <p>The state will utilize this information along with Medicaid claims data to create and share reports on productivity, quality measures and outcomes which will aid in supporting performance improvement and improved consumer outcomes.</p> | <p>This service can be provided by the following provider types. Selected provider types are “bolded” below. Select all that apply:</p> <ul style="list-style-type: none"> ○ Behavioral Health Professionals or Specialists ○ Nurse Care Coordinators ○ Nurses ○ Medical Specialists ○ Physicians ○ Physicians’ Assistants ○ Pharmacists ○ Social Workers ○ Mental Health Workers/BHH Specialists ○ Recovery and Peer Support Specialists ○ Doctors of Chiropractic ○ Licensed Complementary and Alternative Medicine Practitioners ○ Dietitians ○ Nutritionists <p>Other (specify):</p> <ul style="list-style-type: none"> ○ Director ○ Primary Care Nurse Manager / Nurse ○ Primary Care Physician Consultant ○ Administrative Systems Specialist ○ Hospital Transition Coordinator ○ Care Coordinator / Behavioral Health Home Specialists ○ Peer Recovery Specialist |

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| | Service Definition | Ways HIT Will Link | Provider Types Furnishing the Service |
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| <p>Referral to Community and Social Support Services (Provide the service definition and list associated activities. Identify the primary provider types (see list to the right) that will serve as the lead for this service).</p> | <p>Referrals to community and social support services ensure individuals have access to a myriad of formal and informal resources which address social, environmental and community factors all of which impact overall health. Local agency and resource knowledge is required to connect individuals to a wide array of support services to help individuals overcome access or service barriers, increase self-management skills and improve overall health. The Health Home Team must develop and nurture relationships with other community-based providers to aid in effective individual referrals and timely access to services.</p> <p>The types of community and social support services to which individuals will be referred may include, but are not limited to: medical and behavioral health care, entitlements/benefits, housing, transportation, legal services, educational and employment services, financial services, wellness and health promotion services, specialized support groups, substance use treatment, self-help, social integration and skill building, and other services as identified by the individual.</p> | <p>CT plans to leverage existing technology and methodology to collect data from providers. Data will be aggregated and analyzed by the Department or its agent for the purpose of outcome reporting and provision to the health home network.</p> <p>This method will allow the input and sharing of information between the state and BHH providers, as well as, amongst the BHH team. At a minimum, the following information will be included:</p> <ul style="list-style-type: none"> - BHH Eligibility and Enrollment; -Medicaid service utilization, including admissions to EDs or in-patient hospitalizations; -Integrated needs assessments; -BHH person-centered care plan resulting from the integrated assessment; -BHH services received; and -Consumer satisfaction. <p>The state will utilize this information along with Medicaid claims data to create and share reports on productivity, quality measures and outcomes which will aid in supporting performance improvement and improved consumer outcomes.</p> | <p>This service can be provided by the following provider types. Selected provider types are “bolded” below. Select all that apply:</p> <ul style="list-style-type: none"> ○ Behavioral Health Professionals or Specialists ○ Nurse Care Coordinators ○ Nurses ○ Medical Specialists ○ Physicians ○ Physicians’ Assistants ○ Pharmacists ○ Social Workers ○ Mental Health Workers/BHH Specialists ○ Recovery and Peer Support Specialists ○ Doctors of Chiropractic ○ Licensed Complementary and Alternative Medicine Practitioners ○ Dietitians ○ Nutritionists ○ Other (specify): ○ Director ○ Primary Care Nurse Manager / Nurse ○ Primary Care Physician Consultant ○ Administrative Systems Specialist ○ Hospital Transition Coordinator ○ Care Coordinator / Behavioral Health Home Specialists ○ Peer Recovery Specialist |

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| Use of Health Information Technology to Link Services | <p style="text-align: center;">Service Definition</p> <p>CT currently uses a secure FTP (File Transfer Protocol) for the sharing of client identified information with BHH providers. Providers identify and register an authorized representative to be issued an agency-specific password and access to the site through the State’s IT department. Based on SAMHSA consults, CT is exploring the feasibility of acquiring Secure Email/Email encryption to protect the content of information shared by email from being read by anyone but the intended recipient. This will allow for more efficient sharing of data and client information. A statewide body presently meets to plan for a statewide system of HIE.</p> | <p style="text-align: center;">Provider Types Furnishing the Service</p> <ul style="list-style-type: none"> ○ |
| Health Homes Patient Flow (Describe the patient flow through the State's Health Homes system. The state must submit flow-charts of the typical process an individual would encounter) | See attached flow charts. | |
| Medically Needy Eligibility Groups | Select ONE of the following: <ul style="list-style-type: none"> ○ All Medically Needy eligible groups receive the same benefits and services that are provided to Categorically Needy eligibility groups ○ Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups. (if selected, see below. If all MN eligibles receive the same benefits, skip to assurances section). | |
| Medically Needy: Different Benefits: | <ul style="list-style-type: none"> ○ All Medically Needy receive the same services ○ There is more than one benefit structure for Medically Needy eligibility groups <i>(Name each Medically Needy population and identify the Medically Needy eligibility groups that are included in each population. See Health Home Services and describe each Health Home Service and provide the state’s definitions for Health Homes services (as listed above and the specific activities performed under each service.</i> | |
| Monitoring | | |
| Describe the State’s methodology for tracking avoidable hospital readmissions to include data sources and measure specifications. | <p style="text-align: center;">Data Sources</p> | |
| | Medicaid Claims | <p style="text-align: center;">Measures Specifications</p> <p>CT will track avoidable hospital readmissions by calculating the number of ambulatory care sensitive readmissions per 1000.</p> |

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| Describe the State’s methodology for calculating cost savings that result from improved chronic care coordination and management achieved through this program, to include data sources and measures specifications. | Data Sources | Measures Specifications |
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| | Medicaid Claims | CT will perform an annual assessment of cost savings using a pre/post-period comparison of Behavioral Health Home enrollees. Savings calculations shall be risk adjusted to exclude high-cost outliers as defined by the state and shall be net any additional cost of providing behavioral health home services. Savings can further be broken down by category of service, by Behavioral Health Home, by age, by gender, or by any other variable determined by the state. |
| Describe the State’s proposal for using health information technology in providing health home services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their providers.) | <p>CT’s BHH partners, the Departments of MH&AS, Social Services, and Children and Families will partner in a multiple contractor relationship to administer a contract with an Administrative Services Organization. The ASO will, among other things, develop a web-based system to facilitate information exchange. Data elements will include, but will not be limited to, enrollment; Behavioral Health Home assessment, recovery planning and services; and authorizations for services. The web-based system will assist in the collection of data elements needed to produce reports on quality and outcome measures to allow for reporting to CMS.</p> <p>Connecticut’s Department of Mental Health Services has contracted with FEI to implement an open-source system called Web Infrastructure for Treatment Services (WITS) to track substance abuse and mental health services. WITS is a web based and open-source application designed to capture client treatment data and satisfy mandatory government reporting requirements for the planning, administration, and monitoring of Substance Abuse Treatment Programs. WITS facilitates cooperation and collaboration among providers by enabling the sharing of client treatment information via the web. WITS consists of numerous clinical, administrative and reporting modules that are organized by the workflow process allowing DMHAS to customize our system. CT’s WITS development is underway with an anticipated go live date in 2015. All 6 State Operated LMHAs will use WITS. All of the Private-Non-Profit LMHAs operate an electronic health record (EHR).</p> | |

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| Quality Measurement | <ul style="list-style-type: none"> ○ The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State. ○ The State provides assurance that it will identify measurable goals for its Health Home model and intervention and also identify quality measures related to each goal to measures its success in achieving the goals. |
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| Evaluations: | | | | |
| <ul style="list-style-type: none"> ○ The state provides assurance that it will report to CMS information submitted by Health Home providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable care Act and as described by CMS | | | | |
| Describe how the state will collect information from health home providers for the purpose of determining the effects of this program on reducing: | | | | |
| Hospital Admissions | Description | Measure Specification, including numerator and denominator | Data Source | Frequency of Data Collection |
| | IU-HH: Inpatient Utilization | The rate of all acute inpatient care and services per 1,000 enrollee months among Health Home enrollees | Administrative | Annually |
| Emergency Room Visits | Description | Measure Specification, including numerator and denominator | Data Source | Frequency of Data Collection |
| | AMB-HH: Ambulatory Care- Emergency Department visits | The rate of emergency department visits per 1,000 enrollee months among Health Home enrollees | Administrative | Annually |
| Skilled Nursing Facility Admissions | Description | Measure Specification, including numerator and denominator | Data Source | Frequency of Data Collection |
| | NFU-HH: Nursing Facility Utilization | The number of admissions to a nursing facility from the community that result in a short-term (less than 101 days) or long-term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollee months | Administrative | Annually |
| Evaluations - Describe how the state will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use | | | | |

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| of this program as it pertains to the following: | |
| Hospital Admission Rates | The State will utilize integrate Medicaid claims data to assess hospital admission rates. Data can further be broken down by category of service, by Behavioral Health Home, by demographics, or by any other variable determined by the state. |
| Chronic Disease Management | <p>The state will collect outcome data consistent with the CMS Core Set of Health Care Quality Measures for Medicaid Health Home Programs in order to monitor ongoing performance. The following measures will be collected:</p> <p>Measure ABA-HH: Adult BMI Assessment Measure CDF-HH: Screening for Clinical Depression and Follow-up Plan Measure PCR-HH: Plan All-Cause Readmission Rate Measure FUH-HH: Follow-up after Hospitalization for Mental Illness Measure CBP-HH: Controlling High Blood Pressure Measure CTR-HH: Care Transition- Timely Transmission of Transition Record Measure IET-HH: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment Measure PQ-192-HH: Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite</p> <p>Additional measure areas for collection are as follows: Tobacco use/cessation intervention HbA1C Testing for individuals with diabetes LDL-C Screening for individuals with diabetes Satisfaction with care, access, quality, and appropriateness Decreasing homelessness Increasing employment and educational opportunities</p> <p>A web-based system will assist in the collection of data elements needed to produce reports on quality and outcomes measures, including chronic disease management, to allow for reporting to CMS.</p> |
| Coordination of Care for Individuals with Chronic Conditions | The State will assess provision of care coordination services for individuals with chronic conditions in the following fashion: the State will track all encounters provided by health home team members. as well as track face-to-face follow-up by a health team member within 2 days after hospital discharge. An annual audit conducted by the Department or its designee will include a review of service plans for health home enrollees as well as documentation consistent with state-approved processes. |
| Assessment of Program Implementation | The State will monitor implementation through regularly occurring meetings with and reports from Behavioral Health Home providers. Progress will be assessed against an implementation project plan and process indicators. |
| Processes and Lessons Learned | The State will meet with BHH providers, as mentioned above, and with the CT Behavioral Health Oversight Council to elicit feedback for ongoing quality improvement. Information will include operational barriers of implementing health home services, review of evaluation data and reports, and review critical success factors. |
| Assessment of Quality Improvements and Clinical Outcomes | The State will utilize the quality process and outcome measures described in other SPA sections or documents to assess quality improvements and clinical outcomes. Assessment will occur both at the individual practice level, and at the aggregate level for all participating behavioral health homes. The State will track change over time to assess whether statistically significant improvement has |

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| | been achieved. |
| Estimates of Cost Savings (if different from the method described under monitoring) | Same as above in Monitoring |