Connecticut Behavioral Health Partnership

Developing An Integrated System for Financing and Delivering Public Behavioral Health Services For Children and Adults in Connecticut

A Report to the Connecticut General Assembly Pursuant to Public Act 01-2 JSS Section 49 and Public Act 01-8 JSS

Kristine Ragaglia, JD Commissioner	Patricia Wilson-Coker, JD, MSW Commissioner	Thomas A. Kirk, Jr., Ph.D. Commissioner
Connecticut Department of Children and Families	*Connecticut Department of Social Services*	*Connecticut Department of Mental Health and Addiction Services*

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This report was prepared by the Connecticut Behavioral Health Partnership, formed by the Connecticut Departments of Social Services, Children and Families, and Mental Health and Addiction Services to plan and implement a reform of Connecticut's public behavioral health service delivery system. The Partnership Policy Committee and its three Implementation Teams are listed below. The Partnership has been assisted in this work by Child Health and Development Institute of Connecticut, Inc.; William Mercer & Co.; F. Carl Valentine and Associates; Holt, Wexler & Farnam, LLP; and Schofield Consulting. Special thanks are extended to the Connecticut Health Foundation and the Children's Fund of Connecticut, and the Center for Health Care Strategies of the Robert Wood Johnson Foundation, all of which contributed funding to support system planning.

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List of Acronyms

ASO	Administrative Services Organization
CHDI	Child Health and Development Institute of Connecticut, Inc.
CM	Clinical Management
CSSD	Court Support Services Division of the Connecticut Judicial Department
DCF	Connecticut Department of Children and Families
DMHAS	Connecticut Department of Mental Health and Addiction Services
DMR	Connecticut Department of Mental Retardation
DOIT	Connecticut Department of Information Technology
DSS	Connecticut Department of Social Services
EMCS	Emergency Mobile Crisis Services
FFS	Fee for Service (as in Medicaid)
GABHP	General Assistance Behavioral Health Program
HSRI	Human Services Research Institute
HUSKY A	Connecticut implementation of the federal Medicaid program (Title XIX) under managed care, health insurance for children and their parents in families earning below 185% of the federal poverty level.
HUSKY B	Connecticut implementation of State Children's Health Insurance Program (SCHIP or Title XXI), federally subsidized health insurance for uninsured children in families earning from 185% to 300% of the federal poverty level. Unsubsidized coverage is available under HUSKY B for families earning more than 300% of the federal poverty level.
MCO	Managed Care Organization
MOU	Memorandum of Understanding
OPM	Connecticut Office of Policy and Management
QM	Quality Management
RFP	Request for Proposals
SAGA	State Administered General Assistance
SCHIP	State Children's Health Insurance Program (HUSKY B in Connecticut)
SDE	Connecticut State Department of Education
SFY	State Fiscal Year
TANF	Temporary Assistance to Needy Families
UM	Utilization Management

Executive Summary

Behavioral Health Partnership

The Departments of Children and Families (DCF), Mental Health and Addiction Services (DMHAS), and Social Services (DSS) have formed the **Connecticut Behavioral Health Partnership** ("the Partnership") to plan and implement an integrated public behavioral health service system for adults, children, and families. The overall goal of the Partnership is to provide enhanced access to a more complete and effective system of community-based behavioral health services and supports and to improve individual outcomes. This report presents the current plans of the Partnership and provides a status report on implementation.

The Partnership has three objectives 1) *Administrative Integration*, 2) *Service Delivery Redesign* and 3) *Revenue Maximization*. Each of these objectives contributes to the goal of better access to quality services, while also ensuring the efficient use of state resources:

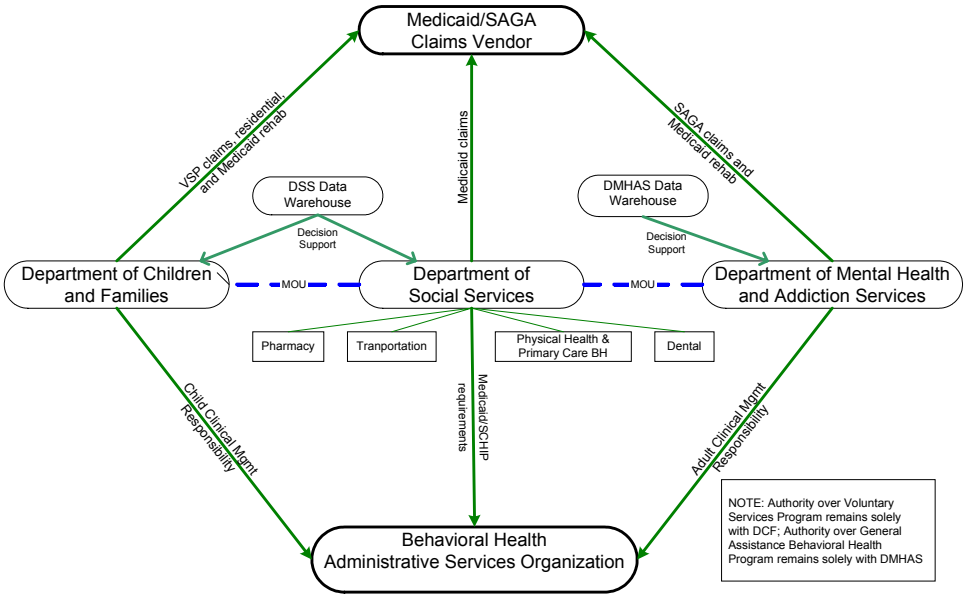
Administrative Integration

Integrated Model

The Departments are developing a common administrative infrastructure to support the efficient management of behavioral health services provided to recipients of HUSKY A (managed Medicaid), HUSKY B (the State Children's Health Insurance Program), Medicaid fee-for-service, the DMHAS General Assistance Behavioral Health Program (GABHP), and the DCF Voluntary Services Program. There are three administrative functions that the Departments are preparing to share including **clinical management, claims processing and data management**.[1] All clinical management services (e.g., prior authorization, utilization review) will be provided by a single Administrative Services Organization (ASO). Similarly, all claims will be processed by a single claims vendor (see Figure 1).

Figure ES-1

Connecticut Behavioral Health Partnership
Administrative Infrastructure



[1] This is not a complete list of administrative services. Member services and provider relations (including contracting) may or may not be shared to the same extent.

The shared administrative infrastructure will integrate diverse funding streams, support comprehensive care planning, reduce administrative cost, and improve the state's ability to design and manage performance-based clinical and administrative service contracts. A common administrative infrastructure will also reduce incentives for cost shifting among health service purchasers (state vs. private), one of the reasons underlying Connecticut's over-reliance on institutional care. This proposed structure represents a substantial departure from the administrative fragmentation and inefficiency that characterizes the current system.

Benefits

The Departments believe that the Partnership and the shared administrative model will greatly benefit service recipients and the providers who serve as the foundation for Connecticut's behavioral healthcare system. A single ASO will reduce the experience of fragmentation by providing a single source for clinical management, benefit information, and various member services (such as a statewide toll-free line for mobile crisis services), while funding streams will be managed behind the scenes, within shared information systems, and thus be seamless to the consumer.[2] The integration of funding streams will make it easier for providers and consumers to develop community-based individualized care plans that rely on multiple funding sources (e.g., Title XIX, state general funds). A single ASO will be able to manage the entire system of services for an individual child or adult, authorizing all admissions to institutional services, facilitating the transition from hospital to residential and outpatient care, and expediting a timely discharge from residential care when goals have been met and a community-based service plan is in place. This will help ease gridlock and support the use of community-based systems of care and recovery oriented care planning.

Timetable for Implementation

The implementation of the shared administrative infrastructure, in whole or in part, is scheduled to begin on July 1, 2003. This date was selected because it coincides with the expiration date of the existing HUSKY MCO contracts and the timetable for reprocurement of the HUSKY program services. DSS will issue a Request for Proposals for the HUSKY program without the behavioral health benefit during the State Fiscal Year 2003 (SFY03). New HUSKY MCO contracts with behavioral health carved-out will take effect July 1, 2003. The ASO must be in place and operational by that date in order to ensure uninterrupted management of the HUSKY behavioral health benefit.

Financing

Under the Partnership MOU, the Departments have committed to the principle of cost neutrality. The Departments believe that the proposed administrative integration and service delivery reforms can be operated within current service and administrative expenditures, adjusted for growth in enrollment and cost-of-living. It is anticipated that the administrative costs will be lower as a percentage of total expenditures than is currently the case for behavioral health services administered under the HUSKY program. The cost of the shared administrative infrastructure will be covered in large part by reductions in administrative functions currently performed by DCF, DMHAS, and DSS, the DSS external utilization review contract, behavioral health administrative funds in the HUSKY program, and administrative funds that support the DMHAS General Assistance Behavioral Health Program ASO.

Service Delivery Redesign

The Departments are redesigning the behavioral health service delivery system to emphasize individuals and their families as partners in care planning *and* improvements in the quality and availability of community-based services and supports. Connecticut Community KidCare is the reform initiative that focuses on the service delivery system for children. The Recovery Healthcare Plan for Adults is a complementary initiative that focuses on the service delivery system for adults. Together, these reforms will improve the ability of children and adults to remain in their homes and communities, to function

[2] There will be differences in available benefits when moving across eligibility categories such as already exist between HUSKY A and B (e.g., EPSDT, non-emergency medical transportation, respite).

independently, to achieve a better quality of life, and to avoid unnecessary hospital and institutional care.

Connecticut Community KidCare

Connecticut Community KidCare (KidCare) is designed to eliminate the major gaps and barriers that exist in the current children's behavioral health delivery system. KidCare is based on the belief that children should receive services in their community whenever possible. Parents and families are an integral part of the planning and decision making process. This helps ensure that services are driven by the needs and preferences of the child and family. KidCare will help ensure that children receive interventions that foster the ability to succeed in the home, school and community. Key characteristics of the KidCare reforms include the following:

- Expansion and enhancement of clinical and non-clinical support services.
- A primary focus on strengthening the family's capacity to help their child with behavioral health needs.
- A strong preference for delivery and management of services within the local community

KidCare Behavioral Health Service Design

The KidCare behavioral health services benefit has two levels. The *Core Service* level includes services currently covered under Connecticut's Medicaid Program (outpatient treatment, extended day treatment, intensive outpatient treatment, partial hospitalization, and inpatient psychiatric hospitalization) as well as new community services such as home-based behavioral health services, emergency mobile crisis services and crisis stabilization beds. The *Enhanced Service* level includes additional specialized community services. These may include care coordination, comprehensive global assessment, intensive home-based behavioral health services, behavior management services, behavioral consultation and respite. Children with complex behavioral health needs ("complex needs") will be eligible to receive these enhanced services. Families and children can begin their behavioral health care at multiple service entry points in the KidCare service system, including schools, crisis services, outpatient clinics and hospitals.

Service Delivery Coordination and Management

In order for KidCare to achieve improvements in clinical care, the service delivery coordination and management processes must support **access** to care, **coordination** of care, **continuity** of care and **quality** of care. KidCare has three enhancements to the service system that support improved care, especially for children with complex needs:

- **Care Coordination.** Care Coordinators will partner with families of children with complex needs and the providers of their care for the child and family to form a Child Specific Team. This team serves as the vehicle for individualized care planning that uses a broad array of clinical services and natural supports in the local system of care.
- **Individualized Service Plans.** The Child Specific Team develops an Individual Service Plan that summarizes the goals of the child and family and the traditional and support services that will be provided to meet those goals.
- **Administrative Services Organization.** The ASO provides a range of services to support effective system management, access to appropriate services, and quality of services.

Expansion and Enhancement of Community-based Services

DCF is in the process of developing an expanded array of culturally responsive, quality services, designed with input from parents and providers. These include the following: emergency mobile crisis services, care coordination enhancement, extended day treatment services, home-based behavioral health services, multi-systemic therapy, behavioral management services, and crisis stabilization beds.

Family Involvement

Families are playing an instrumental role in ensuring that every aspect of the system is accountable and responsive to the needs of children and their families through a newly formed alliance of existing Advocacy organizations comprised of NAMI-CT (National Alliance for the Mentally Ill), Families United (a Chapter of the Federation of Families for Children's Mental Health), Padres Abriendo Puertas, and AFCAMP (African Caribbean American Parents of Children with Disabilities). The newly formed consortium, known as FAVOR, has currently sub-contracted with the Connecticut Association of Foster and Adoptive Parents to employ and provide supervision to the professional Family Advocates, who provide direct and intensive support and guidance to families whose children are receiving care coordination services. In addition, the FAVOR collaborative is providing community outreach in the form of newsletters, web sites, support groups, workshops, advocacy training and public forums to educate parents about advocacy issues, local and statewide resources, and KidCare.

Additional Achievements to Date

Transition to DMHAS Services

Since 1997 over 200 DCF involved youth have successfully transitioned into developmentally appropriate clinical, support and residential services. DCF and DMHAS continue to collaborate to ensure young adults in need of continued mental health support have access to specialized services that enhance their ability to function in the community.

Training and Staff Development

DCF has developed a training plan and curriculum to educate all key players within the children's behavioral health delivery system through a contract with the Child Health and Development Institute of Connecticut, Inc. (CHDI). Training is being provided to parents; front-line, supervisory, and management staff from DCF; providers; community leaders; educators; juvenile justice staff; and other interested parties. Based on a "train the trainer" model, each DCF region is developing a core group of 25 trainers comprised of the above mentioned invested parties who will, in turn, train others in their communities. This training initiative accompanies the regional rollout plan for KidCare services this fiscal year.

Collaboration with the State Department of Education

The State Department of Education convened a statewide Education and Mental Health Task Force to address issues and identify areas for collaboration between local education authorities and the community collaboratives. With the support of Commissioner Theodore Sergi, regional conferences convened by the Regional Educational Service Centers (RESCs) between DCF staff and local school personnel have begun as KidCare unfolds throughout the state (average attendance of 100 at the first three meetings).

Collaboration with Juvenile Justice

The interface between children's mental health and the juvenile justice system has also been the focus of much attention over the past fifteen months. DCF has formed a partnership with the Court Support Services Division of the Judicial Department, the Yale Child Study Center, the UConn Health Center, and the Child Health and Development Institute, with funding from the Connecticut Health Foundation and the Tow Foundation, to create the Connecticut Center for Effective Practice. In addition representatives from the juvenile justice system are participating in various KidCare design workgroups.

Performance Measurement and Evaluation

As part of its KidCare reform, DSS and DCF are developing a comprehensive quality monitoring system for children's behavioral health services. The primary goal of this system will be the provision of ongoing performance data at the state, regional, and contractor levels for the purpose of: (1) monitoring overall access, quality, and cost-effectiveness, (2) monitoring performance-based contracts with administrative and clinical service contractors and administering contract performance bonuses and penalties, (3) designing and monitoring quality management projects, and (4) assuring public accountability by means of regular

KidCare performance report cards. This outcome-focused system will allow the state to allocate resources more efficiently, contract for services, reward provider performance, promote public behavioral health goals, and provide internal feedback to identify problems and initiate continuous quality improvement.

In addition, the CHDI, pursuant to an agreement with DCF and DSS, has contracted with Human Services Research Institute (HSRI) and its subcontractor, the Technical Assistance Collaborative (TAC), to conduct an independent evaluation of KidCare.

Recovery Healthcare Plan for Adults

Under the partnership, DMHAS will assume a significant role in the clinical management of publicly funded behavioral health services. In addition to its present authority over behavioral health services for State Administered General Assistance recipients, DMHAS will assume responsibility for the clinical management of adult Medicaid fee-for-services recipients and parents and other adults enrolled in the HUSKY program, including adults who are receiving Temporary Assistance to Needy Families (TANF).[3] DMHAS has begun collaborative planning with DCF and DSS to examine issues of service access and quality. The planning effort will help to ensure that the clinical management program (hereinafter called the Recovery Management Program) and the practices and interventions of behavioral health providers are appropriate to the needs of adults in the Medicaid fee-for-service and HUSKY programs. This will include development of specialized procedures and ongoing monitoring designed to ensure that single mothers in the TANF program obtain appropriate access to behavioral health care

The term *Recovery Management* describes a set of interventions used to promote positive outcomes for adults with behavioral health problems. The term appropriately conveys the expectation that these individuals will attain substantial improvement with the right combination of treatments and supports, provided that these interventions are delivered at the correct intensity and are continuous and well coordinated. The DMHAS plan for recovery management also reflects current knowledge about the long-term course of behavioral health disorders and how the service system must respond in order to help restore people to healthy lives. In order to improve the quality and recovery orientation of the service system, the DMHAS recovery management program will assure that:

- Treatment is provided at the correct intensity (i.e., level of care) and for the optimal duration of time to be maximally effective and cost efficient.
- Services are not to be interrupted when a person moves between service providers or levels of care. This is particularly important during the transition between acute care and less intensive rehabilitative care.
- Inpatient care and other acute interventions are used only when clinically necessary.
- Individuals in need of behavioral health services are identified and followed, to assure that services are coordinated and that they do not fall through the cracks.
- Services and supports are designed and delivered in a manner that promotes sustained recovery and empowers service recipients to be active participants in the recovery process.

<u>DMHAS Recovery Management Program: Local and Statewide Components</u>

Recovery Management will be comprised of two interlocking components, one conducted at the statewide level and the other locally based:

> **Statewide:** A single statewide ASO performs clinical reviews prior to authorizing care for selected services, monitors care quality, identifies people who are frequent users of acute care services and performs analyses designed to determine whether service providers are using generally accepted care practices.

[3] This would also include a role in coordinating behavioral health care to parents in families where both the parents and children need behavioral health services.

Locally Based: Case Managers employed by Local Mental Health Authorities (LMHAs) and other local service providers perform an initial screening and subsequently, following formal assignment by the ASO, have frequent, face-to-face visits with the service recipient. Guided by a Recovery Plan written with the individual, the Case Manager monitors the person's wellbeing and provides supports in the community.

As part of recovery management, DMHAS will offer care providers the tools and training that they will need to work within a standardized approach to the selection of service recipients, and to level of care (program) assignment and services coordination.

The Recovery Plan

Each person who receives case management services will have a Recovery Plan that serves to guide service delivery. A Recovery Plan:

- Will be comprised of short- and long-term goals.
- Will be developed collaboratively between the adult and an interdisciplinary team of care providers, including family and significant others, when appropriate.
- Will be based on a comprehensive assessment of the person's condition and include goals, objectives and interventions that address all identified needs including environmental and social factors that may assist or impede recovery.
- Will clearly identify the Case Manager and the range of services/supports.

Clinical Policies and Criteria

An interagency team has reviewed current Medicaid provider policies and prior authorization requirements. Recommendations are being developed to revise many of these DSS policies and practices to strengthen the ability of DMHAS to improve outcomes and effectuate systems change through recovery management. These changes include:

- Clarifying service definitions to establish clear standards for program content.
- Easing of some restrictions to facilitate access to lower cost community-based services that offer appropriate alternatives to costly or more restrictive services.
- Adding continued stay review for people admitted to psychiatric hospitals, in order to ensure discharge to rehabilitative care or outpatient services, as soon as appropriate.
- Eliminating prior authorization requirements where no benefit is expected. However, even when prior authorization is not required, the care provider will be required to notify the ASO, so that a comprehensive picture of the person's service delivery pattern can be seen.
- Making prior authorization requirements consistent across all care provider types.

In addition, DMHAS and DSS staff are working to develop clear, written clinical criteria to guide the utilization management process.[4] Currently, prior authorization is required for some mental health and addiction services in the Medicaid fee-for-service program. However, in some cases the decisions are based on individual professional judgment. The availability of written clinical criteria similar to those developed by DMHAS, as part of the GABHP implementation, will help to strengthen the process.

[4] Utilization management involves determining the type, intensity and duration of services to be provided to an individual based on an assessment of strengths and needs, using specific assessment criteria. Utilization management typically involves an assessment prior to the delivery of services (Prior Authorization), another assessment if continued services are needed beyond those approved during the initial assessment (Concurrent or Continued Stay Review), and a final review at discharge (Discharge Review).

Benefits of Proposed Reforms of the Adult Delivery System

This proposed system of recovery management offers significant improvements over the current system of care, which is partially managed – but not coordinated – across DMHAS, Medicaid fee-for-service, and the HUSKY program. The Recovery Healthcare Plan for Adults will offer significant advantages over the present system. The proposed system of care will utilize standardized clinical criteria, customized by DMHAS for Connecticut. These criteria will assure the consistent utilization of services across all regions. The use of local care providers to screen and assess individuals, develop recovery-oriented service plans, and link adults with an appropriate array of services and supports, will assure that treatment and recovery services are well coordinated. The integration into a data warehouse of information about services paid for by both DMHAS and DSS will also promote better coordination of care and the rational use of services.

Revenue Maximization

Many of the behavioral health services currently funded by DCF and DMHAS could be covered under Medicaid if changes were made to the Connecticut Medicaid State Plan. These changes would allow federal financial participation in the funding of behavioral health services and thus reduce the burden on the state budget. Toward this end, the Departments are proposing an expansion of the rehabilitation option, a Medicaid provision that expands flexibility in service coverage and federal claiming, and pursuing other strategies for increasing federal claiming under Medicaid. The option to cover rehabilitation services under Medicaid (the "Rehabilitation Option") gives states the opportunity to support mental health programs that are designed to help people with serious behavioral health disorders attain sustained recovery and lead stable, independent lives in community settings, while simultaneously decreasing reliance on acute care services.

Child Rehabilitation Option

The Rehabilitation Option provides flexibility with respect to place of service and provider, thus allowing the extension of Medicaid coverage to in-home services and other clinical services provided in community rather than clinic settings. If the Rehabilitation Option were expanded to include the community services that DCF is providing under KidCare, 50% of every service dollar spent on the proposed services for Medicaid children would qualify for federal reimbursement.

This benefit expansion is consistent with Connecticut's vision of providing flexible, child-focused, community-based services to children where they reside. However, an expansion of the Rehabilitation Option requires careful review and planning to avoid excessive program expenditures, including: clear distinction between service profiles and definitions; mechanisms to insure that the State does not pay for a high-cost service when a low-cost service was actually delivered; appropriate management of utilization and appropriate professional supervision of services. A decision about whether to implement this option will be made after completion of the actuarial analyses.

The services under consideration for inclusion in the Rehabilitation Option include:

- Comprehensive Global Assessment for Children.
- Emergency Mobile Behavioral Health Services for Children.
- Crisis Stabilization Beds for Children.
- Home-Based Therapy Services for Children.
- Intensive Home-Based Therapy Services for Children.
- Behavior Management Services for Children.
- Behavioral Health Consultation for Children.
- Early Childhood Consultation.

Adult Rehabilitation Option

The expansion of the rehabilitation option to adults would enable the state to obtain federal matching money for DMHAS services that are now supported entirely by General Fund appropriations. However, this option must be carefully implemented to assure that enrolled providers include only those who can offer high quality services that produce positive outcomes for individuals in their care. In addition, planning will involve determining the amount of resources that DMHAS will need in order to continue serving adults who require rehabilitative services, but are not eligible for Medicaid coverage. In order to identify the providers of rehabilitative services through a revision of Connecticut's Medicaid State Plan, DSS and DMHAS will work collaboratively to develop standards and criteria that define the qualifications of providers, and clearly stipulate such standards in the State Plan Amendment (SPA) and regulations.

Based on a review of existing General Fund supported rehabilitation services, and in light of federal rules about the rehabilitation option, the following service categories are being considered for coverage under Medicaid:

- Mental Health Psychosocial Rehabilitation Programs,
- Assertive Community Treatment (ACT) Programs,
- Mobile Crisis Services,
- Crisis Beds,
- Substance Abuse Residential Rehabilitation, and
- Mental Health Residential Rehabilitation.

In order to extend the rehabilitation option to adult services, changes will be needed in several areas. In addition to obtaining federal approval of a Medicaid SPA, DSS would need to enact regulations establishing coverage for rehabilitation services. These regulations would describe provider enrollment and certification requirements, covered services, service recipient eligibility conditions, authorization requirements, and the reimbursement structure. In addition, DSS and DMHAS will develop an MOU describing the role of each agency in the operation of the rehabilitation option.

Section I: Partnership Overview and Integrated Administrative Infrastructure

A. Behavioral Health Partnership

The Departments of Children and Families (DCF), Mental Health and Addiction Services (DMHAS), and Social Services (DSS) have formed the **Connecticut Behavioral Health Partnership** ("the Partnership") to plan and implement an integrated public behavioral health service system for adults, children, and families. The overall goal of the Partnership is to provide enhanced access to a more complete and effective system of community-based behavioral health services and supports and to improve individual outcomes. This report presents the current plans of the Partnership and provides a status report on implementation.

1. Partnership Objectives

The Partnership has three objectives 1) Administrative Integration, 2) Service Delivery Redesign and 3) Revenue Maximization. Each of these objectives contributes to the goal of better access to quality services, while also ensuring the efficient use of state resources:

Administrative Integration

The Departments are developing a common administrative infrastructure to support the efficient management of behavioral health services provided to recipients of HUSKY A (managed Medicaid), HUSKY B (the State Children's Health Insurance Program [SCHIP]), Medicaid fee-for-service (FFS), the DMHAS General Assistance Behavioral Health Program (GABHP), and the DCF Voluntary Services Program. The shared administrative infrastructure will integrate diverse funding streams, support comprehensive care planning, reduce administrative cost, and improve the state's ability to design and manage performance-based clinical and administrative service contracts. A common administrative infrastructure will also reduce incentives for cost shifting among health service purchasers (state vs. private), one of the reasons underlying Connecticut's over-reliance on institutional care.

The overall goal of the Partnership is to provide enhanced access to a more complete and effective system of community-based behavioral health services and supports.

Service Delivery Redesign

The Departments are redesigning the behavioral health service delivery system to emphasize individuals and their families as partners in care planning *and* improvements in the quality and availability of community-based services and supports. Connecticut Community KidCare is the reform initiative that focuses on the service delivery system for children. The Recovery Healthcare Plan for Adults is a complementary initiative that focuses on the service delivery system for adults. Together, these reforms will improve the ability of children and adults to remain in their homes and communities, to function independently, to achieve a better quality of life, and to avoid unnecessary hospital and institutional care.

The child and adult systems are being redesigned along common principles that are consistent with a community-based model of service delivery:

- Children/families/consumers as partners
- Community-based
- Cost-effective
- Culturally competent
- Evidence-based
- Recovery focused
- Flexibly planned
- Informed choice
- Prevention and early intervention
- Coordinated care
- Accountability

Revenue Maximization

Many of the behavioral health services currently funded by DCF and DMHAS could be covered under Medicaid if changes were made to the Connecticut Medicaid State Plan. These changes would allow federal financial participation in the funding of behavioral health services and thus reduce the burden on the state budget. Toward this end, the Departments are proposing an expansion of the rehabilitation option, a Medicaid provision that expands flexibility in service coverage and federal claiming, and pursuing other strategies for increasing federal claiming under Medicaid.

2. Planning Process

The Commissioners of the three Departments agreed in August 2001 to integrate the previously separate planning processes for child and adult behavioral health services. On January 24, 2002, the Commissioners of DSS, DCF, and DMHAS signed a Memorandum of Understanding (MOU) committing to the development of an integrated public behavioral health system for children and adults. This MOU formalizes the Behavioral Health Partnership and establishes a committee structure that supports collaborative decision-making. The committee structure includes a Commissioner-led Behavioral Health Partnership Policy Committee and three interdepartmental teams to guide planning and implementation: the Child Implementation Team for the children's system, the Adult Implementation Team for the adult system, and the Administration and Finance Team to design and implement the common administrative infrastructure. The Policy Committee and the Teams operate on a consensus model. Each Team in turn has created interagency work groups to focus on specific elements of the new system. All three Departments are thus involved in developing the management infrastructure and associated policies, procedures, contracts, and standards. Parents, consumers, and providers are playing a role in various aspects of the planning and pre-implementation activities, through team and workgroup structures as well as statewide advisory groups. The Partnership has also drawn on national experience and expertise to support the planning process.[5] A future MOU will guide the full implementation of the new system.

Partnership Structure

- ***Policy Committee***
- ***Administration and Finance Team***
- ***Child Implementation Team***
- ***Adult Implementation Team***
- ***Technical Work Groups***

3. Organization of this Report

Section I of this report provides an overview of the Partnership and the Departments' efforts to create an integrated administrative infrastructure for the delivery of publicly funded behavioral health services in Connecticut. Section II provides a progress report on the implementation of Connecticut Community KidCare in accordance with Section 49 of P.A. 01-2 JSS. This section of the report describes the service delivery redesign and revenue maximization efforts specific to the child service system. Section III of the report describes the Recovery Healthcare Plan for Adults, including service delivery redesign and revenue maximization efforts specific to the adult service system. Section III is submitted in accordance with PA 01-8, JSS, under which DSS and DMHAS were asked to submit two studies: one concerning the clinical management of mental health services for adults covered by Medicaid, and the other concerning the implementation of adult rehabilitation services under Medicaid, including an implementation plan. It is important to note that the Partnership activities described in this report address several of the major recommendations of the Governor's Blue Ribbon Commission on Mental Health issued in July 2001.

B. Administrative Integration

The Partnership is working to develop an integrated infrastructure for the administration of behavioral health across the child and adult service systems. This infrastructure will provide support for each Department's objectives in the redesign of service delivery practices and create economic efficiencies so

[5] DSS and DCF contracted with the Child Health and Development Institute of Connecticut, Inc. to provide technical assistance and the services of Carl Valentine and Associates for program and service delivery design, the Human Services Collaborative for the training, and Human Services Research Institute (HSRI) to assist with performance measurement and evaluation activities.

that a higher proportion of funding can be spent on direct services.

1. Administrative Model

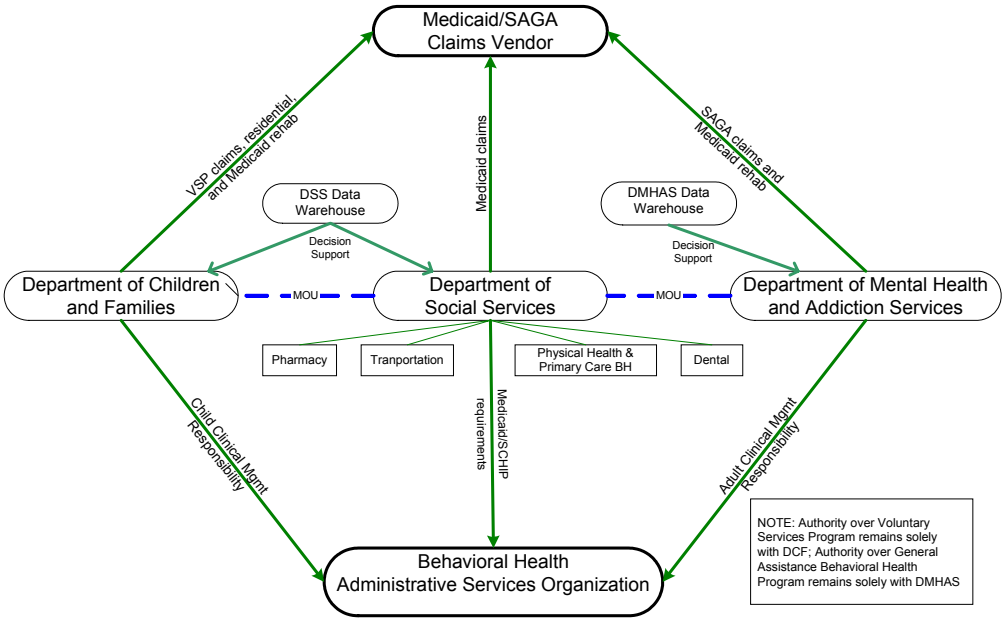
There are three administrative functions that the Departments are preparing to share including **clinical management, claims processing and data management**.[6] All clinical management services (e.g., prior authorization, utilization review) for the HUSKY A, HUSKY B, Medicaid FFS, DMHAS General Assistance Behavioral Health Program, and the DCF Voluntary Services Program will be provided by a single Administrative Services Organization (ASO). Similarly, all claims will be processed by a single claims vendor (see Figure 1).

The Partnership seeks to achieve efficiencies and improved services by integrating clinical management, claims processing, and data management in support of both the child and adult service systems.

The design of this new structure draws on the experience of DSS in the HUSKY and Medicaid FFS programs, of DMHAS in transforming its service delivery system for recipients of State Administered General Assistance, and DCF in managing its largely grant-based behavioral health care services and the Voluntary Services Program. This proposed structure represents a substantial departure from the administrative fragmentation and inefficiency that characterizes the current system. At this time, behavioral health service providers must seek authorization from seven (7) different entities operating under eight (8) different contracts for publicly funded behavioral health services alone. Similarly, providers must submit behavioral health claims to six (6) different claims vendors operating under seven (7) different contracts. The corresponding variation in policies and practices for authorization and claims submission creates a substantial administrative burden on the providers. This in turn contributes to the cost of services and pressure to increase rates. Data management will be consolidated under two data warehouses located at DSS and DMHAS.

Figure I-1

Connecticut Behavioral Health Partnership
Administrative Infrastructure



[6] This is not a complete list of administrative services. Member services and provider relations (including contracting) may or may not be shared to the same extent.

The use of multiple vendors is an important aspect of this model. The state is acting much like a health plan, purchasing administrative services from organizations with special expertise in distinct areas of health service management. A specialized claims vendor can process claims at lower cost and more reliably than most full service managed care organizations. Similarly, a specialized data warehouse (which already exists in DMHAS) can provide better quality, less expensive, and more timely reporting than can typically be obtained from managed care organizations.

Administrative integration will help the state achieve a number of key objectives:

- Reduce unnecessary institutional care;
- Promote sustained recovery;
- Improve administrative efficiency;
- Improve the ability to design and manage performance-based contracts;
- Extend utilization management to historically under managed service areas and populations;
- Improve the transition from child to adult services;
- Reduce incentives to cost-shift from private sector to public sector; and
- Reduce administrative burden on providers.

2. Benefits to the Community

The Behavioral Health Partnership brings together three Departments that have distinct but overlapping service responsibilities to children and adults in various public programs. Historically, these Departments have worked with one another in the interest of developing and operating special programs (e.g., reinsurance, General Assistance, special populations, Project Safe, federal mental health block grant) or projects (e.g., the Governor's Blue Ribbon Commission on Mental Health). However, the Departments have never before come together in the interest of broad-based program integration and coordination of management and services to better serve individuals across the life span. With the signing of the Partnership MOU in January, the Departments committed to a formal structure for sharing planning and decision-making responsibility to ensure that the long-term evolution of Connecticut's public behavioral health system is consistent with a shared, overarching vision.

Administrative integration will support individuals and families across the lifespan and reduce fragmentation for consumers and service providers.

The Departments believe that the Partnership and the shared administrative model will greatly benefit service recipients and the providers who serve as the foundation for the entire system. A single ASO will reduce the experience of fragmentation by providing a single source for clinical management, benefit information, and various member services (such as a statewide toll-free line for mobile crisis services) while funding streams will be managed behind the scenes, within shared information systems, and thus be seamless to the consumer.[7] The integration of funding streams will make it easier for providers and consumers to develop community-based individualized care plans that rely on multiple funding sources (e.g., Title XIX, state general funds). A single ASO will be able to manage the entire system of services for an individual child or adult, authorizing all admissions to institutional services, facilitating the transition from hospital to residential and outpatient care, and expediting a timely discharge from residential care when goals have been met and a community-based service plan is in place. This will help ease gridlock and support the use of community-based systems of care and recovery oriented care planning.

In addition, there will be distinct advantages for families, transitioning youth, and adults:

[7] There will be differences in available benefits when moving across eligibility categories such as already exist between HUSKY A and B (e.g., EPSDT, non-emergency medical transportation, respite).

Families

Care planning for children with complex behavioral health service needs must address all aspects of a child's environment and important relationships in that environment. Healthy relationships are necessary for creating a therapeutic environment in which a child can achieve greater health and independence. On occasion, the parents or siblings of children with complex needs have their own psychiatric or addiction disorders. These disorders can further complicate the relationship between the child and other family members and efforts to develop a consistent, therapeutic environment for the child. When children and family members are eligible for services under the Partnership, a care plan can be developed that addresses the needs of the entire family and this care plan can be authorized and facilitated by a single ASO, under the direction of DCF and DMHAS. The ASO will bring to bear the expertise and resources of all three state agencies in order to ensure that no family member goes without necessary care.

Transitioning Youth

The Behavioral Health Partnership will allow for easier transition from the children's behavioral health network into the adult network due to a host of fiscal, administrative and clinical features that will assist in addressing the needs of youth with complicated behavioral health needs. Adolescents receiving KidCare services will be tracked and the services provided to them will be monitored for effectiveness. As these youth continue to move toward young adulthood, there exists a shared commitment between DCF and DMHAS to begin joint planning for their future needs and to develop services that will seamlessly transition these young adults into the DMHAS system when, and if, necessary. Both agencies are seeking to identify new and effective interventions and to develop a continuum of services to address the developmental and clinical needs of this population. The administrative ability to track progress in various treatment modalities and shared knowledge of the youth in need of transitional services will allow for further enhancement of this specialized service system that is described more fully in Section II.

Adults

The Behavioral Health Partnership will help to improve care and the likelihood of recovery for adults with behavioral health disabilities by integrating the management of various funding streams needed to support seamless care delivery to individuals with complex and changing needs. Integrated management of multiple funding streams will improve care coordination. At present, the unique requirements of these different funding streams contribute to fragmentation in care and confusion in gaining timely access to care as an individual's needs change. No single entity has a reliable means of determining the past and present pattern of services being delivered to a specific individual. The absence of a single integrated information system means that the service recipient can temporarily "disappear" within the delivery system as they move between programs supported by different funding streams. For example, case management staff are sometimes unable to locate a person with whom they are working because they are unaware that an emergency hospitalization has occurred. If the hospital staff fails to contact the case manager (or is unaware of the involvement of a case manager), valuable information needed for successful inpatient treatment and a smooth transition back to the community is lost. This information gap can be highly detrimental to the person's recovery. These are the precise problems that can be addressed in the Behavioral Health Partnership by having a single system containing contemporaneous clinical information about care supported by various funding streams.

3. Agency Authority

Shared administration will require clarity with respect to agency authority over program policy and procedures and access to corresponding quality, utilization, and cost data. The details will be set forth in a follow-up memorandum of understanding pertaining to the operation of the shared infrastructure and management of the associated contracts. As it relates to the Medicaid and SCHIP covered services, DSS will delegate lead clinical management responsibility, including responsibility for developing utilization

management procedures and clinical management protocols, to DCF and DMHAS. DSS will retain the right to participate in these processes and to exercise approval authority as outlined in the terms of an interagency MOU. Sole authority over Voluntary Services and the General Assistance Behavioral Health Program will continue to rest with DCF and DMHAS, respectively.

4. Timetable for Implementation

The implementation of the shared administrative infrastructure, in whole or in part, is scheduled to begin on July 1, 2003. This date was selected because it coincides with the expiration date of the existing HUSKY Managed Care Organization (MCO) contracts and the timetable for reprocurement of the HUSKY program services. DSS will issue a Request for Proposals for the HUSKY program without the behavioral health benefit during SFY 2003. New HUSKY MCO contracts with behavioral health carved-out will take effect July 1, 2003. The ASO must be in place and operational by that date in order to ensure uninterrupted management of the HUSKY behavioral health benefit.

5. Financing

Under the Partnership MOU, the Departments have committed to the principle of cost neutrality. The Departments believe that the proposed administrative integration and service delivery reforms can be operated within current service and administrative expenditures, adjusted for growth in enrollment and cost-of-living. Modest one-time costs are anticipated in SFY 2004 related to transition activities. It is anticipated that the administrative costs will be lower as a percentage of total expenditures than is currently the case for behavioral health services administered under the HUSKY program. The cost of the shared administrative infrastructure will be covered in large part by reductions in administrative functions currently performed by DCF, DMHAS, and DSS, the DSS external utilization review contract, behavioral health administrative funds in the HUSKY program, and administrative funds that support the General Assistance Behavioral Health Program ASO. The Departments have retained an actuary to estimate the administrative costs and savings that can be achieved from the proposed model and provide clinical service cost projections resulting from changes in utilization patterns. The existing rate structure will be re-examined in light of this analysis. The Departments will consider the impact of the proposed changes on providers, service capacity at various levels of care, and the ability to meet access and quality related goals specific to the child and adult initiatives. The actuarial analysis is scheduled to be completed in July 2002.

Cost neutrality: The Departments believe that the proposed administrative integration and service delivery reforms can be operated within current service and administrative

6. Overview of Administrative Functions

Clinical Management

Clinical management is the process of evaluating and determining the appropriateness of the utilization of behavioral health services, as well as providing assistance to clinicians and consumers to ensure appropriate use of resources. Clinical management may include, but is not limited to, prior authorization, concurrent and retrospective review, discharge planning, case management, quality management, provider certification (such as, assuring compliance with quality standards), and provider performance enhancement.

The three departments are preparing to jointly procure an ASO to provide clinical management services through a Request for Proposals process. By forming a purchasing coalition under a Request for Proposals, the state agencies will be able to solicit bids for the management of a much larger volume of services, at a lower cost per beneficiary, than any single agency could achieve independently. The Request for Proposals will require bids on the combined beneficiary pool (i.e., all coverage groups), although the implementation of the services may be phased in by coverage group. The contract will be performance-based. A portion of the administrative contract dollars will be withheld and released annually contingent

The three Departments will jointly procure an Administrative Services Organization to perform clinical management and related functions.

on the contractor's ability to meet access, quality, utilization, and cost targets.

The ASO will form the hub of the DCF and DMHAS clinical management programs because the information systems will contain current and historical data about the type, intensity, location and provider of care for every individual receiving services. The ASO will be responsible for recording or authorizing all requests by care providers to offer services to recipients (including initial requests and continued treatment). The ASO will complement and reinforce the efforts of staff who work with youth, families and consumers to develop care plans, while ensuring that service provision is in accordance with clinical standards for appropriateness.

For selected services, the ASO will authorize care in accordance with predefined clinical criteria established by DCF and DMHAS for their respective target populations and age groups. The ASO will review clinical appropriateness and service necessity through a system of prior authorization, continued stay and discharge reviews, as well as through a quality improvement program designed to detect and intervene in situations where care providers or service recipients have unusual or clinically substandard service utilization patterns (i.e., the Outlier Management Program). Under the Outlier Management Program, the ASO will work with identified care providers to help them bring their practices into conformance with acceptable clinical standards. Clinical information storage, retrieval and sharing will occur with strict conformance to state and federal laws and regulations, including new rules promulgated under the federal Health Insurance Portability and Accountability Act (HIPAA). DCF will require legislative action to provide for the data collection and sharing necessary for effective administration of KidCare.

The main functions of the ASO are as follows:

Linkage with Care Coordinators:[8] Because the ASO will be a clearinghouse for information about all children and adults using services, it will facilitate communication of important information to Care Coordinators. For example, the ASO will authorize all inpatient admissions to private hospitals and thus can promptly notify the accountable Care Coordinator if someone in his/her care is admitted. In accordance with defined duties, the Care Coordinator will begin working with the hospital on discharge planning and will track the person following hospitalization to ensure that a successful transition is made to a rehabilitative level of care.

Because of its role in authorizing care, the ASO will also become aware of individuals who do not have a Care Coordinator, but have been admitted repeatedly to inpatient services or have had frequent hospital emergency department visits. The ASO will be able to determine eligibility for care coordination and facilitate linkage to a Care Coordinator.

Utilization Management (UM): The ASO will prior authorize selected services, including proposed rehabilitation option services, where authorization is necessary to ensure that services are appropriate and consistent with quality standards. Prior notification, rather than authorization, may be necessary for many community-based services to allow monitoring of current service use and to prevent duplication of services. A notification or *service recipient registration process* was developed and implemented by DMHAS as part of the General Assistance Behavioral Health Program, enabling the ASO to focus its clinical reviews on more costly levels of care that require utilization management. The notification process created clinical and fiscal efficiencies, while allowing for real-time data collection and reviews of care providers with significantly higher rates of utilization (i.e. "outliers") in order to insure effective treatment. By limiting the prior authorization to certain levels of care, providers have been relieved of a significant amount of paperwork and administrative burden.

The ASO will also perform continued treatment reviews of inpatient hospitalizations and residential

[8] The term care coordinator is used throughout the section to denote the individual who facilitates individualized service planning in partnership with children with complex behavioral health needs and their families and adults with serious and persistent psychiatric and substance abuse disorders. The DMHAS term for this individual, as is used in Section III, is Case Manager.

treatment admissions to assure effective, goal-oriented care and a return to the community at the earliest appropriate time with a clear plan for aftercare services. Inpatient providers will be able to contact the ASO for assistance in identifying suitable community-based providers if they are having difficulty in locating them. In this example, the ASO and Care Coordinator both assist the hospital or residential treatment provider with developing an appropriate and accessible discharge plan, thus improving the likelihood of effective aftercare and reducing the risk of inpatient readmission. Because of the inter-relationship between DCF protective services, clinical services, and juvenile justice services, non-clinical factors may enter into continued treatment decisions, such that services may be provided beyond what can be covered and federally reimbursed under Medicaid and the State Children's Health Insurance Program. Such factors may include, for example, court orders, adequacy of living arrangements, and safety considerations.

Because hospitals will contact the ASO for requests for emergency admission, the ASO will have the opportunity to deploy a mobile crisis team to evaluate the individual, avert the unnecessary use of hospital services, and arrange for immediate service when a hospital admission is not necessary. This approach has been well tested and found to be effective in certain instances, and is consonant with recent collaborative efforts between DMHAS and general hospital emergency departments throughout the state and with the emerging DCF model for Emergency Mobile Crisis Services.

Coordination of Benefits: The ASO will conduct a *coordination of benefits* review upon receipt of a request for authorization to determine the appropriate payor for the service. The ASO will notify the service provider if a third party payer is legally liable for services rendered.

Member Services: The ASO will be responsible for a limited range of member services, including providing benefit information, referral services, and possibly a toll-free line for accessing urgent care and emergency services (hospital emergency department and mobile crisis teams).

Appeals and Grievances: The ASO will administer a process for resolving appeals and grievances. The ASO's appeals and grievances process will be available to all service recipient eligibility categories. However, appeals related to the denial, suspension, reduction or termination of services provided through Medicaid, General Assistance, or Voluntary Services will be subject to an administrative hearings process.

Claims Processing

Claims processing involves the adjudication and payment of claims submitted by a service provider or another entity acting on the provider's behalf. The claims vendor will either be the existing vendor for DSS or DMHAS, or a new claims vendor for behavioral health jointly procured by the Departments. The claims vendor will adjudicate and pay all fee-for-service behavioral health claims for Medicaid, SCHIP, Voluntary Services, and General Assistance and selected non-entitlement grant services that may be converted to fee-for-service and administered under the Partnership. The claims processing vendor will also be responsible for related services as follows:

A common claims processing vendor will address diverse program requirements in an integrated fashion.

- *Cost-avoidance*. Execution of all applicable cost-avoidance procedures. These procedures involve seeking payment from third parties such as commercial insurers.
- *Cost-sharing.* Implementation of co-payment requirements applicable under SCHIP and the Voluntary Services Program.[9]
- *Provider Enrollment.* Enrollment of providers of Medicaid covered services including providers of rehabilitation services. This includes receiving and processing provider applications, assuring

[9] DAS currently administers cost sharing for voluntary services. The claims vendor can administer co-payments if the voluntary services program is converted to fee-for-service and providers are paid a percentage of total cost and given responsibility for direct collection of co-payments.

that they meet licensure, certification, and/or accreditation standards that may be applicable, obtaining a signed contract with the providers, and entering necessary billing data about each provider into the provider data base.

- *Other provider relations services.* Provision of provider relations services including production and dissemination of Medicaid provider policy manuals, responding to provider inquiries, assistance with electronic data interchange, assistance with claims submission procedures, provider location services referenced by town and provider type, and eligibility verification services.

Data Management

Data management is the administrative process that involves the storage, integration, manipulation, and reporting of data, which may come from multiple sources, for the purpose of supporting program management, performance measurement, and contract enforcement. Data management services will be provided in part by a data warehouse and decision support system that is currently under procurement by DSS and the Department of Information Technology (DOIT) to facilitate program management and fraud and abuse detection. The system will initially be designed to accommodate the transfer of authorization and encounter data including all behavioral health services covered under the Partnership. Each department will be granted access to the decision support and reporting features of this system within their statutory authority. The DSS data warehouse will be able to provide management information and performance measures for both DCF and DMHAS that are based exclusively on authorization and encounter data that tracks each service delivered. The target date for the initial phase of the implementation of this system is April 2003 with a phased-in operational approach over six months. Other management and performance reports will be obtained from the ASO.

DMHAS has developed a separate data warehouse that includes service, claims, and other information regarding persons served in its state operated and private provider system – regardless of funding source. The data warehouse is critical to DMHAS because of its responsibility for the design and management of a statewide behavioral health system for adults. As part of the operation of the *Recovery Healthcare Plan for Adults*, the DMHAS data warehouse will accept authorization and claims data from the claims vendor and program information from the ASO. It will also be linked to other DMHAS information systems. This will enable DMHAS to generate regular reports designed to identify care providers who perform well or poorly, identify adults who may need closer follow-up by their care coordination provider, and track utilization and cost patterns and trends. DCF is developing specialized data capability to capture and analyze data on the delivery of Care Coordination and Emergency Mobile Crisis Services based on the Uniform Client Record adopted for use in the care coordination process.

Section II: Connecticut Community KidCare

A. Introduction

The Commissioner of Social Services and the Commissioner of Children and Families have been charged by the Connecticut Legislature to develop and administer an integrated behavioral health service delivery system for children to be known as **Connecticut Community KidCare ("KidCare").** As described in legislation, KidCare is for children who are eligible to receive services from the HUSKY Plan, Part A; the federally subsidized portion of Part B; or the DCF Voluntary Services program.[10] This section presents a summary of the work to date on the planning and implementation of **KidCare**. **KidCare** has drawn together multiple state agencies, legislators, providers, families, and community leaders in an effort to redesign the behavioral health service system for children. The perspective of the family and child has been particularly critical as Connecticut moves to the forefront of state-level efforts to reform children's behavioral health service systems.

Connecticut Community KidCare Key Features

- ***Comprehensive behavioral health program with flexible benefit package including both treatment and non-traditional support services***
- ***Full carve-out of HUSKY child behavioral health***
- ***Community-based and culturally competent care planning and service delivery***
- ***Greatly expanded community-based service capacity***
- ***Families involved and supported in decision making role with strengthened family advocacy organizations***
- ***Comprehensive training for all agency and system staff and parents***
- ***Efficient balance of local control of care with statewide administrative support structure***
- ***Integrated funding to support broad benefit package***
- ***Routine performance reports on key outcomes and quality measures***

Reform efforts have been underway for the past several years, and the reader is directed to the four previous documents issued by the Departments to review historical material.[11] The interdepartmental Child Implementation Team (CIT) has led the planning for KidCare since September 1999. The CIT has continued its work through the Behavioral Health Partnership since September 2001. This team works closely with the Administration and Finance Implementation Team that is responsible for developing the integrated administrative structure and financial plan to support the Partnership initiatives. Over the past 6 months, interagency workgroups comprised of staff from DCF, DSS, other State agencies as appropriate, providers, and parents have been established to address specific tasks related to the design and operation of KidCare. These work groups include: eligibility, training, evaluation, service definition and design, data management, clinical management, federal revenue maximization strategies, and the role of Community Collaboratives.

The June 2001 legislation identified key features to be included in Connecticut Community KidCare and established July 1, 2003 as the start date for full implementation.[12] This is also the date on which child

[10] Subsection (a) of section 17a-22a of the Connecticut General Statutes, as amended by Public Act 01-2, section 43 (June Special Session)

[11] The four principal documents describing the planning for KidCare include: Connecticut Department of Social Services, in collaboration with the Department of Children and Families, entitled, "Delivering and Financing Children's Behavioral Health Services in Connecticut," a Report to the Connecticut General Assembly prepared by the Child Health and Development Institute of Connecticut, February 2000; Final Report of the Governor's Blue Ribbon Commission on Mental Health, July, 2000; State of Connecticut, Department of Children and Families and Department of Social Services, "Request for Information to Reform the Delivery and Financing of Children's Behavioral Health Services in Connecticut," August 6, 2000; Connecticut Department of Children and Families and Department of Social Services, "Connecticut Community KidCare: A Plan to Reform the Delivery and Financing of Children's Behavioral Health Services in Connecticut." A Report to the General Assembly Pursuant to June Special Session Public Act 00-2, Section 5, January 2001.

[12] In addition to establishing a name and implementation date for the integrated child system, this legislation defines children with complex behavioral health service needs, allows for the extension of system of care services beyond children at imminent risk of removal from home, permits implementation of a portion of the Medicaid rehabilitation option (private non-medical institutions) prior to the enactment of regulations, requires coordination of service planning and funding with other State

and adult behavioral health services will be carved out of the HUSKY program and administered directly by the Partnership through the integrated administrative structure proposed in Section I.

B. Service Delivery Redesign

1. Guiding Design Principles

Connecticut Community KidCare is designed to eliminate the major gaps and barriers that exist in the current children's behavioral health delivery system. KidCare is based on the belief that children should receive services in their community whenever possible. Parents and families are an integral part of the planning and decision making process. This helps ensure that services are driven by the needs and preferences of the child and family. KidCare will help ensure that children receive interventions that foster the ability to succeed in the home, school and community.

A behavioral health service system that is designed to help children succeed is one that supports families, incorporates knowledge of child development, provides access to quality services and supports, recognizes the impact of abuse and neglect, integrates the care system to facilitate continuity of care, responds to cultural differences, and recognizes that every child wants to be valued and accepted at home, in school and with friends.

The KidCare design

- ***Supports families,***
- ***Incorporates knowledge of child development,***
- ***Provides access to quality services and supports,***
- ***Recognizes the impact of abuse and neglect,***
- ***Integrates the care system to facilitate continuity of care,***
- ***Responds to cultural differences, and***
- ***Recognizes that every child wants to be valued and accepted at home, in school and with friends.***

In the KidCare program, community and home-based clinical services are combined with non-traditional, normalizing activities (e.g. participation in sports, clubs, or therapeutic recreation) to help children navigate the important developmental tasks of childhood. Inpatient and residential services will complement the community and family-based services when more intensive services are needed. Collaboration, coordination and consideration of the child's needs for educational success are integral to KidCare. The service plan for any child experiencing the trauma associated with abuse or neglect will incorporate services and supports important for recovery.

The redesign of the child behavioral health system addresses the following key service design features:

- Expand and enhance services including:
  - Crisis response and supports for children and families in the home, school, and community to ensure the best results for children and to avoid unnecessary institutional placement
  - Clinical Care Coordination and Case Management to ensure (a) an appropriate mix of services designed in consultation with the family and (b) quality and continuity of service and care
  - Home-based services
  - Non-clinical supports to increase the child's opportunity to build natural family and community relationships and skills
- A primary focus on strengthening the family's capacity to help their child with behavioral health needs
- A strong preference for delivery and management of services within the local community

Objectives of KidCare with respect to service improvements include:

- Increased access to and use of an array of community-based behavioral health services

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departments, provides for the establishment of a family support and advocacy organization, and provides for a broad-based training program to support the changes in practice that are essential to the new system.

- Increased continuity of care for children with complex behavioral health needs
- Improvements in service coordination when a child and family are involved in multiple services
- Increased timeliness in discharge from residential and inpatient treatment settings
- Decreased use of hospital emergency rooms for crisis intervention
- Improvements in discharge plans and services from acute care
- Increased family satisfaction with the services for their child and family

The emphasis on comprehensive care planning in an enhanced, community-based service system is designed to avoid unnecessary hospitalizations, residential placements and other out-of-home experiences for the child and the family. Intensive services remain an essential element of a full service behavioral health system. The integration of and collaboration among community and out-of-home services is a hallmark of a well functioning system of care.

2. KidCare Behavioral Health Service Design

The KidCare behavioral health services benefit has two levels (see Figure II-1). The *Core Service* level includes services currently covered under Connecticut's Medicaid Program (outpatient treatment, extended day treatment, intensive outpatient treatment, partial hospitalization, and inpatient psychiatric hospitalization) as well as new community services such as home-based behavioral health services, emergency mobile crisis services and crisis stabilization beds. The *Enhanced Service* level includes additional specialized community services. These may include care coordination, [13] comprehensive global assessment, intensive home-based behavioral health services, behavior management services, behavioral consultation and respite. Children with complex behavioral health needs ("complex needs") will be eligible to receive these enhanced services.

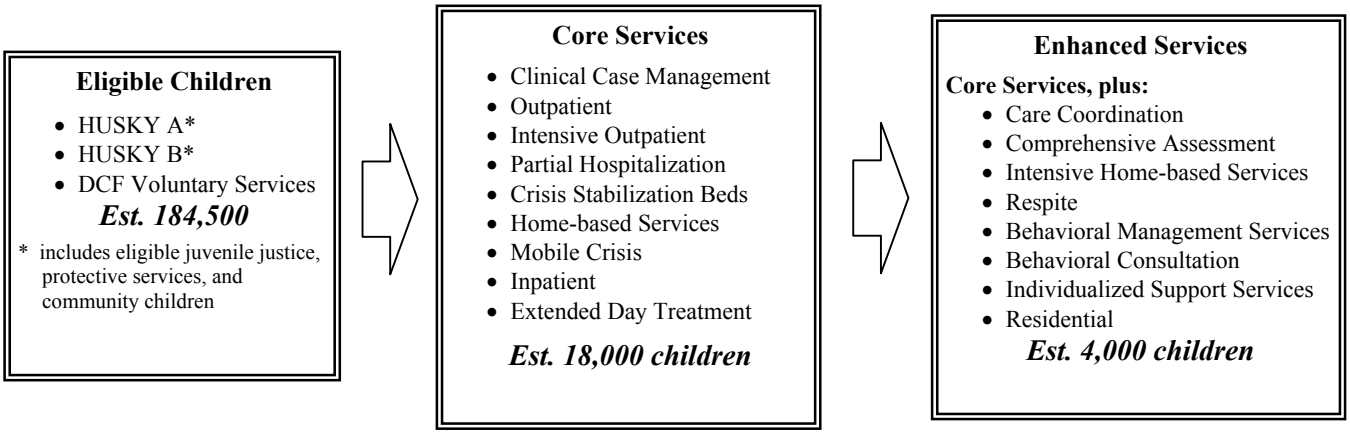
Families and children can begin their behavioral health care at multiple service entry points in the KidCare service system, including schools, crisis services, outpatient clinics and hospitals. Figure II-2 depicts the process for accessing services once KidCare is fully implemented.

3. Service Delivery Coordination and Management

In order for KidCare to achieve improvements in clinical care, the service delivery coordination and management processes must support the key aspects of good care: **access** to care, **coordination** of care, **continuity** of care and **quality** of care.

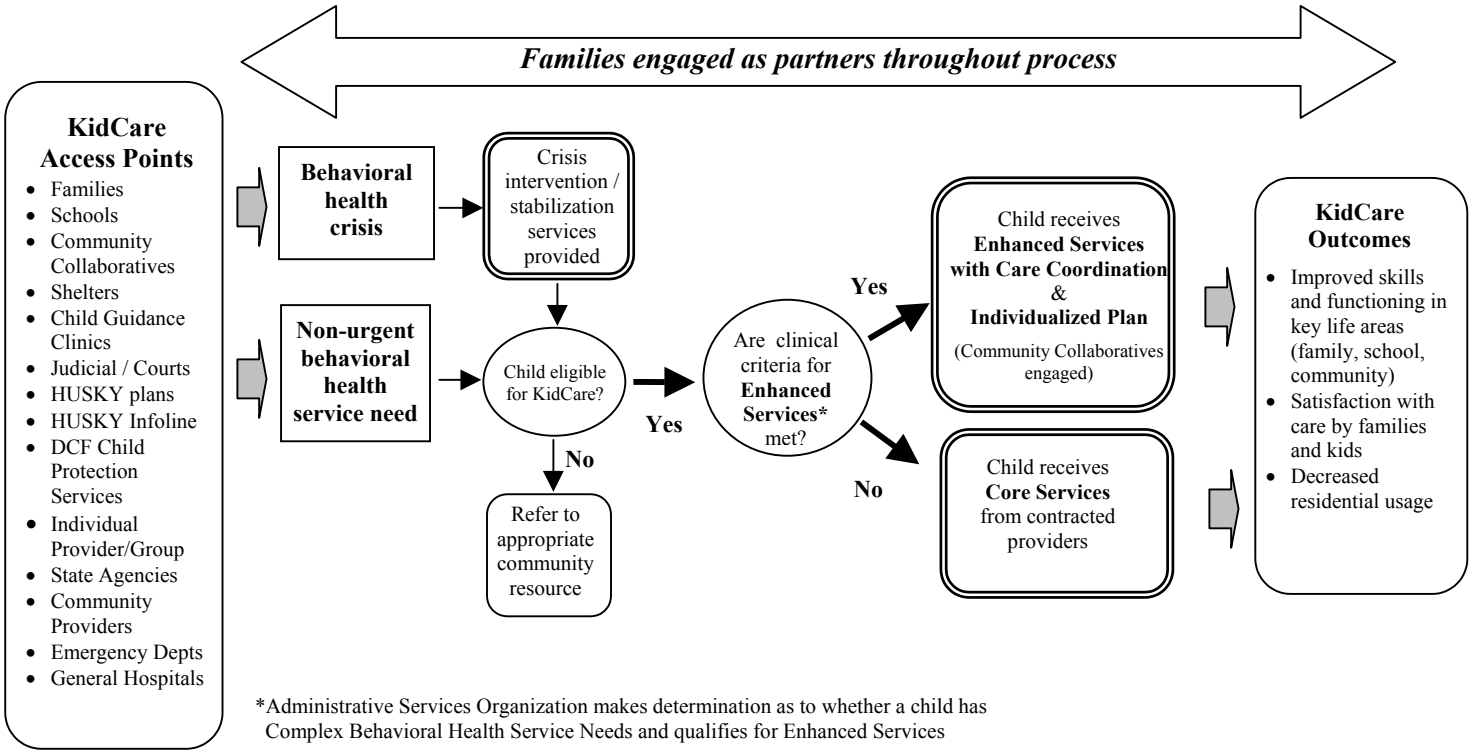
KidCare is designed to meet the needs of all enrolled children and families. Some children will use a few,

Figure II-1: Proposed Kidcare Benefit



[13] Also referred to in System of Care practice standards as Level III Case Management.

Figure II-2 Overview of KidCare Client Flow



*Administrative Services Organization makes determination as to whether a child has Complex Behavioral Health Service Needs and qualifies for Enhanced Services

time-limited services and will not require continued or intensive interventions. Their family, community and school resources will provide these children with ongoing support and guidance.

For children with complex needs and their families, the road to improvement, success and recovery can be complex and challenging. Often these children and families will want and need more intensive and extended services. Children with complex needs and their families will benefit most from a coordinated and comprehensive approach to treatment, problem resolution and improvement. The KidCare program is designed to assist parents and caregivers in identifying and obtaining appropriate, effective treatment for their children. A uniform set of clinical guidelines will be used to guide level of care decisions.

KidCare has three enhancements to the service system that support improved care, especially for children with complex behavioral health needs: (a) the comprehensive, Individualized Service Plan, (b) Care Coordination, and (c) an Administrative Services Organization that provides clinical management services and access to real time service information.

- **Care Coordination.** Children with complex needs often have strengths that are overlooked, have difficulties in multiple areas of their lives, and use multiple services at the same time or over an extended time. Sometimes the courts may be involved and sometimes the child might not be living at home. For children with complex needs, Care Coordinators will partner with families and the providers of care for the child and family to form a Child Specific Team. This team serves as the vehicle for care planning. Care Coordinators are strong family and child advocates, have good knowledge of and relationships with the community providers, and assist the family in navigating and using what can sometimes be a complicated health care system. Through a good and trusting relationship with the child and family, Care Coordinators often recognize a developing problem and can assist before a crisis develops. Care Coordinators also look for strengths in the child or family, help a family access non-clinical community services, and facilitate access and use of physical health care services as they are needed. They also collaborate with the family, child, providers and DCF in monitoring the effectiveness of services. Parents and providers have been active participants in defining the role and activities of the Care Coordinators.

- **Individualized Service Plans.** The service plan summarizes the goals of the child and family and the services that will be provided to assist in meeting those goals. The plan is developed jointly with the child, family and professionals in the Child Specific Team. The particular services in the plan are chosen based on the assessment of the child and family and the input and views of each person on this child's team. It is very useful for providers to join with the family and child in thinking through what the child and family most want to accomplish and to set priorities among problems to be solved. Service plans developed through this process frequently reflect creative, highly individualized, child and family specific objectives and interventions. A good care plan will consider and address the range of interventions that could support this child and family, including social, educational, recreational and peer related areas of life and is expected to assist the child and family to use their unique strengths to meet challenges in the home, school and community.

  Service plans may require prior authorization by the Administrative Services Organization to ensure proper service utilization. DCF and DSS are currently designing the specific processes that will be used to guide referrals and access to enhanced services. Protocols for access to enhanced services are being developed and field-tested at this time in preparation for the July 1, 2003 implementation of the full KidCare administrative structure.

- **Administrative Services Organization.** As described in Section I, the ASO provides a range of services to support effective system management, access to appropriate services, and quality of services. The ASO will authorize admission to hospitals and residential care, applying clinical criteria developed by DCF in consultation with family and provider representatives.

In anticipation of the full system reform, DCF continues to support the development of local Community Collaboratives and improved coordination across all providers. Until the contract with the Administrative Services Organization goes into effect in July 2003, access to services will be handled through existing grants and contracts. HUSKY MCOs will continue to authorize all HUSKY benefits and DCF staff will continue to authorize DCF-funded benefits such as residential treatment.

4. Community Collaboratives

During the past several years, 24 communities in Connecticut have embraced the "system of care" model as espoused by the Federal Center for Mental Health Services. In this model, mental health providers join with other community service providers and with families to better address the needs of children with serious emotional disturbance. In Connecticut, these same groups have united to form Community Collaboratives in order to identify service gaps and develop creative and cooperative approaches to helping families and children. The Collaboratives have helped organize and advocate for improved services and are helping to guide the system's development. In addition, individual providers from the Collaboratives are often among those who participate with family members and other key adults on Child Specific Teams. Community Collaboratives will continue to play a central role in developing the local systems of care, identifying areas where new treatment and non-traditional services and supports can be developed to better meet KidCare objectives, mobilizing natural community resources, and supporting Care Coordinators and Child Specific Teams.

5. Expansion and Enhancement of Community-based Services

DCF is developing an expanded array of culturally responsive, quality services, designed with input from parents and providers. The full complement of behavioral health treatment services include: outpatient treatment, intensive outpatient treatment, extended day treatment, partial hospitalization, behavior management services, behavioral consultation, home-based services, residential treatment, professional parent homes, therapeutic foster care, group homes and inpatient psychiatric hospitalization. In addition, non-traditional supports that encourage and allow children to participate in normalizing activities in their community, such as community sports, club, and arts activities will also become increasingly available. When clinical and support services are combined with Care Coordination and mobile crisis services, a comprehensive system of care exists.

The major areas of service enhancement include:

- **Emergency Mobile Crisis Services.** DCF is procuring emergency mobile crisis services in 12-13 sites statewide (Table II-1, Figure II-3) to provide families with immediate access to behavioral health specialists and to assist in behavioral health emergencies. The service model ensures that teams of professionals are available to conduct emergency mental health assessments, substance abuse screenings, and services for children in their homes, emergency rooms, schools and community settings. A specialized mental health care coordinator will be assigned to provide transitional support and assistance to the child and family as community and other resources are identified as needed for on-going service and treatment.
- **Care Coordination Enhancement.** DCF is procuring additional care coordination services across the State to better serve children with complex behavioral health needs (Table II-1). The total number of Care Coordinators will increase from 16.5 in SFY 2001 to 60 by the end of SFY 2003. Care Coordinators will have a capacity to serve 750-1200 children over the course of a year given average caseloads of 10-12 and average duration of 9 months. Care coordination capacity will continue to expand as resources are gradually shifted from residential treatment and extended subacute hospitalizations.

  Parents were also included in the selection of the providers who will offer care coordination services.

Table II-1

Emergency Mobile Crisis and Care Coordination Enhancement Implementation Schedule

Region	Mobile Crisis Sites / Areas	Additional Care Coordinators*	SFY 2002 Contract	SFY 2003 Contract
South Central	3	7.5	$1,258,320	$2,294,000
Northwest	2-3	7	807,500	1,660,000
North Central	3	16	1,281,000	2,832,000
Eastern	2	6	453,667	1,516,000
South West	2	7	554,333	1,868,000
Total Contract Amount	12-13	43.5	4,354,820	10,170,000
Portion from KidCare Account			3,444,535	8,215,296

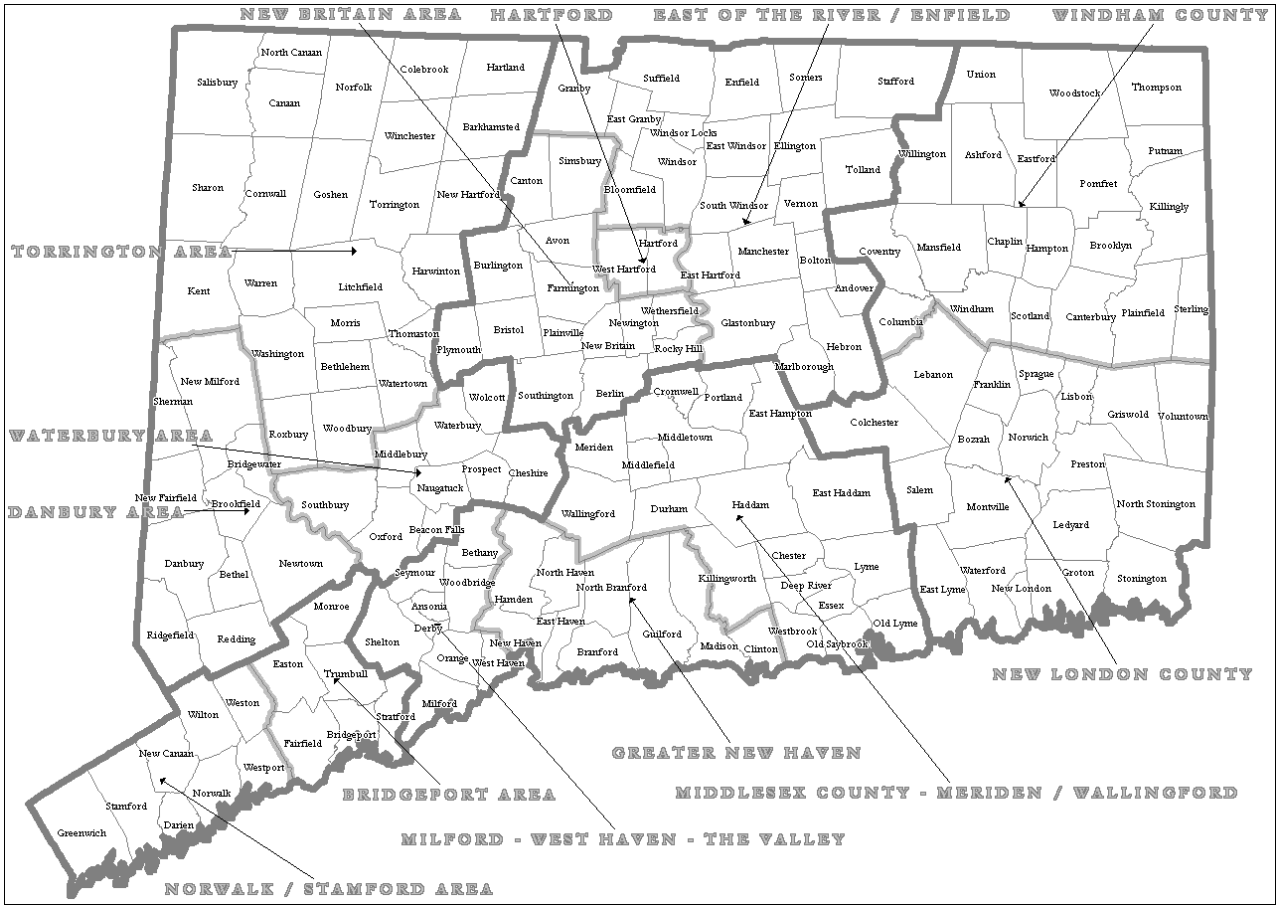
* The total number of Care Coordinators will reach 60 during SFY 2003 when added to the existing resources.

- **Community Service Expansion.** DCF is continuing to expand service capacity in key areas of community service: extended day treatment services, home-based behavioral health services, multi-systemic therapy, and behavior management services. These services are designed to be responsive to children and families that seek care through the crisis programs (or other community venues), and are also an important community system building block that will facilitate diversions from, and shorter stays in, residential treatment services or other more intensive and restrictive levels of care.

  DCF will maintain its contracts with its network of 25 licensed Child Guidance Clinics for behavioral health services and will work closely with the Clinics to ensure the maintenance of existing service capacity. As there are no plans to change structure of these contracts at this time, it is anticipated that the interests of these providers will be safeguarded.
- **Crisis Stabilization Beds.** Specialized crisis intervention and stabilization services are being developed for children in crisis. A KidCare work group is currently developing programmatic and clinical guidelines for crisis stabilization resources with the intent of funding 24-27 beds

statewide by July 1, 2002. These brief, crisis stabilization services, in combination with mobile crisis interventions and expanded in-home services, are intended to assist children and families when a crisis situation might otherwise result in an extended Emergency Room stay, admission to a shelter, or in some cases, hospitalization. A brief separation from family, along with clinical assessment and counseling, can allow children and families to re-stabilize, engage with service providers and maintain much of their daily routine (school, friends, home-life) intact.

Figure II-3 Preliminary Emergency Mobile Crisis Service Areas



6. Family Involvement

Families are playing an instrumental role in ensuring that every aspect of the system is accountable and responsive to the needs of children and their families. DCF is supporting the development of a statewide Family Support Organization to assure that: (1) children and families have a voice, access and ownership in the development and implementation of their service plans; and (2) families are involved as important partners in all system and service design activities.

Families are playing an instrumental role in KidCare.

In March 2001, DCF issued a Request for Proposals for a Statewide Family Advocacy Organization. The focus of the RFP was twofold: (1) to retain and provide supervision to the eight existing professional Family Advocates and (2) to enhance outreach, training and technical assistance to families with children with behavioral health needs, enabling them to build their capacity as advocates for their children. A contract for an annualized amount of $665,000 was awarded on October 1, 2001 to a collaboration of existing Advocacy organizations comprised of NAMI-CT (National Alliance for the Mentally Ill), Families United (a Chapter of the Federation of Families for Children's Mental Health),

Padres Abriendo Puertas, and AFCAMP (African Caribbean American Parents of Children with Disabilities). Connecticut Legal Rights Project provides technical assistance for legal matters.

The newly formed consortium, known as FAVOR, has currently sub-contracted with the Connecticut Association of Foster and Adoptive Parents to employ and provide supervision to the professional Family Advocates. The Family Advocates provide direct and intensive support and guidance to families whose children are receiving care coordination services. Family Advocates attend various meetings with parents and provide support and information from the perspective of another parent who has a child with behavioral health needs. The FAVOR collaborative, under the current fiduciary oversight of NAMI-CT, is providing community outreach in the form of newsletters, web sites, support groups, workshops, advocacy training and public forums to educate parents about advocacy issues, local and statewide resources, and KidCare.

The four advocacy groups help DCF to identify parents to participate in various KidCare related taskforces, workgroups and legislatively mandated committees. Parents comprise a majority of the participants on the Children's Behavioral Health Advisory Committee created by the legislature, which meets routinely. In addition, there is parental participation on the Partnership's Child Implementation Team, which has the authority to make decisions regarding project issues. Parents are also participating on project design work groups.

7. Transition to the DMHAS System

In October 1998, DCF and DMHAS entered into a Memorandum of Understanding regarding the joint development, funding and oversight of a new series of services for young adults with mental health needs who age out of the DCF system. Recognizing that many youth need continuing support services to live independently as they become adults, the Commissioners of DCF and DMHAS, under the direction and support of the Office of Policy and Management (OPM), committed staff time and Departmental funds to develop the young adult programs. Focusing on DCF-identified youth currently in residential or hospital treatment, DMHAS began to design developmentally appropriate community-based services with clinical, vocational, and recreational services provided to clients living in supervised apartments. All services are provided on a voluntary basis and each enrolled youth participates in an educational or vocational program in addition to clinical activities within the program.

Over the past 3 years, over 200 young adults have transitioned into locally operated DMHAS programs.

Over the past three years, over 200 young adults have transitioned into locally-operated DMHAS programs and another 100 youth have been referred and are scheduled to receive services as they age out of the DCF system. The shared administrative structure described in Section I will facilitate the continued improvement of this transition process.

8. Training and Staff Development

DCF has developed a training plan and curriculum to educate all key players within the children's behavioral health delivery system through a contract with the Child Health and Development Institute of Connecticut, Inc. (CHDI). Training is being provided to parents; front-line, supervisory, and management staff from DCF; providers; community leaders; educators; juvenile justice staff; and other interested parties. CHDI partnered with the Human Service Collaborative of Washington, DC to assist in this effort. The purpose of this initial training is to implement competency-based curricula to improve the knowledge, skills and attitudes of all adults working with children with behavioral health needs. Over the last 18 months, a statewide training committee convened by CHDI and comprised of parents, family advocates, providers, DCF staff, University representatives and members from other state departments have worked with the Human Service Collaborative to craft the curriculum that is being used in this training. A five day core curriculum has been developed that focuses on the philosophy of a community-based service system, the needs of children with behavioral health issues, the importance of family involvement, mental health and developmental issues, interagency collaboration, and team building. The

curriculum combines a series of teaching techniques with a focus on group discussion and small group problem solving activities that allow the perspective of each participant to be shared. Feedback from training participants has indicated that parent involvement has been crucial to helping the trainers to recognize the profound impact parents can have on treatment planning and developing positive outcomes for their children.

Feedback from training participants has indicated that parent involvement has been crucial to helping the trainers to recognize the profound impact parents can have on treatment planning and developing positive outcomes for their children.

Based on a "train the trainer" model, each DCF region is developing a core group of 25 trainers comprised of the above mentioned invested parties who will, in turn, train others in their communities. This training initiative accompanies the regional rollout plan for KidCare services this fiscal year. Plans are also underway to create a longer-term investment in training and workforce development.

9. Coordination with Other State Agencies

Many families and children served through KidCare are involved with several other service systems, including education, juvenile justice, and services for persons with developmental disabilities. PA 01-02 JSS requires DCF and DSS to reach out to the State agencies with responsibilities in these areas to explore what resources those agencies could commit to the integrated funding for Connecticut Community KidCare.

Early efforts have focused on developing the basic infrastructure for the implementation of KidCare. As the benefits of the KidCare model are demonstrated, DCF will approach other state agencies to explore integration of additional coverage groups and funding streams within the KidCare plan. The KidCare project team has already engaged the State Department of Education and the Judicial Branch.

State Department of Education

In June 2001, the State Department of Education (SDE) convened a statewide Education and Mental Health Task Force to address issues concerning involvement of Local Educational Agencies (LEAs) and SDE with Connecticut Community KidCare. The 25 member Task Force included principals, teachers, pupil services personnel (i.e., school counselor, nurse, social worker, psychologist), directors of pupil services and special education, superintendents and board of education members, plus representatives from DSS and DCF.

The Task Force, in six meetings to date, has addressed questions concerning the school's role in KidCare, local resource issues and competing/conflicting departmental mandates. As a result of extensive dialogue, a Questions and Issues paper was generated for local distribution.

The KidCare team is reaching out to other state departments with responsibilities in children's behavioral health.

With the support of Commissioner Theodore Sergi, regional conferences convened by the Regional Educational Service Centers (RESCs) between DCF staff and local school personnel have begun as KidCare unfolds throughout the state (average attendance of 100 at the first three meetings). The purpose of these regional meetings is to introduce KidCare to local educators, inform them of the local Community Collaboratives in their neighborhood and invite participation in the individual treatment planning process for children with complex behavioral health needs.

In addition to these regional meetings, Commissioners Sergi, Ragaglia and Wilson-Coker have met, and agreed to discuss ways to address the fiscal impact KidCare may have on local school systems and explore new financial mechanisms to promote more appropriate, cost effective, and successful care for children with behavioral health needs.

Juvenile Justice

The interface between children's mental health and the juvenile justice system has been the focus of much attention over the past fifteen months. As a follow-up to the report issued by the Governor's Blue Ribbon Commission on Mental Health, the Children's Issues Subcommittee of the Mental Health Policy Council has directed much of its attention over the past year to identifying and monitoring the behavioral health issues of the juvenile justice population, and seeking to find a better means of integrating much needed mental health services into the system. The efforts of the Subcommittee thus far have resulted in a series of recommendations that cover the various levels of need within this high risk population including prevention/early intervention, diversion from the juvenile justice system, and expansion of the "system of care" model.

DCF has formed a partnership with the Court Support Services Division of the Judicial Department, the Yale Child Study Center, the UConn Health Center, and the Child Health and Development Institute, with funding from the Connecticut Health Foundation and the Tow Foundation, to create the Connecticut Center for Effective Practice. The initial focus is supporting the expansion of Multisystemic Therapy in Connecticut - an evidence-based practice that is proven effective in the treatment of children with serious conduct disorders who are in or at risk of placement in the juvenile justice system.

Youth involved in the Juvenile Justice system who are Husky A or B eligible, or those with complex behavioral health needs who meet criteria for Voluntary Services will be able to access KidCare services.

In addition, Commissioner Ragaglia continues to meet with Chief Court Administrator Pellegrino and Executive Director of Court Support Services Carbone to explore service needs and treatment options for the juvenile justice population. A point of emphasis within the discussion is the mental health needs of youth in detention.

10. Performance Measurement and Evaluation Program

Historically, Connecticut has lacked a reliable and accurate means to assess the performance of the public sector children's behavioral health system. Those state agencies with responsibility for children's behavioral health care have been unable to measure service accessibility, quality and coordination. This is due in part to the various funding streams that support the service system, disparate data systems designed to administer these funding streams, and heavy reliance on grant-based approaches to funding.

The KidCare reform initiative provides the opportunity to introduce high standards for data-driven program oversight and management. Several aspects of the reform will improve the state's ability to collect standardized information that is the basis for a robust quality monitoring system. KidCare will introduce a single consolidated administrative umbrella and direct state agency contracts with the entities responsible for ensuring access to needed services. Perhaps the most important of the planned changes related to KidCare is the move away from multiple indirect state agency contracts (i.e., DSS' HUSKY HMOs subcontracting to managed behavioral health organizations) to a single contract. DSS and DCF will contract with an administrative services organization to provide statewide clinical/utilization management services and with a claims processing vendor that will streamline billing and provider payment.

The KidCare reform initiative provides the opportunity to introduce high standards for data-driven program oversight and management.

DCF's lead role with respect to program management will allow the development of performance-based contracts with a broad range of sophisticated performance requirements made possible by DCF's clinical management expertise and quality management infrastructure. This expertise will be complemented by DSS's experience with health services management, quality oversight, and contracting. Program oversight, data management, and reporting will be supported by DSS's procurement of a data warehouse. All claims processing and service authorization data will be transferred to this data warehouse. With this infrastructure in place, Connecticut is poised to develop a state of the art performance monitoring system that will help ensure access to high quality, coordinated public behavioral health services and will serve as a model for replication.

In July 2001, DSS, DCF, and the Child Health and Development Institute completed a competitive procurement that resulted in the selection of the Human Services Research Institute (HSRI, Cambridge, MA) to assist with (1) development of a performance measurement system to "grade" overall system performance and (2) evaluation of the system of care reform. These projects are closely related and are described in greater detail below.

Performance Measurement

The development of performance indicators (PI) and report cards has been a priority activity at the federal, state, and national association levels.[14] Considerable progress has been made in: assembling information on existing measures,[15] developing consensus around key concepts,[16] developing conceptual frameworks around which to organize PI measures,[17] and developing instruments to collect client feedback.[18]

As part of its KidCare reform, DSS and DCF are developing a comprehensive quality monitoring system for children's behavioral health services. The primary goal of this system will be the provision of ongoing performance data at the state, regional, and contractor levels for the purpose of: (1) monitoring overall access, quality, and cost-effectiveness, (2) monitoring performance-based contracts with administrative and clinical service contractors and administering contract performance bonuses and penalties, (3) designing and monitoring quality management projects, and (4) assuring public accountability by means of regular KidCare performance report cards.

This outcome-focused system will allow the state to allocate resources more efficiently, contract for services, reward provider performance, promote public behavioral health goals, and provide internal feedback to identify problems and initiate continuous quality improvement. Data from the performance measurement system will be used to create a system-wide report card that will inform payers as well as consumers and family members about the reform's progress and the state's increasing ability to provide behavioral health services that are consistent with the system of care model.

In September 2001, DSS and DCF submitted an application to the Center for Health Strategies to obtain Robert Wood Johnson Foundation funding for the development and implementation of the performance measurement system. This grant was recently approved in the amount of $250,000.

In a related effort, DCF continues to develop and apply performance measures in the care coordination process through the mechanism of the Uniform Client Record and service database.

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[14] Major initiatives include those sponsored by: The National Committee on Quality Assurance (NCQA/HEDIS), Mental Health Statistical Improvement Program (MHSIP), American College of Mental Health Administrators (ACMHA), American Managed Behavioral Health Administration (AMBHA), National Association of State Mental Health Program Directors (NASMHPD), Joint Commission on Accreditation of Health Care Organizations (JCAHO), The Council on Quality and Leadership in Support of Persons with Disabilities, Council on the accreditation of rehabilitation Facilities (CARF), the Rehabilitation Organization, National Alliance for the Mentally Ill (NAMI), American Psychiatric Association (APA), Foundation for Accountability (FACCT), National Association of Psychiatric Health Systems (NAPHS)

[15] Hermann, R. Quality measures for severe and persistent mental illness. DHHS Grant 2001; CONQUEST, an AHCPR funded relational database that allows users to identify quality measures based on domain and characteristics of measures.

[16] American College of Mental Health Administration. Final report of the Santa Fe Summit on Behavioral Health. Pittsburgh, PA, 1997; National Association of State Mental Health Program Directors Research Institute. Five State Feasibility Study on State Mental Health Agency Performance Measures. Outlook: 1998.

[17] Kamis-Gould, E. A Model of Indicators and a Report Card for Assessment of Mental Health Plans' and Systems' Performance. Human Services Research Institute, Cambridge, MA. 1997; National Committee for Quality Assurance. Health Plan Employer Data and Information Set Users' Manual, version 2.0. NCQA, Washington, DC.; Task Force on the Design of the Mental Health Component of a Healthcare Report Card. Mental health report card. Report to the MHSIP Advisory Committee, 1994.

[18] Center for Mental Health Services: The MHSIP Consumer-Oriented Mental Health Report Card. *The Final Report of the Mental Health Statistics Improvement Program (MHSIP) Task Force on a Consumer-Oriented Mental Health Report Card.* Washington, DC: Center for Mental Health Service, April 1996: ECHO Development Team. Experience of Care and Health Outcomes (ECHO) Survey. Field Test Report: Survey Evaluation. Cambridge, MA: Harvard Medical School, May 2001.

Evaluation

The Child Health and Development Institute of Connecticut, Inc. (CHDI), pursuant to an agreement with DCF and DSS, has contracted with Human Services Research Institute (HSRI) and its subcontractor, the Technical Assistance Collaborative (TAC), to conduct an independent evaluation of KidCare. The evaluation team was selected based on a competitive Request for Qualifications. The evaluation will have multiple components: (1) an implementation analysis of system change activities; (2) an analysis of child and family outcomes; and (3) a cost-benefit analysis. The focus of first year evaluation activities will be on the implementation of the emergency mobile psychiatric services and expanded care coordination, examining the fidelity of the implementation to the System of Care model. The study of outcomes through the evaluation process will complement recent research on child and youth outcomes conducted by Dr. Alan Kazdin of Yale University with DSS and DCF funding.

The evaluation is intended to foster accountability, cost effectiveness and responsibility. Parents and providers are continuing to play a role in the design and implementation of the evaluation and in the evaluation process.

Evaluation activities are funded through a $400,000 allocation in the SFY 2003 budget for the implementation of KidCare and grants to CHDI from the Children's Fund of Connecticut and the Connecticut Health Foundation totaling $50,000 to date. The HSRI team is currently completing a detailed evaluation design for the first year activities in consultation with the various interested agencies and others, including parents and research and evaluation specialists in Connecticut.

11. Planning and Implementation Timeline

The Behavioral Health Partnership Administration and Finance Team and Children's Implementation Team, and the various task specific KidCare workgroups continue to meet to identify and address immediate and future issues related to fiscal and programmatic needs. Plans and recommendations for initial start-up services, eligibility criteria, federal reimbursement options, training, evaluation and alternatives to long-term residential treatment have emerged from this process. This report reflects the current thinking of the Partnership and provides a status report on the planning and implementation of KidCare.

The major milestones related to KidCare include

- Full rollout of the funded enhancements to Emergency Mobile Crisis Services and expanded Care Coordination services by July 2002
- Completion of actuarial analyses that will guide further detailed clinical management planning by July 2002
- Development of the detailed Service Delivery Design for July 2003
- Rollout of additional community-based services by July 2002 (and continuing through SFY 2003)
- Implementation of additional services under the Medicaid Rehabilitation Option for children, pending completion of the actuarial analysis
- Carve out of behavioral health services from the HUSKY A and B Managed Care contracts on July 1, 2003 and implementation of the shared administrative infrastructure

As new or enhanced services associated with KidCare become a reality and projected administrative structures are developed and implemented, the Partnership and the Child Implementation Team will use early implementation experience and feedback from the evaluation to refine the program design and project longer-range program and service capacity needs. Similarly, as changes occur, practices, planning, and protocols and the overall project design will continue to be reviewed and revised.

12. Financing KidCare

KidCare services are financed through Medicaid (HUSKY A and fee-for-service), the State Children's Health Insurance Program (HUSKY B), state general funds, and Title IV-E. The KidCare program has received $23 million in new state investments over the 2001-2003 biennium. The Departments are not anticipating the need for additional expenditures for the operation of the KidCare program beyond adjustments for cost of living and overall program enrollment.

A principal objective of KidCare is to move existing investments in institutional care to community services by modifying patterns of service use. This will be achieved through more effective response to behavioral health crises, expanded Care Coordination and community services, improved care practices including a planning partnership with families, and more effective management of high cost services. The joint Administration and Finance Implementation Team of the Partnership is leading efforts to achieve this objective.

Actuarial Analysis

The Department of Social Services in concert with DCF contracted with an actuary to project costs in the KidCare benefit design and to confirm that proposed reforms can be funded within available appropriations. This assessment includes an in-depth review of actual charts of children in services with a goal of determining cost differentials between usual and customary services in the current menu of options vs. the costs and benefits of intensive community-based services. DSS and DCF approach this task with the assumption that the clinical needs of some children can be met in a superior way with intensive community-based care, rather than institutional care, at reduced cost to the state. These analyses will be completed by July 2002.

C. Revenue Enhancement

DCF and DSS are examining whether to expand the Rehabilitation Option for children's behavioral health services, an optional category of Medicaid benefits. A Rehabilitation Option can include a wide range of community-based services, but these must be specifically defined and approved by the federal Centers for Medicare and Medicaid Services (CMS). Currently, Connecticut's Medicaid reimbursable outpatient behavioral health services are primarily organized under a Clinic Option, which limits the delivery of non-traditional, community-based care. With few exceptions, children and families must come to a clinic in order to access the array of available outpatient behavioral health services. Expansion of the Rehabilitation Option would provide more flexibility with respect to type of service and provider, thus allowing the extension of Medicaid coverage to in-home services and other clinical services provided in community rather than clinic settings. If the Rehabilitation Option were implemented, 50% of every service dollar that DCF spends on the proposed services for Medicaid children would qualify for federal reimbursement.

The Child Rehabilitation Option will increase flexibility as to place of service and provider while expanding federal reimbursement.

This benefit expansion is consistent with Connecticut's vision of providing flexible, child-focused, community-based services to children where they reside. However, the Rehabilitation Option requires careful review and planning to avoid excessive program expenditures, including: clear distinction between service profiles and definitions; mechanisms to insure that the State does not pay for a high-cost service when a low-cost service was actually delivered; and appropriate management of utilization and appropriate professional supervision of services. A decision about whether to implement this option will be made after completion of the actuarial analyses.

The services under consideration for inclusion in the Rehabilitation Option include:

- **Comprehensive Global Assessment for Children.** A Comprehensive Global Assessment (CGA) is an intensive, multi-dimensional assessment for children with complex behavioral health

service needs.

- **Emergency Mobile Crisis Services for Children.** Emergency Mobile Crisis Services provide focused clinical interventions to treat a rapidly deteriorating behavioral health condition, reduce risk of harm to self or others, and/or stabilize psychiatric symptoms or behavioral situation problems, including substance abuse. This service provides a mobile alternative to hospital Emergency Department evaluation and stabilization.
- **Crisis Stabilization Beds for Children.** Crisis Stabilization Beds are short-term residential services provided to children with a rapidly deteriorating psychiatric condition in order to reduce the risk of harm to self or others, stabilize psychiatric symptoms or behavioral and situational problems, and avert the need for psychiatric inpatient services.
- **Home-Based Therapy Services for Children.** Home-Based Therapy is a non-intensive (<4 hours/week) rehabilitative service provided to a child with a behavioral health disorder and the child's family in the child's home, school or other community setting.
- **Intensive Home-Based Therapy Services for Children.** Intensive Home-Based Therapy is an intensive (4 or more hours per week) rehabilitative service provided to a child with complex behavioral health needs and the child's family in the child's home, school, or other community setting. This service is provided as part of an Individual Service Plan and is provided to children who have not been effectively treated in office-based behavioral health treatment, and who require intervention in a naturalistic setting.
- **Behavior Management Services for Children.** Behavior Management Services are community-based services provided by trained and supervised non-professionals to children with complex behavioral health needs who require assistance in the development of adaptive social skills, life skills, and self-management strategies. This service is provided to children in the home, school and other community settings such as during recreational events and activities. In some cases, therapeutic mentoring would qualify as a Behavior Management Service.
- **Behavioral Health Consultation for Children.** Behavioral Health Consultation includes the design and support of a therapeutic plan to be followed by caretakers, teachers, *behavior management service* providers (see above), and other individuals responsible for the care, teaching, or supervision of a child with complex behavioral health service needs.
- **Early Childhood Consultation.** Early Childhood Consultation is a behavioral health consultation service provided to children ages birth through five years with behavioral health disorders in a Head Start program, or licensed child care home or center.

D. Concluding Comment

Connecticut Community KidCare is designed to eliminate the major system gaps and barriers that have plagued child behavioral health in recent years. The initiative will allow children with behavioral health problems to grow and develop within nurturing family environments, increasing their ability to succeed in their homes, schools and communities. The new system will be family driven and family focused, giving families choice and helping families to care for children who have behavioral health challenges. The new system will emphasize the strengths of individual families and children and be culturally responsive.

The Governor and the Commissioners of these Departments have defined this vision for reform. For this vision to succeed, a partnership is required among families, providers, community members, legislators and other State agencies. Building this new system is an evolutionary process that will require time for planning, training and capacity building, and a gradual phase-in of fully working systems. It will also require changes in structure, organization, management, financing, practice, and philosophy, affecting those involved at every level, from families to providers to State agencies.

With the commitment and investment of all concerned citizens in Connecticut, this vision can be realized.

Section III: A Recovery Healthcare Plan for Adults

A. Section Summary

Under the partnership, DMHAS will assume a significant role in the clinical management of publicly funded behavioral health services. In addition to its present authority over behavioral health services for State Administered General Assistance recipients, DMHAS will assume responsibility for the clinical management of adult Medicaid fee-for-services recipients and parents and other adults enrolled in the HUSKY program, including adults who are receiving Temporary Assistance to Needy Families (TANF).[19] DMHAS has begun collaborative planning with DCF and DSS to examine issues of service access and quality. The planning effort will help to ensure that the clinical management program (hereinafter call the Recovery Management Program) and the practices and interventions of behavioral health providers are appropriate to the needs of adults in the Medicaid fee-for-service and HUSKY programs. This will include development of specialized procedures and ongoing monitoring designed to ensure that single mothers in the TANF program obtain appropriate access to behavioral health care.

This section provides details about the proposed DMHAS *Recovery Healthcare Plan for Adults* (RHPA), which includes DMHAS plans for a recovery management program and development of the Medicaid Rehabilitation Option for adults. Some clinical examples of how these programs would help to improve care for people receiving services are also presented.

B. Building upon Experience

Effective management of behavioral health services is not new to DMHAS. As the designated single state agency for mental health and addiction services, the Department has spent years developing and refining the design and financing of its delivery system for clinical and support services. These services, offered through a statewide array of programs operated by DMHAS and by over one hundred private non-profit agencies, are helping thousands of Connecticut adults improve the quality of their lives and attain sustained recovery.

DMHAS is drawing on its experience in the development and implementation of its successful General Assistance Behavioral Health Program.

Unlike other human service agencies in Connecticut that may provide behavioral health services as a portion of their overall mission, DMHAS is exclusively focused on behavioral health care. In carrying out its work, DMHAS pays particular attention to the needs of underserved populations, helping to ensure that adults with psychiatric and/or substance use problems have ready access to quality services, especially when no health care insurance or entitlement is available to them. The principal theme in the DMHAS approach is the creation and maintenance of a care system that is highly accessible, quality-driven and cost efficient.

In its collaborative planning with DSS and DCF as part of the Behavioral Health Partnership, DMHAS has been able to draw on considerable experience garnered during development and implementation of its successful General Assistance Behavioral Health Program (GABHP). The GABHP was designed for people receiving benefits under the DSS State Administered General Assistance (SAGA) program. In 1997, the Legislature authorized creation of the GABHP, pursuant to PA 97-08. Based on the terms of an MOU developed between DSS and DMHAS, DSS transferred funds to DMHAS for the reimbursement of behavioral health services and for clinical management of the program. DSS continued and still maintains responsibility for determining the eligibility of SAGA applicants and for payment for general medical services.

Since the inception of the GABHP, DMHAS has designed and implemented the clinical management and

[19] This would also include a role in coordinating behavioral health care to parents in families where both the parents and children need behavioral health services.

claims processing systems using an Administrative Services Organization (ASO), promulgated reimbursement rates, developed a process for verifying provider credentials, established service provider contracts and instituted a full set of policies and procedures governing the program. In addition, at DMHAS' direction, the ASO has implemented a new claims system that is easier to use, results in faster claims payment, and allows DMHAS to proactively predict and better manage its costs. Simultaneously, DMHAS initiated many other performance upgrades in the GABHP, designed to ensure that people receive better quality services.

By SFY 2002 the average number of people receiving SAGA benefits had increased by 42 percent as compared with SAGA enrollment levels at the start of the DMHAS GABHP in SFY 1998.[20] Nevertheless, because of its vigorous management of the program, and despite extraordinary enrollment increases, DMHAS was able to decrease the average cost of care from $277.69 per member per month in SFY 1998, to $243.48 per member per month in SFY 2002, or a 12 percent cost decrease. This was accomplished even though the Consumer Price Index had increased by 17 percent during that period. In addition, DMHAS was able to move from a $12.9 million deficit in SFY 2001, to a balanced budget in SFY 2002. Balancing the GABHP budget in SFY 2002 was made even more challenging when the Department had to absorb an additional $3.5 million rescission in the account. At present, it is expected that the GABHP program will be maintained within its appropriation during the current fiscal year.

As a result of management improvements the GABHP is working effectively and has established a proven track record of success. These efforts will help to ease the transition and minimize the risk inherent in the movement to managed behavioral health services for adult Medicaid recipients. Having achieved significant cost reductions as well as sound management of the GABHP program, DMHAS is accelerating its ongoing emphasis on quality care. DMHAS statewide initiatives such as the implementation of evidence-based practices and use of state-of-the-art information systems (including a data warehouse) will permit health care performance assessment, as well as quality, effectiveness, and cost efficiency comparisons throughout the system for all DMHAS funded programs.

C. Service Delivery Redesign: The Recovery Management Program

The term *Recovery Management* describes a set of interventions used to promote positive outcomes for adults with behavioral health problems. The term appropriately conveys the expectation that these individuals will attain substantial improvement with the right combination of treatments and supports, provided that these interventions are delivered at the correct intensity and are continuous and well-coordinated. The DMHAS plan for recovery management also reflects current knowledge about the long-term course of behavioral health disorders and how the service system must respond in order to help restore people to healthy lives.

Recovery Healthcare Plan for Adults
Key Features

- *Focus on sustained recovery through continuity of care*
- *Comprehensive behavioral health program with flexible benefit package including both treatment and non-traditional support services*
- *Community-based and culturally competent care planning and service delivery*
- *Efficient balance of local control of care with statewide administrative support structure*
- *Integration of adult behavioral health funding streams into a seamless system*
- *Routine performance reports on key outcomes and quality measures*

In order to achieve favorable outcomes, the service delivery system must be designed and operated in a manner that reflects people's needs during the longitudinal course of their illness. In the current system, care is often delivered in discrete episodes, sometimes with little communication or coordination among providers. Thus, care continuity and coordination are not as strong as they could be. This results in unnecessary expenditures and wasted opportunities for

[20] During FY 1998 the average monthly SAGA enrollment equaled 16,235 people, compared with an estimated monthly enrollment of 23,012 in FY 2002.

sustained recovery.[21] All too frequently, clinical services are only provided when adults are in the acute phase of their illness. As soon as symptoms are reduced, the person is discharged, sometimes without follow-up care, or referral is made to another program (usually a lower level of care, such as a rehabilitation program), without any real assurance that the person actually connects to continued rehabilitative treatment. Consequently adults too often relapse and are re-admitted to expensive acute inpatient treatment or end up homeless or in jail.

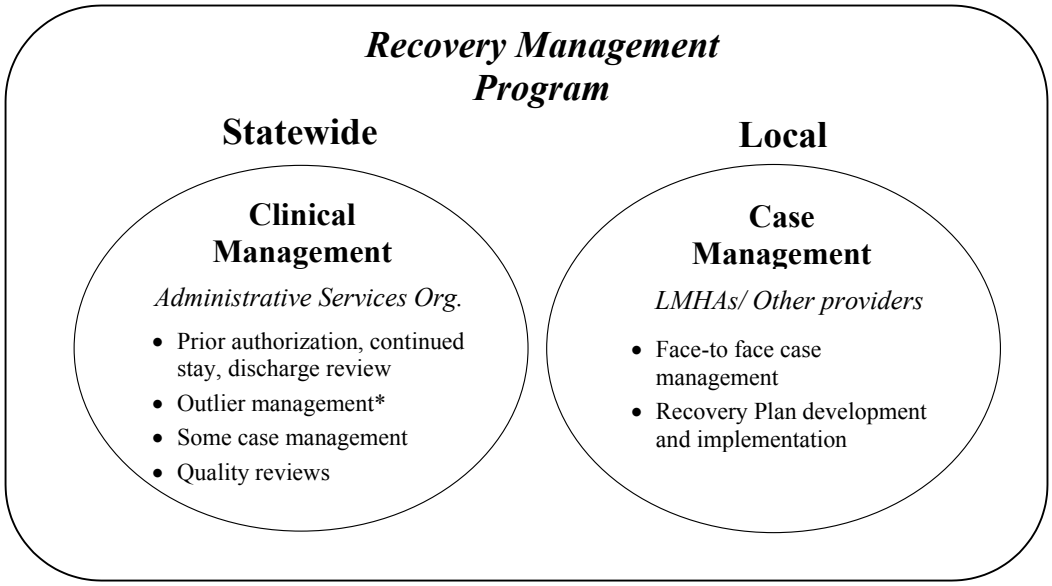
In order to improve the quality and recovery orientation of the service system, the DMHAS recovery management program will assure that:

- Treatment is provided at the correct intensity (i.e., level of care) and for the optimal duration of time to be maximally effective and cost efficient.
- Services are not to be interrupted when a person moves between service providers or levels of care. This is particularly important during the transition between acute care and less intensive rehabilitative care.
- Inpatient care and other acute interventions are used only when clinically necessary.
- Individuals in need of behavioral health services are identified and followed, to assure that services are coordinated and that they do not fall through the cracks.
- Services and supports are designed and delivered in a manner that promotes sustained recovery and empowers service recipients to be active participants in the recovery process.

1. DMHAS Recovery Management Program: Local and Statewide Components

Recovery Management will be comprised of two interlocking components, one conducted at the statewide level and the other locally based (see Figure III-1):

Figure III - 1 System Components



*Outlier management involves working with providers whose outcomes are not as favorable

[21] Throughout this report, *recovery* refers to regaining an improved state of behavioral health and encompasses restoration of self-esteem, positive identity, a meaningful role in society, and, to the extent possible, independent living.

Statewide: A single statewide ASO performs clinical reviews prior to authorizing care for selected services, monitors care quality, identifies people who are frequent users of acute care services and performs analyses designed to determine whether service providers are using generally accepted care practices. Because the ASO has access to service authorization (or service notification)[22] and claims data across the entire system, it can easily detect problems with care delivery patterns. Many of these problems, involving individual adults, are referred to a local Case Manager for follow-up.

Local Case Managers drive the coordinated, consistent delivery of recovery services based on an approved Recovery Plan.

Locally Based: Case Managers are employed by Local Mental Health Authorities (LMHAs)[23] and other local service providers.[24] These staff perform the initial screening that leads to the identification of individuals who need case management services and subsequently, following formal assignment by the ASO, have frequent, face-to-face visits with the service recipient. Guided by a Recovery Plan written with the individual, the Case Manager monitors the person's wellbeing and provides supports in the community. This typically includes teaching rehabilitative skills related to activities of daily living, relapse prevention, medication monitoring and the appropriate use of medications. The Case Manager helps to assure that the individual stays engaged in behavioral health treatment, obtains medical and dental care when needed, and has his/her basic needs met (e.g., food, clothing and appropriate housing). The Case Manager also supports the person in solving day-to-day problems that might otherwise lead to crises and avoidable hospitalizations. Case managers will be required to notify the ASO at the time of admission and to submit a Recovery Plan summary for each person receiving these services. In this way, the ASO can ensure that only a single Case Manager is involved and that appropriate rehabilitation and other covered services are being rendered in accordance with the Recovery Plan.

As part of recovery management, DMHAS will offer care providers the tools and training that they will need to work within a standardized approach to the selection of service recipients, and to level of care (program) assignment and services coordination.

The *case management function* is already a reimbursable service in the Connecticut Medicaid State Plan under the Medicaid Targeted Case Management (TCM) option.

2. The Recovery Plan

Each person who receives case management services will have a Recovery Plan that serves to guide service delivery. A Recovery Plan:

- Will be comprised of short- and long-term goals.
- Will be developed collaboratively between the adult and an interdisciplinary team of care providers, including family and significant others, when appropriate.
- Will be based on a comprehensive assessment of the person's condition and include goals, objectives and interventions that address all identified needs including environmental and social factors that may assist or impede recovery.
- Will clearly identify the Case Manager and the range of services/supports.

[22] "Service notification" involves having the care provider inform the ASO that an individual has been accepted into treatment and is receiving services.

[23] All geographical areas in Connecticut are covered by a system of 15 Local Mental Health Authorities (LMHAs), six operated by DMHAS, and nine run by private non-profit agencies under contract with the Department. Each LMHA provides a broad array of services and is responsible for the administrative and clinical/support needs of indigent adults with severe and persistent mental illness within its assigned area.

[24] Depending on the needs of the adult receiving care, some case management services may also be provided by entities that are not LMHAs. This may include case management services provided by substance abuse treatment agencies, or by employees of the Administrative Services Organization.

3. Determining the Need for Services Provided by a Case Manager

Case Managers will prepare Recovery Plans for individuals with psychiatric or substance use disorders who meet specified service necessity criteria. All adults who meet criteria for case management services will also be able to access rehabilitation services. Proposed criteria for determining the need for case management service may include items such as follows:

- The individual has a diagnosis of major mental illness and significant functional deficits that substantially interfere with life performance in one or more key areas (e.g., vocational capacity, interpersonal relationships). Diagnostic examples include, but are not limited to: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, serious personality disorders, and certain anxiety disorders or, substance use disorders that meet clinical criteria.
- The individual needs rehabilitative support, skill-building and significant assistance with community living in order to remain in the community.
- The individual has a pattern of acute care services utilization, risky behaviors, behavioral turbulence or other risk factors that necessitate ongoing supervision and assistance.
- The individual does not have a principal diagnosis of mental retardation.

4. Clinical Policies and Criteria

An interagency team has reviewed current Medicaid provider policies and prior authorization requirements. Recommendations are being developed to revise many of these DSS policies and practices to strengthen the ability of DMHAS to improve outcomes and effectuate systems change through recovery management. These changes include:

- Clarifying services definitions to establish clear standards for program content.
- Easing of some restrictions to facilitate access to lower cost community-based services that offer appropriate alternatives to costly or more restrictive services.
- Adding continued stay review for people admitted to psychiatric hospitals, in order to ensure discharge to rehabilitative care or outpatient services, as soon as appropriate.
- Eliminating prior authorization requirements where no benefit is expected. However, even when prior authorization is not required, the care provider will be required to notify the ASO, so that a comprehensive picture of the person's service delivery pattern can be seen.
- Making prior authorization requirements consistent across all care provider types.

In addition, DMHAS and DSS staff are working to develop clear, written clinical criteria to guide the utilization management process.[25] Currently, prior authorization is required for some mental health and addiction services in the Medicaid fee-for-service program. However, in some cases the decisions are based on individual professional judgment. The availability of written clinical criteria similar to those developed by DMHAS, as part of the GABHP implementation, will help to strengthen the process.

5. Quality Management and Improved Outcomes

DMHAS is well acquainted with the relationship between quality management and improved outcomes for adults with psychiatric and substance use disorders. Decades of experience in designing and implementing behavioral health systems and overseeing the quality of care, coupled with lessons learned

[25] Utilization management involves determining the type, intensity and duration of services to be provided to an individual based on an assessment of strengths and needs, using specific assessment criteria. Utilization management typically involves an assessment prior to the delivery of services (Prior Authorization), another assessment if continued services are needed beyond those approved during the initial assessment (Concurrent or Continued Stay Review), and a final review at discharge (Discharge Review).

from the General Assistance Behavioral Health Program (GABHP) have helped to provide DMHAS with many practical strategies for improving service quality within a managed care environment. During the past several years, DMHAS has worked diligently to strengthen its quality improvement processes as a means of increasing the likelihood that people in its care will attain greater self-sufficiency and sustained recovery. Improved outcomes help to reduce the use of expensive acute psychiatric inpatient services and help to break the cycle of acute re-admissions. Additionally, better quality treatment using evidence-based practices helps to reduce the likelihood of adverse consequences for adults and the attendant cost and social impact associated with excessive emergency department use, police involvement, homelessness and imprisonment.

An important feature of the DMHAS quality improvement effort has been the emphasis on improving the cultural competence of the entire service system, in both state-operated and private non-profit operated programs. This is particularly relevant to providing services to historically underserved behavioral health populations. During the past five years, DMHAS has developed standards for culturally competent care, implemented extensive staff training, and developed service approaches specially tailored to meet the needs of women and different racial, ethnic and cultural groups. The emphasis on cultural competence as an important aspect of quality care is expected to pay increasing dividends as Connecticut's population continues to become more ethnically diverse over the next decade.

Increasing cultural competence of providers is a central tenet of quality improvement efforts.

The process for monitoring care provider performance and responding to performance concerns will be an essential component of the Medicaid behavioral health program implementation. DMHAS will survey a sample of all providers on a regular basis. In addition, DMHAS will target greater monitoring resources to care providers that engage in less of their own self-monitoring activities. In consultation with DSS, DMHAS will explore whether features present in the DMHAS system for monitoring General Fund supported programs can be adapted for use in the Medicaid behavioral health program. For example:

- All institutional care providers are subject to a standard quarterly review of critical indicators including utilization, critical incidents, complaints, and performance measures. Substandard performance on the quarterly desk review will result in being placed on the "Care Provider Watch List" and will trigger a DMHAS site review. Most such reviews will focus on the particular area(s) of concern identified during the Quarterly Review. However, if multiple areas of substandard performance are noted, or if a serious problem exists in a single, critical function, a comprehensive review will be conducted.
- In addition, institutional providers that have not achieved accreditation by any of the nationally recognized accrediting bodies will receive a comprehensive annual site review. An additional group of accredited care providers (minimally 5-10%) chosen randomly will have a comprehensive site review in any given year.
- Private practitioners will be monitored to ensure that service utilization patterns are within acceptable performance guidelines.

6. Integrating the Components of the Recovery Management Infrastructure

This proposed system of recovery management offers significant improvements over the current system of care, which is partially managed – but not coordinated – across DMHAS, Medicaid fee-for-service, and the HUSKY program. Currently, the Medicaid fee-for-service program provides some prior authorization of services. However, aside from the case management offered to individuals under DMHAS' care, there is no comprehensive assessment, clinical oversight, and outreach function to assure that care is planned to promote recovery through the use of the most cost effective and least restrictive services. Within the HUSKY program, utilization management is performed with the use of standardized clinical criteria. However, the use of recovery planning is not integrated with the utilization management function.

DMHAS has extensive experience in managing services using an ASO and local care provider organizations, such as LMHAs, for their contracted services. The LMHAs have managed a range of services, which are funded through contracts, but have not performed utilization management for services that were paid for by Medicaid, such as inpatient hospitalizations or partial hospitalization programs. In addition, with the exception of services provided under the GABHP, each local area has managed services independently. Thus, no standard set of criteria has been applied to all individuals regardless of location.

The Recovery Healthcare Plan for Adults will offer significant advantages over the present system. The proposed system of care will utilize standardized clinical criteria, customized by DMHAS for Connecticut. These criteria will assure the consistent utilization of services across all regions. The use of local care providers to screen and assess individuals, develop recovery-oriented service plans, and link adults with an appropriate array of services and supports, will assure that treatment and recovery services are well coordinated. The integration into a data warehouse of information about services paid for by both DMHAS and DSS will also promote better coordination of care and the rational use of services.

D. Rehabilitation Services

1. The "Rehabilitation Option" Defined

The option to cover rehabilitation services under Medicaid (the Rehabilitation Option) gives states the opportunity to support mental health programs that are designed to help people with serious and persistent mental illness attain sustained recovery and lead stable, independent lives in community settings, while simultaneously decreasing reliance on acute care services. Although a Rehabilitation Option exists in the Connecticut Medicaid program, this option is limited to children's services. The expansion of this option to adults would enable the state to obtain federal matching money for services that are now supported entirely by General Fund appropriations. However, this option must be carefully implemented to assure that enrolled providers include only those who can offer high quality services that produce positive outcomes for individuals in their care. In addition, planning will involve determining the amount of resources that DMHAS will need in order to continue serving adults who require rehabilitative services, but are not eligible for Medicaid coverage.

The Adult Rehabilitation Option provides federal reimbursement for services designed to help people with serious and persistent mental illness attain sustained recovery and lead stable, independent lives in community settings, while simultaneously decreasing reliance on acute care services.

In order to identify the providers of rehabilitative services through a revision of Connecticut's Medicaid State Plan, DSS and DMHAS will work collaboratively to develop standards and criteria that define the qualifications of providers, and clearly stipulate such standards in the State Plan Amendment (SPA) and regulations. This will satisfy the requirements in Section 1902 (a) (23) of the Social Security Act, and regulations in 42 CFR 431.51, both of which stipulate that Medicaid recipients may obtain services from any qualified Medicaid provider.

The Federal Code of Regulations defines rehabilitative services as "an optional Medicaid benefit that must be recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under State law, for the maximum reduction of a physical or mental disability and to restore the individual to the best possible functional level." While there is wide variation in the types of services states have included under the Rehabilitation Option, the principal concern of the federal Centers for Medicare and Medicaid Services,[26] is that states affirm the goal that treatment is rehabilitative or restorative in nature, and clearly excludes custodial care.

[26] Formerly known as the Health Care Finance Administration (HCFA).

2. Rehabilitation Services Allowed Under Federal Rules

In contrast to services provided under the Medicaid "Clinic Option,"[27] which must be delivered in clinician offices and other facility-based locations, federal rules for Rehabilitation Services make it possible to offer care in a variety of locations including individuals' homes or other community-based settings. Service may include:

- **Basic Living Skills -** providing restoration of skills necessary for independent functioning in the community, including food planning and preparation, maintenance of living environment, community awareness and mobility skills.
- **Social Skills -** including communication and socialization skills and techniques that help individuals reduce social isolation by developing and maintaining meaningful relationships.
- **Counseling and Therapy -** including counseling and therapy services directed toward reduction and ultimate elimination of psychosocial barriers that impede the development or modification of skills necessary for independent functioning in the community.

3. Excluded Services

Service inclusion or exclusion depends on the purpose of the service. The following are examples of types of services that might ***not*** be covered under a Rehabilitation Option depending upon how the service is provided:

- **Vocational Training** - job training, vocational and educational services are usually excluded. However, pre-vocational skills development, as it relates to non-job specific, longer-term preparation for employment can be allowed as a rehabilitation benefit.
- **Personal Care Service** - grooming, personal hygiene, assisting with medications and the preparation of meals - when performed **for** the recipient are not covered, however **teaching** the individual personal care skills can be considered part of a rehabilitation program.
- **Case Management** - while case management type services directed at managing Medicaid rehabilitation benefits may be covered, case management services directed toward gaining access to and/or monitoring non-rehabilitation specific and non-Medicaid services cannot be covered under the Rehabilitation Option.

4. Proposal for Medicaid Covered Rehabilitative Services for Adults in Connecticut

Based on a review of existing General Fund supported rehabilitation services, and in light of federal rules about the Rehabilitation Option, the following service categories are being considered for coverage under Medicaid:

- Mental Health Psychosocial Rehabilitation Programs,
- Assertive Community Treatment (ACT) Programs,
- Mobile Crisis Services,
- Crisis Beds,
- Substance Abuse Residential Rehabilitation,
- Mental Health Residential Rehabilitation.

These are defined in detail below.

[27] The Medicaid "Clinic Option" is already in place for adults in Connecticut.

5. Service Categories and Sub-Categories:

DMHAS is in the process of defining a configuration of rehabilitation services that will improve the likelihood of recovery among adults with behavioral health disorders and can also be effectively and efficiently managed. These include services such as:

- **Mental Health Psychosocial Rehabilitation (Clubhouse) Programs.** A friendly, informal clubhouse atmosphere helps people with serious mental illness gain easy access and feel at home in these highly effective rehabilitation programs. However, underlying the seeming informality is a structured array of services for adults with serious mental illness that are designed to empower the individual in attaining recovery from their illness and to restore their ability to live independently in the community. Staff and other clubhouse members encourage and support individuals in taking charge of their recovery process by making appropriate choices regarding housing, budgeting, work, leisure activities, involvement in behavioral health treatment and avoidance of substance use. Participation by consumers in the governance and operation of the clubhouse is actively supported. Many psychosocial rehabilitation programs contain pre-vocational and transitional employment components[28] designed to prepare clubhouse members for entry (or return) into the workforce. All programs are designed to foster increased independence in the community through establishment of natural support networks and through participation in faith communities, leisure and volunteer activities. The programs also help adults learn appropriate coping and relapse prevention skills, while enhancing understanding of their illness.

- **Assertive Community Treatment (ACT).** ACT includes an array of intensive case management and clinical services for individuals with severe forms of mental illness such as schizophrenia, bipolar disorder and other psychotic disorders and commonly involves people with co-occurring substance use disorders. ACT services are delivered at the person's residence or other community-based setting by a multi-disciplinary team, usually consisting of a psychiatrist, nurse, social worker and other mental health staff. The service is characterized by frequent face-to-face contacts between staff and service recipients (sometimes involving multiple contacts during a single day), and small caseloads. Services include assertive outreach for persons who are having difficulty engaging in treatment, person-centered goal planning, and crisis intervention in the person's home or in other community settings, medication management, and assistance with basic needs – such as food and housing. Numerous scientific studies have shown the effectiveness of ACT services in successfully supporting people with severe and persistent mental illness in the community who would otherwise require hospitalization.

- **Crisis/Sub-acute Beds.** This is a short-term service providing assessment, diagnosis, active treatment and psychiatric stabilization in a residential setting, with full-time on-site clinical care. The program provides concentrated interventions to treat a rapidly deteriorating behavioral health condition, reduce the risk of harm to self or others, stabilize psychiatric symptoms or behavioral and situational problems, including substance abuse. The program is designed to help the person resume independent living, or return to a supervised residential setting or rehabilitation program, as soon as possible. Crisis beds are intended to serve persons who would otherwise be hospitalized or to function as a "step-down" alternative for adults being discharged from a hospital. The program provides immediate access to a psychiatrist, and mobilizes supports to maintain the individual in a non-hospital setting.

- **Mobile Crisis.** This program provides concentrated interventions to treat a rapidly deteriorating behavioral health condition, reduce risk of harm to self or others, or stabilize psychiatric symptoms or behavioral and situational problems, including substance abuse. The goal of the

[28] Transitional employment will continue to require state funding because it cannot be reimbursed under Medicaid.

program is to avert hospitalization and restore the individual to their pre-crisis level of functioning (or higher). Using a rapid response the mobile crisis program assesses and intervenes to address the person's needs wherever he/she is located, including in their home, in a hospital emergency department, or other community setting. Program services are short-term, and include assessment, evaluation, diagnosis, hospital prescreening, medication evaluation and support, and referral for continuing care, if needed. When appropriate, brief clinical treatment is provided (sometimes over a period of several days) by an interdisciplinary team, including a psychiatrist as needed, in order to support the adult until he/she is transferred or stabilized.

- **Substance Abuse Rehabilitation Service in Non-Medical Residential Settings.**[29] Substance abuse recovery programs in non-medical residential settings offer treatment to individuals with alcohol and other substance use disorders, supervised by full-time staff. Services may include an initial biopsychosocial assessment, medical evaluation, psychiatric evaluation, daily individual or group therapy, orientation to self help or similar support groups, instruction in relapse prevention, and coordination of the individual's care. These services are provided in a structured recovery environment with the goal of reintegrating the individual into the community. The following program types are included in this category:
    - Transitional Care/Halfway House,
    - Long-term Residential Care,
    - Intermediate Long-term Residential Treatment,
    - Intensive Residential Treatment.
- **Mental Health Rehabilitation Services in Non-Medical Residential Settings.** These non-medical residential programs are designed to help individuals with severe and persistent mental illness restore their highest level of independent functioning by providing necessary psychiatric treatment and support in a supervised setting. Services may include psychosocial assessment, treatment planning, counseling (individual, group and family), medication education, administration and monitoring, recovery coordination services, and skill assessment and development. The following program types are included in this category:
    - Supported Housing,
    - Supervised Housing,
    - Group Homes.

6. Recommended Program Design

As rehabilitative services are converted from a fixed level of General Fund support to a fee-for-service entitlement-funding stream, it is important that they be managed carefully to ensure appropriate utilization. Medicaid rules allow for such services to be operated within a recovery management program. DMHAS and DSS will use this recovery management opportunity to reach out to adults who have not been adequately served by the rehabilitation service system. This includes people who are engaged in risky behaviors, and consequently are hospitalized repeatedly, become homeless or incarcerated, or are using other high cost services. Utilization management should be established for rehabilitation services, to ensure that reimbursement is offered only to those individuals who meet defined clinical criteria.

At present, Medicaid recipients access rehabilitation services in a variety of ways including through the

[29] Medicaid does not cover the room and board cost of substance abuse or mental health residential services in non-medical settings. Additionally, for individuals under age 21, or 65 and older, these settings must have 16 or fewer beds to qualify for Medicaid coverage.

LMHAs, through referrals from other mental health or substance abuse providers and by self-referral. There is no central means to approve or deny care based on the consistent application of clinical criteria.[30] However, the LMHAs play a role of triaging consumers to ensure that those most in need are given priority access to mental health rehabilitation. In some geographical areas, rehabilitation programs have waiting lists. Data regarding use of rehabilitation services by adults receiving care is collected in the DMHAS information systems. Care providers are expected to report information, including service recipient and provider demographics, admission and discharge dates, and services rendered. These data are reported to DMHAS either directly, or through the LMHAs to DMHAS. An initiative to use the new DMHAS information system and to assure complete and accurate reporting of data on services and demographics is beginning to produce results. Ultimately, however, data collection improves when it is explicitly tied to payment for services.

7. Proposed Infrastructure for Rehabilitation Services Coverage

Payment

Planning is proceeding under the assumption that rehabilitation services will be reimbursed on a fee-for-service basis, similar to other Medicaid services. Some rehabilitation service providers are not experienced in billing and collections in a fee-for-service environment and will need training and technical assistance to handle this process. DMHAS will assess provider readiness and work with care providers in making the transition. Since most rehabilitation providers would only use one or two simple billing codes, the billing process should not be complex to learn or implement. However, for providers that have not had fee-for-service experience, tracking and collecting accounts receivable will require some adjustment in operations. DMHAS is also exploring strategies to ease the change from a prospective to retrospective payment mechanism.

Recovery Management

It is proposed that rehabilitation services utilize the same recovery management described above and applied to other Medicaid-covered behavioral health services. The following components will assure the quality and appropriate use of rehabilitation services:

- DSS may need legislative approval to establish certification requirements for Medicaid covered rehabilitation providers. Care provider certification requirements are especially important because existing state licensure categories do not cover some rehabilitation services. Since it will take some time to finalize certification regulations, the Legislature may elect to deem current General Fund supported rehabilitation providers as certified, until such time as the regulations are adopted.
- The application of clinical criteria should assure that rehabilitation services are directed to people with behavioral health disabilities of sufficient severity to warrant such care.
- Referrals for Medicaid supported rehabilitation services should be required to come from licensed facilities or licensed practitioners acting as Case Managers and be identified in a formalized Recovery Plan.[31]
- Rehabilitation service providers should be required to obtain prior authorization from the ASO for Medicaid covered rehabilitation services. The ASO authorization will help to support the role of the Case Manager in coordinating services and will promote use of standardized care practices.

[30] The DMHAS General Assistance Behavioral Health Program (GABHP) is the exception to this statement. In developing clinical review criteria for the GABHP, DMHAS worked with the Connecticut provider community to evolve a complete set of criteria for substance abuse services based on criteria originally established by the American Society for Addiction Medicine.

[31] Adults with serious mental illness should also be able to participate in General Fund support rehabilitation services, such as psychosocial rehabilitation clubhouse programs, on a walk-in "self-referral" basis.

8. Operational Authority

In order to implement the rehabilitation program, changes will be needed in several areas. In addition to obtaining federal approval of a Medicaid State Plan Amendment, DSS would need to issue regulations establishing coverage for rehabilitation services. These regulations would describe provider enrollment and certification requirements, covered services, service recipient eligibility conditions, authorization requirements, and the reimbursement structure. In addition, DSS and DMHAS will develop an MOU describing the role of each agency in the operation of the Rehabilitation Option.

In order to implement recovery management, DMHAS must be given responsibility for managing Medicaid beneficiaries under the MOU with DSS. Several existing provider policy areas within the Medicaid regulations will need to be amended by DSS to allow DMHAS to manage these services. DSS and DMHAS are exploring whether legislation or some other change may be needed by July 1, 2003. These changes would address the need to:

- Sanction the new role DMHAS will play in providing recovery management (e.g., utilization management) services to Medicaid recipients.
- Require rehabilitation providers be certified by DMHAS in order to enroll in Medicaid.
- Establish DMHAS' authority to certify rehabilitation providers.
- Deem current rehabilitation providers to be DMHAS certified until such time as regulations are developed for the certification process.

E. Examples of How the New System Will work for Adults

Here are two examples that illustrate how the recovery management system will work:

Mr. A has schizophrenia that has been stabilized and is under good control with medications. He has been receiving services from DMHAS for a few years and is Medicaid eligible, by virtue of his disability status, but not yet on Medicare. A Case Manager works with Mr. A, his family, and several care providers of his choice to develop a Recovery Plan. The Plan reflects Mr. A's choice to live in supervised housing and notes his desire and expectation to participate in a psychosocial rehabilitation (PSR) clubhouse. The plan also indicates that Mr. A will receive group therapy once a week and medication management through a community mental health outpatient clinic. His long-term plan is to live independently with periodic home visits from his Case Manager (or if he continues to need extra assistance he would live in supported housing). He also plans to take a part-time job. Under the provisions of a new program called *Medicaid for the Employed Disabled,* Mr. A would be able to work while retaining his Medicaid benefits. So, the Recovery Plan calls for Mr. A to transition from the PSR clubhouse to a vocational rehabilitation program in the next six months, and to move to a more independent living situation within the next year.

After the Case manager reaches agreement with Mr. A on the desired course of treatment, the Case Manager sends a summary of the plan to the ASO. When the supervised housing provider and the PSR clubhouse call for authorization to provide services, the ASO approves their requests because they are consistent with the plan. However, when the community mental health clinic calls for individual therapy three times a week, the ASO points out to them that the Recovery Plan did not identify this as a needed service. They are asked to discuss this with the Case Manager, if they feel it is necessary. However, the ASO notes also that frequent individual therapy, even if it were in the Recovery Plan, would not be clinically necessary and effective, according to DMHAS guidelines. Later, the clinic calls again and asks for group therapy twice a week and medication management. This is approved by the ASO in consultation with the Case Manager.

Due to the unexpected death of his father, Mr. A has an acute setback. He presents at the local emergency room. The hospital calls for authorization of an inpatient psychiatric admission. The ASO deploys a mobile crisis team that arranges an alternative plan. Instead of being hospitalized, Mr. A is admitted to a crisis bed for three days and is quickly stabilized. Before being discharged from the crisis bed, Mr. A's Case Manager has been in contact with a local partial hospitalization program (PHP) to arrange follow-up care. When the PHP calls for authorization, the ASO approves these services even though they are not part of the original Recovery Plan, because the ASO is aware (based on its prior authorization records) of the acute episode just experienced by Mr. A. On the fourth day, a staff member from the LMHA brings Mr. A to the partial hospitalization program, introduces him to staff and helps him to make the initial adjustment. He begins a brief period of service in the new program. Within a month Mr. A's Recovery Plan is back on track.

Ms. B is an adult Medicaid recipient and single mother of two. She has had occasional episodes of depression over the years, and has had outpatient therapy and pharmaceuticals covered through Medicaid in the past. A current episode of depression leaves her unable to get out of bed on most days and neglecting her own safety and health, as well as that of her children. A caring neighbor takes her to a hospital, where it is determined that an emergency inpatient admission is necessary. They call the ASO for authorization and the ASO agrees that admission is appropriate. However, because she does not have a Case Manager and it is not clear whether she has a severe and persistent depression, a Case Manager is notified to assess Ms. B in the hospital.

The assessment determines that Ms. B does not need case management or rehabilitation services. A discharge plan is developed by the hospital, with assistance from the ASO in identifying available community-based providers. Ms. B is discharged with aftercare services arranged, including ongoing individual therapy. Her care providers call the ASO and receive authorization for services. Ms. B becomes clinically stable and is able to resume her part-time job and role as mother.

Attachment

Medicaid Adult Rehabilitation Option – Implementation Plan

NOTE: The following is a summary of important steps that need to be taken in connection with development and implementation of the Medicaid Rehabilitation Option. Significant progress has already been made on many of these items. In the summary that follows, these steps are listed in sequential order within each major area of development. However, there are inter-dependencies among major areas that will determine the overall sequence of development and implementation across the entire project.

Authority to Operate Rehabilitation Services under Medicaid

- DSS and DMHAS define respective roles in operation of Rehabilitation Option.
- Amend State Plan to include Rehabilitation Option and submit for federal review.
- Obtain budget allocation for service coverage and administration.
- Obtain federal approval of State Plan Amendment.
- Draft and publish operating regulations.

Benefit Design

- Develop draft definitions of covered services.
- Obtain stakeholder input on definitions.
- Develop utilization management criteria defining medical necessity for care.

Care Provider Readiness

- Develop care provider readiness assessment tool.
- Assess ability of General Fund supported care providers to fulfill requirements for Medicaid billing and to meet performance standards.
- Offer technical assistance to care providers that need support.
- Enroll rehabilitation providers in Medicaid.

Management of Rehab Services

- Develop clinical criteria to evaluate medical necessity for rehabilitation services.
- Define recovery management infrastructure.

Establish Process for Certification of Rehabilitation Providers

- Identify qualifications for rehabilitation service providers.
- Develop care provider certification process.
- Draft, adjust (based on stakeholder comment), obtain approval and publish final certification regulations.
- Contract with ASO that will assess care provider applications for certification.
- Assign and train staff to review and certify applicants.
- Rehabilitation provider performance monitoring requirements:
    - Establish performance criteria.

- Issue criteria to care providers.
- Offer technical assistance to care providers to help them meet performance requirements.
- Assess care providers periodically as part of re-certification process.

- Care providers complete certification process.
- Ongoing Program Management:
  - Complete information system changes necessary to issue data reports.
  - Determine reports/data needed to monitor program trends and impact.
  - Develop process for periodic review of reports by management team.
  - Commence data transfer (authorization/notification and claims) to DMHAS data warehouse.

Financing of System

- Evaluate alternative funding strategies.
- Determine fiscal impact of conversion on General Fund (grant) supported providers:
  - Determine total dollars DMHAS must retain to support rehabilitation services for people receiving care from DMHAS who are not eligible for Medicaid, as well as for rehabilitation services that are not covered by Medicaid.
  - Review DMHAS fraud investigation process to ensure compliance with Medicaid rules.
  - DMHAS General Fund supported programs begin billing DSS for rehab services.

Payment Infrastructure Building for Rehabilitation Option Services

- Define billable units.
- Draft fee-for-service payment rates and rate setting policy.
- Issue/publish rates and policies for comment and make adjustments as needed.
- Claims: define billing codes, provider types, claims vendor edits system.
  - Set up claims and eligibility data transfer to Administrative Service Organization (ASO)/data warehouse for reporting purposes.
- Write and distribute care provider claims instructions and billing manuals.
- Develop and implement payment transition plan to assure uninterrupted reimbursement of services for people in care.

Operations

- Begin full operation Medicaid reimbursed rehabilitation option services and recovery management system.
- Make operational adjustments as needed.