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CT 15-0014: 508 comlpliant MMDL Health Home SPA Approval Package

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
JFK Federal Building, Government Center
Room 2275
Boston, Massachusetts 02203

Division of Medicaid and Children's Health Operations / Boston Regional Office

September 28, 2016

Roderick L. Bremby, Commissioner
Department of Social Services
55 Farmington Avenue
Hartford, Connecticut 06105-3725

Re: Connecticut State Plan Amendment (SPA) Transmittal Number 15-014

Dear Commissioner Bremby:

The Centers for Medicare & Medicaid Services (CMS) Boston Regional Office has completed its review of Connecticut State Plan Amendment (SPA) Transmittal Number 15-014. This SPA implements Health Homes as authorized under Section 2703 of the Patient Protection and Affordable Care Act. The State plan pages for this SPA were submitted and approved through the Medicaid Model Data Lab. To qualify for enrollment in a health home, Medicaid participants must have one or more serious and persistent mental health condition. This SPA delegates designated providers, as described in Section 1945(h) (6) of the Social Security Act, as the health home provider.

We are approving this SPA with an effective date of October 1, 2015, and have included the approved State plan pages with this letter. In accordance with the statutory provisions at Section 1945(c) (1) of the Social Security Act, for payments made to health home providers under this amendment, during the first eight fiscal quarters that the SPA is in effect, October 1, 2015 through November 30, 2017, the Federal medical assistance percentage (FMAP) rate applicable to such payments shall be equal to 90 percent. The FMAP rate for payments made to health home providers will return to the state's published FMAP rate on October 1, 2017.

This approval is based on the State's agreement to collect and report information required for the evaluation of the health home model. States are also encouraged to report on the CMS' recommended core set of quality measures.

If you have any questions concerning this amendment or require further assistance, please contact me, or have your staff contact Marie DiMartino of my staff at 617-565-9157 or marie.dimartino@cms.hhs.gov. Thank you.

Sincerely,

/s/

Richard McGreal
Associate Regional Administrator

Enclosure

cc:
Kate McEvoy, Director of Medical Administration

Submission Summary

Transmittal Number:
Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

CT-15-0014

Supersedes Transmittal Number:
Please enter the Supersedes Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

New

☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Socia**

Name of Health Homes Program:

Behavioral Health Homes

State Information

State/Territory name:	**Connecticut**
Medicaid agency:	Department of Social Services

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

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The primary contact for this submission package.

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The tertiary contact for this submission package.

Name:	Ginny Mahoney
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Email:	ginny.mahoney@ct.gov

Proposed Effective Date

10/01/2015 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
Effective October 1, 2015, SPA 15-014 establishes behavioral health homes (BHH) as a SPA option pursuant to section 1945 of the Social Security Act for specified Medicaid beneficiaries with a chronic serious mental illness. Those services are offered statewide in collaboration with three partner state agencies: the Department of Social Services, the Department of Mental Health and Addiction Services, and the Department of Children and Families.

Services available under BHH include a variety of care management, care coordination, transitional care activities, individual and family support services, referrals to community and social support services, and other services, each as specified in the SPA. Designated providers are local mental health authorities (LMHAs) and LMHA affiliate providers.

The goals and objectives of BHH include focusing on "whole person" care by integrating primary care functions into a behavioral health and substance abuse setting, which will allow for greater coordination with primary care in the community. Consistent with BHH core services, BHH designated provider agencies will provide comprehensive transitional care, care coordination, individual and family supports and referrals to address acute and long-term care support services.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 8022000.00
Second Year	2017	$ 16435000.00

Federal Statute/Regulation Citation

Section 1945 of the Social Security Act

Governor's Office Review

- (●) **No comment.**
- ( ) **Comments received.**
  Describe:
- ( ) **No response within 45 days.**
- ( ) **Other.**
  Describe:

Transmittal Number: CT-15-0014 Supersedes Transmittal Number: New Approved Effective Date: Oct 1, 2015 Approval Date: Sep 28, 2016

Planned Approved-One Copy Attached
Date Received: 12/30/2015
Effective Date: 10/1/2015

/S/

Date Approved: 9/28/2016
Signature of Regional Official
Title:Associate Regional Administrator
Division of Medicaid and Children's Health Operations
Boston Regional Office

Health Home State Plan Amendment

OFFICIAL

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Transmittal Number: CT-15-0014 Supersedes Transmittal Number: New Approved Effective Date: Oct 1, 2015 Approval Date: Sep 28, 2016 Attachment 3.1-H Page Number: 1

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Submission - Public Notice

Indicate whether public notice was solicited with respect to this submission.

- ( ) **Public notice was not required and comment was not solicited**
- ( ) **Public notice was not required, but comment was solicited**
- (●) **Public notice was required, and comment was solicited**

Indicate how public notice was solicited:

- [ ] **Newspaper Announcement**

☑ **Publication in State's administrative record, in accordance with the administrative procedures requirements.**

Date of Publication:

06/30/2015 (mm/dd/yyyy)

☐ **Email to Electronic Mailing List or Similar Mechanism.**

Date of Email or other electronic notification:

(mm/dd/yyyy)

Description:

☑ **Website Notice**

Select the type of website:

☑ Website of the State Medicaid Agency or Responsible Agency

Date of Posting:

06/29/2015 (mm/dd/yyyy)

Website URL:

http://www.ct.gov/dss and http://www.ct.gov/dmhas

☐ Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

☐ Other

☐ **Public Hearing or Meeting**

☐ **Other method**

Indicate the key issues raised during the public notice period:(This information is optional)

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

Cost

Summarize Comments

Summarize Response

Payment methodology

Summarize Comments

Summarize Response

Eligibility

Summarize Comments

Summarize Response

Benefits

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

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Submission - Tribal Input

☑ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☐ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☑ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner:

☐ **Indian Tribes**

☑ **Indian Health Programs**

Indian Health Programs	
Name of Indian Health Programs:	
Mashantucket Pequot Tribal Nation and Mohegan Tribe	

Indian Health Programs	
Date of consultation: 08/21/2015 (mm/dd/yyyy) Method/Location of consultation: In accordance with Connecticut's approved SPA regarding tribal notifications, on August 21, 2015, email notice was sent to Connecticut's two federally recognized Indian tribes. The state did not receive any comments from the tribes regarding this SPA.	

☐ **Urban Indian Organization**

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: CT-15-0014 Supersedes Transmittal Number: New Approved Effective Date: Oct 1, 2015 Approval Date: Sep 28, 2016

Transmittal Number: CT-15-0014 Supersedes Transmittal Number: New Approved Effective Date: Oct 1, 2015 Approval Date: Sep 28, 2016 Attachment 3.1-H Page Number: 4

Submission - SAMHSA Consultation

☑ **The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.**

Date of Consultation	
Date of consultation: 12/12/2013 (mm/dd/yyyy)	
Date of consultation: 01/03/2014 (mm/dd/yyyy)	

Transmittal Number: CT-15-0014 Supersedes Transmittal Number: New Approved Effective Date: Oct 1, 2015 Approval Date: Sep 28, 2016

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Health Homes Population Criteria and Enrollment

Population Criteria

The State elects to offer Health Homes services to individuals with:

☐ **Two or more chronic conditions**

Specify the conditions included:

- ☐ **Mental Health Condition**
- ☐ **Substance Abuse Disorder**
- ☐ **Asthma**
- ☐ **Diabetes**
- ☐ **Heart Disease**
- ☐ **BMI over 25**

Other Chronic Conditions	

☐ **One chronic condition and the risk of developing another**

Specify the conditions included:

- ☐ **Mental Health Condition**

- [ ] **Substance Abuse Disorder**
- [ ] **Asthma**
- [ ] **Diabetes**
- [ ] **Heart Disease**
- [ ] **BMI over 25**

Other Chronic Conditions	

Specify the criteria for at risk of developing another chronic condition:

- [x] **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:
The criteria to determine BHH eligibility for adults and children (based on serious and persistent mental health condition) are as follows:
• Serious and Persistent Mental Illness: schizophrenia and psychotic disorders, mood disorders, anxiety disorders, obsessive compulsive disorder, post-traumatic stress disorder, and/or borderline personality disorder;
• Medicaid eligible; and
• High Medicaid claims (> $10,000 / 1 year)

Geographic Limitations

- [x] **Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.
BHH is being implemented statewide effective October 1, 2015.

If no, specify the geographic limitations:

- ○ **By county**

Specify which counties:

- ○ **By region**

Specify which regions and the make-up of each region:

○ **By city/municipality**

Specify which cities/municipalities:

○ **Other geographic area**

Describe the area(s):

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the State will use to enroll eligible Medicaid individuals into a Health Home:

○ **Opt-In to Health Homes provider**

Describe the process used:

◉ **Automatic Assignment with Opt-Out of Health Homes provider**

Describe the process used:
Eligible individuals presently receiving services at a BHH designated provider will receive written notification about their auto-enrollment for BHH services. When applicable, parents, legal guardians and conservators will also be notified. The letter will include, but not be limited to, the following information:
1. The BHH to which they will be auto-enrolled (their existing BH provider for BHH services);
2. The option to choose another BHH provider;
3. The option to opt out completely with no changes to their present care; and
4. Examples of services they will receive via the BHH (health information, health screenings, help with care transitions, quitting smoking, others).

Those choosing to participate in the BHH will complete a consent form and appropriate releases of information.

Eligible individuals presently not receiving services from BHH designated providers will receive a notification letter of their eligibility, which will include contact information to request participation in the BHH. Additionally, should non-enrolled, eligible individuals receive services from a hospital (Emergency Department or Inpatient), the Administrative Services Organization (ASO) will provide outreach to offer BHH services as an option as described above.

Draft notification letters have been previously submitted to CMS during the informal review process for this SPA.

☑ **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

○ **Other**

Describe:

☑ **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**

☑ **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**

☑ **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**

☑ **The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**

☑ **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

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Health Homes Providers

Types of Health Homes Providers

☑ **Designated Providers**

Indicate the Health Homes Designated Providers the State includes in its program and the provider qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

☐ Rural Health Clinics

Describe the Provider Qualifications and Standards:

☐ Community Health Centers

Describe the Provider Qualifications and Standards:

☐ Community Mental Health Centers

Describe the Provider Qualifications and Standards:

☐ Home Health Agencies

Describe the Provider Qualifications and Standards:

☑ Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:

☐ Case Management Agencies

Describe the Provider Qualifications and Standards:

☐ Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards:

☐ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:

☑ **Other (Specify)**

Provider	
Name: Local Mental Health Authorities (LMHAs) Provider Qualifications and Standards: Designated Providers: CT Local Mental Health Authorities (LMHA) & designated LMHA affiliates are BHH designated providers, using existing statewide behavioral health infrastructure to implement BHH. Affiliates are private, nonprofit agencies that receive funding from DMHAS for mental health and/or dual diagnoses programs. Contracts w/ these agencies are overseen by LMHA in their area. Affiliates are designated by DMHAS as a BHH provider when they have significant numbers of clients who meet BHH eligibility. As designated providers of BHH services, LMHAs identify BHH staff responsible for providing BHH services. At minimum, each BHH team will include Director, Primary Care Nurse Care Manager, Primary Care Physician (PCP) Consultant, Administrative Systems Specialist, Hospital Transition Coordinator, Licensed Behavioral Health Clinician, Care Coordinator (BHH Specialist), & Peer Recovery Specialist. BHH services focus on "whole person" care by integrating primary care functions into a behavioral health and substance abuse setting, which will allow for greater coordination with primary care in the community. Consistent w/ BHH core services, BHH designated provider agencies will provide comprehensive transitional care, care coordination, individual and family supports, comprehensive care management, health education and promotion, & referrals to address acute & long-term care support services. BHH designated providers must: meet state credentialing rules; have demonstrated ability to provide the 6 core BHH services; & have substantial percentage of individuals eligible for BHH. BHHs will provide the 6 core BHH services. BHHs must follow the minimum requirements and expectations listed below under the heading "General Standards" in section "Provider Standards."	

☐ **Teams of Health Care Professionals**

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

Supports for Health Homes Providers

Describe the methods by which the State will support providers of Health Homes services in addressing the following components:

1. **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,**
2. **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**
3. **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
4. **Coordinate and provide access to mental health and substance abuse services,**
5. **Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care,**
6. **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
7. **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
8. **Coordinate and provide access to long-term care supports and services,**
9. **Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services:**
10. **Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate:**
11. **Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.**

Description:

Providers will be supported in transforming service delivery by participating in no less than quarterly statewide BHH learning collaboratives. The state will contract with an Administrative Services Organization to assess providers' learning needs, as it is expected that there will be varying levels of experience with organizational change, transformation approaches, and knowledge of health home services. BHH providers will be required to participate in the learning collaborative specifically designed to aid in implementation. Support and learning will be provided to providers between Learning Collaborative sessions via provider-specific technical assistance both on-site and telephonically.

The Learning Collaborative curriculum will include, at a minimum, the following: acceptable evidence-based clinical and substance abuse screening assessment instruments and intervention models (including SBIRT); orientation to the DCF system of care and community collaborative infrastructure and process; orientation to, and opportunity for trainer certification from, the CT Department of Public Health on the Chronic Disease Management Model and the CT Department on Aging on the Transitional Care Model.

In addition to the quarterly Learning Collaborative process BHH providers will receive training and technical assistance by the Administrative Services Organization (ASO) with oversight by the state partners on topics resulting from regular polling of providers' training needs including but not limited to: HIT, billing and coding services, random moment time study reporting, health measures and/or integration and management of services.

The ASO is also responsible for establishing a provider and enrollee call line for eligibility review and technical assistance on BHH related matters. This process will allow providers access to information and support between trainings or Learning Collaborative sessions, Monday-Friday 8:30-5:00.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

DMHAS promotes and administers comprehensive, recovery-oriented services in the areas of mental health treatment and substance abuse prevention and treatment throughout Connecticut. DMHAS also provides collaborative programs for individuals with special needs, such as persons with HIV/AIDS infection, people in the criminal justice system, those with problem gambling disorders, substance abusing pregnant women, persons with traumatic brain injury or hearing impairment, those with co-occurring substance abuse and mental illness, and special populations transitioning out of the Department of Children and Families.
The foundation of DMHAS' statewide treatment system is Local Mental Health Authorities. LMHAs are both state-operated and private, non-profit agencies that provide treatment and support at the community level.

LMHAs and contracted LMHA affiliated providers (Affiliates) will serve as designated providers of BHH services. Each LMHA has the specific responsibility for one or more catchment areas assuring statewide coverage. Contract language will be added to the private, non-profit contracts explicitly defining BHH services, HIT requirements including provider reporting standards and processes contributing to the collection of BHH service, billing and core outcome measures. While a number of LMHAs and affiliates constitute the statewide BHH service system, DMHAS will serve as the sole lead Medicaid billing entity.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:
GENERAL STANDARDS

In addition to being a state designated LMHA or Affiliate, all BHHs will be required to meet the following credentialing requirements, which may be amended from time-to-time as necessary and appropriate:
1. Meet all applicable state licensure requirements necessary to perform BHH services;
2. Be accredited by either The Commission on Accreditation of Rehabilitation Facilities or The Joint Commission;
3. Be enrolled in the CT Medicaid program as a mental health clinic or outpatient hospital;
4. Have capacity to serve individuals on Medicaid or those who are dually eligible for Medicare/Medicaid who are eligible for BHH services in the designated service area;
5. Meet staffing requirements to ensure BHH team composition and roles;
6. Meet enhanced access requirements including enhanced enrollee access to the health home team and 24/7 access to crisis intervention and other needed services;
7. Have a strong, engaged leadership committed and capable of leading the provider through the transformation process as demonstrated by the agreement to participate in the learning collaborative and other technical assistance;
8. Conduct a standardized assessment and complete status reports to document enrollees' living arrangement; employment; education; legal, entitlement, and custody status; etc.;
9. Develop and maintain a single person-centered care plan that coordinates and integrates all behavioral health, primary care, and other needed services and supports with documentation to demonstrate that BHH services are being delivered in accordance with program guidelines and requirements;
10. Conduct wellness interventions, as indicated, based on enrollees' level of risk;
11. Agree to convene regular, documented BHH team meetings for case consultation and implementation of practice transformation;
12. Within three months of implementation, become familiar with DCF System of Care Practice Standards that govern the delivery of care within the children's behavioral health service system for all individuals under 18 years of age;
13. Within three months of implementation, develop a contract or MOU with regional hospitals, DCF system of care community collaborative, children's Emergency Mobile Psychiatric Services (EMPS), primary care and other provider systems to ensure a formalized relationship for transitional care planning, to include communication of inpatient admissions as well as identification of individuals seeking Emergency Department (ED) services (for children, these MOUs should build upon those agreements executed between EDs and EMPS providers);
14. Within three months of implementation, develop and maintain referral agreements with regional adult and child primary care practices or federally qualified health centers; hospitals and child/adult residential facilities; and other pediatric resources;
15. Have a comprehensive data collection system capable of communicating with the state's data system;
16. Have the capacity to collect and report data in the form and manner specified by the state on implementation progress, staffing, services, time/activities, outcomes, etc.;
17. Agree to participate in CMS and state-required evaluation activities;
18. Agree to site visits and auditing of records by the state, and develop quality improvement plans to address

identified issues;
19. Maintain compliance with all terms and conditions as a BHH provider or face termination; and
20. Implement a BHH model that the state determines has a reasonable likelihood of being cost-effective. (Improvement on outcome measures will be used to determine cost effectiveness prior to the calculation of return on investment.)

QUALIFICATIONS OF VARIOUS BHH TEAM MEMBERS WITHIN LMHAs:

BHH Director:
Four (4) years of professional experience in Behavioral Health Care and a Master Degree in a clinical discipline, Public Health Administration, Health Care Administration or Hospital Administration preferred.

Primary Care Nurse Care Manager:
Considerable knowledge of behavioral health of individuals; skill working with individual patients/clients, groups and families; ability to provide therapeutic treatment with a variety of patients/clients. Registered Nurse preferred. Possess all required state licenses.

Primary Care Physician (PCP) Consultant:
The BHH Physician Consultant may be a physician, Advanced Practical Registered Nurse (APRN) or a physician assistant.
Qualifications:
Knowledge of principles and practices of general medicine for a diverse client population;
knowledge of clinical diagnostic and treatment protocols and procedures;
Knowledge of prescriptive practices, protocols and procedures; clinical assessment and evaluation skills;
ability to develop and provide in-service training programs.
Possess all required state licenses.

BHH Specialists:
Knowledge of community support systems and resources;
some knowledge of the principles and procedures of psychiatric rehabilitation;
ability to utilize computer software.
Considerable knowledge of psychiatric rehabilitation and/or case management principles, practices and procedures;
knowledge of dynamics of human behavior;
knowledge of community resources and programs;
observation skills; ability to supervise client activity;
ability to interpret and implement agency and/or facility policies and procedures;
ability to apply principles of therapeutic counseling under supervision;
ability to develop curricula and instruct groups;
organizational ability; ability to understand, interpret and carry out oral and written instructions.
Three (3) years' experience direct service experience or BA/BS degree in human services field.

Hospital Care Transitions Coordinator:
Provides care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long term services and supports, and interrupt patterns of frequent hospital emergency department use.
Collaborates with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients' and family members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self-management. BA/BS degree in human services field or 2 years direct service experience.

Licensed Behavioral Health Clinician:
Knowledge of and ability to instruct others about theories of human behavior, current diagnostic categories of mental illness, family dynamics, substance abuse and human sexuality; considerable Knowledge of social, cultural, economic, political, religious, medical, psychological and legal issues which influence behavior of clients, families, service programs and society at large;
Knowledge of statutes, regulations and standards relating to mental health services;
Knowledge of state law governing licensure and scope of practice standards; considerable oral and written communication skills; considerable administrative skills; considerable ability to independently apply in practice

current psychiatric treatment modalities including but not limited to behavioral, cognitive, object-relations, crisis intervention and psychosocial rehabilitation approaches; ability to integrate theory and case material in assessing and devising comprehensive treatment and/or service plans for difficult and/or complex case assignments; ability to lead task groups including but not limited to treatment teams and agency committees.
One year of experience as a licensed behavioral health clinician.

Qualifications:
Possess all required state licenses
Required to have knowledge of sign language and communication ability with the deaf and hearing impaired in designated positions.
Required to have ability in Spanish oral and written communication in designated positions .
Required to be a certified Substance Abuse/HIV Supervisor in designated positions.

Recovery and Peer Support Specialist:
Peer support includes face-to-face interactions that are designed to promote ongoing engagement of participants and promoting the individuals strengths and abilities to continue improving socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Peer support also includes communication and coordination with behavioral health services providers and others in support of the participant.
Qualifications:
Be at least 18 yrs old;
Possess at least a high school diploma or GED;
Possess a valid Connecticut driver's license;
Be certified as a Peer Support Specialist in accordance with requirements set by the Department of Mental Health and Addiction Services (DMHAS);
Meet requirements for ongoing continuing education set by DMHAS; and
Demonstrate ability to support the recovery of others from mental illness and/or substance abuse.

Administrative Support Specialist:
Performs a full range of administrative activities requiring an advanced level of accountability, problem solving and interpersonal contacts.
Considerable knowledge of office administration and management; considerable knowledge of department and/or unit policies and procedures;
considerable knowledge of proper grammar, punctuation and spelling;
considerable knowledge of business communications;
knowledge of business math;
considerable interpersonal skills;
ability to operate office equipment which includes personal computers and other electronic equipment;
ability to operate office suite software;
ability to take notes and ability to work as part of an interdisciplinary team.

ADDITIONAL DESCRIPTION OF PROVIDER STANDARDS AND METHODS TO ASSURE PROVIDER STANDARDS:

Assurance of the provider practice principles and standards / requirements will be initially established through a BHH Designated Provider agency credentialing process to be provisionally completed within six months of project implementation and annually thereafter by the ASO. The credentialing process includes completion by the provider agencies of an application requiring responses to all of the following requirements as well as submission of licensing and other verifications. The Departments will ensure provider preparation for this process, specifically information on evidence-based practices; access to standardized preventive and health promotion information and chronic disease management; through on-going, bi-weekly implementation sessions and quarterly Learning Collaboratives. The credentialing process is a cornerstone of the state's BHH quality management process, identifying areas of future professional development, technical assistance and when applicable, corrective action.

1. Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services as demonstrated or discussed in implementation sessions, learning collaboratives , or contracted, enhanced technical assistance sessions or webinars sponsored by the Departments.

2. Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines, as demonstrated or discussed in implementation sessions, learning collaboratives , or contracted, enhanced technical assistance sessions or webinars sponsored by the Departments. And, as assessed through the annual BHH credentialing process.

3. Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders, as demonstrated or discussed in implementation sessions, learning collaboratives , or contracted, enhanced technical assistance sessions or webinars sponsored by the Departments.

4. Coordinate and provide access to mental health and substance abuse services, as assessed through the annual BHH credentialing process.

5. Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings. Transitional care includes appropriate follow-up from inpatient to other settings, such as participation in discharge planning and facilitating transfer from a pediatric to an adult system of health care, as assessed through the annual BHH credentialing process.

6. Coordinate and provide access to chronic disease management, including self-management support to individuals and their families, as demonstrated or discussed in implementation sessions, learning collaboratives , or contracted, enhanced technical assistance sessions or webinars sponsored by the Departments. And, as assessed through the annual BHH credentialing process.

7. Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services, as demonstrated or discussed in implementation sessions, learning collaboratives , or contracted, enhanced technical assistance sessions or webinars sponsored by the Departments. And, as assessed through the annual BHH credentialing process.

8. Coordinate and provide access to long-term care supports and services, as assessed through the annual BHH credentialing process.

9. Develop a person-centered care plan for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services, as assessed through the annual BHH credentialing process.

10. Demonstrate a capacity to use health information technology to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices, as feasible and appropriate, as assessed through the annual BHH credentialing process.

11. Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level as demonstrated or discussed in implementation sessions, learning collaboratives , or contracted, enhanced technical assistance sessions or webinars sponsored by the Departments. And, as assessed through the annual BHH credentialing process.

Transmittal Number: CT-15-0014 Supersedes Transmittal Number: New Approved Effective Date: Oct 1, 2015 Approval Date: Sep 28, 2016
Attachment 3.1-H Page Number: 7

Health Homes Service Delivery Systems

Identify the service delivery system(s) that will be used for individuals receiving Health Homes services:

☑ **Fee for Service**

☐ **PCCM**

○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☐ **Risk Based Managed Care**

○ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**

☐ **The current capitation rate will be reduced.**

☐ **The State will impose additional contract requirements on the plans for Health Homes enrollees.**

Provide a summary of the contract language for the additional requirements:

☐ **Other**

Describe:

☐ **The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals.**
Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

☐ **Yes**

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**
- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

○ No

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☑ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:
CT's Medicaid program is currently a managed fee-for-service delivery system with Administrative Services Organizations. BHH designated providers (Local Mental Health Authorities [LMHAs] and LMHA affiliates) will be paid at a per member per month rate.

There are no contract requirements specified in this section.

☑ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

Transmittal Number: CT-15-0014 Supersedes Transmittal Number: New Approved Effective Date: Oct 1, 2015 Approval Date: Sep 28, 2016
Attachment 3.1-H Page Number: 8

Health Homes Payment Methodologies

The State's Health Homes payment methodology will contain the following features:

☑ **Fee for Service**

☐ **Fee for Service Rates based on:**

☐ **Severity of each individual's chronic conditions**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Other: Describe below.**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

☑ **Per Member, Per Month Rates**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.
BHH funding methodology based on cost to employ key health & BH staff/professionals to provide BHH services & indirect costs. Payment is statewide monthly bundled rate per client.

BHH services eligible for reimbursement for a client when 1 or more svcs rendered in a billing period & client or representative approves svcs. Billing period for BHH services is cal. month. BHHs shall only bill for BHH thru DHMAS & shall not be eligible for payment thru any other Medicaid billing sys. No more than 1 unit billed for each client in a month. BHH svcs claimed under Medicaid must be substantiated by documentation in client service record. This documentation must be auditable. State assures there will be no duplication of services & pmnt for similar svcs provided under other Medicaid authorities. Payment for BHH services may not duplicate Medicaid payments for other covered svcs If client has active BHH insurance record in DMHAS sys. during month, TCM services will not be billed

for that month. If client has active 1915(c) waiver during month, only services exclusive to BHH will be billed in addition to 1915(c) waiver services for the month.

BHH teams include both pub. & priv. providers. BHH svcs provided by DMHAS employees & private providers under contract w/ DMHAS. Providers submit BHH services to DMHAS each month. DMHAS submits BHH claims for processing in MMIS for each Medicaid BHH client who receives at least 1 BHH service in the month.

Rates for BHH services will be updated annually. DMHAS will be reimbursed at cost for BHH services provided by DMHAS employees & priv. providers under contract w/ DMHAS. BHH reimbursable cost is calculated using CMS approved cost report & CMS approved Random Moment Time Study (RMTS).

CMS approved RMTSs are conducted w/ moments selected on quarterly basis, but Time Study is conducted continually. RMTS percentage efforts are calculated each quarter & SFY quarter results are used to allocate direct costs. Time Study participants include all staff reasonably expected to perform BHH Services during time study period.

DMHAS annually will complete & certify Cost Report for costs related to BHH services provided by DMHAS employees for period fr July 1-June 30. Private providers under contract w/ DMHAS will annually submit to DMHAS a financial rpt for period from July 1-June 30 & DMHAS certifies priv. provider BHH costs. Cost reports due to DSS no later than 10 months after close of SFY during which costs included in Cost Report were incurred. Annual cost report shall include certification of funds in accordance w/ DMHAS-DSS MOU. Submitted cost reports subject to desk review by DSS or designee. Desk review completed in 8 months after receipt of cost reports.

Priv. Provider Expenditures calculated as follows:

i. Total contract amount from DMHAS is compared to total budget amount of provider and a percentage is calculated.

ii. Direct service costs of providing BHH services include salary, wage, & fringe benefits that can be directly charged to BHH services. Direct costs shall not include room & board charges.

iii. Other direct costs including mileage reimbursement, translation & interpreter services, leasing of office equipment, training, necessary office supplies & direct service overhead cost which are directly attributable to support delivery of BHH services. Mileage reimbursement will be supported w/ mileage logs documenting actual mileage specific to BHH services, individual receiving services & their Medicaid status at time of the services.

iv. Total private provider costs are the sum of item ii. & item iii.

v. Private provider service cost attributable to DMHAS is calculated by applying the DMHAS contract funding percentage identified in item i. to item iv.

vi. Medicaid allowable private provider direct BHH services cost net of primary care physician consultant's component is calculated by RMTS results to item v.

vii. Private provider BHH primary care consultant's costs are calculated by using Primary Care Consultant Log. The Primary Care Consultant Log tracks the time primary care consultant spends on BHH consultation on Medicaid BHH clients, in minutes, then converted to hours.

viii. Primary care consultant cost calculated by multiplying hours spent on BHH services to the primary care consultant's hourly rate.

ix. Total Medicaid allowable costs eligible for certification determined by adding total primary care consultant's Medicaid allowable cost from item viii to the Medicaid allowable service costs from item vi.

Payment at Cost for Public Providers calculated as follows:

i. Direct service costs of providing BHH services include salary, wage and fringe benefits that can be directly charged to BHH services. Direct costs shall not include room & board charges.

ii. Other direct costs including mileage reimbursement, translation & interpreter services, leasing of office equipment, training, & necessary office supplies which are directly attributable to support delivery of BHH services. Mileage reimbursement will be supported w/ mileage logs documenting actual mileage specific to BHH services, individual receiving services & their Medicaid status at time of the services.

iii. Total direct costs net of PCP consultant & Physician's costs components is the sum of item i. & item ii.

iv. Direct BHH services cost net of PCP consultant & Physician's costs components is calculated by applying results of the RMTS to item iii.

v. Indirect costs are equal to direct BHH services cost net of PCP consultant & Physician's costs components in item iv multiplied by the indirect cost rate set by U.S. HHS for DMHAS.

vi. Total BHH reimbursable service cost is the sum of items iv and v.

vii. Total primary care consultant's Medicaid allowable cost is calculated by multiplying the hourly rate paid to the primary care consultant by the number of Medicaid billable BHH service hours as reported through Primary Care Consultant Log.

viii. If the primary care consultant is a CT state employee, then their fringe benefits cost will be added to item vii.

ix. If the primary care consultant is CT state employee, then the total primary care consultant's Medicaid allowable cost from item viii. is multiplied by the indirect cost rate set by U.S. HHS for DMHAS.

x. Total primary care consultant's Medicaid allowable cost is the sum of items vii., viii. and ix.

xi. If primary care consultant is a contractor and not CT state employee, then omit step viii. and ix.

xii. Physician's cost are calculated by multiplying the hourly rate paid to the Physician by the number of Medicaid billable BHH service hours as reported by BHH designated providers in the current service system used by DMHAS (WITS). Fringe benefits are also added based on a percentage of outpatient salary to total salary.

xiii. Total Physician's cost from item xii is multiplied by the indirect cost rate set by U.S. HHS for DMHAS.

xiv. Total Physician's Medicaid allowable cost is the sum of items xii. and xiii.

xv. Total Medicaid allowable costs eligible for certification is determined by adding the total primary care consultant's Medicaid allowable cost (item x.), the total Physician's cost (item xiv) and the Medicaid allowable costs (item vi).

Interim Rates

Initial DMHAS BHH interim rate was set at $317 as of 10/1/2015 and is effective for services on or after that date. The rate is statewide bundled rate for both government & private providers.

PMPM rate for BHH services effective 10/1/2015 is based on staff full-time equivalents (FTEs) per 400 Medicaid beneficiaries:
a. Director = 0.4
b. Primary Care Nurse Manager / Nurse = 2.0
c. Primary Care Physician Consultant = 0.2
d. Administrative Systems Specialist = 0.5

e. Hospital Transition Coordinator = 1.3
f. Care Coordinator / Behavioral Health Home Specialists = 8.0
g. Peer Recovery Specialist = 4.0
h. Clinicians (MA level, licensed) = 1.4
i. Total FTE = 17.8
j. Indirect = 10%
k. Total cost = $317.00 PMPM

Interim rates for BHH services shall be updated annually. Interim rates are based upon the cost settlement, as determined below, rounded up to nearest $10. Interim rates are provisional in nature, pending completion of cost reconciliation & cost settlement for that period.

Monthly Rate

Monthly rate for BHH services is calculated by dividing total Medicaid allowable BHH costs by total number of recorded BHH service months for same period. No more than 1 unit will be billed for each Medicaid client in a month.

Settlement

DMHAS claims paid at interim rate for BHH services delivered by DMHAS & private providers during the reporting period, as documented in MMIS, will be compared to total Medicaid allowable costs for BHH services based on the CMS approved Cost Report. DMHAS interim rate claims for BHH services will be adjusted in aggregate. This results in cost reconciliation. Reconciliation will occur within 24 months of the end of the reporting period contained in the submitted cost report.

If it has been determined that an overpayment has been made, DSS will return federal share of the overpayment. If the actual, certified Medicaid allowable costs of BHH services exceed the interim Medicaid rates, DSS will submit claims to CMS for the underpayment. Cost settlement will occur within the timelines set forth in 42 CFR 433 Subpart F. CT will not modify the CMS-approved scope of costs, time study methodology or annual cost report methodology without CMS approval.

Audit

All supporting accounting records, statistical data & all other records related to provision of BHH services delivered by DMHAS & private providers is subject to audit. If an audit discloses discrepancies in accuracy and/or allowances of actual direct or indirect costs or statistical data as submitted for each fiscal year by DMHAS & private providers, DSS payment rate for said period is subject to adjustment.

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (description included in Service Delivery section)**

☐ **Risk Based Managed Care (description included in Service Delivery section)**

☐ **Alternative models of payment, other than Fee for Service or PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.
The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities. A payment for BHH services may not duplicate Medicaid payments made for other covered services. If an eligible beneficiary chooses to enroll in BHH services, TCM would not be billed for the beneficiary. If a client has an active 1915(c) waiver during the month, only services exclusive to BHH will be billed in addition to the 1915(c) waiver services for the month.

☑ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

Submission - Categories of Individuals and Populations Provided Health Homes Services

The State will make Health Homes services available to the following categories of Medicaid participants:

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive Care Management

Definition:
Goal of Comprehensive Care Management (CCM) is initial engagement of individuals, providing information, education, and support so they can make informed decisions about care options to actively participate in care planning.

Individuals, parents/guardians, family members, caretakers and, when applicable, conservators and identified supports (together, "individual") work with care manager(s) and behavioral health, primary care and other community providers to identify and obtain necessary supports and services to assist in achieving and maintaining highest level of health and success. Comprehensive needs assessment completed to help identify medical, behavioral health, pharmacological, housing and recovery and social support needs, and current expectations, providers, benefits, preferences, choices, strengths, resources, motivation, and barriers. Comprehensive assessment tool, identified and/or developed by each BHH used to identify gaps in services and communicated to the individual to help identify BHH goals.

Based on completed comprehensive needs assessment, individuals develop person-centered care plan that prioritizes goals, identifies optimal outcomes and determines assignment of roles and responsibilities of health team members. Individuals periodically reassess (at least annually) person-centered care plan by reviewing needs and goals, identifying progress made toward meeting those goals to achieve positive outcomes and determine individuals' satisfaction with services. Adjustments in plan are made each time it is reassessed.

CCM services include outreach and engagement to support and promote continuity of care. Outcome reports showing progress on individual satisfaction, health status and service delivery will be developed and sent to BHH participants.

Examples of CCM activities include: Assessing needs; Developing Plan of Care; Assigning BHH team members; Monitoring progress.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
CT plans to leverage existing technology and methodology to collect data from providers. Data will be aggregated and analyzed by DMHAS or its agent for the purpose of outcome reporting and provision to the health home network.

This method will allow the input and sharing of information between the state and BHH providers, as well as amongst the BHH team. At a minimum, the following information will be included:
- BHH eligibility and enrollment;
-Medicaid service utilization, including admissions to EDs or in-patient hospitalizations;
-Integrated needs assessments;
-BHH person-centered care plan resulting from the integrated assessment;

-BHH services received; and
-Consumer satisfaction.

The state will utilize this information along with Medicaid claims data to create and share reports on productivity, quality measures and outcomes which will aid in supporting performance improvement and improved consumer outcomes.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Complete assignments resulting from each BHH participant's individual Plan of Care including but not limited to: community support systems and resources; supervise client activity; develop curricula and instruct groups .

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
Work with individual patients/clients, groups and families to facilitate achievement of Plan of Care; provide therapeutic treatment with a variety of patients/clients to support health outcomes identified in Plan of Care.

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Work with individual patients/clients, groups and families to facilitate achievement of Plan of Care; provide therapeutic treatment with a variety of patients/clients to support health outcomes identified in Plan of Care.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

See description below.

Description

* Recovery and Peer Support Specialists:
Provide face-to-face interactions to promote ongoing engagement of participants and achievement of goals and objectives identified in the Plan of Care related to the following: individual's strengths and abilities to continue improving socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Communicate and coordinate with behavioral health services providers and others in support of the participant.

* Director:
Oversight of Plan of Care including: timely completion, quality, monitoring of BHH team assignments and participant progress.

* Primary Care Physician Consultant:
Clinical assessment and evaluation in support of Plan of Care. Develop and provide in-service training programs to staff on integrating physical health needs into the Plan of Care.

* Administrative Systems Specialist:
Administrative activities in support of the creation and monitoring of BHH participants' Plans of Care.

* Hospital Transition Coordinator:
Provide care coordination services designed to streamline plans of care, reduce hospital admissions, ease the transition to long term services and supports, and interrupt patterns of frequent hospital emergency department use. Collaborate with physicians, nurses, social workers, discharge planners, pharmacists, and others to continue implementation of the treatment plan with a specific focus on increasing clients' and family members' ability to manage care and live safely in the community, and shift the use of reactive care and treatment to proactive health promotion and self-management.

Care Coordination

Definition:
Care Coordination is the implementation and monitoring of the individualized person-centered care plan with active involvement of individuals, parents/guardians, family members, caretakers and, when applicable, conservators through appropriate linkages, referrals, coordination, and follow-up to needed services and supports, including referral and linkages to long-term services and supports to achieve outcomes consistent with individual needs, strengths and preferences.

Overarching activities of care coordination include the provision of case management services necessary to ensure individuals, their parent/guardian, family members, caretakers and, when applicable, conservators and their identified supports have access to medical, behavioral health, pharmacology and recovery support services (e.g. housing, access to benefits, vocational, social, and educational, etc.).

Specific care coordination activities are conducted with individuals, their parent/guardian, family members, caretakers, and when applicable, conservators and their identified supports, medical, behavioral health and community providers, across and between care settings to ensure all services are coordinated. Specific activities include, but are not limited to:

Fostering communication with and amongst the individual, her/his providers and her/his identified supports;

Assistance in follow-up care and follow through on recommendations;
Assistance with appointment scheduling and accessing and coordinating necessary health care and recovery support services as defined in the care plan, including transportation;
Skill building and teaching/coaching to help individuals maximize independence in the community;
Conducting referrals and follow-up monitoring;
Participating in hospital discharge processes and other care transition;
Outreach to engage, support and promote continuity of care to individuals; and
Ensuring linkage to medication monitoring if it is an identified need.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
CT plans to leverage existing technology and methodology to collect data from providers. Data will be aggregated and analyzed by DMHAS or its agent for the purpose of outcome reporting and provision to the BHH network.

This method will allow the input and sharing of information between the state and BHH providers, as well as amongst the BHH team. At a minimum, the following information will be included:
- BHH eligibility and enrollment;
-Medicaid service utilization, including admissions to EDs or inpatient hospitalizations;
-Integrated needs assessments;
-BHH person-centered care plan resulting from the integrated assessment;
-BHH services received; and
-Consumer satisfaction.

The state will utilize this information along with Medicaid claims data to create and share reports on productivity, quality measures and outcomes which will aid in supporting performance improvement and improved consumer outcomes.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Complete assignments resulting from each BHH participant's individual Plan of Care including but not limited to: fostering communication with and amongst the individual, her/his providers and her/his identified supports; Assistance in follow-up care and follow through on recommendations; Skill building and teaching/coaching to help individuals maximize independence in the community; Conducting referrals and follow-up monitoring; Outreach to engage, support and promote continuity of care to BHH participants, other providers and community agencies.

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
Work with individual patients/clients, groups and families to fostering communication; Assist in follow-up care and follow through on recommendations; Skill building and

teaching/coaching to help individuals maximize independence in the community; Conduct referrals and follow-up monitoring; Outreach to engage, support and promote continuity of care to other BHH participants, providers and community agencies; ensuring linkage to medication monitoring if it is an identified need.

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Work with individual patients/clients, groups and families to fostering communication; Assist in follow-up care and follow through on recommendations; Skill building and teaching/coaching to help individuals maximize independence in the community; Conduct referrals and follow-up monitoring; Outreach to engage, support and promote continuity of care to other BHH participants, providers and community agencies; ensuring linkage to medication monitoring if it is an identified need.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

See description below.

Description

Recovery & Peer Sppt Specialist: Face-to-face interactions to promote ongoing engagement of clients & achieve goals, objectives in Plan of Care related to: foster communication w/ & among client, providers & ID'd supports; help w/ follow-up care & follow through on recommendations; client's strengths & abilities improve socialization, recovery, self-advocacy, developing natural supports, & maintaining community living skills. Communicate & coordinate w/ BH providers & others supporting client.

Director: Oversee Plan of Care & BHH Team to foster communication w/ & among client, providers & ID'd supports; Assistance in follow-up care & follow through on recommendations; Skill building & teaching/coaching to help maximize independence; Referrals & follow-up monitoring; Outreach to engage, support & promote continuity of care to providers, agencies.

Primary Care Physician Consultant: Clinical assessment & evals. supporting Plan of Care. Follow-up care & follow through on recommendations; Skill building & teaching/coaching to maximize independence; Referrals & follow-up monitoring; Outreach to engage, support & promote continuity of care to medical providers; link to med. monitoring if needed.

Admin. Systems Specialist: Admin. activities such as scheduling, accessing & coordinating care & sppt svcs defined in care plan, incl. transp.

Hosp. Transition Coordinator: Care coordination to streamline plans of care, reduce hosp. admissions, ease transition to long term services & sppts, & interrupt patterns of frequent hosp. emerg. dept use. Foster communication w/ & among client, providers & ID'd sppts; Help w/ follow-up care & follow through on recommendations; Work w/ physicians, nurses, social workers, discharge planners, pharmacists, & others to implement treatment & discharge plans, focus on increasing clients' & family's ability to manage care & live safely in the community, shift reactive care/treatment to proactive health promotion, self-management.

Health Promotion

Definition:
Health Promotion Services encourage and support healthy living to motivate individuals, parents/guardians, family members, caretakers and, when applicable, conservators to adopt healthy behaviors and promote self-management of health and wellness. Health Promotion Services emphasizes self-direction and skill development through health education and wellness interventions so chronic health conditions are monitored and managed, improving health outcomes. A helpful framework for Health Promotion Services are the 8 wellness dimensions defined by SAMHSA as: Financial, Social, Spiritual, Health, Environmental, Emotional, Occupational and Intellectual. DMHAS includes these dimensions in its definition of recovery and they are addressed in individual recovery plan goals.

Activities related to health promotion address BHH participants holistically and include, but are not limited to:
• Health education and wellness interventions specific to chronic condition(s);
• Development of self-management with the individual, parents/guardians, family members, caretakers and, when applicable, conservators;
• Education regarding importance of immunizations & health screenings;
• Healthy lifestyle choices within one's budget;
• Health education about chronic conditions to family members and other natural supports;
• Support for improving social networks; and
• Wellness and health-promoting lifestyle interventions such as, but not limited to, substance use prevention/early intervention and harm reduction, HIV/AIDS prevention/early intervention, STD prevention/early intervention, family planning and pregnancy, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, increasing physical activity, and promoting independence and skill development related self-administration of medications.
• Connection to EPSDT services (if applicable).
For individuals under age 18, parents and guardians will have opportunities to receive the above services.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
Where available and when appropriate, HIT will be used to improve access to care, health education materials and resources, improve care coordination and empower participating individuals and their family members/guardians to actively manage their care.

In addition, CT plans to leverage existing technology and methodology to collect data from providers. Data will be aggregated and analyzed by DMHAS or its agent for the purpose of outcome reporting and provision to the BHH network.

This method will allow the input and sharing of information between the state and BHH providers, as well as amongst the BHH team. At a minimum, the following information will be included:
- BHH eligibility and enrollment;
-Medicaid service utilization, including admissions to EDs or inpatient hospitalizations;

-Integrated needs assessments;
-BHH person-centered care plan resulting from the integrated assessment;
-BHH services received; and
-Consumer satisfaction.

The state will utilize this information along with Medicaid claims data to create and share reports on productivity, quality measures and outcomes which will aid in supporting performance improvement and improved consumer outcomes.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Complete assignments resulting from each BHH participant's individual Plan of Care regarding health education and wellness interventions specific to chronic condition(s); promote self-management; promote healthy lifestyle choices within one's budget; support improvement of social networks; and wellness and health-promoting lifestyle interventions such as, but not limited to, substance use prevention/early intervention and harm reduction, HIV/AIDS prevention/early intervention, STD prevention/early intervention, family planning and pregnancy, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, increasing physical activity, and promoting independence and skill development related self-administration of medications and connection to EPSDT services (if applicable).

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
Work with individual patients/clients, groups and families to provide health education and wellness interventions specific to chronic condition(s); promote self-management, educate regarding importance of immunizations & health screenings; promote healthy lifestyle choices within one's budget; provide health education about chronic conditions to family members and other natural supports; support improvement of social networks; and wellness and health-promoting lifestyle interventions such as, but not limited to, substance use prevention/early intervention and harm reduction, HIV/AIDS prevention/early intervention, STD prevention/early intervention, family planning and pregnancy, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, increasing physical activity, and promoting independence and skill development related self-administration of medications and connection to EPSDT services (if applicable).

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description

Work with individual patients/clients, groups and families to provide health education and wellness interventions specific to chronic condition(s); promote self-management, educate regarding importance of immunizations & health screenings; promote healthy lifestyle choices within one's budget; provide health education about chronic conditions to family members and other natural supports; support improvement of social networks; and wellness and health-promoting lifestyle interventions such as, but not limited to, substance use prevention/early intervention and harm reduction, HIV/AIDS prevention/early intervention, STD prevention/early intervention, family planning and pregnancy, smoking prevention and cessation, nutritional counseling, obesity reduction and prevention, increasing physical activity, and promoting independence and skill development related self-administration of medications and connection to EPSDT services (if applicable).

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

See description below.

Description

Recovery/Peer Sppt Specialist: Face-to-face interactions promote client engagement, achieve goals/objectives in care plan re: self-mgt; healthy lifestyle in budget; soc ntwks; wellness & health-promoting interventions such as substance use, HIV/AIDS, STD prevention/early intervention/harm reduction, fam. plng/pregnancy, smkng prevention/cessation, nutrition counseling, obesity reduction/prevention, phys activity, skill dev, self-admin med & connect EPSDT if <21.

Director: Oversee BHH Team emphasizing self-direction & skill dev thru health ed., wellness to monitor/manage chronic conditions, improve health thru skill building/teaching/coaching to max. independence.

PCP Consultant: Clinical assessment & eval re: health education & wellness specific to chronic condition(s); self-mgt; educate re: vaccines & health screenings; healthy lifestyle; develop curricula & health ed. re chronic conditions; soc ntwks; wellness/health-promoting interventions such as substance use, HIV/AIDS & STD prevention/early intervention/harm reduction, smoking prevention/cessation, nutrition counseling, obesity reduction/prevention, phys activity, indep., skill dev, med self-admin & connect to EPSDT if applicable.

Admin. Sys Specialist: Admin activities such as sppt BHH team health ed. & wellness; develop, send health ed. materials; schedule ed., wellness grps.

Hosp Transition Coordinator: Care coord. streamline care plans, reduce hosp admits, ease transition to LTSS & interrupt patterns frequent hosp ED use via: health ed./wellness re chronic condition(s); self-mgt; vaccines, health screenings; healthy lifestyle in budget;

health ed. re chronic conditions; social ntwks; wellness/health-promoting interventions incl. substance use, HIV/AIDS, & STD prevention/early intervention/harm reduction, fam plng/pregnancy, smkng prevention/cessation, nutrition counseling, obesity reduction/prevention, phys activity, independence, skill dev, med. self-admin, connect to EPSDT if <21.

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

Comprehensive transitional care from inpatient to other settings, including appropriate follow-up

Definition:
Specialized care coord. focused on movement of indiv. between or w/in diff. levels of care/settings (med/BH/LTSS/home/other cmty settings, e.g., shelter) & shifting from reactive to proactive care via health promotion/self-mgt. Svcs to streamline care plans & crisis mgt plans, reduce barriers to timely access, reduce inapprop. hosp & nursing home admits, interrupt patterns of frequent ED use, & prevent svc gaps that could result in (re)admission to higher level of care or longer stays at unnecessary level of care.

Real-time notification of admits/discharges to & from acute & other settings helps provider collaboration. BHH team works w/ hosp EDs, housing providers, hosp psych units, long-term care providers, detox providers & others.

To ensure seamless transitional care to least restrictive setting, care coord. works w/ indiv, parents/guardians, fam, caretakers & when applicable, conservators & facility staff to dev & implement discharge or transition plan. Care coord. develops & implements systematic follow-up protocol w/ indiv as they change levels of care or providers in same lev of care, to ensure timely access to follow-up, medication ed./reconciliation, & other needed svcs/sppts.

DMHAS Young Adult Svcs (YAS) helps young adults transition from DCF sys to adult DMHAS sys. YAS serves individuals: ages 18-25 w/ prior DCF involvement & major mental health issue. LMHA YAS programs work w/ DCF bef indiv turns 18 & dev svc plan together w/ indiv & caregivers. Active involvement of client, family, cmty in developing recovery plan.

Ex. of comprehensive transitional care incl, but not limited to:
* Focusing on indiv's mvt between or w/in different levels of care
* Coordinating services to:
- Streamline care plans
- Reduce hosp admits
- Interrupt patterns of freq use hospital ED for urgent/routine care
- Prevent service gaps that could result in readmission to higher level of care
* Maintain collaborative linkages with hosp & inpatient facilities

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:

CT plans to leverage existing technology and methodology to collect data from providers. Data will be aggregated and analyzed by DMHAS or its agent for the purpose of outcome reporting and provision to the BHH network.

This method will allow the input and sharing of information between the state and BHH providers, as well as amongst the BHH team. At a minimum, the following information will be included:
- BHH eligibility and enrollment;
-Medicaid service utilization, including admissions to EDs or inpatient hospitalizations;
-Integrated needs assessments;
-BHH person-centered care plan resulting from the integrated assessment;
-BHH services received; and
-Consumer satisfaction.

The state will utilize this information along with Medicaid claims data to create and share reports on productivity, quality measures and outcomes which will aid in supporting performance improvement and improved consumer outcomes.

Scope of benefit/service

✓ **The benefit/service can only be provided by certain provider types.**

✓ **Behavioral Health Professionals or Specialists**

Description
Mental Health Workers/BHH Specialists: Complete assignments resulting from any changes in BHH participants' individual Plan of Care resulting from transitions from other levels of care including but not limited to: fostering communication with and amongst the individual, her/his providers and her/his identified supports; Assistance in follow-up care and follow through on recommendations; Skill building and teaching/coaching to help individuals maximize independence in the community; Conducting referrals and follow-up monitoring; Outreach to engage, support and promote continuity of care to BHH participants, other providers and community agencies.

Nurse Care Coordinators

Description

✓ **Nurses**

Description
As it pertains to transitions across levels of care: work with individual patients/clients, groups and families to fostering communication; Assist in follow -up care and follow through on recommendations; help individuals maximize independence in the community; Conduct referrals and follow-up monitoring; Outreach to engage, support and promote continuity of care to other BHH participants, providers and community agencies; ensuring linkage to medication monitoring if it is an identified need.

Medical Specialists

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description

As it pertains to transitions across levels of care: work with individual patients/clients, groups and families to fostering communication; Assist in follow -up care and follow through on recommendations; help individuals maximize independence in the community; Conduct referrals and follow-up monitoring; Outreach to engage, support and promote continuity of care to other BHH participants, providers and community agencies; ensuring linkage to medication monitoring if it is an identified need.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

See description below.

Description

Recovery & Peer Sppt Specialist: Face-to-face interactions promote client engagement & achieve goals & objectives in care plan, discharge plan or changes to care plan resulting in hospitalization or discharge from level of care such as: foster communication among indiv., providers, ID'd supports; follow-up care & follow thru on recommendations; ID indiv's strengths & abilities to improve socialization, recovery, self-advocacy, develop natural supports, & maintain cmty living skills. Coord w/ BH providers & others.

Director: Oversee BHH Team fostering communication; follow-up care & follow thru on recommendations; promote care continuity w/ other providers & agencies; care coord. across levels of care.

PCP Consultant: Assessment & eval support changes to care plan from transitions to or from of other levels of care. Follow-up & follow thru on recommendations; Skill building & teaching/coaching to maximize independence; Referrals & follow-up monitoring; Outreach to engage, sppt & promote care continuity to providers; ensure link to medication monitoring if needed. Educate BHH team on new conditions from recent admits.

Admin Sys Specialist: Activities such as facilitate transitions from other levels of care incl but not limited to receiving, documenting discharge plans, appointments, accessing/coordinating care & recovery support services as defined in care plan, incl transp.

Hosp Transition Coord: Outreach to providers in other levels of care to facilitate care coordination to streamline care plans, reduce hosp admits, ease transition to LTSS, & interrupt patterns of freq hosp ED use. Foster communication among indiv, providers, supports; follow-up care and follow thru on recommendations; Work w/ clinicians, discharge planners, pharmacists & others to implement treatment & discharge plans w/

focus on increasing client & family ability to manage care & live safely in community, & shift from reactive care to proactive health promotion & self-mgt.

Individual and family support, which includes authorized representatives

Definition:
Individual and Family Support Services help BHH participants reduce barriers to achieving goals, increase health literacy and knowledge about chronic condition(s), increase self-management skills such as advocacy, and improve health outcomes. Care coordinators must ensure that individual care plans accurately reflect the preferences, goals, resources, and optimal outcomes of the individual their parent/guardian, family members, caretakers and, when applicable, conservators and her/his identified supports. All communication and information shared with individuals, their parent/guardian, family members, caretakers and, when applicable, conservators and their identified supports must be language, literacy, and culturally appropriate and executed in a location and time convenient to all.

Activities can include, but are not limited to:
• Assistance in accessing self-help, peer support services, technology such as smart phones, support groups, wellness centers, and other self-care programs;
• Teaching and coaching self-advocacy for individuals and families;
• Health education, wellness promotion, and prevention and early intervention services;
• Assistance in identifying and developing social support networks;
• Assistance with obtaining and adhering to prescribed medication and treatments; and
• Helping to identify new resources to aid in reduction of barriers to help support BHH participants attain their highest level of health and functioning within their families and community, including non-medical recovery supports such as transportation and housing.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
CT plans to leverage existing technology and methodology to collect data from providers. Data will be aggregated and analyzed by DMHAS or its agent for the purpose of outcome reporting and provision to the BHH network.

This method will allow the input and sharing of information between the state and BHH providers, as well as amongst the BHH team. At a minimum, the following information will be included:
- BHH eligibility and enrollment;
-Medicaid service utilization, including admissions to EDs or inpatient hospitalizations;
-Integrated needs assessments;
-BHH person-centered care plan resulting from the integrated assessment;
-BHH services received; and
-Consumer satisfaction.

The state will utilize this information along with Medicaid claims data to create and share reports on productivity, quality measures and outcomes which will aid in supporting performance improvement and improved consumer outcomes.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Accurately reflect the preferences, goals, resources, and optimal outcomes of the individual their parent/guardian, family members, caretakers and, when applicable, conservators and her/his identified supports in individual care plans. Ensure all communication and information shared with individuals, their parent/guardian, family

members, caretakers and, when applicable, conservators and their identified supports must be language, literacy, and culturally appropriate and executed in a location and time convenient to all.
Ensure access to self-help, peer support services, technology such as smart phones, support groups, wellness centers, and other self-care programs; coach self-advocacy for individuals and families; provide health education, wellness promotion, and prevention and early intervention services; assist in linking to social support networks; assist with adhering to prescribed medication and treatments; and help to identify new resources to aid in reduction of barriers to help support BHH participants attain their highest level of health and functioning within their families and community, including non-medical recovery supports such as transportation and housing.

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
Provide nursing skills and educational materials which aid the BHH participant in reducing barriers to achieving goals, increase health literacy and knowledge about chronic condition(s), increase self-management skills such as advocacy, and improve health outcomes. Ensure all nursing communication and information shared with individuals, their parent/guardian, family members, caretakers and, when applicable, conservators and their identified supports must be language, literacy, and culturally appropriate and executed in a location and time convenient to all. Provide health education, wellness promotion, and prevention and early intervention services; assists in identifying and developing social support networks; assists with obtaining and adhering to prescribed medication and treatments; and helps to identify new resources to aid in reduction of barriers to help support BHH participants attain their highest level of health and functioning within their families and community, including non-medical recovery supports such as transportation and housing.

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description
Provide social work skills and educational materials which aid the BHH participant in reducing barriers to achieving goals, increase health literacy and knowledge about managing his/her chronic condition(s), increase self-management skills such as advocacy, and improve health outcomes. Ensure all communication and information shared with individuals, their parent/guardian, family members, caretakers and, when applicable, conservators and their identified supports must be language, literacy, and culturally appropriate and executed in a location and time convenient to all. Provide health education, wellness promotion, and prevention and early intervention services; assists in identifying and developing social support networks; and helps to identify new resources to aid in reduction of barriers to help support BHH participants attain their highest level of health and functioning within their families and community, including non-medical recovery supports such as transportation and housing.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

See description below.

Description

Recovery & Peer Sppt Specialists: Communicate, coord. w/ BH providers & others. Support approp & convenient communication w/ indiv, parent/guardian, family, caretakers and, when applicable, conservators and supports ("individual").

Director: Oversee BHH Team reduce barriers to goals, health literacy & knowledge about chronic condition(s), increase self-mgt skills such as advocacy, & improve health. Ensure Care coordinators accurately reflect indiv's preferences/goals/resources/optimal outcomes in care plans. Ensure approp & convenient communication. Ensure BHH team helps w/ self-help, peer sppt svcs, tech such as smart phones, sppt groups, wellness ctrs, other self-care programs; self-advocacy; health ed., wellness promotion, & prevention/early intervention; ID & dev soc ntwks; obtain & adhere to medication & treatments; ID resources to sppt clients attain highest level of health & functioning, incl non-med sppts such as transp & housing.

PCP Consultant: Assessment & eval to reduce barriers to goals, increase health literacy & knowledge about chronic condition(s), increase self-mgt skills such as advocacy, & improve health. Follow-up on care & follow thru on recommendations; health education, wellness promotion, & prevention/early intervention svcs; assist w/ obtaining & adhering to medication & treatments.

Admin Sys Specialist: Incl but not limited to facilitating approp & convenient communication w/ indiv.

Hosp Transition Coord: Accurately reflect indiv's preferences/goals/resources/optimal outcomes. Approp & convenient communication. Ensure access to self-help, peer sppt svcs, tech such as smart phones, sppt groups, wellness ctrs & other self-care programs; self-advocacy; health ed., wellness promotion, prevention/early intervention svcs; assist w/ adhering to medication & treatments; ID new resources to sppt indiv attain highest health & functioning & reduce hosp admits, ease transition to LTSS, & interrupt patterns frequent hosp ED use.

Referral to community and social support services, if relevant

Definition:

Referrals to Community and Socials Support Services ensure BHH participants have access to a myriad of formal and informal resources which address social, environmental and community factors,

all of which impact overall health. In the case of child participants, this information will also be assessed to address the needs of parents and guardians. Local agency and resource knowledge is required to connect individuals to a wide array of support services to help individuals overcome access or service barriers, increase self-management skills and improve overall health. The BHH team must develop and nurture relationships with other community-based providers to aid in effective individual referrals and timely access to services.

The types of community and social support services to which BHH participants will be referred may include, but are not limited to: medical and behavioral health care, entitlements/benefits, housing, transportation, legal services, educational and employment services, financial services, wellness and health promotion services, specialized support groups, substance use treatment, self-help, social integration and skill building, and other services as identified by the individual.

Examples of specific referral activities include but are not limited to:
* Develop and nurture relationships with other community based providers to aid in effective referrals and timely access to services for the individual
* Make direct referrals related to needs identified in the assessment and services the individual identified wanting in the plan of care
* Follow-up with referral sources regarding referrals

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
CT plans to leverage existing technology and methodology to collect data from providers. Data will be aggregated and analyzed by DMHAS or its agent for the purpose of outcome reporting and provision to the health home network.

This method will allow the input and sharing of information between the state and BHH providers, as well as amongst the BHH team. At a minimum, the following information will be included:
- BHH eligibility and enrollment;
-Medicaid service utilization, including admissions to EDs or inpatient hospitalizations;
-Integrated needs assessments;
-BHH person-centered care plan resulting from the integrated assessment;
-BHH services received; and
-Consumer satisfaction.

The state will utilize this information along with Medicaid claims data to create and share reports on productivity, quality measures and outcomes which will aid in supporting performance improvement and improved consumer outcomes.

Scope of benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☑ **Behavioral Health Professionals or Specialists**

Description
Ensure BHH participants have access to a myriad of formal and informal resources which address social, environmental and community factors, all of which impact overall health. In the case of child participants, this information will also be assessed to address the needs of parents and guardians. Be aware of local agencies and resources to connect individuals to a wide array of support services to help individuals overcome access or service barriers, increase self-management skills and improve overall health. Develop and nurture relationships with other community-based providers to aid in effective individual referrals and timely access to medical and behavioral health care, entitlements/benefits, housing, transportation, legal services, educational and employment services, financial services, wellness and health promotion services, specialized support groups, substance use treatment, self-help, social integration and skill building, and other

services as identified by the individual. Follow-up with referral sources regarding referrals.

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description
Primary Care Nurse Manager / Nurse: Provide nursing skills and educational materials which aid the BHH participant in reducing barriers to achieving goals, increase health literacy and knowledge about chronic condition (s), increase self-management skills such as advocacy, and improve health outcomes. Ensure all nursing communication and information shared with individuals, their parent/guardian, family members, caretakers and, when applicable, conservators and their identified supports must be language, literacy, and culturally appropriate and executed in a location and time convenient to all. Provide health education, wellness promotion, and prevention and early intervention services; assists in identifying and developing social support networks; assists with obtaining and adhering to prescribed medication and treatments; and helps to identify new resources to aid in reduction of barriers to help support BHH participants attain their highest level of health and functioning within their families and community, including non-medical recovery supports such as transportation and housing.

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description

Provide social work skills and educational materials which aid the BHH participant in reducing barriers to achieving goals, increase health literacy and knowledge about managing his/her chronic condition(s), increase self-management skills such as advocacy, and improve health outcomes. Ensure all communication and information shared with individuals, their parent/guardian, family members, caretakers and, when applicable, conservators and their identified supports must be language, literacy, and culturally appropriate and executed in a location and time convenient to all. Provide health education, wellness promotion, and prevention and early intervention services; assists in identifying and developing social support networks; and helps to identify new resources to aid in reduction of barriers to help support BHH participants attain their highest level of health and functioning within their families and community, including non-medical recovery supports such as transportation and housing.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

See description below.

Description

Recovery, Peer Sppt Specialist: Ensure access resources re soc, envtl & cmty factors. Info re resources connect sppt svcs overcome access/svc barriers, incr. self-mgt, impr. health. Facilitate communication w/ clients & team re referrals & access to care, benefits, housing, transp, legal svcs, ed & emplmt svcs, fin svcs, wellness/health promotion, sppt grps, substance use treatment, self-help, soc integ., skill bldg & others. Follow-up w/ referrals.

Director: Oversee team re access resources addressing soc, envtl & cmty factors. Ensure team connects indiv to svcs re access/svc barriers, incr self-mgt & improve health. Ensure team works w/ providers re referrals & access to care, benefits, housing, transp, legal svcs, ed & emplmt svcs, fin svcs, wellness/health promotion, sppt grps, substance use treatment, self-help, soc integ., skill bldg & others. Facilitate referrals.

PCP Consultant: Assess & eval, ensure access to resources address soc, envtl & cmty factors. Connect svcs overcome access/svc barriers, incr self-mgt & improve health. Work w/ providers re referrals & access to med & BH svcs. Make referrals.

Admin Sys Specialist: Sppt access to resources address soc, envtl, cmty factors. Info re resources connect svcs overcome access/svc barriers, incr self-mgt & improve health. Communicate w/ providers re referrals & access to med & BH care, benefits, housing, transp, legal svcs, ed & empl svcs, fin svcs, wellness & health promotion, sppt grps, substance use treatment, self-help, soc integration, skill bldg & others. Follow-up w/ referrals.

Hosp Transition Coord: Ensure access to resources addressing soc, envtl & cmty factors. Connect svcs re access/svc barriers, incr self-mgt & improve health. Work w/ providers aid referrals, access to med & BH care, benefits, housing, transp, legal svcs, ed & empl svcs, fin svcs, wellness/health promotion, sppt grps, substance use treatment, self-help, soc integ., skill bldg & others. Follow-up on referrals.

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:
The full description, including updated flow charts are being submitted in August 2016 as part of the package of revisions in response to the CMS post-RAI follow-up questions.

Due to the character limitations in this portal, it is not possible to include the full descriptions here. A very brief description follows:

AUTO-ENROLLED CLIENTS: The Auto Enrollment process is applicable only for the clients enrolled in Phase 1.

DMHAS makes the determination of client(s) who are eligible to be enrolled in Medicaid BHH; all the eligible clients currently open to DMHAS and receiving case management or outpatient services at an

LMHA and/or designated BHH affiliates are Auto-Enrolled in Medicaid BHH.

UPDATED AUTO-ENROLLED CLIENTS: The list of clients eligible for Medicaid BHH is compiled by DMHAS quarterly. The list of eligible clients is sent to the ASO (Value Options). The ASO will then send the list of clients eligible for Medicaid BHH to the designated providers to begin the enrollment process.

NON-AUTO-ENROLLED CLIENTS:

The process begins when client(s) are contacted in the community by ASO (Example: client visits ED or Doctors office) and it is determined that the client(s) might benefit from BHH services. The client is referred to the ASO (Value Options) for screening. The ASO screens the client and determines if the client is eligible for Medicaid BHH.

If the client is not eligible, the ASO will not refer the client to designated provider for BHH services.

☑ **Medically Needy eligibility groups**

◉ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**

○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**

○ **All Medically Needy receive the same services.**

○ **There is more than one benefit structure for Medically Needy eligibility groups.**

Transmittal Number: CT-15-0014 Supersedes Transmittal Number: New Approved Effective Date: Oct 1, 2015 Approval Date: Sep 28, 2016

Transmittal Number: CT-15-0014 Supersedes Transmittal Number: New Approved Effective Date: Oct 1, 2015 Approval Date: Sep 28, 2016
Attachment 3.1-H Page Number: 10

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
Medicaid Claims. CT will track avoidable hospital readmissions by calculating the number of ambulatory care sensitive readmissions per 1,000.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
Medicaid Claims. CT will perform an annual assessment of cost savings using a pre/post-period comparison of BHH enrollees. Savings calculations shall be risk adjusted to exclude high-cost outliers as defined by the state and shall be net of any additional costs of providing BHH services. Savings can further be broken down by category of service, by BHH, age, gender, or any other variable determined by the state.

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless

patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).
CT BHH partners, DMHAS, DSS & DCF partner to administer contract w/ an ASO, which will develop web-based system to facilitate information exchange and other activities. Data elements include, but not limited to, enrollment; assessment, recovery planning & services; & authorizations for services. The web-based system assists in collection of data needed to produce reports on quality & outcome measures for CMS reporting.

DMHAS contracted with FEi Systems, Inc. to implement an open-source system called Web Infrastructure for Treatment Services (WITS) to track BH services. WITS is a web based open-source application designed to capture client treatment data & satisfy reporting requirements for planning, admin, and monitoring of substance abuse treatment programs. WITS facilitates cooperation and collaboration among providers by enabling sharing of treatment information via the web. WITS includes numerous clinical, admin & reporting modules organized by workflow process allowing DMHAS to customize the system. All six state-operated LMHAs will use WITS. All private-non-profit LMHAs use an electronic health record (EHR).

HIT will be used to improve access to care, health education materials & resources, improve care coordination & empower individuals and family/guardians to actively manage care.

The ASO allows input and sharing of information between state and BHH providers, and among BHH team. At least the following information is included:

-BHH eligibility and enrollment;
-Medicaid utilization, including admissions to EDs or inpatient hospitalizations (within time parameters to allow for optimal care transitions);
-Integrated needs assessments;
-BHH person-centered care plan resulting from integrated assessment;
-BHH services received; &
-Consumer satisfaction.

State will use this information with Medicaid claims data to create and share reports on productivity, quality measures and outcomes, supporting improved performance and consumer outcomes.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:

IU-HH: Inpatient Utilization

Measure Specification, including a description of the numerator and denominator.
The rate of all acute inpatient care and services per 1,000 enrollee months among BHH enrollees
Data Sources:
Administrative
Frequency of Data Collection:

- **Monthly**
- **Quarterly**
- ◉ **Annually**
- **Continuously**
- **Other**

Emergency Room Visits

Measure:

AMB-HH: Ambulatory Care- Emergency Department visits

Measure Specification, including a description of the numerator and denominator.
The rate of emergency department visits per 1,000 enrollee months among BHH enrollees
Data Sources:
Administrative
Frequency of Data Collection:

- **Monthly**
- **Quarterly**
- ◉ **Annually**
- **Continuously**
- **Other**

Skilled Nursing Facility Admissions

Measure:

NFU-HH: Nursing Facility Utilization

Measure Specification, including a description of the numerator and denominator.
The number of admissions to a nursing facility from the community that result in a short-term (less than 101 days) or long-term stay (greater than or equal to 101 days) during the measurement year per 1,000 enrollee months
Data Sources:
Administrative
Frequency of Data Collection:

- **Monthly**
- **Quarterly**
- ◉ **Annually**
- **Continuously**
- **Other**

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates

The State will utilize Medicaid claims data to assess hospital admission rates. Data can further be broken down by category of service, BHH, demographics, or any other variable determined by the state.

Chronic Disease Management
The state will collect outcome data consistent with the CMS Core Set of Health Care Quality Measures for Medicaid Health Home Programs in order to monitor ongoing performance. The following measures will be collected:
Measure ABA-HH: Adult BMI Assessment
Measure CDF-HH: Screening for Clinical Depression and Follow-up Plan
Measure PCR-HH: Plan All-Cause Readmission Rate
Measure FUH-HH: Follow-up after Hospitalization for Mental Illness
Measure CBP-HH: Controlling High Blood Pressure
Measure CTR-HH: Care Transition- Timely Transmission of Transition Record
Measure IET-HH: Initiation and Engagement of Alcohol and Other Drug Dependence Treatment
Measure PQ-192-HH: Prevention Quality Indicator (PQI) 92: Chronic Conditions Composite

Additional measure areas for collection are as follows:
Tobacco use/cessation intervention
HbA1C Testing for individuals with diabetes
LDL-C Screening for individuals with diabetes
Satisfaction with care, access, quality, and appropriateness
Decreasing homelessness
Increasing employment and educational opportunities

A web-based system will assist in the collection of data elements needed to produce reports on quality and outcomes measures, including chronic disease management, to allow for reporting to CMS.

Coordination of Care for Individuals with Chronic Conditions
The State will assess provision of care coordination services for individuals with chronic conditions in the following fashion: the State will track all encounters provided by BHH team members, as well as track face-to-face follow-up by a health team member within 2 days after hospital discharge. An annual audit conducted by DMHAS or its designee will include a review of service plans for health home enrollees as well as documentation consistent with state-approved processes.

Assessment of Program Implementation
The State will monitor implementation through regularly occurring meetings with and reports from BHH providers. Progress will be assessed against an implementation project plan and process indicators.

Processes and Lessons Learned
The State will meet with BHH providers, as mentioned above, and with the CT Behavioral Health Partnership Oversight Council to elicit feedback for ongoing quality improvement. Information will include operational barriers of implementing BHH services, review of evaluation data and reports, and review critical success factors.

Assessment of Quality Improvements and Clinical Outcomes
The State will utilize the quality process and outcome measures described in other SPA sections or documents to assess quality improvements and clinical outcomes. Assessment will occur both at the individual practice level, and at the aggregate level for all participating BHHs. The State will track change over time to assess whether statistically significant improvement has been achieved.

Estimates of Cost Savings

☑ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 80 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.