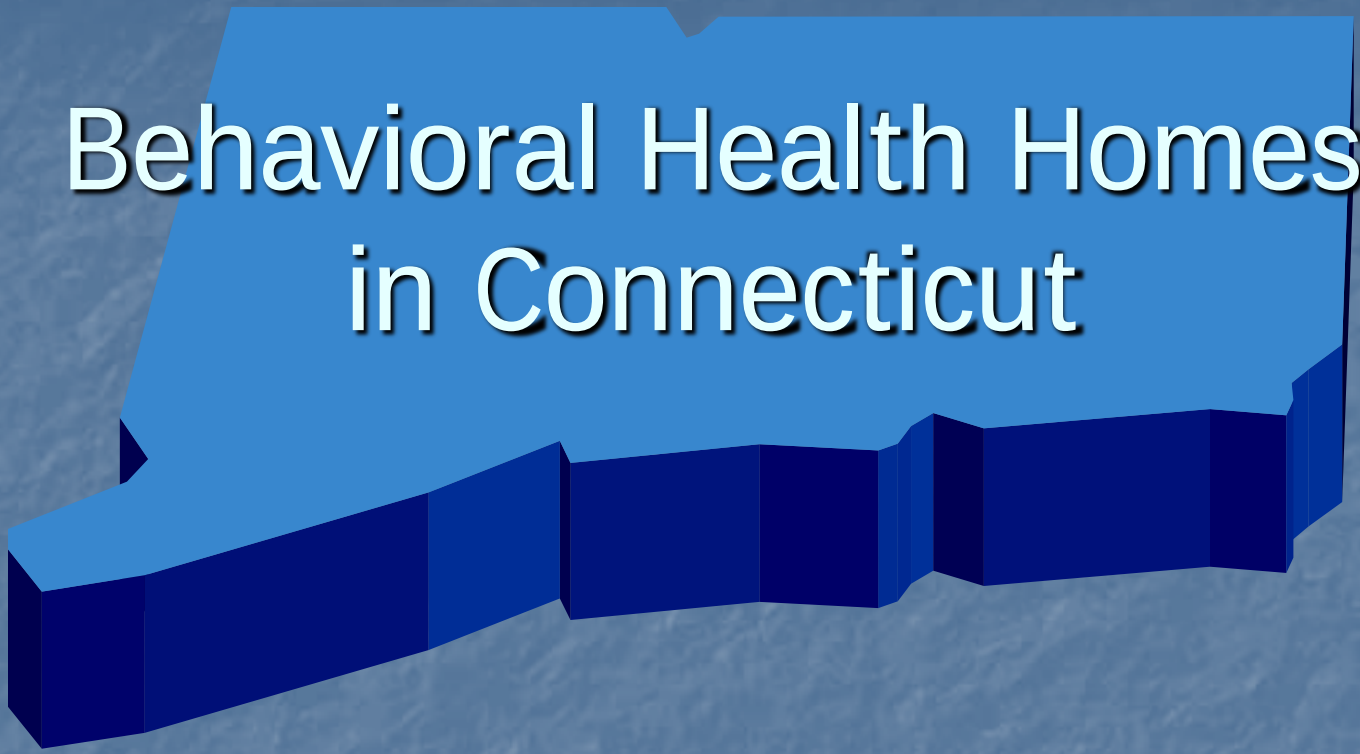
Behavioral Health Homes in Connecticut



System, Process and Purpose

Behavioral Health Partnership Oversight Committee

January 15, 2014

Origin

- In 2010, the Patient Protection and Affordable Care Act (ACA) established a “health home” option under Medicaid that serves enrollees with chronic conditions

The Goals of Health Homes align with the aim of the Affordable Care Act (ACA)

- Improved experience in care
- Improved health outcomes
- Reduction in health care costs

- It has been argued that for those individuals who have relationships with behavioral health organizations, care may be best delivered by bringing primary care, prevention, and wellness activities onsite into behavioral health settings.

SAMHSA-HRSA CENTER FOR INTEGRATED HEALTH SOLUTIONS, MAY 2012

Behavioral Health Home (BHH) Definition

- A Behavioral Health Home is an innovative, integrated healthcare service delivery model for people diagnosed with SPMI that is recovery-oriented, person and family centered and promises better patient experience and better outcomes than those achieved in traditional services

Connecticut's BHH Service Delivery Model

- Facilitates access to:
  - Inter-disciplinary behavioral health services,
  - Medical care, and
  - Community-based social services and supports for individuals with serious and persistent mental illness (SPMI).

Behavioral Health Homes in CT

- In August 2012, the Adult Quality, Access and Policy sub-committee of the Behavioral Health Partnership Oversight Council (CT BHPOC), in conjunction with the State Partners (DMHAS, DSS, DCF), formed a Behavioral Health Home (BHH) workgroup as a vehicle to develop a model and implementation plan

The CT BHH Workgroup

- Established parameters for defining **Eligibility** for BHH
- Established **Service Definitions**
- Identified **Provider Standards**
- Identified CT's BHH **Outcome Measures**
- Reviewed Medicaid and DMHAS enrollment **Data**

Eligibility

Connecticut BHH Eligibility

- Auto-Enrolled Mental Health Consumers include those with:
  - SPMI
    - Schizophrenia and Psychotic Disorders;
    - Mood Disorders;
    - Anxiety Disorders;
    - Obsessive Compulsive Disorder;
    - Post-Traumatic Stress Disorder; and
    - Borderline Personality Disorder.
  - Medicaid Eligibility
  - Medicaid claims $\geq$ $10k/year

Service Definitions

Behavioral Health Home Core Services

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care
- Patient and family support
- Referral to community support services

Comprehensive Care Management

- Assessment of service needs
- Treatment and recovery plan development in conjunction with the individual
- Assignment of health home team members and their roles
- Monitoring of progress

Care Coordination

- Implementation of the treatment and recovery plan in collaboration with the individual to include linkages
- Ensuring appropriate referrals, coordination and follow-up to needed services and supports
- Ensuring access to medical, behavioral health, pharmacological and recovery support services

Health Promotion

- Health education specific to an individual's chronic condition(s)
- Assistance with self-management plans
- Education regarding the importance of preventative medicine and screenings
- Support for improving natural supports/social networks
- Interventions which promote wellness and a healthy lifestyle

Comprehensive Transitional Care

- Specialized care coordination focusing on the movement of individuals between or within different levels of care
- Care coordination services designed to
  - Streamline plans of care
  - Reduce hospital admissions
  - Interrupt patterns of frequent hospital Emergency Department use

Patient and Family Support

- Services aimed at helping individuals to
  - Reduce barriers to achieving goals
  - Increase health literacy and knowledge about chronic conditions
  - Increase self-management skills
- Identifying resources to support individuals in attaining their highest level of wellness and functioning within their families and communities

Referral to Community Support Services

- Ensuring access to a myriad of formal and informal resources which address social, environmental and community factors
- Assist individuals to overcome access or service barriers, increase self-management skills and improve overall health

Provider Standards

BHH Provider Standards

- Meet state credentialing requirements
- Have capacity to serve individuals on Medicaid who are eligible for BHH services in the designated service area
- Meet staffing requirements to ensure BHH team composition and roles
- Be an eligible member of the CT Medicaid Program

BHH Provider Standards

Within three months of implementation:

- Develop a contract or MOU with regional hospitals or 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 services
- Develop and maintain referral agreements with regional primary care practices

Connecticut's BHH Service Delivery Model

- Builds on DMHAS' existing behavioral health infrastructure using designated providers to implement BHH services statewide in a targeted manner

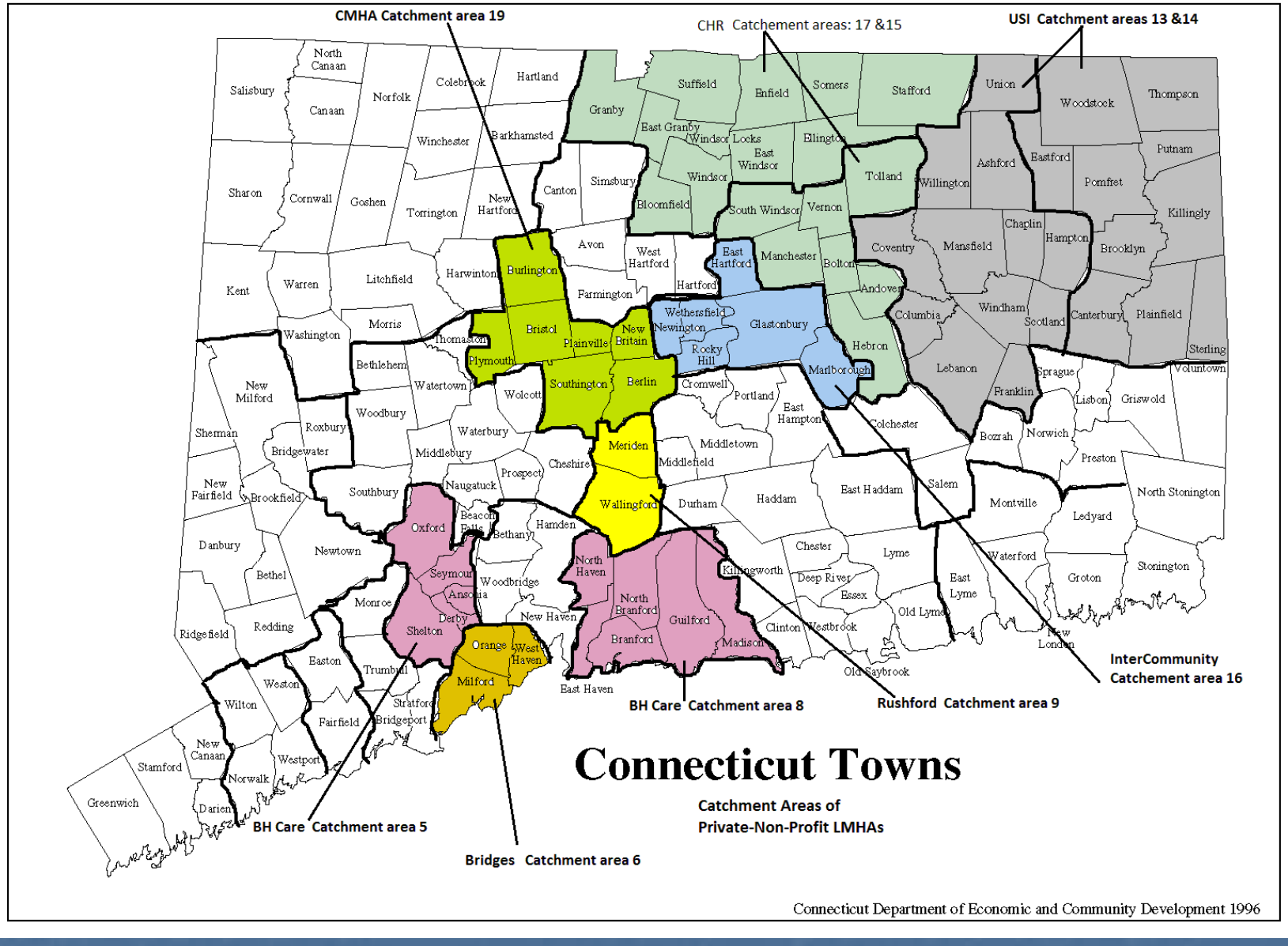
Designated Providers

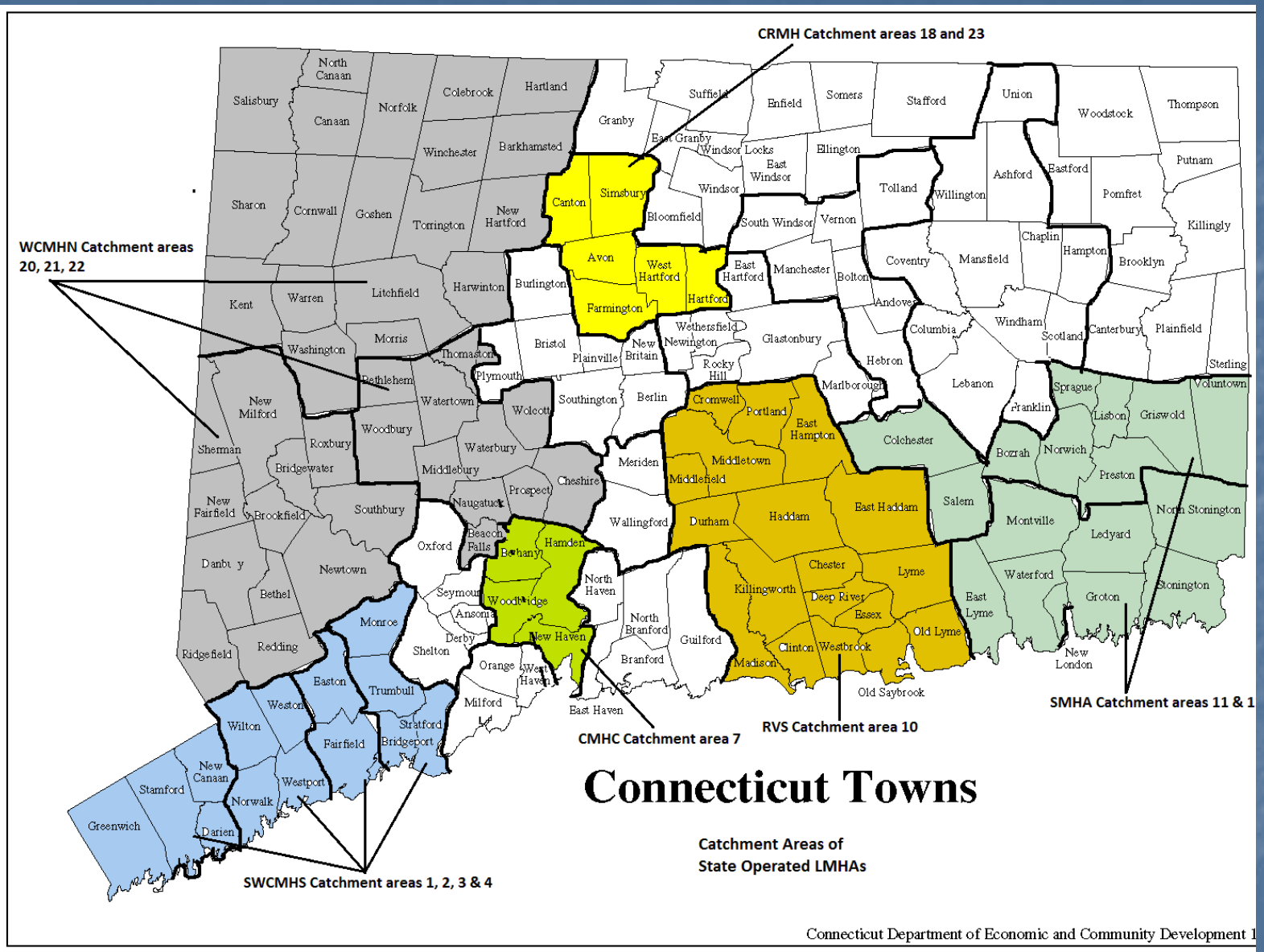
- Local Mental Health Authorities (LMHAs) and contracted LMHA affiliate providers (Affiliates) will serve as designated providers of behavioral health home services

- 7 Designated BHH providers are lifespan providers

Connecticut's LMHA and Affiliate Statewide Service System

- Each LMHA is responsible for one or more catchment areas providing statewide coverage
- Together, LMHAs and Affiliates play a critical role in the overall system of care
  - providing system diversity
  - enhancing local geographic access to underserved populations
  - contributing to a comprehensive network of care


CMHA Catchment area 19
CHR Catchement areas: 17 &15
USI Catchment areas 13 &14
InterCommunity Catchement area 16
BH Care Catchment area 8
Rushford Catchment area 9
BH Care Catchment area 5
Bridges Catchment area 6
Connecticut Towns
Catchment Areas of
Private-Non-Profit LMHAs
Connecticut Department of Economic and Community Development 1996


CRMH Catchment areas 18 and 23
WCMHN Catchment areas 20, 21, 22
SMHA Catchment areas 11 & 1
CMHC Catchment area 7
RVS Catchment area 10
SWCMHS Catchment areas 1, 2, 3 & 4
Connecticut Towns
Catchment Areas of
State Operated LMHAs
Connecticut Department of Economic and Community Development 1

Data

Data Sources

Calendar Year 2012

Medicaid Claims

DMHAS Ddap and Avatar

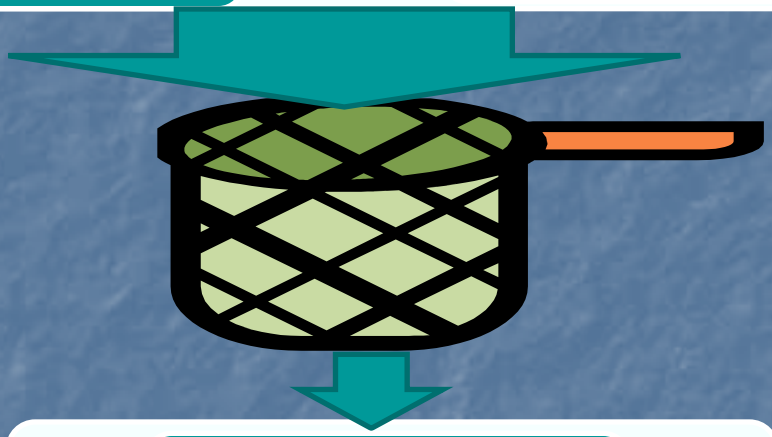
Identifying Consumers Eligible for Auto Enrollment

Medicaid CY 2012

Enrollees with 1 of 6 identified Diagnoses

+

Enrollees with Medicaid Expenditures >$10K



POOL OF ELIGIBLE MEDICAID ENROLLEES

Identifying Consumers Eligible for Auto Enrollment

POOL OF **ELIGIBLE** MEDICAID ENROLLEES

Consumers in DMHAS Ddap & Avatar Data with OP and/or CM services

Projected **Eligible** and **Auto-Enrolled**

Projected **Eligible** but **NOT** Auto-Enrolled

Auto-Enrollment

- Based on these parameters, CT plans to enroll +/- 10,500 individuals (adults and children) in BHH services
  - These 10,500 individuals meet the diagnostic criteria, have Medicaid expenses >$10K and are receiving services from LMHAs or their Affiliates

Participation is Voluntary

- All individuals meeting eligibility criteria for BHH services will be auto-enrolled with the designated BHH provider of record
- Individuals may choose another designated BHH service provider or opt out of BHH services entirely
- Dually eligible individuals who receive services at a BHH designated provider, may opt into the Duals Demonstration Health Neighborhood if available

Outcome Goals and Quality Measures

GOAL 1:

Improve Quality By Reducing Unnecessary Hospital Admissions And Readmissions

- Decrease the readmission rate within 30 days of an acute hospital stay
- Decrease the rate of ambulatory care-sensitive admissions
- Reduce ambulatory care-sensitive emergency room visits

GOAL 2:

REDUCE SUBSTANCE USE

- Increase the number of tobacco users who received cessation intervention
- Increase the percentage of adolescents and adults with a new episode of alcohol or other drug dependence (AOD) who initiated AOD treatment or engaged in AOD treatment

GOAL 3:

IMPROVE TRANSITIONS OF CARE

- Increase the percentage of those discharged from an inpatient facility for whom a transition record was transmitted for follow-up care within 24 hours of discharge
- Increase the percentage of individuals who have a follow up visit within 7 days of discharge from an acute hospitalization for mental health

GOAL 4:

IMPROVE THE PERCENT OF INDIVIDUALS WITH MENTAL ILLNESS WHO RECEIVE PREVENTIVE CARE

- Improve BMI education and health promotion for enrolled individuals
- Early intervention for individuals diagnosed with depression

GOAL 5:

IMPROVE CHRONIC CARE DELIVERY FOR INDIVIDUALS WITH SPMI

- Increase the percentage of individuals with a diagnosis of hypertension (HTN) whose blood pressure (BP) is adequately controlled
- Increase the percentage of individuals with asthma and who were dispensed a prescription for medication
- Increase the percentage of adults with diabetes, whose Hemoglobin HbA1c is within a normal range
- Increase the percentage of adults with coronary artery disease (CAD) whose LDL is within a normal range

GOAL 6:

INCREASE PERSON-CENTEREDNESS AND SATISFACTION WITH CARE DELIVERY

- Increase general satisfaction with care including:
  - access to care;
  - quality and appropriateness of care;
  - participation in treatment; and
  - cultural competence.

GOAL 7:

INCREASE CONNECTION TO RECOVERY SUPPORT SERVICES

- Decrease the number of individuals who experienced homelessness and increase housing stability
- Increase the number of individuals who become involved in employment and/or educational activities

Health Information Technology and the Administrative Services Organization

Use of Health Information Technology to Link Services:

- Use of the MMIS and Administrative Service Organization data to
  - provide Integrated Behavioral Health Home services
  - improve care coordination across the care continuum (e.g. universal care plan, data sharing among providers)

Administrative Services Organization

- Build an interoperable information technology system to collect and disperse data to the health home network
- Oversee provider credentialing, training and technical assistance
- Lead Learning Collaborative

Administrative Services Organization

- Enroll and track service recipients
- Complete data analyses and reporting
- Prepare and submit BHH services for Medicaid claims adjudication through the approved Connecticut Medicaid Management Information System (MMIS)
- Target Start Date: May 2014

CT BHH Fiscal Model

Fiscal Model

- BHH services will be billed using a statewide Per Member Per Month (PMPM) rate
- BHH services are eligible for reimbursement for a recipient when one or more BHH services are rendered during the month
- BHH services claimed under Medicaid must be substantiated by documentation in the individual's service record

Fiscal Model

- CMS approved Random Moment Time Studies (RMTS) will be conducted
- The existing RMTS used for TCM services will be used for BHH services so there will be no new procedures or actions required of providers
- The BHH Learning Collaborative will provide a refresher on RMTS requirements

Fiscal Model

- To maintain service system stability, new dollars will be added to existing human services contracts
- DMHAS will pay providers with prospective quarterly grant payments to assist in the implementation of BHH
- Grant amounts will depend on the number of enrolled, BHH eligible beneficiaries

Fiscal Model

- DMHAS was appropriated $10 million new dollars annually for BHH services
- $1 million of the new funding is for the ASO
- $9 million is for services (PNP=$6, state = $3)
- New funding dollars will be negotiated based on expected enrollment at each BHH

Fiscal Model

- Providers will not need to do additional cost reports
- DMHAS will submit one Commissioner certified cost report for all public and contracted costs associated with BHH

Minimum Behavioral Health Home Staffing

- Director
- Primary Care Nurse Care Manager
- Primary Care Physician Consultant
- Administrative Systems Specialist
- Hospital Transition Coordinator
- Licensed Behavioral Health Clinician
- Psychiatrist
- Care Coordinator (Behavioral Health Home Specialist)
- Peer Recovery Specialist.

LEARNING COLLABORATIVE

- Providers will be supported in transforming service delivery by participating in a statewide learning collaborative

- Providers' learning needs will be identified based on their unique:
  - experience with organizational change
  - transformation approaches
  - knowledge on health home services

- The Learning Collaborative will aid providers in implementing BHH services
- The Learning Collaborative will be supplemented with provider specific technical assistance (on-site and via telephone.)
- http://www.ct.gov/dmhas/cwp/view.asp?a=2900&q=528136

Accomplishments to Date

- Working Agreements among State Partners (DMHAS, DSS, DCF) regarding target population and model
- Model Design with BHH Workgroup
- Piloted Secure Data Exchange with PNP LMHA's
- Working Draft SPA is in place
- CMS contact to review fiscal model (11/21, 1/8)
- TA from SAMHSA (12/12, 1/3)
- Released ASO RFP

Next Steps

- Continued Collaboration among State Partners
- Provider Learning Collaborative
- Formal Conversations with CMS
- SPA Submission Process
- Initiate BHH Contracting
- ASO start date of May 2014
- Begin BHH Implementation by June 2014

Questions?