Table of Contents

State/Territory Name: **NEW JERSEY**

State Plan Amendment (SPA) #: **14-0005**

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
New York Regional Office
26 Federal Plaza, Room 37-100
New York, NY 10278

CENTERS FOR MEDICARE & MEDICAID SERVICES

DIVISION OF MEDICAID AND CHILDREN'S HEALTH OPERATIONS

DMCHO: JM

March 12, 2015

Valerie Harr, Director
Department of Human Services
Division of Medical Assistance and Health Services
P.O. Box 712
Trenton, NJ 08625-0712

RE: NJ SPA #14-0005

Dear Director Harr:

The Centers for Medicare & Medicaid Services (CMS), New York Regional Office, has completed its review of New Jersey State Plan Amendment (SPA) Transmittal Number 14-0005. This SPA implements Health Homes as authorized under Section 2703 of the Patient Protection and Affordable Care Act. To qualify for enrollment in this health home program, an individual must have one or more serious and persistent mental illness (SMI) condition. The SPA was submitted to provide Behavioral Health Home Services to adults in Bergen County with a SMI who are high utilizers of services or at risk of high utilization.

This SPA is approved March 12, 2015, with an effective date of July 1, 2014. Enclosed is a copy of the approved pages for incorporation into the New Jersey State plan.

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, July 1, 2014 through June 30, 2016, 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 July 1, 2016. The Form CMS-64 has a designated category of service Line 43 for States to report health home services expenditures for enrollees with chronic conditions.

Please share with your staff my appreciation for their time and effort throughout this process. If you have any questions regarding this State Plan Amendment, please contact John Montalto at John.Montalto@cms.hhs.gov or (212) 616-2326.

Sincerely,

/s/

Michael J. Melendez
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc: RHolligan
SJew
MLopez
RWeaver
CSpiecher
JHounsell
JHubbs

Health Home State Plan Amendment

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

Transmittal Number: NJ-14-0005 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date: Attachment 3.1-H Page Number:

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.

NJ-14-0005

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 Social Security Act.**

Name of Health Homes Program:

NJ BHH (Adults) Bergen

State Information

State/Territory name: **New Jersey**

Medicaid agency: Division of Medical Assistance and Health Services

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

Name: Julie Hubbs

Title: Regulatory Officer

Telephone number: (609) 588-3001

Email: Julie.Hubbs@dhs.state.nj.us

The primary contact for this submission package.

Name: Vicki Fresolone

Title:	Research Scientist, Division of Mental Health and Addiction Services
Telephone number:	(609) 777-0750
Email:	Vicki.Fresolone@dhs.state.nj.us

The secondary contact for this submission package.

Name:	Valerie Harr
Title:	Director, DMAHS
Telephone number:	(609) 588-2601
Email:	Valerie.Harr@dhs.state.nj.us

The tertiary contact for this submission package.

Name:	
Title:	
Telephone number:	
Email:	

Proposed Effective Date

07/01/2014 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
New Jersey (NJ) plans to provide Behavioral Health Home(BHH) services to adults with a Serious Mental Illness (SMI) who are high utilizers of services or at risk of high utilization, and children who meet qualifying criteria (Specific conditions are detailed in the Children's SPA).Both adults and children must be residents of Bergen County. Eligible BHH agencies must have a site and provide services in Bergen County. This State Plan Amendment represents only the adult health home. The State will concurrently submit a separate SPA detailing the BHH service for children. Behavioral health agencies, licensed through the New Jersey Department of Human Services (DHS), and qualified as BHHs through The State , will be eligible providers of adult BHHs. NJ will work with interested providers to support capacity building efforts and develop the initial BHH provider network. BHH providers will be certified by NJ DHS. However, the provider agencies will be expected to become accredited as a Health Home, by a nationally recognized accrediting body, within two years of receiving state certification. NJs adult BHHs will be administered jointly by the NJ Division of Mental Health and Addiction Services (DMHAS) and Division of Medical Assistance and Health Services (DMAHS). DMAHS and DMHAS will continue to pay for behavioral health treatment through their respective payment mechanisms which include Fee-For-Service (FFS) for DMAHS claims and contracts from DMHAS to support those services not in the Medicaid State Plan. DMAHS will add the ability to reimburse for the core health home services through FFS. The consumers physical health claims will continue to be paid and managed by one of The State's Medicaid Managed Care Organizations.

NJ proposes to provide BHH services to individuals with SMI with the goal of improving health outcomes, decreasing use of acute medical and psychiatric services, thereby decreasing costs and improving consumer satisfaction with care.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 591408.00
Second Year	2015	$ 3644419.00

Federal Statute/Regulation Citation

Social Security Act Section 1945; 42 USC 1396w-4

Governor's Office Review

- ○ **No comment.**
- ○ **Comments received.**
  Describe:
- ○ **No response within 45 days.**
- ◉ **Other.**
  Describe:
  Governor Review is not required pursuant to Section 7.4 of our State Plan.

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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**

Newspaper	
Name: Atlantic City Press Date of Publication: 12/23/2013 (mm/dd/yyyy) Locations Covered: Atlantic County NJ and surrounding area	
Name: Bergen Record Date of Publication: 12/23/2013 (mm/dd/yyyy) Locations Covered: Bergen County NJ and surrounding area	
Name: Courier Post Date of Publication: 12/23/2013 (mm/dd/yyyy) Locations Covered: Camden County NJ and surrounding area	
Name: Newark Star Ledger Date of Publication: 12/23/2013 (mm/dd/yyyy) Locations Covered: Newark NJ and surrounding area	
Name: Trenton Times Date of Publication: 12/23/2013 (mm/dd/yyyy) Locations Covered: Trenton NJ and surrounding area	

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

Date of Publication:

(mm/dd/yyyy)

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

Date of Email or other electronic notification:

12/16/2013 (mm/dd/yyyy)

Description:

Email sent to all County Welfare Agencies (CWAs) for posting as well as other stakeholders.

☑ **Website Notice**

Select the type of website:

☑ Website of the State Medicaid Agency or Responsible Agency

Date of Posting:

12/23/2013 (mm/dd/yyyy)

Website URL:

http://www.state.nj.us/humanservices/providers/grants/public/index.html

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**

Transmittal Number: NJ-14-0005 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date:

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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**

☐ **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: NJ-14-0005 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date:

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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: 05/30/2013 (mm/dd/yyyy)	

Transmittal Number: NJ-14-0005 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date:

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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:

- [x] **Mental Health Condition**
- [x] **Substance Abuse Disorder**
- [x] **Asthma**
- [ ] **Diabetes**
- [ ] **Heart Disease**
- [x] **BMI over 25**

Other Chronic Conditions	

- [ ] **One chronic condition and the risk of developing another**

Specify the conditions included:

- [x] **Mental Health Condition**
- [ ] **Substance Abuse Disorder**
- [x] **Asthma**
- [x] **Diabetes**
- [ ] **Heart Disease**
- [x] **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:
New Jersey plans to provide BHH services to adults with a SMI who are high utilizers of services or who are at risk of high utilization of services and are residents of Bergen County. Adult is defined as age 18 or over if not being served in the children's system of care. If a child is being served in the children's system of care at the age of 18, they can stay in that system to age 21 as the adult and children's systems work to make a seamless transition. If an individual enters the behavioral health system for the first time at 18 or older, they are served in the adult system. For this service, SMI is defined as a mental illness that causes serious impairments in emotional and behavioral functioning that interfere with an individuals capacity to remain in the community unless supported by treatment and services. The determination of risk is made using the Chronic Illness and Disability Payment System (CDPS).

Consumers have a choice of BHH or 1915c, PACT or TCM. Those individuals receiving 1915 (c) services, PACT,or Targeted Case Management services will not be eligible for the BHH service.
Consumers are not discharged from the service unless the consumer moves outside the geographic area of the Behavioral Health Home's responsibility or the consumer declines or refuses services despite the provider's best efforts to develop an acceptable care plan with the consumer. Services can be placed "on hold" if a consumer is hospitalized or incarcerated for an extended period of time (longer than one billing cycle), however, it is expected that services commence upon the consumer's return to community living.

Geographic Limitations

☐ **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.

If no, specify the geographic limitations:

◉ **By county**

Specify which counties:
New Jersey BHHs will be available in Bergen County. Bergen County is the most populous county of the State of New Jersey. As of the 2010 census, its population was 905,116. In calendar year 2011, 3,739 of the county residents who received one or more Medicaid funded services were designated with SMI. Approximately 1,503 individuals are not receiving 1915 (c), PACT or Targeted Case Management, have a psychiatric diagnosis, and are classified as high or medium risk using the CDPS. NJ estimates that 1503 individuals will be eligible for BHH services in Bergen County.

○ **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:
DMAHS and DMHAS will partner with providers to identify and refer eligible consumers to the BHH service. Using claims data, DMAHS will identify consumers for the BHH service. DMAHS will notify the consumers via hard copy mail of their eligibility, how to engage in the service, and choice of provider. DMHAS staff will use the list to assist providers to outreach to eligible consumers not currently engaged in services.

At the time an agency becomes certified as a BHH provider they may have individuals in their care who are eligible for BHH services. Upon verifying eligibility, they can offer the BHH service to those consumers who may choose to participate. The DHS licensed Mental Health treatment provider will continue to deliver behavioral health services to individuals who are BHH eligible but chose not be in the BHH service and those that are not BHH eligible.
Community and acute care providers can also refer to the BHH and individuals may self-refer. The BHH provider will screen consumers for BHH eligibility upon referral. Those who are eligible and elect to receive the BHH service can be enrolled. Providers will obtain signed, informed consent from consumers for the BHH service at intake/assessment. BHH providers will be required to form relationships with local hospitals and develop affiliation agreements that will facilitate communication with, and referral to, the BHH. Consumers are not discharged from the service unless the consumer moves outside the geographic area of the Behavioral Health Home's responsibility or the consumer declines or refuses services despite the provider's best efforts to develop an acceptable care plan with the consumer. Services can be placed "on hold" if a consumer is hospitalized or incarcerated for an extended period of time (longer than one billing cycle), however, it is expected that services commence upon the consumer's return to community living.

Automatic Assignment with Opt-Out of Health Homes provider

Describe the process used:

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:

All BHH provider agencies must be licensed as a mental health provider by the NJ DHS. NJ Mental Health licensure standards are organized by service. There is one overarching rule (N.J.A.C. 10:37) which creates the minimum standards for all mental health providers. There are additional specific rules for each program or service element in the mental health service array.
N.J.A.C. 10:37 sets standards in the areas of: consumer rights, consumer responsibilities, and consumer complaint procedures. The licensure standards that apply to individual service elements include program specific requirements for: guiding principles, admission and discharge criteria, intake and assessment procedures, services to be provided, staffing, management and quality assurance, as well as policies in all of these areas.

New Jersey will allow providers licensed for any one or more mental health service element to apply to become a BHH provider. NJDHS licensure as a mental health service agency provides the State the assurance that a potential BHH provider has an adequate commitment to wellness and recovery and that the agency is qualified to address the special needs of the target population, individuals with SMI.

During Year 1 all licensed mental health providers wishing to become certified as a BHH must meet state certification requirements, complete the BHH Learning Community curriculum (or other state approved Learning activity), and complete an approved implementation plan. By the end of Year 2 and ongoing the agency must become accredited as a BHH by a nationally recognized and state approved accrediting body.

NJ DMHAS will issue an Administrative Order , in coordination with NJ DMAHS which requires ongoing accreditation for BHHs.

☐ **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)**

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:

As described in the State's 1115 Comprehensive Medicaid Waiver, the New Jersey DHS has committed to providing quality driven and cost effective treatment throughout the service delivery system. DHS will support the BHH in these endeavors through a commitment to providing data, technical assistance, training and support. NJ will commit one full time equivalent of staff time who will monitor and assist the BHH in enrolling eligible consumers, monitoring and assisting with data collection, coordinating with other systems and providing any other real time assistance to the BHH provider to meet quality, cost, reporting and efficiency goals. DMAHS will work with the New Jersey Managed Care Organizations to ensure that they coordinate with the BHH in the area of data and facilitate consumer referrals. New Jersey has implemented the BHH Learning Community (LC)

to support capacity-building among potential BHH providers. The LC assists providers in developing a full implementation plan and readiness to change strategy. Through the LC, providers will develop the capacity to implement BHH services such as the development of a person-centered care plan, and will have an opportunity to share problems and develop solutions for connecting with the other systems with which they will be coordinating. Members of the LC will be eligible to apply to New Jersey for funds to implement their plan including startup costs for information technology and staffing. These startup funds are 100% state resources.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.

The BHH Core Team will include: a Nurse Care Manager, a Care Coordinator, a Health and Wellness Educator, consultative services of a Psychiatrist and Primary Care Physician, and Support Staff. Payment for physician time for BHH services is limited to the time spent in face -to -face team meetings and consultation. Optional team members include a nutritionist/dietician, peer, pharmacist and hospital liaison. Support for required and optional members were built into the BHH rate. The State will require the Nurse Care Manager, at a minimum, to be credentialed as a Registered Nurse. Care Coordinators will be credentialed as Licensed Social Workers or Licensed Practical Nurses.

Ultimately Primary care must be fully or partially co-located within the BHH. This can be accomplished by siting a primary care clinic in the BHH or by bringing primary care services into the BHH for up to eight hours of direct service each week. Full or partial co-location must be accomplished no later than three years after initial certification. Until then a formalized partnership must be developed with one or more primary care providers. This includes that the primary care partner be a consultative member of the team and provide the necessary hours of consultation to deliver coordinated care. It is the responsibility of the BHH to communicate with the Primary Care Provider regarding specific consumers concerns. If a consumers choice of Primary Care Provider is not a BHH Team member, the BHH will utilize the Nurse Care Manager as the liaison to that physician.

Each BHH will be required to develop policies and procedures that specify how the BHH team will coordinate with the routine behavioral health services. This would include how the individuals behavioral health provider, including the psychiatrist, will participate in the BHH team, how the BHH team and the behavioral health provider will share information, and how they will collaborate on the care plans.

Provider Standards

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

Providers can provide behavioral health home services on a provisional basis if approved by DMHAS. Provisional certification requires a provider to 1) be licensed by NJ DHS to provide mental health services, 2) complete a DMHAS approved Learning Community curriculum, 3) meet DMHAS certification requirements. A provisionally certified behavioral health home must obtain national accreditation within two years of provisional certification being granted. Provisional certification is reviewed annually.

To become a certified behavioral health home in the State of NJ a provider must: 1) be licensed by NJ DHS to provide mental health services in the State of NJ, 2) complete a DMHAS approved Learning Community curriculum, 3) meet DMHAS certification requirements, 4) be accredited by a national recognized accrediting organization.

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Health Homes Service Delivery Systems

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

- [x] **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:
New Jersey has in place Statewide Managed Care Organizations (MCOs) that manage the physical health services of NJ FamilyCare enrolled individuals. The current MCO contracts support coordination and non-duplication with BHH services. The contracts require that MCOs refer or coordinate referrals of enrollees with mental illness to mental health/substance abuse providers. Currently, any member of an MCO identified as having a potential care management need receives a detailed comprehensive needs assessment and ongoing care coordination from the MCO. The MCO contract will be amended 1/1/15 to reflect that, for MCO enrollees active with a BHH provider, the MCO will utilize the care management provided at the BHH and will not duplicate services. The MCO will coordinate care with the Health Home to ensure all the member's needs are met and refer to BHH when clinically appropriate.

The BHH team members are expected to outreach to the MCO for each enrollee. The BHH Care Manager would be the point of contact for the MCO.

○ **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:

☐ **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: NJ-14-0005 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date:

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Attachment 3.1-H Page Number:

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.

The State will reimburse BHH providers on a capitated Per Member Per Month (PMPM) Case Rate basis for each consumer served. There will be three different rates corresponding to the three pre-defined phases of the program in which consumers will be placed: Engagement, Active and Maintenance. Each phase is defined by clinical indicators, frequency of interventions, and a defined duration. There are mechanisms to override the defined duration and authorize continued care at a given phase based on clinical indicators/need. All applicable procedure code listings and/or rates are published on the Department's fiscal agent's website and can be located using the following links:https://www.njmmis.com/downloadDocuments/CPTHCPCSCODES.pdf

1) The Engagement rate will support efforts by the BHH team to outreach and engage the individual, perform initial assessments of care needs and enroll in the BHH. The rate will be effective for the first three months after a consumer is identified as eligible for the BHH service. This payment will support efforts by the BHH team to engage individuals, perform initial assessment of care needs, enroll in the BHH and begin development of a care plan. A consumer who has completed an engagement stage but has not engaged in the BHH service at either the Active or Maintenance phase can begin a new engagement phase when he or she uses any crisis or hospital service such as Designated Screening, Emergency Room, or psychiatric hospitalization.
2) The Active rate will be effective for the next 24 months post-enrollment in the program, in which it is expected that the BHH team will undertake its key functions of Comprehensive Care Management, Care Coordination, Health Promotion, Comprehensive Transitional Care, Individual and Family Support and Referral to Community and Support Services. The Active Phase of treatment can be extended or reduced based upon clinical need.
3) The Maintenance rate will be effective based on clinical need and, most commonly, following the Active phase. In the Maintenance phase of the program, it is anticipated that consumers will have improved ability to manage their needs such that there will be fewer required interventions by the BHH team. The maintenance phase is appropriate based on consumer functioning. Should a consumer's need for intervention increase, the consumer can move to another, appropriate service phase.

Based our own research into other states' programs, the Engagement rate will be the highest, followed by the Active and Maintenance rates respectively. This ranking reflects the anticipated consumer acuity and the resulting intensity of interventions delivered in the different phases. For example, because there is an expected drop-off in the number of monthly interventions in the Maintenance phase (consistent with the assumption of improved health), the rate for that phase is the lowest of the three.

DMHAS conducted research within and outside the State to inform the requirements for health home team composition, and then developed the rate based on this composition, associated salary/benefit levels, and a caseload of 300 consumers per team. A General and Administrative Expense allowance of 15% of the calculated FTE cost was then added to arrive at a total cost per consumer. Since the majority of the costs with respect to each consumer are expected during the Active phase (given its duration and intensity), that calculated cost per consumer was assumed to be the relevant average cost. A face to face service unit is fifteen minutes. At the outset of the program, the State also expects to provide up-front, development funding to each provider to reimburse them for Information Technology and medical infrastructure needs, as well as other costs required for start-up. The resources for the upfront costs will be 100% state funded.

The State believes that a payment system based on tiered rates will provide adequate compensation for providers costs, and in this way, is consistent with the overall goals of efficiency, economy, and quality of care. Our initial limits of 3 and 24 months for the higher Engagement and Active rates with pre-authorization and/or clinical and utilization criteria required for extension, will also ensure that the duration of service in these more intense and expensive phases of the program are clinically driven and reflect consumer need. This will also encourage providers to continuously attempt to engage new consumers that could benefit from the program.

Providers will bill the NJ FamilyCare program for the PMPM for each consumer and new NJ FamilyCare billing codes will be created for this purpose. Providers must bill at least quarterly for BHH enrolled consumers. In support of these billings, providers will be required to document services in consumer records and make those records available for state audit. Through a combination of this audit process, as well as defined rules in the NJ FamilyCare Management Information System (MMIS), the State will ensure that no consumers are billed for Engagement/Outreach for more than the approved service duration. This system will also ensure that no consumers are receiving PACT, Targeted Case Management or other duplicative home and community-based services waiver services while receiving BHH services.

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.

New Jersey had four 1915(c) waivers that have been subsumed under NJ 1115(a) Comprehensive Waiver with the implementation of Managed Long Term Services and Supports (MLTSS). Those waivers were: Traumatic Brain Injury, Global Options, Community Resource for People with Disabilities, and the AIDS Community Care Alternatives Program. These programs have been consolidated into the Managed Long Term Services and Supports program and are being managed through the states MCOs. The state will pay for MLTSS services through capitated payment to the MCOs. The BHH service is excluded from the MLTSS covered services. However, the MCOs are required to coordinate referrals to the BHH for MLTSS members who meet the eligibility criteria for the BHH and the BHH service is part of the member's plan of care (POC). The only program under 1915(c) waiver currently in place in NJ is the Community Care Waiver (CCW) that serves individuals with developmental disabilities. Individuals

receiving services through the CCW waiver will not be eligible for the BHH services. NJ has instituted an edit in the MMIS system which rejects more than one bill, per individual per month, for duplicative services. This will disallow billing for services duplicative of the BHH, these include TCM, 1915(c), CCW and PACT services. The providers have been educated on these billing rules.

☑ **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.**

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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:
Care management is the primary coordinating function in a Behavioral Health Home. The goal of care management is the assessment of consumer needs, development of the care plan, coordination of the services identified in the care plan and the ongoing assessment and revisions to the plan based on evaluation of the consumer's needs. The Care Manager is the Team Leader.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange (HIE). Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

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

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☑ **Nurses**

Description

Comprehensive care management services are conducted by licensed RNs,PAs, or APNs and involve:

1.Assessment and documentation of eligibility for BHH Services.

2.Nursing assessment.

3.Monitoring health risks by providing screening, preventative care, and early intervention services, analyzing lab/screening reports, and initiating treatment where needed.

4.Monitoring medications and medical treatments for potentially adverse synergistic effects, developing strategies to reduce or eliminate poly-pharmacy, and intervening where needed to protect the health and well-being of the consumer.

5.Development and periodic revision of service plans based on information collected through the consumer assessments, review of consumer records, and input from consumer and family.

6.Ensuring implementation of the plan; to provide or coordinate access to high quality health care services that are informed by evidence-based practices, coordinate and provide access to preventative and health promotion services, coordinate and provide behavioral health services, coordinate and/or provide specialty medical care and dental care, and social services. Plan will include consumer goals and preferences, targeted outcomes, identified service provider, coordinator of services and timeframes for services.

7.Interfacing with specialty medical services.

8.Coordination and supervision of the BHH team.

9.Leading the BHH team in the management of consumer care and the implementation of the service plan.

10.Convening and leading team meetings with BHH team to review and revise consumer service plan periodically and as needed in response to consumer request or other qualifying event, using consumer information and clinical data to monitor adherence to treatment guidelines and best practices for key health indicators.

11.Developing and implementing an internal Quality Assurance program that aligns with CMS required quality measures and is capable of including additional measures.

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☑ **Physicians' Assistants**

Description

Comprehensive care management services are conducted by licensed RNs,PAs, or APNs and involve:

1.Assessment and documentation of eligibility for BHH Services.

2.Nursing assessment.

3.Monitoring health risks by providing screening, preventative care, and early intervention services, analyzing lab/screening reports, and initiating treatment where needed.

4.Monitoring medications and medical treatments for potentially adverse synergistic effects, developing strategies to reduce or eliminate poly-pharmacy, and intervening where needed to protect the health and well-being of the consumer.

5.Development and periodic revision of service plans based on information collected through the consumer assessments, review of consumer records and input from consumer and family.

6.Ensuring implementation of the plan; to provide or coordinate access to high quality health care services that are informed by evidence-based practices, coordinate and provide access to preventative and health promotion services, coordinate and provide behavioral health services, coordinate and/or provide specialty medical care and dental care, and social services. Plan will include consumer goals and preferences, targeted outcomes, identified service provider, coordinator of services and timeframes for services.

7.Interfacing with specialty medical services.

8.Coordination and supervision of the BHH team.

9.Leading the BHH team in the management of consumer care and the implementation of the service plan.

10.Convening and leading team meetings with BHH team to review and revise consumer service plan periodically and as needed in response to consumer request or other qualifying event, using consumer information and clinical data to monitor adherence to treatment guidelines and best practices for key health indicators.

11.Developing and implementing an internal Quality Assurance program that aligns with CMS required quality measures and is capable of including additional measures.

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

APN

Description

Comprehensive care management services are conducted by licensed RNs,PAs, or APNs and involve:

1.Assessment and documentation of eligibility for BHH Services.

2.Nursing assessment.

3.Monitoring health risks by providing screening, preventative care, and early intervention services, analyzing lab/screening reports, and initiating treatment where needed.

4.Monitoring medications and medical treatments for potentially adverse synergistic

effects, developing strategies to reduce or eliminate poly-pharmacy, and intervening where needed to protect the health and well-being of the consumer.
5.Development and periodic revision of service plans based on information collected through the consumer assessments, review of consumer records and input from consumer and family.
6.Ensuring implementation of the plan; to provide or coordinate access to high quality health care services that are informed by evidence-based practices, coordinate and provide access to preventative and health promotion services, coordinate and provide behavioral health services, coordinate and/or provide specialty medical care and dental care, and social services. Plan will include consumer goals and preferences, targeted outcomes, identified service provider, coordinator of services and timeframes for services.
7.Interfacing with specialty medical services.
8.Coordination and supervision of the BHH team.
9.Leading the BHH team in the management of consumer care and the implementation of the service plan.
10.Convening and leading team meetings with BHH team to review and revise consumer service plan periodically and as needed in response to consumer request or other qualifying event, using consumer information and clinical data to monitor adherence to treatment guidelines and best practices for key health indicators.
11.Developing and implementing an internal Quality Assurance program that aligns with CMS required quality measures and is capable of including additional measures.

Care Coordination

Definition:
Care coordination services are provided by Care Coordinators and other Health Team members with the primary goal of implementing the individualized service plan, with active involvement by the consumer, to ensure the plan reflects consumer needs and preferences. Care coordination emphasizes access to a wide variety of services required to improve overall health and wellness.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange. Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

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

☐ **Behavioral Health Professionals or Specialists**

Description

☑ **Nurse Care Coordinators**

Description
Care coordination services include:
1. Engaging and retaining consumers in care.

2. Providing linkages, referrals, and coordination through face-to-face, telephone and or electronic means as necessary to implement the service plan.
3. Monitoring and conducting follow-up activities to ensure the service plan is effectively implemented and adequately addresses consumer needs.
4. Reviewing service plans with consumer and family.
5. Identifying consumers/families who might benefit from additional care management support.
6. Following up with consumers and families to ensure adherence to treatment guidelines and best practices for services and screenings.
7. Coordinating and providing access to individual and family supports including referral to the community, social and recovery supports.
8. Coordinating and referring to health promotion and wellness activities within the BHH.
9. Maintaining regular, ongoing contact with the consumer, health providers, and other providers, family and other community supports to ensure progress on implementing the treatment plan, and resolve any coordination problem encountered.

☑ **Nurses**

Description
Care coordination services include:
1. Engaging and retaining consumers in care.
2. Providing linkages, referrals, and coordination through face-to-face, telephone and or electronic means as necessary to implement the service plan.
3. Monitoring and conducting follow-up activities to ensure the service plan is effectively implemented and adequately addresses consumer needs.
4. Reviewing service plans with consumer and family.
5. Identifying consumers/families who might benefit from additional care management support.
6. Following up with consumers and families to ensure adherence to treatment guidelines and best practices for services and screenings.
7. Coordinating and providing access to individual and family supports including referral to the community, social and recovery supports.
8. Coordinating and referring to health promotion and wellness activities within the BHH.
9. Maintaining regular, ongoing contact with the consumer, health providers, and other providers, family and other community supports to ensure progress on implementing the treatment plan, and resolve any coordination problem encountered.

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☑ **Social Workers**

Description

Care coordination services include:
1. Engaging and retaining consumers in care.
2. Providing linkages, referrals, and coordination through face-to-face, telephone and or electronic means as necessary to implement the service plan.
3. Monitoring and conducting follow-up activities to ensure the service plan is effectively implemented and adequately addresses consumer needs.
4. Reviewing service plans with consumer and family.
5. Identifying consumers/families who might benefit from additional care management support.
6. Following up with consumers and families to ensure adherence to treatment guidelines and best practices for services and screenings.
7. Coordinating and providing access to individual and family supports including referral to the community, social and recovery supports.
8. Coordinating and referring to health promotion and wellness activities within the BHH.
9. Maintaining regular, ongoing contact with the consumer, health providers, and other providers, family and other community supports to ensure progress on implementing the treatment plan, and resolve any coordination problem encountered.

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Case Managers

Description

Care coordination services include:
1. Engaging and retaining consumers in care.
2. Providing linkages, referrals, and coordination through face-to-face, telephone and or electronic means as necessary to implement the service plan.
3. Monitoring and conducting follow-up activities to ensure the service plan is effectively implemented and adequately addresses consumer needs.
4. Reviewing service plans with consumer and family.
5. Identifying consumers/families who might benefit from additional care management support.
6. Following up with consumers and families to ensure adherence to treatment guidelines and best practices for services and screenings.
7. Coordinating and providing access to individual and family supports including referral to the community, social and recovery supports.
8. Coordinating and referring to health promotion and wellness activities within the BHH.
9. Maintaining regular, ongoing contact with the consumer, health providers, and other providers, family and other community supports to ensure progress on implementing the treatment plan, and resolve any coordination problem encountered.

Health Promotion

Definition:
Health promotion activities are conducted with an emphasis on empowering the consumer to improve health and wellness. Health promotion can be provided by members of the team, a certified peer wellness counselor or other certified health educator. Whenever possible these activities are accomplished using evidence based practices and/or curriculum.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange. Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

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

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Health promotion can, and should be provided by any member of the team, however NJ h

Description
1. Engaging the consumer in health promotion planning and activities, including the provision of motivational interventions to increase treatment and medication compliance and support lifestyle changes.
2. Providing health education specific to chronic conditions.
3. Development, with the consumer and if possible the family, of self-management goals to be included in the service plan.
4. Monitoring progress on self-management goals.
5. Providing support for the self-management goals included in the service plan.
6. Providing skill development activities to help the consumer understand and manage the different health conditions affecting him/her.
7. Providing support and best practices to help consumers learn the skills necessary for maintaining a healthy lifestyle. Skills can include, for example: learning how to plan nutritious meals, shop for healthy foods, prepare meals, practice mindfulness in eating, plan and implement a program for regular exercise and fitness, proper sleep, avoid or reduce harmful behaviors (e.g., smoking, substance use, overeating, under eating, etc.), maintain personal hygiene and a healthy home, and other health promotion activities.
8. Facilitating and engaging consumers in community supports, such as helping consumers develop and strengthen family support and other community supports to assist them in recovering from behavioral health problems and other health conditions, and helping consumers develop motivation to engage in attitudes and activities that promote health and wellness.
9. Ensuring access by providing and/or facilitating transportation to appointments, and by accompanying consumers on appointments to reduce consumer apprehension. Health Team members also can ensure better coordination with the provider by accompanying consumers and resolving other concerns that might interfere with access.

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:
BHHs provide comprehensive transitional care and follow-up to consumers transitioning from inpatient care and/or emergency care to the community and to assure seamless transitions between service systems. Comprehensive transitional care is provided for both behavioral and physical healthcare and can be provided by the Nurse Care Manager or other BHH team members.If the consumer requires inpatient treatment, the BHH Team will facilitate the consumer's transition to inpatient primary or behavioral health care or crisis services. This includes interfacing with the treatment team in the inpatient setting, accompanying the consumer to their admission, and continuing contact with the consumer while they are receiving inpatient care.If the consumer receives inpatient care, the BHH team, in collaboration with the hospital or other inpatient care facility, focuses on developing a discharge plan and immediate linkage to community-based care to prevent future ER and inpatient admissions. BHH Team members provide care management and coordination services to ensure that consumers have the requisite support to begin the process of recovery and reintegration

into community living.BHH Team members coordinate care management, care coordination and treatment planning with hospital-based and community-based staff to help consumers and family members better manage the problems that caused the ER/inpatient admission and shift their focus from reactive care to consumer empowerment and proactive health promotion and self-management.BHH Team members will work with consumers, family members, community supports, and other providers to address transition problems employing evidence-based motivational strategies to ensure consumer engagement in problem-solving efforts.BHH Team members will work with providers in the Children's System of Care and as they age to assist BHH participants as they transition between systems of care.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange. Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

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

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Individual and family support, which includes authorized representatives

Definition:
These services can be delivered by the Nurse Care Manager or other members of the home health team. Helping the individual and family recognize the importance of family and community support in recovery, health and wellness, and helping them develop and strengthen family and community supports to aid in the process of recovery and health maintenance. All services can be offered to the family and the consumer together, or separately.They include:1. Engaging the family, support system and/or the individual consumer in services with the goal of ensuring family/support system engagement in supporting the recovery and health maintenance of consumers.
2. Identifying family related goals to be included in the service plan.
3. Providing family education sessions focused on health education, illness management, illness prevention and wellness activities.
4. Linking family members to services needed to improve family stability and overall health such as, family therapy and social support services.
5. Helping individuals and families learn how to advocate for the services and supports they require. Teaching family members strategies for advocating for the consumer and family wellness needs.
6. Encouraging and teaching family strategies for supporting the consumer's ability to self-manage their treatment and wellness activities.

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum:
The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange. Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

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

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

Referral to community and social support services, if relevant

Definition:
Referral to community and social support services involves providing assistance for consumers to obtain necessary community and social supports.These services can be provided by any member of the BHH team and include:

1. Engaging consumer in referral for community and social supports. Since many consumers in high risk circumstances are unable or unwilling to accept needed services, the use of evidence-based interventions such as Motivational Interviewing and other evidence-based approaches is essential for engaging consumers to address critical service needs.
2. Identifying community and social supports needs such as disability benefits, housing, legal and employment services.
3. Identifying available and appropriate community and social support services.
4. Referring to community and social support services and providing the support and/or services needed for consumer to obtain these supports such as arranging transportation, making appointments, arranging for peers or others to accompany consumer

Describe how health information technology will be used to link this service in a comprehensive approach across the care continuum.
The provider standards set by NJDMHAS require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to have an EHR and to be enrolled in, or pursuing enrollment in, an Health Information Exchange. Providers are also expected to use other available means to exchange protected health information safely and securely, to include but not be limited to direct messaging, facsimile, and telephonic services.

Scope of benefit/service

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

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☐ **Other (specify):**

Name

Description

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:
Consumers can enter the BHH service through multiple avenues. Medicaid will notify eligible consumers of the availability of the health home service. Community services can refer, and consumers can self refer. Enrollment in the NJ BHH is an opt in model. Screening for eligiblity is done at the provider site. After a consumer is deemed eligible for health home services he/she enters in to one of three phases of service based on individual needs; Engagement, Active, or Maintenance. Each phase provides the same service delivery components, the difference between the phases is in the intensity of these components and depends upon the consumer's clincal needs and

ability to address thier own care needs. Each phase provides reimburseable services, but only to consumers who are actively enrolled in a certified BHH. Reimbursement is not provided for engaging consumers not already enrolled in a certified BHH. Consumers move between the phases of service described above based upon clinical criteria. Consumers can move seamlessly through phases as clinically needed. Consumers are not discharged from the service unless the consumer moves outside the geographic area of the Behavioral Health Home's responsibility or the consumer declines or refuses services despite the provider's best efforts to develop an acceptable care plan with the consumer.

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: NJ-14-0005 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date:

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Attachment 3.1-H Page Number:

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
For members 18 years and older NJ will measure the population based rate of acute hospital inpatient stays during the measurement period that were followed by an acute readmission for any diagnosis within 30 days. If a child is being served in the children's system of care at the age of 18, they can stay in that system to age 21 as the adult and children's systems work to make a seamless transition. If an individual enters the behavioral health system for the first time at 18 or older, they are served in the adult system. Numerator: number of index hospital stays with an unplanned readmission within 30 days for BHH and comparison populations. Denominator: Number of Index Hospital stays for enrolled comparison populations. Data sources include Health Home enrollment data collected through the BHH EHR and MMIS claims encounter data.

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.
We will measure the change in total spending (Behavioral Health and Physical Health) attributable to BHH enrollment. The Numerator is the sum of costs which is the MMIS FFS Behavioral Health Claims and the MCO provider payments, payments to the state and county psychiatric hospitals for the BHH and the comparison groups. The Denominator is the person months of enrollment for the BHH comparison groups.

We will also: Identify BHH consumers. Those consumers that were enrolled in a SAMHSA funded integration program will be excluded from the study. Look at consumer costs two years prior to BHH enrollment based on MMIS encounter data (MMIS includes STCF costs). Also identify psychiatric hospitalizations. We will

average the utilization costs prior to BHH. That average is our expectation of utilization without BHH services. Then we will measure their utilization costs on a yearly basis. We will also measure the BHH costs separately.

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).
All BHH providers will be required to have an EHR and BHH start up funds will be available to assist providers to either purchase or amend any current EHR.

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:
Compare hospital admission rates of BHH enrolled consumers and a comparison group
Measure Specification, including a description of the numerator and denominator. For members 18 years of age and older, the number of age-sex standardized acute inpatient stays (admissions) during the measurement year. If a child is being served in the children's system of care at the age of 18, they can stay in that system to age 21 as the adult and children's systems work to make a seamless transition. If an individual enters the behavioral health system for the first time at 18 or older, they are served in the adult system. Comparison group will be individuals, 18 or over, who meet the criteria for a BHH but are not receiving BHH services. NJ will use the population from one county where BHH services are not currently available to develop the comparison group. Numerator: Count the number of hospital admissions for enrolled HH clients and comparison group Denominator: Enrolled and comparison populations Data Sources: MMIS claims, encounter and eligibility files; Health Home enrollment data Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

Emergency Room Visits

Measure:

Comparing number of all cause ED visits for BHH enrolled population vs.comparison popula

Measure Specification, including a description of the numerator and denominator.
For members 18 years of age and older, the number and rate treat-and-release (i.e., no inpatient admission) all-cause acute emergency department (ED) visits.If a child is being served in the children's system of care at the age of 18, they can stay in that system to age 21 as the adult and children's systems work to make a seamless transition. If an individual enters the behavioral health system for the first time at 18 or older, they are served in the adult system.
Comparison group will be individuals, 18 or over, who meet the criteria for a BHH but are not receiving BHH services. NJ will use the population from one county where BHH services are not currently available to develop the comparison group.

Numerator: Number of ED visits in enrolled and comparison populations

Denominator: Enrolled and comparison populations
Data Sources:
MMIS claims, encounter and eligibility files; Health Home enrollment data
Frequency of Data Collection:

- Monthly
- Quarterly
- Annually
- Continuously
- Other

Skilled Nursing Facility Admissions

Measure:

Rate of admission to SNF for BHH enrolled population and comparison population

Measure Specification, including a description of the numerator and denominator.
Skilled nursing facility admission rate, comparing BHH rate to comparison group.
Comparison group will be individuals, 18 or over, who meet the criteria for a BHH but are not receiving BHH services. NJ will use the population from one county where BHH services are not currently available to develop the comparison group.

Numerator: Number of admissions to skilled nursing facility in BHH enrolled and comparison population

Denominator: Enrolled and comparison populations
Data Sources:
MMIS claims, encounter and eligibility files; Health Home enrollment data
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
NJ will measure, for members 18 years or older, the number of age-sex standarized acute inpatient stays (Admissions) during the measurement year. If a child is being served in the children's system of care at the age of 18, they can stay in that system to age 21 as the adult and children's systems work to make a seamless transition. If an individual enters the behavioral health system for the first time at 18 or older, they are served in the adult system. The Numerator will be the count of the number of hospital admissions for enrolled BHH client and a comparison group. The Denominator will be enrolled and comparison populations. Data sources will be MMIS claims data and BHH enrollment files.

Chronic Disease Management
New Jersey will require each BHH to utilize an evidenced based disease management program which includes assessment capacity such as the Patient Activation Measure. NJ will require that the BHH report implementation and delivery of the evidenced based program and on client level results of Chronic Disease Management services.

Coordination of Care for Individuals with Chronic Conditions
New Jersey will conduct interviews with the BHH providers and onsite monitoring of client records.

Assessment of Program Implementation
BHH providers are required to participate in a BHH Learning Community in which they will develop a full implementation plan to include the clincal and fiscal models as well as a full IT and QA plan. These implementation plans will be used as the benchmark from which to assess the progam implementation. Program implementation will be measured at six months, one year and anually thereafter. The process will be collaborative between state and program to identify problems and issues for which the state can provide assistance or resources. In addition, the Learning Community members will be convened regularly to self assess their progress and share information. There will be an ongoing fidelity measurement process for BHH.

Processes and Lessons Learned
The Learning Community will be used as a forum to discuss processes and lessons learned. NJ has elected to start the BHH service in only one county and will use the processes and lessons learned to inform the expansion of the service.

Assessment of Quality Improvements and Clinical Outcomes
Each BHH provider will be required, as part of their implementaiton plan, to develop a full quality improvement plan. Providers will be required to report on the progress of that plan and the outcomes. NJ will use Medicaid claims data and medical records to measure indivdual BHH identified clincal outcomes.

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.

Health Homes Administrative Component

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

Health Homes Administrative Component

Name of Health Homes Program:
NJ BHH (Adults) Bergen

Monitoring

Provide an estimate of the number of individuals to be served by the Health Homes program during the first year of operation:

1500

Provide an estimate of the cost-savings that will be achieved from implementation of the Health Homes program during the first year of operation:

$ 0.00

Describe how this cost-saving estimate was calculated, whether it accounted for savings associated with dual eligibles, and if Medicare data was available to the State to utilize in arriving at its cost-savings estimates:
We will measure the change in total spending (Behavioral Health and Physical Health) attributable to BHH enrollment. The Numerator is the sum of costs which is the MMIS FFS Behavioral Health Claims and the MCO provider payments, payments to the state and county psychiatric hospitals) for the BHH and the comparison groups. The Denominator is the person months of enrollment for the BHH comparison groups.

We will also: Identify BHH consumers. Those consumers that were enrolled in a SAMHSA funded integration program will be excluded from the study. Look at consumer costs two years prior to BHH enrollment based on MMIS encounter data (MMIS includes STCF costs). And also identify psychiatric hospitalizations. We will average the utilization costs prior to BHH. That average is our expectation of utilization without BHH services. Then we will measure their utilization costs on a yearly basis. We will also measure the BHH costs separately. Medicare data has not been available to NJ and therefore not included in the cost savings estimates.

Quality Measurement

CMS Recommended Core Measures

For each Health Homes core measure, indicate the data source, the measure specification, and how HIT will be utilized in reporting on the measure.

Health Homes Core Measure		
Adult BMI		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Admission Ambulatory Care-Sensitive Condition		
Care Transition – Transition Record Transmitted to Health care Professional		
Follow-Up After Hospitalization for Mental Illness		
Plan- All Cause Readmission (30 day all caused unplanned readmission rate)		

Health Homes Core Measure		
Screening for Clinical Depression and Follow-up Plan		
High blood pressure control		

Health Homes Administrative Component: Core Measure Detail

Measure
Adult BMI

Measure Specification, including a description of the numerator and denominator.
Group One:
Numerator Description
BHH enrollees for whom BMI was documented during the measurement year or the year prior to the measurement year
Denominator Description
Eligible Members 18-64 enrolled in the BHH
Group Two:
Numerator
Denominator:
Members ages 65 – 74 enrolled in the BHH

Data Sources:
From Provider EHR: For each enrolled consumer who had:
BMI documented at admission
BMI documented at one year post admission
From MMIS:MMIS collects BHH enrollees by age group

Frequency of Data Collection:

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

How Health IT will be utilized
Providers will be submitting health data from their EHRs to the state for collection and analysis.

Health Homes Administrative Component: Core Measure Detail

Measure
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

Measure Specification, including a description of the numerator and denominator.

Three Groups:
Ages 18-64
Ages 65 and older
Sum total of the age stratifications

Numerator Rate 1:
Initiation of Alcohol and other Drug (AOD) Dependence Treatment: Members with initiation of AOD treatment through an inpatient admission, outpatient visit, intensive outpatient encounter, or partial hospitalization within 14 days of diagnosis.
Numerator Rate 2: Engagement of Alcohol and other Drug (AOD) Treatment: Initiation of AOD treatment and two or more inpatient admissions, outpatient visits, intensive outpatient encounters or partial hospitalizations with any AOD diagnosis within 30 days after the date of the Initiation encounter (inclusive). Multiple engagement visits may occur on the same day, but they must be with different providers in order to be counted.

Denominator
BHH population with an AOD diagnosis.

Data Sources:
EHR collects
1) Age
2) AOD Dx
3) date Dx was given
4) Date of first treatment encounter (At agency or at other facility) following the diagnosis
5) Date of subsequent treatment encounter

MMIS: BHH enrollees by age

Frequency of Data Collection:

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

How Health IT will be utilized
Providers will be submitting health data from their EHRs to the state for collection and analysis.

Health Homes Administrative Component: Core Measure Detail

Measure
Admission Ambulatory Care-Sensitive Condition

Measure Specification, including a description of the numerator and denominator.
Three Groups for each condition:
Ages 18 to 64

65+
Total is sum of the age stratifications

Numerator Description
Total number of acute care hospitalizations for the identified ambulatory care sensitive condition

Denominator Description
Eligible population (those with an identified condition) enrolled in a BHH during the measurement year

Data Sources:
MMIS identifies for each consumer:
Hospital admission dates
and Diagnosis and age for BHH enrollees.

Analysis would include using the Ambulatory Care Sensitive Conditions list to identify those individuals with an Ambulatory Care Sensitive Condition Admission

Frequency of Data Collection:

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

How Health IT will be utilized
Data collected from MMIS will be analyzed

Health Homes Administrative Component: Core Measure Detail

Measure
Care Transition – Transition Record Transmitted to Health care Professional

Measure Specification, including a description of the numerator and denominator.
Three Groups:
Ages 18-64
Ages 65+
Total- the total is the sum of the age stratifications
Numerator:
Enrollees for whom a transition record was transmitted to the facility or primary physician or other health care professional designated for follow-up care within 24 hours of discharge.
Denominator: BHH patients discharged from inpatient facility.

Data Sources:

From provider EHR:Numerator comes from EHR/medical record. EHR must indicate and transmit, if and when a transition record was sent by enrollee by age.

From MMIS:Number and identifier of BHH patients discharged from an inpatient facility with date, by age.

Frequency of Data Collection:

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

How Health IT will be utilized
Providers will be submitting health data from their EHRs to the state for collection and analysis.

Health Homes Administrative Component: Core Measure Detail

Measure
Follow-Up After Hospitalization for Mental Illness

Measure Specification, including a description of the numerator and denominator.
Two Groups:
Ages 18-64
Ages 65-74
Numerator: Number of patients with outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days after hospital discharge with specific mental illness diagnoses. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge.
Numerator: Number of patients age with outpatient visit, intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days after hospital discharge with specific mental illness diagnoses. Include outpatient visits, intensive outpatient encounters or partial hospitalizations that occur on the date of discharge
Denominator: Description
Patients discharged alive from an acute inpatient setting (including acute care psychiatric facilities) with specific mental illness diagnoses.

Data Sources:
From MMIS:
Collect acute admission date, acute care discharge date and date of the first ambulatory care visit for all enrollees by age.

Frequency of Data Collection:

- ○ **Monthly**

- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

How Health IT will be utilized
Data collected from MMIS will be analyzed.

Health Homes Administrative Component: Core Measure Detail

Measure
Plan- All Cause Readmission (30 day all caused unplanned readmission rate)

Measure Specification, including a description of the numerator and denominator.
Numerator Description
Count the number of Index Hospital Stays with a readmission within 30 days for each age, gender, and total combination for all BHH enrollees
Group 1:
Denominator Description
Count the number of Index Hospital Stays for BHH enrollees ages 18 to 64
Group 2:
Denominator Description
Count the number of Index Hospital Stays for BHH enrollees ages 65 to 74

Data Sources:
From MMIS - age, gender, hospital d/c date and hospital admission date for BHH enrolled consumers

Frequency of Data Collection:

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

How Health IT will be utilized
Data collected from MMIS will be analyzed.

Health Homes Administrative Component: Core Measure Detail

Measure
Screening for Clinical Depression and Follow-up Plan

Measure Specification, including a description of the numerator and denominator.
Group one:
Numerator: Patients screened for clinical depression on the date of the encounter using an age-appropriate standardized tool and, if positive, a follow up plan is documented on the date of the positive screen.
G8431: positive screen for clinical depression with a documented follow up plan
G8510: Negative screen for clinical depression, follow up not required
Denominator: BHH enrollees ages 18 – 64
with an outpatient visit during the measurement year
Group Two:
Denominator: BHH enrollees ages 65-74
with an outpatient visit during the measurement year

Data Sources:
From EHR:
EHR collects
1) PHQ 9 screen with indication of + or - result (or score of other approved depression screen) documented at admission.
2) Follow up
documentation of an intervention following a positive screen

From MMIS:BHH enrollees by age and provider

Frequency of Data Collection:

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

How Health IT will be utilized
Providers will be submitting health data from their EHRs to the state for collection and analysis.

Health Homes Administrative Component: Core Measure Detail

Measure
High blood pressure control

Measure Specification, including a description of the numerator and denominator.
Numerator: The number of BHH patients in the denominator whose most recent BP is adequately controlled during the measurement year. For a patient's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control). To determine if a patient's BP is adequately controlled, the representative BP must be identified.

Group 1:
Denominator: BHH Patients 18 to 64 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year.
Group 2: Denominator: BHH Patients 65-85 years of age by the end of the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year
Group 3:Denominator: Total BHH Patients in the measurement year who had at least one outpatient encounter with a diagnosis of hypertension (HTN) during the first six months of the measurement year

Data Sources:
BHH provider collects by age category, the BHH enrollees who had at least one outpatient encounter with a diagnosis of Hypertension and both the systolic and diastolic BP of each enrollee.

MMIS- BHH enrollees by age and provider

Frequency of Data Collection:

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

How Health IT will be utilized
Providers will be submitting health data from their EHRs to the state for collection and analysis.

State Goals and Quality Measures

In addition to the CMS recommended core measures, identify the goals and define the measures the State will use to assess its Health Homes model of service delivery:

Health Home Goal		
Decrease in Smoking		

Health Homes Administrative Component: Goal Detail

Health Home Goal:
Decrease in Smoking

Measure		
A reduction in smoking by consumers		

Health Homes Administrative Component: Measure Detail

Measure
A reduction in smoking by consumers

- ○ **The measure is an Evaluation Measure from the Health Homes State Plan for purposes of determining the effect of the program on reducing one of the following:**
  - ○ **Hospital Admissions**
  - ○ **Emergency Room Visits**
  - ○ **Skilled Nursing Facility Admissions**
- ◉ **The measure is not included in the Health Homes State Plan**

Measure Specification, including a description of the numerator and denominator.
Percentage of BHH patients aged 18 years and older who were screened for tobacco use at least once during the measurement period AND who received cessation counseling intervention if identified as a tobacco user

Numerator: BHH Patients who were screened for tobacco use at least once during the measurement period AND who received tobacco cessation counseling intervention (counseling and/or pharmacotherapy) if identified as a tobacco user

Denominator: All BHH patients aged 18 years and older who were seen twice for any visits or who had at least one preventive care visit during the measurement period

Measure specifications: http://www.qualityforum.org/QPS/0028

Data Sources:
Medical record abstraction

Frequency of Data Collection:

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

How Health IT will be utilized
Providers will be submitting health data from their EHRs to the state for collection and analysis.

Measure is related to:

- (•) **Clinical Outcomes**
- ( ) **Experience of Care**
- ( ) **Quality of Care**
- ( ) **Other**

Describe:

PRA Disclosure Statement

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