Table of Contents

State/Territory Name: **NEW JERSEY**

State Plan Amendment (SPA) #: **14-0006**

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

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 #14-0006

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 14-0006. This SPA implements Health Homes as authorized under Section 2703 of the Patient Protection and Affordable Care Act. Children with SED (Serious Emotional Disturbance) will qualify for health home services whereas SED will be defined to include serious emotional disturbance, co-occurring developmental disability and mental illness, co-occurring mental health and substance abuse, or DD (Developmental Disability) eligible (per NJ Statute 10:196) with symptomology of SED. The SPA was submitted to provide Behavioral Health Home Services to children (under the age of 21) in Bergen County by enhancing the current care management teams within the Care Management Organizations.

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

Health Home State Plan Amendment

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

Transmittal Number: NJ-14-0006 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-14-0006

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 (Children) 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: Ruby Goyal-Carkeek

Title:	Deputy Director, Department of Children and Families, Division of C
Telephone number:	(609) 888-7227
Email:	Ruby.Goyal-Carkeek@dcf.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:	Vicki Fresolone
Title:	Research Scientist, Division of Mental Health and Addiction Services
Telephone number:	(609) 777-0750
Email:	Vicki.Fresolone@dhs.state.nj.us

Proposed Effective Date

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

Executive Summary

Summary description including goals and objectives:
NJ plans to provide behavioral health home(BHH)services to children (under the age of 21)in Bergen County, by enhancing the current care management teams within Care Management Organization(CMO),the designated BHH provider.CMOs are agencies that provide direct,face to face care coordination&wraparound care planning for children&their families with the most complex needs&are responsible for facilitating access to a full range of treatment&support services.Children must meet defined medical necessity criteria for BHH eligibility.Children in CMO are either SED,co-occurringDD/MI,Co-Occurring MH/SA,or are determined DD eligible(per NJ Statute 10:196)with symptomology of SED.In anticipation of Statewide rollout of BHH,the CMO agencies in the county will be the designated BHH to provide services to eligible children.NJs Children's System of Care (CSOC) services are managed by a Contracted System Administrator CSA),the single point of access for screening,referral&prior authorization for services, which includes;behavioral health,substance use&services for individuals with intellectual/ developmental disabilities.The CSA makes referrals directly to CMOs.The current care management teams will be enhanced to include medical&wellness expertise for purpose of providing fully integrated & coordinated care for children who meet criteria.A transitional plan is actively pursued between the ages of 18 to 21.The children's system works to identify any resources needed for post children's system involvement.If further involvement with public system is warranted,then applicable eligibility/assessment is pursued for a seamless transition.NJ proposes to provide BHH to individuals with the goal of improving health outcomes,promoting better functional outcomes (such as increased school attendance),decreasing the cost associated with the use of acute medical&psychiatric services,improving child/familys satisfaction w/care,&improving the individual&family ability to manage chronic condition.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2014	$ 0.00
Second Year	2015	$ 1589760.00

Federal Statute/Regulation Citation

Social Security 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 7.4 of the NJ State Plan.

Transmittal Number: NJ-14-0006 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date:

Transmittal Number: NJ-14-0006 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date:
Attachment 3.1-H Page Number:

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-14-0006 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date:

Transmittal Number: NJ-14-0006 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date:
Attachment 3.1-H Page Number:

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-14-0006 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date:

Transmittal Number: NJ-14-0006 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date: Attachment 3.1-H Page Number:

Submission - SAMHSA Consultation

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

Date of Consultation	
Date of consultation: 12/19/2013 (mm/dd/yyyy)	

Transmittal Number: NJ-14-0006 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date:

Transmittal Number: NJ-14-0006 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date: Attachment 3.1-H Page Number:

Health Homes Population Criteria and Enrollment

Population Criteria

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

☐ **Two or more chronic conditions**

Specify the conditions included:

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

Other Chronic Conditions	
Certain Developmental Disorders (organic)	
Cystic Fibrosis	
Eating Disorder	
Hypertension	
Kidney Disease	
Obesity (BMI >=85%)	
Seizure Disorder	
Sickle Cell	

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

Specify the conditions included:

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

Other Chronic Conditions	

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

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

Specify the criteria for a serious and persistent mental health condition:
Children with SED will qualify. For purposes of this SPA, SED will be defined to include serious emotional disturbance, co-occurring developmental disability and mental illness, co-occurring mental health and substance abuse, or DD eligible (per NJ Statute 10:196) with symptomology of SED.

Among children meeting the above criteria, NJ will target behavioral health home services to those individuals who could benefit from the enhanced model of integrated behavioral/medical coordination that the behavioral health home model provides. This targeting will be based on a set of defined medical necessity criteria which

will enumerate eligible medical comorbidities that must be present alongside the targeted conditions listed above. Medical necessity criteria will be determined and reviewed on an ongoing basis by the state and consistently applied by its qualified behavioral health home providers.

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:
NJ BHH will be available in Bergen County. Bergen County is the most populous county of the state of New Jersey. As of the 2011 US Census, its population was 911,004. Children represent 22% of the population (202,352). Bergen has 4.5% of NJ children living below poverty line and the unemployment rate in Bergen is 7.7%. Bergen experienced a 37% increase in children receiving NJFamilyCare/Medicaid from 2008 to 2012 (third highest among all counties).

Bergen's average monthly census in 2013 has been 540. Recent estimates indicate one third of Medicaid enrolled children who use behavioral health care also have serious medical conditions (Pires, March 2013). New Jersey estimates up to 200 youth will be enrolled in the BHH per year.

○ **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:
New Jerseys CSoC services are managed by a CSA. That CSA is the single point of access for screening, referral and prior authorization for childrens service, which includes behavioral health, substance use and intellectual/developmental disabilities. Single access to care is through the DCF/CSOC's Contracted System Administrator, who will provide the authorization to eligible children for BHH services. An authorization is made to the CMO, the designated BHH entity who obtains consent from the parent/guardian or from youth (ages 18-20) for enrollment and participation in BHH. The CSA will continue to screen and prior authorize Bergen County youth for CMO service eligibility. Children and youth who are referred to the CMO will then be screened for Health Home services at the CMO and if eligible, the CMO will request prior authorization for the Health Home service from the CSA. This allows the CMO staff to work directly with the children and their families to explain and discuss the BHH services. Enrollees can opt in or opt out of the Health Home services at the CMO. If an individual opts out of the BHH services they will continue to receive the CMO services that they need. If they opt in to BHH service individual will receive all of the services of the CMO plus the additional BHH services. In addition, if the family indicates to the lead care manager that they no longer wish to be involved with the BHH, the need for continuing authorization would not be pursued. BHH can terminate if the goals have been achieved and a sustainable community plan is in place for the child/family. BHH can also terminate if family moves out of county (during the pilot phase—note, once this is statewide, BHH would terminate if family moved out of State), or child transitions to adult system.

○ **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:

- [x] **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**
- [x] **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**
- [x] **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.**
- [x] **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.**
- [x] **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

Transmittal Number: NJ-14-0006 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date:
Attachment 3.1-H Page Number:

Health Homes Providers

Types of Health Homes Providers

- [x] **Designated Providers**

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

- [ ] **Physicians**

Describe the Provider Qualifications and Standards:

- [ ] **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:

- [ ] **Rural Health Clinics**

Describe the Provider Qualifications and Standards:

- [ ] **Community Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

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

☑ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

The BHH providers will be current CMOs. CMOs are agencies that provide care coordination and wraparound care planning for children and their families with the most complex needs and are responsible for facilitating access to a full range of treatment and support services. They facilitate and work through child-family teams to develop individualized plans of care. The CMOs goals are to keep children in their homes, their schools, and their communities. CMOs are designated by the NJ Department of Children and Families CSOC and regulated by the NJ Division of Medical Assistance and Health Services. Each BHH will be a designated CMO and will be initially certified by the State of NJ as a BHH and will be required to become accredited by a nationally accredited body within two years of certification. To become a certified behavioral health home in the State of NJ a provider must: 1) be a designated CMO provider, 2) complete approved Learning Community curriculum, 3) meet DCF's certification requirements (inclusive of implementing a system of care approach, training on motivational interviewing, appropriate level of staffing, assuring collaboration with pediatric and specialty providers is planned for, policies have been developed) 4) be accredited by a national recognized accrediting organization. CMO's can provide behavioral health home services on a provisional basis if approved by DCF/CSOC. A provisionally certified behavioral health home must obtain accreditation within two years of provisional certification being granted. Provisional certification will be reviewed annually.

☐ **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 NJs 1115 Comprehensive Medicaid Waiver, NJ has committed to providing quality driven and cost effective treatment throughout the service delivery system. NJ's CSOC will support the Behavioral Health Home (BHH) in these endeavors through a commitment to providing data, technical assistance, training and support. The CSA will have staff designated to monitor and assist the BHH in enrolling eligible children, coordinating with other systems, and providing any other real time assistance to the BHH provider to meet quality, cost and efficiency goals. NJ DMAHS will work with the NJ Managed Care Organizations to ensure that they coordinate with the BHH in the area of data, and the facilitation of patient referrals. All BHH providers must be designated as a CMO by the NJ CSOC and therefore be well versed in behavioral health issues. NJ has implemented the Behavioral Health Home Learning Community (LC) for potential BHH providers. The Learning Community assists providers in developing a full implementation and readiness plan. Through the LC, providers will have an opportunity to develop the capacity to implement the BHH services, and the opportunity to share problems and develop solutions for connecting with other systems with which they will be coordinating.The work of the CMO is also supported by the CSA who authorizes, tracks, and coordinates care and service outcomes (reporting IT and coordination of QM function). Family Support Organizations (FSOs) are also an integral partner to a CMO involved child and their family. The FSOs are comprised of family members who are involved or have been involved in the system and who provide direct peer support and advocacy to children and families receiving CMO services.CMOs have enhanced access to the Mobile Response for crisis intervention provided by a mobile response agency. Relationships with community providers and educational partnerships, positions CMOs well to collaborate effectively at a local level.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes Services.
All BHH providers must be designated CMOs. They provide enhanced care coordination (i.e. face-to-face care management and comprehensive service planning for youth and their families with complex needs). CMOs facilitate the development of the child and family team (CFT) and coordinate the CFT meetings and implement individual service plans (ISP). As part of care coordination they identify, and link children and their families to required services and supports that address the needs that are identified on the plan of care. The CMO is well positioned to serve as the bridge for coordinating comprehensive and holistic care for children who also have a chronic medical condition. CMOs work is supported through the CFT which is comprised of minimally the following individuals:
1. A CMO care manager;
2. The child, youth or young adult, and the parent or other caregiver;
3. Any interested person the family wishes to include as a member of the team, including, but not limited to, clergy members, family friends, and any other informal support resource;
4. A representative from the Family Service Organization (FSO), if desired by the family;
5. A clinical staff member who is directly involved in the treatment of the child, youth or young adult that the ISP is being developed for, if desired by the family;
6. Representation from outside agencies the child, youth or young adult is involved with, including, but not limited to, current providers of services, parole/probation officers, and/or educators that the child, youth or young adult and his or her family/caregiver agree to include on the team; and
7. The DCPP caseworker assigned to the child, if the child is receiving child protection or permanency services.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:
An eligible BHH provider must meet the following:

1.Designated CMO 2.Medicaid approved provider 3.Certified as a BHH by the NJ CSoC. 4.Accredited as a specialty Behavioral Health Home by a nationally recognized and state approved accrediting body within two years of receiving state certification 5.Participation in a BHH Learning Community or other learning activity approved by the state

An eligible BHH provider must provide for the following:

6.An approved implementation plan that covers, at minimum, BHH clinical model, financial model, IT and Quality Assurance plan.
7.Enhanced access including, but not limited to 24/7 access to crisis intervention and other needed services
8.Engaged leadership
9.Use of a single care plan that coordinates and integrates all behavioral health, primary care, and other needed

services and supports. 10.A contract or MOU with regional hospitals to ensure a formalized relationship for transitional care planning, to include communication of inpatient admissions as well as identification of individuals seeking Emergency Department (ED) service
11.Coordination with primary care practices or federally qualified health centers on an individual basis; 12.A comprehensive data collection system 13.Capacity to collect and report data as specified by the state 14.Agree to participate in CMS and state-required evaluation activities; 15.Certify that they will collect the data necessary to measure outcomes and participate in any studies required by the state and or federal government. 16.A fully implemented Electronic Health Record. 17.Participation in Health Information Exchanges or if an HIE is not available to the BHH provider they submit a plan that includes, the current capacity for electronic information sharing, the gaps in the system, and how they will overcome those gaps to ensure effective coordination of care. Note: Bergen County has developed the infrastructure for an HIE that is not currently active.

Transmittal Number: NJ-14-0006 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date:
Attachment 3.1-H Page Number:

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-14-0006 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date:
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.

Children, Adolescents, and Young Adults will receive BHH services through the CSoC. CSoC has an existing network of CMOs that provide a variety of care management and support services reimbursed through a monthly per member per month case rate. The BHH will be an enhancement to the existing CMO services for youth that meet BHH eligibility criteria. CMOs will become Childrens BHHs through a state BHH certification process and national accreditation. The BHH rate will be an enhancement to the current CMO rate to support the functions that are specific to the Behavioral Health Home. The rate is inclusive of the CMO base rate and the add-on of the nurse manager and wellness coach. The BHH is a natural fit into the current CMO structure, which leverages the child/family team process to engage and promote better outcomes, so the nurse and wellness coach will become an integral part of delivering the core health homes services. The rate is a fee for service reimbursement structure. All applicable procedure codes listings and/or rates are published on the Department's fiscal agent's website at www.njmmis.com under the link for "rate code and information".

☐ **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.**

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 (BHH). The goal of Care Management is the assessment of child's 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 child's needs. The Care Manager is the Team Leader. The BHH team enhances the existing care management team by providing the medical expertise and support needed to help the child and family manage the chronic condition.

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 NJDCF require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to utilize the State's EHR(CSA). 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

Care Managers

Description

Comprehensive care management services will be provided by care managers and involve:

1. Assessment and documentation of eligibility for BHH Services.
2. Development and periodic revision of service plans based on information collected through the assessments, review of youth's records and input from child and family.
3. Ensuring that implementation of the plan will coordinate access to high quality behavioral health care and facilitate access to health care services that are informed by evidence-based practices, facilitate access to preventative services, specialty medical care and dental care, and social services. Child with chronic conditions who require the

expertise and additional medical support will be delegated to the Nurse Manager. Plan will include child/family's goals and preferences, targeted outcomes, identified service provider, coordinator of services and timeframes for services.
4. Coordination and supervision of the BHH team.
5. Leading the BHH team in the management of care and the implementation of the service plan.
6. Convening and leading team meetings with BHH team to review and revise child's service plan periodically and as needed in response to child/family request or other qualifying event, using patient information and clinical data to monitor adherence to treatment guidelines and best practices for key health indicators. This information will be brought to the team for review and action
7. Developing and implementing an internal Quality Assurance program that aligns with Centers for Medicaid and Medicare Services (CMS) required program measures and is capable of including additional measures as needed.

Care Coordination

Definition:
Care Coordination services are provided by Care Manager with support from the Nurse Manager, with the primary goal of implementing the individualized service plan/plan of care, with active involvement by the child/family, to ensure the plan reflects child/family needs and preferences. Care coordination emphasizes access to a wide variety of services required to improve overall health and wellness. Care Managers can be social workers and/or other trained health care professionals. A license in the health care professions is not required. Nurse Manager must be properly licensed and credentialed (minimum RN).

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 NJDCF require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to utilize the State's EHR(CSA). 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

Care coordination can be provided by any team member including social workers and nur

Description

Care Coordination services include:

1. Engaging and retaining child/family as active participants in their 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 child/family needs.
4. Reviewing service plans with child and family.
5. Identifying patients/families who might benefit from additional care management support.
6. Following up with patients 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 as a member of the BHH Team.
9. Maintaining regular, ongoing contact with the child, 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 child/family to improve health and wellness. 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 NJDCF require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to utilize the State's EHR(CSA). 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 all team members

Description

1.Engaging the child 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 child 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 child/family understand and manage the different health conditions affecting them.
7. Providing support and best practices to help child/family learn the skills necessary for maintaining a healthy lifestyle. 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 child/family in Community Supports: help child/family develop and strengthen family support and other community supports to assist them in recovering from behavioral health problems and other health conditions, and help child/family 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 children on appointments to reduce child/family apprehension. Health Team members also can ensure better coordination with the provider by accompanying children and resolve other concerns that might interfere with access to care

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 children transitioning from inpatient care and/or emergency care to the community. Comprehensive transitional care can be provided by the Care Manager or Nurse Manager, as a team member, if inpatient is medical in nature.
Comprehensive transitional care is provided for every illness that might require intensive 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 NJDCF require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to utilize the State's EHR (CSA). 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
1. If the child requires inpatient treatment, the BHH Team will facilitate the children'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 child to their admission, and continuing contact with the child while they are receiving inpatient care.
2. If the child 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 emergency room and inpatient admissions. BHH Team members provide care management and care coordination services to ensure that child/family have the requisite support to begin the process of recovery and reintegration into community living.
3. BHH Team members coordinate care management, care coordination and treatment planning with hospital-based and community-based physicians, nurses, social workers, discharge planners, pharmacists, and others to help children and family members better manage the problems that caused the emergency room/inpatient admission and shift their focus from reactive care to child/family empowerment and proactive health promotion and self-management activities.
4. BHH Team members will work with children, family members, community supports, and other providers to address transition problems, as they arise, employing evidence-based motivational strategies to ensure child/family engagement in problem-solving

efforts.
5. BHH will coordinate with the adult system of care to coordinate necessary transitions.

☑ **Nurses**

Description

1. If the child requires inpatient treatment, the BHH Team will facilitate the children'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 child to their admission, and continuing contact with the child while they are receiving inpatient care.
2. If the child 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 emergency room and inpatient admissions. BHH Team members provide care management and care coordination services to ensure that child/family have the requisite support to begin the process of recovery and reintegration into community living.
3. BHH Team members coordinate care management, care coordination and treatment planning with hospital-based and community-based physicians, nurses, social workers, discharge planners, pharmacists, and others to help children and family members better manage the problems that caused the emergency room/inpatient admission and shift their focus from reactive care to child/family empowerment and proactive health promotion and self-management activities.
4. BHH Team members will work with children, family members, community supports, and other providers to address transition problems, as they arise, employing evidence-based motivational strategies to ensure child/family engagement in problem-solving efforts.
5. BHH will coordinate with the adult system of care to coordinate necessary transitions.

☐ **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 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 child together, or separately

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 NJDCF require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to utilize the State's EHR (CSA). 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

Provided by care manager or other team members

Description

1.Engaging the family, support system and/or the individual child in services goal of ensuring family engagement in supporting the recovery and health maintenance of children with chronic condition.
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 child and family wellness needs.
6. Encouraging and teaching family strategies for supporting the child's ability to self-manage their treatment and wellness activities.

Referral to community and social support services, if relevant

Definition:
Referral to community and social support services involves providing assistance for child/family to obtain necessary community and social supports. CMO's are well positioned to provide access to needed community supports by having built partnerships for collaborative, effective system of care which are executed locally.

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 NJDCF require that BHH providers are able to interface with primary care, specialty care, hospitals, and support services. Every provider is required to utilize the State's

EHR (CSA). 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

Team members

Description

1.Engaging child/family in referral for community and social supports. Since many children an their families 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 children/families 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 child/family to obtain these supports such as arranging transportation, making appointments, arranging for peers or others to accompany child.

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:
The CSA will continue to screen and prior authorize all Bergen County residents for CMO service eligibility. The CSA makes referrals directly to the CMO. Children and Youth who are referred to the CMO will then be screened for Health Home services at the CMO and if eligible, the CMO will request prior authorization for the Health Home service from the CSA. This allows the CMO staff to work directly with the children and their families to explain and discuss the BHH services. Enrollees can opt in or opt out of the Health Home services at the CMO. If an individual opts out of the BHH services they will continue to receive the CMO services that they need. If they opt in to BHH service, the individual will receive all of the services of the CMO plus the additional BHH services.

☑ **Medically Needy eligibility groups**

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

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

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

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

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
Outcomes (clinical and functional) can be measured through Child and Adolescent Needs and Strengths (CANS) tool. 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. 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 NJ MMIS claims encounter data.
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.

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.

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 Children's BHH providers utilize the Contracted System Administrator's (CSA) electronic record, which is purchased by the State. State is making amendments to the technology to include specific BHH data parameters.

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 up to 21 years of age, the number and rate per 100,000 population of age-sex standardized acute inpatient stays (admissions) during the measurement year. Comparison group will be individuals, up to age 21, 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 BHH 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 up to age 21, the number and rate per 100,000 treat-and-release (i.e., no inpatient admission) all-cause acute emergency department (ED) visits.
Comparison group will be individuals, up to age 21, 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, up to age 21, 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 the number and rate per 100,000 population of age-sex standardized acute inpatient stays (Admissions) during the measurement year. The Numerator will be the count of number of hospital admission of 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
NJ will require that the BHH report on youth level results of Chronic Disease Management services. Children's services is a collaborative model to assist with disease management, through monitoring and achievement of wellness goals.

Coordination of Care for Individuals with Chronic Conditions
Utilization management review can be conducted through the CSA for children. New Jersey can also interview the BHH providers and conduct onsite monitoring of youth's 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 clinical 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 program implementation. 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 implementation 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 individual BHH identified clinical outcomes as well as those identified by CMS in the Medicaid Director letter of January 15, 2013.

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.

Transmittal Number: NJ-14-0006 Supersedes Transmittal Number: NEW Proposed Effective Date: Jul 1, 2014 Approval Date:

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 (Children) Bergen

Monitoring

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

200

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 psychiatric acute care units 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. 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		
Body Mass Index Assessment		
Controlling High Blood Pressure		
Care Transition- Timely Transmission of Transition Record		
Follow-Up After Hospitalization for Mental Illness		
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment		
Plan All-Cause Readmission Readmission Rate		
Admission Ambulatory Care-Sensitive Condition		

Health Homes Core Measure		
Screening for Clinical Depression and Follow-Up Plan		

Health Homes Administrative Component: Core Measure Detail

Measure
Body Mass Index Assessment

Measure Specification, including a description of the numerator and denominator.
Percentage of youth 18-20 years of age who had an outpatient visit and who had their body mass index (BMI) documented annually
Numerator- Body mass index documented annually for youth 18-20
Denominator - Youth 18-20 years of age who had an outpatient visit

Data Sources:
Youth's annual medical report conducted by primary care physician will be provided to nurse to enter into the State's electronic record.

Frequency of Data Collection:

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

How Health IT will be utilized
Information will be recorded within the Statewide Contracted System Administrator's (CSA) electronic record system from which reports will be generated.

Health Homes Administrative Component: Core Measure Detail

Measure
Controlling High Blood Pressure

Measure Specification, including a description of the numerator and denominator.
The percentage of Health Home enrollees ages 18-20 years of age, who had a diagnosis of hypertension (HTN) and whose blood pressure was adequately controlled (<140/90) during the measurement year.
Numerator: Youth 18-20 years of age whose blood pressure (BP) is adequately under control during the measurement period. For a youth's BP to be controlled, both the systolic and diastolic BP must be <140/90 (adequate control)
Denominator - Youth 18-20 years of age who have a diagnosis of hypertension, as defined in the Technical Specifications and Resource Manual for Medicaid Health Home Programs.

Data Sources:
Youth's blood pressure from the annual medical report conducted by primary care physician will be provided to nurse to enter into the State's electronic record.

Frequency of Data Collection:

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

How Health IT will be utilized
Information will be recorded within the Statewide Contracted System Administrator's (CSA) electronic record system from which reports will be generated.

Health Homes Administrative Component: Core Measure Detail

Measure
Care Transition- Timely Transmission of Transition Record

Measure Specification, including a description of the numerator and denominator.
The percentage of youth (age groups 0 to 17, 18 to 20 years of age) discharged from an inpatient facility to home or any other site of care 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.
Numerator-Discharged youth (by age group 0-17, 18-20)with care transition record received by the BHH within 24 hours of discharge.
Denominator-Youth discharged (by age group 0-17, 18-20)from an inpatient facility (e.g. hospital inpatient, skilled nursing facility, or rehabilitation facility).

Data Sources:
Data collected in NJMMIS -Number and identifier of BHH youth discharged from an inpatient facility with date, by age.
Data collected in CSA-(Numerator)Information will be recorded within the Statewide Contracted System Administrator's (CSA) electronic record system from which reports will be generated.

Frequency of Data Collection:

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

○ **Other**

How Health IT will be utilized
Information will be recorded within the Statewide Contracted System Administrator's (CSA) electronic record system from which reports will be generated, particularly to help inform the numerator.

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.
Percentage of discharges of youth (age groups-6 -17 years old and 18-20 years old) who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 7 days of discharge.

Percentage of discharges of youth (age groups 6-17 years old and 18-20 years old) who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter, or partial hospitalization with a mental health practitioner within 30 days of discharge.

Numerator 1: Number of youth (by stratified age group) with an outpatient visit, intensive outpatient encounter, or partial hospitalization within 7 days of discharge.
Numerator 2: Number of youth (by stratified age group) with an outpatient visit, intensive outpatient encounter, or partial hospitalization within 30 days of discharge.
Denominator: Youth 6-17, 18-20 years of age discharged from an acute inpatient setting (including acute care psychiatric facilities) with specific mental illness diagnoses.

Data Sources:
NJMMIS-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 NJ MMIS will be analyzed

Health Homes Administrative Component: Core Measure Detail

Measure
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment

Measure Specification, including a description of the numerator and denominator.
Percentage of youth with a new episode of alcohol or other drug (AOD) dependence who initiated treatment and also were engaged in treatment.
Numerator 1: Number of youth (age groups- 13-17, 18-20) with an initiation of treatment through an inpatient admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of diagnosis.
Numerator 2: Number of youth (age groups-13-17, 18-20) who initiated AOD treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit.
Denominator: Youth (by stratified age groups) who have an AOD dx.

Data Sources:
NJMMIS and data elements (AOD dx, date dx was given, Date of first treatment encounter and date (s) of subsequent treatment encounter) to be entered into the Contracted System Administrator by the BHH.

Frequency of Data Collection:

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

How Health IT will be utilized
Information will be recorded within the Statewide Contracted System Administrator's (CSA) electronic record system from which reports will be generated.

Health Homes Administrative Component: Core Measure Detail

Measure
Plan All-Cause Readmission Readmission Rate

Measure Specification, including a description of the numerator and denominator.
Percentage of acute inpatient stays during the measurement year, which was followed by an acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission.
Numerator: Count of 30 day readmissions
Denominator: Count of Index Hospital Stays for BHH enrollees

Data Sources:
Administrative-Data analyzed through NJMMIS

Frequency of Data Collection:

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

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

Health Homes Administrative Component: Core Measure Detail

Measure
Admission Ambulatory Care-Sensitive Condition

Measure Specification, including a description of the numerator and denominator.
Ambulatory care-sensitive conditions (i.e. asthma, diabetes, hypertension, angina): age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital
Numerator: Total number of acute care hospitalizations for the identified ambulatory care sensitive condition
Denominator: Eligible population (those with an identified condition) enrolled in a BHH during the measurement year.

Data Sources:
NJMMIS identifies age, hospital admission dates, and dx for enrollees

Frequency of Data Collection:

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

How Health IT will be utilized
Data collected from NJMMIS 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.
Percentage of youth (by age group 12-17, 18-20)screened for clinical depression using a standardized tool, Center for Epidemiological Studies Depression Scale (CES-D) (or other age appropriate depression screening tool, normalized and validated for the population) and where a follow-up plan is documented on the date of the positive screen.
Numerator: Number of youth (by age group 12-17, 18-20) with a positive screen and follow-up plan is documented.
Denominator: Number of youth (by age group 12-17, 18-20) with a positive screen.

Data Sources:
Youth's record will be updated by the BHH to indicate that a clinical depression screening tool was administered to eligible population. Score of negative/positive will be indicated and follow up plan will be documented.

Frequency of Data Collection:

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

How Health IT will be utilized
Information will be recorded within the Statewide Contracted System Administrator's (CSA) electronic record system from which reports will be generated.

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		
Reduction in Smoking		

Health Homes Administrative Component: Measure Detail

Measure
Reduction in Smoking

- ○ **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 youth (18 -20) 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: Number of youth 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.
Denominator:Number of youth who were screened for tobacco use at least once during the measurement period and were identified as a tobacco user.

Data Sources:
The BHH will record the information within the Statewide Contracted System Administrator's (CSA) electronic record system.

Frequency of Data Collection:

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

How Health IT will be utilized
Information will be recorded within the Statewide Contracted System Administrator's (CSA) electronic record system from which reports will be generated.

Measure is related to:

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

Describe:

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.