Arkansas Behavioral Health Home State Plan Amendment

NOTE: Bolded text within document denotes required health home language by the Centers for Medicare and Medicaid Services (CMS) with the additional language for context purposes only.

Proposed Effective Date: July, 1 2015

Federal Budget Impact:

	Federal Fiscal Year	Amount
First Year	**2016**	**$23,230,039**
Second Year	**2017**	**$35,794,440**

Executive Summary

A care management model, defined as Behavioral Health Home (BHH), is being developed to deliver an interdisciplinary care approach for the purpose of improving care coordination, patient experience, and health outcomes. As defined by Section 2703 of the 2010 Affordable Care Act, a health home is a Medicaid State Plan Option that provides a comprehensive care coordination delivery approach for Medicaid enrollees with chronic conditions including those with a serious and persistent mental illness.

Planning efforts are underway to address the fragmented health care delivery system challenges faced by individuals with behavioral health issues. To help guide the development of the health homes model for the identified targeted population, the following guiding principles have been outlined to ensure health home planning efforts are advanced in a manner that demonstrates the intent of the authorized provision and aligns with the goals of the Arkansas Payment Improvement Initiative:

- **Health homes must address the comprehensive needs of individuals by utilizing a "whole-person" and "person-centered" approach while ensuring personal choice assurances throughout service planning and service delivery**
- **Health homes will provide services that address issues of access to care, accountability and active participation on behalf of both providers and individuals/families receiving services, continuity of care across all medical, behavioral, and social supports, and comprehensive coordination/integration of all needed services**
- **Health homes will provide services that seek to align a fragmented system of needs assessment, service planning, care coordination, transitional care , and direct care service delivery**
- **Health homes must demonstrate the use of health information technology as a means to improve service delivery and health outcomes of the individuals served**

As a component of the overall Arkansas Health Care Payment Improvement Initiative (AHCPII), the BHH will seek to contribute to improvements to the behavioral health system of care by achieving the triple aim framework that focuses on:

- Improving the health of populations
- Improving the experience of care of individuals receiving services
- Improving quality of care while reducing the growth of health care costs

The Arkansas Department of Human Services (DHS) is working to develop integrated care coordination strategies that will support comprehensive care delivery efforts. The Behavioral Health Home is an integrated care model with expected outcomes of:

- **Emphasizing wellness and prevention for better population-based care management**
- **Providing care management support for behavioral health episodes that are designed to reimbursed effective, coordinated, quality-driven care rather than for individual services**
- **Helping people live as independently as possible**
- **Aligning financial incentives to achieve a transformed system**

Behavioral Health System Transformation - Functional Assessment and Service Level Definitions

In an effort to better address individual needs of clients and families receiving behavioral health services, Arkansas is developing a behavioral health system that will provide enhanced behavioral health services and behavioral health home services in a manner that promotes resiliency and recovery. Primary components of the system transformation efforts include:

- Implementing an independent assessment to identify level of functional care needs
- Implementing a Behavioral Health Home to meet care coordination needs of individuals with higher severity behavioral health needs

Transition into a behavioral health home, into more intensive health home services, and out of a behavioral health home will correspond to the level of functional needs identified by an independent assessment. The assessment is administered by an independent assessor to determine client eligibility, required level of care, and identify the need for health home services. The assessment determines qualifying conditions using a combination of:

1. Functional Assessment utilizing instruments from InterRAI for both adults and youth to evaluate individuals across domains of safety, autonomy, health promotion, social, life and economic issues

2. Historical behavioral health core spend (prior 12 months) that is extracted from Medicaid claims data (Core spend is defined as costs for behavioral health services delivered to clients not including direct dementia or developmental disabilities cost, but does include behavioral health spend for these individuals.)

The proposed system will incorporate services and care coordination to meet the needs of low-needs (Tier 1), moderate-needs (Tier 2), and high-needs (Tier 3) behavioral health populations. Designated levels of needs will be based on the findings from the InterRAI Assessment instrument that will be tailored specifically for children and adult populations of Arkansas.

Behavioral health services will be comprised of clinic-based and 1915(i) home and community-based services and will be determined by individual's identified level of need. Existing behavioral health service options will be enhanced with 1915(i) state plan service options that will provide evidence-based home and community based services as an alternative to inpatient treatment by:

1. Allowing DHS to draw down Federal funds to support reimbursement of needed home and community based services

2. Targeting benefits to a specific population whereby services can differ in amount, duration, and scope (i.e. tiers)

Tier definitions are detailed as follows:

Tier 1: Time-limited behavioral health services provided by qualified licensed practitioners in an outpatient based setting for the purpose of assessing and treating mental health and/or substance abuse conditions. Tier 1 outpatient settings shall mean a behavioral health clinic/office, health care center, physician office, and/or school. Care management responsibilities will be coordinated by the designated primary care provider or Patient Centered Medical Home.

Tier 2: Intensive home and community based behavioral health services coordinated by a qualified behavioral health home agency for the purpose of treating mental health and/or substance abuse conditions. Services shall be rendered and coordinated through a team based approach. Independent Assessment and Independent Assessment Report are required. The Independent Assessment Report will outline the functional level determined by the Independent Assessment and will be utilized to inform the development of the Integrated Care Plan. Tier 2 home and community based settings shall include services rendered in a client's home, community, behavioral health clinic/ office, healthcare center, physician office, and/ or school. Care management responsibilities will be coordinated by the designated Behavioral Health Home.

Tier 3: Most intensive behavioral health services coordinated by a qualified behavioral health home agency for the purpose of treating mental health and/or substance abuse conditions. Services shall be rendered and coordinated through a team based approach. Independent Assessment and Independent Assessment Report are required. Tier 3 behavioral health services shall include services rendered in a client's home, community, behavioral health clinic/office, healthcare center, physician office, and/ or school. Residential treatment services are available—if deemed medically necessary. Care management responsibilities will be coordinated by the designated Behavioral Health Home.

See the appendix for the attached Arkansas Behavioral Health Transformation document for a visual schematic of Behavioral Health Tiers and Behavioral Health Home Services.

Health Home Geographic Coverage and Population Criteria

The Arkansas Behavioral Health Home is an integrated, care management model that addresses comprehensive care coordination needs including physical health, acute care, behavioral health, developmental disabilities, and long term services and supports.

The Arkansas Behavioral Health Home will be available statewide to a target population that includes individuals with one or more serious and persistent mental illness. A serious and persistent mental illness is defined as a serious mental illness or a serious emotional disturbance designation by an independent assessment resulting in a Tier 2 or Tier 3 determination. Serious mental illness and serious emotional disturbance designations are defined as follows:

Serious mental illness includes individuals 18 years of age or over and had a diagnosable mental, behavioral, or emotional disorder as specified in DSM-IV in the past year (excludes clients with only substance abuse or only developmental disorders) and meets at least two of the following in the past year:

- **Impairment in self-care evidenced by at least one of the following:**
  - **Lack of bathing and/or changing clothes in greater than one week**
  - **Lack of seeking care for a medical condition that is life-threatening or that may result in acute hospitalization without professional involvement (includes prenatal care)**
  - **Lack of seeking care for a dental condition that is life-threatening or that may result in acute hospitalization without professional involvement**
  - **Lack of nutritional intake resulting in a BMI <17**
- **Impairment in behavior controls evidenced by at least one of the following:**
  - **History of violating state or federal laws that could result in justice system involvement**
  - **History of being found guilty of a crime in the Arkansas court system**
- **Inability to live in an independent or family setting without supervision as evidenced by:**
  - **Requirement of full-time supervision or support at home**
  - **Homelessness**
  - **Imminent risk of homelessness**
- **Inability to work or attend school full-time demonstrated by at least one of the following:**
  - **Lack of ability to keep a full-time job for more than 3 months**
  - **Lack of ability to stay enrolled in school for more than one semester or course length**
  - **Has been determined to be disabled due to mental illness by the social security administration**
- **Risk of deterioration evidenced by:**
  - **Presence of co-morbid substance abuse or dependence or developmental disability**
  - **Complex care that requires the attention of multiple providers to prevent hospitalization**

or

- **Is a danger to self as evidenced by significant suicidal ideation or a suicide attempt**
- **Is a danger to others as evidenced by significant homicidal ideation, significant intention to harm others, or attempt at pursuing significant harm of others**

Serious emotional disturbance includes children age 0-17 and having a diagnosable mental, behavioral, or emotional disorder as specified in DSM-IV in the past year (excludes clients with only substance abuse or only developmental disorders) and meets at least two of the following in the past year:

- **Impairment in self-care evidenced by at least one of the following:**
  - **Lack of bathing and/or changing clothes in greater than one week**
  - **Lack of seeking care for a medical condition that is life-threatening or that may result in acute hospitalization without professional involvement (includes prenatal care)**
  - **Lack of seeking care for a dental condition that is life-threatening or that may result in acute hospitalization without professional involvement**
  - **Lack of nutritional intake resulting in a BMI <17**
- **Impairment in behavior controls evidenced by at least one of the following:**
  - **History of violating state or federal laws that could result in juvenile justice system involvement**
  - **History of being found guilty of a crime in the Arkansas juvenile justice system**
- **Inability to maintain a safe living arrangement at home as demonstrated by**
  - **Repeated violence toward siblings and/or parents**
  - **Repeated disruption at home requiring intervention from authoritative agency**
  - **Homelessness**
  - **Imminent risk of homelessness**
- **Inability to attend school full-time because of mental illness demonstrated by at least one of the following:**
  - **Lack of ability to stay enrolled in school for more than one semester or course length due to expulsion or repeated suspension**
  - **Lack of ability to stay enrolled in school due to repeated failing grades not explained by a learning disability or language impairment**
  - **Risk of deterioration evidenced by :**
    - **Presence of co-morbid substance abuse or dependence or developmental disability**
    - **Complex care that requires the attention of multiple providers to prevent hospitalization**

or

- **Is a danger to self as evidenced by significant suicidal ideation or a suicide attempt**
- **Is a danger to others as evidenced by significant homicidal ideation, significant intention to harm others, or attempt at pursuing significant harm of others**

<u>Enrollment of Behavioral Health Home Clients, Opt-out Option, and Outreach Efforts</u>

Clients enter the BHH via an eligibility determination by an independent assessment. Existing clients may be referred for the independent assessment by their providers, while prospective, high risk clients may be identified by claims analysis that identifies the potential need of health home services

based on historical service utilization data or by direct referral by a health care or behavioral health provider. Following notification of eligibility for BHH services, clients will choose a Behavioral Health Home or be automatically assigned to a Behavioral Health Home based on previous engagement with a provider and/or geographical access. Clients have the ability to opt out of the assigned behavioral health home or select another behavioral health home provider. Clients who choose to opt out BHH services may do so without being denied behavioral health treatment services.

Outreach to clients prior to BHH enrollment may occur through community supports such as primary care providers, schools-based efforts, Community Mental Health Centers, the National Alliance on Mental Illness (NAMI), judicial system engagement, churches, etc. For example, current behavioral health providers and primary care physicians (PCPs) will have information accessible to clients regarding the role, functions, and services provided by a BHH.

BHH outreach and information to clients will be provided through a variety of efforts to include:

- Direct communications to eligible clients via letters and social media
- SAMHSA funded Family and Youth Liaison System of Care Planning initiative
- SAMHSA funded BRSS TACS (Bringing Recovery Supports to Scale Technical Assistance Center Strategy) policy academy to assist states in promoting wide-scale adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental health conditions.
- Arkansas Act 1593 of 2007 designated activities and efforts to "Ensure Better Utilization and Coordination of the state's Behavioral Health Care Resources Devoted to Serving Children, Youth, and Their Families". The purpose is to facilitate outreach efforts by establishing components of an integrated system to serve children and youth with behavioral health issues identified as having Serious Emotional Disturbance (SED) and their families in their homes and communities with support of Wraparound, Care Coordinating Councils, and Family Support Partners.

Provider Criteria, Team Composition, and Certification Processes

The health home provider will be a designated behavioral health provider certified by the Arkansas Department of Human Services. There are three primary functions of the health home, as well as several additional integrated care team roles. The primary functions of lead BHH roles are:

- **Care Coordination: Direct interaction with a client, the client's family and his/her other treatment providers for care coordination provision.**
- **Care Management: Oversight of BHH care coordination provision, facilitation of problem-solving with case issues, reviewing and updating the Integrated Care Plan on a continuous basis and correlating to reassessment timeframes, and establishing relationships between the BHH and other treatment providers.**
- **Care Direction: Management of budgetary components, operational oversight, and other administrative duties of the BHH.**

The three primary functions are responsible for leading health home efforts in coordination with the extended integrated care team members. The state has established a client to care coordinator ratio of an average 20 clients per Care Coordinator for high acuity behavioral health needs (Tier 3) and an average of 40 clients per Care Coordinator for moderate acuity behavioral health needs (Tier 2) as identified by the independent functional assessment.

Based on the individual client's needs, the Care Coordinator will work with the client/family and specific individuals/organizations that will comprise an integrated care team. The Care Coordinator will be responsible for overall implementation of the integrated care plan, while the broader integrated care team will assist with the coordination and provision of necessary services. In addition to the three primary functions, the BHH will be required to either provide or establish collaborative agreements to guarantee access to the full service array within each tier. Based on individual needs identified as a result of the Independent Assessment Report, the BHH will be required to include the following roles as part of the health home integrated care team:

- **Individual, families, caregivers**
- **Care Coordinator**
- **Care Manager**
- **Care Director**
- **Certified Family Support Partner**
- **Certified Peer Support Specialist**
- **Qualified Behavioral Health Provider (Paraprofessional)**
- **Physician, Advanced Practice Nurse, or Registered Nurse (will be required to be contracted/hired by the BHH based on the medical acuity of the population served)**
- **Licensed Clinician**
- **Licensed Substance Abuse Clinician**
- **Division of Child and Family Services (DCFS) personnel (i.e. child welfare worker)**
- **School-based Mental Health Providers and other school personnel as needed**
- **Judicial or other court system personnel (i.e. probation officer, ad litem representative, etc.)**
- **Supported employment providers, etc.**

Arkansas Behavioral Health Homes must meet state defined core requirements in order to qualify as a provider of health home services for individuals with serious and persistent mental illness. Any provider meeting standards can be certified as a BHH and are expected to render health home services using a person-centered planning approach. The Arkansas Department of Human Services will review, certify, and confirm BHH provider compliance with the following state standards for the purpose of ensuring timely, comprehensive, high quality health home services. **A BHH provider must be certified by the state and meet the following:**

- **Possess Division of Behavioral Health Services (DBHS) BH agency certification to provide services**
- **Complete state BHH enrollment process and practice transformation activities**
- **Demonstrate the capacity to provide:**

    - **Minimum staffing/BHH team composition for BHH panel for established ratios**
    - **Effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs, and practices, preferred languages, health literacy and other communication needs**
    - **Access to services and establish Memoranda of Agreements with organizations to facilitate access to services**
- **Demonstrate capability to utilize EHR/EMR and have the ability to review progress notes, treatment plans, current and past medications, create problem lists, analyze care outcomes and send secure messages**
- **Provide assurances of enhanced patient access to the BHH team (e.g. alternatives to faces to face visits, 24/7 access)**
- **Support the use of evidence-based clinical decision making tools and best practices to achieve optimal patient recovery and resiliency**
- **Utilize a person-centered approach to care management and coordination:**
    - **Employs or contracts Care Coordinators to provide BHH services**
    - **Employs or contracts a Care Manager to supervise Care Coordinators, facilitate problem-solving with case issues, and develop collaborative partnerships between the BHH and other treatment providers**
    - **Employs or contracts a Care Director to manage budgetary and operational components and provide oversight of other administrative duties of BHH**
- **Establish and maintain a continuous quality improvement program:**
    - **Meets metrics and reporting requirements upon program commencement as outlined by the state**
    - **Collects, reports and analyzes data that includes financial, health status, and performance measures to evaluate outcomes outlined by BHH goals**
    - **Identifies gaps and opportunities for improvement based on various inputs from care plan outcomes and quality measures**

To ensure BHH providers receive the needed level of support from the state to be successful in BHH care management delivery, the state will provide BHH support to assist providers to:

- Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,
- Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,
- Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,
- Coordinate and provide access to mental health and substance abuse services,
- 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,
- Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,
- Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,

- Coordinate and provide access to developmental disabilities and long-term care supports and services,
- 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,
- 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,
- 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.

To assist BHH providers with receiving the needed level of support from the state to be successful in BHH care management delivery, the state will provide the following support components to BHH providers:

BHH learning collaborative activities to include:

- **Webinars**
- **Clinical Work Groups**
- **Regional meetings**
- **Informational sessions as a part of partnering BH advocacy groups, school-based organizations, judicial forums, and provider association meetings**
- **Practice transformation support**

The state will also monitor BHH providers to ensure health home services are delivered in accordance to state certification standards and CMS' Health Home State Guidance criteria. The state will provide continuous support and BHH oversight by providing access to a care coordination IT platform that will allow providers to access Independent Assessment Reports to develop, monitor, and update integrated care plans. The state will ensure appropriate BHH oversight by conducting chart reviews, onsite audits, and individualized provider support. The state will also support BHH providers by providing access to care management records, provider communications, and provider reports that will support BHH providers to address specific individualized behavioral health needs, provide care management that facilitates provider linkages and information sharing that promotes a fully integrated care delivery approach.

<u>Primary Care – Behavioral Health Integration</u>

Individuals with high acuity behavioral health needs face many challenges when navigating Arkansas' behavioral health system of care and will require care coordination and care management efforts across primary care and BHH providers to access needed services and optimize health outcomes. Additionally, as outlined in the CMS Health Homes Policy Guidance Letter, individuals with serious mental illnesses have a higher prevalence of co-morbid chronic medical conditions.

In an effort to provide the needed level of care for individuals with high acuity behavioral health needs, Arkansas is taking an integrated care approach to serve this population that will be comprised of both primary care and behavioral health home providers coordinating efforts to meet both physical health and behavioral health needs.

To facilitate the identified needed level of integrated care, supportive functions provided by both primary care providers and BHHs are designed to address the comprehensive needs of individuals with intensive behavioral health needs and are outlined as follows:

Primary Care Provider Functions:

- Coordinate and integrate care across interdisciplinary provider teams
- Provide care management for entire patient panel
- Focus on prevention and management of chronic diseases
- Provide access for all individuals assigned to provider panel
- Provide evidence-informed care
- Provide referrals to high-value providers
- Provide wellness and preventative care
- Provide primary accountability of medical care plan and medical outcomes for patient panel

Behavioral Health Home Functions:

- Coordinate intensive behavioral health care for high acuity behavioral health clients in integrated approach with other integrated care team members
- Coordinate integrated care plan that includes incorporating medical care plan, behavioral health treatment plan, and other specialty care plans and disseminate to full interdisciplinary care team
- Ensure adherence to evidence-based and evidence-informed behavioral health treatment practices
- Serve as accountable provider for behavioral health outcomes for high acuity behavioral health client panel

In coordination with implementation plans for Arkansas' Patient-Centered Medical Home (PCMH) Initiative, clients in Tier 1 will receive care management through their designated PCMH or primary care provider. Tier 2 and 3 (higher acuity) behavioral health clients will receive intensive care coordination and care management services through the BHH.

For Tier 1 clients, the PCMH will be accountable for their total costs of care (medical and behavioral health expenditures). The BHH will be responsible for the behavioral health treatment for Tier 2 and 3 clients, while the PCMH is responsible for medical treatment. Additional key functions of the BHH will include care management activities that incorporate physical health components (i.e. primary care provider integrated care education, use of behavioral health screening tools by primary care providers, and the use of appropriate primary care and specialty care referrals).

For this reason, the state will require behavioral health providers who serve Tier 2 and 3 high needs behavioral health clients to demonstrate, as a part of the certification process, that they have incorporated physical health providers into their BHH models. To accommodate other viable integration models, the state will also allow primary care practices the option of incorporating behavioral health specialists within their practice construct or establishing agreements with behavioral health homes to provide the needed behavioral health integration to meet integrated care needs.

Provider Infrastructure

The BHH infrastructure will consist of lead BHH roles of Care Coordinator, Care Manager, and Care Director working with other interdisciplinary care team members that may include:

- **Certified Family Support Partner**
- **Certified Peer Support Specialist**
- **Qualified Behavioral Health Provider (Paraprofessional)**
- **Physician, Advanced Practice Nurse, or Registered Nurse (Will be required to be hired by the BHH based on the medical acuity of the population served)**
- **Licensed Clinician**
- **Licensed Substance Abuse Clinician**
- **Division of Child and Family Services (DCFS) personnel (i.e. child welfare worker)**
- **School-based Mental Health Providers and other school personnel as needed**
- **Judicial or other court system personnel (i.e. probation officer, ad litem representative, etc.)**

The infrastructure of the care team will be determined by the areas of need outlined on the independent functional assessment to ensure key issues identified upon completion of the assessment process are addressed and facilitated by appropriate care team members.

Facilitation of information sharing and the integration of various care plans and service components will be the responsibility of the Care Coordinators with a care coordination IT platform used to facilitate integrated care plan development/monitoring. Additionally, IT capabilities will be required to include progress notes review, treatment plan review, current and past medications review, creation problem lists for appropriate interventions, service reporting, and care outcomes analysis.

The BHH and integrated care team infrastructure will:

- **Coordinate and integrate client's medical, clinical, and non-clinical health care related needs and services, including referrals to community, social support, and recovery services**

- **Coordinate transitional care across all settings to insure appropriate discharge planning and follow up; provides evidence of working relationships with local providers to ensure proper care transition planning**

- **Coordinates access to health education, promotion, and recovery supports**

Provider Standards

The state will ensure statewide coverage of certified Behavioral Health Homes in accordance with the outlined provider qualifications and standards for designated providers. Behavioral Health Home providers must perform the six core health homes functional service categories outlined by CMS and comply with the following health home components:

- **Provide quality-driven, cost-effective, culturally appropriate, and person- and family-centered Health Homes services,**
- **Coordinate and provide access to high-quality health care services informed by evidence-based clinical practice guidelines,**
- **Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders,**
- **Coordinate and provide access to mental health and substance abuse services,**
- **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,**
- **Coordinate and provide access to chronic disease management, including self-management support to individuals and their families,**
- **Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services,**
- **Coordinate and provide access to long-term care supports and services,**
- **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:**
- **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,**
- **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.**

Additional provider criteria include:

- **Participating in BHH practice transformation activities**
- **Participating in BHH learning collaboratives**
- **Providing enhanced access to care**
- **Establishing lead Care Coordinator, Care Manager, and Care Director functions to fulfill BHH responsibilities and deliver BHH services**
- **Complying with state established Care Coordinator to client ratios**
- **Partnering with needed integrated care team members to care manage and care coordinate across comprehensive care needs and service systems**
- **Facilitating information sharing across comprehensive, integrated care team members**
- **Complying with state reporting requirements**

- **Utilizing outcome data to institute continuous quality improvement efforts to achieve CMS' triple aim goals of:**
    - **Improving the health of populations**
    - **Improving the experience of care of individuals receiving services**
    - **Improving quality of care while reducing the growth of health care costs**
- **Utilizing outcome data to institute continue quality improvement efforts to achieve Arkansas Health Care Payment Improvement Initiative goals of:**
    - **Addressing the comprehensive needs of individuals by utilizing a "whole-person" and "person-centered" approach while facilitating personal choice throughout service planning and service delivery**
    - **Providing services that address issues of access to care, accountability and active participation on behalf of both providers and individuals/families receiving services, continuity of care across all medical, behavioral, and social supports, and comprehensive coordination/integration of all needed services**
    - **Providing services that seek to align a fragmented system of needs assessment, service planning, care coordination, transitional care, and direct care service delivery**
    - **Demonstrating the use of health information technology to facilitate BHH services and improved individual and population-based outcomes**

Service Delivery

Behavioral Health service providers that contract with DHS to provide behavioral health home services will be paid a per member per month (PMPM) rate to provide health home services. The PMPM rate will be adjusted for the level of need of the individual served utilizing the independent assessment. PMPM payments will be processed and paid to providers by standard MMIS payment procedures. Further details on payment delivery are detailed in Payment Methodology section.

Payment Methodology

Arkansas Behavioral Health Homes will be reimbursed by receiving a Per Member Per Month (PMPM) payment adjusted for behavioral health acuity.

The PMPM will be comprised of a base health home PMPM, for which payment is received for ongoing completion of core health home activities and is risk adjusted based on the level of acuity to account for variability in levels of care needs for clients based on tier designations.

The state will reconcile PMPM payments based on monitoring of:

- **Assigned BHH/client attribution, grouper analysis, and enrollment/disenrollment reports**
- **Client IDs**
- **BHH provider IDs**
- **BHH certification requirements**
- **Performance metrics**

The state has developed a two-tiered rate setting system for Behavioral Health Homes. The BHH rate setting methodology is based on the calculation of estimated savings utilizing a bottoms up analysis

that includes estimated time to deliver BHH care coordination to moderate and high needs adults and children. The state is estimating PMPMs as follows:

- **Tier 2 PMPM (Children) – $100 PMPM**
- **Tier 2 PMPM (Adult) – $100 PMPM**
- **Tier 3 PMPM (Children) – $200 PMPM**
- **Tier 3 PMPM (Adult) – $200 PMPM**

PMPM projections assume:

- Care Coordinator projected salary - $35,000
- Care Director/Manager projected salary - $80,000
- Care Director/Manager to Care Coordinator ratio – 1:10
- Average BHH panel size – 250
- Approximately 25% of Care Coordinator's time spent on administrative duties
- Bureau of Labor Statistics; Care Coordinator projected salary comparable to current Wraparound Facilitator salary in Arkansas
- One FTE Care Director/Care Manager required. BHH may be required to hire additional Care Managers based on panel size.
- Assumes fixed ratio of Tier 3 to Tier 2 PMPM of 2:1 to account for additional clinical activities required for Tier 3 clients

The state plans to review implementation of an incentive payment in Year 3 depending on the total savings realized from system changes.

PMPM rates will be reviewed by the state on a regular basis based on costs, savings, and outcomes analyses.

Service Categories

Behavioral Health Home Functions

For identified high needs behavioral health populations, specific responsibilities of the Behavioral Health Home include:

- Coordinating intensive behavioral health care for high acuity behavioral health clients in integrated approach with other integrated care team members
- Coordinating integrated care plan that includes incorporating medical care plan, behavioral health treatment plan, and other specialty care plans and disseminate to full interdisciplinary care team
- Ensuring adherence to evidence-based and evidence-informed behavioral health treatment practices
- Serving as accountable provider for behavioral health outcomes for high acuity behavioral health client panel

Completed independent assessments will result in an independent assessment report that will be utilized to:

- Develop the integrated care plan
- Inform other care team members of specific behavioral health needs for other care plan development (i.e. medical care plan, master treatment plan, educational plan, etc.)

As determined by the independent assessment, integrated care management will be provided to individuals with high behavioral health needs. Behavioral Health Home services include the following:

Comprehensive Care Management

- **Identifying high-risk individuals and utilizing client and population-based data to manage care**
- **Assessing needs of individuals to develop care plans that incorporate client needs and person-centered goals**
- **Facilitating integrated care team engagement to ensuring comprehensive needs are addressed**
- **Monitoring individual and client panel status to inform care plan updates and progress towards stated goals**
- **Monitoring individual and client panel status to inform treatment guidelines and evidence-based/evidenced-informed practice patterns**
- **Coordinating and disseminating information and reports that guide progress of service delivery and outcomes**

Health information technology will be used to link this service in a comprehensive approach across the care continuum by allowing BHH providers to:

- **Track individual and client panel information**
- **Provide care management services to meet individuals and population needs**
- **Utilize IT system to identify population-based profiles to facilitate BHH panel care management strategies**
- **Access independent assessment reports to develop integrated care plans**
- **Monitor and update integrated care plans**
- **Report outcome measures**
- **Track BHH activities (i.e. client contacts and other BHH engagement activities)**

The benefit/service can only be provided by designated providers that are community/behavioral health providers certified as Behavioral Health Home providers.

Care Coordination

- **Integrating care plans across systems (including behavioral health, medical, developmental disabilities, and long-term supports) and provides input for plan updates**

- **Maintaining documentation from all providers involved with client**
- **Supporting and enabling care plan adherence by providing assistance with referrals, scheduling and arrangement for transportation to appointments**
- **Providing regular check-ins with client to understand barriers to plan adherence**
- **Monitoring chronic disease indicators and performance metrics**
- **Developing and maintaining communication between all stakeholders involved with the client**
- **Providing referrals to quality-based services and high performing providers**
- **Coordinating care across all medical, behavioral health and other treatment plans**
- **Participating in hospital discharge planning and coordinating transitional and aftercare services**

Health information technology will be used to link this service in a comprehensive approach across the care continuum by allowing BHH providers to:

- **Track individual and client panel information**
- **Access independent assessment reports to develop an integrated care plan**
- **Monitor and update integrated care plans**
- **Utilize IT platform to facilitate care coordination communications and integrated care team information sharing and engagement**
- **Report outcome measures**
- **Track BHH activities (i.e. client contacts and other BHH engagement activities)**

The benefit/service can only be provided by designated providers that are community/behavioral health providers certified as Behavioral Health Home providers.

<u>Health Promotion</u>

- **Arranging for and/or providing client and family specific health education services**
- **Educating and supporting client on self-management plans and routine clinical care**
- **Coordinating and supporting access to behavioral health care**

Health information technology will be used to link this service in a comprehensive approach across the care continuum by allowing BHH providers to:

- **Facilitate the establishment of a repository of educational information and resources to assist in performing educational services**
- **Facilitate access to individualized educational services and resources based on individual needs**

The benefit/service can only be provided by designated providers that are community/behavioral health providers certified as Behavioral Health Home providers.

<u>Comprehensive Transitional Care</u>

- **Establishing processes to ensure prompt notification of planned and unplanned care (i.e. developing crisis management plans and processes for hospital admissions and emergency department visit notifications)**
- **Coordinating and sharing transition planning with relevant persons/entities**
- **Providing regular education on client access to services and transitional care needs**

Health information technology will be used to link this service in a comprehensive approach across the care continuum by allowing BHH providers to:

- **Facilitate automated processes for inpatient admissions notifications**
- **Facilitate information sharing to integrated care team members on transitional care status and access to individualized educational services and resources based on individual needs**

The benefit/service can only be provided by designated providers that are community/behavioral health providers certified as Behavioral Health Home providers.

<u>Individual and Family Support Services</u>

- **Matching individuals (and families) to support services and advocating on their behalf for participation**
- **Facilitating awareness of and interacting with service providers to ensure they are meeting client needs**

Health information technology will be used to link this service in a comprehensive approach across the care continuum by allowing BHH providers to:

- **Track individual and client panel information**
- **Generate client-specific information/reports to detail:**
  - **Health conditions**
  - **Treatment services**
  - **Hospital, Emergency Department, PCP, and specialty care visits**
  - **Current medications**
- **Facilitate individualized support services based on client-specific information, identified needs, and client/family choice to promoted increased levels of client/family engagement and health outcomes**

The benefit/service can only be provided by designated providers that are community/behavioral health providers certified as Behavioral Health Home providers.

<u>Referral to Community and Social Support Services, if relevant</u>

- **Identifying needs and managing referrals to needed services and supports**
- **Facilitating access to needed care**
- **Promoting self-management and increased client engagement by facilitating access to appropriate community support and wellness programs**

Health information technology will be used to link this service in a comprehensive approach across the care continuum by allowing BHH providers to:

- **Track individual and client panel information**

- **Generate community and support services resource information to:**
  - **Identify available resources**
  - **Facilitate access to needed support services and programs**
  - **Empower individuals and families to actively engage in care delivery**

The benefit/service can only be provided by designated providers that are community/behavioral health providers certified as Behavioral Health Home providers.

Health Homes Patient Flow

See Enrollment of Clients section on page 6 for details regarding BHH enrollment process and the attached Behavioral Health Integrated System schematic detailing independent assessment, health homes, and integrated care plan process flow.

Monitoring

The state will use claims and other administrative data sources to conduct analysis of utilization, cost, and cost avoidance of inpatient admissions, emergency department visits, specialty care, pharmacy, and emergent and non-emergent transportation. **The state will track avoidable hospital readmissions by utilizing claims data and the following measurement specifications:**

- **Count unique IP visits for each BHH client by claim type S and provider type 5 or review of claim type S and revenue code 114 or prior authorization code W1**

The state will monitor cost savings from Behavioral Health Homes by evaluating hospital readmissions, and reviewing total behavioral health and medical care spend using claims data. Savings calculations will be trended for inflation, and will adjust for the claims of high-cost outliers.

The state will coordinate with providers to assist in the exchange of health information and coordinated care management activities for BHHs. Specific use of HIT to facilitate BHH services is detailed in the Service Definitions section beginning on page 15 for each CMS required health home service component.

Evaluations

The state will collect information from health home providers for purposes of determining the effect of this program on reducing the following:

- **Hospital admission**

  Description: Use of data to determine inpatient general hospital/acute care, inpatient alcohol and other drug services, and inpatient mental health services discharges.
  Data Source: Claims and/or EHR
  Frequency of Data Collection: Quarterly

- **Emergency room visits**

Description: Use of data to determine rate of BH ED visits per fixed time frame
Data Source: Claims and/or EHR
Frequency of Data Collection: Quarterly

- **Skilled Nursing Facility admissions**

Description: Use of data to determine discharges for skilled nursing facility services
Data Source: Claims and/or EHR
Frequency of Data Collection: Quarterly

The state has BHH metrics that consist of both process and outcome metrics that include:

Process metrics	**Thresholds (Percentages)**		
	Yr 1	**Yr 2**	**Yr3**
• **% of clients with integrated care plan**	**70**	**80**	**90**
• **% of clients with crisis intervention plan in place**	**90**	**90**	**90**
• **% of clients BHH involved in BH IP discharge planning**	**50**	**65**	**75**
• **% of clients receiving appropriate number of client check-ins**	**70**	**80**	**90**
• **% of clients with BH IP flag in portal for those requiring IP care**	**50**	**65**	**75**
• **% of clients who received a follow-up from BHH with 3 days post-IP encounter**	**50**	**65**	**75**

Outcome metrics
Metric: Child and adult acute IP
Detail: # child and adult acute IP admissions for any cause

Metric: Child and adult acute IP w/readmit within 30 days
Detail: # child and adult acute IP admissions for any cause followed by acute readmission for any cause within 30 days

Metric: Follow-up visit after hospitalization for mental illness
Detail: % clients hospitalized for mental health disorder that visited mental health practitioner with 7 days of IP discharge

Metric: BH acute IP readmit rates
Detail: Rate of BH-related readmission within 30 days of discharge from acute IP facility

Metric: AOD (Alcohol or Other Drug) treatment
Detail: % adolescents and adults with new episode of AOD dependence who received initiation or engagement of AOD treatment

Metric: Depression
Detail: % patients 12 yrs+ screened for clinical depression using standardized tool and follow-up documented

Metric: Blood pressure management
Detail: % of clients (18-85) who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year

Metric: BMI assessment
Detail: % of clients (18-74) who had an outpatient visit and whose BMI was documented during the measurement year or the year prior to the measurement year

Metric: Treatment adherence
Detail: # of outpatient encounters versus # of visits in treatment plan

Metric: Hearing and vision screening
Detail: % youth (under 16) with documented scheduled hearing and vision screen and follow-up plan documented for those with identified need; shows evidence of collaboration with PCMH and/or PCP

Metric: Labs review
Detail: % children (under 18) on antipsychotic agents who have had metabolic lab tests for fasting lipids and glucose documented and reviewed by a physician and or licensed APN

Metric: Acute BH IP utilization
Detail: Rate of utilization of acute BH IP care for BH related services per fixed time frame (acute IP admits PMPY (per member per year)

Metric: BH Emergency Department (ED) visits
Detail: Rate of BH ED visits per fixed time frame (ED visits PMPY)

Metric: Medication adherence
Detail: % of clients with medication possession ration>80% for antipsychotics, mood stabilizers, and antidepressants

Metric: Utilization of residential services (days PMPY)
Detail: Rate of utilization of residential care for care related services per fixed time frame (residential days PMPY)

Metric: Utilization of PCMH
Detail: % individuals who have received at least one documented healthcare visit with their PCMH (or physician or other healthcare provider if individual does not have PCMH) that included a review of the medical plan, if applicable

The state will collect information for purposes of informing the evaluations, which will ultimately determine the nature, extent and use of this program, as it pertains to the following:

- **Hospital admission rates:**
  The state will use claims data and/or EHR to calculate admission rates for general hospital/acute care, inpatient alcohol and other drug services, and inpatient mental health services discharges. In addition, the state will use claims data and/or EHR to calculate the number of inpatient stays that were followed by an acute readmission for any diagnosis within a specified time frame.

- **Chronic disease management**

  The state will use primary care provider information/reports, claims data and/or EHR, along with client surveys to calculate performance measures to monitor the management of the following chronic diseases/conditions: heart disease, hypertension, obesity, diabetes, asthma, schizophrenia, bipolar disorder, and alcohol and other dependencies.

- **Coordination of care for individuals with chronic conditions**

  The state will use primary care provider information/reports, claims data and/or EHR to determine whether BHHs received a reconciled medication list at the time of discharge and to monitor whether transition records were transmitted to BHHs within a specified time frame.

- **Assessment of program implementation**

  The state has identified several quality measures, including both process and outcome metrics that will be used to evaluate process and outcome performance for the purposes of quality improvement. These are described in Section VIII: Quality Measures. Stakeholder surveys may be used to determine lessons learned in reference to informing performance improvement. The state reserves the right to review eligibility at any point.

- **Processes and lessons learned**

  The state plans to implement a Center of Excellence to provide BHH practice transformation support, ongoing BHH training, and facilitate learning collaboratives as an ongoing quality improvement effort. The collaboratives will be established with a group of early adopters of Behavioral Health Homes to identify implementation challenges, potential solutions, and share best practices. Information will be utilized by the state as a quality improvement initiative to strengthen health home provider training and service delivery activities.

- **Assessment of quality improvements and clinical outcomes**

  The state has identified several quality measures, including both process and outcome metrics that will be used to evaluate process and outcome performance for the purposes of quality improvement. See BHH process and outcomes metrics section. Stakeholder surveys may be used to determine lessons learned in reference to informing performance improvement. The state reserves the right to review eligibility at any point.

Appendix

Arkansas Behavioral Health Transformation