VI. BHH Enrollees

BHH Eligibility Criteria:

To be eligible for BHH services, an individual must have:

- One of 6 severe and persistent mental illnesses;
  - ◊ Schizophrenia and Psychotic Disorders
  - ◊ Mood Disorders
  - ◊ Anxiety Disorders
  - ◊ Obsessive Compulsive Disorder
  - ◊ Post-Traumatic Stress Disorder
  - ◊ Borderline Personality Disorder
- Active Medicaid; and
- Medicaid claims > $10,000/year

Once a person is eligible and enrolled in the BHH, reductions in annual Medicaid claims will not change their BHH eligibility status. Medicaid eligibility may have an impact on BHH service provision, depending on the cause and length of the interruption in coverage. For examples of various scenarios, see the Enrollment, Payor and Service Guidelines in Appendix C.

Enrollment Process:

Individuals meeting BHH eligibility criteria should be contacted regarding their BHH eligibility before the BHH Medicaid payor is started. Some individuals may already be receiving other services at your agency and others may not be involved in your services yet. For those already receiving services with a LMHA, the specific provider agency assigned as the BHH is based on where the person was served through:

- Outpatient,
- Assertive Community Treatment (ACT),
- Targeted Case Management (TCM),
- Community Support Programs (CSP),
- Recovery Pathways (RP), and/or
- Other Medicaid funded service(s)

The following steps will occur during the enrollment process:

1. Individuals who meet the eligibility criteria for BHH will be identified by either the Administrative Services Organization (ASO) or the state Department of Mental Health and Addiction Services (DMHAS). Lists of these individuals will be given to the BHH contact at each agency quarterly. Other individuals new to an agency may be identified as eligible by checking with the ASO. Eligible children will not be on rosters. Child serving providers must call to check eligibility for children.
2. Appropriate staff will discuss the BHH initiative with the individual to see if they are interested in receiving more comprehensive services to meet both their physical and behavioral health needs.
3. Individuals receive services through the program to which they are assigned. BHH is not a separate program. BHH eligible individuals who are not active in any other program at your agency should be admitted under the BHH NAE (non-auto enrolled) program code in DDaP/WITS.
4. Individuals who are interested will sign appropriate consent to treat if they don't have one on file. It should be explained that by participating in the BHH initiative, the BHH designated provider agency may have access to information regarding their Medicaid claims for their physical and behavioral health services.
5. The BHH will enter BHH Medicaid, or BHH Waiver (if the client is on a waiver), as an insurance payor in the electronic health record or other data collection system. Speak with your agency's BHH contact to find out the process for doing this at your agency. BHH Practice Guideline #1-Insurance Guidelines should be followed.

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Enrollment Process Continued:

Lists of eligible clients from DMHAS, and/or other confidential materials from DMHAS, are shared through the DMHAS Secure File Transfer System (SFT), formerly known as Tumbleweed. See Appendix I for the form needed to access a secure account.

Clients can choose to go to a different BHH for BHH services, whether or not they are getting other services from your agency. Traditional catchment areas do not apply to BHH eligible individuals and BHH services. Eligible individuals can be served by any behavioral health home statewide, regardless of catchment areas.

Persons interested in BHH, who are not on the list of eligible people, may inquire about their eligibility by contacting member services at 1-844-551-2736.

A process flow for the auto and non-auto enrolled clients, with instructions on insurance start and end dates, can be found in Appendix D.

Community Outreach to Non-Auto Enrolled Clients

BHH designated provider agencies may at times receive a list of clients within their community who are eligible to enroll in BHH, but are not currently receiving services at an agency. To engage this segment of the population, the ASO will assist in community outreach planning. The ASO will work with BHH designated provider agencies to locate opportunities within the community to inform potential clients about their BHH eligibility status.

Education and outreach to the non-auto enrolled may include mailings of posters and brochures to eligible individuals on Medicaid, or other community providers; in addition to community outreach meetings in each BHH region. The purpose of the outreach meetings is to provide BHH information to community agencies, individuals, and BHH staff. Outreach materials are available on the BHH website.

BHH Clients Not Receiving Other Agency Services

BHH eligible individuals that are discharged from other agency services, and/or those who were never admitted to other agency services, are able to receive BHH only services. The data collection and reporting requirements are the same for these individuals. The program they are admitted to in DDaP or WITS is the Non Auto-Enrolled (NAE) program. The NAE program in DDaP/WITS is a treatment level of care and will require those fields required by a treatment program. Agencies should refer to policies and procedures for other treatment programs they operate that do not require the client to receive clinical services or psychiatric oversight, such as CSP or psycho social rehab, to serve BHH only clients.

The BHH NAE program in DDaP/WITS was developed to capture individuals that are not being served elsewhere in the agency OR to capture services to individuals that are only enrolled in Levels of Care that are not part of the program list for billing. Therefore, there may be times when clients in the NAE DDaP/WITS program are served in other programs at your agency.

Right to Refuse BHH Services:

Participation in the BHH services is voluntary. At any time, a person served can decide to discontinue participation in the behavioral health home initiative. If this occurs, the BHH designated provider agency must end date the BHH Medicaid or BHH Waiver insurance payor, effective the date the client decides to withdraw. In addition, the client may elect to rescind a release of information (ROI) or remove individuals from their ROI.

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Withdrawals:

Since the BHH Medicaid and BHH Waiver insurance payor is used to enroll individuals, anytime a BHH enrollee withdraws, the BHH payor must be end dated with the date of the withdrawal. Instructions for managing BHH enrollment, withdrawals, and insurance start and end dates for these situations can be found in Appendix C.

Individuals who are discharged from all services at your agency and do not want to continue with BHH services do not need to withdraw from BHH, unless they are planning to receive their BHH services at a different BHH designated provider agency. In both cases, they should be discharged in DDaP or WITS.

Individuals who are discharged from all other services at your agency, but want to continue with BHH services only, may be served under the BHH NAE program code in DDaP/WITS.

Reenrollment:

Eligible individuals who previously withdrew from BHH services may decide to reenroll in BHH services at later date. In these cases, the BHH designated provider agency must end date the old BHH insurance and add a new start date for the BHH Medicaid or BHH Waiver payor. See Practice Guideline #6 on Managing BHH Payors for detailed guidelines on managing the insurance for clients previously discharged.

Special Populations:

Individuals on various waiver programs may still be eligible for BHH services if they meet eligibility criteria. There are some restrictions on which services can be provided for these groups. Waiver clients are limited to receiving health promotion services in an office location (see Appendix E for instructions) and clients living in Medicaid Rehab Options residences may not be served by the BHH at all unless they are discharging from the group home. For child serving agencies, eligibility and enrollment information for children can be found in Appendix L.

Enrollee Satisfaction:

The BHH State Department partners and the CT Partners for Integrated Care greatly value the opinions of all persons served by the BHH providers and rely on their feedback to improve the content, quality, and delivery of BHH services. Satisfaction will be measured as increased satisfaction in care is one of the Initiative’s outcomes.

To gather valuable enrollee feedback, BHH providers will administer the annual DMHAS Consumer Satisfaction Survey or other designated satisfaction survey. The survey will include questions regarding the content, quality, and delivery of BHH services, access to care, quality and appropriateness of care, participation in services, and cultural competence.

Results of the surveys will be shared with the appropriate state Departments and the BHH providers. Necessary changes will be implemented by the CT Partners for Integrated Care and/or BHH provider(s), based on the feedback given by enrollees.

Enrollee Handbook:

The Enrollee Handbook can be found on the BHH website at http://www.ctintegratedcare.com/enrollees/enroll-handbook.html.