Health Homes Intro

MEDICAID | Medicaid State Plan | Health Homes | MN2016MH0002O | MN-16-012 | Behavioral Health Homes

Package Header

Package ID

Submission Type **Official**

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Superseded SPA ID **MN-16-012**

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Program Authority

1945 of the Social Security Act

The state elects to implement the Health Homes state plan option under Section 1945 of the Social Security Act.

Name of Health Homes Program

Behavioral Health Homes

Executive Summary

Provide an executive summary of this Health Homes program including the goals and objectives of the program, the population, providers, services and service delivery model used

Behavioral health home services are ~~will be made~~ available to adults with serious mental illness and children and youth experiencing an emotional disturbance.
~~Beyond minor technical changes throughout, we have moved language from the payment methodologies section and place it in the provider infrastructure section.~~

This amendment supports improved delivery of BHH services by clearly identifying the expectations of all certified BHH services providers, improving access to services, and improving provider requirements.

This amendment contains changes made by the 2019 Minnesota Legislature to strengthen the framework of BHH services, to support the capacity of providers delivering BHH services and to increase access to services, and is effective upon federal approval.

In addition to the first general assurance below that eligible individuals will be given a free choice of Health Homes providers, the state assures that individuals will be given free choice of providers of all other medical assistance services, and for managed care enrollees, a choice of all other medical providers within the plan's network.

General Assurances

√ **The state provides assurance that eligible individuals will be given a free choice of Health Homes providers.**

√ **The states provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**

√ **The state provides assurance that hospitals participating under the state plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**

√ **The state provides assurance that FMAP for Health Homes services shall be 90% for the first eight fiscal quarters from the effective date of the SPA. After the first eight quarters, expenditures will be claimed at the regular matching rate.**

√ **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.**

√ **The state provides assurance that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

Health Homes Geographic Limitations

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√ **Health Homes services will be available statewide**

Health Homes services will be limited to the following geographic areas

Health Homes services will be provided in a geographic phased-in Approach

Health Homes Population and Enrollment Criteria

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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 (Mandatory and Options for Coverage) Eligibility Groups**

√ **Medically Needy Eligibility Groups**

Mandatory Medically Needy

√**Medically Needy Pregnant Women**

√ **Medically Needy Children under Age 18**

Optional Medically Needy (select the groups included in the population)

Families and Adults

√ **Medically Needy Children Age 18 through 20**

√**Medically Needy Parents and Other Caretaker Relatives**

Aged, Blind and Disabled

√ **Medically Needy Aged, Blind or Disabled**

√ **Medically Needy Blind or Disabled Individuals Eligible in 1973**

Health Homes Population and Enrollment Criteria

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Population Criteria

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

Two or more chronic conditions

One chronic condition and the risk of developing another

√**One serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:

Behavioral health home services will be made available to adults with serious mental illness, and children and youth experiencing emotional disturbance. Serious mental illness and emotional disturbance are defined as an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

Recipients must have a diagnosis by a qualified health professional (including a physician) within the past 12 months that meets the criteria for serious mental illness (SMI) or emotional disturbance (ED). A diagnostic assessment is required within the first six months of BHH services to ensure a person is connected to Medicaid covered behavioral health treatment supports and services. ~~have a current diagnostic assessment as performed or reviewed by a mental health professional employed or under contract with the behavioral health home.~~

Health Homes Population and Enrollment Criteria

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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**

Referral and assignment to Health Homes provider with opt-out

Other (describe)

Describe the process used:

In order to receive BHH services, an individual must have a diagnosis by a qualified health professional (including a physician) within the past 12 months that meets the criteria for serious mental illness (SMI) or emotional disturbance (ED). ~~meet the criteria for serious mental illness or emotional disturbance and have a current diagnostic assessment performed or reviewed by a mental health professional employed or contracted by the behavioral health home.~~

The Department will provide certified behavioral health homes (BHH) with a list of individuals identified by the claims payment system who meet the criteria to receive BHH services and are currently served by the BHH provider.

The state will also support the identification of individuals who ~~that~~ are not currently receiving BHH or other case management services. Certified behavioral health homes will engage eligible individuals, or individuals may self-refer for BHH services. Participation in behavioral health homes is voluntary.

Individuals who meet the criteria will receive information regarding their choice to receive BHH services. ~~participate in a BHH.~~

Individuals will then have the ability to opt in to receive BHH services. The opt-in process will include a consent form that will include the individual rights and responsibilities as a recipient of these services.

Health Homes Providers

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Types of Health Homes Providers

√ **Designated Providers**

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

Physicians

√ **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards

•Be enrolled as a Medical Assistance provider.
•Successfully complete and maintain state certification as a behavioral health home provider.

√ **Rural Health Clinics**

Describe the Provider Qualifications and Standards

•Be enrolled as a Medical Assistance provider.
•Successfully complete and maintain state certification as a behavioral health home provider.

√ **Community Health Centers**

Describe the Provider Qualifications and Standards

•Be enrolled as a Medical Assistance provider.
•Successfully complete and maintain state certification as a behavioral health home provider.

√ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards

•Be enrolled as a Medical Assistance provider.
•Successfully complete and maintain state certification as a behavioral health home provider.

Home Health Agencies

Case Management Agencies

√ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards

•Be enrolled as a Medical Assistance provider.
•Successfully complete and maintain state certification as a behavioral health home provider.

√**Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards

•Be enrolled as a Medical Assistance provider.
•Successfully complete and maintain state certification as a behavioral health home provider.

Other (Specify)

Teams of Health Care Professionals

Health Teams

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Home Services

The state will use the designated provider model for behavioral health homes. Behavioral health homes must be enrolled as a Medicaid provider prior to serving as a behavioral health home and must provide services through a team-based model of care. All behavioral health homes must include the following team members:

Team Member: Team Leader
Required Qualifications:
• Clinic manager
• Medical Director, or
• Other management-level professional

Team Member: Integration Specialist
Required Qualifications:
• Registered Nurse, including and Advanced Practice Registered Nurse, or
• Mental health professional as defined in the state plan in item 6.d.A. of Attachments 3.1-A/B

Team Member: Behavioral Health Home Systems Navigator
Required Qualifications:
~~**• Case manager as defined in Attachments 3.1-A/B, supplement 1; or**~~
• Mental health practitioner as defined in Attachments 3.1-A/B, item 4.b; or
• Community health worker.

Team Member: Qualified Health Home Specialist
Required Qualifications:
• Case management associate as defined in Attachments 3.1-A/B, supplement 1;
• Mental health rehabilitation worker as defined in Attachments 3.1-A/B, item 13.d.;
• Community health worker;
• Peer support specialist as defined in Attachments 3.1-A/B, item 13.d.;
• Family peer support specialist as defined in Attachments 3.1-A/B, item 4.b.;
• Community paramedic as defined in item 5.a.; ~~or~~
• Certified health education specialist; or
• Peer recovery specialist.

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

Minnesota convened a group of providers that were interested in becoming certified BHHs. The group is known as the first implementers group. The purpose of the first implementers group is to receive support from DHS in order to prepare for BHH certification, and to share best practices. Thirty-nine agencies across the state, including the Indian Health Board, have indicated interest in participating. An initial needs assessment was

conducted and will inform the development of curriculum focused on behavioral health home certification and on topics related to integration of mental and physical health.

The Department will continue to encourage ongoing, collaborative learning by offering educational opportunities such as webinars and regional meetings.

Other Health Homes Provider Standards

The state's requirements and expectations for Health Homes providers are as follows

~~All~~ Every BHH services providers must be an enrolled MA provider, and must obtain and maintain certification by the Department as a certified BHH services provider. This certification requires demonstration of the ability and capacity to perform the following:

•Maintain the required BHH services team structure as described above and provide comprehensive care management, care coordination and health promotion, comprehensive transitional care, individual and family support services, and referrals to community and social support services.

•Utilize a team-based model of care including regular coordination and communication between members of the BHH services team.

•Conduct comprehensive screenings that address behavioral, medical, and social service and community support needs. Screenings must be consistent with professional standards of care.

•Create and maintain an individualized health action plan for each recipient that encompasses behavioral health, physical health, social services, and community supports.

•Use health information technology to link services, identify and manage gap sin care, and facilitate communication among team members and other providers.

•Use an electronic health record and patient registry to collect data at the individual and practice levels that allows them to identify, track, and segment the population to improve outcomes over time.

•Establish processes in order to identify and share individual level information in a timely manner with professionals and providers that are involved in the individual's care.

•Demonstrate efforts to engage area hospitals, primary care practices and behavioral health providers to collaborate with the behavioral health home on care coordination.

•When feasible, establish policies and written agreements with primary care providers (or mental health providers when behavioral health home services are delivered in a primary care setting) to ensure communication and integration of care.

•Track individuals' medications and lab results, to support symptom management. BHH services providers will use this data to discuss treatment options with a recipient's primary care or behavioral health professional.

•Demonstrate commitment by leadership to pursue integration and support practice transformation.

•Establish a continuous quality improvement plan, and collect and report data that will inform state and federal evaluations.

BHH teams will be integrated with both primary care and behavioral health professionals:

• In a behavioral health setting, the required integrated team must include a nurse care manager.

• In a primary care setting, the team must include a licensed mental health professional.

Behavioral health home providers must also:

•Directly provide, or subcontract for, the provision of care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services.

•Maintain documentation of all team member qualifications in their personnel files.

•Participate in federal and state-required evaluation activities including documentation of behavioral health home services.

•Comply with all of the terms and conditions of certification.

•A BHH services provider planning to terminate the delivery of behavioral health home services must give 60-day notice to the Department, all of its ~~BHH recipients~~ people receiving BHH services, and applicable managed care plans. Providers must assist the recipient with finding a new behavioral health home provider.

•Provide recipients with BHH services program materials, including the rights and responsibilities document, inform recipients about the choice to participate and obtain consent to participate.

BHH services providers will be expected to ensure that children and youth are cared for by team members who are specifically trained and experienced in working with children, youth and

caregivers. BHH services providers will be expected to maintain ~~the staffing ratios listed in the payment methodologies section of the state plan amendment~~ adequate staffing ratios to deliver the required services in a manner that best meets the needs of the individuals served.

~~If a provider serves 100 or less BHH recipients in their first year of certification, the provider may utilize an adjusted stffaing ratio of a minimum of .5FTE integration specialist and 1FTE systems navigator to serve these recipients. Upon recertification or upon serving more than 100 BHH recipients, these providers must meet and maintain the BHH staffing ratios listed in the payment section of the state plan amendment.~~

Teams will share a case load so that every consumer has access to the expertise and services provided by each of the three unique BHH services team

members. On an ongoing basis after the person's initial 90 days of receiving BHH services, the provider must:

- **Have personal contact with the person or the person's identified support at least once per month. The contact must be connected to at least one of the six required services linked to the person's goals in the health action plan. This contact may include face-to-face, telephone contact or interactive video. A letter, voicemail, email or text alone does not meet the requirement for monthly personal contact.**

- **Meet face-to-face with the person ~~every 60 days~~ at least once every six months. This recurring meeting must be linked to the person's goals and can be attended by any BHH team member. This face-to-face requirement can be met by any of the following:**
  - **meeting face-to-face with the person to complete the six-month review of the health action plan,**

  accompanying a person to an appointment,
  - **providing face-to-face individual or group health education or support services, or**
  - **meeting face-to-face with the person to support their goals.**

- **Meet face-to-face with the person every six months to review and update the health action plan.**

Name	Date Created	
	No items available	

Health Homes Service Delivery Systems

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

√ **Fee for Service**

PCCM

√ **Risk Based Managed Care**

The Health Plans will be a Designated Provider or part of a Team of Health Care Professionals

Yes

√ **No**

Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be avoided

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

Behavioral health home services will be paid as part of the capitation rate, based on a rate set by the state. MCOs will not be a designated provider.

Contracts will include the following:

•The MCO is not permitted to reimburse the following services in the same calendar month that the member received behavioral health home services:

-assertive community treatment (ACT)
-youth assertive community treatment (Youth ACT)
-mental health targeted case management
-relocation services coordination
-health care homes care coordination
-targeted case management for persons not receiving services pursuant to a Section 1915(c) waiver who are vulnerable adults, adults with developmental disabilities, or adults without a permanent residence

•If an enrollee receives care management services from the MCO and BHH services in the same month, the MCO and the BHH must develop a written plan that defines the roles and responsibilities of the MCO care manager and the BHH team. The written plan must demonstrate that the minimal requirements for each entity are met and that duplication between the MCO and the BHH provider is avoided.

•The MCO must provide the BHH with a designated contact to facilitate the sharing of enrollee information and coordination of services.

•The MCO and the BHH must inform each other in a timely manner of any inpatient hospital admission or discharge to promote appropriate follow-up and coordination of services.

•The MCO and the BHH must inform each other in a timely manner of any use of the emergency department by the enrollee.

Other

Other Service Delivery System

Health Homes Payment Methodologies

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Payment Methodology

The State's Health Homes payment methodology will contain the following features

√ **Fee for Service**

Individual Rates Per Service

√ **Per Member, Per Month Rates**

Fee for Service Rates based on

Severity of each individual's chronic conditions

Capabilities of the team of health care professionals, designated provider, or health team

√ **Other**

Describe below

Per member per month rate as described below.

Comprehensive Methodology Included in the Plan

Incentive Payment Reimbursement

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided.

The hourly costs for each professional are based on the salary and benefit expectations for each classification and assumptions around the professionals' time spent on the specific service integration activities. Salary expectations were based on comparable salaries within the existing DHS payment structure.

PCCM (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 PMPM payments (describe below)

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Agency Rates

Describe the rates used

√ **FFS Rates included in plan**

Comprehensive methodology included in plan

The agency rates are set as of the following date and are effective for services provided on or after that date

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Rate Development

Provide a comprehensive description in the SPA of the manner in which rates were set

1. **In the SPA please provide the cost data and assumptions that were used to develop each of the rates**
2. **Please identify the reimbursable unit(s) of service**
3. **Please describe the minimum level of activities that the state agency requires for providers to receive payment per the defined unit**
4. **Please describe the state's standards and process required for service documentation, and**
5. **Please describe in the SPA the procedures for reviewing and rebasing the rates, including**
   - **the frequency with which the state will review the rates, and**
   - **the factors that will be reviewed by the state in order to understand if the rates are economic and efficient and sufficient to ensure quality services.**

Comprehensive Description **Effective for services provided on or after July 1, 2016, payment for BHH services is $245.00 per member, per month. During the recipient's first six months of participation, the BHH will receive an enhanced payment rate of $350.00 per member, per month. This enhanced payment will be made only once in each recipient's lifetime.**

The Department made the following assumptions in developing the monthly payment rates for behavioral health home services:

•The population served by the BHH services management team will have the need for varying level of services depending on the severity of the population's behavioral health conditions and medical comorbidities. Recipients are assigned to one of twelve different classification groups based on their age (children vs. youths vs. adults), the level of their medical comorbidities (no significant comorbidities, one to two medical risk indicators, three or more indicators of medical risk) and, for adults, the relative severity of their behavioral health condition (SMI vs. SPMI). The average rate is based on an assumed distribution of recipient classification based primarily on the existing behavioral and medical risk distribution of the population eligible for the program.

•The anticipated cost built into the rate for each activity is based on the number of expected hours for each activity, the distribution of the professionals assumed to be executing the activity and the expected hourly cost associated with the employment of those professionals.

•The relative amount of time spent on each management activity is based on review of comparable services at the state and national level, and survey information collected from potential participating organizations and groups currently performing similar management activities.

•Additional hours are also expected during the initial six months of a recipient's BHH receipt of services to allow for additional BHH services activities during program acclimation.

•The expectation of monthly cost related to service integration is reduced after the recipient's first six months of BHH services. Specifically, there will be lower expected need for ongoing management once recipients are engaged in the program, their health action plans have been developed and implemented, and they have become acclimated to the program and the activities surrounding their health action plan.

•The multi-disciplinary service integration team is expected to complete specific BHH services requirements each month. The relative time spent by each professional varies by activity (i.e. the anticipated team composition for each activity varies based on the professional requirements necessary to execute the activity).

Additional detail around the assumptions used to develop the rates include:

•The monthly tasks and hours expectations are also differentiated by their assumed frequency. Some services are expected to occur on a monthly basis, whereas others are only attributable to the initial engagement period (e.g. health action plan development) or would be incurred on an "as-needed" basis for a portion of the population (e.g. management of transitions of care). See below for highlights of the overall service integration requirements and the hourly assumptions for specific activities:

-Depending on recipient classification, the range of hours that it is anticipated that a BHH provider will spend on BHH services activities per month per recipient is 5 to 12.5 hours

¿A recipient with SMI with low medical risk is assumed to require an average of 5 hours of monthly service integration, while a recipient with SPMI with high medical risk is

assumed to need an average of 12.5 hours of monthly service integration activities

¿Based on the expected distribution of recipients, the payment rate assumes an average of approximately 5.75 hours of monthly BHH activities

-Beyond the initial health action plan development, each recipient's health action plan will be revised on a regular basis and time is incorporated into the monthly rates for these annual or semi-annual activities.

-The hours of service per month are estimated based on anticipated activities to achieve the behavioral health home goals and needs of the recipients. BHHs will not be required to report monthly hours for the purpose of payment.

-The rate was developed with the assumption of a team-based approach that allows for each team member to complete specific activities connected to the six core health home services and to work at the top of their license or qualifications. ~~The rate is built upon the following caseload ratios:~~

•1 FTE integration specialist for every 224 members
•1 FTE systems navigator for every 56 members
•1 FTE qualified health home specialist for every 56 members

The Department will allow a variance in the staffing ratios of up to 25 percent based on the needs and structure of the behavioral health home.

•The long-term staffing model assumes that new recipients (i.e. recipients requiring the management expectations used to develop the enhanced rate) will be 10% of the overall number of people receiving BHH services.

In order to receive a monthly PMPM payment, the BHH services provider must have personal contact with the person or the person's identified support at least once per month. The contact must be connected to at least one of the six required services linked to the person's goals in the health action plan. This contact may include face-to-face, telephone contact or interactive video. A letter, voicemail, email or text alone does not meet the requirement for monthly personal contact.

DHS will review BHH service rates at least every four years, as follows: DHS will review the Department of Labor prevailing wage for required team members, and average hours spent providing services; and will ensure that BHH rates are sufficient to allow providers to meet required certifications, training and practice transformation standards, staff qualification requirements, and service delivery standards.

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Assurances

√ **The State provides assurance that it will ensure non-duplication of payment for services similar to Health Homes services that are offered/covered under a different statutory authority, such as 1915(c) waivers or targeted case management.**

Describe below how non-duplication of payment will be achieved

Our MMIS system will prevent duplication of payment by preventing payment for the following services in the same month that a recipient receives behavioral health home services:

- **assertive community treatment (ACT)**
- **youth assertive community treatment (Youth ACT)**
- **mental health targeted case management**
- **relocation services coordination**
- **targeted case management for persons not receiving services pursuant to a Section 1915(c) waiver who are vulnerable adults, adults with developmental disabilities, or adults without a permanent residence**
- **health care homes care coordination**

Behavioral health home providers will refer recipients in need of ACT or Youth ACT services to a qualified provider of those services. The provision of BHH services will end once ACT/Youth ACT services commence.

Recipients of waiver services provided under § 1915(c) receive case management services to ensure access to services available under the waiver and to ensure effective utilization of these services. We will require BHH providers to coordinate service delivery with home and community based waiver case managers to ensure that no duplication occurs.

√ **The State meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4), 1902(a)(6), 1902(a)(30)(A), and 1903 with respect to non-payment for provider-preventable conditions.**

√ **The State provides assurance that all governmental and private providers are reimbursed according to the same rate schedule, unless otherwise described above.**

√ **The State provides assurance that it shall reimburse providers directly, except when there are employment or contractual arrangements consistent with section 1902(a)(32).**

Health Homes Services

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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

Comprehensive care management is a collaborative process designed to manage medical, social, and behavioral health conditions more effectively based on population health data and tailored to the individual recipient.

BHHs will:
•Design and implement new activities and workflows that increase recipient engagement and optimize efficiency.

•Use a searchable EHR tool and patient registry to collect individual and practice-level data. This will allow providers to identify, track, and segment the population, improve outcomes over time, manage BHH services, provide appropriate follow-up, and identify any gaps in care.

•Utilize population management, which is a proactive approach to using data to systematically assess, track, and manage health conditions of the recipient panel.

•Design and implement communication and care coordination tools, to ensure that care is consistent among a recipient's providers.

•Select common clinical conditions and target cohorts on which to focus.

•The integration specialist must review the patient registry regularly to track individuals' medications, lab results, support symptom management and use this data to discuss treatment with a recipient's primary care or behavioral health professional as needed. The registry must contain fields as determined by the Department.

•Meet with each recipient and evaluate their initial and ongoing needs.

•Utilize care strategies including HIT and other tools to communicate and coordinate with the recipient and with other caregivers.

•Monitor the use of routine and preventative primary care, dental care, and well-child physician visits.

When the recipient is a child or youth, all activities must include the child's parent/caregiver. The BHH must support the family in creating an environment to support their child in managing their health and wellbeing. For youth, the health action plan must address the plan to support transition from youth to adult services and supports.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All BHHs will be required to utilize electronic health records and a patient registry. Through the certification standards, behavioral health homes must demonstrate their capacity to collect data, exchange information, and monitor population health and to track progress and outcomes.

At a minimum, the BHH provider must:
•Use an electronic health record and patient registry to collect individual and practice-level data.

•Monitor and analyze data in their patient registry and in the Minnesota Department of Human Services Partner Portal for purposes of population health management. The partner portal is a secure, web-based

reporting tool which enables access to information that providers can use to help coordinate care, and manage cost and quality.

Additional HIT-related requirements that will be phased in over the first 18 months include:

•Use of HIT to link services, identify and manage gaps in care, track, and segment the population, and improve outcomes over time.

•Use of electronic and non-electronic tools to use best practices and evidence to guide care.

•Use of HIT to facilitate communication among behavioral health home team members and other providers and with the recipient and with other caregivers.

Behavioral health homes will be monitored on a regular basis to ensure adherence to certification standards.

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

Nurse Practitioner

Nurse Care Coordinators

Nurses

Medical Specialists

Physicians

Physician's Assistants

Pharmacists

Social Workers

Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

Dieticians

Nutritionists

√**Other (specify)**

Provider Type	Description
Integration Specialist	**These services are provided by a registered nurse, including an advanced practice registered nurse, when BHH service are offered in a mental health setting, or a mental health professional, as described in Attachment 3.1-A/B, item 6.d.A, when BHH services are offered in a primary care setting.** **These services may also be supported by other BHH team members.**

Care Coordination

Definition

Care coordination occurs when the BHH acts as the central point of contact in the compilation, implementation, and monitoring of the individualized health action plan through appropriate linkages, referrals, coordination and follow-up to needed services and supports.

BHHs will perform:

Initial Assessment of Need
•Identify recipient’s immediate safety and transportation needs and any other barriers to receiving BHH services.
•Implement a plan to meet immediate identified needs.

Health Wellness Assessment

•Complete the assessment using the template provided by the Department. The assessment process must begin within 30 days of intake and be completed within 60 days.
•Talk with BHH and other professionals involved in the recipient's care to gather information for the health action plan.
•The assessment must include a review of the diagnostic assessment, screenings for substance use, and the domains identified in the comprehensive wellness inventory created by the state.

Development of Health Action Plan
•Draft a patient-centered health action plan based on the comprehensive inventory within 90 days of intake. BHHs must use the health action plan template provided by the Department.
•Update the health wellness assessment and health action plan at least every six months thereafter.

Ongoing Care Coordination
•Maintain regular and ongoing contact with the recipient and/or their identified supports.
•Monitor progress on goals in the health action plan and the need for plan alterations.
•Assist the recipient in setting up and preparing for appointments, accompanying the recipient to appointments as appropriate, and follow-up.
•Identify and share individual-level information with professionals involved in the individual's care.
•Ensure linkages to medication monitoring as needed.
•Coordinate within the BHH team on behalf of the recipient.

When the recipient is a child or youth, all activities must include the child's parent/caregiver.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All BHHs will be required to utilize electronic health records and a patient registry. Through the certification standards, behavioral health homes must demonstrate their capacity to collect data, exchange information, and monitor population health and to track progress and outcomes.

At a minimum, the BHH provider must:
•Use an electronic health record and patient registry to collect individual and practice-level data.

•Monitor and analyze data in their patient registry and in the Minnesota Department of Human Services Partner Portal for purposes of population health management. The partner portal is a secure, web-based reporting tool which enables access to information that providers can use to help coordinate care, and manage cost and quality.

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•Use of HIT to facilitate communication among behavioral health home team members and other providers and with the recipient and with other caregivers.

Behavioral health homes will be monitored on a regular basis to ensure adherence to certification standards.

Scope of service

The service can be provided by the following provider types

- Behavioral Health Professionals or Specialists
- Nurse Practitioner
- Nurse Care Coordinators
- Nurses
- Medical Specialists
- Physicians
- Physician's Assistants
- Pharmacists
- Social Workers
- Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

Dieticians

Nutritionists

√ **Other (specify)**

Provider Type	Description
Behavioral Health Home Systems Navigator	**Care coordination services are provided by either ~~a case manager as defined in Attachments 3.1-A/B, supplement 1, or~~ a mental health practitioner as defined in Attachments 3.1-A/B, item 4.b or community health worker. These services may also be supported by other BHH team members.**

Health Promotion

Definition

Health and wellness promotion services encourage and support healthy living and motivate individuals and/or their identified supports to adopt healthy behaviors and promote better management of their health and wellness. They place a strong emphasis on skills development so individuals and/or their identified supports can monitor and manage their chronic health conditions to improve health outcomes.

BHHs will be responsible to:
•Provide recipients with information to increase their understanding of the illnesses/health conditions identified in the health wellness assessment, and educate recipients on how those conditions relate to and impact various facets of their health and well-being.

•Work with recipients to increase their knowledge about their specific health conditions and support recipients in developing skills to self-manage their care and maintain their health.

•Support recipient participation in activities aimed at developing skills to self-manage their care and reach their health goals.

•Support recipients in recovery and resiliency.

•Offer or facilitate the provision of on-site coaching, classes, and information on topics related to the identified needs of recipients, including: wellness and health-promoting lifestyle interventions, substance use disorder prevention/early intervention and cessation, HIV/AIDS prevention/early intervention, STD prevention/early intervention, family planning and pregnancy support, nicotine prevention and cessation, nutritional counseling, obesity reduction and prevention, increasing physical activity, and skill development.

When the recipient is a child or youth, all activities must include the child's parent/caregiver. The BHH must support the family in creating an environment to support their child in managing their health and wellbeing. For youth, the health action plan must address plan to support the transition from youth to adult services and supports.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All BHHs will be required to utilize electronic health records and a patient registry. Through the certification standards, behavioral health homes must demonstrate their capacity to collect data, exchange information, and monitor population health and to track progress and outcomes.

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•Use of HIT to link services, identify and manage gaps in care, track, and segment the population, and improve outcomes over time.

•Use of electronic and non-electronic tools to use best practices and evidence to guide care.

•Use of HIT to facilitate communication among behavioral health home team members and other providers and with the recipient and with other caregivers.

Behavioral health homes will be monitored on a regular basis to ensure adherence to certification standards.

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

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Nurses

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√Other (specify)

Provider Type	Description
Qualified Health Home Specialist	**Health promotion services are provided by either a:** **• Case management associate as defined in Attachment 3.1-A/B, supplement 1.** **• Mental health rehabilitation worker as defined in Attachment 3.1-A/B, item 13.d.** **• Community health worker** **• Peer support specialist as defined in Attachment 3.1-A/B, item 13.d.** **• Family peer support specialist as defined in Attachment 3.1-A/B, item 4.b.** **• Community paramedic as defined in item 5.a.** **• Certified health education specialist** **• Peer recovery specialist** **These services may also be supported by other BHH team members.**

Comprehensive Transitional Care from Inpatient to Other Settings (including appropriate follow-up)

Definition

Comprehensive transitional care activities are specialized care coordination services that focus on the movement of recipients between different levels of care or settings. The BHH will:

•Ensure recipient services and supports are in place:
-Following discharge from a hospital or treatment center;
-Following departure from a homeless or domestic violence shelter, a correctional facility, foster care, and any other setting with which the recipient and family may be involved.
-In conjunction with children and family services, treatment foster care, special education and other services with which the recipient and family may be receiving.

•In partnership with the recipient and their identified supports, establish a transition plan to be followed after discharge from hospitals, residential treatment, and other settings. The plan should be in place prior to discharge, when possible, and should include protocols for:
-Maintaining contact between the BHH and the recipient and their identified supports during and after discharge;
-Linking recipients to new resources as needed;
-Reconnecting to existing services and community and social supports; and
-Following up with appropriate entities to transfer or obtain recipient's service records as necessary for continued care.

•Develop relationships with local hospitals and inform them of the opportunity to connect existing In-reach services to BHH.

•Advocate on behalf of the recipient and their families to ensure they are included in transition planning. When the recipient is a child or youth, all activities must include the recipient's family or identified supports.

BHHs must:
•Ensure plans are developmentally appropriate

•Ensure plans include the parent/caregiver.

•Collaborate with the parent/caregiver in all discharge planning.

•Ensure that the parent/caregiver has adequate information about the children's condition to support the child and family in self-management.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All BHHs will be required to utilize electronic health records and a patient registry. Through the certification standards, behavioral health homes must demonstrate their capacity to collect data, exchange information, and monitor population health and to track progress and outcomes.

At a minimum, the BHH provider must:
•Use an electronic health record and patient registry to collect individual and practice-level data.

•Monitor and analyze data in their patient registry and in the Minnesota Department of Human Services Partner Portal for purposes of population health management. The partner portal is a secure, web-based

reporting tool which enables access to information that providers can use to help coordinate care, and manage cost and quality.

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•Use of HIT to facilitate communication among behavioral health home team members and other providers and with the recipient and with other caregivers.

Behavioral health homes will be monitored on a regular basis to ensure adherence to certification standards.

Scope of service

The service can be provided by the following provider types

Behavioral Health Professionals or Specialists

Nurse Practitioner

Nurse Care Coordinators

Nurses

Medical Specialists

Physicians

Physician's Assistants

Pharmacists

Social Workers

Doctors of Chiropractic

Licensed Complementary and alternative Medicine Practitioners

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Nutritionists

√**Other (specify)**

Provider Type	Description
Behavioral Health Home Systems Navigator	**This service is provided by either ~~a case manager as defined in Attachments 3.1-A/B, supplement 1, or~~ a mental health practitioner as defined in Attachments 3.1-A/B, item 4.b, or community health worker. This service may also be supported by other BHH team members.**

Individual and Family Support (which includes authorized representatives)

Definition

Individual and family support services are activities, materials, or services aimed to help recipients reduce barriers to achieving goals, increase health literacy and knowledge about chronic condition(s), increase self-efficacy skills, and improve health outcomes.

The BHH will:

•Provide person-centered, consistent, and culturally-appropriate communication with recipients and their identified supports.

•Accurately reflect the preferences, goals, resources, and optimal outcomes of the recipient and their identified supports in the creation of the health action plan

•Utilize the recipient's formal and informal supports as chosen by the individual, to assist in the recipient's recovery, promote resiliency, and support progress toward meeting the recipient's health goals.

•Assist recipients and families with accessing self-help resources, peer support services, support groups, wellness centers, and other care programs focused on the needs of the recipient and his or her family and/or identified supports.

•Assist recipients with obtaining and adhering to prescribed medication and treatments.

•Offer family support and education activities.

•Support recipients and/or recipients' identified supports in improving their social networks.

•Teach individuals and families how to navigate systems of care in order to identify and utilize resources to attain their highest level of health and functioning within their families and community.

When the recipient is a child or youth, all activities must include the child's parent/caregiver.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

All BHHs will be required to utilize electronic health records and a patient registry. Through the certification standards, behavioral health homes must demonstrate their capacity to collect data, exchange information, and monitor population health and to track progress and outcomes.

At a minimum, the BHH provider must:

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√**Other (specify)**

Provider Type	Description
Behavioral Health Home Systems Navigator	**This service is provided by either a mental health practitioner as defined in Attachments 3.1-A/B, item 4.b. or community health worker. ~~case manager as defined in Attachments 3.1-A/B, supplement 1, or a mental health practitioner as defined in Attachments 3.1-A/B, item 4.b.~~ This service may also be supported by other BHH team members.**

Referral to Community and Social Support Services

Definition

Referral to community and social support services occurs in collaboration with the recipient and/or their identified supports.

The BHH provider:
•Identifies appropriate resources,

•Refers recipients to a variety of services,

•Assists recipients in setting up and preparing for appointments, and

•Accompanies the recipient to appointments as appropriate.

The BHH will:
•Have a process in place to learn about and understand the
recipient's culture and individual preferences and include the recipient in identifying resources that meet their cultural needs.

•Ensure that recipients have access to resources in order to address the recipient's identified goals and needs. Resources should address social, environmental and community factors all of which impact holistic health; including but not limited to, medical and behavioral health care, entitlements and benefits, respite, housing, transportation, legal services, educational and employment services, financial services, long term supports and services, wellness and health promotion services, specialized support groups, substance use prevention and treatment, social integration and skill building, and other services as identified by the recipient and their identified supports.

•Check in with the recipient and their family after a referral is made in order to confirm if they need further assistance scheduling or preparing for appointments, or assistance following up after connecting with community resources.

•Develop and maintain relationships with other community and social support providers to aid in effective referrals and timely access to services.

Adult recipients will be encouraged to identify family or other supports to participate in BHH services. When the recipient is a child or youth, BHHs must include the parent/caregiver in activities and ensure resources are developmentally appropriate.

Describe how Health Information Technology will be used to link this service in a comprehensive approach across the care continuum

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√**Other (specify)**

Provider Type	Description

Provider Type	Description
Behavioral Health Home Systems Navigator	**This service is provided by either a mental health practitioner as defined in Attachments 3.1A/B, item 4.b or community health worker. ~~a case manager as defined in Attachments 3.1-A/B, supplement 1, or a mental health practitioner as defined in Attachments 3.1-A/B, item 4.b.~~ This service may also be supported by other BHH team members.**

Package Header

Package ID

SPA ID **MN-19-0015**

Submission Type **Official**

Initial Submission Date **9/30/2019**

Approval Date 12/10/2019

Effective Date **10/1/2019**

Superseded SPA ID **MN-16-012**

Health Homes Patient Flow

Describe the patient low through the state's Health Homes system. Submit with the state plan amendment low-charts of the typical process a Health Homes individual would encounter

See attached documents.

Name	Date Created	
BHH Macro Map Submission	**8/16/2016 5:12 PM EDT**	
BHH Micro Map Submission	**8/16/2016 5:12 PM EDT**	

Health Homes Monitoring, Quality Measurement and Evaluation

MEDICAID | Medicaid State Plan | Health Homes | MN2016MH0002O | MN-16-012 | Behavioral Health Homes

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Monitoring

Describe the state's methodology for calculating cost saving (and report cost savings annually in Quality Measure Report). Include savings that result from improved coordination of care and chronic disease management achieved through the Health Homes Program, including data sources and measurement specifications, as well as any savings associated with dual eligibles, and if Medicare data was available to the state to utilize in arriving at its cost-savings estimates

The Department will use data from FFS claims and encounter data to estimate the savings achieved. We will compare the relative claim costs and annual cost increases of the BHH enrolled population to the overall Medicaid population and the "control" population of the BHH-eligible members who are not enrolled in a BHH. The observed relative costs and year-to-year trends will be reasonably adjusted for the populations' relative Medicaid program distributions and risk (i.e. risk adjusted) and, for the BHH-enrolled vs. control group comparison, the classification of the member (SED, SMI, SPMI, etc.). The Department will also measure the relative costs by broad and detailed claim cost categories to understand the key drivers of the observed aggregate savings and provide additional feedback to the participating providers. Where appropriate, the Department may choose to adjust for the impact of high-cost cases, although the relative prevalence of high-cost cases will likely be retained as part of the overall performance assessment. Where sufficient enrolled lives exist to develop credible estimates, the Department may also choose to examine the cost savings achieved by individual BHHs.

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)

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Quality Measurement and Evaluation

√ **The state provides assurance 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**

√**The state provides assurance that it will report to CMS information submitted by Health Homes providers to inform evaluations, as well as Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS**

√ **The state provides assurance that it will track avoidable hospital readmissions and report annually in the Quality Measures report**