MN - Submission Package - MN2022MS0006O - (MN-22-0036) - Health Homes

CMS-10434 OMB 0938-1188

Package Information

Package ID MN2022MS0006O

Program Name Behavioral Health Homes

SPA ID MN-22-0036

Version Number 1

Submitted By Patricia Callaghan

Package Disposition

Submission Type Official

State MN

Region Chicago, IL

Package Status Approved

Submission Date 12/14/2022

Approval Date 2/3/2023 1:15 PM EST

Health Homes Providers

MEDICAID | Medicaid State Plan | Health Homes | MN2022MS0006O | MN-22-0036 | Behavioral Health Homes

Package Header

Package ID MN2022MS0006O

Submission Type Official

Approval Date 2/3/2023

Superseded SPA ID MN-21-0005

SPA ID MN-22-0036

Initial Submission Date 12/14/2022

Effective Date 10/1/2022

Types of Health Homes Providers

_X_ Designated Providers

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

___Physicians

_X_ Clinical Practices or Clinical Group Practices

Describe the Provider Qualifications and Standards

·Be enrolled as a Medical Assistance provider, and provide a medical assistance covered primary care or behavioral health service.
·Successfully complete and maintain state certification as a behavioral health home provider.

_X_ Rural Health Clinics

Describe the Provider Qualifications and Standards

·Be enrolled as a Medical Assistance provider, and provide a medical assistance covered primary care or behavioral health service.
·Successfully complete and maintain state certification as a behavioral health home provider.

_X_ Community Health Centers

Describe the Provider Qualifications and Standards

·Be enrolled as a Medical Assistance provider, and provide a medical assistance covered primary care or behavioral health service.
·Successfully complete and maintain state certification as a behavioral health home provider.

_X_Community Mental Health Centers

Describe the Provider Qualifications and Standards

·Be enrolled as a Medical Assistance provider, and provide a medical assistance covered primary care or behavioral health service.
·Successfully complete and maintain state certification as a behavioral health home provider.

___ Home Health Agencies

___ Case Management Agencies

_X_Community/Behavioral Health Agencies

Describe the Provider Qualifications and Standards

·Be enrolled as a Medical Assistance provider, and provide a medical assistance covered primary care or behavioral health service.

·Successfully complete and maintain state certification as a behavioral health home provider.

_X_ Federally Qualified Health Centers (FQHC)

Describe the Provider Qualifications and Standards

·Be enrolled as a Medical Assistance provider, and provide a medical assistance covered primary care or behavioral health service.
·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:
· 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;
· Mental health certified peer support specialist as defined in Attachments 3.1-A/B, item 13.d;
· Mental health certified family peer support specialist as defined in Attachments 3.1-A/B, item 4.b;
· Community paramedic as defined in Attachments 3.1-A/B, item 5.a;
· Qualified substance use disorder 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

Every BHH services provider must be an enrolled MA provider and provide a medical assistance covered primary care or behavioral health service, 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 and refer an individual to resources appropriate to the individual's screening results. Screenings must be consistent with professional standards of care.

· Create and maintain an individualized health action plan for each recipient that accurately reflects the individual's preferences, goals, resources, and optimal outcomes for the individual and the
- individual's identified supports, and encompasses behavioral health, physical health, social services, and community supports. In addition, providers must:
- provide a central point of contact to ensure successful navigation of the array of services that may affect the person's health and well-being;
- have capacity to assess the person's readiness for change and capacity to integrate new supports into one's life;
- offer of facilitate wellness and prevention education specific to the prevention and management of common chronic conditions;
- assist the person with setting up and preparing for appointments (medical, behavioral health, social service, or community support services), including accompanying the person, and following up with the person after appointments;
- offer or facilitate health coaching related to chronic disease management and coaching on navigating complex systems of care, to the person, the person's family and identified supports;
- connect the person, family and identified supports to appropriate support services that help the person overcome access or service barriers, increase self-sufficiency skills, and improve overall health;
- provide effective referrals and timely access to services;
- establish a continuous quality improvement process for providing behavioral health home services;
- create a plan with the person and the person's identified supports for the support of the person after discharge from a hospital, residential treatment program, or other setting. The plan must have protocols for maintaining contact between the assigned BHH provider team member, the person and the person's identified supports during and after discharge; linking the person to new resources; reestablishing the person's existing services and community supports; and following up with other entities to transfer or obtain the person's service records as necessary for continued care.

· Use health information technology to link services, identify and manage gaps in 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 and have policies and procedures to track referrals to ensure that the referral met the individual's needs.

·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 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 adequate staffing ratios listed 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, the provider may utilize an adjusted staffing 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. At a minimum, the BHH team must offer a face to face visit with the person every six months. If the person declines the offer of a face to face visit, the visit may be completed by telephone contact or interactive video.

Variance Authority:
The commissioner has authority to grant a variance of requirements related to behavioral health home services providers:

- Services provider requirements
- Services provider training and practice transformation requirements
- Services staff qualifications
- Services delivery standards

The variance may be granted if the commissioner finds that:
(1) failure to grant the variance would result in hardship or injustice to the applicant;
(2) the variance would be consistent with the public interest; and
(3) the variance would not reduce the level of services provided to individuals served by the organization.

The commissioner may also grant a variance from one or more requirements in the above subsections, to permit a services provider to offer behavioral health home services of a type or in a manner that is innovative, as long as there is no resulting impediment to achievements required by these subsection, and approval may improve services to the applicant.

Health Homes Service Delivery Systems

MEDICAID | Medicaid State Plan | Health Homes | MN2022MS0006O | MN-22-0036 | Behavioral Health Homes

Package Header

Package ID MN2022MS0006O

SPA ID MN-22-0036

Submission Type Official

Initial Submission Date 12/14/2022

Approval Date 2/3/2023

Effective **Date** 10/1/2022

Superseded SPA ID MN-19-0015

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

_X_ Fee for Service

___PCCM

_X_ Risk Based Managed Care

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

__ Yes

_X_ 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

_X_ 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.

*For a person enrolled in a managed care plan, the BHH services provider will notify the BHH services contact designated by the managed care plan within 30 days of a person beginning receipt of services; and adhere to the the managed care plan communication and coordination requirements described in the BHH services manual.

__ Other

__ Other Service Delivery System

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MN2022MS0006O | MN-22-0036 | Behavioral Health Homes

Package Header

Package ID MN2022MS0006O

Submission Type Official

Approval Date 2/3/2023

Superseded SPA ID MN-21-0005

SPA ID MN-22-0036

Initial Submission Date 12/14/2022

Effective **Date** 10/1/2022

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

_X_ 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 guidance 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 guidance provided by the Department.
·Update the 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.

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

_X_Other

(specify)

Provider Type	Description
Behavioral Health Home Systems Navigator	Care coordination services are provided by either 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.

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

_X_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 · Mental health certified peer support specialist as defined in Attachment 3.1-A/B, item 13.d. · Mental health certified family peer support specialist as defined in Attachment 3.1-A/B, item 4.b. · Community paramedic as defined in Attachment 3.1-A/B, item 5.a. · Qualified substance use disorder 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.

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

_X_ 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. 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:
·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

_X_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. 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

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

X 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. This service may also be supported by other BHH team members.

Health Homes Services

MEDICAID | Medicaid State Plan | Health Homes | MN2022MS0006O | MN-22-0036 | Behavioral Health Homes

Package Header

Package ID MN2022MS0006O

Submission Type Official

Approval Date 2/3/2023

Superseded SPA ID MN-21-0005

SPA ID MN-22-0036

Initial Submission Date 12/14/2022

Effective Date 10/1/2022

Health Homes Patient Flow

Describe the patient flow through the state's Health Homes system. Submit with the state plan amendment flow-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	