DEPARTMENT OF HUMAN SERVICES

SUMMARY

Medicaid State Plan Amendment
Draft MN-24-0025

This state plan amendment adopts two changes made by the Minnesota Legislature. The first is the adoption of an annual adjustment to rates, based on the Medicare economic index, which starts with rate changes in 2025.

The second is the removal of a reference to a tool known as the DHS Partner Portal that did not work as intended. In its place, providers will use a population health management tool, approved by the Minnesota Department of Human Services, to identify past and current treatment or services. and identify potential gaps in care.

MN - Submission Package - MN2024MS0003O - (MN-24-0023) - Health Homes

DRAFT

Health Homes Payment Methodologies

MEDICAID | Medicaid State Plan | Health Homes | MN2024MS0003O | MN-24-0023 | Behavioral Health Homes

Package Header

Package ID MN2024MS0003O

SPA ID MN-24-0025

Submission Type Official

Initial Submission Date N/A

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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 January 1, 2024, payment for BHH services is $252.35 per member, per month. During the recipient's first six months of participation, the BHH will receive an enhanced payment rate of $360.50 per member, per month. This enhanced payment will be made only once in each recipient's lifetime.

Effective for annual adjustments to payment rates made on or after January 1, 2025, payments must be adjusted according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year.

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 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.

Health Homes Payment Methodologies

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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 has developed payment methodologies and rates that are consistent with section 1902(a)(30)(A).

☐ 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).

Optional Supporting Material Upload

Name	Date Created	
No items available		

Health Homes Services

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System-Derived

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 an additional population health management tool, approved by the Minnesota Department of Human Services, to identify past and current treatment or services and identify potential gaps in care.

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 licensed nurse, including an advanced practice registered nurse, registered nurse, and a licensed practical 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.

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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 tool approved by the Minnesota Department of Human Services to identify past and current treatment or services and identify potential gaps in care.

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
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.

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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 tool approved by the Minnesota Department of Human Services to identify past and current treatment or services and identify potential gaps in care.

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.

Health Homes Services

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System-Derived

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 tool to identify past and current treatment or services and identify potential gaps in care.

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
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.

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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 tool to identify past and current treatment or services and identify potential gaps in care.

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
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- [ ] Dieticians
- [ ] Nutritionists
- [ ] 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.

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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 tool to identify past and current treatment or services and identify potential gaps in care.

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
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 | MN2024MS0003O | MN-24-0023 | Behavioral Health Homes

Package Header

Package ID MN2024MS0003O

SPA ID MN-24-0023

Submission Type Official

Initial Submission Date N/A

Approval Date N/A

Effective Date N/A

Superseded SPA ID MN-23-0027

System-Derived

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	

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