Behavioral health home services overview

Beginning July 1, 2016, behavioral health home services are a Medical Assistance (MA) covered service in Minnesota. The health home model is a provision of the Affordable Care Act (Sec. 1945 of the Social Security Act) available to states to serve the needs of complex populations covered by Medicaid. It provides an opportunity to build a person-centered system of care that achieves improved outcomes for individuals and reduced costs to the health care system.

The health home model expands upon the concept of person-centered medical homes (health care homes in Minnesota) and makes a more concerted effort through design, policy levers and outcome measures to serve the whole person across primary care, mental health, substance use disorder treatment, long-term services and supports, and social service components of our health care delivery system.

Health homes services authorized under Sec. 1945 of the Social Security Act are federally required to provide the following six core services:

- Comprehensive care management
- Care coordination
- Health and wellness promotion
- Comprehensive transitional care
- Individual and family support
- Referral to community and social services

States must establish eligibility criteria and determine which chronic condition(s) to focus on in their health home model. The Health Care and Community Supports Administrations of the Department of Human Services (DHS) have worked together to design a behavioral health home services model that will operate under a “whole person” philosophy and ensure access to coordinated delivery of primary care, behavioral health and social services for adults and children with serious mental illness.

Population

DHS is starting with the behavioral health home services model because people with serious mental illness have known barriers to health care access, high co-occurrence of chronic health conditions, and early mortality.

Eligibility for BHH services

To be eligible for behavioral health home services, a person must have serious mental illness (SMI) or emotional disturbance (ED) as defined in Minnesota statute, 245.462, subdivision 20, paragraph (a), or Minnesota statute, 245.4871, subdivision 15, clause (2), and have a current diagnostic assessment as performed or reviewed by a mental health professional employed or under contract with the behavioral health home. Serious mental illness and emotional disturbance are umbrella terms which include people diagnosed with serious and persistent mental illness (SPMI) and severe emotional disturbance (SED).

Duplication services

Medicaid payment for duplicative services is prohibited, therefore, a person is not able to receive behavioral health home services and any of the following services in the same calendar month:

- Mental health targeted case management (MH-TCM)
- Assertive Community Treatment (ACT) or Youth Assertive Community Treatment (YouthACT)
- Relocation service coordination targeted case management (RSC-TCM)
• Vulnerable adult/developmental disability targeted case management (VA/DD-TCM)
• Health care homes care coordination

A person who meets the eligibility criteria for one or more of these covered services must choose which service best meets his or her needs. The concept of consumer choice is at the heart of the Olmstead settlement and is a key component of the federal health home model.

**Characteristics of the behavioral health home services model**

The goals of the health home framework are to:

1. Improve health outcomes (preventative, routine, treatment of health conditions) of individuals.
2. Improve experience of care for the individual.
3. Improve the quality of life and wellness of the individual.
4. Reduce health care costs.

The guiding principles of behavioral health home services are:

- Behavioral health home services are distinguished by the presence of a multi-disciplinary team that shares information and collaborates to deliver a holistic, coordinated plan of services and care.
- Behavioral health home services create an opportunity to meet the needs of individuals experiencing serious mental illness and their families by addressing the individual’s goals for physical health, mental health, substance use and wellness.
- Providers will deliver behavioral health home services with a person-centered ecological perspective, considering the varying social factors that ultimately impact a person’s health, and will engage and respect the individual and family in his or her health care and recovery and resiliency.
- Providers will deliver behavioral health home services using a strength based approach and will respect, assess, and use the cultural values, strengths, languages, and practices of the consumer and family in supporting the individual’s health and wellness goals.

Through the delivery of behavioral health home services, individuals will have their comprehensive physical, behavioral health, and social service needs addressed in a coordinated manner. This includes a health wellness assessment and subsequent development of a health action plan to address chronic conditions, ongoing coordination of care between behavioral and physical health, and coordination with non-clinical services so that people will have their health care coordinated with social and community supports. Behavioral health home services will also support individuals and families in developing skills to improve health literacy, wellness and self-management.

**Multi-disciplinary team approach**

Providers will administer behavioral health home services through a team-based approach. Teams will share a caseload so that every person has access to the expertise and services provided by each of the unique behavioral health home team members. Team members will communicate on a regular basis regarding their shared caseload.

At a minimum, a behavioral health home team must include the members listed below.

**Team Leader**

To qualify as a team leader, a person must meet at least one of these qualifications:

- Clinic manager
- Medical director
- Other management-level professional

**Integration Specialist**

To qualify as an integration specialist, a person must meet at least one of these qualifications:

- When behavioral health home services are offered in a mental health setting, the integration specialist must be a registered nurse (including advanced practice registered nurses).
• When behavioral health home services are offered in a primary care setting, the integration specialist must be a mental health professional as defined in Minnesota Statutes, section 245.4871, subdivision 27, clauses (1)–(6) or Minnesota Statutes, section 245.462, subdivision 18, clauses (1)–(6).

Systems Navigator
When behavioral health home services are offered in a mental health setting, the systems navigator must meet one of the following qualifications:

- A case manager as defined in Minnesota Statutes, section 245.4871, subdivision 4 (excluding paragraph a), and Minnesota Statutes, section 245.462, subdivision 4 (excluding paragraph a).
- A mental health practitioner as defined in Minnesota Statutes, section 245.4871, subdivision 26 or Minnesota Statutes, section 245.462, subdivision 17.

When behavioral health home services are offered in a primary care setting, the systems navigator must meet one of the following qualifications:

- Case manager as defined in Minnesota Statutes, section 245.4871, subdivision 4 (excluding paragraph a), Minnesota Statutes, section 245.462, subdivision 4 (excluding paragraph a).
- Mental health practitioner as defined in Minnesota Statutes, section 245.4871, subdivision 26, or Minnesota Statutes, section 245.462, subdivision 17.
- Have three years of experience providing care coordination to adults, youth or children with mental illness and either:
  - Meet Minnesota Statutes, section 245.4871, subdivision 4 (g) and one of the following:
    - subdivision 4 (b, 1-4)
    - subdivision 4 (d)
    - subdivision 4 (m)
  - Meet Minnesota Statutes, section 245.462, subdivision 4 (f) and one of the following:
    - subdivision 4 (b, 1-3)
    - subdivision 4 (c)
    - subdivision 4 (j)

Qualified Health Home Specialist
A qualified health home specialist must meet at least one of these qualifications:

- Community health worker as defined in Minnesota Statutes, 256B.0625, Subd. 49
- Peer support specialist as defined in Minnesota Statutes, 256B.0615
- Family peer support specialist as defined in Minnesota Statutes, 256B.0616
- Case management associate as defined in Minnesota Statutes, 245.462, Subd. 4 (g) or 245.4871, Subd. 4 (j)
- Mental health rehabilitation worker as defined in Minnesota Statutes, 256B.0623, Subd. 5 (4)
- Community paramedic as defined in Minnesota Statutes, 144E.28, Subd. 9
- Certified health education specialist

Payment
The per-member per-month (PMPM) payment methodology for behavioral health home services includes an enhanced rate of $350 and an on-going rate of $245. The enhanced rate will be provided for the first six months that a person receives behavioral health home services to account for additional costs associated with engaging the person, conducting the initial screenings and assessments, implementing initial referrals and linkages to address pent-up needs, and establishing relationships with the person and his or her supports.

In order to receive a monthly PMPM payment, a BHH provider must have personal contact with the person or the person’s identified support at least once per month. This contact may include face-to-face, telephone contact or interactive video. A letter, voicemail or text alone does not meet the requirement for monthly personal contact.
Provider responsibilities
Behavioral health home services providers must have the capacity to perform the six core health home services specified by CMS, and must be certified as a behavioral health home by DHS. Providers will be required to use an electronic health record and patient registry to collect individual and practice-level data that allows them to identify, track and segment the population and improve outcomes over time.

During the initial 90-day engagement period, providers must meet face-to-face with the person to:
- Complete the intake process and the brief needs assessment
- Complete the initial health wellness assessment within 60 days after intake
- Develop the health action plan within 90 days after intake

Provider certification
DHS will certify behavioral health home services providers according to federal and state standards. The certification process will include an initial certification and an annual recertification process at the onset of implementation of the model. Information about the certification process can be found on the behavioral health home website and Behavioral Health Home Certification Standards (DHS-6766-ENG).

Reporting and evaluation
Behavioral health home services providers will be expected to participate in reporting and evaluation requirements. The federal health home provision details specific state monitoring, quality improvement reporting and evaluation requirements. In addition, DHS has identified performance measures to demonstrate outcomes for those who receive behavioral health home services and to monitor service providers.

Questions
For more information, contact Behavioral.Health.Home.Services@state.mn.us.