

Behavioral health home services overview

Behavioral health home (BHH) services is Minnesota's version of the federal "health home" benefit. In July 2016, Minnesota adopted a state plan amendment and established BHH services through the health home model provision authorized in the Affordable Care Act under Sec. 1945 of the Social Security Act available to states to serve the needs of complex populations covered by Medicaid. The Department of Human Services (DHS) implemented the BHH services model in response to the known barriers to health care access, high co-occurrence of chronic health conditions and early mortality that individuals with serious mental illness disproportionately experience.

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.

BHH services is available to individuals receiving Medical Assistance who are adults with mental illness or children with emotional disturbance, as defined in Minnesota statute, [section 245.462](#), subdivision 20, paragraph (a), or Minnesota statute, [section 245.4871](#), subdivision 15, clause (2). Mental illness and emotional disturbance are umbrella terms that include individuals diagnosed with serious and persistent mental illness and severe emotional disturbance.

BHH services is not a place to live. BHH services aims to reduce costs to the health care system and improve outcomes for individuals by utilizing a person-centered, team-based, coordinated approach to deliver a set of core services focused on the integration of primary care, behavioral health services and social services and supports.

The six federally required health home services include:

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

BHH services follows four guiding principles to deliver the health home services:

- Utilize a multidisciplinary team that will share information and collaborate to deliver a holistic, coordinated plan of care.
- Meet the needs of individuals experiencing serious mental illness and their families by addressing the individual's physical, mental, substance use and wellness goals.
- Take a person-centered approach, and engage and respect individuals and families in their health care, recovery and resiliency.
- Respect, assess and use the cultural values, strengths, languages and practices of individuals and families in supporting an individual's health goals.

The goals of BHH services are that each individual:

- Has access to and utilizes routine and preventative health care services
- Has consistent care for mental illness and other health conditions
- Gains knowledge of health conditions and associated effective treatments
- Increases self-efficacy and improves health management practices
- Has access to and utilizes wellness and recovery resources
- Has access to and uses social and community supports to assist with meeting wellness goals

BHH services providers may be located in a variety of settings, including primary care clinics, community mental health centers and more formally integrated primary care health settings. The BHH services model offers a multidisciplinary approach and utilization of allied professionals including but not limited to mental health professionals, registered nurses, mental health practitioners, community health workers, peer support specialists and community paramedics. This model allows BHH services providers to share information, communicate regularly and deliver services in a unique way. The team-based model also offers flexibility in how the services are delivered between the professionals on the BHH services team. DHS works with providers to support a population health management approach that ensures the integration of behavioral health and primary care. This approach requires that the provided services be:

- Quality-driven
- Cost-effective
- Culturally appropriate
- Person- and family-centered
- Coordinated across primary care, mental health, substance use disorder treatment, long-term services and supports, and social service components
- Proactive in the use of health information technology to target and match individuals and populations with needed services and care

Provider responsibilities

BHH services providers must have the capacity to perform the six core health home services specified by the Centers for Medicare and Medicaid Services (CMS), and must be certified as a behavioral health home by DHS. The BHH services team is required to include the following members: Team Leader, Integration Specialist, Systems Navigator and Qualified Health Home Specialist. [BHH Services Certification Standards](#) (DHS-6766-ENG) outlines the required qualifications for the respective team members.

Provider certification

DHS certifies BHH services providers according to federal and state standards. Information about the certification process can be found on the [BHH services website](#) and in the [BHH Services Certification Standards](#) (DHS-6766-ENG).

Reporting and evaluation

BHH services providers are expected to participate in reporting and evaluation requirements. The federal health home provision details specific state monitoring, quality improvement reporting and evaluation requirements.

Payment

The per-member, per-month (PMPM) payment methodology for BHH services includes an enhanced rate of \$350 and an ongoing rate of \$245. The enhanced rate is provided for the first six months that a person receives BHH services, to account for additional costs associated with engaging the person, conducting the initial screenings and

assessments, implementing initial referrals and linkages to address emergent needs and establishing relationships with the person and his or her supports.

In order to receive a monthly PMPM payment, a BHH services provider must have personal contact with the person or the person's identified support at least once per month. This contact may be face-to-face, over the telephone or via interactive video. A letter, voicemail or text alone does not meet the requirement for monthly personal contact.

Duplicative services

Medicaid payment for duplicative services is prohibited. Therefore, a person is not able to receive BHH 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.

Questions

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