



Behavioral health home services overview

The health home model is a provision of the Affordable Care 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 MN) 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 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, and
- 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 DHS have worked together to design a behavioral health home (BHH) model which will operate under a “whole person” philosophy and ensure access to and coordinated delivery of primary care, behavioral health and social services for adults and children with serious mental illness.

Population

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

A number of recent multi-state studies demonstrate that people served by the public mental health system die, on average, 25 years earlier than the general population. Cardiovascular disease, diabetes, high blood pressure and cholesterol, and obesity contribute to this early mortality. However, many of these health risks can be prevented or managed by early detection, treatment, and healthy lifestyle changes. People with serious mental illness often lack access to adequate health care, and when there is access, there are barriers to the use of preventative and routine care.

This was confirmed by a recent study supported by our CMS Health Home Planning grant conducted by the MN Chapter of National Alliance on Mental Illness. NAMI-MN conducted a series of focus groups and in-person interviews with people living with mental illness across the state to gather input regarding health promotion, medical and mental health experience of care, care coordination/care management and care transitions. Findings revealed overarching themes including provider relationship and trust; barriers to care; and lack of education and information. Recommendations from the study include the addition of more peer-based support to help individuals get acclimated to medical and mental health systems; facilitated system navigation; and wellness and recovery education.

Eligibility

BHH services are available to adults and children eligible for Medical Assistance in fee-for-service or enrolled in managed care. Enrollment in BHH services is voluntary. Eligibility for BHH services must be determined by state-certified BHH providers. BHH services are available to individuals who have a current diagnostic assessment and who meet the definition of serious mental illness or emotional disturbance as defined in Minnesota Statutes 245.462, subdivision 20, paragraph (a), or 245.4871, subdivision 15, clause (2).

Characteristics of the behavioral health home 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 homes are:

1. BHH 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.
2. BHH services create an opportunity to better meet the needs of individuals experiencing serious mental illness and their families by addressing the individual's physical, mental, substance use, and wellness goals.
3. Providers will deliver BHH 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 their health care and recovery/resiliency.
4. BHH services include processes that ensure they are designed to respect, assess and use the cultural values, strengths, languages, and practices of the individual and family in supporting the individual's health 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 BHH services through a team based approach. Teams will share a case load so that every individual has access to the expertise and services provided by each of the three unique BHH team members. Team members will communicate on a regular basis regarding their shared case load.

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, or
- Other management-level professional.

Integration Specialist

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

- Registered Nurse, including Advanced Practice Registered Nurse, when BHH services are offered in a mental health setting.
- Mental health professional as defined in M.S. 245.4871 Subd. 27, 1-6 or M.S. 245.462 Subd. 18 1-6 when BHH services are offered in a primary care setting.

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); or
- 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); or
- Mental health practitioner as defined in Minnesota Statutes section 245.4871, subdivision 26, or Minnesota Statutes section 245.462, subdivision 17; or
- 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) OR
 - 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

To qualify as a qualified health home specialist a person must meet at least one of these qualifications:

- Community health worker as defined in M.S. 256B.0625 Subd. 49,
- Peer support specialist as defined in M.S. 256B.0615,
- Family peer support specialist (upcoming definition and certification at DHS),
- Case management associate as defined in M.S. 245.462 Subd.4 (g) or M.S. 245.4871 Subd. 4 (j),
- Mental health rehabilitation worker as defined in M.S. 256B.0623 Subd. 5 (4),
- Community paramedic as defined in M.S. 144E.28 Subd. 9, or
- Certified health education specialist.

Payment

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

DHS is federally required to ensure that health home payments will not pay for duplicative services. Therefore, Minnesota will focus outreach efforts to people that are not receiving Mental Health Targeted Case Management (TCM) or Assertive Community Treatment (ACT).

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. 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, or text alone does not meet the requirement for monthly personal contact.

Provider Responsibilities

Behavioral health home service 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.

Providers will be held accountable to deliver services consistent with state standards for frequency and face-to-face contact. In addition to the monthly contact requirement, providers must meet face-to-face with the person every 60 days. 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 homes according to federal and state standards. The certification process will include an initial certification and recertification process.

Reporting and evaluation

BHH 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 in order to demonstrate outcomes for those served by BHH and to monitor service providers.

Questions

For more information, contact: Behavioral.Health.Homes@state.mn.us.

SNBC Member Case Example

Sarah

- Diagnoses:
 - Bipolar Disorder
 - Alcohol Substance Use Disorder
 - Various physical conditions causing her chronic pain

- CADI Waiver Services:
 - homemaking
 - ILS
 - PCA
 - home delivered meals
 - med machine



SNBC Member Case Example Continued

Barriers to keeping Sarah Connected to Services:

- She could be very volatile with her service providers
- Excessive substance use made providers uncomfortable and fearful for their safety
- Certain service providers weren't trained/experienced in how to approach someone with such severe mental illness
- SNBC Case Manager role capacity



SNBC Member Case Example Continued

3rd case manager joined the picture through a pilot project and that role looked much like a BHH team member could play.

- Able to intervene face-to-face and act as an intermediary between the client and service providers on an unlimited contact basis
- Work with waiver case manager to find new service providers that were the best fit
- Boots on the ground, out-of-the-box interventions

