Table of Contents

State/Territory Name: MN

State Plan Amendment (SPA) #: 15-0004

This file contains the following documents in the order listed:

Department of Health & Human Services
Centers for Medicare & Medicaid Services
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

April 14, 2016

Marie Zimmerman, State Medicaid Director
Minnesota Department of Human Services
P.O. Box 64983
St. Paul, MN 55164-0983

Dear Ms. Zimmerman:

Enclosed for your records is a revised approved copy of the following State Plan Amendment (SPA):

Transmittal #15-0004 -- Implementation of behavioral health home services to adults with serious mental illnesses, and children and youth experiencing emotional disturbances.

-- Effective Date: July 1, 2016

This approval package has been revised per the state's notification to the Centers for Medicare and Medicaid Services (CMS) that the PDF format of CMS' MMDL version of the approved state plan pages contain missing language from certain text boxes. Additionally, some text was not readable. We acknowledge the glitch in our MMDL system. This revised approval package provides a corrected version of the CMS-approved state plan pages.

The official approval date of this SPA remains March 21, 2016.

If you have any additional questions, please have a member of your staff contact Sandra Porter at (312) 353-8310 or via e-mail at Sandra.Porter@cms.hhs.gov.

Sincerely,

/s/

Ruth Hughes
Associate Regional Administrator
Division of Medicaid and Children's Health Operations

Enclosure

cc: Ann Berg, MDHS
Sean Barrett, MDHS

Health Home State Plan Amendment

OMB Control Number: 0938-1148
Expiration date: 10/31/2014

Transmittal Number: MN-15-0004 Supersedes Transmittal Number: Approved Effective Date: Jul 1, 2016 Approval Date: Mar 25, 2016 Attachment 3.1-H Page Number:

Submission Summary

Transmittal Number:
Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

MN-15-0004

Supersedes Transmittal Number:
Please enter the Supersedes Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY = the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.

☑ **The State elects to implement the Health Homes State Plan option under Section 1945 of the Social Security Act.**

Name of Health Homes Program:

Behavioral Health Homes

State Information

State/Territory name:	**Minnesota**
Medicaid agency:	Department of Human Services

Authorized Submitter and Key Contacts

The authorized submitter contact for this submission package.

Name:	Ann Berg
Title:	Deputy Medicaid Director
Telephone number:	(651) 431-2193
Email:	ann.berg@state.mn.us

The primary contact for this submission package.

Name:	Sean Barrett

Title:	Health Care Compliance Specialist Sr.
Telephone number:	(651) 431-2298
Email:	sean.barrett@state.mn.us

The secondary contact for this submission package.

Name:	
Title:	
Telephone number:	
Email:	

The tertiary contact for this submission package.

Name:	
Title:	
Telephone number:	
Email:	

Proposed Effective Date

07/01/2016 (mm/dd/yyyy)

Executive Summary

Summary description including goals and objectives:
Behavioral health home services will be made available to adults with serious mental illness and children and youth experiencing an emotional disturbance.

Federal Budget Impact

	Federal Fiscal Year	Amount
First Year	2016	$ 649000.00
Second Year	2017	$ 9019000.00

Federal Statute/Regulation Citation

Section 1945 of the Social Security Act

October 13, 2015	March 21, 2016
PLAN APPROVED – ONE COPY ATTACHED	
EFFECTIVE DATE OF APPROVED MATERIAL: July 1, 2016	**SIGNATURE OF REGIONAL OFFICIAL:** /s/
TYPED NAME Ruth A. Hughes	**TITLE** Associate Regional Administrator

Governor's Office Review

- (●) **No comment.**
- ( ) **Comments received.**
  Describe:
- ( ) **No response within 45 days.**
- ( ) **Other.**
  Describe:

Transmittal Number: MN-15-0004 Supersedes Transmittal Number: Approved Effective Date: Jul 1, 2016 Approval Date: Mar 25, 2016
Attachment 3.1-H Page Number:

Submission - Public Notice

Indicate whether public notice was solicited with respect to this submission.

- ( ) **Public notice was not required and comment was not solicited**
- (●) **Public notice was not required, but comment was solicited**
- ( ) **Public notice was required, and comment was solicited**

Indicate how public notice was solicited:

- [ ] **Newspaper Announcement**
- [ ] **Publication in State's administrative record, in accordance with the administrative procedures requirements.**
  Date of Publication:
  (mm/dd/yyyy)
- [x] **Email to Electronic Mailing List or Similar Mechanism.**
  Date of Email or other electronic notification:
  03/09/2015 (mm/dd/yyyy)
  Description:
  An email was sent to those registered to receive updates from the Department when draft state plan amendments are available for review. The comments received were generally supportive,

with specific comments primarily focused on provider infrastructure requirements, the payment methodlogy, the use of HIT, and covered services. The comments were considered and revisions were made where appropriate.

☑ **Website Notice**

Select the type of website:

☑ Website of the State Medicaid Agency or Responsible Agency

Date of Posting:

03/09/2015 (mm/dd/yyyy)

Website URL:

http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSIO

☐ Website for State Regulations

Date of Posting:

(mm/dd/yyyy)

Website URL:

☐ Other

☐ **Public Hearing or Meeting**

☐ **Other method**

Indicate the key issues raised during the public notice period:(This information is optional)

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service Delivery**

Summarize Comments

Summarize Response

☐ **Other Issue**

Transmittal Number: MN-15-0004 Supersedes Transmittal Number: Approved Effective Date: Jul 1, 2016 Approval Date: Mar 25, 2016
Attachment 3.1-H Page Number:

Submission - Tribal Input

☑ **One or more Indian health programs or Urban Indian Organizations furnish health care services in this State.**

☑ **This State Plan Amendment is likely to have a direct effect on Indians, Indian health programs or Urban Indian Organizations.**

☑ **The State has solicited advice from Tribal governments prior to submission of this State Plan Amendment.**

Complete the following information regarding any tribal consultation conducted with respect to this submission:

Tribal consultation was conducted in the following manner:

☑ **Indian Tribes**

Indian Tribes	

☑ **Indian Health Programs**

Indian Health Programs	

☑ **Urban Indian Organization**

Urban Indian Organizations	

Indicate the key issues raised in Indian consultative activities:

☐ **Access**

Summarize Comments

Summarize Response

☐ **Quality**

Summarize Comments

Summarize Response

☐ **Cost**

Summarize Comments

Summarize Response

☐ **Payment methodology**

Summarize Comments

Summarize Response

☐ **Eligibility**

Summarize Comments

Summarize Response

☐ **Benefits**

Summarize Comments

Summarize Response

☐ **Service delivery**

Summarize Comments

Summarize Response

☑ **Other Issue**

Issues	
Issue Name:	
Summarize Comments No comments received. **Summarize Response**	

Submission - SAMHSA Consultation

☑ **The State provides assurance that it has consulted and coordinated with the Substance Abuse and Mental Health Services Administration (SAMHSA) in addressing issues regarding the prevention and treatment of mental illness and substance abuse among eligible individuals with chronic conditions.**

Date of Consultation	
Date of consultation: 02/26/2015 (mm/dd/yyyy)	

Transmittal Number: MN-15-0004 Supersedes Transmittal Number: Approved Effective Date: Jul 1, 2016 Approval Date: Mar 25, 2016
Attachment 3.1-H Page Number:

Health Homes Population Criteria and Enrollment

Population Criteria

The State elects to offer Health Homes services to individuals with:

☐ **Two or more chronic conditions**

Specify the conditions included:

☐ **Mental Health Condition**
☐ **Substance Abuse Disorder**
☐ **Asthma**
☐ **Diabetes**
☐ **Heart Disease**
☐ **BMI over 25**

Other Chronic Conditions	

☐ **One chronic condition and the risk of developing another**

Specify the conditions included:

☐ **Mental Health Condition**
☐ **Substance Abuse Disorder**
☐ **Asthma**
☐ **Diabetes**
☐ **Heart Disease**
☐ **BMI over 25**

Other Chronic Conditions	

Specify the criteria for at risk of developing another chronic condition:

☑ **One or more serious and persistent mental health condition**

Specify the criteria for a serious and persistent mental health condition:
Behavioral health home services will be made available to adults with serious mental illness, and children and youth experiencing emotional disturbance. Serious mental illness and emotional disturbance are defined as an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that seriously limits a person's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

Recipients must have a current diagnostic assessment as performed or reviewed by a mental health professional employed or under contract with the behavioral health home.

Geographic Limitations

☑ **Health Homes services will be available statewide**

Describe statewide geographical phase in/expansion. This should include dates and corresponding geographical areas that bring the program statewide.
Behavioral health home certification will be available to any eligible provider throughout the state.

If no, specify the geographic limitations:

○ **By county**

Specify which counties:

○ **By region**

Specify which regions and the make-up of each region:

○ **By city/municipality**

Specify which cities/municipalities:

○ **Other geographic area**

Describe the area(s):

Enrollment of Participants

Participation in a Health Homes is voluntary. Indicate the method the State will use to enroll eligible Medicaid individuals into a Health Home:

◉ **Opt-In to Health Homes provider**

Describe the process used:
In order to receive BHH services, an individual must meet the criteria for serious mental illness or emotional disturbance and have a current diagnostic assessment performed or reviewed by a mental health professional employed or contracted by the behavioral health home.

The Department will provide certified behavioral health homes (BHH) with a list of individuals identified by the claims payment system who meet the criteria to receive BHH services and are currently served by the BHH.

The state will also support the identification of individuals that are not currently receiving BHH or other case management services. Certified behavioral health homes will engage eligible individuals, or individuals may self-refer for BHH services. Participation in behavioral health homes is voluntary.

Individuals who meet the criteria will receive information regarding their choice to participate in a BHH.

Individuals will then have the ability to opt in to receive BHH services. The opt-in process will include a consent form that will include the individual rights and responsibilities as a recipient of these services.

○ **Automatic Assignment with Opt-Out of Health Homes provider**

Describe the process used:

☐ **The State provides assurance that it will clearly communicate the opt-out option to all individuals assigned to a Health Home under an opt-out process and submit to CMS a copy of any letter or other communication used to inform such individuals of their right to choose.**

○ **Other**

Describe:

- [x] **The State provides assurance that eligible individuals will be given a free choice of Health Homes providers.**
- [x] **The State provides assurance that it will not prevent individuals who are dually eligible for Medicare and Medicaid from receiving Health Homes services.**
- [x] **The State provides assurance that hospitals participating under the State Plan or a waiver of such plan will be instructed to establish procedures for referring eligible individuals with chronic conditions who seek or need treatment in a hospital emergency department to designated Health Homes providers.**
- [x] **The State provides assurance that it will have the systems in place so that only one 8-quarter period of enhanced FMAP for each Health Homes enrollee will be claimed. Enhanced FMAP may only be claimed for the first eight quarters after the effective date of a Health Homes State Plan Amendment that makes Health Home Services available to a new population, such as people in a particular geographic area or people with a particular chronic condition.**
- [x] **The State assures that there will be no duplication of services and payment for similar services provided under other Medicaid authorities.**

Health Homes Providers

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**

Describe the Provider Qualifications and Standards:

- [x] **Clinical Practices or Clinical Group Practices**

Describe the Provider Qualifications and Standards:
•Be enrolled as a Medical Assistance provider.
•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.
•Successfully complete and maintain state certification as a behavioral health home provider.

☑ **Community Health Centers**

Describe the Provider Qualifications and Standards:

•Be enrolled as a Medical Assistance provider.
•Successfully complete and maintain state certification as a behavioral health home provider.

☑ **Community Mental Health Centers**

Describe the Provider Qualifications and Standards:

•Be enrolled as a Medical Assistance provider.
•Successfully complete and maintain state certification as a behavioral health home provider.

☐ **Home Health Agencies**

Describe the Provider Qualifications and Standards:

☑ **Other providers that have been determined by the State and approved by the Secretary to be qualified as a health home provider:**

☐ **Case Management Agencies**

Describe the Provider Qualifications and Standards:

☑ **Community/Behavioral Health Agencies**

Describe the Provider Qualifications and Standards:

•Be enrolled as a Medical Assistance provider.
•Successfully complete and maintain state certification as a behavioral health home provider.

☑ **Federally Qualified Health Centers (FQHC)**

Describe the Provider Qualifications and Standards:

•Be enrolled as a Medical Assistance provider.
•Successfully complete and maintain state certification as a behavioral health home provider.

☐ **Other (Specify)**

☐ **Teams of Health Care Professionals**

Indicate the composition of the Health Homes Teams of Health Care Professionals the State includes in its program. For each type of provider indicate the required qualifications and standards:

☐ **Physicians**

Describe the Provider Qualifications and Standards:

☐ **Nurse Care Coordinators**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Professionals**

Describe the Provider Qualifications and Standards:

☐ **Other (Specify)**

☐ **Health Teams**

Indicate the composition of the Health Homes Health Team providers the State includes in its program, pursuant to Section 3502 of the Affordable Care Act, and provider qualifications and standards:

☐ **Medical Specialists**

Describe the Provider Qualifications and Standards:

☐ **Nurses**

Describe the Provider Qualifications and Standards:

☐ **Pharmacists**

Describe the Provider Qualifications and Standards:

☐ **Nutritionists**

Describe the Provider Qualifications and Standards:

☐ **Dieticians**

Describe the Provider Qualifications and Standards:

☐ **Social Workers**

Describe the Provider Qualifications and Standards:

☐ **Behavioral Health Specialists**

Describe the Provider Qualifications and Standards:

☐ **Doctors of Chiropractic**

Describe the Provider Qualifications and Standards:

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Describe the Provider Qualifications and Standards:

☐ **Physicians' Assistants**

Describe the Provider Qualifications and Standards:

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.

Provider Infrastructure

Describe the infrastructure of provider arrangements for Health Homes 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:
• Case manager as defined in Attachments 3.1-A/B, supplement 1; or
• Mental health practitioner as defined in Attachments 3.1-A/B, item 4.b.

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;
• Peer support specialist as defined in Attachments 3.1-A/B, item 13.d.;
• Family peer support specialist as defined in Attachments 3.1-A/B, item 4.b.;
• Community paramedic as defined in item 5.a.; or
• Certified health education specialist.

Provider Standards

The State's minimum requirements and expectations for Health Homes providers are as follows:
All BHH providers be an enrolled MA provider, and must obtain and maintain certification by the Department as a BHH. This certification requires demonstration of the ability and capacity to perform the following:

•Maintain the required BHH 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 team.

•Conduct comprehensive screenings that address behavioral, medical, and social service and community support needs. Screenings must be consistent with professional standards of care.

•Create and maintain an individualized health action plan for each recipient that encompasses behavioral health, physical health, social services, and community supports.

•Use health information technology to link services, identify and manage gapsin 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 providers will use this data to discuss treatment options with a crecipient'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.

•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 provider planning to terminate the delivery of behavioral health home services must give 60-day notice to the Department, all of its BHH recipients, and applicable managed care plans. Providers must assist the recipient with finding a new behavioral health home provider.

•Provide recipients with BHH program materials, including the rights and responsibilities document, inform recipients about the choice to participate and obtain consent to participate.

BHH 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 providers will be expected to maintain the staffing ratios listed in the payment methodologies section of the state plan amendment.

If a provider serves 100 or less BHH recipients in their first year of certification, 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 team members.

Health Homes Service Delivery Systems

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

☑ **Fee for Service**
☐ **PCCM**

○ **PCCMs will not be a designated provider or part of a team of health care professionals. The State provides assurance that it will not duplicate payment between its Health Homes payments and PCCM payments.**

○ **The PCCMs will be a designated provider or part of a team of health care professionals.**

The PCCM/Health Homes providers will be paid based on the following payment methodology outlined in the payment methods section:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Requirements for the PCCM participating in a Health Homes as a designated provider or part of a team of health care professionals will be different from those of a regular PCCM.**

If yes, describe how requirements will be different:

☑ **Risk Based Managed Care**

◉ **The Health Plans will not be a Designated Provider or part of a Team of Health Care Professionals. Indicate how duplication of payment for care coordination in the Health Plans' current capitation rate will be affected:**

☐ **The current capitation rate will be reduced.**

☑ **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:
-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

•The MCO is not permitted to reimburse behavioral health home services in the same calendar month that the member received assertive community treatment (ACT) or youth assertive community treatment (Youth ACT).

•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.

☐ **Other**

Describe:

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

Provide a summary of the contract language that you intend to impose on the Health Plans in order to deliver the Health Homes services.

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

The State intends to include the Health Homes payments in the Health Plan capitation rate.

○ **Yes**

☐ **The State provides an assurance that at least annually, it will submit to the regional office as part of their capitated rate Actuarial certification a separate Health Homes section which outlines the following:**

- **Any program changes based on the inclusion of Health Homes services in the health plan benefits**

- **Estimates of, or actual (base) costs to provide Health Homes services (including detailed a description of the data used for the cost estimates)**
- **Assumptions on the expected utilization of Health Homes services and number of eligible beneficiaries (including detailed description of the data used for utilization estimates)**
- **Any risk adjustments made by plan that may be different than overall risk adjustments**
- **How the final capitation amount is determined in either a percent of the total capitation or an actual PMPM**

☐ **The State provides assurance that it will design a reporting system/mechanism to monitor the use of Health Homes services by the plan ensuring appropriate documentation of use of services.**

☐ **The State provides assurance that it will complete an annual assessment to determine if the payments delivered were sufficient to cover the costs to deliver the Health Homes services and provide for adjustments in the rates to compensate for any differences found.**

○ **No**

Indicate which payment methodology the State will use to pay its plans:

☐ **Fee for Service**

☐ **Alternative Model of Payment (describe in Payment Methodology section)**

☐ **Other**

Description:

☐ **Other Service Delivery System:**

Describe if the providers in this other delivery system will be a designated provider or part of the team of health care professionals and how payment will be delivered to these providers:

☐ **The State provides assurance that any contract requirements specified in this section will be included in any new or the next contract amendment submitted to CMS for review.**

Transmittal Number: MN-15-0004 Supersedes Transmittal Number: Approved Effective Date: Jul 1, 2016 Approval Date: Mar 25, 2016

Health Homes Payment Methodologies

The State's Health Homes payment methodology will contain the following features:

☑ **Fee for Service**

☐ **Fee for Service Rates based on:**

☐ **Severity of each individual's chronic conditions**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Other: Describe below.**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee-for-service rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.

☑ **Per Member, Per Month Rates**

Provide a comprehensive description of the rate-setting policies the State will use to establish Health Homes provider reimbursement fee for service or PMPM rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the reimbursable unit(s) of service, the cost assumptions and other relevant factors used to determine the payment amounts, the minimum level of activities that the State agency requires for providers to receive payment per the defined unit, and the State's standards and process required for service documentation.
Effective for services provided on or after July 1, 2015, payment for BHH services is $245.00 per member, per month. During the recipient's first six months of participation, the BHH will receive an enhanced payment rate of $350.00 per member, per month. This enhanced payment will be made only once in each recipient's lifetime.

The Department made the following assumptions in developing the monthly payment rates for behavioral health home services:

•The population served by the BHH 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 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 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.

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.

In order to receive a monthly PMPM payment, a BHH provider must:
•Have personal contact with the recipient every month. This contact may include face-to-face or telephonic contact. A letter or voicemail alone does not constitute personal contact.

•Deliver and document activities every month under at least two of the six required services linked to recipient's individual goals identified in the health action plan.

•Meet face-to-face with the recipient every 60 days. This must be linked to the recipient's individual goals and could be accomplished by any member of the BHH team. The face-to-face contact requirement may be met by meeting face-to-face with the recipient to complete the 6-month review of the health action plan, accompanying a recipient to an appointment, providing face-to-face health education, or other face-to-face contact as necessitated in the individual's health action plan. With the exception of the face-to-face requirements for completing and updating the intake, initial needs assessment, health wellness assessment, and health action plan, the face-to-face requirement may be met using two-way interactive video or store-and-forward technology.

•Meet face-to-face with the recipient every six months to review and update the health action plan.

☐ **Incentive payment reimbursement**

Provide a comprehensive description of incentive payment policies that the State will use to reimburse in addition to the unit base rates. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain: the incentives that will be reimbursed through the methodology, how the supplemental incentive payments are tied to the base rate activities, the criteria used to determine a provider's eligibility to receive the payment, the methodology used to determine the incentive payment amounts, and the

frequency and timing through which the Medicaid agency will distribute the payments to providers.

☐ **PCCM Managed Care (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 PM/PM payments (describe below)**

☐ **Tiered Rates based on:**

☐ **Severity of each individual's chronic conditions**

☐ **Capabilities of the team of health care professionals, designated provider, or health team.**

Describe any variations in payment based on provider qualifications, individual care needs, or the intensity of the services provided:

☐ **Rate only reimbursement**

Provide a comprehensive description of the policies the State will use to establish Health Homes alternative models of payment. Explain how the methodology is consistent with the goals of efficiency, economy and quality of care. Within your description, please explain the nature of the payment, the activities and associated costs or other relevant factors used to determine the payment amount, any limiting criteria used to determine if a provider is eligible to receive the payment, and the frequency and timing through which the Medicaid agency will distribute the payments to providers.

Explain how the State will ensure non-duplication of payment for similar services that are offered through another method, such as 1915(c) waivers or targeted case management.
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:

• 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 provides assurance that all governmental and private providers are reimbursed according to the same rate schedule**

☑ **The State provides assurance that it shall reimburse Health Homes providers directly, except when there are employment or contractual arrangements.**

Submission - Categories of Individuals and Populations Provided Health Homes Services

The State will make Health Homes services available to the following categories of Medicaid participants:

☑ **Categorically Needy eligibility groups**

Health Homes Services (1 of 2)

Category of Individuals
CN individuals

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.

•Utilize the state-developed Mental Health Information System (MHIS) for reporting data to the state for federal reporting purposes.

•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 benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Integration Specialist

Description

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 template 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 template provided by the Department.
•Update the health wellness assessment and 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.

•Utilize the state-developed Mental Health Information System (MHIS) for reporting data to the state for federal reporting purposes.

•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 benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Behavioral Health Home Systems Navigator

Description

Care coordination services are provided by either a case manager as defined in Attachments 3.1-A/B, supplement 1, or a mental health practitioner as defined in Attachments 3.1-A/B, item 4.b. 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.

•Utilize the state-developed Mental Health Information System (MHIS) for reporting data to the state for federal reporting purposes.

•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 benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Qualified Health Home Specialist

Description

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
- Peer support specialist as defined in Attachment 3.1-A/B, item 13.d.
- Family peer support specialist as defined in Attachment 3.1-A/B, item 4.b.
- Community paramedic as defined in item 5.a.
- Certified health education specialist.

These services may also be supported by other BHH team members.

Health Homes Services (2 of 2)

Category of Individuals
CN individuals

Service Definitions

Provide the State's definitions of the following Health Homes services and the specific activities performed under each service:

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.

•Utilize the state-developed Mental Health Information System (MHIS) for reporting data to the state for federal reporting purposes.

•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 benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Behavioral Health Home Systems Navigator

Description

This service is provided by either a case manager as defined in Attachments 3.1-A/B, supplement 1, or a mental health practitioner as defined in Attachments 3.1-A/B, item 4.b. 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.

•Utilize the state-developed Mental Health Information System (MHIS) for reporting data to the state for federal reporting purposes.

•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 benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name

Behavioral Health Home Systems Navigator

Description

This service is provided by either a case manager as defined in Attachments 3.1-A/B, supplement 1, or a mental health practitioner as defined in Attachments 3.1-A/B, item 4.b. This service may also be supported by other BHH team members.

Referral to community and social support services, if relevant

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.

•Utilize the state-developed Mental Health Information System (MHIS) for reporting data to the state for federal reporting purposes.

•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 benefit/service

☑ **The benefit/service can only be provided by certain provider types.**

☐ **Behavioral Health Professionals or Specialists**

Description

☐ **Nurse Care Coordinators**

Description

☐ **Nurses**

Description

☐ **Medical Specialists**

Description

☐ **Physicians**

Description

☐ **Physicians' Assistants**

Description

☐ **Pharmacists**

Description

☐ **Social Workers**

Description

☐ **Doctors of Chiropractic**

Description

☐ **Licensed Complementary and Alternative Medicine Practitioners**

Description

☐ **Dieticians**

Description

☐ **Nutritionists**

Description

☑ **Other (specify):**

Name
Behavioral Health Home Systems Navigator

Description
This service is provided by either a case manager as defined in Attachments 3.1-A/B, supplement 1, or a mental health practitioner as defined in Attachments 3.1-A/B, item 4.b. This service may also be supported by other BHH team members.

Health Homes Patient Flow

Describe the patient flow through the State's Health Homes system. The State must submit to CMS flow-charts of the typical process a Health Homes individual would encounter:
See attached documents.

☑ **Medically Needy eligibility groups**

◉ **All Medically Needy eligibility groups receive the same benefits and services that are provided to Categorically Needy eligibility groups.**

○ **Different benefits and services than those provided to Categorically Needy eligibility groups are provided to some or all Medically Needy eligibility groups.**

○ **All Medically Needy receive the same services.**

○ **There is more than one benefit structure for Medically Needy eligibility groups.**

Health Homes Monitoring, Quality Measurement and Evaluation

Monitoring

Describe the State's methodology for tracking avoidable hospital readmissions, including data sources and measurement specifications:
The Department will use FFS claims and encounter data to calculate the avoidable hospital readmissions. Avoidable readmissions are those that occur within 30 days of the previous admission. The annual readmission rate is calculated by dividing the number of readmissions within 30 days by the total number of admissions (admissions plus readmissions) during the measurement year, multiplied by 100, calculated to the second decimal.

Describe the State's methodology for calculating cost savings that result from improved coordination of care and chronic disease management achieved through the Health Homes program, including data sources and measurement specifications.
The Department will use data from FFS claims and encounter data to estimate the savings achieved. We will compare the relative claim costs and annual cost increases of the BHH enrolled population to the overall Medicaid population and the "control" population of the BHH-eligible members who are not enrolled in a BHH. The observed relative costs and year-to-year trends will be reasonably adjusted for the populations' relative Medicaid program distributions and risk (i.e. risk adjusted) and, for the BHH-enrolled vs. control group comparison, the classification of the member (SED, SMI, SPMI, etc.). The Department will also measure the relative costs by broad and detailed claim cost categories to understand the key drivers of the observed aggregate savings and provide additional feedback to the participating providers. Where appropriate, the Department may choose to adjust for the impact of high-cost cases, although the relative prevalence of high-cost cases will likely be retained as part of the overall performance assessment. Where sufficient enrolled lives exist to develop credible estimates, the Department may also choose to examine the cost savings achieved by individual BHHs.

Describe how the State will use health information technology in providing Health Homes services and to improve service delivery and coordination across the care continuum (including the use of wireless patient technology to improve coordination and management of care and patient adherence to recommendations made by their provider).
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.

•Utilize the state-developed Mental Health Information System (MHIS) for reporting data to the state for federal reporting purposes.

•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.

Quality Measurement

☑ **The State provides assurance that it will require that all Health Homes providers report to the State on all applicable quality measures as a condition of receiving payment from the State.**

☑ **The State provides assurance that it will identify measureable goals for its Health Homes model and intervention and also identify quality measures related to each goal to measure its success in achieving the goals.**

States utilizing a health team provider arrangement must describe how they will align the quality measure reporting requirements within section 3502 of the Affordable Care Act and section 1945(g) of the Social Security Act. Describe how the State will do this:

Evaluations

☑ **The State provides assurance that it will report to CMS information submitted by Health Homes providers to inform the evaluation and Reports to Congress as described in Section 2703(b) of the Affordable Care Act and as described by CMS.**

Describe how the State will collect information from Health Homes providers for purposes of determining the effect of the program on reducing the following:

Hospital Admissions

Measure:

Hospital Admissions

Measure Specification, including a description of the numerator and denominator.
Denominator: The Denominator (D) is the total number of enrollee months during the year. To be included in the denominator, enrollees must meet the specific criteria listed in this section.

•Age Criteria: One through 64 years of age, calculated as of December 31st of the contract year.

•Enrollment Criteria: Enrolled in Medical Assitance for at least one month during the calendar year.

Numerator: The Numerator (N) is the unduplicated number of index admissions during the year. Index admissions exclude avoidable readmissions as defined above.

The admission date is defined as the beginning service date on the managed care encounter claim. Admissions less than two days apart for the same enrollee will be combined into one admission to avoid over counting admissions due to transfers and multiple claims for an inpatient stay. Inpatient claims that are combined may be for the same, or different hospitals.
Data Sources:
We will use FFS claims, encounter claims, and enrollment data from records received by the state no later than May 31st of the year following the contract year.
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Emergency Room Visits

Measure:

Emergency Room Visits

Measure Specification, including a description of the numerator and denominator.
The Denominator (D) is the total number of enrollee months during the year. To be included in the denominator, enrollees must meet the following criteria:

•Age: 0 through 64 years of age, calculated as of December 31st of the Contract Year.

•Enrollment: Enrolled in MA for at least one month during the calendar year.

The Numerator (N) is the unduplicated number of emergency department visits during the year for enrollees who meet the denominator criteria.
Data Sources:
We will use FFS claims, encounter claims, and enrollment data from records received by the state no later than May 31st of the year following the contract year.
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Skilled Nursing Facility Admissions

Measure:
Skilled Nursing Facility Admissions
Measure Specification, including a description of the numerator and denominator.
Rate of skilled nursing facility stays lasting 1 to 99 days among enrollees per 1000 member months.

The Denominator (D) is the sum of enrollment in Medicaid fee-for-service or managed care for each month during the reporting year (i.e. the sum of the 12 monthly enrollment totals).

The Numerator (N) is a count of all SNF stays over the past 12 months where:

•The recipient was not in a SNF for a period of 30 consecutive days prior to the measurement period, and

•Remained in the SNF for a period of 1 to 99 days.

Measure calculation: (Admissions/Enrollment months) x 1,000
Data Sources:
We will use FFS claims, encounter claims, and enrollment data from records received by the state no later than May 31st of the year following the contract year.
Frequency of Data Collection:

- ○ **Monthly**
- ○ **Quarterly**
- ◉ **Annually**
- ○ **Continuously**
- ○ **Other**

Describe how the State will collect information for purpose of informing the evaluations, which will ultimately determine the nature, extent and use of the program, as it pertains to the following:

Hospital Admission Rates
The Department will annually track the hospital admission rates based on the number of hospital admissions divided by the number of enrollee-months multiplied by 1000, calculated to the second decimal.

Chronic Disease Management
The state will require certified behavioral health homes to create and maintain a searchable patient registry to record participant information and track participant care. Data from these registries may be utilized to evaluate chronic

disease management. The state will work in partnership with a contracted vendor to develop a full program evaluation plan.

Coordination of Care for Individuals with Chronic Conditions
Data from patient registries may be utilized to evaluate chronic disease management. The state will work in partnership with a contracted vendor to develop a full program evaluation plan.

Assessment of Program Implementation
Program implementation will be monitored through processes developed by the state. The state will work in partnership with a contracted vendor to develop a full program evaluation plan. The plan will be informed by stakeholder feedback and will include specific program implementation measures and evaluation methodology. The program evaluation results will inform the ongoing development of behavioral health home policies. Recipient feedback related to recipient experience and satisfaction will be a key component of the evaluation plan.

Processes and Lessons Learned
The first implementers group will be utilized to gather feedback on the process and lessons learned in the initial implementation of the behavioral health homes model. The state will contract with an entity to lead this learning collaborative and to gather lessons learned in order to inform the ongoing development of behavioral health homes.

Assessment of Quality Improvements and Clinical Outcomes
The state will utilize the Health Home Core Measures to evaluate quality improvement and clinical outcomes and will determine additional state-specific measures.

Estimates of Cost Savings

☑ **The State will use the same method as that described in the Monitoring section.**

If no, describe how cost-savings will be estimated.

PRA Disclosure Statement