UCare Connect/Connect + Medicare and MSC+/MSHO

Care Coordination and LTSS

Title: Coordination with members receiving Behavioral Health Home (BHH) services.

Purpose: To ensure UCare Care Coordinators (CC) working with members who are receiving Behavioral Health Home Services understand what the BHH service is, how this service will interact with CC's and the expectation around a CC's involvement when a member is receiving Behavioral Health Home services.

Definition: The term "behavioral health home" services refer to a model of care focused on integration of primary care, mental health services, and social services and supports for adults diagnosed with mental illness. The BHH services model of care utilizes a multidisciplinary team to deliver person-centered services designed to support a person in coordinating care and services while reaching his or her health and wellness goals.

Goals of BHH Services

The goals of BHH services are that an individual:

- Has access to and utilizes routine and preventative health care services;
- Has consistent treatment of mental health and other co-occurring health conditions;
- Gains knowledge of health conditions, effective treatments, and practices of self- management of health conditions;
- Learns and considers healthy lifestyle routines; and
- Has access to and uses social and community supports to assist the individual in meeting his or her health wellness goal.

Eligible Providers

To provide BHH services, a clinic or agency must be enrolled as a MHCP provider and must successfully complete the MHCP certification process. Link to DHS certified BHH providers.

Duplicative services

Medicaid payment for duplicative services is prohibited. Therefore, a person is not able to receive BHH services and any of the following services in the same calendar month:

- Mental Health Targeted Case Management (MH-TCM)
- Assertive Community Treatment (ACT) or Youth Assertive Community Treatment (Youth ACT)
- Relocation service coordination targeted case management (RSC-TCM)
- Vulnerable adult/developmental disability targeted case management (VA/DD-TCM)
- Health Care Home care coordination

A person who meets the eligibility criteria for one or more of these covered services must choose which service best meets his or her needs.

BHH referrals

BHH services is available to adults receiving Medical Assistance with mental illness. Mental illness and emotional disturbance are umbrella terms that include individuals diagnosed with serious and persistent mental illness, substance use disorder, and severe emotional disturbance.

A member who needs additional coordination around their behavioral health needs that meets BHH criteria may be referred to a BHH. CCs or members can call one of the certified BHH service providers to schedule a diagnostic assessment (DA) to identify if members are appropriate for BHH services.

Certified BHH service providers will determine a member's eligibility for BHH services through conducting a DA or through the review of a previously completed DA. Upon determination that the member is eligible for BHH services, the BHH provider will fax the completed Notification of Eligibility for BHH Services (DHS-4797) (PDF) form to UCare within 30 days .

Care Coordinator Collaborative Process:

1. When UCare is notified that a member is working with a BHH, UCare will notify the assigned delegate of the BHH start date, provider, and BHH contact information via secure fax/secure email to the contact information from the *Care Coordination Contact List* located on the UCare® - Care Managers site.

2. CCs are responsible to contact the BHH provider within 30 business days of receiving notification that the member is receiving BHH. During this call, the CC will:
   - Provide the BHH staff with the CC's contact information.
   - Share information related to the members support plan.
   - Establish contact frequency between BHH provider and CC.
   - Discuss what the preferred method of communication will be between the CC and the BHH staff.

Note: CCs are to include BHH service on a member's support plan and ICT as well as document all contacts they have with BHH staff in the member's record.

3. BHH staff and CCs are to work cooperatively and collaboratively, to ensure that services and activities are coordinated to most effectively meet the goals of the person and to ensure that duplication is avoided. In the communication between CCs and BHH staff, conversations are to occur related to what activities and services the BHH are supporting members through.

4. CCs are responsible to notify the member's BHH provider in a timely manner of learning of a member utilizing the Emergency Room or hospital admission.

5. CCs are responsible to notify the member's contact at the BHH in a timely manner of learning of a member transition of care, such as discharge from a hospital stay or a transition from a nursing home/institution setting. CCs are responsible to share with the BHH any post discharge plans.

6. BHH providers are required to notify the MCO when a member is no longer receiving BHH services. UCare will share this information with our delegate agencies via secure fax.

Contact requirements for MCO/Care Coordinator

Activity	BHH Provider	MCO/Care Coordinator
Starting BHH services	The BHH services provider must send a copy of the Notification of Eligibility for BHH Services (DHS-4797) (PDF) to the MCO within 30 days of intake.	UCare as the MCO will notify delegates of BHH services. A copy of the DHS-4797 will be faxed/emailed to the assigned delegate agency. For internally managed members, the assigned CC will be notified through the documentation system with an activity.
Assessment, support plan, and monitoring	If the individual receiving BHH services has been assigned a case manager or care coordinator by the health plan, the BHH services team must record the case manager or care coordinator's name and contact information in the person's BHH services record(s), and a schedule for how frequently the BHH services team will check in with the CM/CC.	CC must record the BHH name and contact information on the member's support plan and a schedule for frequency of contact with BHH team. CC must document contacts with BHH service providers as they normally would document other provider contacts.
Emergency Room Visits and Hospitalizations	BHH to alert UCare or individuals CC (if known) of any ER admission, hospitalization admission and/or discharge.	CC to alert BHH of any known ER admission, or hospitalization admission and/or discharge.
Transitions of Care	BHH to contact member to ensure that the member is able to access all needed services and supports at the time of discharge or other transition. BHH to notify UCare or individuals CC (if known) if the member requires assistance to ensure access to needed treatment or services upon discharge	CC to notify BHH of any transitions of care, post discharge plans, follow-up plans.

References

- Behavioral health home services / Minnesota Department of Human Services (mn.gov)
- DHS-6307 BHH services overview (state.mn.us)
- BHH Services MCO Roles and Responsibilities (mn.gov)