

Behavioral Health Home Services

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Overview

The term “behavioral health home” services refers 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 or children diagnosed with emotional disturbance. The behavioral health home (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
- Has access to and uses social and community supports to assist the individual meet his or her health wellness goals

Eligible Providers

To provide BHH services, a clinic or agency must be enrolled as a Minnesota Health Care Programs (MHCP) provider and must successfully complete the MHCP [certification process](#).

Certification Process and Variance Requests

To be certified to deliver BHH services, an agency must demonstrate that all locations from which BHH services will be provided are enrolled with MHCP, and that all BHH services teams operated by the agency or entity meet the BHH services certification standards outlined in [Behavioral Health Home \(BHH\) Services Provider Standards \(DHS-6766\) \(PDF\)](#). The BHH services certification process consists of an online application and a site visit. Detailed information about certification requirements and standards are available on the Minnesota Department of Human Services (DHS) [How to become a certified BHH services provider](#) webpage.

BHH services applicants and certified providers may request a variance on specific service requirements. The variance request must include the reason for the variance request and the time period the variance is requested. DHS may grant a variance from the requirements when:

- the failure to grant the variance would result in hardship to the provider. A hardship may be considered something greater than an inconvenience or that may result in significant costs to the clinic to implement.
- the variance is consistent with public interest.
- the variance would not reduce the level of services provided to individuals served by the organization, or
- the variance is innovative and will improve the delivery of BHH services.

To request a variance, a provider will have to complete and submit the BHH services [Variance Request \(DHS-8026\) \(PDF\)](#) for review and approval.

Eligible Members

To be eligible for BHH services, a member must be [MA](#) eligible and have a current diagnosis from a qualified health professional of a condition that meets the definition of mental illness as described in [Minnesota Statutes, 245.462, subdivision 20](#), paragraph (a), or emotional disturbance as defined in section [Minnesota Statutes, 245.4871, subdivision 15](#), clause (2). For BHH services, a “current” diagnosis is considered by DHS to be a diagnosis made within the past 12 months by a qualified professional. A qualified health professional includes:

- Physician
- Physician assistant
- Advanced practice registered nurse
- Licensed mental health professional

The list of allowable mental health diagnostic code ranges under which providers can bill for BHH services can be found in the [mental health diagnostic codes section](#) of the provider manual.

Certified BHH services providers must ensure that the following elements are complete before determining eligibility for BHH services:

- The BHH services provider confirms that the member has current MA coverage.
- The BHH services provider reviews and explains the [Behavioral Health Home \(BHH\) Services Rights, Responsibilities and Consent \(DHS-4797B-ENG\) \(PDF\)](#) to the member. The provider must document the member’s agreement to receive BHH services by keeping a DHS-4797B signed by the member in the provider’s records. The BHH services provider should give the member a copy of DHS-4797B for the member’s records. If the member is receiving a duplicative service, the member must decide which service he or she wants to receive.
- The BHH services provider confirms and documents the member has a diagnosis from a qualified health professional within the previous 12 months that indicates the member has a condition that meets the federal definition of serious mental illness (adults) or emotional disturbance (children).
- Intake for BHH services is considered complete as of the date that all of the preceding elements have been completed. BHH services providers must determine and document an individual’s eligibility before providing and billing for BHH services.

Diagnostic Assessments

Individuals receiving BHH services are required to obtain a diagnostic assessment (DA) within six months of intake completion for BHH services. If the member has a current DA in place (current means within the past 12 months), another DA is not needed at the time the member starts BHH services nor within six months of enrollment into BHH services.

Please note, it is required that a mental health professional employed by or under contract at your organization reviews the diagnostic assessment.

One of the following types of diagnostic assessments is allowable for purposes of eligibility for BHH services:

- Standard diagnostic assessment
- Extended diagnostic assessment
- Adult diagnostic assessment update

Assessments must be performed according to requirements outlined in the [Diagnostic Assessment](#) section of the MHCP Provider Manual.

Covered Services

BHH services providers must have the capacity to deliver the following core services based on the individual's needs and according to [BHH Certification Standards \(DHS-6766-ENG\) \(PDF\)](#).

Care Management

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 member.

Care Coordination

Care coordination occurs when the BHH services team 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. Specific care coordination activities are conducted with members and their identified supports, medical, behavioral health and community providers, and across and between care settings.

Health and Wellness

Health and wellness promotion services encourage and support healthy living and motivate people and their identified supports to adopt healthy behaviors and promote better management of their health and wellness. The providers place a strong emphasis on skills development so individuals and their identified supports can monitor and manage their chronic health conditions to improve health outcomes.

Comprehensive Transitional Care

Comprehensive transitional care activities are specialized care coordination services that focus on the movement of people between different levels of care or settings. Transition services are designed to streamline plans of care and crisis management plans, reduce barriers to timely access, reduce inappropriate hospital, residential treatment, and nursing home admissions, interrupt patterns of frequent emergency department use, and prevent gaps in services which could result in (re)admission to a higher level of care or longer lengths of stay at an unnecessary level of care.

Individual and Family Supports

Individual and family support services are activities, materials or services aimed to help people reduce barriers to achieving goals, increase health literacy and knowledge about chronic conditions, increase self-efficacy skills, and improve health outcomes.

Referral to Community Supports

Referral to community and social support services are activities that ensure people have access to resources to address their identified goals and needs. Resources should address social, environmental and community factors. These factors impact holistic health, including but not limited to, medical and behavioral health care, entitlements and benefits, respite, housing, transportation, legal services, educational, employment services and financial. The BHH services team will close the loop on all referrals to ensure people are supported in achieving their goals.

Service Delivery Requirements

Service delivery requirements are listed in the [BHH certification standards \(DHS-6766-ENG\) \(PDF\)](#). Adherence to the service delivery requirements will be monitored as part of ongoing certification.

Initial Engagement and Assessment

BHH services providers must meet and deliver initial engagement and assessment services that meet the requirements of [BHH services certification standard 5D \(DHS-6766\) \(PDF\)](#). During the initial 90-day engagement period, a staff member of the BHH services team must have contact with the person to:

- Complete the intake process and the brief needs assessment and develop a plan to address immediate needs as appropriate
- Complete the initial health wellness assessment within 60 days after intake
- Develop the health action plan within 90 days after intake
- BHH services providers must update a person's health action plan at least every six months

Telehealth

If a member accepts the offer for a face-to-face visit at six months, providers who are eligible to provide services via telehealth may do so. Providers must have a valid [Telehealth Provider Assurance Statement \(DHS-6806\) \(PDF\)](#) on file with DHS and must comply with all MA telehealth requirements for equipment, privacy and billing to serve individuals receiving BHH services through telehealth. Refer to the following sections for requirements, billing and additional information:

- [Telehealth](#) subsection of the [Physician and Professional Services](#) MHCP Provider Manual section
- [Telehealth Delivery of Mental Health Services](#) MHCP Provider Manual section

Noncovered Services

Individuals eligible for BHH services are eligible for all MA-covered services. However, payment for duplicative services in the same calendar month is prohibited. The member must choose which available MA-covered service best meets the member's needs.

The following services are considered duplicative of BHH services:

- Adult mental health targeted case management (AMH-TCM)
- Children's mental health targeted case management (CMH-TCM)
- Assertive community treatment (ACT)
- Vulnerable adult/developmental disability targeted case management (VA/DD-TCM)
- Relocation services coordination targeted case management (RSC-TCM)
- Health care home (HCH) care coordination services

For people who have fee-for-service MA coverage, MHCP will pay on the first claim submitted in a calendar month for any one of the duplicative services. Subsequent claims in the same calendar month for one of the identified duplicate services will not be paid. Medicaid managed care organizations (MCO) are also prohibited from payment of duplicative services in the same calendar month. However, MCOs may develop different mechanisms to avoid duplicate payments, such as a take-back of payment following a reconciliation of monthly claims, or denial of a subsequent duplicate claim in the same calendar month. Providers should contact the MCO directly to learn what procedures the MCO will use to ensure no duplicate payment. Refer to [BHH services MCO Contact Information \(PDF\)](#).

Integration of BHH Services and other MA Covered Services

BHH services are designed to help connect people to medically appropriate services, and to help people remove barriers that keep them from effectively engaging with medically necessary services.

Unless a service has been specifically identified as a duplicative service (review the [Noncovered Services](#) section), it is permissible for a BHH services provider to bill for other MA-covered services delivered to a person who is also receiving BHH services. The BHH services rate was developed as a per member, per month payment to allow the provider flexibility to provide the right service, at the right time, based on the member's needs and circumstances.

Examples

Example 1

BHH services provider "A" is also certified to provide ARMHS. A member receiving BHH services has been determined to be eligible for ARMHS. The BHH services provider organization is permitted to bill for both services if the provider organization has met the billing requirements for each service.

Example 2

BHH services provider "B" is also a primary care services provider. A person receiving BHH services has been determined to need asthma education. The BHH services provider organization is permitted to bill for both services if the provider organization has met the billing requirements for each service.

Billing

Certified BHH services providers are required to carry out a service eligibility determination before billing for BHH services.

To submit claims for delivery of BHH services, certified providers must:

- Have personal contact with the person or the identified support at least once per month. Personal contact may include face-to-face, telephone contact or interactive video. An email, letter, voicemail or text alone does not meet the requirement for monthly personal contact.
- At a minimum, offer a face-to-face visit with the member at least every six months. If the member declines the offer of a face-to-face visit, the visit may be completed by telephone contact or interactive video.
- Bill BHH services online using [MN-ITS 837P](#).
- Include the rendering NPI of an MHCP-enrolled BHH services team member when BHH services are submitted by a mental health billing entity.

Billing information for procedure codes S0280 and S0281

Procedure Code	Modifier	Service	Unit	Limitations
S0280	U5	BHH services care engagement, initial plan	1 = month	Lifetime limit of six enhanced payments in member's lifetime. One payment per month.
S0281	U5	BHH services ongoing standard care maintenance of plan	1 = month	One payment per month.

An individual may receive up to six payments at the enhanced rate per member per month. Any claim beyond the six enhanced payments will automatically be processed at the base rate.

Additional billing information:

- The initial plan code (S0280 U5) can be billed at any time and no break is required to bill for the six maximum lifetime services. For example, code S0280 U5 can be billed for the months of January-June or January, February and November
- Code S0281 U5 (maintenance plan) does require that code S0280 U5 (initial plan) be submitted before the S0281 U5
- Code S0280 U5 cannot be submitted in the same month as S0281 U5
- The claim for BHH services must use the NPI and address listed on the organization's BHH services certification approval letter to receive payment

Managed Care

Notification

If a person who has been determined eligible for BHH services is enrolled in managed care, the BHH services provider must send a copy of the [Notification of Eligibility for Behavioral Health Home \(BHH\) services \(DHS-4797-ENG\) \(PDF\)](#) to the MCO's designated contact. BHH services providers should consult the [BHH services MCO Contact Information \(PDF\)](#) to obtain the appropriate contact information for the MCO.

Communication and Coordination

BHH services providers are required to communicate and coordinate with MCOs to ensure that services and activities are coordinated to most effectively meet the goals of the person and to ensure that duplication between the MCO and the BHH services provider is avoided. BHH services providers and MCOs must adhere to the communication and coordination protocols established in [BHH services MCO Roles and Responsibilities worksheet](#). An MCO and a BHH services provider can choose to add requirements for communication or coordination to the BHH Services MCO Roles and Responsibilities worksheet by mutual agreement. If the MCO and the BHH services provider agree to make additions to the worksheet, the MCO and the BHH services provider must provide a copy of the updated worksheet and signatures from responsible staff at the MCO and the BHH services provider to demonstrate that both entities have agreed to the additional terms specified in the updated worksheet.

For individuals who are enrolled in an MCO, BHH services providers need to contact the individual's MCO to determine what the MCO requires on the claim for BHH services. Refer to the [BHH services MCO Contact Information \(PDF\)](#) for more information.

Legal References

[Minnesota Statutes, 256B.0757](#), Coordinated Care through a Health Home

[Minnesota Statutes, 256B.0757](#), subdivision 4d (8), Diagnostic Assessment

[Minnesota Statutes, 245.461 to 245.468](#), Minnesota Comprehensive Adult Mental Health Act

[Minnesota Statutes, 245.462](#), Definitions

[Minnesota Statutes, 256B.0625](#), subdivision 20, Mental Health Case Management

[Minnesota Statutes, 245.462](#), subdivision 20, paragraph (a)

[Minnesota Statutes, 245.4871](#), subdivision 15, clause (2)

[Minnesota Statutes, 256B.0625](#), subdivision 3b, Medical Assistance Telemedicine

[Minnesota Rules, part 9505.0372](#), subpart 1, item B or C

[U.S. Code, title 42, section 1396w-4](#)