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**DATE**

August 25, 2017

**OF INTEREST TO**

County Directors

Social Services Supervisors and  
Staff

Tribal Directors

Children's Mental Health  
Treatment ProvidersState- Contracted Managed  
Care Organizations**ACTION/DUE DATE**Please read information and  
prepare for implementation**EXPIRATION DATE**

August 25, 2019

## Mental Health Targeted Case Management in Certified Community Behavioral Health Clinics

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### TOPIC

Mental Health Targeted Case Management services in Certified Community Behavioral Health Clinics. This includes eligibility, service core components, funding, payment, data collection, and reporting.

### PURPOSE

To provide information on Mental Health Targeted Case Management services delivered by Certified Community Behavioral Health Clinics.

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### SIGNED

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Assistant Commissioner  
Community Supports Administration

### TERMINOLOGY NOTICE

The terminology used to describe people we serve has changed over time. The Minnesota Department of Human Services (DHS) supports the use of "People First" language.

# INTRODUCTION

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Minnesota has been selected by the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA) as a federal demonstration state for Certified Community Behavioral Health Clinics (CCBHCs). Six CCBHCs in Minnesota will demonstrate this service model from July 1, 2017 through June 30, 2019.

## I. BACKGROUND

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Certified Community Behavioral Health Clinics (CCBHCs) are required to offer Mental Health Targeted Case Management (MH-TCM). There is no county share for people that are enrolled in Medical Assistance (MA) when a CCBHC is providing MH-TCM during the demonstration period. MH-TCM services delivered by a CCBHC must follow CCBHC criteria and each CCBHC's policies and procedures approved by the Commissioner of Human Services or their designee.

The CCBHC federal demonstration program in Minnesota does not change the county's role as the local mental health authority in the fee-for-service (FFS) model. The CCBHC federal demonstration program in Minnesota does not change the tribal authority for providers enrolled in the Minnesota Health Care Programs as a recognized MH-TCM provider. The CCBHC federal demonstration project in Minnesota does not change Managed Care Organizations' (MCOs) role in eligibility determination for MH-TCM for enrolled members. The policy covered in this bulletin must be read with applicable MH-TCM statute(s) and rule(s) and CCBHC criteria. This bulletin will address questions on MH-TCM and changes to MH-TCM implementation during the demonstration period for CCBHCs and recipients.

## II. Caseload Size

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The maximum average caseload size for full time equivalent (FTE) case managers does not change for MH-TCM recipients in a CCBHC. According to Minnesota Rules, part 9520.0903, subpart 2 the maximum average caseload of a case manager providing services to children is 15 children to 1 FTE; the maximum average caseload of a case manager providing services to adults is 30 adults to 1 FTE.

## III. Eligibility Determination and Service Provision

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CCBHC recipients who are on MA will have direct access to MH-TCM without county approval or authorization.<sup>1</sup> MH-TCM eligibility in a CCBHC will be determined by each CCBHC through completion of a Preliminary Screening, Risk Assessment and Initial Evaluation. The Initial Evaluation will document the need for assistance, diagnosis, medical necessity and referral(s) for MH-TCM within the CCBHC.

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<sup>1</sup> Retrieved from Bulletin Number 17-53-02 [DHS Provides Policy for Certified Community Behavioral Health Clinics](#)

In order to be eligible for AMH-TCM delivered by a CCBHC(s), an adult must meet case management eligibility criteria. An exception to eligibility criteria for CCBHC AMH-TCM criteria is that it also includes persons deemed at high risk of suicide. This expanded eligibility criteria for CCBHC includes people in transition from an emergency department or psychiatric hospitalization. Mental health professionals within each CCBHC will exercise clinical judgment to determine if a person meets this expanded eligibility criteria.

## **A. Assessment**

The Initial Evaluation is completed by a mental health professional within 10 days of first contact and establishes eligibility for CCBHC recipients for services available within the CCBHC. For CCBHC recipients of Adult Mental Health Targeted Case Management (AMH-TCM) a Functional Assessment (FA) is still required. The results of the FA are then incorporated into the required Comprehensive Evaluation for each adult CCBHC recipient.

The Comprehensive Evaluation includes a psychosocial assessment, including an assessment of level of care needs (CASII, ECSII for children and adolescents and/or LOCUS for adults) and synthesizes data gathered by the CCBHC in the initial evaluation, FA, and any other services received. The Comprehensive Evaluation is completed within 60 days of first contact for all new CCBHC recipients and updated or repeated according to the existing standards for MH-TCM for children and adults. The FA is also completed and updated according to the existing standards for AMH-TCM.

## **B. Planning**

CCBHCs complete a comprehensive person and/or family-centered diagnostic and treatment planning evaluation (Comprehensive Evaluation) as a basis for the Integrated Treatment Plan. The Integrated Treatment Plan applies to all services received at the CCBHC (including Care Coordination) and is informed by the Initial Evaluation, the FA (for adult recipients) and the Comprehensive Evaluation and any other information gathered about the person throughout early service delivery. The Integrated Treatment Plan is completed in lieu of the individual community support plan (ICSP) and individual family community support plan (IFCSP) for CCBHC recipients.

New MH-TCM CCBHC recipients collaboratively complete a person and/or family-centered Integrated Treatment Plan within 60 days of the first point of contact. Existing MH-TCM CCBHC recipients collaboratively complete the Integrated Treatment Plan update within 90 days of receiving a CCBHC covered service after July 1, 2017. The Integrated Treatment Plan is required to be updated every 90 days.

CCBHCs provide MH-TCM to assist recipients in gaining access to needed educational, health, legal, medical, social, vocational and other services and supports. There are four, core components of MH-TCM. These four core components must be present in evaluative and planning documents for people receiving MH-TCM in a CCBHC. The four, core components of MH-TCM are: assessment, planning, referral/linkage and monitoring/coordination.

## C. Closure, Termination and Transfer of Services

Transitioning a child/family or person from MH-TCM services is a participatory and mutual decision. MH-TCM services may close when a person no longer meets eligibility criteria, upon receipt of a mental health professional's written opinion that they no longer need MH-TCM services or when it's agreed upon by the child/family, person and care team. Transitioning a MH-TCM recipient (e.g., in cases of relocation or recipient choice) is also a collaborative and planful decision and process.

MH-TCM services may close when there has been no face-to-face contact between the case manager and child for 90 consecutive days or no face-to-face contact between the case manager and adult for 180 days. CCBHCs must demonstrate assertive engagement and outreach efforts for children and adults receiving MH-TCM prior to closure. In cases where consensus cannot be reached by both the recipient and case manager on closure, termination or transfer of MH-TCM services, the underlying reasons why a child/family and/or person disagrees with the decision must be explored and addressed by the case manager and CCBHC. Appeal/grievance procedures and reason(s) for closure, termination or transfer must be explained to the recipient.

## D. Mandated Services

Certain MH-TCM services are mandatory. The county of financial responsibility and the county's role as the local mental health authority does not change for mandated services during the CCBHC demonstration. Counties maintain their authority and role to coordinate and monitor mandatory services and statuses such as Out of Home (OOH) placement plans and civil commitments for CCBHC recipients.

In the circumstance of either an OOH placement plan or civil commitment for CCBHC recipients, contracted vendors, counties and tribes may deliver MH-TCM services in the same month as a CCBHC. The CCBHC, contracted vendor, county or tribal agency may each bill for MH-TCM services in the same month according to Minnesota Statutes, section 256B.0625, subdivision 20(g):

If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, **the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month.** In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

The county of financial responsibility or tribe may elect to coordinate and monitor mandatory services in the same month(s) the CCBHC provides MH-TCM services. The CCBHC and county or tribe must ensure there is no duplication of services. Each entity's role must be clearly documented in evaluative and planning documentation. If multiple MH-TCM providers deliver the service in the same month, this decision must be person and family-centered, documented in the comprehensive diagnostic and treatment planning evaluation and agreed upon by all parties.

DHS' Mental Health Division recommends that each CCBHC outline the designated role/responsibilities of each CCBHC and host county and that roles are formally clarified and documented between each

CCBHC and host county. Formal documentation may be in the form of CCBHC Care Coordination Agreements, contracts, etc. between the CCBHC and the host county.

## IV. Funding and Payment

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### A. Mandated Services

This bulletin describes the provision of mandatory services such as OOH and civil commitment under section *D. Mandated Services*. As outlined in section *D. Mandated Services* it is possible for a CCBHC recipient to receive MH-TCM from multiple providers in the same month. In this circumstance a county will receive the county rate, a tribe will receive the encounter rate and the CCBHC will receive the county negotiated TCM rate. In addition, CCBHCs will receive a monthly prospective payment system (PPS) supplemental wrap payment which will cover all CCBHC services.

The county of financial responsibility must cover associated costs for residential treatment as this is not included in the CCBHC service model or PPS. Examples include Institutions for Mental Disease (IMD), children's residential facilities (CRF), Anoka Metro Regional Treatment Center (AMRTC), Minnesota Security Hospital (MSH), Community Behavioral Health Hospitals (CBHH) or other residential placements.

### B. Grant funding

In consultation with the grantor, each CCBHC determines whether or not grant funding may be used for a CCBHC recipient. This determination depends on how each CCBHC completed their cost report in relation to non-direct service costs. An example of a non-direct service cost eligible for grant funding in a CCBHC is transportation.

CCBHC services are paid through the prospective payment system (PPS). There is no county share when MA pays the CCBHC prospective payment. CCBHCs may utilize adult mental health initiative (AMHI) grants, community support program (CSP) grants, respite grants, etc. that covers client-specific needs not covered by the PPS rate.

## V. Data Collection/Reporting

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CCBHCs are required to collect and report data during the demonstration period beginning July 1, 2017. There are 22 federally required quality measures for the demonstration period. CCBHCs will collect/report on 9 of these 22 federally required quality measures and provide data for the 8 state-chosen impact measures.

In addition to reporting on the CCBHC quality measures, MH-TCM providers (counties, tribes and contracted vendors) will collect/report on employment and housing outcome measures. MH-TCM data collection/reporting is implemented on July 1, 2017 for adults and January 1, 2018 for children ages 13

-18 years old.<sup>2</sup> MH-TCM providers (counties, tribes and contracted vendors) will report data in either the Mental Health Information System (MHIS) or the Social Service Information System (SSIS).

## Legal References

Minnesota Statutes, section 256B.0625, subdivision 20(g)

Minnesota Rules, parts 9520.0900 through 9520.0926

Minnesota Rules, parts 9505.0370, 9505.0371 and 9505.0372

Minnesota Statutes, section 245.462, subdivision 11(a)

Minnesota Statutes, section 245.4871, subdivision 19

Minnesota Statutes, section 245.462, subdivision 12

Minnesota Statutes, section 245.735

Minnesota Statutes, section 245.4711

For more information see the Minnesota Health Care Programs' [CCBHC Federal Demonstration Project Provider Manual Page](#).

## Americans with Disabilities Act (ADA) Advisory

This information is available in accessible formats for people with disabilities by calling 651-431-2225 (voice) or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.

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<sup>2</sup> [Frequently Asked Questions \(FAQs\): Mental Health Targeted Case Management Transition to Outcome Reporting](#) (published May 5, 2017)