Minnesota Department of
Human Services

Chemical and Mental Health Services

Our Mission

The Minnesota Department of Human Services, working with many others, helps people meet their basic needs so they can live in dignity and achieve their highest potential.

Our Values

- We focus on people, not programs.
- We provide ladders up and safety nets for the people we serve.
- We work in partnership with others; we cannot do it alone.
- We are accountable for results, first to the people we serve, and ultimately to all Minnesotans.

We practice these shared values in an ethical environment where integrity, trustworthiness, responsibility, respect, justice, fairness and caring are of paramount importance.

MENTAL HEALTH SERVICE DELIVERY AND FINANCE REFORM:

Case Management Roles and Functions of Counties and Health Plans

Report to the Legislature
February 2008

Prepared by:
Department of Human Services

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Legislative Report 2008: Mental Health Services Delivery and Finance Reform – Case Management Roles and Functions of Counties and Health Plans

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Executive Summary

Charge

This report fulfills Minnesota Statutes 245.4682 requirement that DHS to bring to the legislature and the State Advisory Council on Mental Health recommendations for legislation to update the role of counties and to clarify the case management roles, functions, and decision-making authority of health plans and counties, and to clarify county retention of the responsibility for the delivery of social services.

Background

Adults with mental illness and children with emotional disturbance and their families have told of their experience of a state public mental health system that is not meeting their needs. Too often health services do not treat the individual holistically, separate physical health and mental health care, and lack sufficient coordination by providers, including coordination with the education system for children. Mental health services are often not evidence-based; and many needed services are not available until the individual is disabled by the illness. Too often, the system's incentives are for the provider to delivery more services rather than to achievement health outcomes.

Health data indicates that people with serious mental illness are more likely to experience higher rates of major physical health problems. Yet, these people too often do not have their physical health problems identified promptly, and the problems are undertreated. Also, care received is frequently not coordinated, and does not provide consistent follow-up. Poor health outcomes result. The most striking data indicates that adults with serious mental illness have a life expectancy 25 years less than their age cohorts. This is largely due to the physical illnesses, and inadequate treatment of these illnesses.

Conversely, people who have major physical health problems are more likely to experience mental illness and/or substance abuse problems. Health outcomes for these people experiencing dual health problems are poor because the mental illness is often undiagnosed and undertreated. Symptoms of mental illness like depression often impair self-care and adherence to treatments for chronic medical illnesses by the individual.

These factors result in a large cost to the individuals and society in terms of lost productivity, lost school achievement, family dysfunction and crisis, and higher incarceration and juvenile justice rates.

During the 2007 session of the Minnesota State Legislature, legislation (245.4682) was passed which directs the Minnesota Department of Human Services (DHS) to undertake a series of reforms to address the underlying structural, financial, and organizational problems in Minnesota's mental health system. The goal is to improve the availability, quality and accountability of mental health care within the state.

This legislation and its implementation are referred to as the *2007 Mental Health Initiative* (MHI). This legislation reflects years of input and planning by stakeholders including Adults with mental illness and children with emotional disturbance and their families. The work of the Minnesota Mental Health Action Group has been particularly valuable in shaping the goals and direction of Minnesota's reform. In design and implementation of these reforms, DHS is continuing to consult with consumers, families, counties, tribes, advocates, primary care and mental health providers, managed care organizations, and other stakeholders.

As part of the larger system reform, the legislation directs DHS to bring to the legislature, and the State Advisory Council on Mental Health recommendations for legislation to update the role of counties and to clarify the case management roles, functions, and decision-making authority of health plans and counties, and to clarify county retention of the responsibility for the delivery of social services.

This report addresses the need for better coordination and case management of physical health and mental health and social services; and the roles and functions of counties and managed care organizations.

The report describes the continued participation of stakeholders and their input in this planning.

DHS' priority is the development of an effective and accountable mental health and chemical health system to assure that Minnesota adults and children with a mental health or chemical dependency diagnosis will experience improving outcomes. A growing proportion of adults will function in the community, live independently and work. A growing proportion of children will function at their best in school and at home, stay out of the juvenile justice system and graduate from high school.
To accomplish this, DHS strategies include improving access to quality chemical and mental health services by updating state policy to reflect state-of-the-art service delivery and by investing in the service-delivery infrastructure, implementing research-informed practices in the delivery of chemical and mental health services, improving the integration of chemical, mental and physical health services and the coordination, including schools, of this holistic health care approach with social services, and increasing the accountability and transparency of the chemical health and mental health service delivery systems by developing, monitoring, and reporting outcome and performance measures.

DHS Findings and Recommendations

After at least 65 meetings with external stakeholders since the end of the 2007 session and with the input of the Mental Health Initiative Advisory Group, DHS has identified these findings:

- Case managers and other mental health providers include very dedicated, qualified staff who provide valuable services to adults with serious and persistent mental illness and children with severe emotional disturbance; however, their efforts are hampered by legal restrictions and a complex system where it is often difficult to determine who is responsible for what, and needed services are often difficult to access.
- Likewise, county administrators and supervisors have demonstrated some excellent examples of collaborative work with health plans, schools, hospitals, housing agencies and many others. However, again, the system is not structured in a manner which facilitates and rewards these types of efforts.
- Consumers, families and their advocates want to see mental illness treated on a par with any other illness, and brought into the mainstream of health care. This approach reduces stigma and supports recovery.
- To the extent that mental health services are covered as health care services, the health care coverage should be primary and there is no need for counties to duplicate that coverage.
- The new federal rule relating to case management affirms that Medicaid mental health case management includes not only coordination of covered health care services, but also assistance in gaining access to other services such as housing, education, or social services.
- Primary care is the locus of most mental health care – more focus is needed on mental health services in this setting; although for some individuals, mental health service settings may be the best health care home.
- Primary care is uniquely situated to provide early identification and intervention of mental health problems.
- Services must be culturally competent; and developmentally appropriate, including early identification and intervention services.
- Care coordination involving the education system is critical for children with physical and mental health needs.
- The legislative Health Care Access Commission and the governor's Health Care Transformation Task Force are considering a number of health care reforms which rely on and support the implementation of flexible models of integrated care coordination and case management like the DIAMOND disease management program and Health Care Homes.
- Adults and children with mental illness and emotional disturbance have a range of needs and preferences regarding care coordination and case management. Those needs and preferences can change as the individual changes. The service system needs to be responsive to those needs and changes in those needs. Each enrollee is an individual; "one size does not fit all" when it comes to service models and systems.

- Health plans are already responsible for coordination of covered health care services. The best way to be responsive to consumer needs is to integrate mental health case management with the health plans' existing care coordination responsibilities, to the extent that the federal Center for Medicare and Medicaid Services allows mental health case management to be covered as a Medicaid service.
- Concerning the inclusion of case management in the contract with MCOs, DHS' expectation is that the MCO has a "see to it" responsibility for assuring access, coordination, quality and outcomes in an integrated system of care. The MCO can choose to contract with counties or other qualified providers for these services, and is expected to do so in a manner that will enhance coordination and integration with all of the other services that may be needed by the individual.
- DHS will use its contracting process with health plans to assure that the comprehensive mental health benefit set, including mental health case management, will be available as needed to all individuals who are enrolled in MA, GAMC or MinnesotaCare pre-paid plans. Mental health case management within the pre-paid plans will have to meet at least the same standards for quality and availability as fee-for-service.
- Existing contractual safeguards to assure access, quality, communication and appeal rights will be enhanced by safeguards developed specific to this initiative, by the external evaluation, and the legislative-funded participation of the Ombudsman for State Managed Health Care Program.
- For individuals not in pre-paid plans, i.e. in fee-for-service, DHS will maintain current standards and coverage, to the extent allowed by federal rules.
- Clear lines of authority and responsibility for the provision of children's residential mental health services would be best served by making the health plan responsible for all the costs of the child's residential care for their enrollees. However, since the entire capitation paid to PrePaid Medical Assistance Program (PMAP) plans is matched with federal Medicaid funds, it cannot include funding for services (like room and board) that are outside the benefit set. Some other funding mechanism would need to be established to cover these costs outside of the PMAP capitation. As an alternative, the state, counties, providers and health plans can collaborate on developing joint guidelines for the screening, admission, discharge and payment to the residential facilities for children enrolled in pre-paid plans.

For those individuals who are enrolled in a pre-paid health plan under MA, GAMC or MinnesotaCare, 2007 legislation makes the health plan responsible for mental health case management effective January 1, 2009. The planning process and stakeholder input described in this report has identified a number of ideas, issues, principles, strategies and service models that will be useful as DHS implements this legislation. Many elements of the DHS implementation plan are a direct result of the stakeholder input leading up to this report. DHS is of the opinion that remaining concerns can be addressed in the implementation process and that the 2007 legislative decision continues to be the right decision for consumers and their families.

At the same time, this report reaffirms the continuation of the following county roles:

1) system-wide responsibilities for overall planning and development of the services defined in the Mental Health Acts for all residents of that county;
2) specific responsibilities to provide these services to uninsured individuals;
3) specific responsibilities to provide these services to insured individuals who need services beyond what is covered by their health insurance;
4) coordination of the above responsibilities with other entities such as health plans; and
5) consultation with the local Mental Health Advisory Council regarding unmet needs and implementation of the above duties.

Most of the new mental health funding appropriated by the 2007 Legislature was for "infrastructure investments" which, for the most part, are directly in support of the above county responsibilities. A significant amount of that funding (over $11 million for the next two years) is currently being awarded to counties for development and ongoing provision of mental health crisis services. This new state funding demonstrates the state's continued commitment to counties as the local mental health authority.

Counties and health plans each have critically important roles in Minnesota's mental health system. Adults with mental illness and children with emotional disturbance need the unique resources and abilities of both parties, preferably working together. The 2007 Legislature authorized DHS to "to solicit, approve, and implement up to three projects to demonstrate the integration of physical and mental health services within prepaid health plans and their coordination with social services." These projects must be locally defined county-health plan partnerships. DHS is working with stakeholders to assure successful implementation of these projects, and is using those discussions to improve county – health plan cooperation for all populations.

Legislative Report 2008: Mental Health Services Delivery and Finance Reform – Case Management Roles and Functions of Counties and Health Plans

Legislative Charge

This report fulfills the legislature's direction to DHS to bring recommendations for legislation to update the role of counties and to clarify the case management roles, functions, and decision-making authority of health plans and counties, and to clarify county retention of the responsibility for the delivery of social services. The statute is noted below.

Minnesota Statutes 245.4682 MENTAL HEALTH SERVICE DELIVERY AND FINANCE REFORM.

> *Subdivision 1.* ***Policy.*** *The commissioner of human services shall undertake a series of reforms to address the underlying structural, financial, and organizational problems in Minnesota's mental health system with the goal of improving the availability, quality, and accountability of mental health care within the state.*
> *Subd. 2.* ***General provisions.*** *(a) In the design and implementation of reforms to the mental health system, the commissioner shall:*
> *(1) consult with consumers, families, counties, tribes, advocates, providers, and other stakeholders;*
> ***(2) bring to the legislature, and the State Advisory Council on Mental Health, by January 15, 2008, recommendations for legislation to update the role of counties and to clarify the case management roles, functions, and decision-making authority of health plans and counties, and to clarify county retention of the responsibility for the delivery of social services as required under subdivision 3, paragraph (a); (emphasis added)***
> *(3) withhold implementation of any recommended changes in case management roles, functions, and decision-making authority until after the release of the report due January 15, 2008;*
> *(4) ensure continuity of care for persons affected by these reforms including ensuring client choice of provider by requiring broad provider networks and developing mechanisms to facilitate a smooth transition of service responsibilities;*
> *(5) provide accountability for the efficient and effective use of public and private resources in achieving positive outcomes for consumers;*
> *(6) ensure client access to applicable protections and appeals; and*
> *(7) make budget transfers necessary to implement the reallocation of services and client responsibilities between counties and health care programs that do not increase the state and county costs and efficiently allocate state funds.*
> *(b) When making transfers under paragraph (a) necessary to implement movement of responsibility for clients and services between counties and health care programs, the commissioner, in consultation with counties, shall ensure that any transfer of state grants to health care programs, including the value of case management transfer grants under section 256B.0625, subdivision 20 , does not exceed the value of the services being transferred for the latest 12-month period*

for which data is available. The commissioner may make quarterly adjustments based on the availability of additional data during the first four quarters after the transfers first occur. If case management transfer grants under section 256B.0625, subdivision 20, are repealed and the value, based on the last year prior to repeal, exceeds the value of the services being transferred, the difference becomes an ongoing part of each county's adult and children's mental health grants under sections 245.4661, 245.4889, and 256E.12.

(c) This appropriation is not authorized to be expended after December 31, 2010, unless approved by the legislature.

Subd. 3. ***Projects for coordination of care.*** *(a) Consistent with section 256B.69 and chapters 256D and 256L, the commissioner is authorized to solicit, approve, and implement up to three projects to demonstrate the integration of physical and mental health services within prepaid health plans and their coordination with social services. The commissioner shall require that each project be based on locally defined partnerships that include at least one health maintenance organization, community integrated service network, or accountable provider network authorized and operating under chapter 62D, 62N, or 62T, or county-based purchasing entity under section 256B.692 that is eligible to contract with the commissioner as a prepaid health plan, and the county or counties within the service area. Counties shall retain responsibility and authority for social services in these locally defined partnerships.*

(b) The commissioner, in consultation with consumers, families, and their representatives, shall:

(1) determine criteria for approving the projects and use those criteria to solicit proposals for preferred integrated networks. The commissioner must develop criteria to evaluate the partnership proposed by the county and prepaid health plan to coordinate access and delivery of services. The proposal must at a minimum address how the partnership will coordinate the provision of:

(i) client outreach and identification of health and social service needs paired with expedited access to appropriate resources;

(ii) activities to maintain continuity of health care coverage;

(iii) children's residential mental health treatment and treatment foster care;

(iv) court-ordered assessments and treatments;

(v) prepetition screening and commitments under chapter 253B;

(vi) assessment and treatment of children identified through mental health screening of child welfare and juvenile corrections cases;

(vii) home and community-based waiver services;

(viii) assistance with finding and maintaining employment;

(ix) housing; and

(x) transportation;

(2) determine specifications for contracts with prepaid health plans to improve the plan's ability to serve persons with mental health conditions, including specifications addressing:

(i) early identification and intervention of physical and behavioral health problems;

(ii) communication between the enrollee and the health plan;

(iii) facilitation of enrollment for persons who are also eligible for a Medicare special needs plan offered by the health plan;

(iv) risk screening procedures;

(v) health care coordination;

(vi) member services and access to applicable protections and appeal processes;
(vii) specialty provider networks;
(viii) transportation services;
(ix) treatment planning; and
(x) administrative simplification for providers;
(3) begin implementation of the projects no earlier than January 1, 2009, with not more than 40 percent of the statewide population included during calendar year 2009 and additional counties included in subsequent years;
(4) waive any administrative rule not consistent with the implementation of the projects;
(5) allow potential bidders at least 90 days to respond to the request for proposals; and
(6) conduct an independent evaluation to determine if mental health outcomes have improved in that county or counties according to measurable standards designed in consultation with the advisory body established under this subdivision and reviewed by the State Advisory Council on Mental Health.
(c) Notwithstanding any statute or administrative rule to the contrary, the commissioner may enroll all persons eligible for medical assistance with serious mental illness or emotional disturbance in the prepaid plan of their choice within the project service area unless:(1) the individual is eligible for home and community-based services for persons with developmental disabilities and related conditions under section 256B.092; or (2) the individual has a basis for exclusion from the prepaid plan under section 256B.69, subdivision 4 , other than disability, mental illness, or emotional disturbance.
(d) The commissioner shall involve organizations representing persons with mental illness and their families in the development and distribution of information used to educate potential enrollees regarding their options for health care and mental health service delivery under this subdivision.
(e) If the person described in paragraph (c) does not elect to remain in fee-for-service medical assistance, or declines to choose a plan, the commissioner may preferentially assign that person to the prepaid plan participating in the preferred integrated network. The commissioner shall implement the enrollment changes within a project's service area on the timeline specified in that project's approved application.
(f) A person enrolled in a prepaid health plan under paragraphs (c) and (d) may disenroll from the plan at any time.
(g) The commissioner, in consultation with consumers, families, and their representatives, shall evaluate the projects begun in 2009, and shall refine the design of the service integration projects before expanding the projects. The commissioner shall report to the chairs of the legislative committees with jurisdiction over mental health services by March 1, 2008, on plans for evaluation of preferred integrated networks established under this subdivision.
(h) The commissioner shall apply for any federal waivers necessary to implement these changes.
(i) Payment for Medicaid service providers under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

Background

During recent years, there have been significant changes in the way society views mental illness – mental illness is being viewed more and more as an illness, and is thus appropriately addressed in the health care system, preferably without stigma, and on a par with physical health care. At the same time, there have been significant development of better ways, supported by research evidence (http://mentalhealth.samhsa.gov/), to treat serious mental illness and emotional disturbance. Research continues to indicate that a range of community based services is needed that goes beyond the traditional inpatient hospitalization and outpatient therapy. Many of these services were recently covered for people with the most disabling mental illnesses by Medical Assistance (Medicaid) under a fee-for-service reimbursement model. Yet many of these needed services have not been covered in publicly-funded managed care and generally not covered by private and commercial health plans.

More than $1.2 billion is spent each year on all public and private mental health services in Minnesota; and there are hundreds of public and private mental health programs, activities and agencies. However, there continues to be unmet needs. And despite all this money and activity the system is not working the way it should. Many recipients and their families are often dissatisfied because their needs are not being met. There needs to be improved collaboration between public and private services; and coordination between the primary health care and behavioral health care and county social services systems.

Individuals with mental illness and youth with an emotional disturbance often have to become functionally disabled before being able to access comprehensive mental health services. The current mental health system does not adequately emphasize screening and early intervention which can often assist the individual before the individual experiences major functional losses and disability.

Individuals with serious mental illnesses or severe emotional disturbances have higher rates of major physical health problems. People with serious mental illness have higher rates of diseases such as breast cancer, hypertension, diabetes, cardiac disease, obesity, HIV infection and hepatitis B and C (Bazelon, 2004). These health problems often go undiagnosed and untreated or undertreated in primary care. Care is often not well coordinated with their mental health treatment, and the continuity of care is inconsistent (Nasrallah, 2006). Primary care providers may lack the necessary time, training, confidence, or resources to provide appropriate treatment for mental health problems. Symptoms of mental illness like depression often impair self-care and adherence to treatments for chronic medical illnesses by the individual. This can result in poor health outcomes. A huge disparity found by a recent study is that persons with serious mental illness have a life expectancy 25 years less than their age cohort (Colton, 2006).

Of additional concern is that this disparity in life span appears to be worse in 2006 than in 1986. These increased morbidity and mortality are due to: treatable medical conditions that are caused by modifiable risk factors such as smoking, obesity, substance abuse, lack of exercise; vulnerability; impact of symptoms of serious mental illness, symptoms that

mask symptoms of other illnesses; impact of medications; and lack of access to appropriate care and lack of coordination between mental health and general health care providers (NASMHPD, 2006).

Individuals who are the most disabled by their mental illness and who receive mental health treatment in mental health setting (like a community mental health center) are frequently reluctant or unable to manage their health care needs adequately in a primary health care setting.

Conversely, the mental health needs of children and adults with acute and chronic illnesses are also underestimated and under treated. In particular, adjustment disorders and depression are common concomitants of illnesses including diabetes, cardiac illness, cancers, and HIV infection (Health Resources and Services Administration of the U.S. Department of Health and Human Services). The Minnesota Student Survey data shows that children with special health care needs have elevated levels of depressed mood and suicidal ideation. Individuals may fail to recognize or correctly identify their mental illness symptoms, and even when they do, they may be reluctant to seek care due to stigma.

Most mental health care occurs in the primary care clinic or office. The 10 most common problems that bring patients to primary care, including chest pain, fatigue, dizziness, headaches, back pain and insomnia, account for 40% of all primary care visits. But only 26% of visits have a confirmed biological cause. This indicates a need for greater training of our primary care clinics to enable identification of and appropriate treatment of mental health concerns.

Primary care is particularly likely to be the site in which mental health treatment is obtained for young children and for the elderly (Surgeon General's Report on Mental Health, 1999), as well as for those in rural areas (Minnesota Department of Health, 2005). However, older adults, children and adolescents, individuals of ethnic minority groups, and uninsured and low-income patients seen in the public sector are particularly unlikely to receive care for mental disorders (President's New Freedom Commission on Mental Health: Subcommittee on Mental Health Interface with General Medicine 2003).

Individuals seen in many public services settings have higher rates of mental illness and emotional disturbance. 30 percent of children in the child welfare system have serious mental health disorders. 70 percent of youth in the juvenile justice system have serious mental health disorders (SAMHSA 2007).

Mental illness in the United States is a leading cause of productivity loss and absenteeism in the workplace, including a $150 billion annual cost for untreated mental illness and a $70 billion cost for untreated depression alone (SAMHSA, 2007).

The President's New Freedom Commission on Mental Health (2003) reports that although mental and medical conditions are highly interconnected, medical and mental health care systems are separated in many ways that inhibit effective care. Treatable mental or medical illnesses are often not detected or diagnosed properly, and effective

services are often not provided. Improved mental health care at the interface of general medicine and mental health requires educated consumers and providers; effective detection, diagnosis, and monitoring of common mental disorders; valid performance criteria for care at the interface of general medicine and mental health; care management protocols that match treatment intensity to clinical outcomes; effective specialty mental health support for general medical providers; and financing mechanisms for evidence-based models of care. Successful models exist for improving the collaboration between medical and mental health providers (Unützer, 2006).

Overall health is essential to mental health. Recovery includes wellness.

More than four years ago, the Minnesota Department of Human Services (DHS) began meeting with consumers, families, providers, counties, health plans and other stakeholders as part of the Minnesota Mental Health Action Group (MMHAG). MMHAG is a coalition of people and groups who are working on mental health reforms, led by a core group of influential public and private sector leaders who have vision and leadership roles within their own constituencies to effectively champion change. (MMHAG website)

Consumers and families told MMHAG how much they appreciate the services that they receive, but too often, consumers:

- fall through the cracks,
- they can't get the right service at the right time,
- their lives have to fall apart before they can get the help they need (at which time it becomes much harder to help them),
- they are not eligible for appropriate mental health services; and
- services they receive are not well coordinated with other services.

To address these needs, MMHAG developed a set of guiding principles and outcomes for Minnesota's mental health system:

- *Flexible to meet the needs of different populations, ages and cultures*
- *Provides the right care and service at the right time*
- *Delivers care and services in the least intensive site possible*
- *Uses a sustainable and affordable financial framework with rational incentives*
- *Easily navigated by consumers and providers because it operates in efficient, understandable pathways*
- *Uses evidence-based interventions and treatment to produce the desired outcomes*
- *Employs effective health promotion and prevention strategies*
- *Has appropriate providers and service capacity*
- *Clearly defines accountability among all parties*

MMHAG also developed desired outcomes for Minnesota's mental health system (see Appendix A):

- *Public/private partnerships to assure that all aspects of the mental health system are working to serve consumers and families.*
- *A different fiscal framework for public and private mental health funding that creates rational incentives for the right care to be delivered in the right setting at the right time.*
- *Quality of care for consumers and families, as measured by standardized assessment of performance and outcomes.*
- *Innovative workforce solutions to assure an adequate supply of appropriately trained and qualified mental health professionals.*
- *Earlier identification and intervention so that consumers and families are willing to seek, and able to access help when needed.*
- *Coordination of care and services so that the mental health system is easy for consumers and families to navigate and they receive the right combination of services to achieve the desired health and social outcomes.*

DHS has been working with and implementing the MMHAG recommendations in several ways:

- Phased inclusion of a comprehensive mental health benefit set including adult mental health rehabilitation services (Adult Rehabilitative Mental Health Services, Intensive Residential Treatment Services, Crisis Response Services, and Assertive Community Treatment) into the state-funded PrePaid Medical Assistance Program (PMAP);
- Developed the Governor's recommendation (legislation passed in 2007) to expand coverage under GAMC and MinnesotaCare to include this comprehensive mental health benefit set (see above);
- Developed Governor's recommendation (legislation passed in 2007) to provide infrastructure grants to expand availability of crisis response services, housing support services, culturally specific services, respite, school linked mental health services, children's early intervention and other community-based services for all persons with serious mental illness, including the uninsured; and
- Developed Governor's recommendation (legislation passed in 2007) to solicit, approve, and implement up to three projects called Preferred Integrated Networks (PINS) to demonstrate the integration of physical and mental health services within prepaid health plans and their coordination with county social services.

Mental health case management services, and children's residential treatment, are scheduled to be added to this common benefit set effective January 1, 2009 as part of the contracted responsibilities of managed care organizations (MCOs) in Minnesota Health Care Programs (MHCPs).

This addition will be a key component of the 2007 Mental Health Initiative strategy of the integration of mental and physical health care, and the coordination of this care with

county social services and the education system. Case management and care coordination must bridge the current gap between primary care and mental health services. This expanded responsibility of MCOs is to treat the enrollee more holistically: assess the individual's broad needs -not just primary care; plan and link the individual to resources to assure access to medical care, mental health, housing, employment, school, social and other services; and monitoring that the treatment, services and resources are accessed by the individual; and that the individual's preferences are respected and goals achieved.

Integrated mental and physical care ("integrated care") is emerging both nationally and internationally as a needed, promising and soon to be standard model of service delivery. Support for integrated care is developing in many sectors in response to accumulating information about problems related to the long-standing but artificial separation of physical and mental health. Studies of integrated care (Katon, 1995) have shown dramatic improvements in adherence, satisfaction with treatment, and outcomes.

Many policy and advocacy organizations have become involved in the identification of successful models of integrated care. Three recent studies have demonstrated that a variety of models may have utility in serving particular populations or particular communities. In brief:

- The Bazelon Center for Mental Health Law (2004) focused on models specifically developed to serve adults with serious and persistent mental illness. They grouped these models into four types: primary care embedded in a mental health program; unified programs; co-location of mental health specialists within primary care; and collaborations between separate providers. They noted particular barriers that were difficult to surmount in the fourth type, but identified successful implementations of each of the other three models in sites around the country.
- The National Council for Community Behavioral Healthcare (2003) took a broader look at the forms of integrated care which might serve different populations defined by the acuity of their physical and mental health care needs. Coordination between health and mental health systems is needed for all populations, but clinical care coordination might be led by the area in which a patient or client faces the most serious risks. When risks to both physical and mental health are both high, integration may require specific disease management, psychiatric services or consultation, connections to community resources, and close communication and collaboration.

In February, 2007, the Robert Wood Johnson Foundation issued a report which it had commissioned, prepared by Health Management Associates, to identify and describe existing models of publicly funded integrated service programs. The project was intended to include initiatives that reflected a broad range of settings and approaches, without close definition of integration. Sixteen programs in settings across the country were identified for inclusion, and responded to a set of fifty-five questions to determine how integration was accomplished in each. As expected, the integration goals varied, as did the primary integration activities and the level at which integration was conceptualized

and executed. Despite all this variability, though, a set of commonalities across approaches which suggest fundamentals of integration implementation. In brief, these are:

1. *Existence of Conceptual Framework*: All programs were vested in a shared belief that the core of integration is treating the whole person. Most project sites then implemented this belief through models that emphasized either improved behavioral health care or improved management of chronic care.
2. *Use of Communication Tools and Case Management*: All programs developed enhanced communication among providers and with consumers, primarily through routine team meetings and/or with information technology (electronic health records, patient registries, decision support systems). All but one utilized care coordinators or case managers to facilitate planning and communication.
3. *Screening*: All programs used routine screening and assessments to determine behavioral health care needs. In one case, a behavioral health care provider also routinely screened patients for chronic medical conditions, e.g., respiratory disorders, diabetes and hypertension.
4. *Clinical Approach*: Evidence-based algorithms and treatment protocols were a commonplace across programs. These included chronic disease management protocols and evidence-based behavioral health practices (ACT, IDDT). All but one program had identifiable care management strategies to support patients in managing their conditions.
5. *Funding*: All programs had some specific source of start-up funding, and some had additional revenue streams to support or offset the costs of delivering services. The report notes, however, that not all programs had pursued or maximized reimbursement under the sources available to them.
6. *Sustainability*: Programs were united in their concern for this factor, although they varied in whether they were designed to be sustainable for the duration, had required revamping of their original models in order to be sustainable, or were continuing to address this issue. The common challenge was in identifying funding mechanisms for service coordination and linkage services, essential to effective care management.
7. *Outcomes and Evaluation*: The stages of development and sophistication of approaches varied, with some programs able to quantify and describe the health and financial benefits of integrating services. Other programs had attained specific system improvements, e.g., sustained housing, while yet others continued to collect data and refine their evaluation strategies. Notably, the programs that had been able to demonstrate cost savings were the same ones which were positioned for long term sustainability.

Consultation with Mental Health System Stakeholders

DHS Mental Health Initiative staff has had over 65 meetings with external stakeholders since the end of the 2007 legislative session. The 2007 Mental Health Initiative legislation reflects years of input and planning by stakeholders including individuals experiencing serious mental illness and severe emotional disturbance and their families to

reform the mental health system in Minnesota. The work of the Minnesota Mental Health Action Group has been particularly valuable in shaping the goals and direction of Minnesota's reform.

Below is a list of stakeholder groups and a brief description of DHS' consultation with them. Many of the major themes of the issues, concerns, ideas and findings noted in this report reflect the input from stakeholders.

Mental Health Initiative (MHI) Advisory Group

DHS convened a large advisory group referred to as the 2007 Mental Health Initiative Advisory Group; its membership includes representatives of consumers, families, advocacy groups, providers, counties, county mental health social workers, health plans, unions, and others. The group has meet about every three weeks, and typically about 40 people attend. Many of the membership are knowledgeable of the gaps in the health system for people experiencing serious mental illness or emotional disturbance, and the challenges to integration of systems to improve access and quality. Many group members were active in the development of the 2007 Mental Health Initiative.

The group has helped DHS to identify needs and experiences, positive and negative, of mental health consumers and families obtaining mental health and primary health and case management services in Minnesota. The group has focused on assuring that future integration of services is focused on the consumer with appreciation that needs for case management and care coordination vary with each individual, with different experiences of mental illness and/or physical health needs, and change over time. The group reviewed and identified challenges and issues to address in integration of primary and mental health services. Individual choice of services, respect for confidentiality, participation in health care planning, recognition of different experiences and needs of children with emotional disturbance and their families are principles in an integrated system.

Written profiles of persons with differing levels of physical health problems and mental illness symptoms and living situations were used to promote discussion of various case management/care coordination needs of consumers (see Appendix B and C). This discussion and related presentations and literature distributed noted the differing models/demonstrations of case management/care coordination. This includes self-management of their own health care, which is preferred by many consumers. Consumers and their families need to be supported with information about their health conditions, resources information and understandable and straight forward appeals processes.

Several presentations were arranged for the group to hear about co-occurring health problems of consumers; systems gaps; principles, demonstrations, and evaluation of primary and behavioral service integration; and demonstrations of models of case management and care coordination.

Presentations included:

- Dr. Macaran Baird, Head of University of Minnesota Department of Family Medicine and Community Health. *"Ensuring Sustainable Integrated Mental Health/Primary Care"*. Dr. Baird's presentation focused on strategies and self-inventory for improving collaboration and integration; and the Minnesota Complexity Assessment Method for assessing "complexity of patients needs and situation (rather than diagnosis-focus), and matching patient with needed level of care coordination.
- Dr. Read Sulik – CentraCare Health System *"CentraCare Integrated Behavioral Health Improving Access to Care and Quality of Care Through Innovation and Creativity."* Dr. Sulik presented on the changing role of primary care in mental health care; noting as an example the impact of the severe shortage of child and adolescent psychiatrists; and "The St. Cloud Model" of integrated behavioral health and primary care for child and adolescents which includes:
    1. Collocation on child and adolescent psychiatrist in pediatric clinic;
    2. Education on children's mental health to school professionals, health care professionals, parents, social services professionals;
    3. School-based integrated model of crisis triage therapists, emergency access to psychiatric evaluations and therapy appointments, mobile wellness center to provide interdisciplinary comprehensive evaluation in schools`; and
    4. Integrated care team.
- Dr. Karen Lloyd presented on HealthPartners' Case Management Project, a telephonic model of care coordination and disease management; and on the DIAMOND – the Depression Improvement Across Minnesota Offering a New Direction – an evidence-based best practice care management program for adults with depression. The program uses components of: initial standardized assessment, follow-up tracking and monitoring for treatment problems and effectiveness; stepped care approach for treatment modification; relapse prevention; care management in the primary care setting; and psychiatric phone consultation with the primary care physician and caseload supervision for the care manager.
- Leota Lind of South Country Health Alliance (SCHA) presented on their county based purchasing *Community Resource Management Teams* model, comprised of a public health nurse and a county social worker who work together to promote service accessibility and provide comprehensive coordination of all services to meet the needs of SCHA members across the continuum; social services, public health, medical and other community services.
- Nancy Abramson, Mental Health Resources; Karen Hovland, Resources, Inc.; and a representative of UBH/Medica presented an existing program where Medica has contracted with these two providers to provide short-term intensive community team treatment and case management for enrollees of a private health plan who are facing urgent mental health needs. Initial results are encouraging to support these non-disabled enrollees through difficult times. In part, this serves as a demonstration of

a private health plan adapting a public system model to meet needs of private system enrollees.

- Meghan Mohs, Ramsey County, reported on a Dakota County study of the daily activities preformed by their adult and children's mental health case managers in provision of case management and social services. John Sullivan and Linda Hall, Ramsey County reported on Ramsey County's process for intake and linking consumers to appropriate services.

There are two subcommittees of the MHI Advisory Group: the *Request for Proposals (RFP) Advisory Workgroup,* and the *Children's Issues Advisory Workgroup*.

The *RFP Workgroup:*

This workgroup is advising DHS on development of the request-for-proposes (RFP) for the forthcoming Preferred Integrated Network (PIN) program. Must of the discussion is about how MCOs and counties will coordinate services. This group is limited to consumers, family members, advocates, and others who do not have a potential conflict of interest with the RFP/contracting process for the Preferred Integrated Networks (PIN).

This group had presentations made to it by "interested groups" who wanted to share their perspective regarding provision of integrated services, and on what the interested groups believe the RFP process should contain. Common themes in the presentations were the recommendation for "flexibility for innovation" with clear expectations/safeguards/ outcomes in the PINs. The RFP Workgroup developed a list of questions that presenters were asked to address. This list serves as an example of concerns and challenges in the implementation of the PIN project, and serves as an important reference for the development of the RFP. (see *Appendix D)*

Presenters represented:

- Joint planning efforts of the Minnesota Council of Health Plans and the Minnesota Association of County Social Service Administrators (MACSSA). They reported a positive joint working and planning experience; lessons learned in implementation of the Minnesota Senior Health Options; and their desire for the PIN RFP/contract to allow "flexibility" for innovation in provision and coordination of services, and supported measurable outcomes and expectations in the contract with DHS.
- County-based purchasing providers represented by Prime West and South Country Health Alliance
- Joint presentation by Minnesota Association of Counties and MACSSA.
- Minnesota Council of Health Plans

The *Children's Issues Workgroup*:

The Children's Issues Workgroup had a broad membership from county social service administrators, children's case managers, non-profit providers, family members and

advocacy groups. The group's purpose is to advise the Department on mental health initiative implementation issues related to children.

Earlier work by MMHAG groups had identified children's residential mental health treatment as a particular coordination challenge because our current Medical Assistance benefit uses the Medicaid rehabilitation services option to cover only the treatment costs of the service, leaving the room and board costs associated with the treatment a county responsibility. This creates a scenario where health plans and counties would have to agree in their authorization of admissions, length of stay and discharges. While not impossible, it would be very difficult to agree on procedures to make timely decisions on these points that were consistently in the best interests of the child and their family.

In working on this issue, the group reviewed applicable state and federal laws and regulations governing foster care and various options for Medicaid reimbursement of children's residential treatment, including:

- the rehabilitation services option,
- the psychiatric residential treatment facility option for persons under 21 years of age, and
- the new state plan home and community-based services option created under the Deficit Reduction Act of 2006.

After reviewing all of these options, the group recommended that the state continue to use the Medicaid rehabilitation service option, and that some financial restructuring of room and board costs for children enrolled in pre-paid health plans would be sufficient to properly align authority and responsibility for treatment decisions regarding the enrolled children's care.

<u>Mental Health Rehabilitation Services Phase In to MHCPs Advisory Workgroup</u>

The DHS staff implementing the "phase in" of adult mental health rehabilitation services (Crisis Response Services, Adult Mental Health Rehabilitative Services, Assertive Community Treatment, and Intensive Residential Treatment Services) into the Prepaid Medical Assistance Program, MinnesotaCare, and General Assistance Medical Care – formed a large advisory workgroup to address administrative and operational issues. This workgroup included representatives of consumer groups, families, the State Advisory Council on Mental Health, advocacy organizations, counties, providers, managed care organizations, and others. As planning for the 'phase in' of each rehabilitation service (they were on different timelines) into PMAP occurred, representatives of providers of that specific rehabilitation were added to the Advisory Group, and training targeted for those providers.

The work of this advisory group is noteworthy because mental health case management services will be added to the contracted benefit set for these public health programs beginning January 1, 2009. The workgroup serves as one setting to build communication between health plans, counties, providers, advocates and others in implementation of integrated services; plan transitions (example; clarify health plan access to county-

contracted programs Appendix E); identify and resolve problems; discuss licensing and provider certification standards, establish or update procedures; identify training needs, and monitor implementation.

This workgroup helped DHS to plan for the transition of these mental health services to be covered within a managed care contract with goals to minimize any disruption of services/confusion for recipients, to inform providers of their roles in relationship to health plans, discussions of provider credentialing and service prior authorization, to clarify communication and roles of health plans and counties, to inform health plans about these services (examples: utilization data, services standards, provider contacts).

Each MCO implemented the addition of these new mental health service benefits somewhat differently, but largely accepted (for now) existing standards of provider licensing, staff qualifications, and service thresholds and standards. Although not without concerns, the 'phase in' transition of these services has gone well.

With the inclusion of mental health case management services in the publicly funded pre-paid health plans effective January 1, 2009, DHS will use this group to advise and assist with administrative and operational issues relating to the "phase in" of case management services (Appendix F).

Minnesota State Advisory Council on Mental Health

DHS staff working presented to the Minnesota State Advisory Council on Mental Health (SACMHon at least four occasions - topics covered included:

- overview of PINS legislation/project
- overview of phase in of adult rehabilitation services into publicly funded pre-paid health plans;
- overview of proposed new Federal rule on case management;
- brief overview of MHI Advisory Workgroup discussion of "client profiles" and list of themes generated by the workgroup's discussion on care coordination/case management.
- review of legislative language regarding the role of the Advisory Council; and
- review of the draft legislative report (this draft was reviewed with the SACMH Children's Subcommittee, too)

Several members of the SMHAC and its Children's Subcommittee are serving on one or both the MHI Advisory Group and the Rehabilitation Services Phase In Advisory Group

County Local Mental Health Advisory Councils (LACs)

DHS staff had individual meetings with four metropolitan county LACs to review the Mental Health Initiative and implementation plan, and to solicit their input.

American Indian Tribes

DHS staff met with the Tribal Health Directors, and staff met with the American Indian Mental Health Advisory Council to discuss the Mental Health Initiative.

The Assistant Commissioner had a focus group with Tribal leaders to obtain their perspective on the Initiative and to hear their needs and ideas concerning the mental health needs of their members. Tribal health leaders indicated their continued interest in expanding their capacity to provide community-based mental health services to their adult and child members; and their interests related to the infrastructure development aspects of the Mental Health Initiative.

Enrolled tribal members are excluded from mandatory enrollment in all publicly funded prepaid plans, and thus will only be affected by changes relating to MCOs if they voluntarily choose to enroll in a prepaid plan. Tribal members enrolled in MHCP can also access health services from Tribal health clinics.

DHS Tribal liaison staff presented to the DHS MHI team *consumer profiles* of mental health care access issues unique to tribal members living on reservations, and the roles of tribal leadership.

Counties

County communication over the past seven months has been primarily through representatives from the Minnesota Association of County Social Service Administrators (MACSSA) appointed by MACSSA to serve on the Mental Health Initiative Advisory Group and Children's Issues Workgroup. In addition to these venues, DHS staff has engaged counties on MHI implementation issues at a meeting of the Association of Minnesota Counties (AMC) Health and Human Services Policy Committee and two meetings of a DHS/AMC/MACSSA Quarterly Health Care Meeting. The latter group largely addressed issues related to the mental health initiative in the larger context of health care reform efforts underway for persons with disabilities.

Finally, counties participated in three presentations to the RFP Advisory Workgroup. The first was a presentation by a joint County / Health Plan workgroup that has been meeting on issues on mutual interest since 2006. Second was a presentation of counties involved in the county-based purchasing model of health care delivery and finally was a presentation from AMC / MACSSA itself.

Managed Care Organizations

In addition to their participation on the Mental Health Initiative Advisory Group and Children's Issues Workgroup, DHS staff has twice been invited to meet with members of the Minnesota Council of Health Plans at monthly meetings of their behavioral health units. DHS staff also met once with representatives from county-based purchasing MCOs.

Providers

Providers are represented on both Advisory Workgroups described above. In additional, DHS has participated in meetings and statewide videoconferences about the MHI. DHS has presented about the Governor's MH Initiative at statewide training conferences, and to provider associations.

Assistant Commissioner 2007 MH Initiative Focus Groups

During the months of July and August, the Assistant Commissioner of Chemical and Mental Health Services held a series of focus group discussions with the major stakeholders groups in the 2007 Mental Health Initiative. Each focus group meeting was specifically for one of the stakeholder group only; this was to create a setting in which frank discussions of ideas, concerns and issues of that stakeholder group could be addressed, and to assure that all stakeholder groups were heard.

The discussions focused on the interests and expectations regarding the development of integrated service networks, challenges in implementation, encouraging participation, maintaining open communication, and any other topics concerning the initiative.

The groups included the unions, consumers and family and advocates, counties, tribes, providers, and MCOs.

Definitions of Case Management Services and Care Coordination

As noted, integrated case management and care coordination/management is an essential component of improving health outcomes and linking individuals to needed services. However, these terms have different meanings depending on who is doing the defining. For the purposes of this report, the term *case management* is used consistent with the responsibilities/activities in Minnesota's definition; *care coordination* is used to mean services with a principal focus on primary care. Where the two terms are used together, the intent is the concept of an integrated model. Below are some reference definitions.

Mental health case management in Minnesota

Mental health case management in Minnesota is currently targeted for two groups: children with severe emotional disturbance and adults with serious and persistent mental illness. Mental Health case management has the following definitions, which are somewhat different for children and adults.

For a child with severe emotional disturbance (SED):

MS 245.48 71 Subd. 3. **Case management services.** "Case management services" means activities that are coordinated with the family community support services and are designed to help the child with severe emotional disturbance and the child's family obtain needed mental health services, social services, educational services, health services, vocational services, recreational services, and related services in the areas of volunteer

services, advocacy, transportation, and legal services. Case management services include assisting in obtaining a comprehensive diagnostic assessment, if needed, developing a functional assessment, developing an individual family community support plan, and assisting the child and the child's family in obtaining needed services by coordination with other agencies and assuring continuity of care. Case managers must assess and reassess the delivery, appropriateness, and effectiveness of services over time.

For an adult with serious and persistent mental illness (SPMI):
MS 245.462 Subd. 3. **Case management services.** "Case management services" means activities that are coordinated with the community support services program as defined in subdivision 6 and are designed to help adults with serious and persistent mental illness in gaining access to needed medical, social, educational, vocational, and other necessary services as they relate to the client's mental health needs. Case management services include developing a functional assessment, an individual community support plan, referring and assisting the person to obtain needed mental health and other services, ensuring coordination of services, and monitoring the delivery of services.

<u>Federal Center for Medicare and Medicaid definition of case management</u>
The federal Center for Medicare and Medicaid Services (CMS) defines case management (general – not specific to mental health) as: "services that will assist individuals eligible under the State plan in gaining access to needed medical, social, educational, and other services" and includes the following components:

1) Assessment and reassessment, including: taking history; identifying needs; gathering information from family, providers, educators, social workers;
2) Development of a care plan that includes:
   - Goals and actions
   - Active participation of the client
   - Identifies course of action to respond to assessed needs;
3) Referral and related activities (scheduling, linking to other programs and services); and
4) Monitoring and follow-up to ensure that the care plan is addressing needs. At least one "annual monitoring" is required to determine whether:
   - services are in accordance with care plan
   - services are adequate
   - changes in need are met.

Case management does not include the "direct delivery of underlying medical, educational, social, or other services".

Mental health case management is a form of "targeted case management" in CMS' definition (targeted for a specific "disability population").

Targeted case management can include contacts with people who are not Medicaid recipients if the contacts are related to a recipient's needs.

Exclusions from case management:

- Activities that are an integral component of another Medicaid covered service
- Activities that are the direct delivery of underlying medical, educational, social or other services to which the client has been referred. This specifically (but not exclusively) includes: parole, probation, guardianship, special education, child welfare/protective services and foster care.
- Activities that are considered integral to foster care: research and completion of documentation required for foster care; assessing placements; recruiting and interviewing potential parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements.
- Activities that are integral to the administration of a non-medical program (guardianship, child welfare/protective, parole, probation, or special education except for TCM included in the IEP).
- If a state covers TCM, activities that can be covered under that TCM cannot be claimed as administrative expenditures.
- If case management services are also furnished by another federally-funded program, the state must use cost allocation methods and reflect those methodologies in the cost allocation plan.

Minnesota Health Care Programs definitions

In Minnesota's Special Needs Basic Care model contract for primary care, there are the following definitions:

Care Management for all Enrollees means the overall method of providing on-going health care in which the MCO manages the provision of primary health care services with additional appropriate services provided to an Enrollee.

Case Management means the assignment of an individual who coordinates Medicare and Medicaid health services for an Enrollee.

Care System means any entity that an MCO contracts with and delegates some portion of its Care Management and/or Primary Care responsibilities.

Care Coordination for MSHO Enrollees means the assignment of an individual who coordinates the provision of all Medicare and Medicaid health and long-term care services for MSHO Enrollees, and who coordinates services to an MSHO Enrollee among different health and social service professionals and across settings of care. This individual must be a social worker, public health nurse, registered nurse, physician assistant, nurse practitioner, or physician.

Care Management for all Enrollees means the overall method of providing ongoing health care in which the MCO manages the provision of primary health services with additional appropriate services provided to an Enrollee.

Care Plan means the document developed in consultation with the Enrollee, the Enrollee's treating physician, health care or support professional, or other appropriate individuals, and where appropriate, the Enrollee's family, caregiver, or representative that, taking into account the extent of and need for any family or other supports for the Enrollee, identifies the necessary health and Home and Community-Based services to be furnished to the Enrollee.

General use of the terms of case management, care coordination/management

"Care coordination" and "care management" are terms that many people use interchangeably with "case management". However, the terms are generally used differently in primary care vs. mental health care:

For most people in primary care services, "care coordination" and "care management" means services that are physician-directed efforts by clinic staff to monitor the patient's receipt of recommended health services, communication with other primary care providers specific to the individual's treatment, and referral to needed health resources. Primary care coordination services, to the extent that they are available to an individual, overlap somewhat with mental health case management services, but largely focus on the physical health needs of individuals, are generally not well coordinated with mental health case management, and do not include assistance (other than occasional referral) in helping the individual access services outside of primary care.

For people who are served by MCOs, "care coordination" generally refers to MCOs' existing responsibilities to coordinate the delivery of health care services which are included in the benefit set of the MHCP contract. In recent years, MCOs have begun to cover certain mental health services which were previously considered to be social services, such as rehabilitation components of Community Support Programs. Coordination of mental health services which are covered by the MCO is currently part of the MCO's care coordination responsibilities.

There are several models of case management (Hodge, 1997), care coordination/ management, and the integration of the two. These reflect the range of levels of support offered by the model, services coordinated, and the participating providers. They include, but are not limited to:

- *Self-management* – where the individual largely coordinates his/her own care without the help of a provider case manager/care coordinator. It is important to note that most individuals do not have and often don't want a provider manager of their "case'. Individuals do need information specific to their health problems, resource information about treatment options and services available, opportunities for consultation when needed, and understandable service appeals processes to obtain services.
- *Telephonic* – these are case management/care coordination services provided solely, or largely, over the telephone. These services assure that the individual has access to recommended health resources, often monitor the individual's receipt of recommended services/medications, and provide information. Telephonic services are usually not intensive services, or targeted for individual who have significant difficulty in managing their own care.
- *Broker* – this is the model of the CMS rule and Minnesota. The case manager is a third party who does not provide treatment services, but assesses the individual's needs, develops a plan, helps the individual to access services, and monitors the individual receipt of and outcomes of treatment/rehabilitation services.

- *Blended/comprehensive* – provision of mental health treatment/rehabilitation services is part of what the case manager is skilled at and provides in addition to case management services. This can create efficiencies in services provision.
- *Intensive case management* – service targeted for individuals with multiple/complex health conditions and living situations who are not skilled in managing their own access to care, and often have difficulty coping. Services are usually more frequent, in-home and community, and broader than 'broker' model.
- *Team case management* - rather than single case manager, a team provides the services – offers the individual more staff resources/areas of expertise, increased service availability, more potential relationships from which the individual can find ones that are most helpful.
- *Assertive Community Treatment* – mental health evidenced-based practice that uses team approach (including psychiatrist) with responsibilities for case management, rehabilitation, psychiatric, and crisis services.
- *Integrated care team* – team approach which includes primary care members including physician and behavioral services members.
- *Shared Care Psychiatry* - under "shared care" the psychiatrist is based in a primary care clinic and shares each patient's care and record with the family physician. The family physician continues to be the primary physician for each patient's psychiatric care. The primary care physician refers patients to the shared care psychiatrist for psychiatric assessments, follow-up appointments and recommendations. The "shared care" psychiatrist acts in a supportive role and the patient is returned to the primary physician when stable. This increases the primary physicians comfort in providing mental health care and emphasizes the medical aspect of mental health. Because each patient has a primary physician to access psychiatric care, psychiatric care is reliable and accessible to the customer/patient. Additionally, community based mental health professionals and case managers can identify each customer's primary care physician and prompt a physician consult or referral to shared care. The result is greater integration of medical and community based services and easy access for customers/patients. Because the "shared care" psychiatrist returns patients to their primary physician, he or she remains available to see more patients/customers and service care capacity increases. In contrast, tradition psychiatric providers retain ongoing patients over a longer period of time and service capacity eventually becomes limited.
- *Disease management* – a multi-disciplinary, continuum-based approach to improve the health of Enrollees that proactively identifies populations with, or at risk for, certain medical conditions. In addition, this program: 1) supports the physician/patient relationship and place of care; 2) emphasizes prevention of exacerbation and complications utilizing cost-effective evidence-based practice guidelines and patient empowerment strategies such as self-management; and 3) continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving overall health. (from MDHO model contract)
- *Medical home* – this model has the following components:

1. A plan of care is developed by the physician, child or youth, and family and shared with other providers, agencies, and organizations involved with the care of the patient.
2. Care among multiple providers is coordinated through the medical home.
3. A central record or database containing all pertinent medical information, including hospitalization and specialty care, is maintained at the practice.
4. The medical home physician shares information among the child or youth, family and consultant and provides specific reason for referral to appropriate pediatric medical subspecialists, surgical specialists, and mental health/developmental professionals.
5. Families are linked to family support groups, parent to parent groups, and other family resources.
6. When a child or youth is referred for a consultation or additional care, the medical home physician assists the child, youth, and family in communicating clinical issues.
7. The medical home physician evaluates and interprets the consultant's recommendations for the child or youth and family, and consultation with them and subspecialists, implements recommendations that are indicated and appropriate.
8. The plan of care is coordinated with educational and community organizations to insure that special health needs of the individual are addressed. (AAP, 2002)

Consumers and Family Views of Case Management and Care Coordination

When consumers and their families are asked about what they may need from care coordination and case management services, common components include:

- Information about their illness or condition that is thorough yet understandable;
- Information about different treatment options and the effectiveness of and side effects/limitations of the treatments;
- Information about different providers and information about the effectiveness of the provider;
- Timely access to treatment and services;
- Rights and appeals processes that are understandable, reasonable, not set up to deny services, timely;
- Advocates to help when barriers are encountered that are beyond the skills/ knowledge of the consumer/family members;
- Help in identifying their strengths, needs, and preferences;
- Development of plans and strategies to reach goals and obtain services;
- Review of plans and strategies; and updates to reach goals and services;
- Referral, linkage, accompaniment to services and resources;
- Timely access and responsiveness of care/case coordinators;
- Appreciation that the consumer/family needs and strengths change over time and with differing situation;
- Respect for one’s culture;
- Straight forward access to their own health files and plans;

- Respect for their privacy, and decisions in information sharing;
- Respect for decisions at the consumer/family make;
- "Coaches" to help them understand the system and support the consumer/families own efforts to access services;
- "Navigators" to help them understand the complexities, barriers, and processes of our primary care, behavioral health, human services and other systems – providers, MCOs, counties, school, employment, social, housing, and others; and
- Support in their recovery; and see them as "whole" individuals.

These identified consumer needs are a combination of guidelines developed in past efforts by the State Mental Health Advisory Council and Subcommittee on Children's Mental Health (1995); modifications and additions made by Minnesota's mental health consumer and advocacy organizations as part of the MMHAG effort, and input from consumers and families members on the MHI Advisory Workgroup.

Other Related DHS Care Programs for People with Disabilities

DHS staff of the MHI team is coordinating with staff of these programs to learn from the experience of implementation of these programs, to utilize relevant contract language, for development of consistent policy, and to review issues and outcomes. The SNBC contract may serve as the basic contract for the MHI PINs project. Purchasing specifications tailored to adults with serious mental illness and children with emotional disturbance will be added.

Minnesota Disability Health Options (MnDHO) program integrates Medicare, Medicaid services, Medicaid long term care services, extensive case management, community based services, some nursing home care, and drug coverage (but not mental health targeted case management). Enrollment is voluntary, and open to people ages 18-64 residing in the 7 county metro area with primary physical disabilities (not targeted for people with serious mental illness) who are MA eligible or dually eligible for MA and Medicare.

Special Needs Basic Care (SNBC) program integrates Medicare and Medicaid services and drug coverage starting January 2008. Most Medicaid waiver and long term services remain fee for service. Enrollment is voluntary, and open to people ages 18-64 with disabilities, including adults with serious mental illness, who are MA eligible or dually eligible for MA and Medicare. The benefit set includes most Medicaid mental health services including adult mental health rehabilitation services. In 2009, covered services will include mental health targeted case management services. Additional purchasing specifications tailored to people with disabilities have been added to the contract with MCOs.

Primary Care Coordination (PCC) project will demonstrate the delivery of "medical home" or "health care home" services to improve care coordination for people with complex and chronic medical needs (including adults with serious mental illness). PCC

provides an average $50 per member per month payment to primary care providers who deliver "Medical Home" or "Health Care Home" services, as defined by DHS. In order to receive reimbursement, providers will have to meet specific DHS criteria such as having a dedicated care coordinator, the ability to develop and maintain care plans, participation in quality improvement processes, and the ability to engage patients and families in the delivery of care. PCC is authorized to serve enrollees in Medical Assistance fee-for-service (it is not a managed care model).

Current Provision of Mental Health Case Management Services

Mental health case management provides an essential service to help adults with mental illness and children with emotional disturbance and their families navigate complex physical and mental health systems. Expanded capacity to improve coordination with primary care and offering case management/care coordination options that better match the needs of consumers are an important strategies to improve both the access to services and the health for consumers.

As noted by the National Alliance on Mental Illness-Minnesota (NAMI-MN, 2007), "many of our members have personally experienced the effectiveness of case management services and have been able to access critical services needed to live, work and participate in their communities as a direct result of case management services.

Research confirms that individuals with serious mental illnesses who receive case management services achieve better outcomes, such as stable housing and improved functioning. They also experience fewer hospitalizations and less involvement with the criminal justice system. Yet, despite these well documented findings, these services remain out of reach for many individuals with mental illnesses and their families, who often struggle for years, unable to identify and secure access to services and supports in their communities.

Case management services are critically important to individuals with serious mental illnesses because the service system for mental healthcare is so fragmented and broken. The New Freedom Commission urged that systems work together to overcome these barriers. Case management is a critical component of that solution because case managers coordinate care and help consumers and families navigate the complexities of the various agencies and rules that govern services and supports."

Currently, mental health case management services in Minnesota are targeted for adults with *serious and persistent mental illness* and children with *severe emotional disturbance*. Case management is provided by counties and county contracted agencies. The split between contracted and county provided services is roughly 50/50. Case management caseload sizes and practice standards are governed by statute and administrative rule, commonly referred to as "Rule 79". Mental health case management is a fee-for service only benefit under the state's Medical Assistance (Medicaid) program. It is not covered under the capitations paid in publicly funded pre-paid health plans.

Counties bear a significant share of the mental health case management costs. They pay the non-federal share (50%) of costs when a federal Medicaid match is available and 100% of costs for persons not eligible for federal match. Counties also pay for mental health case management services for the uninsured and those with private insurance since it is not typically a covered service. State mental health grants offset a portion of county case management expenditures.

State statute recommends an adult case management caseload of 30 clients-to-1 full time equivalence case manager; children's caseloads of 15-1. The reality is that caseload sizes vary significantly county to county, and program to program. Thus the capacity of individual case manager to provide active coordination of services on behalf of their clients varies significantly. The 2004 DHS Mental Health Management Report indicates an average children case management caseload size of 18.8 clients with a range of 11 to 36 clients for counties with at least a full time child mental health case manager, and the 2002 DHS Mental Health Management Report (the most recent with caseload size data) indicates an average adult caseload size of 25.4 with a range of 7 to 53 clients.

Minnesota's formal mental health case management model is a "broker" model – where the case manager completes an assessment, develops a service plan with the client; refers to other needed services and resources; monitors progress of client and other services; and participates in discharge planning. Case management does not include mental health treatment and rehabilitation services.

The reality reported by most counties and providers is that often the case manager finds it helpful and efficient to provide treatment, rehabilitation and/or supportive services. Why "refer" someone to a service; especially if the need is short-term and the case manager is skilled to provide it? Also, there is immediacy to some client needs. Sometimes, there is not time for referral and intake to another provider to address urgent client needs. Case managers, acting in a different capacity, can be involved in many other activities – mental health commitment processes; transporting client; crisis intervention; counseling; skills training/rehabilitation services, and personal care services.

Although dedicated to their clients' recovery, mental health case managers and providers often work with caseload sizes that do not allow sufficient individual time and flexibility to address the changes needs of all their clients. Some mental health case managers indicate that they spend the majority of their time attending to the most urgent/immediate needs of just of portion of their clients; and have insufficient time for consistent coordination with other providers of services, including physical health care providers.

DHS Mental Health Management Report information suggests that about half of the adults eligible for Rule 79 mental health case management services who are receiving mental health rehabilitation services chose not to accept the case management services. There are various reported reasons for this including consumers desire to manage their own health care, not wanting involvement of additional providers, and lack of knowledge of the value of the service. It is the individual's choice.

Some consumers and family members express frustration that if consumers move from once county to another they experience a disruption of services and services provided in different ways.

The following tables provide information about the number of recipients of mental health case management, payment responsibility, spending, average hours provided per recipient, and average hourly cost.

Current Payment Responsibility for Mental Health Case Management

Mental Health - Targeted Case Management (MH-TCM)

State & County Clients - CY2006

	Adults	%	Children	%
• Total unduplicated number of persons getting MH case management from counties / county contracted providers.	21,412	100%	9,543	100%
• Number enrolled in fee-for-service MA or MnCare w/ FFP. (counties pay 50% of costs)	12,137	57%	5,231	55%
• Number enrolled in pre-paid MA or MnCare w/ FFP. (counties pay 50% of costs)	1,956	9%	2,763	29%
• Total spending on MH-TCM with 50% federal financial participation	$40,294,326		$23,610,190	
• Number enrolled in GAMC, MnCare, MA w/o FFP. (counties pay 100% of costs)	4,205	20%	66	1%
• Number of MH-TCM clients without any state subsidized health coverage. (counties pay 100% of costs)	5,550	26%	2,746	29%
• Total spending on MH-TCM without federal financial participation	$11,733,343		$4,164,950	

Counties pay 50% of costs for about 60% of adult clients and 100% of costs for the rest. They pay 50% of costs for about 80% of child clients and 100% of costs for the rest. There is no "state share" per se, though state grants do offset a portion of county case management expenses. When counties pay 100% of costs, they are permitted to charge for the service on a sliding fee basis, but this service is generally provided free of charge.

Many consumers chose not to receive mental health case management services. It is not a requirement to access other mental health services funded by MA. Case management is not meant to serve as a "gatekeeping" function to other mental health services.

It is important to note that the majority of recipients of mental health case management will NOT be impacted by the inclusion of this service in the PINs and publicly funded pre-paid health plans. The three demonstrations of the PINs are limited to enrollment of no more than 40% of eligible recipients in the state. It is unlikely that enrollment will approach this cap. Enrollment is voluntary. Adults with SPMI and children with SED (decision by parents) can opt out of PMAP.

Adult Mental Health – Case Management – State and County Clients – CY 2006

Statewide

PAID THROUGH MMIS	Number of Adults	Percent of Total	Total Estimated Hours	Total Payment	Average Estimated Hours	Average Payment per Person	Average Payment per Est. Hour
Medical Assistance with FFP [1, 2]							
MA FFS - SPMI exclusion (EE)	435	2%	7,808	$967,316	17.9	$2,224	$123.89
MA FFS - Disabled exclusion (BB, QQ, UU) or disabled basis of eligibility	11,166	52%	290,324	$34,564,865	26.0	$3,096	$119.06
MA FFS - Other or no exclusion	825	4%	8,570	$1,033,327	10.4	$1,253	$120.57
		0%					
Total Fee for Service	12,135	57%	306,702	$36,565,509	25.3	$3,013	$119.22
Prepaid Plans	1,937	9%	29,891	$3,701,306	15.4	$1,911	$123.83
Unduplicated Total	13,172	62%	336,593	$40,266,814	25.6	$3,057	$119.63
		0%					
MinnesotaCare with FFP (LL) [2, 3]		0%					
Fee for Service	2	0%	7	$940	3.3	$470	$142.42
Prepaid Plans	19	0%	251	$26,572	13.2	$1,399	$105.95
Unduplicated Total	20	0%	257	$27,512	12.9	$1,376	$106.88
		0%					
Total Paid through MMIS	13,190	62%	336,851	$40,294,326	25.5	$3,055	$119.62

PAID BY COUNTIES	Number of Adults		Total Hours	Total Estimated Payment	Average Hours	Average Estimated Payment per Person	Average Estimated Payment per Hour
Medical Assistance without FFP [4, 6]							
Fee for Service	1,293	6%	11,693.1	$1,398,737	9.0	$1,082	$119.62
Prepaid Plans	75	0%	338.9	$40,539	4.5	$541	$119.62
Unduplicated Total	1,319	6%	12,031.5	$1,439,216	9.1	$1,091	$119.62
		0%					
MinnesotaCare with FFP (FF) [5, 6]		0%					
Fee for Service	37	0%	40.6	$4,857	1.1	$131	$119.62
Prepaid Plans	149	1%	1,142.3	$136,643	7.7	$917	$119.62
Unduplicated Total	149	1%	1,182.8	$141,487	7.9	$950	$119.62
		0%					
MinnesotaCare without FFP [6]		0%					
Fee for Service	91	0%	183.0	$21,891	2.0	$241	$119.62
Prepaid Plans	449	2%	3,183.9	$380,860	7.1	$848	$119.62
Unduplicated Total	455	2%	3,367.1	$402,775	7.4	$885	$119.62
		0%					
General Assistance Medical Care (GAMC) [6]		0%					
Fee for Service	1,643	8%	5,531.2	$661,646	3.4	$403	$119.62
Prepaid Plans	1,704	8%	11,906.2	$1,424,228	7.0	$836	$119.62
Unduplicated Total	2,282	11%	17,437.5	$2,085,886	7.6	$914	$119.62
		0%					
Other County Clients Reported to CMHRS [6]		0%					
Non-MHCP	5,550	26%	64,070.1	$7,664,110	11.5	$1,381	$119.62
		0%					
Estimated Total Paid by Counties	9,519	44%	98,088	$11,733,343	10.3	$1,233	$119.62
		0%					
Unduplicated Grand Total	21,412	100%	434,939	$52,027,668	20.3	$2,430	$119.62

Child Mental Health – Case Management – State and County Clients – CY 2006

PAID THROUGH MMIS	Number of Children	Percent of Total	Total Estimated Hours	Total Payment	Average Estimated Hours	Average Payment per Person	Average Payment per Est. Hour
Medical Assistance with FFP [1, 2]							
MA FFS - SED who have opted out (EE)	1,627	17%	55,862	$5,355,551	34.3	$3,292	$95.87
MA FFS - Disabled exclusion (BB, QQ, UU) or disabled basis of eligibility	1,913	20%	71,942	$7,482,274	37.6	$3,911	$104.00
MA FFS - Other or no exclusion	2,053	22%	38,372	$3,637,415	18.7	$1,772	$94.79
		0%					
Total Fee for Service	5,170	54%	166,176	$16,475,239	32.1	$3,187	$99.14
Prepaid Plans	2,455	26%	67,538	$6,270,446	27.5	$2,554	$92.84
Unduplicated Total	6,540	69%	233,714	$22,745,686	35.7	$3,478	$97.32
		0%					
MinnesotaCare with FFP (LL) [2]		0%					
Fee for Service	61	1%	392	$32,760	6.4	$537	$83.53
Prepaid Plans	308	3%	8,878	$831,745	28.8	$2,700	$93.69
Unduplicated Total	312	3%	9,270	$864,504	29.7	$2,771	$93.26
		0%					
Total Paid through MMIS	6,781	71%	242,984	$23,610,190	35.8	$3,482	$97.17

PAID BY COUNTIES	Number of Children		Total Hours	Total Estimated Payment	Average Hours	Average Estimated Payment per Person	Average Estimated Payment per Hour
Medical Assistance without FFP [3, 4]							
Fee for Service	65	1%	486.3	$47,253	7.5	$727	$97.17
Prepaid Plans	3	0%	16.7	$1,623	5.6	$541	$97.17
Unduplicated Total	66	1%	503.2	$48,895	7.6	$741	$97.17
		0%					
MinnesotaCare with FFP (FF) [4]		0%					
Fee for Service	0	0%	0.0	$0			
Prepaid Plans	0	0%	0.0	$0			
Unduplicated Total	0	0%	0.0	$0			
		0%					
MinnesotaCare without FFP [4]		0%					
Fee for Service	0	0%	0.0	$0			
Prepaid Plans	0	0%	0.0	$0			
Unduplicated Total	0	0%	0.0	$0			
		0%					
General Assistance Medical Care (GAMC) [4]		0%					
Fee for Service	0	0%	0.0	$0			
Prepaid Plans	0	0%	0.0	$0			
Unduplicated Total	0	0%	0.0	$0			
		0%					
Other County Clients Reported to CMHRS [4, 5]		0%					
Non-MHCP	2,746	29%	42,360.6	$4,116,084	15.4	$1,499	$97.17
		0%					
Estimated Total Paid by Counties	2,812	29%	42,864	$4,164,950	15.2	$1,481	$97.17
		0%					
Unduplicated Grand Total	9,543	100%	285,847	$27,775,140	30.0	$2,911	$97.17

How Would Case Management Change under the 2007 Mental Health Initiative

Under the MHI legislation passed in 2007, mental health case management services will be the responsibility of the MCO for those individuals enrolled in publicly funded pre-paid health plans. Rule 79 mental health case management will remain a required service; although the MCO will have the flexibility to offer other models/levels of case management/care coordination. Also, case management/care coordination services can be offered to other enrollees, not just those eligible for Rule 79.

DHS, with the input of stakeholders, continues to clarify case management and care coordination responsibilities between counties and MCOs. Also, new federal regulations regarding federal rule and financial participation in these services has been pending for some time and an interim final rule has recently been announced. This is why implementation of changes for these services is not planned until 2009, and why the department's bill proposed to report to the legislature on implementation recommendations prior to the 2008 legislative session. (see current analysis of the Federal rule below)

Moving case management into the benefit sets of all the state's health care programs means expanding the entitlement nature of the services for health care program enrollees and an increased role for the state in funding case management services. County financial participation in this service will be reduced.

When provided through a pre-paid plan, the state will be responsible for 100% of the non-federal costs; counties will have no financial participation in the capitation rates to pre-paid plans. When provided through fee-for-service, counties will continue to be responsible for 50% of the cost. The balance of the cost will be a state or federal responsibility, depending on the clients' eligibility for federal Medicaid matching funds.

When provided through pre-paid plans, the state can take advantage of the flexibility permitted under pre-paid plans to better tailor the amount/models of case management/care coordination provided to the needs of the enrollee. For example, the enrollee would no longer have to meet serious and persistent mental illness or severe emotional disturbance criteria in order to get some level of care coordination. Creative approaches employed in New Mexico's and Massachusetts' pre-paid contracts specify that the health plan will provide four levels of care coordination/case management that vary in intensity based on the client's need and level of functioning. The less intense levels of service can be provided telephonically, or through periodic, face-to-face meetings at the client's clinic. More intensive levels are much like the case management models that Minnesota currently uses for clients with SPMI or SED, and may include intensive short-term team approaches.

Again, since the largest portion of current case management recipients are in the state's fee-for-service Medical Assistance program little will change for them in 2009. They will remain on fee-for-service, getting mental health case management from county or county contracted providers.

However, if they are enrolled in a state pre-paid health care program, or if they live in a county that chooses to partner with a pre-paid health plan in creating a PIN that DHS selects to contract with (legislation permits up to three PINs), they would be given the option to participate in that network (voluntary enrollment). Under that arrangement, care coordination/case management responsibility for health care, including mental health care would transfer to the health plan. This has a potential to improve the integration between physical and mental health care. Also, for dual eligibles, this can improve coordination of Medicare and Medicaid benefits, especially for Medicare Part D drug benefits. The plans could provide some of these functions themselves, or contract with other vendors or counties to provide the service. The county and health plan would work out how this would interface with county social services in the development of the preferred integrated networks. Responsibility for provision of social services would remain with the county.

Current DHS Analysis of New Federal Targeted Case Management Rule

In General: This is an interim final regulation, implementing the changes in Title XIX from the Deficit Reduction Act related to targeted case management (72 Fed. Register 68077-68093 Dec. 4, 2007), as well as numerous statutory amendments relating to case management dating back to 1985. The effective date of this rule is March 3, 2008. Comments are due February 4, 2008. Because this is an interim final rule, it will take effect March 3, 2008, whether or not CMS decides to amend it further based on the comments received.

CMS' stated purpose is to implement "…the statutory provisions permitting coverage of case management and targeted case management as optional services under a State Medicaid plan, in accordance with sections 1905(a)(19) and 1915(g) of the Act, as amended by the DRA, and all other relevant statutory provisions."

However, via conference call on December 12/13/07, CMS staff informed states that they are now interpreting this regulation to apply to all forms of Medicaid case management, whether or not the care is provided under the "state plan" category for case management and targeted case management. This means that CMS considers the requirements of the regulation to apply to case management under the various home and community-based waiver programs, and any other form of case management covered by Medicaid. It is unknown at this time how this announcement may affect categories of service such as physician services and other primary and acute care, and how it may affect our current claim for federal matching funds on administrative expenditures (such as the social services time study, or the Medicaid administrative time study).

Major Issues:
The effective date. The regulation becomes effective March 3, 2008. On the 12/13/07 conference call, CMS staff acknowledged that states would be in various stages of

compliance with the new regulation on March 3, and yet they elected to not to allow time for transition.

Exclusion of other programs. The regulation excludes from the definition of case management services those services that are "integral components" of another Medicaid service. They also exclude activities that constitute the "direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has been referred…" The regulation specifically refers to guardianship, child welfare, child protection, parole, probation, and special education (not included in an IEP) as an "underlying program."

Bundled rates. The regulation requires that payment rates for case management services must be paid based on a unit of service that does not exceed 15 minutes. This will affect all forms of targeted case management in Minnesota. It is unknown how CMS plans to apply this requirement to administrative expenditures.

One case manager. The regulation requires that the state provide comprehensive case management services to a client through one case manager. This is especially problematic if the regulation applies to administrative activities (LTCC, LCTS) and waiver case management (EW, DD, CADI, CAC and TBI), in addition to the state plan forms of TCM -targeted case management (MH, RSC, VA/DD, home care).

Institutional status. Because CMS believes that discharge planning is paid for through payment rates to institutional providers, it is limiting payments for targeted case management to 60 days for people residing in institutions for six months or more, and to 14 days for people residing in institutions for less than six months. This is a change from previous policy, which allowed for unlimited case management within the six-month window prior to discharge**.**

Freedom of choice, gatekeeping, and administrative decisions. The regulations require that individuals be able to choose their own case manager. Also, clients have the right to refuse case management services altogether. CMS states that permitting case managers to perform "gatekeeping" functions is a restriction on access to services, which is contrary to the statutory definition of case management. Finally, CMS states that authorization of medical services is a Medicaid administrative function and must be billed as administrative costs—not case management. All of these requirements, put together, create a particular concern for case management under Minnesota's home and community-based waivers, where the county case manager develops and approves the care plan for waiver services, and is a key to assuring that the federal health and safety requirements are met.

Implications of new federal rule for this report:

The new federal rule applies to MA fee-for-service coverage, and will almost certainly mean some narrowing in what Minnesota's MA fee-for-service program can cover as mental health case management. At this point, the exact impact in fee-for-service is not

clear, nor is it clear whether the new rule will apply to pre-paid plans. CMS has stated their intent to apply the new rule to all forms of Medicaid case management. However, under federal law, pre-paid MA plans are also responsible for coordination of covered health care services, including covered mental health services. This responsibility is technically not the same as case management, but it overlaps with the federal definition of case management. Since a key element of the new federal rule is the concept of a single case manager and a unified care plan, DHS expects that CMS will be supportive of integration of care coordination and case management. Pre-paid plans also offer the potential to capture savings in inpatient costs which may result from effective case management. These savings can be reinvested in case management and other covered services.

The 2007 MH Initiative legislation approved the transfer of certain state mental health grants from counties to pre-paid plans in order to fund part of the non-federal share of case management in pre-paid plans. The legislation (M.S. 245.682, subd. 2(b)) specified that "*the commissioner, in consultation with counties, shall ensure that any transfer of state grants to health care programs, including the value of case management transfer grants under section 256B.0625, subdivision 20, does not exceed the value of the services being transferred …"* DHS has established a state-county workgroup which is analyzing the impact of the new federal case management rule. If the rule has the effect of narrowing the definition of case management, DHS will use that analysis to reduce the amount of grant funds to be transferred from counties to pre-paid plans. We hope to complete that analysis in time to reflect this adjustment in the calendar year 2009 grant allocations which would normally be announced to counties in July 2008.

Some individuals have misinterpreted the above transfer of funds as reducing the funding available to counties for noncovered services or for uninsured or underinsured individuals. Note that the legislation was carefully constructed to assure that the transfer of funds does not exceed the value of the responsibility that is being transferred. State funding to counties for noncovered services and for uninsured and underinsured individuals was maintained and, in fact, greatly increased.

County and MCO Responsibilities under the MHI

Duties of Counties from Children's Mental Health Act

Below is the statutory language outlining the duties of County Board related to local children's mental health services.

245.4874 DUTIES OF COUNTY BOARD.

Subdivision 1. ***Duties of county board.*** *(a) The county board must:*
(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4889;
(2) establish a mechanism providing for interagency coordination as specified in section 245.4875, subdivision 6;
(3) consider the assessment of unmet needs in the county as reported by the local

children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;
(4) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4889;
(5) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;
(6) assure that mental health services delivered according to sections 245.487 to 245.4889 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;
(7) provide the community with information about predictors and symptoms of emotional disturbances and how to access children's mental health services according to sections 245.4877 and 245.4878;
(8) provide for case management services to each child with severe emotional disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5 ;
(9) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility, acute care hospital inpatient treatment, or informal admission to a regional treatment center;
(10) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4889;
(11) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;
(12) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age;
(13) assure that culturally competent mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage; and
(14) consistent with section 245.486, arrange for or provide a children's mental health screening to a child receiving child protective services or a child in out-of-home placement, a child for whom parental rights have been terminated, a child found to be delinquent, and a child found to have committed a juvenile petty offense for the third or subsequent time, unless a screening or diagnostic assessment has been performed within the previous 180 days, or the child is currently under the care of a mental health professional. The court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing. The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations, and shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer

or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include training in the administration of the instrument, the interpretation of its validity given the child's current circumstances, the state and federal data practices laws and confidentiality standards, the parental consent requirement, and providing respect for families and cultural values. If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment, as defined in section 245.4871. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results shall be considered private data and the commissioner shall not collect individual screening results.

(b) When the county board refers clients to providers of children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the desired services components not covered under section 256B.0943 and identify the reimbursement source for those requested services, the method of payment, and the payment rate to the provider.

Subd. 2. ***Responsibility not duplicated.*** *For individuals who have health care coverage, the county board is not responsible for providing mental health services which are within the limits of the individual's health care coverage.*

Duties of Counties from Adult Mental Health Act

Below is the statutory language outlining the duties of County Board related to local adult mental health services.

245.465 DUTIES OF COUNTY BOARD.

Subdivision 1. ***Use of mental health funds.*** *The county board in each county shall use its share of mental health funds allocated by the commissioner according to the mental health plan approved by the commissioner. The county board must:*

(1) develop and coordinate a system of affordable and locally available adult mental health services in accordance with sections 245.461 to 245.486;

(2) with the involvement of the local adult mental health advisory council or the adult mental health subcommittee of an existing advisory council, develop a biennial adult mental health plan which considers the assessment of unmet needs in the county as reported by the local adult mental health advisory council under section 245.466, subdivision 5, clause (3). The county shall provide, upon request of the local adult mental health advisory council, readily available data to assist in the determination of unmet needs;

(3) provide for case management services to adults with serious and persistent mental illness in accordance with sections 245.462, subdivisions 3 and 4; 245.4711; and 245.486;

(4) provide for screening of adults specified in section 245.476 upon admission to a residential treatment facility or acute care hospital inpatient, or informal admission to a regional treatment center;

(5) prudently administer grants and purchase-of-service contracts that the county

board determines are necessary to fulfill its responsibilities under sections 245.461 to 245.486; and
(6) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract with the county to provide mental health services have experience and training in working with adults with mental illness.
Subd. 2.[Repealed, 2006 c 282 art 16 s 17]
Subd. 3. ***Responsibility not duplicated.*** *For individuals who have health care coverage, the county board is not responsible for providing mental health services which are within the limits of the individual's health care coverage.*

Discussion regarding State, County and Health Plan/MCO Mental Health Responsibilities

Although the legislative charge for this report specified the need to define county and health plan responsibilities, many stakeholders have pointed out that state responsibilities must be addressed at the same time.

State Mental Health Responsibilities

The Comprehensive Mental Health Acts as well as separate legislation defining duties of the Commissioner of Human Services (M.S. 245.696) include the following state responsibilities:

1) create and ensure a unified, accountable, comprehensive mental health service system;
2) seek federal and other funding for mental health services;
3) supervise the development and coordination of locally available mental health services;
4) review and evaluate local programs;
5) promote coordination between the mental health system and other human service systems, including education, health, housing and employment; and
6) consult with the State Mental Health Advisory Council and other advisory groups regarding unmet needs and implementation of the above duties.

In addition, the 2007 MH Initiative legislation (M.S. 245.4682) cited at the beginning of this report requires the Commissioner to "undertake a series of reforms to address the underlying structural, financial, and organizational problems in Minnesota's mental health system with the goal of improving the availability, quality, and accountability of mental health care within the state."

Many stakeholders have noted that the DHS legislative proposal for the 2007 MH Initiative represented exemplary leadership in carrying out its duties. DHS worked with stakeholders to identify unmet needs, explored creative ways to maximize existing resources and requested legislative approval for new resources to implement the shared vision of all stakeholders. This legislative report is an example of DHS' continuing commitment to work with all stakeholders towards the "unified, accountable,

comprehensive mental health service system" that was identified in the original 1987 Mental Health Act.

County Mental Health Responsibilities

In the excerpts above, note Subdivision 2 in the Adult Mental Health Act and Subdivision 3 in the Children's Mental Health Act. These subdivisions were added by the 2007 Legislature in recognition of the fact that health care coverage increasingly includes services which have traditionally been a county mandate under the Mental Health Acts. When these services are covered by public or private health insurance, there is no need for counties to duplicate that responsibility. At the same time, these subdivisions recognize that not everyone has health care coverage, and even for those that have it, there are limits to what is covered.

With the addition of these subdivisions, the Legislature effectively differentiated county responsibilities as follows:

1) system-wide responsibilities for overall planning and development of the services defined in the Mental Health Acts for all residents of that county;
2) specific responsibilities to provide these services to uninsured individuals;
3) specific responsibilities to provide these services to insured individuals who need services beyond what is covered by their health insurance;
4) coordination of the above responsibilities with other entities such as health plans; and
5) consultation with the local Mental Health Advisory Council regarding unmet needs and implementation of the above duties.

Regarding #3 above, many stakeholders have expressed concern about the potential for health plans to shift costs to counties. This has been a concern ever since the Legislature mandated county responsibility for mental health services. This concern was alleviated somewhat by passage of Minnesota's parity legislation (M.S. 62Q.53) in 1997, and by other legislative and court actions relating to state-regulated health plans (see additional discussion later in this report regarding court-ordered services). However, significant concerns remain regarding federally regulated self-insured plans which are largely exempt from state regulation. These concerns support the need for passage of effective mental health parity legislation at the federal level.

Lack of clarity regarding health plan and county responsibilities for individuals who have health insurance complicates case management functions by requiring these issues to be worked out on a case-by-case basis. The 2007 MH Initiative and this report represent efforts to clarify roles and streamline access; if we can be successful in these efforts, case managers will spend less time figuring out who is responsible for what, and instead be able to focus on assuring the right mix of treatment and supports for each client.

Client-specific responsibilities of counties are also governed by other sections of the Mental Health Acts which allow counties to charge fees based on the client's ability to pay, and which limit county responsibilities to the extent funds are available.

In addition to the above duties specified in the Mental Health Acts, counties continue to be responsible for their roles in the Commitment Act, child protection, vulnerable adults, eligibility determination for health care and financial benefits, licensing and certification of certain types of providers, provision of social services, public health, corrections and other duties.

MCO service responsibilities

As recommended by MMHAG, the 2007 Legislature included responsibility for a comprehensive mental health benefit set in the responsibilities of publicly funded pre-paid health plans. Most of these benefits became effective January 1, 2008 and are now included in DHS contracts with the MCOs that administer the pre-paid plans. The Legislature recognized that transfer of responsibilities for case management and children's residential treatment may require additional transition time, and therefore set the effective date for those responsibilities at January 1, 2009. This transfer of responsibility only applies to individuals who are enrolled in publicly funded pre-paid health plans.

MCO responsibilities are spelled out in the MHCP contracts that DHS has with MCOs.

Prior to the 2007 Session, DHS worked with advisory groups to conceptualize mental health service responsibilities under a comprehensive benefit set. As part of that work, DHS developed the charts below, with the first chart entitled "Respective Service Responsibilities for Pre-Paid Health Plan (PPHP) Enrollees with Mental Health Service Needs" and a second chart titled "Ongoing Care Coordination Responsibilities between MCOs and Counties for PPHP Enrollees."

The charts are a useful visual to make clear the service responsibilities of MCOs and counties. Each chart has three columns. The left hand columns identify the health care services and coordination responsibilities of MCOs. The right hand columns identify the mental health service/social/related services, and coordination responsibilities of counties. The center column identifies the areas of overlapping or complementary coordination responsibilities, and coordination challenges. The overlapping and challenging responsibilities have been a particular focus of the discussion and input of the stakeholders, and in DHS' planning.

Mental health case management for enrollees will become a mental health services responsibility of MCOs on January 1, 2009. The overlapping responsibilities and challenges related to case management, care coordination and service coordination are addressed in the *Addressing Coordination Challenges and Other Issues* section below.

Some of coordination of areas of overlap and challenge will be demonstrated in the PINs projects; and are opportunities for innovation and cooperation between MCOs and counties. It is important the there be a communication/resolution process addressing counties and MCOs responsibilities to assure that consumer access to needed services is

not interrupted or delayed. The responsibility lies with the MCO/counties, not with the consumer. The RFP and contracting process will focus on assuring that this process exists in the coordination between MCO and counties.

County responsibilities as the local mental health authority continue as defined in statute. (see above)

Respective Service Responsibilities for PrePaid Health Plan Enrollees with Mental Health Service Needs – 11/22/06 Discussion for Future Planning

(Two Pages)

Health Care Activities – MCO Responsibility	**Coordination Challenges**	**Social Service and Related Activities – County Responsibilities**
Mental Health Services ▪ Assertive Community Treatment (ACT) ▪ Adult Rehabilitative Mental Health Services (ARMHS) ▪ Client Outreach ▪ MH screening as part of EPSDT ▪ Diagnostic assessment/testing ▪ Children's therapeutic services & supports (CTSS) ▪ Children's residential MH treatment (treatment portion) ▪ Treatment foster Care (treatment portion) ▪ Crisis assessment, intervention, and stabilization (inc. residential) ▪ Day treatment/partial hospitalization ▪ Individual/family/group therapy ▪ Inpatient and outpatient treatment ▪ Intensive residential treatment services (IRTS) ▪ Neuropsychological assessment and rehab ▪ Medication management ▪ Court ordered MH treatment ▪ * *As of 1/1/09 – Mental health targeted case management (** Mental Health Case Management services will become a MCO mental health services responsibility January 1, 2009 for the PMAP, MinnesotaCare, and General Assistance Medical Care programs, and in the Preferred Integrated Network (PINs) *Projects for coordination of care*.)	▪ Client Outreach ▪ Children's Residential MH Treatment – level of care determinations, coordinating safety / medical necessity, continued stay. ▪ Treatment foster care – same issues as above. ▪ Court ordered assessments / treatment services. ▪ Follow-up assessments and treatment for kids identified through MH screening of CW & JJ cases. ▪ Certification of providers ▪ Maintaining / initiating eligibility for benefits. ▪ RTC stays deemed not medically necessary. ▪ Non-medical transportation ▪ Housing access ▪ Care coordination – see other sheet!	Mandated Services: ▪ Client Outreach ▪ Waiver Services (CAC, CADI, TBI, MR/RC) ▪ Foster care portion of children's residential MH treatment and treatment foster care ▪ Mental health screening of child welfare and juvenile justice cases ▪ Pre-petition screening ▪ MI / MI-D Commitment Process ▪ PASAAR (OBRA level II)? ▪ *Community Support Program services – CSP ▪ MH service infrastructure development, maintenance Community Education ▪ Sex Offender Commitments ▪ Services to incarcerated in county jails ▪ Regional Treatment Center (if not medically necessary) Non-Mandated Services: ▪ Drop-in Centers / Club Houses ▪ Youth Mentoring Programs ▪ Respite Care *(*Community Support Program (CSP) services are also a county mandated mental health services.)*

Health Care Activities – MCO Responsibility	**Coordination Challenges**	**Social Service and Related Activities – County Responsibilities**
Other Basic Care Services ▪ Advanced Practice Nurse Services ▪ Cancer Clinical Trials ▪ Care Management Services - (Acute Medical) ▪ Chemical Dependency Treatment Services ▪ Child and Teen Checkups ▪ Chiropractic Services ▪ Clinic Services ▪ Dental Services ▪ Disease Management ▪ Family Planning Services ▪ Home Care Services – Specified: ▪ Home Health Aid (HHA), Home Care Therapies (PT, OT, RT, ST), Private Duty Nursing (PDN) ▪ Some portion to be covered under new basic managed care program (to be determined) ▪ Hospice Services ▪ Inpatient Hospital Services ▪ Interpreter Services ▪ Laboratory, Diagnostic and Radiological Services ▪ Medical Emergency, Post-Stabilization Care, and Urgent Care Services ▪ Medical Supplies and Equipment ▪ Medical Transportation Services ▪ OBRA Level 1 (NF) ▪ Obstetrics and Gynecological Services ▪ Outpatient Hospital Services ▪ Physician Services ▪ Podiatric Services ▪ Prescription and Over-the-Counter Drugs Not Otherwise Covered by Part B or D ▪ Prosthetic and Orthotic Devices ▪ Public Health Services (immunizations) ▪ Reconstructive Surgery ▪ Regional Treatment Centers (under certain circumstances) ▪ Rehabilitation and Therapeutic Services – PT, OT, RT, ST ▪ Transplants ▪ Tuberculosis-Related Services ▪ Vaccines and Immunizations ▪ Vision Care Services		▪ Information & Referral ▪ Basic Needs Assessment ▪ Child Protection Assessment / Investigation ▪ Child welfare services (foster care, shelter, group residential facilities parent training, alternative response, adoptions, etc.) ▪ Adult protection ▪ Child care ▪ Child support ▪ DD case management ▪ Day training & habilitation ▪ CD Services – Detox, extended care, halfway house ▪ Eligibility determination, assistance and maintenance ▪ Financial assistance ▪ Funeral/Burial Payment ▪ Employment services ▪ Homemaking Services ▪ Home Delivered Meals/Congregate Dining ▪ Homeless Services ▪ Housing access /on-going support ▪ Interpreter Services ▪ Long Term Care coordination ▪ MFIP ▪ Public Health Services (broader) ▪ Re-Entry Services (from corrections) ▪ Non-Medical Transportation Vocational & Vocational Rehab Services

Organizing Care Coordination Responsibilities between MCOs and Counties for PPHP Enrollees

Health Care Activities – MCO Responsibility	Overlapping or complementary responsibilities to be coordinated	Social Service & Related Activities – County Responsibility
Providing information about available clinically appropriate health care services. Assuring access to clinically appropriate health care services (including court order care). Assure coordination with county for needed social, income maintenance and protective services (esp. commitment). Assuring coordination of health care treatment plans with school-based services for children. Assuring coordination of health care treatment plans with community corrections. (May be more of an issue for children.) Monitor health service utilization and effectiveness at an individual and macro level. Health outcomes measurement Assuring clinically appropriate integration of physical and behavioral health care. Assuring early identification and intervention for physical and behavioral health care (immunizations, preventive care, screenings, etc.) Assure access to Rule 25 assessments. Maintaining health care benefit eligibility.	Coordinate / facilitate referral and access to needed services that are shared responsibility or the responsibility of other entities. Coordinate to maintain eligibility	Providing information about available county administered services. Assuring access to county administered services. Assure coordination w/ MCO for needed health care services (esp. MFIP families) Assuring coordination of social services with school-based services for children. Assuring coordination of social services with community corrections. (May be more of an issue for children.) Monitor social, income maintenance and protective service utilization and effectiveness at an individual and macro level. Social support service outcomes measurement. Maintain eligibility for health, social service and income maintenance programs. (Includes connections with Housing Voc Rehab, VA, etc.)

NOTES:

1. At what level is each function most appropriately delivered? Provider level or managing entity level?
2. Clarify when actions taken are done at a micro, mezzo, macro level – for individual clients to subgroups to broader populations.
3. What kinds of standards should be established for those "cross-over" or "hand-off" intersections of responsibilities? What mechanism, timelines, et

Addressing Coordination Challenges and Other Issues

The overlapping responsibilities and challenges from the two charts above (and others identified by stakeholder input) that relate to case management, care coordination and service coordination are addressed below.

The topics are organized into two lists: enrollee specific and system-wide responsibilities and opportunities.

A) Enrollee specific

1. Eligibility determinations and maintenance of eligibility
   Other than for covered services, historically health plans have not had a significant role in assisting enrollees in finding, applying for, and maintaining eligibility for needed services, benefits, and resources. With mental health case management services being added to the plan benefit set, the health plan will be responsible for assisting enrollees, once enrolled, in accessing and maintaining eligibility for other needed services and resources – including housing, housing assistance, employment training/supports, social services, and other services consistent with enrollee needs. Case management services should be offered to enrollees where medically appropriate to assist the enrollee in becoming self-sufficient and integrated in his/her community. Health plans must offer Rule 79 case management to enrollees who are eligible for that service, but it is an expectation that health plans will offer other options of care coordination/case management to match individual enrollee's needs, situation, and references.

   Legislation passed last year requires DHS to mail a renewal notice to enrollees notifying the enrollees that the enrollees' eligibility must be renewed. For enrollees receiving services through managed care plans, the MCO must provide a follow-up renewal call at least 60 days prior to the enrollees' renewal dates to give notice by mail, and a 60-day call to enrollees prior to renewal of their medical assistance eligibility.

   As part of their new responsibility for mental health case management for their enrollees, MCOs will need to either hire staff or contract with agencies (such as counties and community mental health centers) who are qualified to assist the client in accessing and maintaining health care benefits, and maintaining eligibility for other needed services.

   Counties will continue their roles in social services/financial assistance functions. This includes eligibility determination for programs such as MA, GAMC, GRH, GA, MSA, MFIP. It does not include eligibility determination for school district services, VA benefits, SSI, SSDI, Medicare, Section 8, Bridges, vocational

rehabilitation services, and many other programs that continue to be administered by other agencies.

Counties and MCOs will need to coordinate and have processes for clarifying responsibility for health care for individuals who may come in and out of health plans so as to ensure continuity of care and services when possible.

2. Health promotion and coaching
   Both counties and MCOs have general responsibilities for promotion and education concerning good health and lifestyle practices. In general, counties have responsibilities for all residents; MCOs are responsible for enrollees. This presents an opportunity to coordinate efforts in health promotion.

   Health coaching is generally meant to promote healthy lifestyle practices and preventive care for people on an individual need basis; and would be addressed in individual care/community support plans for respective clients of counties and MCOs.

3. "Transition points" responsibilities
   For people recovering from mental illness and children experiencing emotional disturbances, there can be important transition points in their lives that should be targeted for offering additional care coordination/case management services. People discharged from treatment settings like hospitals and residential treatment often can benefit from planning that anticipates and links the individual to new resources, and that increases support services and monitoring that the individuals adjustment to/return to different living situations goes well. This can also include transition points like release from prison or juvenile justice settings; move to new home or community; change of school or job, and homelessness.

   Another important transition point is when an adolescent reaches adulthood. This means that some health services and resources must be accessed through the "adult" system which can mean changes in eligibility and providers and resources.

   For enrollees who need case management/care coordination, MCO should assure that their care coordinators/case managers have the flexibility and capacity to increase their services to enrollees at significant transition points; and have the knowledge and contacts with the county system to access needed social and other services for their enrollees.

4. Integration of chemical health and mental health services for dual diagnosed enrollees
   The use of integrated treatment approaches to help adolescents and adults with mental health and substance use disorders is a nationwide direction in service models. DHS has a statewide strategy for implementation of the evidence-based practice of Integrated Dual Disorder Treatment and several other evidence-based practices. Selected mental health and chemical dependency providers are

receiving intensive training, individualized consultation and fidelity monitoring of their implementation of this practice. MCOs will be expected to be familiar with this practice, have provider capacity within their provider network, and offer this treatment option to enrollees.

MCOs will be required to assure that providers in their network develop these and other evidence-based practices and provider staff competencies. Care coordinators/case managers must be familiar with these evidence-based practices so as to make appropriate assessments; and be knowledgeable of qualified providers to refer enrollees for assessment and/or treatment.

Systematic use of chemical dependency/substance abuse screening tools, and mental illness screening tools to identify enrollees with one or both of these problems will be an expectation of MCOs.

Of additional importance will be the effective coordination of care for and obtainment of health outcomes of individuals experiencing significant physical health problems and mental illness and chemical dependency.

Counties and MCOs need to work together to assure that chemical health and mental health services providers are working more closely together, and that cross referrals and cross training is occurring.

5. Follow-up assessments and treatment for children and adolescents identified through mental health screening of child welfare and juvenile justice cases
   If the county screening activity identifies children in need of a mental health assessment, the assessment is a covered service and a health plan responsibility. The MCO will be expected to respond promptly to family requests to have their child assessed and to coordinate the results of the assessment and any subsequent treatment.

6. Court ordered services
   DHS Bulletin #07-53-02 describes and interprets current statutes pertaining to county and MCO responsibilities relating to court-ordered services for individuals in private and public health plans. The primary statute is M.S. 62Q.535. The term "court-ordered" includes not only those mental health services required under the Commitment Act, but also services that may be required by "a court of competent jurisdiction," which could include juvenile courts, criminal courts, and others. When a court orders a service that is covered by the MCO, the court order is the determination of medically necessity for that service. The MCO must provide that service. Counties must include the MCO in the screening and recommendations to the court; and the MCO is required to participate. This has been state law since 2001.

   Under the Commitment Act, counties were traditionally the primary payer for court-ordered assessments and followup treatment. After the state law changed in 2001, counties were able to arrange health plan payment for (or provision of)

covered assessments and followup treatment for health plan enrollees. The Commitment Act also requires the county to provide followup case management after commitment. Some counties currently choose to use contracted case management providers to carry out this function. When MCOs become responsible for mental health case management, counties will be able to expect MCOs to pay for or provide case management for committed health plan enrollees, similar to the earlier changes that occurred with responsibility for assessment and treatment. This will not replace county responsibility for functions that are not covered services, or any function that the county is not allowed to delegate under the Commitment Act. DHS will work with counties and MCOs to facilitate a unified individual care plan, as required by the new federal case management rule.

DHS will seek clarification as to exactly which commitment-related services can be covered as case management under the new federal rules. DHS contracts with MCOs will include those functions which are federally allowable as Medicaid covered health care services. DHS will also consult with experts in the field regarding the Commitment Act and best practices relating to commitment. Some stakeholders are of the opinion that the current system leans towards institutional commitments without paying adequate attention to less restrictive alternatives, and that more training is needed regarding best practices.

For individuals who are enrolled in pre-paid health plans, the commitment process will be a critical area for continued cooperation between counties and MCOs. Well before January 1, 2009 (before publicly funded MCOs become responsible for mental health case management), DHS will update Bulletin #07-53-02 to clarify county and MCO responsibilities and will explore other methods to educate stakeholders, including cooperative efforts with the Civil Commitment Training and Resource Center in the Office of the Ombudsman for Mental Health and Developmental Disabilities. These efforts will include the State District Courts and County Attorneys. As part of these efforts, DHS will consider MACSSA's recommendation to facilitate the development of operational agreements between the State District Courts, MCOs and counties so that all parties understand the respective roles of counties and MCOs in the commitment process, as well as other court proceedings affecting children and adults with mental illness.

7. Children's residential mental health treatment

The coordination challenges inherent in children's mental health residential treatment are among the toughest. The state, counties, health plans, and providers will have to deal with as the mental health initiative moves forward. Currently, only the treatment portion of the residential service is eligible for Medical Assistance reimbursement, and only on a fee for service basis with the county funding the non-federal share of the costs. The room and board costs of the treatment are a county foster care expense, some of which are reimbursed through federal Title IV-E funds.

Legislation passed last session makes health plans responsible for the Medical Assistance portion of the services for their enrolled children with SED. This is a good change in that it makes the health plan responsible for the continuum of care, limits opportunities for cost shifting and provides incentives for earlier intervention with more appropriate community-based services. On the other hand, it means that for those who must be admitted to residential care, the health plan and the county would have to coordinate the screening, admission, discharge and payment to the residential facility.

Members of the Children's Issues Workgroup believe that it would be best to avoid this situation by making the health plan responsible for all the costs of the child's residential care. However, since the entire capitation paid to PMAP plans is matched with federal Medicaid funds, it cannot include funding for services (like room and board) that are outside the benefit set. Some other funding mechanism would need to be established to cover these costs outside of the PMAP capitation. AS an alternative, the state, counties, health plans and providers can collaborate on developing joint guidelines for the screening, admission, discharge and payment to the residential facilities for children enrolled in pre-paid plans.

All of this is complicated further by the recent release of draft federal rules governing Medicaid reimbursement of rehabilitation services. In Minnesota, children's residential mental health treatment is categorized as a rehabilitation service in Medical Assistance. Based on these rules, there may be substantial changes required in the structure and funding of children's residential treatment. However, congressional action has delayed finalization and implementation of these rules and it is impossible to tell when or if they will ever take effect.

The department will use the children's Issues Workgroup to continue to work through issues related to the interface between mental health treatment, foster care, and county child welfare and protection services.

8. Transportation

   The MCO must assure sufficient network capacity to serve the medical transportation needs of enrollees with disabilities, ensure minimal wait times for transportation, and must implement written protocols for expedited authorization of services. Transportation services include ambulance services and special transportation services for an enrollee who is physically or mentally incapable of transport by taxicab or bus. The MCO shall provide common carrier transportation (by a bus, taxicab, or other commercial carrier or by private automobile). MCO need to appreciate that some mental health rehabilitation services involve the provision of these services in community settings for reasons of skills training and support (ie. grocery stores, social settings). Enrollees may need transportation assistance to these community settings.

The county shall remain responsible for reimbursing the enrollee for private automobile transportation to non-emergency covered services.

This is another area of potential collaboration between counties and MCOs; and additional clarification remains.

9. Housing, employment and education

Minnesota's definition of mental health case management includes activities to help adults with serious and persistent mental illness in gaining access to needed medical, social, educational, vocational, and other necessary services as they relate to the client's mental health needs. The federal definition includes: "services that will assist individuals eligible under the State plan in gaining access to needed medical, social, educational, and other services".

It will be a responsibility of the MCO to provide/contract for mental health case management services that assist enrollees with mental health needs in obtaining housing, employment, educational and other opportunities and services.

Again, this is an area that makes sense for collaboration and coordination among counties, MCOs, local housing authorities, and housing providers.

B) System-wide responsibilities and opportunities

1. Partnership in accountability

As the work to make the service delivery and financing changes envisioned by the legislation passed last year, the state, counties and health plans must work together constructively to hold each other accountable for providing the best possible level of service to our citizens. This must play out on both a client and system level.

At a client level, counties have a role in helping DHS hold health plans accountable for their responsibilities. This can be done informally, advocating directly with the health plan on behalf of the enrollee, or more formally through the managed care ombudsman and managed care contract managers at DHS. The legislature's appropriation for additional staff in these areas will help ensure the state can be timely in responding to concerns that arise. Likewise, health plans', or their care coordinators and case managers can advocate directly with counties for access to social services and can access both formal and informal intervention through the state should that fail.

At a system level, all three parties have actively developed mechanisms for jointly addressing problems. DHS has facilitated meetings with various combinations of stakeholders as necessary to bring the right people together to solve design and implementation problems and will continue to do so. MACSSA and the Minnesota Council of Health plans have also begun to meet independently to work on mental health service issues as well as broader topics where the share

clients or related responsibilities. DHS, AMC and MACSSA also come together on a quarterly basis to discuss the mental health initiative and the broader context of health care reforms. To date, these relationships have been constructive and conducted in good faith. There is every reason to expect they will remain so.

2. County and MCOs contractual opportunities
   Particularly in the PINs project, there are opportunities for increased coordination and partnering between MCOs, counties and county contracted providers. Under Minnesota Seniors Option Program, most MCOs have contracted with counties to continue to provide case management services for enrollees, but with enhanced connections to physical health care.

   Inclusion of case management in MCO responsibilities affords the opportunity and flexibility for MCOs to learn from and purchase the experience of counties in the provision of mental health case management. It is an opportunity for county mental health case management staff to learn more about primary care systems and coordination functions.

   Also, this relationship of MCOs and counties and public health care establishes a framework for MCOs to contract with counties and community mental health providers for service provision for private plan enrollees.

   County social services have expertise in connecting consumers to support services and community resources. Some counties have already built a positive relationship with private providers and health plans through a team approach.

   This framework applies to private providers to serve private plan enrollees, too. One of the presentations that the MHI Advisory Workgroup heard was about was an UBH/Medica contracted program for short-term intensive mental health and case management services for enrollees in a private plan.

3. Access and coordination of mental health Community Support Program (CSP) services
   As the local mental health authority, counties will continue to be responsible for the provision of or contracting for non-MA CSP services for eligible individuals (including eligible enrollees in publicly funded pre-paid health plans). Counties will continue to receive state grant funds for provision of these services. Access to CSP services by eligible enrollees is a specific area where counties and MCOs will need to coordinate.

   As the entity responsible for mental health case management, the MCO will be responsible to identify non-medical assistance mental health services needs of enrollees; and to help enrollees to gain access to these services.

4. Licensing and certification
   The state will continue to exercise its responsibility for licensing/certification/ fidelity monitoring of mental health services providers.

   Counties will continue to have their role in the certification of rehabilitation providers.

   With the addition of mental health rehabilitation services to the publicly funded pre-paid health plans benefit set, MCOs have initially recognized DHS' standards and processes for licensing/certification/fidelity compliance monitoring of these services. MCOs have the opportunity to learn more about these services and providers; and have the authority to add criteria/efficiencies/standards in their recognition of these providers in the MCOs provider network. MCOs have demonstrated flexibility in the transition of assuming responsibility for rehabilitation services so as to minimize disruption of these services to enrollees currently receiving them. One way that MCOs have demonstrated this flexibility is by the temporary recognition of and payment to current providers of services to enrollees making the transition into a health plan.

5. Professional provider credentialing
   State and national licensing boards largely determine mental health professional credentials and licensing. The Rehabilitation Professional credential does recognize a national certification.

   While MCOs have recognized most statutory definitions of mental health professionals, MCOs have the authority to require additional credentials and/or experience of professionals in their provider networks. This also applies to mental health practitioners, and para-professionals.

   Discussions in the Mental Health Rehabilitation Services Phase In to MHCPs Advisory Workgroup, will address professional clinical supervision of case management services.

   DHS expects that MCO professional/individual provider credentialing process to be efficient and not unnecessarily time consuming.

6. Responsibility to serve people without insurance
   As indicated earlier, counties continue to have responsibilities for people without health insurance. The 2007 Legislature provided additional funding for counties to carry out these responsibilities. In fact, most of the new funding in the 2007 Mental Health Initiative was in the form of "infrastructure" grants, many of which are being awarded to counties or regional groupings of counties such as the Adult Mental Health Initiatives.

   MCOs have responsibility to serve enrollees; and to help enrollees maintain their eligibility for health care services.

7. DHS collection of service and outcome information
   Currently, DHS collects data from counties and providers through the Medicaid Management Information System (which includes encounter data), and the Community Mental Health Reporting System.

   Counties will continue to have present reporting responsibilities for the services that counties are responsible for.

   MCOs will be required to report or assure that providers in their networks provide this information to DHS.

   DHS is developing a clinical outcomes reporting systems that providers will be expected to participate in.

   In addition, there will be an external evaluation of the Preferred Integrated Networks program which will require the participating MCOs and counties to submit information specific to this new program. The content of the external evaluation which will be detailed in a report in March, 2008

   MHCP contracts include additional outcome reporting for "process improvement projects", incentives programs, disease management program development. The PINs program will have additional information requirements and outcomes to be determined in the RFP process. The RFP is being developed; and an advisory group will help DHS with its development.

8. Role of consumers/families giving input to MCOs
   Minnesota Statute 256B.69 Subd. 28 (2) (e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

   Existing contract language in the SNBC contract provides a model for consumers and family input through the stakeholder group. The contract language reads: *The MCO will establish and maintain a local or regional stakeholders group pursuant to Minnesota Statutes §256B.69 subd. 28(2) (f), and obtain periodic feedback from members on satisfaction with care, problem identification, and suggestions for improving the delivery system. This process must include a way to use this information to improve access to, and quality of, the care delivered to members with disabilities. Results of consumer feedback activity mechanisms shall be shared with the STATE.*

   In addition, the contract requires an annual Enrollee satisfaction survey to identify unmet healthcare needs and access issues specific to their disabilities. A Follow-up Plan must be implemented by the MCO to address specific issues identified in the SNBC survey.

If the MCO or any of its contracted Care Systems conduct an Enrollee satisfaction survey in addition to the disability survey in 7.5(1) that involves SNBC Enrollees, including the Medicare Consumer Assessment of Health Plans Satisfaction (CAHPS), the MCO must provide the STATE with a copy of the survey results in a timely manner.

In addition to Stakeholder Group, individual enrollees will have the opportunity to give input via their case manager/care coordinator; and through the complaints/appeal processes.

9. Coordination between MCOs and counties about crisis/emergency response system

This is another area where there are some common interests and opportunities for coordination.

As the local mental health authority, counties will continue to be responsible for the development of a local mental health crisis/emergency response system for residents (including eligible enrollees in publicly funded pre-paid health plans), and for provision of services to people without health insurance.

As indicated earlier, counties continue to have responsibilities for people without health insurance. Counties will continue to receive state grant funds for provision of these services. The 2007 Legislature provided additional funding for counties specifically for crisis services development and provision. DHS is currently awarding about $11 million to counties for expansion of crisis services. DHS continues its responsibility to support counties, in their role as the local mental health authority, but specific services responsibilities being picked up by health plans.

MCOs are responsible for the development of the service capacity and the funding of contracted services including crisis response and emergency services.

As the entity responsible for mental health case management, the MCO will be responsible to identify mental health services needs of enrollees; and to help enrollees to gain access to these services, including crisis/emergency services.

Crisis response and emergency service is another opportunity for counties and MCOs to coordinate their efforts. The East Metro Adult Crisis Stabilization Collaborative program and the Metro Children's Crisis Services partnership are successful cooperative efforts involving counties, MCOs, hospitals, providers that have improved the mental health crisis/emergency response system with augmentations of inpatient services, alternatives to hospitalization for some individuals in crisis, improved coordination of crisis intervention communication, and an integration of efforts and resources, rather than a fractured system of crisis service delivery.

10. Identification of unmet needs and development of needed services
    As indicated earlier in the section relating to state responsibilities, DHS has the responsibility to consult with the State MH Advisory Council and other advisory groups to identify unmet needs and to take appropriate action to create and ensure a unified, accountable, comprehensive mental health service system. This activity must be done in coordination with other departments such as Education, Health, Department of Employment and Economic Development, Correction, Juvenile Justice, the Housing Finance Agency, Commerce and others to support the counties as local mental health authorities.

    While the State plans statewide and regionally, counties and multiple-county mental health initiatives and collaboratives need the flexibility and resources to assess and develop services in response to local needs.

    DHS contracts and Health Department rules require MCOs to assure access to covered services for their enrollees. These responsibilities overlap with the county's broader responsibilities. Rather than develop a separate system for individuals with health insurance, it makes sense for MCOs to work with the state and counties to develop a comprehensive mental health system that can meet everyone's needs. Examples of these types of efforts are described above in the crisis services discussion.

11. Mental health services for American Indian tribal members
    Provision of effective mental health services for tribal members presents unique coordination challenges and opportunities due to cultural differences and the presence of an additional responsible entity – tribal government. Tribal representatives have expressed concern about the unwillingness or inability of counties and MCOs to provide appropriate mental health services for tribal members. These concerns led to statutory exemptions which allow tribal members to be excluded from mandatory pre-paid plans; even when a member chooses to be in a pre-paid plan, he/she can still receive services directly from tribal health clinics without going through the plan. Tribes receive some funding directly from the state and federal governments for health care, including mental health services. However, this funding is inadequate to meet the needs, and therefore it is essential for DHS to continue, and enhance, efforts to promote increased coordination among tribes, counties and MCOs.

DHS Findings and Recommendations

After at least 65 meetings with external stakeholders since the end of the 2007 session and with the input of the Mental Health Initiative Advisory Group, DHS has identified these findings:

- Case managers and other mental health providers include very dedicated, qualified staff who provide valuable services to adults with serious and persistent mental illness and children with severe emotional disturbance; however, their efforts are hampered by legal restrictions and a complex system where it is often difficult to determine who is responsible for what, and needed services are often difficult to access.
- Likewise, county administrators and supervisors have demonstrated some excellent examples of collaborative work with health plans, schools, hospitals, housing agencies and many others. However, again, the system is not structured in a manner which facilitates and rewards these types of efforts.
- Consumers, families and their advocates want to see mental illness treated on a par with any other illness, and brought into the mainstream of health care. This approach reduces stigma and supports recovery.
- To the extent that mental health services are covered as health care services, the health care coverage should be primary and there is no need for counties to duplicate that coverage.
- The new federal rule relating to case management affirms that Medicaid mental health case management includes not only coordination of covered health care services, but also assistance in gaining access to other services such as housing, education, or social services.
- Primary care is the locus of most mental health care – more focus is needed on mental health services in this setting; although for some individuals, mental health service settings may be the best health care home.
- Primary care is uniquely situated to provide early identification and intervention of mental health problems.
- Services must be culturally competent; and developmentally appropriate, including early identification and intervention services.
- Care coordination involving the education system is critical for children with physical and mental health needs.
- The legislative Health Care Access Commission and the governor's Health Care Transformation Task Force are considering a number of health care reforms which rely on and support the implementation of flexible models of integrated care coordination and case management like the DIAMOND disease management program and Health Care Homes.
- Adults and children with mental illness and emotional disturbance have a range of needs and preferences regarding care coordination and case management. Those needs and preferences can change as the individual changes. The service system needs to be responsive to those needs and changes in those needs. Each enrollee is an individual; "one size does not fit all" when it comes to service models and systems.

- Health plans are already responsible for coordination of covered health care services. The best way to be responsive to consumer needs is to integrate mental health case management with the health plans' existing care coordination responsibilities, to the extent that CMS allows mental health case management to be covered as a Medicaid service.
- Concerning the inclusion of case management in the contract with MCO's, DHS' expectation is that the MCO has a "see to it" responsibility for assuring access, coordination, quality and outcomes in an integrated system of care. The MCO can choose to contract with counties or other qualified providers for these services, and is expected to do so in a manner that will enhance coordination and integration with all of the other services that may be needed by the individual.
- DHS will use its contracting process with health plans to assure that the comprehensive mental health benefit set, including mental health case management, will be available as needed to all individuals who are enrolled in MA, GAMC or MinnesotaCare pre-paid plans. Mental health case management within the pre-paid plans will have to meet at least the same standards for quality and availability as fee-for-service.
- Existing contractual safeguards to assure access, quality, communication and appeal rights will be enhanced by safeguards developed specific to this initiative, by the external evaluation, and the legislative-funded participation of the Ombudsman for State Managed Health Care Program.
- For individuals not in pre-paid plans, i.e. in fee-for-service, DHS will maintain current standards and coverage, to the extent allowed by federal rules.
- Clear lines of authority and responsibility for the provision of children's residential mental health services would be best served by making the health plan responsible for all the costs of the child's residential care for their enrollees. However, since the entire capitation paid to PMAP plans is matched with federal Medicaid funds, it cannot include funding for services (like room and board) that are outside the benefit set. Some other funding mechanism would need to be established to cover these costs outside of the PMAP capitation. As an alternative, the state, counties, providers and health plans can collaborate on developing joint guidelines for the screening, admission, discharge and payment to the residential facilities for children enrolled in pre-paid plans.

For those individuals who are enrolled in a pre-paid health plan under MA, GAMC or MinnesotaCare, 2007 legislation makes the health plan responsible for mental health case management effective January 1, 2009. The planning process and stakeholder input described in this report has identified a number of ideas, issues, principles, strategies and service models that will be useful as DHS implements this legislation. Specific DHS implementation plans are described earlier in this report. Many elements of the DHS implementation plan are a direct result of the stakeholder input leading up to this report. DHS is of the opinion that remaining concerns can be addressed in the implementation process and that the 2007 legislative decision continues to be the right decision for consumers and their families.

At the same time, this report reaffirms the continuation of the following county roles:

1) system-wide responsibilities for overall planning and development of the services defined in the Mental Health Acts for all residents of that county;
2) specific responsibilities to provide these services to uninsured individuals;
3) specific responsibilities to provide these services to insured individuals who need services beyond what is covered by their health insurance;
4) coordination of the above responsibilities with other entities such as health plans; and
5) consultation with the local Mental Health Advisory Council regarding unmet needs and implementation of the above duties.

Most of the new mental health funding appropriated by the 2007 Legislature was for "infrastructure investments" which, for the most part, are directly in support of the above county responsibilities. A significant amount of that funding (over $11 million for the next two years) is currently being awarded to counties for development and ongoing provision of mental health crisis services. This new state funding demonstrates the state's continued commitment to counties as the local mental health authority.

Counties and health plans each have critically important roles in Minnesota's mental health system. Adults with mental illness and children with emotional disturbance need the unique resources and abilities of both parties, preferably working together. The 2007 Legislature authorized DHS to "to solicit, approve, and implement up to three projects to demonstrate the integration of physical and mental health services within prepaid health plans and their coordination with social services." These projects must be locally defined county-health plan partnerships. DHS is working with stakeholders to assure successful implementation of these projects, and is using those discussions to improve county – health plan cooperation for all populations.

Evaluation

Federal regulations require evaluation of state managed care initiatives through what is known as the External Quality Review Organization (EQRO) process. This process requires an objective evaluation by a contracted organization that is separate from both DHS and its contracted MCOs. The PINS and the inclusion of mental health case management in publicly funded pre-paid plans will be evaluated through this process. DHS is charged with consulting with stakeholders on the evaluation and presenting an evaluation plan to the legislature by March 2008. DHS' evaluation of the MH Initiative will have clear criteria and measurement and quality standards.

References

2002 DHS Mental Health Management Report

2004 DHS Mental Health Management Report

Bazelon Center for Mental Health Law (2004). Get It Together: How to Integrate Physical and Mental Health Care for People with Serious Mental Disorders. Washington, D.C. and www.bazelon.org.

Colton and Manderscheid "Morbidity and Mortality in People with Serious Mental Illness", *Preventing Chronic Disease* in April, 2006

Committee on Quality of Health Care in America, Institute of Medicine (2001). Crossing the QualityChasm: A New Health System for the 21st Century. Washington, D.C.: National AcademyPress.

Federal Registry: 72 Fed. Reg. 68077-68093 (Dec. 4, 2007). The effective date of the rules is March 3, 2008. Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services published interim final rules governing case management services provided by state Medicaid programs.

Gelber, Suzanne and Dougherty, Richard *Disease Management for Chronic Behavioral Health and Substance Use Disorders.* Center for Health Care Strategies, Inc. resource paper.

Health Management Associates (2007). Integrating Publicly Funded Physical and Behavioral Health Services: A Description of Selected Initiatives (Final Report). Prepared for The Robert Wood Johnson Foundation. Lansing, MI.

Hodge, Martha and Giesler, Linda *Case Management Practice Guidelines for Adults with Severe and Persistent Mental Illness.* National Association of Case Management, July, 1997

Hogg Foundation for Mental Health (2006). Integrated Health Care Priority Issue. www.hogg.utexas.edu/programs_ihc.html.

Katon, W. (1995). Collaborative Care: Patient Satisfaction, Outcomes and Medical Cost-Offset. *Family Systems Medicine*, *13*, 351-365.

Minnesota Department of Health (2005). Rural Health Advisory Committee's Report on Mental Health and Primary Care.

Nasrallah HA, Meyer JM, Goff DC, McEvoy JP, Davis SM, Strouup TS, Lieberman JA: Low rates of treatment for hypertension, dyslipidemia, and diabetes in schizophrenia: Data from the CATIE schizophrenia trail at baseline. Schizophrenia Research 2006: 86: 15-23.

National Alliance on Mental Illness-Minnesota: Weekly Legislative Update February 2, 2007.

National Association of State Mental Health Program Directors (2006). Technical Report: Morbidity and Mortality in People with Serious Mental Illness. www.nasmhpd.org

National Council for Behavioral Healthcare (2003). Background paper: Behavioral Health/Primary Care Integration Models, Competencies and Infrastructure. www.nccbh.org (Quick Links/Primary Care Integration).

National Council for Behavioral Healthcare (2006). National Council News: Behavioral Health and Primary Care Coordination. Rockville, MD and www.nccbh.org.

President's New Freedom Commission on Mental Health (2003)

President's New Freedom Commission on Mental Health: Subcommittee on Mental Health Interface with General Medicine (2003)

Rosenberg, L. (2006). Addressing a National Tragedy. *Behavioral Healthcare*, December, 2006.www.behavioral.net.

Substance Abuse and Mental Health Services Administration: National Mental Health Information Center http://mentalhealth.samhsa.gov/

SAMHSA News Nov/Dec 2007 Volume 15, Number 6

Unützer, J., Schoenbaum, M., Druss, B.G., & Katon, W.J. (2006). Transforming Mental Health Care at the Interface With General Medicine: Report for the President's Commission. *Psychiatric Services,* 57, 3747.

Links

American Academy of Pediatrics http://www.aap.org

The Disease Management Association of America (DMAA)
http://www.dmas.org/definition.html

Massachusetts Behavioral Health Partnership website: Care Management Services
http://www.masspartnership.com/

Minnesota Mental Health Action Group
http://www.citizensleague.org/mentalhealth/html/about_mhag.html

National Association of Case Management http://www.yournacm.com/about.html
www.integratedprimarycare.com/integrated_primary_care_bibliography.htm (check link - this one doesn't work)

Substance Abuse and Mental Health Services Administration: National Mental Health Information Center http://mentalhealth.samhsa.gov/

Appendix

Appendix A	MMHAG Workgroup on Ease of Access and Coordination of Care: Update
Appendix B	Physical Health and Mental Health Needs Conceptual Model
Appendix C	2007 Mental Health Initiative Implementation Advisory Workgroup: Discussion Themes
Appendix D	Presentations to MHI Advisory Group/Preferred Integrated Network RFP Subcommittee
Appendix E	Role/Responsibility Issues Relating to Intake/Admission/Discharge of MCO clients into ACT, IRTS and Residential Crisis Stabilization
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Appendix A

MINNESOTA MENTAL HEALTH ACTION GROUP
MMHAG Workgroup on Ease of Access and Coordination of Care: Update
January 31, 2006

WORK GROUP CHARGE
The Access and Coordination Work Group was charged with making recommendations to the MMHAG Steering Committee and to other work groups on ways to:

(1) make the complicated and scattered mental health system easier for consumers to understand and use;
(2) make sure that the different mental health agencies, programs and providers work together and coordinate all the services an individual or family needs; and
(3) have smooth transitions for consumers and families when services or providers change.

WORK GROUP PARTICIPANTS. Ron Brand (chair, MN Assoc. of Community Mental Health Programs); Nancy Abramson (Mental Health Resources, Inc.); Sharon Autio (MN DHS); Gwen Carlson (Hennepin Co.); Scott Craven (United Behavioral Health), Donna Draves (Consumer Representative), Glenace Edwall (MN DHS), Tom Geskerman (HealthPartners), Katy Gorman (Generations); Mark Kuppe (Human Services Inc.); Sandra Meicher (Mental Health Assoc. of MN); Judd Perko (St. Louis Co.); Lynn Skinner (Olmsted Co.); Michael Triangle (HealthPartners); and Mark Zipper (Allina). **Committee Staff**: Michael Scandrett & Lisa Benrud-Larson (Halleland Health Consulting)

PRELIMINARY CONCLUSIONS (as of 1/30/06)
The Work Group concluded that the various mental health services are not coordinated very well in the current system, especially for children, families and adults with multiple needs. This is very frustrating for consumers and families who work with more than one agency, program or mental health provider, or who make changes in their services or providers. The main problem is that programs and services are fragmented into many different, disconnected pieces that do not talk to each other:

(1) There lots of "silos." Usually each of the different programs and services are located in different places, have different eligibility requirements, and provide or pay for different services. It is very hard for people to find out what is available to them and to get authorization to receive services.
(2) Different agencies and providers are paid to provide services to the same consumers and families, but they are usually not paid for the time it takes to talk with each other and to coordinate their services.
(3) Providers and agencies are organized in ways that create barriers to communication and coordination with each other.

Fortunately, some great work is being done in Minnesota and other parts of the country to improve coordination for consumers and families who receive services from more than one agency or provider. The work group has looked at these successful models, and believes several changes should be made to improve access and coordination:

PRELIMINARY RECOMMENDATIONS:

PRIMARY GOAL: To improve behavioral health care (mental health and chemical dependency) so that it is easy for children and adult consumers and their families to access and navigate. In reaching this goal, the following recommendations should be considered:

A. **A Common Benefit Set for Health Coverage**. Health insurance plans and government health care programs should all use a "common benefit set" so that all Minnesotans can be assured that they will have access to high quality mental health services regardless of where they live, what kind of health coverage they have, or whether or not they are eligible for public assistance. This will also make it easier for people to understand what services are covered by their health insurance plan or government program.

B. **Combine mental health programs and funds.** The many different programs, funding streams and eligibility requirements should be combined and simplified. Also, there should be more flexibility so that each consumer and their family can get services based on their own unique needs, rather than being limited in their choices due to a particular program's requirements. Finally, agreements should be worked out between the agency people who administer different programs as to which agency is responsible for providing or paying for which services. Any disputes about agency roles or financing should be worked out among the agencies themselves so that consumers and families are not caught in the middle and possibly be left without services because all the agencies expect someone *else* to take care of the problem.

C. **Coordinate behavioral health care with other services.** To the extent possible, mental health, chemical dependency, and other health care services should be provided in an integrated system under a unified, collaborative treatment plan. All medical, mental health and chemical dependency conditions should be treated simultaneously. These health care services should also be coordinated with other non-health care services a consumer or family needs, such as educational services, social services, corrections and court-ordered treatment. There should also be smooth transitions between providers and types of services. (For example, from inpatient psychiatric hospitalization to day treatment and from day treatment to outpatient treatment.)

D. **Use Community Support Programs (CSPs)**. The work group believes these programs are very effective and should be preserved. Although CSPs primarily serve the seriously mentally ill, the model could be expanded to serve individuals with less severe illnesses who may still benefit from a self-help model.

E. **Assign Responsibility for Coordinating Care**. It should be clear who is responsible for coordinating services for a consumer or family. This can be accomplished either through a designated care manager or through agreements among the agencies and providers about who is responsible for coordination.

F. **Provide Easy Access to Information about Available Services.** It should be easy for providers, consumers and families to find out what services are available to a consumer or family. Ideally, this information should be readily available at the different places where people first seek help or treatment. Information will be easier to understand if the different providers, agencies and programs use the same procedures, assessment tools, and clinical and eligibility criteria, and if a common benefit set is used by all health plans, agencies, and funding sources. The information should be available electronically and in other formats.

G. **Provide Access to Critical Services Without Regard to Payment Source.** Certain critical services should be provided to all residents in a community regardless of their insurance coverage or eligibility for public programs. For example, a single community crisis intervention program may work better than having multiple crisis programs, and all payers should support the single program.

H. **Cover the costs of coordination.** The new Payment Model should reward agencies and providers for coordinating care.

I. **Use Electronic Technology.** To improve access and coordination, all programs and providers should be able to communicate and coordinate electronically about clients they serve jointly.

J. **Stay Flexible: One Size Does Not Fit All.** The Payment Model and Performance Measurement System should be flexible enough to accommodate differences in three areas:
   1. Individual Preferences of Consumers and Families.
   2. Intensity of Services Needed.
   3. Needs of Rural vs. Metropolitan Areas.

K. **Provide Information on Quality of Coordination.** The new mental health quality program should include information on how well different providers and agencies coordinate care for their clients.

L. **Follow Effective Models.** Even if many of the different services, programs and funding streams are consolidated, some coordination of services will be needed. For persons needing multiple services provided by different agencies or providers, the most effective models seem to use interdisciplinary teams, have a designated coordinator and have agreements among the agencies about roles and responsibilities.

Appendix B

Integrated Primary Care and Mental Health Care

Consumer/Family Physical Health and Mental Health Needs Conceptual Model

Physical Health needs-HIGH

Setting of services *Primary Care services* *MH services* *Care coordination(CC)* *Mental Health CM* *Social Services (SS)* LOW-Mental Health needs ↔↕	*Setting of services* *Primary Care services* *MH services* *Care coordination(CC)* *Mental Health CM* *Social Services (SS)* ↕ ↔ Mental Health needs-HIGH
↕	↕↔
Setting of services *Primary Care services* *MH services* *Care coordination(CC)* *Mental Health CM* *Social Services (SS)*	*Setting of services* *Primary Care services* *MH services* *Care coordination(CC)* *Mental Health CM* *Social Services (SS)*

Physical Health needs-LOW

Characteristics:

- Care system would need to be flexible in response to changing recipient needs, resources, recovery;
- Recipients don't necessarily stay in same quadrant;
- No one mental health case management/care coordination model;
- Primary site (home) of services might vary – no one model;
- Individual staff may function on more than one team; in more than one setting;
- Many non-health/social care considerations/issues;
- Single client file – electronic – access to information;
- Medication tracking may be important function
- MH includes substance abuse/chemical dependency treatment

Appendix C

2007 Mental Health Initiative Implementation
Advisory Workgroup

Discussion Themes

Below are some of the "themes" about care coordination/case management that are generalized from the small group discussions of 8 hypothetical client profiles of children and adults with various levels of physical and/or mental health needs.

(These themes are not meant to be comprehensive/complete or reflective of consensus. Rather part of the continuing work of the workgroup to examine care coordination and case management as part of this initiative.)

Themes of discussion of care coordination/case management:

- If care were structured and delivered in a coordinated way in and of itself, there would be far less need for any external or free standing care coordination function.
- Many/most parents do well at handling what care coordination is necessary at a given point in time. This ability relies on ongoing, quality communication between the parents and each of the providers and school personnel. The need for external care coordination often varies over time.
- There is a critical need for coordination around the early identification and intervention functions. Often the school or primary/urgent care providers are the first to pick up on problems and should be equipped to alert the parents to the fact that intervention is needed and to help bring in the necessary resources.
- Primary care needs to take lead role in assuring that individuals/families are informed of and hooked up to needed education (example: diabetes care) and support groups. There also needs to be primary care connection with the school around monitoring and administration of medications.
- Monitoring of adjustment, mood and school functioning during major primary care changes is needed.
- Primary care – either nurse or MD should consult with the treating MH professional (assuming SMI or ED) to help them understand the effects and prognosis of major physical diseases (example: cystic fibrosis).
- Connect with the county is necessary to determine qualification for and use of CADI/CAC waiver services.
- Primary care, mental health, chemical health, and school personnel need to be on top of a youth's condition, and their respective roles in keeping him engaged in treatment and positive about life.
- Parents can be stressed at time, and need support as care givers.
- With some individual there may be a primary need to focus on building trust, and begin with the needs/care that the individual may be more ready to acknowledge.
- Assistance with "paperwork" may be a basic need to access services/benefits.
- Veterans' services and health care benefits should not be forgotten.

- A public health nurse (nurse) will need to be part of a team (not separate approaches) with mental health professionals/practitioners to address primary/mental health needs of some individuals.
- There needs to be a smooth process for "handoffs" to other team members/providers based on the individual's needs and readiness to accept services.
- A single entity should have the "see-to-it" responsibility to make sure that the individual gets the right mix of quality services and care coordination at the right time, and that, if the individual gets his care through a managed care organization (MCO), the MCO should have that "see-to-it" responsibility. Ideally, the MCO would then also have the funds to pay for needed services. The MCO should also have provisions in their contracts with providers to require providers to coordinate with each other.
- To assure patient-centered care, an accountable entity must have broad range of responsibility and flexibility.
- Some individuals/families will need some care coordination as a separate service, but the care coordination needs to be flexible and broad-ranged to meet the client's changing needs and developing willingness to accept the broad range of services that he needs. Each provider of direct services for this client also needs to connect with his other providers, especially at critical "hand-off" points. Somebody needs to make sure the direct service providers are doing that.
- Chemical dependency/substance abuse is more common in this targeted population. Screening is important. Planning/coordination must reflect and begin with the needs/care that the individual may be more ready to acknowledge.
- Family members/spouses often function as care providers; and can sometimes be taught to perform functions of an external caregiver.
- Some individuals need intensive, short-term services (including in-home) immediately following major episodes of treatment in hospital/transitional facilities.
- Issues of housing, transportation, employment, homelessness impact access to needed health services.

Appendix D

2007 Mental Health Initiative Advisory Group

Presentations to MHI Advisory Group/Preferred Integrated Network RFP Subcommittee

Presentations to the PIN/RFP Advisory Group are an opportunity for potential bidders as a PIN site to raise issues and provide information they feel important for consideration in the drafting of the RFP and the ongoing success of the preferred integrated networks.

In its own deliberations, the Preferred Integrated Network RFP Advisory Group has identified several issues it considers important and would like to solicit input on these issues from other stakeholders. In your presentations, please consider addressing the following, most of which relate to criteria to be included in the RFP and used by DHS in deciding which projects qualify as PINs:

Health Plan / County Partnership

- What criteria should be used to ensure a functional partnership that allows counties and health plans to hold each other accountable for their respective responsibilities, but allows enough flexibility to meet diverse local needs?
- What should counties be able to rely on health plans to provide? What should health plans be able to rely on from counties?
- What can we learn regarding effective county/health plan relationships from your experience with managed care for seniors and other populations?

Communication Issues

- An environment of improved integration and coordination of care and social supports will require a high level of timely and effective communication. How can the RFP criteria best ensure that applicants demonstrate the ability for that level of communication with the proposed PIN?
- What RFP criteria would be most helpful to ensure that applicants have a solid plan for communicating with enrollees and potential enrollees about available benefits, service options, denial and appeal rights in a succinct and meaningful way?
- How should the RFP ensure that applicants have worked through the data privacy issues inherent in this high level of communication?
- How should the RFP insure that enrollees have *ease* of access to their own charts/records?

Integration of Treatment and Supportive Services

- What criteria should be used to ensure improved integration of physical and behavioral health care?
- What are the primary challenges to be overcome in improving the integration of physical and behavioral health care?
- What can be done to ensure that family members are actively and appropriately involved in the planning and delivery of services?
- What do you see as the greatest points of opportunity to do comprehensive assessment work? Early identification and intervention?
- To what extent should the partnership be responsible for non-medical services such as housing, employment and non-medical aspects of Community Support Programs?

Care Coordination / Case Management

- What criteria should be used in order to ensure that applicants have an adequate plan for meeting the diverse care coordination and case management needs of those enrolled in the PIN?
- How can we ensure that successful applicants will have a mechanism/information system in place for facilitating cross referrals and consumer access between county social service provider networks and health plan provider networks?
- What criteria should be in place to ensure that schools are appropriately connected with the preferred integrated network in order to effectively coordinate services to children?
- What transitional points (e.g. discharge from acute care, prison or residential treatment to community), homelessness are critical enough to warrant specific criteria?

Accountability / Evaluation

- The foremost policy objectives of the MH Payment Model workgroup were to improve access, quality and accountability. What do you suggest for outcome measures related to these goals?
- What requirements do you suggest in order to make the PINs accountable at a community level? State level?
- How can the RFP incent reductions in administrative cost and increases in direct services?

Drug Formulary

- Considering Medicare Part D constraints, what provisions should be included in the RFP to assure that enrollees have access to appropriate medications?

Provider Networks

- To what extent should the partnership be required to contract with providers of specialized services, such as eating disorder programs and programs for cultural and ethnic minorities?
- Should the partnership be responsible to track unmet health care needs of its enrollees and development of specialized services to meet those needs?
- What RFP criteria will ensure service authorization does not put enrollees at risk?

Interaction with Commitment Laws

- Should the partnership incorporate the county's existing responsibilities under the Commitment Act, and if so, how?

Appendix E

DRAFT 1/17/08

Role/Responsibility Issues Relating to Intake/Admission/Discharge of MCO clients into ACT, IRTS and Residential Crisis Stabilization– DRAFT for Discussion

Provider Role

- Ensure capability to meet client's needs within state standards
- May close intake based on limited capacity
- May decline a referral or discharge a client due to:
    - Provider's inability to meet the client's needs
    - Provider's choice to focus on a clinically defined target population or specialty service
- May exercise preference for local clients based on clinical "close to home" rationale to the extent that this is consistent with individual client needs and preferences
- May decline a referral due to lack of payer source
- Must abide by civil rights non-discrimination provisions

County Role as Local MH Authority

- MH Act designates county as responsible entity for development of mandated services and accessibility to those services
- County recommends to DHS approvable ACT, IRTS and crisis providers, including total budgets and MA fee-for-service rates
- Can a county require their providers to use a central intake process for:
    - County-funded clients – yes
    - MA-FFS clients – see below
    - MCO-funded clients who are also county case mgmt clients – see below
    - MCO-funded clients who are not county case mgmt clients - see below
    - Privately funded (non-public) clients - see below
- Allowable basis of central intake
    - As a way to help providers exercise their responsibility to best match client needs with available resources
    - As a way to manage the provider network to ensure that critical services are available to those most in need, e.g. reserving a crisis bed or managing an overall waiting list for all clients, based on individual needs assessment
    - The county does not have authority to require other payers to participate in a central intake process, but other payers could choose to do so due to the potential benefits to the client
    - Central intake decisions must be subject to appeal (DHS Social Services Appeal Process)
    - MA-FFS clients are subject to federal free choice of provider provisions
    - Cannot prohibit admissions from other counties
    - Geographic preferences, if included, must consider individual client needs and preferences, e.g. "close to home" rationale may fit most clients, but not all
- Budget management / interaction with non-county funding sources

County Role as Individual Case Manager for MCO Clients (until 1/1/09)

- Client acceptance of MH-TCM cannot be a requirement for receipt of other MA-funded services
- MH-TCM is supposed to be a linkage / access service, not a gatekeeper function
- Client has less choice and county has more authority and responsibility when commitment or provisional discharge is involved
- If the MCO is providing ACT (which is required to include case management), MH-TCM should not be claimed through FFS, except for the first and last months on ACT

MCO Role as Individual Case Manager for MCO Clients

- Ensure access to covered services based on individual needs
- Implement MCO service authorization procedures
- Cooperate with pre-petition and other commitment-related issues
- After 1/1/09, MCO will be responsible for the full range of mental health targeted case management services

MCO Role as Network Manager

- Ensure availability of a broad network to meet the needs of enrollees
- May direct clients to preferred providers which the MCO determines are most likely to meet client needs, including care coordination objectives, in a cost-effective manner

Financial / Local Match Considerations

- When ACT and IRTS providers were first approved for MA, funds were transferred from the county or regional state MH grants to cover the match for projected MA-FFS capacity; this was a permanent change in the county's ongoing grant allocation. It is **not** like MH-TCM, where the county is billed for the match every month based on actual utilization.
- As responsibility for ACT and IRTS moves from MA-FFS to PMAP, dollars have moved into the PMAP capitation based on the projected value of that responsibility: PMAP will be responsible for medically necessary ACT and IRTS for those clients who are in PMAP.
- Additional funds are being transferred from county or regional state MH grants to cover part of the cost of ACT and IRTS coverage under GAMC and MinnesotaCare effective 1/1/08. The final transfer amount will be based on the amount the county spent for these services for these clients during CY07. Final data is not expected until late 2008; estimated data from prior periods is being used until then.
- For clients who qualify for GRH (which includes almost everyone on MA or GAMC), the room and board will be funded by GRH after the county financial worker has confirmed eligibility.
- If a county or a health plan is concerned that existing ACT or IRTS capacity is inadequate in a given area, please contact your regional Adult MH Consultant. State staff will work with you and other payers regarding a financing plan for expanded capacity if there is mutual agreement that additional capacity is needed.

- A health plan may work directly with a provider regarding expanded capacity; however, if this results in the need for a change in the ACT or IRTS MA-FFS rate (or an increased need for grant funding for non-MA covered ACT services), the county and state are not obligated to approve that change.
- The preferred approach is development of a plan that is acceptable to all affected parties, including the provider, the county, the health plan(s) and the state.

Appendix F
Implementation Steps for Phase In of Mental Health Case Management

Next Implementation Steps for Inclusion of Mental Health Case Management

April, 2008	Mental Health Rehabilitation Services Phase In to MHCPs Advisory Workgroup meeting – overview of children's case management services, overview of adult case management, service utilization information, and transition issues identification
	Addition of case management provider representatives to Advisory Workgroup
July, 2008	Mental Health Rehabilitation Services Phase In to MHCPs Advisory Workgroup meeting - transition issues identification and discussion, review of codes, models of care coordination/case management - presentation
August, 2008	Training for MCOs on Rule 79 case management standards, codes
September, 2008	Mental Health Rehabilitation Services Phase In to MHCPs Advisory Workgroup meeting - transition issues identification and discussion, models – presentation, MCO implementation strategy
	Statewide videoconference training for case management agencies on managed care contracting and roles
November, 2008	Mental Health Rehabilitation Services Phase In to MHCPs Advisory Workgroup meeting - transition issues identification and discussion, MCO implementation strategy
	RA message to providers and MCOs
January, 2009	Mental Health Case Management included in MCO responsibilities
February, 2009	Mental Health Rehabilitation Services Phase In to MHCPs Advisory Workgroup meeting – review phase in from perspective of stakeholders, discuss successes/issues
April, 2009	Mental Health Rehabilitation Services Phase In to MHCPs Advisory Workgroup meeting - review phase in from perspective of stakeholders, discuss successes/issues