TARGETED CASE MANAGEMENT PROGRAM DESIGN

GENERAL STRUCTURE

Agency responsible for overseeing TCM for youth with SED

Department of Public Health and Human Services – Children's Mental Health Bureau

Entities providing TCM for youth with SED

Children's Mental Health Providers – Licensed Mental Health Centers with a Youth Case Management Endorsement

Number of youth served through TCM for youth with SED annually

TCM for Youth with SED is an entitlement program with no cap. Utilization will vary based on eligibility, reimbursement, and program requirements.

Historical Data:

Fiscal Year	Youth Served	Expenditures	Notes
SFY 2017	5,000	$10,773,146	
SFY 2018	4,713	$6,441,124	
SFY 2019	3,546	$4,704,099	Based on claims paid through 9/23/2019
SFY 2020	1,946	$548,851	

Estimates for children/youth served:

- NRI estimates 6-12% of youth aged 5-17 in Montana have an SED.
- Based on Montana Medicaid claims in 2018 24% of youth had a diagnosed mental health condition.
- As of September 2019, there were 100,743 youth enrolled in Montana Medicaid. An additional 22,516 youth are enrolled in Healthy Montana Kids (CHIP).

Action Item: Projection based on eligibility criteria, proposed rate, and budget.

Population(s) served / Medical necessity criteria

Families with youth meeting SED Criteria as described in the Children's Mental Health Medicaid Provider Manual. Emphasis on youth with functional impairments in home or school settings, youth with risk of harm to self or others, or substance abuse.

Medical Necessity Criteria proposed for Manual:

Youth must meet the SED criteria as described in this manual and the parent/caregiver gives consent and agrees to participate in TCM, and:

(1) Within 14 days of admission, the youth and family have been assessed and have documented need for case management based on:
(a) complexity of youth and family service needs and/or interventions;
(b) severity of youth's behavioral health symptoms; or
(c) strengths, preferences, and needs within family capacity; and
(2) Youth and family's needs have been assessed and documented that TCM services are necessary to maximize benefit and leverage resources from other systems in which the family is involved, with an emphasis on natural supports.

ELIGIBILITY AND SCREENING

Tool used for eligibility screening

Clinical Assessment: Performed by clinical professional within the Licensed Mental Health Center.
Recommendation: Leave clinical assessment as is.

Eligibility tiers determined for TCM for youth with SED	**Recommendation:** TCM work group is not recommending tiers within the TCM program/reimbursement model currently. Note: Once we have baseline CASII / ECSII data, DPHHS will reevaluate tiers and/or PMPM.
Entity that authorizes enrollment in TCM for youth with SED / **Individual/entity that conducts eligibility screening**	Licensed Mental Health Centers with a Youth Case Management Endorsement. Targeted Case Management for Youth with SED is not a prior authorized service, nor is it managed care, so there is no official entry into the service. Provider will be responsible for enrolling children into the service that meet determined medical necessity criteria. Monitoring will be provided by QAD. Clinical assessment by qualified licensed professional as required in ARM 37.106.1915. The clinical assessment must meet Mental Health Center licensing criteria.
Tool(s) used for assessment once children are enrolled	**Current:** Mental Health Center Clinical Assessment is required in ARM 37.106.1915. **Recommendation:** Continue to perform Mental Health Clinical Assessment as required in ARM 37.106.1915. **AND ADD** The Child and Adolescent Service Intensity Instrument (CASII) is a standardized assessment tool that provides a determination of the appropriate level of service intensity needed by a child or adolescent and his or her family. It is unique in its capacity to determine a service intensity need, guide treatment planning, and monitor treatment outcome in all clinical and community-based settings. The Early Childhood Service Intensity Instrument (ECSII) is a standardized tool used to determine the intensity of services needed for infants, toddlers, and children from ages 0-5 years. CASII or ECSII assessment to be performed within the first 21 days and repeated every 90 days. Findings should support continued benefits from TCM, reflected in individual service planning. Service plan should reflect the least restrictive and appropriate level of care and include discharge and transition planning. **Note:** ARMs will reference functional impairment/acuity tool approved by Department, rather than specific tool.
Criteria for discharge from TCM for youth with TCM	**Current:** MHC discharge criteria located in ARM 37.106.1917 **Recommendation:** The youth must be discharged when treatment plan goals have been met, no longer desires case management, or no longer meet criteria for entry into targeted case management services.
REQUIREMENTS FOR TARGETED CASE MANAGERS AND SUPERVISORS	
Education requirement for targeted case managers	**Current Requirements:** ARM 37.106.1935*: "*Employ or contract with case managers who have the knowledge and skills needed to effectively perform case management duties. Minimum qualifications for a case manager are a bachelor's degree in a human services field with at least one year of full-time experience serving people with mental illnesses. Individuals with other educational backgrounds who, as providers, consumers, or advocates of mental health services have developed the necessary skills, may also be employed as intensive case managers. The mental health center's case management position description must contain equivalency provisions;" **Recommendation:** Leave as is – bachelor's degree or equivalent.
Certification requirements for targeted case managers	**Recommendation:** Mental Health Center's with youth case management endorsement must ensure that the agency has a process to ensure timely access to CASII/ECSII assessments by certified CASII/ECSII.

Caseload requirements	**Recommendation:** Use COA language allows for flexibility, still holds providers accountable. COA language: *Caseload sizes are sufficiently small to permit case managers to respond flexibly to differing service needs of individuals and families, including frequency of contact.*
Credentialing requirements for supervisors of targeted case managers (clinical supervision)	**Current Requirements:** Employ or contract with a program supervisor, experienced in providing services to individuals with a mental illness. The program supervisor shall meet with each intensive case manager, either individually or in a group meeting, at least every 30 days. Individual supervision of case managers must be offered by the mental health center as needed and may be initiated by either the case manager or the supervisor; *Note: ARM 37.106.1902 currently defines program supervisor.* **Recommended language:** Targeted case managers must have regular supervision. Frequency must be at least once a month, or more frequent based on documented skills and competencies of the targeted case manager. Supervision will be skills-based and promote competencies in key skill sets such as, developing child and family treatment plans, facilitating family treatment team meetings, and child and family system knowledge. In addition, targeted case managers must have access to clinical consultation through the treatment team meeting.
Supervisor to targeted case manager ratio	**Recommendation:** Will not include prescriptive guidance in ARMs.
Minimum training requirements for targeted case managers	**Recommended Language:** Each agency has a written protocol that includes initial training, and 20 hours of annual continuing education. Areas of focus should include initial and booster trainings to promote competencies in key skill sets such as, developing child and family treatment plans, facilitating family treatment team meetings, and child and family system knowledge. Training protocol also must include training on suicide prevention, including crisis and safety planning.
ACCESS	
Requirements for initial contact after referral to TCM services	**Recommended Language:** Case Management endorsed agencies must have policies in place that encourage timely access of services. If a provider has waitlists, policies must detail communication standards to referral sources and families, including other service providers.
Requirements of provider to provide access to crisis services	**Current Requirements:** ARM 37.106.1945 – Crisis Telephone Services **Children's Mental Health Medicaid Provider Manual:** **The case manager's role during crises.** The case manager's function includes assisting the family in anticipating and describing the crises they may experience; as well as developing a crisis plan to address these crises. CFR 42.441.18, subpart (c) states targeted case management does not include direct service. As long as the crisis plan does not identify the case manager as the primary responder to the person's crisis, it is appropriate for the case manager to be available to assist the family in activating the resources they identified in the crisis plan. **Recommendation:** Leave as is.
TARGETED CASE MANAGEMENT SERVICE REQUIREMENTS	
Required components of Individual Treatment Plan (ITP)	**Current Requirements:** ARM 37.106.1916 - Documents requirements for Individual Treatment Plans for a Mental Health Center. **Recommendation:** Leave as is.

Requirements surrounding family engagement	**Recommended Language:** Upon admission and prior to all treatment team meetings of Targeted Case Management Services, a family treatment team meeting preparation checklist / questionnaire must be completed by the targeted case manager with the youth and family/caregiver. Family treatment team meeting preparation checklist / questionnaire must contain the following components: • Explanation of the treatment meeting and documentation of parent/caregivers • Documentation of natural supports in child's life • Documentation that service delivery and individual treatment plans are delivered at times and in places that are flexible, accessible, and convenient to the youth and caregivers, including evenings and weekends, and sessions located at the location of the youth and caregivers' choice. • Evaluation with the youth and caregivers to identify and address risk and safety concerns across the home, school, and community. • Evaluation with the youth and caregivers to identify strengths that can be used as the basis for elements of the treatment plan in the areas of: school, vocational, family, social, and community functioning as well as towards meeting developmental skills/abilities. Additionally, individual treatment plans (and those participating in treatment team meetings) must: • Use language that is understandable to the youth and caregivers and, where necessary, translates clinical terminology (e.g., diagnoses and acronyms) into language that is understandable • Include natural supports • Actively seek to understand and demonstrate respect for the unique and diverse backgrounds of the youth and caregivers (e.g., roles, values, beliefs, races, ethnicities, sexual orientations, gender expressions, gender identities, languages, traditions, communities, and cultures) • Crisis plans should include the identification of safety concerns, potential crises, triggers, de-escalation and coping strategies, actionable stabilization steps, prevention measures, and youth-and caregiver-identified supports.
Requirements to strengthen family skills	**Recommendation:** Assessment of family skills will be tied to treatment goals.
Treatment goals	**Recommendation:** Treatment goals are measurable, strength-based, and in alignment with assessed needs, intake criteria, and discharge plan.
Minimum / maximum contacts	**Recommendation:** Case management contacts should be driven by individual treatment plan. One face to face contact with client per month out of the office in a home or community setting is required. Telehealth is allowable with documented need.
Rural differential payment	**Recommendation:** Use criteria to identify services provided to children who live in frontier communities. Incentivize services in frontier communities by offering a rural differential payment of 115% of unit rate. OPTIONS: • USDA Frontier and Remote Zip Code database based on the US census. • General Rural Designation of <6 people per square miles • CMS Super Rural Designation – Designed for Ambulance Providers Action item: Complete analysis and determine what our current Medicaid claims system is capable of performing.
Requirements to coordinate ITPs with concurrent services (CSCT, Outpatient, etc.)	**Current Requirement:** in ARM 37.106.1916 (7) If the mental health center develops separate treatment plans for each service, the treatment plans must be integrated with one another and a copy of each treatment plan must be kept in the client's record. **Recommendation**: No changes made to requirement to coordinate treatment plans.
Services that cannot be provided concurrently	**Recommendation**: For initial design, recommendation is that there are no CMHB services that cannot be provided concurrently, with the intention to evaluate this as the Department redesigns Home Support Services. Intention to allow TCM when a child is discharging from a PRTF, however, if a youth enters a PRTF with a Targeted Case Manager, the PRTF must prioritize maintaining that relationship.

EVALUATION AND MONITORING	

Outcome Measurement and Reporting	**Recommendation:** Baseline and repeated measurement of outcomes are routinely and reliably measured and shared with the youth and caregivers, including: emotional and behavioral functioning of the youth, living situation, school outcomes, risk of harm to self or others, substance use, and progress toward individualized goals for the youth and caregivers. This will be shared with the youth and caregivers through quarterly treatment meetings and measured by the 90-day CASII / ECSII assessments.
	
	Additionally, the Children's Mental Health Bureau and Mental Health Centers providing Targeted Case Management will work together to gather data and report on the following:
	
	• **Emotional and Behavioral Functioning of the Youth**
	  ○ 90 day CASII / ECSII assessments will be performed by MHCs
	  ○ Data will be collected by MHCs and sent to CMHB
	  ○ Information will be used to evaluate future changes within the CMHB Continuum of Care.
	• **In-Home, In-School and Out of Trouble**
	  ○ Biannual HB 583 Template – Required by law September and February
	  ○ Data is collected by MHCs and sent to CMHB
	  ○ Information will be shared with providers and reported on to the Legislature
	• **Youth and Caregiver Satisfaction Survey**
	  ○ Annual MSHIP Survey – already being performed on an annual basis
	  ○ CMHB to further develop utilization of data received and reporting methods
	  ○ Data is collected by MHCs and sent to AMDD
	• **Fidelity to Family Engagement**
	  ○ Quality review tool that will be posted on the Children's Mental Health Bureau website which will include criteria for family engagement and/or observation of program
	  ○ Performed biannually by CMHB using a sample from the HB 583 data pull
	  ○ CMHB will provide quality monitoring and routinely provide feedback and generate reports that assist in supervision and management of the targeted case management program
	• **Utilization Reports**
	  ○ CMHB will perform analysis on TCM Medicaid claims to monitor utilization
	  ○ Analysis will be used for internal monitoring by DPHHS and will be shared with MHCs
	
	CMHB and MHCs will use these measurements to inform decision-making, aid in external reporting of CMHB services, and as a tool for continuous evaluation and program improvement on our capacity to serve Montana youth within the state of Montana.
	
	Additionally, these measures will assist DPHHS and providers in the growth of behavioral health outcome measurements to assist in the development of pay for performance payment models.
	
	Action item: Once approved create an implementation plan for new measurements.

Entity responsible for tracking outcomes	Provider organizations collect data for some measures DPHHS CMHB collects from providers and compiles into reports
FINANCING FOR TARGETED CASE MANAGEMENT FOR YOUTH WITH SED	
Funding mechanisms for TCM for youth with SED	Medicaid
TCM for youth with SED rate and billing structure	FFS / 15 min units
Medicaid vehicles used to finance TCM for youth with SED	Montana Medicaid State Plan