



# Bulletin

**NUMBER**

#15-53-02

**DATE**

December 1, 2015

**OF INTEREST TO**

County Directors  
Social Services Supervisors  
and Staff

Minnesota Health Care  
Program providers

Managed Care  
Organizations

Tribal Agencies

Collaboratives

**ACTION/DUE DATE**

Please read information  
and plan for implementation  
in your community.

**EXPIRATION DATE**

December 1, 2017

## Children's Mental Health Division: Youth Assertive Community Treatment

**TOPIC**

Youth Assertive Community Treatment service description, service standard requirement, rate setting methodology, and contracting process.

**PURPOSE**

To provide information on the Youth Assertive Community Treatment benefit for Minnesota Health Care Program participants as described in Minnesota Statutes, section 256B.0947.

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**SIGNED**

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**TERMINOLOGY NOTICE**

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

## **Introduction/Purpose**

This bulletin provides information for mental health providers, counties, tribal authorities, health plans and youth servicing organizations of legislation that was passed authorizing a new benefit to Minnesota Health Care Program (MHCP) participants. This bulletin contains information on the components of the service, service standards, clinical and administrative standards, rate setting methodology, and contract standards for Youth Assertive Community Treatment (Youth ACT).

### ***Legislative Authority***

The 2011 Minnesota State Legislature passed Minnesota Session Laws 2011, chapter 86, and section 20 describing a new intensive rehabilitative mental health service to be added to the Minnesota Health Care Program's benefit package for Children's Mental Health. The legislation directs the commissioner of the Department of Human Services to create service, clinical and administrative contracting standards for this service. Youth ACT is a service within the MHCP benefit package and has been added to Minnesota's State Plan and approved by the Centers for Medicare and Medicaid Services.

## **Background**

In the early 2000s, the Children's Mental Health Division began assessing and describing the unique and intense needs of youth struggling with mental illness who are transitioning from the children's to the adult's system of mental health care. The Minnesota State Legislature passed the first version of this intensive non-residential rehabilitative mental health service in 2005, which in 2011 became the legislative authority to create the Youth ACT service. The service description was amended in 2009, 2010, and in both the regular 2011 session and the 2011 Special Session. Over the years, the eligibility criteria, service package, and service description were honed to reflect the information received from the Child and Adolescent Intensive Service Workgroup listening sessions (Fall 2010), the Acute Care Needs Report (March 2009), and the Chemical and Mental Health Services Transformation Advisory Task Force Report (December 2010).

It is clear that there is a distinct need in the State of Minnesota for an intensive mental health service for youth ages 16-20, suffering from severe mental illness and/or co-occurring disorders, who need assistance (due to the severity of their symptoms), with coordinating mental health, school/employer, housing, family, and physical health services.

## **Client Eligibility and Admission Criteria**

Youth ACT is an intensive rehabilitative service that requires a diagnosis and documentation of a serious mental illness or co-occurring mental illness and substance abuse addiction as well as the medical necessity of intensive rehabilitative mental health services because the youth did not acquire the skills that are developmentally appropriate for their age because of their mental illness or lost capacity because of the onset and functional impairment of their mental illness.

An eligible youth is an individual on MHCP who:

- (1) is age 16, 17, 18, 19, or 20; and
- (2) is diagnosed with a serious mental illness or co-occurring mental illness and substance abuse addiction, for which intensive nonresidential rehabilitative mental health services are needed; and
- (3) has received a level-of-care determination using the Child and Adolescent Service Intensity Instrument (CASII) that indicates a need for intensive integrated intervention without 24-hour medical monitoring and a need for extensive collaboration among multiple providers; and
- (4) has a functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; or who is likely to need services from the adult mental health system within the next two years; and
- (5) has had a recent diagnostic assessment, as provided in Minnesota Rules, part 9505.0372, subpart 1, by a mental health professional who is qualified under Minnesota Rules, part 9505.0371, subpart 5, item A, that documents that intensive nonresidential rehabilitative mental health services are medically necessary to ameliorate identified symptoms and functional impairments and to achieve individual transition goals.

## **Frequently Asked Questions:**

### ***What does “serious mental illness or co-occurring mental illness and substance abuse addiction” mean? What diagnoses meet criteria for this service?***

Serious mental illness indicates that the youth has a mental illness and it has caused serious clinical impairment in their life. The diagnostic assessment needs to describe the medical necessity of this service and how it will appropriately treat both the mental illness and severity of symptoms and clinical impairment on the youth’s life. Co-occurring mental illness and substance abuse addiction means a dual diagnosis of at least one form of mental illness and at least one substance use disorder—disorders can include alcohol or drug abuse or dependence, excluding nicotine use.

## **Service Components**

Minnesota Statutes, section 256B.0947 describes an array of components that must be available within the Youth ACT service. In order to be a provider of this service, all components must be available for the youth:

- Individual family and group psychotherapy
- Individual, family, and group skills training
- Crisis assistance
- Medication management

- Mental health case management
- Medication education
- Care coordination
- Psychoeducation to, and consultation and coordination with, the client's support network
- Clinical consultation to the client's employer or school
- Coordination with, or performance of, crisis intervention and stabilization services
- Assessment of client's treatment progress and effectiveness of services using outcome measurements
- Transition services
- Integrated dual disorders treatment
- Housing access support

## **Frequently Asked Questions**

### ***What does medication education entail for Youth ACT clients?***

Medication education as described in the [MHCP Provider Manual](#) educates a youth and family about mental illness and symptoms, the role and effects of medications in treating symptoms of mental illness, and the side effects of medications. Medication education needs to be coordinated with, but not duplicative of, medication management services. Medication education can also include activities that instruct a youth, family and/or significant others in the correct procedures for maintaining a youth's prescription medication regimen.

### ***Where can I find a description of care coordination in a Youth ACT model context?***

The care coordination standard is described in [Minnesota Youth Assertive Community Treatment Standards](#), which can be found on the [Youth and Transition Services](#) page for the Children's Mental Health Division. Care coordination includes the responsibility of arranging and following through with the youth's health care needs and ongoing communication with the primary care provider--including an annual Well Check/Child and Teen Check-up, dental appointments and all other necessary follow up appointments.

### ***What is psychoeducation?***

"Psychoeducational Services" means individual, family, or group psychoeducation services, delivered by a mental health professional, designed to explain, educate and support the individual or family in understanding the child's symptoms of mental illness, their impact on the youth's development and needed components of treatment and skill development to prevent relapse, prevent the acquisition of co-morbid disorders and to achieve optimal mental health and long-term resilience.

***Does the Youth ACT team have to be a certified crisis response provider?***

No, a Youth ACT team may contract for crisis services from a certified crisis provider if the team is not willing or able to provide the crisis coverage services. Crisis services must be available to the youth receiving services at all hours and days of the week while enrolled in the Youth ACT service.

***What are transition services?***

Minnesota Statutes, section 256B.0947 defines transition services as including:(1) activities, materials, consultation, and coordination that ensures continuity of the client's care in advance of and in preparation for the client's move from one stage of care or life to another by maintaining contact with the client and assisting the youth to establish provider relationships; (2) providing the youth with knowledge and skills needed post-transition; (3) establishing communication between sending and receiving entities; (4) supporting a youth's request for service authorization and enrollment; and (5) establishing and enforcing procedures and schedules.

***What is integrated dual disorders treatment?***

Minnesota Statutes, section 256B.0947 defines integrated treatment of co-occurring mental illness and substance use disorders by a team of cross-trained clinicians within the same program, and is characterized by assertive outreach, stage-wise comprehensive treatment, treatment goal setting, and flexibility to work within each stage of treatment.

***What is included in housing access support?***

Minnesota Statutes, section 256B.0947 defines housing access support as an ancillary activity to help an individual find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.

***Can you bill Youth Act and CADI?***

Yes. CADI waivers and Youth ACT can happen at the same time. You must ensure that, you are not duplicating services that currently are fall under Youth ACT.

***Can you bill for Youth ACT Services at 21?***

No, once your client turns 21 services are ended. Youth ACT teams must plan ahead prior to the 21<sup>st</sup> birthday for transitional services.

## **Provider Contract Requirements**

Minnesota Statutes, 256B.0947 states that Youth ACT providers need to have a contract with the Department of Human Services in order to be an eligible provider of this service. Providers may be counties, private non-profit or for-profit agencies, or tribal mental health agency.

Minnesota Statutes, section 256B.094, subdivision 4 mandates that the Department must create clinical and administrative standards in order to determine who can contract to become a Youth ACT provider. These standards are published on the Department's Youth and Transition Services webpage. The Department will publish a Request for Proposals (RFP) once the Youth ACT service is officially added to Minnesota's State Plan for Minnesota Health Care Programs, so that providers can demonstrate their ability to meet the clinical and administrative standards to provide this service.

Youth ACT falls within the rehabilitative mental health service benefit for youth receiving MHCP insurance. Therefore, in order to be a provider of Youth ACT the agency needs to be a certified rehabilitative service provider demonstrated either through a Children's Therapeutic Services and Supports (CTSS) and/or an Adult Rehabilitative Mental Health Services (ARMHS) certification with the Department of Human Services.

In addition to having all the clinical infrastructure and administrative structure required by both CTSS and ARMHS, a Youth ACT provider must be able to demonstrate an ability to work within the children's mental health, adult mental health and the chemical dependency treatment systems.

If an agency is CTSS certified and wishes to become a Youth ACT provider the agency would demonstrate the following competencies in the proposal:

- Training tracking policy
- Staff performance review policy

Please see the [ARMHS certification](#) application and material for more detail on requirement.

If an agency is ARMHS certified and wishes to become a Youth ACT provider the agency would demonstrate the following competencies in the proposal:

- Notification of adverse legal history
- Ethical conduct policy
- Mental health service history
- Family education and involvement
- Outcomes

Please see the [CTSS certification](#) application and material for more detail on requirements.

All Youth ACT providers need to demonstrate the following:

- Memoranda of understanding (MOU) with host counties and local Tribal communities detailing the referral, collaboration and financial responsibility agreements between child welfare, adult and children’s mental health case management, chemical dependency, housing services, Tribal services and financial support services. Included in the MOU will be information on access to ancillary services like respite, emergency shelter services, Tribal supportive services and other resources that are currently accessed through Rule 79 case management. Providers will not be penalized if a county in the targeted service region is unable to contribute to the project after a good faith effort at collaboration.
- Letters of support and understanding with local school systems, local homeless youth shelter and housing providers, and vocational rehab (VRS) programs within the region.
- Programs also need to describe history of working with transition age youth and projected client numbers, referral processes and specialty population (if applicable).

<b><i>Youth ACT &amp; Other Concurrent Services</i></b>			
<b><i>The Youth ACT team must coordinate all concurrent services</i></b>			
When requesting authorization, clearly document medical necessity for the additional service(s). Include the reasons Youth ACT does not/cannot meet recipient’s needs (specialty service, transitional service, etc.).			
<b>Other Service</b>	<b>Is service included in Youth ACT?</b>	<b>Can service be provided in addition to Youth ACT?</b>	<b>Service Limitations</b>
MH-TCM	Yes	No	Case management functions are bundled in the Youth ACT rate. CMH-TCM is covered only in the month of admission or discharge from Youth ACT. CMH-TCM must request authorization for coverage other than month of admission/discharge.
Children’s Mental Health Day Treatment	No	When authorized	Day Treatment program must request authorization. If Youth ACT team approves Day Treatment, Youth ACT team must provide a statement to the Day Treatment provider for authorization request purposes. Day Treatment providers may not be additional Youth ACT team members. Day Treatment providers must accept clinical direction from the Youth ACT team.

<b>Other Service</b>	<b>Is service included in Youth ACT?</b>	<b>Can service be provided in addition to Youth ACT?</b>	<b>Service Limitations</b>
Children's Residential Treatment Services	No	No	Cannot be billed separately. No authorization required.
Partial Hospitalization	No	Yes	Partial hospitalization thresholds and limitations apply.
IRTS	No	Yes	Youth ACT and IRTS may be provided concurrently without authorization.
CTSS and ARMHS	Yes	No	Rehabilitative skills training is a component of Youth ACT services, cannot be billed separately.
Mental Health Behavioral Aide Services	No	No	Cannot be billed separately.
Crisis Assessment and Intervention (mobile)	Yes	No	A component of Youth ACT. Team must provide or contract with a Crisis provider for this service. Cannot be billed separately. No authorization required.
Crisis Stabilization – Non-residential	Yes	No	A component of Youth ACT. Cannot be billed separately. No authorization required.
Crisis Stabilization – Residential	No	Yes	Service limits apply. Services must be coordinated between the Youth ACT and residential crisis providers.
Medication Management	Yes	No	Provided by physician or advanced practice registered nurse team members.
Outpatient Psychotherapy	Yes	No	A component of Youth ACT. Cannot be billed separately. No authorization required.
Inpatient Hospitalization	No	Yes	Inpatient hospitalization services are reimbursed separately from Youth ACT.
Waivered Services	No	Yes	County must approve concurrent care.
Other medical services (e.g., PCA)	No	Yes	Service limits apply to each service.

## Service Standards

The Minnesota Youth ACT model is based on the adult Assertive Community Treatment model and the service is to be provided in a team format. The youth will have a relationship with the team rather than one particular staff member. The program must provide the services at a time and place convenient to the client and at least 50% of the face-to-face encounters every week must be made outside of the office. On the average, youth will receive three or more face-to-face visits with a total service time of at least 85 minutes per week unless specified in the treatment plan or as part of a transition/discharge plan to other services.

Minnesota Statute section 256B.0947 specifies that the staffing ratio for Youth ACT must not exceed 10 clients to one full-time equivalent treatment team position. In addition, the treatment team may not carry more than 80 clients total at one time. After the 80 client limit is met, then a new team must be established.

The entire treatment team will meet two times a week to discuss client treatment needs and all unlicensed mental health staff will meet with the clinical supervisor for supervision three hours per month or as described in their clinical supervision plan (additional team meetings will be scheduled by the team for treatment planning, staff training, and administrative purposes). The clinical supervisor is required to be an active member of the treatment team with direct service responsibilities (at least .25FTE for direct service time). Team members are expected to provide services to youth outside of regular office hours—including evenings, weekends, and holidays to meet the youth's needs. Nonclinical members of the treatment team will have prompt access in person or by telephone to a mental health practitioner or professional. The Youth ACT team must demonstrate capacity to appropriately respond to emergent needs and make necessary staffing adjustments.

The core treatment team, by statute, must contain the following members:

- Clinical Supervisor (Licensed Mental Health Professional)
- Advance-practice registered nurse with certification in psychiatric or mental health care or a board-certified child and adolescent psychiatrist who must be credentialed to prescribe medications
- Licensed alcohol and drug counselor who is trained in mental health interventions
- Peer specialist

Based on the needs of the target population and the Youth ACT team, the following may also be a part of the core team:

- Additional mental health professionals
- A vocational specialist
- An educational specialist
- A child and adolescent psychiatrist who is retained on a consultant basis
- Mental health practitioners
- Mental health case manager
- A housing access specialist

Treatment teams may also include client specific members who join for a particular youth's team but who are not employed by the team and must accept overall clinical direction from the treatment team during the youth's treatment with the Youth ACT team. Client-specific treatment team members may include (when applicable):

- The mental health professional treating the client prior to entering the Youth ACT team (includes therapist and/or psychiatrist)
- The current substance abuse counselor
- A lead member of the client's individualized education program or school-based mental health provider
- A representative from the youth's Tribe
- The client's probation agent or other juvenile justice representative
- The client's current vocational or employment counselor

Further information concerning the Youth Assertive Community Treatment benefit can be found on the [Youth and Transition Services](#) webpage. Helpful information includes:

- A link to the statute: Minnesota Statutes, section 256B.0947;
- Clinical and Administrative Service Standards outlined in Minnesota Statutes, section 256B.0947, subdivision 4; and
- A sample Treatment Plan for Youth ACT

## **Frequently Asked Questions:**

***There are a lot of different services within this benefit; does the youth need a treatment plan for each component of the service?***

No, the youth, guardian (if applicable) and team should all work from one treatment plan. There is guidance in the Service Standards appendix 1 as to the timing and development of the plan.

There is a sample treatment plan template in appendix 2 of this document that is based off of the Rule 79 Individual, Family, and Community Support Plan, the Care Coordination plan used by healthcare homes, a rehabilitative services treatment plan and a chemical dependency treatment plan.

## **Billing Rates and Structure**

Minnesota Statutes, section 256B.0947, subdivision 7 gives structure for a rate setting methodology. Payments for this service will be made on a per diem basis comprising a daily encounter rate plus travel time. The daily encounter will encompass all service provided to that client on a calendar day (including all rehabilitative services, supports and ancillary activities, staff travel time to provide the service, and crisis response services). The rate is to be cost-based according to the following items:

1. The cost for similar services in the health care trade area;
2. Actual costs incurred by entities providing the service;
3. The intensity and frequency of services to be provided to each client;
4. The degree to which clients will receive non-Youth ACT services; and
5. The costs of other services that will be separately reimbursed.

Only the provider agency of Youth ACT can submit a claim for mental health services (including psychotherapy and medication management) for a client participating in a Youth ACT service. If there is a client specific team member that requires payment from Minnesota Health Care Programs for their service, the Youth ACT provider team (including the ad hoc member) determines how to distribute payment amongst the members.

The Youth ACT daily rate encounter has been created utilizing the parameters listed above. The Department formed a committee to look at the known costs of providing this service. In order to do that, submitted claims data was analyzed from all current Minnesota Health Care Programs (MHCP) services:

- Outpatient CD treatment
- Mental Health Targeted Case Management
- Community Intervention (Adult ACT services)
- Crisis Assessment
- Crisis Intervention
- CTSS Crisis Assistance
- CTSS Psychotherapy—Individual, Family and Group
- CTSS Skills Services—Individual, Family and Group
- Health Care Home Care Coordination
- Medication Education
- Medication Management
- Psychiatric Consultation

Submitted claims data was broken down to Average Hourly/Session Fee-For-Service rates which created an average total hourly rate of \$178.30 for the cost of the known services required for Youth ACT. Data was also generated for each of the regions in the State of Minnesota: Southeast, Southwest, Northeast, Northwest, Central and Metro.

A ratio methodology was created because not all of the services listed above are routinely available in all regions of the state which would have led to inequities in regional rates when averaging the data. It was determined to then utilize consistent data based on submitted claims of services that are available in every region and create a ratio for each region so that a region would not be penalized for having an undeveloped service in their area.

The regional Youth Assertive Community Treatment rates based on the recommended ratio are the following:

<b>Region</b>	<b>Rate</b>
Central	\$190.66
Metro	\$192.65
Northeast	\$178.60
Northwest	\$185.28
Southeast	\$149.63
Southwest	\$170.01

It is expected that each team provide, at a minimum, an average of 3 face-to-face encounters a week to total at least 85 minutes of intervention time.

In order to submit a claim for this service each agency will need to have a contract with the department demonstrating the above listed competencies and service structure.

## **Frequently Asked Questions:**

### ***Are the rates sufficient to cover the costs of a program?***

If a program were to have 40 clients and see each client 16 times per month with the average rate of \$137 per billable encounter, the program would generate \$1,052,160 annually. If a program were to have 80 clients and see each client 16 times per month with the average rate of \$137 per billable encounter, the program would generate \$2,104,320 annually. These projected figures do not include travel time.

***Is travel time included in the per diem regional rates listed above?***

Travel time plus the Youth ACT rate create the total per diem for the service. This is done to acknowledge the great variability of travel time required to serve youth throughout the state.

***What are the rates for Tribal providers?***

Indian Health Service facilities and facilities operated by federally recognized Indian Tribes with Public Law 93-638 funding remain eligible for the federally negotiated daily encounter rate.

***Are Youth ACT teams able to submit a claim for face-to-face appointments without the client present (i.e. for family psychoeducation, clinical consultation and family therapy without the client present)?***

Yes, family psychoeducation, clinical consultation to school or employer, and family therapy without the client present may be counted as a face-to-face appointment as long as the need for the client's absence is documented. All other services need to have the client present in order to count as a face-to-face billable encounter.

***When should I send it for reauthorizations?***

Once the client is at 75 hits, you will get denials from MA. You must then submit the Prior Authorization Form, #DHS-4695-ENG, completed and print out the clients' DA and ITP FA covering the current time frame. This includes current SDQ & CASII also, or they will send it back asking for them. Please remember on the Treatment Plans that all clients need to sign, and Parents/Guardians need to sign also. Any staff involved with the client should also sign them, as the DA has to be marked "initial, extended or brief."

Staff needs to go into MNITS and request the authorization and they can assign an authorization number. Please print out that sheet because you need to include it in the fax documents you send off to KePRO, Medical Review Agent.

Before faxing, write the long authorization number on every page you are faxing to them. If an error code appears, you need to figure out what it means. The main one that you can leave and submit is Error Code: 475, Line 01 Procedure Code not valid for patient age- always write the comment: YOUTH ACT is age 16-20 years old.

## **Americans with Disabilities Act (ADA) Advisory**

This information is available in accessible formats for people with disabilities by calling (651) 431-2321 (voice) or toll free at (800) 627-3529 or by using your preferred relay service. For other information on disability rights and protections, contact the agency's ADA coordinator.