State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-NINTH SESSION

H. F. No. 1611

03/09/2015 Authored by Backer
The bill was read for the first time and referred to the Committee on Health and Human Services Reform

A bill for an act

relating to mental health; authorizing a demonstration project; modifying definitions and requirements related to mental health services; authorizing rulemaking; appropriating money; amending Minnesota Statutes 2014, sections 256B.0622; 256B.0624, subdivision 7; proposing coding for new law in Minnesota Statutes, chapter 245.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. **[245.735] EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.**

Subdivision 1. **Excellence in Mental Health demonstration project.** The commissioner of human services shall develop and execute projects to reform the mental health system by participating in the Excellence in Mental Health demonstration project.

Subd. 2. **Federal proposal.** The commissioner shall develop and submit to the United States Department of Health and Human Services a proposal for the Excellence in Mental Health demonstration project. The proposal shall include any necessary state plan amendments, waivers, requests for new funding, realignment of existing funding, and other authority necessary to implement the projects specified in subdivision 4.

Subd. 3. **Rules.** By January 15, 2017, the commissioner shall adopt rules that meet the criteria in subdivision 4, paragraph (a), to establish standards for state certification of community behavioral health clinics, and rules that meet the criteria in subdivision 4, paragraph (b), to implement a prospective payment system for medical assistance payment of mental health services delivered in certified community behavioral health clinics. These rules shall comply with federal requirements for certification of community behavioral health clinics and the prospective payment system and shall apply to community mental health centers, mental health clinics, mental health residential treatment centers, essential

community providers, federally qualified health centers, and rural health clinics. The commissioner may adopt rules under this subdivision using the expedited process in section 14.389.

Subd. 4. **Reform projects.** (a) The commissioner shall establish standards for state certification of a clinic as a certified community behavioral health clinic in accordance with the criteria published on or before September 1, 2015, by the United States Department of Health and Human Services. Certification standards established by the commissioner shall require that:

(1) clinic staff have backgrounds in diverse disciplines, include licensed mental health professionals, and are culturally and linguistically trained to serve the needs of the clinic's patient population;

(2) clinic services are available and accessible and crisis management services are available 24 hours per day;

(3) fees for clinic services are established using a sliding fee scale and patients are not denied services or subject to limited services due to an inability to pay for services;

(4) clinics provide coordination of care across settings and providers to ensure seamless transitions for patients across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, community-based mental health providers, and other community services, supports, and providers. Community services, supports, and providers include, but are not limited to, schools, child welfare agencies, juvenile and criminal justice agencies, Indian Health Services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(5) services provided by clinics include:

(i) crisis mental health services, emergency crisis intervention services, and stabilization services;

(ii) screening, assessment, and diagnosis services, including risk assessments and level of care determinations;

(iii) patient-centered treatment planning;

(iv) outpatient mental health and substance use services;

(v) targeted case management;

(vi) psychiatric rehabilitation services;

(vii) peer support and counselor services and family support services; and

(viii) intensive community-based mental health services, including mental health services for members of the armed forces and veterans; and

(6) clinics comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data.

(b) The commissioner shall establish standards and methodologies for a prospective payment system for medical assistance payments for mental health services delivered by certified community behavioral health clinics in accordance with guidance issued on or before September 1, 2015, by the Centers for Medicare and Medicaid Services. During the operation of the demonstration project, payments must comply with federal requirements for a 90 percent enhanced federal medical assistance payment.

Subd. 5. **Public participation.** In developing the projects under subdivision 4, the commissioner shall consult with mental health providers, advocacy organizations, licensed mental health professionals, and Minnesota health care program enrollees who receive mental health services and their families.

Subd. 6. **Information systems support.** The commissioner and the state chief information officer shall provide information systems support to the projects as necessary to comply with federal requirements and the deadlines in subdivision 3.

Sec. 2. Minnesota Statutes 2014, section 256B.0622, is amended to read:

256B.0622 INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES.

Subdivision 1. **Scope.** Subject to federal approval, medical assistance covers medically necessary, ~~intensive nonresidential~~ assertive community treatment and intensive residential rehabilitative mental health services as defined in subdivision 2, for recipients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) ~~"Intensive nonresidential rehabilitative mental health services" means adult rehabilitative mental health services as defined in section 256B.0623, subdivision 2, paragraph (a), except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, the Fairweather Lodge treatment model, as defined by the standards established by the National Coalition for Community Living, and other evidence-based practices, and directed to recipients with a serious mental illness who require intensive services.~~ "Assertive community treatment" means intensive nonresidential rehabilitative mental health services provided according

to the evidence-based practice of assertive community treatment. Core elements of this service include, but are not limited to:

(1) a multidisciplinary staff who utilize a total team approach and who serve as a fixed point of responsibility for all service delivery;

(2) providing services 24 hours per day and seven days per week;

(3) providing the majority of services in a community setting;

(4) offering a low ratio of recipients to staff;

(5) assisting with employment and engagement with family or friends; and

(6) providing service that is not time-limited.

(b) "Intensive residential rehabilitative mental health services" means short-term, time-limited services provided in a residential setting to recipients who are in need of more restrictive settings and are at risk of significant functional deterioration if they do not receive these services. Services are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting. Services must be directed toward a targeted discharge date with specified client outcomes ~~and must be consistent with the Fairweather Lodge treatment model as defined in paragraph (a), and other evidence-based practices~~.

(c) "Evidence-based practices" are nationally recognized mental health services that are proven by substantial research to be effective in helping individuals with serious mental illness obtain specific treatment goals.

(d) "Overnight staff" means a member of the intensive residential rehabilitative mental health treatment team who is responsible during hours when recipients are typically asleep.

(e) "Treatment team" means all staff who provide services under this section to recipients. At a minimum, this includes the clinical supervisor, mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6); mental health practitioners as defined in section 245.462, subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision 5, clause ~~(3)~~ (4); and certified peer specialists under section 256B.0615.

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is eligible for medical assistance;

(3) is diagnosed with a mental illness;

(4) because of a mental illness, has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced;

(5) has one or more of the following: a history of two or more or prolonged inpatient hospitalizations in the past year, significant independent living instability, homelessness, or very frequent use of mental health and related services yielding poor outcomes; and

(6) in the written opinion of a licensed mental health professional, has the need for mental health services that cannot be met with other available community-based services, or is likely to experience a mental health crisis or require a more restrictive setting if intensive rehabilitative mental health services are not provided.

Subd. 4. **Provider certification and contract requirements.** (a) The ~~intensive nonresidential rehabilitative mental health services~~ assertive community treatment provider must:

(1) have a contract with the host county to provide intensive adult rehabilitative mental health services; and

(2) be certified by the commissioner as being in compliance with this section and section 256B.0623.

(b) The intensive residential rehabilitative mental health services provider must:

(1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;

(2) not exceed 16 beds per site;

(3) comply with the additional standards in this section; and

(4) have a contract with the host county to provide these services.

(c) The commissioner shall develop procedures for counties and providers to submit contracts and other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

Subd. 5. **Standards applicable to both ~~nonresidential~~ assertive community treatment and residential providers.** (a) Services must be provided by qualified staff as defined in section 256B.0623, subdivision 5, who are trained and supervised according to section 256B.0623, subdivision 6, except that mental health rehabilitation workers acting as overnight staff are not required to comply with section 256B.0623, subdivision 5, clause ~~(3)~~ (4), item (iv).

(b) The clinical supervisor must be an active member of the treatment team. The treatment team must meet with the clinical supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting shall include recipient-specific case reviews and general treatment discussions among team members. Recipient-specific case reviews and planning must be documented in the individual recipient's treatment record.

(c) Treatment staff must have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider must have the capacity to

promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to assure the health and safety of recipients.

(d) The initial functional assessment must be completed within ten days of intake and updated at least every ~~three months~~ 30 days for intensive residential services and every six months for assertive community treatment, or prior to discharge from the service, whichever comes first.

(e) The initial individual treatment plan must be completed within ten days of intake for assertive community treatment and within 24 hours of admission for intensive residential services. Within ten days of admission, the initial treatment plan must be refined and further developed for intensive residential services, except for providers certified according to Minnesota Rules, parts 9533.0010 to 9533.0180. The individual treatment plan must be reviewed with the recipient and ~~reviewed and~~ updated at least monthly ~~with the recipient~~ for intensive residential services and at least every six months for assertive community treatment.

Subd. 6. **Standards for intensive residential rehabilitative mental health services.** (a) The provider of intensive residential services must have sufficient staff to provide 24-hour-per-day coverage to deliver the rehabilitative services described in the treatment plan and to safely supervise and direct the activities of recipients given the recipient's level of behavioral and psychiatric stability, cultural needs, and vulnerability. The provider must have the capacity within the facility to provide integrated services for chemical dependency, illness management services, and family education when appropriate.

(b) At a minimum:

(1) staff must be available and provide direction and supervision whenever recipients are present in the facility;

(2) staff must remain awake during all work hours;

(3) there must be a staffing ratio of at least one to nine recipients for each day and evening shift. If more than nine recipients are present at the residential site, there must be a minimum of two staff during day and evening shifts, one of whom must be a mental health practitioner or mental health professional;

(4) if services are provided to recipients who need the services of a medical professional, the provider shall assure that these services are provided either by the provider's own medical staff or through referral to a medical professional; and

(5) the provider must assure the timely availability of a licensed registered nurse, either directly employed or under contract, who is responsible for ensuring the effectiveness and safety of medication administration in the facility and assessing patients for medication side effects and drug interactions.

Subd. 7. **Additional standards for ~~nonresidential services~~ assertive community treatment.** The standards in this subdivision apply to ~~intensive nonresidential rehabilitative mental health~~ assertive community treatment services.

(1) The treatment team must use team treatment, not an individual treatment model.

(2) The clinical supervisor must function as a practicing clinician at least on a part-time basis.

(3) The staffing ratio must not exceed ten recipients to one full-time equivalent treatment team position.

(4) Services must be available at times that meet client needs.

(5) The treatment team must actively and assertively engage and reach out to the recipient's family members and significant others, after obtaining the recipient's permission.

(6) The treatment team must establish ongoing communication and collaboration between the team, family, and significant others and educate the family and significant others about mental illness, symptom management, and the family's role in treatment.

(7) The treatment team must provide interventions to promote positive interpersonal relationships.

Subd. 8. **Medical assistance payment for intensive rehabilitative mental health services.** (a) Payment for intensive residential ~~and nonresidential~~ services and assertive community treatment in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible recipient in a given calendar day: all rehabilitative services under this section, staff travel time to provide rehabilitative services under this section, and nonresidential crisis stabilization services under section 256B.0624.

(b) Except as indicated in paragraph (c), payment will not be made to more than one entity for each recipient for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team must determine how to distribute the payment among the members.

(c) The commissioner shall determine one rate for each provider that will bill medical assistance for residential services under this section and one rate for each ~~nonresidential~~ assertive community treatment provider. If a single entity provides both services, one rate is established for the entity's residential services and another rate for the entity's nonresidential services under this section. A provider is not eligible for payment under this section without authorization from the commissioner. The commissioner shall develop rates using the following criteria:

(1) ~~the cost for similar services in the local trade area;~~

~~(2)~~ the provider's cost for services shall include direct services costs, other program costs, and other costs determined as follows:

(i) the direct services costs must be determined using actual costs of salaries, benefits, payroll taxes, and training of direct service staff and service-related transportation;

(ii) other program costs not included in item (i) must be determined as a specified percentage of the direct services costs as determined by item (i). The percentage used shall be determined by the commissioner based upon the average of percentages that represent the relationship of other program costs to direct services costs among the entities that provide similar services;

(iii) ~~in situations where a provider of intensive residential services can demonstrate actual program-related physical plant costs in excess of the group residential housing reimbursement, the commissioner may include these costs in the program rate, so long as the additional reimbursement does not subsidize the room and board expenses of the program~~ physical plant costs calculated based on the percentage of space within the program that is entirely devoted to treatment and programming. This does not include administrative or residential space;

(iv) ~~intensive nonresidential services~~ assertive community treatment physical plant costs must be reimbursed as part of the costs described in item (ii); and

(v) subject to federal approval, up to an additional five percent of the total rate ~~must~~ may be added to the program rate as a quality incentive based upon the entity meeting performance criteria specified by the commissioner;

~~(3)~~ (2) actual cost is defined as costs which are allowable, allocable, and reasonable, and consistent with federal reimbursement requirements under Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and Budget Circular Number A-122, relating to nonprofit entities;

~~(4)~~ (3) the number of service units;

~~(5)~~ (4) the degree to which recipients will receive services other than services under this section; and

~~(6)~~ (5) the costs of other services that will be separately reimbursed~~; and~~.

~~(7) input from the local planning process authorized by the adult mental health initiative under section 245.4661, regarding recipients' service needs.~~

(d) The rate for intensive rehabilitative mental health services must exclude room and board, as defined in section 256I.03, subdivision 6, and services not covered under this section, such as partial hospitalization, home care, and inpatient services.

(e) Physician services that are not separately billed may be included in the rate to the extent that a psychiatrist is a member of the treatment team. Physician services, whether billed separately or included in the rate, may be delivered by telemedicine. For purposes of this paragraph, "telemedicine" has the meaning given to "mental health telemedicine"

in section 256B.0625, subdivision 46, when telemedicine is used to provide intensive residential treatment services.

~~(e)~~ (f) When services under this section are provided by an ~~intensive nonresidential service~~ assertive community treatment provider, case management functions must be an integral part of the team.

~~(f)~~ (g) The rate for a provider must not exceed the rate charged by that provider for the same service to other payors.

~~(g)~~ (h) The rates for existing programs must be established prospectively based upon the expenditures and utilization over a prior 12-month period using the criteria established in paragraph (c). The rates for new programs must be established based upon estimated expenditures and estimated utilization using the criteria established in paragraph (c).

~~(h)~~ (i) Entities who discontinue providing services must be subject to a settle-up process whereby actual costs and reimbursement for the previous 12 months are compared. In the event that the entity was paid more than the entity's actual costs plus any applicable performance-related funding due the provider, the excess payment must be reimbursed to the department. If a provider's revenue is less than actual allowed costs due to lower utilization than projected, the commissioner may reimburse the provider to recover its actual allowable costs. The resulting adjustments by the commissioner must be proportional to the percent of total units of service reimbursed by the commissioner and must reflect a difference of greater than five percent.

~~(i)~~ (j) A provider may request of the commissioner a review of any rate-setting decision made under this subdivision.

Subd. 9. **Provider enrollment; rate setting for county-operated entities.** Counties that employ their own staff to provide services under this section shall apply directly to the commissioner for enrollment and rate setting. In this case, a county contract is not required ~~and the commissioner shall perform the program review and rate setting duties which would otherwise be required of counties under this section~~.

Subd. 10. **Provider enrollment; rate setting for specialized program.** A county contract is not required for a provider proposing to serve a subpopulation of eligible recipients ~~may bypass the county approval procedures in this section and receive approval for provider enrollment and rate setting directly from the commissioner~~ under the following circumstances:

(1) the provider demonstrates that the subpopulation to be served requires a specialized program which is not available from county-approved entities; and

(2) the subpopulation to be served is of such a low incidence that it is not feasible to develop a program serving a single county or regional group of counties.

~~For providers meeting the criteria in clauses (1) and (2), the commissioner shall perform the program review and rate setting duties which would otherwise be required of counties under this section.~~

Subd. 11. **Sustainability grants.** The commissioner may disburse grant funds directly to intensive residential services providers and assertive community treatment providers to maintain access to these services.

Sec. 3. Minnesota Statutes 2014, section 256B.0624, subdivision 7, is amended to read:

Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis stabilization treatment plan must be developed which meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8; and

(3) services must be delivered according to the treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis stabilization treatment plan, supportive counseling, skills training, and collaboration with other service providers in the community.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting, the recipient must be contacted face-to-face daily by a qualified mental health practitioner or mental health professional. The program must have 24-hour-a-day residential staffing which may include staff who do not meet the qualifications in subdivision 8. The residential staff must have 24-hour-a-day immediate direct or telephone access to a qualified mental health professional or practitioner.

(c) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and ~~no more than two are recipients of crisis stabilization services~~ one or more individuals are present at the setting to receive residential crisis stabilization services, the residential staff must include, for at least eight hours per day, at least one individual who meets the qualifications in subdivision 8, paragraph (a), clause (1) or (2).

(d) If crisis stabilization services are provided in a supervised, licensed residential setting that serves more than four adult residents, and one or more are recipients of crisis stabilization services, the residential staff must include, for 24 hours a day, at least one individual who meets the qualifications in subdivision 8. During the first 48 hours that a recipient is in the residential program, the residential program must have at least two staff

working 24 hours a day. Staffing levels may be adjusted thereafter according to the needs of the recipient as specified in the crisis stabilization treatment plan.

Sec. 4. **RATE-SETTING METHODOLOGY FOR COMMUNITY-BASED MENTAL HEALTH SERVICES.**

The commissioner of human services shall conduct a comprehensive analysis of the current rate-setting methodology for all community-based mental health services for children and adults. The report shall include an assessment of alternative payment structures, consistent with the intent and direction of the federal Centers for Medicare and Medicaid Services, that could provide adequate reimbursement to sustain community-based mental health services regardless of geographic location. The report shall also include recommendations for establishing pay-for-performance measures for providers delivering services consistent with evidence-based practices. In developing the report, the commissioner shall consult with stakeholders and with outside experts in Medicaid financing. The commissioner shall provide a report on the analysis to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance by January 1, 2017.

Sec. 5. **EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.**

By January 15, 2016, the commissioner of human services shall report to the legislative committees with jurisdiction over human services issues on the progress of the Excellence in Mental Health demonstration project under Minnesota Statutes, section 245.735. The commissioner shall include in the report any recommendations for legislative changes needed to implement the reform projects specified in Minnesota Statutes, section 245.735, subdivision 4.

Sec. 6. **APPROPRIATIONS.**

(a) $282,000 in fiscal year 2016 and $565,000 in fiscal year 2017 are appropriated from the general fund to the commissioner of human services for respite care programs for families of children with serious mental illnesses.

(b) $118,000 in fiscal year 2016 and $236,000 in fiscal year 2017 are appropriated from the general fund to the commissioner of human services to establish a psychiatric residency position.

(c) $922,000 in fiscal year 2017 is appropriated from the general fund to the commissioner of human services for grants to mental health agencies with expertise in early childhood mental health to provide mental health consultation in child care agencies.