Change Item Title: Mental Health Uniform Service Standards

Fiscal Impact ($000s)	FY 2022	FY 2023	FY 2024	FY 2025
General Fund				
Expenditures	241	257	257	174
Revenues	0	0	0	0
Other Funds				
Expenditures	0	0	0	0
Revenues	0	0	0	0
Net Fiscal Impact = (Expenditures – Revenues)	241	257	257	174
FTEs	**3**	**3**	**3**	**2**

Recommendation:

The Governor recommends a multi-phase reform and simplification of the regulations and service standards for Minnesota's mental health care system. This initiative will align common standards to reduce administrative burden, refocus the standards on supporting quality and equitable services, and establish a unified licensing framework to build accountability where it matters. This is a system wide improvement effort, but has a particular focus on the barriers facing children of color and Native Americans.

Rationale/Background:

Minnesota has a long history of establishing an innovative range of community-based mental health care services to meet the needs of our communities, providing hope and recovery for families and individuals who are impacted by mental illnesses. Our mental health care system includes services ranging from school-linked mental health care that helps children build resiliency and develop the skills they need, to intensive residential treatment that can help individuals avoid hospitalization or transition back into the community.

As Minnesota innovated over time, the standards that guide our range of mental health care services have become increasingly complex. Our current mental health care service standards are located in various statutes, rules and other authorities, some dating to the 1950s. Many providers and key stakeholders have raised significant concerns about the prescriptiveness and complexity of these regulations – even a diligent provider can find themselves out of compliance with this web of laws, potentially facing denied payments or other challenges.

For example, there are forty-seven different locations in statute, rule, or variances to rule where Minnesota defines what qualifies a person as a "mental health professional." Among these different locations, there are ten substantively different sets of language, each of which has at least one omission or error.

The current regulatory structure is also unjustifiably complex. Under current law, some mental health care services are licensed, some are certified, and some have no clear oversight. This means that various areas of DHS including provider enrollment and the behavioral health and licensing divisions are conducting similar reviews of the same providers, often at different times. This complexity has serious implications – providers report significant costs associated with hours spent on duplicative or unproductive compliance activities, and DHS has limited ability to effectively and consistently regulate these services and support providers in delivering high quality person- and family-centered mental health care. For example, the complexity of current regulations around telemedicine was a significant issue when providing rapid guidance to providers seeking to safely serve their clients during the COVID-19 pandemic.

Integrated care is the future of behavioral health care, including mental health care, substance use disorder treatment and physical health care. It must be connected to community resources, particularly housing supports, where untreated illness can be a major driver of homelessness. The current standards simply don't support this. There are too many silos and outdated requirements, and providers working towards integration face many barriers.

As Minnesota continues to build on the integrated care model of Certified Community Behavioral Health Clinics (CCBHCs), it is vital to begin streamlining the service standards providers must meet. Since 2017, mental health professionals, advocacy groups, provider associations, Tribes, counties, and other community partners have participated in the design and work to create new, unified standards. Much of the proposed language has been available for review, discussion, and improvement during this process, and reflects significant discussion from all involved.

Proposal:

This proposal, which is the first phase of the Mental Health Uniform Service Standards (USS) project, takes steps to support our mental health care system to ensure that we are managing our state's resources wisely and getting the best outcomes for our investments.

Specifically, this proposal creates a common "core" of standards that apply to all mental health care programs and begins to transition the regulatory structure of our mental health care system to a unified licensing structure. When standards are clear and consistent, providers can spend more time delivering their full range of services and less time at their desks navigating confusing and ambiguous compliance requirements. When the timelines for completing or approving documents are realistic, providers are better able to focus on developing trusting therapeutic relationships and delivering high quality services. A unified licensing structure ensures greater consistency in the guidance given to providers, supports meaningful integration, centralizes reporting and investigations of complaints, and provides the enforcement tools necessary to protect Minnesotans.

Under this proposal, the licensures to transition to the unified regulatory structure are residential crisis stabilization (RCS) and intensive residential treatment services (IRTS). For services currently certified by the Behavioral Health Division, this proposal includes conforming changes to apply the new common "core" of standards. These services will transition to the unified licensing structure in future phases of the project upon further legislative authorization. The regulation of "mental health centers and clinics" (commonly referred to as Rule 29 Clinics) will be modernized, with much more flexible standards replacing now outdated requirements that do not deliver significant value.

Additionally, this proposal combines mobile crisis standards for adults and children to eliminate unintentional differences, and clarifies how mobile crisis teams can work with family members and other third parties calling on behalf of someone in need of crisis assistance. This proposal will also repeal outdated administrative rules governing outpatient mental health services and codify in state law the components that are still relevant.

Finally, this proposal directs DHS to collaborate with partners and stakeholders and return in subsequent legislative sessions to transition the remaining mental health care services to the unified licensing framework. This planning work will identify ways to further align mental health and substance use disorder service requirements where possible to promote and support models of integrated care. The proposal also requires DHS to develop a licensing fee schedule for this new framework and to solicit community input to set fees in a way that is fair to providers, incentivizes efficient reviews, and appropriately raises revenue to offset regulatory costs. This fee schedule would be proposed to the Legislature in a future session.

Fiscal Impact:

With such a complicated present state, significant analysis is necessary to maximize opportunities for simplification, while still ensuring health, safety and the integrity of public funding. These trade-offs are important

as changes can have unintended consequences. Stakeholders have requested that DHS provide detailed information on what potential changes would be made in each service area. The resources in this proposal are intended to ensure a smooth transition with sufficient support for providers in navigating the change.

To facilitate this regulatory transformation, this proposal appropriates $497,000 from the General Fund in fiscal years 2022-2023 and $429,000 in fiscal years 2024-2025. This includes ongoing licensing staff to implement the unified licensing framework, and temporary staffing for policy analysis and stakeholder engagement to provide transparent and accurate understanding of how changes would impact different providers. While the ultimate goal of this project will be to reduce administrative complexity for both DHS and providers, the work of untangling the current structure does require initial resources.

The two new FTEs in the Licensing Division will support a smooth transition for both providers and people receiving services by providing individualized technical assistance and training, creating operational templates and tools for providers, and processing variance requests for providers who want to transition to new standards early. The top priority will be in helping providers understand and comply with client rights under the new residential discharge standards and investigating complaints of unfair discharges. This is a major priority for counties, mental health advocates, homeless shelters, and DHS. IRTS programs do need to ensure that they are maintaining an appropriate level of care, and are ensuring the safety of all clients. But unplanned and hasty discharges have negative impacts on other parts of the system as well as the client. To better ensure the well-being of clients and the quality of our safety net services, Minnesota needs to formalize the expectations for communication and planning before a person is discharged by an IRTS program.

The FTE in the CCIR Division will ensure transparency of decision making related to the USS project, avoiding unintended consequences by meaningfully engaging and partnering with the community throughout implementation of this proposal and through the development of future phases of the project. This includes ongoing support to stakeholders and partners (for example, creation of accessible documents summarizing research and policy analysis), and additional engagement with communities directly served to ensure we're hearing from a variety of sources. The proposal would require federal approval for changes impacting Medical Assistance services, and DHS is targeting July 1, 2022 as the effective date for the first services to be licensed or certified under the new standards.

Impact on Children and Families:
The Mental Health Uniform Service Standards proposal directly addresses several challenges that many children and families experience when attempting to access mental health care services in the current state. Particularly impactful changes included in this proposal are changes to how diagnostic assessments and individual treatment plans are used in service delivery. Additional discussion specific to children of color and Native American children is in the Equity and Inclusion section.

The diagnostic assessment is used to determine what (if any) mental illness is affecting the client, for service authorization, and to inform treatment planning. The new diagnostic assessment standards included in this proposal integrate an age-appropriate and evidence-based diagnostic classification for infants, toddlers and preschool children to ensure these young Minnesotans receive accurate diagnoses and the most appropriate mental health care services. The new diagnostic assessment standards also increase flexibility for mental health providers to complete the assessment in a more family-centered way, allowing providers to build rapport and trust with children and families before asking some of the most sensitive assessment questions.

This proposal also makes changes to the requirements for individual treatment plans in a way that maintains the focus on family engagement while reducing arbitrary barriers to services that many children currently experience. Specifically, school-based and Children's Therapeutic Services and Supports (CTSS) providers have noted significant challenges related to the current requirement for a parent or guardian to review and physically sign the child's treatment plan every 90 days. Frequently, a child will come to services on their own if the provider is based

in the school, or be brought to services by a non-custodial relative who is caring for the child or assisting with transportation. Parents who are facing their own mental health challenges, working multiple jobs, or experiencing housing instability are particularly hard pressed to meet up or return the paperwork on time. If the provider does not have a signed treatment plan, the child's needed mental health services may be interrupted.

This proposal extends the treatment plan authorization period from 90 days to 180 days in most situations, which better reflects the time it takes to build recovery and resiliency, and allows more flexibility for how the child's treatment plan is approved, including allowing the parent or guardian to approve the plan via documented phone call. This proposal also includes specific provisions allowing a mental health professional an additional 30-day grace period when the professional is actively working toward re-engagement. Minnesota's focus on family engagement is critical to a child's treatment – this proposal continues to emphasize collaboration with parents or guardians. However, this proposal restructures the family engagement requirements in a way that prioritizes continuity of service and recognizes the access barrier that physically signed paperwork can present.

In developing these changes to how diagnostic assessments and individual treatment plans are implemented in services, the agency consulted providers and other stakeholders with experience as family members, as well as advocacy groups with significant connections to families of children served.

Equity and Inclusion:

This proposal will advance equity in mental health care in Minnesota by promoting more accurate diagnoses and increased retention in services among non-majority populations, and mitigating bias in residential programs' decisions to discharge clients.

In order to get high quality mental health care, families and individuals need to build trust with their provider and be able to convey the full picture of what they are experiencing. When this assessment process is both rigid and rushed, the most significant consequences fall on families and individuals already experiencing disparities: people of color, Native Americans, and people using an interpreter to access services. Providers serving and representing these communities had significant input in identifying ways in which the current mental health care regulatory standards contribute to client distrust of or disengagement in services.

For example, one provider told DHS about trying to collect a trauma history, which is a required element in the diagnostic assessment, from a client who was a refugee known to have faced violence in their homeland. The language the provider and client shared, however, does not have a word for "trauma" – there was simply not enough time to build a shared understanding of the concept of trauma and explore the client's experience with trauma. Similarly, a Tribal provider also raised concerns with how the rigidity of the current diagnostic assessment process requires the provider to ask many sensitive questions on the first visit; particularly when serving an elder in the community, raising these topics too soon could be perceived as disrespectful and inauthentic. Other providers noted the disproportionate number of children of color, particularly Black children, diagnosed with conditions like "oppositional defiant disorder." These providers raised concerns about misdiagnoses resulting from the current state of inflexible requirements that can rush the diagnostic process. A hasty diagnostic process may miss a child's history of trauma or Adverse Childhood Experiences (ACES), and leave the child with less effective treatment.

To address these concerns, this proposal makes changes in the assessment and service authorization language. Specifically, this language will address a significant number of access issues that racial and ethnic minorities experience, by allowing providers and clients more time to develop trusting and therapeutic relationships before the provider is required to ask some of the most sensitive diagnostic assessment questions. This allows providers and clients to reach the correct diagnosis in a more humane way, and plan treatment accordingly. The Department intends to measure this impact through analysis of disaggregated diagnostic data and disaggregated trends in persistence in treatment.

Another significant impact on equity is related to the new discharge standards for adult residential mental health programs that the community negotiated after robust discussion. One of the most common complaints that the DHS Licensing Division receives is complaint of unfair discharge – anecdotally, clients from non-majority populations are more likely to feel they have been unfairly discharged. The circumstances leading to provider-initiated discharge are often subjective, leaving ample opportunity for bias to seep into the decision-making process. The current lack of documentation and reporting requirements related to discharge, however, prevent us from fully understanding the scope of this equity issue in Minnesota. But research continues to find that implicit bias pervades the mental health system and affects the ways in which providers interpret and respond to a client's symptoms.

Two elements of the proposed discharge standards for adult residential mental health programs will support more equitable delivery of mental health services. First, the service termination review process for provider-initiated discharges will require license holders to slow down and be more deliberate in their decisions to discharge clients; this will allow providers to review the circumstances leading up to the decision, and consider the ways in which implicit bias may have influenced staff interpretation and response to a client's symptoms. Second, the increased minimum requirements for documentation of the circumstances leading to a client's discharge will allow the DHS Licensing Division to investigate complaints of unfair client discharge

IT Related Proposals:

Prior versions of this proposal have included a more extensive IT ask. This revision removes this cost. While DHS remains committed to finding paperless solutions for license holders in the future, this work will require resources that are not available in the short term. A minor change to update licensing software to reflect the new license types is included.

Results:

DHS will conduct a provider survey starting with the current state of the regulatory system and continuing through implementation of the first phase of development. The Department intends to survey providers throughout the additional phases of this project. Providers will rank the clarity and consistency of the feedback they receive, the level of effort required to schedule and respond to site visits from DHS, and the availability of DHS-sponsored training or technical assistance to improve their practice. This will measure the extent to which the transition works for providers and how time and resources previously used for approving providers is being redeployed in support of improved service quality. DHS will look for reductions in health disparities by examining trends in the rate of diagnosis for conditions that are commonly over-identified in people of color and Native Americans.

Fiscal Detail:

Net Impact by Fund (dollars in thousands)			FY 22	FY 23	FY 22-23	FY 24	FY 25	FY 24-25
General Fund			241	257	498	257	174	431
HCAF								
Federal TANF								
Other Fund								
Total All Funds								
Fund	**BACT#**	**Description**	**FY 22**	**FY 23**	**FY 22-23**	**FY 24**	**FY 25**	**FY 24-25**
GF	11	Licensing USS Admin	186	250	436	250	250	500
GF	13	HCA USS Admin	136	122	258	122	0	122
GF	REV1	Administrative FFP @32%	(103)	(119)	(222)	(119)	(80)	(199)
GF	11	Systems ELMS Cost	45	9	54	9	9	18
GF	REV1	Systems ELMS FFP @50%	(23)	(5)	(28)	(5)	(5)	(10)
		Requested FTE's						
Fund	**BACT#**	**Description**	**FY 22**	**FY 23**	**FY 22-23**	**FY 24**	**FY 25**	**FY 24-25**
GF	11	Licensing – 1 for 9 & 1 for 6 mo. in FY22	2	2		2	2	
GF	13	Community Care Integration – 1 for 12 mo. in FY22	1	1		1		