# HOUSE RESEARCH

## Bill Summary

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**Authors:** Anderson, D. and Abeler

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**Analyst:** Lynn F. Aves



## Overview

This policy bill makes technical changes to implement the commissioner's new rate setting methodology which was required by statute and the Center for Medicare and Medicaid Services. It makes changes to implement recommendations of the advisory task force regarding the continuum of services for individuals with complex needs. Changes are made to reflect a three tiered medical assistance reimbursement system.

**1** **Day treatment services.** Amends § 245.462, subdivision 8. Strikes obsolete language. Changes the number of days per week for adult day treatment services from one to two. This change is needed to maintain consistency with rules.

**2** **Diagnostic assessment.** Amends § 245.467, subdivision 2. Provides that if an adult diagnostic assessment has been completed within three years prior to admission, and the adult's mental health status has not markedly changed, an adult diagnostic assessment update is necessary. Requires a complete diagnostic assessment when there has been a marked change in mental health status.

**3** **Duties of county board.** Amends § 245.4874, subdivision 1. Changes the requirement for children's mental health screenings from an opt-out to an opt-in for youths found to be delinquent or repeat juvenile petty offenders. Requires written informed consent from a parent unless the court finds a screening would be in the best interest of the child.

**4** **Licensing moratorium.** Amends § 245A.03, subdivision 7. Permits new foster home licenses (corporate) to be issued by the commissioner if the commissioner determines the homes are needed due to the restructuring of state-operated services.

**5** **Health officer.** Amends § 253B.02, subdivision 9. Adds mental health professionals providing mental health mobile crisis intervention services to the definition of "health officer."

**6** **Rules; appeal.** Amends § 254B.03, subdivision 5. Updates language to give the commissioner rulemaking authority for chemical dependency treatment, chapter 254B. Current rulemaking authority is tied to 1986 session law that created the chemical dependency treatment chapter.

**7** **Commissioner to select vendors and set rates.** Amends § 254B.03, subdivision 9. Requires vendors

of chemical dependency treatment services to include program standards for each rate and rate enhancement in the vendor's Minnesota health care program provider agreement.

**8** **Vendor eligibility.** Amends § 254B.05.

**Subdivision 1. Licensure required.** Adds that programs which do not meet the room and board provider requirements (subd. 1a) and additional provider requirements (subd. 1b) are not eligible vendors. Strikes unnecessary language.

**Subd. 1a. Room and board provider requirements.** Establishes specific requirements for vendors of room and board in order to be eligible for chemical dependency treatment fund payments.

**Subd. 1b. Additional vendor requirements.** Adds new duties for room and board providers.

**Subds. 2 to 4.** No changes.

**Subd. 5. Rate requirements.** Paragraph (a) instructs the commissioner to establish rates for chemical dependency services and enhancements funded under this chapter.

Paragraph (b) provides that eligible chemical dependency treatment services include outpatient treatment, medication assisted therapy services, residential treatment services, hospital-based treatment services, adolescent treatment programs, and room and board facilities.

Paragraph (c) instructs the commissioner to establish higher rates for programs that meet specified criteria.

Paragraph (d) allows adolescent residential programs to be exempt from some criteria established in paragraph (c).

**9** **Rate methodology.** Amends § 254B.12. Deletes obsolete language. Requires the commissioner to establish a new rate methodology for the CCDTF. Requires the commissioner to review financial information provided by vendors to determine the need for rate adjustments at least biennially.

**10** **Program evaluation.** Amends § 254B.13, subdivision 3. Extends the evaluation date for the chemical dependency pilot projects from 2013 to 2014.

**11** **Inpatient treatment for mental illness.** Amends § 256.9693.

**Subdivision 1. Continuing care benefit program.** Strikes the word "person" and substitutes the term "adults and children." Adds that for prepaid programs, this program must be covered by the plan's capitation payments.

**Subd. 2. Transfer of funds.** Allows the commissioner to transfer funds from the CABHS appropriation for the purpose of child and adolescent treatment under this section.

**12** **Medical assistance payment for intensive rehabilitative mental health services.** Amends § 256B.0622, subdivision 8. Requires the commissioner to determine one rate for each provider. Currently, each host county can determine a provider rate. Establishes the criteria the commissioner must use in establishing the rates. States that rates for existing programs will be established prospectively based on approved allowable expenditures and utilization during the prior year.

Establishes a settle-up process for entities that discontinue services. Provides that actual costs and reimbursements for the previous 12 months will be compared and the department reimbursed for excess payments or the provider reimbursed if the revenue was less than costs.

**13** **Eligibility.** Amends § 256B.0623, subdivision 3. Adds the term "adult diagnostic assessment update."

**14** **Diagnostic assessment.** Amends § 256B.0623, subdivision 8. Permits ARMHS providers to complete an adult diagnostic assessment update if a full diagnostic assessment has been completed in the prior 3 years and the patient's mental health status has not changed significantly. Requires a face-to-face interview with the client.

**15** **Definitions.** Amends § 256B.0624, subdivision 2. Adds that mobile crisis intervention teams can provide services in a hospital emergency room.

**16** **Provider entity standards.** Amends § 256B.0624, subdivision 4. Requires providers of adult mental health crisis response services to coordinate with county emergency services, community hospitals, ambulance, transportation services, social services, law enforcement, and mental health crisis services through regularly scheduled interagency meetings.

**17** **Crisis assessment and mobile intervention treatment planning.** Amends § 256B.0624, subdivision 6. Adds that during a crisis assessment consideration is to be given to the patient's preferences as verbally communicated by the patient or in an advance psychiatric directive.

**18** **Day treatment services.** Amends § 256B.0625, subdivision 23. Strikes obsolete references to rules.

**19** **Payments for mental health services.** Amends § 256B.0625, subdivision 38. Strikes outdated reference related to medical assistance reimbursement for social work services.

**20** **Admission review team; responsibilities; composition.** Amends § 256B.0926, subdivision 2. Allows the commissioner to authorize a patient's admission to a state-operated services facility without the admission review team's assurance that the provider can meet the needs of the patient.

**21** **Intensive rehabilitative mental health services.** Amends § 256B.0947.

**Subdivision 1. Scope.** No changes.

**Subd. 2. Definitions.** Paragraph (a) modifies the definition of "intensive nonresidential rehabilitative mental health services." Clarifies that these services are for recipients ages 16 to 21 with a serious mental illness or co-occurring mental illness and substance abuse addiction.

Paragraphs (b) to (k) add definitions of "co-occurring mental illness and substance abuse addiction," "diagnostic assessment," "education specialist," "housing access support," "integrated dual disorders treatment," "medication education services," "peer specialist," "provider agency," "substance use disorders," and "transition services."

Paragraph (l) modifies the definition of "treatment team."

**Subd. 3. Client eligibility.** Provides the eligibility criteria for youths from age 16 to 20.

**Subd. 3a. Required service components.** Paragraph (a) provides that subject to federal approval, medical assistance covers medically necessary intensive nonresidential rehabilitative mental health services and supports under a single daily rate per client. Requires services to be provided by an eligible provider.

Paragraph (b) lists the services, supports, and ancillary activities covered by the single rate.

Paragraph (c) lists provider requirements for services and documentation of services.

**Subd. 4. Provider contract requirements.** Requires the provider to have a contract with the commissioner. Specifies that the commissioner must develop administrative and clinical

contract standards and performance evaluation criteria.

**Subd. 5. Standards for intensive nonresidential rehabilitative providers.** Clarifies that services can only be provided by an entity that meets the requirements in subdivision 4. Requires the treatment team to be composed of core team members and client-specific team members. Lists the staff that must be available as team members.

Requires the clinical supervisor to be an active member of the treatment team and be a practicing clinician.

Provides that the staffing ratio cannot exceed ten clients to one FTE treatment team position.

States that the treatment team cannot serve more than 80 clients at one time.

Requires the provider to participate in the evaluation of the youth ACT model.

**Subd. 6. Service standards.** Requires the initial assessment to be complete within ten days of intake and updated at least every three months. Requires that an individual treatment plan must be completed for each client. Requires the treatment team to communicate and collaborate with the client's family and significant others. Allows the treatment team to disclose protected health information under specified circumstances and consistent with federal regulations.

**Subd. 7. Medical assistance payment and rate setting.** Provides that payment will be made based on one daily encounter rate per provider. Allows one entity to be paid for each client for services provided on a given day. Instructs the commissioner to establish regional cost-based rates. States that a rate for a provider cannot exceed the rate charged by that provider for the same service to other payors.

**Subd. 7a. Noncovered services.** Lists the services not eligible for medical assistance payments under this section.

**Subd. 8. Provider enrollment.** Requires the commissioner to give consideration to regional distribution of treatment teams.

**Subd. 9. Service authorization.** Instructs the commissioner to publish prior authorization criteria and standards.

**22** **Juvenile treatment screening team.** Amends § 260C.157, subdivision 3. Adds that a juvenile treatment screening team is to conduct screenings and prepare case plans under chapters 260C and 260D, and section 245.487, subdivision 3. Requires screenings to be completed with 15 days of a request. Adds the child's parent, guardian, or permanent legal custodian to the treatment team.

**23** **Child in voluntary foster care for treatment.** Amends § 260D.01. Adds a cross-reference to the juvenile treatment screening team.

**24** **Repealer.** Repeals §§ 254B.01, subdivision 7 (definition of room and board rate); and 256B.0622, subdivision 8a (intensive rehabilitative mental health services; adjustments based on actual costs and units).