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State of Minnesota

S.F. No. 3290 - DHS Mental Health Bill

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Sections 1 (245.465) and 4 (245.4874) [Duties of the County Board] modify the duties of the county board, to clarify that the county board is not responsible for providing mental health services to individuals who have the services covered under their health care coverage.

Section 2 (245.4682) [Mental Health Service Delivery and Finance Reform] establishes the mental health service delivery and finance reform.

Subdivision 1 sets out the policy of the mental health reform, which provides that the commissioner must undertake a series of reforms to improve the underlying structural, financing, and organizational problems in the state's mental health system, with the goal of improving the availability, quality, and accountability of mental health care in the state.

Subdivision 2 provides the design and implementation of the reforms. The commissioner is required to:

(1) consult with consumers, families, counties, tribes, advocates, providers, and other stakeholders;

(2) report to the legislature and the state Mental Health Advisory Council by January 15, 2007, with any recommendations for legislative changes;

(3) ensure continuity of care for persons affected by the reforms;

(4) provide accountability for the efficient and effective use of public and private resources in achieving positive outcomes for consumers;

(5) ensure client access to applicable protections and appeals; and

(6) make budget transfers that do not increase the state share of costs to effectively implement improvements to the mental health system and efficiently allocate state funds.

Subdivision 3, paragraph (a), authorizes the commissioner to solicit, approve, and implement regional projects to demonstrate the integration of physical and mental health services within prepaid health plans and their coordination with social services. The commissioner, in consultation with consumers, families, and their representatives shall:

(1) determine criteria for approving the regional projects;

(2) require that each project be based on locally defined partnerships;

(3) waive any administrative rule not consistent with the implementation of the regional projects; and

(4) begin implementation of the regional projects no earlier than January 1, 2008.

Paragraph (b) requires the commissioner to enroll all medical assistance eligible persons with serious and persistent mental illness or severe emotional disturbance in the prepaid plan of their choice, unless; (1) an individual has another basis for exclusion from the prepaid plan, or (2) an individual has a previously established a therapeutic relationship with a provider who is not included in the available prepaid plans.

Paragraph (c) allows the commissioner to assign a plan if a person with serious and persistent mental illness or severe emotional disturbance declines to choose a plan.

Paragraph (d) requires the commissioner, in consultation with consumers, families, and their representatives, to refine the design of the regional service integration projects and expand the number of regions engaged in the programs as additional applications are received.

Paragraph (e) requires the commissioner to apply for federal waivers necessary to implement this section.

Section 3 (245.4835) [County Maintenance of Effort] requires the counties to maintain a level of expenditures for mental health services, so that each year's county expenditures are at least equal to that county's average expenditures from 2004 and 2005. The commissioner will annually adjust the county's base level. If a county fails to maintain expenditures, the county must develop a corrective action plan. If the county fails to develop an acceptable action plan, or does not comply with the action plan, the county loses protections under Minnesota Statutes, section 245.4895, which would expose the county to possible claims against the county by recipients of services or service providers.

Section 5 (245.4889) [Children's Mental Health Grants] establishes children's mental health grants.

Subdivision 1 authorizes the commissioner to make grants to assist counties, Indian tribes, children's collaboratives, or mental health service providers in providing services to children with emotional disturbances and their families, and to young adults who are younger than 21 years of age who are receiving transition services. The services must be designed to help the child function and remain with the child's family, and must be delivered consistent with the child's treatment plan. Transition services must be designed to foster independent living in the community.

Subdivision 2 provides the grant application process and the reporting requirements. The applicant must submit an application and budget, and the commissioner must give priority to those counties that plan to collaborate in the development, funding, and delivery of services with other agencies in the local system of care.

Section 6 (246.54, subdivision 1) modifies the public institutions chapter of law, specifically the statute relating to the counties financial responsibility for the cost of care. Current law requires the county to pay for 20 percent of the cost of care. The bill modifies the payment provisions by requiring the county to pay for 20 percent of the cost of care for the first 60 days, and 50 percent of the cost of care for 61 or more days. This section is effective January 1, 2007.

Section 7 (246.54) provides an exception to the language in section 6, for state-operated community behavioral health hospitals. For services at the behavioral health hospitals, payments to the state from the county equal 50 percent of the cost of care. The county is not entitled to reimbursement from the client, the client's estate, or from the client's relatives, except under the existing statute related to claims against the estate of a deceased client under section 246.53.

Section 8 (256B.0625, subdivision 20) amends Medical Assistance covered services, specifically mental health case management, by striking language related to the calculation of mental health grants, payment for mental health finances, and obsolete language. New language specifies that 50 percent of the cost of mental health case management services that are paid by the state without a federal share through fee-for-service is the responsibility of the recipient's county of responsibility. Also, language is added stating that prepaid medical assistance, general assistance medical care, and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the non federal share is paid by the state and there is no county share.

Sections 9 and 10 amend residential services for children with severe emotional disturbances.

Section 9 (256B.0945, subdivision 1) strikes obsolete language.

Section 10 (256B.0945, subdivision 4) modifies the payment rates by providing that per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per day contract rate that relates to rehabilitative mental health services, and must not include payments for costs or services that are billed in the IV-E program as room and board. Paragraph (c) allows the commissioner to set aside five percent of federal funds earned for county expenditures for administration.

Sections 11 and 12 (256B.69, subdivisions 5g and 5h) modify the PMAP statutes by excluding from the payment reduction provisions mental health services added as covered benefits after December 31, 2006.

Section 13 (256B.763) [Critical Access Mental Health Rate Increase] establishes the critical access mental health rate increase. The services rendered on or after July 1, 2007, specified in paragraph (b), must be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

(1) psychiatrists or advanced registered nurses with a psychiatric specialty;

(2) community mental health centers; and

(3) certain mental health clinics and centers, or hospital outpatient psychiatric departments designated as essential community providers.

Paragraph (b) states that the increase under paragraph (a) applies to group skills training when provided as a component of children's therapeutic services and support, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, and psychological testing, neuropsychological services, direction of behavior aides, and inpatient consultation.

Paragraph (c) specifies that the rate increase does not apply to "other clinic services" under section 256B.0625, subdivision 30, certain outpatient mental health services under section 256B.761, paragraph (b), other cost-based rates, rates that are negotiated with the county, rates that are established by the federal government, or rates that increased between January 1, 2004, and January 1, 2005.

Paragraph (d) requires the commissioner to adjust rates paid to prepaid health plans under contract with the commissioner to reflect the rate increases in paragraph (a), and the prepaid health plan must pass the increase to the providers identified in paragraph (a).

Section 14 (256D.03, subdivision 4) modifies general assistance medical care covered services to strike outpatient services provided by a mental health center or clinic, and add mental health services covered under chapter 256B. The bill also strikes the following covered services; day treatment services for mental illness provided under contract with the county board, psychological services, and mental health telemedicine and psychiatric consultation. Further, new language provides that payments for mental health services added as covered benefits after December 31, 2006, are not subject to the reductions in other paragraphs of this section of law.

Sections 15 to 17 amend MinnesotaCare statutes.

Section 15 (256L.03, subdivision 1) modifies MinnesotaCare covered services by striking language related to mental health services.

Section 16 (256L.035) expands MinnesotaCare covered services for single adults and households without children to include mental health services under chapter 256B.

Section 17 (256L.12, subdivision 9a) excludes payments for mental health services added as a covered benefit after December 31, 2006, from the ratable reduction.

Section 18 is a technical revisor's instruction.

Section 19 repeals Minnesota Statutes 2004, section 245.465, subdivision 2 (Residential and community support programs: 1992 salary increase), section 256B.0945, subdivisions 5 (Quality measures), 6 (Federal earnings), 7 (Maintenance of effort), 8 (Reports), and 9 (Sanctions), and section 256B.83 (Maintenance of effort for certain mental health services).

JW:mvm

Senators Berglin, LeClair, Solon, Rosen and Kiscaden introduced–

S.F. No. 3290: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; providing children's mental health grants; establishing mental health service delivery and finance reform; modifying mental health case management and rates; modifying general assistance medical care coverages; amending Minnesota Statutes 2004, sections 245.465, by adding a subdivision; 246.54, subdivision 1, by adding a subdivision; 256B.0625, subdivision 20; 256B.0945, subdivisions 1, 4; 256B.69, subdivisions 5g, 5h; 256L.12, subdivision 9a; Minnesota Statutes 2005 Supplement, sections 245.4874; 256D.03, subdivision 4; 256L.03, subdivision 1; 256L.035; proposing coding for new law in Minnesota Statutes, chapters 245; 256B; repealing Minnesota Statutes 2004, sections 245.465, subdivision 2; 256B.0945, subdivisions 5, 6, 7, 8, 9; 256B.83.

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

Section 1. Minnesota Statutes 2004, section 245.465, is amended by adding a subdivision to read:

Subd. 3. **Mental health services already provided.** For individuals who have health care coverage, the county board is not responsible for providing mental health services which are covered by the entity that administers the health care coverage.

Sec. 2. **[245.4682] MENTAL HEALTH SERVICE DELIVERY AND FINANCE REFORM.**

Subdivision 1. **Policy.** The commissioner of human services shall undertake a series of reforms to improve the underlying structural, financing, and organizational problems in Minnesota's mental health system with the goal of improving the availability, quality, and accountability of mental health care within the state.

Subd. 2. **General provisions.** In the design and implementation of reforms to the mental health system, the commissioner shall:

(1) consult with consumers, families, counties, tribes, advocates, providers, and other stakeholders;

(2) report to the legislature and the state Mental Health Advisory Council by January 15, 2007, with any recommendations for amending statutes, including to update the role of counties;

(3) ensure continuity of care for persons affected by these reforms including:

(i) ensuring client choice of provider by requiring broad provider networks;

(ii) allowing clients options to maintain previously established therapeutic relationships; and

(iii) developing mechanisms to facilitate a smooth transition of service responsibilities;

(4) provide accountability for the efficient and effective use of public and private resources in achieving positive outcomes for consumers;

(5) ensure client access to applicable protections and appeals; and

(6) make budget transfers that do not increase the state share of costs to effectively implement improvements to the mental health system and efficiently allocate state funds. When making transfers necessary to implement movement of responsibility for clients and services between counties and health care programs, the commissioner shall ensure that any transfer of state grants to health care programs does not exceed the value of the services being transferred for the latest 12-month period for which data is available. The commissioner may make quarterly adjustments based on the availability of additional data during the first four quarters after the transfers first occur.

Subd. 3. **Regional projects for coordination of care.** (a) Consistent with section 256B.69 and chapters 256D and 256L, the commissioner is authorized to solicit, approve, and implement regional projects to demonstrate the integration of physical and mental health services within prepaid health plans and their coordination with social services. The commissioner, in consultation with consumers, families, and their representatives, shall:

(1) determine criteria for approving the regional projects and use those criteria to solicit regional proposals for integrated service networks;

(2) require that each project be based on locally defined partnerships that include at least one health maintenance organization, community integrated service network, or accountable provider network authorized and operating under chapter 62D, 62N, or 62T, or county-based purchasing entity under section 256B.692 that is eligible to contract with the commissioner as a prepaid health plan, and the county or counties within the region;

(3) waive any administrative rule not consistent with the implementation of the regional projects; and

(4) begin implementation of the regional projects no earlier than January 1, 2008.

(b) Notwithstanding any statute or administrative rule to the contrary, the commissioner shall enroll all medical assistance eligible persons with serious and persistent mental illness or severe emotional disturbance in the prepaid plan of their choice within the project region unless:

(1) they have no other basis for exclusion from the prepaid plan under section 256B.69, subdivision 4; or

(2) the individual has a previously established therapeutic relationship with a provider who is not included in the available prepaid plans.

(c) If the person with serious and persistent mental illness or severe emotional disturbance declines to choose a plan, the commissioner may preferentially assign that person to the prepaid plan participating in the integrated service network. The commissioner shall implement the enrollment changes within a regional project on the timeline specified in that region's approved application.

(d) The commissioner, in consultation with consumers, families, and their representatives, shall refine the design of the regional service integration projects and expand the number of regions engaged in the demonstration projects as additional qualified applicant partnerships present themselves.

(e) The commissioner shall apply for any federal waivers necessary to implement these changes.

Sec. 3. **[245.4835] COUNTY MAINTENANCE OF EFFORT.**

Subdivision 1. **Required expenditures.** Counties must maintain a level of expenditures for mental health services under sections 245.461 to 245.484 and 245.487 to 245.4887 so that each year's county expenditures are at least equal to that county's average expenditures for those services for calendar years 2004 and 2005. The commissioner will adjust each county's base level for minimum expenditures in each year by the amount of any increase or decrease in that county's state grants or other noncounty revenues for mental health services under sections 245.461 to 245.484 and 245.487 to 245.4887.

Subd. 2. **Failure to maintain expenditures.** If a county does not comply with subdivision 1, the commissioner shall require the county to develop a corrective action plan according to a format and timeline established by the commissioner. If the commissioner determines that a county has not developed an acceptable corrective action plan within the required timeline, or that the county is not in compliance with an approved corrective action plan, the protections provided to that county under section 245.485 do not apply.

Sec. 4. Minnesota Statutes 2005 Supplement, section 245.4874, is amended to read:

245.4874 DUTIES OF COUNTY BOARD.

Subdivision 1. **Duties of the county board.** (a) The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4887;

(2) establish a mechanism providing for interagency coordination as specified in section 245.4875, subdivision 6;

(3) consider the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide, upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(4) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4887;

(5) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;

(6) assure that mental health services delivered according to sections 245.487 to 245.4887 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

(7) provide the community with information about predictors and symptoms of emotional disturbances and how to access children's mental health services according to sections 245.4877 and 245.4878;

(8) provide for case management services to each child with severe emotional disturbance according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

(9) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility, acute care hospital inpatient treatment, or informal admission to a regional treatment center;

(10) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4887;

(11) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;

(12) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age;

(13) assure that culturally informed mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage; and

(14) consistent with section 245.486, arrange for or provide a children's mental health screening to a child receiving child protective services or a child in out-of-home placement, a child for whom parental rights have been terminated, a child found to be delinquent, and a child found to have committed a juvenile petty offense for the third or subsequent time, unless a screening has been performed within the previous 180 days, or the child is currently under the care of a mental health professional. The court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing. The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations, and shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include training in the administration of the instrument, the interpretation of its validity given the child's current circumstances, the state and federal data practices laws and confidentiality standards, the parental consent requirement, and providing respect for families and cultural values. If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment, as defined in section 245.4871. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results shall be considered private data and the commissioner shall not collect individual screening results.

(b) When the county board refers clients to providers of children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the desired services components not covered under section 256B.0943 and identify the

reimbursement source for those requested services, the method of payment, and the payment rate to the provider.

Subd. 2. **Mental health services already provided.** For individuals that have health care coverage, the county board is not responsible for providing mental health services which are covered by the entity which administers the health care coverage.

Sec. 5. **[245.4889] CHILDREN'S MENTAL HEALTH GRANTS.**

Subdivision 1. **Establishment and authority.** The commissioner is authorized to make grants from available appropriations to assist counties, Indian tribes, children's collaboratives under section 124D.23 or 245.493, or mental health service providers in providing services to children with emotional disturbances as defined in section 245.4871, subdivision 15, and their families; and to young adults meeting the criteria for transition services in section 245.4875, subdivision 8, and their families. Services must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults must be designed to foster independent living in the community.

Subd. 2. **Grant application and reporting requirements.** To apply for a grant an applicant organization shall submit an application and budget for the use of the money in the form specified by the commissioner. The commissioner shall make grants only to entities whose applications and budgets are approved by the commissioner. In awarding grants, the commissioner shall give priority to those counties whose applications indicate plans to collaborate in the development, funding, and delivery of services with other agencies in the local system of care. The commissioner shall specify requirements for reports, including quarterly fiscal reports, according to section 256.01, subdivision 2, paragraph (q). The commissioner shall require collection of data and periodic reports that the commissioner deems necessary to demonstrate the effectiveness of each service.

Sec. 6. Minnesota Statutes 2004, section 246.54, subdivision 1, is amended to read:

Subdivision 1. **County portion for cost of care.** Except for chemical dependency services provided under sections 254B.01 to 254B.09, the client's county shall pay to the state of Minnesota a portion of the cost of care provided in a regional treatment center or a state nursing facility to a client legally settled in that county. A county's payment shall be made from the county's own sources of revenue and payments shall be paid as follows: payments to the state from the county shall equal 20 percent of the cost of care, as determined by the commissioner, for each ~~day~~ of the first 60 days, or the portion thereof, that the client spends at a regional treatment center or a state nursing facility. After the

first 60 days, the county share is 50 percent. If payments received by the state under sections 246.50 to 246.53 exceed 80 percent of the cost of care for the first 60 days or 50 percent for any additional days, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53. ~~No such payments shall be made for any client who was last committed prior to July 1, 1947.~~

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 7. Minnesota Statutes 2004, section 246.54, is amended by adding a subdivision to read:

Subd. 3. **Additional exception for community behavioral health hospitals.** Subdivision 1 does not apply to services provided at state-operated community behavioral health hospitals. For services at these facilities, a county's payment shall be made from the county's own sources of revenue and payments shall be paid as follows: payments to the state from the county shall equal 50 percent of the cost of care, as determined by the commissioner, for each day, or the portion thereof, that the client spends at the facility. If payments received by the state under sections 246.50 to 246.53 exceed 50 percent of the cost of care, the county shall be responsible for paying the state only the remaining amount. The county shall not be entitled to reimbursement from the client, the client's estate, or from the client's relatives, except as provided in section 246.53.

EFFECTIVE DATE. This section is effective January 1, 2007.

Sec. 8. Minnesota Statutes 2004, section 256B.0625, subdivision 20, is amended to read:

Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the state agency, medical assistance covers case management services to persons with serious and persistent mental illness and children with severe emotional disturbance. Services provided under this section must meet the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, excluding subpart 10.

(b) Entities meeting program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, are eligible for medical assistance reimbursement for case management services for children with severe emotional disturbance when these services meet the program standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

(c) Medical assistance and MinnesotaCare payment for mental health case management shall be made on a monthly basis. In order to receive payment for an eligible child, the provider must document at least a face-to-face contact with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:

(1) at least a face-to-face contact with the adult or the adult's legal representative; or

(2) at least a telephone contact with the adult or the adult's legal representative and document a face-to-face contact with the adult or the adult's legal representative within the preceding two months.

(d) Payment for mental health case management provided by county or state staff shall be based on the monthly rate methodology under section 256B.094, subdivision 6, paragraph (b), with separate rates calculated for child welfare and mental health, and within mental health, separate rates for children and adults.

(e) Payment for mental health case management provided by Indian health services or by agencies operated by Indian tribes may be made according to this section or other relevant federally approved rate setting methodology.

(f) Payment for mental health case management provided by vendors who contract with a county or Indian tribe shall be based on a monthly rate negotiated by the host county or tribe. The negotiated rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the county or tribe may negotiate a team rate with a vendor who is a member of the team. The team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or tribe, except to reimburse the county or tribe for advance funding provided by the county or tribe to the vendor.

(g) If the service is provided by a team which includes contracted vendors, tribal staff, and county or state staff, the costs for county or state staff participation in the team shall be included in the rate for county-provided services. In this case, the contracted vendor, the tribal agency, and the county may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each entity must document, in the recipient's file, the need for team case management and a description of the roles of the team members.

~~(h) The commissioner shall calculate the nonfederal share of actual medical assistance and general assistance medical care payments for each county, based on the higher of calendar year 1995 or 1996, by service date, project that amount forward to 1999, and transfer one-half of the result from medical assistance and general assistance medical care to each county's mental health grants under section 256E.12 for calendar year 1999.~~

~~The annualized minimum amount added to each county's mental health grant shall be $3,000 per year for children and $5,000 per year for adults. The commissioner may reduce the statewide growth factor in order to fund these minimums. The annualized total amount transferred shall become part of the base for future mental health grants for each county.~~

~~(i) Any net increase in revenue to the county or tribe as a result of the change in this section must be used to provide expanded mental health services as defined in sections 245.461 to 245.4887, the Comprehensive Adult and Children's Mental Health Acts, excluding inpatient and residential treatment. For adults, increased revenue may also be used for services and consumer supports which are part of adult mental health projects approved under Laws 1997, chapter 203, article 7, section 25. For children, increased revenue may also be used for respite care and nonresidential individualized rehabilitation services as defined in section 245.492, subdivisions 17 and 23. "Increased revenue" has the meaning given in Minnesota Rules, part 9520.0903, subpart 3.~~

~~(j)~~ (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility, as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

(i) Notwithstanding Minnesota Rules to the contrary, prepaid medical assistance, general assistance medical care, and MinnesotaCare include mental health case management. When the service is provided through prepaid capitation, the nonfederal share is paid by the state and there is no county share.

~~(k)~~ (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the reporting or other requirements of this section. The county of responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any federal disallowances. The county or tribe may share this responsibility with its contracted vendors.

~~(l)~~ (k) The commissioner shall set aside a portion of the federal funds earned for county expenditures under this section to repay the special revenue maximization account under section 256.01, subdivision 2, clause (15). The repayment is limited to:

(1) the costs of developing and implementing this section; and

(2) programming the information systems.

~~(m)~~ (l) Payments to counties and tribal agencies for case management expenditures under this section shall only be made from federal earnings from services provided

under this section. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors shall include ~~both~~ the federal earnings, the state share, and the county share.

~~(n) Notwithstanding section 256B.041, county payments for the cost of mental health case management services provided by county or state staff shall not be made to the commissioner of finance. For the purposes of mental health case management services provided by county or state staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.~~

~~(o)~~ (m) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

~~(p)~~ (n) If the recipient is a resident of a nursing facility, intermediate care facility, or hospital, and the recipient's institutional care is paid by medical assistance, payment for case management services under this subdivision is limited to the last 180 days of the recipient's residency in that facility and may not exceed more than six months in a calendar year.

~~(q)~~ (o) Payment for case management services under this subdivision shall not duplicate payments made under other program authorities for the same purpose.

~~(r) By July 1, 2000, the commissioner shall evaluate the effectiveness of the changes required by this section, including changes in number of persons receiving mental health case management, changes in hours of service per person, and changes in caseload size.~~

~~(s) For each calendar year beginning with the calendar year 2001, the annualized amount of state funds for each county determined under paragraph (h) shall be adjusted by the county's percentage change in the average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, in comparison to the prior fiscal year.~~

~~(t) For counties receiving the minimum allocation of $3,000 or $5,000 described in paragraph (h), the adjustment in paragraph (s) shall be determined so that the county receives the higher of the following amounts:~~

~~(1) a continuation of the minimum allocation in paragraph (h); or~~

~~(2) an amount based on that county's average number of clients per month who received case management under this section during the fiscal year that ended six months prior to the calendar year in question, times the average statewide grant per person per month for counties not receiving the minimum allocation.~~

~~(u) The adjustments in paragraphs (s) and (t) shall be calculated separately for children and adults.~~

EFFECTIVE DATE. This section is effective January 1, 2008.

Sec. 9. Minnesota Statutes 2004, section 256B.0945, subdivision 1, is amended to read:

Subdivision 1. **Provider qualifications.** Counties must arrange to provide residential services for children with severe emotional disturbance according to sections 245.4882, 245.4885, and this section. Services must be provided by a facility that is licensed according to section 245.4882 and administrative rules promulgated thereunder, and under contract with the county. ~~Facilities providing services under subdivision 2, paragraph (a), must be accredited as a psychiatric facility by the Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation. Accreditation is not required for facilities providing services under subdivision 2, paragraph (b).~~

Sec. 10. Minnesota Statutes 2004, section 256B.0945, subdivision 4, is amended to read:

Subd. 4. **Payment rates.** (a) Notwithstanding sections 256B.19 and 256B.041, payments to counties for residential services provided by a residential facility shall only be made of federal earnings for services provided under this section, and the nonfederal share of costs for services provided under this section shall be paid by the county from sources other than federal funds or funds used to match other federal funds. Payment to counties for services provided according to this section shall be a proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(b) Per diem rates paid to providers under this section by prepaid plans shall be the proportion of the per day contract rate that relates to rehabilitative mental health services and shall not include payment for costs or services that are billed to the IV-E program as room and board.

(c) The commissioner shall set aside a portion not to exceed five percent of the federal funds earned for county expenditures under this section to cover the state costs of administering this section. Any unexpended funds from the set-aside shall be distributed to the counties in proportion to their earnings under this section.

EFFECTIVE DATE. This section is effective January 1, 2008.

Sec. 11. Minnesota Statutes 2004, section 256B.69, subdivision 5g, is amended to read:

Subd. 5g. **Payment for covered services.** For services rendered on or after January 1, 2003, the total payment made to managed care plans for providing covered services under the medical assistance and general assistance medical care programs is reduced by .5 percent from their current statutory rates. This provision excludes payments for nursing home services, home and community-based waivers, ~~and~~ payments to demonstration projects for persons with disabilities, and mental health services added as covered benefits after December 31, 2006.

Sec. 12. Minnesota Statutes 2004, section 256B.69, subdivision 5h, is amended to read:

Subd. 5h. **Payment reduction.** In addition to the reduction in subdivision 5g, the total payment made to managed care plans under the medical assistance program is reduced 1.0 percent for services provided on or after October 1, 2003, and an additional 1.0 percent for services provided on or after January 1, 2004. This provision excludes payments for nursing home services, home and community-based waivers, ~~and~~ payments to demonstration projects for persons with disabilities, and mental health services added as covered benefits after December 31, 2006.

Sec. 13. **[256B.763] CRITICAL ACCESS MENTAL HEALTH RATE INCREASE.**

(a) For services defined in paragraph (b) and rendered on or after July 1, 2007, payment rates shall be increased by 23.7 percent over the rates in effect on January 1, 2006, for:

(1) psychiatrists and advanced practice registered nurses with a psychiatric specialty;

(2) community mental health centers under section 256B.0625, subdivision 5; and

(3) mental health clinics and centers certified under Minnesota Rules, parts 9520.0750 to 9520.0870, or hospital outpatient psychiatric departments that are designated as essential community providers under section 62Q.19.

(b) This increase applies to group skills training when provided as a component of children's therapeutic services and support, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, psychological testing, neuropsychological services, direction of behavioral aides, and inpatient consultation.

(c) This increase does not apply to rates that are governed by sections 256B.0625, subdivision 30, and 256B.761, paragraph (b), other cost-based rates, rates that are negotiated with the county, rates that are established by the federal government, or rates that increased between January 1, 2004, and January 1, 2005.

(d) The commissioner shall adjust rates paid to prepaid health plans under contract with the commissioner to reflect the rate increases provided in paragraph (a). The prepaid health plan must pass this rate increase to the providers identified in paragraph (a).

Sec. 14. Minnesota Statutes 2005 Supplement, section 256D.03, subdivision 4, is amended to read:

Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

(4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations provided by a physician or optometrist;

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services as covered under the medical assistance program;

(15) ~~outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62~~ mental health services covered under chapter 256B;

~~(16) day treatment services for mental illness provided under contract with the county board;~~

~~(17)~~ (16) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

~~(18) psychological services;~~ (17) medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

~~(19)~~ (18) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

~~(20)~~ (19) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

~~(21)~~ (20) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171; and

~~(22)~~ (21) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b~~; and~~.

~~(23) mental health telemedicine and psychiatric consultation as covered under section 256B.0625, subdivisions 46 and 48.~~

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A $1,000 deductible is required for each inpatient hospitalization.

(b) Effective August 1, 2005, sex reassignment surgery is not covered under this subdivision.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a

manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Recipients eligible under subdivision 3, paragraph (a), shall pay the following co-payments for services provided on or after October 1, 2003:

(1) $25 for eyeglasses;

(2) $25 for nonemergency visits to a hospital-based emergency room;

(3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

(4) 50 percent coinsurance on restorative dental services.

(e) Co-payments shall be limited to one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $12 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (f).

(f) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

(g) Any county may, from its own resources, provide medical payments for which state payments are not made.

(h) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

(i) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

(j) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

(k) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (i).

(l) Payments for all other health services except inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

(m) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

(n) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

(o) Fee-for-service payments for nonpreventive visits shall be reduced by $3 for services provided on or after January 1, 2006. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse, audiologist, optician, or optometrist.

(p) Payments to managed care plans shall not be increased as a result of the removal of the $3 nonpreventive visit co-payment effective January 1, 2006.

(q) Payments for mental health services added as covered benefits after December 31, 2006, are not subject to the reductions in paragraphs (i), (k), (l), and (m).

EFFECTIVE DATE. This section is effective January 1, 2007, except mental health case management under paragraph (a)(i)(15) is effective January 1, 2008.

Sec. 15. Minnesota Statutes 2005 Supplement, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. **Covered health services.** For individuals under section 256L.04, subdivision 7, with income no greater than 75 percent of the federal poverty guidelines or for families with children under section 256L.04, subdivision 1, all subdivisions of this section apply. "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services other than services covered under section 256B.0625, subdivision 9, orthodontic services, nonemergency medical transportation services, personal care assistant and case management services, nursing home or intermediate care facilities services, inpatient mental health services,

and chemical dependency services. ~~Outpatient mental health services covered under the MinnesotaCare program are limited to diagnostic assessments, psychological testing, explanation of findings, mental health telemedicine, psychiatric consultation, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.~~

No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

Covered health services shall be expanded as provided in this section.

EFFECTIVE DATE. This section is effective January 1, 2007, except mental health case management under subdivision 1 is effective January 1, 2008.

Sec. 16. Minnesota Statutes 2005 Supplement, section 256L.035, is amended to read:

256L.035 LIMITED BENEFITS COVERAGE FOR CERTAIN SINGLE ADULTS AND HOUSEHOLDS WITHOUT CHILDREN.

(a) "Covered health services" for individuals under section 256L.04, subdivision 7, with income above 75 percent, but not exceeding 175 percent, of the federal poverty guideline means:

(1) inpatient hospitalization benefits with a ten percent co-payment up to $1,000 and subject to an annual limitation of $10,000;

(2) physician services provided during an inpatient stay; and

(3) physician services not provided during an inpatient stay; outpatient hospital services; freestanding ambulatory surgical center services; chiropractic services; lab and diagnostic services; diabetic supplies and equipment; mental health services as covered under chapter 256B; and prescription drugs; subject to the following co-payments:

(i) $50 co-pay per emergency room visit;

(ii) $3 co-pay per prescription drug; and

(iii) $5 co-pay per nonpreventive visit.

The services covered under this section may be provided by a physician, physician ancillary, chiropractor, psychologist, ~~or~~ licensed independent clinical social worker, or other mental health providers covered under chapter 256B if the services are within the scope of practice of that health care professional.

For purposes of this section, "a visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by any health care provider identified in this paragraph.

Enrollees are responsible for all co-payments in this section.

(b) Reimbursement to the providers shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (c).

(c) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

EFFECTIVE DATE. This section is effective January 1, 2007, except mental health case management under paragraph (a), clause (3), is effective January 1, 2008.

Sec. 17. Minnesota Statutes 2004, section 256L.12, subdivision 9a, is amended to read:

Subd. 9a. **Rate setting; ratable reduction.** For services rendered on or after October 1, 2003, the total payment made to managed care plans under the MinnesotaCare program is reduced 1.0 percent. This provision excludes payments for mental health services added as covered benefits after December 31, 2006.

Sec. 18. **REVISOR'S INSTRUCTION.**

In the next edition of Minnesota Statutes, the revisor of statutes shall change the reference to sections 245.487 to 245.4887, the Children's Mental Health Act, wherever it appears in statutes or rules to sections 245.487 to 245.4889.

Sec. 19. **REPEALER.**

Minnesota Statutes 2004, sections 245.465, subdivision 2; 256B.0945, subdivisions 5, 6, 7, 8, and 9; and 256B.83, are repealed.

245.465 DUTIES OF COUNTY BOARD.

Subd. 2. **Residential and community support programs: 1992 salary increase.** In establishing, operating, or contracting for the provision of programs licensed under Minnesota Rules, parts 9520.0500 to 9520.0690 and programs funded under Minnesota Rules, parts 9535.0100 to 9535.1600, for the fiscal year beginning July 1, 1991, a county board's contract must reflect increased salaries by multiplying the total salaries, payroll taxes, and fringe benefits related to personnel below top management by three percent. This increase shall remain in the base for purposes of wage determination in future contract years. County boards shall verify in writing to the commissioner that each program has complied with this requirement. If a county board determines that a program has not complied with this requirement for a specific contract period, the county board shall reduce the program's payment rates for the next contract period to reflect the amount of money not spent appropriately. The commissioner shall modify reporting requirements for programs and counties as necessary to monitor compliance with this provision.

256B.0945 RESIDENTIAL SERVICES FOR CHILDREN WITH SEVERE EMOTIONAL DISTURBANCE.

Subd. 5. **Quality measures.** Counties must collect and report to the commissioner information on outcomes for services provided under this section using standardized tools that measure the impact of residential treatment programs on child functioning and/or behavior, living stability, and parent and child satisfaction consistent with the goals of section 245.4876, subdivision 1. The commissioner shall designate standardized tools to be used and shall collect and analyze individualized outcome data on a statewide basis and report to the legislature by December 1, 2003. The commissioner shall provide standardized tools that measure child and adolescent functionality, placement stability, and satisfaction for youth and family members.

Subd. 6. **Federal earnings.** Use of new federal funding earned from services provided under this section is limited to:

(1) increasing prevention and early intervention and supportive services to meet the mental health and child welfare needs of the children and families in the system of care;

(2) replacing reductions in federal IV-E reimbursement resulting from new medical assistance coverage;

(3) paying the nonfederal share of additional provider costs due to accreditation and new program standards necessary for Medicaid reimbursement; and

(4) paying for the costs of complying with the data collection and reporting requirements contained in subdivision 5.

For purposes of this section, prevention, early intervention, and supportive services for children and families include alternative responses to child maltreatment reports under chapter 626 and nonresidential children's mental health services outlined in section 245.4875, subdivision 2, and family preservation services outlined in Minnesota Statutes 2002, section 256F.05, subdivision 8.

Subd. 7. **Maintenance of effort.** (a) Counties that receive payment under this section must maintain a level of expenditures such that each year's county expenditures for prevention, early intervention, and supportive services for children and families is at least equal to that county's average expenditures for those services for calendar years 1998 and 1999.

(b) The commissioner may waive the requirements in paragraph (a) if any of the conditions specified in section 256F.13, subdivision 1, paragraph (a), clause (4), items (i) to (iv), are met.

Subd. 8. **Reports.** The commissioner shall review county expenditures annually using reports required under sections 245.482 and 256.01, subdivision 2, clause (17), to ensure that counties meet their obligation under subdivision 7, and that the base level of expenditures for prevention, early intervention, and supportive services for children and families and children's mental health residential treatment is continued from sources other than federal funds earned under this section.

Subd. 9. **Sanctions.** The commissioner may suspend, reduce, or terminate funds for prevention, early intervention, and supportive services for children and families up to the limit of federal revenue earned under this section to a county that does not meet one or all of the requirements of this section. If the commissioner finds evidence of children placed in residential treatment who do not meet the criteria outlined in section 245.4885, subdivision 1, the commissioner may take action to limit inappropriate placements in residential treatment.

256B.83 MAINTENANCE OF EFFORT FOR CERTAIN MENTAL HEALTH SERVICES.

APPENDIX

Repealed Minnesota Statutes: 06-4971

Any net increase in revenue to the county as a result of the change in section 256B.0623 or 256B.0624 must be used to provide expanded mental health services as defined in sections 245.461 to 245.486, the Comprehensive Adult Mental Health Act, excluding inpatient and residential treatment. Increased revenue may also be used for services and consumer supports, which are part of adult mental health projects approved under section 245.4661. "Increased revenue" has the meaning given in Minnesota Rules, part 9520.0903, subpart 3.

Senator ..... moves to amend S.F. No. 3290 as follows:

Page 1, line 16, delete "Mental health services already provided" and insert " Responsibility not duplicated"

Page 2, line 5, after "counties" insert "and health plans"

Page 2, line 19, after "programs" insert ", including the value of case management transfer grants under section 256B.0625, subdivision 20,"

Page 3, line 1, after "2008" insert ", with not more than 20 percent of the statewide population described in subpart (b) included during calendar year 2008 and additional individuals included in subsequent years"

Page 3, line 6, delete "they have no other" and insert "an individual has another"

Page 3, line 8, delete "the" and insert "an"

Page 6, line 3, delete "Mental health services already provided" and insert " Responsibility not duplicated"

Page 6, line 9, delete "in" and insert "for"

Page 6, line 20, delete "those counties whose" and after "applications" insert "that"

Page 11, after line 32, insert:

"Sec. 11. Minnesota Statutes 2005 Supplement, section 256B.0946, subdivision 1, is amended to read:

Subdivision 1. **Covered service.** (a) Effective July 1, 2006, and subject to federal approval, medical assistance covers medically necessary services described under paragraph (b) that are provided by a provider entity eligible under subdivision 3 to a client eligible under subdivision 2 who is placed in a treatment foster home licensed under Minnesota Rules, parts 2960.3000 to 2960.3340.

(b) Services to children with severe emotional disturbance residing in treatment foster care settings must meet the relevant standards for mental health services under sections 245.487 to 245.4887. In addition, specific service components reimbursed by medical assistance must meet the following standards:

(1) case management service component must meet the standards in Minnesota Rules, parts 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10;

(2) psychotherapy, crisis assistance, and skills training components must meet the standards for children's therapeutic services and supports in section 256B.0943; and

(3) family psychoeducation services under supervision of a mental health professional."

2.1 Page 12, line 31, delete "sections" and insert "section"

2.2 Page 12, line 32, delete "and" and insert "or"

2.3 Renumber the sections in sequence and correct the internal references

2.4 Amend the title accordingly

Senator ..... moves to amend S.F. No. 3290 as follows:

Page 11, after line 3, insert:

"Sec. 9. Minnesota Statutes 2004, section 256B.0625, subdivision 28, is amended to read:

Subd. 28. **Certified nurse practitioner services.** Medical assistance covers services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, ~~or~~ a certified geriatric nurse practitioner, a clinical nurse specialist in mental health, or a certified psychiatric nurse practitioner in independent practice, if:

(1) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate;

(2) the service is otherwise covered under this chapter as a physician service; and

(3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171. "

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Senator ..... moves to amend S.F. No. 3290 as follows:

Page 2, line 15, delete "share of" and insert "and county"

Page 2, line 18, after "commissioner" insert ", in consultation with counties,"

Page 2, after line 34, insert:

"(3) allow potential bidders at least 90 days to respond to the request for proposals;"

Page 2, line 35, delete "(3)" and insert "(4)"

Page 3, line 1, delete "(4)" and insert "(5)"

Senator ..... moves to amend the SCS3290A-2 amendment to S.F. No. 3290 as follows:

Page 1, line 4, after "plans" insert "in mental health services, including case management"

Minnesota Department of **Human Services**

Fast Facts:
2006 Legislative Session

Governor's mental health initiative (HF 3630 and SF 3290):
Improving care for children and adults with mental illness

Issue:

- Many Minnesotans with mental illness do not receive the care they need, when they need it. They often must become very sick before they receive appropriate services.
- The current system is fragmented, with varying levels of access and care coordination. There is little incentive for early identification and intervention and many opportunities for cost shifting and cost avoidance.
- People often have both physical and mental health problems at the same time, yet the current health care system artificially separates their treatment.
- Mental health treatment needs to move into the mainstream of health care delivery rather than exist on the margins.

Proposal:

Based on the recommendations of the Minnesota Mental Health Action Group, the governor's initiative would reform the financing and delivery of publicly funded mental health care services for children and adults to improve access, quality and care coordination and to encourage identification and intervention. The proposal includes $50 million in new investments and $59 million in redirected government investments. Key components are:

Adoption of a comprehensive mental health benefit set across publicly funded health care programs *($26.8 million over three years; offset by $22.8 million redirected adult mental health grant funds)*

- Evidence-based mental health services currently available under the Medical Assistance fee-for-service program will be added to General Assistance Medical Care and MinnesotaCare for consistency across programs.
- Services that are now available on an "as funds are available" basis through state and county grants will become part of the mental health benefit set and available based on need. Variations in access from county to county will be eliminated.

Integration of mental and physical health care and the effective coordination of health care with social services and education *($32.5 million over three years; offset by $28.4 million redirected state grant funds)*

- Certain services which are now only available through MA fee-for-service (mental health case management and children's residential treatment) will be available in Prepaid Medical Assistance Plans for individuals already enrolled in those plans.
- Integrated care networks will be established through a request for proposals process in consultation with consumers, advocates and other stakeholders.
- Enrollment will be phased in region by region as integrated care networks are approved.
- Clear accountability for performance based on client outcomes is established through an integrated payment and service model.

Targeting investments to support an effective mental health infrastructure, including:

- Shore up children's school-based mental health services infrastructure for uninsured and under-insured children *($17.4 million)*
- Develop statewide mental health crisis intervention and stabilization infrastructure as a first-line safety net for children and adults *($13.5 million offset by $8.2 million redirected from increase in county share for commitments to state operated hospitals)*
- Monitor and track availability of mental health services *($253,000)*
- Develop and support evidence-based practices *($5.7 million)*
- Address workforce shortages, including psychiatrists and other critical mental health professionals *($7.5 million)*
- Develop capacity to address the mental health care needs of specialty populations *($5 million)*
- Create a system for measuring mental health service outcomes *($323,000).*

Benefits:

- Making a single entity responsible for the entire continuum of mental health services allows for a more holistic approach to a consumer's health and improves accountability for performance.
- Promoting early intervention will help assure consumers receive services before they are very ill.
- Involving large provider networks associated with managed care will give consumers more choice and more opportunity for consistency in access to care across geographic areas.
- Investing in an expanded mental health benefit set for public sector clients will demonstrate the efficacy of offering an expanded benefit set to private sector clients.

Fiscal impact:

- FY 2007: $3.4 million net cost, $3.6 million redirected from existing mental health grants.
- FY 2008: $24 million net cost, $15.2 million redirected from existing mental health grants.
- FY 2009: $22 million net cost, $32.3 million redirected from existing mental health grants.

Funds redirected from existing mental health grants will follow clients to new payers. The amount of redirected mental health grant funding ($51 million) represents about 21 percent of county mental health grants ($243 million total). The balance of redirected funds in the proposal ($8.2 million) is from an increase in the county share for commitments to state operated hospitals.

Number of people affected:

- 108,040 adults in state's publicly funded health care programs receiving mental health services
- 41,524 children in state's publicly funded health care programs receiving mental health services

Timeline:

- CY 2006: Establish workgroup, including advocates and stakeholders, to develop and issue a request for proposals for regional projects featuring integrated care networks.
- CY 2007: Increase benefit set for publicly funded Minnesota health care programs to match that of Medical Assistance; select regional projects/integrated care networks.
- CY 2008: Implement regional projects/integrated care networks and begin enrollment phase-in.

Related information:

- Department of Human Services Web site at www.dhs.state.mn.us/MHInitiative
- Finance Web site at www.finance.state.mn.us.

DHS Communications: March 22, 2006

Minnesota Department of **Human Services**

Governor's Mental Health Initiative: Questions and Answers

Overview

What are the key elements of the Governor's mental health initiative?
The Governor is proposing over three years to invest $50 million in new Health Care Access Fund investments and redirect $59 million in existing funds to finance the transformation of the mental health system. The key elements to be financed include:

- Adopting a comprehensive mental health benefit set with proven treatment across all publicly funded health care programs *($26.8M; offset by $22.8M in redirected grants)*.
- Requiring the integration of mental and physical health care and the effective coordination of health care with social services and education *($32.5M; offset by $28.4M in redirected state grants)*; and,
- Targeting significant investments to support an effective mental health infrastructure *($49.6M; offset by $8.2M in redirected revenues)*.

Bipartisan legislation has been introduced to implement this initiative. To view the latest version, go to www.leg.state.mn.us/leg/legis.asp and enter HF3630 or SF3290.

What is the purpose of the Governor's Mental Health Initiative?
The purpose of the mental health initiative is to improve access, quality, and accountability in the delivery of mental health services for children and adults. We want mental illnesses to be recognized as health issues that can be successfully treated. We know that when mental health care and physical health care are integrated, the outcomes for both are improved.

Mental health treatment needs to move into the mainstream of the health care delivery and financing structures rather than existing on their margins. This will improve care and result in more equitable statewide access to mental health services. It will provide incentives to deliver care to people before their mental health issue becomes a major mental illness. It is a major step toward achieving mental health parity in our publicly funded health care system.

What is meant by improving "access, quality, and accountability?
The mental health initiative is based on the vision and recommendations of the Minnesota Mental Health Action Group (MMHAG). MMHAG was first organized in the autumn of 2003 under a vision of "a comprehensive mental health system that is accessible and responsible to consumers, guided by clear goals and outcomes, and grounded in public / private partnerships." Its membership includes consumers, families, advocacy organizations, mental health providers, hospitals, health plans, counties, and state agencies.

In the document "Road Map for Mental Health System Reform in Minnesota", MMHAG identified the following desired outcomes:

- Public / private partnerships to assure that all aspects of the mental health system are working to serve consumers and families.

- A new fiscal framework for public and private mental health funding that creates rational incentives for the right care to be delivered in the right setting at the right time.
- Quality of care for consumers and families, as measured by standardized assessment of performance and outcomes.
- Innovative workforce solutions to assure an adequate supply of appropriately trained, qualified mental health professionals.
- Earlier identification and intervention so that consumers and families are willing to seek and able to access help when needed.
- Coordination of care and services so that the mental health system is easy for the consumers and families to navigate and they receive the right combination of services to achieve the desired health and social outcomes.

The mental health initiative's framework for access, quality, and accountability is taken from MMHAG's recommendations for a new mental health payment model. These recommendations include the following list of key policy objectives:

Access and Choices

- Ensures statewide access to needed services – minimizes geographic differences in access
- Ensures timely access for all services with special consideration for persons in urgent need.
- Improves continuity of coverage
- Establishes and defines a uniform entitlement to public funding of mental health services.
- Minimizes uncompensated care
- Supports the development of a sustainable infrastructure

Quality and Innovation

- Facilitates integration of and parity between physical and mental health care
- Encourages earlier identification and intervention
- Removes negative effects of cost and risk-sharing on clinical decision making
- Rewards better (evidence-based) decision making
- Emphasizes best practices and effective care over gate-keeping

Accountability

- Manages public funds efficiently
- Clarifies public / private health care payer responsibilities
- Builds a continuous evaluation of the effectiveness of the mental health system in achieving desired policy objectives
- Discourages cost and risk shifting
- Provides clear and continuous accountability

How will the Mental Health Initiative affect consumers?

As indicated above, the basic direction of the Mental Health Initiative is to make services more accessible, more accountable and more responsive to individual consumers' needs. During the past year, about 108,000 adults and 41,000 children received publicly funded mental health services. The Mental Health Initiative takes great care to recognize the huge variation in need and circumstances which is reflected by the current clients as well as by those who need services and are not now receiving them. A number of provisions (described below) have been included to address individual circumstances and particularly to ensure that nobody loses needed services as a result of the proposed changes.

One of the objectives is to integrate physical and mental health care. Since consumers now receive their physical health care (and their health care coverage in general) in a variety of ways and through a variety of payers, much of the complexity of the Mental Health Initiative results from trying to address and simplify existing variations in health care coverage.

Adopting a Comprehensive Mental Health Benefit Set For All Public Health Care Programs

What is meant by adopting a comprehensive mental health benefit?
Minnesota's medical assistance (MA) fee-for-service program offers mental health services that are not available in our General Assistance Medical Care (GAMC) program, MinnesotaCare, and the Prepaid Medical Assistance Program (PMAP). Many of these services have been added to the MA fee for service program over the past 5 years and are considered evidence-based and proven to be effective for treating and supporting people with mental illnesses.

This proposal adds mental health services to GAMC, MinnesotaCare, and PMAP so that all of Minnesota's publicly financed health programs offer the same, comprehensive outpatient mental health benefit set. These services include:

1. Assertive Community Treatment (ACT);
2. Intensive Residential Treatment Services (IRTS);
3. Adult Rehabilitative Mental Health Services (ARMHS);
4. Adult Crisis Services; and,
5. Case Management or Care Coordination;

Who benefits?
Some individuals now enrolled in GAMC and MinnesotaCare have access to these services only to the extent that funds are available through capped state grants, county funds, or a combination of both. For this reason, access to mental health services varies from region to region and county to county.

By adding these services to the GAMC and MinnesotaCare standard benefit set, all enrollees in Minnesota's health care programs will have access based on need. This will improve access for current enrollees and future enrollees. This may also provide incentives for persons with mental health issues to enroll and stay enrolled in these programs, which in turn, will result in better access to preventive physical and mental health care.

What is the cost of adding these benefits?
The total cost of the comprehensive benefit set is expected to be $26.8 million over the next three years. This cost is offset by the redirection of $22.8 million from capped, state mental health grants. The redirected funds represent money following the clients from the current payer (counties) to the new payer (state health programs). The amount of redirected funds is based on the value of these services now paid by state and county grants that in the future will be paid as part of the health care programs' standard benefit set. The services and the provider do not change, but the payer will.

Why is the cost of adding these benefits $4 million more than the amount of redirected grants?
Four million dollars in new funds are needed because access to these services will improve. The current payer (counties) provides these services within the limits of capped state and county grants. The new payer (public health programs) must offer these services to anyone who requires them.

How will the Mental Health Initiative affect Supported Employment?
Supported Employment is currently funded mostly through the Department of Employment and Economic Development, and the Mental Health Initiative will not affect that. Federal law places strict limits on the use of MA for supported employment. We do use MA for Adult Mental Health Rehabilitative Services (ARMHS) to do skills training to help clients learn how to deal with their mental illness in a variety of settings, including employment settings. The Mental Health Initiative uses some of the proposed new funding to expand GAMC and MnCare to include ARMHS, so in that sense the Governor's Initiative will assist Supported Employment.

What will happen with case management under the Mental Health Initiative?
For the majority of publicly funded mental health clients (those who are MA-disabled), nothing will change unless and until we receive a proposal from a health plan - county partnership for an integrated network that meets the requirements of the proposed new RFP. Our intention is to incorporate into that RFP the work that is being done by the MMHAG Service Access and Care Coordination Workgroup. The group has broad representation and is looking for creative ways to accomplish case management functions in a way that is more effective for clients. As far as funding for case management, we are assuming that state and county funding for case management will continue at least at current levels. Not enough information is available yet to predict the future of federal case management funding, but we believe this proposal puts Minnesota into a better position to deal with potential federal reductions to Targeted Case Management revenues.

Does the Mental Health Initiative support a psycho-social rehabilitation model of care?
Yes, the inclusion of services such as ACT, IRT and ARMHS in the standard benefit set for all publicly funded health care programs is a clear indication of the state's support for the psycho-social rehabilitative model of care. New research is increasingly showing mental illness as an illness, and services such as ACT have been proven to be effective when they are provided according to fidelity standards. The traditional medical model is evolving to embrace new research in mental health and DHS intends to support this change. We believe that integration of psycho-social rehabilitation with an evolving model of physical health care will be more effective than implementation of either model alone.

Requiring the Integration of Mental and Physical HealthCare

Why is the integration of mental health care and physical health care so important?
Physical and mental health problems co-occur. There are high rates of mental illness that accompany certain physical diseases and conditions such as diabetes, hypertension, obesity, breast cancer, and hepatitis B. Depressive disorders have been related to increased risk for developing coronary health disease, increased insulin resistance, increased risk of developing some cancers, and accelerated progression of HIV infection to AIDS.

Consumers of mental health services are under-treated. Studies show that only 11% of individuals with a serious mental illness received preventative physical care during a visit with a psychiatrist, and 48% of women's health issues were undiagnosed by psychiatrists. Consumers report that the issues they raise about physical health care concerns are often dismissed as psychosomatic. Surveys also indicate that children with special health needs are at significantly increased risk of mental health disorders.

A recent study of children and adolescents receiving services in Minnesota Health Care programs found that 60% of those prescribed psychotropic medications received these without any accompanying mental health service. Health plans in Minnesota report that primary care providers are prescribing up to 80% of the psychotropic prescriptions for both children and adults covered by private insurance.

The benefits of integrated care models are proven in a number of studies. One showed that 74% of people with major depression in an integrated treatment plan showed significant symptom reduction compared with only 44% of patients who had physician treatment and referral to mental health services at a separate site.

With primary care physicians serving as the first point of contact for most children, bifurcated physical and mental health treatment often results in the neglect of early diagnosis and treatment at early stages. This is clearly the case for children with pediatrics playing the central role in caring for common and emerging mental health problems.

Communication, co-location, and shared responsibility among primary care providers and mental health clinicians are all critical elements of better treatment and improved outcomes.

What is the strategy for achieving the integration of mental health treatment with other health care services?
The primary strategies for integrating the mental health care treatment with other health care services are to integrate the payment and require the development of integrated service models. This includes the removal of the "opt out" provision for individuals who qualify for enrollment into the Prepaid Medical Assistance Program (PMAP), and the enrollment of individuals who are disabled as the result of serious mental illnesses into health networks that include the choice of at least one "preferred integrated care network". The end of the "opt out" provision and enrollment of persons who are disabled would be thoughtfully phased in region by region. The first phase is anticipated to be implemented in January, 2008 and is projected to reach 20% of the state's potential enrollees. This is a projection for the pace of phasing in enrollment. Actual enrollment may be more or less than 20%.

What is a "preferred integrated care network"? What will determine the pace of the phase in period?
A "preferred integrated care network" is a mental and physical health care network that has been specifically designed to effectively integrate mental health care and physical health care and to coordinate these services with social services and education. "Preferred integrated care networks" will be identified through an RFP process. Consumers, advocates and other primary stakeholders with no direct financial interest will participate in the development of the RFP. The successful selection of these networks will be the primary determinant of the pace of phasing in enrollment.

Who can respond to the RFP and what will be the requirements for a successful bidder?
Approved projects will be based on locally defined partnerships that include at least one health plan or county-based purchasing entity, and the county or counties within the region.

The bidder will need to demonstrate the ability to accept and manage risk for the cost of physical and mental health services. "Preferred integrated care networks" will also need to demonstrate:

- The capacity to deliver effective care and treatment across the spectrum of physical and mental health care needs;
- The ability and commitment to integrate care across health care, social services, and education systems;

- An effective strategy for care coordination within and across systems of care;
- The ability to foster and maintain working relationships with varied partners, including counties, schools, Children's Mental Health Collaboratives, and Adult Mental Health Initiatives;
- An understanding and commitment to the application of best practices for mental health treatment;
- The ability to comply with reporting requirements and meet identified outcome standards;
- The ability to administer client protections and safeguards; and,
- The ability to bill third party payers including Medicare.

Will the counties have a voice on who is selected as a "preferred integrated care network?
Yes, the ability to coordinate mental and physical health care with social services will be a requirement of any bidder. This cannot be accomplished without a prearranged relationship with the counties covered in the region.

How will standards for access and care be established for "integrated care networks" and how will these standards be enforced?
Contract standards to be applied to the integrated care networks will be developed with significant input from consumers and advocates. These standards will address the specific needs and interests of persons with mental illnesses. Examples include:

- Standards of care and treatment;
- Requirements and incentives for developing and applying current and emerging best practices;
- Performance standards, outcome measures, and reporting requirements;
- Standards for behavioral service utilization reporting;
- Standards for access to mental health professionals and services;
- Care coordination standards;
- Requirements for coordination and integration with social services and education systems;
- Due process provisions for patient complaints; and,
- Requirements for continuity of care to assure that individuals can continue to receive services from qualified providers.

Does the proposal require all persons to enroll? Will there be the guarantees for continuity of care?
The proposal presumes enrollment into the care networks; however, exceptions will be made to allow an "opt out" for individuals who have previously established therapeutic relationships with specific providers who are not part of the integrated care network.

Will people be able to choose among all available health provider networks or will they be required to enroll in the "preferred integrated care network"?
Everyone will have the choice of enrolling in any available health networks. If no choice is made, the person will be enrolled in the "preferred" network. All health networks must provide the complete mental health benefit set and must work with counties to coordinate health care with social services. Counties must provide required social services to individuals regardless of what health network is chosen.

Will consumers have to go through a managed care plan to get their services?
The answer depends on your health care eligibility:

If you receive your physical health care through a managed care plan now, you already receive some of your mental health services through that plan. After January 1, 2007, GAMC, MnCare and PMAP plans will also include coverage for Assertive Community Treatment (ACT), Intensive Residential Treatment (IRT), Adult Rehabilitative Mental Health Services (ARMHS) and crisis services. After January 1, 2008, these plans will include coverage for mental health case management. These changes will help ensure more consistent, statewide access to these services, and better coordination with your physical health care.

If you are currently on MA fee-for-service (usually this is the same as "MA-disabled"), you will continue to receive both your physical and your mental health services through fee-for-service until the state has approved an integrated care network for your county. As indicated above, an integrated care network must demonstrate a working partnership between a county, a health network, and probably other agencies. It won't happen if the state determines that the partnership is unable to meet the criteria for integrated care (see above). The earliest date for integrated care networks to begin is January 1, 2008. Only 20% of the state is expected to qualify by that date. Other areas will begin later.

Receiving your health care through a managed care plan does not require approval for every service. In recent years, managed care plans have streamlined their service authorization requirements, thus allowing direct access to service providers in most situations.

What if I have a previously established therapeutic relationship with a specific provider under MA fee-for-service, and that provider is not included when the new integrated care network is developed?
The state will require the new integrated care networks to include a broad network of providers, so it's very unlikely that your provider would not be included. However, if that should occur, you would then have the option of staying in fee-for-service and continuing with your current provider.

Why does this Initiative include the health plans?
Our focus is on integration of physical health care, mental health care and social services in order to meet clients' needs. Most physical health care is currently provided through public or private health plans, while most social services are provided by counties. Currently there is an ineffective dichotomy between these systems, and this is not good for clients. In some areas, counties have begun this integration process through public health plans (county-based purchasing) and are reporting very promising results. Background regarding the need for integrated care is described in a paper available on the DHS website at www.dhs.state.mn.us/MHInitiative.

How will DHS monitor and manage health plan performance?
DHS uses several levels of monitoring including internal DHS staff and external sources. Each contract is assigned to a contract manager who is responsible for review of all plan materials and network changes, tracking of required reports and submissions and for tracking and ensuring resolution of service delivery, access or payment issues.

DHS works closely with the Minnesota Department of Health (MDH) in their regulatory and oversight process. If MDH identifies deficiencies or makes recommendations, DHS reviews those items to determine whether there is an impact on contract compliance. DHS monitors for resolution of deficiencies or may separately require that the plan develop and complete a corrective action plan.

The plans are also subject to review by an external quality review organization (EQRO), which reviews systems in place to assure access, timeliness and quality of services. If there are issues, a corrective

action plan may be required. The EQRO reviews for completion of the required corrective action plan at a subsequent visit. The EQRO also does special studies as designated by DHS related to access, timeliness and quality of services.

Prior to the implementation of the integrated care networks we will develop additional contract standards that are designed to address unique service and protection interests of people with mental illnesses. We have committed to seeking the input of consumers and consumer representatives in the development of these additional standards.

What due process and client protections will be in place?
Clients will have the same access to the state fair hearing (DHS appeal) process that they now have under fee for service. In addition, they will also have access to complaint and grievance processes at the plans as required by state and federal law. Minnesota Health Care Program enrollees in managed care plans have access to assistance from the Department of Human Services Managed Care Ombudsman for complaints and grievances. In addition, managed care plan enrollees may file complaints with the Minnesota Department of Health.

In fact, due process will improve significantly for persons enrolled in GAMC and MinnesotaCare. Once these programs include the expanded mental health benefit set, appeals will be determined solely on the individual's need for services. Today, counties do not have to provide these services if it can be demonstrated that there is a lack of available funding.

Under the proposal, are there limits or caps on the services that I can use?
Under a contract, the entity must provide all the services that are medically necessary. There are no "caps" or "limits" on services except for the inpatient cap already in place under the MinnesotaCare Limited Benefit (MLB) set. The governor's proposal adds the ACTs, IRTS, ARMHS and crisis services to the GAMC and MinnesotaCare benefit sets. We are also proposing to amend the MinnesotaCare Limited Benefit (MLB) set to allow reimbursement of all appropriate mental health provider types. However, MLB enrollees will still be subject to the $10,000 inpatient cap which is a combined limit for all types of MLB inpatient including psychiatric and non-psychiatric.

The contracted entities may require periodic review of treatment plans and may periodically authorize services, but they may not arbitrarily limit services.

What funding changes are necessary to finance the integration of mental health and physical health care?
Movement of clients and services from fee-for-service into managed care has two types of fiscal impacts: 1) the one-time cash flow cost of pre-payment; and 2) state assumption of non-federal match that is currently paid by counties for MH-TCM and Rule 5 Children's Residential services for persons in PMAP, GAMC and MnCare. State assumption of local match currently paid by counties will be offset by a reduction in county grants. The legislation proposes discontinuation of the state grants offsetting the local share of mental health targeted case management as the primary source of offsetting funds. The cost of these changes both statewide and within the regional projects is projected at $32.5 million; offset by $28.4million in redirected state grants.

How does this proposal relate to the Adult Mental Health Initiatives (AMHIs)?
The AMHIs began about 10 years ago in response to concerns that were similar to the concerns being addressed by this Mental Health Initiative. However, the AMHIs were focused on adults with serious and persistent mental illness, whereas the current initiative attempts to improve accessibility and quality

for all publicly funded mental health services, including adults and children, as well as improving continuity and parity with broader health care coverage, including public and private coverage. This Mental Health Initiative builds on the numerous successes that have been achieved by the AMHIs and uses the AMHI structure to further improve mental health infrastructure for adults (as well as the children's collaboratives for children).

This initiative does not affect the employment status of state staff assigned to the AMHIs.

Targeting Significant New Investments to Support an Effective Mental Health Infrastructure

What new mental health infrastructure investments are being recommended?

- Developing statewide mental health crisis intervention and stabilization infrastructure as a first line safety net for children and adults*($13.5M; offset by $8.2M available from increases in the county share for commitments to state operated hospitals);*
- Developing and supporting best practices *($5.7M)*;
- Developing capacity to address the mental health care needs of specialty populations *($5M)*;
- Shoring up children's school-based mental health services through local collaboratives *($17.4M)*;
- Reducing workforce shortages, including psychiatrists and other professionals by improved rate setting *($7.5M)*;
- Monitoring and tracking the availability of psychiatric hospital beds and other community-based mental health services *($253,000)*; and,
- Developing performance-based systems for accountability that focus on client outcomes *($323,000)*;

See separate document, Governor's Mental Health Initiative: Investments in the Mental Health Service Infrastructure, available at www.dhs.state.mn.us/MHInitiative

Financing

If the Governor proposes $50 million in new investments over 3 years, what is proposed as the annual amount of new investment?

The amount of new funding on an ongoing basis will be approximately $22 million per year by SFY 2009. Since some of these investments are for increased benefits in the publicly funded health care programs, they will be adjusted each year according to how much enrollment and use is projected for each program. Net startup costs for the initiative amount to $3.4 million in SFY2007.

Why is the Health Care Access Fund (HCAF) being used to finance mental health services?

This initiative and the accompanying transformation of mental health services are based on the principle that mental illness is a health care issue. Providing care and treatment for mental health issues is a health care responsibility. While MinnesotaCare is financed by the HCAF, so are many other activities designed to support access to health care. The access challenges faced by people with mental illnesses are clearly documented.

Simply stated, we believe that improving access to critical mental health services is an appropriate and necessary use of the HCAF because we believe that mental illness should be viewed and treated as a health care issue.

Where does this money come from? Does the HCAF have surplus funding available?
Currently, the HCAF is showing significant surpluses in the fund balance statement. By the end of state fiscal year (SFY) 2009, the HCAF is expected to have over $175 million in surplus funds and a structural balance (annual amount of revenues exceeding expenditures) of over $42 million. The mental health initiative requires $50 million of new funding from the HCAF by the end of SFY 2009 and has an on-going annual cost of $22 million per year. After fully financing the mental health initiative there still remains $125 million in surplus funds at the end of SFY 2009 and a structural balance of $20 million per year. This remains available for other uses that may be proposed during the 2006 session.

Using the HCAF to finance the mental health initiative will have no impact on the current MinnesotaCare program or other existing HCAF investments.

If this proposal redirects approximately $59 million of existing investments, are you taking away mental health money from one service to fund another?
The redirection of mental health grants simply allows the money to follow the clients to new payers. It does not require the services or the provider to change. For example, once we add mental health benefits to GAMC and MinnesotaCare, the same services that are now being provided on an "as funds are available" basis become part of the standard mental health benefit set. Not only does this support the integration of mental health services with other health care, but it makes these services available to all enrollees who need them. Today, these mental health services might be available to GAMC and MinnesotaCare enrollees, but only to the extent that counties have state grant funds or county funds in an amount sufficient to pay for the cost.

This initiative moves only the amount of the state grant dollars from counties to the public health programs equal to the value of the services that are moving from one payer to another. The amount of redirected mental health grant funding ($51 million over three years) represents about 21 percent of state mental health grants ($243 million total). The balance of redirected funds in the proposal ($8.2 million) is from an increase in the county share for commitments to state operated hospitals.

We are also proposing new funding for the GAMC and MinnesotaCare programs that is in addition to the redirected grants, because we know that access to mental health services will improve once they become part of a standard benefit set.

Will you be taking financial support away from local programs that are critical to people with mental illness?
No. This proposal does not make funding less available to current uses. We strongly support the continuation of programs such as club house models and other innovative services models and do not see the availability of these changing as a result of this proposal. We do hope that earlier intervention can prevent more intensive levels of service. The payer of the service may change if the service is one that is added to the benefit set of the public funded health care programs. The application of a county maintenance of effort will also benefit local programs to the extent that the programs rely on local financing. However, while there will be a floor applied to the amount of county investment, counties still have discretion on where to invest these local funds in mental health services. Counties also have this discretion today.

Which programs and funding sources are not affected by this proposal?
As indicated elsewhere in this Q&A, this proposal, as introduced, does not affect the employment status of current state staff in the Adult MH Initiatives and it does not affect state appropriations for Supported

Employment through the Department of Employment and Economic Development. Likewise, it does not affect appropriations for the Regional Treatment Centers, Community Behavioral Health Hospitals, Bridges housing subsidies, Group Residential Housing (GRH), home and community-based waiver programs such as CADI, CAC and TBI, home health and PCA services, mental health grants for American Indians, compulsive gambling programs, crisis housing and 45-day contract beds.

Changes to the County Role

Does the mental health initiative significantly change the county role in the administration of the mental health system?
Counties will continue to have a primary role in the delivery of social services. Counties in partnership with the state will be responsible for supporting a viable mental health infrastructure and for the provision of mental health care for people who are uninsured or underinsured. Beyond this, DHS intends to engage counties and stakeholders in a dialogue about the future role of counties in the public mental health system. The experience of the regional projects will inform that dialogue. Broad changes to the Mental Health Acts will not be proposed until a full discussion has occurred. In the short term, we'll propose clarifying that counties are not responsible for mental health services which are legally the responsibility of health plans.

Are there other changes being proposed that directly affect counties?
Counties, which now contribute considerable resources toward funding mental health services, will be expected to maintain current levels of funding so that the new investments are not used to supplant existing resources.

Increases in the county share for state operated hospital commitments are also being proposed. This is to align financial incentives to encourage the development and use of community-based alternatives to reduce unnecessary institutional placements. The incentives are carefully constructed so the *necessary* hospital placements are not discouraged. These county share increases are not expected to increase total county cost, since increases to the county share will be applied to the county maintenance of effort requirements. The new revenues generated from the increased county share are used to offset the cost of increasing statewide crisis capacity, and this in turn should reduce state hospital commitments and unnecessary use of community psychiatric hospital beds.

How will these changes and investments affect the counties' ability to address the service needs of the uninsured and underinsured?
Those who are currently uninsured or underinsured realize the greatest benefit from the infrastructure investments in this proposal. Nearly all of the new investments are directed at improving access to effective mental health treatment by qualified professionals. As previously mentioned, the expansion of the model mental health benefit set to the GAMC and MinnesotaCare programs means that the same individuals plus many more will have access to these services. The availability of mental health benefits may also serve as an incentive for people to enroll and stay enrolled in the public health programs. This in turn could result in improved access to preventative care.

Those who are underinsured or uninsured are also expected to be the greatest beneficiaries of the investments in crisis services, school-based treatment, the monitoring and tracking of psychiatric bed and community service capacity, improvement to current workforce shortages of mental health professionals, developing services for specialty populations, and developing best practices.

Does this proposal turn a county-based mental health system into a state run system?
A key objective of this initiative is to improve statewide access to mental health treatment and to gain more equity in service access from county to county and across the state. This requires a stronger state commitment to mental health services which this initiative represents. This especially applies to the state's commitment to people with mental illness who qualify for service through the state funded health care programs (GAMC, Medical Assistance, and MinnesotaCare).

About $51M dollars over three years are moving from state grants directed to counties to state funded health programs. Again, this represents the value of the services now funded through county contracts that will move to state health programs due to the addition of mental health service to the benefit sets of all health programs. This change provides guaranteed access to needed mental health treatment for all GAMC and MinnesotaCare enrollees and the integration of mental health treatment with other health care services.

The funds redirected from county grants to health programs are significantly offset by the $50M in new investments. A significant portion of the new infrastructure investments will be issued through county contracts.

A Work in Progress

Is the work on this initiative complete and final?
No, it is a work in progress. The mental health initiative is based upon the non-partisan work, recommendations, and input of the many consumers, advocates, counties, providers, hospitals, health plans, and state agencies who participate on the MMHAG steering committee, workgroups and advisory committees. These groups are still active and we are committed to continue to seek a broad range of input as the proposal progresses to the implementation phase.

What issues are still being addressed by MMHAG members and the Department of Human Services ?
The development of the "preferred integrated care networks" relies heavily on the development of an RFP as well as the development and enforcement of clear contract standards. Consumers, advocates, and other stakeholders who have no direct financial interest as bidders will participate in drafting both products. Standards are expected to include performance measures based on client outcomes as well as requirements for care coordination and management. Both of these elements are subjects of active MMHAG workgroups which are expected to complete their work over the next few months. Some examples of specific issues still being addressed include:

- Ensuring continuity of services and access to qualified providers;
- Developing standard reporting requirements related to outcome measures and encounter data;
- Identifying care coordination and management standards based on critical functions;
- Ensuring adequate client protections and due process;
- Changes to the Mental Health Acts to reflect changes in state and county roles, and
- Access to "preferred integrated care networks" by new enrollees.

We expect that many of these issues can be addressed in the RFP and service contracts. Any additional law changes can be addressed in the 2007 Legislative Session prior to the implementation of the first phase of enrollment that is slated for January, 2008.

Minnesota Department of **Human Services**

Governor's Mental Health Initiative: Investments in the Mental Health Service Infrastructure

Statewide Crisis Mental Health Services Intervention and Stabilization Infrastructure

Service Description:

Mobile mental health crisis response teams composed of a mental health professional and one or more practitioner level staff. The team provides crisis intervention and assessment services. Crisis stabilization services may be provided on site, or in crisis beds that are part of a residential program.

Issues to be addressed:

Even though crisis services are a top priority under the Mental Health Act, the state has struggled for years to develop and maintain an adequate capacity for these services. A number of factors make it difficult to put together a crisis services program that is economically viable without a source of operating subsidy:

- A large portion of those needing crisis services are uninsured – especially among adults. This is no surprise as the uninsured have minimal access to preventative care.
- By its nature, the demand for crisis services is sporadic and any effort to maintain 24/7 availability will have a significant amount of time that is not providing direct service and therefore not "billable time."
- It is doubly difficult to operate crisis services in rural areas. A region large enough to generate a reasonable client base is frequently too large to allow acceptable response time for the mobile crisis services.

Proposed Funding Mechanism:

Counties, Adult Mental Health Initiatives, Children's Mental Health and Family Service Collaboratives and tribes will be eligible apply for competitive grants to subsidize crisis services delivery. Regional applications will receive preference. Grants will operate on a quarterly "settle-up" basis to offset uncompensated time to the limit of the grant award. Grant funds may also be used to follow-up with crisis services users and assist them in gaining ongoing health care coverage.

Expected Outcomes:

- Reduced unnecessary use of emergency room resources for mental health crisises.
- Reduced demand for psychiatric hospital resources.
- Clients will retain more of their existing housing.

Minnesota Examples:

- In the St. Could area, CentraCare, local schools, and the 4 area counties (Benton, Sherburne, Stearns, Wright) have cooperated in a public/private partnership to develop the "Children's Emergency Assessment System." This mobile crisis response unit provides on-site crisis response services to children in schools and childcare providers and builds on an earlier local effort that established co-located child psychiatry services in CentraCare pediatric clinics and other local primary care sites.

- A public-private partnership of representatives from hospitals, county social service departments, health plans and DHS Mental Health Divisions has developed comprehensive crisis service models to divert children and adults who are experiencing a mental health crisis from unnecessary emergency room visits and inpatient hospital stays. For adults, the East Metro Adult Crisis Stabilization program has been in existence for 2 ½ years and has served over 1000 adults. Follow up data seven months after discharge from the program indicate that the overwhelming majority of these individuals have not been hospitalized. Of note, 30 percent of those who received services were uninsured and were covered by time limited grant funding. Similarly, the "Metro Children's Crisis System" provides a first line safety net for children with emotional disturbance and their families, and supplies critical linkages to community-based services.

Monitor and Track Available Mental Health Service Capacity

Description:

Develop a statewide, web-based, resource to track and provide real-time information regarding the current, staffed psychiatric acute care capacity for children, adolescents and adults within the state. The system will track both the beds currently in use and those available for new admissions. Over time, expand this to track the availability of other key mental health services.

Issues to be addressed:

A Minnesota Department of Health, Health Economics Issues Brief released in August 2005 stated: *"In recent years, there has been increasing concern about the availability of mental health and chemical dependency beds. Anecdotal evidence and media reports have suggested high occupancy rates and long waiting periods for inpatient mental health and chemical dependency beds, especially in the Twin Cities. To date, however, systematic information on capacity and occupancy rates for inpatient chemical dependency and mental health services has not been available."* Further, it reported: *"The occupancy rates reported for mental health beds ranged from 0 to 100 percent, with more than half of the hospitals reporting occupancy rates of 75 percent or higher. The occupancy rates reported for pediatric mental health beds ranged from 63 percent to 100 percent with a median of 91 percent."*

With these high occupancy rates, people in psychiatric crisis need a resource to help direct them to near by hospitals with available capacity in order to avoid unnecessary travel time, long emergency room stays and delays in admission. In addition, administrators and policy makers need improved information to determine the appropriate means of addressing the apparent crisis in acute care capacity.

Proposed Funding Mechanism:

Tracking of available service capacity will be an administrative activity of the Department of Human Services. In order to be available as a 24/7 statewide resource, DHS will either contract with an outside vendor for this activity, operate the system from its central office, or incorporate it within the centralized intake and admissions system under development for state operated community behavioral health hospitals.

Expected Outcomes:

- Improved timely access to psychiatric acute care and other mental health services, through improved information regarding service availability for crisis services providers, law enforcement, emergency room staff and hospital admissions staff.
- Improved targeting and coordination of state, county, health plan and provider efforts to free up resources in short supply when they are being used inappropriately.
- Concrete information to inform policy changes to address the apparent shortage of psychiatric acute care capacity.

School-Based Mental Health Services

Service Description:

Day treatment programs and co-located mental health professionals in schools to provide assessment, crisis intervention services and psychotherapy. Also included will be mental health support for home visiting, maternal & child health, and pre-school programs.

Issues to be addressed:

All of the above services can be critical to the educational success of many children with emotional problems. Unfortunately, access to these services is in peril due to recent federal policy for Title IV-E and Medicaid administrative claiming. This funding mechanism was the basis for the Local Collaborative Time Study (LCTS), the primary funding source for children's collaboratives. LCTS will lose an estimated $40 million annually due to these changes – more than 2/3rds of their annual funding. Children's collaboratives have historically expended over $9 million annually on these services.

Proposed Funding Mechanism:

Funds will be made available initially to Children's Mental Health and Family Service Collaboratives on a competitive grant basis. Once comparable data is available across grantees, the allocation of funds among grantees will be in proportion to the number of children they serve adjusted for the portion that cannot access third party coverage.

Expected Outcomes:

- Fewer classroom disruptions and improved attendance, classroom participation and grades among children served.
- Healthy child development and improved school readiness.
- Sustain a viable system of co-located mental health services in schools.

Minnesota Examples:

- Northern St. Louis County Family Services Collaborative – contracts with the Range Mental Health Center to provide mental health services on-site in 12 schools. Providing assessments, psychotherapy and rehabilitative services in the schools saves parents travel time and better coordinates the mental health care with the educational and special education programs. The result for children is improved school performance and greater stability in their lives.
- The Carver County Integrated Services Council has arranged to have a county mental health case manager in the schools. This improves access and coordination of mental health, social services and special education service for children with mental health problems and their families.

Address Critical Shortages of Qualified Mental Health Professionals

Service Description:

Provide an increased rate in MA, GAMC and MinnesotaCare for certain outpatient mental health services which currently have long waiting lists and other access problems. The concept is similar to what was proposed in 2005 in SF 2211 and what is done now for hospitals and dental providers.

Issues to be addressed:

Currently, 70 of Minnesota's 87 counties meet federal criteria as mental health professional shortage areas. The shortage of mental health professionals has far reaching effects on the state's mental health system. It limits access to quality assessments, up-to-date treatment planning and medication monitoring. Historically poor reimbursement rates in public mental health programs has often been cited as contributing to the problems of attracting and retaining mental health professionals.

Proposed Funding Mechanism:

Under this proposal, a 20-25% rate increase is provided to psychiatrists, advanced practice registered nurses (APRNs) with a psychiatric specialty, and "Critical Access Providers" when they provide the following services:

- CTSS group skills training, psychotherapy, medication management, evaluation and management, diagnostic assessment, explanation of findings, psychological testing, neuropsychological services, direction of behavioral aides and inpatient consultation

- "Critical Access Providers" eligible for the rate increase include community mental health centers (CMHCs) and providers who are certified by the Department of Health as Essential Community Providers and who do not already receive higher (or cost-based) rates through other provisions. Therefore, this proposal does not affect Indian Health Services, Federally Qualified Health Centers and Rural Health Centers.

This proposal does not include adult day treatment, partial hospitalization, Crisis Response services, ARMHS, ACT, IRTS, Rule 5 or MH-TCM, most of which have cost-based rates or which received significant rate increases in 2004.

MHCP rates (other than cost-based rates) are generally recognized as being less than the average actual cost of the services. This proposal would bring these rates closer to, but not over, actual cost.

It is assumed that the process of obtaining federal approval and implementing differential rates will delay implementation until 7/1/07.

Expected Outcomes:

- Attract more mental health professionals to serving public sector clients or to increase the portion of public sector clients they serve.
- Reduced waiting times for publicly funded clients to see psychiatrists or other MH professionals
- Reduced travel time and expense for clients to access psychiatrists or other MH professionals
- Provision of more appropriate, more effective services

Minnesota Examples:

- None related directly to mental health. The state has pursued this strategy to increase access to dental care for enrollees in the states health care programs.

Develop and Support Evidence-Based Practices and Best Practices

Service Description:

Grants will support and leverage the local implementation of evidence based mental health treatment practices including:

- Integrated Dual Diagnosis (MI/CD) Treatment across the service delivery system;
- Assertive Community Treatment (ACT) teams in the 7 county metro area;
- Models of integrated care including co-location of MH services in primary care settings and schools;
- Application of treatment research in daily clinical decision making for children and adolescents (Hawaii Project);
- Use of technology to aid in effective treatment planning; and,
- Housing with support services

Issues to be addressed:

The mental health field is changing rapidly with advances in both physiological and psycho-sociological approaches to treatment. As the pace of change accelerates, it becomes increasingly important to devote resources to staying current in order to provide quality, effective care. There are many barriers to adopting and embracing change. These grants are to provide incentives to try new approaches and to offset the costs associated with implementing them.

Proposed Funding Mechanism:

Grants will be awarded on a competitive basis to counties, Adult Mental Health Initiatives, collaboratives, tribes and mental health provider organizations. The grants will generally be short term, to offset start-up costs associated with adopting new technology in mental health treatment.

Expected Outcomes:

- Reduced demand for regional treatment center capacity by metro area clients;
- Improved quality of mental health care provided through primary care clinics;
- Improved quality of treatment planning based on client diagnosis and demographic information.

Minnesota Examples:

- A key best practice in the children's mental health field is to identify and treat emotional problems before they are compounded by more intractable behavioral problems. Ramsey County has provided strong leadership in pulling together local Head Start programs, schools, pediatric clinics and mental health providers in a strategic planning effort to foster early identification and brief, effective early intervention for children.

- Recognizing the need for a more seamless service for persons who were experiencing difficulty in managing their independence in the community and who were served by either the public or private sector, St. Louis County Social Services, Human Development Center, Range Mental Health Center , DHS- Mental Health Division and Medica- United Behavioral Health developed an Assertive Community Treatment Team to serve public and privately funded clients in need of this intensive

evidence-based service. Follow up data indicate a marked reduction in Emergency Room use, improved community tenure and improved client satisfaction with services.

- Given the shortage of mental health providers in the area and the large rural geographic region, the 10 county South Central Adult Mental Health Initiative is in the process of establishing 36 telehealth sites that will be able to be used by all the mental health providers, county social service agencies, and others to improve communication, conduct client assessments and provide other medically necessary services via this technology. This is expected to help with improving access to needed services.

Cultural Specific and other Specialty Services

Service Description:

This proposal provides competitive grants to counties, Adult Mental Health Initiatives, tribes, collaboratives, and mental health providers to address special treatment populations and service-delivery infrastructure that falls outside the expertise or capacity off the existing locally available service infrastructure. The grants will fund costs related to provider training, co-location of specialty providers, recruitment of specialty providers, development of professional consultation and tele-health, and client outcomes data collection and evaluation. Grants will develop care delivery infrastructure for medically necessary services that are eligible for reimbursement through Minnesota Health Care Programs and private payers.

Issues to be addressed:

Some mental health disorders, such as eating disorders or treatment resistant psychoses, require highly specialized treatment that either cannot be effectively delivered by mainstream mental health service providers, or are difficult to make economically viable due to the low incidence of the disorders.

Some populations, such as people from racial and ethnic minorities or those who are deaf, hard-of-hearing, or deaf and blind are most effectively treated by persons with the specialized skills necessary to communicate with them and the knowledge to draw on the context and strengths of their culture. Racial and ethnic minorities—including both immigrants and well-established minority populations—continue to experience mental health care outcomes that are substandard by comparison with the general population. Too many mental health providers lack the expertise to distinguish cultural variation from psychopathology and lack training in using cultural strengths as an effective treatment tool.

Proposed Funding Mechanism:

This proposal would fund a strategically-coordinated series of competitive grants, issued via RFP's, to encourage innovative approaches and gap-filling infrastructure. Eligible applicants would be counties, tribes, collaboratives, and mental health providers. Grantees must show how their proposed approach will meet the needs of the target group and how it will coordinate with existing service infrastructure and access third party payment whenever possible. Grantees must be willing to serve as models from which the rest of the state can learn. Preference will be given to regional or multi-jurisdictional proposals that define a service area based on the natural incidence of its target population, rather than by political subdivisions. Proposals based on short-term start-up funds and / or ongoing funding support will be accepted.

Expected Outcomes:

- Treatment outcomes among racial and ethnic minority populations will achieve parity with outcomes of all Minnesotans
- People with highly specialized or challenging treatment needs will receive high quality care inside Minnesota.

Minnesota Examples:

- Community University Health Care Clinic in Minneapolis and AH Wilder Southeast Asian program in St. Paul receive grant funding from DHS to develop culturally competent mental health services to the growing Somali and Southeast Asian communities. Both programs employ staff from the respective communities who are knowledgeable about the cultures and specific approaches to mental health treatment.

- 25 percent of the federal mental health block grant (about $1.5 million) is dedicated to providing community-based mental health services to American Indians. These funds are awarded to 9 tribes and 4 urban programs. We are also working with the tribes to become Medicaid providers.

- The PACT 4 children's collaborative serves Kandiyohi, Meeker, Renville, and Yellow Medicine counties and the Upper Sioux Community in west central Minnesota. The collaborative has been contracting with two metro area providers, CLUES (Comunidades Latinas Unidas en Servicio) and the La Familia Guidance Center to help bring culturally competent mental health services to the Chicano/Latino population in west central Minnesota.

- DHS funded creation of the Multi-Cultural Specialty Providers Network to increase the provider pool of culturally and linguistically competent providers. This association of culturally diverse children's metal health providers mentored new ethnically-diverse community-based providers in obtaining managed care provider contracts and developed a training curriculum to increase the cultural competence of the state's children's mental health providers. The goal is to eliminate the disparities in mental health outcomes between cultural groups.

Minnesota Department of **Human Services**

Governor's Mental Health Initiative: Background on Integrated Care

Integrated physical and mental health care is emerging as a needed, promising and soon to be standard model of service delivery. In August, 2005, a coalition of 24 health care provider, public health and consumer groups comprising *The Health Care for the Whole Person Collaborative* issued a joint statement calling for the integration of behavioral and mental health services into the nation's primary and public health systems. The *Collaborative*, whose member organizations include the American Psychological Association, the American Public Health Association, the American College of Obstetricians and Gynecologists, The American Nurses Association, the National Association of Community Health Centers, Families USA and the Consumers Union, among others, said that "the current model of health care in the United States artificially separates emotional and mental health from physical health leading to higher health care costs and negative effects on health care access and outcomes."

Recent studies from the Bazelon Center for Mental Health Law (2004), the National Institute for Health Care Management (NIHCM, 2005), and numerous academic research groups have argued the case for integrated care and demonstrated specific ways in which integration can be achieved.

I. Physical and Mental Health Problems Co-Occur

Integration is a needed model because physical and mental health problems are not separable, and previous models which have treated them in isolation have actually exacerbated both. The Bazelon study particularly demonstrates that people with serious mental illnesses have poor physical health, including:

- High rates of diabetes [prevalence rates of 15% for those with major mood disorders; 16-25% for those with schizophrenia; 25% for bipolar disorder; and 50% for schizoaffective disorder]
- Significant hypertension [34% among those with serious mental illnesses] and cardiac disease [16%]
- High rates of obesity
- Elevated risks of breast cancer [9.5 times higher in women with SMI], HIV infection [eight times U.S. prevalence], and hepatitis B and C [five and eleven times the U.S. prevalence, respectively]

In addition to these specific risks, depressive disorders have been related to an increased risk of developing coronary heart disease; increased insulin resistance; increased risk of developing some cancers; and accelerated progression of HIV infection to AIDS (Health Resources and Services Administration [HRSA], 2001).

Despite these high rates of physical disease, consumers of mental health services are undertreated. In two studies reported by Bazelon, only 11% of individuals with a serious mental illness received preventive physical care during a visit to a psychiatrist, and 48% of women's health issues were undiagnosed by psychiatrists. Consumers interviewed by Bazelon staff reported that too often "they

have raised issues related to physical illness with their mental health provider, only to have their complaints dismissed as psychosomatic or the result of their mental illness" [p. 11].

Conversely, the mental health needs of children and adults with acute and chronic illnesses are also underestimated and undertreated in systems which have carved apart physical and mental health care. A triennial national survey of children with special health care needs (CSHCN) has repeatedly demonstrated that these children and adolescents are at significantly increased risk of mental health disorders, with common children's mental health diagnoses occurring at up to twice the rate of non-CSHCN children. Minnesota Student Survey data similarly shows that children who identify themselves as having special health needs have elevated levels of depressed mood and suicidal ideation.

For adults, data from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services clearly demonstrates the ubiquity of mental health problems – usually unidentified and untreated – among persons with chronic health conditions:

- Depression occurs in 35-45% of patients who have had a heart attack, and depression may be an independent risk factor for death in patients who have experienced heart attack and others with coronary heart disease.
- 10-15% of people with diabetes have depression, and almost 80% of these have a re-occurrence of depression during a five-year follow-up period.
- Almost half of all cancer patients have a mental health disorder, with adjustment disorders and depressive disorders being the most common.
- Between 22-32% of HIV-infected patients have depression.

II. Primary Care is the Locus of Most Mental Health Care

Despite the current bifurcation of physical and mental health service delivery, the majority of mental health care is delivered in the context of primary care. The *Health Care for the Whole Person Collaborative* reports that the ten most common problems which adult patients bring to primary health care services, including chest pain, fatigue, dizziness, headaches, back pain and insomnia, account for 40 per cent of all primary care visits – but only 26 per cent of these problems have a confirmed biological cause. Not surprisingly, primary care providers often respond to these visits by initiating pharmacological treatment. A recent study of children and adolescents receiving services under Minnesota Health Care programs found that 60% of those prescribed psychotropic medications received these without any accompanying mental health services. Health plans in Minnesota report that primary care providers may prescribe up to 80% of psychotropic prescriptions for both children and adults covered by private insurance.

NIHCM's study noted that primary care is playing a substantial and growing role in mental health treatment for children and youth: from the mid-1980s to the late 1990s, the percentage of children's physician visits that included a mental health diagnosis nearly tripled, and nearly all of this increase was for visits at which psychotropic medications were prescribed (p. 13).

Primary care was similarly noted by the Surgeon General's Report on Mental Health (1999) to be a "pivotal setting for the identification and treatment of mental disorders in older people" (p. 68). This report noted studies which had found a preference among the elderly to receive mental health treatment in primary care, and argued that primary care offers the elderly the potential advantages of proximity, affordability, convenience, and coordination of care for mental and somatic disorders, "given that comorbidity is typical" (p. 68).

III. Integrated Behavioral and Primary Care Improves Care Effectiveness

The rapid growth of mental health treatment in primary care has raised awareness of both the limitations of current practice and the opportunities that exist to enhance practice through integration. Primary care providers have been noted to misdiagnose mental health conditions, have less than optimal outcomes with medications, and generally not provide or refer to psychosocial services along with medication (NIHCM, p. 14). However, the addition of consulting mental health professionals to primary care practices has led to substantial improvements in practice and outcomes, as demonstrated, for example, by Unity Health System in Rochester, NY, and Kaiser Permanente in California (NIHCM, p. 14).

In addition to the benefits of mental health consultation, specific advantages accrue when mental health and primary care providers work side-by-side in the same clinics. Katon (1992, 1995) and his collaborators at the University of Washington have provided some of the most closely controlled studies on interventions that can help primary care physicians manage mental health disorders, and particularly depression, more effectively. Katon's integrated protocol for depression included patient education and brief treatment with a psychiatrist or psychologist who was co-located within the primary care setting; patient visits with the biomedical provider alternated with visits with the mental health provider. The results associated with this protocol were significant and substantial: 74% of the people with major depression in the integrated treatment plan showed significant symptom reduction while only 44% of the patients who had physician treatment and referral to mental health services at a separate site showed similar improvement. Katon's work as a whole has shown that "a model of collaborative management...dramatically improves adherence, satisfaction with treatment, and depressive outcomes" (Katon, 1995, p. 364).

IV. Primary Care is Uniquely Situated to Provide Early Identification and Intervention

One of the most salient consequences of the bifurcated physical and mental health treatment system is a focus of mental health resources on children and adults with the most complicated and serious needs, to the neglect of early identification of disorders and optimal treatment at early, tractable stages. This is clearly the case for children, as noted by the Commonwealth Fund in its analysis of the central role of pediatrics in caring for common and emerging mental health problems. Similarly, NIHMC notes that primary care providers remain the first point of contact for most children, particularly in infancy and the preschool years: "In those years especially, when prevention and early intervention can have significant long-term impact, primary care providers and organizations have a critical role to play in developmental and behavioral screening, parent counseling, and referral to community resources" (p. 13).

A similar case can be made for screening for depression and other common mental health disorders in adults, as recommended by the New Freedom Commission Report on Mental Health (2004), and particularly for older adults (Surgeon General, 1999). The Surgeon General's report argued that older adults, who commonly present with medical disorders which may affect their mental health, either through a disease process or via multiple medications that may affect mental functioning, are more likely to have their symptoms detected and treated if primary care is structured to do so.

Early identification and intervention within primary care is also more tractable than in other systems such as education or social services because of greater assurance of confidentiality, reduced stigmatization associated with location or service type, and the provider's ability to simultaneously consider both physical and mental etiology. For example, a group of parents of diverse ethnicity in a local early childhood system expressed reservations about mental health screening in an educational

setting, but agreed that they would readily complete the same instrument if their doctor recommended it. This acceptance was also noted by the Rural Health Advisory Committee's Task Force on Mental Health and Primary Care (2004), which recommended primary care as the optimal setting for mental health care provision in underserved areas of the state.

V. A Variety of Models of Integrated Care Are Being Developed and Tested

The Bazelon study (2004) referenced above demonstrated that there is not a single model for integrated care, but that a variety of emerging models demonstrate the advantages and challenges of different forms of integration. Bazelon grouped these models into four types and reported in detail on several examples of each type. These models, examples, advantages and challenges are briefly described in the sections below.

Model 1: Primary Care Embedded in a Mental Health Program

The embedding of primary care in a mental health program ensures strong linkages between primary care and mental health providers and may be particularly effective for adults with serious mental illnesses. Bazelon studied four examples of such programs:

- Center for Integrated Care, Chicago, IL. A collaboration between a psychiatric rehabilitation center and the College of Nursing at the University of Chicago, this program provides the primary care services of advance-practice nurses and a consulting family physician to psychiatric clients at the Center and satellite sites, including homeless shelters. Approximately 58% of the Center's 700 clients are regular users of primary care services, with an average of 4.3 visits per year for physical health care.
- Comprehensive Care Services, Pittsburg, PA. This program is operated by Western Psychiatric Institute at the University of Pittsburg Medical Center, and is staffed by a primary care physician, physician assistant and nurse. Primary care and pharmacy services are provided to approximately 850 individuals with serious mental illnesses per year. Consumers who choose to receive their primary care elsewhere may have that care coordinated through CCS.
- EXCEL Group, AZ: A nonprofit Medicaid health plan providing services to adults and children with serious mental illnesses has a small primary care clinic staffed by a family practice physician, physician assistant, nurse practitioner and medical assistants, located within a behavioral health service clinic. Primary care services are provided to individuals receiving outpatient mental health services, with approximately 50 patients seen each day for physical care; the medical staff also conducts daily rounds at an adult inpatient psychiatric facility and a children's residential treatment center.
- Massachusetts Behavioral Health Partnership: Three primary care projects are embedded in psychiatric day programs for seriously mentally ill adults in Springfield, Hyannis and Lawrence. One site is specialized to serve homeless adults with co-occurring mental health and substance abuse disorders.

Advantages of embedded primary care:

- Staffing patterns in these programs have been developed to allow for longer patient visits and more comprehensive assessments
- Working on-site at mental health programs allows the development of strong working relationships between health care and mental health providers. Both groups expanded their knowledge and skills as a result of reciprocal consultation, common training and continuing education.

- Integrated electronic medical records have facilitated communication and treatment planning in these programs. Client confidentiality and informed consent are closely monitored, and consumers are generally more comfortable with information exchange in these programs than they may be with exchange between agencies.
- Access to care, including preventive health care for problems which are common among persons with serious mental illnesses, was substantially improved in all these programs. Specialized diabetes care is an element of all the programs.

Challenges to embedded primary care:

- In all of these programs, the primary care staff is small and available for limited hours.
- All programs had continuing funding challenges, and needed sources of support beyond third party reimbursement for direct services.

Model 2: Unified Primary Care and Mental Health Programs

Combining publicly funded primary care and behavioral health into a unified approach was described by Bazelon as the most "seamless approach" of the models studied, integrating delivery of care, administration and financing. Bazelon studied three sites, each providing a full range of primary care and behavioral health services, utilizing multidisciplinary teams.

- Cherokee Health System, East Tennessee: A nonprofit organization operates both a community mental health center and a federally qualified health center (FQHC); it created its first integrated primary care and behavioral health clinic in 1984 and now provides integrated services in 21 sites and serves approximately 40,000 individuals annually. Full ranges of both primary care and mental health services are provided, including day programs, case management and substance abuse treatment.
- Washtenaw Community Health Organization, Michigan: A collaboration of the University of Michigan Health System, a Medicaid managed care health plan, a county and the state, this organization provides integrated mental health, substance abuse, and primary and specialty care health services to Medicaid, low income and indigent populations.
- Massachusetts Mental Health Services Program for Youth: A collaboration of all state-level child-serving agencies with the Neighborhood Health Plan, a managed care plan associated with Harvard Pilgrim Health Care, MMHSPY has been in operation since 1998. It provides integrated mental health and physical care to adolescents with serious emotional disorders and youth who are at risk of out of home placement, or who are returning from placements to their homes and communities. The program capacity is 30 youth at any one time.

Advantages of unified care:

- Financing flexibility allows corresponding flexibility in utilization of varied providers' time, and supports collaboration at the individual case level.
- There is some evidence that unified arrangements are economically efficient. The Massachusetts Youth Program, for example, reduced per client costs by 18% below the capitation rate while also improving service access.
- High levels of provider collaboration, based on unified treatment planning, characterize these programs.
- These programs were also noted to improve consumer satisfaction, improve care access, and provide better preventive care to recipients.

Challenges to unified care:

- Only the Cherokee Health System is of substantive size. Problems associated with moving from demonstration-level projects to scale for the most part remain to be discovered or analyzed.
- Recruitment of providers who are comfortable and willing to work across disciplinary boundaries is necessary, but can be challenging.

Model 3: Co-Location of Mental Health Specialists within Primary Care

Co-location of mental health professionals within primary care is a popular model of integration; it is used extensively in Minnesota by HealthPartners as well as in demonstration projects supported by other health plans. Bazelon notes that a number of research studies have demonstrated the effectiveness of this model, particularly for children and adults with less severe mental disorders. Bazelon references several examples of co-location:

- Multnomah County, OR: Mental health and substance abuse providers are located at several primary care clinics, primarily treating depression and anxiety disorders.
- Network Health, MA: This provider-sponsored, Medicaid-only managed care organization ended its carve-out and brought behavioral health services in-house. Members are followed by medical, behavioral and social case managers, and integrated team meetings are held weekly.
- Hackley Community Care Center, MI: The staff of this FQHC includes a social worker who assesses individuals' mental health, provides brief interventions for those with less serious problems, and refers those with serious mental illness to community mental health centers.
- Lifeways, MI: This community mental health program has located a psychiatrist at a local health center one day per week, where she provides psychiatric consultations and medication evaluations. The health center has also made case managers responsible for linking primary care clients with behavioral health issues to other needed services.

Advantages of co-location:

- Depression is prevalent among primary care patients, who often present with physical complaints. Co-location has been found to increase access to care, resolution of symptoms, and consumer satisfaction among these patients.
- Co-location projects also improve treatment for individuals with serious physical illnesses, who often have co-occurring depression or other mild to moderate mental health problems.
- This model can improve both the productivity and the skills of the primary care provider, by clarifying and supporting his or her scope of practice in managing mental health problems.
- Access to crisis evaluations and brief therapy is increased by having these services available at the primary care site.

Challenges of co-location:

- Clarifying the roles of the co-located mental health professional and the time that will be required for each (crisis evaluations, routine evaluations, therapy, consultation) is critical to success. An unsuccessful example provided by the Bazelon report involved a co-located psychologist whose schedule was so quickly filled with therapy appointments that he became unavailable for consultation with primary care providers.
- If the co-located mental health professional is employed by an agency other than the primary care clinic, fiscal and information sharing problems may pose barriers to optimal integration.

Model 4: Improving Collaboration between Separate Providers

Integration of care is difficult when providers practice independently and have separate administrative, information and funding systems; technically, the fourth model is not genuinely integrative. But because this approach causes the least disruption to traditional models of practice, it has numerous applications. Bazelon noted that Massachusetts, Michigan, Oregon and Oklahoma have introduced a number of strategies to increase collaboration, including:

- Special targeted programs;
- Financial incentives;
- Managed care contract requirements; and
- Provider education and training.

All of these strategies have provided some improvements in access to care. But collaboration can be difficult to establish or sustain without larger, systemic changes to make it a routine and viable way of doing business.

Governor's Mental Health Initiative: Implementation Timelines — March 16, 2006

Implementation Area	July 2006	January 2007	July 2007	January 2008	July 2008
Administration / Planning Activity	▫ Continue stakeholder meetings, with focus on implementation issues; criteria for regional projects RFP and future role of county in MH system. ▫ DHS supplies counties with projected grant changes for 2007 and estimated county share of RTC costs data.	▫ DHS releases RFP for regional projects. ▫ Continue stakeholder meetings – focus on implementation & transition issues. ▫ DHS reports to legislature on further recommendations & future role of counties in MH system.	▫ DHS selects regional project sites from RFP responses, begins working on transition with applicant counties and care networks. ▫ Stakeholder oversight of initiative progress and implementation continues. ▫ DHS calculates grant transfers for regional projects.	▫ Regional Projects begin. ▫ DHS provides TA and monitors local implementation. ▫ Stakeholder oversight of initiative progress and implementation continues. ▫ DHS releases RFP for second round of regional projects.	▫ DHS selects additional regional project sites from RFP responses, begins working on transition with applicant counties and care networks. ▫ Stakeholder oversight of initiative continues. ▫ DHS calculates grant transfers for new regional projects.
MHCP Benefit Changes	None.	▫ GAMC and MnCare begin coverage for ARMHS, ACT, IRTS, Crisis Services. ▫ These services made available through MHCP prepaid plans.	None.	▫ Case management and children's residential treatment move from fee-for-service only to also being available through prepaid plans.	None.
MHCP Enrollment Changes	None.	None.	None.	▫ Within approved regional projects, SED/SPMI persons on fee-for-services MA are transitioned to prepaid plans / preferred integrated care networks.	▫ Continue transition to preferred integrated care networks.
County Changes	▫ Counties begin CY2007 budget/service planning. ▫ Counties begin discussions w/ local prepaid plans about coordination issues.	▫ County share of AMRTC/CBHH placement cost increases.	▫ Counties begin CY2008 budget/service planning.		▫ Counties begin CY2009 budget/service planning.
Outcome Measurement	▫ MMHAG Outcomes measurement group finalizes its recommendations. ▫ DHS begins work on system requirements and design.	▫ DHS continues on system design. ▫ DHS pilots outcomes measurement system.		▫ Outcomes measurement system operational.	
Other	▫ DHS releases RFP for first round of MH Infrastructure Grants.	▫ MH Infrastructure Grants begin. ▫ Psychiatric bed tracking system operational.	▫ MHCP 23.7% rate increase for psychiatrists, APRNs, selected MH services and providers begins.	▫ DHS releases RFP for second round of MH Infrastructure Grants.	▫ Second round of MH Infrastructure Grants begin.

Brief Descriptions of ARMHS, ACT and IRT

These services are currently available through MA fee-for-service, and on a limited basis through counties for non-MA eligibles. The Governor's Initiative proposes to add coverage for these services in PMAP, GAMC and MnCare for individuals currently enrolled in those programs.

Adult Rehabilitative Mental Health Services (ARMHS) are mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, when these abilities are impaired by the symptoms of mental illness. A person can receive this service if they an MA eligible individual who is age 18 or older; is diagnosed with a medical condition, such as a serious mental illness or traumatic brain injury, for which adult rehabilitative mental health services are needed.

Assertive Community Treatment (ACT) is an intensive, non-residential rehabilitative mental health service that is an identified evidence-based practice. Services are consistent with adult rehabilitative mental health services (ARMHS), except ACT services are provided by multidisciplinary staff using a total team approach, and directed to adults with a serious mental illness who require intensive services.

Intensive Residential Treatment (IRT) is a 24-hour-a-day program under the clinical supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit.

DHS Mental Health Division
March 16, 2006

Michael Scandrett

MN Mental Health Action Group

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(As of March 2006)

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POSITION STATEMENT---March 2, 2006

The State Advisory Council on Mental Health and the Subcommittee on Children's Mental Health support the governor's mental health initiative released on Friday, February 24, 2006. This proposal was developed in collaboration with stakeholders including representatives of consumers, families, advocates, providers, health plans and counties, through the Minnesota Mental Health Action Group (MMHAG).

The Council and Subcommittee believe that this proposal, which includes the introduction of new money into the mental health system, is moving in the right direction.

Because the legislative language is not yet available and many of the details remain to be worked out over the next year, the Department of Human Services and MMHAG have stated that they will continue to work collaboratively with stakeholders in the mental health system redesign process; the Council and Subcommittee look forward to working with them to resolve issues and concerns that may be identified as the work continues.

Patricia Siebert

MARCH 23, 2006

To: Interested persons
From: Minnesota Disability Law Center
Re: SF 3290, amendment permitting a disenrollment option

SF3290 permits the commissioner to implement regional projects to demonstrate the integration of physical and mental health services within prepaid plans and their coordination with social services. The regional projects will affect no more than 20% of the population of persons with serious and persistent mental illness or severe emotional disturbance. The bill mandates that these medical assistance recipients *must* enroll in the regional projects. There is a limited opt out provision for individuals who have a previously established relationship with a provider not part of the regional project, and for those still exempted under 256B.69, Subd. 4.

While overall MDLC is supportive of the goals of SF 3290, we are opposed to mandatory enrollment without the opportunity to disenroll. We have had a number of discussions with DHS on this issue, which has resulted in a limited opt out provision for individuals whose providers are not in the project network. We have not heard a convincing rationale as to the necessity of mandatory enrollment for this group of disabled Medical Assistance recipients, but not others. Because the regional projects are demonstration models for the integration of physical and mental healthcare and social services, the effectiveness of these models and their actual impact on individuals' lives is an open question. Individuals who have been enrolled by the commissioner should be able to opt out for any reason if they are dissatisfied with the results of their participation in the plan. The option of disenrollment is an essential safeguard for the individual consumer, and should be supported for a number of important reasons:

1. **Other integrated health care models for disabled Minnesotans on MA are voluntary and recognize the importance of being able to disenroll should the plan not meet the individual's needs.** Such plans include the Axis/UCare model. These models honor the right of the consumer to make the health care choices that work best for them. The regional projects in the mental health initiative should be no less respectful and no less responsive to consumer needs.
2. **Medicare Special Needs Plans (SNPs) in Minnesota are required by federal law to be voluntary plans.** One hope of the mental health initiative in SF3290 is that individuals will be able to successfully combine Medicare and Medicaid dollars into one coordinated plan. **Creating a situation where the individual may disenroll from the Medicare SNP part of an integrated delivery model when it does not work for them, but requiring them to continue with the Medicaid part of the same model creates yet another fragmented mental health system** that does not respond to the individual consumer and does not combine the available funding for the most effective result.
3. **The social services individuals use, which will also be integrated in this model, are by law voluntary, and individuals may choose to disenroll from those services.** Again, the regional demonstration models ought to be consistent with the expectation that individuals will choose what is best for them and should not have to participate in a program simply because it is mandated. This conflict of mandatory and voluntary

services creates a new opportunity for a mental health system that is fragmented--just in a different way.

4. **Let the market place play a role in the regional demonstration projects. If plans have to work to attract and to keep individuals, they will provide the best services they can for the dollars they receive.** If plans are not doing the job, then people ought to be able to vote with their feet. By not allowing disenrollment, the bill creates a captive audience, and does not provide the right kind of incentives for the best results possible.
5. Most people, when enrolled by the commissioner in the demonstration projects, will likely elect to stay there. Others, however, will have good reasons for electing other options. **By allowing individuals the option of disenrolling, this amendment strikes a balance between maximizing enrollment for the benefit of the regional projects, and acknowledging the right of the individual** to go where the best benefits are for his/her own situation.

PROPOSED AMENDMENT TO SF 3290

(b) Notwithstanding any statute or administrative rule to the contrary, the commissioner shall enroll all medical assistance eligible persons with serious and persistent mental illness or severe emotional disturbance in the prepaid plan of their choice within the project region unless:

(1) they have no other basis for exclusion from the prepaid plan under section 256B.69, subdivision 4; or

(2) the individual has a previously established therapeutic relationship with a provider who is not included in the available prepaid plans.

(c) If the person with serious and persistent mental illness or severe emotional disturbance declines to choose a plan, the commissioner may preferentially assign that person to the prepaid plan participating in the integrated service network. The commissioner shall implement the enrollment changes within a regional project on the timeline specified in that region's approved application.

NEW <u>(d) The person with serious and persistent mental illness may elect to disenroll from any prepaid plan within the project region at any time. The disenrollment is effective the first of the next month from the date disenrollment was elected.</u>

Commissioner Gail Dorfman Testimony on SF3290
Senate Health and Human Services Policy Committee
March 23, 2006

Senator Lourey, Senator Berglin, and Members of the Committee,

I am Hennepin County Commissioner Gail Dorfman. I'm pleased to testify today as a representative of the Association of Minnesota Counties and as the AMC representative to the Minnesota Mental Health Action Group. I am also representing Hennepin County, the most populous county in the state and the one with the greatest concentration of individuals that will be impacted by this bill. We estimate that there are 46,000 adults and 16,000 children in Hennepin County with serious mental illnesses. Twenty-two thousand of these adults have serious and persistent mental illnesses.

In Senator Berglin's committee in January, I spoke about the great interest of counties in seeing movement on mental health reform. Now that we have legislation before us, I would like to address some of the specifics of SF3290.

I first want to say quite clearly that all 87 Minnesota counties applaud this effort to address critical issues around mental health care, including prevention and early intervention, equal access to evidence-based treatment and services, creation of a system that's both accountable and affordable, that's consumer-centered, and that begins to erase the stigma of mental illness. Our mental health system in Minnesota is all too fragmented. AMC recognizes that system reform is warranted.

The primary goal of counties is to assure that this new system will in fact improve services for people, including those who are the most vulnerable due to serious mental illness. The availability of housing, employment, school supports and other community-based services is essential for these individuals in order to maintain their independence and affectively cope with their mental health problems.

A second goal for counties is to insure that we continue to have the resources to be at the front-line in providing safety net services for both the mentally ill and for other clients in need of protection, such as abused and neglected children.

With these goals in mind, let me briefly comment on some of the key components of the bill.

Expanded Benefits: We support expanding the Mental Health benefit set for GAMC and MinnesotaCare to achieve parity with Medical Assistance. We believe this change will improve access to mental health services, prevent more costly inpatient care, and provide consistent access to services throughout the State.

However, we are concerned that the bill does not expand the number of persons eligible for these programs. In fact, program cuts going back to the 2003 legislative session have resulted in an overall reduction in the number of persons covered through MinnesotaCare and GAMC. From September 2003 to December 2004, over 2,000 less people from Hennepin County were being served by these programs. At the same time, the amount of uncompensated care provided by Hennepin County Medical Center rose over 37%. We also saw an increase in the number of persons going through the commitment process, which we think is partially attributable to the decline in availability of public program insurance.

For people cycling on and off of public programs, which is not uncommon, the problem of maintaining continued insurance eligibility must be addressed. This is an especially difficult issue for persons with serious mental illness. In 2004, more than 15,000 Hennepin County residents on state programs lost coverage but re-enrolled within six months. We know that a significant percent of this group experienced serious mental health problems that made it difficult for them to maintain coverage.

We appreciate the rationale for early movement of case management functions into the benefit set in order to retain federal funding for this service. However, counties are concerned about the role of case managers within these healthplans. We urge you to assure that the funds currently used by counties for case management are not taken away from counties before the case management function is fully defined and incorporated into healthplans or integrated care networks. We also

urge you to include language to assure that case management will not only address mental health care, but also assist people in linking with other critical community services such as schools, corrections, courts, public program enrollment assistance, and other supports required to promote stability and independence.

Regional Projects: Counties support a phased-in approach to the regional projects that integrates physical and mental health. As I've emphasized, integration with social services is a critical piece in the development of integrated care networks. As the unit of government that is closest to the community and that is responsible for safety net functions, counties must have a key role in the development and selection of the regional integrated care networks. We wish to suggest that this role be more clearly established in the legislation.

The legislation indicates that individuals living in the regions with demonstration projects will have the ability to choose between the new integrated network or healthplans. This will mean that some persons will obtain services, including case management, from the integrated network while others will receive care from plans that do not have integrated services and have no requirements for integration with county social services. Counties will therefore continue to be responsible for a portion of the population without a clear relationship with these healthplans. In Hennepin County this could include several different healthplans. We suggest that all regions in Minnesota be permitted to develop single integrated networks for the entire populations targeted for the initiative, and that all healthplans be required to develop formal relationships with county social services as a condition of their assumption of new case management duties.

We would also like to encourage you to consider the possibility of phasing-in the development of integrated networks within a region, especially in larger counties, where integrated networks for segments of the population, such as children with SED, might be developed as a first-stage in a larger initiative.

Infrastructure Supports: We applaud the Governor and the Department for recognizing that, in addition to access to medical care, an improved infrastructure is needed to support the transformation of the mental health system and we support the areas targeted for additional investments.

There are two areas in the bill that we must oppose. The first is the county maintenance of effort requirement. We understand and appreciate the importance of keeping mental health dollars in the system. However, with the large reductions in state funds in recent years and the projected loss of up to $94 million statewide in federal targeted case management funding, we think it is unrealistic to tie our hands at this point while we wait for clarity about the implications of the federal government rule changes. In Hennepin County, child protection system is as an important piece of our children's mental health system and we may need to redirect resources to offset federal funding reductions in this area. The maintenance of effort provisions in the bill need to be adjusted to permit this type of flexible decision-making.

If the intent is to assure that funding currently used for mental health services continues to address mental health needs, then comparable provisions must be placed on all funds being shifted to healthplans. Specifically, language must be included that requires that the additional money given to health plans be used to fund mental health care. Secondly, health plans should be required to reinvest in the counties from which the transfer of funds occurred. According to recent information from the Minnesota Department of Health, over the last six years (1999-2004), HMOs in Minnesota made over $218 million on their PMAP enrollees. We urge you to assure that public funds are reinvested to address public needs, not to underwrite business losses in other market segments. From a Hennepin County perspective, we also want to make sure that public funds previously invested in meeting the needs of Hennepin County residents remain available to meet the needs of Hennepin residents.

The second issue we oppose is the increased county cost share imposed on persons placed in 16-bed units and the Anoka Regional Treatment Facility. People are place in these facilities, and often remain in these facilities for longer periods of time because of a judge's order or doctor's recommendation. Difficulty in the development of local services is often due to the complexity of the needs of the individual, and the challenges of securing basic supports such as housing. If this cost-sharing provision is included in the bill, it should be limited to situations where counties have clear responsibilities for ensuring timely discharge from a State facility, with appropriate notification, and there should be clearly stated exceptions to the county cost-sharing provisions

related to court ordered treatment, medical necessity, or other factors that inhibit our ability to secure appropriate community programming.

What's missing? We would like to see more investments in primary prevention and more consumer oversight of the mental health system including activities within the new integrated care systems. Hennepin County residents and providers have benefited from the strong involvement by our local citizens advisory committee. This community oversight shouldn't be lost, and instead should be replicated within the new system.

AMC understands the role of counties in our mental health system will be changing. Please understand that the AMC concerns expressed today are not opposition to reform, but are out of concern for the needs of the mentally ill and our desire to assure that adequate resources remain in place to integrate primary care, mental health care, and critical social services for this vulnerable population. AMC is committed to work with you and with the Minnesota Department of Human Services to make the needed changes in this legislation, and to promote system redesign moving forward. I thank the Committee for your interest in mental health reform and for taking testimony on behalf of Minnesota county governments.

I would now like to introduce Peggy Heglund from Yellow Medicine County to share some specific information with you.

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Health and Family Security Committee
Testimony on S.F. 3290
March 23, 2006

My name is Barbara H. Flanigan and I am here today to speak for the League of Women Voters of Minnesota. The League opposes S.F. 3290 as currently written. It fails to give a high priority to the estimated 73,000 Minnesotans with serious and persistent mental illness. It would jeopardize the excellent services which have developed in the county-based system created by the 1987 Comprehensive Mental Health Act with targeted funding.

When the first state hospitals were closed, at Hastings and Rochester, many patients were discharged to their communities with minimal services. Many re-hospitalizations, recommitments and much homelessness resulted. As a result, the 1987 Comprehensive Mental Health Act mandated that counties provide an array of services and give priority to serving people with serious and persistent mental illness (SPMI) and acute mental illness. Required services included community support programs (CSPs) and case management. CSPs provide a wide range of flexible supports: peer support groups, outreach, help with finding and supporting housing, help in applying or re-applying for benefits, and assistance in finding volunteer or paid work. Unfortunately, while many excellent and innovative services have developed, they have never been funded at a level sufficient for them to serve all eligible people appropriately for extended periods of time.

It is true, of course, that serious and persistent mental illness is a chronic physical illness like diabetes. Medical intervention is crucial to stability .But, unlike people with diabetes, many people with SPMI need wrap-around psycho-social services not ordinarily part of a medical model. Regularly scheduled medical appointments, for instance, may require staff help for a person to meet them. People with SPMI are unlikely to be strong advocates for themselves, a necessity for most of us in dealing with health plans. Since the illness has cycles, a client's need for specific services may fluctuate.

We have been told "trust us" when we raise questions about the future of people with SPMI if this bill passes as presently drafted. Yet history teaches that it is essential for specific guarantees for service to be legislated for people with SPMI. Even with the progress under the 1987 Act, services are still inadequate. These vulnerable adults are unpopular, lack political clout, are hard to treat, and are very rarely "cured." Without conscious, explicit provisions to meet their needs they will fall between the cracks.

Mental illnesses like schizophrenia and bipolar disorder can very rarely be prevented. But people experiencing them can flourish in the community with strong supports, social as well as medical.

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We have been told "trust us" when we raise questions about the future of people with SPMI if this bill passes as presently drafted. Yet history teaches that it is essential for specific guarantees for service to be legislated for people with SPMI. Even with the progress under the 1987 Act, services are still inadequate. These vulnerable adults are unpopular, lack political clout, are hard to treat, and are very rarely "cured." Without conscious, explicit provisions to meet their needs they will fall between the cracks.

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State of Minnesota

S.F. No. 2881 - Expanding Interstate Contracts for Mental Health Services to Include Chemical Health

Author: Senator Julie A. Rosen

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: March 22, 2006

This bill modifies the Department of Human Services Act, specifically the section of law related to interstate contracts for mental health services. The sections in this bill modify three subdivisions in this section of law, which expand the interstate contract for mental health services to also include chemical health.

Section 1 amends the definition of "receiving agency" to include "chemical health treatment facility." Further, a receiving agency may provide mental health or "chemical health" services.

Section 2 expands the purpose and authority of this section of law to include chemical health.

Section 3 amends the subdivision related to special contracts and bordering states to include a reference to chemical health.

JW:mvm

Senators Rosen, Ranum, Berglin, Kiscaden and Koering introduced–

S.F. No. 2881: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; providing for interstate contracts for chemical health services; amending Minnesota Statutes 2004, section 245.50, subdivisions 1, 2, 5.

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

Section 1. Minnesota Statutes 2004, section 245.50, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Bordering state" means Iowa, North Dakota, South Dakota, or Wisconsin.

(b) "Receiving agency" means a public or private hospital, mental health center, chemical health treatment facility, or other person or organization which provides mental health or chemical health services under this section to individuals from a state other than the state in which the agency is located.

(c) "Receiving state" means the state in which a receiving agency is located.

(d) "Sending agency" means a state or county agency which sends an individual to a bordering state for treatment under this section.

(e) "Sending state" means the state in which the sending agency is located.

Sec. 2. Minnesota Statutes 2004, section 245.50, subdivision 2, is amended to read:

Subd. 2. **Purpose and authority.** (a) The purpose of this section is to enable appropriate treatment to be provided to individuals, across state lines from the individual's state of residence, in qualified facilities that are closer to the homes of individuals than are facilities available in the individual's home state.

(b) Unless prohibited by another law and subject to the exceptions listed in subdivision 3, a county board or the commissioner of human services may contract with

an agency or facility in a bordering state for mental health or chemical health services for residents of Minnesota, and a Minnesota mental health or chemical health agency or facility may contract to provide services to residents of bordering states. Except as provided in subdivision 5, a person who receives services in another state under this section is subject to the laws of the state in which services are provided. A person who will receive services in another state under this section must be informed of the consequences of receiving services in another state, including the implications of the differences in state laws, to the extent the individual will be subject to the laws of the receiving state.

Sec. 3. Minnesota Statutes 2004, section 245.50, subdivision 5, is amended to read:

Subd. 5. **Special contracts; bordering states.** (a) An individual who is detained, committed, or placed on an involuntary basis under chapter 253B may be confined or treated in a bordering state pursuant to a contract under this section. An individual who is detained, committed, or placed on an involuntary basis under the civil law of a bordering state may be confined or treated in Minnesota pursuant to a contract under this section. A peace or health officer who is acting under the authority of the sending state may transport an individual to a receiving agency that provides services pursuant to a contract under this section and may transport the individual back to the sending state under the laws of the sending state. Court orders valid under the law of the sending state are granted recognition and reciprocity in the receiving state for individuals covered by a contract under this section to the extent that the court orders relate to confinement for treatment or care of mental illness or chemical dependency. Such treatment or care may address other conditions that may be co-occurring with the mental illness or chemical dependency. These court orders are not subject to legal challenge in the courts of the receiving state. Individuals who are detained, committed, or placed under the law of a sending state and who are transferred to a receiving state under this section continue to be in the legal custody of the authority responsible for them under the law of the sending state. Except in emergencies, those individuals may not be transferred, removed, or furloughed from a receiving agency without the specific approval of the authority responsible for them under the law of the sending state.

(b) While in the receiving state pursuant to a contract under this section, an individual shall be subject to the sending state's laws and rules relating to length of confinement, reexaminations, and extensions of confinement. No individual may be sent to another state pursuant to a contract under this section until the receiving state has enacted a law recognizing the validity and applicability of this section.

(c) If an individual receiving services pursuant to a contract under this section leaves the receiving agency without permission and the individual is subject to involuntary confinement under the law of the sending state, the receiving agency shall use all reasonable means to return the individual to the receiving agency. The receiving agency shall immediately report the absence to the sending agency. The receiving state has the primary responsibility for, and the authority to direct, the return of these individuals within its borders and is liable for the cost of the action to the extent that it would be liable for costs of its own resident.

(d) Responsibility for payment for the cost of care remains with the sending agency.

(e) This subdivision also applies to county contracts under subdivision 2 which include emergency care and treatment provided to a county resident in a bordering state.

Senate Counsel, Research, and Fiscal Analysis

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State of Minnesota

S.F. No. 2535 - Report on Case Management and Other Social Services

Author: Senator Becky Lourey

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: March 22, 2006

S.F. 2535 modifies the report to the legislature related to case management, by expanding the report to include other social services, in addition to case management. The bill requires findings and recommendations for improving quality of care case management and other social services, instead of draft legislation, and modifies the detailed list of issues the report must contain.

JW:mvm

Senator Lourey introduced–

S.F. No. 2535: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; requiring a report on case management and other social services; amending Laws 2005, First Special Session chapter 4, article 7, section 59.

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

Section 1. Laws 2005, First Special Session chapter 4, article 7, section 59, is amended to read:

Sec. 59. **REPORT TO LEGISLATURE.**

The commissioner shall report to the legislature by December 15, 2006, on ~~the redesign of~~ case management and other social services. In preparing the report, the commissioner shall consult with representatives for consumers, consumer advocates, counties, labor organizations representing county social service workers, and service providers. The report shall include ~~draft legislation~~ findings and recommendations for improving quality of care case management ~~changes~~ and other social services that will include:

(1) options to streamline administration while maintaining sufficient county social services staff to ensure the delivery of social services;

(2) an analysis of past and projected county case management and other social services staffing and caseload levels;

(3) an analysis of the fiscal and social services impact of reduced Medicaid reimbursements resulting from the federal Deficit Reduction Act of 2005 and options to restore lost revenues and ensure the continuation of county case management and other social services;

(4) a comprehensive report of past and current contracting out-of-county case management and other social services to private vendors, to include costs, qualifications of staff, outcomes and impact on quality of care, and any reported conflicts of interest;

~~(2)~~ (5) a report of current practices and options to improve consumer access to case management and other social services;

~~(3)~~ (6) ~~address~~ a report of current assessment protocols and options for the use of a comprehensive universal assessment protocol for persons seeking community supports;

(7) development of a quality of care impact statement to be used to assess the cost and outcomes and any adverse effects on quality of care prior to contracting out case management and other social services to private vendors; and

~~(4)~~ (8) ~~establish~~ a recommended list of case management and other social services performance measures~~;~~ that best support the findings and recommendations in clauses (1) to (7).

~~(5) provide for consumer choice of the case management service vendor; and~~

~~(6) provide a method of payment for case management services that is cost-effective and best supports the draft legislation in clauses (1) to (5).~~

Sec. 2. **EFFECTIVE DATE.**

Section 1 is effective the day following final enactment.

Senator ..... moves to amend S.F. No. 2535 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Laws 2005, First Special Session chapter 4, article 7, section 59, is amended to read:

Sec. 59. **REPORT TO LEGISLATURE.**

The commissioner shall report to the legislature by December 15, 2006, on the redesign of case management services. In preparing the report, the commissioner shall consult with representatives for consumers, consumer advocates, counties, labor organizations representing county social service workers, and service providers. The report shall include draft legislation for case management changes that will:

(1) streamline administration;

(2) improve consumer access to case management services;

(3) address the use of a comprehensive universal assessment protocol for persons seeking community supports;

(4) establish case management performance measures;

(5) provide for consumer choice of the case management service vendor; and

(6) provide a method of payment for case management services that is cost-effective and best supports the draft legislation in clauses (1) to (5).

Sec. 2. **IMPACT ON REDUCED MEDICAID REIMBURSEMENTS.**

The commissioner of human services shall report to the chairs of the house health policy and finance committee and the chairs of the senate health and family security committee and Health and Human Services Budget Division by December 1, 2006, on the impact of reduced Medicaid reimbursements resulting from the federal Deficit Reduction Act of 2005. The report shall include options to restore lost revenues and ensure the continuation of targeted case management and other affected social services.

Sec. 3. **EFFECTIVE DATE.**

Sections 1 and 2 are effective the day following final enactment."

Amend the title accordingly

Senator ..... moves to amend the SCS2535A-3 amendment toS.F. No. 2535 as follows:

Page 1, after line 2, insert:

"Section 1. **[256K.60] RUNAWAY AND HOMELESS YOUTH ACT.**

Subdivision 1. **Findings and needs.** There are hundreds of homeless youth in Minnesota every night and many come from homes of abuse and neglect or have been abandoned. Homeless and runaway youth are largely an invisible population. Many homeless and runaway youth have no families or primary caregivers. Many are exploited by adults or are forced to compromise their values to survive on the streets. Homeless and runaway youth are in need of outreach, crisis intervention, adult mentorship, family reunification, safe drop-in spaces, shelter, housing, case management services, and life skills training. It is necessary to offer a continuum of care and services directed at homeless and runaway youth.

Subd. 2. **Definitions.** (a) The definitions of this subdivision apply to this section.

(b) "Commissioner" means the commissioner of human services.

(c) "Homeless youth" means a person 21 years or younger who is unaccompanied by a parent or guardian and is without shelter where appropriate care and supervision are available, whose parent or legal guardian is unable or unwilling to provide shelter and care, or who lacks a fixed, regular, and adequate nighttime residence. The following are not fixed, regular, or adequate nighttime residences:

(1) a supervised publicly or privately operated shelter designed to provide temporary living accommodations;

(2) an institution publicly or privately operated shelter designed to provide temporary living accommodations;

(3) transitional housing;

(4) a temporary placement with a peer, friend, or family member that has not offered permanent residence, a residential lease, or temporary lodging for more than 30 days; or

(5) a public or private place not designed for, nor ordinarily used as, a regular sleeping accommodation for human beings.

Homeless youth does not include persons incarcerated or otherwise detained under federal or state law.

(d) "Youth at risk of homelessness" means a person 21 years or younger whose status or circumstances indicate a significant danger of experiencing homelessness in the near future. Status or circumstances that indicate a significant danger may include youth exiting out-of-home placements, youth who previously were homeless, youth whose parents or primary caregivers are or were previously homeless, youth who are exposed to abuse and

neglect in their homes, youth who experience conflict with parents due to chemical or alcohol dependency, mental health disabilities, or other disabilities, and runaways.

(e) "Runaway" means an unmarried child under the age of 18 years who is absent from the home of a parent or guardian or other lawful placement without the consent of the parent, guardian, or lawful custodian.

Subd. 12. **Homeless and runaway youth initiative.** (a) The commissioner shall develop a comprehensive initiative for homeless youth, youth at risk of homelessness, and runaways. The commissioner shall contract with organizations and public and private agencies, including faith-based organizations, to provide street outreach, emergency shelter services, drop-in services, family mediation counseling and conflict resolution, transitional living services, case management services, life skills training, and family reunification services to youth, to the extent that funds exist or become available. The programs must be culturally competent to serve specific populations and must provide voluntary services to homeless youth, youth at risk of homelessness, and runaways in an appropriate and responsible manner.

(b) The commissioner shall plan for and coordinate services for homeless, runaway, and at-risk youth. The commissioner may provide support services required to achieve the objectives and goals of the initiative.

(c) Nothing in this section relieves counties from existing responsibilities to provide services for homeless youth, youth at risk of being homeless, or runaways under section 626.556, chapter 256E, or other applicable laws.

(d) Nothing in this section is intended to preclude homeless youth ages 18 to 21 from utilizing other services or programs available to homeless adults.

Subd. 13. **Street and community outreach and drop-in program.** Youth drop-in centers must provide walk-in access to crisis intervention and on-going supportive services including one-to-one case management services on a self-referral basis. Street and community outreach programs must locate, contact, and provide information, referrals, and services to homeless youth, youth at risk of homelessness, and runaways. Information, referrals, and services provided may include, but are not limited to:

(1) family reunification services;

(2) conflict resolution or mediation counseling;

(3) assistance in obtaining temporary emergency shelter;

(4) assistance in obtaining food, clothing, medical care, or mental health counseling;

(5) counseling regarding violence, prostitution, substance abuse, sexually transmitted diseases, and pregnancy;

(6) referrals to other agencies that provide support to services to homeless youth, youth at risk of homelessness, and runaways;

(7) assistance with education, employment, and independent living skills;

(8) after-care services;

(9) specialized services for highly vulnerable runaways and homeless youth, including teen parents, emotionally disturbed and mentally ill youth, and sexually exploited youth; and

(10) homelessness prevention.

Subd. 4. **Emergency shelter program.** (a) Emergency shelter programs must provide homeless youth and runaways with referral and walk-in access to emergency, short-term residential care. The program shall provide homeless youth and runaways with safe, dignified shelter, including private shower facilities, beds, and at least one meal each day, and shall assist a runaway with reunification with the family or legal guardian when required or appropriate.

(b) The services provided at emergency shelters may include, but are not limited to:

(1) family reunification services;

(2) individual, family, and group counseling;

(3) assistance obtaining clothing;

(4) access to medical and dental care and mental health counseling;

(5) education and employment services;

(6) recreational activities;

(7) advocacy and referral services;

(8) independent living skills training;

(9) after-care and follow-up services;

(10) transportation; and

(11) homelessness prevention.

Subd. 5. **Supportive housing and transitional living programs.** Transitional living programs must help homeless youth and youth at risk of homelessness to find and maintain safe, dignified housing. The program may also provide rental assistance and related supportive services, or refer youth to other organizations or agencies that provide such services. Services provided may include, but are not limited to:

(1) educational assessment and referrals to educational programs;

(2) career planning, employment, work skill training, and independent living skills training;

(3) job placement;

(4) budgeting and money management;

(5) assistance in securing housing appropriate to needs and income;

(6) counseling regarding violence, prostitution, substance abuse, sexually transmitted diseases, and pregnancy;

(7) referral for medical services or chemical dependency treatment;

(8) parenting skills;

(9) self-sufficiency support services or life skill training;

(10) after-care and follow-up services; and

(11) homelessness prevention."

Page 1, after line 25, insert:

"Sec. 4. **APPROPRIATION.**

$..... is appropriated for the biennium ending June 30, 2007, from the general fund to the commissioner of human services for purposes of Minnesota Statutes, section 256K.50."

Page 1, line 27, delete "1 and 2" and insert "2 and 3"

Renumber the sections in sequence and correct the internal references

Amend the title accordingly