DEPARTMENT OF HUMAN SERVICES

Legislative Report

Children's Mental Health Residential Treatment

Room and board funding for children's mental health residential services

Minnesota Department of Human Services

August 1, 2023

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I. Executive summary

The Children's Mental Health (CMH) Residential Services, hereinafter referred to as "Third Path," is a new option for children with a severe emotional disturbance (SED) to access treatment at children's residential facilities (CRFs), outside of the child protection system. The goal of CRF services are to prevent the need for referrals to more intensive, restrictive, and cost prohibitive settings. CRF treatment services are designed to support children and their families in improving the child's functioning within the family, school, and community. The desired outcomes also include increasing the child's ability to gain and maintain positive social interaction skills while building resiliency.

The Third Path provides a child with a SED and the child's family an additional way to gain access to a licensed children's residential facility (CRF). The Third Path is a service option, not a placement. The child and family do not sign a voluntary placement agreement. The parent or the child's legal representative selects the level of county or Initiative tribe's involvement when a child uses this path. The county or Initiative tribe does not receive Title IV-E reimbursement[1] while maintaining responsibility for payment of the CRF using the CMH Residential Services Path state allocated funds.

This report is submitted in response to Laws of Minnesota 2021, First Special Session, Chapter 7, Article 11, Section 34. The legislation directs the commissioner of Minnesota's Department of Human Services (DHS) to organize workgroups that will develop recommendations on how to efficiently and effectively fund room and board costs when a child receives the CMH Residential Services in a children's mental health residential treatment in compliance with the children's mental health act. DHS was required to consult with counties, tribal entities, children's mental health residential providers, and children's mental health advocates in developing recommendations.

The workgroup consisted of participants from counties, Tribal Nations, children's mental health residential treatment providers, children's mental health advocacy groups, and community based mental health providers. DHS staff from the Behavioral Health Division, Financial Operations Division, and the Child and Family Services Administration participated in the workgroup. DHS hosted a series of meetings between September 2021 and February 2022. Three of the meetings specifically focused on identifying systemic barriers when a child is discharged from residential treatment and transitioning children back to their home community. Three of the workgroup meetings focused on identifying effective ways to sustainably fund room and board costs for children in a CRFs.

[1] Children's Bureau, An Office of the Administration for Children and Families. Title IV-E

II. Legislation

Laws of Minnesota, First Special Session, Chapter 7, Article 11, Section 34

The commissioner of human services, in consultation with counties, children's mental health residential providers, and children's mental health advocates, must organize a workgroup and develop recommendations on how to efficiently and effectively fund room and board costs for children's mental health residential treatment under the children's mental health act. The workgroup may also provide recommendations on how to address systemic barriers in transitioning children into the community and community-based treatment options. The commissioner shall submit the recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 15, 2022.

III. Introduction

Background

During the 2020 Legislative session, the DHS recommended legislation that would bring Minnesota into compliance with new federal requirements for foster care from the 2018 Family First Prevention Services Act ("Family First"). This legislation applied Family First requirements for Qualified Residential Treatment Programs (QRTPs) to both chapters in state law regarding foster care: Chapter 260C (child protection) and chapter 260D (voluntary "placement" for treatment). To obtain federal approval for its Title IV-E state plan before the federal deadline of October 1, 2021, legislation that including Family First requirements for children in QRTPs needed to pass in the 2020 legislative session.

In March 2020, mental health advocates and providers raised concerns that Family First requirements should not apply to families accessing voluntary foster care for mental health treatment under chapter 260D. Advocates and providers felt that children should not be required to enter a "placement" through the child welfare system in order to access healthcare treatment. DHS supports ongoing reforms to ensure children can access voluntary mental health services, without child welfare, county, or judicial involvement.

Following discussions on this topic, the 2021 Legislature removed language that specifically applied Family First requirements to chapter 260D. Through ongoing stakeholder discussions and workgroup meetings, DHS determined that not including Minnesota's 260D voluntary foster care requirements in Family First compliance would result in county loss of $2-3 million in annual Title IV-E reimbursements. In addition, the Legislature appropriated funding to DHS to reimburse counties and Initiative tribes for a portion of the costs of room and board, in licensed children's residential facilities.[2] County and tribal governments are responsible for funding a portion of the costs of treatment in children's residential facilities using the DHS allocation.

The Third Path differs from the two existing service entry points or "paths." When a child enters a licensed CRF through the Third Path, the court is not involved. The county or initiative tribe would not receive Title IV-E reimbursement. The county or initiative tribe[3] has placement authority when a child enters a Children's Residential Facility (CRF) using the existing methods. The child may enter residential services through the child welfare system via a voluntary placement agreement (VPA) or the child enters an out of home placement due to a child protection matter. In both circumstances the court is involved. Counties and initiative tribes receive federal Title IV-E reimbursement for eligible children in a treatment placement if the court makes a finding that the child is in need of protection or services or that the child has been neglected in foster care. The agency with placement authority uses Title IV-E reimbursement to partially cover room and board, while a child is in an CRF. Mental health service costs are paid for through Medical Assistance (MA) or private health insurance.

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[2] Laws of Minnesota 2021, First Special Session, Chapter 7, Article 16, Section 2, subdivision 32, paragraph (a)

[3] Initiative tribes include the Red Lake Nation, Leech Lake Band of Ojibwe, and the White Earth Nation.

The Behavioral Health Division facilitated a workgroup to develop recommendations to guide the implementation of the third path. Workgroup participants stated people who were voluntarily seeking services were concerned the court proceedings would be construed to be or lead to the child becoming involved in a child protection matter. The stated concerns were believed to have contributed to situations where those in need of services avoided county or Initiative tribe involvement. The concerns were particularly noted by the underserved and communities of color. Because of the concerns, children who needed the necessary treatment did not get the help they needed. With the option of the Third Path, parents can choose the desired level of county involvement and avoid a court process. Family and children will now have access to residential treatment to address their individual and specific needs without the fear of court involvement. The child who needed treatment services but did not approach the county or Initiative tribe before now constitutes a new set of eligible children.

Because children accessing the Third Path will not be in an out-of-home placement, counties and initiative tribes will not be eligible to receive IV-E funding. As a result, a funding source and payment structure is needed to cover the cost of room board.

Systemic barriers in transitioning children into the community

DHS engaged community partners to identify the barriers that can impede a child's successful discharge from a licensed CRF when they are transitioning back to their home community. Historically, despite having county and tribal partnership, difficulties have occurred in the transition process. One barrier has been distance. Due to lack of resource availability, some children have had to enter CRFs far away from the family home. In the most extreme cases, children have been placed entered CRFs in other states. This has made it difficult for children and their families to maintain close relationships. The CRFs have been challenged in engaging with families due to geographical distance. This has made it difficult to develop and implement workable and realistic discharge plans that will support the child upon their return to their home community. Additionally, the distance has made it difficult for the provider to link the child and family with ongoing services in his or her community.

Priority has not been placed on the choices of the family. The county and Initiative tribe case management process involved collaboration with the CRF, participation in discharge planning, and linking the child and family to aftercare services. Historically these processes have not placed priority on parental involvement and choice, rather decisions have been driven by the agency with placement authority. Community partners are hopeful that the Third Path will be a parent-driven option. Specifically, the family is active in designing and making choices about the child's plan. The voice of the child and family will be key as they determine the service that fits their needs. This active participation and ownership of the plan will promote the achievement of successful outcomes for the child as they return to their home community.

IV. Funding room and board costs

During the 2021 legislative session, the legislature appropriated $1,964,000 in fiscal year 2022 and $1,979,000 in fiscal 2023 to the commissioner of the Department of Human Services to reimburse counties and Tribal governments for a portion of the treatment costs for children's mental health residential services.[4]

The workgroup discussed supporting a funding strategy that has stability and reduces administrative burden for providers. The workgroup identified the Behavioral Health Fund (BHF) as a consistent, long-term strategy to pay room and board costs.

[4] Laws of Minnesota 2021, First Special Session, Chapter 7, Article 16, Section 2, subdivision 32, paragraph (a)

V. Strategies to address systemic barriers

Systemic barriers influence the outcomes and successful transition of children from the CRFs back to their home communities from children's mental health residential treatment. The workgroup noted the following factors had an impact on a child's successful return to their home community: work force issues; limited family supports; prohibitive costs; and a need to expand the continuum of care. Further detail around these barriers can be found in the chart below. They are noted using the voice of the stakeholders.

Systemic barriers to children transitioning to the community from mental health residential treatment

Barrier 1: Work Force Issues	Barrier 2: Limited Family Supports	Barrier 3: Cost Barriers	Barrier 4: Continuum of Care
Mental Health Professionals are overwhelmed, burned out, and leaving the field	Stigma continues to be a barrier for families to seek support	Mental Health Parity Commercial payers not covering services	Lack of early intervention options
Agencies are competing for Mental Health Professionals and struggling to recruit new employees	Transportation: Children often receive Mental Health Residential Treatment in a facility distant from their family and community	Inability to provide and receive reimbursement for family therapy while the child is in residential treatment	Family peers are underutilized due to process of accessing this service and cost of service
Rural areas have limited resources and hiring pools	Family situations are often unchanged when the child returns home Because of limited engagement with families while child is in CRF, outcomes are poor	Grant funded services limit access for some services such as CIBS and Wraparound	Current continuum is service oriented and not approached from a holistic perspective, which limits natural family supports

Barrier 1: Work Force Issues	Barrier 2: Limited Family Supports	Barrier 3: Cost Barriers	Barrier 4: Continuum of Care
Limited support within the community	Family peers and cultural matches or culturally specific services are limited Person/family centered planning	Reimbursement rates don't cover the cost of engagement with families	Some services are available and shown as promising, but are not accessible to all

The workgroup reviewed past reports containing recommendations related to children's mental health. The reports included the Children's Intensive Mental Health Services Study, 2018 report to the legislature, Governor's Task Force on Mental Health Report 2016, and 2009 Intensive Service Mental Health Acute Care Report. Information on these reports is in included in the Appendix.

Services

Stakeholders within the workgroup identified the following as services that would assist and support families while addressing existing barriers.

Wraparound

Wraparound (high fidelity wraparound model) is a care planning process designed to help children with complex mental health or behavioral challenges and their families. The high fidelity model includes intensive evaluation using national and state measures. The measures study both qualitative and quantitative processes. The children and families are served by multiple agencies. The children are at risk of entering or are transitioning from an out-of-home setting. The Wraparound process brings a team of family, friends, community members, professionals, and cross-system supports together to create a plan of care that aligns with the family's vision and story while taking into account the child's strengths, and needs.

Wraparound is a process within a System of Care (SOC) broad framework. SOC is a community based philosophy where services are designed to meet the needs of children with serious mental health needs and their families. It involves partnerships with families, children, public organizations and private service providers. The partners have the goal of building on the strengths of the child. The goals include address the child's mental health needs while effectively delivering mental health services and supports. SOC is designed to be child-centered, family driven, strength-based, and culturally competent while engaging the child and involving interagency collaboration.

Wraparound differs from traditional case management or other types of care coordination. The family-driven process leads to the development of a single, integrated plan of care. The plan is reviewed by the Child and

Family Team (CFT) to ensure progress. The process also emphasizes the importance of informal supports to help the family address their identified needs.

Concepts

- Services are child and family centered
- Child and family are actively involved in planning and setting goals
- Goals include building on the child's strengths, including culture, and while addressing the child's needs
- Teams consist of formal service providers and informal community supports
- Teams work together to solve problems and support the child in meeting the goals outlined in the child's plan of care
- Teams document the child's progress in goal attainment, adjusting to plan as the child's functioning changes

Workgroup Feedback

- *Families may feel overwhelmed and forced to participate by professionals*
- *Diversity and ethnicity missing at the table in this service*
- *Has been tried at various times in MN with varying degrees of success*
- *Cultural responsiveness should be considered. There is a need to improve how we look at how family wants to build team. They often already have natural supports available that aren't always considered. Person and family centered planning approach might be a better way to engage families.*
- *Wraparound care coordinator works extensively with family*
- *Child protection and juvenile justice clients may feel the process is involuntary*
- *Need for culturally specific wraparound care coordinators*
- *Need to work with community organizations vs. institutions*
- *Implementation needs to be culturally sensitive*
- *Family voice needs to be at center of process*

Collaborative Intensive Bridging Services

Collaborative Intensive Bridging Services (CIBS) is a treatment program designed to serve children ages 8 to 17 and their families. The service is used in circumstances where the child's mental health symptoms exceed what community-based services can address. The children are eligible to enter a CRF. This multi-faceted, strength-based model is based on Structural Family Therapy. CIBS relies on intensive in-home therapy with active parental engagement, and often a brief, intensive CRF placement (Phase II of CIBS).

CIBS concepts

- Stabilize child's behavior so they are able to live in their home and access community-based services
- Help develop parenting, communication and relational skills that support a child and promote a family's ability to function
- Improve a family's capacity to effectively manage crisis situations

- Provide seamless coordination of care to a family to minimize multiple service providers during differing stages of treatment
- Based on Multi-systemic therapy (MST)
- Rely upon intensive in-home therapy with extensive family engagement
- Use brief periods of institutional care

Workgroup Feedback

- *Issues with rural implementation and lack of access to CRF*
- *Intensive in-home services are many times not available*
- *Success depends on work force participation*
- *Connections with CRF*
- *May not be for every child/ family*
- *Need to further define who would be a good fit for this service*
- *Need for more cultural responsiveness*

Certified Family Peer Specialists

Certified family peer specialists (CFPS) are individuals with a lived experience who support children with an emotional disturbance (ED) or SED and their families. The child must concurrently receive mental health treatment. The goal is to promote the child's resiliency and recovery. The peer is nonclinical. The peer supports the family in building on the strengths of the family while assisting the family and children in achieving the desired outcomes.

CFPS concepts

- Provide the family with skills, knowledge and assistance
- Strengthen the family and increase parents' ability to support the child's treatment goals
- Support the child in functioning better within the home, school and community while achieving progress with recovery and improving resiliency.
- CFPS must be identified in the individualized treatment plan of the child.
- Does not require Mental Health Practitioner or professional status

Stakeholder Feedback

- *This option would not be impacted by work force issues if rate was sustainable and providers could recruit peers with competitive pay*
- *There needs to be more of a clear process for individuals on how to become a family peer specialist*
- *Promotes opportunities for more culturally matched peers*
- *Help engage families and connect children and their families to on-going services when they return to the community because of their experience and knowledge of these systems*
- *Family peer specialists are integral to early family engagement*
- *Ability to bill is key*
- *The current way this is billed is not sustainable*

- *Risk of losing these services because there are not currently sustainable ways to pay for them*
- *Lack of sustainability results in fragmentation in families involved in system*
- *An existing residential program is piloting a model where family peers engage the family and provide aftercare and has had very positive experience with family engagement*
- *Barriers to further implementation include funding*
- *For this model to be effective a higher reimbursement rate is needed*
- *Medical necessity is required before a person can receive family peer services – a child should have the option of family peer specialist services on the front end.*
- *CFPS service help increase the likelihood of families following through with services after discharge from residential treatment.*

Intensive Rehabilitative Mental Health Services/Youth ACT

Intensive Rehabilitative Mental Health Services/Youth Assertive Community Treatment (IRMHS/Youth ACT) provides services to youth between the ages of 16 and 20. The youth must have a serious mental illness or co-occurring mental illness and substance use disorder. The youth must require intensive services. The goal must be the prevention of admission into an inpatient psychiatric hospital or placement in a CRF. Additionally, this is a service available to individuals who require an intensive service to support transitioning from an inpatient or residential setting to community-based care. The service is provided by a multidisciplinary team.

Workgroup Feedback

- *Youth ACT expansion – more availability statewide*
- *Rates do not cover cost of service delivery*
    - *Rate increase in July 2021*
    - *Rate adjustments will be based on actual costs annually*
    - *Will be statewide average*
- *Clinical service model still in development*
- *RFP out now to recruit new teams*
- *DHS will be doing more outreach to potential teams*
- *How will Youth ACT model be tailored to youth?*
    - *Based on adult ACT but have some flexibility to adapt for youth*
- *Support for families that are not involved with county case management to engage in Youth ACT services*
- *Need to scale up models and ensure reimbursement actually covers costs of service provision*
- *Need for clinicians/ providers of color and culturally appropriate services*

Intensive Treatment in Foster Care

Intensive Treatment in Foster Care (ITFC) is a comprehensive mental health service for children with significant mental health symptoms and functional impairments. The child must reside in a family foster care setting. Services includes psychotherapy, psycho-education, clinical consultation, and crisis assistance.

ITFC Concepts

- Child must have a Child and Adolescent Service Intensity Instrument (CASII) score of 4 or higher
- All ITFC services provided to MHCP members must be provided by a qualified mental health professional or a clinical trainee working under the supervision of a licensed mental health professional.
- Mental health professionals must be certified in one of the following evidence-based practices (EBP):
    - Trauma Informed Child Parent Psychotherapy (TI-CPP), or
    - Trauma Focused Cognitive Behavioral Therapy (TF-CBT)
- Child's biological, foster and/or pre-adoptive families must be involved in treatment and service delivery
- Services may be provided in the child's home, daycare, school or other community-based setting

Workgroup Feedback

- *ITFC is an option but limited to children in foster care*
- *Need to look at the target population*

VI. Recommendations

The Behavioral Health Division organized workgroups to develop recommendations on how to efficiently and effectively fund room and board costs for children's mental health residential treatment in accordance with the children's mental health act. The workgroup recommends supporting a funding strategy that has stability and reduces administrative burden for providers. The workgroup identified the Behavioral Health Fund (BHF) as a consistent, long-term strategy to pay room and board costs for Children's Mental Health Residential Treatment. The fund is a forecasted, stable funding source to pay room and board costs for children seeking residential mental health care.

VII. Implementation language

Modify Minnesota statute 254B.05, Subd. 1a (15) with the language below to include Children's Mental Health Residential Services Path as an allowable program to access room and board funds.

Subd. 1a.**Room and board provider requirements.**

(a) Effective January 1, 2000, vendors of room and board are eligible for behavioral health fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) is determined to meet applicable health and safety requirements;

(3) is not a jail or prison;

(4) is not concurrently receiving funds under chapter 256I for the recipient;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site 24 hours per day;

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

(c) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section 256B.0622 or 256B.0624 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

(d) Programs providing children's residential treatment services pursuant to section 245.4882 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

VIII. Appendix

Recommendations from four previous studies on children's mental health.

Children's Intensive Mental Health Services Study, Wilder Research (March 2019)[5]
Minnesota State Advisory Council on Mental Health, Subcommittee on Children's Mental Health 2018 Report to the Governor and Legislature[6]

[5] Children's Intensive Mental Health Services Study, Wilder Research (March 2019)

[6] Minnesota State Advisory Council on Mental Health, Subcommittee on Children's Mental Health 2018 Report to Governor and Legislature

Governors Mental Health Task Force Report (November 2016)[7]
Mental Health Acute Care Needs Report (2009)[8]

[7] Governor's Mental Health Task Force Report (November 2016)

[8] Mental Health Acute Care Needs Report (2009)