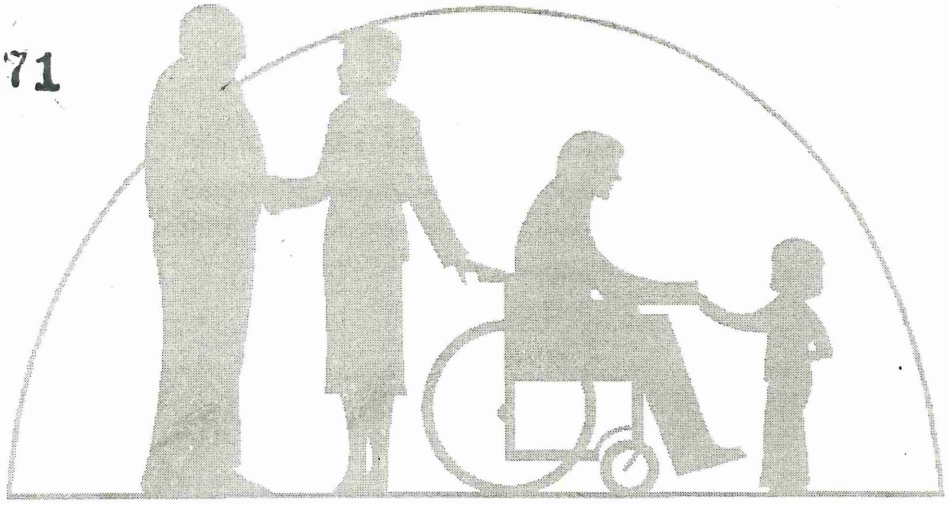

Minnesota Department of **Human Services**

STATE-OPERATED SERVICES

1998 LEGISLATIVE REPORTS

METO Phase II Plan ◆

Anoka Metro RTC Short Term-Treatment ◆

State-Operated Services & Managed Care ◆

Regional Treatment Center/Health Plan Pilot Project ◆

1997 Minn. Laws Chap. 203 Art. 1
Sec. 2 Subd. 7

1997 Minn. Laws Chap. 203 Art. 9
Sec. 13 Subd. 2

In accordance with Mn Stat 3.197 th *000.*

Consolidation of State-Operated Services (SOS) Reports

The Department of Human Services (DHS) has chosen to consolidate four legislative reports required by the 1997 Legislature into a single document. The reports include: 1) the Minnesota Extended Treatment Options (METO) Phase II Plan; 2) the Anoka Metro Regional Treatment Center (AMRTC) Short-Term Mental Health Treatment Program; 3) the Role/Funding Arrangements of SOS in Managed Care Systems Serving Disabled Persons; 4) Regional Treatment Center (RTC)/Health Plan (acute mental health [MH] and chemical dependency [CD]) Contracting Pilot Project; and all are required in Laws of 1997, Chapter 203.

The purpose of consolidating these reports is to provide a common foundation that will allow for a clearer presentation of the analysis and recommendations being made relative to these four distinct areas. There are similar elements in all of these reports in that they are all focused on attempting to define or redefine a part of the SOS system for the future.

At the outset, it is useful to consider some of the trends of the past several decades within the SOS system itself that have influenced and continue to influence where the opportunities will be for SOS to function as an important and effective component of the broader, rapidly changing, health care delivery system in Minnesota. A look at these trends will also allow for some distinctions to be drawn between the SOS RTC system safety net role, its' enterprise activity and the advent of the adult MH community initiatives.

SOS Trends Leading to Redefinition of the RTC Safety Net

Historically the RTC safety net function has been represented by three distinct components. First are all of the appropriations based services provided in the RTC system. The second component is the enterprise activity, which includes all of the various facilities and services that are required to operate on the revenues they generate. Finally, there are the adult MH initiatives which utilize state staff and other non-monetary resources in support of the community mental health service system, as well as a mix of third-party revenue and state mental health grants to counties. There is a shifting of emphasis among these three aspects of the SOS system although they will all continue to exist for

the foreseeable future and will all play important, albeit very distinct, roles in addressing the treatment needs of the populations served by SOS.

The societal expectation of the RTCs (formerly state hospitals) during much of this century was for them to function as asylums. They provided a protective environment for vulnerable disabled persons, where all of the service needs of these persons were provided by the RTC and funded entirely by state appropriations.

By the late 1980's legislative decisions pointed the way toward development of state-operated, community-based alternatives for persons with developmental disabilities and mental illness. The Consolidated Chemical Dependency Treatment Fund was established which created an entirely new revenue based funding approach through which, for the first time, the SOS system participated in the market place along with private providers in securing payment for treatment of persons who are chemically dependent. Direct appropriations for RTC CD programs were eliminated.

The early to mid-1990s saw the development of some specialized, more narrowly targeted programs such as the adolescent, traumatic brain injury and small nursing home programs at Brainerd, and the sex offender treatment program at St. Peter. This same period saw great emphasis on the integration of RTC and community services as Moose Lake RTC services were transitioned to area communities and the campus transferred to the Department of Corrections. Similarly legislation to end service delivery on the Faribault and Cambridge RTC continued the state policy to transition SOS for developmentally disabled persons from institutional care to community-based services throughout the metropolitan area, and other eastern Minnesota communities.

In the latter half of the 1990s the Minnesota Extended Treatment Options (METO) program for persons who have developmental disabilities and who also present a public safety risk was established at Cambridge. In addition, the landmark adult MH initiatives legislation passed creating new partnerships between SOS, counties and community mental health providers. Paralleling these changes in state operated services, there was major expansion of managed care in Minnesota and SOS took the first steps toward becoming part of health networks for acute mental health services.

Throughout this period of significant change there has been a gradual decline in the size of the campus based RTC program while at the same time the enterprise activity and community initiative components have been growing. As a result, the overall SOS system has been able to expand the number of clients served with essentially the same staff and budget resources. The opportunity for growth will continue to be predominantly in enterprise activity and the community initiative components.

The convergence of these and other trends necessitate that DHS take a fresh look at the State's safety net for persons with disabilities and re-evaluate how SOS might best serve vulnerable persons into the next century. Tremendous advances in the treatment of mental illness, chemical dependency, and developmental disabilities lead to greater and more flexible life options for persons who have chronic conditions. Also, diversification in the health care delivery system in Minnesota has the potential to result in duplication of responsibility and funding. This has blurred the roles of the traditional components of the health care delivery system, including SOS, and contributed to less efficient use of scarce public and private sources of payment.

Redefining the State Safety Net

Beginning in the Fall of 1997, DHS began a systematic review of the services provided by the SOS delivery system to vulnerable clients across Minnesota. Using staff from the RTCs, discussions focused on chemical dependency, adult mental illness, adolescent mental illness, psychopathic personality, developmental disabilities, geriatrics, and traumatic brain injury, representing all of the populations served by SOS. For each respective population, DHS examined relevant public policy, evaluated the current SOS role in serving the population group, and defined the specific services required for the population.

Current and future discussions will include all major stakeholders and will focus on defining what the future state operated "safety net" should be. In carrying out this next phase, we will consider several underlying principles: 1) The safety net should be a narrow set of essential services provided by SOS that will be available at all times, and at state expense, to persons who are unable to provide for themselves because of disability; 2) services are designed to be time limited, rehabilitative and transitional in nature, and focused on returning the disabled person to the community; 3) services represent a standard benefit package that is consistently provided throughout the State; 4) services

may be designed, operated and administered differently across the State as long as the benefit package remains the same; 5) services are integrated and coordinated with other services provided in the private and public community health network; and 6) the RTCs and other SOS entities may engage in other related enterprise activities in response to market place forces in their regions.

Consensus recommendations will be developed and submitted to the Legislature for consideration in the 1999 legislative session.

SOS Developmental Disabilities Program Changes and METO Phase II Development

In the SOS system, services for persons with developmental disabilities have been most successful in community integration, but have the greatest need for a redefined safety net. Legislation enacted in 1995 created the Minnesota Extended Treatment Options (METO) program, a specialized, narrowly focused, campus based program for persons with developmental disabilities who present a risk to public safety coupled with an expansive array of community support services intended to strengthen the capacity to maintain and eventually return these individuals to the community. More recently the Legislature in Laws of 1997, chapter 203, article 1, section 2, subdivision 7, required DHS to prepare a plan and recommendations for second phase development of METO.

Background

In the initial 1995 legislation, the Commissioner was directed to "develop a specialized service model at the Cambridge Campus to serve citizens of Minnesota who have a developmental disability and exhibit severe behaviors which present a risk to public safety." This specialized service model has now become known as the METO program. The following year, the 1996 Legislature authorized bonding for the construction of the "first 36 out of 72 beds proposed" and remodeling of the two existing buildings at Cambridge for recreational and work activity program space as part of the METO program. As cited above, the 1997 Legislature directed the Commissioner "to develop and present a plan and recommendations to the Legislature by January 15,1998, for the second phase of the METO program at Cambridge Regional Human Services Center to serve persons with developmental disabilities who pose a public risk. Phase two shall increase the on-campus program capacity of METO by at least 36 additional beds, unless program configuration changes are agreed to by the affected exclusive bargaining representative."

Purpose

To determine the appropriate number of beds and potential alternate services to be developed in the second phase of the METO program.

Discussion/Findings

Since the METO population has now been consolidated at the Cambridge campus, the best assessment of future needs was deemed to be an assessment of current actual usage and analysis of short-term trends.

◆The Cambridge Regional Human Services Center (CRHSC) has been monitoring its on-campus population with regard to METO-eligible clients since July, 1996. During that period, the total number of METO-eligible clients on campus has ranged from 37 to 47 with an average daily population of 43.35 (see Table 1). All METO-eligible clients who resided at other RTC developmental disabilities programs have been transferred to CRHSC and are now included in the count of METO population.

METO-Eligible Client Admissions/Discharges

Table 1

Year	Month	Admissions	Transfers	Discharges	Population *
1996	July	6	1	2	42
	August	1	1	0	44
	September	1	0	2	43
	October	2	3	1	47
	November	2	0	2	47
	December	1	0	6	42
1997	January	1	1	2	42
	February	0	1	3	40
	March	4	0	0	44
	April	0	0	4	40
	May	3	1	1	43
	June	5	0	2	46
	July	4	0	4	46
	August	1	0	2	45
	September	3	0	5	43
	October	4	0	1	46
				Average Daily Pop. =	43.35

**In house population at end of month.*

◆Community Support Services have not been completely developed and METO transition services have not yet begun. The impact of these additional services on the METO population, especially the addition of four more crisis beds scheduled to come on line in Dakota County in the summer of 1998, is yet to be determined.

Conclusions/Recommendations

◆The 36 residential METO beds currently authorized and in development will be insufficient to serve the METO population.

◆At present there is no compelling reason to project growth of the METO population beyond the current utilization range of 37 - 47 beds.

◆Authorization and funding for the immediate development of 12 additional METO specialized residential beds at Cambridge and the associated necessary site modifications have been included in the FY 1998 Capital Budget Request. This would bring the METO specialized residential bed capacity to a total of 48.

◆The Department will continue to monitor the need for METO specialized residential beds and request authorization for development of additional specialized bed capacity or alternative services should the need become apparent. The design strategy adopted for the initial METO residential development of employing small units (12 beds to a building) lends itself to this incremental approach.

SOS MH Program Changes and AMRTC Short-Term Treatment Program Alternatives

Several years of experience with short-term MH treatment program contracts between AMRTC and community hospitals in Anoka, Hennepin, and Ramsey Counties have demonstrated the feasibility of serving segments of a population that heretofore has generally been regarded as not responsive to treatment outside of an RTC. This opens the question of the suitability of the present safety net definition and whether the assumptions that we currently operate under are based in fact. This past Legislative Session, in Laws of Minnesota, Chapter 203, Article I, Section 2, Subdivision 7, DHS was directed to complete a report and make recommendations on the establishment of a short-term treatment program (45 days or less) for mentally ill persons at AMRTC.

Background

AMRTC's licensed bed capacity has been 247 for several years. Prior to FY 1995, AMRTC diverted large numbers of persons committed as mentally ill to outstate RTCs, as there was insufficient bed space to treat these individuals at AMRTC. This situation generated many complaints from consumers and their families as well as county case managers in the AMRTC catchment area. As one response to the problem, AMRTC entered into contracts with community hospitals to treat those patients committed as mentally ill from metropolitan counties. The goal of this contract bed program was to reduce, and eventually eliminate, transfers to outstate RTCs while not incurring greater cost to the State of Minnesota.

The progress made in the past three fiscal years is reflected in the data below:

Table 2

	FY 1995	FY 1996	FY 1997
AMRTC Admissions	438	521	543
Diverted Admissions	238	112	12
Contract Bed Admissions	175	285	259

Criteria for admission to the Contract Bed Program include civil commitment as mentally ill, Medical Assistance eligibility, and ability to be successfully treated to discharge within 45 days (the last criterion is based on clinical assessment and history). All contract bed hospitals bill Medical Assistance directly for services provided to inpatients in this program. AMRTC conducts regular utilization review of every patient admitted to the program to assure appropriate admissions and appropriate and timely discharges. Based on the numbers of clients admitted and an average length of stay of approximately 30 days, AMRTC would need an additional 25 beds to handle this demand.

The per diem costs for the Contract Bed Program in FY 1998 ranged from $525 to $630. Because these community hospitals are not designated as IMDs (Institution for Mental Diseases), they are able to bill Medical Assistance, thus allowing the State to obtain federal financial participation (approximately 53%) for the patients' care. These rates of care in the community are equivalent to the estimated costs of serving these clients at AMRTC if it were to establish a program for acute MI

hospital care. At present, AMRTC operates with a single per diem cost of $324 per day. This rate, however, is heavily weighted by the long lengths of stay for a majority of the patients served by AMRTC. Efforts are underway to move the entire RTC system to a cost-based billing system within the next two years. Preliminary SOS cost accounting information indicates that the highest costs are incurred during the first 10 days of psychiatric care and rates in the range of $600-$700 per day would be anticipated.

Purpose

As cited above, the 1997 Legislature called for a report from the Department detailing how a similar 45-day program could be established at AMRTC to be administered by RTC staff.

Discussion/Findings

◆Under current statutes AMRTC has all the authority necessary to treat patients in 45 days or less. During FY 1997, AMRTC discharged 68 patients within 45 days.

◆Space may well be an issue if AMRTC were to establish a short stay treatment program. As indicated on the previous page, the existing community contract beds and AMRTC's current capacity appears to meet the metro area demands for MI commitments. DHS will not submit a bonding request for expansion because there is community capacity. To divert this capacity to state operation is fiscally unsound since there is no way to collect for the costs of care because AMRTC is classified as an Institute for Mental Disease (IMD). Also, the length of stay (LOS) in AMRTC's inpatient programs has been decreasing (the median LOS is now about 100 days), and this quicker patient turn-around will continue to permit expansion of admissions within the existing bed complement. With the adult MH initiatives becoming fully functional, further reductions in LOS, as well as decreased recidivism, is anticipated because of better community support for discharged patients.

Conclusions/Recommendations

◆No legislative changes are needed for AMRTC to discharge patients within 45 days. To accomplish more discharges within this time frame will require continuing work with AMRTC staff to increase their efficiency and continuing development of discharge supports, which are already being phased in under the adult MH initiatives.

◆Capital expansion is not financially feasible or warranted at this time. Experience has proven that a segment of the committed MI patients can be successfully treated in community facilities, allowing for continuity of care and continuation of treatment with their personal community psychiatrist.

◆As AMRTC is licensed and accredited as a psychiatric hospital, it is designated as an IMD. No program operated under the auspices of AMRTC, even if it is at a different geographic location or contains 15 or fewer beds, will be eligible for Medical Assistance reimbursable for persons between the ages of 21 and 64. Under the existing federal regulations, it is impossible to develop a plan to qualify an AMRTC program of less than 45 days for Medical Assistance reimbursement.

SOS and Managed Care Initiatives

One of the most fundamental issues affecting the SOS system and the safety net redefinition discussions is the emergence of managed care and associated health care delivery networks across Minnesota. This has major implications for all of the traditional roles and relationships between the SOS system and the courts, county agencies, other service providers, third party payers and health plans. Recognizing the significance of this phenomenon, the 1997 Legislature specified that DHS complete two reports on SOS and managed care related topics.

The first of the reporting requirements is found in Laws of 1997, chapter 203, article 9, section 13, and calls for DHS to study and make recommendations concerning the appropriate role and funding arrangements through which SOS can effectively operate in managed care systems serving persons with disabilities. This study cannot address the requirements of the legislation until other work is completed: (1) implementation of the two Disability Demonstration Projects (estimated to occur by January, 1999); and (2) finalization of the redefinition of the SOS safety net in the months ahead. Within the framework and guiding principles under which the safety net redefinition discussions are taking place, there is no intent to use SOS appropriations funding in the two Disability Demonstration Projects. As these two demonstration projects get underway DHS will incorporate questions about potential managed care roles for SOS in the evaluation of the projects by various participating stakeholder groups. However, a definitive picture of possible roles for SOS won't emerge until we have much more experience with the projects.

The second managed care reporting provision is located in Laws of 1997, article 1, section 2, subdivision 7, and enables RTCs to enter into contracts with health plans to serve publicly funded acute mental health and chemical dependency clients and report back to the Legislature on the development and implementation of the project. Because of the potential opportunities for the SOS system to test this option in the northwest region of the State, Fergus Falls RTC was designated as the site at which to concentrate this effort. It was intended that the entire SOS system could benefit from the Fergus Falls experience and that quite possibly a model that could be used system-wide would be devised. Equally important, this project would inform the safety net redefinition discussions around the SOS role in services for mental health and chemical dependency.

Background:

The Commissioner of Human Services is permitted by legislative action to authorize regional treatment centers to enter into contracts with health plans that provide services to publicly funded clients. These services are limited to mental health and chemical dependency, and must collect revenue sufficient to cover costs.

The catchment area for Fergus Falls Regional Treatment Center (FFRTC) includes 17 rural counties in northwestern Minnesota. This area has a low population density which makes it inefficient for private providers to develop inpatient treatment programs. Three private mental health inpatient programs are currently operating in Douglas, Otter Tail, and Polk Counties. Only a portion of the needs for acute mental health services can be met by these private hospitals. The FFRTC was selected by the Commissioner as the initial site to contract with health plans and meet these unmet needs.

The rates for mental health services in the regional treatment centers have been based on an all inclusive per diem that essentially averages the cost of all services. Contracting with health plans has required that FFRTC move to a charge based cost structure which differentiates acuity and the corresponding cost of providing services to an individual client. This change is necessary to accurately capture the State's costs and avoid subsidizing third party payers. For this purpose, FFRTC moved to a charge based approach on a partial facility basis because not all services are currently being purchased by third parties. These changes were initiated after thorough discussions

with the federal Medicare intermediary to assure that all regulatory cost reporting factors were accounted for.

Purpose:

To develop the means by which the FFRTC can participate as a provider of acute mental health services to citizens of northwestern Minnesota who are enrolled in health plans under the Prepaid Medical Assistance Program (PMAP).

Implementation Status:

◆FFRTC has developed the financial processes necessary for establishing charges, billing, and collections. This experience will benefit the other RTCs as they begin to explore similar arrangements with health plans around the State.

◆To date, no final contract has been completed between FFRTC and any of the health plans. Negotiations are nearly complete with Blue Cross/Blue Shield and are progressing with Health Partners and U Care. One aspect that has slowed these negotiations has been concern by some health plans about the Tort Claims Law (M.S. 3.736) limits as they apply to SOS as a participant in their provider networks.

◆Because rate agreements have been accomplished with certain health plans, since the end of December 1997, 36 covered admissions have occurred at FFRTC even though contracts are not yet in place.

◆In the FFRTC catchment area there are four counties now enrolled in PMAP. As more counties join in PMAP, or county-based purchasing of prepaid health care for eligible low income persons, the pool of persons covered by the health plans will increase. The FFRTC is in a position to be a fully participating member of the provider network for their region.

◆In implementing the program, FFRTC operates under the current definitions of the plan for medical necessity and the corresponding limits on services. These have not proven to be substantial barriers to effective treatment for referred clients.

◆FFRTC has found that existing charting requirements are sufficient to meet the utilization review criteria for plans.

State Safety Net Redefinition: Going Forward

As evidenced by the discussion of issues in the four individual legislative reports included here, the redefinition of the State safety net is both timely and very relevant. As this consolidated legislative report is being submitted to the Legislature, the seven development groups have completed the initial safety net reports for chemical dependency, adult mental illness, psychopathic personality, developmental disabilities, geriatrics and traumatic brain injury.

With the 1999 legislative session rapidly approaching, the Department intends to carry forward the safety net redefinition effort by: 1) establishing consensus on a clear direction for the continued evolution of the SOS system for each disability group served; 2) establishing consensus on priorities for sequencing major system changes; 3) proposing legislative changes to codify the redesigned SOS system during the 1999 legislative session.

The Department will involve stakeholders on many fronts to pursue these aims in the months ahead. It is critical that counties, consumer and advocacy interests, employee representatives, department advisory bodies and program leadership within the Department itself, be afforded the opportunity to contribute to the safety net redefinition dialogue and refinement of the final proposals. By properly laying a solid foundation with the coming legislative session, the Department intends to have in place a SOS system infrastructure that is ready to embrace the service delivery needs reflected by stakeholders as we move into the next century.