Evaluation of HF XXXX: Network Inclusion of Psychiatric Residential Treatment Facilities

Report to the Minnesota Legislature Pursuant to Minn. Stat. § 62J.26

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This report was prepared by the American Institutes for Research (AIR), with actuarial analysis by Actuarial Research Corporation (ARC), at the request of the Minnesota Department of Commerce. AIR and ARC created this document for internal use by the Minnesota Department of Commerce pursuant to Contract No. 216732. The document assumes reader familiarity with the proposed mandated health benefits currently under consideration by the Minnesota State Legislature. The document was prepared solely to assist the Minnesota Department of Commerce. No other use of this document or the information or conclusions contained herein is authorized.

Defrayal analysis completed by the Minnesota Department of Commerce is independent of AIR's evaluation.

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Executive Summary

This proposed mandate would require certain health plans to include Psychiatric Residential Treatment Facilities (PRTFs) in their networks. A PRTF is a facility other than a hospital that provides psychiatric services to individuals under age 21 in an inpatient setting. Under current law, PRTFs in Minnesota provide a specific set of psychiatric and other supportive services to Medicaid enrollees. This bill does not mirror coverage under Minnesota Medicaid, but would require certain plans to cover all medically necessary mental health services, as defined under Minn. Stat. § 62Q.53, that are provided in a PRTF by a licensed mental health provider. This House bill is sponsored by Rep. Liebling and has yet to be introduced.

Research suggests that care received in PRTFs may result in improved psychosocial functioning, particularly for youth populations, when compared to other treatment settings. Research supporting the clinical effectiveness of care delivered in residential facilities is evolving. Increased coverage for different types of psychiatric care settings along the care continuum may provide more appropriate treatment for individuals with mental or behavioral health conditions.

Access to clinically appropriate mental health services has demonstrated reduced negative downstream effects that otherwise result from unmet mental health needs. The comparatively higher costs associated with residential facilities compared to outpatient services may be outweighed by savings from improved clinical outcomes, such as reduced utilization of emergency services.

There was no actuarial analysis conducted for this proposed mandate because such analysis would require additional clarity regarding specific services covered, level of coverage required, and potential cost-sharing parameters.

The potential fiscal impact of this mandate is as follows:

- The State Employee Group Insurance Program estimates the cost of this legislation for the state plan to be $479,880 for partial Fiscal Year 2024 (FY24) and $1,007,748 for FY25.
- Commerce has determined that this proposed mandate would likely not require defrayal under the Affordable Care Act because it is a provider-based update rather than mandating a new benefit. While some services provided through PRTFs (such as nonemergency medical transportation) are not covered under commercial policies, this would only constitute a benefit mandate if the bill were interpreted as requiring coverage for such services.
- There is no estimated cost to public programs because PRTFs are part of the current Medicaid coverage for individuals 21 and under.

Pursuant to Minn. Stat. § 62J.26, subd. 3, the Minnesota Department of Commerce (Commerce) is required to perform an evaluation of the first engrossment of House File XXXX on network inclusion of psychiatric residential treatment facilities from the 92nd Legislature (2021–2022). The purpose of the evaluation is to provide the legislature with a detailed analysis of the potential impacts of any mandated health benefit proposal.

House File XXXX on network inclusion of psychiatric residential treatment facilities meets the definition of a mandated health benefit proposal under Minn. Stat. § 62J.26, which indicates the following criteria:

A “mandated health benefit proposal" or "proposal" means a proposal that would statutorily require a health plan company to do the following:

(i) provide coverage or increase the amount of coverage for the treatment of a particular disease, condition, or other health care need;

(ii) provide coverage or increase the amount of coverage of a particular type of health care treatment or service or of equipment, supplies, or drugs used in connection with a health care treatment or service;

(iii) provide coverage for care delivered by a specific type of provider;

(iv) require a particular benefit design or impose conditions on cost-sharing for:

(A) the treatment of a particular disease, condition, or other health care need;

(B) a particular type of health care treatment or service; or

(C) the provision of medical equipment, supplies, or a prescription drug used in connection with treating a particular disease, condition, or other health care need; or

(v) impose limits or conditions on a contract between a health plan company and a health care provider.

"Mandated health benefit proposal" does not include health benefit proposals amending the scope of practice of a licensed health care professional.

Introduction

In accordance with § 62J.26, Commerce performs, in consultation with the Minnesota Department of Health (MDH) and Minnesota Management and Budget (MMB), a detailed evaluation of all relevant benefit mandate proposals. Evaluations focus on the following areas:

i. Scientific and medical information regarding the proposal, including the potential for benefit and harm
ii. Overall public health and economic impact
iii. Background on the extent to which services/items in the proposal are utilized by the population
iv. Information on the extent to which services/items in the proposal are already covered by health plans and which health plans the proposal would impact
v. Cost considerations regarding the potential of the proposal to increase cost of care as well as its potential to increase enrollee premiums in impacted health plans
vi. The cost to the state if the proposal is determined to be a mandated benefit under the Affordable Care Act (ACA)
    a. As part of these evaluations, Commerce also seeks public feedback on the requested benefit mandate evaluations. This public feedback is summarized and incorporated into the analysis.
    b. The following analysis describes the proposed benefit mandate's impact on the health care industry and the population health of Minnesotans.

Evaluation Components

For the purposes of this evaluation, we used the following terms to describe the impact of the proposed mandate:

Public health. The science and practice of protecting and improving the health and well-being of people and their communities. The field of public health includes many disciplines, such as medicine, public policy, biology, sociology, psychology and behavioral sciences, and economics and business.

Economic impact. The general financial impact of a drug, service, or item on the population prescribing or utilizing the drug, service, or item for a particular health condition.

Fiscal impact. The quantifiable cost to the state associated with implementation of the mandated health benefit proposal. The areas of potential fiscal impact that Commerce reviews for are the cost of defrayal of benefit mandates under the ACA, the cost to the State Employee Group Insurance Program (SEGIP), and the cost to other state public programs.

Bill Requirements

This House bill is sponsored by Rep. Liebling and has yet to be introduced.

If enacted, this bill would require certain health plans to cover Psychiatric Residential Treatment Facility (PRTF) services. A PRTF is a facility other than a hospital that provides a specific set of psychiatric services to individuals under age 21 in an inpatient setting.[1] PRTFs must be licensed and certified by the state, and the Minnesota Medicaid program covers the following services delivered in PRTFs:

- Psychiatrist or physician services for development of an individual care plan, reviewed every 30 days
- Active treatment that may include individual, family, and group therapy Individual therapy a minimum of twice per week
- Family engagement activities a minimum of once per week 24-hour nursing care
- Consultation with other professionals including case managers, primary care professionals, community-based mental health providers, school staff, or other support planners
- Coordination of educational services between local and resident school districts
- Supportive services for daily living and safety and positive behavior management

This bill does not articulate the same set of services covered under Minnesota Medicaid. Rather, the mental health services associated with this proposed mandate include all medically necessary services, as defined under Minn. Stat. § 62Q.53, provided in a PRTF.

Related Health Conditions

"Serious mental illness" (or "SMI") is used in the medical community to describe mental disorders that result in serious functional impairment or serious interference with major life activities.[2] In 2020, 10.9% of children ages 3–17 in Minnesota received mental health care in the past year, compared to 10.8% of children in the United States.[3] In 2021, it was reported that 1,784,012 people in Minnesota

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[1] Minnesota Code, 2022 Minnesota Statutes, Public Welfare and Related Activities, Chapter 256B, Section 256B.0625. Psychiatric Residential Treatment Facility Services definition. https://www.revisor.mn.gov/statutes/cite/256B.0625

[2] National Institute of Mental Health (NIMH). (n.d.). *Mental illness.* https://www.nimh.nih.gov/health/statistics/mental-illness.https://www.nimh.nih.gov/health/statistics/mental-illness

[3] Kaiser Family Foundation. (2022, April 21). *Mental health and substance use state fact sheets*. https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/minnesota/https://www.kff.org/statedata/mental-health-and-substance-use-state-fact-sheets/minnesota/

live in a community that does not have enough mental health professionals available to receive mental health treatment.[4]

PRTFs began providing covered services to Minnesota Medicaid enrollees in 2018. Between 2018 and 2021, the most common billed diagnoses for individuals in PRTFs were post-traumatic stress disorder, disruptive mood dysregulation disorder, oppositional defiant disorder, reactive attachment disorder of childhood, and other reactions to severe stress.[5]

"Substance use disorder" (or "SUD") is used when the recurrent use of alcohol or drugs causes clinically significant impairment.[6] Although current data on all types of SUD diagnoses in Minnesota are not available, in 2019–2020 approximately 13.3% (572,000) of adults in Minnesota and 11% (27.6 million) of adults in the United States reported alcohol use disorder.[7] In 2017, 4.3% of U.S. Children aged 12-17 met the diagnostic criteria for an SUD.[8] We note that, although Minnesota PRTFs were not established to treat individuals with a primary diagnosis of SUD, individuals in PRTFs may have co-occurring SUD and Minnesota Medicaid will cover SUD services concurrently with a PRTF stay.

Related State and Federal Laws

This section provides an overview of state and federal laws related to the proposed mandate and any external factors that provide context on current policy trends related to this topic. The review of current state and federal laws considers how implementation of the proposed mandate may be affected by federal and Minnesota state health care laws and provides examples of similar legislation or policies in other states.

Federal Laws Relevant to This Proposed Mandate

Federal regulations pertaining to PRTFs exist mainly in Medicaid, as the ACA does not require exchange plans to include PRTFs in their networks, and Medicare does not require coverage of residential psychiatric treatment.

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[4] National Alliance on Mental Illness. (2021, February). *Mental health in Minnesota*. https://www.nami.org/NAMI/media/NAMI-Media/StateFactSheets/MinnesotaStateFactSheet.pdf

[5] Minnesota Department of Human Services. "Psychiatric Residential Treatment Facilities (PRTF) Overview." Presentation, July 1, 2021. Available online at: https://mn.gov/dhs/assets/prtf-overview_tcm1053-490953.pdf

[6] SAMHSA. (n.d.). *Mental health and substance use disorders.* https://www.samhsa.gov/find-help/disorders#:~:text=Substance%20use%20disorders%20occur%20when,work%2C%20school%2C%20or%20home

[7] Kaiser Family Foundation. (n.d.). *Individuals reporting alcohol dependence or abuse in the past year* (2018–2019). https://www.kff.org/other/state-indicator/individuals-reporting-alcohol-dependence-or-abuse-in-the-past-year/?currentTimeframe=0

[8] Hamersma, S., & Maclean, J. C. (2020). Insurance expansions and adolescent use of substance use disorder treatment. *Health Services Research, 56*(2), 256–267. https://doi.org/10.1111/1475-6773.13604

The Social Security Amendments of 1972 allowed state coverage of inpatient psychiatric hospital services under Medicaid for individuals under 21.[9] State Medicaid agencies may cover PRTF inpatient services, provided the facility meets certain conditions of participation.[10]

Additionally, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires health plans to provide mental health or SUD benefits that are equivalent to medical and surgical benefits covered by the plan.[11,12] While MHPAEA prohibits plans from imposing benefit limitations for mental/behavioral health or SUD that make them less generous than physical health benefits, it does not require plans to cover specific mental/behavioral health or SUD benefits. Further, MHPAEA does not address specific care settings such as PRTFs.

Minnesota State Laws Relevant to This Proposed Mandate

In addition to the Minnesota statutes cited in the proposed mandate, Minn. Stat. § 256B.0941[13] outlines eligibility requirements, services, and general facility guidelines. This statute only applies to individuals younger than 21 years of age and does not address access to mental health services in a PRTF for individuals 21 years and older.

State Comparison

States vary considerably in their requirements regarding commercial insurance coverage of care delivered in PRTFs, making policy comparisons across states challenging. The proposed mandate updates standards in Minn. Stat. § 62K.10 and provides more detailed requirements for network adequacy than in other states. For example, Washington State's law on general standards for network access requires health carriers to provide a "sufficient" amount of access to psychiatric facilities,[14] whereas Minn. Stat. § 62K.10, with proposed changes, states this: "In determining network adequacy, the commissioner of health shall consider availability of services, including the following … [Subd. 4] mental health and substance use disorder treatment providers, including but not limited to residential treatment facilities, PRTFs, and hospitals available and accessible through the network or contract arrangement."

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[9] Social Security Act § 1905. https://www.ssa.gov/OP_Home/ssact/title19/1905.htm

[10] Centers for Medicare & Medicaid Services. (n.d.). *What is a PRTF.* https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/whatisaprtf.pdf

[11] The Mental Health Parity and Addiction Equity Act (MHPAEA). https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet

[12] H.R. 6983 – 110th Congress. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. https://www.congress.gov/bill/110th-congress/house-bill/6983

[13] 2022 Minnesota Statutes, Sec. 256B.0941. https://www.revisor.mn.gov/statutes/cite/256B.0941

[14] Washington Administration Code 284-170-200. https://apps.leg.wa.gov/wac/default.aspx?cite=284-170-200

Public Comments Summary

To assess the public health, economic, and fiscal impact of expanding health care insurance coverage for services in PRTFs, Commerce solicited stakeholder engagement on the potential health benefit mandate. The public submitted comments in response to Minnesota's RFI process, which enabled the state to collect information from consumers, health plans, advocacy organizations, and other stakeholders. This process helped Commerce gather opinions, identify special considerations, and secure additional resources to support the evaluation. This section includes a summary of the key themes collected from stakeholders that submitted comments. Interviews were conducted with a subset of stakeholders that provided resources or comments that prompted follow-up questions to gather more detail on the impact the proposed mandate might have on Minnesotans. Interview protocols and processes were reviewed and conducted in accordance with an institutional review board in 45-minute virtual sessions. Feedback obtained in these interviews is included throughout this section.

Any studies, laws, and other resources identified by stakeholders, through public comment or interviews, were evaluated based on criteria used for the literature scan. Please refer to the Methodology section for analysis of the reviewed literature. Responses to the RFI may not be fully representative of all stakeholders or of the opinions of those impacted by the proposed mandate.

Stakeholder Engagement Analysis

For this proposed mandate, Commerce received 23 stakeholder comments. The overwhelming majority of comments were in support of this bill (n = 19), while four stakeholders expressed no opinion but provided facts and information. The types of stakeholder groups that submitted responses included health care providers and physicians, state and commercial health carriers, organizations providing psychiatric and behavioral health support, and individuals impacted by PRTF services. Stakeholder interviews were conducted with two of the respondents.

Here are key takeaways from stakeholder feedback in favor of the bill:

- **The mandate could increase enforcement of existing law.** Stakeholders noted that current Minnesota law (Minn. Stat. § 62Q.47) and federal law (MHPAEA) effectively require health plans to cover residential care and urged the state to enforce these laws. They also reiterated that under MHPAEA, health plans may not restrict coverage based on facility type for physical health and residential treatment facilities. Stakeholders flagged the work of other states in aligning with MHPAEA and noted considerations indicating coverage of PRTFs would not be subject to defrayal.[15]

[15] Beyer, J. (2022). *Behavioral health emergency services under E2SHB 1688 (Chap. 263, Laws of 2022)* [Memorandum]. Washington State, Office of the Insurance Commissioner. https://www.insurance.wa.gov/sites/default/files/documents/e2shb-1688-mhpaea-memo.pdf

Related to service appropriateness and medical necessity determinations for PRTFs, one stakeholder noted that requirements should be in place for the use of evidence-based medical necessity protocols in coverage decisions. This stakeholder recommended current best practices associated with standard use of the Level of Care Utilization System (LOCUS/CALOCUS), which is a system to "assess service needs of adults to quantify service based on the amount and scope of resources available to clients at each level of service."[16] Example legislation from California was provided for the legislature's consideration in defining level-of-care criteria.[17]

- **Commercially insured individuals face gaps in access to residential treatment.** Medicaid provides coverage for PRTF services, while individuals with commercial health plans experience gaps in coverage of residential psychiatric services. Additionally, even if an individual has coverage for PRTF services, there is limited PRTF availability in Minnesota, causing long wait lists and forcing individuals to seek care in other states or locations far from their home and community. Stakeholders raised concerns about the economic impact for those who lack coverage and about families who offload assets to obtain Medicaid eligibility for PRTF coverage.

  Respondents also noted that there are gaps in mental health coverage in Minnesota. Increasing access and ensuring reliable funding for PRTFs will assist in addressing these gaps. Currently, PRTFs are not widely available because of gaps in access or coverage. As a result of expanding commercial health plan coverage to PRTFs, individuals will have more care options that allow them to stay connected to existing social supports in their communities (e.g., family and local services).

  One stakeholder commented that because the proposed health benefit mandates only apply to fully insured plans, they may have the potential to drive more employer groups to switch to self-insured coverage to avoid potential costs associated with benefit mandates. This stakeholder referenced a source that showed enrollment changes in self-insured and fully insured plans since 2011. This source indicated that, while enrollment trends have increased for self-insured private health care plans and decreased in fully insured private health care plans, enrollment in public health care plans has also increased simultaneously. The source does not provide data to indicate whether a causal relationship exists between the state insurance mandates and employer selection of self-insured plans given other variables that may account for changes in enrollment.[18,19]

- **The limited number of PRTFs in Minnesota will continue to drive access challenges.** Stakeholders expect this bill would put greater pressure on PRTFs and create longer wait times for patients if

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[16] Fisher, D. G., Pilon, D., Hershberger, S. L., Reynolds, G. L., LaMaster, S. C., & Davis, M. (2009). Psychometric properties of an assessment for mental health recovery programs. *Community Mental Health Journal, 45*(4), 246–250. https://doi.org/10.1007/s10597-009-9213-8

[17] *SB-855 Health coverage: Mental health or substance use disorders* [California legislative information]. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB855

[18] Minnesota Department of Health. (2022, July). *Trends and variation in health insurance coverage* (Chartbook Section 2). https://www.health.state.mn.us/data/economics/chartbook/docs/section2.pdf

[19] The federal Employee Retirement Income Security Act of 1974 (ERISA) preempts state laws that "relate to" a covered employee benefit plan. Under ERISA, a state cannot deem a self-funded employee benefit plan as insurance for the purpose of imposing state regulation. Therefore, self-funded (or self-insured) plans may be exempt from abiding by a state-imposed health benefit mandate.

more facilities are not built. Alternatively, by increasing commercial insurance coverage of PRTFs, stakeholders predict more facilities may be built to meet demand. One stakeholder noted that residential care is a critical part of the care continuum and that lack of coverage has created a gap in the behavioral and mental health services individuals need. It has also caused stress on other facilities that are not equipped to provide residential care services.

Stakeholders indicated that many families have significant access challenges given the limited number of PRTF facilities and the geographic hurdles. Proponents of the mandate noted that commercial plans offer improved reimbursement compared to Medicaid plans, which may result in improved quality of care at these facilities as well as an increase in facility openings.

- **Lack of PRTF coverage can have significant effects on the pediatric population.** Stakeholders voiced that, currently, children with suicidal ideation or aggression are "boarded" in emergency rooms (ERs) due to limited access to residential facilities. However, ERs are not long-term care facilities where individuals can receive effective and sustainable behavioral health services. Stakeholders recommended that cost savings associated with forgone ER visits should be considered as part of the economic impact of the mandate.

  Another stakeholder noted that without adequate resources to assist children in need of psychiatric and behavioral health services, other social services are overwhelmed and exhausted (i.e., inadequate resources "often lead to the frequent and unnecessary use of hospitals and law enforcement, delaying an effective response and often compounding the problem").

- **Potential economic impacts of the mandate should consider extraneous costs outside of the health care system.** One stakeholder noted that evaluators should consider the reduction of costs in the criminal justice system and labor force due to the reduction in unmet mental and behavioral health needs.

  Stakeholders and MMB provided the following cost estimates related to the proposed health benefit mandate:

  - MMB provided Commerce with SEGIP's estimated fiscal impact of the proposed mandate. For Fiscal Year 2024 (FY24), SEGIP's health plan administrators estimate a potential per member per month (PMPM) increased cost of $0.62.
  - A health plan issuer commented that their plan currently provides some coverage for these treatment facilities. For commercial group business, this represents $1.85 PMPM of paid claims. If utilization was assumed to increase by approximately 10% and there was broader coverage, the stakeholder estimated that it could increase costs by as much as $0.40 PMPM and would then be passed back into premiums.

Cost estimates shared in RFI responses may reflect different methodologies, data sources, and assumptions than those used in the actuarial analysis for this evaluation. Therefore, stakeholders' results may or may not reflect generalizable estimates for the mandate.

Evaluation of Mandated Health Benefit Proposal

The methodology for relevant sections of these evaluations is described in the corresponding evaluation below and consisted of a three-pronged approach:

- Medical/scientific review
- Actuarial analysis to assess economic impact
- Defrayal analysis to assess fiscal impact

Methodology for Analysis of Reviewed Literature

This evaluation used critical review of research databases to identify scientific, medical, and regulatory sources relevant to the mandate. The literature scan utilized

I. key scientific, medical, and regulatory terms that emerged from the initial review of the proposed mandate;
II. additional key terms that were identified and reviewed by AIR's technical and subject matter experts, Commerce, and MDH; and
III. additional terms and research questions following public comment and stakeholder engagement interviews.

The key terms guided the search for relevant literature in PubMed and the National Bureau of Economic Research (NBER). PubMed was used to identify relevant biomedical literature and NBER to identify relevant literature that might address the potential public health, economic, and fiscal impacts of the mandate. The inclusion factors prioritized peer-reviewed literature and independently conducted research on any articles or databases identified through public comment. In addition, criteria included publication within the last 10 years, relevance to the proposed health benefit mandate, generalizability of the findings, and quality of the research, as guided by the Joanna Briggs Institute Clinical Appraisal Tools. The analysis included identified key themes and shared patterns related to the medical, economic, or legal impact of the proposed health benefit mandate.

Public Health Impact

Due to limitations in the literature, the potential impact of this proposed mandate can only be evaluated based on a broad set of published evidence that may not directly align with the model of PRTF service delivery in Minnesota. Most of the current literature is not specific to PRTFs as they function in Minnesota, rather, there is wide variation in the services, facility types, insurance (public vs.

private), and populations studied. This evaluation includes studies that have information that is potentially relevant for both PRTFs and other residential treatment facilities. Many studies that address the impact of PRTFs and other residential treatment facilities evaluate the outcomes of individuals with mental health conditions, including substance abuse disorders. There may be concerns, diagnoses, or sets of services that are uniquely provided in Minnesota PRTFs that are not reflected in the available literature.

Some research suggests that PRTFs and residential facilities may be an important part of the care continuum for certain mental and behavioral health diagnoses and associated clinical presentations. Care received in these settings may also result in improved psychosocial functioning compared to other treatment settings, particularly for youth populations.[20,21] Research supporting the clinical effectiveness of PRTFs and residential treatment facilities is still evolving.[20,22] Given the wide range of residential facility quality, subtypes, and services offered, as well as the diversity of needs of children and adolescents who access the services, determinations about clinical effectiveness must account for the variability in the data.[22]

Effectiveness of treatment received in residential facilities may be specific to a particular diagnosis or specific comorbidities, such as depression or post-traumatic stress disorder (PTSD). Some research suggests that the effectiveness of care in residential treatment facilities may be specific to practice patterns and specific interventions.[22] Another study indicates that an increase in coverage for different types of psychiatric care settings along the care continuum (e.g., outpatient versus residential care) may be associated with more appropriate treatment for individuals with mental or behavioral health conditions.[23] The effectiveness of treatment received in PRTFs and other residential facilities may depend on the extent to which individuals receive the appropriate level of care in these settings.[22]

One study highlighted the gaps in coverage for mental and behavioral health services for specific subpopulations. Nondisabled, childless, and nonelderly adults (i.e., those who are typically ineligible for Medicaid) had a high prevalence of SMI and SUD but lacked coverage for care.[24] In evaluating Medicaid coverage expansion, data shows that increased coverage may reduce barriers for currently underserved populations by providing an increase in facility openings and reduced out-of-pocket expenses for families and individuals in need of these services. This data suggests that expanded

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[20] Kapp, S., Rand, A., & Damman, J. L. (2015). Clinical gains for youth in psychiatric residential treatment facilities: Results from a state-wide performance information system. *Residential Treatment for Children & Youth, 32*(1), 37–57. https://www.tandfonline.com/doi/full/10.1080/0886571X.2015.1004287?scroll=top&needAccess=true

[21] Cantor, J., Jelveh, Z., & Tong, P. (n.d.). The impact of access to substance abuse treatment on disability. https://www.nber.org/sites/default/files/2020-05/dNB18-Q9%20Cantor%2C%20Jelveh%2C%20Tong.pdf

[22] Lanier, P., Jensen, T., Bryant, K., Chung, G., Rose, R., Smith, Q., & Lackmann, L. (2020). A systematic review of the effectiveness of children's behavioral health interventions in psychiatric residential treatment facilities. *Children and Youth Services Review*, *113*, 104951. https://doi.org/10.1016/j.childyouth.2020.104951

[23] Hamersma, S., & Maclean, J. C. (2020). Insurance expansions and adolescent use of substance use disorder treatment. *Health Services Research, 56*(2), 256–267. https://doi.org/10.1111/1475-6773.13604

[24] Maclean, J. C., Tello-Trillo, S., & Webber, D. (2019). *Losing insurance and psychiatric hospitalizations* (NBER Working Paper 25936). National Bureau of Economic Research. https://doi.org/10.3386/w25936

coverage may increase access to evidence-based treatments and may also improve treatment outcomes for individuals with co-occurring mental health conditions.[25]

Economic Impact

Because parity laws for SUD and SMI may increase costs to carriers associated with coverage for residential facilities compared to outpatient services,[26] this has potential to increase premiums. However, based on PMPM projections from MMB, this could be a small change, and the degree of downstream impact is highly dependent on potential changes in utilization.

The costs associated with coverage for services provided in a PRTF may be outweighed by savings associated with improved clinical outcomes,[27] which may in turn minimize the effect of this mandate on premiums. Lack of insurance or the lack of coverage specifically for residential care correlates with low utilization of outpatient mental health and SUD services, as well as increased hospitalizations and ER visits. One studies suggest that the adoption of mental health parity laws may improve the utilization of services for otherwise unmet mental health needs, such as for those with SUD. Adoption of parity law has been shown to increase treatment for SUD by 21%, driven primarily by privately insured individuals.[28] An increase in coverage and resulting utilization for residential facilities may be associated with savings from forgone hospitalizations and other care services.[29] It is currently unknown whether the savings from reduced ER visits and inpatient hospitalizations would be outweighed by the increased cost of residential treatment, or to what degree these findings are specific to the conditions treated in Minnesota PRTFs.

Access to outpatient and residential treatment options for mental health conditions, such as SUD, may have a net economic benefit for society, by lowering costs associated with crime, unemployment, and disability. Reduced coverage may be associated with less secure employment and fewer individuals participating in the labor force due to unmet medical needs.[30] Integrated care in residential facilities

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[25] Shover, C. L., Abraham, A., D'Aunno, T., Friedmann, P. D., & Humphreys, K. (2019). The relationship of Medicaid expansion to psychiatric comorbidity care within substance use disorder treatment programs. *Journal of Substance Abuse Treatment, 105,* 44–50. https://doi.org/10.1016/j.jsat.2019.07.012

[26] Ettner, S. L., Huang, D., Evans, E., Rose Ash, D., Hardy, M., Jourabchi, M., & Hser, Y.-I. (2006). Benefit-cost in the California Treatment Outcome Project: Does substance abuse treatment "pay for itself"? *Health Services Research, 41*(1), 192–213. https://doi.org/10.1111/j.1475-6773.2005.00466.x

[27] Kapp, S., Rand, A., & Damman, J. L. (2015). Clinical gains for youth in psychiatric residential treatment facilities: Results from a state-wide performance information system. *Residential Treatment for Children & Youth, 32*(1), 37–57. https://www.tandfonline.com/doi/full/10.1080/0886571X.2015.1004287?scroll=top&needAccess=true

[28] Hamersma, S., & Maclean, J. C. (2020). Insurance expansions and adolescent use of substance use disorder treatment. *Health Services Research, 56*(2), 256–267. https://doi.org/10.1111/1475-6773.13604

[29] Maclean, J. C., Tello-Trillo, S., & Webber, D. (2019). *Losing insurance and psychiatric hospitalizations* (NBER Working Paper 25936). National Bureau of Economic Research. https://doi.org/10.3386/w25936

[30] Cantor, J., Jelveh, Z., & Tong, P. (n.d.). *The impact of access to substance abuse treatment on disability.* National Bureau of Economic Research. https://www.nber.org/sites/default/files/2020-05/dNB18-Q9%20Cantor%2C%20Jelveh%2C%20Tong.pdf

may be more effective than outpatient care for the treatment of mental health comorbidities,[31] which may lead to fewer disability claims. This data is specific to primary treatment of SUD, with other SMI comorbidities. Another study found that treatment in residential facilities was more likely to reduce clinical and societal costs associated with SUD, but when standardized for cost of care, outpatient services had the highest net benefit.[32] This may or may not reflect applicable scenarios for SMI.

Limitations

Limited data that is specific to PRTFs may obscure the negative or positive impacts of residential coverage found in the literature. Analyses in the literature often report the impact of both outpatient and residential treatments rather than facility- or service-specific effects, particularly in studies looking at the relationship between coverage, utilization, and clinical outcomes. Furthermore, there is wide variability in facility types and services offered in PRTFs, with outcomes typically addressing facility-level rather and service-level data. The studies identified in this scan and those shared by stakeholders that address outcomes associated expanded coverage focused largely, but not exclusively, on coverage through Medicaid versus commercial plans. The immediate effect on access is unknown, and the magnitude of the mandate's potential impact may depend on constraints for facilities.[33]

Actuarial Analysis [34]

There was no actuarial analysis conducted for this proposed mandate, as this mandate would not require certain health plans to cover specific or additional care, treatment, or services. Potential actuarial analysis could include analysis of current utilization of PRTFs and the effects of expanded coverage on cost-sharing, premiums, and overall expenditures. However, any actuarial analysis would require additional clarity regarding specific services covered, level of coverage required, and potential cost-sharing parameters. Additionally, in consultation with MDH, it was determined that the necessary data, even as basic as identifying PRTFs as a place of service on medical claims, and a comprehensive understanding of the current landscape and utilization of such facilities in the state of Minnesota are not available or able to be incorporated into this report.

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[31] Shover, C. L., Abraham, A., D'Aunno, T., Friedmann, P. D., & Humphreys, K. (2019). The relationship of Medicaid expansion to psychiatric comorbidity care within substance use disorder treatment programs. *Journal of Substance Abuse Treatment, 105,* 44–50. https://doi.org/10.1016/j.jsat.2019.07.012

[32] Ettner, S. L., Huang, D., Evans, E., Rose Ash, D., Hardy, M., Jourabchi, M., & Hser, Y.-I. (2006). Benefit-cost in the California Treatment Outcome Project: Does substance abuse treatment "pay for itself"? *Health Services Research, 41*(1), 192–213. https://doi.org/10.1111/j.1475-6773.2005.00466.x

[33] Corredor-Waldron, A., & Currie, J. (2022). Tackling the substance use disorder crisis: The role of access to treatment facilities. *Journal of Health Economics, 81,* 102579. https://doi.org/10.1016/j.jhealeco.2021.102579

[34] Michael Sandler and Anthony Simms are actuaries for Actuarial Research Corporation (ARC). They are members of the American Academy of Actuaries and meet the qualification standards of the American Academy of Actuaries to render the actuarial opinions contained herein.

Fiscal Impact

The potential fiscal impact of this legislation for the state includes the estimated cost to SEGIP as assessed by SEGIP in consultation with health plan administrators, the cost of defrayal of benefit mandates as understood under the ACA, and the estimated cost to public programs.

- SEGIP estimates the cost of this legislation for the state plan to be $479,880 for partial Fiscal Year 2024 (FY24) and $1,007,748 for FY25.
- There are no defrayal costs assessed by Commerce.
- There is no estimated fiscal impact for public programs.

Fiscal Impact Estimate for SEGIP

MMB provided Commerce with SEGIP's fiscal impact analysis, which assessed historical claims data, potential changes in utilization, and previously rejected claims data associated with mental illness and SUD. According to SEGIP's estimate, the fiscal year impact of legislation on SEGIP will be $479,880 in partial FY24 ($0.62 PMPM × 129,000 members × 6 months).

ACA Mandate Impact and Analysis

The ACA defined 10 essential health benefits (EHBs) that must be included in non-grandfathered plans in the individual and small-group markets. Pursuant to section 1311(d)(3)(b) of the ACA, states may require qualified health plan issuers to cover benefits in addition to the 10 EHBs but must defray the costs of requiring issuers to cover such benefits by making payments either to individual enrollees or directly to qualified health plan issuers on behalf of the enrollee.

Any state-required benefits enacted after December 31, 2011, other than for purposes of compliance with federal requirements, would be considered in addition to EHBs even if embedded in the state's selected benchmark plan.[35] States must identify the state-required benefits that are in addition to EHBs, and qualified health plan issuers must quantify the cost attributable to each additional required benefit based on an analysis performed in accordance with generally accepted actuarial principles and methodologies conducted by a member of the American Academy of Actuaries and must report this to the state.[36]

Commerce has determined that this bill, absent further specification as to what specific services or treatments are covered by a PRTF, would not constitute a benefit mandate as defined under the ACA. This bill makes changes to what kinds of providers are included in the network rather than setting new requirements for specific care, treatment, or services. Based on this assessment, there would be no defrayal requirement associated with passage of this bill.

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[35] See 45 CFR § 155.170(a)(2).
[36] See 45 CFR § 155.170(a)(3) and § 155.170(c).

Fiscal Impact for Public Programs

There is no estimated cost to public programs because PRTFs are part of the current Medicaid coverage for individuals 21 and under.

Appendix A: Bill Text

Addition of Psychiatric Residential Treatment Facility (PRTF) Services to Commercial Health Plan Coverage

Sec. 1. Minn. Stat. § 62A.152, subdivision 3, is amended to read:

62A.152 BENEFITS FOR AMBULATORY MENTAL HEALTH SERVICES.

Subd. 3. Provider discrimination prohibited. All group policies and group subscriber contracts that provide benefits for mental or nervous disorder treatments in a hospital must provide direct reimbursement for those services at a hospital or psychiatric residential treatment facility if performed by a mental health professional qualified according to section 245I.04, subdivision 2, to the extent that the services and treatment are within the scope of mental health professional licensure.

This subdivision is intended to provide payment of benefits for mental or nervous disorder treatments performed by a licensed mental health professional in a hospital or psychiatric residential treatment facility, and is not intended to change or add benefits for those services provided in policies or contracts to which this subdivision applies.

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Sec. 2. Minn. Stat. § 62D.124, subdivision 1, is amended to read:

62D.124 GEOGRAPHIC ACCESSIBILITY.

Subdivision 1. **Primary care; mental health services**; **general hospital services**. Within the health maintenance organization's service area, the maximum travel distance or time shall be the lesser of 30 miles or 30 minutes to the nearest provider of each of the following services: primary care services, mental health services, and general hospital services. The health maintenance organization must designate which method is used. Mental health services includes the scope of all medically necessary services, as defined under Minn. Stat. § 62Q.53, provided in a psychiatric residential treatment facility (PRTF).

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Sec. 3. Minn. Stat. § 62K.10, subdivision 4, is amended to read:

62K.10 GEOGRAPHIC ACCESSIBILITY; PROVIDER NETWORK ADEQUACY.

Subd. 4. **Network adequacy**. Each designated provider network must include a sufficient number and type of providers, including providers that specialize in mental health and substance use disorder services, to ensure that covered services are available to all enrollees without unreasonable delay. In determining network adequacy, the commissioner of health shall consider availability of services, including the following:

(1) primary care physician services are available and accessible 24 hours per day, seven days per week, within the network area;

(2) a sufficient number of primary care physicians have hospital admitting privileges at one or more participating hospitals within the network area so that necessary admissions are made on a timely basis consistent with generally accepted practice parameters;

(3) specialty physician service is available through the network or contract arrangement;

(4) mental health and substance use disorder treatment providers, including but not limited to residential treatment facilities, psychiatric residential treatment facilities, and hospitals, are available and accessible through the network or contract arrangement;

(5) to the extent that primary care services are provided through primary care providers other than physicians, and to the extent permitted under applicable scope of practice in state law for a given provider, these services shall be available and accessible; and

(6) the network has available, either directly or through arrangements, appropriate and sufficient personnel, physical resources, and equipment to meet the projected needs of enrollees for covered health care services.

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Sec. 4. Minn. Stat. § 62Q.47 paragraph (b) is amended to read:

62Q.47 ALCOHOLISM, MENTAL HEALTH, AND CHEMICAL DEPENDENCY SERVICES.

(b) Cost-sharing requirements and benefit or service limitations for outpatient mental health and outpatient chemical dependency, psychiatric residential treatment facilities (to the extent that the services and treatment are within the scope of mental health professional licensure), and alcoholism services, except for persons placed in chemical dependency services under Minnesota Rules, parts 9530.6600 to 9530.6655, must not place a greater financial burden on the insured or enrollee, or be more restrictive than those requirements and limitations for outpatient medical services.

Appendix B: Key Search Terms for Literature Scan

Accessibility

Child coverage

Child mental health

Geographic accessibility

Mental health facilities

Network adequacy

Non-acute patient care

Psychiatric residential treatment facility

Psychiatric treatment

Serious mental illness

Substance abuse

Substance use disorder

Youth coverage

Youth mental health

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