

Rate Setting Methodology for Intensive Adult Mental Health Services

Adult Mental Health Division
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I. Executive summary

Assertive Community Treatment (ACT), Intensive Residential Treatment Services (IRTS) and Adult Residential Crisis Services (RCS) are all critical to the continuum of adult mental health services available to Minnesotans with mental illness. These intensive services provide support, treatment and stabilization to individuals who would otherwise need inpatient psychiatric hospitalization, as well as provide psychiatric rehabilitative services post-hospital discharge. These three distinct services also represent our highest level of community-based care for those with mental illness in Minnesota.

This report finds that:

- Acute problems in the current methodology for ACT, IRTS and RCS have threatened the sustainability of intensive community mental health services available to individuals with the highest service needs.
- Intensive mental health service programs are vulnerable to closure, face barriers to improving service delivery and face challenges in flexibility to meet the changing needs of service recipients.
- There is an urgent need for payment reforms for ACT, IRTS and RCS and state funds should be granted to programs to prevent further closures.

In addition, this report reveals that the lack of qualified workforce interested and available to work within Minnesota's public mental health service system is a challenge to providing quality mental health services, particularly in rural areas. Providers report difficulty in recruiting and retaining qualified entry level mental health practitioners, let alone highly qualified mental health professionals and psychiatric prescribers.

Therefore, this report offers several short-term recommendations to prevent further closures while addressing longer term payment restructure including:

IRTS:

- Request grant funding to cover facility costs to prevent further IRTS closures. Based on actual costs submitted by providers for fiscal year 2014 the shortfall for facility-related costs is estimated at \$1.1 million.
- The recommendation is to award grants directly to residential providers.
- Request grant funding to residential service providers for health and safety and therapeutic building enhancements.
- Retain Medicaid payment for treatment; consider alternatives to cover facility costs at a level that is sustainable. Use existing Group Residential Housing funds differently to create a separate funding mechanism for residential providers.

Residential Crisis Services:

- Request grant funding to cover all unreimbursed or under-reimbursed facility costs to maintain current bed capacity and prevent further closures of Residential Crisis Services.
- Study alternative rate structures which allow providers to flexibly respond to variable severity and acuity of persons served (e.g. a uniform tiered rate structure). The study must identify outcomes and a mechanism for determining varying levels of care and service intensity needs within a single program.

ACT Services:

- Request grant funding to assist any ACT team who had a 20 percent or more reduction in their per diem rate from year to year. This decrease in per diem rate was a direct result of a team's costs going down and individuals served increasing. The current rate methodology creates an inadvertent disincentive for teams to serve practice efficiently. Analyze the feasibility and impact of establishing one statewide per diem rate.

These changes support a more uniform geographic distribution of a continuum of intensive adult mental health services and would serve to shore up providers across the state and thereby enhance client access to services.

Lastly, while the intent of the report is to address the current problems with payment rates and make recommendations for sustainable payment of services, it can never be forgotten that the Department's first and foremost obligation is to provide quality service delivery to those in need. When implemented, the recommendations will not only sustain access to these vital services, but could also increase service quality through greater staff retention and continuity.

II. Legislation

Laws of Minnesota 2014, Chapter 312, Article 29, Section 15:

REPORT ON RATE SETTING METHODOLOGY FOR MENTAL HEALTH SERVICES.

The Commissioner of Human Services shall provide a report to the chairs of the Health and Human Services Finance Division, by February 1, 2015, that assesses the current rate setting methodology for intensive residential treatment services (IRTS), adult (residential) crisis (services; RCS) and assertive community treatment (ACT). The report will include an assessment of alternative payment structures consistent with the intent and direction of the federal centers for Medicare and Medicaid Services which could provide adequate reimbursement to sustain community-based mental health services regardless of geographic location. Stakeholders will be included in the development of the report and the report will also include concerns regarding payment rates for other mental health services that may require further analysis in the future.

III. Introduction

Purpose:

The 2014 Minnesota Legislature directed the Department of Human Services, Adult Mental Health Division, in consultation with stakeholders, to study the rate methodology of three mental health services which are a part of Minnesota's continuum of community-based adult mental health services. This report accomplishes the following objectives:

- Assess the current rate setting methodology for IRTS, RCS and ACT;
- Assess alternative payment structures consistent with the intent and direction of the federal centers for Medicare and Medicaid Services which could provide adequate reimbursement to sustain community-based mental health services regardless of geographic location.
- Identify concerns regarding payment rates for other mental health services that may require further analysis in the future.

This report is submitted to the chairs of the Health and Human Services Finance Division pursuant to Laws of Minnesota 2014, Chapter 312, Article 29, Section 15.

As directed by the legislative mandate, DHS Adult Mental Health Division staff convened a stakeholder group comprising representatives from mental health provider agencies, counties, associations, other DHS divisions and advocacy groups to review the three service areas. Subgroups were then created for specific focus on the individual mental health service areas of ACT, IRTS and RCS. Distinct issues relevant to residential services (IRTS and RCS) are identified and emphasized separately from non-residential service (ACT) within the body of the report.

This report (a) identifies acute problems in the current rate methodology for ACT, IRTS and RCS which threaten the sustainability of intensive community mental health services available to individuals with the highest service needs, (b) assesses alternate payment structures and (c) makes recommendations for adequate reimbursement to sustain community-based mental health services regardless of geographic location.

Additionally, this report addresses the need for a rate methodology which supports access to mental health services by 1) preventing further closures of programs, 2) allowing for expansion including to unserved/underserved geographic regions and 3) providing cost-effective alternatives to mental health treatment outside of a hospital setting.

While the intent of the report is to address the current problems with payment rates and make recommendations for sustainable payment of services, the Department's obligation to provide quality service delivery is integrated into the methodology of the study and subsequent recommendations. When implemented, the recommendations will not only sustain access to these vital services, but will allow for an increase in service quality.

The findings of the study contained in this report draw attention to needed payment reforms for ACT, IRTS and RCS and make an urgent request for state funds to be granted to programs to prevent further closures. The report is intended to inform legislators, the public and payers about the issues threatening the sustainability of intensive community-based mental health services, which serve as alternatives to costly psychiatric inpatient care.

The Problem:

The study identified several problems inherent in the current reimbursement rate structure, which make intensive mental health service providers vulnerable to closure, prevent structural building changes for improved service delivery, and create barriers to hiring qualified staff to meet the complex needs of recipients.

Key issues identified:

- Uncompensated physical plant costs borne by residential service providers; these costs are not covered as a part of the Medicaid rate and are not adequately covered by other sources.
- The prospective nature of the current rate formula does not allow programs to cover expenses in a timely manner. This inhibits program changes that would improve quality and increase the capacity of programs. The prospective rate setting process also puts some programs at higher risk when unexpected costs arise.
- Year over year fluctuations in service units drive the following year's rate. The current formula has a paradoxical effect: if costs decrease and the number of individuals served increases, a program's rate drops the following year (i.e. efficient service delivery is not supported). The current rate methodology creates an inadvertent disincentive for teams to serve practice efficiently.

Within calendar year 2014, one IRTS closed and one IRTS will not renew their license in 2015 due to a combination of factors, including the inability to recruit and retain qualified staff, as well as financial difficulties related to unreimbursed physical plant costs.

Two Adult Foster Care programs offering residential crisis stabilization beds closed. These programs had received a non-negotiated per diem of \$262 per day.¹ This low reimbursement rate was a reason that they could no longer provide the service.

In a Residential Provider survey conducted as a part of this report, two additional IRTS programs indicated that they are in imminent risk of closure in calendar year 2015 due to uncompensated building related costs. Analysis of the current rate-setting methodology within this report identifies the barriers to sustaining and improving intensive mental health service delivery infrastructure. Recent developments such as the closure of key critical residential mental health facilities and the imminent closure of others demonstrate the financial fragility of the intensive community-based service system.

How the report was prepared:

This report was prepared by the Chemical and Mental Health Services Administration, Adult Mental Health Division, in collaboration with numerous stakeholders. Work group members were solicited by invitation to designate one primary and one alternate to represent mental health provider associations, counties, consumer and family advocacy organizations, health plans and mental health provider agencies. Work group meetings were held on a monthly basis from August to December 2014 with smaller workgroups convening during this same time period to focus on issues specific to residential and non-residential service provision and rate methodology.

Stakeholder participants:

- IRTS, ACT, RCS Providers
- DHS Licensing Division
- DHS Children and Family Services Division
- DHS Federal Relations
- County representatives
- Health Plan representatives
- Provider Associations
- Minnesota Hospital Association
- Mental Health Advocacy Organizations
- Consumer Organizations

A comprehensive list of stakeholder and subgroup participants is included in Appendix A.

Survey: The Department, in collaboration with a number of community based mental health providers, hospital and health plan representatives and advocates, conducted a study of the financial status of residential psychiatric rehabilitative services. Through a web-based survey the Department sought input from residential providers to provide data to substantiate

¹ Service rates for crisis beds located within Adult Foster Care programs receive a flat per diem and are not subject to the cost-based rating setting methodology applied to crisis beds located within licensed IRTS programs.

recommendations for reform of the current rate methodology and future policy proposals the workgroup has developed. Relevant findings from 36 respondents are included within the body of the report.

Consultation with DHS Health Care Administration: The study includes input from internal subject matter experts within the DHS Health Care Administration (HCA). Federal Relations staff provided information specific to federal regulations of mental health services and the Purchasing and Service Delivery Division staff supplied information specific to rate methodology.

IV. Background

In this section, we first provide relevant background that the three service areas (ACT, IRTS and RCS) have in common. We then break the report into two sections, intensive residential services (IRTS and RCS) and intensive non-residential services (ACT).

A. Definitions

Assertive Community Treatment (ACT) is an evidence-based practice that serves a subset of individuals with severe mental illness. ACT is an intensive, comprehensive, *non-residential* treatment and rehabilitative mental health service team model. Services are provided by multidisciplinary, qualified staff who have the capacity to provide most mental health services necessary to meet the recipient's needs. ACT uses a total team approach, directed to recipients with a serious mental illness who require intensive services, available to recipients 24 hours per day, 7 days per week, 365 days per year. ACT services are not time limited.

Intensive residential treatment services (IRTS) are time-limited mental health services provided in a residential setting. The average length of stay in fiscal 2014 was 64.3 days. Recipients of IRTS are in need of more structured settings (versus community settings) and are at risk of significant functional deterioration if they do not receive these services. IRTS are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency and skills to live in a more independent setting.

Residential Crisis Services (RCS) are time-limited within a residential setting. The average length of stay in fiscal 2014 was 6.2 days. Services include crisis assessment, intervention services and crisis stabilization; including referrals, updating the crisis stabilization treatment plan, supportive counseling, skills training and collaboration with other service providers in the community. These services must be individualized and designed to restore the person to his/her prior level of functioning.

B. Relevant Background

Effective January 1, 2012, changes to the rate methodology for ACT, IRTS and RCS programs were made in order to conform to federal policy which required that the state Medicaid agency develop a statewide payment rate methodology. Since that time the Department has had the sole responsibility for determining provider rates. Previously, the counties directly negotiated a payment rate with the service provider; statutory revisions to MN Statute 2010, section 256B.0622, subdivision 8 (c) eliminated the county's rate setting role beginning in 2012.

Additional changes were implemented to the rate calculation for existing programs, moving from a settle up payment approach to a prospective payment approach with clarification of allowable costs. The new process preserved the cost-based approach for direct services, which includes direct service staff costs, training for direct service staff and service-related transportation. Other program-related costs are paid through a flat rate percentage arrived at by averaging the costs of similar programs across the state. The state provision also allowed for a supplemental rate to pay for physical plant costs when room and board payments are insufficient. Statute also allows for a performance incentive of up to 5 percent; however this provision was not approved by Centers for Medicare and Medicaid Services (CMS).

Moving from a settle-up process to a prospective payment based on expenditures and utilization over a prior 12-month time period, as the basis for setting the rate in the next funding period, (256B.0622 subd. 8 (g))² eliminated the settle-up process for existing programs.³

CMS approved the current rate methodology in September 2014 with a retroactive effective date of January 1, 2014. The current payment methodology only reimburses providers for their program related costs, other non-medical, non-rehabilitative expenses—such as paying for program participants’ room and board, rent deposits, or vocational training for particular jobs—cannot be reimbursed by Medicaid. CMS specifically sought an assurance that the physical space allocated within the Medicaid rate was for treatment only and not related to room and board.

**C. Current Rate Setting Methodology
(MN Statute, Section 256B.0622, subdivision 8(c))**

Minnesota statute establishes the criteria the Commissioner uses to develop one daily rate (per diem) per provider for intensive rehabilitative mental health services rates. Rates are adjusted on an annual basis based on:

- (1) The cost for similar services in the local trade area;
- (2) The provider’s cost for services include direct service costs, other program and overhead expense,⁴ and Other costs as determined as follows:
 - (i) The direct services costs must be determined using actual costs of salaries, benefits, payroll taxes and training of direct service staff and service related transportation.

² The previous fiscal year expenditures and service utilization (occupancy) are used to calculate the next calendar year rate. E.g. July 1, 2013-June 30, 2014 expenditures and utilization determine the rate for calendar year 2015.

³ Entities that discontinue services are subject to a settle-up whereby actual costs and reimbursement for the previous 12 months are compared as defined in 256B.0622 subd. 8 (h).

⁴ Other Program and Overhead Expenses include, but are not limited to the following: administrative staff, salaries, and benefits, non-service related transportation, central office allocations, professional liability insurance, organizational dues and subscriptions, training provided to non-direct service staff, supplies and materials, equipment and electronic medical records.

- (ii) Other program costs not included in item (i) are determined as a flat percentage of the direct service costs as determined in item (i). The flat percentage was determined by the Commissioner based upon the average of percentages that represent the relationship of other program costs to direct services costs among the entities that provider similar services. The current flat percentages are 37 percent for residential providers and 41 percent for non-residential providers.
 - (iii) Residential providers (IRTS and RCS) can demonstrate actual program-related physical plant costs in excess of the group residential housing reimbursement; the commissioner may include these costs in the program rate, so long as the additional reimbursement does not subsidize the room and board expenses of the program.⁵
 - (iv) Nonresidential services physical plant costs must be reimbursed as part of the costs described in item (ii).
 - (v) Performance incentive (up to 5 percent)⁶
- (3) Actual cost is defined as costs which are allowable, allocable and reasonable and consistent with federal reimbursement requirements under Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and Budget Circular Number A-122, relating to nonprofit entities
 - (4) The number of service units⁷
 - (5) The degree to which recipients will receive services other than services under this section
 - (6) The costs of other services that will be separately reimbursed
 - (7) Input from the local planning process authorized by the adult mental health initiative under section 245.4661, regarding the recipient's needs.

⁵ Physical plant costs in excess of the group residential housing reimbursement was determined by CMS to not be an allowable cost to be included within the Medicaid rate; therefore, DHS implemented and CMS approved an Allocated Space rate component for IRTS & RCS programs treatment and program space, based on square footage.

⁶ CMS did not oppose the original 5 percent performance incentive related to wellness initiatives. CMS offered technical assistance to help implement the incentive payment ongoing (per DHS federal relations).

⁷ In late 2013, the Department sought to ameliorate rate fluctuations caused by changes in occupancy by instituting a 5 percent limitation on increases and decreases to a program's per diem rate. CMS did take issue with the 5 percent cap on rate fluctuations. DHS initially included language in the most recent state plan amendment that limited rate increases and decreases to 5 percent. CMS was concerned that the language was not comprehensive because a provider could not be sure of their payment rate. We removed the cap language.

D. Identifying the problem

A study of the rate methodology undertaken by DHS and its stakeholder group identified a number of problematic aspects which contribute to barriers in statewide access to services and create barriers to optimal intensive rehabilitative mental health service delivery.

The current methodology used to establish a provider's per diem payment (referred to as a prospective cost based rate⁸) uses the provider costs, incurred in the previous fiscal year to establish the following calendar year's per diem rate. This methodology prevents all three service provider types (ACT, IRTS and RCS) from adding program staff because the program incurs significant costs that are not reflected in the payment rate until the following rate year. Increasing the number of nurses or mental health professional staff, or adding staff such as a psychiatrist, other prescriber type or a certified peer specialist increases the quality and the array of services a provider can offer. Among the stakeholders there was (near) unanimous agreement regarding the need for a rate structure that allows for increased treatment costs when they are incurred by the provider.

A second problem with the current rate structure, universal to all intensive mental health rehabilitative providers whose rates are set under the current cost-based rate methodology, involves the impact of units of service on the rate formula. A unit of service for residential (IRTS and RCS) and nonresidential services (ACT) is a per diem (i.e., per day). The current calculation is simply program costs divided by units; therefore, when a provider serves a lower number of clients in a fiscal year compared to the previous reporting period and their costs remain the same (or even increase), the result is an increased rate. Conversely, when a provider maintains their cost level with an increase in service units, or reduces costs with the same number of service units, the rate for the following calendar year decreases. This calculation incentivizes providers to serve fewer clients and not reduce costs, while disincentivizing providers who serve more clients while keeping costs low.

The third and most pressing problem is specific to the room and board payment for services delivered in a licensed residential setting. The payment source for room and board is separate from the service payment. The Medicaid service payment is exclusive to costs related to the delivery of treatment and prohibits any building-related costs related to the residential facility. Residential providers rely on a state-funded program, Group Residential Housing (GRH), to compensate for room and board costs. However, the GRH rate is insufficient to cover the costs of operating a facility, including depreciation and capital improvements. Based on fiscal year 2014 building-related costs submitted to DHS, the average monthly provider expense is estimated to

⁸ 256B.0622 [Subd. 8](#) (g) the rates for existing programs must be established prospectively based upon the expenditures and utilization over a prior 12-month period using the criteria established in paragraph (c)

be \$1,200, whereas the 2014 GRH rate is \$876. Reliance on the current payment structure, which separates reimbursement for services from facility costs, creates an operating hole that has caused some programs to close or to operate at a loss.

E. Relevant Background for Intensive Residential Services

Licensing: Minnesota has 45 licensed programs that are enrolled in Minnesota Health Care Programs (MHCP) to provide “intensive” residential services for short-term, time-limited rehabilitation of adults with mental illness. These programs are licensed by the Department of Human Services according to Minnesota Rules, parts 9520.0500-9520.0670 with an IRTS variance and by the Minnesota Department of Health (MDH) as a supervised living facility, a boarding care home, or a board and lodging facility or its equivalent from a local health department. MDH license ensures the construction, equipment, maintenance, and operation of the facility as it relates to sanitation and safety of the buildings, to the health, treatment, comfort, safety and well-being of the persons being served. Intensive residential programs may serve up to 16 recipients per program. A number of licensed IRTS programs hold a certification to provide crisis stabilization services.

Additionally, crisis stabilization services are provided in a small number of licensed Adult Foster Care programs. Adult Foster Care programs can be licensed for up to four beds and are not subject to the same standards or payment methodology as for crisis services provided within an IRTS setting. The disparity in service standards and payment for crisis services within Adult Foster Care programs is addressed within the Residential Crisis Services sections of this report.

Payment: The current payment structure for a Medicaid recipient relies on a payment for rehabilitative services delivered, while the room and board expenses are paid by a state-funded housing program called Group Residential Housing (GRH) for eligible recipients, or if ineligible, are billed to the individual client.

A person must meet certain eligibility requirements to receive GRH funds to cover their room and board costs while receiving treatment in an intensive residential treatment service. These requirements include being aged, blind, or over age 18 and disabled according to the criteria used by the Social Security Administration, or certain criteria for Minnesota’s General Assistance program. In addition, there are income and asset maximums. Counties administer the GRH program for the state and are responsible for determining eligibility. The GRH is a payment made directly to the residential provider on behalf of the eligible person. Because GRH may also be being used to pay for the individual’s housing in the community, in that case it could not be used to pay room and board at the facility without putting the client’s on-going housing at risk.

Providers are often unable to collect the GRH payment from the county for room and board costs for an individual because the client is discharged before eligibility for GRH is confirmed. When an individual is not eligible for GRH they are billed out of pocket for room and board costs; the client portion of room and board expenses is even more difficult to collect. RCS providers are especially affected because of shorter lengths of stay; on average a crisis residential stay is 6.2 days, limiting the time for eligibility determination. Information collected in the 2014 Residential Provider Survey indicates that 70-100 percent of room and board is uncollected for clients receiving crisis stabilization services within an IRTS setting.

Need for capital improvements: As mentioned above the current payment structure does not cover the costs for health and safety or therapy-related building enhancements within an IRTS. According to the recent Residential Provider Survey, 47 percent of respondents indicated a need for health and safety related building improvements. Responses included installation of an elevator, making rooms handicap accessible, increased lighting and cameras for security and increasing space dedicated to nursing services. The same survey indicated that 62 percent of respondents' programs could benefit from building enhancements to improve therapeutic services offered. Examples of these capital improvements include increased therapeutic space for treatment and programming, creating private client bedrooms, and additional office space for 1:1 meetings with client and client's family.

Capacity to service individuals with high needs: In 2012, the Department convened a steering committee and workgroup related to Mental Health Reform 2020 to identify the services needed within a medically monitored, 24-hour treatment setting to support individuals with co-occurring and complex needs. The workgroup recognized at that time the need for increasing qualified staff within these service settings and the need for changes to the rate methodology to incorporate the cost of hiring new staff into a program's current rate. Detailed recommendations are included in Appendix B.

In 2013, the legislature allocated funds to address some of the barriers to individuals moving from AMRTC and MSH in a timely manner. One barrier that was identified was that there was a short supply of individuals qualified to provide treatment and rehabilitative services to individual with high needs. This was both within service options such as ACT and IRTS.

Centers for Medicaid and Medicare Services (CMS) compliance: During the most recent Medicaid state plan amendment approval process, CMS clearly stated that payment could not include reimbursement for any room and board costs. In order to calculate physical plant costs, the Department requires providers to submit a floor plan to clearly identify the space devoted solely to treatment.

The rules and regulations for funding facility costs are complex and any solution implemented is likely to require rule or legislative changes, along with CMS approval for any changes made to Medicaid services or payment (i.e. state plan amendment).

F. Relevant Factors specific to Intensive Residential Treatment Services

IRTS are time-limited mental health services provided in a residential setting. Based on discharge data during fiscal year 2014 the average length of stay for IRTS clients is 64.3 days. Recipients of IRTS are in need of 24/7 monitoring and supervision and are at risk of significant functional deterioration if they do not receive these services. IRTS are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency and skills to live in a more independent setting. In calendar 2013, IRTS programs enrolled with Minnesota Health Care Programs (MHCP) served 2,127 people. Within calendar year 2014 one IRTS program closed and in 2015 one program will not renew their IRTS license due to factors related to the funding structure identified above; these issues are relevant to all IRTS providers and continue to threaten the continuity of residential treatment services.

IRTS services can prevent the need for inpatient psychiatric hospitalization and provide additional recovery following discharge from inpatient settings. The need for a sustainable rate structure is critical in order to meet the demand, and in some areas of the state increase bed capacity. Anoka, Becker, Hennepin, Scott and Carver counties have recently submitted geographic needs assessments to DHS, demonstrating the need for an increased number of IRTS and crisis stabilization beds to serve their own and surrounding county residents. Potential providers in these areas have been cautious about entering into a new service line without assurance of a sustainable payment mechanism.

G. Relevant Factors specific to Residential Crisis Services

Residential crisis programs provide services to adults who experience a mental health crisis and need further intensive support to avoid a hospitalization or other institutional service. These programs can also be the first step out of a community hospital for individuals who continue to need support. People stay at the programs on a short term basis, usually seven days or less. These programs provided over 2500 episodes of service in calendar year 2013

Rates for residential crisis stabilization services provided within a licensed Intensive Residential Treatment Services are calculated based on the same formula as the Intensive Residential Services Rates. Rates for the programs vary from region to region and program to program. Service delivery requirements are in place to assure quality services.

Residential crisis stabilization services can also be provided in licensed Adult Foster Care programs. Adult Foster Care programs are limited to a maximum of five beds. These programs

receive a flat per diem rate of \$262 to pay for staff and material to serve them. Service delivery requirements for crisis services within a licensed foster care program (MN Statute [256B.0624 Subdivision 7 \(b\) and \(c\)](#)) are less than for crisis services provided within a licensed IRTS. Additional reimbursement is needed in order for Adult Foster Care programs with crisis beds to meet higher crisis service requirements.

Concerns with current rate methodology: All of the concerns that are discussed globally for residential providers are the same as those for RCS licensed under the IRTS variance. Issues that are not sufficiently accounted for under the current rate methodology for RCS include:

- **Difficulty of receiving funding for room and board costs.** GRH eligibility is not confirmed before the person is discharged from the program. This is especially problematic due to the nature of the crisis stabilization episode lasting on average 3-4 days.
- **Short term stays increase administrative, billing and program costs.** On average, two people use each crisis bed in each month. This high turnover service use creates high costs for admission and discharge procedures and billing. Some of the time, an individual will be admitted to the program but not stay overnight. However, the time spent at the facility is enough to help the person stabilize and return to their own home
- **People who use residential crisis stabilization programs have a high level of symptoms and support needs.** These programs are used in lieu of a hospital. Many of the people that are served would have gone to a hospital for services in the past. Because of the high needs, highly-trained staff people are required for these programs. Individuals who use residential crisis services also need more one-to-one time with staff people. This need creates a requirement for a higher ratio of staff people to the number of people receiving services.
- **Crisis response programs have high staff turnover.** Staff people move to other programs because of the low pay and high demands of the service. This results in high hiring, training and supervision costs for the crisis programs.
- **Crisis programs admit on a 24 hour basis.** This admission policy requires staff with practitioner or professional credentials to be available to perform the admission process. The programs need to have 24 hour nursing staff available to assure that the people at the program, especially new admissions, get the correct medication and are not a health risk to others in the programs.
- **Crisis programs need to have program capacity available when a person is in crisis.** Because they need to keep space available, their overall occupancy is lower and their income is less than a program that is consistently full.
- **Crisis programs serve more people who have commercial insurance.** Commercial insurance plans usually cover a more limited set of services for mental health issues than

publicly funded programs. Many of the commercial plans do not cover residential crisis stabilization programs.

- **The rates for the small crisis programs do not support the cost of providing the services.** Programs licensed as Adult Foster Care programs (five beds and under) are not required to meet the IRTS variance standards, therefore are not eligible for the cost-based rate. The two residential crisis programs that have recently closed have been receiving the non-negotiated per diem of \$262 per day. Low reimbursement rate prompted the program closures.

H. Intensive Non-Residential Services Delivered as Assertive Community Treatment

Minnesota has 27 (ACT teams, with a little over half (52 percent) located in the metro areas. ACT teams serve a subset of individuals with highly complex needs, and teams are capped in terms of capacity per evidence based practice guidelines. Teams in Minnesota serve between 35-100 individuals depending on need and geographic location. In 2013, there were 1,991 individuals served within Minnesota ACT programs. Assertive Community Treatment services are paid primarily through Medicaid fee for service and Managed Care Organizations (MCOs) with some private insurance or self-pay.

Current rate calculation: ACT program rates are calculated based on the same formula as described in the Rate Setting Methodology section previously outlined on page 12 of this report. DHS uses actual expenditure and utilization data from a previous 12-month period to establish future per diem, bundled (i.e., episode based payment) reimbursement rates for ACT. While the ACT subgroup stakeholders found that the concept of a daily per diem rate/per ACT recipient is fundamentally good, they did outline some concerns and barriers with the current methodology.

Acute concerns with current methodology: As previously outlined on page 14, one acute current concern and barrier with our current ACT rate methodology was the *prospective* cost based rate. ACT providers indicated that the prospective cost based rate made it untenable to add staff and expand existing teams to serve more individuals or increase staff qualification. The prospective cost based rate requires the provider to hire and expend dollars for wages, training and benefits FIRST before the cost of adding staff is included in the rate. This results in the current rate being 12-months behind actual costs expended when adding new staff. For example, one county wanted to add a peer specialist to their team but was unable to do so as they did not have the funds to pay for this addition for one year before reimbursement of costs. Further, the prospective rate put programs at a higher risk when unexpected costs arise. They have little ability to recoup costs in a timely manner. This issue seemed to impact smaller provider agencies compared to larger provider agencies that have more fluid resources to address the ebb and flow of costs.

Another concern was the level of variability across all teams and rate of payment. The 2015 daily/per service recipient unit of pay ranged from \$133.98 to \$316.71. This range suggested there may be some large variability in services delivered under the ACT umbrella, as well as variation in team sizes. This is especially problematic with an evidence based practice such as ACT; given the required basic components of an ACT team, there should be very little variability among programs. Additionally, this cost base rate system does not yet allow for any pay for performance measures. Quality of services delivered is not integrated into the current methodology. In fact, a paradoxical effect occurred as programs that cut costs and added service recipients were actually penalized as the per diem rate dropped the following year.

The stakeholders also identified other factors that contribute to how adequately ACT programs are funded and that impact ACT services. Two factors in particular were reviewed: (1) supplemental grant funds for ACT and (2) expansion and clarification of what services are allowable for ACT to bill Medicaid.

- (1) Supplemental grant funds were established in 2007 and were to assist ACT teams in covering costs that were required by the ACT model, but were not reimbursable by Medicaid. Specifically, the supplemental funds were granted for ACT teams to provide employment services to clients that were not otherwise included in the Medicaid service rate. It also contributed toward a small fund of flexible dollars that facilitate service delivery by identifying and meeting client needs quickly (e.g. security deposit for an apartment). These funds were meant to directly go to the provider; however, over the past seven years, some counties and initiatives have utilized the funds elsewhere leaving some ACT programs short.
- (2) ACT is considered a “package” of services; however, current interpretation is that only rehabilitative services can be billed. It was discussed that clarifying and expanding the taxonomy of what is considered a billable ACT service may increase the revenue generated and offset program costs.

V. Overall Findings – summary/analysis

The need for community mental health services continues to grow. As a result of the Jensen Settlement, Minnesota implemented a comprehensive Olmstead Plan, driving policies and services that support integrated community living for persons with disabilities. Additionally, community providers have faced increased pressures to deliver services to persons with increasingly complex and co-occurring medical, substance use and social needs. Since 2013, the Department has engaged in an initiative to address barriers to discharge from state-run facilities. ACT and IRTS programs continue to be critical resources in the successful discharges of individuals with multiple barriers to community placement.

The report, in collaboration with stakeholders, makes recommendations to address and resolve each of the issues identified in the rates study over the course of multiple years. These recommendations are described in detail in the following section VI. The most pressing problem identified is the separation of room and board payment from the service payment for residential providers, creating an operating hole that has caused some residential programs to close or to operate at a loss. The second most crucial problem with the rate structure is the year over year fluctuation in service units impacting on the following year's rate. As an example, three ACT program's annual rate decreased more than 20 percent from 2014 and 2015. And third, the prospective nature of the current rate formula does not allow programs to cover expenses in a timely manner.

The study revealed that the lack of qualified workforce, interested and available to work within Minnesota's public mental health service system is a confounding factor contributing to the risks and challenges of providing quality mental health services, particularly in rural areas. Providers report difficulty in recruiting and retaining even qualified entry level mental health practitioners, let alone highly qualified mental health professionals and psychiatric prescribers.

Because the Department is in the process of requesting funds from the legislature for an in-depth study of the payment for all mental health services over the next two years, the mid and long-range recommendations of this report can be further explored within a comprehensive study of mental health service rates. Currently, the Department is undertaking a State-County Mental Health Targeted Case Management (MH-TCM) Rates Work Group. The goal of this group is to develop recommendations, in partnership with counties, about how best to reform Minnesota's MH-TCM rate structure in a way that is consistent with CMS guidelines. This work will be completed by early summer 2015 in preparation for the 2016 legislative session.

Additional specific findings and summaries are presented according to service type:

Residential Services

IRTS: The continuation of a cost-based, per diem payment was supported by DHS stakeholders. Pursuit of the report's mid- and long-range recommendations will be needed to address the specific problems identified with the separation of room and board payment from the service payment, rate fluctuations based on service units, and the prospective nature of the rate calculation.

Residential Crisis Stabilization: Overall findings of the study identify unique aspects for RCS. Mid- and long-range recommendations will need to address licensing standards in conjunction with DHS policy and licensing divisions and MDH to study how to adequately license and fund programs of varying sizes. A reformed rate structure needs to account for the shorter-term stay, higher client turn over and lower occupancy of crisis services to adequately reimburse for the administrative costs while assuring availability of access to services.

Non-residential Services (ACT)

The current rate methodology for ACT was deemed fundamentally sound by stakeholders in that they like the per diem bundled rate. The largest acute concern was the prospective nature of the rate setting methodology, including the inability to collect expenses in a timely manner which inhibited program changes that would improve quality or capacity of current ACT programs. Additionally, there were other challenges such as a narrow definition of what were MA reimbursable ACT services and the supplemental funds targeted for ACT that some providers are not receiving, that were identified as impacting the overall fiscal health of ACT teams.

VI. Report recommendations

Specific recommendations will be detailed according to service type, with overall recommendations delineated at the end of this section. The Mental Health Rates Study work group created urgent, mid-range and long-range recommendations to address the most pressing issue of imminent closure of residential services and allow for more in-depth study and longer term quality improvement and payment reform.

A. Intensive Residential Treatment Services

The stakeholder group recommended providing short term funding to maintain current bed capacity and prevent further closures of IRTS while exploring longer-term solutions simultaneously.

Urgent (2015)

1. Request grant funding to cover facility costs to prevent further closures of IRTS and Crisis Residential Services.
 - Based on actual costs submitted by providers for fiscal year 2014 the shortfall for facility-related costs is estimated at \$1.1 million.
 - The recommendation is for grants to be awarded directly to residential providers.
2. Request grant funding to residential service providers for health and safety and therapeutic building enhancements.
 - These grants will be awarded in a competitive RFP process
3. Develop a rate structure to allow for increased treatment costs when they are incurred rather than based on expenditures and utilization over a prior 12-month period.

Department's Response to this recommendation

- While the Department recognizes this as an urgent recommendation, a resolution will need to be developed through further study and reform of the overall rate structure that the Department intends to undertake 2016-2018.

Midrange (2016-2017)

1. Retain Medicaid payment for treatment; consider alternatives to cover facility costs at a level that is sustainable. Explore using existing GRH funds differently to create a separate funding mechanism for residential providers.
2. Consider ways to fund health and safety-related facility modifications ongoing.
3. Consider ways to fund building modifications as need to enhance therapeutic milieu ongoing.
4. Address room and board costs across both mental health and chemical dependency residential treatment programs, as chemical dependency programs will encounter the same challenges as services are moved into Medicaid coverage.

Long-range (2018)

1. Pursue a classification (using medical rehabilitation as an analogous model) to allow for both facility and treatment costs under a single rate structure.

Department's Response to this recommendation

- o Medicaid only allows for room and board payments for inpatient hospitals, ICFs, nursing facilities and PRTFs. The Department's pursuit of this, as with all recommendations, will need to align with payment structures consistent with the intent and direction of the federal centers for Medicare and Medicaid Services.
2. Study alternative rate structures which allow providers to flexibly respond to variable severity and acuity of persons served (e.g. a uniform tiered rate structure). The study must identify outcomes and a mechanism for determining varying levels of care and service intensity needs within a single program.

B. Residential Crisis Services:

The following are recommendation from the Residential Crisis Stabilization stakeholder group.

Urgent (2015)

1. Request grant funding to cover all unreimbursed or under-reimbursed facility costs to maintain current bed capacity and prevent further closures of Residential Crisis Services.
 - o Based on actual costs submitted by providers for fiscal year 2014 the shortfall for facility-related costs is estimated at \$400,000.
 - o Funds will be granted to RCS providers
2. Request grant funding from the legislature to allow all Residential Crisis Services providers to provide for health and safety and therapeutic building enhancements.
 - o These grants will be awarded in a competitive RFP process
3. Develop a rate structure to allow for increased treatment costs when they are incurred rather than based on expenditures and utilization over a prior 12-month period.

Department's Response:

While the Department recognizes this as an urgent recommendation, a resolution will need to be developed through further study and reform of the overall rate structure that the Department intends to undertake 2016-2018.

4. Recommend that facilities licensed as Adult Foster Care obtain IRTS license and enroll as an IRTS provider in order to receive a cost-based rate. These providers can request a variance to acknowledge differences in requirements for fewer Residential Crisis Service beds.
5. Consider ways to fund room and board costs for clients who stabilize in a short time period (1-7 days), thus; discharging from the program prior to eligibility determination for GRH payment. One solution discussed and recommended by providers is to assume presumptive eligibility for GRH with all individuals receiving RCS.

Midrange (2016-2017)

1. Recommends that the Department convene a workgroup in conjunction with Minnesota Department of Health to develop facility standards (physical plant, food preparation,) and funding for programs of varying sizes.
2. Assess the current Unit of Service definition and identify alternatives for billing of partial day services or services without an overnight stay.
3. Develop a formula that captures the higher administrative costs and need to assure availability of access to services of Residential Crisis Services compared to Intensive Residential Crisis Services.

Long-range (2018)

1. Pursue a classification (using medical rehabilitation as an analogous model) to allow for both facility and treatment costs under a single rate structure.

Department's Response to this recommendation

- o Medicaid only allows for room and board payments for inpatient hospitals, Intermediate Care Facilities (ICFs), nursing facilities and Psychiatric Residential Treatment Facilities (PRTFs). The Department's pursuit of this, as with all recommendations, will need to align with payment structures consistent with the intent and direction of the federal centers for Medicare and Medicaid Services.
2. Study alternative rate structures which allow providers to flexibly respond to variable severity and acuity of persons served (e.g. a uniform tiered rate structure). The study must identify outcomes and a mechanism for determining varying levels of care and service intensity needs within a single program.

C. Non-residential Assertive Community Treatment (ACT) Services

These are recommendations based on the ACT stakeholder subgroup.

Urgent (2015)

1. Request grant funding to assist any ACT team who had a 20 percent or more reduction in their per diem rate from year to year. This decrease in a per diem rate was a direct result of a team's costs going down and individuals served increasing. The current rate methodology creates an inadvertent disincentive for teams to serve practice efficiently.
2. Direct the Department to clarify with CMS regarding allowable services billed under ACT benefit.
3. To support teams in getting adequate reimbursement, assess which providers are getting full access to the supplemental grant dollars delineated for ACT-only services.

Mid-range (2016-2017)

1. After clarification with CMS on what are MA allowable services for ACT, potentially expand the taxonomy of what is a billable ACT service. Provide technical assistance to all programs to assure they are maximizing MA revenue for ACT services. For example, billing for a medical consultation when the person is not present to enhance the integration of primary care.
2. Evaluate the direct service component portion of the ACT methodology and review where required components (of the ACT model) are currently captured/not captured within the per diem rate. For example, ACT is required to have a program assistant, but this position is not included in the direct service cost.
3. Re-establish protocols to assure the supplemental grant dollars are passed through to ACT providers and not utilized in other ways. This to include requiring counties and Adult Mental Health Initiatives via clear language in their grant awards to continue to directly pass through this funding to providers.
4. Analyze the feasibility and impact of establishing one statewide per diem rate that is reviewed and re-calculated on an annual basis with the flexibility to add modifiers (e.g., travel, geographical concerns, staffing patterns, size). However, a caution was raised to have minimal modifiers to keep the process simple and uniform. The group did not come to any conclusions of what a state-based per diem rate would be or how that would be calculated.
5. Further explore whether a rate could be established which would cover the costs of running a high fidelity (high quality) ACT team and pay providers at this rate based on ongoing fidelity reviews. Teams/Providers that do not meet a certain minimum quality threshold would get a lesser rate. Included in our recommendation is to have ongoing stakeholder groups in concert with the Health Care Administration to assure any changes would pass CMS guidelines.
6. We recommend the creation of a work group that reviews the necessity of a host county contract for ACT teams.

Long-range (2018)

1. Review the use of quality incentives for meeting certain quality indicators of the evidence-based practice of ACT (e.g., pay for performance indicators).

VII. Implementation language

256B.0622

Subd. X Grants; administration

The commissioner may grant funds directly to intensive rehabilitative treatment service providers to maintain access to these services.

Appendix A: Minnesota Rates Study Stakeholders Group

^a denotes members of the ACT subgroup

^b denotes members of the Residential subgroup

^c denotes members of the Residential Crisis Services subgroup

Lori Schmidt, ^{abc} Central MN Mental Health Center

Jim Riebe, Central MN Mental Health Center

Tracy Hinz, ^a Central MN Mental Health Center

Jeff Bradley, ^{bc} Mental Health Provider Association of Minnesota

Hugh Aylward, ^b Mental Health Provider Association of Minnesota

Catie Lee, PrimeWest Health

Ann Challes, PrimeWest Health

Theresa Dolata, MN Mental Health Consumer/Survivor Network

Glenn Anderson, ^{ab} MN Mental Health Consumer/Survivor Network

Ed Eide, ^b Mental Health Association of Minnesota

Ben Ashley-Wurtmann, ^b Mental Health Association of Minnesota

Scott Johnson, ^b Southwestern Mental Health Center, Inc.

Bruce Weinstock, State Advisory Council – *invited*

Grace Tangjerd Schmitt^{ab} & Ken Carr, Guild & Minnesota Association of Community Mental Health Providers

Craig Meyers, Des Moines Valley Health and Human Services

Steve Bartsch, ^a Hennepin County, ACT and RCS contract manager

Pat Ruhland, Hennepin County, IRTS contract manager

Matt Burdick, ^{ac} NAMI-MN/DHS –CMHSA, legislative liaison

Sue Abderholden, NAMI-MN

Darrin Helt, ^{bc} MN Health Plans

Nancy Houlton, ^{bc} MN Health Plans

Ellen Benavidas, ^b Consumer Survivor Network (CSN)

Jennifer McNertney, ^c Minnesota Hospital Association

Roberta Cordano, Wilder Programs SE Asian ACT team - *invited*

Tony Yang, ^a Wilder SE Asian ACT team

Pahoua Yang, ^a Wilder SE Asian ACT team

Claire Wilson, Minnesota Association of Community Mental Health Providers

Tom Alf, ^a ResCare

Tom Paul, ^a South Metro Human Services

Franki Rezek, ^a Ramsey County Human Services, ACT Team Leader

Linda Holcomb, ^a Woodland Centers

Sarah Ackerman,^a Western Mental Health Center, Executive Director

Linda Sjoberg,^a

Jim Getchell,^a Human Development Center, Executive Director

Amanda Mackie,^c Horizon Homes, Inc.

Sara Emich,^c South Central Community Based Initiative

Beth Nelson,^c Productive Alternatives, Crisis Stabilization Unit

Janis Allen,^c Range Mental Health, Wellstone Recovery Center

Jennifer Weigelt,^c People, Inc.

Amy Shillabeer,^c CREST Initiative, Olmstead County

Carolyn Wheeler,^c South Central Human Relations Center

Glenace Edwall, DHS, CMHSA, Director Children's and Adult MH Divisions

Carol LaBine, DHS, CMHSA, Deputy Director, Adult MH Division

Julie Pearson, DHS, CMHSA, Supervisor, Adult MH Division

Lorraine Pierce, DHS, CMHSA, Crisis Services Policy

Lynette Studer, DHS, CMHSA, ACT Policy

Sean Barrett, DHS, HealthCare Administration, Federal Relations representative

Kristine Davis, DHS, Children and Family Services – GRH representative

Julia Welle Ayres,^b DHS, Children and Family Services – GRH representative

Paula Halverson,^b DHS, OIG, Licensing Division, Supervisor

Appendix B: Mental Health Reform 2020

IRTS Work group Recommendations

February 27, 2013

Purpose: To identify the service components that are needed to meet the needs of individual, who no longer meet medical necessity for hospital level of care, but due to their co-occurring and complex needs, continued to require a medically monitored, 24-hour staffed treatment programs.

Scope of work: Focus on service components which are not included in the current IRTS model, but may be offered in addition to the currently available service components. The target population identified for these services includes individuals who have co-occurring physical health needs and/or psychiatric symptoms which may result in aggressive behavior following medical stability.

The workgroup met three times: September 24, October 22 and November 7, 2012

1. Recommend that DHS support the development of a higher intensity IRTS (with subsequent higher rate) to ensure that individuals with greater needs have access to a more intensive service when it is needed.
 - Rate setting rules need to change so new staff can be funded by paying providers now rather than a year from hiring.
 - Based on recommendations, we are suggesting that there is some flexibility to add staff as needed. However, the workgroup charge was to establish standard components of a higher intensity service, and this is also endorsed.
2. DHS should develop a way to identify IRTS programs according to the level of service intensity that is available at the program.
 - Service intensity is defined by staffing ratios, interdisciplinary team participation and service specialization.
3. Recommend DHS provide IRTS programs technical assistance and opportunity to negotiate modification of rates or payment methods related to co-occurring substance use treatment integration.
4. Recommend DHS develop IRTS program flexible rate adjustments to ensure that certified peers, registered nurses, or varied other staff are in accordance to the individual's services plan.
5. Recommend DHS provide IRTS programs technical assistance and opportunity to negotiate corresponding rate changes or payment methodology to ensure that programs

have the capacity to provide side-by-side skills training (to address identified skills needs).

- Supported skills training should also include supported exercise, supported employment and independent living skills, etc.
6. Recommend DHS develop a crisis transportation service that includes community and state- operated providers so that law enforcement is not the default means of transferring clients.
 7. Recommend DHS establish a risk and safety management committee to identify and evaluate high risk situations and review needs and type of care provided to individuals.
 - This focus would be proactive (vs. reactive) and address some of the barriers. Include Licensing, Ombudsman, community providers, AMHD, county, etc. representation.
 8. Recommend DHS explore the development of a team of staff that would be available to IRTS programs specifically when an individual is transitioning to community treatment or is evaluated to have increased risk and complex needs not readily available in the community.
 - As needs arise at the community location, the staff pool can be deployed to a program to adjust service intensity based on needs. The pool would help reduce potential re-hospitalizations by providing added care at the facility. The staffing pool must include culturally competent and expert staff, which would be supplementary to AMRTC and the private provider. The cost of the team could be covered by the IRTS rate and the IRTS provider could access added staff through a contract with the State Operated Services or another arrangement, if necessary.
 9. Recommend DHS authorize mental health practitioners who qualify as clinical trainees and receives clinical supervision from a mental health professional be eligible to provide diagnostic assessments at IRTS programs, consistent with the requirements in MN Rule 9505.0370 – 9505.0372 (rule governing outpatient mental health reimbursement).