

REFORMING MENTAL HEALTH IN MINNESOTA

Governor's Task Force
July 2016

INSTITUTIONALIZATION

1866-1986

BIRTH OF THE STATE HOSPITALS

Early reformers promoted the responsibility of states to ensure humane care, and relieve the burden on families and local governments. St. Peter opened in 1866. However, overcrowding, poor sanitation, and other conditions still hampered progress.

Prior to modern treatment, 30% of patients returned home within a year. The rest could expect to spend the rest of their lives institutionalized. The size of the programs expanded, exceeding 10% of the total Minnesota state budget in 1871.



Fergus Falls State Hospital c. 1900. Minnesota Historical Society.

A NEW VISION

In 1963, President Kennedy signed the Community Mental Health Act, intending to create a network of care to deliver improving techniques for therapy and new medications. However, the funding provided was not sufficient to build out these services.

In 1981, this funding was significantly cut and reorganized into block grants. Adjusted for population growth and medical inflation, state spending on mental health is only 12% of what was spent in 1955.



Photo: Bill Allen, Associated Press

1982 COMMITMENT ACT

The 1982 Commitment Act substantially revised the process for involuntary commitment. It built on prior reforms and the recommendations of a workgroup comprised of psychiatrists and other providers, attorneys, public officials, advocates, and state hospital leadership.

- Ended indefinite commitments for most individuals
- Commitments were specified by the cause of disability
- Modernized the language and approach
- Requires a finding that the person's condition poses a likelihood of physical harm if left unaddressed.

MINNESOTA'S COMPREHENSIVE MENTAL HEALTH ACTS

1987-2006

EVOLVING STRUCTURES

LOCATING FUNDING AND ACCOUNTABILITY

Minnesota is one of a handful of states to still retain the county administered/state supervised model in social and health services.

- Each county is the Local Mental Health authority, with the ultimate responsibility to provide a wide range of services.
- Based on models of service where there was mostly state and local funding, not Medicaid participation.
- As Minnesota added services to the Medicaid platform, funds have been redirected to pay for the state share of those costs. However, significant administrative and quality oversight remains at the county level. Eg: Host county contracts with service providers.
- County funds are overall a smaller portion of the services delivered, but are still important, because they are more flexible than Medicaid.

ADULT MENTAL HEALTH ACT

In 1987, Governor Perpich signed the Adult Mental Health Act. New community services were created, along with dedicated funding.

- Community Supports, including Case Management
- Counties charged with creating emergency services for mental health
- Local Advisory Councils to foster collaboration between individuals, families, providers, and county staff.



Gov. Rudy Perpich, Minnesota Historical Society

CHILDREN'S MENTAL HEALTH ACT

In 1989, Minnesota followed up with the Children's Mental Health Act. However, there was significantly less funding attached. Priorities included:

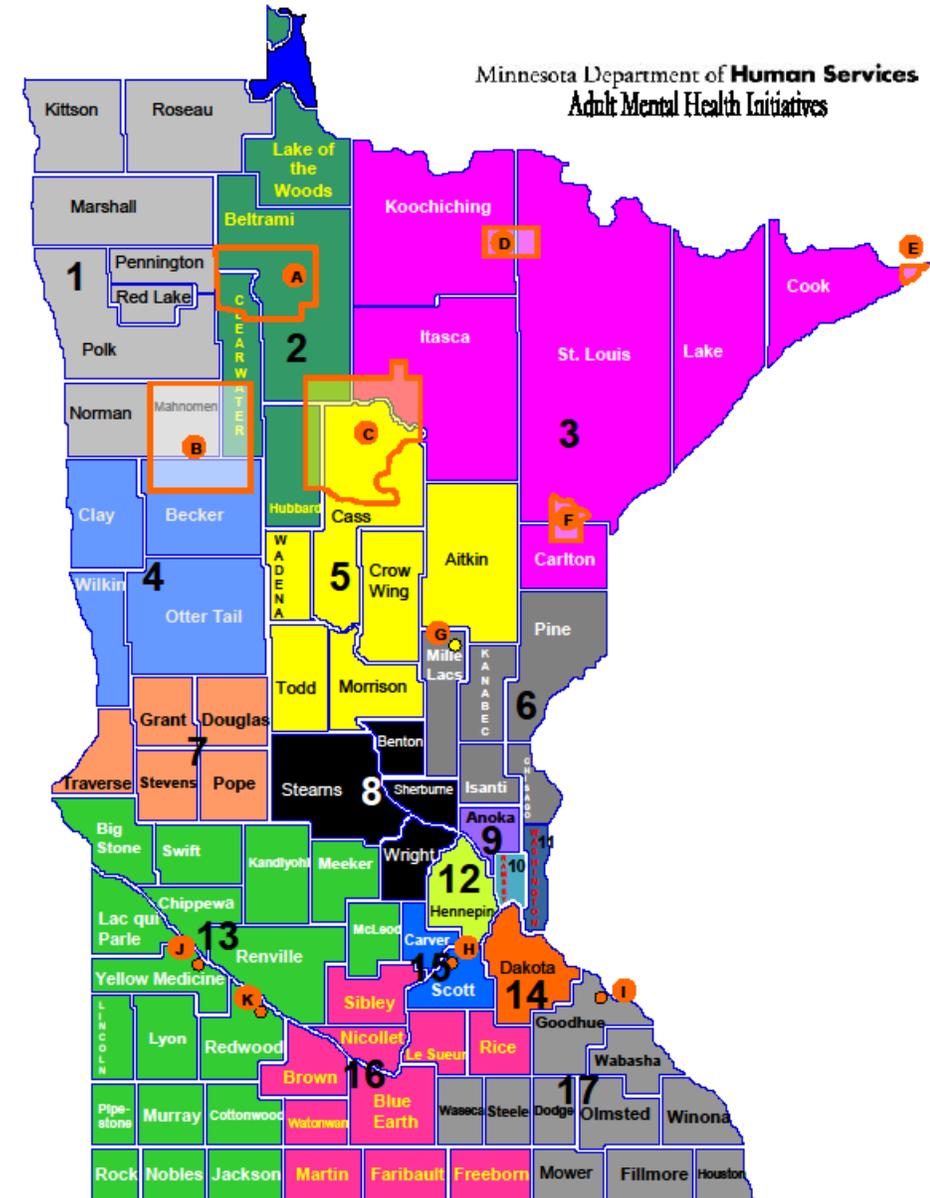
- Emergency services
- Outpatient services
- Screening and early identification
- Case management
- Residential treatment

AMHI AND COUNTY BLOCK GRANTS

The number of clients served in state hospitals decreased from a peak in the 50's, declining through the 70's and 80's.

As locations closed, some of the funding was redirected into the Adult Mental Health Initiatives (AMHI). Most are multi-county collaboratives. Initiatives were called on to be innovative and creative. Over time, most spending concentrated on basic infrastructure.

Because the AMHI money was a partial redirection of state hospital funding, there is no direct equivalent in the Children's system.



MEDICAID, PARITY, AND RECESSION

2007-2012

REHABILITATIVE SERVICES

Many services for people with mental illnesses are not clinical, but still meet medical goals. Just like physical rehabilitation, these services focus on how a condition affects a person's functioning in their daily life, and seeks to restore their capacity to work, learn, or be in their community. These services are typically delivered in a community setting, including an individual's home.

From 2002-2007, Minnesota approved the following services as Medicaid benefits.

- Intensive Residential Rehabilitative Health Services (IRTS)
- Adult Rehabilitative Mental Health Services (ARMHS)
- Residential Crisis
- Assertive Community Treatment (ACT)
- Children's Therapeutic Services and Supports (CTSS)

2007 MENTAL HEALTH ACT

In 2007, Governor Pawlenty signed a bipartisan mental health act. The Mental Health Action Group (including advocates, providers, hospitals, state agencies, health care payers) was instrumental in designing and promoting this work.

- Developed Model Mental Health Benefit set under Medicaid including rehabilitative services (ARMHS, CTSS, ACT)
- Supportive Housing
- School Linked Mental Health
- Respite Care for Families
- Community Behavioral Health Hospitals (State operated, but sized to qualify for Medicaid payment.)



RECESSION

Right after these investments were approved, the economic downturn in 2008-2009 created significant budget pressures in Minnesota. Significant portions of the 2007 reforms were deferred, subjected to cuts, or cancelled outright.

Other services, especially Personal Care Assistance, were changed to reduce hours of service and tighten eligibility.

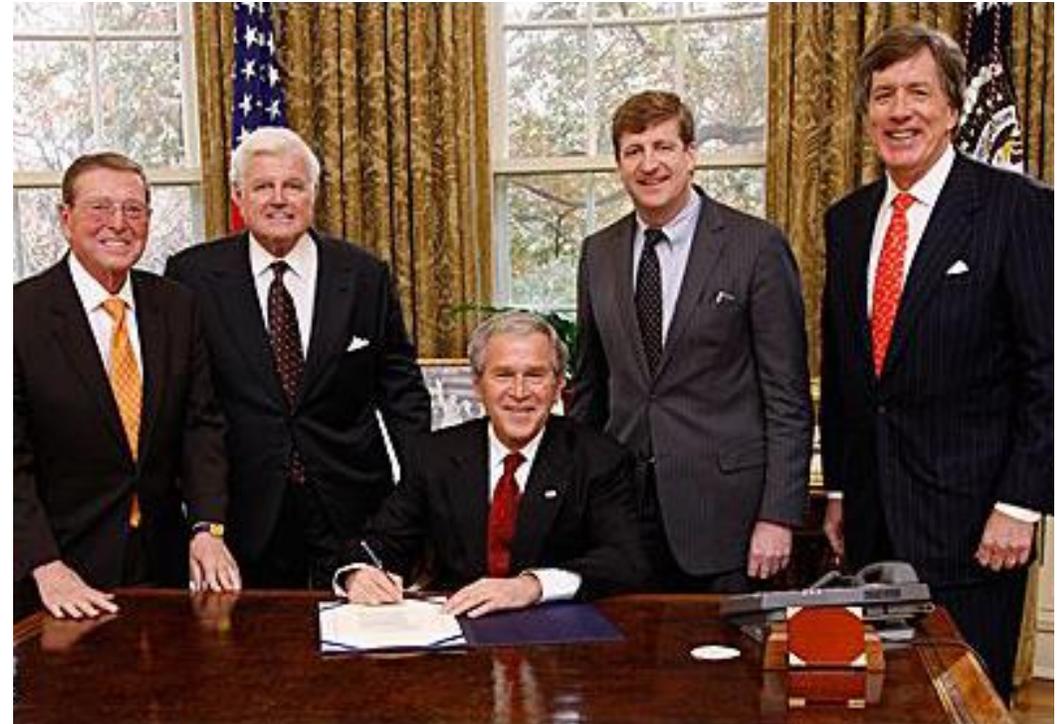
Unemployment is consistently higher among adults living with serious mental illness, and the recession intensified that issue.

WELLSTONE-DOMENICI

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008

- Covers public and private organizations over 50 employees, including self-insured plans.
- Includes both mental health and substance use disorders; any medical limitations can be no more restrictive than other medical/surgical benefits.
- Financial requirements need to be equitable, including co-pays and deductibles.

Final regulations were not released until November 2013, and some challenges remain, including the fact that the Model Mental Health Benefit set has not been covered by private insurance.



*Sen. Domenici, Sen. Kennedy, Pres. G.W. Bush, Rep. Kennedy, Rep. Ramstad
Photo Courtesy of Rep. Ramstad*

NEW INVESTMENTS, CHALLENGES

2013-2016

BUILDING TOGETHER

In 2013 and 2015, Governor Dayton signs bipartisan packages of mental health reforms. Highlights include:

- Additional Direct Care & Treatment beds.
- Funding to build out crisis services.
- Expanded ACT, a high intensity comprehensive community service.
- Comprehensive rate setting study.
- Funding and policy to expand options for hospital and residential beds for children.
- Expanded School Linked Mental Health
- Addressing workforce shortages



Governor Dayton, Signing Ceremony for 2015 Mental Health Provisions

ONGOING WORK

- State allocation, and additional Federal Block Grant funding, is being contracted out to residential crisis and IRTS providers to start new programs, add capacity, and improve safety at current programs.
- Funding and technical assistance to continue progress towards statewide 24/7 mobile crisis. Includes development of unified standards to ensure high quality services when teams are called.
- A comprehensive rate study and report exploring how to align rates with overall system goals. This will include examining regional disparities, and the use of modifiers or incentive payments to reward strong implementation of evidence based practices.
- Analysis to bring additional services into the Medicaid platform, including housing support services, children's respite care, and children's crisis residential services.

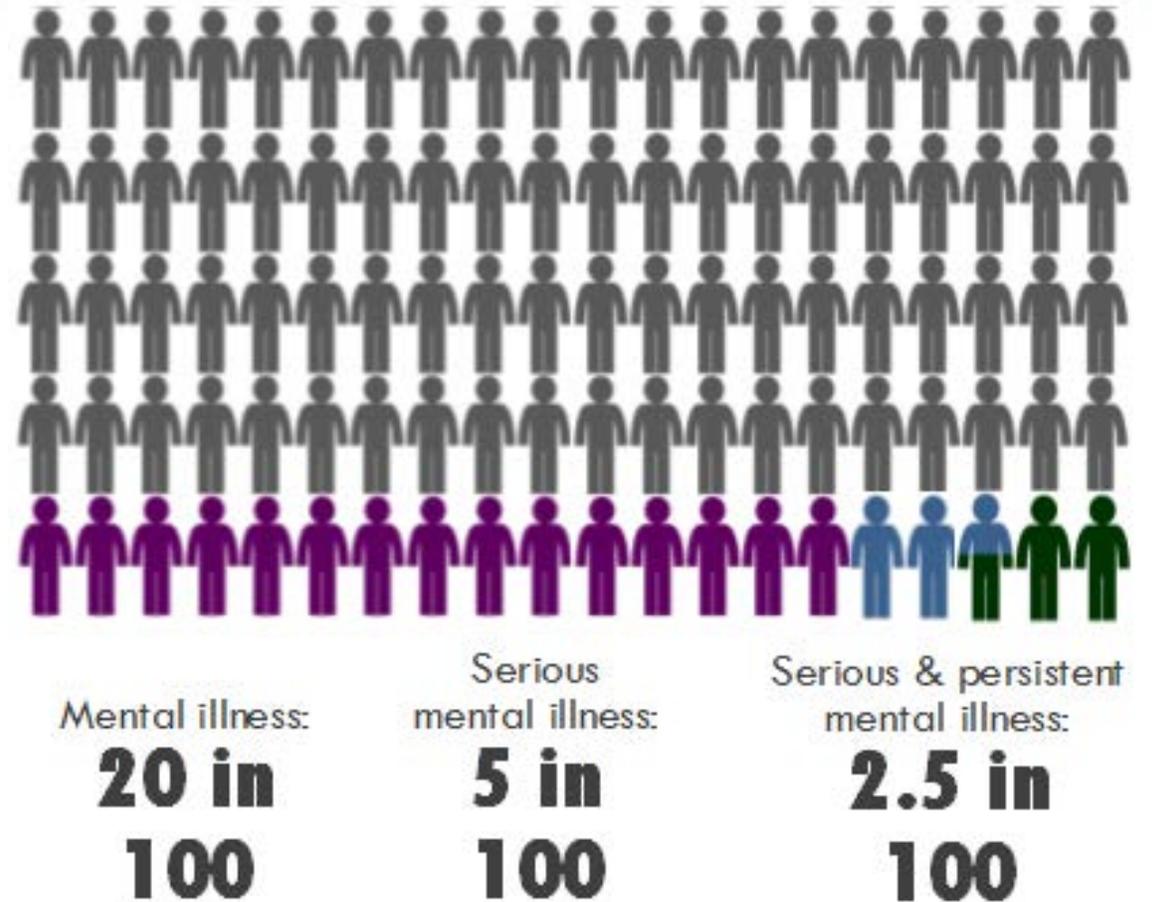
A CONTINUUM OF CARE



MENTAL ILLNESS AND EMOTIONAL DISORDERS

Approximately 1 in 5 adults will experience a diagnosable mental health condition within a given year. About 5.4% experience a serious mental illness (SMI). The underlying cause can be any mental illness, distinguished by a severity that impacts that person's function in major life areas. Risks increase, such as decreased physical health or unemployment.

About half of that population, or 2.6% of the general population, experience serious and persistent mental illness (SPMI). This is defined in Minnesota by a person's frequent or long-term use of high intensity services, such as inpatient hospitalization or a crisis team.

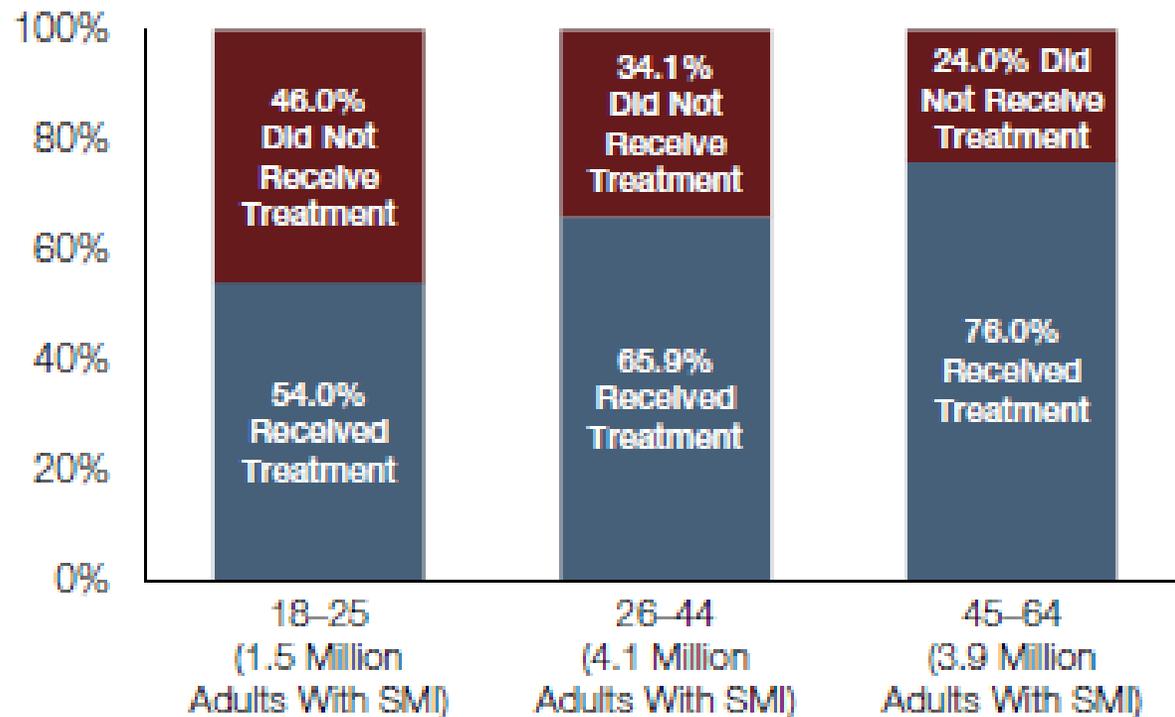


WHO DELIVERS CARE?

- **Mental Health Professional:**
 - Includes prescribing providers, such as a psychiatrist or psychiatric nurse
 - Qualified therapists, such as psychologists, or Licensed Independent Clinical Social Workers
 - Requires post-graduate work and supervised practice
- **Mental Health Practitioners**
 - .Bachelors Degree in a related field and supervised practice OR
 - Fluency in a non-English language, serving clients with that ability, and supervision OR
 - 6000 hours of supervised practice OR
 - Individuals in training who are receiving appropriate supervision
- **Direct Support Staff**
 - Certified Peer Specialists
 - Rehabilitation Workers
 - Mental Health Behavioral Aides

FIRST STEPS

Grants/ County	Medicare
Medical Assistance	Private/ Commercial Insurance



SAMSHA 2014

The most commonly accessed resource for mental health is primary care providers. Stigma or difficulty accessing more specialized resources can prevent individuals from taking further steps.

Outpatient therapy might be the first specialized treatment a person seeks.

For children, one option can be School Linked Mental Health, where a provider is embedded in the school, removing barriers to treatment.

DHS is also implementing First Episode Psychosis in partnership with the University of Minnesota, to provide intervention services shown to be effective in preventing the further development of a person's illness.

Grants/
County

Medicare

Medical
Assistance

Private/
Commercial
Insurance

COMMUNITY REHABILITATION SUPPORTS

Adult Rehabilitative Mental Health Services (ARMHS)

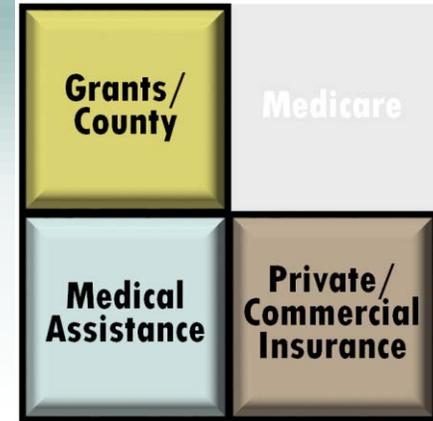
Support for individuals with rehabilitative goals, in community settings. Can include:

- Support transition from a higher intensity setting (IRTS, AMRTC, etc)
- Medication Education
- Services from a Certified Peer Specialist
- Support for developing skills for independence and seeking employment
- Community Intervention to address concerns that might cause relapse, a loss of housing, or other significant issues.

Children's Therapeutic Services and Supports (CTSS)

Support for children with emotional disturbance or mental illness. Skill building to help the child return to expected developmental milestones

- Skills for anger management and improved social function
- Following directions and expressing feelings
- Addresses child's needs in the context of their family
- Includes Children's Day Treatment
- Individualized in-home therapy



MOBILE CRISIS SERVICES

Counties have the responsibility to provide or contract for services. DHS provides dedicated grant funding to deliver these services.

Minnesota is on track to have 24/7 coverage in 2018.

~85% diversion rate from in-patient care for adults.

Challenges in providing services tailored for children when a single team responds to all calls.

With all teams “firehouse” time is necessary for good service, but harder to pay for. Other challenges include long travel times, or coordinating response with law enforcement when there may be a safety risk.

INTENSIVE OUTPATIENT SERVICES

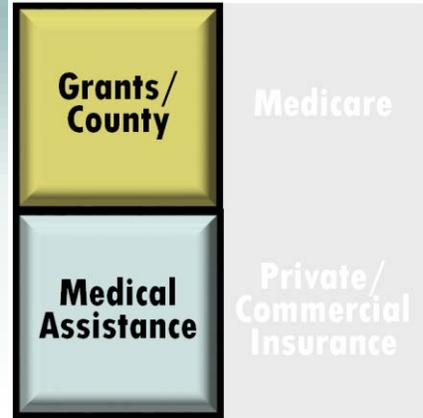
Grants/ County	Medicare
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Partial Hospitalization: Team led treatment, with a physician as head of the team. Includes group therapy and other services.

Adult Day Treatment: Short term group services, treatment team led by Mental Health Professional, with a mix of therapy and rehab services.

(Dialectical Behavioral Therapy (DBT): Specialized outpatient programming with group and individual therapy. Minnesota was the first state to obtain permission from CMS to allow for Medicaid billing with DBT services. DBT gives individuals specific coping skills about redirecting unwanted thoughts and emotional states, and improving that person's function in life, work and community.

ASSERTIVE COMMUNITY TREATMENT



ACT

ACT is an intensive, team based approach, which is recognized as an evidence based practice that lowers use of in-patient care and incidence of homelessness.

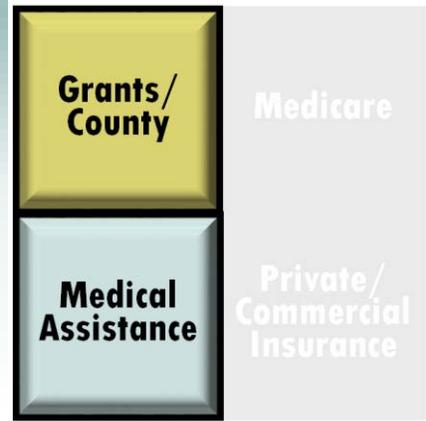
A full range of services are provided where the person is, including psychiatry, housing and employment support, chemical dependency treatment, and rehabilitation.

Teams need to be available to clients 24/7 to respond to crisis, and have reduced case loads so that they can focus time on the clients who need it the most.

2016 legislation clarified standards, and set definitions for small, medium, and large teams based on needed staff and caseload. This will help more communities support high quality ACT services.

Youth ACT

This service meets the needs of youth ages 16-20 suffering from severe mental illness and/or co-occurring disorders, who need assistance, with coordinating mental health, school/employment, housing, family, and physical health services.



ADULT RESIDENTIAL TREATMENT

Intensive Residential Rehabilitative Treatment Services (IRTS)

IRTS can be used as a stepdown, or diversion from a hospital setting.

Stays are intended to be 30-90 days.

Only treatment costs are paid by Medicaid. Room and board costs are typically paid through GRH or county funds.

Some private plans pay for treatment costs.

4 DCT programs.

Total: 609 beds, about 150 can be used for Crisis.

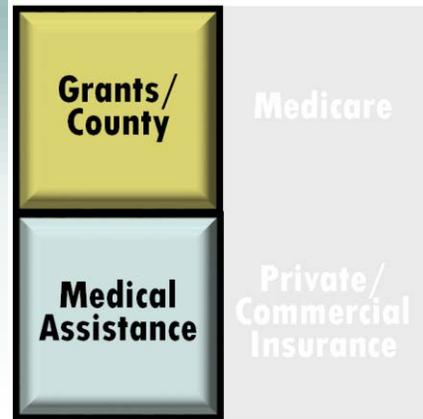
Residential Crisis

Residential crisis may be provided in a dedicated setting, or through a few beds reserved at an IRTS.

Stays are typically 3-10 days.

Residential crisis services have a diversion rate of ~90%, reducing demand for in-patient hospitalization.

CHILDRENS RESIDENTIAL TREATMENT



Psychiatric Residential Treatment Facility (PRTF)

This service is used in other states, and in development in Minnesota. Our statute defines PRTF services as an inpatient level of care, other than a hospital.

Authorized in 2015.

We are on track to have 150 beds operating by July 2018. First 50 beds July 2017.

Medically directed care and admissions, by physician and team.

Residential Treatment (Children)

Treatment costs are paid by Medicaid, but room and board is paid by the lead agency.

Can be a placement by a lead agency, eg: Child Welfare.

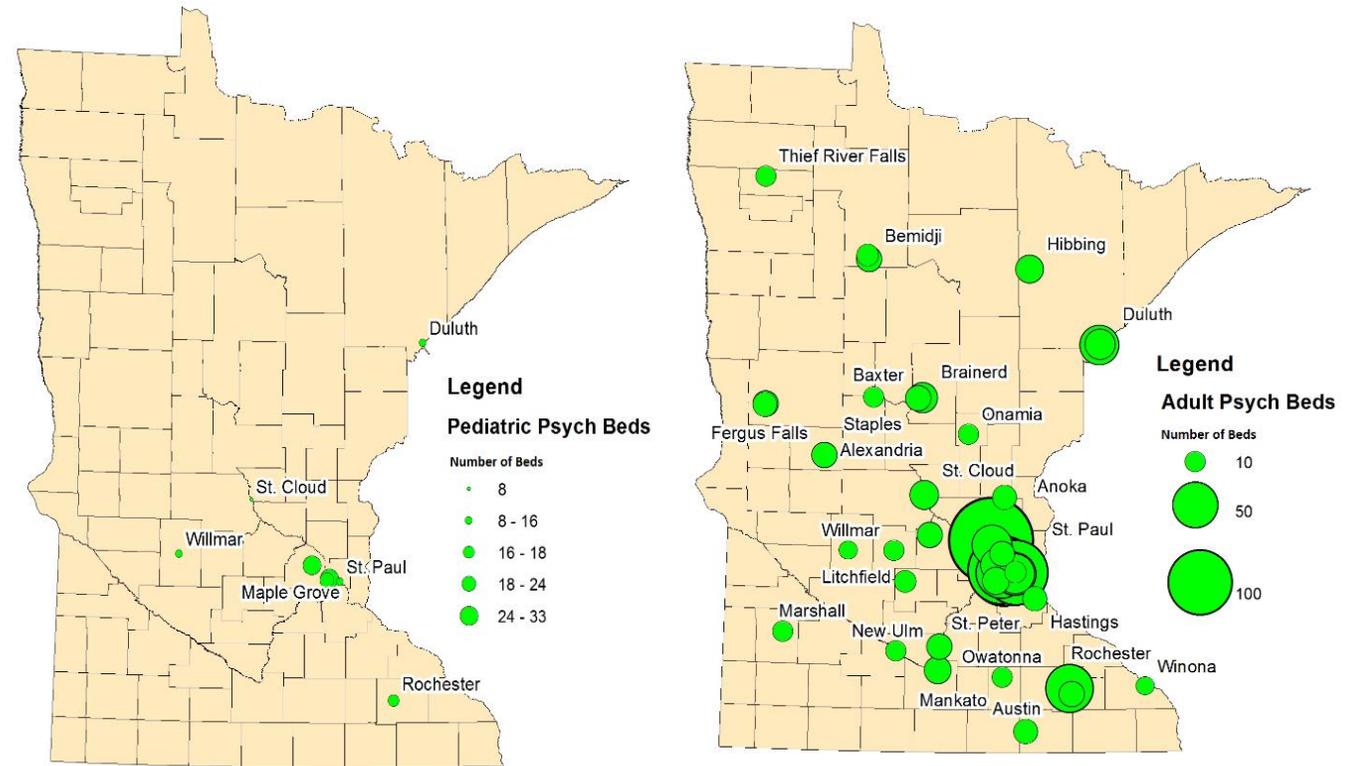
Beds that are licensed in this manner are also used by other services, including Juvenile Justice.

INPATIENT HOSPITALIZATION



Minnesota has a total of 181 pediatric and 593 adult licensed psychiatric beds. This does not include Direct Care & Treatment.

Unit sizes vary. Stand-alone mental health hospitals are capped at 16 for Medicaid. Hospitals that provide physical and other care can have quite sizeable psychiatric units.



Grants/ County	Medicare
Medical Assistance	Private/ Commercial Insurance

DIRECT CARE AND TREATMENT

Adults

Minnesota Security Hospital (MSH): Serves individuals who are committed Mentally Ill and Dangerous (MI&D) and individuals ruled by a court to lack capacity to stand trial (Rule 20)

Anoka-Metro Regional Treatment Center (AMRTC) is a 110-bed psychiatric hospital, divided into 25-bed units.

- Multiple and complex conditions
- Mental illness and who face a criminal trial
- High levels of behavioral issues.

Community Behavioral Health Hospital (CBHH): 16 bed maximum capacity to align with Medicaid requirements. Locations around greater Minnesota.

Children

Child & Adolescent Behavioral Health Services (CABHS): Specialized inpatient hospital services, often children with significant aggression as part of their symptoms.

Grants/
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Assistance

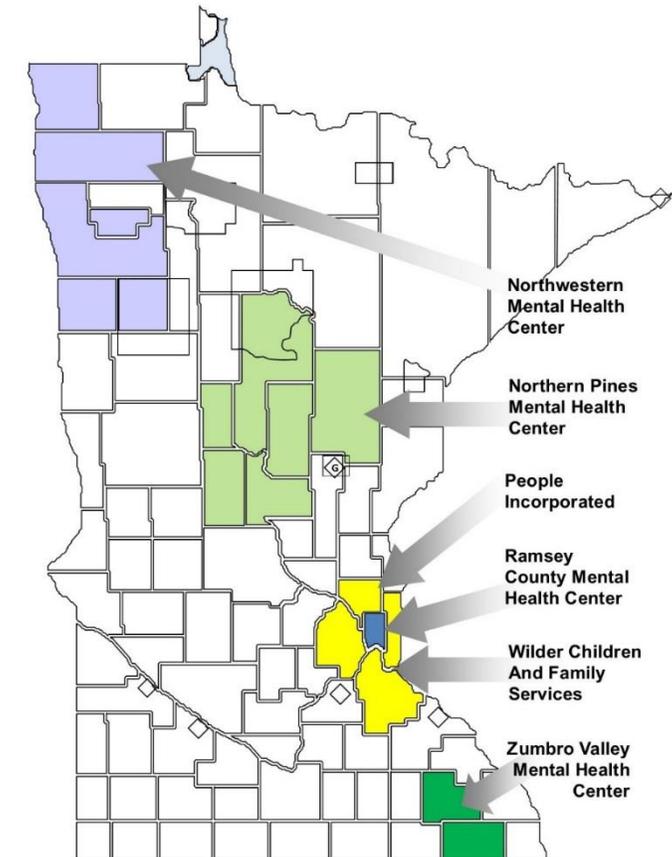
Private/
Commercial
Insurance

MOVING TO INTEGRATED CARE

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CENTERS (CCBHC)

Highly integrated dual diagnosis treatment. Providers must be able to perform a broad range of CD and MI services in-house for adults and children, not by referral.

- Crisis Mental Health, including withdrawal management and crisis stabilization
- Screening, Assessment and Diagnosis, including risk assessment and level of care
- Patient Centered Treatment Planning
- Outpatient Mental Health and Substance Use Services
- Targeted Case Management
- Psychiatric Rehabilitation (ARMHS and CTSS)
- Peer Support and Family Supports
- Intensive Community Based mental health, including services for veterans



Grants/
County

Medicare

**Medical
Assistance**

Private/
Commercial
Insurance

MOVING TO INTEGRATED CARE BEHAVIORAL HEALTH HOMES (BHH)

Behavioral health homes use a multi-disciplinary team to provide the following six core services:

- Comprehensive care management
- Care coordination
- Health and wellness promotion
- Comprehensive transitional care
- Individual and family support
- Referral to community and social services

Providers get a per-member per month payment, based on in providing at least two of the required services each month, as identified in the individual's health action plan. Enhanced federal participation is currently available.

SUPPORT IN THE COMMUNITY

Adults

- Targeted Case Management (TCM)
- Personal Care Assistance (PCA)/Community First Services and Supports (CFSS)
- Community Access for Disability Inclusion (CADI)
- Adult Foster Care
- Supportive Housing
- Supportive Employment

Children

- Targeted Case Management (TCM)
- Personal Care Assistance (PCA)/Community First Services and Supports (CFSS)
- Community Access for Disability Inclusion (CADI)

DECISION POINTS

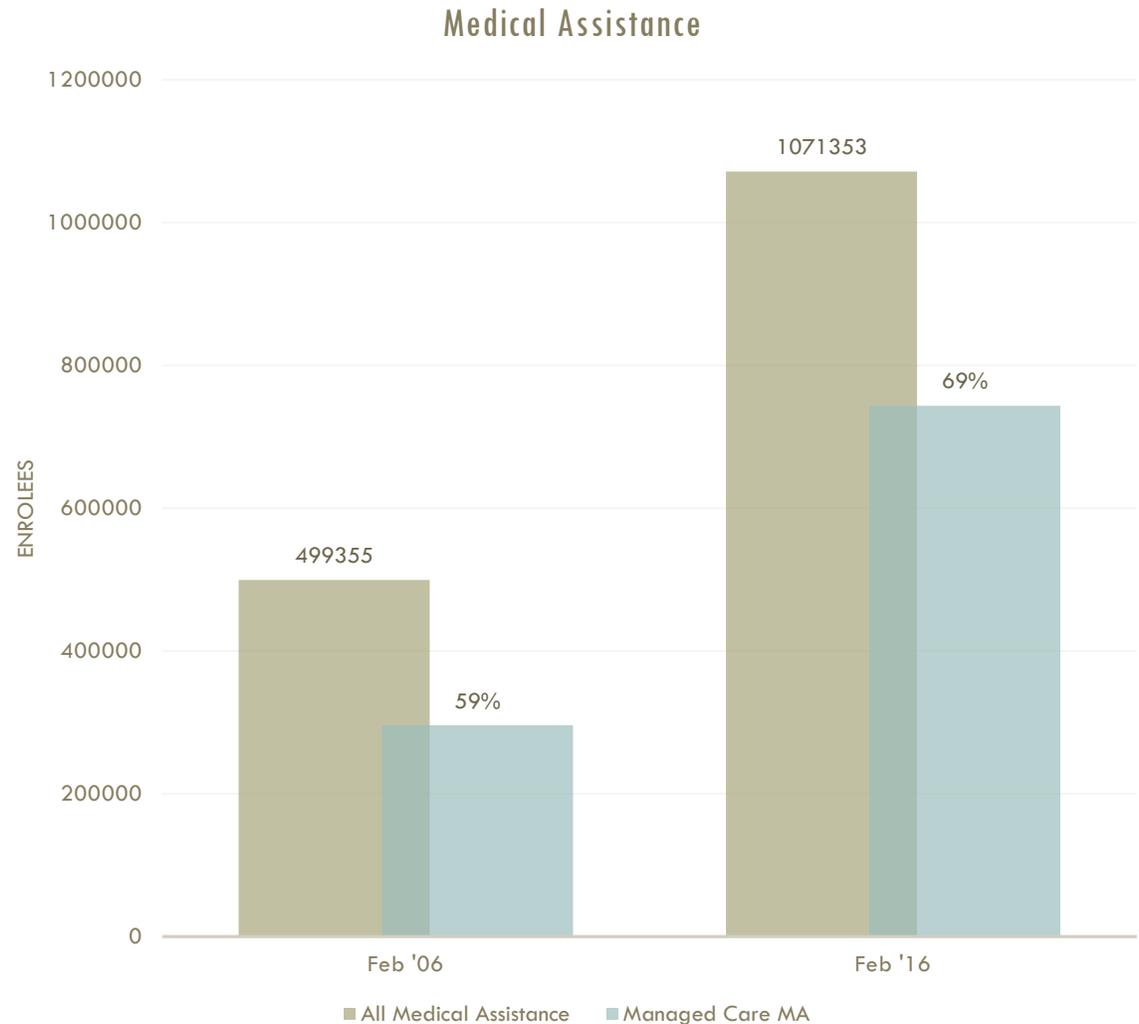
Present

BUILDING PROVIDERS, CONTAINING COSTS

The mental health reforms in 2007 and 2015 both depend on strong implementation of Medicaid paid services. Significant attention was given to what rates needed to be paid to providers to build and maintain service capacity across Minnesota.

During that same time frame, Minnesota increasingly focused on Managed Care models for Medicaid, away from Fee for Service. Overall Medicaid expansion and reforms lowered the uninsured rate to 4.5%.

Contracting for Managed Care has helped contain costs, but the state forgoes direct control over what providers are paid.



THE RIGHT CARE AT THE RIGHT TIME

Minnesota and Federal standards limit payment for high intensity resources to situations where it is medically necessary. This is a key cost containment measure, but can create unintended consequences when the system is strained.

A community hospital or emergency department holding a client waiting for AMRTC may have to absorb the cost since the stay no longer meets medical necessity for Medicaid. Meanwhile, AMRTC charges counties 100% of the daily cost for another patient who could be discharged, but the county might lack funding to be able to create housing options for that client. Costs rack up, but the system moves no closer to resolving the underlying issues.

Each person who is “stuck” in the wrong level of care creates a further cascade of individuals who cannot transition to the next stage of their treatment and recovery.

CREATING AND SUSTAINING SERVICES

Who is charged with:

Determining what services need to be developed?

Financing the development of new services?

Paying for the services once they are ongoing?

Ensuring access or operates safety net for uninsured/underinsured individuals?

Developing and monitoring standards for provider quality?

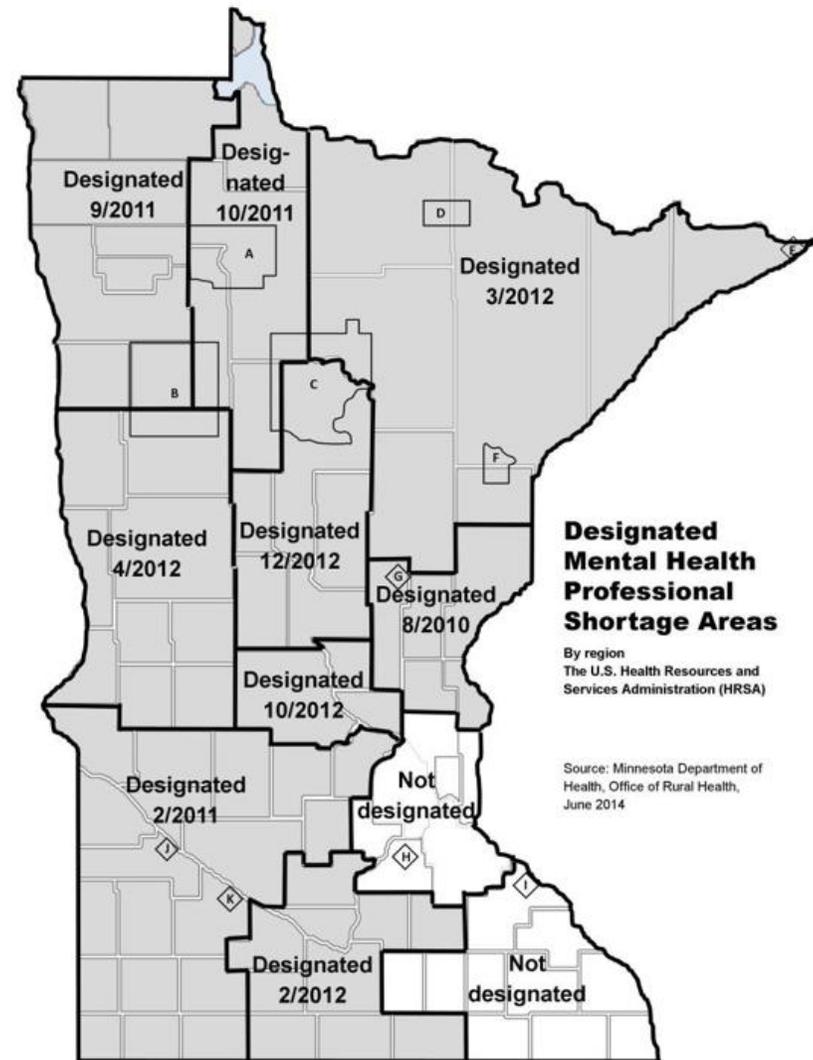
REGIONAL DISPARITIES

The distribution of services across the state is not even. One of the key issues is workforce shortages, something that has come to the foreground in the past few years.

A related concern is the time and mileage it may take for people to reach a given service, or if the population of an area can financially sustain a specialized provider.

Some responses already underway:

- Expanded use of tele-health to maximize provider availability
- Expanding Student Loan Forgiveness grants to Mental Health Professionals



QUESTIONS?

