NAMI Minnesota
2015 Minnesota Legislative Session
Summary of New Laws Affecting
Children and Adults with Mental Illnesses and Their Families

Adult Mental Health

Anoka Metro Regional Treatment Center

Additional funding of approximately $3 million per year is provided to the Anoka Metro Regional Treatment Center (AMRTC) in order to open an additional 15 beds on the campus. They should be open in September.

The county share for treatment costs at Anoka will increase from 60% to 100% for each day that a person in at AMRTC when the staff at AMRTC determines that it is clinically appropriate for the person to be discharged into the community. The hope is that counties will have a greater financial incentive to develop community services for those people who no longer need to be at AMRTC. The percentage of people who don't need to be there is typically 30 to 40%. Keeping them at AMRTC creates a huge backlog where people are waiting for countless days in the community psychiatric wards to get into AMRTC, which actually even backs up people in the emergency room since there are no open beds. Chapter 71

Assertive Community Treatment Teams (ACT)

Funding is increased by $1.322 million for ACT teams so that they can be expanded to meet the needs. ACT teams are intensive community treatment services often referred to as "hospitals without walls" and are evidence-based. Funds will be used to start one Forensic ACT team for people leaving the prisons and to add two regular ACT teams each year. Language is changed in the law to refer to them as ACT teams and not "intensive nonresidential rehabilitation mental health services." The core elements were added to the statute including use of a multidisciplinary approach, providing services 24/7, providing the majority of services in a community setting, offering a low ratio of recipients to staff and providing a service that is not time-limited. Eligibility is changed to instead of requiring a history of two or more hospitalizations in the past year, to requiring a history of recurring or prolonged inpatient hospitalizations in the past year. A functional assessment must be conducted every six months. The treatment plan must be reviewed with the person and updated every six months. Chapter 71

Beltrami County Project

The legislature appropriated $2 million for Beltrami County to plan and develop a comprehensive mental health program. To receive funding the county must submit to the Department of Human Services (DHS) a formal commitment and plan to fund, operate, and sustain the program and services after the onetime grant money is spent. The plan must include the funding streams that will be used and how the project will be sustained after the one time grant. The model must be an integrated care model for mental health and substance use disorders and include mobile crisis, crisis residential, outpatient and community-based services. It will serve individuals who are under arrest or subject to arrest who are experiencing a mental health crisis, under a transport hold, or are in immediate need of mental health crisis services. The departments of human services and housing are encouraged to provide technical assistance to

address housing needs in the area. A report must be submitted to the legislature on November 1, 2017 on the status of the planning and development and the plan to financially support it in the future. Chapter 71

Club House Programs
The Department of Human Services, in consultation with stakeholders, will develop service standards and a payment methodology to reimburse clubhouse services under Medical Assistance (MA). To get MA, clubhouses would have to be accredited by Clubhouse International or an equivalent standard. Once federal approval is obtained, the department must go back to the legislature to obtain approval. Right now services provided in clubhouses (similar to Community Support Programs) rely on state and county grant funding. If this were an MA service, transportation to and from the program could also be paid for by MA. Examples of clubhouses are Vail Place, Second Step, Power Up, Next Step, Friendship House, Friends on First, County Connection, Bridge on Center, Minnesota Ave Resource Center, Northern Lights, and Upward Bound 5th. Chapter 71

Farmers' Mental Health
$226,000 is for statewide mental health counseling support to farm families and business operators. South Central College will serve as the fiscal agent. Special Session Chapter 4

Housing with Supports
The funding for supportive housing grants for people with mental illnesses is increased by $4.654 million for this biennium and $6.146 for the next biennium. Supportive housing is for people who need on-site supports such as front desk coverage, meal preparation, etc. In 2013, there were 420 households for persons with serious mental illness being served by the housing with support grants, this proposal - over time - will increase the households served to 1,260. Chapter 71

Intensive Residential Treatment Services (IRTS)
A functional assessment must be conducted within 10 days of admission and updated every 30 days. A treatment plan must be developed within 24 hours of admission and must be reviewed with the individual and updated at least monthly. Chapter 71

Rates for Mental Health Services and Funding for ACT and IRTS
The Department of Human Services (DHS) will conduct an analysis and develop recommendations on how to better fund mental health services across the board, especially those programs that use separate funding for room and board costs. The department is to consult with stakeholders and with outside experts on Medicaid financing. The report is due January 1, 2017.

An additional $5.547 million is appropriated for the report and to stabilize intensive services such as Assertive Community Treatment (ACT), Intensive Residential Treatment (IRTS) and crisis residential beds, while the analysis is conducted. For the IRTS' rate, DHS will look at the costs of the physical plant costs calculated based on the percentage of space that is devoted to treatment and programming. Psychiatrists' services can be included in the rate if not billed separately and can include telemedicine. Chapter 71

Southeast Asian Veterans
$100,000 is appropriated to nonprofit organizations to provide resources and referrals for culturally specific mental health services to Southeast Asian veterans born before 1965 who do not qualify for services available to veterans formally discharged from the U.S. armed forces. Chapter 71

Minnesota Security Hospital
Funding of $11.190 million is appropriated so that MSH can meet the terms of the conditional license requiring more staff and training. Chapter 71

Children's Mental Health

Adverse Childhood Experiences
Grants will be available in fiscal year 2018 to children's mental health and family services collaboratives for training on adverse childhood experiences (ACEs). Funds can be used for raising awareness, cross-sector collaboration, capacity building, data analysis and learning more about ACEs and trauma. The goal is to reduce the number of adverse childhood experiences and increase resiliency. A total of $363,000 is appropriated for both FY 2018 and FY 2019. Chapter 71

Children's Contract Beds
As part of the Governor's plan to expand access to longer-term hospital beds for children with mental illnesses in Minnesota, he proposed using contract beds much like our state does for adults. The state pays for the person to remain in the hospital after a certain number of days. NAMI and others were concerned because current hospital beds are already filled and there are waiting lists. Paying hospitals to keep children longer would only add to the backlog. The solution that passed is to contract with PrairieCare. They are moving to a new facility this fall and their current facility will become a 20-bed program for children under age 21 with 8 to 12 of those beds set aside for children who need longer stays due to the complexities of their condition. There are protections in place for both sides to ensure that this exception to the hospital moratorium is in the public interest. In addition, the Child and Adolescent Behavioral Health Services (CABHS) program in Willmar will not be closed. Chapter 71

Children who are Deaf, Deafblind, Hard-of-Hearing
Funding of $850,000 is set aside for grants to provide linguistically and culturally appropriate mental health services to children who are deaf, deafblind and hard-of-hearing. Chapter 71

Children's Therapeutic Services and Supports
Technical changes are made to CTSS such as including a clinical trainee under direct service time along with telemedicine, clarifying that service eligibility includes youth with a mental illness up to age 21, and defining psychotherapy and rehabilitative services. Providers must be certified for the three core rehabilitation services of psychotherapy, skills training, and crisis assistance and must have a "back-up" mental health professional.

In developing treatment plans providers must allow parents and guardians to observe or participate in individual and family treatment services, assessment, and treatment planning. A child's parent may approve the individual treatment plan by secure electronic signature or by documented oral approval that is later verified by written signature.

Day treatment must be year-round at least three to five days per week, two or three hours per day, unless the normal five-day school week is shortened by a holiday, weather-related cancellation, or other district-wide reduction in a school week.

Psychotherapy must be documented as part of the child's ongoing treatment. A provider must deliver, or arrange for, medically necessary psychotherapy, unless the child's parent or caregiver chooses not to receive it. When a provider delivering other services to a child deems it not medically necessary to provide psychotherapy to the child for a period of 90 days or longer, the provider entity must document the medical reasons why psychotherapy is not necessary. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record.

Clarifying language is added for skills training to make it clear that it's provided by a mental health professional, clinical trainee, or mental health practitioner. It must be targeted to the specific deficits or maladaptations of the child's mental health disorder and be used in conjunction with psychotherapy to address the underlying condition. Skills training delivered to the child's family must teach skills needed by parents to enhance the child's skill development, to help the child utilize daily life skills taught by a mental health professional, clinical trainee, or mental health practitioner, and to develop or maintain a home environment that supports the child's progressive use of skills. Other language is added providing some flexibility for group sessions when group size temporarily drops below the minimum. Chapter 78

Crisis Beds
The Department of Human Services (DHS) will, in consultation with stakeholders, develop recommendations on funding for children's crisis residential services that will allow for timely access without requiring county authorization or child welfare placement. Counties have ten days to approve a voluntary placement and by that time, the crisis is over. NAMI hopes that we will be able to develop a model that does not use county IVE funds for the room and board costs and thus voluntary placement agreements will not be needed. See crisis services listed under mental health for more information on mobile crisis teams. Chapter 71

Grants for Uninsured Children
Funding is increased to $437,5000 for a program started last year that gives grants to community mental health centers to provide care to children and young adults under age 21 who are uninsured. The money will be distributed based on the percentage of clients with children under 21 who are uninsured and have income below 275% of poverty. Chapter 71

Juvenile Justice Diversion
Funds are made available to pilot the Minnesota Model of School-based Diversion for students with co-occurring disorders in three schools. The pilots will be a collaborative effort between the Department of Human Services (DHS), the MN Chiefs of Police, the schools and local law enforcement and county attorneys' offices. The model assists schools and their partners in becoming more selective about making referrals to the juvenile justice system and helping them develop alternatives to addressing these types of incidents. $65, 000 is appropriated for the second year of the biennium and then $161,000 each year of the next biennium. Chapter 71

Psychiatric Residential Treatment Facilities (PRTF)
PRTFs are established for the first time under the state's Medical Assistance program. Up to 150 new beds in up to six sites can be opened beginning in 2017 with 50 beds and additional beds in subsequent years. This is less intensive than inpatient hospital care but more intensive than our current residential programs. It is for children with who require a more intensive level of care due to medical or mental health symptoms such as significant aggressive behaviors, developmental disorders, psychosis or physical health.

PRTFs provide active treatment versus rehabilitation. In a survey by counties an estimated 300 children per year could have used this level of service but either did not receive what they needed or went out of state for treatment. A psychiatrist or physician is required to be employed as a Medical Director and 24 hour nursing is required. The rates include room and board and thus parents don't need to go to counties and through the county child protection/voluntary placement process. PRTFs are exempted from the IMD (Institute for Mental Disease) exclusion, which prohibits Medicaid funding from paying for treatment in any facility greater than 16 beds.

Youth can be served up to age 21 – age 22 if they turn 21 while in the program. This is effective July 1, 2017 or upon federal approval whichever is later. $6.616 million is appropriated for PRTFs and for the contract beds mentioned above. Chapter 71

Respite Care
Respite care grants are increased by $847,000 for the next biennium, which should allow many more families to access respite care for their child with a mental illness. Funding will also be used to look at possible options for using Medical Assistance (MA) dollars for respite through a 1915i or similar option. The intention would not be to replace the grants with MA funding but to provide additional funding streams. Chapter 71.

TEFRA Fees
For parents who access Medical Assistance through the TEFRA program (where your child qualifies based on their needs and income and the parents' income isn't considered), the fees were reduced. The sliding fees will be reduced for families whose income is between 275% and 545% of the federal poverty guidelines from 2.48% to 2.23% of adjusted gross income at 274% of poverty and from 6.75% to 6.08% for those at 545% of poverty. If the adjusted income is between 545% and 674%, it will be reduced from 6.75 to 6.08%. For families whose income is between 675% and 975% of poverty the scale will be between 6.08% and 8.1%; and for those above 975% it will be 10.13%. Chapter 71

Criminal Justice/Juvenile Justice/Legal Issues

Alternatives to Juvenile Detention
$300,000 each year is for grants to nonprofit organizations to conduct training, technical support and peer-learning opportunities for counties interested in implementing juvenile detention reform and addressing disparities in the juvenile justice system to accomplish cost-effective interventions that leverage the strength of families and communities. This is a onetime appropriation. The matching requirement changed from two times the amount to a dollar for dollar match. The maximum size grant went up from $50,000 to $75,000. Chapter 65

Child Advocacy Centers
$400,000 each year is for grants to new and existing child advocacy centers whose primary purposes are (1) to coordinate the investigation, treatment, and management of abuse cases and (2) to provide direct services to abuse victims. Chapter 65

Collections
Currently, IRS regulations prohibit a non-profit hospital from taking extraordinary collection efforts (sale of a debt to a third party, adverse credit reporting, denying care) against a patient until the hospital has notified the patient about their financial assistance policy and made reasonable efforts to determine if the patient qualifies for aid under that policy. Now a patient can bring an action to stop a non-profit hospital's extraordinary collection efforts if the hospital has not provided a plain language summary of their financial assistance policy to the patient. In addition, a patient who prevails in securing an injunction is entitled to attorney's fees and costs. Chapter 20

Crime Victim Support
$150,000 per year is available for grants to a nonprofit organization to provide immediate and long-term emotional support and practical help for families and friends of individuals who may have died by suicide, overdose, accident or homicide. Chapter 65

Electronic Surveillance
If a court orders an adult or juvenile adjudicated delinquent to serve any portion of the disposition on electronic surveillance, the court may require that the person be kept in custody, or that the probation agent directly supervise the person until electronic surveillance is activated. It is the responsibility of the parent or guardian of the juvenile placed on electronic surveillance to ensure that the juvenile's residence is properly equipped and the residence's telecommunications system is properly configured to support electronic surveillance prior to the juvenile being released from custody or the direct supervision of a probation agent. Chapter 65

Family Law
This law creates changes in how the court decides custody and parenting time for married and unmarried parents. There are 12 factors used by the court (used to be 13) and it includes "the physical, mental or chemical health issues" of a parent that affects the child's safety and well-being. In considering these factors, the court must start with the presumption that the parents are capable of having a nurturing relationship unless there is a reason to believe otherwise. The court is prevented from using a disability covered by the Minnesota Human Rights Act from being a determining factor in deciding on custody. Chapter 30

Firearms and Ammunition
If you can't own a firearm, you can't own ammunition. Any person who purchases or otherwise obtains a firearm on behalf of or for transfer to a person known to be ineligible to possess or purchase a firearm pursuant to federal or state law is guilty of a gross misdemeanor. Chapter 65

Legal Services to Low-Income Clients in Family Law Matters
$948,000 is appropriated each year is to improve the access of low-income clients to legal representation in family law matters. The funds will go out to legal services programs. Chapter 65

Lifesaver Grant Program
Funding is made available for a lifesaver grant program to assist local law enforcement agencies with the costs of developing lifesaver rapid response programs designed to quickly find individuals with medical conditions that cause wandering and result in many of these individuals becoming lost and missing. The search and rescue program must electronically track a lost or missing vulnerable senior citizen or an individual who is mentally impaired due to autism, Down Syndrome, Alzheimer's disease, or other mental impairment that causes wandering. The lifesaver program participant wears a small transmitter on the wrist to allow the local law enforcement agency to electronically locate the participant, if necessary, using a radio receiver. Chapter 65

Minnesota Security Hospital
A patient at the Minnesota Security Hospital in St Peter (whether committed as mentally ill and dangerous or there for a competency evaluation) could be charged with a felony if he or she does the following to a staff person at the hospital: (1) assaults the person and inflicts demonstrable bodily harm; or (2) intentionally throws or otherwise transfers urine, blood, semen, or feces onto the person. The person may be sentenced to imprisonment for not more than two years or pay a fine of not more than $4,000. The hospital administration and the county attorney will take into account whether the person is competent to do this intentionally or whether it is due to their mental illness. Chapter 23

Peace Officer Training
The Peace Officer Training Board (POST) received $200,000 for the biennium for training state and local community safety personnel in the use of crisis de-escalation techniques. This is a onetime appropriation. Chapter 65

Youth Intervention Programs
$750,000 is appropriated per year for Youth Intervention Programs. Youth intervention programs are nonresidential community-based programs providing advocacy, education, counseling, mentoring, and referral services to youth and their families experiencing personal, familial, school, legal, or chemical problems with the goal of resolving the present problems and preventing the occurrence of the problems in the future. Chapter 65

Early Childhood, Education and Special Education

Full Service Community Schools
This law allows for the development of full-services community schools. These schools provide early childhood, academics, parent involvement, mental and physical health care, community involvement, and positive discipline practices. $250,000 a year is appropriated. Special Session Chapter 3

Intermediate Districts
Allows Independent School Districts Nos. 108, 110, 111, and 112 of Carver County, Independent School Districts Nos. 716, 717, 719, 720, and 721 of Scott County, and Independent School District No. 2905 of Le Sueur County, whether or not contiguous, to become an intermediate school district to jointly and cooperatively provide instruction in, special education, career and technical education, adult basic education, and alternative education. Special Session Chapter 3

Paperwork
The Department of Education must develop ways to help special education teachers comply with legal requirements, including providing training to teachers. The department must work collaboratively with special ed teachers, other school and district staff, and representatives of affected organizations, including Education Minnesota, Minnesota School Boards Association, and Minnesota Administrators of Special Education, to identify obstacles to and solutions for teachers' confusion about complying with legal requirements governing special education programs and services.

The department must also identify strategies to effectively decrease the amount of time teachers spend completing paperwork for special education programs and services, evaluate whether the strategies are cost-effective, and determine whether other schools and districts are able to effectively use the strategies given available staff and resources.

The Department of Education must determine the current reading level of its special education forms and develop, if needed, alternative forms to accommodate people who use or read the forms. Special Session Chapter 3

Paraprofessionals
Requires paraprofessionals to have the knowledge and skills to meet the disability specific and behavioral needs of the students with disabilities with whom they work. Training is required to be provided to enable the paraprofessionals to understand how each student's unique and individual needs and disability affect the student's education and behavior. Special Session Chapter 3

Seclusion and Restraints
Makes the annual recommendations on how to reduce the use of seclusion and restraints to the commissioner permissive. The task force recommended this since there might not be any need to change the goals and outcomes from year to year. Special Session Chapter 3

Statewide Testing
The Department of Education will develop a list of circumstances in which a student may be unable to take a statewide test. The list includes but is not limited to: students transferring to Minnesota from another state, students transferring from nonpublic to public school and students hospitalized. Students unable to participate in statewide assessment due to a circumstance on the list cannot be penalized for missing the opportunity to take a test. Special Session Chapter 3

Teacher Shortage
There is a loan forgiveness program to address teacher shortages that can be used for certain geographic locations or types of teachers. There has long been a shortage of special education teachers. Chapter 69

Transportation
Clarifies a school board's responsibility to provide transportation for a child with a disability not yet enrolled in kindergarten in order for the child to receive special instruction and services. Transportation is required for special instruction for a child placed in an early childhood program to address the child's level of functioning and needs. Special Session Chapter 3

Employment

IPS Employment

Individual Placement and Supports, an evidence-based supported employment program for people with mental illnesses, received an additional $1 million a year to continue the projects that were converted to IPS last year. Special Session Chapter 1

Resource, Inc.

Resource, Inc. received $1 million for the biennium to to provide low-income individuals career education and job skills training that are fully integrated with chemical and mental health services. Special Session Chapter 1

Health Care

Dental Care

Many people on Medical Assistance (MA) in rural Minnesota have complained about the lack of access to dental care. Rates for rural dentists will increase to help address this problem. Chapter 71

E-Health

Minnesota has a statewide plan for providers to have interoperable electronic health records systems. Language is added this year so that individual health care providers in private solo practice and health care providers that do not accept reimbursement from insurance, are excluded from the requirements of this section. Chapter 78

Health Care Disparities

The Commissioner of Health already has a set of standardized measures to assess the quality of health care services provided including for preventive services, heart disease, depression, diabetes, and asthma. New law would require the commissioner to stratify these quality measures by race, ethnicity, preferred language and country of origin. In addition, the commissioner of human services is to develop a methodology to pay a higher rate to health care providers and services that takes into consideration the higher cost, complexity and resources needed to serve patients who experience the greatest health disparities in order to achieve quality outcomes. Chapter 71

Health Care Financing Task Force

A task force is established to advise the governor and legislature on how to increase access and improve the quality of health care for Minnesotans and specifically how to provide and fund programs like Medical Assistance (MA) and MinnesotaCare. There will be seven members of the house and seven of the senate and the governor will appoint 11 people. The commissioners of health, human services and commerce will also serve along with the executive director of MNSure. The report is due January 2016. Chapter 71

Hospital Payment Rates

Hospital payment rates will be changing and the “runs” showed that rates for many inpatient psychiatric units would be reduced by about 4.2%. Over the years when rates for hospitals were reduced, inpatient psychiatric units were exempted, so this raised concerns in the mental health

community. To address this issue, funding of $2 million is included to hold harmless inpatient psychiatric units, meaning that their rates would largely not be reduced.

A new distribution formula for Disproportionate Share Hospital (DSH) payments is included. This is for hospitals that serve a high number of people on Medical Assistance. Funding targets children's hospitals, psychiatric inpatient services, transplants and high volume Medical Assistance providers. Chapter 71

Integrated Care for High-Risk Pregnant Women
A pilot program is established for pregnant women on Medical Assistance who are at elevated risk for adverse outcomes of pregnancy such as opiate addiction, substance abuse, low birth weight and preterm birth and for those women who reside in a targeted area of the state (we don't know where those are yet). Projects are to provide integrated care (mental health, substance use disorders, perinatal care, etc.) and enhanced services to these women during and after the pregnancy. The department will report in January 2019 to the legislature on who used the services, outcomes and recommendations for future programs. Chapter 71

Medical Assistance for Employed Persons with Disabilities
The premiums for people on MA-EPD were reduced from a minimum of $65 a month to $35 a month. People who have unearned income will only pay one-half of one percent instead of five percent. This is effective September 1, 2015. Chapter 71

Medication Therapy Management
This service is changed so that anyone with one or more chronic health care conditions, regardless of the number of medications being taken, is eligible for the service. Eligibility in the past requires that someone take three or more medications. It may also be delivered by secure interactive video. Chapter 71

MinnesotaCare
The legislature cut $65 million from the MinnesotaCare program by increasing the cost sharing. This will result in raised premiums and triple out-of-pocket costs for households earning 133 to 200 percent of the federal poverty guideline ($15,654 to $23,540 for an individual). It's estimated that someone around 133% of poverty would have an increase in their premium of $7 a month. At 200% of poverty, people pay about $50 a month and that could increase to $68 a month. Others have said the average annual increase will be over $300 per person. These increases will go into effect in August. Chapter 71

Nonemergency Medical Transportation
Nonemergency medical transportation is a program under Medical Assistance that pays for transportation to take people on Medical Assistance to their medical appointments or any MA funded service. Due to a report by the Office of the Legislative Auditor, a number of changes were recommended to increase quality, decrease fraud, and increase cost-effectiveness. While many of those changes passed last year, funding was not included so some of the changes weren't implemented.

Funding is included this year so all providers will be subject to the same vehicle standards and all drivers and staff of providers will have to have training and background checks. Volunteer

drivers do not need a background check although agencies can require them. Drivers will have trip logs and either the individual or medical care provider must sign that the trip occurred.

The new "modes" of transportation will be implemented. They include client reimbursement, volunteer transport, unassisted transport, assisted transport, lift-equipped/ramp transport, protected transport and stretcher. The very new mode is protected transport, which is for someone who is experiencing a mental health crisis. The crisis team can determine that this mode is appropriate. The vehicle cannot be an ambulance or police car, but must have safety locks, a video recorder, a transparent thermoplastic partition and drivers/aides who have received specialized training. This is a more dignified way to transport people with mental illnesses in crisis.

To encourage less expensive modes of transportation, the individual mileage rate is increased from 20 to 22 cents per mile and the volunteer rate is increased to 100% of the IRS business deduction. The rates for all providers will go up by eliminating the 4.5% reduction to rates and by implementing the new rates according to the new modes. NEMT providers are also eligible for a rate increase when they are driving someone in defined super rural areas. Chapter 71

There are some additional requirements for providers to verify trips. Chapter 78

Telemedicine
The Minnesota Telemedicine Act was passed. Basically, it requires parity under health plans and Medical Assistance for health care services provided by telemedicine or in-person, including payment rates and co-payments or deductibles. Telemedicine does not include phone calls, email or faxes. Chapter 71

Housing/Homelessness

Bridges
The Bridges housing program, which provides rental assistance for people with mental illnesses who are eligible for Section 8 housing, is increased by $2.5 million a year. The Minnesota Housing Finance Agency is to give priority to eligible people who want to move to more integrated community-based settings. Special Session Chapter 1

Homeless Youth
An additional $2 million is appropriated for the homeless youth act. Of that, $500,000 is for greater Minnesota and at least 25% must go to new providers. Chapter 71

Housing Trust Fund
An additional $2 million is granted to focus on highly mobile youth. Special Session Chapter 1

Long Term Homelessness
An additional $2 million is provided to increase services and supports to people experiencing long-term homelessness. Chapter 71

Human Services

ABLE Plan

Establishes the ABLE plan in Minnesota. This is to encourage individuals and families to set aside funds to support people with disabilities to maintain health, independence, quality of life, and have secure funding for the future, up to $100,000. It's based on a new federal law. These funds don't disqualify people for other benefits. Note that it's only available to people who were deemed disabled before the age of 26. Chapter 71

Background Studies

Providers of group residential housing or supplementary services must have background checks. Chapter 71

Child Protection

There were major reforms made to the child protection system along with providing additional funding. An additional $22 million per year goes to counties to increase staff, $3 million for new initiatives to address racial disparities, and $1.25 million for additional staff, improved training, quality assurance and child fatality reviews at the Department of Human Services. The focus of the reforms is to put the well-being of the child first. There will be uniform guidelines for screening or evaluating child maltreatment reports. Family assessment will be renamed Differential Response and will not be used for high-risk cases such as sexual abuse or substantial child endangerment. When it is used, counties must document whether abuse occurred and if the parent(s) does not cooperate must not close the case until reviewing the risks and safety of the child with the county attorney.

Counties will be required to share reports with police. Previous reports can now be viewed when evaluating a current report. A mandated reporter can learn about what happened, such as was a child protection case opened or was the family referred for other services. The grants for racial disparities will go to develop, implement and evaluate activities to address racial disparities and disproportionality in the child welfare system. Child protection workers will have to have background checks. A legislative task force on child protection is established to oversee the changes and efforts in this area and to issue a report in February 2016 to relay progress and any other needed changes. Chapter 71

Group Residential Housing

Many technical changes were made to the GRH program such as defining terms such as supportive housing, qualified professional, professional statement of need and long-term homelessness. It changes the agreement between counties and providers to require staff that have direct contact with people to have minimal skills and knowledge or experience with the population being served. Certain supportive housing arrangements are exempted from being licensed but have to have a habitability inspection among other things.

DHS will work with advocates and stakeholders to build on these reforms and look at restructuring payment rates, exploring assessment tools and other ideas to have a more cost-effective program. The rate reform will look at establishing a "tiered" system and the assessment tool will look at the differing needs of groups such as people with mental illnesses, individuals who are homeless, and people with substance use disorders. Chapter 71

Home and Community Based Waivered Services
Technical changes were made to the law governing waivered services such as the CADI waiver. One notable change is that the progress reports must be sent at leave five working days prior to the progress review meeting if requested by the team. The changes to the plan have to be sent ten working days after the meeting. If the person or their legal representative does not respond within 10 days, the plan is considered to be approved.

Another problem with the waivers that is addressed was counties not using their allocations. The legislature directed the commissioner to recoup overspending on the waivers only when the the statewide spending exceeds the appropriation. Some counties were nervous about exceeding their allocation and having the money recouped so they simply didn't use their full allocation. If the county spends less than 97 percent of their allocation while maintaining a waiting list, they must submit an action plan to the commissioner.

The statutory definition of "home and community-based settings" is revised. This definition affects where individuals on waivers can receive services. The statute now references the final Center for Medicaid and Medicare (CMS) rules, the state's transition plan that is being implemented, and the state's waiver plans. In addition, settings that were previously exempted will now be required to comply. The changes are effective July 2016. One item of discussion over the past three years has been how housing settings with more than 25% of tenants receiving waiver services will be categorized. With these changes, the state will look at settings of all sizes to make sure that none has characteristics of isolation.

Lastly, the department must determine the number of individuals who were determined ineligible to receive Community First Services and Supports (CFSS the old PCA program) because they did not require constant supervision or cueing in order to accomplish the activities of daily living. NAMI and others are very concerned that people with mental illnesses will not be eligible because they do not require constant supervision. We had hoped to eliminate the word "constant" but there was a high fiscal note. Chapter 71

Changes were made to clarify when a waiver provider can temporarily suspend services, particularly when they can't meet the health care needs or the individual poses an imminent risk of physical harm to self or others. When deciding if the person can return to the program the team must consider the recommendation of the licensed health professional, mental health professional, or other licensed professional involved in the person's care or treatment when determining whether the person no longer poses an imminent risk of physical harm to self or others and can return to the program. Chapter 78

Public Assistance Programs
A great effort was made to simply the definitions across all the public assistance programs such as MFIP (welfare), group residential housing, childcare assistance, Minnesota Supplemental Aid, refugee cash assistance and general assistance. This includes uniform definitions of income and unearned income, how earnings are deducted, and when changes must be reported. Chapter 71

Receivership
Expands the ability of the commissioner of human services to take over nonresidential programs (it can already do this for residential programs) voluntarily or nonvoluntarily in order to prevent them from closing. This will help if a community mental health provider closes. Chapter 78

Mental Health

Behavioral Health Homes

The Department of Human Services (DHS), along with providers and advocates, has been planning to create behavioral health homes. Legislation was passed that will move them forward beginning in July 2016. These "virtual homes" are for children and adults who have mental illnesses and physical health problems and need to have more intensely coordinated care. Note that the person does not have to have a serious and persistent mental illness or a serious emotional disturbance. Community mental health centers, a clinical group practice and others can become a health home. Chapter 71

Commitment Act

People who are committed as mentally ill and dangerous will now have a review at least every three years by the special review board. It used to be that people were indeterminately committed and had to request a review. This recommendation came from a task force on the plight of people committed as mentally ill and dangerous. NAMI served on the task force. In addition, the special review board must submit a report to the commissioner summarizing the barriers faced by people whose petitions were denied for not progressing in their treatment and include any recommendations to help people progress. This is effective January 1, 2016 with hearings starting no later than February 1, 2016. Funding of $884,000 was needed to carry this out. Chapter 71

Another change is to allow civil commitment hearings and reconsideration hearings to be conducted by interactive video conference under General Rules of Practice, Rule 131, and Minnesota Rules of Civil Commitment, Rule 14. Chapter 65

Consultation

Allows licensed independent clinical social workers and licensed marriage and family therapists to provide consultation to primary care practitioners. This leaves just one mental health professional – licensed professional clinical counselors – from being able to do this under the Medical Assistance program. Chapter 71

Crisis Services

Private health plans in Minnesota must cover mental health crisis services defined as an immediate response service available on a 24-hour, seven-day-a-week basis for persons having a psychiatric crisis, a mental health crisis, or emergency. Crisis services will also receive a rate increase under Medical Assistance so that it equals a psychotherapy visit, which is $140 for 60 minutes.

An additional $8.57 million is appropriated for crisis services. Note that the Governor asked for $4.6 million. Funds will be used to expand mobile teams across the state – there are 12 teams covering 34 counties that are not 24/7 and 13 counties without any mobile crisis team. In distributing funding, the state will also look at access per population so that counties with high population but small teams can access funding.

A central telephone number will be established where calls can be routed to the appropriate crisis team. There are currently about 44 phone numbers making it difficult to publicize them. DHS will establish and implement state standards for crisis teams to increase quality and uniformity.

Telephone consultation will be available 24/7 for teams who are serving people with traumatic brain injuries or intellectual disabilities that are experiencing a mental health crisis.

Grants will be provided to adult mental health initiatives, counties, tribes or community mental health providers for crisis residential beds. There are currently 137 crisis residential beds in Minnesota. Priority will be given to regions that do not have have crisis beds, that do not have an inpatient psychiatric unit within the region or within 90 miles or have a demonstrated need based on the number of beds relative to the population. At least 50% of the funds must be distributed to rural parts of the state. Funding can be used for start-up costs, renovations, furnishings and staff training. Grant applications must provide details on how it will address the needs and demonstrate collaboration with crisis teams, police, mental health providers and hospitals.

Crisis stabilization services that are provided in a licensed residential setting must employ residential staff that are a mental health professional or practitioner.
Chapter 71

Data Sharing
Sharing data in the welfare/social services area will be allowed in order to coordinate services for an individual or family and to a health care provider for the same reason. Note that sharing of health care records requires a person's consent. This was done for the project in Hennepin County. DHS and Hennepin County will have to report to the legislature in January 2017 as to the fiscal impact, including savings, the number of clients receiving care coordination and their outcomes due to this change. Chapter 71

Excellence in Mental Health Grant
In 2014, Congress created a demonstration program based on the Excellence in Mental Health Act. The purpose of the demonstration program is to increase access to community mental health and substance use treatment services and improve funding for them under Medicaid. A key component is to define a "Certified Community Behavioral Health Clinic" and ensure that they provide an array of intensive, individually focused, evidence-based screening, assessment, diagnostics, treatment, prevention, and wellness services. States will be able to apply for a planning grant in August in order to seek input, provide training and capacity building to become a community behavioral health clinic. Of the states that receive a planning grant, eight states will be selected for the two-year pilot program and will receive a higher federal match under the Medicaid program.

To prepare Minnesota to apply for the planning grant and this demonstration project, language is adopted that would require the commissioner to apply and granted the commissioner the authority to include any amendments to the state Medicaid plan, needed waivers, requests for new funding, and realignment of existing funding.

Standards for these clinics were included such as 1) Requiring staff to have backgrounds in diverse disciplines, and to be culturally and linguistically trained to serve the needs of clients; 2) Providing clinic services and having crisis management 24 hours per day; 3) Having a sliding fee based on ability to pay; 4) Providing coordination of care across settings and providers; and 5) Having a detailed list of services they must provide including outpatient, rehab, intensive services, and services for members of the armed forces and veterans.

Providers would need to comply with quality reporting requirements as well. The commissioner must establish a prospective payment system. In developing this proposal, the department must consult with mental health providers, advocates, mental health professionals and people who use mental health services. $398,000 is appropriated to do this. Chapter 71

First Episode Program
Funding of $260,000 is available to mental health providers to pilot evidence-based interventions for youth at risk of developing and experiencing a first episode of psychosis and for a public awareness campaign on the signs and symptoms of psychosis. Evidence-based programs include the programs under the RAISE project that offers coordinated specialty care including case management, psychotherapy, psychoeducation, support for families, cognitive remediation, and supported employment and/or education. These programs provide intensive treatment right away for someone experiencing symptoms of psychosis. Chapter 71

Mental Health Grants
There are "block" grants and specific grants that go to counties, groups of counties (Adult Mental Health Initiatives) and sometimes providers for services and supports for both children and adults with mental illnesses. Over time, these funds have often been targeted for cuts due to the lack of data on numbers served and outcomes, particularly on the adult side. A biennial report to the legislature will now be required for both the adult mental health grants and children's mental health grants on the amount of money that was spent, programs and services that were funded, gaps in services that each initiative reported to the commissioner, and outcome data for the programs and services that were funded.

For the adult mental health grants, three specific grant programs were identified: mental health crisis services, housing with supports, and projects for assistance in transitioning from homelessness (PATH). Funding can also be used for 21 other programs such as community education, peer support, community support programs, Intensive Community Rehab Services (ICRS), housing subsidies and treatment. For the children's area, 16 programs were identified including transition, crisis, culturally specific, evidence-based practices, school-linked, early childhood, trauma informed care and first episode programs. Chapter 71

Suicide Prevention
An additional $449,000 is appropriated to expand the suicide prevention programs under the Department of Health. This is a nearly 54% increase in funding. In 2001, there was $1.1 million in funding and then the funding was eliminated in 2005. Funding was restored in 2008 but then cut again in 2010 so there has only been $98000 per year in grant funding available. The suicide rate in Minnesota has gone from 440 people in 2000 to 678 in 2013. Suicide grants will be expanded to train school staff, peace officers, firefighters, EMTs, paramedics, primary care providers and others. Evidence-based postvention training can also be funded in order to provide technical assistance to communities after a suicide in order to prevent clusters and contagion.

In addition, the commissioner, in consultation with stakeholders, will submit a report to the legislature that includes a detailed plan identifying methods to improve the timeliness, usefulness, and quality of suicide-related data to help identify the scope of the suicide problem, identify high-risk groups, set priority prevention activities, and monitor the effects of the suicide prevention programming. The report will include how to improve injury coding, how to obtain and release data in a timely manner, and how to support the use of psychological autopsies.

The program called Text4Life, which targets youth who tend to text and not make a phone call received an additional $1 million for the biennium. Chapter 71

Mental Health Workforce

Foreign Trained Health Care Professionals

$200,000 is appropriated to the foreign-trained health care professionals grant program that encourages state licensure of foreign-trained health care professionals who commit to practicing at least five years in underserved areas of the state. This includes physicians, nurses, dentists, pharmacists, mental health professionals and other allied health care professionals. Special Session Chapter 1

MERC

The MERC program, which funds medical education, but includes psychologists, clinical social workers and community health workers, received increased funding. Chapter 71

Peer Specialists

Peer specialists are people who live with a mental illness, are in recovery and have received special training. They can now be a case manager associate. The commissioner of human services with input from stakeholders must also study and report on how peer specialists are used in the mental health system. It will include an assessment of the use of certified peer specialists within existing resources, an evaluation of the benefits of using certified peer specialists in hospital settings and intensive residential treatment services (IRTS), an analysis of the existing duties of certified peer specialists, options for expanding their duties and the benefits of expanding their duties, methods for obtaining reimbursement for services they provide, an analysis of the cost of expanding reimbursement, and any necessary proposed legislation. In assessing the use of certified peer specialists in hospital settings and IRTS, the commissioner shall make recommendations on how to obtain reimbursement for wraparound services by these specialists and warm handoffs to community services that facilitate the successful transition of persons with mental illness to the next level of care. Chapter 78

Physician Assistants

Physician assistants can now be reimbursed under Medical Assistance in outpatient settings for medication management and evaluation and management services if they have completed 2000 hours of clinical experience in the evaluation and treatment of mental health and are supervised by a psychiatrist. Chapter 71

Rural Loan Forgiveness Program

The rural loan forgiveness program is expanded to include mental health professionals, dental therapists and public health nurses. This program offers loan forgiveness funds to those agreeing to practice in rural areas. A rural area includes city or township outside the metro area but excluding Duluth, Mankato, Moorhead, Rochester and St. Cloud. The person can be in a training or education program or have already graduated and must practice for a minimum of three years in a rural area. Preference is given to applicants who document diverse cultural competencies. Over $5 million in funding is available. Chapter 71

Residency Programs
$3 million for the biennium is appropriated to the Commissioner of Health to expand the primary care residency program. This includes family medicine, general internal medicine, general pediatrics, psychiatry, geriatrics and general surgery. It sets aside four slots for psychiatry residents.

An international medical graduate assistance program is also established to assist immigrant international medical graduates to integrate into Minnesota's health care system and increase access to primary care in rural and underserved areas of the state. Psychiatry is included. Grant funding of $1 million is available. Chapter 71

Social Workers Emeritus License
An emeritus license for social workers is created. This would allow a retired social worker, for a reduced fee, to provide pro bono or unpaid social work practice or provide licensing supervision. Chapter 71

Substance Use Disorders

C.A.R.E.
The C.A.R.E. programs were not shut down and will continue but will be reduced in size to 16 beds (except the Anoka facility). These programs are in Carlton, Fergus Falls, St. Peter and Willmar. The program in Anoka will be reduced to 22 beds. The C.A.R.E. program in Brainerd (Four Winds) will stay at its current capacity and will continue to operate as a culturally specific program for American Indians. All the C.A.R.E. programs will serve people whom under civil commitment and have complex needs. Community providers serving these individuals will receive an enhanced rate. Chapter 71

Chemical Dependency Prevention
$300,000 is appropriated for grants to nonprofit organizations to provide chemical dependency prevention programs in secondary schools. Chapter 71

Chemical Dependency Programs that serve Parents with Their Children
Chemical dependency treatment programs that serve parents with their children will have to take extra steps to ensure the child/children are safe. This includes educating the parent related to safe bathing and reducing the risk of sudden unexpected infant death and abusive head trauma from shaking infants and young children.

The provider must also assess the parent's capacity to meet the health and safety needs of the child while on the facility premises, including identifying circumstances when the parent may be unable to adequately care for their child due to: (1) the parent's physical or mental health; (2) the parent being under the influence of drugs, alcohol, medications, or other chemicals; (3) the parent being unable to provide appropriate supervision for the child; or (4) any other information available to the license holder that indicates the parent may not be able to adequately care for the child.

There must also be written procedures on what to do if a parent is or becomes unable to adequately care for the child. Chapter 78

Fetal Alcohol Grants
$500,000 is for grants to be administered by the MN Organization on Fetal Alcohol Syndrome to provide comprehensive services to pregnant and parenting women suspected of or known to use alcohol or drugs. Chapter 71

High Intensity Services
The Department of Human Services (DHS) must establish a new rate for high intensity residential treatment services that provide 30 hours of clinical services each week for people who have been committed to the commissioner and who present complex and difficult care needs and are a potential threat to the community. This affects the CARE program. Chapter 71

Opiate Antagonists
$290,000 is appropriated to give grants to the eight regional emergency medical services programs to purchase opiate antagonists and to educate and train emergency medical services persons on how to use them in the event of an opiate or heroin overdose. Chapter 71

All chemical dependency providers must educate their clients on recognition of and response to opioid overdose and the use and administration of naloxone. Chapter 78

Opioid Prescribing Improvement Program
The commissioners of health and human services will work together to develop an opioid prescribing improvement program to reduce the dependency on and abuse of opioids. A workgroup will be formed including health care providers and people who have been impacted by opioid abuse. The workgroup will develop criteria for prescribing, educational materials about dealing with pain, disenrollment standards, etc. Prescribers for people on Minnesota health care programs will be required to follow the protocols developed. There is an annual report to the legislature that must report on the implementation of the program and utilization data. Chapter 71

A client being administered or dispensed a high dose of methadone or buprenorphine daily, and for each subsequent increase, must meet face-to-face with a prescribing physician. The meeting must occur before the administering or dispensing of the increased dose. Chapter 78

Rates for CD Providers
Rates for chemical dependency providers are increased 2% after July 1, 2015. This includes outpatient treatment, medication-assisted therapy services, medication-assisted therapy plus enhanced treatment services, residential treatment services, hospital-based treatment services and adolescent treatment programs. Chapter 71

Telemedicine
Subject to federal approval, chemical dependency services that are otherwise covered as direct face-to-face services may be provided via two-way interactive video. The use of two-way interactive video must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services. Chapter 78

Withdrawal Management Programs
A new model for detoxification programs is established, called Withdrawal Management. It is to meet the needs of people who need appropriate detoxification, assessment, intervention and referral services. The commissioner is required to develop a payment methodology for services, seek federal approval for the rate methodology, and obtain legislative approval before implementing the program. This program includes stabilization planning and the use of recovery peers, it must be trauma informed and culturally competent, provide patient education, and have nursing and a medical director. Chapter 71

Other

Family and Medical Leave
The Department of Employment and Economic Development, in collaboration with the Departments of Labor and Industry and Health and Human Services, shall report on the most efficient and effective mechanisms that would provide partial wage replacement for workers taking parental, family, or medical leave. Special Session Chapter 1

Human Research Subjects
Legislation requires the Board of Regents of the University of Minnesota to report monthly, beginning July 1, 2015, to the legislature on their progress in developing and implementing a plan to conduct human subject research at the university that incorporates the recommendations of the external review report. The monthly reports must continue until the plan has been fully implemented. The reports must provide specific details about: (1) the changes to Institutional Review Board membership, policies, and practices; (2) the procedures required for obtaining and reviewing consents by individuals with impaired decision-making abilities; and (3) the policy with respect to responding to concerns of family and others for the well-being of human research subjects. Chapter 69

Olmstead Office
Funding of $2.6 million is for the Olmstead Implementation Office. Special Session Chapter 1.

Ombudsman for Mental Health and Developmental Disabilities
This office received an additional $341,000. Chapter 71

Violence Against Health Care Workers
Hospitals have to pull together a committee of representatives of health care workers employed by them to develop and implement action plans to respond to acts of violence that occur at the hospital. Acts of violence include hitting, kicking, scratching, harassing, urinating on, etc., a health care worker by a patient or visitor. All health care workers must receive training on de-escalation techniques, how to identify potentially violent situations, and how to respond. Every year this committee will look at the effectiveness of the plan and the number of acts of violence. The hospitals cannot interfere or discourage a health care worker from contacting the police about an act of violence. Chapter 71