State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 1390

02/22/2021 Authored by Bierman
The bill was read for the first time and referred to the Committee on Human Services Finance and Policy

A bill for an act

relating to human services; modifying certified community behavioral health clinic provisions; establishing an advisory working group; authorizing rulemaking; requiring a report; amending Minnesota Statutes 2020, sections 245.735, subdivisions 3, 5, by adding subdivisions; 256B.0625, subdivision 5m; repealing Minnesota Statutes 2020, section 245.735, subdivisions 1, 2, 4.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2020, section 245.735, subdivision 3, is amended to read:

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish a state certification process for certified community behavioral health clinics (CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified under this chapter to be eligible for reimbursement under medical assistance, without restrictions on service delivery based on geographic area or region. Entities that choose to be CCBHCs must:

~~(1) comply with the CCBHC criteria published by the United States Department of Health and Human Services;~~

(1) comply with state licensing requirements and other requirements issued by the commissioner according to subdivision 3a;

(2) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals and licensed alcohol and drug counselors, and staff who are culturally and linguistically trained to meet the needs of the population the clinic serves;

(3) ensure that clinic services are available and accessible to individuals and families of all ages and genders and that crisis management services are available 24 hours per day;

(4) establish fees for clinic services for individuals who are not enrolled in medical assistance using a sliding fee scale that ensures that services to patients are not denied or limited due to an individual's inability to pay for services;

(5) comply with quality assurance reporting requirements and other reporting requirements, including any required reporting of encounter data, clinical outcomes data, and quality data;

(6) provide crisis mental health and substance use services, withdrawal management services, emergency crisis intervention services, and stabilization services, such as mobile crisis teams; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; person- and family-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans~~;~~. CCBHCs must directly provide the majority of these services to enrollees, but may coordinate some services with another entity through a collaboration or agreement, pursuant to paragraph (b);

(7) provide coordination of care across settings and providers to ensure seamless transitions for individuals being served across the full spectrum of health services, including acute, chronic, and behavioral needs. Care coordination may be accomplished through partnerships or formal contracts with:

(i) counties, health plans, pharmacists, pharmacies, rural health clinics, federally qualified health centers, inpatient psychiatric facilities, substance use and detoxification facilities, or community-based mental health providers; and

(ii) other community services, supports, and providers, including schools, child welfare agencies, juvenile and criminal justice agencies, Indian health services clinics, tribally licensed health care and mental health facilities, urban Indian health clinics, Department of Veterans Affairs medical centers, outpatient clinics, drop-in centers, acute care hospitals, and hospital outpatient clinics;

(8) be certified as mental health clinics under section 245.69, subdivision 2;

(9) comply with standards established by the commissioner relating to ~~mental health services in Minnesota Rules, parts 9505.0370 to 9505.0372~~ CCBHC screenings, assessments, and evaluations;

(10) be licensed to provide substance use disorder treatment under chapter 245G;

(11) be certified to provide children's therapeutic services and supports under section 256B.0943;

(12) be certified to provide adult rehabilitative mental health services under section 256B.0623;

(13) be enrolled to provide mental health crisis response services under sections 256B.0624 and 256B.0944;

(14) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

(15) comply with standards relating to mental health case management in Minnesota Rules, parts 9520.0900 to 9520.0926;

(16) provide services that comply with the evidence-based practices described in paragraph (e); and

(17) comply with standards relating to peer services under sections 256B.0615, 256B.0616, and 245G.07, subdivision 1, paragraph (a), clause (5), as applicable when peer services are provided.

(b) If ~~an entity~~ a certified CCBHC is unable to provide one or more of the services listed in paragraph (a), clauses (6) to (17), the ~~commissioner may certify the entity as a~~ CCBHC~~,~~ ~~if the entity has a current~~ may contract with another entity that has the required authority to provide that service and that meets ~~federal CCBHC~~ the following criteria as a designated collaborating organization~~, or, to the extent allowed by the federal CCBHC criteria, the commissioner may approve a referral arrangement. The CCBHC must meet federal requirements regarding the type and scope of services to be provided directly by the CCBHC.~~:

(1) the entity has a formal agreement with the CCBHC to furnish one or more of the services under paragraph (a), clause (6);

(2) the entity provides assurances that it will provide services according to CCBHC service standards and provider requirements;

(3) the entity agrees that the CCBHC is responsible for coordinating care and has clinical and financial responsibility for the services that the entity provides under the agreement; and

(4) the entity meets any additional requirements issued by the commissioner under subdivision 3a.

(c) Notwithstanding any other law that requires a county contract or other form of county approval for certain services listed in paragraph (a), clause (6), a clinic that otherwise meets CCBHC requirements may receive the prospective payment under section 256B.0625, subdivision 5m, for those services without a county contract or county approval. As part of the certification process in paragraph (a), the commissioner shall require a letter of support from the CCBHC's host county confirming that the CCBHC and the county or counties it serves have an ongoing relationship to facilitate access and continuity of care, especially for individuals who are uninsured or who may go on and off medical assistance.

(d) When the standards listed in paragraph (a) or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements for services reimbursed under medical assistance. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders, as described in subdivision 4, before granting variances under this provision. For the CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

(e) The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs, and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice, the quality of workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list and any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

(f) The commissioner may grant a variance to allow an applicant for CCBHC certification to demonstrate compliance with standards in paragraph (a) if the CCBHC will contract with

a designated collaborating organization to provide all services for which a particular licensure or certification listed in paragraph (a) is required.

(g) The commissioner shall provide a CCBHC with adequate notice of the commissioner's decision regarding a variance request. The notice of the commissioner's decision must include information providing for an appeals process through which the CCBHC may appeal the commissioner's decision.

~~(f)~~ (h) The commissioner shall recertify CCBHCs at least every three years. The commissioner shall establish a process for decertification and shall require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application and certification process.

Sec. 2. Minnesota Statutes 2020, section 245.735, is amended by adding a subdivision to read:

Subd. 3a. **Additional CCBHC criteria; rulemaking.** Notwithstanding the requirements under this section, any criteria and requirements established by the commissioner to implement this section shall be adopted as rules published by the commissioner with notice and a public comment period. Sections 14.125 and 14.128 do not apply to rulemaking under this subdivision.

Sec. 3. Minnesota Statutes 2020, section 245.735, subdivision 5, is amended to read:

Subd. 5. **Information systems support.** The commissioner and the state chief information officer shall provide information systems support to the projects as necessary to comply with state and federal requirements.

Sec. 4. Minnesota Statutes 2020, section 245.735, is amended by adding a subdivision to read:

Subd. 6. **Demonstration entities.** The commissioner may operate the demonstration program established by section 223 of the Protecting Access to Medicare Act if federal funding for the demonstration program remains available from the United States Department of Health and Human Services. To the extent practicable, the commissioner shall align the requirements of the demonstration program with the requirements under this section for CCBHCs receiving medical assistance reimbursement. A CCBHC may not apply to participate as a billing provider in both the CCBHC federal demonstration and the benefit for CCBHCs under the medical assistance program.

Sec. 5. Minnesota Statutes 2020, section 256B.0625, subdivision 5m, is amended to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers certified community behavioral health clinic (CCBHC) services that meet the requirements of section 245.735, subdivision 3.

(b) The commissioner shall ~~establish standards and methodologies for a~~ reimburse CCBHCs on a per-visit basis under the prospective payment system for medical assistance payments ~~for services delivered by a CCBHC, in accordance with guidance issued by the Centers for Medicare and Medicaid Services~~ as described in paragraph (c). The commissioner shall include a quality ~~bonus~~ incentive payment in the prospective payment system ~~based on federal criteria~~, as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC prospective payment system.

(c) ~~Unless otherwise indicated in applicable federal requirements, the prospective payment system must continue to be based on the federal instructions issued for the federal section 223 CCBHC demonstration, except:~~ The commissioner shall ensure that the prospective payment system for CCBHC payments under medical assistance meets the following requirements:

(1) the prospective payment rate shall be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable costs for CCBHCs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under section 245.735, subdivision 3, paragraph (a), clauses (6) and (7); and other costs such as insurance or supplies needed to provide CCBHC services;

(2) payment shall be limited to one payment per day per medical assistance enrollee for each CCBHC visit eligible for reimbursement. A CCBHC visit is eligible for reimbursement if at least one of the CCBHC services listed under section 245.735, subdivision 3, paragraph (a), clause (6), is furnished to a medical assistance enrollee by a health care practitioner or licensed agency employed by or under contract with a CCBHC;

(3) new payment rates set by the commissioner for newly certified CCBHCs under section 245.735, subdivision 3, shall be based on rates for established CCBHCs with a similar scope of services. If no comparable CCBHC exists, the commissioner shall establish a clinic-specific rate using audited historical cost report data adjusted for the estimated cost

of delivering CCBHC services, including the estimated cost of providing the full scope of services and the projected change in visits resulting from the change in scope;

~~(1)~~ (4) the commissioner shall rebase CCBHC rates at least once every three years;

~~(2)~~ (5) the commissioner shall provide for a 60-day appeals process after notice of the results of the rebasing;

~~(3) the prohibition against inclusion of new facilities in the demonstration does not apply after the demonstration ends;~~

~~(4)~~ (6) the prospective payment rate under this section does not apply to services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. An entity that receives a prospective payment system rate that overlaps with the CCBHC rate is not eligible for the CCBHC rate;

~~(5)~~ (7) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall complete the phase-out of CCBHC wrap payments no later than July 1, 2021, for CCBHCs reimbursed under this chapter, with a final settlement of payments due made payable to CCBHCs no later than 18 months thereafter;

~~(6) initial prospective payment rates for CCBHCs certified after July 1, 2019, shall be based on rates for comparable CCBHCs. If no comparable provider exists, the commissioner shall compute a CCBHC-specific rate based upon the CCBHC's audited costs adjusted for changes in the scope of services;~~

~~(7)~~ (8) the prospective payment rate for each CCBHC shall be ~~adjusted~~ updated annually by rebasing or by trending each provider-specific rate by the Medicare Economic Index ~~as defined for the federal section 223 CCBHC demonstration~~ for primary care services. CCBHCs must provide data on costs and visits to the state annually using the CCBHC cost report established by the commissioner; and

(9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of services that are expected to adjust the CCBHC payment rate by 2.5 percent or more. The CCBHC must provide the commissioner with information regarding the changes in the scope of services, including the estimated cost of providing the new or modified services and any projected increase or decrease in the number of visits resulting from the change. Rate adjustments for changes in scope are limited to one per year per CCBHC and are effective on the date of the annual CCBHC rate update.

~~(8) the commissioner shall seek federal approval for a CCBHC rate methodology that allows for rate modifications based on changes in scope for an individual CCBHC, including for changes to the type, intensity, or duration of services. Upon federal approval, a CCBHC may submit a change of scope request to the commissioner if the change in scope would result in a change of 2.5 percent or more in the prospective payment system rate currently received by the CCBHC. CCBHC change of scope requests must be according to a format and timeline to be determined by the commissioner in consultation with CCBHCs.~~

(d) Managed care plans and county-based purchasing plans shall reimburse CCBHC providers at the prospective payment rate. The commissioner shall monitor the effect of this requirement on the rate of access to the services delivered by CCBHC providers. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision. This paragraph expires if federal approval is not received for this paragraph at any time.

(e) The commissioner shall implement a quality incentive payment program for CCBHCs that meets the following requirements:

(1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric thresholds for performance metrics established by the commissioner, in addition to payments for which the CCBHC is eligible under the prospective payment system described in paragraph (c);

(2) a CCBHC must be certified and enrolled as a CCBHC for the entire measurement year to be eligible for incentive payments;

(3) each CCBHC shall receive written notice of the criteria that must be met in order to receive quality incentive payments at least 90 days prior to the measurement year; and

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner shall notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

(f) All claims to managed care plans for CCBHC services as provided under this section shall be submitted directly to, and paid by, the commissioner no later than January 1 of the following calendar year, if:

(1) one or more managed care plans does not comply with the federal requirement for payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42, section 447.45(b), and the managed care plan does not resolve the payment issue within 30 days of noncompliance; and

(2) the total amount of clean claims not paid in accordance with federal requirements by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims eligible for payment by the managed care plan.

Sec. 6. **DIRECTION TO THE COMMISSIONER; CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC ADVISORY WORKING GROUP.**

By July 1, 2021, the commissioner of human services shall establish an advisory working group, collaborating with certified community behavioral health clinics (CCBHCs) and other relevant stakeholders to identify regulatory options that balance optimal program oversight, program integrity, and compliance with state and federal requirements with the desire to minimize the administrative burden and costs for providers. The working group shall review and make recommendations on available options for licensing or certifying CCBHCs that receive medical assistance reimbursement, including specific requirements for CCBHCs and possible state licensing or certification authorities. The commissioner shall submit a written report summarizing the advisory working group's findings and recommendations to the members of the legislative committees with jurisdiction over health and human services no later than January 10, 2022.

Sec. 7. **REPEALER.**

Minnesota Statutes 2020, section 245.735, subdivisions 1, 2, and 4, are repealed.

245.735 EXCELLENCE IN MENTAL HEALTH DEMONSTRATION PROJECT.

Subdivision 1. **Excellence in Mental Health demonstration project.** The commissioner shall develop and execute projects to reform the mental health system by participating in the Excellence in Mental Health demonstration project.

Subd. 2. **Federal proposal.** The commissioner shall develop and submit to the United States Department of Health and Human Services a proposal for the Excellence in Mental Health demonstration project. The proposal shall include any necessary state plan amendments, waivers, requests for new funding, realignment of existing funding, and other authority necessary to implement the projects specified in subdivision 3.

Subd. 4. **Public participation.** In developing and implementing CCBHCs under subdivision 3, the commissioner shall consult, collaborate, and partner with stakeholders, including but not limited to mental health providers, substance use disorder treatment providers, advocacy organizations, licensed mental health professionals, counties, tribes, hospitals, other health care providers, and Minnesota public health care program enrollees who receive mental health services and their families.