State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FIRST SESSION

H. F. No. 3445

02/17/2020 Authored by Morrison, Albright and Schultz
The bill was read for the first time and referred to the Long-Term Care Division
02/26/2020 Adoption of Report: Re-referred to the Committee on Health and Human Services Policy
03/04/2020 Adoption of Report: Placed on the General Register as Amended
Read for the Second Time

A bill for an act

relating to human services; eliminating requirement to involve state medical review agent in determination and documentation of medically necessary psychiatric residential treatment facility services; requiring establishment of per diem rate per provider of youth psychiatric residential treatment services; permitting facilities or licensed professionals to submit billing for arranged services; amending Minnesota Statutes 2018, section 256B.0941, subdivisions 1, 3.

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

Section 1. Minnesota Statutes 2018, section 256B.0941, subdivision 1, is amended to read:

Subdivision 1. **Eligibility.** (a) An individual who is eligible for mental health treatment services in a psychiatric residential treatment facility must meet all of the following criteria:

(1) before admission, services are determined to be medically necessary ~~by the state's medical review agent~~ according to Code of Federal Regulations, title 42, section 441.152;

(2) is younger than 21 years of age at the time of admission. Services may continue until the individual meets criteria for discharge or reaches 22 years of age, whichever occurs first;

(3) has a mental health diagnosis as defined in the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders, as well as clinical evidence of severe aggression, or a finding that the individual is a risk to self or others;

(4) has functional impairment and a history of difficulty in functioning safely and successfully in the community, school, home, or job; an inability to adequately care for one's physical needs; or caregivers, guardians, or family members are unable to safely fulfill the individual's needs;

(5) requires psychiatric residential treatment under the direction of a physician to improve the individual's condition or prevent further regression so that services will no longer be needed;

(6) utilized and exhausted other community-based mental health services, or clinical evidence indicates that such services cannot provide the level of care needed; and

(7) was referred for treatment in a psychiatric residential treatment facility by a qualified mental health professional licensed as defined in section 245.4871, subdivision 27, clauses (1) to (6).

~~(b) A mental health professional making a referral shall submit documentation to the state's medical review agent containing all information necessary to determine medical necessity, including a standard diagnostic assessment completed within 180 days of the individual's admission. Documentation shall include evidence of family participation in the individual's treatment planning and signed consent for services.~~

(b) The commissioner shall provide oversight and conduct utilization reviews of referrals to and admitted clients in psychiatric residential treatment facilities to ensure that eligibility criteria, clinical services, and treatment planning are reflective of clinical, state, and federal standards for psychiatric residential treatment facility level of care. The commissioner shall coordinate a statewide list of children and youth who meet the medical necessity criteria for psychiatric residential treatment facility level of care and who are awaiting admission. The statewide list must not be used to direct admission of children and youth in specific facilities.

Sec. 2. Minnesota Statutes 2018, section 256B.0941, subdivision 3, is amended to read:

Subd. 3. **Per diem rate.** (a) The commissioner ~~shall~~ must establish ~~a statewide~~ one per diem rate per provider for psychiatric residential treatment facility services for individuals 21 years of age or younger. The rate for a provider must not exceed the rate charged by that provider for the same service to other payers. Payment must not be made to more than one entity for each individual for services provided under this section on a given day. The commissioner ~~shall~~ must set rates prospectively for the annual rate period. The commissioner ~~shall~~ must require providers to submit annual cost reports on a uniform cost reporting form and ~~shall~~ must use submitted cost reports to inform the rate-setting process. The cost reporting ~~shall~~ must be done according to federal requirements for Medicare cost reports.

(b) The following are included in the rate:

(1) costs necessary for licensure and accreditation, meeting all staffing standards for participation, meeting all service standards for participation, meeting all requirements for active treatment, maintaining medical records, conducting utilization review, meeting inspection of care, and discharge planning. The direct services costs must be determined using the actual cost of salaries, benefits, payroll taxes, and training of direct services staff and service-related transportation; and

(2) payment for room and board provided by facilities meeting all accreditation and licensing requirements for participation.

(c) A facility may submit a claim for payment outside of the per diem for professional services arranged by and provided at the facility by an appropriately licensed professional who is enrolled as a provider with Minnesota health care programs. Arranged services ~~must be billed by the facility on a separate claim, and the facility shall be responsible for payment to the provider~~ may be billed by either the facility or the licensed professional. These services must be included in the individual plan of care and are subject to prior authorization ~~by the state's medical review agent~~.

(d) Medicaid ~~shall~~ must reimburse for concurrent services as approved by the commissioner to support continuity of care and successful discharge from the facility. "Concurrent services" means services provided by another entity or provider while the individual is admitted to a psychiatric residential treatment facility. Payment for concurrent services may be limited and these services are subject to prior authorization by the state's medical review agent. Concurrent services may include targeted case management, assertive community treatment, clinical care consultation, team consultation, and treatment planning.

(e) Payment rates under this subdivision ~~shall~~ must not include the costs of providing the following services:

(1) educational services;

(2) acute medical care or specialty services for other medical conditions;

(3) dental services; and

(4) pharmacy drug costs.

(f) For purposes of this section, "actual cost" means costs that are allowable, allocable, reasonable, and consistent with federal reimbursement requirements in Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and the Office of Management and Budget Circular Number A-122, relating to nonprofit entities.