256B.0622 INTENSIVE REHABILITATIVE MENTAL HEALTH SERVICES.

Subdivision 1. **Scope.** Subject to federal approval, medical assistance covers medically necessary, intensive nonresidential and residential rehabilitative mental health services as defined in subdivision 2, for recipients as defined in subdivision 3, when the services are provided by an entity meeting the standards in this section.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Intensive nonresidential rehabilitative mental health services" means adult rehabilitative mental health services as defined in section 256B.0623, subdivision 2, paragraph (a), except that these services are provided by a multidisciplinary staff using a total team approach consistent with assertive community treatment, the Fairweather Lodge treatment model, as defined by the standards established by the National Coalition for Community Living, and other evidence-based practices, and directed to recipients with a serious mental illness who require intensive services.

(b) "Intensive residential rehabilitative mental health services" means short-term, time-limited services provided in a residential setting to recipients who are in need of more restrictive settings and are at risk of significant functional deterioration if they do not receive these services. Services are designed to develop and enhance psychiatric stability, personal and emotional adjustment, self-sufficiency, and skills to live in a more independent setting. Services must be directed toward a targeted discharge date with specified client outcomes and must be consistent with the Fairweather Lodge treatment model as defined in paragraph (a), and other evidence-based practices.

(c) "Evidence-based practices" are nationally recognized mental health services that are proven by substantial research to be effective in helping individuals with serious mental illness obtain specific treatment goals.

(d) "Overnight staff" means a member of the intensive residential rehabilitative mental health treatment team who is responsible during hours when recipients are typically asleep.

(e) "Treatment team" means all staff who provide services under this section to recipients. At a minimum, this includes the clinical supervisor, mental health professionals as defined in section 245.462, subdivision 18, clauses (1) to (6); mental health practitioners as defined in section 245.462, subdivision 17; mental health rehabilitation workers under section 256B.0623, subdivision 5, clause (3); and certified peer specialists under section 256B.0615.

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is eligible for medical assistance;

(3) is diagnosed with a mental illness;

(4) because of a mental illness, has substantial disability and functional impairment in three or more of the areas listed in section 245.462, subdivision 11a, so that self-sufficiency is markedly reduced;

(5) has one or more of the following: a history of two or more inpatient hospitalizations in the past year, significant independent living instability, homelessness, or very frequent use of mental health and related services yielding poor outcomes; and

(6) in the written opinion of a licensed mental health professional, has the need for mental health services that cannot be met with other available community-based services, or is likely to experience a mental health crisis or require a more restrictive setting if intensive rehabilitative mental health services are not provided.

Subd. 4. **Provider certification and contract requirements.** (a) The intensive nonresidential rehabilitative mental health services provider must:

(1) have a contract with the host county to provide intensive adult rehabilitative mental health services; and

(2) be certified by the commissioner as being in compliance with this section and section 256B.0623.

(b) The intensive residential rehabilitative mental health services provider must:

(1) be licensed under Minnesota Rules, parts 9520.0500 to 9520.0670;

(2) not exceed 16 beds per site;

(3) comply with the additional standards in this section; and

(4) have a contract with the host county to provide these services.

(c) The commissioner shall develop procedures for counties and providers to submit contracts and other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

Subd. 5. **Standards applicable to both nonresidential and residential providers.** (a) Services must be provided by qualified staff as defined in section 256B.0623, subdivision 5, who are trained and supervised according to section 256B.0623, subdivision 6, except that mental health rehabilitation workers acting as overnight staff are not required to comply with section 256B.0623, subdivision 5, clause (3)(iv).

(b) The clinical supervisor must be an active member of the treatment team. The treatment team must meet with the clinical supervisor at least weekly to discuss recipients' progress and make rapid adjustments to meet recipients' needs. The team meeting shall include recipient-specific case reviews and general treatment discussions among team members. Recipient-specific case reviews and planning must be documented in the individual recipient's treatment record.

(c) Treatment staff must have prompt access in person or by telephone to a mental health practitioner or mental health professional. The provider must have the capacity to promptly and appropriately respond to emergent needs and make any necessary staffing adjustments to assure the health and safety of recipients.

(d) The initial functional assessment must be completed within ten days of intake and updated at least every three months or prior to discharge from the service, whichever comes first.

(e) The initial individual treatment plan must be completed within ten days of intake and reviewed and updated at least monthly with the recipient.

Subd. 6. **Standards for intensive residential rehabilitative mental health services.** (a) The provider of intensive residential services must have sufficient staff to provide 24-hour-per-day coverage to deliver the rehabilitative services described in the treatment plan and to safely supervise and direct the activities of recipients given the recipient's level of behavioral and

psychiatric stability, cultural needs, and vulnerability. The provider must have the capacity within the facility to provide integrated services for chemical dependency, illness management services, and family education when appropriate.

(b) At a minimum:

(1) staff must be available and provide direction and supervision whenever recipients are present in the facility;

(2) staff must remain awake during all work hours;

(3) there must be a staffing ratio of at least one to nine recipients for each day and evening shift. If more than nine recipients are present at the residential site, there must be a minimum of two staff during day and evening shifts, one of whom must be a mental health practitioner or mental health professional;

(4) if services are provided to recipients who need the services of a medical professional, the provider shall assure that these services are provided either by the provider's own medical staff or through referral to a medical professional; and

(5) the provider must assure the timely availability of a licensed registered nurse, either directly employed or under contract, who is responsible for ensuring the effectiveness and safety of medication administration in the facility and assessing patients for medication side effects and drug interactions.

Subd. 7. **Additional standards for nonresidential services.** The standards in this subdivision apply to intensive nonresidential rehabilitative mental health services.

(1) The treatment team must use team treatment, not an individual treatment model.

(2) The clinical supervisor must function as a practicing clinician at least on a part-time basis.

(3) The staffing ratio must not exceed ten recipients to one full-time equivalent treatment team position.

(4) Services must be available at times that meet client needs.

(5) The treatment team must actively and assertively engage and reach out to the recipient's family members and significant others, after obtaining the recipient's permission.

(6) The treatment team must establish ongoing communication and collaboration between the team, family, and significant others and educate the family and significant others about mental illness, symptom management, and the family's role in treatment.

(7) The treatment team must provide interventions to promote positive interpersonal relationships.

Subd. 8. **Medical assistance payment for intensive rehabilitative mental health services.** (a) Payment for residential and nonresidential services in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible recipient in a given calendar day: all rehabilitative services under this section, staff travel time to provide rehabilitative services under this section, and nonresidential crisis stabilization services under section 256B.0624.

(b) Except as indicated in paragraph (c), payment will not be made to more than one entity for each recipient for services provided under this section on a given day. If services under this

section are provided by a team that includes staff from more than one entity, the team must determine how to distribute the payment among the members.

(c) The host county shall recommend to the commissioner one rate for each entity that will bill medical assistance for residential services under this section and one rate for each nonresidential provider. If a single entity provides both services, one rate is established for the entity's residential services and another rate for the entity's nonresidential services under this section. In developing these rates, the host county shall consider and document:

(1) the cost for similar services in the local trade area;

(2) that the proposed costs incurred by entities providing the services are allowable, allocable and reasonable, and are consistent with federal reimbursement requirements including Code of Federal Regulations, title 48, chapter 1, part 31, as relating to for-profit entities, and Office of Management and Budget Circular Number A-122, as relating to nonprofit entities;

(3) the intensity and frequency of services to be provided to each recipient, including the proposed overall number of units of service to be delivered;

(4) the degree to which recipients will receive services other than services under this section;

(5) the costs of other services that will be separately reimbursed; and

(6) input from the local planning process authorized by the adult mental health initiative under section 245.4661, regarding recipients' service needs.

(d) The rate for intensive rehabilitative mental health services must exclude room and board, as defined in section 256I.03, subdivision 6, and services not covered under this section, such as partial hospitalization, home care, and inpatient services. Physician services that are not separately billed may be included in the rate to the extent that a psychiatrist is a member of the treatment team. The county's recommendation shall specify the period for which the rate will be applicable, not to exceed two years.

(e) When services under this section are provided by an assertive community team, case management functions must be an integral part of the team.

(f) The rate for a provider must not exceed the rate charged by that provider for the same service to other payors.

(g) The commissioner shall approve or reject the county's rate recommendation, based on the commissioner's own analysis of the criteria in paragraph (c).

(h) Paragraph (c), clause (2), is effective for services provided on or after January 1, 2010, to December 31, 2011, and does not change contracts or agreements relating to services provided before January 1, 2010.

Subd. 8a. **Adjustments based on actual costs and units.** (a) After each calendar year, the commissioner shall compare actual costs and units of service for each provider to the costs and units of service that were used as the basis for the approved rate.

(b) For purposes of this subdivision, "revenue" means actual units of service multiplied by the approved rate and "allowed cost" means costs that are consistent with the budget that was used as the basis for the approved rate, or other costs subsequently approved by the county and the commissioner based on the criteria in subdivision 8, paragraph (c), clause (2).

(c) The commissioner shall require repayment from the provider if the provider has not incurred the costs included in the approved budget, if costs are determined to be unallowable under the criteria in subdivision 8, paragraph (c), clause (2), or if a provider's revenue is more than 105 percent of actual allowed costs due to utilization beyond the projections in the approved budget. The repayment to the commissioner will be proportional to the percent of total units of service reimbursed by the commissioner.

(d) If a provider's revenue is less than 95 percent of actual allowed costs due to lower utilization than projected, the commissioner may adjust the rate so that the provider can recover 95 percent of actual allowable costs. The resulting additional payment by the commissioner will be proportional to the percent of total units of service reimbursed by the commissioner.

(e) The commissioner has the authority to audit programs using all applicable state and federal laws and regulations, including those referenced in subdivision 8, paragraph (c), clause (2).

(f) This subdivision is effective for services provided on or after January 1, 2010, to December 31, 2011, and does not change contracts or agreements relating to services provided before January 1, 2010.

Subd. 9. **Provider enrollment; rate setting for county-operated entities.** Counties that employ their own staff to provide services under this section shall apply directly to the commissioner for enrollment and rate setting. In this case, a county contract is not required and the commissioner shall perform the program review and rate setting duties which would otherwise be required of counties under this section.

Subd. 10. **Provider enrollment; rate setting for specialized program.** A provider proposing to serve a subpopulation of eligible recipients may bypass the county approval procedures in this section and receive approval for provider enrollment and rate setting directly from the commissioner under the following circumstances:

(1) the provider demonstrates that the subpopulation to be served requires a specialized program which is not available from county-approved entities; and

(2) the subpopulation to be served is of such a low incidence that it is not feasible to develop a program serving a single county or regional group of counties.

For providers meeting the criteria in clauses (1) and (2), the commissioner shall perform the program review and rate setting duties which would otherwise be required of counties under this section.

History: *1Sp2003 c 14 art 3 s 19; 2004 c 288 art 3 s 23; 1Sp2005 c 4 art 2 s 7; 2007 c 147 art 8 s 17; 2009 c 79 art 7 s 14; 2009 c 167 s 9,10*