

Mental Health Day on the Hill – Issue Highlights

Mental Health Parity

Mental Health Parity laws require private health plans to offer equal coverage for mental health and substance use disorder treatment. Mental health parity violations discriminate against people living with mental illnesses and lead to higher costs, unique burdens to seeking treatment, and the denial of coverage for essential mental health care. We need to strengthen the ability of the Departments of Health and Commerce to enforce the laws that currently exist.

Mental Health Workforce Needs

Minnesota continues to face a significant mental health workforce shortage. We support bills that address these shortages in a variety of ways, including broadening the paths that qualified workers can take to employment in mental health professions, ensuring that clinical trainees can be reimbursed by private insurance, and student loan forgiveness programs for mental health professionals.

Sustainability

Many mental health providers are being paid below the fee-for-service rate through Medicaid managed care. We believe there should be a “floor,” not a ceiling, in Medicaid rates, and we support a bill that requires all managed care organizations and county based purchasers to reimburse at or above the fee-for-service rate for the same mental health service.

Children’s Mental Health

School-linked mental health grants allow for the co-location of a mental health provider within Minnesota schools, greatly decreasing the barriers for students to access the mental health care they need. Many schools do not have school-linked mental health programming. We support expansion of school-linked mental health services to help additional children.

The federal government will soon stop Medicaid payments to children’s residential treatment programs, and “stop-gap” funding was appropriated by the Legislature through 2019. We support extending this stop-gap funding through at least the end of the next biennium to ensure that children receive needed of residential treatment.

Suicide is the second leading cause of death for youth between the ages of 10 and 17. We support increased funding for the Kognito At-Risk Training, which prepares Minnesota teachers across the state to recognize the symptoms of mental distress, have a meaningful conversation about suicide with their students, and know when it’s time to refer the student for additional support.

We support additional funding to address the mental health needs of young children and their parents. Funding will be used for multi-generational grants, mental health consultation for early learning staff, closing a loophole that forces parents on child-only MFIP to choose between seeking mental health treatment and caring for their child, and increasing rates for mother baby programs.

System Flow Issues

Minnesota’s mental health system is currently facing significant flow issues. Too many people are being boarded in emergency rooms as they await an open inpatient psychiatric bed or placement in an IRTS. Just as frustrating, those people often struggle to leave the hospital or the Anoka RTC when they no longer require this level of care.

To address this issue there is a need for additional inpatient community hospital beds, additional investments in the transitions to community program, expansion of coverage under the elderly waiver, a pilot project for a forensic IRTS facility with longer stays, community competency restoration, and making it easier to fund and develop IRTS.

Housing

Housing is consistently cited as one of the most significant needs in our mental health system. Without access to safe and affordable housing, people with a mental illness are unable to focus on recovery. We support funding increases for Bridges, which is a housing voucher for people with a mental illness waiting for section 8 funding, as well as additional supportive housing dollars, which will allow people to access mental health services within their residence.

Medicaid/Health Insurance Issues

Since its origin in 1965, Medicaid has promised a safety net for people who fall through the cracks of our employment-based health care system. Many states, as well as some Legislators in Minnesota, are considering imposing work-requirements in order to be eligible for Medicaid. Adding new eligibility and documentation requirements to Medicaid will cause people to lose health coverage, making it more difficult for people with a mental illness to get the treatment they need.

Solitary Confinement

The Department of Correction's use of solitary confinement as a disciplinary tool has been the subject of an investigation by the Star Tribune. More than 1,600 prisoners have spent at least 6 months in solitary confinement over the last decade, with 437 having lived in isolation for a year or longer. Just as troubling, Minnesota is falling behind other states in having laws regulating the use of restrictive solitary confinement.

We need to change the way we use solitary confinement in Minnesota prisons. Research indicates that that solitary confinement has a debilitating effect on inmates, especially those with mental illness. We support proposed legislation that would address the issue of solitary confinement in corrections, as well as require reporting on its use.

Civil Commitment

Minnesota's civil commitment statute is out-of-date and does not reflect the current mental health system. NAMI convened a task force last summer to approach the civil commitment statute comprehensively. Stakeholders included sheriffs, hospitals, community providers, mental health professionals, counties, defense attorneys, DHS, advocacy organizations like the MN Disability Law Center, as well as people with lived experience with the civil commitment process.

There is more work to do in the upcoming biennium, but there is a bill (HF3021) to address some of these issues. The law governing civil commitment is complex, and any changes made to it must include stakeholder input.

Mental Health Day on the Hill -- Issue Briefing

Mental Health Parity

Mental Health Parity laws require private health plans to offer equal coverage for mental health and substance use disorder treatment. The three pillars of mental health parity are:

- Cost Sharing: cannot have higher out-of-pocket costs or separate deductibles or out-of-pocket limits for mental health care.
- Treatment Limits: forbids arbitrary limits on mental health care, such as the number of appointments.
- Non-Quantitative Treatment Limits (NQTLs): cannot have different non-numerical limitations to the scope or duration of mental health benefits, including step-therapy for a medication, different standards for a provider to enter a network including reimbursement rates, or other limits based on facility type or provider. While a health plan may use NQTLs to manage their benefit set, they cannot use NQTLs more stringently to limit mental health care than other medical or surgical benefits.

Mental health parity violations discriminate against people living with mental illnesses and lead to higher costs, unique burdens to seeking treatment, and the denial of coverage for essential mental health care. A recent national report analyzed payment rates under the same diagnostic codes for primary care, specialists, and psychiatrists. It found that in Minnesota, primary care physicians were paid 179.6% of the Medicare rate while psychiatrists were paid 126.4% - a more than 40% difference – for the same code.

We need to strengthen the ability of the Departments of Health and Commerce to enforce the laws that currently exist. HF 1974/SF 2028, HF 3359, SF 2944, SF 2945 would:

- Define NQTL according to federal law and repeat that an NQTL cannot be used more stringently to restrict mental health or substance used disorder treatment.
- Require health plans to submit an annual report that documents every NQTL that is applied, as well as analysis that confirms that the NQTL standards are not applied more stringently to mental health benefits.
- Require the Departments of Commerce and Health to monitor the implementation of mental health parity, including market conduct surveys.
- Provide an annual report to the legislature from the Departments of Commerce and Health to document all efforts regarding mental health parity, including any enforcement actions taken.

Mental Health Workforce Needs

Minnesota continues to face a significant mental health workforce shortage. To try to address the shortages several bills have been introduced.

HF 871/SF 1577 proposes allowing reimbursement under private health insurance for all services and treatment provided by a clinical trainee, so long as these services are within the trainee's scope of practice. This is currently allowed under Medical Assistance.

SF 1452 sets aside appropriates \$3 million per year for the loan forgiveness program specifically for mental health professionals. 10% of this funding must be set aside for those who will provide care in non-rural communities where over 50% of clients are on Medical Assistance.

HF 3432/SF 3066 helps address current mental health workforce needs by proposing a streamlining/centralizing of the qualifications for working as a Mental Health Rehabilitation Worker and Mental Health Practitioner, while maintaining additional service specific requirements within service lines. The bill also broadens the paths that qualified candidates can take into these roles.

Sustainability

Many mental health providers are being paid below the fee-for-service rate through Medicaid managed care. The MHLN believes there should be a “floor” not a ceiling in Medicaid rates. SF 2884 from Senator Wiklund does just this and requires all managed care organizations and county based purchasers to reimburse at or above the fee-for-service rate for the same mental health service.

Children’s Mental Health

School-linked mental health grants allow for the co-location of a mental health provider within Minnesota schools, greatly decreasing the barriers for students to access the mental health care they need. Nearly half of the students served by school-linked mental health grants received mental health care for the first time and half of these students were diagnosed with a serious mental illness.

Many schools do not have school-linked mental health programming. Currently, 76 school districts have a school-linked program in 1-25% of their buildings, while 130 districts still lack this programming in 26-50% of their buildings. HF 960/SF 1369 and HF 3378/SF 2815 which will expand school-linked mental health services to help additional children.

The federal government will soon stop Medicaid payments to children’s residential treatment programs due to their designation as Institutions of Mental Disease (IMD), which are facilities serving people with mental illnesses with over 16 beds.

During the past session, the legislature appropriated state dollars to make up for the potential loss of federal funding for children’s residential treatment. This was meant to serve as a bridge until the state was able to identify a viable alternative for children’s residential treatment. Unfortunately, this stop-gap funding expires on May of 2019, which is far too soon, and may leave residential treatment facilities without the funding to serve children with a mental illness. HF 3134 /SF 2663 will extend the availability of this stop-gap funding through at least the end of the next biennium to ensure that children receive needed of residential treatment.

Suicide is the second leading cause of death for youth between the ages of 10 and 17. There was an underlying mental illness in 90% of the youth who have completed suicide. Minnesota suicide rate for 10-19 year olds is higher than the national rate (7.0 per 100,000 compared to 5.3 per 100,000). In Minnesota, 48 youth aged 10-19 died by suicide in 2016. Properly trained teachers can play an invaluable role in engaging youth with mental illnesses and reducing the risk of suicide.

To address this growing problem, HF 3167/ SF 2774 funds the online Kognito Suicide Prevention Training Program which would provide two years of access to every school district in the state for \$273,000 dollars or 44 dollars a year per school.

The Kognito At-Risk Training will prepare Minnesota teachers across the state to recognize the symptoms of mental distress, have a meaningful conversation about suicide with their students, and know when it’s time to refer the student for additional support. Kognito offers a cost-effective platform to meet the need for suicide prevention training for Minnesota teachers, which is required as part of their continuing education.

With early identification and intervention children and young adults can obtain the treatment they need to develop socially, succeed academically, and prevent a mental illness from becoming disabling. In 2016, Minnesota spent over \$5 million dollars providing intensive mental health services to young children who were expelled from childcare. An early intervention with less intensive services can prevent this, leading to better outcomes for the child and lower costs for the state.

HF 2101/SF 1978 includes a spending package to address the mental health needs of young children and their parents. Funding will be used for multi-generational grants, mental health consultation for early learning staff, closing a loophole that forces parents on child-only MFIP to choose between seeking mental health treatment and caring for their child, and increasing rates for mother baby programs.

System Flow Issues

Minnesota's mental health system is currently facing significant flow issues. Too many people are being boarded in emergency rooms as they await an open inpatient psychiatric bed or placement in an IRTS. Just as frustrating, those people often struggle to leave the hospital or the Anoka RTC when they no longer require this level of care. While there are many reasons for these problems, the two most significant causes were the passage of the 48 Hour Law and additional Minnesotans accessing mental health care for the first time.

To address this issue there is a need for additional inpatient community hospital beds, additional investments in the transitions to community program, expansion of coverage under the elderly waiver, a pilot project for a forensic IRTS facility with longer stays, community competency restoration, and making it easier to fund and develop IRTS. SF 2690 will do this.

There are other bills addressing the County Contract issue for IRTS facilities, including HF 2945 / SF 2545 from the MN hospital association. Like the NAMI bill, this legislation eliminates the requirement for an IRTS facility to have a contract with the host county to provide these services. To avoid over-building, the provider must document that existing programs do not meet the service needs of the area and request a certificate of need from the local mental health authority. Similar legislation from People Inc. is forthcoming as well.

Housing

Housing is consistently cited as one of the most significant needs in our mental health system. Without access to safe and affordable housing, people with a mental illness are unable to focus on recovery. For those with a serious mental illness, a stable housing situation prevents repeated hospitalizations, entering the criminal justice system, and even homelessness.

The MHLN supports funding increases for Bridges, which is a housing voucher for people with a mental illness waiting for section 8 funding. MHLN will also be advocating for additional supportive housing dollars, which will allow people to access mental health services within their residence. Both of these proposals are part of the 2018 Homes for All Legislative Agenda.

Medicaid/Health Insurance Issues

Since its origin in 1965, Medicaid has promised a safety net for people who fall through the cracks of our employment-based health care system. Many states, as well as some Legislators in Minnesota, are considering imposing work-requirements in order to be eligible for Medicaid. Proponents say these changes would help people out of poverty, but the reality is much more complex. Adding new eligibility and documentation requirements to Medicaid will cause people to lose health coverage, making it more difficult for people with a mental illness to get the treatment they need.

Over one million Minnesotans access Medicaid every year. Changes in eligibility requirements in the Medicaid program would have a broad impact on Minnesotans' access to health care. Unfortunately, the federal government is encouraging states to apply for work requirement waivers, and have already approved multiple states' moves in this direction. If pursued here, additional barriers for enrollees of Medicaid would threaten the coverage, health, and well-being of Minnesotans in all corners of the state.

Meanwhile, the majority of working-age, healthy people on Medicaid are already employed. In Minnesota, 73 percent of low-income families participating in Medicaid include at least one adult with a full-time job, and the majority of adult Medicaid enrollees already work. The new requirements would place an unnecessary burden on the individual and personnel from both the state and county, adding additional paperwork and reporting requirements onto what is already a confusing system. People who do everything right may still see their coverage terminated due to paperwork delays, beginning a spiral of missed care and missed work. We believe that new reporting requirements will be particularly challenging for people living with a mental illness.

People with undiagnosed mental health or substance use disorder will be forced to declare themselves permanently disabled to access more expensive care through the disability door to Medicaid. Thanks to the Medicaid expansion under the Affordable Care Act, many people now receive comprehensive services through Medicaid without having to spend down deeper into poverty to access coverage. This is a better deal for people and for the state; covering Minnesotans through the non-disability door on Medicaid is cheaper than covering under disability coverage.

Here in Minnesota, we are very concerned about the decision to end the MinnesotaCare provider tax, which is a vital funding source for the Healthcare Access Fund. In the past, Minnesota imposed a series of gross revenue taxes on various health care providers in order to pay for the MinnesotaCare program, which provides state-subsidized healthcare for low-income individuals. The Legislature voted to sunset the provider tax, which will threaten the financial viability of MinnesotaCare. HF 2948 / SF 2876 would reinstate the provider tax and ensure the sustainability of MinnesotaCare.

Solitary Confinement

The Department of Correction's use of solitary confinement as a disciplinary tool has been the subject of an investigation by the Star Tribune. More than 1,600 prisoners have spent at least 6 months in solitary confinement over the last decade, with 437 having lived in isolation for a year or longer. Just as troubling, Minnesota is falling behind other states in having laws regulating the use of restrictive solitary confinement.

HF 742/SF 608, as amended in the House would:

- Require the Department of Corrections to develop graduated sanctions for rule violations, so that segregation becomes the last resort.
- Establish appropriate physical conditions of segregated units, including reduced lighting during nighttime hours, rights of communication and visitation, and furnished cells.
- Review disciplinary status of inmate in segregation status every 15 days by the warden of institution and every 15 days thereafter. Once an inmate serves 60 days in disciplinary segregation, the inmate's segregation status must be reviewed by the commissioner or deputy or assistant commissioner and then every 30 days.
- Requires inmate to serve at least 30 days in the general population before their release.
- Require a mental health professional to review the transfer to general population of any inmate that has spent 30 or more days in solitary confinement.
- Require Department of Corrections to issue a yearly report to the legislature that documents the use of solitary confinement including the number of inmates in solitary, their ages, the number of inmates transferred from segregation to the mental health unit, the nature of infractions leading to segregation.

We need to change the way we use solitary confinement in Minnesota prisons. Research indicates that that solitary confinement has a debilitating effect on inmates, especially those with mental illness.

Civil Commitment

Minnesota's civil commitment statute is out-of-date and does not reflect the current mental health system. NAMI convened a task force last summer to approach the civil commitment statute comprehensively. Stakeholders included, sheriffs, hospitals, community providers, mental health professionals, counties, defense attorneys, DHS, advocacy organizations like the MN Disability Law Center, as well as people with lived experience with the civil commitment process.

The problems with the civil commitment statute were so widespread that the task force was unable to complete a total update in time for the 2018 session but was able to come to an agreement on a few issues to push this year. HF 3021 includes a number of important changes including:

- Clarifying language for sections of statute including emergency holds and dual commitments.

- Adding protections so that people don't slip through the cracks of the commitment process, including a grace-period for administrative errors that end the commitment of someone still at risk of harming them self or others.
- Expanding the definition of examiners and clarifying the difference between examiners and court examiners.

There is still more work to do in the next biennium, but this is a good start that will lead to a better civil commitment process.