Minnesota Association of County Social Service Administrators

# Position Statement

For 2023 Session

## Serving People with High Acuity needs and State Responsibility as Safety Net Provider

## Proposal

**Issue:**

Throughout Minnesota there are significant gaps and inadequate capacity in the service system/continuum of care, for services needed to support children and adults with high acuity, complex and/or co-occurring conditions including developmental or intellectual disabilities, mental illnesses, substance use disorders, symptoms that include violent or sexually inappropriate behavior, physical health challenges, sex offender status. Children and adults are being boarded in hospital acute care emergency departments for days, weeks, months and potentially a year or more while county agencies work to locate providers who may be willing to provide services. In many cases this involves dozens of calls both within and outside of Minnesota to try to locate a provider to meet the person's needs. Adults are being held in local jails without MH treatment awaiting treatment beds, and some juveniles are in detention settings awaiting treatment options. These gaps can and do result in people not receiving the services they need, accessing services outside of Minnesota or receiving a patchwork of services to attempt to meet the needs.

Minnesota's health and social services providers experience barriers to service provision that can be difficult to overcome, including the lack of qualified staff to serve a particular set of needs, the difficulty of hiring qualified staff (especially in rural areas), fear of liability, physical plant challenges, need for upfront investment in site development, and service rates that may not cover the cost of the initial investments or ongoing services. In addition, County or tribal case managers work tirelessly to try to find providers to meet the needs of individuals with complex needs. Much of the time, specialized resources are not available in local communities or even within the State.
To add to these complexities, major mental health related service and policy decisions by the Department of Human Services has changed and impacted any existing State safety net system for people in need of services and Counties and Tribes rely upon.

The Governor's Task Force on Mental Health (2016 Report) identified Governance as one of the top issues to be addressed in transforming our mental health system into one that is more effective, comprehensive, understandable and accountable. Responsibility and accountability (in a State directed, County administered system) for services, funding, and quality is blurred, and there is significant variation in service availability across Counties and regions of the State. Integrated, person-centered care is difficult to achieve with many different decision-making bodies and funding sources.

Currently, the State's role in assuring Safety Net services availability is frequently confused with Minnesota Statute 245.466 outlining the county role as the Local Mental Health Authority. As part of the role of the local mental health authority, a plan must include adequate capacity for Regional Treatment Center Inpatient Services as described by Minnesota Statute 245.474, however, this statute designates the responsibility of Regional Treatment Services (RTC) to the Commissioner of Human Services. The county is unable to directly influence the availability of Regional Treatment Center Inpatient Services, and therefore this continues to be one of many factors that contribute to the result of stagnation of increasing capacity of RTC Inpatient Services.

Currently, the State's Direct Care and Treatment system is woefully underdeveloped to address the immediate need of Minnesota's residents. The demand for the most secure setting for mentally ill individuals is the forensic facilities for treating the mentally ill and dangerous population. As the forensic facilities are at capacity, anyone committed and needing forensic services are being placed by the State at other state institutions, such as Anoka Metro Regional Treatment Center (AMRTC). Currently, approximately 75% of the patients at Anoka Metro Regional Treatment Center are in need of forensic hospital-level of care, yet they are inappropriately placed at AMRTC or another facility, taking bed space for others in need of hospital-level of care. This continues to place extreme pressure downward on all levels of care in the community.

When the State delegates the development of services or systems of care, either explicitly or because of the absence of services, the result is a system that is inequitable throughout MN, people who are served differently throughout the State, people who must travel great distances, which doesn't align with person-centered care. For children there can be real damage and harm to their relationships with caregivers, siblings, and family systems that significantly impact their growth and development when they must be served several hours away or even several States away from their home.

There is a significant crisis in serving children with high acuity needs. Numerous counties throughout the state have resorted to 'boarding' children in county office spaces, hotel rooms, etc. and staffed these settings with County Human Services and in some situations, Law Enforcement, due to the lack of resources available.

People qualifying for safety net services could include people currently unable to leave the Anoka Metro Regional Treatment Center, community hospitals/emergency departments, or the Minnesota Security Hospital, jails or detention facilities because of a lack of community provider capacity as well as those who are in community-based settings, their own home or residing with family or others.

**Implementation Strategy:**

Counties and DHS must work in partnership to address the needs of the most vulnerable people – children and adults with a high acuity needs whose service needs are not able to be met by private providers. This crisis of service need cannot be solved without partnership. This partnership must address both short- and long-term strategies.

Pursue and support legislation to address the State as safety net service provider for people who are unable to be served by community provider capacity, who meet safety net criteria, who have high acuity needs. This could include people currently unable to secure a bed or leave the Anoka Metro Regional Treatment Center (AMRTC), Community Behavioral Health Hospitals (CBHH), Children and Adolescent Behavioral Health Hospital (CABHH), community acute care and/or psychiatric hospitals/emergency departments, jail/detention or the Minnesota Security Hospital due to lack of community provider capacity or provider ability to provide care to people with complex, high acuity needs. Institute a measure in which expansion of the safety net must occur, including expansion of beds and related services for the most vulnerable, highest need Minnesotans. Using wait list data, or another measurable data points, the state must physically expand or contract the safety net based on the demand for services. Measures used must align with other forms of health care to demonstrate parity between physical and behavioral health. Therefore, the threshold of any measure used to determine the systemic level of need for which the safety net must expand or contract service must be reasonably similar to that of what response would be required for other forms of health care.

Clarify Mn Statute 245.466, Local Mental Health Authority, so that it is not confused with MN Statute 245.474 which designates the responsibility of Regional Treatment Services, to specifically include safety net services, as the responsibility of the Commissioner of Human Services. The local mental health authority has no ability to influence or act as a decision-maker regarding services that are the responsibility of the Commissioner of Human Services, and this should be made clear in statute. This is the first step in moving past the stagnation that occurs on addressing capacity at the highest levels of service.

Require consideration of location and cultural needs in the establishment of services to ensure an adequate system of care throughout the State. People should have options that do not remove them from the very social supports that are often relied upon to help them integrate back into their chosen community.
In considering safety net services, the services and proposals must include an assessment of community based and outpatient service options as well and ensure equal access to these services, including the step-down services to allow people to leave more restrictive settings when they no longer meet medical criteria.

Amend statutory language regarding ability to appeal a does not meet criteria finding to include Counties. This decision is currently made by State employed or contracted providers and can only be appealed by the person. The County plays a vital role in serving the person, is the payer and should have the ability to appeal the finding. Additionally, require the determination of does not meet criteria to include an assessment and recommendation of an appropriate level of care and ensure access to the services.
Allow counties the ability to act as other payers do in health care systems. In traditional health care, utilization management (or the process that evaluates the efficiency, appropriateness and medical necessity of treatments and services on a case-by-case basis) is run by or on behalf of purchasers, not the treating doctors. While hospitals and medical institutions may have their own internal prospective or concurrent utilization management process, when it comes to actual payment for services, utilization management (or appropriateness of treatment) is determined solely by the payor. The state uses an internal utilization management team to determine clinical

appropriateness for hospital level of care, a determination which, in statute, is linked to financial responsibility of the county. Allowing counties to contract with an entity to provide a third-party utilization management review on a case-by-case basis, either concurrently or retrospectively, would eliminate concerns regarding the state's conflict-of-interest in self-determining appropriateness of care when linked to potential financial burden. Based on current policy, a statutory change would need to occur to allow for this independent review to influence financial burden, either the county or the state. The independent review will also help to inform current treatment if the patient remains hospitalized, as utilization management reviews can also be productive to suggest other proven treatments.

Request participation, County and Tribal voice, in the work to "assess State-operated direct care and treatment services to the extent to which the services function as safety net services and to make recommendations with a report required to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by October 15, 2023". If DHS does not agree to the request, pursue legislative action to require DHS to include Counties and Tribes as partners in the process.

Codify the definition of Safety Net – One such definition and resource is found in the Transitioning MSOCS Residential to a Safety Net Services Final Report 12.30.2015. Appendix 2: Safety Net Definition, Attached for reference.

## Systemic Priority Alignment (highlight all that apply and explain why)

- **Equity**
- **Integrated Services**
- **Fiscal Framework**

From the GARE Toolkit (See www.racialequityalliance.org): What are the racial equity impacts of this particular decision? Who will benefit from or be burdened by it? Are there strategies to mitigate unintended consequences?

**Comments:**

## Relevant Committee (highlight all that apply and explain why)

- **Adult Services**
- **Behavioral Health**
- **Children's Services**
- **Modernization**
- **Policy**
- **Self-Sufficiency**

**Why:**
Counties are experiencing a crisis in finding services for children and adults with complex, high acuity needs and who typically are difficult to serve. Without an adequate continuum of care or the State serving as a true safety net, Counties not only must search for services out of State but are more and more frequently patching together supervision plans in County buildings or hotels.
Counties and DHS need to work in partnership to address this crisis and the work. This must span across multiple division of DHS: behavioral/mental health services, adult services, and children's services in terms of who it impacts and who we serve.
The concept and idea of a safety net and how Minnesota treats the most vulnerable people in our State is a policy issue. Minnesota has patched together a system without it being policy driven towards a system of care and continuum of care. To change this, policy factors in the various areas need to be addressed.

## Rationale/Background:

In a State directed, County administered system, the State must be the entity that provides for the safety net services for the most vulnerable adults and children residing in Minnesota.
This finding was identified in the 2013 Legislative Auditors Report and the 2015 Transitioning MSOCS Residential to a Safety Net Services Final Report 12.30.2015.

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