

# **Blueprint for a Children's Mental Health System of Care**

**Minnesota  
Children's Mental Health  
Task Force**



**Final Report**

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<http://www.dhs.state.mn.us/childint/Programs/ChildMentalHealth/CMHtaskforce.htm>

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## Summary

This report is a blueprint for repairing and re-building the Minnesota children's mental health system of care.

In February 2002, the Minnesota Department of Human Services convened a task force to:

- Agree on desired outcomes for children in need of mental health services
- Adopt a vision for the children's mental health system in Minnesota
- Develop strategies for that vision; and
- Lay a foundation for integrated interagency legislative proposals.

The task force focused on both the public and private sectors of the children's mental health system of care. Legislators, state agency commissioners and deputy commissioners, parents and experts in the field of children's mental health services delivery were involved. The task force recommended strategies to improve the children's mental health system of care within the context of the current federal and state statutory and financial frameworks. The following are some of the task force's main findings.

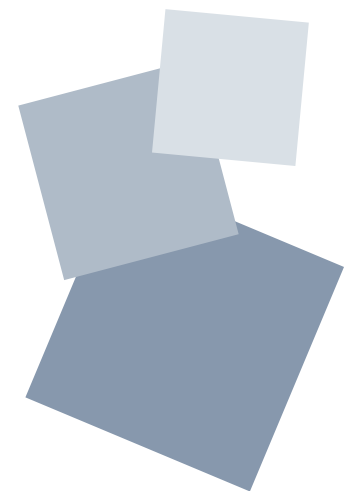
Minnesota children's mental health system of care is fragmented because of federal and state funding stream requirements and the many state agencies and other entities that have roles in the children's mental health service system. The system of care does

not serve all children and families equally. Funding has not been adequate to meet the mandates of Minnesota's Comprehensive Children's Mental Health Act, so the burden of implementing the act falls heavily on the counties. Service access disparities and parental contribution differences exist across the state. Although most people in Minnesota have some type of health insurance, health insurance plans differ and may or may not cover children's mental health services. Even though Minnesota has a parity law that requires certain health plans that offer mental health benefits to offer them at the same level as they do other benefits, this law does not apply to self-insured plans that cover more than one-third of Minnesotans. Even where the parity law applies, managed care strategies limit services.

There is a national scarcity of mental health providers, but Minnesota is feeling the crunch even more than most states. For its population, Minnesota is below the national average regarding the number of child and adolescent psychiatrists available to serve children. At the same time, the state is experiencing a severe shortage of child and adolescent psychiatric inpatient hospital beds. Minnesota's child population is becoming increasingly more culturally diverse, including many new immigrant groups. There is an increasing need for providers who understand these cultures and how mental illness is viewed and dealt with within them. Aggressive

recruitment of mental health providers, tuition incentives, review of licensure requirements for providers from other countries or states, and review of health plan provider credentialing requirements are all parts of the answer. Co-locating mental health providers and primary care providers or creating consultation networks of mental health providers with primary care providers are also solutions. But, even with these strategies, providers—especially public sector providers-- will not stay in Minnesota if they cannot make a living. Providers report that Medical Assistance reimbursement rates are too low to allow providers to break even.

Other service gaps exist. As clinical services have become scarce, Minnesota has tried to fill the clinical gap with social services. However, giving children with mental health needs what the system has does not mean that children are getting what they need. A more effective use of dollars would be to focus on clinical services that are evidence-based. There is a need for more flexibility in Medical Assistance



services packages and increased transition services and supports for children moving back into the community from out-of-home placement or from the children's mental health system to the adult mental health system. There is a need to increase early identification efforts and intervention.

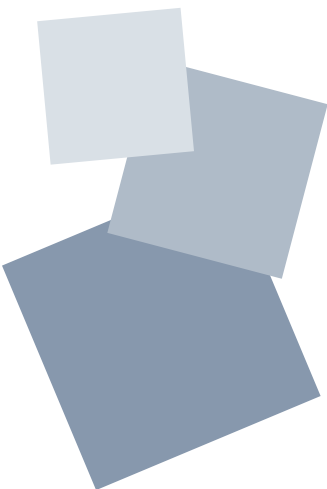
Minnesota should do more to build American Indian tribes' capacity to provide direct mental health services to American Indian children and adolescents. When tribes provide their own services, Medical Assistance reimburses those services at

100 percent of the indicated rate; there is no state share requirement. Building tribal capacity not only makes sound financial sense, but also ensures that the services provided to American Indian children are culturally competent. Tribal Medical Assistance billing for children's mental health services is still in its infancy. The task force recommended that tribes have access to more state and federal funding sources even if that requires tribes, at their option, to be designated local mental health authorities.

Families should be a cornerstone of the children's mental health system of care. Great strides have

been made to be more inclusive of families in planning services for their children as well as designing the system of care. However, more work is needed in these areas. Families also need more services, such as respite care and crisis intervention services, to help them care for their children at home and in their communities.

More information on the task force can be found online at <http://www.dhs.state.mn.us/chiladint/Programs/ChildMentalHealth/CMHtaskforce.htm>.



## Introduction

The Minnesota Children's Mental Health Task Force met during the first half of 2002 to address issues in the children's mental health system of care and develop strategies for dealing with them. This report is a summary of the task force's work.

The task force limited the scope of its discussion to the Minnesota children's mental health system of care. However, the task force recognized that mental health, physical health and social health are closely interwoven and deeply interdependent. Children's mental health is a product of genetics as well as environment—the social, political and economic realities in which children grow and learn. A complete

response to ensuring children's mental health requires a commitment by society to creating environments and policies that promote children's mental health and children's health in general. Any mental health system of care will have limited success if the environments in which children grow and learn are not conducive to good mental health. The task force believes that the responsibility for ensuring children's mental health belongs to us all.

The charge of the task force was to:

- Agree on desired outcomes for children in need of mental health services;
  - Adopt a vision for the children's mental health system in Minnesota;
  - Develop strategies to implement that vision; and
  - Lay a foundation for integrated agency legislative proposals regarding children's mental health.
- A description of the mandates, funding streams and agencies that play a role in the current children's mental health system; and
  - The complete recommendations of the task force.

This report includes:



- The task force's vision for the children's mental health system of care;
- A list of desired outcomes for children;
- A summary of the issues facing Minnesota with regard to the provision of children's mental health services;
- A summary of the recommendations of the task force; and
- Appendices containing:
  - A description of the task force;

The task force appreciates the help of the many stakeholders who participated in focus groups, surveys and interviews as well as other resource people who shared their expertise.

The children's mental health system of care in Minnesota is complex. The issues facing the children's mental health system of care cannot be addressed without an understanding of the many facets of that system gathered from a number of different viewpoints. Although stakeholders sometimes recommended different solutions for resolving issues facing the system, the issues identified by stakeholders were essentially the same.

The task force sees the implementation of these recommendations as a long-term process spanning several years. The current system of care developed incrementally over time with an emphasis on local control. Changes to the system will likely be made in the same way.



## A Mental Health System of Care

The system of care model is based on a philosophy built on three hallmark tenets:

- Mental health service systems are driven by the needs and preferences of the child and family;
- Services are community based; their management is built on multiagency collaborations; and
- The services offered, the agencies participating, and the programs generated to meet the mental health needs of the children are both responsive and sensitive to the cultural context and other characteristics of the populations being served.

To develop a system of care consistent with the theoretical model described above, a community must focus its developmental and program activities at two distinct levels:

- Infrastructure to house, organize, coordinate and manage the integration and conduct of program elements; and
- Service Delivery to undertake the services and interventions that directly serve and involve children and families.<sup>1</sup>

The principles of the system of care model underlie the Minnesota Comprehensive Children's

Mental Health Act that governs the state's county-based, publicly-funded children's mental health service system. The Minnesota Comprehensive Children's Mental Health Act ("the Children's Mental Health Act") went into effect in 1989.<sup>2</sup>

The system of care principles assume that there are services to coordinate or that resources exist to develop services. However, task force members and stakeholders agreed that the service mandates in the Children's Mental Health Act were never adequately funded. Since 1989, the state's child population has increased as well as become more culturally diverse, putting even more pressure on scarce clinical and social services resources. Although funding has increased, it has not kept pace with service demands. The Minnesota Department of Human Services is mindful that more unfunded mandates will not build or fix a system of care.

This report deals with the mental health system of care for all children in Minnesota, not just those receiving services through the county-based, publicly-funded service system. **Appendix B** outlines the frameworks, entities and agencies that constitute the current Minnesota children's mental health system of care and a description of their respective roles.



## Vision for the Minnesota Children's Mental Health System of Care

The Task Force envisions a mental health system of care serving Minnesota children and their families that:

- Identifies the mental health needs of children correctly and as early as possible, specifically targeting children at risk of developing serious mental health disorders;
- Provides services and family supports that meet children's mental health needs;
- Employs evidence-based practices;
- Ensures efficiency, accessibility, cost-effectiveness and accountability in a way that is fair and sustainable; and
- Employs public and private partnerships.

<sup>1</sup> ANNUAL REPORT TO CONGRESS ON THE EVALUATION OF THE COMPREHENSIVE COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN AND THEIR FAMILIES PROGRAM, EXECUTIVE SUMMARY, 1998. Atlanta, GA: Macro International Inc.

<sup>2</sup> The Minnesota Comprehensive Children's Mental Health Act is found at Minnesota Statutes §§245.487 – 245.4888 (2002).

## Desired Outcomes for Children

The task force believes that such a children's mental health system of care should:

- Assure recovery for as many children as possible;
- Decrease effects of symptoms on daily life;
- Assure treatment plans are based on children's individual needs and serve children in the community where possible and appropriate;
- Maximize participation and performance in appropriate learning environments;
- Recognize and resolve chemical health issues;
- Increase employment skills for older youth;
- Increase independent life skills for older youth;
- Decrease violent behavior and contacts with police and juvenile justice; and
- Have communities, schools and families that support children with mental health needs.

## The Children to be Served

There are an estimated 1,286,894 children under age 18 in Minnesota.<sup>3</sup> Children under 18 make up 26 percent of the state population.<sup>4</sup> According to federal estimates<sup>5</sup>, approximately 9 percent of children ages 9 to 17 in Minnesota have an emotional disturbance.<sup>6</sup> (Federal estimates do not exist for children under age 9.)

Sixteen percent of Minnesota children are American Indian, African American, Asian or Latino.<sup>7</sup> Since 1990, the number of children from these culturally specific groups has doubled and the number of children born to foreign-born mothers has increased.<sup>8</sup> Minnesota is the home to a growing number of immigrants and refugees from places such as Somalia, Tibet and the former Soviet Union.<sup>9</sup> Minnesota has a growing Latino population.<sup>10</sup> It also has the largest population of Somalis and the second largest Hmong populations in the nation.<sup>11</sup> More than 55,000 school children in Minnesota are non-English speakers.<sup>12</sup>

In 2001, Minnesota's county-based, publicly-funded children's

mental health system served over 20,000 children.<sup>13</sup> While American Indian, African American, Asian and Latino children make up 16 percent of the state's general child population, they make up 22.4 percent of children in the publicly-funded children's mental health system.<sup>14</sup> In Hennepin and Ramsey Counties, children from these culturally specific groups constitute over half of the children receiving mental health services from the publicly-funded system.<sup>15</sup>

The county-based, publicly-funded children's mental health system makes up only a part of the children's mental health system of care. Children also receive mental health services and supports through schools, corrections, health departments and through health plan coverage. The entities involved in the children's mental health system of care are described in **Appendix B**.

## Issues Facing the Minnesota Children's Mental Health System of Care

Stakeholders and task force members identified the following issues facing the children's mental health system of care in Minnesota:

<sup>3</sup> U.S. Bureau of the Census, Census 2000.

<sup>4</sup> Id.

<sup>5</sup> Children with Serious Emotional Disturbance: Estimation Methodology, 63 Fed. Reg. 38661 (1998).

<sup>6</sup> The federal definition of "serious emotional disturbance" is equivalent to the definition of "emotional disturbance" under Minnesota law. See Minn. Stat. § 245.487, subd. 15 (2002).

<sup>7</sup> U.S. Bureau of the Census, Census 2000.

<sup>8</sup> Barbara J. Ronnigen, Minnesota Planning State Demographic Center, So! How are the Children?, Presentation to Minnesota Department of Human Services, Children's Services Division, July 25, 2002. See also Ronnigen, Barbara J., Minnesota Planning State Demographic Center, Minnesota Planning: Immigration Trends in Minnesota, June 8, 2002. Online at <http://www.mnplan.state.mn.us/demography/DownloadFiles/immig2002.ppt>

<sup>9</sup> Id.

<sup>10</sup> Id.

<sup>11</sup> Id.

<sup>12</sup> Minnesota Planning State Demographic Center, Immigration in Minnesota: An Increasingly Diverse Population, Minnesota Department of Planning Population Notes (December 2000).

<sup>13</sup> As reported by the counties and providers to the Minnesota Department of Human Services' Community Mental Health Reporting System, Calendar Year 2001.

<sup>14</sup> Id.

<sup>15</sup> Id.

- Need for more mental health service providers;
- Needs of families and need for more family involvement;
- Need for culturally competent providers and services;
- Need for use and dissemination of evidence-based practices;
- Need for greater access to services;
- Need to recognize and support tribal capacity to provide services;
- Need for increased quality assurance and oversight;
- Need for more effective coordination;
- Need to identify children with mental health needs early; and
- Need for improvements in health plans and health plan coordination with other systems.

### ● Need for More Mental Health Service Providers

Stakeholders identified a scarcity of child and adolescent psychiatrists. The ratio of child and adolescent psychiatrists per 100,000 children for the United States as a whole is 6.73.<sup>16</sup> For Minnesota, the ratio is 4.6 per 100,000 children.<sup>17</sup> Stakeholders noted a particular scarcity of providers from culturally diverse backgrounds. There is a large need

for such providers because of the number of children from such backgrounds in the child population and in the population served by the public sector in particular.

The scarcity of child and adolescent psychiatrists has been a documented nationwide problem for over two decades.<sup>18</sup> There are several reasons for this scarcity. Despite an increasing child population, the number of residents in child psychiatry has remained relatively static over the years.<sup>19</sup> The number of American Indians, African Americans and Latinos entering any type of psychiatric residency programs has remained consistently low.<sup>20</sup> The current cost of becoming a psychiatrist drives many new practitioners into jobs that will pay enough to recoup the costs of education.<sup>21</sup> Stakeholders indicated that current reimbursement rates are too low to make provision of psychiatric services for Medical Assistance patients profitable. Additionally, not all health plans cover mental health services.

Current health plan practices may also hinder hiring of new psychologists and other mental health professionals. Many health plans require certain periods of work experience before the health plans will credential these profes-

sionals to work under their plan, even though these professionals are licensed by the state. However, without being credentialed by health plans, new mental health professionals have difficulty obtaining work experience.

The current patient access criteria are reflective of the scarcity of providers in the state. Minnesota law requires health maintenance organizations (HMOs) to meet certain geographic distance criteria to ensure patient access to services but does not require any per capita access criteria.<sup>22</sup> State insurance programs, such as MinnesotaCare and Pre-paid Medical Assistance Program (PMAP), contract with HMOs to provide services. However, none of these state contracts contain per capita access criteria.

Because of the shortage of child psychiatrists and psychologists, other professionals such as primary care physicians, pediatricians, bachelor's and master's level mental health professionals, teachers and school professionals provide the majority of children's mental health referral and treatment. However, there are concerns that none of these professions have the expertise to properly identify and treat children's mental health issues.<sup>23</sup>

<sup>16</sup> Christopher Thomas, National Distribution of Child and Adolescent Psychiatrists, *Journal of the American Academy of Child and Adolescent Psychiatry* 9, 11 (January 1999). Also online at [http://findarticles.com/cf\\_0/m2250/1\\_38/53643805/print.jhtml](http://findarticles.com/cf_0/m2250/1_38/53643805/print.jhtml)

<sup>17</sup> Id. at 12.

<sup>18</sup> REPORT OF THE AACAP TASK FORCE ON WORK FORCE NEEDS: MEETING THE MENTAL HEALTH NEEDS OF CHILDREN AND ADOLESCENTS: ADDRESSING THE PROBLEMS OF ACCESS TO CARE, *American Academy of Child and Adolescent Psychiatry*, June 1, 2001.

<sup>19</sup> 2000-2001 RESIDENT CENSUS, *American Psychiatric Association Office of Graduate and Undergraduate Education*, November 2001, Table 10. Online at [http://www.psych.org/med\\_ed/census\\_main.cfm](http://www.psych.org/med_ed/census_main.cfm)

<sup>20</sup> Id. at Table 4.

<sup>21</sup> REPORT OF THE AACAP TASK FORCE ON WORK FORCE NEEDS, ETC., *supra* note 18.

<sup>22</sup> Minn. Stat. § 62D.124 (2002)

<sup>23</sup> U.S. Department of Health and Human Services, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL, Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health, 138 (1999).



## ● Needs of Families and Need for More Family Involvement

Family involvement is a cornerstone for the children's mental health system of care. Plans for children must be child-centered and family-driven to be effective. Parent stakeholders said they often felt excluded or left out of decision-making processes, not only with regard to planning services for their children, but also in local advisory councils and collaborative boards. Families indicated that they needed to be involved in all aspects of planning, including planning regarding service design and delivery.

Parent stakeholders expressed a need for greater access to family-friendly services such as respite care, crisis services and stipends to cover expenses of travel to meetings. Parents were concerned that service availability differed county-to-county. Parents also voiced concern that the rates required for parental contribution for services vary county-to-county. This is because Minnesota's children's mental health system is county based and largely funded from local property taxes. This results in families in one county paying more for services than similarly situated families in another county.

## ● Need for Culturally Competent Providers and Services

Both social interaction and mental illness deal in the currency of behavior. Behavior is the founda-

tion of social interaction and often the expression of cultural identity. Behavior also may be the outward manifestation of mental illness. The ability to understand how mental illness can manifest itself in behavior within a particular social and cultural context is a part of cultural competency. Cultural competency is not only necessary for accurate diagnoses, but for provision of treatment and



interventions at all stages. Cultural competence is a means of taking a holistic approach to the needs of families.

The population of children 18 and under is far more culturally diverse than the population of people over 18.<sup>24</sup> The number of children from diverse cultural backgrounds is growing; and in particular urban areas, children from so-called "minority populations" are actually the majority.

Stakeholders reported the following needs:

- For an infusion of culturally competent practices statewide in all aspects of treatment and diagnosis;

- To recruit more culturally specific and culturally competent providers;
- To pay those providers for providing consultations on culturally competent practices; and
- To obtain reimbursement for culturally specific or culturally traditional services.

## ● Need for Use and Dissemination of Evidence-based Practices

Evidence-based practices are those that have consistently shown improved clinical or functional outcomes for children with emotional disorders in controlled trials in settings realistic enough to allow generalization of their effectiveness. Promising practices are those that have similarly demonstrated effectiveness in one or a few settings, and should now be tested for additional generalization capability.

There is a great deal of knowledge about "what works" in children's mental health with particular populations.<sup>25</sup> However, "what works" is not necessarily what is done. Task force members heard from Gayle Porter, Ph.D. (psychologist) and Dr. Mary Tierney (pediatrician) from the American Institutes for Research regarding evidence-based practices, cultural competence and integrating primary care with mental health. Task force members also developed a special subgroup to discuss specific recommendations for promulgating and promoting evidence-based practices.

<sup>24</sup> Barbara J. Ronnigen, *supra* note 8.

<sup>25</sup> Information on evidence-based practices in children's mental health can be found in a number of places including:

- The Center for Advancement of Children's Mental Health, Division of Child & Adolescent Psychiatry, Columbia University. See web site at <http://www.kidsmentalhealth.org>.
- The National Institute of Mental Health (online at <http://www.nimh.nih.gov>).
- Michael Jellinek, M.D., Bina P. Patel, M.D., and Mary C. Froehle, Ph.D., eds., *Bright Futures in Mental Health*, National Center for Education in Maternal and Child Health, Georgetown University (2002) (online at <http://www.brightfutures.org/mentalhealth/index.html>).

Task force members noted that a perennial scarcity of clinical services has led counties and collaboratives to fill the clinical service gap with social services. These services may be what the system has to offer, but they might not be what work best for a particular child or a particular diagnosis. Using practices and services that are evidence-based is an efficient use of resources.

Task force members emphasized that the field of evidence-based practices is constantly changing. New and improved practices will come to light. Additionally, not everything will be recognized as an evidence-based practice even though it is important and effective. Not everything that makes good sense is conducive to measurement. Task force members indicated that there must always be room for promising practices or best practices within a mental health system of care.

### ● Need for Greater Access to Services

Lack of access to services is a particularly pressing problem because of the nature of children's mental health diagnoses. Untreated or under-treated mental health problems easily escalate to create functional difficulties in school and community—problems that intensify children's distress and create increasingly complicated problems for their families. When families cannot readily access appropriate mental health services for their children, the effects are felt

everywhere from the children's classroom to the parents' jobs. Without proper treatment, these problems can become worse as children become adults.

Stakeholders, particularly families, expressed needs for greater service availability in order to meet children's mental health needs. The issue of greater access to services touched on numerous aspects of the current service system, including:

- The need for expedited access to and flexibility of service components in Medical Assistance service packages;
- Lack of uniformity in the types of services available across the state;
- Shortages of specialty care providers and programs for children and adolescents with particular mental health needs;
- Long waiting times for services;
- Lack of choice of providers to correspond to families' cultural needs or treatment preferences; and
- Insufficient lengths or intensity of treatment.

Some county social services agencies noted that, while changes to the Medical Assistance service array will help make services accessible for those children eligible for Medical Assistance, access for children who are not eligible will still be an issue. More access

to mental health services under private insurance is also necessary to meet children's mental health needs in the system of care.

Stakeholders noted severe access problems for the most intensive services such as inpatient psychiatric hospitalization. They also noted severe access problems regarding services such as day treatment, crisis response and respite, which are designed to avert hospitalization and support children and their families in their homes and communities. County social service directors also report rapid increases in applications for children's mental health case management. Stakeholders also noted a scarcity of "transition services"—services designed to help children transition from the children's mental health system into adult life, which might or might not include involvement with the adult mental health system.

The shortage of adolescent and child psychiatric inpatient beds is particularly dire. There are approximately 150 adolescent psychiatric inpatient beds state-wide for a population of over 1.2 million children. There are only two facilities in the state designed to serve children under age 13. Together they have a 34-bed capacity. Recent news articles have documented the drastic need for adolescent and child psychiatric inpatient beds.<sup>26</sup> At the same time, there has been an increased demand for these services. The Minnesota Hospital and Health Care Partnership (MHHP) noted

<sup>26</sup> Tom Majeski, Adolescent Mental Health Care Faces Crisis: Metro Youths Sent to Duluth, Other Cities, St. Paul Pioneer Press, May 28, 2002; Josephine Marcotty and Glenn Howatt, Health Plans, Hospitals to Pay for More Psychiatric Beds, Star Tribune, September 18, 2002.

that adolescent psychiatric hospital admissions grew by 24 percent between 1999 and 2002.<sup>27</sup>

Stakeholders noted serious mental health service access issues for children in the juvenile justice system. All mandated services under the Minnesota Children's Mental Health Act are available to children in the juvenile justice system. However, stakeholders indicated that probation officers need more training regarding how to access those services. Stakeholders also said there were difficulties in transitioning children from juvenile correctional facilities to the community because of, among other things, scarce case management follow-up services as well as administrative difficulties in re-establishing children on Medical Assistance.

### ● **Need to Recognize and Support Tribal Capacity to Provide Services**

**Appendix B** summarizes the history of tribes, their special status as sovereign nations and the laws and service frameworks affecting mental health services for American Indian children.

Perhaps in no other area is the need for infrastructure and mental health service capacity building as great as it is for tribes. And perhaps in no other area is there better federal support for doing so. As discussed in **Appendix B**, if tribes themselves provide direct Medicaid-eligible mental health services, the federal government reimbursement rate is 100 percent.

The state does not need to make a 50 percent match. Therefore, from a purely economic standpoint, it is to the benefit of both the state and the tribes to build tribal capacity to provide direct services. But more importantly, building tribal infrastructure helps to increase the system's capacity to provide culturally competent services for American Indian children. To increase mental health service capacity to American Indian children and increase the capacity of the mental health system of care as a whole, Minnesota must recognize tribes as a major part of the infrastructure for delivering mental health services to American Indian children.

The Minnesota Department of Human Services is already providing technical assistance to tribes regarding Medical Assistance. However, infrastructure and capacity building would be aided by

- Making other state funds and grants available to tribes;
- Allowing tribes, at their option, to be recognized as the local mental health authority, making them eligible to apply for certain state and federal grant opportunities;
- Supporting the development of American Indian provider referral networks; and
- Supporting tribal efforts to get members enrolled in private insurance, state health plans and Medical Assistance.

### ● **Need for Increased Quality Assurance and Oversight**

One of the key system issues creating frustration for families, providers and policymakers lies in the complexity of the mental health service delivery and funding system. The underlying structure of the Minnesota children's mental health system of care is outlined in **Appendix B**. Quality assurance and oversight become challenging in a complex system because the complexity can obscure structures of accountability and fragment attempts to assure quality of services.

Under the Children's Mental Health Act, county social service agencies are the local mental health authorities, and the Minnesota Department of Human Services is the state mental health authority. Stakeholders requested that counties, collaboratives and the state establish closer and more clearly defined roles and responsibilities to assure access to mandated children's mental health services, accountability for compliance with service requirements, identification of service gaps and opportunities for service enhancement and coordination. Mental health professionals as private providers or under health plans or Medical Assistance provide core clinical mental health services. Stakeholder concerns argue the need for enhanced quality assurance and oversight activities in both the private and public sectors as well as between them. Training for providers on compliance with Medical Assistance requirements is also needed.

<sup>27</sup> Josephine Marcotty and Glenn Howatt, *supra* note 26.



## ● Need for More Effective Coordination

The mental health system of care model, by its very definition, presumes effective coordination of services. Meaningful access to mental health services requires that public agencies (including local public health, social services, education and corrections) as well as health care providers are equipped to coordinate with and refer to the social and clinical services that constitute the local system of care.

Stakeholders noted gaps in service coordination and systems coordination between various agencies and entities including schools, corrections and health plans. The section below entitled “Need for Improvements in Health Plans and Health Plan Coordination with Other Systems,” deals specifically with recommendations regarding coordination with health plans.

A system of care based on local control can increase the complexity of service coordination.

Children’s mental health collaboratives and family services collaboratives were created to facilitate coordination among systems at the local level. Even though collaboratives have resulted in increased flexibility of services and increased coordination, stakeholders felt there were still improvements to be made to collaboratives. The Minnesota Department of Human Services, in collaboration with the University

of Minnesota’s Humphrey Institute of Public Affairs, will submit a report in January 2003 to the legislature regarding the status of children’s mental health and family services collaboratives in Minnesota. This study will provide policymakers with more in-depth information and recommendations regarding improvements to collaborative operations.

## ● Need to Identify Children with Mental Health Needs Early



Families, providers and other stakeholder groups offered messages consistent with research literature in children’s mental health:

- Many mental health problems can be identified and treated much earlier than they typically are;
- Early intervention is effective and cost-effective; and
- Untreated or under-treated mental health problems get

worse over time, causing increasing and additional complications for families, schools and communities.

Both locally and nationally, correctional systems in particular are becoming default mental health providers—a direct consequence of a lack of early intervention.<sup>28</sup>

Early identification must be accurate if appropriate interventions are to be selected and effective. Stakeholder groups noted critical training issues among mental health professionals as well as in allied professions. The task force debated how to increase numbers of providers while also assuring appropriate training and experience credentials for those who provide diagnostic evaluations for children. Critical to increasing capacity for this vital function is the establishment and maintenance of closer ties between the research community in Minnesota’s colleges and universities, and the public and private mental health service delivery systems.

## ● Need for Improvements in Health Plans and Health Plan Coordination with Other Systems

Most people in Minnesota have some type of health insurance.<sup>29</sup> Most mental health care that Minnesotans receive is paid for through private insurance from employer-based or commercial health insurance plans. A brief

<sup>28</sup> U.S. Public Health Service, REPORT OF THE SURGEON GENERAL’S CONFERENCE ON CHILDREN’S MENTAL HEALTH: A NATIONAL ACTION AGENDA, Washington, D.C. Department of Health and Human Services, 11 (2000).

<sup>29</sup> INSURANCE FOR BEHAVIORAL HEALTH, Office of the Legislative Auditor, State of Minnesota, 13 (February 12, 2001).

description of health insurance and the Minnesota laws governing it is in **Appendix B**.

Stakeholders said that there are often long waits to see mental health providers. Additionally, they complained of “phantom providers”—those providers who were on the health plan’s list of eligible providers but who accept no new clients.

Stakeholders complained about inadequate benefit sets—plans that either didn’t cover mental health services or didn’t cover them as well as stakeholders would have liked. Minnesota has a mental health parity law that requires certain health plans offering mental health benefits to offer them at the same level as they do other benefits.<sup>30</sup> Some plans, however, do not offer mental health benefits. Additionally, Minnesota’s parity law does not apply to self-insured

plans. About 37 percent of Minnesotans are covered by self-insured plans.<sup>31</sup> Self-insured plans are governed by the federal Employee Retirement Income Security Act (ERISA).

Stakeholders also complained that health benefit sets and provider networks are not always the same plan-to-plan. If parents change jobs, their children’s psychiatrists or other providers might have to change as well, affecting continuity of services. Stakeholders expressed distress at the consequences for treatment when needing to make such changes. This situation reflects the evolution of the current employer-based health care system where benefits are selected and paid for at the employer level, not at the employee level.

Stakeholders expressed confusion about complaints and appeals. Because children’s mental health

services can be provided through a number of sources, including private insurance, a number of appeal processes exist. Additionally, although statute governs the time health plans have to respond to complaints and “clean” claims, stakeholders said that some health plans were not responding to complaints or claims in a timely manner. Without a response or denial, patients have nothing from which to appeal.

The Minnesota Council of Health Plans made a presentation at the July 24, 2002 task force work group meeting. Among other things, task force members and health plans discussed the need to wed mental health services and early identification with primary care. Health plans and state agencies voiced a commitment to work together on children’s mental health service issues.

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<sup>30</sup> Minn. Stat. §62Q.47 (2002).

<sup>31</sup> INSURANCE FOR BEHAVIORAL HEALTH, *supra* note 29.



## Summary of Task Force Recommendations

The following is a summary of the task force's proposed strategies for addressing each of the issues facing the Minnesota children's mental health system of care. The full list of strategies is in Appendix C.

### ● Need for More Mental Health Service Providers

- Grow, recruit and retain psychiatrists and psychologists by providing funding for on-site training, developing resources for loan re-payment, enhancing recruitment efforts, reviewing licensing requirements for providers from other states and working on strategies (including increasing reimbursement rates) to ensure existing providers can practice profitably.
- Work with health plans to eliminate barriers to credentialing mental health professionals.
- Increase contact between primary care and mental health practitioners either through consultant networks or co-location of mental health and primary care personnel.
- Provide more training to primary care providers, school personnel, juvenile corrections personnel and other professionals dealing with children's mental health.
- Support development of informal supports including families, friends, neighbors and community organizations.



### Needs of Families and Need for More Family Involvement

- Eliminate barriers to family, parental and child involvement and participation in treatment and in system design.
- Support parent leadership, liaison and mentor activities.
- Increase access to respite and crisis services.
- Support other services that encourage family involvement and access to services such as transportation supports.
- Review parental fee contribution structure.

### ● Need for Culturally Competent Providers and Services

- Recruit more culturally diverse providers.
- Provide more cultural competency training across all disciplines.
- Incorporate traditional and cultural elements into treatment plans.
- Seek Medical Assistance and insurance reimbursement

for culturally specific consultations.

- Engage racial/cultural/age/gender groups in design process to reduce disparities.
  - Promote cultural competency guidelines and hold state grantees and state-contracted health plans accountable for provision of culturally competent services.
- ### ● Need for Use and Dissemination of Evidence-based Practices
- Establish links with research centers.
  - The Minnesota Department of Human Services should spearhead a multiagency approach to disseminating evidence-based practices, involving families and diverse communities in all aspects of this effort.
  - Create incentives for utilization of evidence-based practices through funding and contracting.
  - Update clinical standards and practices in residential treatment facilities.
  - Emphasize development and retention of clinical resources.

### ● **Need for Greater Access to Services**

- Make existing services, particularly those reimbursed through Medical Assistance, more readily available and more flexibly delivered.
- Expand availability of partial hospitalization and inpatient psychiatric bed capacity.
- Work with counties to expand specific services such as case management, transition services, crisis and respite care.
- Coordinate social service and educational resources to offer school and community-based services more widely: expand school-based mental health supportive services and after-school and summer services for children with emotional disturbances.
- Ensure access to children's mental health services for those children primarily served in or identified by other systems by providing training and technical assistance to probation officers, school special services personnel and local public health in service access and coordination.
- Assess whether a "checkbook" model similar to that used in the developmental disability area would be possible and advantageous for providing children's mental health services under Medical Assistance.

### ● **Need to Recognize and Support Tribal Capacity to Provide Services**

- Work with tribes to enhance tribal ability to provide direct services.
- Work with tribes to enhance tribal ability to bill Medical Assistance.
- Allow tribes, at their option, to be designated the local mental health authority.
- Allow tribes access to all state grant funds and Local Collaborative Time Study funds.
- Increase technical assistance to tribes regarding outcomes, data collection and best practices.
- Support creation of a referral network of American Indian providers.
- Use the American Indian Mental Health Advisory Council to review the managed care organization state contracts for the ability to provide culturally competent services.
- Support tribal efforts enroll members private insurance, state health plans (MinnesotaCare, etc.) and Medical Assistance.

### ● **Need for Increased Quality Assurance and Oversight**

- Provide the Minnesota Department of Human Services, in conjunction with other state agencies serving children and adolescents, the capacity to develop and monitor best practices in compliance with mandates for access to children's mental

health services.

- Ensure quality of children's mental health services provided by or facilitated through the children's mental health collaboratives and the family services collaboratives.
- Develop a group to further analyze accountability in a state-supervised, county-administered system under the current children's mental health act and discuss if and how the act should be changed.
- Increase training for potential Medical Assistance providers as well as compliance and oversight mechanisms.

### ● **Need for More Effective Coordination**

- Coordinate technical assistance from state agencies with roles in children's mental health services delivery: state leadership should provide unified vocabulary, tools and services that bridge agencies, purchasing and records policies.
- Make outcomes reporting uniform and systematized across state agencies.
- Coordinate identification, referral and assessment activities across agencies.
- Integrate appropriate transition services planning (e.g., child to adult, juvenile justice to community) into service systems and case planning at all levels.

## ● Need to Identify Children with Mental Health Needs Early

- Increase public awareness of children's mental health needs: fund anti-stigma campaigns; promote media accountability for portrayals of mental health issues; target outreach to culturally specific groups who may be under-served.
- Educate providers and policymakers regarding evidence-based practices and tools for mental health screening: establish common standards for screening procedures and tools across agencies, including their developmental and cultural appropriateness.
- Train the existing mental health workforce in screening, assessment and diagnosis: establish training and experience criteria for persons who conduct screening; train school-based staff in communicating mental health screening or assessment needs to families; train mental health professionals in evidence-based assessment procedures, including cultural appropriateness, for diagnosing disorders of childhood and adolescence.
- Create or expand targeted venues for mental health screening: establish regular screening schedules in special needs child care facilities, home visiting programs, child protection, juvenile corrections, and in conjunction with chemical health assessments.

- Create an incentive for agencies to invest in front-end services by allowing them to retain cost savings from operations to be used for front-end services the next year.

## ● Need for Improvements in Health Plans and Health Plan Coordination with Other Systems

The Minnesota Department of Human Services and other state agencies should work with health plans to:

- Incorporate culturally competent and family driven standards.
- Link mental health screening and assessment with primary care and develop reimbursement schemes that make mental health screening economically viable.
- Enhance multiagency coordination and develop reimbursement schemes that encourage coordination.
- Support and assist in the development of public relations campaigns regarding children's mental health issues and the importance of insurance and appropriate mental health benefit sets.
- Enhance communication regarding actual access and service availability to consumers.
- Create a forum at which public and private mental health insurers/providers exchange information regarding evidence-based practices.
- Consolidate regulation of managed care and private

insurance through consistent standards enforced by one state agency.

- Streamline and consolidate complaint and appeal process for insurance and Medical Assistance.
- Reduce administrative burdens.
- Set targeted goals to further reduce the rate of uninsured children, particularly for groups where disparities exist.
- The Minnesota Departments of Commerce and Health should increase enforcement of statutes requiring insurers to respond to claims and complaints within a timely manner and review those statutes to determine whether changes need to be made.



- The Minnesota Department of Human Services, working with health plans and others, should encourage Congress to require mental health coverage parity under Employee Retirement Insurance Security Act (ERISA) plans.

# Appendix A

## Minnesota Children's Mental Health Task Force Membership

### Senators:

Linda Berglin  
Leo T. Foley  
Sheila M. Kiscaden

### Representatives:

Jim Abeler  
Fran Bradley  
Mindy Greiling  
Alice Seagren

### State Agency Commissioners:

Linda Anderson, Minnesota Department of Human Services\*  
Jim Bernstein, Minnesota Department of Commerce  
Sheryl Ramstad Hvass, Minnesota Department of Corrections  
Christine Jax, Minnesota Department of Children, Families and Learning  
Jan Malcolm, Minnesota Department of Health  
Michael O'Keefe, Minnesota Department of Human Services\*  
Pamela Wheelock, Minnesota Department of Finance

### Work Group:

Andrea Ayres, Children's Subcommittee, Minnesota State Advisory Council on Mental Health  
Anne Barry, Deputy Commissioner, Minnesota Department of Finance  
Scott P. Borchert, Director, Enforcement Division, Minnesota Department of Commerce  
Julie Brunner, Deputy Commissioner, Minnesota Department of Health  
Mark Carey, Deputy Commissioner, Minnesota Department of Corrections  
Karen Carlson, Assistant Commissioner, Minnesota Department of Children, Families and Learning  
Dr. Glenace Edwall, Director, Children's Mental Health Division, Minnesota Department of Human Services  
Gayle Hallin, Assistant Commissioner, Minnesota Department of Health  
Mary Kennedy, Medicaid Director, Minnesota Department of Human Services  
Candy Kragthorpe, Mental Health Programs Coordinator, Minnesota Department of Health  
Vernon LaPlante, Tribal Relations Representative, Minnesota Department of Human Services  
Steve Lepinski, Executive Director, Washburn Child Guidance Center  
Elliott R. Phillips, M.D., Staff Psychiatrist, HealthPartners  
Bill Pinsonnault, Minnesota Association of County Social Services Agencies  
Betty Poitra, Mental Health Program Consultant, Minnesota Department of Human Services  
James Schowalter, Finance Agency Coordinator, Minnesota Department of Finance  
Cindy Shevlin-Woodcock, Minnesota Department of Children, Families and Learning  
Carolyn Strnad, parent  
Erin Sullivan Sutton, Assistant Commissioner, Minnesota Department of Human Services  
Tim Walsh, Director, Juvenile Services, Minnesota Department of Corrections  
Dawn Witthaus, parent  
Barbara Yates, Deputy Commissioner, Minnesota Department of Children, Families and Learning

\* Commissioner O'Keefe, and later Acting Commissioner Anderson, served as chairs of the task force.



## Background on the Task Force

Over the past several years, the Minnesota Department of Human Services has been engaged in a review of the children's mental health system through the "Toward Better Mental Health Initiative" and through public hearings conducted by the Minnesota State Advisory Council for Mental Health. In February 2002, Commissioner Michael O'Keefe convened the Minnesota Children's Mental Health Task Force. The task force's charge was to

- Agree on desired outcomes for children in need of mental health services.
- Adopt a vision for the children's mental health system in Minnesota.
- Develop strategies to implement that vision.
- Lay a foundation for integrated agency legislative proposals regarding children's mental health.

The task force brought together a core group of legislators, commissioners, deputy commissioners and experts in the children's mental health system. The task

force's work group, composed of all members except agency commissioners and legislators, met separately nine times during the life of the task force to review stakeholder recommendations and compile information. The legislators and agency commissioners joined the work group for four additional meetings at the beginning, middle and end of the task force to review progress and offer guidance and input.

The task force's work group also developed a statement of shared values to preface their discussions regarding the Minnesota children's mental health system of care. The task force utilized reports and publications of previous initiatives and public hearings and actively engaged stakeholders from across the state. The meeting summaries for all meetings as well as a resource reading list is on line at the task force's web site: <http://www.dhs.state.mn.us/childdint/Programs/ChildMentalHealth/CMHtaskforce.htm>.

## Stakeholders

The Minnesota Department of Human Services contracted with the University of Minnesota's Institute on Criminal Justice to collect stakeholder input. The department also collected stakeholder input on its own. Stakeholder input was collected either by focus group, interview or survey. The following groups and individuals were contacted for stakeholder input.

American Indian Mental Health Advisory Council  
Children, Youth and Families Consortium,  
University of Minnesota  
Children's Committee of the Minnesota Association  
of County Social Service Agencies (MACSSA)  
Children's mental health case managers from across  
the state  
Children's mental health collaboratives  
Children's Justice Initiative  
Children's Law Center of Minnesota  
Education Minnesota teachers  
Local advisory councils  
Local public health authorities  
Mental Health Legislative Network (which includes  
Minnesota Chapter of the National Alliance for  
the Mentally Ill (NAMI); the Minnesota Disability  
Law Center-Mental Health Advocacy Project;

Minnesota Association of Community Mental  
Health Programs; Mental Health Association of  
Minnesota)  
Minnesota Association for Children's Mental  
Health (MACMH)  
Minnesota Association of Community  
Corrections Act Counties (MACCCAC)  
Minnesota Child Psychologists and Child and  
Adolescent Section of the Minnesota Psychiatric  
Association  
Minnesota Council of Child Caring Agencies  
(MCCCA)  
Minnesota Department of Children, Families and  
Learning's Youth Advisory Council  
Minnesota Department of Human Services,  
Children's Mental Health Division staff  
Minnesotans for Improved Juvenile Justice  
Ombudsman for Mental Health and  
Mental Retardation  
Parent Advocacy Coalition for Educational Rights  
(PACER)  
Parent Leadership Network  
Special Services Providers in Schools  
Specialty Provider Network  
Windmill Project



## Presentations

The task force's work group heard the following presentations:

Don Allen, Minnesota Department of Human Services, Children's Mental Health Division, on funding of the children's mental health system.

Scott P. Borchert, Minnesota Department of Commerce, on the role of the Department of Commerce in the children's mental health system and Minnesota law regarding mental health insurance parity provisions.

Debra Davis-Moody, Minnesota Department of Human Services, Children's Mental Health Division, on the Specialty Providers Network.

Minnesota Council of Health Plans (including Medica, Blue Cross and Blue Shield/Blue Plus of Minnesota, First Plan, HealthPartners, Metropolitan Health Plans, PreferredOne, Sioux Valley, UCare Minnesota) regarding the work of the task force and proposed recommendations.

Dr. Gayle Porter, Ph.D. (psychologist) and Dr. Mary Tierney, M.D. (pediatrician) from American Institutes for Research, on cultural

competence and integration of primary care with mental health.

Cindy Shevlin-Woodcock, Minnesota Department of Children, Families and Learning, on the work of the Special Education Leadership Committee.

Elaine Timmer, Assistant Commissioner, Minnesota Department of Human Services, State Operated Services, on the Public Behavioral Health Systems Project.

## Finance and Accountability Subgroups

In addition to task force work group members, the following persons participated:

**Finance Subgroup:** Tom Delaney, Minnesota Department of Children, Families and Learning; Barb Johnson, Minnesota Department of Corrections; and Kent Peterson, Minnesota Department of Health

**Accountability Subgroup:** Judith Brumfield, Minnesota Association of County Social Services Agencies and Scott County Social Services. Ann Sessoms, Minnesota Department of Human Services, served as facilitator for the Accountability Subgroup.

## Appendix B

### Roles and Responsibilities in Service Delivery: The Structural Underpinnings of the Current Children’s Mental Health System of Care

When discussing the children’s mental health system of care, people often say: “The money should follow the child.” Two concepts are inherent in this statement:

- The need for individualized services; and
- Frustration with the strings attached to money paying for those services.

In essence, people want a system that will pay for services that fit children’s needs, not fit children into the services that can be paid for. But it is a fact that money (particularly federal money) comes with strings attached and criteria for eligibility. Additionally, roles and relationships around money and oversight at the federal, state and local level drive forces that can limit services or the responsibility to provide them. The Minnesota children’s mental health system of care is complex. There are several state and federal statutory frameworks and many agencies and entities that play roles in the provision of children’s mental health services in Minnesota. Additionally, an emphasis on local control has resulted in a variety of organizational structures and funding methods across the state for some funding streams and services. The following section discusses the mandates, funding streams and methods of accountability within each of these agencies, entities and frameworks.

#### ● State and County Social Services

Minnesota has a state-supervised, county-administered social services system. The Minnesota

Department of Human Services is the state mental health authority. The county social services agencies and their respective county boards are the local mental health authorities. The counties are responsible for providing, contracting for and managing publicly-funded mental health services for their residents. The Minnesota Department of Human Services is responsible for licensing providers, managing federal and state grants, administering federal reimbursement programs such as Medicaid and supervising county administration of mental health services.

The Minnesota Comprehensive Children’s Mental Health Act (“Children’s Mental Health Act”) mandates that counties must develop a children’s mental health service system that includes the following services:

- Education and Prevention;
- Mental Health Identification and Intervention;
- Emergency Services;
- Outpatient Treatment;
- Family Community Support Services (includes day treatment);
- Residential Treatment;
- Acute Hospital Inpatient Treatment Services; and
- Case Management.<sup>32</sup>

County social services agencies must provide case management and family community support services to meet the needs of children in the county with severe emotional disturbances (SED).<sup>33</sup> However, neither the Commissioner of Human Services nor the counties are required to fund any services beyond the limits of legislative appropriations.<sup>34</sup>

County property taxes, along with a combination of state and federal dollars and insurance, pay for children’s mental health services. State funding has not

<sup>32</sup> Minn. Stat. § 245.4875, subd. 2 (2002)

<sup>33</sup> State law defines “severe emotional disturbance” as follows:

“For the purposes of eligibility for case management and family community support services, “child with severe emotional disturbance” means a child who has an emotional disturbance and who meets one of the following criteria:

- (1) the child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for an emotional disturbance; or
- (2) the child is a Minnesota resident and is receiving inpatient treatment or residential treatment for an emotional disturbance through the interstate compact; or
- (3) the child has one of the following as determined by a mental health professional:
  - (i) psychosis or a clinical depression; or
  - (ii) risk of harming self or others as a result of an emotional disturbance; or
  - (iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or a psychic trauma within the past year; or
- (4) the child, as a result of an emotional disturbance, has significantly impaired home, school or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.” Minn. Stat. § 245.487, subd. 6 (2002)

been sufficient to meet the mandates of the Children’s Mental Health Act. Therefore, the burden of implementing the Act falls heavily on counties. A feature of Minnesota’s state-supervised, county-administered system is that service arrays and parental contribution responsibilities<sup>35</sup> vary from county to county due to the differing property tax bases in each. As a result, counties with a higher tax base will have more services or be able to serve more children than smaller or poorer counties using local dollars. Many children in poverty are also American Indians or children from other diverse communities. Therefore, this structure can affect children from diverse backgrounds disproportionately.

A review of denial of service from county social services is administrative and is heard through the Minnesota Department of Human Services. The Act does not create a right of private action by individuals. As a last resort, the Minnesota Department of Human Services can assume control of the local mental health authority.

### ● **Medical Assistance**

“Medical Assistance” is Minnesota’s name for the federal “Medicaid” program. Medical Assistance is composed of federal, state and local shares and pays for medical services, including some mental health services. The Minnesota Department of Human Services administers the Medical Assistance program, including setting policy, processing claims for fee-for-service beneficiaries and ensuring compliance, among other things. The Minnesota Department of Human Services contracts with health plans for the health care of most seniors, families and children. Persons eligible due to disability, including disabled children, are not required to enroll in health plans but may choose to do so. A minimum service package is required under federal law. States may elect, with federal approval, to augment this minimum benefit set, and Minnesota has worked to create a package of benefits specifically to benefit children with serious emotional disturbances.

Children must meet certain income and/or disability requirements to qualify for Medical Assistance.

Eligibility is determined at the local level through use of the Minnesota computerized eligibility system (MAXIS).

Medical Assistance is paid on a fee-for-service basis or at a capitated rate (pre-paid per member per month rate) through managed care contracts with health plans or counties. Under the prepaid Medical Assistance program (PMAP), the Minnesota Department of Human Services contracts with health plans to provide Medical Assistance services at a capitated rate. Under the county-based purchasing method (CBP), the department contracts with a county or group of counties to provide Medical Assistance coverage at a capitated rate.

Medical Assistance for children’s mental health services, for the most part, is made up of half state money and half federal money. However, counties are responsible for a certain percentage of the following services provided under Medical Assistance, even under PMAP and CBP: 25 percent of the rate for regional treatment center treatment; 50 percent of the rate for mental health targeted case management (Rule 79); and 50 percent of the rate for residential treatment.

Once an individual is enrolled in the Medical Assistance program, the individual is entitled to benefits covered under the program. Under fee-for-service coverage, there is an administrative appeal process through the Minnesota Department of Human Services with recourse to the court system. Where Medical Assistance services are provided under managed care, there is an internal appeal process through the health plan as well as an administrative appeal process through the Minnesota Department of Human Services with recourse to the court system. Complainants do not have to exhaust the health plan’s complaint process before appealing to the Minnesota Department of Human Services.

### ● **MinnesotaCare**

MinnesotaCare is a publicly subsidized health insurance program. The program is available to families with children whose income is at or below 275 percent of the federal poverty guidelines and who

<sup>34</sup> Minn. Stat. § 245.486 (2002)

<sup>35</sup> Minnesota Statutes § 245.481 (2002) governs client and parental fee contributions.

meet other criteria. Premiums are charged on a sliding fee scale. MinnesotaCare is provided by managed care plans, and benefits for children are the same as those under Medical Assistance. Funding for MinnesotaCare comes from a tax on health care providers and enrollee premiums as well as Medicaid funding from the federal government through waivers granted to cover certain groups of enrollees.

There is an internal appeal process through the health plan and an administrative appeal process through the Minnesota Department of Human Services with recourse to the court system. Those with complaints do not have to exhaust the health plan's complaint process before appealing to the Minnesota Department of Human Services or going to district court.

### ● **Schools and the Minnesota Department of Children, Families and Learning**

There are 343 public school districts and 69 charter schools in Minnesota. The Minnesota Department of Children, Families and Learning supervises this locally-based education system.

The federal Individuals with Disabilities Education Act (IDEA) requires school to provide special education and “related services” to a student who meets eligibility criteria in one of 13 disability categories.<sup>36</sup> Special Education is defined as “specially designed instruction designed to assist the child to benefit from and access general curriculum.” Some children qualifying for services under IDEA may have a mental health diagnosis and the services received could be for that mental health diagnosis.

Most IDEA services are funded by state dollars. Federal reimbursement has never been more than 11 percent, although the federal government had contemplated reimbursement of 40 percent. The state reimburses local district excess costs at a rate of 75 percent.

The review of denial of service and other appeals under IDEA is administrative through a due process hearing. Federal law mandates certain procedural safe-

guards and due process. Conciliation and mediation processes are available. Appeals of final administrative due process decisions can be taken to district court. For information on the appeal process, look online at <http://cfl.state.mn.us/dmc/sec/conflictres.html>.

The federal Americans with Disabilities Act of 1990 (ADA) and section 504 of the Rehabilitation Act of 1973 (Section 504) also affect children in schools. To be eligible for protections under Section 504, children must have a physical or mental impairment. This impairment must substantially limit at least one major life activity. Section 504 does not guarantee services; it only guarantees nondiscrimination on the basis of a disability and access to a free and appropriate education. Any institution that receives federal funds for any services must comply with section 504. However, there are no funds dedicated for providing these services.

The ADA does not delineate specific due process procedures. People with disabilities have the same remedies that are available under Title VII of the Civil Rights Act of 1964, as amended in 1991. Thus, individuals who are discriminated against may file a complaint with the relevant federal agency or sue in federal court. Enforcement agencies encourage informal mediation and voluntary compliance.

Section 504 requires notice to parents regarding identification, evaluation, placement, and before a “significant change” in placement is made. Written notice is recommended. Following IDEA procedural safeguards is one way to meet Section 504 mandates. Local education agencies are required to provide impartial hearings for parents who disagree with the identification, evaluation or placement of a student. Parents must have an opportunity to participate in the hearing process and to be represented by counsel. Beyond this, due process is left to the discretion of local districts.

In 1998, Minnesota passed the Interagency Services for Children with Disabilities Act.<sup>37</sup> The system is now formally referred to as the Minnesota System of

<sup>36</sup> For an overall comparison of IDEA, ADA and Section 504 see <http://ericec.org/digests/e606.html> and <http://www.wrightslaw.com/info/sec504.summ.rights.htm> or <http://ericec.org/digests/e606.html> (September 24, 2002).

<sup>37</sup> Minn. Stat. §§125A.023 and 125A.027 (2002).



Interagency Coordination (MnSIC) by state and local partners. The Minnesota Department of Children, Families and Learning headed up a multiagency effort to implement the legislation. This legislation requires Minnesota to develop and implement a coordinated, multidisciplinary, interagency, intervention system for children and youth with disabilities ages 3 to 21 and their families.<sup>38</sup> This includes children with mental health issues, particularly children with individual education plans (IEP) under IDEA. As part of this, Minnesota must:

- Develop guidelines for implementation of policies to ensure a comprehensive, coordinated system of all state and local agency services.
- Develop guidelines to assist local governing boards of the Interagency Early Intervention Committees (IEICs) to carry out their duties under Minnesota Statutes §125A.027.
- Identify and develop a common, standardized written plan for every child and youth with a disability.
- Identify adequate, equitable funding sources to streamline services.
- Coordinate multidisciplinary evaluation and assessment of children with disabilities.
- Develop a common dispute resolution process.
- Evaluate the success of state and local interagency efforts through this initiative.

Minnesota law mandates that coordinated service provision be available for all children up to age 21 by July 1, 2003. A standardized plan of care has been developed called the Individual Interagency Intervention Plan (IIIP). It is suitable for use for children up to age 21.

Because the statute mandated a different way of doing business rather than the development of new services, the Minnesota legislature did not provide funding at the local level for MnSIC. The statute does not set forth what measures should be taken to ensure compliance with the law.

Two school-based federal grant programs also deal with children's mental health issues in some way. Under the Safe and Drug Free Schools Act, Minnesota has obtained federal grant money to deal with truan-

cy issues. Federal prevention monies are allocated to schools on a formula basis that factors in total school enrollment and low socioeconomic status of student population. The federal "No Child Left Behind Act of 2001" re-authorizes and amends the Elementary and Secondary Education Act of 1965, providing grants to improve the mental health of children. The grants are to fund innovative programs that integrate school and mental health systems to increase access to mental health services for children. Funds to grantees are distributed based on a competitive grant process.

### ● **Correctional Delivery System and the Minnesota Department of Corrections**

There are three different correctional delivery systems across the state providing juvenile corrections/probation services:

- **Community Corrections Act (CCA):** Thirty-one counties operate under the Community Corrections Act. Each county has a local corrections advisory board under a comprehensive plan approved by the Department of Corrections (DOC). CCA programs receive a state grant and local funding. The local advisory board determines the services to be delivered.
- **Non-CCA county probation:** 29 counties have county probation agents and 27 counties use state agents under contract to the counties. In both cases, state pays for 50 percent of probation officer's salary.
- **Department of Corrections:** The Minnesota Department of Corrections oversees correctional facilities as well as services for adults on probation, supervised release or parole in non-CCA counties.

Mental health services are involved in the corrections system because juvenile court is designed to be rehabilitative as well as punitive. Probation and correctional services are an administrative arm of the court. Sometimes a probation officer prepares recommendations for the court or arranges for juveniles to get assessments. The court often follows those recommendations. Nearly all services to children are contracted out.

<sup>38</sup> For a description of the 14 federal and state programs and initiatives to be coordinated under MnSIC, look at THE MATRIX online at <http://www.mnsic.org/products/default.html> (September 24, 2002).



There are no state mandates or federal mandates regarding provision of children’s mental health services except those tied to specific grant funds. Involvement in the provision of mental health services is a byproduct of involvement with other systems, such as collaboratives or as a means to facilitate transition to society or limit liability that could result if an individual harms self or others as a result of mental illness. The Department of Corrections provides technical assistance and is responsible for inspection and licensing of state and local correctional facilities, including juvenile detention centers and other juvenile correctional residential facilities. The Minnesota Department of Corrections and the Minnesota Department of Human Services have been working for several years on an “Umbrella Rule” designed to create the same standards for detention and primary treatment as part of licensing across the Department of Corrections and the Department of Human Services. The rule is now complete, but must go through the approval process.

Federal law prohibits Medicaid dollars from being used for “inmates of public institutions.” A person in a secure facility is not eligible for Medical Assistance. However, if it is not a secure facility, the person is eligible for Medical Assistance if

- the facility is privately run; or
- the facility is a publicly-run facility, but has less than 25 beds.

Because juvenile detention and most juvenile correctional residential facilities are secure facilities, children and youth in these facilities are not eligible for Medical Assistance while they are residents. However, these children remain eligible for services under the Minnesota Comprehensive Children’s Mental Health Act and other laws.

### ● Minnesota Department of Health

Regarding mental health services and service delivery, the Minnesota Department of Health:

- Licenses and inspects facilities;
- Licenses and regulates managed care systems and community integrated service networks;

- Regulates unlicensed mental health service providers and other service providers;
- Administers federal and state programs for mental health professional recruitment and loan repayment;
- Provides consumer information regarding health and health insurance;
- Conducts mental health promotion activities either through its own budget or through the administration of federal or other grants;
- Collects information on services provided to patients under health insurance plans and Medicaid; and
- Supervises the county-based local public health authorities.

The Minnesota Department of Health licenses and inspects hospitals, nursing homes and other health care providers. It also certifies health care facilities and other providers who take part in the federal Medicare and Medicaid programs. In this capacity, the Minnesota Department of Health can:

- Issue correction orders for violations of state licensing requirements;
- Notify providers of certification deficiencies that potentially affect their participation in Medicare and Medicaid;
- Take appropriate legal action against facilities that fail to come into compliance with state or federal law; and
- Handle consumer complaints involving neglect or abuse of patients covered by Minnesota’s laws regarding vulnerable adults as well as possible violations of the state’s patients’ and residents’ bill of rights.

The Managed Care Systems section of the Minnesota Department of Health licenses and regulates managed care systems operating in Minnesota, which include Health Maintenance Organizations (HMOs), Community Integrated Service Networks (CISNs), county-based purchasing entities, Accountable Provider Networks (APNs) and Essential Community Providers (ECPs). With regard to complaints leading to an investigation, the Department of Health can issue an order to provide a service or pay a bill if the department finds a violation of law or rule. Corrective action plans are developed by HMOs if the department finds a pattern of difficulties. After approval of the

plan, the department monitors to verify that changes were made. If there is not compliance with a corrective action plan, the department has the authority to remove the license or take other actions.

The Minnesota Department of Health also regulates unlicensed mental health practitioners and alcohol and drug counselors as well as others.<sup>39</sup> Minnesota Statutes §148B.60–71 creates an office of mental health practice in the Minnesota Department of Health. Activities include examining applicants and credentialing occupations, approving continuing education programs and credits, investigating allegations of illegal conduct, taking disciplinary action through administrative proceedings, and referring to criminal authorities when appropriate. Sanctions might include limiting, suspending or revoking their right to practice; civil penalties up to \$10,000; ordering them to perform public service; censure or reprimand; assessing proceedings costs against the practitioner or requiring them to enroll in a training program.

The Minnesota Department of Health administers federal and state programs to recruit providers and enhance service capacity in rural areas.

The Minnesota Department of Health collects Health Plan Employee Data and Information Set (HEDIS®). HEDIS® is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care plans. The National Committee for Quality Assurance (NCQA), an independent non-profit organization, sponsors, supports and maintains HEDIS®. Over 90 percent of health plans across the nation use HEDIS® measures to measure their performance.<sup>40</sup> In Minnesota, the data is collected by each of six population groups (commercial, Prepaid Medical Assistance Plan (PMAP), General Assistance Medical Care (GAMC), MinnesotaCare, Minnesota Senior Health Options (MSHO) and Medicare) and includes data on aggregate service utilization in those groups. For example, two categories of data are Antidepressant Medication Management (a certain number and type of provider visits

for patients diagnosed with depression and treated with antidepressants) and inpatient utilization data for mental illness. HEDIS® data are collected based upon audited procedures for administrative or chart-review data. The data is used to verify that HMOs conduct quality evaluation and quality improvement initiatives as well as by consumers to assess the quality of health plans. Non-client specific data is also shared with state agencies, public health groups and others that are involved in quality improvement as well the public upon request.

The Minnesota Department of Health also is involved in the following grant-based and other activities that have an impact on children's mental health:

- Family home visiting program;
- Maternal and child health;
- Youth risk behavior funds;
- Fetal alcohol syndrome;
- Suicide prevention; and
- Minnesota children with special health needs program.

### ● Minnesota Department of Commerce

The Minnesota Department of Commerce is responsible for assuring that policyholders are protected against financially unsound insurance companies and from illegal, unfair and discriminatory business practices.

They do this by:

- Detecting, as early as possible, those insurers in financial trouble and/or engaging in unlawful and improper activities.
- Initiating and monitoring regulatory action against financially troubled companies.
- Reviewing insurance policies for compliance with Minnesota laws.
- Reviewing insurance rates for legality and soundness.
- Licensing companies and individuals doing business and selling insurance products in Minnesota; and
- Initiating and monitoring state and federal legislative actions regarding regulatory changes in the insurance industry, focusing on actions affecting Minnesota's consumers.

<sup>39</sup> The authority for this activity is found in Minn. Stat. 214.13, 148.511 to 148A.5199, 148B.60 et seq., 153A.13 et seq. and Chapter 148C (2002).  
<sup>40</sup> See <http://www.ncqa.org/about/president.htm> (September 25, 2002)

## ● Tribes

There are 11 federally recognized American Indian tribes in Minnesota.<sup>41</sup> As residents of the state, American Indians in Minnesota must be afforded the same rights as other residents of the state.<sup>42</sup> American Indians who are enrolled in federally recognized tribes are also citizens of their respective tribal sovereign nations. Tribes are sovereign nations that have the right to

- Form a government;
- Determine tribal membership;
- Regulate tribal property;
- Regulate individual property;
- Tax;
- Maintain law and order;
- Exclude nonmembers from tribal territory;
- Regulate domestic relations; and
- Regulate commerce and trade.<sup>43</sup>

Prior to March 3, 1871, the United States government entered into treaties with tribes. After March 3, 1871, the federal government refused to acknowledge the ability of tribes to make treaties (but recognized the legality of treaties which tribes entered into with the United States before that time).<sup>44</sup> However, the federal government follows the doctrine of “trust responsibility” based on the fact that in the treaties, tribes gave up their land in exchange for promises from the federal government. “Trust responsibilities” is the federal government’s obligation to honor the trust inherent to these promises and to represent the best interests of the tribes and their members.

Generally, only the federal government regulates tribes outside of the tribes’ own self-regulation. However, Public Law 83-280 ( P.L. 280) required Minnesota to take jurisdiction in certain designated areas of Indian country over certain matters. P.L. 280 requires Minnesota to apply and enforce state law regarding offenses and civil causes of action regarding private persons and private property in all areas

of Indian country, except the Red Lake Reservation, to the same extent as it does elsewhere in the state. Tribal laws are enforced to the extent they do not conflict with state laws in these areas. To the extent that federal law regarding the rights of American Indians conflicts with state law, federal law supercedes state law.

Minnesota has a state-supervised, county-administered system of delivering mental health services for its citizens. As a result, the county maintains a responsibility to provide services to American Indian people living on and off reservations as residents of the state. At the same time, the federal government has encouraged the development of tribal infrastructure for governance and service delivery through the American Indian Self-Determination and Education Assistance Act of 1975. As a result of federal recognition of tribal sovereignty and an increasing tendency to operate on a government-to-government relationship, the potential and capacity of tribes to deliver services has grown.

***Tribes and the Children’s Mental Health Act:*** American Indian children have the same rights as other children to services through counties mandated under the Minnesota Comprehensive Children’s Mental Health Act. Tribal governments also have an infrastructure to provide services. One component of this is the American Indian Health Service (discussed below).

***Tribes and Medical Assistance:*** American Indian people are entitled to the same Medical Assistance services as other residents of the state. However, there is 100 percent federal financial participation for reimbursement of direct services provided by tribes for qualifying American Indians. That is, there is no state share of service cost reimbursement. Only direct services receive 100 percent federal financial participation; contracted services do not receive 100 percent federal financial participation. All tribal and “638 facilities” (qualifying tribally owned and operated health clinics or “compact” sites) can bill for Medical Assistance covered

<sup>41</sup> In Minnesota, there are seven Anishinaabe (Chippewa, Ojibwe) reservations and four Dakota (Sioux) communities. The Anishinaabe reservations include Grand Portage, Bois Forte, White Earth, Leech Lake, Fond du Lac, Mille Lacs and Red Lake. The four Dakota Communities include: Shakopee Mdewakanton, Prairie Island, Lower Sioux and Upper Sioux.

<sup>42</sup> All Indians born in the United States are citizens of the United States. 8 U.S.C. § 1401(a)(2)(1924). All persons “born or naturalized in the United States...are citizens of the United States and the State wherein they reside.” U.S. CONST., art. XIV, § 1.

<sup>43</sup> For an overview of the core rights of tribes as sovereign nations see Stephan L. Pevar, *THE RIGHTS OF INDIANS AND TRIBES: THE BASIC ACLU GUIDE TO INDIAN AND TRIBAL RIGHTS*, 2nd ed., Southern Illinois University Press (Carbondale and Edwardsville) (1992) or William C. Canby, Jr., *AMERICAN INDIAN LAW IN A NUTSHELL*, West Group (St. Paul, Minnesota) (1998).

<sup>44</sup> 25 U.S.C. § 71: “No Indian nation or tribe within the territory of the United States shall be acknowledged or recognized as an independent nation, tribe, or power with whom the United States may contract by treaty; but no obligation of any treaty lawfully made and ratified with any such Indian nation or tribe prior to March 3, 1871, shall be hereby invalidated or impaired.”

services. In the past few years, the Minnesota Department of Human Services has added the services:

- Child welfare targeted case management; and
- Mental health targeted case management.

Tribal facilities are in the process of meeting the provider requirements in order to bill for these services. Several tribes have already met the requirements, and one tribe (Fond du Lac) has been billing for child welfare-targeted case management for more than a year. The Minnesota Department of Human Services is providing training and technical assistance to tribes regarding obtaining Medical Assistance reimbursement.

***Indian Health Service (IHS):*** The Indian Health Service is funded each year through appropriations by the United States Congress. The Indian Health Service is not an entitlement program (such as Medicare or Medicaid), an insurance program or an established benefits package.<sup>45</sup> Funds appropriated by Congress currently only cover an estimated 60 percent of all health care needs of the eligible American Indian and Alaska Native people.<sup>46</sup> Additionally, only certain American Indians are eligible for Indian Health Services care.<sup>47</sup>

Two types of services are provided by the Indian Health Service: direct health care services, which are provided by an IHS facility; and contract health services, which are provided by a non-IHS facility or provider through contracts with the IHS.

- **IHS Direct Health Care Services:** Generally, a member of a federally recognized tribe may obtain care at any IHS facility, provided funds and staff are available. Sometimes, the sites are operated by the federal government. There are three such federally operated IHS sites in Minnesota: Red Lake, Leech Lake and White Earth. However, some facilities are operated in whole or in part by tribes instead of the federal government. These are called “compact” IHS facilities. If a tribe operates the facility instead

of the federal government, the tribe may decide, due to lack of funding, to limit services to its own tribal members. The following tribes operate their own IHS facilities: Grand Portage, Bois Forte, Fond du Lac and Mille Lacs.

- **IHS Contract Health Services:** Services provided by a non-IHS facility, or a provider through contracts with the IHS, are called contract health services. Contract health services are provided principally for members of federally recognized tribes who reside on or near the reservation established for the local tribe(s) in geographic areas called contract health service delivery areas. The eligibility requirements are stricter for contract health services than they are for direct care. Recipients of contract health services must live on the reservation or within the contract health services delivery area. Therefore, individuals who move away from the reservation or the contract health services delivery for their tribe are not eligible for the Indian Health Services contract funds.

If an American Indian is eligible to receive contract health services, all other payer sources must be exhausted first. That is, the Indian Health Service is the payer of last resort.<sup>48</sup> Therefore, if children are eligible for another federal funding source (including Medicaid), state program or local dollars, those funds need to be accessed before Indian Health Service dollars. Most contract health services provided are for urgent or emergency needs, as defined by the local service unit, and require prior approval for non-emergency care and notification within 72 hours for emergency care.

***Tribes and the Center for Mental Health Services (CMHS) Federal Block Grant:*** State law provides tribes with 25 percent of the federal block grant funding it receives from the Center for Mental Health Services.<sup>49</sup> This amounts, after administrative costs, to only about \$1,300,000 in grant dollars divided among the 11 tribes and four urban programs. The tribes and urban programs submit proposals and are awarded grants. Tribes and programs enter into contracts with the Min-

<sup>45</sup> Frequently Asked Questions, Indian Health Services web site (September 24, 2002) online at <http://www.ihs.gov/GeneralWeb/HelpCenter/CustomServices/approp.asp>.

<sup>46</sup> Id.

<sup>47</sup> The most common standard applied for eligibility for health services from the Indian Health Service is that the individual is an enrolled member of a federally recognized Tribe. The Indian Health Services Manual sets out eligibility requirements. See the requirements online at <http://www.ihs.gov/GeneralWeb/HelpCenter/CustomServices/elig.asp> (September 24, 2002).

<sup>48</sup> 42 C.F.R. § 36.61

<sup>49</sup> Minn. Stat. §245.713 (2002).



nesota Department of Human Services regarding how they spend the grant dollars.

***Indian Child Welfare Act (ICWA) of 1978; Minnesota Indian Family Preservation Act (MIFPA):***

The Indian Child Welfare Act of 1978<sup>50</sup> is a federal law that governs foster care placement and termination of parental rights proceedings involving American Indian children from federally recognized tribes. (It does not include proceedings involving custody in divorce proceedings or placements based upon an act which, if committed by an adult, would be deemed a crime). It raises the evidentiary standard necessary for placement and for termination of parental rights with regard to American Indian children; creates exclusive jurisdiction for tribes over placement and parental rights termination matters for certain American Indian children; provides a procedure for transfer of placement and termination matters to tribal courts and establishes required notification to tribes of out-of-home placement and termination of parental rights proceedings. ICWA comes into play whenever out-of-home placement, including voluntary placement, is contemplated for children from federally recognized tribes. Therefore, ICWA is involved whenever out-of-home placement for treatment is contemplated for American Indian children. The Minnesota Indian Family Preservation Act<sup>51</sup> is the Minnesota counterpart to ICWA and adds additional notice requirements and other safeguards.

Compliance with ICWA and MIFPA is enforced through the court system with appeals to the Minnesota Court of Appeals and the Minnesota Supreme Court.

● **Family Services and Children’s Mental Health Collaboratives**

There are 93 collaboratives in Minnesota. Of these, 51 are family services collaboratives (FSC), 13 are children’s mental health collaboratives (CMHC), and 29 are joint or integrated family services and children’s mental health collaboratives. Counties and schools are mandated partners for all collaboratives. The lead partner in a children’s mental health col-

laborative is the county. The lead partner in a family services collaborative is the school district. The Minnesota Department of Children, Families and Learning has oversight for grant dollars for the family services collaboratives; and the Department of Human Services for the children’s mental health collaboratives. The state agency with oversight for all collaboratives regarding Local Collaborative Time Study (LCTS) funding (a Title-IVE based funding stream) is the Minnesota Department of Human Services. As a general matter, family services collaboratives do not provide or coordinate traditional children’s mental health services, although a few do. Children’s mental health collaboratives or integrated children’s mental health/family services collaboratives may provide or coordinate traditional children’s mental health services, although each is allowed to define its own target population.

Minnesota Statutes §124D.23 governs family services collaboratives and community-based collaboratives. Minnesota Statutes §245.491 - 245.496 govern the children’s mental health collaboratives and the children’s mental health integrated fund. The legislation was enacted to develop a seamless system of care for children and their families, connecting fragmented systems and promoting local control of services.

Collaboratives are funded by a combination of cash contributions from members, public and private grants, local collaborative time study earnings, and extensive in-kind contributions.

The Minnesota Departments of Human Services and/or Children, Families and Learning review applications to become a collaborative, and recommend approval or provide technical assistance to the applicant. These agencies provide oversight for their respective collaborative grant dollars. All collaboratives are required to complete an annual collaborative report that is reviewed by staff from both departments. Collaboratives report on spending of Local Collaborative Time Study Funds (LCTS) (Title IV-E funds). Children’s mental health collaboratives are additionally required to submit the following

<sup>50</sup> 25 U.S.C § 1901, et. seq.

<sup>51</sup> Minn. Stat. § 260.751 through §260.835 (2002).

data: functional assessment information at intake, discharge and during every six months of service; demographic information; and mental health services provided. State staff provide technical assistance to collaboratives based on information in their annual report, from their data reports, or by request. Collaborative partners enter agreements (either “inter-agency” or “joint powers”) that set forth their mutual obligations and liabilities.

### ● **Minnesota Office of Ombudsman for Mental Health and Mental Retardation**

The Minnesota Office of Ombudsman for Mental Health and Mental Retardation serves as an advocacy and resource center for people and their families regarding mental illness and mental retardation services. The office assists people with:

- Concerns or complaints about services;
- Questions about rights;
- Grievances;
- Access to appropriate services;
- Ideas for making services better;
- General questions or the need for information concerning services for persons with mental disabilities.

An agency, facility or program is required to report to the Office of the Ombudsman the death or serious injury of a client within 24 hours of the incident.

The office also provides training to consumers and their families, as well as organizations, regarding the Minnesota Commitment and Treatment Act<sup>52</sup> and related law.

### ● **Juvenile Court**

Children with mental health issues can be “children in need of protection or services” pursuant to Minnesota Statutes §260C.007 if the children are without the special care made necessary by a physical, mental or emotional condition because the children’s parents, guardians or custodians are unable or unwilling to provide that care, including children in voluntary placement due solely to developmental disability or emotional disturbance. A county social services agency or a private individual can serve and file a

petition alleging that a child is in need of protection or services and seek relief from the court, requesting that the child be placed out of home for treatment or that other services are provided.

Federal law (Title IV-E) and state law require review of cases involving out-of-home placement. Children in out-of-home placement, either involuntarily (by court order) or voluntarily for treatment or otherwise (by parent, guardian or child consent) must, after a certain period of time, undergo a permanency determination. In this determination, the court must order a permanent placement for the children or find compelling reasons why a change of custody/termination of parental rights is not warranted.

The court can, among other things, order that services be provided and that providers pay for such services as long as certain conditions under law are met.<sup>53</sup> Courts are required to appoint guardians ad litem for children. Children and parents also have the right to effective assistance of counsel in hearings. Under certain conditions and when appropriate, the court may appoint counsel at public expense. Appeals from district court orders are made to the Minnesota Court of Appeals and ultimately to the Minnesota Supreme Court.

Juvenile courts can also order mental health services for children as part of juvenile petty offender or juvenile delinquency dispositions.

### ● **Health Insurance**

Most people with health insurance are covered through their employer. Over the last 20 years, the trend has been away from a traditional indemnity insurance model (also known as “fee-for-service”) and instead, toward a managed care model. In fee-for-service, health care is provided and then the provider submits a bill to the insurer. In managed care, a number of financial arrangements with providers exist. A managed care plan attempts to contain costs by providing health care services through a defined network of primary care physicians, hospitals and other providers. Costs are also managed through decisions about patient care, disease management, care coordination and utilization of services. Most people with

<sup>52</sup> Minn. Stat. § 253B.01, et. seq. (2002)

<sup>53</sup> Minn. Stat. § 62Q.535 (2002)

insurance are under a managed care system.

Historically, insurance plans have covered mental health care at lower levels than physical health care. Sometimes mental health care is not covered at all. Minnesota has a mental health parity law that requires certain plans offering mental health benefits to offer them at the same level as they do other benefits.<sup>54</sup> However, the law only applies to state-regulated, fully-insured plans. Self-insured health plans are regulated under federal ERISA law and are exempt from state health insurance and HMO laws.<sup>55</sup> Self-insured plans cover about 37 percent of the state's population<sup>56</sup> and are often used by large businesses. The parity provision comes into play depending upon who is paying. For example, if a health plan is administering a self-insured plan, state parity law does not apply. If it is working as a state-governed health plan, then state parity law does apply. There is some debate regarding whether mental health parity laws have much of an impact in managed care environments. While mental health parity laws may make a difference in fee-for-service environments where payment for services depends on health plan contract language, most mental health care is provided under a managed care system where services are provided based upon a determination of "medical necessity."<sup>57</sup> If service is denied based upon a health plan's determination that the service is not medically necessary, the only recourse is for the patient to appeal. A recent United States Supreme Court decision may have opened the door for state review of medical necessity determinations under self-insured (ERISA) plans as well.<sup>58</sup>

Health plans have internal review processes for complaints with recourse to external review processes.<sup>59</sup> Requests for external review are made to

the Minnesota Department of Health if the complaint regards a health maintenance organization or the Minnesota Department of Commerce if the complaint involves a health insurance policy sold by a for-profit or non-profit company. The external reviews, whether received by the Department of Health or the Department of Commerce, are conducted by a single independent contracted entity, the Center for Health Dispute Resolution. The decision of the external review is binding on the insurance company, but not the enrollee. The enrollee is free to seek review of the external review decision in the courts; the health plan can only seek judicial review of the external review decision on the grounds that the decision was arbitrary and capricious or involved an abuse of discretion.

In the first Special Session of 2001, the Minnesota Legislature passed a number of provisions ensuring greater coverage for persons under non-ERISA plans and those not receiving fee-for-service services through Medical Assistance or General Assistance Medical Care. All other plans:

- Must pay for court-ordered services if the services are covered by the plan and the court's order is based upon a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist.<sup>60</sup>
- Cannot exclude or reduce coverage for a person whose need for health care arose out a suicide or suicide attempt. (This also applies to blanket accident and sickness insurance and coverage purchased as a supplement to Medical Assistance)<sup>61</sup>
- Must cover anti-psychotic drugs needed to treat a mental illness or emotional disturbance, even if the drug is not in the health plan's formulary, provided certain conditions are met.<sup>62</sup>

<sup>54</sup> Minn. Stat. §62Q.47 (2002)

<sup>55</sup> In 1996, Congress passed the Mental Health Parity Act sponsored by Senator Pete Domenici (R-N.M.) and the late Senator Paul Wellstone (D-MN). This act amended ERISA and the Public Health Service Act to require that annual lifetime dollar limits for mental health coverage (if offered) be no more restrictive than for all medical and surgical coverage. 29 U.S.C. §1185a and 42 U.S.C. §300gg-5 (1996). The provisions of the act expired on September 30, 2001. On November 15, 2002, following Senator Wellstone's death, both the United States House and Senate passed legislation (H.R. 5716) extending the 1996 federal Mental Health Parity Act through December 31, 2003.

<sup>56</sup> NSURANCE FOR BEHAVIORAL HEALTH CARE, Office of the Legislative Auditor, State of Minnesota, 13 (February 12, 2001).

<sup>57</sup> Id. at 48-50.

<sup>58</sup> See Rush Prudential HMO, Inc. v. Moran (U.S. Supreme Court, June 20, 2002). Online at <http://caselaw.lp.findlaw.com/cgi-bin/getcase.pl?court=US&navby=case&vol=000&invol=00-1021>

<sup>59</sup> Minn. Stat. § 62Q.73, subd. 3 (2002) governs the external review process.

<sup>60</sup> Minn. Stat. § 62Q.535 (2002). See also Health Plans and Court-Ordered Mental Health Services, Minnesota Department of Human Services Bulletin #02-53-12.

<sup>61</sup> Minn. Stat. § 62Q.471 (2002).

# Appendix C

## Specific Task Force Recommendations

The task force sought stakeholder input and developed recommendations. The following list addresses each problem area and the suggested strategies for resolving the problem:

### ● Need for More Mental Health Service Providers

#### 1. Grow, recruit and retain mental health professionals.

- The Minnesota Department of Human Services should continue working with the Minnesota Department of Health's (MDH) Office of Rural Health and Primary Care to explore using federal programs such as the federal loan repayment program for mental health professionals who agree to serve in shortage areas.<sup>63</sup>
- The Minnesota Department of Human Services should work with the Minnesota Department of Health regarding recruitment of providers such as through the J-1 Visa Waiver Processing Program which allows internationally trained physicians and psychiatrists to remain in the United States and practice in under-served areas.
- The Minnesota Department of Human Services should work with the Minnesota Department of Health to review licensing requirements to determine what changes may need to be made to make it easier for providers from other states to work in Minnesota.
- Use Medical Education and Research Costs (MERC) trust fund to cover reimbursement for trainees/supervision.
- Work with health plans to eliminate barriers to credentialing mental health professionals.
- For Medical Assistance, look at the Adult Rehab Option method of credentialing providers to streamline the process.
- Develop state and foundation loan repayment programs for mental health professionals to address lack of culturally specific providers and distribution of providers.
- Develop state grants for recruitment of providers, particularly culturally specific providers.

- Create state loan incentive programs for psychiatrists and psychologists who agree to practice for certain period of time in areas of need.
- Provide funding for training opportunities: Currently, supervision of trainees is not often covered by health plans and is not covered by Medical Assistance. Work with health plans and others to create a trainee friendly system, exploring reimbursement (insurance and Medical Assistance) for trainee and supervisory time, direct grants from state and or other sources, etc.
- Increase Medical Assistance reimbursement rates to retain the work force we have.
- Work with health plans with state contracts to adopt a per capita as well as a geographic distance criteria for determining access to psychiatrists and psychologists. Set goals related to increasing access on a per capita basis.
- Develop our own base of providers by recruiting at Minnesota's state colleges and universities.

#### 2. Connect mental health professionals with primary care.

- Co-locate mental health professionals in primary care and pediatric clinics, and direct reimbursement procedures accordingly.
- Create a consultation network, connecting psychiatrists with primary care practitioners.
- Allow reimbursement for consultation with family practitioners and other providers.

#### 3. Train other professionals.

- The Minnesota Department of Human Services should continue to promote the utilization of the statutory "case management associate" option, which allows certain experience to substitute for a degree.
- Enhance training for social workers, probation officers, teachers and school professionals.

<sup>63</sup> The list of federally designated shortage areas is found in 67 Fed. Reg. 7740 (2002).



#### 4. Encourage informal family supports.

- Support development of informal supports including families, friends, neighbors and community organizations.

### ● Needs of Families and Need for More Family Involvement

#### 1. Eliminate barriers to family, parental and child involvement and their participation in treatment and in system design.

- Support parent, family and child involvement in the child's mental health planning, including through the young adult transition years.
- Incorporate family perspectives in all stages of system design and implementation.
- Involve parents in discussions regarding service quality and system accountability.
- Provide services that support, educate and strengthen families.
- Offer stipends to increase involvement of parents in service quality and system accountability forums.

#### 2. Support parent leadership, liaison and mentor activities.

- Support the Parent Leadership Network.
- Increase parent mentor and liaison activities in collaboratives.

#### 3. Increase access to respite care services.

- Explore alternative funding strategies for respite care.
- Re-define standards for respite care providers to encourage family members or significant adults in children's lives to become respite providers.
- Offer flexibility to allow parents to keep their children at home by making in-home services reimbursable and by providing other incentives for children to receive home-based vs. institutional care.
- Make respite care services more generally reimbursable under Medical Assistance: Currently, respite services are reimbursable under a Medical Assistance waiver program only.

#### 4. Increase access to crisis services.

- Create mobile crisis teams such as adult services has.
- Partner with law enforcement to create trauma response teams (could use Local Collaborative Time Study dollars to fund this).
- Develop regionalized crisis units for children's mental health that are not linked with child protection.
- Increase crisis care capacity.

#### 5. Support other services that encourage family involvement and access to services.

- Train paraprofessionals to help families from the screening process to assessment and services.
- Build cultural and linguistic capacity to assist non-English speaking families.
- Train culturally-specific health promoters/advocates or parent liaisons/family facilitators.
- Increase funding resources for transportation to treatment and school.
- Create incentives for the system to create more continuous relationships with children, e.g., the same workers having roles in children's lives as the children move through treatment and different systems.

#### 6. Review parental fee contribution structure.

- The Minnesota Department of Human Services should assess, with county input, the ramifications of setting uniform parental contribution fees across counties under the Children's Mental Health Act.

### ● Need for Culturally Competent Providers and Services

#### 1. Recruit more culturally diverse providers.

(See "Need for More Mental Health Service Providers" recommendations above.)

#### 2. Provide more cultural competency training across all disciplines.

#### 3. Incorporate traditional and cultural elements into treatment planning.

- Work with health insurance plans to adopt cultural competency guidelines.

- Explore Medical Assistance reimbursement of culturally traditional treatments. (This would require federal approval.)
  - Use cultural resources available in community (e.g., integrate traditional healers into treatment).
4. Seek Medical Assistance and insurance reimbursement for culturally specific consultations.
  5. Engage racial/cultural/age/gender groups in designing processes to reduce disparities.
  6. Promote cultural competency guidelines.
    - Provide cultural competency guidelines in mental health care for use in grants and state contracted health plans. Hold plans and grantees accountable for providing culturally competent services.

### ● **Need for Use and Dissemination of Evidence-based Practices**

1. Build relationships between state and local levels and between public and private provider systems to support change.
  - Establish links from research to practice; establish Centers of Excellence for children's mental health similar to those for medical specialties (e.g., UCLA Center for School-Based Best Practices; Columbia University Center for Children's Mental Health Services).
  - Build links with Minnesota colleges and universities to enhance capacity for evaluation, research and dissemination of findings.
  - Incorporate family and cultural perspectives in all stages of system design and implementation.
  - Survey cultural groups to assure comprehensiveness and applicability of evidence-based practice identification.
  - Build statewide capacity to continuously evaluate practice implementation.
  - Make recommendations to the federal government regarding children's mental health research needs and develop sites in Minnesota for national research projects.
2. The Minnesota Department of Human Services (DHS) should spearhead a multiagency approach

to disseminating evidence-based practices, involving families and diverse communities in all aspects of this effort.

3. Create incentives for utilization of evidence-based practices through funding and contracting.
  - Target funding to support the introduction and maintenance of evidence-based practices.
  - Work with health plans to develop contract specifications within the Prepaid Medical Assistance (PMAP) program to provide incentives for implementing evidence-based practices; these plans should then provide best-practice models.
4. Update clinical standards and practices in residential treatment facilities.
5. Emphasize development and retention of clinical resources.

### ● **Need for Greater Access to Services**

1. Make existing services more readily available and more flexibly provided.
  - Revise or add to Medical Assistance rules (or pass appropriate legislation) to allow more services to be available for reimbursement to children with emotional disturbances. There are some services now only available to children with severe emotional disturbances that would well serve children with emotional disturbances, e.g., crisis assistance and skills training.
  - Revise or add to Medical Assistance rules (or pass appropriate legislation) to allow more services to be available for reimbursement simultaneously. There are some combinations of services that would be helpful to children that are currently just in one service package and therefore not available to children at the same time. For example, children currently cannot get day treatment and family community support services paid for by Medical Assistance at the same time.
  - Categorize Medical Assistance reimbursable services into tiers of level of need. Medical Assistance reimbursable services could be arranged in a menu from which individual selections could be made. The menu would be arranged in separate tiers corresponding to different levels of service need. Requests for

- services from a higher level service need tier would be pre-authorized. This would increase mental health services available to children who are eligible for medical assistance, making services available at the early stages of need so that more costly treatments later on can be avoided.
- Assess feasibility of “checkbook” waiver model for children’s mental health services
2. Expand availability of partial hospitalization and inpatient psychiatric bed capacity.
    - Increase adolescent psychiatric inpatient services across the state.
  3. Work with counties to expand specific services.
    - Create best practice models for assisting adolescents and families through the transition period.
    - Publicize fact that Children’s Mental Health Division grants can be used for transition services.
    - The Minnesota Department of Human Services should continue work at the federal level to increase access to State Children’s Health Insurance Program (SCHIP) funding.
    - Explore Oregon’s model and create a “medication fund” to subsidize medicine for those who cannot otherwise pay for it.
    - Allow reimbursement for trainees of in-home provision of services.
    - Provide at least a six month overlap between adult and children’s mental health case management allowing children to have both adult and children’s mental health case managers reimbursed.
    - Increase case managers and reduce case loads.
    - Create more semi-independent living arrangements for 18-22 year olds.
  4. Coordinate resources to offer more school and community-based services.
    - The Minnesota Department of Human Services should continue its work with schools to help them claim Medical Assistance reimbursement for qualifying services.
- Provide more after-school services and activities.
  - Provide school programs and services that are designed to prevent dropouts such as programs that challenge children and work with their strengths.
  - Increase mental health service provision in schools.
  - Provide and fund more programs through schools or other venues for children with mental health needs in the summer months to help provide continuity.
  - Study means of improving school attendance and graduation rates for children with emotional and behavioral disorders.
  - Pursue full federal funding of special education in Minnesota.
5. Ensure access to mental health services for children primarily served in other systems.
    - Explore the potential for volume purchasing by the Minnesota Departments of Human Services and Corrections and local detention and correctional facilities.
    - The Minnesota Departments of Human Services and Corrections should collaborate in educating probation officers and social services agencies that children in the juvenile justice system are eligible for services under the Children’s Mental Health Act.
    - Provide for intense case management for juveniles released from detention or incarceration for at least 60 days after release.
- **Need to Recognize and Support Tribal Capacity to Provide Services**
1. Build tribal service capacity to maximize use of Medical Assistance (which is 100 percent federal financial participation for tribally provided direct services).
  2. Provide technical assistance to tribal social services to help them enroll as Medical Assistance providers.
  3. Work on making traditional treatments Medical Assistance reimbursable (would require federal approval).

4. Assist tribes in implementing useful outcome measures that would provide information regarding the efficacy of alternative methods.
5. Enhance provider capacity through training on best practices models.
6. Enhance data collection capabilities and assist urban and tribal communities to become automated.
7. Base referral for services upon culturally specific screenings and/or assessments.
8. Use American Indian Mental Health Advisory Council to review the managed care organization state contracts with regard to ability to provide culturally competent services.
9. Support tribal efforts to get members enrolled in private insurance, state health plans (MinnesotaCare, etc.) and Medical Assistance.
10. Restructure mental health and chemical dependency grants to encourage culturally appropriate and holistic services.
11. Support the creation of a referral network of American Indian providers that will be utilized by tribal social services, county social services and health plans.
12. Assure tribal mental health programs access to all funds designated for mental health services, including Local Collaborative Time Study Funds and grant funds.
13. Change state statute to allow tribal governments to be designated, at their option, as the local mental health authorities. Some state and federal dollars are only available to local mental health authorities.
14. Work at federal level to allow tribes direct access to federal funds (e.g., Title IV-E currently requires a tribal-state agreement.)

### ● **Need for Increased Quality Assurance and Oversight**

1. Provide the Minnesota Department of Human Services, in conjunction with other state agencies serving children and adolescents, the capacity to develop and monitor best practices in compliance with mandates for access to children's mental health services.

2. Ensure quality of children's mental health services provided by the children's mental health collaboratives and the family services collaboratives.
3. Increase Medical Assistance compliance and oversight.
  - Increase staff in the Medicaid fraud and abuse investigation unit.
  - Create mandatory training requirement for potential MA providers regarding compliance.
4. Develop a group to further analyze accountability in a state-supervised, county-administered system under the current children's mental health act; discuss if and how the act should be changed.

### ● **Need for More Effective Coordination**

1. Coordinate state technical assistance and planning to optimize local service coordination.
  - The Minnesota Department of Human Services should continue its work to adopt a unified approach and philosophy to providing a coordinated service array centered around four major areas: assessment, primary treatment, care management and formal and informal wraparound supports.
  - Expand coordinated efforts among health, human services, corrections, and education with regard to coordinated discharge plans, transition services, purchasing and coordinated early intervention activities by doing the following:
    - Consolidating purchasing to enhance ability of corrections to provide needed medication to juveniles.
    - Adopting a statewide policy to "suspend" Medical Assistance status of juvenile prior to incarceration so that once the juvenile is released, there will not be a lengthy lapse in Medical Assistance coverage.
    - Ensuring that a minimum of 30 days of medication is available upon discharge from a juvenile facility, if clinically appropriate.
    - Encouraging as a best practice the provision of the Individual Education Plan (IEP) and mental health records of children to juvenile corrections facility before the children enter the facilities or



as soon thereafter as possible. (Statute already provides for IEP records to go to a facility licensed by the Department of Human Services or the Department of Corrections, but mental records require parental consent).

- Promoting better coordination of collaboratives with their county partners.
  - Disseminate collaborative operational best practices.
  - Develop incentives for employing collaborative operational best practices.
  - Enhance state technical assistance capacity.
2. Create uniform, systematic outcomes reporting across agencies.
    - Improve coordination of collaborative reporting with existing state reporting systems.
    - Introduce reporting requirements using specific, uniform measures to demonstrate the effectiveness of intervention.
    - Implement uniform review standards for community-based plans that address children's mental health, including Community Social Services Act, Community Health Plan and Community Corrections Act plans.
    - Implement uniform review standards for grant applications for state or federal funds and grants made by collaboratives.
  3. Coordinate identification, referral and assessment activities across agencies.
    - Clarify what the Minnesota Government Data Practices Act and the Health Insurance Portability and Accountability Act (HIPAA) say regarding inter-agency sharing of information and publicize/disseminate clarifications to local and state units of government or seek legislative changes for clarification.
  4. Ensure seamless transitions across service systems.
    - Assess if changes are needed in Adult Mental Health Act and/or Children's Mental Health Act to better provide and coordinate transition services for children from the children's mental health service system to the adult mental health system or from the children's mental health system to adulthood (vocational and life skills).

## ● Need to Identify Children with Mental Health Needs Early

1. Increase public awareness of children's mental health.
  - Fund local and state campaigns to combat the stigma surrounding mental health.
  - Target outreach to culturally specific groups and the various providers who serve them. Enlist health plans and pharmaceutical companies to endorse and fund these campaigns.
  - Engage stakeholder groups who will hold the media accountable for portrayals of mental illness.
2. Educate providers and policy makers about screening.
  - Publish and disseminate clinical and cultural best practices for screening for children's mental health, including normative and validation data.
  - Establish standards for selection and use of appropriate screening tools
    - Establish common standards for screening tools across agencies, including their developmental and cultural appropriateness.
    - Establish common criteria for screening, mental health assessments and multidisciplinary evaluations across agencies.
  - Incorporate mental health screening into chemical health assessments.
3. Train existing mental health workforce regarding screening, assessment and diagnosis.
  - Establish training and experience criteria for persons who will conduct screening.
  - For Screening:
    - Promulgate screening tools that have been identified as reliable and valid, and have normative data to match the cultural groups in which they are to be used.
    - Cross-train with chemical dependency assessors.
    - Train primary care physicians, staff and pediatricians in mental health screening (e.g., Bright Futures curriculum).

- For Assessment/Diagnosis:
  - Offer continuing education for mental health professionals who diagnose disorders of childhood and adolescence in assessment methods and tools, including those that are culturally appropriate.
- For Screening
  - Train teachers and school-based support staff to communicate with families regarding needs for screening/assessment (by working with Minnesota State Colleges and Universities (MNSCU)) to incorporate this into post-secondary programs).
- For Assessment/Diagnosis:
  - License more categories of mental health professionals for provision of intervention services, but increase training and experience requirements for assessment and diagnosis. (This would mean modifying Medical Assistance reimbursement regulations, program licensing rules and the Adult and Children’s Mental Health Acts).

4. Create/expand targeted venues for mental health screening.

- Expand and enhance home visiting programs to include mental health screening and referral.
- Target venues for screening.
  - Establish regular screening schedules in venues where children are or where they are at risk of developing mental health problems, including:
    - Special needs child care/preschools\*
    - Home visiting programs/Women, Infants and Children Program (WIC)\*
    - Head Start and Early Childhood Family Education
    - Child protection\*
    - Shelter residence
    - Juvenile detention\*
    - Temporary Assistance for Needy Families (TANF) case planning
    - Chemical health assessments

- School failure/suspension
- Alternative learning centers

*\*Areas of particular emphasis.*

- Establish routine screening in typical childhood venues.
  - Determine whether a mental health component should be included in pre-kindergarten screening.
  - Include a distinct mental health component in Early and Periodic Screening, Diagnostic Treatment (EPSDT) service screening, and expand the settings in which these screenings can be reimbursed.
- Establish central referral assistance function by county or region to help families access evaluation or other services following screening by utilizing the 211 telephone access and referral line.
- Increase reimbursement for diagnostic testing and evaluation/diagnosis.

5. Provide incentives for front-end services.

- Explore statewide budget incentive planning such that savings from tertiary interventions are allowed to carry over from end of one fiscal year to be used in front-end services in the next fiscal year, irrespective of the current biennium restrictions.

● **Need for Improvements in Health Plans and Health Plan Coordination with Other Systems**

1. The Minnesota Department of Human Services, the Minnesota Department of Health and the Minnesota Department of Commerce should work with health plans to do the following:

- Incorporate culturally competent and family driven standards.
- Communicate to families exactly which mental health providers on eligible providers’ lists are actually taking new patients.
- Develop a care management benefit that can be the basis for integration of public and private services.
- Reimburse providers for time spent in feedback sessions, multidisciplinary team meetings, continuity of care meetings, etc.

- Institute a statewide public relations campaigns regarding children’s mental health issues, evidence-based practices and the importance of all health plans (including self-insured plans) having adequate mental health benefit sets.
  - Consolidate regulation of managed care and private insurance through consistent standards enforced by one state agency.
  - Streamline and consolidate complaint and appeal processes for insurance and Medical Assistance.
  - Ensure that consumers are clearly informed of incentives offered to providers by health maintenance organizations that could impact their care.
  - Identify mental health screening tools and opportunities for screening.
  - Provide timely, developmentally and culturally appropriate evaluations following screening.
  - Make mental health screening by appropriately credentialed providers, which may include paraprofessionals under supervision, reimbursable.
- Offer, at a minimum, the same benefit set offered by the Medical Assistance benefit plan.
  - As part of statewide planning, create a forum at which public and private mental health insurers/providers can agree on well-established, evidence-based practices and the criteria for determining a practice is evidence-based.
  - Set targeted goals to further reduce the rate of uninsured children, particularly for groups where disparities exist.
2. The Minnesota Departments of Commerce and Health should increase enforcement of statutes requiring insurers to respond to claims and complaints within a timely manner and review those statutes to determine whether changes need to be made.
  3. The Minnesota Department of Human Services, working with health plans and others, should encourage Congress to require mental health coverage parity in ERISA plans.









Minnesota Department of **Human Services**

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