Case Study: Minnesota's Mental Health Initiative and the Expansion of Mental Health Services in the State's Programs to Cover the Uninsured

In 2007, the Governor proposed and the Legislature Passed a Mental Health Initiative. One of the most important components of the initiative was legislation amending Minnesota's two programs for the uninsured - MinnesotaCare and General Assistance Medical Care (GAMC) – to include a comprehensive mental health benefit.

Who Is Covered? Minnesota Care covers children and pregnant women, parents and caretakers up to 275% of the federal poverty limit (FPL), except parents and caretakers gross income cannot exceed $50,000. Single adults without children increased to 200% FPL by January 1, 2008 and will rise to 215% by January 1, 2009. GAMC covers those with income at or below 75% FPL who meet one or more of additional criteria known as GAMC qualifiers. Among others, this includes waiting or appealing disability determination by Social security administration or state medical review team; or homeless or live in shelter, hotel or other place of public accommodation.

What Services Are Covered? For Minnesota Care, there are limits of $10,000 on inpatient care for any condition (physical, mental health or addictions) for parents over 175% FPL and childless adults. For GAMC, inpatient benefits are fully covered. Both programs cover chemical dependency outpatient services. An intensive array of outpatient and residential mental health services are available. See box below.

What is the Cost? Adding mental health rehabilitative services (including ARMHS, ACT, IRT and crisis services) to MinnesotaCare was projected to cost $3.40 per person per month. For GAMC, which includes a homeless population, the cost was $7.01 per person per month. The additional targeted case management service was projected to cost $2.22 per person per month for MinnesotaCare and $7.66 for GAMC. The legislature appropriated a total of $ 1 million in additional state dollars in FY 2008 and $ 3.5 million in FY 2009 to add the adult rehabilitative services and case management in Minnesota Care. State funds previously targeted for case Management were moved from the counties to the state in an amount of $4.4 million in FY 2009.

What Led Minnesota to Amend its Programs for the Uninsured to Include Comprehensive Mental Health and Addiction Coverage? The state collected data on the residents served by MinnesotaCare, GAMC, and Medicaid managed care plans serving non-disabled populations, and discovered that an increasing number of individuals with serious mental illnesses were in these plans. There were also highly successful experiments reducing costs and improving outcomes for commercial and non-disabled Medicaid clients who were offered a more intensive community based mental health service that improved coordination with and linkages to behavioral healthcare, primary care and other needed services.[1]

The state supported this initiative because it sought to bring intensive mental health and addiction services into the mainstream of healthcare. Minnesota's mental health agency and other stakeholders desired to move mental illness from its historical treatment as a social disease requiring social services to an illness like any other. This change required rethinking medical

necessity determinations, provider credentialing, procedure codes and other processes common to private insurance plans. Under this new approach, the state purposely developed relationships between commercial plans and public providers.[2] This change was strongly supported by providers and by the private insurance industry.[3]

How Did It Get Through the Political Process? Three factors significantly contributed to the political viability of a benefit expansion in the MinnesotaCare and GMAC programs:

1. Governor Tim Pawlenty and members of his administration provided strong leadership. The provisions to expand the mental health benefits in these plans were part of the Governor's Mental Health Initiative, set forth in advance of the 2007 legislative session;[4]
2. An extremely strong coalition of stakeholders formed the Minnesota Mental Health Action Group (MMHAG). This group is co-chaired by a representative from the Department of Human Services and also included representation from the private insurance industry. MMHAG members also included representatives from the well organized and knowledgeable advocacy and provider communities. The cohesiveness and skill level of this group rendered it highly effective. Much of the Governor's initiative reflected the work of the MMHAG;[5] and
3. There was strong support in the legislature for the expansion of benefits in MinnesotaCare and GAMC, including key legislators such as Mindy Greiling, a member of the Finance Committee in the House, who also has a son with schizophrenia. The creation of a mental health division in the Health and Human Services Policy Committee also helped move the policy discussion forward.[6]

Adult Rehabilitative Mental Health Services (ARMHS) are mental health services which are rehabilitative and enable the recipient to develop and enhance psychiatric stability, social competencies, personal and emotional adjustment, and independent living and community skills, when these abilities are impaired by the symptoms of mental illness….

Assertive Community Treatment (ACT) is an intensive, non-residential rehabilitative mental health service that is a federally identified evidence-based practice and is provided according to national fidelity standards. …ACT services are provided by multidisciplinary staff using a total team approach, and directed to adults with a serious mental illness who require intensive services.

Intensive Residential Treatment (IRT) is a 24-hour-a-day program under the clinical supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit.

Mental health crisis assessment means an immediate face-to-face assessment by a physician, a mental health professional, or mental health practitioner under the clinical supervision of a mental health professional, following a screening that suggests that the adult may be experiencing a mental health crisis or mental health emergency situation.

Mental health mobile crisis intervention services means face-to-face, short-term intensive mental health services initiated during a mental health crisis or mental health emergency to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, and begin to return to the recipient's baseline level of functioning…

Mental health crisis stabilization services means individualized mental health services provided to a recipient following crisis intervention services which are designed to restore

[1] Craven, S. Intensive Community Based Services (ICBS): Filling Service Gaps for High Risk Individuals with Medical-Community-Behavioral Linkages, September 2007.
[2] Phone call with John Zakelj, Mental Health Budget and Legislation, Mental Health Division, Minnesota, November 30, 2007.
[3] Phone call with Ron Brand, Executive Director, Minnesota Association on December 7, 2007
[4] Fast Facts: 207 Legislative Session Governor's Mental Health Initiative: Improving Health Care For Adults and Children with Mental Illness, retrieved at http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-5154-ENG.
[5] The Minnesota Mental Health Action Group, Road Map for Mental Health System Reform In Minnesota, June 2005.
[6] Phone call with Sue Abderholden, Executive Director of NAMI MN, December 5, 2007.