#07-53-02

Bulletin

July 9, 2007

Minnesota Department of Human Services □ P.O. Box 64941 □ St. Paul, MN 55164-0941

OF INTEREST TO

- County Directors
- Social Services Supervisors and Staff
- Community MH Centers
- Contracted MH Case Mgmt. Providers
- Regional Treatment Centers
- Adult MH Initiative Contacts
- Local Mental Health Advisory Council Chair
- Health Plans
- Children's MH Collaboratives
- Tribal Representatives

ACTION/DUE DATE

Please become familiar with these provisions as you work with clients who have health plan coverage and who need court-ordered treatment.

EXPIRATION DATE

Dated 2 years from the date the bulletin is issued.

Health Plans and Court-Ordered Mental Health Services Update

TOPIC

Bulletin #01-53-04 provided information regarding 2001 legislation which requires health plans to pay for court-ordered mental health services, while bulletin #02-53-12 offered answers to many of the questions that developed following that important change. This bulletin replaces those bulletins and provides an updated and combined version of those previous communications, including revised contact information.

PURPOSE

To provide updated and consistent answers to questions related to court-ordered mental health services. This presents counties and providers with an opportunity to obtain revenue and to improve the continuity of care for their clients.

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BACKGROUND

The 2001 legislative session saw significant changes relating to health plans' responsibility for mental health services, especially court-ordered services. While the 2001 session was proceeding, the state attorney general also worked out a related settlement with Blue Cross. The settlement was effective June 2001, and had a number of provisions that go beyond the actual legislative changes. The Blue Cross settlement provisions also applied to Blue Cross affiliates, including First Plan of Minnesota. Since that time, the attorney general negotiated similar agreements with Health Partners and Medica.

Due to this change in legislation, it has become increasingly important that counties and providers determine which clients are covered by which health plans. Even if court-ordered services are not involved, it is good practice to coordinate social and mental health services with any medical services being provided by the plan. In many cases, the client's social and mental health services may be covered by the plan and reimbursement may be feasible. Note that in most cases, the law requires counties and mental health agencies to obtain the client's consent to share mental health data.

As soon as a county or mental health provider becomes aware that a client may need court-ordered services, the agency should contact the person's health plan. In some cases, the plan may be willing to pay for services which would not otherwise be covered if the plan determines that the services may be a cost-effective alternative to covered services. Note the following excerpt from the bulletins issued by the Departments of Health and Commerce to HMOs and indemnity plans regarding court-ordered services:

> *We expect managed care organizations to work more closely with their enrollees and mental health benefit managers to develop voluntary, community based treatment which could be a cost effective alternative to court-ordered treatment. Managed care organizations should participate in the pre-petition screening and commitment process to help develop an individual treatment plan for care in the most appropriate, least restrictive environment.*

LEGAL REFERENCES

Minnesota Statutes, section 62Q.535 (2001) Coverage for court-ordered mental health services.
Subdivision 1. **Mental health services.** For purposes of this section, mental health services means all covered services that are intended to treat or ameliorate an emotional, behavioral, or psychiatric condition and that are covered by the policy, contract, or certificate of coverage of the enrollee's health plan company or by law.
Subd. 2. **Coverage required.** (a) All health plan companies that provide coverage for mental health services must cover or provide mental health services ordered by a court of competent jurisdiction under a court order that is issued on the basis of a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive

environment. The health plan company must be given a copy of the court order and the behavioral care evaluation. The health plan company shall be financially liable for the evaluation if performed by a participating provider of the health plan company and shall be financially liable for the care included in the court-ordered individual treatment plan if the care is covered by the health plan and ordered to be provided by a participating provider or another provider as required by rule or law. This court-ordered coverage must not be subject to a separate medical necessity determination by a health plan company under its utilization procedures.
(b) A party or interested person, including a health plan company or its designee, may make a motion for modification of the court-ordered plan of care pursuant to the applicable rules of procedure for modification of the court's order. The motion may include a request for a new behavioral care evaluation according to this section.

The following sections provide the Department of Human Services (DHS) explanation of the above legislation.

Payment for Court-ordered Mental Health Services (Minnesota Statutes, section 62Q.535)

All fully insured health plans, including managed care and indemnity plans, must pay for court-ordered mental health services under the following circumstances:

- the services are otherwise covered by the plan; and
- the court's order is based on a behavioral care evaluation performed by a licensed psychiatrist or a doctoral level licensed psychologist, which includes a diagnosis and an individual treatment plan for care in the most appropriate, least restrictive environment; and
- the care is provided by a participating provider of the health plan company; or by another provider if appropriate care is not available through the plan, or if another provider is required by state law or rule.

This court-ordered coverage must not be subject to a separate medical necessity determination by a health plan company under its utilization review procedures.

Payment for Clinical Evaluation

The health plan must pay for the clinical evaluation used by the court if it is performed by a health plan participating provider.

Effective Dates for Above Provisions

The above provisions have been effective for commercial contracts issued or renewed after July 1, 2001. This means that for most commercial plans the above requirement took effect January 1, 2002. For DHS funded prepaid plans (such as Prepaid Medical Assistance Program {PMAP}), the law was effective July 1, 2001. DHS has provided health plans with additional funding appropriated by the legislature for this purpose retroactive to July 1, 2001.

Definition of "Court-ordered"

The specific nature of a county's or provider's involvement with court procedures will depend on the type of legal proceeding. If a petition is filed for commitment, the county's pre-petition screening unit must conduct an investigation and prepare a report for the court. Legislation enacted prior to 2001 requires that this investigation include "seeking input from the proposed patient's health plan company to provide the court with information about services the enrollee needs and the least restrictive alternatives."

Under the Commitment Act, the term "court-ordered mental health services" includes mental health services which are provided as part of: a court hold, any type of commitment (which may include an order for early intervention), a stay of commitment, a continuance, or a revocation of a provisional discharge. However, the above legislation is not limited to the Commitment Act, since it refers to "mental health services ordered by a court of competent jurisdiction." As long as the above criteria are met, this could also include mental health services which are ordered by a juvenile court for a child who is adjudicated as needing protection or services, mental health services which may be ordered by a criminal court as a condition of probation, or other circumstances in which a court of competent jurisdiction has included provision of, or participation in, mental health services as a condition in its findings.

Questions and Answers

1. Does this legislation apply to Medical Assistance (MA), General Assistance Medical Care (GAMC) and MinnesotaCare?

This legislation does not apply when the enrollee in each of these programs receives coverage directly from the state through fee-for-service. This legislation **does** apply when the enrollee receives coverage through a health plan, such as a PMAP, Prepaid General Assistance Medical Care (PGAMC) or MinnesotaCare plan, or through a county-based purchasing arrangement such as South Country Alliance. There are some exceptions for certain services as discussed in responses to #7 and #8.

2. Does this legislation apply to self-insured plans?

The legislation does not apply to private self-insured plans. It does apply to health plans for non-federal government employees, including state, county, city, school district, etc, regardless of whether those plans are self-insured. Private self insured plans may choose to adopt similar provisions.

3. Does this legislation apply to indemnity plans written by out-of-state insurers?

All indemnity plans, whether originating from in or out-of-state, must comply with Minnesota laws if they are not self-insured, and if they cover more than 25 employees in Minnesota. If you

are not sure whether an indemnity plan is governed by Minnesota laws, contact the Minnesota Department of Commerce at 651-296-2488 or 1-800-657-3602.

4. Can a court order a health plan to pay for services which are not otherwise covered by the plan, or to exceed coverage limits?

No, not under the authority provided by this legislation. The primary effect of this legislation is to require the health plan to deem a court order for mental health services as a determination of medical necessity. This does not change the types or amounts of services covered by the plan. For example, this legislation does not give courts the authority to change the $10,000 per year limit on inpatient coverage which applies to most adults in MinnesotaCare plans.

5. Will health plans pay for treatment which is not court-ordered?

Yes, if it is a covered service which is determined by the plan to be medically necessary. It is assumed that most of the services paid by health plans will continue to be non-court-ordered.

6. Will this legislation provide an incentive for patients and families to seek court orders to bypass the health plans' determination of medical necessity?

The court process is difficult and expensive for all concerned, and we hope it will be used only as a last resort. By making health plans liable for court-ordered treatment, the legislature intended to clarify responsibilities and provide an incentive for health plans, patients, families, counties, providers and others to work together to develop cost-effective, non-court-ordered alternatives.

7. Are health plans responsible for court-ordered children's residential treatment (Rule 5)?

As required by Minnesota Statutes, section 62A.151, state-regulated private health plans cover residential treatment for children with emotional disturbance. However, for PMAP and MinnesotaCare enrollees, the state has chosen to cover this service through fee-for-service reimbursement to the counties, and not through the plans. Recently passed legislation makes publicly funded plans responsible for children's residential treatment effective January 1, 2009.

8. Are health plans responsible for mental health case management?

Health plans usually cover coordination of medical benefits, but not mental health case management, as it is defined in Minnesota Rules, parts 9520.0900-9520.0926 (informally known as DHS Rule 79). Counties are required to coordinate the provision of (i.e. to provide and/or contract for) targeted case management to adults with serious and persistent mental illness

(SPMI) and children with severe emotional disturbance (SED). As a result of recently passed legislation, targeted case management will be covered under all publicly-funded health care programs effective January 1, 2009. Also, if an individual is enrolled in a pre-paid health plan, the state will pay for any non-federal costs. Currently, if the individual is in PMAP, mental health case management is available through MA fee-for-service.

9. Are health plans responsible for court-ordered inpatient treatment in state-operated regional treatment centers (RTCs) or community-based behavioral health hospitals (CBHHs)?

Yes, if the plan is a state-regulated plan which comes under this legislation.

10. What if the individual is receiving state-operated services other than inpatient treatment?

The answer to this question depends on the specific type of service the person is receiving and whether that service is a covered service in the individual's health plan. For example, some RTCs provide residential treatment in beds which are not licensed as hospital beds. Most plans, including PMAP, do not cover adult mental health residential treatment. (However, recently passed legislation makes publicly funded plans responsible for adult residential treatment effective January 1, 2008.) As indicated in Question #4 above, this legislation does not give courts the authority to order plans to pay for services which are not covered services. However, plans may choose to pay for these services as an alternative to a covered service.

11. Aren't PMAP enrollees automatically disenrolled from PMAP if they enter an RTC?

No, not any longer. Although it was standard DHS practice in the past to disenroll all people admitted to an RTC, this legislation allows most enrollees to have RTC inpatient services covered by the health plan. Some exceptions apply as noted in the response to #4 and #10.

12. Would a PMAP enrollee be disenrolled from PMAP if they become officially disabled?

If a PMAP enrollee (under age 65) becomes certified disabled, the individual can choose to transfer to fee-for-service coverage regardless of where they live. If the person's only basis of eligibility is MA disabled, the person would be required to transfer to fee-for-service. If the person also has another basis of eligibility which allows enrollment in a managed care plan (for example, Minnesota Family Investment Program {MFIP}) the person would be able to choose between staying in the health plan or transferring to fee-for-service. Note also that adults with serious and persistent mental illness and children with severe emotional disturbance can choose to disenroll at any time.

13. Does this legislation make health plans responsible for court-ordered evaluations?

Under this legislation, a health plan is responsible for an evaluation if the evaluation is:

- done by a health plan participating provider,
- used by the court to determine need for mental health treatment, and
- performed by a licensed psychiatrist or a doctoral level licensed psychologist.

Note that some health plans have paid for evaluations which are done by master's level psychologists. However, master's level psychologists do not meet the requirements as an examiner. We advise that you check with the specific plan to determine whether coverage is broader than the minimum required by law. Also, check with the court to make sure the evaluator's credentials will meet court requirements.

14. Does the health plan have to cover a second evaluation?

Yes, if it meets the same criteria as above.

15. Does the court have to use a health plan provider for the evaluation?

Courts continue to have the same authority and responsibility as before to determine which evaluations are done, who does them, and how. If the court wants to take advantage of the opportunity to have the health plan pay for the evaluation, the court needs to use a health plan provider.

16. Timelines for court-ordered evaluations are very short. Can health plans and their providers comply?

Health plans have indicated they will place a priority on requests for court-ordered evaluations and treatment. When calling for authorization, be clear that the request relates to court-ordered services.

17. Are health plans responsible for court-ordered evaluations to determine parental competency, competency to stand trial, or other evaluations which are for purposes other than determining need for mental health treatment?

Some health plans may include coverage for those types of evaluations, but that is not required by the legislation described in this bulletin.

18. What types of courts are covered by this legislation?

This legislation refers to "mental health services ordered by a court of competent jurisdiction." As long as the other criteria are met, this could include a civil court in commitment proceedings, a family court for a child needing protection or services, a criminal court imposing a condition of probation, a tribal court, or other situations in which a court of competent jurisdiction has included provision of, or participation in, mental health services as a condition in its findings.

19. Are health plans responsible for court-ordered sex-offender treatment?

Under the Commitment Act, sex-offender treatment is considered mental health treatment. If the treatment which is ordered by a court for a sex offender is a type of service which is otherwise covered by the plan, then the plan is responsible for the treatment.

20. Are health plans responsible for court-ordered chemical dependency treatment?

This legislation does not include chemical dependency (CD) treatment. CD treatment is governed by other statutes.

21. Are health plans responsible for hold orders?

Under the described legislation, a health plan is responsible if the hold order is a "court hold" which is imposed while the court is considering a petition for commitment. All hold order coverage is limited to holds which occur in a type of facility which would otherwise be covered by the plan, such as an inpatient hospital (unless the plan agrees to substitute an alternative facility). If the hold order is an emergency 72 hour hold, this legislation does not apply. However, see Minnesota Statutes, section 62Q.55 which requires all plans to provide coverage for emergency medical services, and Minnesota Statutes, section 62M.07, which prohibits health plans from requiring prior authorization for emergency confinement or treatment.

22. If the hold order is in an RTC or CBHH, and the individual has health plan coverage, will State Operated Services bill the health plan?

Yes, since August 1, 2002. Prior to that date, the state did not have the authority to bill health plans other than PMAP, PGAMC or MinnesotaCare for hold orders. New legislation passed in 2002 provided the necessary authority to bill private plans.

23. Are health plans responsible for inpatient treatment provided in a community hospital for a person who has been committed to an RTC, but who is waiting for RTC admission?

Yes, inpatient treatment in this situation would be considered part of the court ordered treatment. In this situation, all parties should work together to explore the possibility of providing all of the court-ordered treatment in the community.

24. Are counties required to involve health plans in the prepetition screening process?

Yes. If a petition is filed for commitment, the county's pre-petition screening unit must conduct an investigation and prepare a report for the court. The investigation must include "seeking input from the proposed patient's health plan company to provide the court with information about services the enrollee needs and the least restrictive alternatives " (See Minnesota Statutes, section 253B.07, subd. 1 (a) (v).)

25. Do state and federal data privacy laws allow counties to share pre-petition screening information with a health plan?

Yes, the county must share private data to the extent necessary to comply with Minnesota Statutes, section. 253B.07, subd. 1 (a) (v) (see above). State data privacy laws allow sharing of private data without patient consent when this is specifically authorized by statute. Federal Health Insurance Portability and Accountability Act (HIPAA) regulations allow private health care data to be released without patient consent for purposes of treatment, payment and health care operations. The county must inform all patients that private data about them will be shared with the person's health plan for purposes of treatment planning and payment.

Some county attorneys have questioned whether the above statute provides enough authority for the court to share patient evaluation data with the plans. Since this is data that the plans may need to determine their liability for payment, it is recommended that the court order include authorization to share patient evaluation data with the patient's plan as needed for purposes of payment and care coordination.

26. How does all this relate to "contract beds"?

The legislation does not apply directly to "contract beds."

"Contract beds" refers to a benefit under MA fee-for-service in which DHS contracts with community hospitals to provide extended psychiatric inpatient services for patients who are committed, or who agree to voluntary hospitalization. For more information, see DHS bulletin #06-53-01 titled, "DHS amends contracts for Extended Psychiatric Inpatient Services in Community Hospitals" at:
http://www.dhs.state.mn.us/main/dhs_id_059496

As part of the health plan's compliance with the legislation described in this bulletin, health plans have the option of negotiating with hospitals to provide services for their enrollees which are similar to what MA fee-for-service pays for in the contract bed program.

27. I was not able to participate in the 2001 DHS-sponsored video conferences where health plans answered questions about this subject. Can I get a video tape of those workshops?

A two hour tape is available by calling John Zakelj at 651-431-2231.

28. How can I find out what is covered by my health plan, or how to access services?

Grids describing the contact numbers for publicly funded plans are available at the DHS web site at:
http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs_id_056879.pdf

a. Metro area: http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4485-ENG

b. Non-metro: http://edocs.dhs.state.mn.us/lfserver/Legacy/DHS-4484-ENG

29. My health plan said it would cover a particular service, but then changed its position after the service was provided. What can I do?

Most of the health plans have stated that they will honor commitments made by their representatives, even if a mistake was made. An exception would be a service which, under state law, is required to be paid for in a different manner.

30. My health plan is not complying with the legislation. What can I do?

We recommend that you first check with the health plan, and make sure the plan's representative understands you are asking about court-ordered mental health treatment. If you are not satisfied with the plan's response, please contact the following complaint numbers:

For state-regulated indemnity insurers, plans for government employees and Blue Cross:	Minnesota Department of Commerce 651-296-2488 (metro) (800) 657-3602 (non-metro)
For state-regulated health maintenance organizations:	Minnesota Department of Health 651-201-5100 (metro) (800) 657-3916 (non-metro)
For state managed care public programs, including PMAP, GAMC and MinnesotaCare plans:	Ombudsman for State Managed Care 651-431-2660 (metro) (800) 657-3729 (non-metro)

or the following DHS website:

http://www.dhs.state.mn.us/main/dhs_id_019847

SPECIAL NEEDS

This information is available in other forms to people with disabilities by contacting DHS at 651-582-1990 (voice), or through the Minnesota Relay Service at 1-800-627-3529 (TTY), 711 or 1-877-627-3848 (speech-to-speech relay service).