The KAISER-HCFA State Symposia Series

Transitioning to Managed Care:
Medicaid Managed Care in Mental Health

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Executive Summary

This report reflects the discussion of nine states participating in "Transitioning to Managed Care: Medicaid Managed Care in Mental Health". The symposium was funded by the Henry J. Kaiser Family Foundation and the federal Health Care Financing Administration (HCFA).

Integrating Physical and Mental Health Care: To Carve Out or Not to Carve Out?

No single model has yet emerged on how to best meet the needs of the person with mental illness in a managed care environment. States have developed a variety of approaches, which are evolving as their experience grows. States choose specific models for a number of reasons. Some states use a model which integrates mental health services into traditional HMOs, believing it better integrates physical and mental health care, is more likely to reduce or eliminate cost shifting and confusion, prevents consumers from “falling through the cracks”, avoids the possibility that clients are stigmatized, provides greater access to medical services, and could result in savings. Other states use a model that offers mental health services completely separate from physical health services. They believe these carve-outs improve the capacity to meet enrollee mental health needs, are an important first step in developing expertise, compensate for mainstream plans’ lack of experience/capacity/willingness to provide mental health services, improve access; assure that mental health needs will not “fall through the cracks”, alleviate the bias of the traditional medically-oriented managed care system, may reduce or prevent risk selection, and allow for reinvestment of savings. States using partial carve out models seek to tailor their programs to get the best of both strategies.

How states organize their systems is less significant than the goals in moving mental health services or populations. Those goals are:

- To integrate physical and mental health care to provide a seamless system of care that treats the whole person
- To help individuals with mental illness toward recovery and toward maximizing their choices and independence
- To promote community-based, highly individualized services
- To use dollars more efficiently.

Integrating medical, mental health, and supportive services is complex regardless of whether programs are "carve-out" or "carve-in" designs. Service integration is often multi-dimensional — integrating one area can create fragmentation in another. Because persons with mental illness need a range of services and supports, state Medicaid programs also need to coordinate with other government funders and providers.

Benefit packages need to be designed to provide sufficient accountability but still allow enough flexibility to encourage plans to develop individualized, consumer-sensitive care approaches and to overcome the institutional bias of fee-for-service Medicaid. Several states have attempted to encourage more flexible benefits by pooling Medicaid and mental health dollars in the capitation rate paid to plans.
Plan and Provider Issues

The capacity to provide effective managed mental health care relies upon a competent and available network of plans and providers. States need to evaluate the capacity of plans and providers and set clear goals for them prior to launching managed mental health care. States use a variety of approaches in bringing plans and providers together to help address the special mental health needs of Medicaid beneficiaries.

Reimbursement influences plan and provider behavior. States felt strongly that managed care allows the important freedom to purchase the services consumers need, not the traditional fee-for-service approach of “what you need is what we can get paid for”.

Community-based providers tend to have an orientation toward consumers different from that of the medical community. Consumers often approach managed care with trepidation, fearing loss of a trusted care manager, loss of needed “wrap-around” or supportive services, and the medicalization of their care. The choices states make to select plans and providers will affect consumer satisfaction and the program’s success.

Oversight/Monitoring Quality

The critical first step to monitoring quality is to be clear about the expected results of services for the system, plans and consumers. From a consumer’s perspective, the goal of managed mental health care is to assist recovery and build functional capacity.

States are moving toward stressing accountability of outcomes. However, the science of outcome measurement is not sufficiently advanced to rely on these measures exclusively. Outcome measures currently used by some states include: length of time the consumer is in the community, ability of the consumer to participate in school or work, and consumer improvements on pre/post-treatment symptoms and community functioning. In addition to outcome measures, states monitor quality through such process measures as access, types of providers, ability to serve special needs populations, caseload ratios, and HEDIS-type quality indicators.

Quality monitoring takes place at multiple levels — the managed care organizations, the behavioral health organizations, providers, etc.

Consumer Involvement

States agreed on the importance of engaging broadly with consumers and family members, and including consumer involvement from the very beginning of program design. States use a variety of approaches to assure consumer involvement. A multi-pronged approach increases the chances that the information gathered represents the views of a wide variety of consumers. Approaches include inclusion in advisory groups, interviews, focus groups, satisfaction surveys, and grievances and complaints.

Mechanisms must be in place to assure that consumer input is used in planning or modifying the program. Feedback loops create ways to make sure such input is used.
Using peer leaders to educate consumers on their rights and responsibilities as managed care enrollees was stressed. Some states also use special care coordinators who teach persons with mental illness how to enroll and use the system with no disruption of care.

**Administrative Issues**

Many states agreed that it is difficult to acquire and synthesize all the data needed to set rates and determine risk sharing arrangements. There does not seem to be one best way to set rates that guarantees states are paying properly for services.

Appropriate data, although extremely important, is difficult to come by. Problems arise even when data is available since plans', providers', and states' systems are difficult to coordinate, and data collected is often not comparable since definitions and outcome measures are not standardized.

States need staff and data resources to contract for, evaluate, and monitor managed mental health care and to develop needed relationships with stakeholders.
I. Introduction

The Henry J. Kaiser Family Foundation and the federal Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services, have launched a state symposia series, "Transitioning to Managed Care". These symposia convene small groups of state officials to explore critical issues in building Medicaid managed care programs. Each symposium focuses on a single topic. The National Academy for State Health Policy is organizing these symposia.

Within 3 years, all states are expected to have some form of Medicaid managed mental health care, making it an obvious topic choice for the second symposium. Held April 24, 1997 in Washington, D.C., "Transitioning to Managed Care: Medicaid Managed Care in Mental Health" was attended by approximately 40 individuals representing states, HCFA, consumer advocates, other managed care experts, and the Henry J. Kaiser Family Foundation and National Academy for State Health Policy staff (see Appendix A for a complete lists of participants).

Nine states participated in the symposium: Colorado, Connecticut, Delaware, Iowa, Massachusetts, Oregon, Tennessee, Washington, and Wisconsin. They were selected due to their diverse approaches to Medicaid managed mental health care. All currently enroll Medicaid beneficiaries.

The paper is not intended to provide a detailed explanation of individual state approaches to managed mental health care but to present the lessons these states have gleaned from their work. Appendix B provides a brief description of each state’s approach. Appendix C contains charts summarizing these states’ initiatives.

The symposium and this paper limit discussion to mental health, not the full range of behavioral health. This was done only as a means to organize complex information and allow a substantive one-day discussion, about which this paper reports.

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II. Integrating Physical and Mental Health Care: To Carve Out or Not to Carve Out?

System Design

States have developed a variety of approaches to Medicaid managed mental health care. Considerable nuance exists among these approaches; none are pure “models”. However, for the purposes of the discussion, state approaches are characterized as:

- **Integrated model**: in which mental health services are included in the general physical managed care program.²

- **Partial carve-out model**: in which some mental health services are integrated, but other mental health services and/or populations operate under a separate managed care program.²

- **Full carve-out**: in which mental health services and/or populations are completely separated from the physical health care program into their own managed care program.²

States’ approaches to managed mental health care are evolving as their experience grows. None of the approaches are absolute. For example, Tennessee’s currently carved out mental health program will be integrated into general managed care plans by January 1, 1999.

States choose specific models for a number of reasons:

- **Integrated model**: Four of the states participating in the symposium treat managed mental health care as a “carve-in”: Connecticut, Massachusetts (HMO program), Oregon (in 12 counties), and Wisconsin. These states believe such an approach:
  - Better integrates physical and mental health care
  - Prevents consumers needing mental health services from “falling through the cracks”

² These definitions are all from The Lewin Group, Inc. for the Substance Abuse and Mental Health Services Administration Managed Care Tracking System. (Phase 1 Draft, November 1996.)

² National Academy for State Health Policy
• Improves medical care, especially for people with severe and prolonged mental illness

• Is more likely to reduce or eliminate cost shifting and confusion

• Avoids the possibility that clients are stigmatized

• Provides greater access in rural areas, where specialty providers may not be available

• Could result in savings. (For example, a National Institutes of Mental Health study found that 80% of those who do not consult mental health specialists for mental health problems will seek care from primary care practitioners for physical ailments related to their emotional problems.3)

• **Full carve-out model:** Six of these states operate full carve-out mental health programs: Colorado, Iowa, Massachusetts (PCCM program), Oregon, Tennessee, Wisconsin (pilot programs). These states believe a carve-out approach:

  • Improves the capacity to meet the mental health needs of severe and persistently mentally ill adults and children

  • Is an important first step in developing expertise in managed mental health care

  • Compensates for mainstream plans’ lack of experience, capacity or willingness to provide mental health services

  • Improves access; assures that mental health needs will not “fall through the cracks”

  • Alleviates the bias of the traditional medically-oriented managed care system against mental health

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National Academy for State Health Policy ✴ 3
- May operate more effectively and efficiently (professionals who perform large numbers of specialized procedures for certain conditions should enjoy economies of scale⁴)

- May reduce or prevent risk selection

- Allows for reinvestment of savings gained from inpatient and other 24-hour care into other mental health services

- Clarifies administrative tasks (For example, prior to carving out managed mental health programs, several states noted that many HMOs subcontracted behavioral health to other organizations, making these services difficult for the state to monitor).

- Partial carve-out model: Delaware and Washington both have partial carve-out models, but their models have little in common:
  
  - In Delaware, managed care organizations can only provide less acute mental health services. State agencies continue to provide many services (such as psychiatric hospitalization and residential treatment) for adults and children with severe and prolonged mental illness. This system arose from the concern that the managed care organizations did not have the capacity to provide deep-end services.

  - Washington carves out nearly all mental health services, except those provided in primary care settings, limited psychological testing and one hour per month with a psychiatrist. Washington’s community mental health program operates under legislatively mandated regional (county-based) authorities. Supporting the established, if ever-changing, system of care for people with mental illness is the chosen course.

States using partial carve outs seek to tailor their programs to get the best of both strategies.

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⁴ National Academy for State Health Policy
Goals of Managed Mental Health Care

States asserted that the issue is not whether to carve out mental health managed care, but how care can best be managed for persons with mental health needs. These states believed that managed care can move the current medically-based system to a system promoting prevention, rehabilitation, and recovery, but emphasized that the goals in moving mental health services or populations into managed care must be clear. They agreed that the goals of mental health managed care are to:

- Integrate physical and mental health care to provide a seamless system of care that treats the whole person.\(^5\)
- Help individuals with mental illness toward recovery and toward maximizing their choices and independence
- Promote community-based, highly individualized services
- Use dollars more efficiently.

While there has been considerable criticism about the cost-saving goals of managed care, these states stressed that the current payment system of care for persons with mental illness is not efficient for the consumers nor for the payers. Fee-for-service Medicaid limits the types of services provided and has a strong institutional bias, while managed care has the potential to provide more flexible, consumer-oriented benefits. Most of 35 states (plus the District of Columbia) offering mental health services through managed care have used the savings from managed care to broaden their service coverage for mental health.\(^6\) For example, the Massachusetts Medicaid program used funds saved through the increased efficiency of managed care to build 600 needed residential beds for persons with mental illness. Iowa added supported living services for clients of its mental health carve-out program. Colorado developed a more extensive array of community-based services.

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\(^5\) A study completed by Indiana’s Medicaid agency of its non-institutionalized Medicaid disabled population found that nearly 30% of the beneficiaries with a psychiatric diagnosis also had serious physical health problems. Croze, Collette, 1995. Medicaid Managed Mental Healthcare. Portland, Maine: National Academy for State Health Policy.

States cautioned that the growing popularity of disease management within managed care is generally inconsistent with the goals of maximizing choice for consumers and providing care that best addresses the needs of the whole person. They cautioned that disease management can be medically-oriented and diagnosis-based while the goals of the managed mental health care system are to further functional capacity and recovery.

Coordinating Medical and Non-medical Care

Integrating medical, mental health, and supportive services is complex regardless of whether programs are "carve-out" or "carve-in" designs. Given the complex needs of persons with mental illness, state policymakers are considering new approaches to managed care and recognizing that, for this population, the primary care provider is often a team representing both medical and mental health capacities rather than an individual provider. Several states suggested carving primary care services out of an HMO and into a BHO, thereby maximizing its capacity to provide a range of services. Wisconsin established a commitment from managed care organizations to manage all services for specific populations, including people with mental illness. The managed care organizations involved must show expertise in handling different primary presenting conditions.

State Medicaid programs also need to coordinate with other government mental health funders. Frequently, Medicaid beneficiaries requiring mental health services also receive services from state mental health programs, departments of social services, and a range of housing, vocational, educational, social and health service providers. When a state proposes to manage all Medicaid resources for a complex population, there is likely to be tension among different entities of government over the locus of control for the program and its public financing. Moreover, state programs are challenged to coordinate care among other service networks, such as substance abuse, criminal justice, foster care, housing, vocational, educational, special needs children, child welfare, and others. Providing care is further complicated when serving populations who are receiving court-ordered services.

- In two counties in Wisconsin, care is carved out for a small group of children with severe emotional disturbances. In the Children Come First program, primary care is provided fee-for-service, while comprehensive mental health and support services are provided through managed care. The Medicaid capitation

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rate is paid to the counties, which combine it with their own capitation. The state capitation payment covers only Medicaid-covered services, including mental health and substance abuse services. The county capitation provides for non-Medicaid-covered services such as respite, mentoring or education aides.

The Children Come First program assigns a lead agency to provide case management based on a child’s presenting problems. The lead can be, for example, a juvenile justice or mental health center. The case manager is responsible for coordinating one plan — including all physical health, mental health, and ancillary services — that has been developed by the treatment team for each of one to eight families in his/her caseload. The treatment team includes the child and family, as well as professionals (formal supports) and non-professionals (informal supports — people important to the family such as neighbors, clergy or other extended family members). The case manager has full responsibility and authority to obtain mental health and support services and is responsible for coordinating with the primary care provider. Health care other than mental health and substance abuse services are paid for through the fee-for-service system, but the case manager and treatment team can help in obtaining medical care. To further integrate care, the local agency heads meet monthly to work out problems.

- In Iowa, funding for the mental health carve-out program can be used for any services believed to help the client. Program policies require joint treatment planning with other funders as part of authorizing flexible Medicaid funding for these clients.

- In Delaware, the Medicaid agency and the Department of Services for Children, Youth and their Families (DSCYF) have an informal relationship, but the Medicaid program does hold DSCYF accountable for serving the children involved. The Medicaid agency pays DSCYF a bundled rate for each child served in the previous month. If, in its monitoring efforts, the Medicaid agency develops a question regarding the service provided, it retains the reimbursement until the issue is resolved. Service accountability is also monitored through an external quality review organization.

Coordinating services remains a challenge for even the most experienced state mental health managed care programs. Integration is often multi-dimensional — benefit packages, payment system, administration, etc. Integrating one area can create fragmentation in another.

Prescription drug policy is an example of this complexity. Drugs are often prescribed by both primary and mental health providers. Indeed, efforts to maximize the function
of individuals and their capacity to remain in the community, rather than in institutions, may require extensive use of prescription drugs, especially new and developing psychotropic drugs with often unpredictable costs. States struggle with rate-setting and the need to decide whether the primary care or behavioral health plan includes prescription drugs in the capitation rate. While the state may save money on the decreased need for institutionalization, HMO rates could be increased due to increased need for prescription drugs. No state has resolved the issues around pharmaceutical policy to their satisfaction.

- Massachusetts and Delaware exclude pharmacy from the capitation rate, concerned that good data on pharmacy costs are not available. Massachusetts conducts monthly peer utilization reviews to provide an incentive for doctors to be cost-effective.

- In Colorado, prescription drugs are included in the HMO rate or not in the BHO's rate, even if prescribed by its providers.

- Colorado has convened a joint HMO-BHO Pharmacy Committee, facilitated by the state's Medicaid and mental health agencies, to address these issues. Thus far, the Committee has developed a memorandum of understanding regarding dispute resolution, information sharing, formularies, etc. Most managed care organizations have decided to follow its suggestions.

- Tennessee includes prescription drugs in both the HMO and BHO rates, but has determined specific drugs for which the BHO will always pay (regardless of where the prescription originates).

An example of the complexity particular to carve-outs is in determining which provider is responsible for services overlapping between mental and physical health. Oregon has identified a list of such services to be covered by the capitation to HMOs, including medication, medication management, and laboratory services.8

**Engaging Stakeholders**

Effective service delivery to persons with mental illness requires access to a wide array of health, mental health, support, educational, vocational and other services. Managing mental health care, therefore, requires coordination among multiple stakeholders. The importance of stakeholders during the planning and implementation process cannot be overlooked. Stakeholders can have a large influence on decision-making. For example,

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8 National Academy for State Health Policy
in Oregon⁹, program planners originally envisioned mental health services integrated into the general managed care benefit package. However, county mental health authorities and community mental health centers (which historically provided mental health services) believed their continued viability to be threatened by such an arrangement. Their successful lobbying of the legislature resulted in the program to provide expanded managed mental health services being scaled back from 100% to 25% of the Medicaid population, modified the RFP to allow community mental health centers (as well as fully capitated health plans) to respond, and maintained state-only mental health funding for the counties.

**Lessons**

- Be clear about the goals for moving mental health services or populations into managed care. Use these goals to determine whether or not to carve out managed mental health care services.

- Realize that regardless of “carving in” or “carving out” managed mental health care, integrating physical and mental health services is a very complex challenge. Integrating one area of care may fragment another in unforeseeable ways.

- Know the managed care community’s abilities and willingness to provide managed mental health services before making the decision to carve in or out.

- Be aware of stakeholder concerns. Key stakeholders can influence many issues during both planning and implementation. Work with key stakeholders throughout the process to minimize resistance. Collaboration between Medicaid and mental health agencies is especially important.

- Consider all the services that could be wrapped around consumers. The more system boundaries are removed, the more seamless the system will be to the consumer, and the less likely cost will be shifted or services duplicated. Determine how best to work with other state agencies serving these clients.

- Be cautious about disease management models, which may run counter to the goals of managed mental health care.

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⁹ This example taken from *Medicaid Carve-Outs: Policy and Programmatic Considerations*. Submitted to the Center for Health Care Strategies (Princeton, New Jersey) by The MEDSTAT Group (Cambridge, Massachusetts), January 1997. Tab H, p. 4.
III. Plan and Provider Issues

The capacity to provide effective managed mental health care relies upon a competent and available network of plans and providers. States need to evaluate the capacity of plans and providers and set clear goals for them prior to launching managed mental health care.

Massachusetts requires aggressive purchasing specifications to assure services provided are designed for the population to be served and not simply "off-the-shelf". Massachusetts also examines quality assurance plans and monetary incentives for MCOs.

Plan and Provider Coordination and Training

States use a variety of approaches in bringing plans and providers together to help address the special needs of Medicaid beneficiaries. Realizing the Medicaid program is a public one, some plans recognize if they do not voluntarily share information, the state can identify these best practices independently.

- New York plans to contract with consumer groups to provide technical assistance in helping build the capacity of plans and providers and to encourage them to do business differently. Consumer organizations will also be contracted with to teach plans and providers some creative ways to provide services differently.

- Wisconsin’s AFDC HMO initiative convenes regional mental health/substance abuse work groups that include members from their HMOs, BHOs, substance abuse providers, subcontractors, consumers, counties, and advocates to talk about the effectiveness of treatments and brainstorm on ways to improve. Despite a competitive environment, plans in Wisconsin are willing to share best practices. This information sharing helps assure that the system is continuously improving. It also gives technical assistance to all plans and providers, both mental health and primary care.

- Massachusetts requires each MCO to have an advisory group made up of consumers and providers. The Medicaid agency also convenes ongoing meetings with the Department of Mental Health, Department of Medical Assistance, and managed care organizations to discuss specific indicators such as access, quality (including diagnosis-specific), system development, and financing.
• Iowa is developing the capacity to profile providers. These profiles are shared among providers and summary information is made available, but specific provider profiles are not.

States warned that providers working in BHOs need to learn new behaviors. Some providers are very happy in the new environment; they feel there is an opportunity to be creative in the delivery of services they did not have in the fee-for-service Medicaid system. Other providers view managed care as being too regulatory and requiring too much data.

States need the capacity to continuously monitor providers and their networks. States can require contractors to periodically review their subcontractors and report the results back, or can contract directly with providers. Some suggested the use of pinpoint purchasing, which while complex, allows states to selectively purchase certain services.

Iowa’s provider roundtable convenes monthly. These meetings allow discussions of provider profiling, consumer and provider satisfaction results, quality assurance and other current issues. They also provide a forum for providers to train other providers on what does and doesn’t work. In contrast, other states believe provider profiling could get too emotional and countered that profiling could arbitrarily put limits on how to meet patients’ needs.

Community-Based Providers and Financing Issues

In the transition to managed mental health care, many changes occur in the service delivery system, resulting in winners and losers. States agreed the argument is not which essential community providers should be supported, but rather what essential community services must be retained to provide the best care for beneficiaries. Community Mental Health Centers (CMHCs) and public mental health programs are often challenged by state Medicaid initiatives in mental health managed care. These traditional, essential community providers have had to change and compete — confronted with new expectations for management, accounting, quality assurance, and other requirements of managed care.

• Massachusetts holds CMHCs harmless during the first year of mental health managed care. This means that CMHCs are not penalized during the first year if they do not achieve the quality standards set in the contract. The state feels this gives CMHCs a chance to learn how to function in the managed care environment.
In Wisconsin, smaller providers feared they would be forced out of business, either because they were not offered a subcontract from a plan, or because they could not compete with larger providers. To counter this problem, a memorandum of understanding (MOU) was established between county mental health boards and HMOs. The HMOs are required to sign a memorandum with all qualified mental health providers. These agreements discuss, for example, how HMOs need to comply with providing court-ordered services. Reimbursement arrangements are also in the MOU to eliminate cost-shifting.

Oregon gives their county mental health system first right to refuse the BHO contract.

In Delaware, the Medicaid agency encouraged MCOs to contract with community providers of public child mental health services. As a result, nearly all have become MCO providers, thus promoting continuity of care.

Reimbursement influences plan and provider behavior. States felt strongly that managed care allows the important freedom to purchase the services consumers need, not the traditional fee-for-service approach of "what you need is what we can get paid for". Historically, Medicaid has been viewed as a provider entitlement in which discrete services were reimbursed to certain predetermined providers. Managed care allows considerable flexibility and consumer direction in developing plan and provider networks and benefit packages.

As Medicaid programs capitate mental health benefits, Community Mental Health Centers and other community-based mental health providers may lose some funding because managed care organizations tend to only buy certain services from local mental health providers. Absent those additional Medicaid dollars, CMHCs will have difficulty sustaining their traditional range of services. Historically, in some states Medicaid dollars supplemented their services and allowed them to serve the uninsured. Some states allow profits made under managed care to be used to serve the uninsured. In Colorado, some of the profits made through managed mental health care must be used to serve the non-Medicaid population. Other states reported they have seen less impact on access for the uninsured, but more impact on "soft services" such as counseling and marriage counseling.

In many states, inpatient mental health services are provided by state institutions. If behavioral managed care is successful, it can be expected that deinstitutionalization will increase resulting in empty hospital beds, which creates a funding problem for state hospitals. States noted that the speed and size of reductions in inpatient care was astonishing. Similar problems are created for community hospitals that serve as inpatient mental health units. Because private inpatient rates were higher than public
rates in some states, the state planners thought the impact of non-hospital based services would be on those private facilities. In fact, the private hospitals lowered their rates and it was the public hospitals that were most affected by deinstitutionalization. Policymakers will need to made aware that such changes will occur and should be viewed as a result of managed care, not poor care; for good managed care will reallocate money to where it is needed most.

Community-based providers tend to have an orientation toward consumers different from that of the medical community. Consumers often approach managed care with trepidation, fearing loss of a trusted care manager, loss of needed “wrap-around” or supportive services, and the medicalization of their care. The choices states make to select plans and providers will affect consumer satisfaction and the program’s success. For example, if a state decides to carve mental health services into the general managed care plans, the question is: What is the capacity of the primary care physician (PCP) to gate-keep or access mental health? If a state decides to carve-out, the question is: What is the capacity of the mental health provider to gate-keep or access medical problems? States stressed that individuals should not be made to choose between their PCP or their mental health provider. Every effort should be made to coordinate the two. States encouraged program developers to consider a team of providers as the PCP, not simply one individual provider.

Managed mental health care allows considerable flexibility and consumer direction in the development of plan and provider networks and benefit packages, and creates the incentive to purchase the services clients need.

Lessons

- States should be specific about what they want to buy in managed care and build strong expectations for consumer involvement and choices.

- Plans and providers need technical assistance and training. Managed mental health care is different from fee-for-service; you cannot expect providers or plans to immediately change their way of doing business overnight.

- Building the capacity of plans and providers should be a team effort on everyone’s part — state, consumers, plans, and providers.

- Defining what successful mental health managed care will should be a public process.

- Change and practice take time. Be realistic with goals.
• Provider buy-in is essential. Experience does not always change opinions. Some will love managed care and others will do everything to sabotage its success.

• Large-scale reduction of inpatient care will happen rapidly. Expect and prepare for significant impact on hospitals, especially state-run facilities and prepare for continuous access to outpatient care amidst this downsizing.

• Expect and create constant input. If you think you have talked with everyone, you haven’t.

IV. Oversight/Monitoring Quality

Monitoring quality focuses on two issues:

• Is the intervention accomplishing for its consumers what it is supposed to accomplish?

• Is the state buying cost-efficient services?

Determining Goals

With these two issues in mind, the critical first step to monitoring the quality of managed mental health care is to be clear about the expected results of services for the system, plans and consumers.

Several states noted the importance of engaging stakeholders early on to determine the goals of mental health managed care and how they ought to be measured.

• New York’s Quality Assurance Task Force surveyed approximately 2000 stakeholders regarding desired outcomes.

• As part of its year-long recontracting process, Massachusetts convened workgroups of different stakeholders, which created standards included in purchasing specifications.

• Iowa used a Request for Information process to obtain stakeholder input on performance measures. Sixty indicators developed are now in use.
Various stakeholders often have conflicting goals and priorities. Purchasers, consumers and providers all view quality differently; balancing these views can be challenging.

States stressed that the standards traditionally used by commercial managed care organizations may not work for non-commercial populations. One way to work around this is to create evaluation teams for the creation and review of the requests for proposals including the Medicaid agency, mental health departments, other state agencies, and consumers.

From a consumer’s perspective, the goal of managed mental health care is to assist recovery and build functional capacity. This can be measured in "non-medical ways" such as the capacity to hold a job or participate in school. States need to be flexible in measuring these goals, as such quality of life issues can be difficult to define. Wisconsin’s Children Come First program’s performance measures include the child’s success in school, lack of involvement with the juvenile justice system, and expressed family satisfaction. The effectiveness of case managers in this program is measured through specific client/family outcomes, such as level of functioning and skills developed, as well as the measures listed above.

**Measuring Success**

Quality assessment calls for observing and collecting information on three aspects of care:

- The "structural" elements, such as accreditation status of a health plan
- The “processes”, or what practitioners do to and for their patients from prevention and screening to diagnosis, treatment, rehabilitation or support services
- The “outcomes”, both short-and long-term.\(^\text{10}\)

States are moving toward stressing accountability of outcomes or results, rather than simply accountability of finances. However, the science of outcome measurement has not sufficiently advanced to rely on these measures exclusively. Efforts currently underway to develop such outcomes include:

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\(^\text{10}\) Donabedian, Avedis, “Evaluating the Quality of Medical Care,” *Millbank Memorial Fund Quarterly*. July 1966, Part 2.
• The Center for Self-Help Research at the University of California at Berkeley developed an empowerment scale examining the person's ability to make decisions on concrete issues in his/her personal life, meeting basic needs, and participating in organizations.11

• The Center for Psychiatric Rehabilitation at Boston University developed an empowerment scale used in consumer-run self-help programs. It examines such issues as control over one's life, achievement of goals, self-esteem and self-efficacy.12

• The outcome measurement system developed by the University of Cincinnati's Quality Center is now being used in 12 states. It tracks four measures: mental health symptoms, daily social functioning, perception of physical health and patient satisfaction.13

• The Child Welfare League of America's Odyssey Project is examining outcomes for about 2,500 emotionally disturbed children and teens in residential settings. Outcomes to be examined at the end of treatment include: placements into less intensive settings, family reunifications and adoptions, educational achievements, level of life skills, behavioral problems, and social competencies. Outcomes at one- and two-year follow-ups include: employment, educational achievement, personal satisfaction with life, satisfaction with services, connections with family and friends, contacts with juvenile and criminal justice, and alcohol and drug use.14

Bench marking and states using each other's data may provide the comparison point currently unavailable from the fee-for-service system. However, the difference in states' Medicaid mental health managed care systems may make developing such benchmarks very difficult. The Center for Mental Health Services, a division of the U.S. Department of Health and Human Services' Substance Abuse and Mental Health

11 Segal, Steven, Silverman, Carol, Temkin, Tanya, Empowerment Scale. Center for Self-Help Research, Berkeley, CA.

12 Making Decisions: Empowerment Scale, Boston University, Center for Psychiatric Rehabilitation, Sargent College of Allied Health Professionals, Boston, MA.


16 National Academy for State Health Policy
Services Administration, has given grants to 20 states to pilot test a mental health consumer “report card”, measuring access, appropriateness and outcomes of mental health services for various populations.\(^\text{15}\)

In addition to any available outcome measures, states monitor quality through such process measures as:

- **Access** - maximum distance to a hospital, maximum time for response to a phone call, maximum wait at an emergency room or for a hospital bed, etc.

- **Types of providers** - children’s providers, gerontologists, social service providers, etc.

- **Ability to serve special needs populations** - individuals dually diagnosed with mental illness and substance abuse issues, children in foster care, etc.

- **Caseload ratios** especially with regards to special populations

- **Quality indicators** such as those in HEDIS.

In its first bid for mental health managed care, Massachusetts held plans accountable to the measures listed above. Now in its second bidding process, the state has added these criteria for review:

- Length of time the consumer is in the community

- Length of time the consumer is in a single living situation which he/she likes

- Ability of the consumer to participate in school or work (including supported work).

Delaware’s performance indicators for the Child Mental Health Public/Private Partnership\(^\text{16}\) include:

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\(^{15}\) Ibid.

\(^{16}\) *A Public MCO Innovation: The Role of the Division of Child Mental Health Services in Medicaid Managed Care’s Child Mental Health Public/Private Partnership*. State of Delaware, Diamond State Health Plan, Department of Services for Children, Youth and Their Families. February 1996.
• Effectiveness:
  • Client improvements on pre/post symptoms and community functioning
  • Consumer satisfaction
  • Low rates of unplanned readmissions, premature discharges, failed transitions

• Efficiency:
  • Average cost per quintile of population served
  • Controlled lengths of bed stays, hospital and residential treatment
  • Cost per admission to deep end services

• Appropriateness:
  • Levels of intervention based on levels of severity; judicious use of bed resources
  • Clients move toward less restrictive levels of care
  • Parents participate in treatment planning
  • Treatment team leaders validate selection of level

• Accessibility:
  • Services are geographically accessible
  • Services are equally available across age range
  • Minority groups are appropriately represented across levels
  • Service populations represent various disability groups
  • Follow-on services, e.g., for 17 year olds, are accessible

• Provider Capacity:
  • Adequate service capacity in various levels to accommodate inflows
  • Adequate support for intake/assessment, clinical services management, provider administration
  • Clients move appropriately between commercial MCOs and public MCO (managed by the Division of Child Mental Health)

Using the Data

Once goals are in place, specificity of desired results in the procurement and contracting process can keep states in control of the process. Explicit criteria standardize the assessment of quality by using rules that are known to those being assessed and that can be updated over time as new treatments are introduced or more is learned about...
the effectiveness of existing treatments in different populations. However, while an outcome can be specific, the state may not want to spell out the means to that outcome. For example, if reimbursement is limited to only the covered services enumerated, new service development can be slowed or prohibited.

States suggested that contract provisions include:

- The performance standard expected; (if available) the outcome desired
- The type(s) of data necessary to show that this standard/outcome has been met
- The method for gaining this data
- The definition of non-compliance to the standard/outcome and the sanction(s) for that non-compliance.

Determining performance standards and targets is difficult without having prior data to show what is reasonable. Trying to compare services delivered through risk-based managed care and fee-for-service systems does not work well, for several reasons:

- Different organizational structures make comparison difficult
- Managed care may provide more flexible benefits than fee-for-service
- Fee-for-service beneficiaries may experience access barriers which would affect their use of services
- Managed care is often provided in more urban areas, complicating comparisons with fee-for-service, which may have a more rural focus
- In many areas, data is incomplete or not comparable between fee-for-service and managed care.

Focusing on what is realistic — as opposed to what is merely possible — makes for a stronger contracting and monitoring process. The staff time needed to monitor quality — in most cases already more complicated and time-consuming than overseeing the fee-for-service system — increases with every additional measure to be evaluated. (Tennessee noted that the 110 performance measures in its initial contract were too

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many for appropriate measurement and reporting. Those measures have been reduced to 33 for the next bid.) Also, there may not be enough people receiving a certain type of care for its meaningful evaluation. Finally, the contractor being evaluated must have the ability to affect the issue being measured.

Monitoring takes place at multiple levels — the managed care organizations, the behavioral health organizations, providers, etc. States must also monitor the system as a whole, as changes made in one area may affect other areas in unforeseen ways.

Monitoring also involves other state agencies. In its children’s program, Delaware’s Medicaid agency holds the Division of Child Mental Health Services (Department of Services for Children, Youth and their Families) accountable by withholding the reimbursement if problems with services arise.

Agencies can also work together to monitor managed care organizations and providers. Data collected by one agency may be valuable as performance measures to another agency’s monitoring efforts.

- In Washington, payroll data submitted by employers to the Department of Employment Security is being used to measure employment as an outcome for people serviced in the mental health, developmental disability, substance abuse and vocational rehabilitation systems. This is considered much more reliable than case manager reports.

- In Wisconsin’s Children Come First program, the Medicaid and mental health agencies share data collected by the mental health agency. Both agencies negotiate contracts together and share staff for monitoring.

Monitoring must provide immediate results as well as long-term results. Tennessee implemented consumer cohort studies to gain immediate feedback on the system. When starting the program, Iowa kept daily track of treatment authorizations and inpatient utilization in order to combat public fears that enrollees would not be able to obtain services.

Quality monitoring needs to take a multi-pronged approach. Monitoring mechanisms used by states include:

- Advisory committees, including members of different stakeholder groups
- Spot inspections
- Consumer input (see Consumer Involvement section)
Lessons

- Involve stakeholders in developing goals and performance standards. National standards may be less important than standards desired by stakeholder groups. In Iowa, stakeholders consisted of anyone who chose to respond to the Request for Information. Wisconsin’s Children Come First program worked with a family advocacy group, Wisconsin Family Ties, to design a family satisfaction tool. Surveys are returned by families to Family Ties rather than to the state.

- Different stakeholders often have conflicting goals and priorities.

- Create evaluation teams for the creation and review of the RFPs including the Medicaid agency, mental health departments, other state agencies, and consumers.

- Staff time needed to conduct oversight and monitor quality is significant.

- State agencies working together can improve the effectiveness of oversight. Data collected by one agency may be valuable as performance measures to another agency’s monitoring efforts. Agencies may have to work out agreements regarding how to share data.

- Focus on performance standards that are realistic for plans to gather meaningful data and for state staff to manage/evaluate.

- Specificity of desired results in the procurement and contracting process can allow states to remain in control of the process. Contract provisions should include:
  - The performance standard expected; (if available) the outcome desired
  - The type(s) of data necessary to show that this standard/outcome has been met
  - The method for gaining this data
  - The definition of non-compliance to the standard/outcome and the sanction(s) for that non-compliance.

- Monitoring must provide immediate results as well as long-term results. In the early days of its program, Iowa used authorization data to build public confidence that the door to mental health care remained open and that services were being provided. Colorado conducted extensive evaluations of pilot projects prior to expanding them.
Monitoring takes place at multiple levels — the managed care organizations, the behavioral health organizations, providers, etc. States must also monitor the system as a whole.

V. Consumer Involvement

States agreed on the importance of engaging broadly with consumers and family members, and including consumer involvement from the very beginning of program design. Those who rely upon services provided should be involved in all aspects of managed care, including benefit design, rate setting, contracting, governance, monitoring and oversight. Outcome measures, in particular, must incorporate consumer input to accurately evaluate the effectiveness of the managed mental health care service delivery system. States stressed the importance of the commitment to both seeking out consumer input, and to using this input in crafting and fine-tuning programs. It was noted that adults with mental illness generally wish to represent themselves and not be represented by family members who may have different goals. On the other hand, families are important stakeholders in children’s mental health programs.

States use a variety of approaches to assure consumer involvement. A multi-pronged approach increases the chances that the information gathered represents the views of a wide variety of consumers. States recommended such approaches as:

- New York developed a Quality Assurance Task Force, which surveyed over 2,000 stakeholders, including consumers, on desired outcomes.
- Massachusetts and Colorado require managed care organizations to have consumers and family members on advisory groups.
- Colorado has held approximately 20 focus groups with adult consumers, family members of adult consumers, and parents of child consumers. They increased participation by offering child care and refreshments, and by having Community Mental Health Centers (CMHCs) mention upcoming groups to clients. Managed care contractors are not allowed to be present, but are provided post-focus group feedback.
- Washington conducts 20-minute interviews with consumers on such issues as access, voice and ownership (CAVO) of the treatment process.
New York is developing a peer education program in their Prepaid Mental Health Program. Beneficiary-run organizations will receive funding to assist beneficiaries learn about the program and to monitor enrollment practices.

Some states have found it especially difficult to get children and adolescents as well as their families to the planning table. States have used strategies such as paying for gas and child care, but noted it was also important to have staff support for the consumers to educate and support them in understanding the issues.

Many states use consumer and/or family member satisfaction surveys, but stressed that by themselves they may be of limited use. Research has shown that most people will express satisfaction with any service provided. More useful information may be obtained by asking consumers about improvements in their quality of life or ability to live independently.

Consumer input can also be gained through grievances and complaints. States gain this type of input through:

- Offering consumer hotlines and 800 phone numbers
- Employing consumer advocates
- Studying plan disenrollment and switching
- Aggressively reviewing informal complaints
- Establishing ombudsman programs outside the system

Delaware found that many Medicaid beneficiaries speak freely with enrollment brokers. The beneficiaries recognize these brokers as independent of either the plans or the state. The brokers are often available at community areas, and considered responsive by Medicaid beneficiaries. To take advantage of this informal practice, the state combined the ombudsman and enrollment functions. However, others worry that the independence of the enrollment brokers will be compromised if they take on responsibilities for complaints and grievances.

Using peer leaders to educate consumers on their rights and responsibilities as managed care enrollees was stressed. Some states also use special care coordinators who teach persons with mental illness how to enroll and use the system with no disruption of care.
Initiatives under way may prove effective in facilitating consumer involvement. For example, the Foundation for Accountability (FACCT), an organization primarily of consumer and purchaser representatives, is seeking to develop new performance measures for managed care that are “patient centered”. Brandeis University has developed a Consumer Access, Voice and Ownership (CAVO) survey.

Finally, mechanisms must be in place to assure that consumer input is used in planning or modifying the program. Feedback loops create ways to make sure such input is used.

Lessons

- Consumer involvement must be early and regular throughout program development, operation and monitoring. Resources must be invested to obtain and use consumer input. Consider developing and funding practical assistance for consumer involvement.

- Use multiple strategies to obtain consumer input. Using one mechanism (such as a consumer satisfaction survey) may be of limited usefulness.

- Consumers do not speak with one voice. Issues are different for different populations of consumers, family members, etc. Be sure consumer engagement is culturally sensitive and that samples are stratified.

- Medicaid programs should reach out to mental health programs for input from consumers and nomination of consumers to participate.

- Complaints and grievances can not be overlooked as a source of consumer input.

- Build in feedback routes to assure that consumer input is used in planning or modifying the program.

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VI. Administrative Issues

The transition to managed mental health care creates administrative demands for state agencies. States need significant time and resources to successfully implement managed mental health care and to develop new relationships among state agencies, with consumer groups, and with other stakeholders. Iowa urged states in the pre-implementation stage to allow sufficient time to develop the new mental health delivery system and recommended that BHOs begin developing networks, policies and training 6 months before capitation begins since many issues need to be addressed and other unanticipated ones will surface. Issues to be worked out include claims processing, data and payment systems. Colorado spent three years in the planning process and had a smooth implementation process and consumer transition. Even then, unexpected administrative issues arose.

New partnerships need to be formed at the state level as well as the county, regional, and local levels depending on how providers are organized. Needed training should be coordinated three ways among states’ mental health and Medicaid programs, MCOs and local providers.

States warned that cost-shifting is real during periods of transition, particularly between institution- to home-treatment. It was suggested that contractors pay transition costs to minimize cost-shifting. For example, if contractors are held accountable for two to three weeks of residential care, some of the incentives to cost-shift would be minimized.

Rate-Setting and Risk Sharing

States use several options to set rates for mental health managed care programs. There does not seem to be one best way to set rates that guarantees states are paying properly for services. Many states agreed that it is difficult to acquire and synthesize all the data needed to set rates and determine risk sharing arrangements. In risk sharing, MCOs must prove they are able to sustain service delivery at the rate the state has determined.

- Colorado uses historical fee-for-service claims data, geography, age, eligibility category, and health status to set rates. The state planned to establish a stop loss pool, in which it would withhold part of the BHOs’ capitation rate to offset high cost consumers. However, the BHOs felt confident they could take on the risk themselves.

- Oregon uses an actuary firm to set rates. However, the state does not know whether they are paying too much or not enough, realizing that the actuary firm
must make many assumptions in determining rates. As for risk sharing, the
BHOs are required to participate in the state's stop-loss insurance or to self-
insure.

- Massachusetts has established risk corridors and is considering adopting a case-
mix approach to payments.

In Tennessee, the Medicaid program (TennCare) also implements the state's mental
health program (TennCare Partners), and is responsible for delivering mental health
services. This interdepartmental relationship gives the Medicaid program
responsibility for monitoring the BHOs, and for paying the capitation rates.

Massachusetts also has a Medicaid/mental health agency relationship. Soon after
converting the medical and mental health systems to managed care, the Medicaid
agency realized many beneficiaries were also receiving services through the
Department of Mental Health. The two agencies have developed a relationship in
which the Department of Mental Health transfers money to the Medicaid agency to
cover mental health services supplied by MCOs. Medicaid covers acute services; the
Department of Mental Health covers continuing care, quality, clinical oversight and
policy.

States expressed interest in efforts to limit MCO profits, but noted that such initiatives
were very easy to "game". They also warned that plans may need higher administrative
payments to be certain they quality assurance standards. Colorado created limits on
profits but noted that the elements of accounting had to be very clearly defined to
monitor those provisions.

Data Systems

Under fee-for-service, claims data was readily available. In managed care, Medicaid
agencies do not receive claims information directly from providers. Instead claims
information is sent to the plans. Medicaid agencies must request claims information
from the plans, making this information more difficult to come by. Problems arise even
when data is available since plans', providers', and states' different systems are difficult
to coordinate, and the data collected is often not comparable since definitions and
outcome measures are not standardized. Information needed for quality assurance,
program planning, and setting future capitation rates is obtained in part by tracking
high-cost consumers, identifying areas of underservice for specific services, and
identifying gaps in continuity of care and preventative care. States also stressed the
importance of tracking the authorization of services and ensuring the services
authorized were actually delivered. Many states reported difficulties setting up data systems, but agreed that such data is very important and worth the effort.

- Connecticut expressed lack of time and support as barriers to setting up their data system. They also encountered problems such as the claim system not being linked to the eligibility system. This creates a problem in determining the number of clients to pay capitation to the BHO on a monthly basis. Other states expressed concern about eligibility management issues and how to handle retroactive eligibility in paying plans.

- Delaware’s Division of Child Mental Health Services has established a data system that provides immediate and accurate information on every child in the system. It allows the Division to track clients and service provision and provides the data necessary to produce its system indicators: service demand, rates of referral, unduplicated number of clients served in the month, service loads at the various levels of care, and psychiatric hospital days. It also supports their bundled rate. Delaware is having trouble tracking its clients across systems.

Before transitioning to managed care for mental health consumers, all participating state agencies, plans, and providers should convene to discuss data needs and data collection strategies.

**Contracting**

It is important for states to evaluate the capacity of plans and providers and to set clear goals prior to launching managed mental health care. States should be specific about what services plans must provide and have clear expectations on the outcomes. However, states were not in agreement on what format the contract should take. Some felt it should be very specific with services listed, with the desired outcomes and stipulations if the outcomes are not met. Those in disagreement felt that stringent contracting confined BHOs and did not allow them to be creative in developing new, cost-effective approaches to care. A question states will need to answer before negotiating contracts is how standards should be set in the contract.

- Colorado establishes a minimum package of benefits MCOs must provide, but provides no ceiling or limits.

- Washington is reluctant to have all measures and outcomes specified in their contracts for fear BHOs will only perform to those standards. They believe the contract needs to be flexible depending on the organization and population, since many outcomes vary by population.
Massachusetts requires aggressive purchasing specifications to assure services provided are designed for the population being served and not carried over from a general MCO's contract. All MCOs are granted financial incentives if quality standards are met in their 6-month reviews. The state often increases standards striving for continuous quality improvement.

States must also ensure that consumers receive appropriate care from the plan and its network. States can require plans include specific services appropriate to a consumer’s diagnosis in the benefit package. If the plan is unable to provide such services, guidelines should be in the contract to determine the procedure to refer out of network and who will pay. In Wisconsin, if the state finds that it is an unrealistic expectation for the network to provide a service, the state allows beneficiaries to disenroll and the state pays fee-for-service. If the service should be available in the network and isn't, the plan must pick up the cost. The reimbursement arrangement is developed so MCOs are not penalized if their network cannot provide all services.

**Lessons**

- Work towards eliminating system boundaries to increase flexibility and decrease duplication of services.

- Transitioning mental health consumers into managed care is a complex initiative. Plan carefully.

- Be careful about how managed mental health care is promoted. Some states increased expectations, promising to manage outcomes, but insufficient outcome measures exist to prove this promise.

- Clear standards and monitoring strategies, with data systems which can collect needed information, must be in place.

- It is important for states to evaluate the capacity of plans and providers and set clear goals prior to launching managed mental health care.

- Rate-setting strategies need to be developed carefully in consideration of the diverse needs of the population being served.
VII. Conclusion

More and more states are expanding Medicaid managed care initiatives to include mental health. No single model has yet emerged on how to best meet the needs of the person with mental illness in a managed care environment. Some states carve out mental health services, others integrate those services within traditional HMOs, while still others include some services within HMOs while offering other services through specialty providers. States participating in the symposium concluded that each state, working with consumers and key stakeholders, would need to identify its own approach to meeting these four goals:

- Integrate physical and mental health care to provide a seamless system of care that treats the whole person
- Help individuals with mental illness toward recovery and toward maximizing their choices and independence
- Promote community-based, highly individualized services
- Use dollars more efficiently.

Because persons with mental illness need a range of services and supports, managed care programs should maximize coordination with other services (educational, juvenile justice, vocational, supportive, etc.) assisting the beneficiary. Benefits need to be designed to provide sufficient accountability but still allow enough flexibility to encourage plans to develop individualized, consumer-sensitive care approaches and to overcome the institutional bias of fee-for-service Medicaid. Several states have attempted to encourage more flexible benefits by pooling Medicaid and mental health dollars in the capitation rate paid to plans.

Development of appropriate plans and providers requires a focus on the special needs of persons with mental illness and a recognition that managed care will result in significant reduction of inpatient use. Plans need the capacity to develop and obtain the wide range of services needed by persons with mental illness.

Clear expectations, reflecting consumer input, must be monitored carefully. These expectations must recognize that managed mental health care is a work in progress, requiring ongoing revisions, particularly regarding the appropriateness of rates and risk-sharing adjustments.

States will be challenged to develop effective systems of managed mental health care. They need sufficient resources (staff, data capacity, quality oversight, consumer and stakeholder involvement) to meet the task.
Appendices
Appendix A
The Kaiser-HCFA State Symposia Series
Transitioning to Managed Care: Medicaid Managed Care in Mental Health

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Appendix B - Summary of Selected State Approaches

Colorado's fully carved out Medicaid managed mental health care program operates under a 1915(b) waiver in 51 counties, serving approximately 70% of the state's Medicaid population. The program will become statewide in early 1998.

The state's seven managed mental health contractors, known as Mental Health Assessment Services Agencies (MHASAs), are responsible for covering all Medicaid managed mental health services within their respective regions. Four are community mental health centers (CMHCs); three are run by partnerships of CMHCs and a commercial plan. Each is paid a capitated rate by the state for all mental health services needed by enrollees.

All Medicaid mental health services are included in the capitation except prescription drugs and therapeutic services to youth in designated residential treatment centers. (Prescription drugs are included in the capitated rate paid to HMOs responsible for covering the enrollee's physical health care needs. Services to the youth in designated residential treatment centers are provided fee-for-service.) No benefits are limited. Enrollment is mandatory for AFDC and related populations, SSI beneficiaries, individuals dually eligible for Medicaid and Medicare, medically needy individuals and individuals in foster care.

Connecticut fully integrates mental health services into its managed care program, although the state does allow commercial MCOs to carve out some mental health services to subcontractors. The state's managed care program, operated under a 1915(b) waiver, is mandatory for AFDC and related populations and for children in foster care throughout the state.

All Medicaid mental health services are included in the capitation except services for children admitted to Riverview Hospital (a state-owned facility). No benefits are limited.

Delaware operates its statewide partial carve-out program under an 1115 waiver. Most services are provided through one of the four commercial MCOs contracted to provide both physical and mental health care.
Services provided through MCOs are limited. Adults can receive 30 units of inpatient care, 20 units of outpatient care, or any combination thereof. Children can receive 30 units of outpatient care. Once this basic benefit has been exhausted:

- **Children** - The Department of Services for Children, Youth and their Families, Division of Child Mental Health Services (DCMHS) acts as a public managed care organization. MCOs must contact the DCMHS Intake/Assessment Unit when a child receives the 15th hour of outpatient services, initiating collaborative planning which may include transition to the DCMHS system. Similar advance notice is made to MCOs by DCMHS when discharge of a client is anticipated, so that in-community support within the 30-hour benefit may be provided whenever necessary.1

- **Adults** - must be determined to be suffering from severe and prolonged mental illness by the Department of Health and Social Services’ Division of Alcoholism, Drug Abuse and Mental Health. If so determined, this agency covers services as long as necessary. If they do not meet the criteria, they are served by the Division until January 1, then return to the MCO.

Program enrollment is mandatory for all Medicaid-eligible populations except dual eligibles and individuals covered by the state’s 1915(c) waiver.

**Iowa**'s statewide, fully carved out managed mental health care program is operated under a 1915(b) waiver. Enrollment is mandatory for all Medicaid beneficiaries under age 65 except for those in the comprehensive HMO program. Each county is required to have its own managed mental health care plan for non-Medicaid beneficiaries or services.

Services throughout the state are provided through one commercial BHO. The state has an open panel requirement, in which the BHO must work with any willing provider. All Medicaid mental health services are included in the capitation. There are no limits on benefits. The contract requires the BHO to develop "alternative services" but does not specify which or how many services. The contractor has expanded coverage to include 10 services not previously covered, including mobile crisis, mobile counseling, respite services, community support programs, and assertive community treatment.

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1 A Public MCO Innovation: The Role of the Division of Child Mental Health Services in Medicaid Managed Care's Child Mental Health Public/Private Partnership. State of Delaware, Diamond State Health Plan, Department of Services for Children, Youth and their Families. February 1996. P. 15.

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The state fully capitates mental health services including administrative costs; the capitation rate is set at 86% of the state's fee-for-service cost.

Throughout Massachusetts, Medicaid beneficiaries have two ways of receiving managed mental health care services:

- In the HMO program, enrollees receive integrated physical and mental health services (some HMOs subcontract to other providers for mental health services).
- In the PCCM program, enrollees receive mental health services through a managed care program fully carved out from their primary medical care.

The decision was made to offer two options on the basis that coordination of care might be more problematic between HMOs and the carve-out vendor than between PCCM physicians and the vendor. Massachusetts operates its managed care programs through a 1915(b) waiver.

Enrollment in managed care (through either the HMO or PCCM programs) is mandatory for AFDC and related populations, and for medically needy individuals. It is voluntary for SSI beneficiaries and dual eligibles. A HCFA-approved 1115 waiver would allow eligibility to be expanded to non-Medicaid populations as of July 1, 1997, if approved by the state legislature.

Acute mental health services are provided through managed care (through either a commercial HMO in the HMO program or a commercial BHO in the carve-out). Continuing care (such as residential care, state mental hospital stays, and drop-in centers) is the responsibility of the Department of Mental Health. The commercial contractor is responsible for managing acute mental health services financed both by Medicaid and the Department of Mental Health.

In 20 of Oregon's 36 counties, managed mental health services are carved out and managed by BHOS. These carve-outs serve approximately 25% of the state's Medicaid beneficiaries. In the rest of the state, mental health services are integrated into the state's Medicaid managed care program, but the state pays for these services on a fee-

\[2\] Medicaid Carve-Outs: Policy and Programmatic Considerations. Submitted to the Center for Health Care Strategies (Princeton, New Jersey) by The MEDSTAT Group (Cambridge, Massachusetts), January 1997. Tab D, p. 3.

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for-service basis. Program planners are seeking to phase in managed mental health services for the rest of the state by July 1997, and to capitate these services by October 1997.

The general Medicaid managed care program is run under an 1115 waiver. Enrollment is mandatory for AFDC and related populations, SSI beneficiaries, medically needy individuals, and children in foster care.

In Multnomah County, Oregon is providing capitated mental health services to children under a 1915(b) waiver.

Services funded by the Oregon Health Plan are prioritized based on the efficacy of treatment, including patient outcomes, costs associated with proper/improper treatment, and effects on quality of life, in combination with such factors as age, productivity, equity, and access to care. The number of service categories covered each year depends on the amount of funds allocated by the state legislature. Thirty-eight mental illnesses are currently covered. Services provided include acute psychiatric care, medication management, case management, consultation, evaluation, therapy, skills training, daily structure and support, urgent and emergency services. Benefits are limited to medically appropriate services.

Contractors include community mental health centers (CMHCs), fully capitated health plans, a nonprofit corporation and a regional alliance of CMHCs. Commercial plans are required to coordinate with CMHCs. CMHCs receive state mental health money to provide services not included in the managed mental health care benefit.

**Tennessee** operates its statewide managed mental health care program under an 1115 waiver. It is currently fully carved out from the managed physical health care program, but the state plans to reintegrate it by January 1999. If at that time the managed care plans contracted for the TennCare program decide they do not want to provide mental health services, they must withdraw from the entire TennCare program.

Enrollment is mandatory for all Medicaid-eligible individuals, and for uninsured and uninsurable individuals.

Services include up to 60 days of psychiatric inpatient (for adults), up to 45 days of psychiatric outpatient (for adults), psychiatric pharmacy and laboratory services,

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transportation, mental health case management, residential treatment, housing, crisis services, and psychosocial rehabilitation. Services are provided through two BHOs. The state requires each HMO to partner with one of these BHOs.

**Washington** operates a statewide partial carve-out under a 1915(b) waiver. Nearly all mental health services are carved out, except those provided in primary care settings. Services provided in primary care settings, limited psychological testing, and one hour per month with a psychiatrist are integrated into the general managed care program. Community mental health rehabilitation is provided through the carve-out. Assuming HCFA approves the state's waiver application, community psychiatric inpatient care will be added to the benefit package in October 1997.

Services are managed through 14 county-operated managed behavioral health organizations called Regional Support Networks (RSNs). These RSNs operate in one or several counties as prepaid health plans. The RSNs are prepaid health plans, and subcontract with CMHCs to deliver services.

Enrollment is mandatory for AFDC and related populations, SSI beneficiaries, medically needy individuals, and children in foster care.

**Wisconsin** has several programs operating under 1915(b) waivers.

- Its statewide Medicaid HMO program, in which plans must provide all services covered under Medicaid fee-for-service, includes mental health services. Enrollment is mandatory for AFDC recipients except for children with severe emotional disturbances and adults with severe and prolonged mental illness. These individuals can request exemption from the program to complete lengthy treatment.

- The Independent Care Program (I Care), and Wisconsin Partnership Program (Partnership) are voluntary programs for SSI beneficiaries residing in certain counties. Each includes mental health services as part of an integrated benefit package. Clients of community support programs are disenrolled from I Care.

Services provided in these programs include inpatient hospital, outpatient hospital and clinic, day treatment, community support programs, and in-home treatment for children with serious emotional disturbances.

In addition to these programs, Children Come First, a 2-county carve-out program, serves children with serious emotional disturbances who are at imminent risk of
institutionalization. This program has no waiver; enrollment is voluntary. The capitation payment from the state covers only Medicaid covered services, including mental health and substance abuse services. Each of the 2 counties also provides a per person per month capitation which funds non-Medicaid covered services such as respite, mentoring or education aides.

Services are managed by:

- Medicaid HMO program: by commercial HMOs
- I Care: by a commercial HMO in affiliation with a rehabilitation agency
- Partnership: by a community-based organization.
- Children Come First: by a county or nonprofit MCO under contract to a county
### National Academy for State Health Policy - Summary of State Medicaid Managed Mental Health Care Approaches

<table>
<thead>
<tr>
<th></th>
<th>Colorado</th>
<th>Connecticut</th>
<th>Delaware</th>
<th>Iowa</th>
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<td>HMO - Integrated; PCCM - Full carve-out</td>
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<td>Integrated</td>
<td>Partial carve-out*</td>
<td>Full carve-out</td>
<td>Integrated &amp; carve-out*</td>
<td>Full carve-out</td>
<td>Partial carve-out*</td>
<td>Mostly integrated; 2 counties - Full carve-out</td>
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<td><strong>Funding</strong></td>
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<td>Voluntary***</td>
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**Notes:**
- Extended MH services over the limit included in the MCO benefit for children and adults.
- Everyone but DMR.
- With zero spend-down.
- Offers both integrated and carve-out models. Also, some services continue to be excluded from the benefit package offered.
- Uninsured, uninsurable.
- Nearly all MH services carved out, except those provided in primary care settings, and limited to psychological testing.
- Program for SED children includes capitated dollars from each of the 2 counties in which it operates.
- Children with SED, at imminent risk of institutionalization - 2 counties.
- Children with SED and adults with serious mental illness may request exemption from these programs. Exemptions may be granted to complete treatment or for longer periods of time.
- Dual eligibles, 55 years and older, nursing home eligible - 2 counties.

Appendix C
## National Academy for State Health Policy - Summary of State Medicaid Managed Mental Health Care Approaches

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</table>

**Notes:**
- WA: County operated managed behavioral health
- WI: Counties

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<table>
<thead>
<tr>
<th>State</th>
<th>Benefits Description</th>
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</thead>
<tbody>
<tr>
<td>Colorado</td>
<td>All are included except therapeutic services to youth in designated Residential Treatment Centers (RTCs). No benefits are limited.</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Comprehensive benefit package. Originally none excluded. However, CT has just instituted a policy to disenroll children admitted to State-owned facility (Riverview Hospital).</td>
</tr>
<tr>
<td>Delaware</td>
<td>Adults - 30 units of inpatient, 20 units of outpatient, or any combination thereof in cap. All other and SPI provided by Adult Mental Health (state agency). Children - 30 units of outpatient in cap, all inpatient and over 30 outpatient is delivered by an MCO model developed by the Division of Child Mental Health.</td>
</tr>
<tr>
<td>Iowa</td>
<td>All mental health services covered by FFS are included. No limitations. Contractor mandated to do other alternatives and step-down services as well.</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Acute care. Continuing care responsibility of Department of Mental Health.</td>
</tr>
<tr>
<td>Oregon</td>
<td>Acute psychiatric care, medication management, case management, consultation, evaluation, therapy, skills training, daily structure and support, urgent and emergency services. Limited to medically appropriate services only.</td>
</tr>
<tr>
<td>Tennessee</td>
<td>Limited psychiatric inpatient (60-day max for adults) and outpatient (45-unit max), psychiatric pharmacy and lab, transportation, MH case management, residential treatment, housing, crisis services, psychosocial rehab.</td>
</tr>
<tr>
<td>Washington</td>
<td>Community mental health rehabilitation; community psychiatric inpatient (waiver submitted; anticipated start date 10/1/97). Limited psychological testing; one hour per month psychiatrist.</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>Inpatient hospital, outpatient hospital and clinic, day treatment, community support programs, in-home treatment and targeted case management for SED kids in 2 counties.</td>
</tr>
</tbody>
</table>
## Appendix D - Glossary

**AFDC**  
Aid to Families with Dependent Children, a cash assistance program for low income families. This Federal program — whose participants were automatically Medicaid-eligible — has been replaced with Temporary Assistance for Needy Families, or TANF — which makes no automatic connection to Medicaid. However, former AFDC recipients (even those who will not receive assistance under TANF) continue to be Medicaid-eligible.

**BHO**  
Behavioral health organization: a managed care organization that provides mental health (and frequently substance abuse treatment) services.

**Capitation**  
A form of payment for health care services in which insurers are paid a set amount per enrollee per month (referred to as the capitation payment) for providing all covered health care services for that enrollee.

**Capitation Rate**  
The per-person per-month rate paid (in this case, by the state) to a managed care organization to provide care to enrollees. This rate is set independently of the actual number and costs of treatment an individual enrollee uses.

**Carve-out**  
A population or service not included in the managed care plan.

**CMHC**  
Community Mental Health Center

**Contractors**  
can be a variety of organizations. Several are frequently mentioned.  
- *MCOs or HMOs* are managed care organizations/health maintenance organizations that provide physical health care services. They may or may not provide mental health services.  
- *BHOs* (behavioral health organizations) are managed care organizations that provide mental health (and frequently substance abuse treatment) services.

**Fee-for-service**  
A form of payment for health care services in which the payer (here, the state) pays providers for each service rendered to an eligible individual. Payment does not exceed the provider’s billed charge for that service.

**Full Carve-Out Model**  
A management approach in which mental health services and/or populations are completely separated from the physical health care program into their own managed care program.

**HCFA**  
Health Care Financing Administration (part of the U.S. Department of Health and Human Services): (among other things) grants Medicaid waivers to states which allow them to pursue managed care.
HMO

Health Maintenance Organization: a managed care organization that provides physical health care services. HMOs may or may not provide mental health services.

Integrated Model

A management approach in which mental health services are included in the general physical managed care program.

Managed Care

A system for delivering health care services where the provision of an agreed upon set of health care services is coordinated by an entity or person (a health plan or primary care case manager) obligated by contract or other agreement to be responsible for the care provided (or not provided) to an individual. Medicaid managed care can be either risk-based or non-risk in the form of primary care case management programs (PCCMs - see below).

Management Approach

The approaches used by states to deliver Medicaid managed mental health care have been broken down into three options. (Bear in mind that states do not follow these models exactly in “real life”.)

• Integrated model: in which mental health services are included in the general physical managed care program
• Partial carve-out model: in which some mental health services are integrated, but other mental health services and/or populations operate under a separate managed care program
• Full carve-out model: in which mental health services and/or populations are completely separated from the physical health care program into their own managed care program

Mandatory Enrollment

State managed care programs which require beneficiaries to enroll into managed care without an option to remain on fee-for-service.

Medicaid

A state-administered federal/state program which pays for certain medical expenses for eligible low income people. Mandatory services which may be particularly relevant to mental health care include:

• Inpatient hospital services
• Outpatient hospital services
• Physician services
• Rural health clinic (including Federally Qualified Health Center) services
• Early and periodic screening, diagnosis, and treatment (EPSDT) services for children below age 21.

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1 These definitions are all from The Lewin Group, Inc. for the Substance Abuse and Mental Health Services Administration Managed Care Tracking System. (Phase 1 Draft, November 1996.)

National Academy for State Health Policy
Optional services which may be particularly relevant to mental health care include:

- Services provided by other licensed practitioner (including psychologists and medical social workers)
- Clinic services
- Prescription drugs
- Psychiatric inpatient hospital services and nursing facility services for individuals aged 65 and older in an institution for mental diseases
- Inpatient psychiatric services for individuals under age 21
- Case management.

Medically Needy

In states with medically needy programs (optional under Medicaid law) individuals are considered “medically needy” if they meet the Medicaid disability criteria, and have incomes and/or assets above the standards for categorically needy coverage, but below State-established medically needy standards (Westmoreland, forthcoming).

MCO
Managed Care Organization

Network
The group of physicians, hospitals and other service providers contracted by a managed care organization to serve its enrollees.

Partial Carve-Out Model
A management approach in which some mental health services are integrated, but other mental health services and/or populations operate under a separate managed care program.

PCCM
Primary Care Case Management: a system of assigning responsibility for the care of a particular Medicaid beneficiary to a specific primary care provider who receives payment on a fee-for-service basis and who (typically) receives a small additional fee per enrollee per month to compensate for case management functions.

Risk-based Medicaid Managed Care
A health care delivery system in which the state Medicaid agency contracts with an entity or individual (the contractor) to provide or arrange for the provision of an agreed upon set of services in exchange for a set fee where the prepaid fee does not vary based on services used by the individual enrollee. In other words, in risk-based managed care the contractor assumes some level of financial risk for providing care to enrollees.

Risk Limitation Mechanism
A strategy employed by the state to minimize the greater financial risk faced by managed care plans in meeting the complicated care needs of certain high-cost populations. It also lessens the possibility of risk selection (see below) occurring.

National Academy for State Health Policy
<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tr>
<td>Spend Downs</td>
<td>Individuals whose incomes/assets fall above the state medically needy standard, but who would fall below if their medical expenses were factored in.</td>
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<tr>
<td>SSI</td>
<td>Supplemental Security Income, a Federal program that provides cash assistance to persons who: (1) are elderly, blind or disabled and (2) whose income falls below 75% of the Federal poverty line. SSI recipients are automatically eligible for Medicaid in most states.</td>
</tr>
<tr>
<td>Voluntary Enrollment</td>
<td>Managed care programs in which the Medicaid beneficiary can choose to obtain health services through the state’s risk based managed care program, PCCM program, or traditional fee-for-service system.</td>
</tr>
<tr>
<td>Waiver</td>
<td>Granted by the Health Care Financing Administration (HCFA), it exempts the state from certain federal Medicaid requirements.</td>
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