

MANAGED CARE AND  
THE ROLE OF MENTAL  
HEALTH PLANNING

---

AND ADVISORY

COUNCILS



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**Presented By:**  
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## **I. OVERVIEW/INTRODUCTION**

There is no denying that managed care is changing the way mental health services are delivered in both the public and private sectors. The shift to managed care in some states has been rapid and complete. What are mental health planning councils to do about this situation?

As the federally mandated citizen oversight bodies, planning councils are asked to regularly review, monitor and evaluate community based mental health services. Yet, planning councils sometimes lack the information and tools necessary to successfully accomplish this important task.

*Managed Care and the Role of Mental Health Planning and Advisory Councils* used case examples, focused presentations, and group discussions to enable planning councils to understand, review, monitor and evaluate the operations of managed care in the public sector more effectively. This regional conference targeted planning council members and other advocates from Arizona, Colorado, Idaho, Montana, New Mexico, Utah and Wyoming.

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# Day One

## **II. WELCOME AND INTRODUCTORY REMARKS**

Joseph de Raismes, Chair of the NAMHPAC Board of Directors and Mary Graham, Vice President of Health Care Reform at the National Mental Health Association opened the conference with a quick overview of the philosophy behind this meeting and what information would be covered. Ms. Graham briefly discussed the movement of managed care into the public healthcare system and the need for these types of educational opportunities for advocates. Ms. Graham also thanked Chuck Ingoglia, Executive Director of NAMHPAC and Melanie Lewis for all of their work in organizing the meeting.

## **III. OPENING PLENARY: MENTAL HEALTH SERVICES UTILIZATION IN MEDICAID**

Jeffrey Buck, Director of the Office of Managed Care, Center for Mental Health Services presented this overview of the research analysis available for Medicaid managed care. This presentation explored the question: Is Medicaid managed care the right response? One important theme that permeated the session was that there are not enough current data available on the utilization of mental health services in Medicaid managed care arrangements.

### **What We Know About Medicaid Mental Health and Substance Abuse Consumers**

In order to answer the question of whether managed care will effectively serve mental health and substance abuse consumers, one must understand the composition and needs of this group. Dr. Buck presented data on mental health and substance abuse service utilization within Medicaid. This information from the early 1990's provides a snapshot of pre-managed care service utilization. The collection and analysis of this data was the result of collaboration between SAMHSA and the Health Care Financing Administration (HCFS). Dr. Buck indicated that there is a lack of current data on Medicaid service utilization. Key findings of the pre-managed care study included:

- Twenty-eight percent of Medicaid dollars were spent on mental health and substance abuse consumers.
- Mental health and substance abuse consumers made up 10% of all Medicaid enrollees.

- Of this population, 87% were mental health consumers only, 8% were substance abuse consumers only, and 5% were both mental health and substance abuse consumers.
- Inpatient stays for mental health and substance abuse consumers were 7% of total Medicaid inpatient stays, but this population accounted for 20% of all hospital stays (includes non-MH/SA services).
- The average length of stay for mental health and substance abuse consumers was 11 days, versus an average of 5 days for all of Medicaid consumers.
- Outpatient visits by mental health and substance abuse consumers were nearly 40% of the total outpatient visits (includes non-MH/SA visits).
- Of all Medicaid expenditures, MH/SA services accounted for nearly 25% of spending for children aged 6 - 14 and 18% of that for those aged 15-20.

### **Is Medicaid Managed Mental Health Care the Right Response**

Dr. Buck followed the data reporting with a brief discussion about the purpose of managed care and how it would affect the Medicaid system. He stressed that because of the lack of data on this issue, concrete answers cannot be determined. Managed care is used as a vehicle to reduce costs and manage provider services. Dr. Buck reported that unfortunately, managed care changes often are seen as “one-time” fixes to Medicaid troubles instead of as one step in a process of reforms to the system.

### **What Do Planning Councils Need**

As mental health oversight bodies, planning councils are responsible for monitoring their State’s mental health systems. This is a very daunting task, which has become even more complicated by the introduction of managed care. Dr. Buck emphasized to the conference group that in order to monitor managed mental health care services, planning councils need more and better data. Dr. Buck listed the types of data needed as:

- Mental health expenditures as a percent of Medicaid spending.
- Penetration (access) rates.
- Mental health inpatient admission rates and lengths of stay.
- Demographics of this population (age, sex...).

Dr. Buck offered some possible solutions to this problem. The first was to establish the principle that comprehensive Medicaid mental health encounter data are essential to monitor the real stress or failure of managed care.

## IV. MEDICAID AND MANAGED CARE OVERVIEW

This program provided an overview of managed care and its development and introduction to the public and private sector. Planning councils were given advocacy suggestions for working on the Medicaid system in their state. Rita Vandivort-Warren, Public Health Analyst for the SAMHSA Office of Managed Care began the meeting with the latest trends in managed care data. Chuck Ingoglia, Executive Director of NAMHPAC led the second half of the discussion, urging planning councils to consider advocacy options in their state.

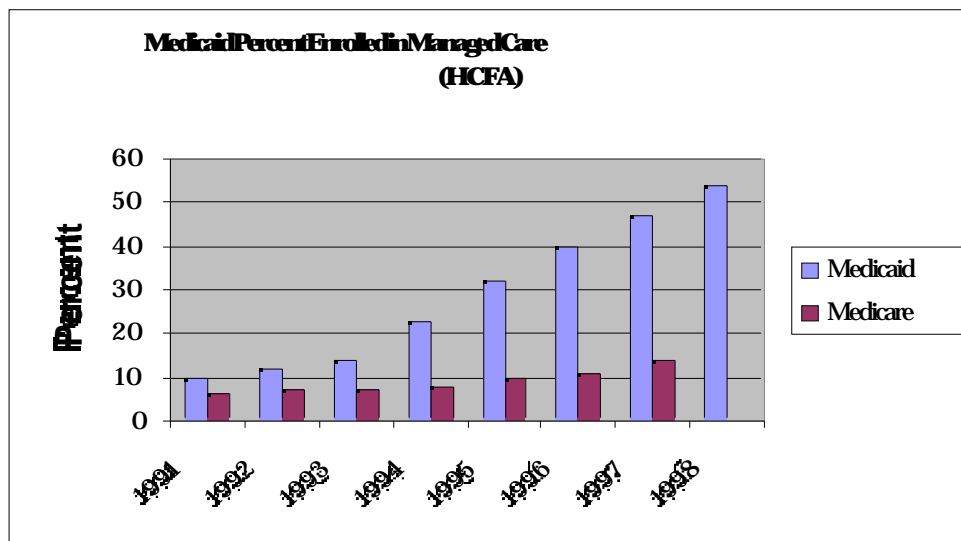
### SAMHSA Managed Care Tracking Project

The Substance Abuse and Mental Health Services Administration (SAMHSA) collects data and describes public sector managed behavioral healthcare programs in 50 States and the District of Columbia through the Managed Care Tracking System. Ms. Vandivort-Warren reported on information collected between January and July of 1999 by the independent contractor, the Lewin Group. The purpose of this tracking system is to provide detailed information on how managed behavioral healthcare systems are affecting public sector mental health and substance abuse services. Information collected by the Lewin Group was taken from 1999 SAMHSA State tracking data, the Health Care Financing Administration, the Kaiser Commission on Medicaid, and recent State reports and studies on managed care.

### Brief history of Managed Care

Throughout the 1990's, managed care Organizations have steadily increased their participation in private and public healthcare services. The number of states with managed behavioral healthcare has tripled in 3 years. Between 1988 and 1998, managed care enrollment for private health insurance has increased by 57%. Medicaid enrollments in managed care have also increased dramatically in the past 7 years. Figure 1 shows the rapid rise of Medicaid enrollments in managed care.

Figure 1. This chart shows the rise of managed care enrollments in Medicaid and Medicare in the past decade.



The introduction of managed care into the Medicaid system has had a dramatic effect on the organization, administration, financing and delivery of services, particularly to populations with disabilities. Early implementation of managed care included AFDC/TANF populations, but it excluded consumers with chronic conditions. Now, 1 in 4 non-elderly disabled Medicaid beneficiaries is enrolled in a managed care program, and the number is growing. Tennessee is an example of this, as 100% of disabled Medicaid beneficiaries are enrolled in the TennCare managed care program.

### **Managed Care Arrangements**

Medicaid is the primary purchaser for public behavioral healthcare, and often the only major new source of revenue for the public mental health system in many States. In public behavioral healthcare programs where Medicaid is the only source of funding, most programs are integrated with physical health programs, but when money from State mental health agencies is included as a funding source, carve-out programs focused on mental health services are more common. Carve-out programs are more likely to provide mental health and substance abuse specialty services such as residential programs, rehabilitation, prevention and consumer-run programs.

Findings from data collection and managed care tracking projects can be used by various agencies and organizations to evaluate the behavioral healthcare system and make improvements. Ms. Vandivort included this list of the key findings from the 1999 Health Care Reform Tracking Project in her presentation:

- There was an initial increase in access to services, but access to extended care services was compromised in most states.
- Although most reforms require family involvement, implementation is still inconsistent among states.
- Most reform efforts do not affect the overall level of cultural competence in most states.
- MIS systems are considered inadequate in most states.
- Most states have level of care criteria for children's mental health services.

Ms. Vandivort-Warren discussed some major changes to the public behavioral healthcare system that have taken place in the past few years. Between 1998 and 1999, 8 states have added new managed care programs (only in Arkansas and Nevada were these the first managed care programs), and two states, Montana and North Carolina, have returned to fee-for-service programs. Another great change in the behavioral healthcare system is who is providing services. A number of mergers have taken place in the field, and the large behavioral health care organizations are growing, while the smaller organizations are leaving Medicaid. The three top organizations, Magellan, Value Options and United Behavioral Healthcare, represent 57% of the National market.

### **Managed Care Reform**

Current "reforms" of the welfare system have resulted in a loss of Medicaid coverage for millions of Americans. Between 1996 and 1998, an estimated 1.3 million poor children lost their Medicaid coverage. Half of this population lost its coverage as a result of incomes rising above the poverty level. The majority of children that left Medicaid became uninsured. To combat this situation, the State Children's Health Insurance Program (SCHIP) was created. This program got off to a slow start, but during the first

6 months of 1999, enrollment grew by 467,000 from 834,790 to 1,310,959 participants. Although growth in participation was seen around the country, almost half of the growth was in 3 states: New York, California, and Florida. Many states now report finding one Medicaid eligible child to every SCHIP eligible child among new enrollments.

Ms. Vandivort-Warren described a trend found in the tracking report that state legislatures are taking action on managed care reform. In 1999, ten states passed parity legislation, raising the total to 29 at the end of that year. Forty-three states have passed legislation on patient's rights; an example of this is the ban on gag clauses passed in 46 states. Three states (Texas, Missouri and California) have passed insurance liability legislation.

### **Cultural Competency**

The SAMHSA Managed Care Tracking Project also collected information on the cultural competency of services provided under managed care. A much larger percentage of African-American consumers reported delays in care, limited treatment options, and confusing rules compared to European-American consumers. Ms. Vandivort-Warren suggested that there is a need for increased training for systems in the area of cultural competency. Further, Ms. Vandivort-Warren mentioned the cultural competency standards developed by the National Mental Health Association as a tool for advocates to improve the system.

This part of the session was concluded with a section on conflicts in managed care and an overview of where we are today. The latest trends have shown some conflicts occurring in managed care:

- Public buyers are becoming more demanding in designing managed care programs;
- Providers are consolidating and asking for more money;
- Consumers are more vocal about access to specialists, medications and new treatments; and
- Commercial HMOs are faltering financially and are becoming more skeptical of public business.

Managed care has swiftly come in and taken over the public behavioral healthcare system, and it is here to stay. Under this system there is continued access to primary health care, but there are many questions concerning access to specialty and long-term care, as purchasers are less willing to spend money on mental health and substance abuse services. Ms. Vandivort-Warren expressed the immediate need for more consumers and advocates to effect change on the system and increase access to behavioral healthcare services.

### **Advocacy Suggestions**

Following Ms. Vandivort's presentation on the trends in managed behavioral healthcare, Chuck Ingoglia discussed some areas of action for planning councils to effect reform. Advocates must become involved in the monitoring and reform of the Medicaid system. He emphasized that now is a time for action because:

- Medicaid affects our most vulnerable population;
- Drastic changes are taking place rapidly;
- The primary motive of these changes is often cost containment or cost reduction; and

- Consumers, family members and advocates have not had a sufficient role in this process.

Mental Health Planning and Advisory Councils are established in every state and territory and are given the broad responsibility to monitor the quality of mental health services provided in the state. Planning councils have a legitimate role in the planning, oversight, and monitoring of managed care arrangements in the public sector as part of their planning and oversight mission.

### **Areas of Focus**

Mr. Ingoglia suggested that planning councils focus on three main areas of advocacy:

- Access:
  - Eligibility/enrollment/disenrollment;
  - Provider network/benefit adequacy; and
  - Treatment authorization process;
- Consumer rights; and
- Contract terms (particularly sanctions).

He also provided the council members with some recommendations for action that planning councils could take. Only 70% of eligibles enroll in Medicaid, and less eligibles are enrolling in SCHIP. In order to correct this situation, councils can review how outreach occurs and who is involved in this process. Another issue related to access is disenrollment. Disenrollment should not occur for treatment non-compliance, disruptive behavior, high treatment costs, missed appointments, or exercising rights. Planning councils can help by reviewing the managed care organizations' policies, talking to consumers and families and reviewing data for major fluctuations. Also, planning councils should ensure that there is a policy for persons with fluctuating incomes. Some more suggestions for improving access were:

- Compare what services are available to what are required by Medicaid;
- Examine the provider list to get a feel for the number, distribution and variety of clinicians available;
- Test out the 800 number and ensure that consumers and family members can receive assistance with questions;
- Determine how consumers and families "navigate" gatekeepers; and
- Examine strategies for rural areas.

Mr. Ingoglia recommended focussing on restrictions on access to medications. These can include budget cuts, formularies with "fail first" and/or prior authorization paperwork, tiered copayments, generic or therapeutic class substitutions, and limits on the number of prescriptions and dosage.

### **Utilization Review**

Mr. Ingoglia expressed the need for planning councils to monitor utilization review. This process uses medical necessity definitions and/or level of care criteria to determine who may receive services. These definitions vary greatly between managed care organizations. Planning councils can review these documents for common problems. Often these documents will not address the continuum of services, will not include consumer-run or community support services, will not make a differentiation for

children and will not address substance abuse and/or other co-occurring disorders. Other issues to look out for in utilization review are that often there is a failure to assess the family or support network of the consumer, appropriate linguistic support services are not provided, or coordination between providers is not required.

### **Consumer Rights**

Mr. Ingoglia indicated that later in the day there would be a session discussing consumer rights in more detail, but in general some recommendations to planning councils are to:

- Review confidentiality policies;
- Review the information given to enrollees on their rights;
- Ask consumers about their ability to access their records;
- Determine if there is a mental health ombudsman or other program for assistance;
- Ask consumers if they can selectively refuse undesired services without the loss of desired ones; and
- Investigate the state's processes for establishing advanced psychiatric directives and appointing surrogate decision makers.

### **Cultural Competency**

Mr. Ingoglia encouraged council members to review the cultural competency plans of providers and examine the composition of advisory boards and the different formats for consumer information. Ensure that policies go beyond providing language support services, and also address faith, sexual orientation, and multi-cultural family dynamics.

### **Obtaining a Meaningful Role**

There are a number of steps that planning councils can take in order to obtain a meaningful role in the process of monitoring Medicaid managed care. Councils must identify and form relationships with key state personnel who are involved in the drafting, awarding and monitoring of contract compliance. Getting involved early during the writing of the RFP is a very effective way to ensure services will be effective. Councils need to be aware of, and in compliance with, review deadlines so that their opinions and demands will be heard. Council members can request a seat at the proposal and contract reviewing tables and represent the council's ideas.

### **Resources**

Both presenters gave conference attendees resources that they can access to obtain more information on Medicaid managed care.

NMHA Resources include:

- The *State Advocacy Update* Newsletter
- SCHIP Tracking and Outreach Guidebooks
- Managed Care Standards
- The Advocacy Tool Kit
- Best and Worst Practices documents on Level of Care Criteria and Confidentiality
- Cultural Competency Position Statement
- Advocacy Resource Center

CMHS and SAMHSA Resources include:

- The Knowledge Exchange Network
- The National Clearinghouse on Alcohol and Drug Information
- The managed care information page on the SAMHSA website

## V. STATE COUNCIL PRESENTATIONS

This conference focused on the role of planning councils and managed care in seven regional states. (As Wyoming chose not send representatives to the conference, there were a total of six regional states represented). Each state council was asked to choose one representative to report on the monitoring and advocacy efforts of the council (within the last year) in the area of managed care. These brief, 5-10 minute presentations described the variety of managed care arrangements in each state and identified creative solutions to common problems.

- **Arizona**--Sue Gilbertson, Chair of the planning council, presented an overview of the state's managed care system. Arizona currently operates two managed care programs that provide behavioral health services--one for comprehensive physical and behavioral health services (the Arizona Health Care Cost Containment System/AHCCCS) and one for wraparound child welfare services (the Interagency Case Management Project/ICMP). Under these services, the state provides behavioral health managed care services through two arrangements. The first is the Arizona Department of Health Services (ADHS), a behavioral health "carve out" for all Serious Emotional Disturbance (SED) and non-SED children under 18 years old and all Seriously Mentally Ill (SMI) and non-SMI adults. The second is the Arizona Long-Term Care System (ALTCS), a carve-in long-term care system that offers acute medical care services, institutional services, home- and community-based services to the elderly and physically disabled populations.

The carve-out program contracts with five Regional Behavioral Health Authorities (RBHAs) which include four non-profits and one for-profit entity in Maricopa County (included in February 1999). RBHAs receive state dollars and block grant funds to provide behavioral health services to non-Medicaid populations based on appropriations from ADHS. Depending on the RBHA, provider contracts are either capitated or paid on a fee-for-service basis. Federal, state and county monies fund the carve-in program for long-term care. Program contractors are paid prospectively on a capitated basis. ALTCS capitation rates that include nursing facility, home- and community-based, acute medical care, behavioral health, and case management services.

The council has focused its efforts on addressing domestic violence, co-occurring disorders, and insurance parity. Arizona now has a new state hospital that has a greater coordination of physical and mental health providers.

- **Colorado** - Colorado currently operates two managed care programs-one Medicaid program for mental health (Colorado Mental Health Capitation and Managed Care Program), and one for substance abuse that includes managed care concepts such as single entry process and uniform assessments. The mental health program, which operates under a 1915(b) Medicaid waiver program, is administered by the Department of Human Services, Mental Health Services (MHS) under a written Memorandum of Understanding with the Department of Health Care Policy and Financing, the State Medicaid agency. Populations covered under this program include Temporary Assistance to Needy Families (TANF), Social Security Income (SSI), dually eligible (Medicaid/Medicare), and foster children. The State Mental Health Authority contracts with eight Mental Health Assessment and Service Agencies (MHASAs) on a capitated basis to provide mental health services. Each MHASA is organized in one of four different models: 1) Two Independent Community Mental Health Centers in four counties, 2) CMHC consortium formed a behavioral health managed care organization, 3) Public/Private Partnership between BHMCO and CMHCs, and 4) Non-profit health maintenance organization (HMO) with a private, for-profit administrative services only (ASO) arrangement.

The state issued a Request for Proposal (RFP) in May 1999, to re-bid contractors who will operate the mental health program in the eight geographic service areas of the state, as the first of its five-year contracts for Medicaid mental health services expire on June 30, 2000. Only one contractor will be selected to operate the program in each service area. Contractors will receive a monthly pre-paid capitated payment for each Medicaid-eligible individual enrolled in the program.

For substance abuse services, the Alcohol and Drug Abuse Division (ADAD) contracts with four managed service organizations (MSO) that are public, private, non-profit, and/or for-profit, depending on the MSO. Each MSO then subcontracts with community providers to serve Medicaid and non-Medicaid eligible adults and children statewide. This program is financed primarily with federal substance abuse block grant funds and state general funds. While this program uses managed care techniques MSOs are not placed at risk.

The planning council has established a number of committees including a Medicaid Capitation Sub-Committee to monitor services provided under Medicaid. Through advocacy efforts, the council has had a great impact on the development of a Recovery Model Ombuds Program. The planning council has developed its support group for consumers. The council is having some issues with transportation of members to council meetings.

**Delaware**-- Joseph Connor, chair of the Delaware planning council, was present at the conference and reported on the status of managed care in his state and the council's activities. Recent advocacy efforts of this council have focused on different aspects of the state's managed care program.

In January of 1996, the State of Delaware implemented a statewide managed care program for Medicaid recipients through the Federal Title XIX 1115 waiver. This program, called the Diamond State Health Plan, is administered by the DHSS/Division of Social Services.

Delaware's Diamond State Health Plan (DSHP) is a mandatory Medicaid managed care program that provides comprehensive physical health and limited behavioral health benefits to the TANF and SSI populations through contracts with MCOs. Once children with an SED have exhausted benefits provided by the MCO, they receive services from the Division of Child Mental Health Services (DCMHS) - DCMHS serves as a public sector specialty managed care organization and is accredited by JCAHO. Adults with SMI who exhaust their MCO-covered benefits under DSHP receive services under the Medicaid fee-for-service system.

In October of 1998, DHSS issued a Request for Information (RFI) to manage long term care for persons with severe and persistent mental illness and/or substance abuse disorders. This program is called Diamond State Cares. In the managed long term behavioral health care model, DADAMH will enter into risk-sharing contracts with at least two, and potentially as many as four, qualified provider organizations, referred to as "lead agencies", serving residents of New Castle, Sussex and Kent Counties. The lead agency will provide, or arrange for provision of, a broad range of services and will establish a network of long term behavioral health care providers.

- **Idaho**-- There is not much penetration of managed care into the Medicaid system or into the state as a whole. Idaho operates one statewide non-waiver substance abuse managed care program. The Department of Health and Welfare contracts with a private behavioral health firm to provide administrative services only (ASO) on a managed fee-for-service basis. The program provides screening and pre-authorization of all substance abuse services funded by the State. Medicaid services in Boise, Idaho have converted to managed care under the Region IV Demonstration Project. This project uses a carve-out model for the management and delivery of mental health services. It is also working to increase consumer participation on the state steering committee, building consumer quality teams and conducting consumer focus groups in order to enhance the service delivery system.

Mental health and substance abuse services funded by Medicaid remain under the traditional fee-for-service system. Services funded by the State mental health authority are operated by seven Regional Mental Health Authorities (RMHAs), including two inpatient facilities. RMHAs provide public mental health services, which are reimbursed on a fee-for-service basis.

- **Missouri**--Judy Bradford, Chair of the Missouri planning council, was in attendance and gave a brief update on the status of managed care and their

council's activities. The Medicaid Authority within the Department of Social Services bid for Medicaid managed care in 1994-95. The planning council was able to have some influence on the design of the new Medicaid system. The council wanted to incorporate "better" elements of managed care into the system and to create better coordination among the systems. The council feels that the needs of children with SED are not adequately addressed in the current system and is working to improve these services.

- **Montana**--The Montana mental health system has undergone significant changes in 1999. The State's behavioral health managed care program (Mental Health Access Plan), a joint venture between a private behavioral health care organization and coalition of public providers, was terminated in March of 1999. On July 1, the Department of Public Health and Human Services (DPHHS) reverted back to a fee-for-service system. All of the members of the Mental Health Access Plan have been transferred to the new system, referred to as the Mental Health Services Plan (MHSP).

The most critical system change has been that consumers are now expected to pay for a portion of their mental health care. Recipients must pay a \$5 copayment for generic medications, a \$15 to \$25 copayment for brand-name drugs, and \$100 per hospitalization. All Medicaid mental health services are now purchased on a fee-for-service basis. Funding for mental health and substance abuse services is provided through several federal programs: Medicaid, The Substance Abuse Prevention and treatment Block Grant, the Mental Health Block Grant, and the PATH grant. The state has appointed a Mental Health Oversight Committee to monitor the development of a new program expected to be implemented in July 2000; it has yet to be determined if the new program will be fee-for-service or managed care. The Mental Health Legislative Oversight Committee receives summaries from the planning council on current issues. The council has been dealing with a new involuntary outpatient commitment statute, which has a "three strikes" rule for persons with mental illness.

- **New Mexico**--New Mexico operates one Medicaid managed care system-SALUD! Under risk-based capitation management with HMOs, the entities provide benefits for all medical/surgical and specialty health care services, including mental health and substance abuse. Under SALUD!, New Mexico's Medicaid agency contracts directly with three for-profit HMOs. The HMOs are required to identify and partner with providers experienced in delivering behavioral health services.

One of the HMOs' behavioral health departments is contracting directly with Regional Care Coordinators (local provider groups) to deliver services. The responsibilities of the RCCs vary depending on the geographic area of the state and their negotiated relationship to the HMO. In addition, the HMOs' payment arrangements with the RCCs may be either fee-for-service or capitated. A wide range of traditional services (such as inpatient/outpatient for mental health services) and non-traditional services (transitional living,

shelter care, and school-based therapy) to TANF, SSI, and Native American populations. Native Americans recently attempted, but failed, to pass a law to reverse state policy, which automatically enrolls them in managed care, unless they opt out via written correspondence. HIS facilities are eligible to be in all MCO provider networks.

The New Mexico planning council feels that Medicaid programs are meeting the needs of most populations, but they are not reaching those with severe disabilities. There can be confusion within the state, as there are 5 regions in the state and each has a planning council. SALUD! and each Behavioral Health Organization has a planning council as well. There needs to be more collaboration and communication between these groups. The planning council has a good relationship with the legislature, and is dealing with insurance parity and working to improve data collection within the state.

- **Utah** -Utah operates one public sector Medicaid managed care program for mental health, referred to as the Prepaid Mental Health Plan (PMHP), under a 1915(b) waiver. This program is currently a mental health stand-alone that covers mental health services in 25 of 29 counties for Temporary Assistance for Needy Families, disabled populations, and medically needy clients. The Division of Health Care Financing (DHCF) has sole-source capitated contracts with eight Community Mental Health Centers (CMHCs). All PMHPs subcontract with hospitals for inpatient psychiatric services, and to some degree, with selected community providers to deliver outpatient mental health services.

Utah has submitted a Section 1115 waiver to both expand Medicaid eligibility categories and geographic areas participating in the PMHP. Upon approval of this waiver, the 1915(b) PMHP waiver will be subsumed into this new waiver, but mental health services will remain carved-out in a separate program. Pending federal approval, the Medicaid agency also plans to provide substance abuse services on a capitated basis in selected areas of the state in January of 2000. Under this waiver, mental health and substance abuse services would continue to be provided as a carve-out from physical health care services. Some major issues that the council is facing include parity, consumer rights, cultural competence, and children's health insurance.

## **VI. CONCURRENT SESSIONS**

## **A. Systems of Care for Kids**

This practical workshop reviewed the current status of children's mental health in this country and provided an overview of the philosophical underpinnings and operation of comprehensive systems of care to meet this children's needs. Juliet Choi, Director of Children's Services & Policy at NMHA, facilitated this one hour session on Saturday afternoon. Ms. Choi began the program with some statistics, which illustrated the current status of children's mental health.

- At least 1 in 5 children in the U.S may have a behavioral, emotional or mental health problem.
- As many as 6 million may have a serious emotional disturbance.
- An estimated 67% of all young people with mental health problems who need help are not getting help.
- The estimated prevalence rate of children with serious emotional disturbance is 50% higher than adults with serious mental illness.

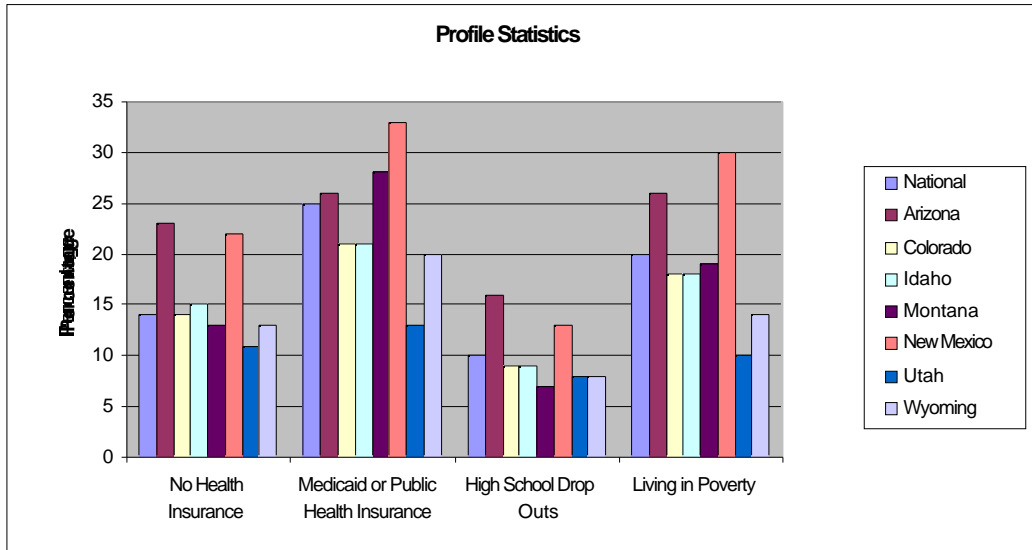
Ms. Choi addressed the issue of children's well being as such indicators have a high correlation with the population of children in need of or receiving mental health services. She highlighted such indicators for each state represented at the conference. A profile on the national status of children's health and health insurance was compiled from a *1999 Kids Count Data Book* written by the Annie E. Casey Foundation . This information was then compared to each individual profile for the six states. This composite of information enabled planning council members to determine the status of their state's children's mental health program and what issues each planning council should address.

After detailing the challenges children and their families face in accessing mental health services, Ms. Choi presented an overview of what a system of care is and how it should work. She explained that a system of care for kids is child-centered and family-focused. This holistic approach to care is proven to be much more effective when working with children with mental disorders or severe emotional disturbance.

This service delivery model also calls for a collaborative infrastructure between all child serving and human services agencies. Along with providing necessary services to children, these community-based programs should also be involved in data and outcomes collection. This will help agencies to evaluate the programs and implement changes to improve the system. As in all types of health care, services must be culturally competent and sensitive in order to be effective.

Children and their families need coordinated support from multiple sources such as, schools, community mental health centers, human services and community organizations. Ms. Choi emphasized that systems of care for children are developed around a community based service model, which has been proven to produce better outcomes and to be cost effective.

Figure 1. This chart compares the profile statistics for each state to the national average. The figure used for poverty was Average Family of 3 with Income of \$12,500 or lower.



### **Systems of Care as a National Movement**

Systems of Care for Children has truly become a national movement. Communities are mobilizing to respond to unavailable or inappropriate treatment. Some examples of this are state mandates, which have been passed in Georgia, Virginia, California, Vermont and Texas. Another illustration of the momentum towards systems of care is the 1999 Surgeon General's Report. This report affirmed that mental health is a public health concern and in chapter three of the Report emphasized that kids are not getting the help they need. The Surgeon General's report discussed the need for schools to be engaged as a key partner in providing services and addressing mental health needs.

### **Best Practices**

Two different programs exemplifying best practices in systems of care were spotlighted during this session. The first of which was a program entitled *Comprehensive Community Mental Health Services for Children and Their Families*, authorized by Congress in 1992. This new program was designed to improve multi-agency service delivery for children with serious emotional disturbance and their families and is administered by the federal Center for Mental Health Services, Child and Adolescent Family Branch. The five-year grants awarded to local and state public agencies require interagency collaboration and significant local/state match. Currently there are 43 active grant communities, and 3 more will be added within the next year. The budget for FY 2000 is approximately \$83 million.

The second program Ms. Choi described was the *Safe Schools / Healthy Students Initiative* authorized by Congress in 1998. This initiative proposes to develop effective mental health and prevention programs in school-based settings. This school anti-violence mental health initiative is administered through the federal Center for Mental Health Services and is a federal interagency collaboration between CMHS, the Department of Education and the Department of Justice.

The grants, awarded to local schools, mental health centers, or community-based organizations are either 2 years for community organizing and planning (40 communities) or 3 years for program implementation (54 communities). Another significant attribute of this program is that community based organizations are also eligible to apply these grants.

### **Suggestions for Programs and Advocacy**

Ms. Choi provided some guidelines for who should be included in systems of care and some advocacy suggestions for planning councils. Any system of care should include:

- Mental health organizations;
- Child welfare;
- Local schools;
- Juvenile justice department;
- Substance abuse organizations;
- Research and data collection;
- Community organizations; and
- Family and advocacy organizations.

The theory of managed care is compatible with systems of care. Both systems work to administer comprehensive, effective and cost effective treatment while at the same time collecting data and outcomes. As a council, it is crucial to get in on the planning process early to ensure that the children's programs are comprehensive and will serve the targeted population.

Communities that have implemented a system of care via a managed care framework include:

- Wraparound Milwaukee (a managed care capitated program)
- The Dawn Project, Indianapolis (a behavioral healthcare org)
- Lane County, Oregon (restricted/reduced dollars & cost shifting)

Traditional and progressive financial strategies for systems of care programs can include:

- Utilize federal and foundation grants
- Build local pilot programs to bring kids back from residential placements and reinvest savings into expanding community-based services and programs
- Make a policy commitment to divert residential \$ into community services
- Look to implement "memos of understanding" across agencies to facilitate the beginnings to multi-agency work.
- Develop an infrastructure to share staff across public agencies

Here is a brief listing of factors to consider in developing system of care and policy:

- Implement State wide legislation
- Infuse system of care philosophy statements, including cultural competency, into policies and infrastructure of service systems.
- Leverage block grant for demonstration projects
- Build pilot programs

- Create local mandates
- Provide financial incentives and inducements
- Create and monitor performance indicators
- Design the system of care to assure appropriate access and services to historically under-served or inappropriately served culturally diverse populations.

## **B. Substance Abuse, Co-Occurring Disorders and Managed Care**

This program was presented by Mary Graham, Vice President of Health Care Reform at the National Mental Health Association. This session provided an overview of the prevalence of substance abuse and co-occurring disorders in the mental health population and described the barriers and opportunities presented by managed care arrangements for program innovation.

### **Snap-Shots of Prevalence**

Ms. Graham introduced this topic by presenting some general statistics on the prevalence of substance abuse and co-occurring disorders in the United States. Some of the facts included were that:

- 27% of the US population have a substance abuse diagnosis at some time in their lives.
- 33 million Americans engage in binge drinking (5+ drinks on one day within the last 30 days).
- 10 million Americans have co-occurring mental health and substance abuse diagnoses each year.

### **Insurance Issues**

Insurance parity is an important issue for mental health services, but it is as important an issue for substance abuse treatment. In the private sector, 70% of those who use illicit drugs and 75% of alcoholics are employed, but only 2% of these populations have insurance plans that adequately cover substance abuse treatment. In the public sector, Medicaid covers substance abuse sparingly, but consumers with co-occurring disorders are often “dumped” back and forth between substance abuse and mental health services.

### **Treatment Issues**

When co-occurring illnesses are treated in integrated systems, there are fewer service gaps, duplicative efforts and care coordination problems. The cost of not providing treatment for substance abuse disorders is too great to ignore the problem.

- Medical expenses of people with untreated substance use are 100% higher than of those who receive appropriate treatment.
- 65% of emergency room visits are alcohol or drug related.
- Nearly half of all workers’ compensation claims are related to substance abuse.

- 52% of those in the criminal justice system report the use of alcohol or drugs while committing their crime.

### **Some Suggestions for Programs**

Funding for integrated services and treatment is often difficult to find. There is some debate surrounding the issue of treatment for co-occurring disorders that further complicates efforts in funding these programs. Experts disagree on whether substance use has to be under control before tackling the mental illness-- or whether they can be addressed simultaneously. Ms. Graham suggested that one resource that will become more important in the next few years for funding these programs is money from the tobacco settlement. Over the next 25 years, States will receive over \$206 billion from the tobacco settlement. Currently, only 12 States have proposed legislation related to mental health or substance abuse and the use of tobacco settlement dollars.

Ms. Graham also presented some best practices in managed care to replicate. These included:

- Some MCO's facilitate substance abuse screenings in primary care settings.
- Many provided education about substance abuse to beneficiaries and their families.
- Several companies have detailed protocols for special treatment needs of pregnant women.
- Some facilitate and even require the involvement of the family where appropriate and desired.

### **Concerns for Advocates**

Stigma is often a greater issue for those with an addiction than for individuals with a mental illness. This makes it difficult to organize the greatly needed consumer voice that should be shaping service systems. Misperceptions and turf battles are common between the mental health and substance abuse advocacy communities as they are often competing for the same funds. Advocates must unite to push for greater funding for services, insurance parity, system reform, and confidentiality protections and to expand the services under Medicaid and SCHIP. Public education campaigns are needed to reduce stigma and encourage consumers to access care as well as mental health and substance abuse screenings in the community. There is a need to be particularly vigilant regarding services to people of color. The history of prejudice and discrimination makes them more likely to be diagnosed for substance abuse disorders without consideration of other psychiatric maladies.

## **VII. CONCURRENT SESSIONS**

## **A. Cultural Competency in Managed Behavioral Healthcare**

Vivian Jackson, a Social Worker and a mental health and addictions consultant, led this discussion on cultural competence as it relates to managed care services. This session reviewed the impact that cultural competence has on positive outcomes and costs in behavioral healthcare, and offered suggestions for designing managed care systems that respond to the diverse needs of the populations being served.

Ms. Jackson opened the session with definitions of key terms and an explanation of why cultural competency is important in managed care. In these terms, cultural competence is the integration of cultural sensitivity and awareness into every aspect of business.

### **Integration of Cultural Competence To All Aspects of Service**

In order for managed care services to provide quality care that is also complete and inexpensive, cultural competency standards must be integrated into every facet of the services. This includes:

- The diagnoses of disorders;
- Intervention styles;
- Psychopharmacology; and
- Access to delivery systems.

When reviewing treatment options, the client/clinician relationship must be considered. In order for success to occur in this relationship, two things must be present: a feeling of emotional safety by the client and an alignment of goals within the relationship. It is important for the clinician to understand the key social role of the client. Treatment goals should be concerned with restoration of the individual to that role.

### **Treatment Journey**

Ms. Jackson defined seven stages in the “treatment journey” and suggested that cultural competency should be addressed at each step. The seven stages of the journey are:

- Identification of need;
- Help seeking behavior;
- Help accessing process;
- Intake/assessment;
- Implementation of the plan;
- Termination or case closure; and
- Follow-up.

### **Flexibility of Benefit Plan**

The design of the benefit plan has a great deal of influence on the services provided. Flexibility is required in the plan design in order to build culturally competent services. One example Ms. Jackson gave to illustrate this idea was that for many services, family counseling only includes blood-related family

members. Today, the composition of the family unit, as defined by the client, is very diverse, and this must be taken into account.

### **Conclusions**

Several suggestions were given to incorporate the ideas and practices of cultural competence into provider services. Some addressed the organizational philosophy:

- Maintain a diverse staff at all levels.
- Provide cultural competency training for ALL staff.
- Include cultural competency in personnel performance standards.
- Enact executive compensation for upholding cultural competency standards.
- Enhance the role of consumers/community in the organization.

## **B. Consumer Rights and Protections**

This overview of consumer rights and protections was facilitated by Jennifer Heffron, Senior Director of State Affairs at NMHA, Paolo Del Vecchio, Public Health Advisor, Center for Mental Health Services' Office of Policy, Planning and Administration and Joseph de Raismes, Chair of the Board for NAMHPAC. This session provided a general outline of the sources of consumer rights, the types of protections that should be advocated for and current legislative activity at the federal and state level to protect mental health consumers under managed care.

Jennifer Heffron discussed the major obstacles to protecting consumer rights and some suggestions for how consumers, family members and advocates can become involved in managed care contract formation and monitoring. Ms. Heffron explained that protecting consumer rights is a challenge for many reasons including: a lack of specific language addressing these rights in the managed care contract, that rights exist on paper but are often vaguely written, or that consumers are unaware of them. She also described pending federal legislation in this area and provided an overview of the Presidential Patients Bill of Rights.

Two controversial issues that were discussed in this session are liability and confidentiality. Jennifer Heffron addressed the first issue explaining that there are a number of barriers to suing an MCO:

- Half of the states have laws on the books that prevent corporations from practicing medicine. As a result, MCOs claim that they do not practice medicine, and therefore cannot be sued for malpractice.
- Most states have not created causes of action that allow people to sue plans that improperly delay or deny care.
- The federal Employee Retirement Income Security Act (ERISA) preempts states from establishing remedies on behalf of those who receive healthcare coverage through a self-insured private employer.

Confidentiality of information and records is the second issue that must be addressed when discussing consumer rights and protections. Information and records that identify the consumer should be strictly confidential. They should only be disclosed as needed for the provision and coordination of services and the determination of medical necessity. Medical records and patient information should only be disclosed with the consumers' informed consent, and after an explanation of the purpose and scope of the disclosure.

Paolo Del Vecchio described the basic contents and purpose of President Clinton's Consumer Bill of Rights and Responsibilities. Mr. Del Vecchio explained that this report on consumer rights was developed by the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, created by President Clinton in 1997. This document creates standards in contracting for the protection of consumer rights and applies to federal agencies such as Medicaid, SCHIP and Medicare. The areas this report addresses are:

- Information disclosure;
- Choice of providers and plans;
- Access to emergency services;
- Participation in treatment decisions;
- Respect and nondiscrimination;
- Confidentiality of health information;
- Complaints and appeals; and
- Consumer responsibilities.

### **Additional Rights Regarding Benefits and Service Delivery**

Along with the rights mentioned above, the presenters put forward additional rights that consumers should expect and advocates should work to protect. For example, services should be timely, culturally appropriate and in the patient's own community. Patients have the right to the least restrictive and least intrusive response or treatment. Consumers have the right to be fully informed of treatment side effects and must be able to refuse undesired treatment services without the loss of desired services.

### **Sample Legislation**

Jennifer Heffron described Colorado's law on referral to out-of-network providers. This states that in any case where the carrier has no providers to offer a covered benefit, the carrier must arrange for a referral and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from a participating provider.

Some states are working to implement legislation to reform the appeals and grievances process within managed care. New Mexico has passed legislation that requires grievance procedures to be in writing and clearly communicated to consumers. A toll-free number must be set-up to assist consumers with any questions and they must be aware that there are representatives that can assist them in filing grievances. Managed care organizations are required to help consumers file grievances and must provide:

- Specific timeframes for the grievance process;

- A graduated review process; and
- An expedited and external review must be available.

### **Obtaining and Protecting Consumer Rights**

Ms. Heffron outlined some steps advocates can take to ensure consumer rights.

- As an advocacy community, identify the rights consumers need most but are not yet guaranteed in your state.
- Prioritize them
- Investigate whether or not the rights exist on paper-whether the problem is a lack of the right or a lack of enforcement.
- If the problem is lack of rights on paper:
  - Introduce new consumer rights legislation;
  - Work to create new state or county regulations;
  - Amend the contract between the state and the MCO; and
  - Expand the list of rights in treatment facilities.
- If the problem is a lack of enforcement:
  - Ensure that consumers are aware of and are asking for their rights to be met;
  - Hold meetings with state agency officials, MCO executives and/or employers;
  - Use the media to apply pressure; and
  - File lawsuits, but only as a last resort!

### **Ombudsman Programs**

Joseph de Raismes described the use of mental-health-specific ombuds programs as one option to help improve mental health delivery systems for consumers. Programs vary in structure and formality, but in general they should:

- Educate consumers and families about available options;
- Educate consumers and families about their rights, especially concerning access to services;
- Assist consumers with denials of care and exhaustion and “cumulative” appeals;
- Collect information on consumer problems and system response;
- Network with other systems; and
- Provide regular reports.

Ombuds programs that are mental-health-specific are necessary to respond to the unique challenges faced by these individuals, some of which include:

- Individuals seeking mental health services through a carve-out program may encounter different problems than those faced by people trying to access physical health services;
- The nature of mental illness may create unique challenges for individuals who are trying to access mental health services; the ombudsman may need to take a more active role in helping a consumer obtain services than for someone seeking physical health services; and
- A mental health-specific program may be more advantageous than a program designed to serve a broader population because it will inevitably cost less money to serve fewer people.

Mr. de Raismes also listed some factors that may promote the success of a mental-health-specific ombuds program:

- Clear scope;
- Clear services definition;
- Adequate funding;
- Independence;
- Staff expertise and commitment;
- Technology to manage complications;
- Effective coordination with plans;
- Networking with Protection and Advocacy and other ombuds programs;
- Access to legal and mental health expertise (may be through a contract with an outside entity);
- Consumer and family satisfaction surveys;
- Regular reports; and
- Independent evaluation.

Mr. de Raismes used Colorado's ombuds program as a model and to illustrate how such a program might work. Brian Garrity, Program Specialist for the Montana Mental Health Ombudsman, also spoke about his program.

### **Conclusion**

The presenters concluded this program with some suggestions for council members who are interested in leading advocacy efforts to protect consumer rights in their state. Planning councils can and should lead the effort to establish, evaluate and improve these programs. Councils must ascertain the major problems facing consumers within the managed care system and then determine the best course of action to protect consumers. This may include restructuring the contract, consumer protection laws, creation of an ombuds program, regulation of services, or civil action.

Jennifer Heffron encouraged planning council members and other advocates to contact the Healthcare Reform Advocacy Resource center at 703.838.7524 or by e-mail at [shcrinfo@nmha.org](mailto:shcrinfo@nmha.org) for more assistance and information.

# Day Two

## **VIII. REPORT ON LESSONS LEARNED IN DAY ONE**

Joseph de Raismes, Chair of the NAMHPAC Board of Directors, opened the second day of the conference by presenting an outline of the lessons learned from Day 1 of the conference. Mr. de Raismes then briefly reviewed each session presented during Day 1. After his report, conference participants discussed the issues and made suggestions of additional items that they learned throughout the previous day. This session helped to redirect the group in its efforts and to focus on the key issues in managed care facing planning councils.

### **Conference Overview and State Presentations**

- There was a wide variety of managed care arrangements represented at the conference.
- There were different levels of involvement by planning and advisory councils with respect to the planning, implementation and oversight of managed care arrangements.
- The general consensus was that their needs to be increased stakeholder oversight in the process of managed care organizations moving into behavioral health, and particularly Medicaid.
- Planning and advisory councils that have a culturally diverse membership that reflect the population receiving services increase the likelihood that issues regarding the needs of the diverse population will be included in the council's deliberations.
- Planning councils need more and better data in order to evaluate the managed care systems.

#### *Types of data needed:*

- Encounter/access data
- Outcome/performance data
- Medicaid penetration/utilization/cost data
- Data need to be assessed by race/culture/ethnicity to identify any discrepancies in services in specific groups

#### *Goal of data: system change and improvement.*

- Planning councils must build and enhance their relationships with other state agencies, especially with Medicaid agencies.
- There is a general desire among planning council members for the behavioral healthcare system to embrace a recovery model for treatment of mental health.
- We must preserve and/or enhance access to:
  - Community-based services;

- Alternative or consumer-run services;
- Culturally acceptable services- including traditional healers; and
- Effective medications.

### **Role of Planning Councils**

- Planning councils must have an increased and more formalized presence in the monitoring and evaluation of Medicaid managed care arrangements.
- Planning councils need to ask and receive data from key State agencies.
- Planning councils can leverage the Mental Health Services Block Grant for demonstration projects in order to encourage systems change.
- Planning councils should form a committee or formal structure to monitor and address managed care.
- Council members need increased training in managed care.
- Planning councils should consider using their personal influence or advocacy efforts to enhance consumer protections or to create ombuds programs in their states.

### **Substance Abuse and Co-Occurring Disorders Program**

- There are insufficient funds for co-occurring disorders services (Medicaid, SCHIP, private insurance).
- There is poor integration and cross-training of providers.
- There is a lack of data on efficacy of treatment outcomes and utilization of services when mental health and substance abuse services are integrated.
- Oversight of the Substance Abuse Block Grant is inadequate.
- Managed care providers fail to attend to consumers with substance abuse or co-occurring disorders, these populations are not receiving needed services.
- The stigma attached to substance abuse and addictions is very strong.
- Suggestions for planning councils:
  - Public education and anti-stigma campaigns
  - Coalition building across interests/advocacy groups
  - Push for parity and expand benefits in the public sector
  - Monitor the Substance Abuse Block Grant and managed care contracts.
  - Pool funding for mental health and substance abuse and train providers so that treatment can become integrated.
  - Provide special attention for consumers from racial and ethnic minorities.

### **Cultural Competency in Managed Behavioral Healthcare**

- Look at intra-group issues regarding race and culture in your council and work on those relationships.
- Consider using cultural competency consultants.

- The entire treatment system must be addressed when talking about cultural competency, from assessment through termination of services and at each level of the system from janitor and receptionist, to clinician and administrators.
- Mental health benefits need to be flexible as does the working environment of the managed care organization (staff, provider network...)
- Planning councils need to:
  - Push for system reform, using cultural competency guidelines, such as the *Cultural Competence Standards in Managed Mental Health Care for Four Underserved/Underrepresented Racial/Ethnic Groups* developed by the Center for Mental Health Services, and ongoing monitoring;
  - Become better educated themselves; and
  - Push for data to be examined by various cultural groups.

### **Systems of Care for Children**

- Local communities need easy access to technical assistance in planning for and implementing systems of care. Advocates must be able to recognize different levels of community capacity and encourage local initiatives.
- Schools and public education agencies must truly become partners in the systems of care for children. This can be a challenge because although school involvement is critical to successful systems of care, educators can be very difficult to engage.
- We need substantial financial incentives for agencies to work as partners and overcome turf issues.
- Advocates must increase and improve public education around IDEA to leverage and increase mental health services.
- The role of planning councils is to:
  - Infuse system of care philosophy statements, including cultural competency, into policies and infrastructures of service systems;
  - Track state mental health dollars, specifically children's mental health funding;
  - Track the number of and the funding for residential placements. Propose local pilot programs to bring kids back and reinvest savings into the community-based services;
  - Find creative and cost-effective strategies to involve family members as "para-professional" service providers; and
  - Look into implementing "memos of understanding" across agencies to facilitate the beginnings of multi-agency work.
  - Assure appropriate attention to the unique needs of culturally diverse consumers.

### **Consumer Rights**

- Ensure that contracts have specific language to protect consumers. This includes:

- Confidentiality;
  - Informed consent;
  - Treatment options, especially culturally acceptable options;
  - Advance directives;
  - Treatment alternatives/side-effects;
  - Ability to selectively refuse undesired services; and
  - Access for culturally diverse consumers including language/interpretation services, culturally acceptable location of services, and inclusion of the appropriate persons for decision-making.
- Contracts should contain language on the grievances and appeals process. This language should specify timelines and create an appeals process that is tiered, has an independent level of review and is binding. Communication to consumers on the grievances and appeals process should be written in language that consumers can understand.
  - Consumers and family members must have increased access to education about their rights and to advocates who can help.

### **Ombudsman Programs**

- This is one option to help consumers understand and navigate the appeals and grievances system. This program should inform consumers of their rights and help in the appeals process. The program should be accessible to consumers of diverse cultures and languages.
- Ombuds programs should collect data on the appeals process to be used for system reform and change. The information should be analyzed by the diverse cultural groups served by the system.
- Independent and adequate funding as well as a specific mission and scope are critical for success of the program.
- Planning councils can lead the effort to establish, evaluate and improve these programs.
- Some recommendations to planning councils:
  - Ascertain the level and types of problems with Medicaid managed care.
  - Determine the best course of action to protect consumers. This may include restructuring the contract, consumer protection laws, regulation of services, or legal action.
  - Develop consensus and propose creation of an ombuds program.

## **Comments and Suggestions from Conference Participants**

### **Family Support**

- Provide increased support and education to family members who care for adult and child consumers. (Total Family recovery models)
- If Children qualify for Developmental Disability monies, use this resource to help the families.
- Consumers and family members should be more involved in the treatment and provider networks because they can reach out to those in need and build trusting relationships (free of stigma).
- When working to reform systems of care for children, attend to issues of family abuse.
- Liaison with state Medicaid office and managed care organizations on behalf of consumers and family members.

### **Coalition Building**

- Work towards a consensus on definitions of terms, which relate to council composition:
  - Family Member
  - Consumer
  - Provider
- Enhance leadership development within coalitions.
- Need statewide consumer organizations to help with bidding process, conferences and education for all stakeholders.
- Collaborate more with developmental disabilities community, especially for co-occurring disorders population.
- Facilitate consumer involvement and consumer-run services.
- Foster an empowered planning council.
- Planning councils should meet more often in order to be proactive in planning and to exert influence over state agencies.
- Infusion of cultural competency across all discussions and trainings.

### **Advocacy Efforts**

- Planning councils must be more assertive on legislation
- Develop a relationship and work more with the criminal justice system.
- Make sure the state plan follows the strategic plan.
- Increase involvement of state legislators in the planning council.
- When approaching legislators, bring solid solutions with you, not just complaints.
- Be persistent, the future is bright!!
- With assertive community treatment, avoid involuntary treatment. Give people choices, including the ability to make a bad choice.

### **Financial Development**

- Talk to your legislative auditor, ask for line-item information on government mental health spending. This is a good way to track funding.
- Focus on service innovations and efficient use of money as well as increasing funding and financial resources.
- Look into uses of state tobacco settlement funds to support community-based services.

## **IX. ALL CONFERENCE SESSION**

During the morning's opening remarks, the conference moderators agreed that it would be easier to keep everyone together as a group, rather than split up for three concurrent sessions. This all conference session discussed the three topics of Assertive Community Treatment, Homeless Services and Consumer-Run Programs. NAMHPAC and CMHS have produced two guides for planning councils. One describes Evidence Based Assertive Community Treatment and the second covers Mental Health and Homelessness. These brochures provide examples of best practices in the field as well as some tips for structuring and implementing these programs. These brochures are available to all planning councils members through NAMHPAC and were distributed at the conference. Chuck Ingoglia began the session with the first topic.

### **A. Assertive Community Treatment**

Chuck Ingoglia described Assertive Community Treatment (ACT) as one of the most documented and effective models of integrated care for people with serious and persistent mental illness. ACT is a preventive approach to mental health services that helps people avoid further hospitalization. Consumers receive a full range of medical, psychosocial, and rehabilitative services where they live and work. Through ACT, a multi-disciplinary team:

- Provides direct treatment, rehabilitation, and support services to people with severe and persistent mental illness;
- Refers consumers minimally to outside providers;
- Provides services on a long-term care basis;
- Delivers 75% or more of services outside of office settings; and
- Emphasizes outreach, relationship building and individualized services.

In addition, the ACT team typically is on-call 24 hours a day for emergency treatment, actively monitors physical health care and has frequent contact with both consumers and their family members. Mr. Ingoglia encouraged conference participants to read through their copy of the NAMHPAC and CMHS brochure titled, *Evidence Based Assertive Community Treatment*.

## **B. Homeless Services**

Joseph de Raismes presented this overview of current best practices in homeless services currently being used as well as suggestions for funding programs. Mr. de Raismes began by giving some background information on homelessness and the need for services. He explained that more than 600,000 people are homeless in the U.S. on any given night. The Center for Mental Health Services (CMHS) estimated that approximately one-third of these people have a serious mental illness. There are a few outreach programs that work to provide the necessary services to this population and transition them out of the streets, but many more are needed.

The group briefly discussed a CMHS grant program entitled Projects for Assistance in Transition from Homelessness (PATH), as a best practice to replicate. PATH funds are distributed to counties and community nonprofit agencies to provide outreach, rehabilitation and community mental health services to those in need. This program is described in a guide for planning councils created by NAMHPAC and sponsored by CMHS.

Mr. de Raismes encouraged members of planning councils to raise the issue of homeless services in their State. He gave some suggestions for funding these programs, one of which was the Mental Health Block Grant. He also discussed the option of using waivers for financial support.

## **C. Consumer-Run Programs**

Paolo Del Vecchio explained in this session that choice is imperative in modern mental health services delivery. Consumer-run programs have proven to be a very effective tool for treatment of mental illness and provide consumers with a choice that may be more compatible. As always, funding is the largest stumbling block to the creation of this type of program. Mr. Del Vecchio cited a monograph on 15 CMHS - funded consumer-run projects. This report describes the program and the funding resources used. He also encouraged conference attendees to contact him if they had specific questions about implementing or supporting a consumer-run program. This session ended with a description of examples of several consumer-run programs and a lengthy and lively discussion with participants in strategies for implementing these programs.

# Conclusion

The shift to managed care in the public sector has occurred. *Managed Care and the Role of Mental Health Planning and Advisory Councils* provided a forum for planning

**council members to increase their understanding of managed care arrangements, how other planning councils have responded to this challenge, and how their own council can increase their involvement in the evaluation, monitoring and improvement of these arrangements.**

**This regional conference demonstrated the role that planning councils have and can continue to play in creating responsive managed care arrangements. The conference also highlighted the need for continued training and information sharing for and between planning councils.**