



managed care in the public sector

a guide for mental health planning + advisory councils



US Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

This tool kit provides an introduction to managed care in the public sector. It will help State mental health planning and advisory council members and others assess the implications of using managed care to serve people with serious mental illness in the public sector.

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Managed Care in the Public Sector

Introduction

The rapid and pervasive shift to managed care in the public healthcare sector raises questions about the adequacy of services provided to people with mental and addictive disorders, and the level of needed oversight of these arrangements. Stakeholders – including consumers, family members, providers and advocates - may be under-represented in the design, implementation, and monitoring of these managed care arrangements.

Medicaid is the largest source of funding for public behavioral healthcare programs. The use and structure of managed care in the public system are complicated and vary among States. Our goal is to prepare State mental health planning council members for the planning, monitoring and evaluation of these arrangements. This brochure is meant to provide planning council members with an introduction to the structure and operation of managed care in the public sector, specifically under Medicaid. The Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) and The National Association of Mental Health Planning and Advisory Councils (NAMHPAC) are pleased to make the enclosed information available to assist State mental health planning councils to be more effective in accomplishing their goals as well.

Medicaid, a Federal-State partnership; the Federal Mental Health and Substance Abuse Block Grants; and State and county mental health and substance abuse budgets all provide funding for the public mental health system. As with managed care, the funding of community mental health systems varies among States. In many States, Medicaid accounts for nearly one-third of community mental health funding.

Medicaid accounts for approximately 20% of many States' overall budgets and the costs continue to increase. In light of rising expenditures, many States are turning to the solution used in the private health insurance market: managed care. In 1988, only 29% of Medicaid recipients were enrolled in managed care plans; by 1998 the figure rose to 54%.

Because of Medicaid's significant financing of mental health services, this brochure will-

- Provide an overview of the structure and operation of managed behavioral healthcare through Medicaid;
- Suggest avenues for State mental health planning council and other stakeholder input in to the design, implementation and monitoring of these systems;
- Offer suggestions for data collection as well as for appeals and grievance procedures; and
- Address the critical issue of cultural competency in managed care plans.

Federally mandated State mental health planning councils are established in every State and territory to review spending for mental health block grants and to monitor the quality of mental health services provided. 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. Also, all State Medicaid Agencies must have a Medical Care Advisory Committee. Planning councils are encouraged to engage these committees to discuss issues related to the delivery of behavioral healthcare services in Medicaid managed care.

What is Managed Care

The term managed care describes a variety of strategies used by health care plans to control costs and to ensure service quality. A managed care organization (MCO) can be either a for-profit company or a non-profit organization. Their organization and financing are often quite complex and vary considerably from plan to plan. However, in general, the managed care entity will -

- Receive a fixed fee for each person enrolled in the plan in exchange for providing specified services when needed. This per person fee is known as a capitation rate;
- Require enrolled individuals to use specific providers; and
- Periodically review a consumer's need for treatment, services and support.

Many factors have contributed to the growth of managed care over the last 20 years. Rising healthcare costs were a chief concern as per capita spending for healthcare rose from \$204 in 1965 to \$3,299 in 1993; during the same period, national healthcare expenditures more than doubled from 5.9% to 13.9% of the gross domestic product (GDP). Through the use of managed care, both private and public insurers are attempting to contain costs while ensuring access to good quality services.

Mental health services can be delivered in different ways under managed care plans. Some plans are comprehensive and include both physical and mental health services; these are known frequently as "integrated" or "carve-in" plans. Other plans "carve-out" mental health services from physical health services and provide them through a specialty managed care plan. Important differences between carve-in and carve-out plans are shown in the chart on page 4.

Some stakeholders are concerned about the effects of integrated programs. One such concern is that integrated plans may reduce the amount and quality of mental health services provided by restricting access to vocational rehabilitation, early intervention, prevention, wrap-around, and other needed services.

States have also turned to managed care to provide consumers with mental health and/or alcohol or drug addiction services for several other reasons:

- To reduce the use of inpatient services;
- To reorganize the service system to expand effective community services and provide consumers with a more significant say in their treatment; and

Differences Between Behavioral Health Plans

Carve-In

Mental health benefits are managed by the same MCO that manages physical health benefits.

An individual's physical and mental healthcare services are likely to be coordinated and integrated.

System may be more susceptible to financial and access problems due to competition for funds between physical and mental health.

Some of the States that have carve-in models include Connecticut, Hawaii, Minnesota, Missouri and Vermont.

Carve-Out

Mental health is managed by a separate MCO.

It is generally easier for consumers to access specialty mental health providers because they do not need a referral.

Coordination of physical and mental healthcare may be more fragmented.

Mental health experts usually manage the plan.

Mental health dollars are more likely to be preserved; not redirected to physical health services.

Some of the States that have carve-out models include Colorado, Iowa, Utah and Washington.

- To improve access to primary medical care for individuals with mental illness and addictions.

Most managed care entities receive a flat payment for each person covered by their plan. In return for this capitated payment, the managed care organization agrees to provide specific mental health, substance abuse, or physical health-care services unless otherwise specified in the contract. Because the managed care organization receives the same amount of money per person, no matter how many services are used, there is an incentive to control costs by managing utilization. Some MCO's respond to this challenge by developing alternative community-based services and increasing prevention services to replace more expensive in-patient services.

Managed care organizations most often control the use of services by reviewing treatment decisions made by mental health professionals and other providers. In this process, known as utilization review, the managed care organization looks at cost, medical necessity, and appropriateness of the requested service.

Medicaid Managed Care

To participate in the Medicaid program, States must comply with a number of requirements governing the program's implementation. Historically, to pursue mandatory managed care enrollment for Medicaid recipients, States first had to receive "waivers" from the relevant Medicaid statute and regulations. These waivers are granted by the Centers for Medicare and Medicaid Services (CMS) the Federal agency that administers the Medicaid program in partnership with the States. These waivers fall into three main categories: Section 1915(b), Section 1115 and Section 1932(a).



A Section 1115 waiver allows a State to operate its system of care for Medicaid enrollees in a manner different from that prescribed by the Centers for Medicare and Medicaid Services. Through these 1115 waivers, States may expand eligibility categories or change benefit-package structures, financing mechanisms, and payment relationships.

Section 1915(b) is a statutory provision that allows a State to limit the choice of providers for Medicaid enrollees. Provisions from the 1997 Balanced Budget Act (BBA) require States to allow Medicaid beneficiaries to change MCOs within the first 90 days of enrollment and once a year thereafter.

In 1999, 41 States had some form of managed behavioral health program operating in the public sector. The only States without managed behavioral healthcare were Montana, Wyoming, Kansas, Louisiana, Mississippi, North Carolina, Alaska, New Jersey, and Maine.

Section 1932(a) of the Balanced Budget Act (BBA) of 1997 gives States more flexibility to make these arrangements through the use of plan amendments. The BBA also contains provisions for increased evaluation, improved beneficiary protections, enrollment and disenrollment provisions, and choice mechanisms. When using plan amendments, States can change programs without going through the waiver process. The amendment process should concern planning councils and others, as it may lead to faster changes with less stakeholder involvement. Planning and advisory councils should be aware of the use of plan amendments by State Medicaid agencies.

Planning Council Involvement



States generally develop managed care contract provisions through a process of debates and discussions among public officials and concerned members of the public. States frequently create oversight committees made up of stakeholders, including mental health consumers, family members, and providers. These committees advise the State on the design of the managed care system. Additionally, in many States, monitoring committees oversee the implementation and ongoing functioning of these arrangements. State mental health planning councils should be involved at every stage of the design process to ensure a complete managed behavioral healthcare arrangement responsive to the needs of all enrollees. State mental health planning council representatives also should participate in discussions regarding system financing, benefit design, Request for Proposal (RFP) drafting, contract negotiation and selection processes. (An RFP is a request for bids to provide specific services, such as mental health benefits, to a specific population.) Because most States already have some form of managed care, State mental health planning councils should extend their monitoring and evaluation functions to the managed care contract. The planning council can encourage the State to measure the MCO's performance against the standards established in the contract. Active

involvement of the State Medicaid agency through membership on the State mental health planning council, may help accomplish these processes more effectively.

Data Collection: **The Heart of Managed Care**

In an effort to measure the effects of managed care in the lives of mental health consumers, State mental health planning councils can suggest that contracts contain specific performance standards in order to evaluate the performance of the MCO. These "outcome measures" should focus on the effects of services for mental health consumers. These types of measures focus on the end product of service rather than on the services provided by Medicaid or other service providers.

Performance measurement is a critical goal for all areas of mental health service delivery, regardless of the payor. Examples of possible outcome measures might include the number of adult consumers experiencing reductions in their psychiatric symptoms and -

- Living in their own home or in housing arrangements of their own choosing;
- Working or at school;
- Not involved with the criminal justice system;
- Maintaining a social support network;
- Succeeding in managing their daily lives; and
- Reporting an improved quality of life, including symptom reduction.

The development and implementation of outcome-oriented performance measures require careful planning and thoughtful action. Care must be taken to ensure that measures will provide stakeholders useful information.



Certain process measures are useful to monitor as well. These measures can indicate whether or not services are timely, user-friendly, accessible and appropriate. State mental health planning councils may want to know whether:

- Consumers receive clear, understandable information about their rights, the services to which they are entitled, how to access services, and how to object or complain;
- Consumers, (and where appropriate Social Security representative payees) actively participate in decisions about their treatment;
- Consumers receive the information they need to make informed choices;
- Consumers are satisfied with the services they receive;
- Staffing levels match the services delivered and meet requirements for cultural and linguistic competence;
- Appropriate linkages exist to other agencies serving consumers; and
- A quality assurance system exists to examine adverse clinical events.



Data on both clinical outcomes and process measures within managed care arrangements must complement financial information. As States and localities look to managed care to reduce expenditures, State mental health planning councils and other stakeholders need to remind systems of the value of preserving and improving health outcomes as well as cost-savings.

Once a contract is awarded and the managed care system is in place, monitoring and oversight activities help ensure that contractors are meeting their obligations. In the event the MCO is not performing adequately, the State mental health planning council and other bodies charged with oversight, can recommend a variety of responses to encourage compliance and should start by pointing out areas of deficiency and developing a plan for contract compliance. In cases in which

the compliance goals are not met, State intervention may include the addition of performance measures that carry financial penalties, or in extreme cases, withholding payment. Keep in mind that because these contracts are for a fixed period of time, the contracting process is likely to repeat itself with a new RFP. Armed with expertise from the first contracting process and experience with the system, planning councils can take a stronger role in working toward improvements the next time around.

Appeals and Grievance Procedures

Mental health consumers have the right to complain and to be heard by impartial decision-makers when services they need are denied or delayed. The mechanism most often used to voice this complaint and to seek redress is the appeal and grievance process.

States offer a broad array of grievance procedures. State mental health planning councils should request that in-plan grievance procedures (those provided by the managed care plan) have different levels of appeal, the highest of which engages and impartial third-party to make a determination. Because most complaints relate to services being denied, delayed or reduced, the review of complaints needs to be timely. Timelines for grievance resolution must be spelled out very clearly in the contract. All beneficiaries will receive notice of their appeal and grievance rights when they enroll in the MCO. Additionally, contractors will provide annual information on the total number of grievances filed, their outcomes, and the length of time taken to resolve grievances. State mental health planning councils may benefit from communicating with local Protection and Advocacy agencies to determine if fair hearing processes are working correctly.

Medicaid law mandates access to a specifically structured, State fair hearing process: Individuals must receive notice of an action, such as a termination of previously authorized services, in writing, mailed at least 10 days before the hearing is to take place. The notice must explain the intended

action, the reason for that action, and information on how to request a fair hearing. The hearing officer must issue a written decision within 90 days from the date of the request of the hearing. State mental health planning councils need to ascertain if the MCO is following fair hearing processes and ensure that in-plan activities do not interfere with the State fair hearing process.

Another option for the resolution of member complaints implemented in several States is the creation of a managed care ombuds program. Effective ombuds programs assist beneficiaries in filing grievances and making fair hearing requests. The programs also will represent beneficiaries in the grievance process or refer them to legal services. The Colorado Mental Health Planning Council spearheaded the development of an independent, consumer-run ombuds program for people enrolled in the State's managed care program.

Managed Care and Services for Children



According to the Center for Mental Health Services, about one in five children suffers from a diagnosable mental, emotional, or behavioral disorder, and a significant proportion of these children have disorders that have a substantial impact on their ability to function. More disturbing is the fact that nearly 80 percent of children with mental health needs go without treatment.

Since the mid-1980s, reform efforts in the children's mental health field have focused on the development of community-based systems of care for children, adolescents, and their families. This approach to organizing services is sometimes also referred to as "wraparound" because they attempt to address all aspects of the child and family's needs. Many children with serious emotional disorders (SED) have multiple problems and require services from more than one

child-serving entity such as mental health, child welfare, special education and/or juvenile justice.

Systems of care attempt to respond to these multiple needs by creating interagency collaborations and coordinated treatment planning and service provision. More information on systems of care can be found in a separate brochure developed by CMHS in collaboration with NAMHPAC on that topic.

While this brochure addresses managed care arrangements in the public sector generally, State mental health planning councils should pay special attention to how these managed care arrangements hinder or encourage the creation of systems of care and other wraparound approaches to services for vulnerable children and adolescents. We know that 97% of public sector managed care plans cover children on public assistance (Aid to Families with Dependent Children [AFDC] / Temporary Assistance to Needy Families [TANF]), 80% cover children who are on Supplemental Security Income (SSI), and 63% cover children in the child welfare system. In other words, the vast majority of children and adolescents in the public health and welfare sector now receive their health and mental healthcare in managed care arrangements.

State mental health planning councils and other advocates, should review managed care contracts and monitor existing arrangements with an eye toward their ability to foster coordination, cooperation, and collaboration among child and adolescent services. Managed care funding mechanisms, like capitation, if used correctly, can contribute to the development of comprehensive and flexible community-based services for children and their families. At the same time, if capitation or other managed care tools are used incorrectly or narrowly, they can serve as barriers to creating the kinds of systems needed by children and adolescents with serious emotional disturbance.

Cultural Competency

Based on current demographics and with the expected continuing diversity of the United States, the need for culturally competent services is unassailable. Research indicates that consumers benefit from appropriate services that match their linguistic and cultural patterns. To this end, the Center for Mental Health Services has created Cultural Competency Standards for Managed Behavioral Healthcare Services. To ensure that all members of the population covered by the managed care plan receive culturally competent services. State mental health planning councils should assess the extent to which the managed care contract:

- Establishes cultural competency guidelines appropriate to the particular populations the MCO serves;
- Requires the MCO to have providers and administrators who speak the languages most common in the service area;
- Requires the MCO to train providers in cultural issues relevant to the populations served; and
- Requires the MCO to cover alternative services, such as those of tribal healers.

For more information, please see *Cultural Competency Performance Measures for Managed Behavioral Healthcare Programs* available from the Center for Mental Health Services (CMHS). Some State Medicaid Agencies may choose to adopt cultural competency standards as well. (See Resources, p 15.)

How to Use This Information

This document does not attempt to address all the issues of managed care in the public sector in a comprehensive fashion. Instead, State mental health planning council members should use this as a primer to advance their knowledge and to stimulate further involvement with this issue.

To assess the impact of managed care in your State:

- Gather the resources listed in this document and distribute them to council members.
- Host a planning meeting and invite stakeholders with expertise on managed care to address the topic.
- Host town hall meetings and other community forums to gather information from consumers, family members and others affected by system change.
- Invite representatives from the managed care organization and the State Medicaid and Mental Health departments to address your council on a regular basis.
- Appoint a task force or subcommittee to meet with State and MCO officials to review utilization data and engage in ongoing monitoring and evaluation activities.

Next Steps

The Center for Mental Health Services (CMHS) of the Substance Abuse and Mental Health Services Administration (SAMHSA) is currently sponsoring the Managed Care in the Public Sector Study. The purpose of the study is to increase knowledge about the effects of public sector managed behavioral healthcare on patterns of service use, service costs, clinical outcomes, and consumer satisfaction. Results from these critical studies will be made available to planning councils in subsequent communication from the Center for Mental Health Services and your National Association of Mental Health Planning and Advisory Councils.

Additional Information

These organizations may be useful contacts for more information about managed care and the role of State mental health councils in that system:

Bazelon Center for Mental Health Law

1101 Fifteenth Street, NW, Suite 1212
Washington, DC 20005
phone: (202) 467-5730 • fax: (202) 223-0409
www.bazelon.org

Center for Mental Health Services, Substance Abuse and Mental Health Services Administration

5600 Fishers Lane, Room 17-99
Rockville, MD 20857
phone: (800) 789-CMHS
www.cmhs.samhsa.gov

The National Mental Health Association's Advocacy Resource Center

1021 Prince Street
Alexandria, VA 22314
phone: (703) 838-7524 • fax: (703) 684-5968
www.nmha.org

Families USA

334 G Street, NW
Washington, DC 20005
phone: (202) 628-3030 • fax: (202) 347-2417
www.familiesusa.org

Centers for Medicare and Medicaid Services Center for Medicaid and State Operations

7500 Security Boulevard
Baltimore, MD 21244
phone: (410) 786-3000
www.cms.gov

National Alliance for the Mentally Ill (NAMI)

Colonial Place Three
2107 Wilson Boulevard, Suite 300
Arlington, VA 22201-3042
phone: (800) 950-6264 • fax: (703) 524-9094
www.nami.org

National Technical Assistance Center for State Mental Health Planning

66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
phone: (703) 739-9333 • fax: (703) 548-9517
www.nasmhpd.org
email: ntac@nasmhpd.org

American Managed Behavioral Healthcare Association

700 Thirteenth Street, NW, Suite 950
Washington D.C., 20005
phone: (202) 434-4565 • fax: (202) 434-4564
www.ambha.org

Resources

The following documents form the basis of this brochure. Additional literature reviews are cited to build a greater understanding of managed care and the role of State mental health planning councils.

Center for Mental Health Services. (1998). *Cultural Competence Performance Measures For Managed Behavioral Healthcare Programs*. Unpublished document developed by The New York State Office of Mental Health and The Research Foundation for Mental Hygiene.

An Evaluation of Contracts Between State Medicaid Agencies and Managed Care Organizations for the Prevention and Treatment of Mental Illness and Substance Abuse Disorders. S. Rosenbaum, K. Silver, and E. Wehr. Managed Care Technical Assistance Series, Vol. 2. Substance Abuse and Mental Health Services Administration (1997).

Designing Substance Abuse and Mental Health Capitation Projects: A Managed Care Guide for State and Local Officials. C. Brach. Managed Care Technical Assistance Series, vol. 3. The Substance Abuse and Mental Health Services Administration (1998).

Managed Mental Health Care: What to Ask, What to Look For. Center for Mental Health Services. (1996).

Center for Mental Health Services. (2000). *Cultural Competence Standards In Managed Care Mental Health Services: Four Underserved/Underrepresented Racial/Ethnic Groups.* Rockville, MD: U.S. Department of Health and Human Services.

Managed Behavioral Health Services, An Annotated Bibliography. Center for Mental Health Services. (1994).

Blueprints for Managed Care; Mental Healthcare Concepts and Structure. F. McGuirk, A. Deller, C. Croze. Center for Mental Health Services. (1995).

Managed Care Tracking System: State Profiles on Public Sector Managed Behavioral Health Care and Other Reforms. Substance Abuse and Mental Health Services Administration. (1998).

Partners in Planning: Consumers' Role in Contracting for Public-Sector Managed Mental Health and Addiction Services. Managed Care Technical Assistance Series, Vol. 10. The Substance Abuse and Mental Health Services Administration. (1998)

Substance Abuse and Mental Health Services Administration

The Substance Abuse and Mental Health Services Administration (SAMHSA) within the Department of Health and Human Services is comprised of three Centers that carry out the agency's mission of improving the quality and availability of prevention, treatment, and rehabilitation services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

The Center for Mental Health Services (CMHS) is the agency of SAMHSA that leads Federal efforts to treat mental illnesses by promoting mental health and by preventing the development or worsening of mental illness when possible. Congress created CMHS to bring new hope to adults who have serious mental illnesses and to children with serious emotional disorders.

The National Association of Mental Health Planning and Advisory Councils

The state mental health planning and advisory councils have joined together to form the National Association of Mental Health Planning and Advisory Councils (NAMHPAC). Federal law requires the establishment of mental health planning councils to review state applications for block grant funding, to serve as advocates for adults with serious mental illnesses and children with serious emotional disturbances, and to monitor and evaluate state mental health planning systems. Although these activities are mandated, many states do not provide funding to support them. In many cases, this lack of funding combined with council members' often short tenures prevent these organizations from making their full impact on service delivery and consumer empowerment. NAMHPAC provides technical assistance to these organizations in the areas of exemplary practices, organizational development, and information sharing. In addition, NAMHPAC provides a national presence on mental health policy issues on behalf of the state planning and advisory councils.

We hope that each planning and advisory council member will closely read this document and use its information to develop the state plan for fiscal year 2002 and beyond. In addition, NAMHPAC will contact members of state councils to encourage them to use these materials, to evaluate how the materials were used, to identify topics for future pamphlets, and to gather suggestions for dissemination of such pamphlets.

Feedback Form

CMHS and **NAMHPAC** are interested in your feedback. To help make this and future best practices brochures useful to planning and advisory council members, please fill out this section and either cut along the dotted line or photocopy this page and mail it to NAMHPAC at 1021 Prince Street, Alexandria, Virginia 22314-2971. Telephone: (703) 838-7522. Fax: (703) 684-5968.

Suggestions for future best practices topics:

- Integrated Services
- Recovery
- Adult and Juvenile Justice
- Consumer-Run Programs
- Employment
- Other _____

Suggested Changes in Brochure Format or Content:



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