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MEDICAID MANAGED CARE

Four States' Experiences With Mental Health Carveout Programs

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The Honorable Edward M. Kennedy
The Honorable Paul Wellstone
United States Senate

Mental health services, such as crisis stabilization and partial hospitalization,[1] are an important component of the health services covered under Medicaid, a joint federal-state program that pays for the health care of nearly 31 million low-income Americans. In 1996, federal and state governments spent an estimated $12.6 billion on Medicaid mental health services, representing about 8 percent of total Medicaid expenditures for that year.[2] On average, Medicaid mental health expenditures grew almost 9 percent a year between 1986 and 1996. In an effort to control costs and improve services, many states, beginning in the early 1990s, received waivers of certain Medicaid rules to establish new managed care programs for mental health services. For example, many states "carved out" or separated mental health services from physical health services, placing them under separate financing and administrative arrangements. They also contracted with public and private prepaid health plans (PHP) and required beneficiaries to obtain their mental health care through the PHPs.[3] Many managed care programs, including mental health carveouts, seek to reduce reliance on hospitalization by substituting community-based mental health services that many experts consider more appropriate as well as less costly.

PHPs are paid a fixed amount per person—known as a capitated payment. Capitation creates financial incentives to contain program costs by providing services in the least costly setting as well as by limiting the volume of services through methods such as prior authorization. As with other capitated plans, there is a risk that PHPs may undertreat illnesses in

[1]Crisis stabilization and partial hospitalization, which are provided as alternatives to hospitalization, offer intensive, short-term psychiatric treatment in a structured environment. Crisis stabilization provides continuous 24-hour observation; partial hospitalization offers daily psychiatric treatment.

[2]Although more recent Medicaid data are available through the Health Care Financing Administration (HCFA), HCFA data do not systematically separate mental health care costs from general physical health care costs. The most recent year for which Medicaid mental health cost estimates are available is 1996. See David McKusick et al., "Spending for Mental Health and Substance Abuse Treatment, 1996," Health Affairs, Sept.-Oct. 1998, p. 150.

[3]A PHP, for the purposes of this report, is an organization that provides a specified or limited set of health services, such as mental health services. Like a health maintenance organization (HMO), a PHP receives fixed monthly payments for each person enrolled (capitation) and bears the financial risk for the services it provides to its enrollees.

order to contain costs or increase profits.[4] Underservice can be particularly problematic for Medicaid beneficiaries needing mental health services.[5] For states, the challenge is to design and monitor mental health programs that provide Medicaid beneficiaries with the care that they need while reducing or containing the growth in costs.[6]

Because of your concerns about beneficiaries' access to appropriate mental health services under managed care, we reviewed how states design and monitor these Medicaid programs and how, at the federal level, the Health Care Financing Administration (HCFA) exercises its oversight of the Medicaid program. We focused on mental health carveouts because their use and importance are increasing in state Medicaid programs. Although many carveout programs provide both mental health and substance abuse services, we focused only on mental health services in this study. As discussed with your offices, we analyzed, for selected states, (1) the extent of beneficiary choice in capitated mental health carveouts, the range of covered mental health services, and access to these services; (2) the states' approaches to monitoring the quality of care in their Medicaid mental health carveouts; and (3) HCFA's oversight of states' mental health carveouts.

For this study, we selected 4 states for intensive analysis—Colorado, Iowa, Massachusetts, and Washington—out of the 30 states that used Medicaid waivers for managed mental health services when we began our review.[7] When we designed our study, these four states had all completed at least one contracting cycle and therefore had more experience than most other states in contracting for their Medicaid mental health services on a capitated risk basis. These states also included rural and urban areas; statewide and regionally based contracts; and for-profit, not-for-profit, and

[4]Joseph P. Newhouse et al., "Risk Adjustment and Medicare: Taking a Closer Look," Health Affairs, Vol. 16, No. 5 (1997), pp. 26-43; Medicaid Managed Care: Challenge of Holding Plans Accountable Requires Greater State Effort (GAO/HEHS-97-86, May 16, 1997), p. 7.

[5]Specialists report that persons with severe mental illness frequently function poorly as consumers and often do not follow prescribed treatments, such as taking their medications. Because of their illnesses, they are often unable to obtain or maintain employment, resulting in low income; many are also homeless.

[6]States often began managed care programs because of increased Medicaid and mental health costs. In Massachusetts, for example, Medicaid costs before the implementation of its waiver program rose from $1.5 billion in fiscal year 1988 to nearly $2.7 billion in fiscal year 1990, according to the state's waiver application. In Colorado, total expenditures for Medicaid mental health services rose from $54 million in 1990 to about $98 million in 1995—an 83-percent increase—under fee-for-service (FFS) Medicaid.

[7]As of July 1998, 36 states had Medicaid waivers for managed mental health services. Sixteen of these states had waivers for carveout programs for Medicaid mental health services for adults, often combined with substance abuse services, according to the Managed Care Tracking System Report published by the Substance Abuse and Mental Health Services Administration (SAMHSA) on July 31, 1998.

county-based PHPs. Experts we consulted in designing our study recommended these states, which had undergone considerable development as state and plan managers gained experience. As a result of this selection process, the Medicaid mental health programs in these states are not representative of Medicaid mental health carveouts elsewhere. We conducted our work between July 1997 and July 1999 in accordance with generally accepted government auditing standards. (Appendix I provides details on our scope and methodology.)

Results in Brief

In the four states we studied, the mental health carveouts limited Medicaid beneficiaries to a single prepaid mental health plan. Because there was no choice of carveout plan, these states generally tried through contractual provisions to ensure that PHPs did not limit beneficiaries' access to services inappropriately in order to contain costs. For example, as HCFA required, these states allowed beneficiaries to choose their providers from within a PHP's network and sometimes from outside the network. The states also set standards in their contracts for determining appropriate levels of services, using broad definitions of medical necessity, and the states and plans generally reduced or eliminated requirements for prior authorization for access to outpatient care. The states generally expanded the range of covered community-based mental health services, compared with their prior fee-for-service (FFS) programs, and reduced the use of inpatient services. To discourage the underprovision of services, these states also capped PHPs' profits, losses, or administrative expenditures. Colorado and Iowa required PHPs to invest a portion of their profits (or savings, in the case of not-for-profits) in new community-based mental health services.

The states' approaches to monitoring the quality of their Medicaid mental health carveouts were based on federal laws and HCFA's regulations governing quality assurance systems, grievance and appeals systems, medical audits, independent assessments of waiver programs, and data requirements. These federal requirements for managed care programs are more extensive than those for FFS programs because of the need to compensate for capitated plans' incentives to underserve beneficiaries. Each of the four states supplemented these federal requirements with additional strategies for monitoring quality, in part because these requirements were developed for managed care programs generally and do not specify the unique mental health requirements that states say they need. The states' supplemental strategies included the use of site visits to PHPs to analyze access to services and choice of provider, among other

issues. Some of the states we studied established ombudsman programs and advisory committees, composed of mental health providers and consumers, to help ensure that the programs address beneficiaries' needs. They also used quantitative mental health performance goals, to which two states attached monetary rewards and penalties. However, the states did not widely use some potentially powerful tools, such as the analysis of data linking consumers' diagnoses and services, although state officials told us that they plan to use such analyses more in the future. The four states also generally did not use HCFA's optional quality guidance because they considered it too general for their mental health carveouts.

HCFA's oversight of the four mental health carveouts consisted primarily of reviewing and approving states' applications for Medicaid waivers and requests for waiver renewal—reviews intended to ensure that states met Medicaid requirements for managed care programs. Between these review periods, HCFA's oversight generally targeted specific issues, such as the adequacy of the provider network during program implementation. HCFA's regional offices conducted much of the oversight for the mental health carveout programs, and it varied in both content and intensity. HCFA provided minimal written guidance to its staff for the oversight of Medicaid mental health programs, and HCFA's staff had limited expertise in mental health managed care issues, according to HCFA and state officials we interviewed. HCFA has recently taken several steps, such as establishing an ongoing collaboration with the Substance Abuse and Mental Health Services Administration (SAMHSA) and test-piloting an early monitoring program, to strengthen its oversight of Medicaid mental health programs.

Background

For low-income persons, Medicaid is a critical source of financing for health care services. In fiscal year 1998, Medicaid expenditures for physical and mental health care totaled $177 billion. Medicaid is a significant funder of mental health care; its expenditures represented an estimated 19 percent of nationwide mental health expenditures in 1996, the most recent year for which estimates are available. Families with low incomes can qualify for Medicaid under specified federal and state criteria. Low-income disabled persons, including those with mental disabilities, become eligible for Medicaid in most states if they receive Supplemental Security Income (SSI) payments under the Social Security Act. In December 1997, about one-third of SSI adults with disabilities for whom

diagnoses were available had a mental disability.[8] Compared with the privately insured, the Medicaid population includes a higher proportion of people who experience severe mental disorders and who use mental health services.

Medicaid is administered and partially funded by the states, in accordance with federal statutes and regulations that allow states flexibility in operating their programs. At the federal level, HCFA, within the Department of Health and Human Services (HHS), provides states with federal matching funds and broad oversight of the Medicaid program. Medicaid covers both required health services (such as inpatient and outpatient services) and optional services (such as rehabilitation) selected by the states. Mental health services are included within these broad health categories. Generally, these health benefits must be provided in the same amount, duration, and scope to all Medicaid beneficiaries. Reflecting Medicaid's medical focus, Medicaid mental health services have traditionally been provided by physicians, including psychiatrists, working at hospitals, clinics, and other organizations. These services have also been provided, to a lesser extent, by other practitioners, such as psychologists and psychiatric social workers. Under traditional FFS Medicaid programs, beneficiaries were allowed to choose any qualified provider who was willing to accept Medicaid patients.

In addition to HCFA's funding of Medicaid mental health services, other governmental agencies and organizations, notably SAMHSA, are involved in mental health programs and funding. SAMHSA oversees federal block grants to states for mental health services and provides technical assistance on managed mental health services to HCFA and the states. States and counties, using their own revenues as well as federal grant funds, also provide important mental health services to low-income consumers.[9] Since their establishment in 1963 by the Community Mental Health Centers Act, community mental health centers (CMHC) have provided mental health services for both Medicaid and non-Medicaid consumers, with increasing emphasis on serving persons with persistent mental illnesses.

[8]Diagnostic information was available for about 2.9 million of the 3.5 million disabled adult SSI recipients in December 1997. About one-third of these recipients—or 977,000 people—were diagnosed with mental disorders other than mental retardation. The December 1997 data are the latest available that report diagnoses for SSI recipients.

[9]The term "consumer" rather than beneficiary or patient is commonly used in the mental health programs that we studied. It reflects a treatment philosophy in which the person receiving services is an active participant in care.

Medicaid Managed Care

States are increasingly using managed care approaches involving capitated payments for their Medicaid programs. In capitated programs, states contract with HMOs and PHPs, which are paid a fixed amount each month, in advance, for each person enrolled, in return for a contracted array of health services. Capitation payments do not vary with an individual's use of services. In June 1998, more than 40 percent of the Medicaid population—about 12.6 million people—were enrolled in some form of fully or partially capitated managed care.[10]

States can implement Medicaid managed care programs under one of three options, subject to certain federal requirements: the state Medicaid plan, section 1915(b) program waivers, and section 1115 demonstration waivers.[11] Before the enactment of the Balanced Budget Act of 1997 (BBA) (P.L. 105-33), the state plan option allowed states to contract with managed care plans only if enrollment was voluntary and if beneficiaries were ordinarily permitted to disenroll at any time and return to the Medicaid FFS program.[12] If states wanted to mandate enrollment in managed care plans, require beneficiaries to remain in a plan for more than a month, or contract with plans that enrolled predominantly or only Medicaid beneficiaries, they needed to obtain HCFA's approval for waivers from the relevant Medicaid requirements. However, under a new section 1932 in the BBA,[13] state Medicaid agencies have greater authority to establish managed care programs under their state plan, including the authority to mandate enrollment in managed care for most beneficiaries.[14] Under section 1932, states generally must allow Medicaid beneficiaries to choose from at least two managed care organizations (MCO) or primary care case managers, but states can still apply for waivers that limit Medicaid beneficiaries to one such entity. The BBA also strengthened quality assurance requirements for managed care programs under state plans.

[10]Under partial capitation, the state and plan share the financial risk in some way, such as each paying half of any losses or keeping half of any profits above or below a specified amount. Partial capitation can also refer to an arrangement whereby a plan is paid for providing services to enrollees through a combination of capitation and FFS reimbursements.

[11]Except as otherwise noted, any reference in this report to a section is a reference to the Social Security Act.

[12]An exception existed for federally qualified HMOs and certain other federally designated organizations. After a 1-month trial period had passed, the states were allowed to restrict an enrollee's ability to disenroll for 5 months.

[13]On September 29, 1998, HCFA issued proposed rules for the implementation of the BBA for Medicaid managed care programs. HCFA has received comments but does not expect to publish final rules until late in 1999.

[14]Exceptions include "dual eligibles," who are enrolled in both Medicare and Medicaid.

The BBA did not make significant changes to the section 1915(b) or section 1115 waiver programs. Section 1915(b) program waivers allow states to mandate enrollment and contract selectively with providers and plans. In most cases, beneficiaries have the freedom to disenroll every 30 days.[15] Program waivers are valid for 2 years and can be renewed for successive 2-year periods. Section 1115 demonstration waivers, used increasingly in recent years, allow broader authority to waive nearly any provision of the Medicaid statute to study mechanisms that may help promote the program's objectives. This type of waiver has been used to mandate enrollment and lock in beneficiaries to a plan for longer periods. Typically approved for up to a 5-year period, section 1115 demonstration waivers have also been used to develop innovative Medicaid programs, including the expansion of eligibility to people formerly ineligible.[16]

Oversight and Guidance of Medicaid Managed Care Programs

HCFA oversees managed care programs under both state plans and Medicaid waivers. HCFA approves initial state plans and can approve or disapprove plan amendments. HCFA can also withhold federal payments if it determines that a state plan is not complying with federal requirements, although in practice the process to deny payments is slow, allowing the states the opportunity to come into compliance, and HCFA has never withheld any funds. In the case of waivers, HCFA can grant or deny waiver requests from the states. The nature of HCFA's requirements and oversight of waiver programs depends on the type of waiver that is authorized. For a section 1115 demonstration waiver, HCFA develops terms and conditions of approval that vary by state, depending on the provisions being waived. For both section 1115 demonstration waivers and section 1915(b) program waivers, HCFA is responsible for ensuring that access to services be at least equal to access under traditional FFS programs and that federal costs do not increase because of the waiver.

With the advent of capitated care, oversight of quality became increasingly important, especially for vulnerable populations such as people with mental illnesses. In contrast to FFS payments, which financially reward providers' overutilization of services, capitation creates incentives for plans to limit access and underserve their enrollees. Although other factors such as clinical standards and professional norms may offset this incentive to limit care, concerns about access and potential underservice remain. Because of such concerns, HCFA developed and published

[15]States can lock in enrollment for up to 6 months for prepaid plans that meet certain federal requirements.

[16]The BBA provided for section 1115 demonstration waivers to be extended for an additional 3 years.

guidelines for the states on quality assurance under managed care. These guidelines are intended to supplement Medicaid statute and regulation, but the states are not required to use them.

HCFA issued the first of these guidelines in 1993 under its Quality Assurance Reform Initiative (QARI). The QARI guidelines contained a framework for a health care quality improvement system for Medicaid managed care and recommendations for (1) standards for managed care programs' internal quality assurance programs; (2) priority clinical areas of concern, use of clinical indicators, and practice guidelines; and (3) types of activities for external quality reviews. The second guideline, the Quality Improvement System for Managed Care (QISMC), was published in September 1998 and was designed to update the QARI guidelines. The QISMC standards direct managed care programs to (1) operate an internal program of quality assessment and performance improvement that achieves demonstrable improvements in enrollee health, functional status, and satisfaction; (2) collect and report data reflecting its performance on standardized measures of health care quality and meet any performance standards specified in its contract with the state; and (3) demonstrate compliance with basic requirements for administrative structures and operations that promote quality of care and beneficiary protection.

The Four States We Studied

The four states we studied all implemented their capitated mental health carveout programs before January 1996, which allowed them to have experienced more than one round of the contracting cycle before we began our review. In 1992, Massachusetts was the first state to establish a statewide capitated mental health carveout. Washington followed in 1993, Iowa and Colorado in 1995. In Colorado and Washington, the carveouts were administered through the state mental health divisions. Colorado had regionally based, mostly not-for-profit plans, and Washington had public, county-based plans. In contrast, in Massachusetts the Medicaid agency took the lead in managing the mental health program, while in Iowa a team with members of both the Medicaid and the substance abuse divisions jointly managed the program. Iowa and Massachusetts each contracted with a for-profit mental health plan to serve the entire state. (See table 1.)

Table 1: Characteristics of Four States' Medicaid Mental Health Carveout Programs

Characteristic	Colorado	Iowa[a]	Massachusetts[b]	Washington[c]
Date implemented	Aug. 1995	Mar. 1995	Nov. 1992	July 1993
Waiver type	1915(b)	1915(b)	1115; before July 1997, 1915(b)	1915(b)
State carveout manager	Mental health division[d]	Joint Medicaid-substance abuse divisions	Medicaid division	Mental health division[e]
Waiver program area	State	State	State	State
Plan contract area	Region	State	State	Region
Number of plans	8	1	1	14
Types of plans	Mostly not-for-profit	For-profit	For-profit	Public; one or more county governmental entities
Approach to financial risk under capitation	Plan bears full risk	Plan bears full risk	Financial risk shared between plan and state	Plan bears full risk
Total number of Medicaid carveout enrollees, state fiscal year 1998[f]	238,570[g]	264,191[h]	401,052[i]	718,109[j]

(Table notes on next page)

[a]Iowa's carveout program since January 1999 has included both mental health and substance abuse services. The program is administered jointly by the Division of Medical Services and the Division of Substance Abuse and Health Promotion, each in a different department. The Division of Mental Health and Developmental Disabilities and the Division of Medical Services are both within the Department of Human Services.

[b]The column refers only to the Massachusetts carveout program. Consumers can also choose an HMO health care program that provides both physical and mental health services.

[c]Washington covered only outpatient mental health services under its first section 1915(b) program waiver. The program is now making a transition under a new program waiver to an integrated carveout offering both inpatient and outpatient services. Nine of the 14 plans had signed integrated service contracts as of June 30, 1999, according to state officials.

[d]Although Colorado's waiver program administration was the responsibility of the state Medicaid agency, the program was managed by Mental Health Services within the Department of Human Services, through an interdepartmental memorandum of understanding with the Department of Health Care Policy and Financing.

[e]In Washington, the Mental Health Division within the Department of Social and Health Services was also the contract administrator.

[f]Enrollment figures include both children and adults.

[g]Colorado's figure represents number of member months paid divided by 12 months and is not an unduplicated count. Enrollment figures include two plans that were new to the capitation program in May and June 1998, although these plans had not yet provided services to their enrollees.

[h]Iowa's figure is an unduplicated count for the state fiscal year ending June 1998.

[i]Massachusetts' enrollment data are a May 1998 end-of-month "snapshot."

[j]Washington's enrollment data are a June 1998 end-of month "snapshot." According to state officials, Washington "casts a wide net" for Medicaid eligibility. Officials believe that this may account for the carveout's relatively high enrollment figure compared with figures for the other states.

The States Limited Beneficiaries' Choice in Mandated Programs While Making Efforts to Ensure Their Access to Services

Three of the four states we studied required that nearly all Medicaid beneficiaries enroll in the mental health plan that served the area in which they lived and did not offer beneficiaries a choice of plan. The fourth state, Massachusetts, mandated enrollment in managed care and offered beneficiaries a limited choice between two kinds of capitated arrangements. Freedom of plan choice can help promote quality and offset incentives to restrict access.[17] However, enrollment in a single carveout plan offered advantages as well as disadvantages to beneficiaries and the states in terms of beneficiary protections and program oversight. The four states generally tried in their contract provisions to promote access to services in their mental health carveouts, generally expanding the range of community-based services and reducing the use of inpatient services.

[17]Under the BBA, states are required to permit Medicaid beneficiaries to choose from at least two plans. States can still apply for waivers that further limit choice to a single plan.

Mandated Enrollment in a Single Plan Has Advantages and Disadvantages for Medicaid Beneficiaries and for the States

Colorado, Iowa, and Washington mandated enrollment in their capitated mental health carveouts for most Medicaid beneficiaries, including SSI disabled beneficiaries and people with chronic mental illnesses.[18] Enrollment in the mental health carveout was automatic in these states, according to state officials. In Massachusetts, Medicaid beneficiaries were also required to enroll in a capitated program for their mental health services,[19] and most people eligible for Medicaid in Massachusetts, especially SSI beneficiaries, were enrolled in the mental health carveout program. Colorado and Washington included Medicaid beneficiaries in nursing homes in their carveouts, but Iowa, Massachusetts, and Washington excluded beneficiaries in state psychiatric hospitals from the carveouts.[20] Typically, only a small portion of enrollees used mental health services in these carveouts, ranging from a statewide average of about 7 percent of enrollees in Washington for fiscal year 1998, for outpatient services only, to 25 percent in Massachusetts.[21]

In addition to mandating enrollment, the four states we studied did not offer beneficiaries a choice of competing mental health carveout plans: Iowa and Massachusetts each had a single statewide carveout plan, and Colorado and Washington had one plan for each geographic region. The single-plan approach in these carveout programs, in conjunction with mandated enrollment, has mixed implications for enrollees. Among the benefits are that (1) the carveout plans cannot favorably select the healthiest enrollees for their own financial advantage, leaving the sickest for other plans;[22] (2) enrollees are not exposed to marketing abuses that

[18]In contrast, in physical health Medicaid managed care programs, states often made enrollment voluntary for beneficiaries with disabilities, such as SSI disabled beneficiaries—or they enrolled them only after the program had been established for other eligibility groups, because of concerns about potential shortcomings in the availability or quality of services for populations with special needs. See Medicaid Managed Care: Serving the Disabled Challenges State Programs (GAO/HEHS-96-136, July 1996), p. 22.

[19]In Massachusetts, Medicaid beneficiaries could choose either an HMO plan providing both physical and mental health services or a joint program entailing a primary care case management (PCCM) plan for physical health services and the capitated carveout PHP for mental health services. Although families and children can be assigned to the HMO or the PCCM/mental health carveout plan, the PCCM/mental health carveout was the default for SSI beneficiaries. For a discussion of some of the issues in coordinating physical and mental health services in these four states, see app. II.

[20]Adults between 21 and 65 in institutions for mental diseases cannot receive Medicaid benefits for the services these institutions provide.

[21]For more information on the number and percentage of service recipients, as well as on capitation rates in the four carveout programs, see app. III.

[22]Some argue that eliminating plans' ability to select enrollees may outweigh the loss of choice for beneficiaries. See Haiden Huskamp, State Requirements for Managed Behavioral Health Care Carve-Outs and What They Mean for People With Severe Mental Illness (n.p.: National Alliance for the Mentally Ill, Nov. 1996), p. 7.

have occurred elsewhere when several plans compete for enrollees;[23] and (3) carveout plans cannot encourage beneficiaries to disenroll because of an adverse change in their health.[24] One drawback is that mandating enrollment in a single plan prevents consumers who are dissatisfied with their mental health care from acting on their dissatisfaction by choosing another plan or returning to FFS. Because there is no competition among plans, enrollees must accept the coverage and quality of services that the plan provides.

For states, the single-plan approach—together with mandated enrollment—also has mixed implications for program development and oversight. It may, for example, make it possible for rural states, such as Iowa, to establish reasonably sized financial-risk pools for plans by ensuring a sufficient enrollee base.[25] Monitoring a single plan may also be more manageable and less complex than monitoring several plans. However, if there are major problems with a plan's performance, state officials may be less prepared to force it to improve performance or to cancel the contract when an entire state or area would be affected by the decision, because this action could disrupt mental health care for many people.[26] Such issues may be compounded with statewide contracts, as in Iowa and Massachusetts. Similarly, if the single plan representing an area or an entire state decides to terminate its contract, then the state can be faced with the need to quickly replace the plan midstream—a tricky proposition—or return to FFS until the state is able to rebid the contract.[27]

The States Made Efforts to Promote Access to Mental Health Services

The states we studied tried to promote Medicaid beneficiaries' access to mental health services through their contractual provisions regarding providers, provider choice, medical necessity standards, and prior authorization requirements. The states generally required their carveout plans to broaden the range of community-based mental health services

[23]Medicaid: States' Efforts to Educate and Enroll Beneficiaries in Managed Care (GAO/HEHS-96-184, Sept. 1996), pp. 4-6.

[24]Disenrollment was largely limited in the four states to changed circumstances, such as when beneficiaries moved out of the service area or became ineligible for Medicaid.

[25]Iowa's program staff said that they preferred a statewide program to a county-based program because in most counties the state has a small Medicaid population over which to spread risk. Washington set a minimum number of citizens for each contractor for similar reasons.

[26]See Medicaid Managed Care: More Competition and Oversight Would Improve California's Expansion Plan (GAO/HEHS-95-87, Apr. 1995), p. 18, for a discussion of this point.

[27]This situation occurred in Montana when the single statewide Medicaid mental health plan terminated its contract with the state. State officials told us in June 1999 that the state is reverting to FFS until Montana can develop and contract for a new mental health plan.

offered. In addition, states decreased the use of inpatient services and included payment incentives in their contracts to discourage potential underservice.

Provider Networks

To help ensure an appropriate and adequate network of providers, as well as continuity of care under the carveouts, states and plans generally built upon existing mental health service systems. They all included in their networks traditional Medicaid not-for-profit provider agencies, such as CMHCs, as well as individual providers. In Washington, the plans—which are county governmental entities—generally provided services through the same CMHCs that existed under FFS. In Colorado, most plans were themselves CMHCs—singly, in consortium, or in partnership with for-profit organizations.[28] In Iowa, CMHCs were included among the providers and were important, according to plan officials, for treating people with severe mental illnesses and for providing traditional outpatient services and some community support programs. Massachusetts allowed individual contracts with providers, including CMHCs, that met credentialing standards.

By itself, contracting with traditional providers is no guarantee of the quality of services. However, using traditional providers gives some assurance of experience with Medicaid populations, which have a much higher proportion of severe mental illnesses than members of employee-based plans. Including traditional mental health providers allows some continuity of providers from before capitation but may also result in the retention of inefficient providers. Plans generally profiled providers' performance to identify inefficient providers and take corrective action. For example, the Massachusetts contract required the plan to have a system for profiling providers and to report their improvement goals annually to the state.

Provider Choice

Although the mental health carveouts we reviewed typically did not allow a choice of plan, they allowed enrollees to choose their providers from among those in the plans' network, as required by HCFA, and allowed some flexibility to change providers periodically. In some cases, enrollees in Colorado and Massachusetts were allowed to use out-of-network providers. While plans' policies and practices may be more critical than choice of providers in determining the care that consumers receive, the ability to select one's own provider constitutes a meaningful choice to

[28]In a January 1997 report, Colorado officials noted that many consumers viewed the loss of choice of provider under the capitated program as a significant negative of the program. Under FFS, most consumers received services from their local CMHCs, but some went to private practitioners. Most CMHCs continue to provide mental health services under the capitated program.

consumers, as it is under FFS.[29] This is especially so if choice allows consumers to have continuity of care or convenient access to a provider or if it allows them to obtain the services of a provider with a particular cultural or linguistic background.

Medical Necessity Standards for Authorizing Services

Medical necessity standards are the criteria used to determine clinically appropriate services and the necessary level and intensity of care under the terms of a contract. In effect, they establish the conditions under which services must be provided. In commercial plans especially, medical necessity standards tend to be based on medical and institutional models of care.[30] However, such medical models do not encompass certain community and social services that mental health professionals, state officials, and advocacy organizations believe are important to help improve the functioning of consumers with mental illnesses.[31] Concerns have therefore been raised about plans' potential use of these standards to restrict Medicaid consumers' access to services.[32]

To ensure that the need for nonmedical services in mental health was recognized, the states we studied generally defined medical necessity broadly in contracts to include preventive and social models of care. In Washington, medical necessity criteria included services designed to "prevent, diagnose, or alleviate the worsening of conditions." Massachusetts used similar language in its definition of medical necessity. Colorado required its plans to provide "all necessary mental health services," including practice in daily living skills and social interactions designed to maximize clients' ability to live and function independently in the community. Colorado's contract added that plans have the "flexibility to deliver whatever services are necessary and appropriate to effectively treat each client's illness." Iowa required that service authorizations be based on "psychosocial necessity" instead of medical necessity. Psychosocial necessity refers to "clinical, rehabilitative, or supportive"

[29]See GAO/HEHS-95-87, p. 18.

[30]For example, medical necessity criteria often call for "substantial improvement," or even cure, as a condition for recommending therapies—requirements that pose problems for people with disabilities, for whom maintenance and avoidance of deterioration may be acceptable goals.

[31]With medically focused standards, providers of services that are regarded as social or residential, such as clubhouses or halfway houses, may not be reimbursed by plans—even though providers and consumers may regard these services as important aspects of mental health care.

[32]According to a SAMHSA official, advocates and consumers frequently expressed concerns to agency officials about the effect of medical necessity standards on mental health care. Medical necessity issues were also discussed in Sara Rosenbaum et al., "Special Report: Mental Illness and Addiction Disorder Treatment and Prevention," Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts, 2nd ed. (Washington, D.C.: George Washington University Center for Health Policy Research, Mar. 1998), pp. vii and viii, 30-35, and 71-72.

mental health services, including services that may avert the need for more intensive treatment to maintain functioning.

Of the four states we studied, Massachusetts established the most extensive medical necessity standards while also incorporating psychosocial concepts. For each type of mental health service, the contract included a definition of the service as well as the criteria for admission, exclusion, continuing care, and discharge. However, Massachusetts also incorporated social concepts and social services in its definitions of mental health services. For example, community support services were described as services that used mobile, multidisciplinary teams to assist people with persistent mental illnesses in addressing basic needs, such as obtaining food, housing, and community services.

In some cases, these broader definitions appeared to be more in the nature of statements of treatment philosophy rather than enforceable standards. This was the situation, for example, when plans were "expected" to provide new services, as in Colorado, or when service definitions did "not limit or preclude" a plan from providing psychosocial rehabilitation services or other innovative services and supports, as in Washington. Massachusetts' medical necessity definitions were probably the most easily enforceable because of their specificity. However, as one way of helping to ensure that needed mental health services were not denied by plans, all the carveouts we studied showed a distinct shift away from narrow, medically based criteria for authorizing services.

Prior Authorization Policies for Outpatient Services

Although prior authorization of services is a key aspect of managed care, the carveouts we studied generally did not require plans' prior approval for outpatient services until service use reached certain limits, if at all. Massachusetts replaced its earlier prior authorization requirement with a system whereby providers notified the plan about the number of outpatient services they expected to provide. No further authorizations were needed and there were no limits on the number of sessions allowed; instead, the plan shifted to a system of profiling providers and managing outliers. Most Colorado plans allowed consumers to have from about eight to ten outpatient visits without prior authorization, according to officials we interviewed. Under Iowa's 1999 contract, prior approval was not required for individual, family, and group therapy; medication management; initial evaluation; and targeted case management services. In Washington, prior authorization practice varied among the plans and was monitored by the state, according to state officials.

Reducing preauthorization requirements for outpatient services primarily serves consumers with less severe illnesses, whose needs may be satisfied with a limited number of visits, rather than consumers with severe and persistent mental illnesses, who generally need more intensive and extensive services. However, reducing the need for prior authorization also simplifies consumers' initial access to outpatient services, compared with more typical managed care practices regarding specialty care. It can also allow time for developing treatment plans for additional services.

Community-Based Mental Health Services

To varying degrees, the four states required mental health plans to offer an expanded array of community-based mental health services, including services that were not previously covered by traditional FFS Medicaid. For example, in addition to traditional Medicaid mental health services, such as individual and group therapy, Colorado expected its plans to provide nontraditional options, such as peer counseling and support services, family preservation services, consumer drop-in centers, and early intervention services. Similarly, Iowa's 1999 contract required the plan to provide services such as mobile crisis counseling, peer support groups, and supported community living,[33] as well as assertive community treatment[34] and intensive psychiatric rehabilitation for consumers with severe mental illnesses. Other examples of nontraditional services offered under the carveouts included telemedicine consultation, vocational rehabilitation programs, halfway houses, crisis triage centers, and residential support for older adults released from state hospitals.

The carveout plans in Colorado, Iowa, and Washington used the flexibility possible under capitation to tailor mental health services to the special needs of individual consumers, according to plan and other officials. Sometimes this was done by providing nonmedical assistance to help stabilize individuals in their communities. For example, plans in these states purchased items and made payments to help support individual consumers' fundamental needs—such as being able to eat, hold a job, contact their mental health providers in a crisis, and remain in their

[33]"Supported community living" services include 24-hour crisis services and counseling as well as services that teach needed practical social and personal skills, such as hygiene, cooking, shopping, and housekeeping, and help with the development of personal support networks in the community. Supported community living services may also include crisis residential services, which are small community residential facilities that function as alternatives to inpatient care.

[34]Assertive community treatment (ACT) programs are targeted to consumers with serious and persistent mental illnesses. ACT programs involve community support services and intensive treatment by a multidisciplinary team. The goal of this treatment is to increase the consumers' independent functioning through symptom management and direct assistance with daily needs, such as housing and vocational support. In June 1999, HCFA issued a letter to state Medicaid directors suggesting that states consider positive findings about the effectiveness of ACT programs in their plans for comprehensive approaches to community-based mental health services.

homes. Interventions described to us included purchasing, for different individuals, a microwave oven and a bicycle, and paying apartment security deposits. Although unusual, such interventions illustrate how plans can be flexible in designing individual treatment plans while remaining at financial risk for their choices.

The carveout plans we studied typically expanded the range and use of community mental health services in part by decreasing the use of inpatient services. For example, according to a program report to Colorado's state assembly, Colorado's expenditures for inpatient psychiatric hospital services decreased from $30 million in fiscal year 1995—before the capitated program began—to less than $10 million in fiscal year 1996, the first year of the capitation program. The report noted that during this time expenditures for alternative community-based services increased—from about $30 million in fiscal year 1995 to about $47 million in fiscal year 1996.[35] In Iowa, the carveout reduced the percentage of expenditures for inpatient psychiatric care from 51 percent under the previous FFS Medicaid program to 29 percent for inpatient services in the second year of the capitated program, according to state documents. Moreover, under capitation, 20 percent of expenditures—nearly $9 million—were for community-based services that were not previously covered under Iowa's Medicaid FFS program. An independent study of Massachusetts' program reported significant decreases in its PCCM/mental health carveout in the number of inpatient days and the average length of stay in the hospital: For example, inpatient days for SSI beneficiaries fell nearly 40 percent over a 3-year period.[36] According to Massachusetts officials, the carveout program concurrently experienced increased utilization at other levels of care and new utilization of services that had not existed before the carveout began. In Washington, state officials also reported declines in inpatient usage and expenditures.[37]

[35]According to an October 1998 report by Colorado's state auditor, Colorado is spending more per person served for mental health services under the carveout than under the FFS program. (State of Colorado, Report of the State Auditor: Department of Human Services, Medicaid Capitation for Mental Health Services, Financial Review (Denver, Colo.: Oct. 1998).) Colorado program officials disputed this finding. An earlier study on the cost of serving adults with severe and persistent mental illnesses before and after the carveout produced mixed results. Where the state contracted with CMHCs, costs remained about the same. Where the state contracted with joint ventures of one or more CMHCs and a private managed care firm, costs decreased under capitation. (Joan R. Bloom and others, "Mental Health Costs Under Alternative Capitation Systems in Colorado: Preliminary Findings for the First Six to Nine Months Following Implementation," Berkeley, California, July 1, 1997.)

[36]The Lewin Group, Report on Impact of Massachusetts' Medicaid Managed Care Initiatives. Presented to Division of Medical Assistance, Oct. 9, 1997.

[37]Washington plans were responsible for authorizing admissions and length of stay for psychiatric inpatient care, although inpatient care was not included in their service contracts until recently.

Plans in Colorado and Iowa reinvested savings[38] from the carveout programs in the development of alternative community-based mental health services, focusing on the needs of geographical areas that historically were considered underserved, such as rural service areas, or the needs of special populations, such as adults with severe and persistent mental illnesses. The two for-profit plans we visited in these states generated savings beyond contractually allowed profits. In Iowa, for example, in the first 3 years of the carveout program, the statewide plan reinvested $1 million each year in pilot mental health service projects, such as mobile counseling and therapeutic socialization programs for adults with severe mental illnesses.[39] In Colorado, one plan we visited saved about $1.3 million in the first year of the program, from a budget of about $15 million, and $1.9 million in the second year, according to plan officials. The plan reinvested these savings in alternative services such as telemedicine, of particular importance in rural areas; 24-hour psychiatric treatment programs for patients with serious mental disorders; and increased respite care. Colorado's PHPs were required to submit business plans for state approval proposing how reinvestment funds would be spent.

Colorado also required its PHPs to reinvest savings—after ensuring that "all enrolled Medicaid clients . . . received all necessary services"—to provide mental health services for indigent consumers who did not qualify for Medicaid.[40] This reinvestment requirement reflected the state's intention not to differentiate among those in need of services on the basis of their Medicaid eligibility. However, according to a June 1998 HCFA policy statement, states cannot require in their contracts that PHPs use savings from their capitation payments for services for non-Medicaid consumers under future Medicaid waivers or state plans. HCFA considered it inappropriate for states to essentially leverage Medicaid funds to provide

[38]In Colorado, "savings" refers to additional plan revenues over expenses, after allowable profits, which are capped. In Iowa, savings refers to the amount by which actual claims are less than expected claims, if any, for the plan's claim period. The amount of savings, which were shared between the state and the plan, was determined 12 months after the claims period ended. According to state officials, Iowa's reinvestment plan called for setting aside $1 million for reinvestment projects first and then sharing any remaining savings between the state and plan. The reinvestment plan was designed to reduce the amount of the shared savings and to keep funding in mental health services.

[39]In the third year, the $1 million was also used to fund provider rate increases. Iowa's 1999 contract did not require that savings be reinvested. Instead, it required the plan to set aside 2.5 percent of its capitation payment as a community "reinvestment" account, which could include financing one pilot project each year on the prevention of mental health problems.

[40]According to the Colorado Department of Human Services, by serving non-Medicaid populations with excess funds not spent for services to Medicaid beneficiaries, the state received more than $6 million in additional federal funds during fiscal years 1996 and 1997. Colorado's state auditor agreed that additional federal funds were brought into the state. (Colorado, Report of the State Auditor, p. 18.)

services for non-Medicaid consumers. States will no longer be permitted to continue this practice when their existing waiver programs are renewed.

Not surprisingly, the states varied in the degree to which they achieved their goals of expanding the array of service options. In Iowa, providers and advocates suggested that some new, nontraditional services were not uniformly available and that other services that appeared to be new under the carveout had been previously available to consumers. For example, before the mental health carveout, Iowa counties paid for half of the state's Medicaid share for targeted case management services, partial hospitalization, and day treatment, which were usually viewed as county services; under the carveout, these services were fully funded by the state and federal governments. The counties formerly paid for community support services, but now the Medicaid carveout shares in the funding of these services. Washington officials noted that some alternative services, such as clubhouses[41] and consumer support groups, were new not to the mental health community but only to the Medicaid program.

Payment Incentives

The states we studied also attempted to reduce the financial incentives for capitated plans to underserve mental health consumers. In addition to Washington's and Colorado's use of mostly not-for-profit plans, states limited profits, losses, and administrative expenditures.

Colorado, Iowa, and Massachusetts limited plan profits in different ways. Colorado capped profits at 5 percent of pre-tax payments under its first carveout contract and retained a similar profit cap in its second contract. Iowa set a cap on profits in its first contract: Beyond the first $1 million in savings, which had to be reinvested in services, the plan could retain as profit 20 percent of any savings in services from its $43 million contract. According to state officials, the plan could also retain any savings from administrative costs. Massachusetts shared both profits and losses with the statewide for-profit plan through a contract arrangement called a "risk corridor." Under this arrangement, if the plan achieves savings, the state shares in these savings, according to a set percentage.[42] If the plan has losses, it is responsible for 45 percent of the first $11 million of service expenditures that exceed the capitation rate payments; the state is responsible for the rest, as well as for all losses greater than $11 million. According to Massachusetts officials, in designing this risk corridor they

[41]Clubhouse programs emphasize vocational opportunities and client empowerment. Individuals participating in clubhouses are considered members rather than clients.

[42]The Massachusetts plan can also receive additional revenues by meeting performance indicators attached to financial incentives.

wanted to allow an opportunity for a for-profit plan to earn profits while limiting the incentives to deny care—that is, they did not want the contractor to limit services either to avoid losing money or to increase profits. However, it is harder for states to predict savings or losses with a shared-risk arrangement than with a full-risk arrangement. This limitation may make shared-risk arrangements less attractive to some states, despite their potential advantages to plans and consumers.

Administrative expenditures under capitation are important because they typically include service authorization, quality assurance, claims payments, and data systems. Nevertheless, Iowa, Washington, and Massachusetts tried to shape plans' behavior and maximize funding for direct services by limiting administrative payments to contractors or limiting the use of such funds as a source of profits. Iowa capped contract administration payments at 19 percent of the capitation payment in the first program cycle, according to state officials, and at 15 percent in the second. Under Iowa's 1999 combined mental health and substance abuse carveout, profits on a $77 million contract[43] can be made only from savings in the plan's capped administrative expenditures and from financial incentives of up to $1 million linked to performance measures. Washington capped mental health plans' administrative costs at 25 percent and required that 75 percent of funds be used to provide direct services.

Massachusetts' more complex arrangement for administrative expenses resulted, according to state officials, from its experience with its first contractor. Under that contract, the plan reduced staffing for service authorization requests and claims payments to reduce costs and increase profits, resulting in delays in authorizing services and paying claims. The contract ended with a $20 million settlement in outstanding claims, according to state officials. In amending the state's second contract—with a different plan—Massachusetts officials sought to avoid a recurrence of this problem by paying for administrative expenses separately from the capitation payment and capping the profit that the plan could earn on administrative expenses.

[43]Of the $77 million, $15 million represents a block grant for substance abuse services, according to program officials.

The States Supplemented Federal Quality Assurance Requirements With Additional Monitoring Approaches

In overseeing their mental health carveouts, the states we studied must adhere to federal quality assurance requirements. These requirements are generally the same as those for MCOs (such as grievance and appeals procedures) and those for programs operating under Medicaid waivers (such as the independent assessments for section 1915(b) program waivers). However, mental health carveouts are currently exempt from HCFA's requirement for annual external quality reviews of managed care plans. HCFA also has quality assurance guidance, developed for comprehensive managed care programs. This guidance is optional and generally was not used by the states we studied. Instead, the states supplemented HCFA's requirements with their own methods to ensure quality. While the states' methods were similar in many respects, we found that two states relied heavily on conducting site visits of plans and involving stakeholders, while the two other states made extensive use of quantitative performance goals and measurements, to which monetary rewards and penalties were attached. Acting on their experience and various means of oversight, states and plans made numerous and often substantial changes in their mental health carveouts over time.

The States Used Federally Required Approaches in Overseeing Their Mental Health Carveouts

In monitoring their carveout programs, the states we studied used methods of quality assurance that were federally required. The requirements for MCOs are quite general. All plans must have an internal quality assurance system and procedures for appeals and grievances that meet certain standards; they must also undergo an annual medical audit. In addition to these broad requirements, HCFA requires that all MCOs except PHPs be reviewed each year by a HCFA-certified independent review organization. For section 1915(b) program waivers, HCFA requires independent assessments of the program's cost, quality, and access; section 1115 demonstration waiver programs must collect encounter data and follow the specific provisions included in the waiver. (See table 2.) HCFA provides little guidance that states considered useful about how these systems and procedures should be adapted for mental health carveouts.

Table 2: Major Federal Requirements for Monitoring Medicaid Managed Care Programs

	Program	Requirement	Detail
Federal requirements	All Medicaid managed care	Internal quality assurance system	Plans must have a quality assurance system that is consistent with Medicaid utilization control requirements and provides —for review by appropriate health professionals of the process followed in providing health services, —for systematic data collection of performance and patient results, and —for interpretation of these data to practitioners and for making needed changes. (42 C.F.R. 434.34)
		Grievances and appeals	States must provide for granting an opportunity for a fair hearing to any individual whose Medicaid claim is denied or not acted upon with reasonable promptness. (42 U.S.C. 1396a(a)(3)) Managed care contractors must provide for an internal grievance procedure that —is approved in writing by the state Medicaid agency, —provides for prompt resolution of grievances, and —ensures the participation of individuals with authority to require corrective action. (42 C.F.R. 434.32)
		Medical audits	States must —conduct audits at least once a year for each contractor, —identify and collect management data for use by medical audit personnel, and —ensure that data include reasons for enrollment and termination and use of services. (42 C.F.R. 434.53)
	All Medicaid managed care except PHPs	Annual external quality review	States must use, with limited exception, a utilization and quality control peer review organization to conduct an independent, external review of the quality of services furnished, and the results must be made available to the state and certain federal officials. (42 U.S.C. 1396a(a)(30)(C))
HCFA requirements	Section 1915(b) program waivers	Independent assessments	States must conduct an assessment of cost, quality, and access for the whole program that is —performed on a 2-year cycle and —required for first two waiver renewals only.
	Section 1115 demonstration waivers	Encounter data	HCFA requires all states with these waivers to collect all encounter data.
		Terms and conditions	The initial terms and conditions of approval contain HCFA's specific monitoring requirements for section 1115 waiver states.

The four states' requirements for plans' quality assurance systems varied. For example, Iowa required the mental health plan's quality assurance program to assess the clinical impact of services and consumers' functioning as well as to conduct semi-annual surveys of client satisfaction and quality of life, annual surveys of referral agencies, and annual surveys of provider satisfaction. Colorado emphasized outcomes in its requirements for plans: In addition to identifying key indicators of clinical outcomes, quality assurance programs in Colorado must include methods to collect outcome data, criteria to determine if outcomes are satisfactory, evaluation of outcomes, methods to improve outcomes, and strategies to report quality improvement efforts.

For beneficiaries who cannot choose their health plan—such as those in the four states' mental health carveout programs—the grievance and appeals process is especially important. None of the plans in the states we visited received a large number of grievances and appeals, which could mean that the programs were working well. However, it could also mean that consumers with mental illnesses had difficulties filing grievances. For example, some consumers may not know where or how to file a grievance, since different kinds of grievances are addressed by different organizational units in the plan or by the state. In addition, consumer advocates reported that some consumers had concerns that providers might retaliate for complaints, particularly if consumers complained directly to a plan. Although a relatively low number of complaints is often found as well in public sector managed care programs for physical health care, consumers in these programs can choose to change plans (although they may have to wait for an open season) rather than file a complaint. This option is not available to consumers in the mental health carveout programs we visited.

To provide an alternative route for consumers to register concerns about mental health plans, Washington established independent ombudsman programs for each plan to help consumers navigate the carveout system. Colorado established an independent statewide ombudsman program to help consumers with the public mental health system, including the grievance process. Grievance and appeals systems may be helpful for dealing with specific plan problems as well as individual consumers' complaints. However, it is questionable whether the number of grievances and appeals can be used alone as a measure of quality, because it is difficult to determine whether a small number of reported grievances indicates barriers to registering grievances or consumers' satisfaction with the plan and its care. Grievance and appeals data, used in conjunction with

other indicators, such as satisfaction surveys, may provide important insights, however.

Medical audits, which are conducted annually, are designed to ensure that each plan furnishes quality and accessible health care to enrolled beneficiaries. These audits can be conducted by the state Medicaid agency, another state agency, or an external body. According to officials, Iowa contracted with an external organization for a medical audit of its statewide plan, but Washington and Colorado conducted their own audits. Washington officials told us that their clinical review team, which included clinicians in private practice as well as state officials, conducted chart reviews of 1 percent of the cases at provider agencies. In addition, the team, following a structured protocol, conducted in-depth performance-based reviews of three cases per provider agency—chosen by the plan—for a total of about 180 case reviews each year statewide. State officials viewed these review sessions as opportunities to reinforce positive practices and generate new ideas. They were therefore not concerned that the number of cases per agency was small or that the selection of cases might not fully represent the plan's caseload. While some providers viewed these audits as a learning experience, others questioned the state audit teams' qualifications to conduct the reviews and said that three cases per agency were insufficient to draw conclusions about their programs.

During the period of our study, mental health carveout plans, as PHPs, were exempted from annual external quality reviews, an important monitoring requirement for Medicaid MCOs.[44] HCFA officials signaled a change in their approach to this issue in the agency's September 29, 1998, proposed rule. This rule, which will implement the Medicaid portion of the BBA for MCOs, would also require PHPs to have annual external quality reviews. If this requirement is retained in the final rule, future mental health carveouts will be subject to an external quality review unless the Secretary of HHS specifically waives that requirement. However, according to HCFA officials, HCFA does not, as a matter of policy, waive quality provisions. In commenting on a draft of this report, HCFA stated that it is finalizing the rule and that it will require PHPs, including those providing mental health services, to have annual external quality reviews.

[44]External quality reviews are conducted by peer review organizations (PRO), a PRO-like entity, or an accreditation agency under contract to states, and they are funded jointly by HCFA and the states. These organizations most often carry out focused studies in which they review medical records to determine specific types of services delivered to a group of people—for example, immunizations given to children. Two important aspects of these external quality reviews are that they are done by qualified professionals who are independent of the plan and that they tend to be focused evaluations of each plan's quality of care.

To receive approval for the renewal of section 1915(b) program waivers, states must provide HCFA with independent assessments of waiver programs at the end of the second and fourth years of the waiver period. Independent assessments are unlike other quality assurance tools, such as external quality reviews, in several ways. Independent assessments are reviews of an overall state program, whereas external quality reviews focus on the quality of services in each plan within a state. This is a critical difference for states like Washington and Colorado that have several regionally based mental health plans. Independent assessments are conducted only every 2 years for the first 4 years of a waiver, while external quality reviews would be required annually.

Although independent assessments are intended primarily to provide HCFA with information about the extent to which states have met their commitments under the waiver agreements, these assessments are often of uncertain quality, according to a HCFA official. During our site visits, we found little evidence that HCFA offered the states guidance on the design of the assessments. According to one state official, when he asked HCFA officials for a model independent assessment, HCFA was unable to provide one. Although HCFA officials acknowledged that the quality of assessments was uneven, they said that they have not typically suggested to states how to improve inadequate assessments. To address some of these concerns, in December 1998, HCFA issued guidance to states on independent assessments. This guidance describes criteria for entities conducting independent assessments; the content of the independent assessment, which includes beneficiaries' access to services, the quality of services, and the cost-effectiveness of the waiver program; and related quality improvement strategies and activities. However, this guidance is generic, applying to all section 1915(b) program waivers, and does not specifically address mental health assessments.

Encounter data—similar to claims data under FFS and sometimes called "shadow claims"—are potentially important because they can be used to examine services by type of client, program, provider, diagnosis, or region and to detect evidence of possible under- or over-service. The four states we studied collected individual-level encounter data—although only Massachusetts was required to do so for its section 1115 demonstration waiver. State officials reported that they were not using the data systematically so far, although Massachusetts officials told us that they planned to use encounter data to adjust capitation rates in accordance with case mix and to issue quality management reports.

State officials reported that they sometimes found it difficult to obtain encounter data from the mental health plans, whose information systems did not always meet the states' specifications. Data from some plans were untimely, incomplete, and inaccurate. Such difficulties are not unique to mental health carveouts. There is often little incentive to collect encounter data in managed care plans, in which reimbursement does not depend on billing for specific services. Encounter data require adequate information systems, and when data from several systems are combined, both technical and definitional issues must be resolved. In addition, some nontraditional mental health services are difficult to track. For example, clubhouses and self-help groups are not considered environments in which it is realistic or desirable to track the participants by name. If states and plans address some of these data problems, encounter data could be used to monitor plan performance, even if the data were limited to services provided by professional staff in more traditional environments. Colorado recently began fining plans that did not submit required data on time as a way of encouraging them to meet the state's requirement. Similarly, Iowa included penalties for late submission of encounter data in its 1999 contract.

The initial terms and conditions for section 1115 demonstration waivers serve as HCFA's minimum assessment standards in its monitoring of states' demonstration waiver programs. These terms and conditions are detailed and specific in the content and timing of reporting requirements. For example, HCFA has required specific patient-provider ratios for plans and maximum travel times and distances to providers in such waivers, in contrast to section 1915(b) waiver programs, for which HCFA has suggested more generally that providers be located near beneficiaries.

Mental Health Carveouts Generally Did Not Use HCFA's Managed Care Quality Guidelines

The states we studied made little use of HCFA's guidelines for helping them monitor managed care plans to ensure program quality. From 1993 until the fall of 1998, the QARI guidelines were available for states' use. These guidelines were intended to "chart a course of action" for states and plans that serve the Medicaid population using capitated payments. While the QARI guidelines were advisory, 26 states have used some aspects of QARI for physical health programs, according to a survey conducted by the National Academy for State Health Policy.

However, the states we studied did not use the QARI guidelines for their mental health carveouts, including Washington, which piloted QARI for its physical health managed care programs. There are several explanations

for this. In Massachusetts, the carveout plan followed National Committee for Quality Assurance guidance because it was working toward accreditation from the committee. In Iowa, according to one state official, the state decided against using the QARI guidelines as a monitoring tool because QARI did not set specific measurable goals. In addition, the QARI guidelines were developed when Medicaid programs largely focused on enrolling mothers and children in managed care and other populations were not generally included. Although QARI guidelines could in principle be applied to mental health carveouts, HCFA did not encourage the states we studied to use the guidelines in their programs.

In September 1998, HCFA updated the QARI guidelines with QISMC, which sets out health care quality improvement standards and guidelines for Medicare and Medicaid programs contracting with MCOs. While QISMC refers to mental health and physical health generally, it lacks the specificity in mental health issues that at least one state official sought from guidance.[45] For example, the clinical focus areas are generic rather than tailored specifically to mental health.

The States Used Additional Strategies to Ensure Quality

The four states we studied supplemented federal requirements with a wide range of approaches to quality assurance and monitoring of plans. The states drew upon a fairly standard set of monitoring techniques, including site visits to plans, performance measurement, clinical reviews, and consumer advocate advisory committees. However, the states had distinctly different emphases in monitoring. Colorado and Washington relied heavily on site visits to plans and provider agencies and on the views of stakeholders in overseeing their mental health carveouts, although they also collected quantitative data about plan performance. Iowa and Massachusetts, while they also involved stakeholders to various degrees in their programs, relied heavily on the use of quantitative performance goals, to which they attached monetary rewards and penalties. Performance measures functioned both as oversight tools and as incentives to encourage plans to focus on issues the states considered important. Most carveout plans used a range of approaches to quality assurance—including conducting patient satisfaction surveys, establishing and monitoring standards, and having consumer committees.

[45]In April 1998, HCFA issued draft guidance on using managed care systems for persons with special health care needs, including those with mental illnesses. This guidance was intended to help states identify and resolve access problems for special needs populations, ensure adequate provider networks, and address social and support needs. Although SAMHSA, among other federal agencies, participated in the guidelines' development, the guidelines were meant to apply broadly to all populations with special health care needs.

In Colorado and Washington, the approach to monitoring was generally "hands on." Colorado program officials reported that they made regular site visits to each plan. In their site reviews of plans, Colorado officials followed a structured protocol in talking to a plan's staff, conducting focus groups with mental health consumers, and meeting with community agencies. Final reports on each plan discussed the population served, the services provided, access to services, consumers' choice of providers, consumer satisfaction, and complaints and appeals. The reports also noted strengths, areas for improvement, and follow-up expected from the plans. Colorado officials also conducted annual programmatic site reviews of every CMHC participating in the capitated carveout. These reviews, which lasted for several days, included chart reviews, quality assurance reviews, and reviews of critical incidents, such as suicides. State officials reported that they also provided the carveout plans with technical assistance and guidance. Colorado worked extensively with consumer advocates and other stakeholders through their participation in the state's advisory committees and plans' consumer advisory boards.

In Washington, administrative and clinical teams similarly conducted annual reviews of Washington's county-based plans. State officials also required the plans to have an independent team of consumers and family members visit each service location at least once a year to conduct focus groups with consumers, family members, social services, and community representatives. The state surveyed at least 2 percent of consumers each year about four areas: access, helpfulness of services, areas for improvement, and respect.

In contrast, Massachusetts and Iowa officials relied heavily—although not exclusively—for their monitoring on the use of performance measures to which they attached financial incentives and, in some cases, penalties.[46] According to state officials, Massachusetts uses performance measurement and financial incentives and penalties to shape systemic changes in its program. In its contract with the carveout plan, Massachusetts established twenty performance measures. These measures included medication monitoring after discharge, notification of hospitalization to the outpatient primary care physician, after-care planning, and intensive case management for persons with both a psychiatric and a substance abuse diagnosis. In a contract totaling almost $199 million for fiscal year 1998, a maximum of $6.7 million could be paid

[46]For example, Massachusetts established stakeholder advisory councils for both the state and the plan, and state officials met regularly with the plan's staff to monitor the plan's performance. In addition, medical directors from the state and plan met weekly to review the quality of clinical care being provided, according to state officials.

in incentives, and individual incentives were as much as $700,000. Penalties could reach $3.7 million overall and up to $500,000 for a single measure.[47] Iowa similarly tied monetary rewards and penalties to performance measures that were developed in consultation with stakeholders.

Performance measures must, however, be used with care. Both Massachusetts and Iowa learned that, to be effective, measures must be well developed, clearly written, and not subject to "gaming." For example, in Massachusetts' first year of using performance measures, one measure was the percentage of clients readmitted to the hospital for the same diagnosis within 7 days. To keep their percentages down, providers could simply change the diagnosis. Furthermore, performance measures carry the risk that plans will focus on areas that carry financial awards or penalties, to the exclusion of other equally important areas.

Monitoring Carveout Programs Resulted in Programmatic Changes

Multiple monitoring methods and sources of information helped the states and plans modify their mental health carveout programs over time. For example, in addition to HCFA's required monitoring efforts and the states' use of site reviews and performance measures, the states and plans examined rates at which enrollees used services, conducted outcome studies, assessed consumer functioning, and conducted consumer and provider surveys. From their analyses of these multiple sources of information, the states and plans made changes over time from when the programs were first implemented. Important changes already discussed included reducing or eliminating requirements for prior authorization of services and establishing ombudsman programs. Others included adding financial incentives and penalties to performance measures in contracts and making changes in the handling of administrative payments. Among its other changes, Massachusetts instituted a performance measure to increase consumer involvement in treatment planning. Plans in Washington established four triage centers, and state officials told us that they revamped their screening processes and length-of-stay requirements. Iowa changed its criteria for when inpatient services are appropriate and solicited stakeholder comments on performance measures, and Colorado made changes to improve response times in the carveout's emergency services system.

[47]In addition, the Massachusetts PHP developed a formula for sharing up to $1 million in achieved incentive payments with providers who met the plan's goals for four performance measures. The PHP would similarly impose a penalty on providers if both the plan and providers failed to meet two of these measures. This effort was limited to specific goals that the PHP has had a difficult time meeting.

HCFA Provided Limited Oversight of Mental Health Carveouts

HCFA's oversight of Medicaid mental health carveouts in the four states varied in both content and intensity. Oversight of the carveouts was most intensive at waiver development and approval and at continuation or renewal. Otherwise, HCFA's oversight tended to be more reactive than proactive and was usually restricted to problem issues. HCFA staff in different regional offices took different approaches to monitoring. According to state and HCFA officials, these variations may stem from limited written guidance for monitoring the mental health carveouts and HCFA staff's lack of experience with managed mental health care.

HCFA Monitored Carveouts Largely Through the Medicaid Waiver Process

HCFA oversees Medicaid waiver programs largely at two points in time: when states apply for approval of a Medicaid waiver and when they apply for extension or renewal. First, initial waiver applications enumerate the specific requirements requested to be waived and give an overview of the program. HCFA's central office scrutinizes section 1115 demonstration waiver applications. HCFA officials reported that regional offices play a significant role in the approval of section 1915(b) program waivers, although HCFA's central office takes the lead. The Office of Management and Budget (OMB) and other HHS agencies such as SAMHSA also participate in the reviews of both section 1115 demonstration waivers and section 1915(b) program waiver applications.[48] In the states we studied, HCFA regional staff worked with state officials in preparing the waiver applications, providing advice and guidance insofar as they were able.

Second, HCFA examines waiver programs when states request extensions—every year for the continuation of section 1115 demonstration waivers and every 2 years for the renewal of section 1915(b) program waivers. For renewals and extensions, states are required to summarize their programs' accomplishments: Section 1115 demonstration waiver programs are required to provide quarterly and annual reports and encounter data for continuation, while section 1915(b) waiver programs are required to provide independent assessments.

Other than reviewing at these fixed milestones, HCFA generally monitored the mental health carveouts when problems were brought to its attention by providers, advocacy groups, or HCFA's own reviews and previous site visits. For example, one HCFA regional office raised concerns during the carveout's implementation about the adequacy of the plan's provider networks, especially in rural areas, and later about the plan's backlog in

[48]OMB reviews cost-effectiveness analyses and examines the potential effect of a waiver on Medicaid costs.

handling complaints and grievances. Regional office staff responsible for other states we visited noted that they did not carry out as many site visits as they would have liked and that such visits were most often made in response to perceived problems.

HCFA Made Little Attempt to Standardize Review Criteria and Policy Across Regional Offices

Although HCFA has issued monitoring guides for Medicaid managed care programs, its officials reported that HCFA had few written protocols or guidance outlining the type of program monitoring and oversight that its staff should perform on mental health carveouts.[49] HCFA's regional office staff conducted much of the monitoring of Medicaid mental health carveouts, and HCFA's central office officials told us that some regional offices were better than others in monitoring the states. Regional staff expressed particular concern about the lack of guidance, until recently, for states in developing their independent assessments of the carveouts, because these assessments provide information on quality, access, and cost that are used for waiver renewals.

HCFA's Oversight of Mental Health Carveouts Was Based on Minimal Criteria and Expertise

HCFA and state officials reported that HCFA had minimal criteria for evaluating and overseeing Medicaid mental health carveouts. HCFA officials in the central office told us that there were sometimes no criteria for evaluating certain aspects of new waivers, such as the composition of a proposed provider network. HCFA regional office staff for both Colorado and Massachusetts also told us that HCFA had little written guidance for states' mental health managed care programs and had limited mental health monitoring protocols for the regional offices. The December 1998 guidance that HCFA provided to states did not provide criteria for regional staff to evaluate independent assessments.

According to HCFA and state officials, HCFA regional office staff responsible for the states we studied had limited expertise or experience in mental health and managed care issues. For example, according to HCFA staff, the regional office for Iowa did not have a managed care specialist on staff when Iowa's first request for proposal was issued. Officials from the HCFA regional office covering Colorado said that when they reviewed Colorado's waiver application, they had difficulty reviewing the section on performance standards and outcome measures because they had no written guidance on mental health standards and measures.

[49]A 1997 draft monitoring guide for HCFA regional offices listed mental health disorders as a factor in its section on special populations. The section on mental health and substance abuse disorders was drafted later, and HCFA officials reported that the entire document remained a working draft when we completed our work.

To help address the need for mental health expertise, HCFA now routinely asks SAMHSA to review all Medicaid waiver applications involving mental health and to provide comments to HCFA.[50] HCFA officials also reported that they have relied on SAMHSA's expertise regarding performance measures and outcomes for mental health programs. Furthermore, to help monitor new Medicaid mental health waiver programs, HCFA has developed, with SAMHSA, an "early warning" system to monitor behavioral health managed care programs. The system's purpose is to help HCFA quickly detect access and quality problems in ongoing programs and during the implementation of a new managed care program. In this system, a limited set of clinical and administrative indicators are collected weekly, monthly, or quarterly. The indicators include, for example, data on service authorizations, homelessness, inpatient recidivism, and involuntary admissions for use in monitoring access, outcomes, and quality. Although not originally designed for mental health services, this early monitoring program is now being used to monitor Pennsylvania's behavioral health waiver program. According to HCFA, early test results have been promising and may lead to an expansion of the monitoring system. In the spring of 1999, HCFA also issued a new standardized waiver application form—for states' use in requesting section 1915(b) waivers—that notes issues pertinent to special populations, including people with mental illnesses.

Observations

Under these four states' experiences, capitated mental health carveouts generally provided a broader array of community-based services than was possible under Medicaid FFS. The lack of competition in the mental health carveout plans had some benefits, giving the plans a larger risk pool than they would otherwise have had, significantly limiting the need for marketing, and largely eliminating adverse selection. Through their contracts with plans, the four states tried to counter possible adverse consequences of consumers' lack of choice among plans and to minimize capitation's potential for underservice. Key contract provisions included expanding the range of services available, broadening definitions of medical necessity, and capping profits, losses, or administrative expenditures.

Because consumers were generally restricted to what one plan chose to provide and could not exit the plan at will, quality assurance functions were particularly important. In the four states we studied, there was

[50]SAMHSA has also published a contracting guide for public purchasers of managed care programs and has developed a managed care tracking system to monitor mental health and substance abuse care in the public sector, including Medicaid waiver programs. SAMHSA was also working with states to develop a common framework or report card for measuring program quality.

considerable variation in the ways that the states monitored quality and held plans accountable, although all states were required to follow quality assurance provisions in federal law and HCFA regulations. They supplemented federal requirements with their own monitoring practices, and the carveout programs changed as they matured, handled problems, and received feedback from stakeholders and others.

HCFA's recent actions suggest that it recognizes its need to oversee mental health carveouts more systematically. First, HCFA's final rule, which is in development, would require PHPs, such as mental health carveouts, to have annual external quality reviews. Second, HCFA is drawing more on SAMHSA's expertise than previously. Third, HCFA is piloting an "early warning" program for monitoring mental health services and, if the system proves successful, will expand its use.

Agency and State Comments

We provided a draft of this report to the Administrator of HCFA and the Administrator of SAMHSA. HCFA generally agreed with our findings, stating that enhancing its oversight of mental health carveouts was one of its highest priorities. HCFA pointed to recent efforts to make its oversight more systematic, including the development of a final rule requiring PHPs to have annual external quality reviews, as well as a draft report to the Congress, on safeguards for individuals with special health care needs who are enrolled in managed care. HCFA also noted that it collaborated with SAMHSA on several major projects, such as entering into an interagency agreement to evaluate state Medicaid experience in supporting interdisciplinary treatment programs for persons with serious and persistent mental illness. HCFA cited, as a recent example of guidance that it provides to states, its technical assistance to Montana in the state's transition from a managed care delivery system to FFS. SAMHSA discussed the ongoing collaboration between HCFA and SAMHSA on Medicaid mental health waiver programs. In response to these comments, we revised the draft report as appropriate. (For HCFA's and SAMHSA's comments, see apps. IV and V.)

We also provided a draft of this report to Medicaid and mental health staff in the four states we studied. The four states generally agreed with the draft report and emphasized the importance of expanding access to community mental health services under their carveout programs. HCFA, SAMHSA, and the four states also provided technical comments that we incorporated as appropriate.

We are sending copies of this report to the Honorable Nancy-Ann Min DeParle, Administrator of HCFA; the Honorable Nelba Chavez, Administrator of SAMHSA; and representatives of the four states we studied. We will also make copies available to others on request.

Please contact me on (202) 512-7114 if you or your staffs have any questions. Major contributors to this report are listed in appendix VI.

William J. Scanlon
Director, Health Financing
and Public Health Issues

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Abbreviations

ACT	assertive community treatment
ASO	administrative services only
BBA	Balanced Budget Act of 1997
CMHC	community mental health center
FFS	fee-for-service
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HMO	health maintenance organization
MCO	managed care organization
OMB	Office of Management and Budget
PCCM	primary care case management
PHP	prepaid health plan
PRO	peer review organization
QARI	Quality Assurance Reform Initiative
QISMC	Quality Improvement System for Managed Care
SAMHSA	Substance Abuse and Mental Health Services Administration
SSI	Supplemental Security Income

Scope and Methodology

For this study, we conducted case studies that included site visits to four states with Medicaid mental health carveouts—Colorado, Iowa, Massachusetts, and Washington. We focused our review on states that enroll Supplemental Security Income (SSI) beneficiaries in their Medicaid mental health managed care carveout programs. We focused on care for adults only and did not include Medicaid substance abuse services or services for beneficiaries with mental retardation and other developmental disabilities. We also focused our work on capitated mental health programs—emphasizing managed care that is based on financial risk—because prepayment for services can potentially result in underservice to enrolled beneficiaries. We decided to study mental health carveouts because an increasing number of states are favoring carveout arrangements and because mental health care practices and policies can be discerned and analyzed more clearly in carveout programs than in integrated programs, which merge mental health and general physical health services into one system. Carveouts also presented potentially greater coordination issues with physical health care than integrated programs, as noted in app. II.

In the course of this study, we analyzed numerous documents, such as federal law, regulations, policy statements, and quality guidance. In addition, we reviewed journal articles and other publications on mental health services and managed care. For the four states, we reviewed waiver applications and renewals, requests for proposals to contract for prepaid mental health services, contracts with participating prepaid health plans (PHP), program evaluations, and auditors' reports as well as data from various state and PHP reports.

In addition, we interviewed officials from the Health Care Financing Administration's (HCFA) headquarters and regional offices responsible for the states we studied and from other federal agencies, such as the Substance Abuse and Mental Health Services Administration (SAMHSA). We also discussed Medicaid mental health and capitation issues with mental health service researchers and representatives of national mental health advocacy groups. During our site visits to the four states, we interviewed officials from state Medicaid and mental health agencies and from public and private PHPs as well as inpatient and outpatient providers of mental health services and representatives of consumer advocacy organizations.[51] We conducted these site visits between November 1997 and April 1998. Since then, we have conducted follow-up interviews with state officials

[51]Consumer advocates included representatives of state and plan advisory boards and legal groups, families of people with mental illnesses, and consumers of mental health services.

and obtained more recent documents and data as needed. For this report, we did not independently verify state or PHP data or analyze their assumptions.

In selecting the states for site visits, we first identified 30 states that when we designed our study had had experience in using capitated carveouts to deliver mental health services to adult Medicaid beneficiaries.[52] From these states, we selected those that (1) had "carved out" Medicaid mental health services from general physical health services; (2) had capitated, risk-based programs; (3) had implemented their capitated mental health programs no later than January 1, 1996, which allowed them to have experienced more than one round of the contracting cycle before our review; (4) included SSI disabled beneficiaries in their program; and (5) served adults. The four states we selected—Colorado, Iowa, Massachusetts, and Washington—represented a mix of rural and urban areas and statewide and regional carveouts. They also had carveouts that were administered in different ways—for example, through the Medicaid or mental health departments, using private for-profit plans, public not-for-profit plans, and county-based plans. Importantly, experts we consulted recommended these four states for study more often than carveout programs in most other states. We also included Washington because it was one of the three states that pilot-tested the use of the Quality Assurance Reform Initiative (QARI) guidelines for HCFA.

Except for Massachusetts, the states we selected had capitated carveouts only for mental health services until recently. Massachusetts had a carveout program that provided both mental health and substance abuse services, although we concentrated on the mental health aspect of the program. Colorado and Washington had Medicaid capitated carveouts solely for mental health services. Iowa had a separate mental health carveout until January 1999, when it combined what had been separate mental health and substance abuse carveout programs into one joint mental health and substance abuse program.

Colorado, Iowa, and Massachusetts included both outpatient and inpatient services in their mental health carveouts; until recently, Washington included only outpatient mental health services in its carveout program. Washington's plans, all of which are county-based governmental entities, have the right of first refusal in deciding whether to cover inpatient as well as outpatient services under the current round of contracts. As of June 30,

[52]Our analysis was based on the 1997 SAMHSA Managed Care Tracking System reports, which discussed the status of state and Medicaid mental health programs as of spring 1997.

1999, 9 of the 14 Washington plans had contracted to provide both inpatient and outpatient mental health services.

The states we selected also reflected differences in types of managed behavioral care organizations under contract to the states. These ranged from public, governmental plans to private for-profit PHPs. Iowa and Massachusetts, for example, both contracted with private for-profit PHPs. Washington, in contrast, contracted solely with public, county-based administrative organizations known as regional support networks. Two of these county plans had administrative services only (ASO), no-risk contracts with a private for-profit plan. The ASO organization handled authorizations and claims payments. Colorado's eight regionally based contracts were with a range of organizations. They included public organizations that were either individual community mental health centers (CMHC) or groups of CMHCs, partnerships of CMHCs with a private for-profit PHP, and most recently a private, not-for-profit, health maintenance organization (HMO).

Another characteristic of the states we selected was that they reflected both statewide and regional approaches to program administration. Iowa and Massachusetts each had a statewide contract, while Colorado and Washington had regional contracts based on geographic catchment areas. Iowa's statewide contractor had a subcapitation contract for a six-county area with a nonprofit organization formed by a hospital and a CMHC.

We conducted our work between July 1997 and July 1999 in accordance with generally accepted government auditing standards.

Coordination of Mental and Physical Health Care

Because Medicaid consumers with a psychiatric diagnosis can also have physical health problems,[53] it is important to integrate or coordinate mental health care with physical health care. In the states we studied, state and plan officials generally agreed that while they did not view the coordination of mental health with physical health care as a major problem, coordination remains challenging and could be improved. Coordinating medical and mental health care can be complex, whether programs are integrated or carved out. However, coordination is generally considered potentially more problematic when there is a carveout, because benefit packages, provider networks, payment systems, and program administration are separate for the mental health carveout and the general medical program. Medication management can become a major issue, for example, because drugs are often prescribed by both physicians and psychiatrists operating under different payment and benefit systems. Issues can arise when a psychiatrist under the capitated carveout prescribes a medication that is paid for by a Medicaid HMO. In the states we studied, the mental health carveout programs were not responsible for the cost of pharmaceuticals, which were paid under the Medicaid FFS or HMO programs when they were prescribed by the carveout mental health practitioner. To improve the coordination of pharmaceuticals in Washington, the mental health carveout provider asks consumers for a medical history during intake assessments. Coordination of care can also be difficult when not all mental health consumers have a primary care physician, as providers in Washington and elsewhere noted.

One way the states we studied tried to improve coordination was to work out memorandums of understanding and other agreements between key entities. For example, in Colorado mental health plans had written cooperative agreements with Medicaid HMOs to improve the coordination of physical health care and mental health services. In Washington, mental health contractors were required to have “cross-system partnerships” with allied community providers, including local Medicaid managed care plans and state psychiatric hospitals and other county programs. In Iowa, the mental health plan was required to establish linkages with HMOs and with the substance abuse carveout plan to ensure the coordination of services. And in Massachusetts, the mental health carveout and primary care case management (PCCM) plans had a communication protocol for providers as well as a performance measure requiring hospitals to notify the PCCM if a disabled beneficiary is receiving psychiatric inpatient treatment. In most of these cases, it was unclear how such cooperative agreements and linkages

[53]For example, a study of Indiana’s Medicaid agency found that nearly 30 percent of beneficiaries with a psychiatric diagnosis also had serious physical health problems, as noted by Collette Croze in Medicaid Managed Mental Healthcare (Portland, Me.: National Academy for State Health Policy, 1995).

could be enforced. A further issue was that in Colorado and Washington, most or all SSI consumers—which would include people with severe mental illnesses—were in FFS programs for their physical health care, according to program officials. Officials we interviewed considered it more difficult to develop policies and coordinate care with many individual physicians than with a distinct organization like an HMO.

In some cases, confidentiality requirements can become barriers to coordination between mental health and physical health care providers. For example, Washington had confidentiality protections that allowed mental health providers access to medical records but that prohibited medical providers from viewing mental health records. Under an integrated health plan, in which the primary care physician refers the patient for psychiatric care, the coordination between physical and mental health care would appear to be somewhat less problematic.

Mental Health Capitation Rates and Persons Served

Capitation rates in the four states we studied varied by Medicaid eligibility category and sometimes also by other factors, such as age group, region, and gender. In most cases, the capitation rate for SSI enrollees was considerably higher than for other eligibility categories. Colorado and Washington, with their regionally based contracts, showed considerable variation across PHPs in their capitation rates as well for each category of eligibility. (See table III.1.) In all, Colorado had a total of 75 rates across enrollment groups, plans, and CMHCs.

Table III.1: Comparison of Medicaid Monthly Capitation Rates for Adult Enrollees in Four Carveout States, Fiscal Year 1999

	Capitation rate	
State	**SSI adults**	**Non-SSI adults**
Colorado	$25-$172	$4-27
Iowa[a]	$72-$84	$20-$31
Massachusetts[b]	$112	$23-$78
Washington[c]	$121	$13

[a]Iowa 1999 rates are for a behavioral health capitated program that includes substance abuse services as well as mental health services. Rates differ by gender, age, and eligibility category. This table does not include rates for beneficiaries who are dually eligible for Medicaid and Medicare because the rates cover children as well as adults and are therefore not comparable to the rest of the data presented here. Capitation rates for “dual eligibles” range from $40 to $45, depending on gender.

[b]Massachusetts’ 1999 rates are for a behavioral health capitated program that include substance abuse services as well as mental health services. The rates do not distinguish between children and adults.

[c]Washington’s capitation rates, which include both inpatient and outpatient services, apply to 9 of the 14 PHPs that have contracted for integrated services. The other PHPs do not yet cover inpatient services. The rates represent statewide averages and exclude the medically needy.

Source: State capitation data.

Typically, only a small portion of enrollees in the carveouts actually used mental health services during the year. (See table III.2.)

Table III.2: Number and Percentage of Enrollees Served in Four Mental Health Carveout States, Fiscal Year 1998

State	Number of service recipients	Percentage of enrollees served
Colorado[a]	20,722	11.9%
Iowa	33,982	12.8%
Massachusetts[b]	100,491	25.1%
Washington[c]	50,560	7.0%

[a]In Colorado, the percentage of enrollees served was based on a total average enrollment figure of 174,765. The higher enrollment figure cited in table 1 of this report was inappropriate for analyzing percentage of enrollees served because it included two new plans that had enrolled, but not yet provided services to, Medicaid beneficiaries.

[b]Adult SSI beneficiaries represented 41 percent of enrollees and 61 percent of service users, according to Massachusetts' utilization data.

[c]The percentage of enrollees served in Washington represented outpatient services only.

Source: State program summary data.

Comments From HCFA

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

AUG 19 1999

TO: William J. Scanlon, Director
Health Financing and Public Health Issues

FROM: Michael M. Hash
Deputy Administrator, Health Care Financing Administration

SUBJECT: General Accounting Office (GAO) Draft Report, "Medicaid Managed Care: Four States' Experience with Mental Health Carveout Programs"

We appreciate the opportunity to review your draft report to Congress concerning four states' experience with Medicaid mental health carveout programs.

We note that the draft report recognizes the success that these states have had in providing coverage to those who receive mental health services under carveout programs. HCFA has, and will continue to, work with states who chose to implement managed mental health programs.

We recognize your concerns about the need for more systematic HCFA oversight of mental health waivers. As indicated in your draft report, HCFA is evaluating our approach to mental health services oversight. Recent efforts, cited in your draft report, include 1) the involvement of SAMHSA and HRSA as members of waiver review teams on waivers for persons with mental illness, substance abuse problems, or HIV/AIDS; 2) collaborations with SAMHSA on several major projects, recognizing the broad experience and expertise of SAMHSA's staff; and 3) a collaboration with SAMHSA and the State of Pennsylvania to pilot an "early warning system" to monitor behavioral managed care health programs. In addition we have also developed and released a new capitated waiver preprint application that will help states and HCFA focus on the need to address issues essential to quality care for special populations.

We are developing a final rule that will implement the Balanced Budged Act (BBA) of 1997 by requiring prepaid health plans, including those providing mental health services, to conduct annual reviews.

In addition, we are in the process of preparing a Report to Congress required under the BBA, entitled "Safeguards for Individuals with Special Health Care Needs Enrolled in Medicaid Managed Care." This report will focus on all special populations, including those who receive mental health services.

Finally we note that HCFA does provide guidance and assistance to states. Montana recently moved from a managed care program, the Montana Mental Health Access Plan, to a fee-for-service mental health delivery system. Montana requested assistance from HCFA to assist the state in maintaining the transition. HCFA's Central and Regional Offices provided significant technical assistance to the State of Montana as they developed a plan and prepared for the seamless movement of beneficiaries while assuring access and quality of care.

I want to assure you that we are committed to working with GAO on this and other issues. Enhancing our oversight of mental health carveouts is one of our highest priorities. Attached are our specific comments.

Attachment

Comments From SAMHSA

DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services
Center for Substance Abuse Prevention
Center for Substance Abuse Treatment
Rockville MD 20857

AUG 9 1999

TO: Director, Health Financing and Public Health Issues
Health, Education, and Human Services Division
U.S. General Accounting Office

FROM: Administrator

SUBJECT: Draft Report - Medicaid Managed Care: Four States' Experiences with Mental Health Carveout Programs (GAO/HEHS-99-118)

Thank you for the opportunity to review and comment on this draft report, which contains some valuable information which will be of assistance to SAMHSA in conducting its activities in the managed care arena. However, we would like to offer the following specific suggestions which we believe could improve the report:

Now on page 4.

Now on page 32.

Now on page 5.

- In a number of places, the collaboration between HCFA and SAMHSA on mental health waiver programs should receive greater attention. For instance, at the bottom of page 5, in the last sentence, the report comments on HCFA's "limited expertise in mental health managed care issues." It would be appropriate here to point out the ongoing collaboration with SAMHSA on waiver proposals, waiver renewals and site visits to provide expertise on mental health, substance abuse and managed behavioral healthcare. On page 43, in the second full paragraph, the collaborative relationship between HCFA and SAMHSA is well described, but this information also needs to be included in the Results in Brief section, as many readers may not go beyond this summary. Also, on page 7, in the second paragraph, SAMHSA is described merely as a funder of services and should also receive recognition for its extensive role in providing the states and HCFA with technical assistance on managed mental health and substance abuse services (especially as the report references many of these SAMHSA technical assistance documents).

Now on page 13.

- It is unclear why only mental health is referred to throughout the report, as three of the four programs cover substance abuse as well as mental health (only Washington is mental health only). For instance, on page 17, the second paragraph's reference to "traditional mental health providers" could add "substance abuse." There are other places where the report also could incorporate "substance abuse" into the language.

Now on page 25-26.

- On page 34, the first paragraph reiterates the often used argument that managed care companies have little incentive to collect encounter data because there is no need to bill for specific services under capitated systems. Almost all providers, though, still are under discounted fee-for-service arrangements and still submit bills. However, if you accept the earlier statement in this paragraph that encounter data from some plans were "untimely,

Now app. III.

incomplete, and inaccurate," then the validity of the data in Appendix II regarding the number of service recipients must be questioned. The fact that Washington could provide this fundamental program statistic only for outpatient services highlights the shortcoming.

Now on page 31.

- On page 40, at the bottom of the page, the report states that "HCFA has no written protocol or guidance outlining the type of program monitoring and oversight that HCFA staff should perform on mental health carveouts." However, related guidance (*Interim Review Criteria for Children with Special Needs*) has been issued during recent waiver application processes that may be useful to note as an example, even though this report focuses on adults.

Now on page 32.

- On page 42, the first full paragraph describes SAMHSA's "early warning data system". The project should be referred to as a monitoring system, not as a "data" system. In fact, a recent press release contains language that better describes the effort: "The purpose of the program is to design and test a limited set of clinical and administrative process indicators in order to quickly detect health systems problems during the implementation of a new managed care program and for programs which have not achieved or have lost stability."

We hope these comments are useful. If you have any further questions or need additional information, please contact Robert Willcoxon, the SAMHSA GAO liaison, on 301-443-4543.

Nelba Chavez, Ph.D.

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