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Report to Congressional Requesters

September 2013

MEDICAID MANAGED CARE

Use of Limited Benefit Plans to Provide Mental Health Services and Efforts to Coordinate Care

GAO-13-780

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GAO Highlights

Highlights of GAO-13-780, a report to congressional requesters

Why GAO Did This Study

Medicaid is the largest payer of mental health services in the United States and Medicaid spending on such services is likely to grow. Some states provide mental health services to Medicaid beneficiaries separately from physical health care services through contracts with limited benefit plans, which are paid on a per person basis to provide a defined set of services. While using these plans to provide mental health services may control costs, it can also increase the risk that these services will not be coordinated with physical health care services. Coordinated care is important for Medicaid beneficiaries with mental illnesses because they are more likely than others to have ongoing health conditions. GAO was asked for information on states' use of Medicaid managed care. In this report, GAO examined the (1) extent that states provide mental health services through limited benefit plans, and (2) steps states and CMS have taken to facilitate the coordination of mental and physical health care services for adult beneficiaries enrolled in these plans.

GAO collected information on enrollment, payments, and services from the 13 states that contracted with limited benefit plans to provide mental health services to adult beneficiaries. GAO also selected 4 states based on, among other criteria, the number of beneficiaries enrolled in limited benefit plans. GAO reviewed documents from the 4 states and CMS, and interviewed officials to identify steps taken to coordinate care.

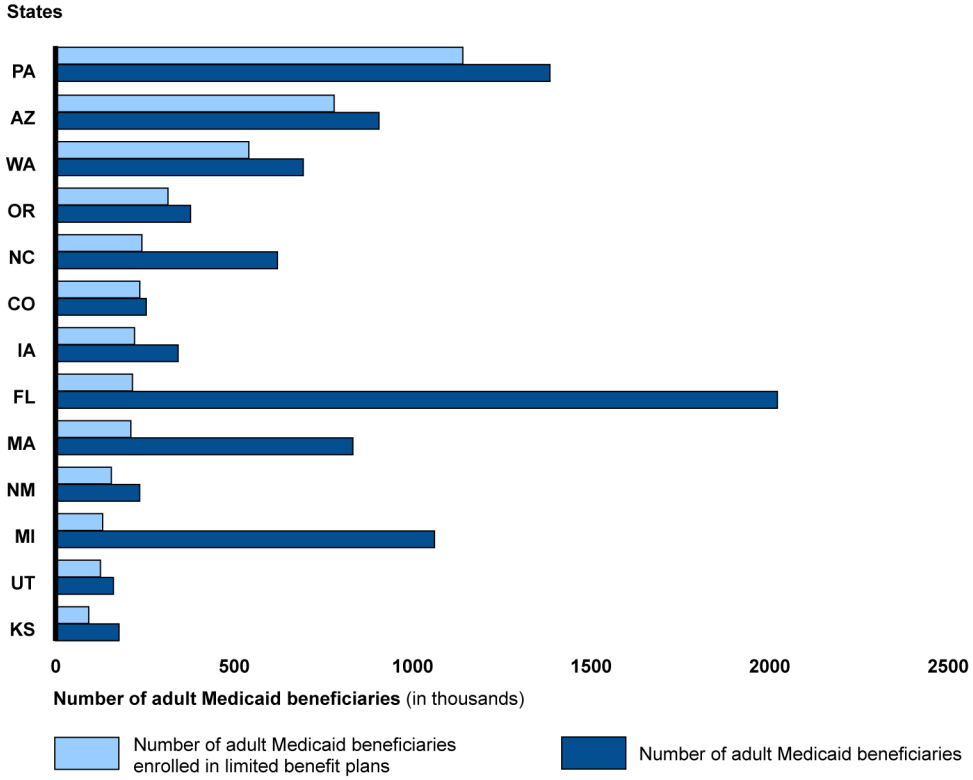
The Department of Health and Human Services provided technical comments, which GAO incorporated, as appropriate.

View GAO-13-780. For more information, contact Carolyn L. Yocom at (202) 512-7114 or yocomc@gao.gov.

What GAO Found

Thirteen states reported that in fiscal year 2012 they paid a total of about $5.6 billion to limited benefit plans to provide mental health services to about 4.4 million adult Medicaid beneficiaries. States can enroll different populations—such as adults who are blind, disabled, or have developmental disabilities—in limited benefit plans, which could contribute to the variation in the number of adults enrolled and level of capitated payments made across the 13 states.

Number of Adult Medicaid Beneficiaries Enrolled in Limited Benefit Plans Providing Mental Health Services, Fiscal Year 2012



Source: GAO analysis of state reported data.

Four selected states—Florida, Kansas, Michigan, and Washington—took three steps to facilitate the coordination of mental and physical health care services:

1. incorporating care coordination requirements in limited benefit plan contracts;
2. implementing additional steps to coordinate care, such as policies that included incentives to coordinate care; and
3. monitoring limited benefit plans' implementation of care coordination.

GAO found that the Centers for Medicare & Medicaid Services' (CMS) did not take direct steps to facilitate care coordination, because its role is to oversee and provide technical assistance. In its oversight role, CMS reviewed and approved state submitted documents, such as contracts with mental health limited benefit plans, some of which contained care coordination requirements.

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Abbreviations

CMS	Centers for Medicare & Medicaid Services
EQR	External Quality Review
EQRO	External Quality Review Organization
PAHP	Prepaid Ambulatory Health Plan
PIHP	Prepaid Inpatient Health Plan

U.S. GOVERNMENT ACCOUNTABILITY OFFICE
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September 30, 2013

The Honorable John D. Rockefeller, IV
Chairman
Subcommittee on Health Care
Committee on Finance
United States Senate

The Honorable Henry A. Waxman
Ranking Member
Committee on Energy and Commerce
House of Representatives

Medicaid, a joint federal-state program that finances health insurance coverage for certain categories of low-income individuals, is the largest payer of mental health services in the nation. Many of the 67 million beneficiaries enrolled in Medicaid have mental health care needs.[1] Between 1998 and 2009, Medicaid spending on mental health services increased from about $16.5 billion to $39.1 billion.[2] Spending for mental health services in Medicaid is likely to continue growing as millions of individuals become eligible to receive Medicaid coverage under the Patient Protection and Affordable Care Act.[3] We previously reported that Medicaid beneficiaries sometimes experience challenges accessing

[1]Medicaid enrollment is for 2010, see Centers for Medicare & Medicaid Services, *Medicaid Enrollments and Payments, USA, FY 2006-2010*, Medicaid Statistical Information System and Medicaid Financial Management Report, accessed June 19, 2013, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html.

[2]The Patient Protection and Affordable Care Act required all states to expand eligibility for Medicaid to nonelderly individuals whose income does not exceed 138 percent of the federal poverty level by January 1, 2014; however, the Supreme Court has ruled that this expansion is optional. Pub. L. No. 111-148, § 2001(a)(1),124 Stat. 119, 271 (Mar. 23, 2010); *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012). See Substance Abuse and Mental Health Services Administration, National Expenditures for Mental health Services & Substance Abuse Treatment, 1986-2009, HHS Publication No. SMA-13-4740 (Rockville, Md.: 2013).

[3]See Congressional Budget Office, Estimates for Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision (Washington, D.C.: July 2012).

mental health services.[4] For some populations, such as individuals with complex health care needs, accessing mental health services can be especially problematic.

The Centers for Medicare & Medicaid Services (CMS), within the Department of Health & Human Services, is the federal agency responsible for overseeing the Medicaid program. Within broad federal requirements, states administer the day-to-day operations of their Medicaid programs and provide services to Medicaid beneficiaries through a variety of health care arrangements. Some states have elected to provide mental health services separate from physical health care services through limited benefit plans, which are managed care arrangements designed to provide a narrowly defined set of services. Under limited benefit plans, states make capitation payments—a fixed dollar amount per Medicaid beneficiary—for a specified set of services.[5] Through the use of limited benefit plans, states seek to ensure a ready source of providers, control costs, and improve quality of care through better management of beneficiary needs. Separating mental and physical health care services increases the risk that these services will not be coordinated; yet, little is known about how states and health care providers coordinate care for beneficiaries enrolled in limited benefit plans.

You requested information on states' use of managed care to deliver health care services to Medicaid beneficiaries. We previously issued a report examining variation in states' use of managed care and reported concerns about the availability of information on limited benefit plans.[6] This report examines (1) the extent to which states provide mental health services to adult Medicaid beneficiaries through limited benefit plans, and (2) the steps states and CMS have taken to facilitate the coordination of

[4]We found that states frequently reported having difficulty ensuring a sufficient number of Medicaid providers for psychiatric services. See GAO, Medicaid: States Made Multiple Program Changes, and Beneficiaries Generally Reported Access Comparable to Private Insurance, GAO-13-55 (Washington, D.C.: Nov. 15, 2012).

[5]For purposes of this report, we define "limited benefit plans" as health plans that contract with states on a capitated basis to provide mental health services to adult Medicaid beneficiaries, which we define as individuals 18 years and older.

[6]See GAO, Medicaid: States Use of Managed Care, GAO-12-872R (Washington, D.C.: Aug. 17, 2012).

mental and physical health care services for adult Medicaid beneficiaries enrolled in limited benefit plans.

To determine the extent to which states provide mental health services to adult Medicaid beneficiaries through limited benefit plans, we collected and analyzed Medicaid enrollment and payment data for fiscal year 2012 from all of the 13 states that contracted with limited benefit plans to provide mental health services to adult Medicaid beneficiaries on a capitated basis.[7] We identified these states by reviewing CMS's most recent Medicaid managed care enrollment report and interviewing CMS officials,[8] and sent the 13 states a data collection instrument we developed. Additionally, we obtained information on how these states collected the reported data and checks they performed to ensure accuracy. Based upon states' responses, we determined that data collected were sufficiently reliable for our purposes.

To determine the steps that states and CMS have taken to facilitate the coordination of mental and physical health care services, we interviewed officials and reviewed relevant documents from selected states and CMS. To obtain information on state actions, we selected four states—Florida, Kansas, Michigan, and Washington—that varied in terms of (1) the percentage of Medicaid beneficiaries enrolled in limited benefit plans providing mental health services, (2) the size of their Medicaid programs, and (3) geographic location. (See app. I for more information on program characteristics of the selected states.) For these states, we collected and reviewed relevant documents for fiscal years 2011 and 2012, including state contracts with limited benefit plans, and findings from reviews conducted on limited benefit plans. We also interviewed officials from the selected states and external stakeholders, including the National Quality Forum and the National Association for Mental Illness, to collect information on the steps states have taken to facilitate the coordination of mental and physical health care services. To determine the steps CMS has taken to facilitate the coordination of mental and physical health care

[7]We asked the 13 states to provide enrollment and payment data for adult beneficiaries in limited benefit health plans providing mental health services. We did not request enrollment and payment data separately for the different adult population groups enrolled in these plans, such as individuals who are aged, blind, disabled, or have developmental disabilities.

[8]Centers for Medicare & Medicaid Services, Medicaid Managed Care Enrollment Report: Summary Statistics As of July 1, 2011 (Baltimore, Md.).

services for adult Medicaid beneficiaries enrolled in limited benefit plans, we reviewed relevant federal waiver applications,[9] state contract review results, and regional monitoring guidance. We also interviewed officials from CMS's central office and the four regional offices responsible for overseeing the four selected states.

We conducted this performance audit from October 2012 to September 2013 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Background

CMS and states jointly administer the Medicaid program. States have flexibility within broad federal parameters for designing and implementing their Medicaid programs. For example, state Medicaid programs must cover certain populations and benefits—known as mandatory populations and benefits—but may choose to also cover other populations and benefits—known as optional populations and benefits.[10] Also, states may choose different payment and delivery systems to provide benefits to Medicaid beneficiaries, such as fee-for-service or managed care. Under a fee-for-service system, health care providers claim reimbursement from state Medicaid programs for services rendered to Medicaid beneficiaries. Under a Medicaid managed care system, states contract with managed care organizations to provide or arrange for medical services, and prospectively pay the organizations a per person, or capitated, payment. In turn, the managed care organizations pay providers, such as hospitals and physicians, for services provided to Medicaid enrollees. States contract with managed care organizations to provide a comprehensive set

[9]States seeking to provide mental health services through limited benefit plans may do so by obtaining a waiver of certain Medicaid requirements under sections 1915(b) or 1115 of the Social Security Act. States seeking to provide such services under a waiver must submit an application to CMS for approval.

[10]Mandatory Medicaid benefits include, for example, inpatient hospital and physician services which can encompass the delivery of mental health services. Federal law does not contain explicit provisions concerning the exact types of mental health services that can be provided, but all state Medicaid programs provide some mental health services to beneficiaries.

of services to Medicaid beneficiaries; states may also contract with limited benefit plans to provide a defined set of services, such as mental health services. CMS reviews and approves states' plans to implement their Medicaid programs.

Medicaid is an important source of mental health services for millions of vulnerable individuals. In 2009, an estimated 5.8 million adult Medicaid beneficiaries, or 30 percent of all adult Medicaid beneficiaries, were diagnosed with some type of mental illness.[11] States that provide mental health services through limited benefit plans establish these delivery systems under Medicaid waivers. Sections 1115 and 1915(b) of the Social Security Act allow the Secretary of Health and Human Services to waive certain federal requirements, such as limitations on a state's ability to require certain beneficiaries to enroll in managed care.[12] States that provide Medicaid benefits through managed care arrangements, including limited benefit plans, must comply with certain requirements, including those requiring states to establish procedures to monitor managed care program operations.[13] Federal regulations require states to ensure that managed care organizations coordinate mental and physical health care services; however, states have the option to exempt limited benefit plans from these requirements.[14] States seeking to provide Medicaid services through managed care waivers must submit an application to CMS and obtain approval. Medicaid managed care waivers approved under section 1915(b) of the Social Security Act—the most common type of waiver states use to establish limited benefit plans to provide mental health services to beneficiaries—are typically authorized for a period of two years. At the end of the waiver period, the state can request an extension of the waiver or submit an application for a new waiver.

[11]Estimates based on special tabulation from the 2009 National Survey on Drug Use and Health provided by Substance Abuse and Mental Health Services Administration, September 2013.

[12]42 U.S.C. §§ 1315(a), 1396n(b).

[13]Federal requirements describe two types of limited benefit plans: prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs). In general, PIHPs provide inpatient and outpatient services, whereas PAHPs provide ambulatory services. See 42 CFR pt. 438.

[14]42 C.F.R. § 438.208(a)(2). None of the four states we reviewed exempted limited benefit plans from this requirement.

Care coordination is broadly defined as the integration of patient care activities between two or more providers involved in a patient's care with the goal of facilitating the appropriate delivery of services. Activities to coordinate mental and physical health care services include sharing information—such as medical records, test and lab results, and prescribed medications—across providers and care delivery sites. States and limited benefit plans can implement specific care practices with the purpose of facilitating communications and the sharing of information. Care coordination is particularly important for Medicaid beneficiaries with mental illnesses because they are more likely to have other medical conditions requiring ongoing physical health care services than beneficiaries without mental illnesses. For example, in 2003, 14 percent of all Medicaid beneficiaries had a costly medical condition, such as diabetes and heart disease; however, among adults who were receiving mental health services, 21 percent had such medical conditions.[15]

Enrollment, Payment, and Scope of Services Varied Across All 13 States Using Limited Benefit Plans for Mental Health Services

Across the 13 states that contracted with limited benefit plans to provide mental health services to adult Medicaid beneficiaries, the enrollment levels, total payments, and services provided varied.[16] States can enroll different adult populations—such as individuals who are blind, disabled, or have developmental disabilities—in limited benefit plans, which could contribute to variation in the number of adults enrolled, as well as the level of capitated payments states made to these plans.[17] State officials reported that about 4.4 million adult Medicaid beneficiaries were enrolled in limited benefit plans, about 48.6 percent of all adult Medicaid beneficiaries in the 13 states. The number of adults enrolled in these plans ranged from about 93,000 beneficiaries in Kansas to over 1.1 million beneficiaries in Pennsylvania. (See fig. 1.) Across these

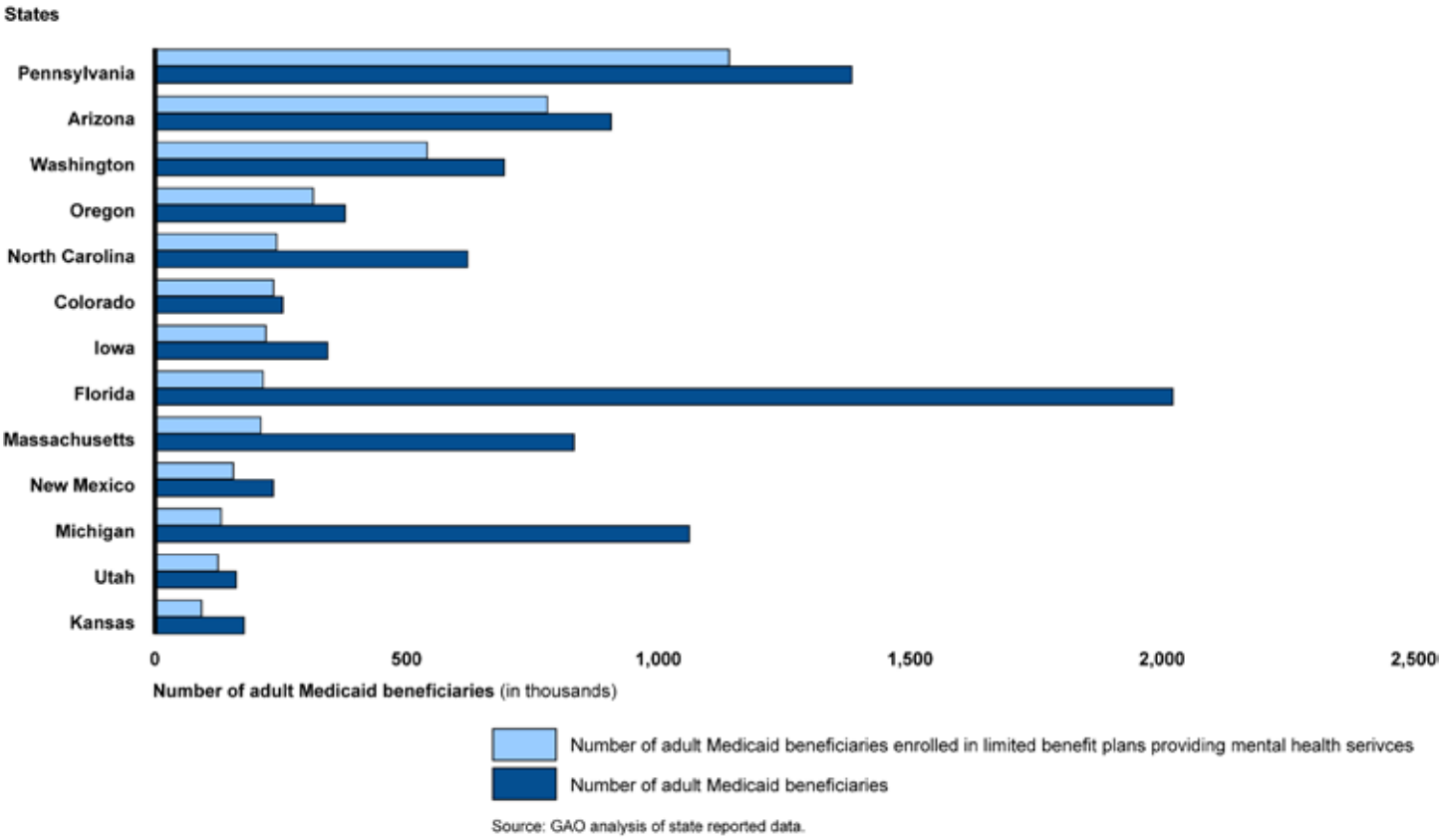
[15]See Substance Abuse and Mental Health Services Administration, *Mental Health and Substance Abuse Services in Medicaid, 2003: Charts and State Tables*, HHS Publication No. (SMA) 10-4608 (Rockville, Md.: 2010).

[16]We collected data from the 13 states—Arizona, Colorado, Florida, Iowa, Kansas, Massachusetts, Michigan, New Mexico, North Carolina, Oregon, Pennsylvania, Utah, and Washington—that contracted with limited benefit plans to provide mental health services to adult Medicaid beneficiaries—individuals 18 years and older.

[17]States also have flexibility in setting eligibility criteria for limited benefit plans providing mental health services. For example, a state can choose to enroll all Medicaid beneficiaries in limited benefit plans, or establish enrollment criteria for limited benefit plans and enroll those beneficiaries that meet such criteria.

13 states, the percentage of adult Medicaid beneficiaries enrolled in limited benefit plans ranged from about 10.7 percent in Florida to about 93.0 percent in Colorado. (See app. II for more information on enrollment in Medicaid and limited benefit plans in the 13 states.)

Figure 1: Number of Adult Medicaid Beneficiaries and Number of Adult Medicaid Beneficiaries Enrolled in Limited Benefit Plans Providing Mental Health Services, Fiscal Year 2012



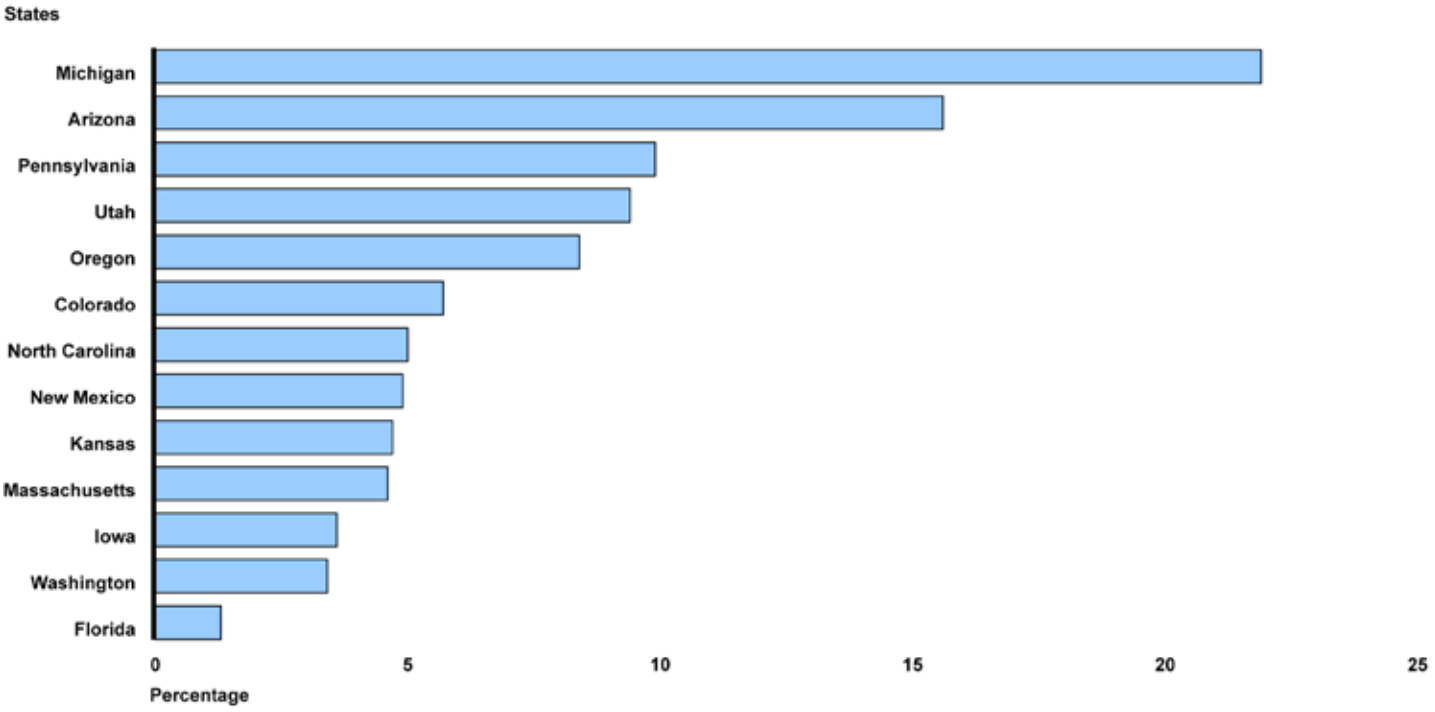
Source: GAO analysis of state reported data.

Note: Enrollment data are for unduplicated adult Medicaid beneficiaries—individuals 18 years and older—in fiscal year 2012. Beneficiaries who enrolled more than one time during the year are reported only once in the unduplicated total.

Capitated payments to limited benefit plans providing mental health services to adult Medicaid beneficiaries also varied across the 13 states in fiscal year 2012. State officials reported that capitated payments to these plans totaled about $5.6 billion, or about 9.0 percent of total Medicaid payments for all adult beneficiaries in these 13 states. Capitated payments to these plans ranged from about $86.5 million in New Mexico to almost $2.0 billion in Michigan. As a share of total Medicaid payments

for adult Medicaid beneficiaries, capitated payments to limited benefit plans providing mental health services ranged across the 13 states from 1.3 percent in Florida to 21.9 percent in Michigan (see fig. 2). (See app. III for more information on Medicaid payments in the 13 states.)

Figure 2: Percent of Total Medicaid Payments to Limited Benefit Plans Providing Mental Health Services, Fiscal Year 2012



Source: GAO analysis of state reported data.

Note: Total Medicaid payments are for adult Medicaid beneficiaries—individuals 18 years and older. Payments to limited benefit plans are capitation payments—a fixed dollar amount per adult Medicaid beneficiary per month.

States also reported variations in the scope of services provided by limited benefit plans to adult Medicaid beneficiaries in fiscal year 2012. Specifically, 3 states contracted with limited benefit plans to provide only mental health services, while 10 states contracted with limited benefit plans to provide both mental health services and services for substance use disorder. Two of these 10 states—Oregon and Utah—contracted with some plans to provide only mental health services and contracted with other plans to provide both mental health services and services for substance use disorders. (See table 1.)

Table 1: Scope of Services Provided by Limited Benefit Plans by State, Fiscal Year 2012

State	Contracted with plans that provide only mental health services	Contracted with plans to provide both mental health services and services for substance use disorders
Arizona		X
Colorado		X
Florida	X	
Iowa		X
Kansas	X	
Massachusetts		X
Michigan		X
New Mexico		X
North Carolina		X
Oregon	X	X
Pennsylvania		X
Utah	X	X
Washington	X	

Source: GAO analysis of state reported data.

Note: Scope of services limited benefit plans were contracted to provide care for adult beneficiaries—individuals 18 years and older.

Selected States Generally Took Three Steps to Facilitate Coordination of Care, and CMS Reviewed Waivers and Contracts

The four selected states we studied generally took three steps to facilitate the coordination of mental and physical health care services, but specific activities varied. CMS's efforts to facilitate the coordination of mental and physical health care services focused primarily on reviewing states' federal waiver documents and contracts with limited benefit plans.

Four Selected States Took Steps to Facilitate the Coordination of Mental and Physical Health Care Services

The steps that selected states—Florida, Kansas, Michigan, and Washington—generally took to facilitate the coordination of mental and physical health care included (1) incorporating care coordination requirements in the contracts with limited benefit plans; (2) implementing additional steps to coordinate care; and (3) monitoring limited benefit plans' implementation of care coordination.

Care Coordination Requirements in State Contracts with Plans

The four states' contracts with limited benefit plans included general provisions regarding the types of entities that health plans are required to coordinate with in order to manage beneficiaries' health care needs. Additionally, each state's contracts specified the particular coordination activities the limited benefit plans were required to perform.

General Contractual Provisions on Coordination

All four states required limited benefit plans to coordinate mental and physical health services with a broad range of providers and other entities. Each state required its limited benefit plans to coordinate with physical health care providers and community organizations, mental health providers, and the state's Medicaid agency.

- All four states required some coordination with physical health care providers and community organizations. For example, in Michigan, in addition to coordinating with beneficiaries' primary care providers, limited benefit plans were required to coordinate with public and private community agencies that provide social support and other non-health care services to individuals with mental illnesses.

- States' contracts also required limited benefit plans to coordinate with a wide range of mental health providers that were part of the plans' network of providers, including mental health providers and case managers that provide ancillary services. For example, Washington required its limited benefit plans to coordinate with social workers to ensure that they shared information on health care needs and services.

- States also required health plans to coordinate with other state departments and agencies whose clients include Medicaid beneficiaries. For example, Florida required its limited benefit plans to have agreements with state agencies responsible for serving the homeless to ensure coordination and avoid duplication of services. In Kansas, the state required limited benefit plans to coordinate with other state agencies, along with local and regional agencies whose

clients included Medicaid beneficiaries. Michigan required its limited benefit plans to coordinate with the criminal justice system, including police/sheriffs, court personnel, and attorneys.

Specific Contractual Requirements for Coordination

All four states' contracts with limited benefit plans required the plans to undertake specific activities to facilitate coordination of mental and physical health care services. These required activities generally fell into the following categories: sharing information and establishing communications between providers and across care settings; identifying patients' mental and physical health care needs and creating individual care plans; and developing measures and collecting data on coordination of care.

- All four states required limited benefit plans to implement mechanisms to share information or standardize communications between providers and across care settings. For example, contracts in Florida, Michigan, and Washington required limited benefit plans to develop written plans or agreements outlining when, and in some cases how, care will be coordinated between mental health, primary care, and other providers. Kansas' contract required all limited benefit plan network providers to request a standardized release of information form from each beneficiary to allow providers to coordinate with primary care physicians and other treatment team members.

- All four states required limited benefit plans to identify beneficiaries' health care needs, including mental and physical health care needs; develop individual care plans for beneficiaries' to address all needs identified; and update these care plans on a regular basis. One part of the individual care plan development and updating process included coordinating with primary care and other providers as needed, and making appropriate referrals. For example, Washington's contract required limited benefit plans to create and then update these plans every 180 days, identify patient mental and physical health care needs, ensure coordination between systems that are meeting patients' needs, and require providers to make appropriate referrals to health care providers when medical concerns are identified.

- Two of the four states required limited benefit plans to collect and submit data to monitor care coordination. For example, Kansas required limited benefit plans to collect data from network providers and enrollees to monitor care coordination; and Florida required limited benefit plans to collect information on follow-up services

enrollees received within seven days of discharge from all inpatient facilities for a mental health diagnosis.

Additional State Steps to Encourage Care Coordination

Officials from all four states reported taking additional steps beyond contract requirements to encourage coordination and further integration of mental and physical health care. For example, in 2012, officials from all four states reported that their state implemented Medicaid policies allowing providers to bill for two services, such as mental and physical health care services, in one day for the same beneficiary. In doing so, limited benefit plans can work to integrate and improve access to care by providing mental and physical health services at the same location and allowing both providers to receive reimbursement for services furnished on the same day. Since 2012, officials from two of the four states reported that they have taken steps to further integrate mental and physical health care services. Officials from Kansas reported that in January 2013 the state stopped providing mental health services through a limited benefit plan and implemented a comprehensive managed care arrangement providing both mental and physical health care services to Medicaid beneficiaries, and officials from Florida reported that the state is taking steps to implement similar arrangements in 2014.

State Monitoring of Limited Benefit Plan Performance

During 2011 and 2012, all four states we studied conducted a variety of reviews that were either directly focused on the coordination of mental and physical health care services or assessed such coordination as part of broader reviews. States conducted monitoring through five different types of reviews, the use of which varied by state.

- *Desk reviews* are state Medicaid agency evaluations of documents and reports that plans, including limited benefit plans, submit. States generally conduct these types of reviews at their Medicaid offices. All four states reported that they conduct some form of desk review of reports and data related to the coordination of mental and physical health care services received under limited benefit plans. The states did not issue reports on the findings of these desk reviews.

- *External quality reviews* (EQR) are federally required reviews conducted by independent organizations, called External Quality Review Organizations (EQROs), with expertise in assessing the quality of and access to care provided by managed care plans. Federal law requires EQROs to annually review Medicaid managed

care plans, including limited benefit plans that provide inpatient services.[18] These reviews assess limited benefit plans' strengths and weaknesses with respect to quality, timeliness, and access to health care services provided to Medicaid beneficiaries. All three states in which limited benefit plans were subject to these reviews—Florida, Michigan, and Washington—had EQRs conducted that included an assessment, in either 2011 or 2012, of limited benefit plans' compliance with care coordination contract requirements.[19] In Michigan, the EQR findings did not include any specific results on care coordination in 2011, but found that the state and limited benefit health plans were in compliance with managed care requirements and contractual agreements.[20] In Washington, the EQR findings in 2011 questioned the effectiveness of one limited benefit plan's intervention to increase the quality of care coordination, including the validity of the methods used to assess care coordination. In Florida, officials reported that the EQR is conducted annually in conjunction with two process improvement projects. One limited benefit plan in this state participated in a project that examined the documentation of services in an effort to improve communication and coordination of services between physical and mental health providers in limited benefit plans. This project is still ongoing.

- *Internal onsite reviews* are reviews conducted by the state Medicaid agency at providers or managed care plan offices, or at locations where Medicaid beneficiaries receive services. Three of the four states—Florida, Michigan, and Kansas—conducted onsite reviews during the 2011 through 2012 time period. Florida officials reported that the state conducted onsite reviews annually to evaluate limited benefit plans' administrative and clinical compliance, including care coordination. Some of these reviews identified needed improvements; for example, in a 2012 review of one limited benefit plan in Florida, the

[18]Federal law requires states contracting with managed care organizations and PIHPs to ensure these entities undergo an annual EQR to monitor compliance with certain managed care standards and requirements. PAHPs are exempt from this requirement. 42 U.S.C. § 1396u-2(c)(2); 42 C.F.R. § 438.350.

[19]Kansas provided mental health services through a PAHP and was exempt from EQR requirements.

[20]Michigan's contractor did not conduct any compliance monitoring activities during the 2010-2011 reporting period. This report presented a summary of previously reported results for 2009-2010 compliance monitoring reviews.

state found that the plan needed to establish a process for providing Medicaid beneficiaries immediate access to psychiatric services upon their release from a jail or juvenile detention facility to ensure prescribed medications were available. Michigan officials reported that their reviews occurred biennially and, in part, assessed limited benefit plans' capacity to coordinate physical and mental health services for Medicaid beneficiaries. Some of these reviews identified needed improvements; for example, in a 2011 review of one limited benefit plan, the state was unable to find evidence of communication and coordination between a psychiatric hospital and a Medicaid beneficiary's primary care physician or health plan and recommended that the limited benefit plan devise a coordination plan. In 2011 and 2012, Kansas conducted an onsite review of the one limited benefit plan that state contracted with to examine plan guidelines used to identify and authorize the coordination of care for beneficiaries with high needs, including those with certain mental health diagnoses. In regard to care coordination, the state found that the limited benefit plan met its contractual requirements and had an acceptable process to identify Medicaid beneficiaries with high physical and mental health needs, and provided these beneficiaries with ongoing care coordination between their mental health providers and other providers and entities delivering treatment and service. State reviewers also found that the plan had coordinated its activities with other social service, disability, and welfare systems, including the state's criminal justice and disability agencies.

- *Independent assessments* are federally required reviews through which states operating Medicaid managed care programs under section 1915(b) waivers must evaluate and maintain data regarding the cost-effectiveness of their programs, the effect of the programs on beneficiaries' access to services, and the quality of services provided under the program.[21] At a minimum, a state is required to conduct an independent assessment for its first two waiver periods. Of the four states, Kansas was the only state required to conduct an independent assessment during the time period of our review because it began providing mental health services through a contract with a limited benefit plan under a waiver in 2007. Kansas' 2009 assessment found that a small percentage of Medicaid beneficiaries enrolled in the

[21]42 C.F.R. § 431.55. Centers for Medicare & Medicaid Services, *Independent Assessment Requirement for Section 1915(b) Waiver Programs: Guidance to States* (Dec. 22, 1998).

limited benefit plan received care coordination, and recommended that the state should increase the share of beneficiaries receiving these services.[22] The 2011 assessment found improvement in the state's care coordination. Specifically, the report noted that the state expanded and enhanced its care coordination activities in an effort to increase the share of Medicaid beneficiaries in the limited benefit plan whose care was coordinated.

- *Focused care coordination studies* examine a state's coordination of mental health and physical health care services. Michigan was the only state to conduct a focused care coordination study of limited benefit plans during the time period of our review. The study, which was conducted by an independent organization under contract, examined Medicaid utilization patterns to assess whether care coordination occurred. While the report did not draw specific conclusions on whether care coordination occurred or make recommendations to the state, it did indicate that Medicaid beneficiaries with serious mental health diagnoses had more emergency room, ambulatory visits, and inpatient admissions than other groups.

CMS Reviewed State Waiver Applications and Contracts with Limited Benefit Plans

GAO found that CMS did not take direct steps to facilitate the coordination of mental and physical health care services for adult Medicaid beneficiaries enrolled in limited benefit plans because its role is to provide oversight of, and technical assistance to, the states in carrying out their Medicaid programs. In its oversight role, the agency reviewed and approved state-submitted managed care waiver applications and contracts with limited benefit plans providing mental health services, some of which contain care coordination provisions. Federal regulations require managed care plans to coordinate mental and physical health care services and identify persons with special health care needs. However, states providing health care services through limited benefit plans may exempt these plans from these requirements.[23] States requiring limited benefit plans to comply with these requirements must

[22]The scope of our study included fiscal years 2011 and 2012. However, we collected and reviewed Kansas' 2009 assessment, because the 2011 assessment followed-up on findings from the earlier assessment.

[23]See 42 U.S.C. § 438.208(a)(2). None of the four states we reviewed exempted limited benefit plans from this requirement.

include these details in their waiver applications and assure that plans comply with these rules. CMS officials told us that the agency reviews the waiver application's care coordination provisions as part of its broader review of states' waiver applications. The officials added that CMS also reviews the results of EQRs of states' programs, and provides final agency approval for contracts between states and limited benefit plans. Beyond these activities, CMS officials indicated that their role was to provide technical assistance to states, as needed; for example, when states are designing their programs.

CMS's regional offices also provided oversight of states' contracting with limited benefit plans; however, none of their activities directly assessed care coordination provided by limited benefit plans. In the four regional offices we studied, we found that the number and frequency of regional office reviews of limited benefit plans varied.[24] Regional officials we spoke to cited several activities ranging from periodic managed care calls with states, to comprehensive and focused onsite and desk reviews to ensure limited benefit plans met all federal managed care requirements. Officials in one region explained that CMS generally conducted additional regional office reviews on limited benefit plans that were newer or raised special concerns.

Agency Comments

The Department of Health and Human Services reviewed a draft of this report and provided technical comments, which we incorporated as appropriate.

We are sending copies of this report to the Secretary of Health Human Services and other interested parties. In addition, the report is available at no charge on the GAO website at http://www.gao.gov.

[24]The number and frequency of regional office reviews varied based upon the number of limited benefit plan contracts in each state and whether the states utilized a standard contract across plans, in which case a regional office may have only reviewed the standard contract once.

If you or your staff have any questions about this report, please contact me at (202) 512-7114 or yocomc@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this report. GAO staff who made major contributions to this report are listed in appendix IV.

Carolyn L. Yocom
Director, Health Care

Appendix I: Summary of Selected States' Use of Limited Benefit Plans to Provide Mental Health Services, Fiscal Year 2012

Program characteristic	Florida	Kansas	Michigan	Washington
Year limited benefit plan was first implemented	1996	2007	1998	1993
Number of contracts with limited benefit plans	10	1	18	13
Scope of services that limited benefit plans were contracted to provide to adult Medicaid beneficiaries[a]	Mental health services	Mental health services	Mental health services and services for substance use disorder	Mental health services
Number of adult Medicaid beneficiaries	2,021,882	177,449	1,061,587	693,719
Number of adult Medicaid beneficiaries enrolled in limited benefit plans providing mental health services[b]	215,303	92,938	131,671	541,225
Percent of adult Medicaid beneficiaries enrolled in limited benefit plans	10.65%	52.37%	12.40%	78.02%
Number of adult Medicaid beneficiaries enrolled in limited benefit plans that received at least one service	32,098	29,588	126,778	70,060

Source: GAO analysis of CMS and state reported data.

[a]Adult Medicaid beneficiaries are individuals 18 years and older.

[b]States have flexibility in setting eligibility criteria for limited benefit plans providing mental health services. States can choose to enroll all Medicaid beneficiaries in limited benefit plans, or establish enrollment criteria for limited benefit plans and enroll those beneficiaries that meet such criteria. For example, in Michigan Medicaid beneficiaries seeking more than 20 outpatient visits to address their mental health needs are enrolled in limited benefit plans.

Appendix II: Adults Enrolled in Medicaid and Limited Benefit Plans Providing Mental Health Services, Fiscal Year 2012

State	Number of adult beneficiaries enrolled in Medicaid	Number of adult Medicaid beneficiaries enrolled in limited benefit plans providing mental health services	Beneficiaries enrolled in limited benefit plans providing mental health services as a share of total adult beneficiaries enrolled in Medicaid (percent)
Arizona	905,958	780,049	86.10%
Colorado	253,623	235,847	92.99
Florida	2,021,882	215,303	10.65
Iowa	343,213	220,989	64.39
Kansas	177,449	92,938	52.37
Massachusetts	832,855	210,833	25.31
Michigan	1,061,587	131,671	12.40
New Mexico	235,294	155,820	66.22
North Carolina	621,387	241,761	38.91
Oregon	337,905	314,825	83.31
Pennsylvania	1,384,689	1,140,832	82.39
Utah	161,865	125,619	77.61
Washington	693,719	541,225	78.02
Total	**9,071,426**	**4,407,712**	**48.59%**

Source: GAO analysis of state reported data.

Note: Enrollment data are for unduplicated adult Medicaid beneficiaries—individuals 18 years and older—in fiscal year 2012. Beneficiaries who enrolled more than one time during the year are reported only once in the unduplicated total. States can enroll different adult populations—such as individuals who are blind, disabled, or have developmental disabilities—in limited benefit plans, which could contribute to variation in the number of adults enrolled in these plans.

Appendix III: Total Medicaid Payments and Capitated Payments to Limited Benefit Plans for Adults, Fiscal Year 2012

State	Total Medicaid payments (dollars)	Total capitated payments to limited benefit plans providing mental health services (dollars)	Total capitated payments to limited benefit plans providing mental health services as a share of total Medicaid payments (percent)
Arizona	$5,247,777,549	$818,480,488	15.60%
Colorado	2,639,786,248	151,333,340	5.73
Florida	6,885,414,675	90,850,448	1.32
Iowa	2,519,319,401	90,332,042	3.59
Kansas	1,830,720,329	86,756,599	4.74
Massachusetts	6,645,146,452	308,656,503	4.64
Michigan	9,017,361,836	1,975,853,600	21.91
New Mexico	1,771,298,790	86,483,081	4.88
North Carolina	6,071,247,483	302,281,898	4.98
Oregon	1,818,946,739	152,034,715	8.36
Pennsylvania	13,145,125,395	1,295,669,270	9.86
Utah	1,134,377,096	106,341,638	9.37
Washington	3,020,009,857	$103,594,864	3.43
Total	**$61,746,531,849**	**$5,568,668,486**	**9.02%**

Source: GAO analysis of state reported data.

Note: Total Medicaid payments and capitated payments to limited benefit plans are for adult beneficiaries—individuals 18 years and older. States can enroll different adult populations—such as individuals who are blind, disabled, or have developmental disabilities—in limited benefit plans, which could contribute to variation in the level of capitated payments made to these plans.

Appendix IV: GAO Contact and Staff Acknowledgments

GAO Contact

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Staff Acknowledgments

In addition to the contact named above, Tim Bushfield, Assistant Director; Shaunessye Curry; Kristin Ekelund; Sandra George; and Drew Long made key contributions to this report.