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Application of Managed Care to Public-Sector Mental Health and Addiction Services

Michael Anthony Michaud

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THE APPLICATION OF MANAGED CARE TO PUBLIC-SECTOR MENTAL
HEALTH AND ADDICTION SERVICES

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B.A., University of Hartford, 1985

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THE APPLICATION OF MANAGED CARE TO PUBLIC-SECTOR MENTAL
HEALTH AND ADDICTION SERVICES

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Introduction

This thesis will address the issues related to a major transition concerning the management of public-sector mental health and addiction services. The application of managed care to these healthcare systems has been in evolution, to varying degrees, in many parts of the country for the past ten to fifteen years.

This analysis is important because as publicly funded systems undergo financial restructuring, the clinical integrity of mental health and addiction services is at stake. While federal, state, county and local governments reorganize the way mental health and addiction services are funded and managed, it is imperative that the quality of, and access to those services improve.

While the changes to be discussed are still evolving, it is essential to carefully define these emerging organizational and financial arrangements so that important policy options can be clearly understood. As many different arrangements are possible, there are also many issues of policy which need to be specified and anticipated. Not the least of these is that of avoiding failures that are harmful to the consumers of public-sector managed mental health and addiction services.
Background

Managed care is intended to improve the quality of healthcare, while reducing its cost. To achieve this end, managed care overlays administrative structures to healthcare services. Access to services, quality clinical outcomes, and consumer satisfaction are the criteria by which we can measure success of managed care models. Public-sector behavioral healthcare\(^1\), within the context of this paper, refers to publicly funded services provided to individuals with severe and persistent mental illness and/or debilitating addictions to alcohol and drugs\(^2\). The term “consumers,” within the context of this paper, refers to individuals who receive public behavioral health services.\(^3\) This paper focuses on how well managed care both maximizes quality of care for consumers of public-sector behavioral healthcare while controlling costs.

Throughout the country managed care has generated controversy. Limited success in the application of managed care for non-disabled, non-poor populations underscores the dauntingly complex task of implementing managed care systems for poor individuals with long-term disabilities. In addition, stigmatizing attitudes toward the poor, especially those with mental illnesses and addictions, compound the challenge of both reducing the cost of publicly funded treatment, while increasing the quality of care for this vulnerable population.

While managed care has been working its way into general health for well over twenty years, behavioral healthcare plans have emerged mainly within the last fifteen years. While some managed behavioral health organizations (MBHOs) have enjoyed
some success in developing public-sector managed behavioral healthcare systems, others have failed. Many MBHOs operate as for-profit companies, which means that since a slice of MBHO funds go toward generating new profits and sustaining an additional administrative layer, a portion of the MBHO budget is unavailable for treatment and services.

In most states mental health and substance abuse administrations have functioned completely autonomously and identified ostensibly distinct target populations. Individuals deemed eligible for publicly funded mental health services have had to meet eligibility criteria for severe and persistent mental illness which has typically meant the presence of a major thought disorder or major mood disorder. Eligible persons would typically have had to be indigent or to have exhausted medical benefits. Additional criteria may have included being at risk to one’s self, to others, or of becoming less stable and requiring hospitalization. A further stipulation may have included that the symptoms and/or risk factors present were not the result of substance abuse. Individuals with the co-occurring disorders of mental illness and substance abuse often found themselves as the subject of debate over who should provide services to them. With the advent of “behavioral” healthcare, integration of these two systems is occurring in many states and with it a commitment to serving both populations and those with co-occurring disorders.

Prior to the arrival of managed care principles and technologies, mental health and addiction services did not comprise a “system” with a single managerial mechanism that could ensure consistent quality of services. Programs and agencies receiving state funding and federal block grants, as well as those receiving publicly funded fee-for-service reimbursement (Medicaid and Medicare), functioned with relative autonomy.
Both inpatient and outpatient programs, for example, could choose which clients they would serve, and were free to discharge them without providing appropriate aftercare referrals. As a result, multiple providers existed outside a cohesive system of care, in which one could reliably measure continuity of care, access to care, placement in appropriate levels of care, clinical outcomes and consumer satisfaction.

In the application of managed care to public-sector mental health and addiction services, the MBHO acts as the centralized administrative entity, whose authority is sustained through the control of fiscal reimbursement to providers. Ideally, individual public-sector mental health and addiction services programs form part of a cohesive, and more efficient managed system of care, in which the MBHO maintains administrative control through micro and macro management tools. (Utilization management is a micro management control tool, in that it is “case specific,” i.e., applied to every individual receiving services. Macro management tools employ aggregate data collected through clinical outcomes and consumer satisfaction studies.) Through these tools, duplicative services may be consolidated, eligibility criteria standardized, utilization management implemented, and public funding mechanisms streamlined. For example, a public sector behavioral healthcare system might pool projected costs to provide services to an identified cohort from several sources (federal block grants, state grant-in-aid, Medicare, Medicaid, etc.) into one managed care contract. Typically, 10% or less of the total estimated costs for this cohort are subtracted before the contract is established in anticipation of the expected savings under managed care.

Utilization management (UM) is the primary technology used by MBHOs to ensure that individuals are receiving the most appropriate clinical care while controlling
costs. Utilization management tools include prior-authorization, continuous stay (concurrent) review and discharge review, and control the type, amount and duration of treatment to be paid for under a particular contract.

In addition to UM, other technologies used by MBHOs include: (1) care management to ensure that treatment is individualized and the most appropriate level of care is utilized; (2) outcomes measurement to ensure that measurable, defined clinical outcomes are used to guide service planning and eliminate ineffective services; and (3) provider profiling and network development to select providers based on their ability to deliver the desired outcomes at an acceptable cost.

The application of managed care to the administration of public behavioral health services occurs in various forms. The state agency or payer for services has the authority to choose the format in which managed technologies will be administered. Of principal importance is which entity will perform the managed care functions. The entity can be public or private, for-profit or non-profit. The state authority can, itself, elect to administer the technologies, or to contract out these services to private, non-profit or for profit organizations, or a combination of both. Arrangements can be made to have the managed care entity perform administrative services only as an Administrative Services Organization (ASO) or to operate as a full-blown managed care organization (MCO) in which the managed care entity has a great deal of authority in making decisions about client care, and may be partially or fully at risk financially.

When a managed care entity functions as an ASO, the contractor, or payer, is purchasing certain technologies offered by this profit or non-profit corporation. Primary functions of the ASO typically include utilization management, the development and
operations of management information systems (MIS), managing provider relations and
claims processing and payment, actuarial support and design of the benefit plan. The
ASO is paid an administrative fee for its services and has no profit-making incentive to
limit care.

MCOs however, make their money quite differently and typically operate using
capitation. In a fully capitated system, managed care organizations agree to provide a set
of services to a defined group of individuals (both specified in the contract), for a
payment negotiated in advance on a per member (per capita) per month basis. Under this
arrangement, the managed care organization is given a financial incentive to decrease
services in order to save or make money. “This directly, and deliberately, creates the
opposite incentive to that in a fee-for-service system, where providers’ income increases
if more services are furnished.”5 Should the MCO pay out less in claims than budgeted,
the MCO stands to make greater profits; conversely it loses should claims run high. Thus
in MCO contracts, unlike in ASO contracts, the managed care entity has financial
incentives to limit care, and can stand to lose money when too many high cost services
are authorized.

A more conservative and flexible approach to financing the plan allows for the
public agency to share the cost for members who use a significantly higher level of
services by paying a higher capitation rate for these members. This method is called risk
adjustment. An additional method known soft capitation, or through the use of risk-
corridors, the MBHO could require the public agency to pay more if the total amount of
services it delivers exceeds a predetermined amount.
When states intend to transition their Medicaid recipients to managed care, they are subjected to the rules laid out under the federal Medicaid authority, the Health and Human Services Department, Healthcare Finance Administration (HCFA). The transition from a Medicaid fee-for-service grant system to managed care has often occurred as part of a Medicaid waiver obtained through HCFA. States can apply for either an 1115 waiver or 1915(b) waiver to enroll Medicaid beneficiaries, providing certain conditions are met, on an involuntary basis. State agencies have to go through a long and arduous process to obtain either waiver from HCFA, the 1115 waiver being the more difficult. However, when Congress passed the Balanced Budget Act of 1997 (BBA), states were given the option to bypass the waiver process by submitting a state-plan amendment to HCFA. By utilizing the state-plan amendment option, states can secure indefinite approval for their managed care plan rather than the two-year approval issued under the waivers. If the State is transitioning its system from general revenue grant-in-aid or General Assistance fee-for-service systems to managed care without pooling the Medicaid funding stream into the finance structure, HCFA approval is not necessary.

Controlling costs is an important objective for public agencies in implementing managed care. However, state authorities must restrain themselves from setting funding levels too low and compromising the range and quality of services already existing in the system. Substantial gains, in terms of cost containment, can be made by applying managed care to public-sector behavioral healthcare. Savings are achieved through eliminating duplicative services, consolidation of funding streams, the development of a
broad continuum of community support services as alternatives to inpatient treatment, and the appropriate use of utilization management. When managed care effectively addresses these functions, cost containment and quality care objectives are brought into alignment; and, happily, treatment philosophy and consumer focused values also come into alignment.

A prime example of this alignment can be found in the deinstitutionalization and closing of state psychiatric hospitals. From a philosophical stance in setting up behavioral healthcare systems (as defined by both providers and consumers) it is desirable to have persons with severe and persistent mental illness living in the community. And, as is known, the cost of providing community support services is astronomically less than inpatient care. But, for persons to be successful in the community, they often must have quick access to a range of support services, crisis intervention services and treatment options. The behavioral healthcare sector is discovering that the same is true for persons with debilitating dependency on alcohol and drugs. Extensive community supports—such as case management for substance dependent clients—help consumers maintain stable living circumstances as an alternative to inpatient detox recidivism.

Many professionals and consumers working in the managed care field see opportunities for public-sector mental health and substance abuse services to make fundamental improvements in the financing structure of these service systems. A consultant with the Technical Assistance Collaborative in Boston states that “the trend toward managed care provides an opportunity for public mental health [and addiction services] systems to shift from traditional finance models that link payments to specific
services to models that link payments to individual clients based on their particular needs.  

New financing mechanisms “have the potential to bring together different funding streams to create a single service package that fits the requirements of the consumer.” Thus, under managed care, quality of care and cost containment have the potential to be congruous objectives. After all, the “ultimate goal of managed care in this area is to maximize the impact of investments in mental health [and addiction] services by producing positive, effective outcomes.” Prior to discussing Connecticut’s approach, the next chapter explores what set the stage for managed care in public behavioral health systems and what other states have done in this arena.

Remaining chapters focus on managed care models utilized in other states, with an in-depth description of the Connecticut approach and objectives as it begins testing the waters of managed care through its ASO contract. An additional chapter discusses the role of consumers in public-sector managed care contracting; and the final chapter offers my summary and conclusions.

References

1 The term “behavioral health” is included reluctantly within this paper. “Behavioral” health itself—a concept evolved in the managed care era and used by MBHOs—suggests that mental illness and addictions are a result of personal behavior, not illness. The “Substance Abuse and Mental Health Services Administration” (SAMHSA) of the U.S. Department of Health and Human Services in its publication “Partners in Planning: Consumers’ Role in Contracting for Public-Sector Managed Mental Health and Addiction Services,” avoids using the term because many consumers find it objectionable. The publication notes that the term does not reflect the “medical or rehabilitative services needed for recovery.” Because, at the time of this writing, the term has met with widespread use within all facets of the field, it is used within this paper.

2 This narrows the definition of public behavioral health to one that applies to serving those only with severe mental illness and substance abuse problems. Individuals comprising this population have traditionally not only qualified for fee-for-service reimbursement through Medicaid or Medicare, but have met stricter eligibility criteria that have qualified them to receive services from agencies receiving state-administered grant-in-aid.
Thus, “consumer,” is used more narrowly in this paper and is not intended to describe all clients of mental health and addiction services. Instead, “consumers” defines a cohort of severely impaired individuals who have experienced profound symptoms of mental illness and/or substance abuse.

Because managed behavioral healthcare organizations (MBHOs) have saturated the traditional market of employer-based health plans, and because of recent trends within state governments to reduce their healthcare budgets, the public behavioral sector has become a competitive playing field for MBHOs.


National Technical Assistance Center (NTAC) for State Mental Health Planning, National Association of State Mental Health Program Directors (NASMHPD), Managed Care Presents Opportunities. (Fall 1996): 4-5.

Ibid., 5.

Ibid.
Part One: DMHAS’s Early Attempts to Develop Managed Care Type Structures

A. Background – LMHAs

Until 1995, Connecticut’s various mental health and substance abuse administrations functioned autonomously. At that time, addiction services, formerly a component of the Department of Public Health and Addiction Services (DPHAS), merged into the Department of Mental Health (DMH) to create The Department of Mental Health and Addiction Services (DMHAS). DMH had already developed locally managed systems of care throughout the state for indigent persons with severe and persistent mental illness through the Local Mental Health Authority (LMHA) system. A description of the LMHA system is essential in appreciating Connecticut’s initial attempts at developing managed systems of care for consumers of mental health services and to further understand the structure that remains in place today.

Connecticut began implementing the LMHA structure in the early 1990’s. Twenty-three catchment areas were restructured into eighteen LMHA service systems with oversight from the Department’s five regional offices. Each LMHA assumed responsibility for the clinical, fiscal and administrative management of the local DMHAS-funded Managed Service System (MSS). Contractual mandates placed on the LMHAs included:

1. Conducting needs assessments.
2. Outlining priorities for program development and service delivery.
3. Allocating a fixed set of financial resources within the MSS.
4. Developing an annual plan to meet the identified needs of the residents of the service system area, given the fixed set of financial resources available.

5. Ensuring the participation of clients of the MSS and their families, providers who work within the MSS and within the geographical service area and members of "natural" support networks.

6. Ensuring revenue enhancements for the MSS, including Medicaid options insurance reimbursements, state and federal funding initiatives, foundation grants, and United Way funding.

7. Developing a centralized point of client registrations and service planning which ensure continuity of care among the components of the service system and inpatient providers.

8. Monitoring clinical practices and the quality of care within the service system through the development of a quality assurance program which includes regular case reviews, critical incident reviews, monitoring hospital utilization and length of stay, and mediation of differences among service providers around service planning and delivery.

9. Monitoring the performance of affiliate agencies in accordance with grant requirements, and withholding funding from affiliates to purchase needed services elsewhere in cases where affiliate agencies deny services to clients.

10. Assuring that each client of the MSS has an individualized service plan and receives services as outlined in that plan.²

The LMHA contractual mandates drew upon key managed care principles and technologies. By becoming "a centralized point of client registrations and service planning," the LMHA assumed the fundamental authority to develop administrative structures that would operate as quasi-managed care entities. Many LMHAs achieved their mandates by implementing rudimentary forms of utilization management – e.g., prior authorization, continued stay review and discharge review – to "ensure continuity of care among the components of the service system." In these LMHA systems, in order for subcontracted programs to continue to receive funding, they would now be required to obtain prior authorizations as well as discharge authorizations by the LMHA.

Additionally, the LMHA would periodically conduct reviews on active clients (concurrent review) to ensure that they were receiving the appropriate level of care. Such protocol would allow the LMHA to prioritize service slots. Rather than applying
utilization management to episodes of care, the LMHA has been applying it to program caseloads. Since the LMHA is responsible for fiscal management, the programs have a financial incentive to serve those clients whose care has been authorized, as only those clients who are registered (authorized) for a particular service count toward the program's capacity, and meeting capacity requirements are necessary to receive continued funding.

This utilization management approach to operating a client registry, allows the LMHA to determine which clients are in the greatest need of services and to assure timely access for these individuals. By administering standardized discharge review requirements, the LMHA could now verify that a client discharged from a program was either no longer in need of that service, or had been linked to another appropriate level of care. No longer are programs free to discharge clients on the basis of being “non-compliant,” “treatment refractory,” “diagnostically complex,” “primary substance abuse,” “criminal or anti-social,” etc., without developing a workable plan to ensure treatment or availability of services.

Individuals deemed eligible for mental health services within the LMHA system must meet eligibility criteria for severe and persistent mental illness, which typically means the presence of a major thought or mood disorder. Eligible individuals are either indigent or have exhausted medical benefits. Additional criteria include being a risk to oneself or others, or the likelihood of significant instability in the absence of a requested service. Admissions staff will also consider whether symptoms and/or risk factors are primarily the result of substance abuse. Clients with primary substance abuse problems are usually referred to addiction services programs or programs designed to service individuals with coexisting disorders (mental health and substance abuse). The LMHA is
the final authority, with the oversight of the Department when necessary, in determining client eligibility.

**B. Background – General Assistance**

Connecticut's General Assistance (GA) program provides healthcare benefits to individuals who are indigent and lack private health insurance. In 1993, the Connecticut General Assembly mandated DMHAS to implement GA Managed Care Projects in the states three major cities: Hartford, Bridgeport and New Haven. This number grew to cover twenty-one towns over the next three years. During these first years LMHAs operated all of the GA Projects. The Connecticut Department of Social Services (DSS) and local town welfare offices were jointly responsible for contracting with and reimbursing providers, on a fee-for-service basis, for delivering care.

To illustrate the magnitude of this program, in 1996 approximately 15,000 individuals were eligible for GA healthcare benefits. In the same fiscal year, $80 million were spent on GA healthcare benefits. Of this $80 million, $33 million were spent on beneficiaries of mental health and addiction services. Almost two-thirds of these expenditures were for inpatient detoxification or mental health services.

In the spring of 1996 DMHAS determined that it would develop a new “managed system of care.” Over the next fifteen months, through the use of workgroups and focus groups, DMHAS constructed a framework for managed care that focused on the “special needs” of the public-sector behavioral health client. In its October 1997 report to the legislature, DMHAS noted that it was playing host to “several forums in which public and private stakeholders had the opportunity to critique managed care related policy as it
was being developed,” and that these forums had “significant consumer and advocate participation.”

In April 1997, as part of a welfare reform initiative in Connecticut, DSS developed State Administered General Assistance (SAGA). Under this program, DSS became responsible for determining eligibility for individuals in the eleven cities and towns identified as having the highest number of GA beneficiaries, which amounted to 80% of the total GA caseload statewide. In July 1998, DSS assumed the administration of GA for all of the state’s cities and towns (with the exception of Norwich). This move made possible the implementation of a centralized, statewide eligibility information system aimed at promoting consistency in the administration of GA.

C. Utilizing Managed Care Technologies

Managed behavioral healthcare starts with the identification of client needs, and then defines services and treatment necessary to address those needs. MBHOs employ the concept of “levels of care.” These are descriptions of services or treatment offered across a continuum varying in type and/or intensity of service.

In collaboration with providers, DMHAS formulated clinical levels of care criteria for mental health and substance abuse problems. Each level of care was supported by an accompanying description of the need or problem it sought to address. (DMHAS substance abuse criteria were modeled on those developed by the American Society for Addiction Medicine (ASAM), though tailored to suit Connecticut’s substance abuse treatment system. From a fixed budget, DMHAS would fund managed care projects to reimburse providers for authorized services; payment for services was contingent upon prior and continued stay authorizations. By implementing an initial
Utilization Management plan, DMHAS played a coordinating role in developing a system for GA behavioral healthcare. Progress in the application of managed care tools, however, still fell short of functioning statewide, as the local managed care projects operated in only 11 of the state’s 169 towns. DMHAS was not yet fully responsible for managing behavioral health care for individuals on GA.

Part Two: Implementing a Managed System of Care for Individuals on GA

A. Objectives

During its 1997 legislative session, the Connecticut General Assembly directed DMHAS to implement managed behavioral healthcare for Connecticut GA recipients. The objective of this initiative was to “manage the care of GA recipients in a manner that improves access to appropriate services while maintaining costs within the available appropriation.”

DMHAS intended through this initiative to build on the strengths of existing systems of services. In its October 1997 report, DMHAS summarized three strengths of existing services:

“1. Locally managed systems of care, throughout the state, for indigent people with serious and persistent mental illness [the LMHA system]: this system assures accountability, continuity, and access to community-based treatment services. 2. An extensive array of multiple levels of care for people with mental health and addictive disorders, including an ability to provide culturally competent services to clients. 3. A proactive and well established citizen advisory process, which evaluates and assists in planning for the mental health and addictions service delivery needs of Connecticut’s Citizens.”

In its October 1997 report to the legislature, DMHAS outlined 5 objectives for developing a GA managed system of care:

“1. To provide appropriate treatment services to eligible individuals. 2. To utilize GA funds effectively by maximizing access to needed behavioral
health services. 3. To increase the self-sufficiency of individuals seeking GA through the coordination of behavioral health services with vocational services and entitlement assistance. 4. To return individuals to maximum productivity through the provision of high quality, relevant and coordinated services. 5. To create a model for healthcare and welfare reform to be replicated for other programs servicing indigent and uninsured individuals in Connecticut.”

B. Transitional Plan

For the first time, under legislative direction, DMHAS was given the mandate and the authority to develop a comprehensive, managed behavioral healthcare system for a substantial number of its clients. While this first initiative was limited to the GA population, DMHAS viewed it as both a test of its ability to manage behavioral healthcare, and as a developing blueprint to be used for future behavioral healthcare initiatives. Faced with the challenge to implement this plan in a short time-frame (a startup date of August 1), DMHAS developed an interim plan aimed at ensuring a smooth transition to the new system for thousands of GA clients.

Under this interim plan, certain elements of the current system would be initially retained, but were to be reserved for modification at a later date. These elements included: payment rates for various services, provider eligibility requirements, billing procedures (including forms and procedure codes), and provider responsibility for verifying client eligibility for GA. Modifications occurring on August 1 included:

"1. Provider requirements regarding the necessity for obtaining prior authorization, continued stay and discharge reviews for certain services. Providers must now contact the Department’s Utilization Management Entity [see below] to obtain prior approval before delivering services. 2. Involvement of the DMHAS Behavioral Health Units [see below] as the initial point of behavioral healthcare assessment for GA applicants throughout Connecticut. 3. The inclusion of private, freestanding psychiatric hospitals among facilities eligible to provide services to GA clients. 4. Room and board reimbursement procedures. Although room and board rates remained unchanged, residential
substance abuse treatment facilities began sending their bills to the Departments Utilization Management Entity. 

DMHAS executed an interim, sole-source contract with Advanced Behavioral Healthcare (ABH) of Middletown Connecticut, the first time DMHAS contracted with an MBHO. The contract established ABH as the Department’s interim utilization management entity. Under this contract, providers delivering mental health or substance abuse services to GA clients would have to adhere to UM protocol established by the Department in order to be fiscally reimbursed for services rendered. A statewide 24-hour toll free number was established for providers to contact ABH clinicians who performed the telephonic UM procedures. Services subjected to the UM protocol included acute inpatient psychiatric hospitalization, medically managed inpatient detox in general hospitals, medically monitored inpatient detox, 24 hour observation/flex beds, mental health partial hospital, substance abuse day/evening treatment, and outpatient treatment. These services required prior and continued stay authorization and discharge review. Approval was obtained via telephone (with the exception of outpatient services for which authorization could be obtained via fax); and discharge review was not. Under this initiative, ABH provided information on authorizations to DSS, who continued to process and pay claims to providers. Additionally, provider agreements were not made with either DMHAS or ABH, but continued to exist with DSS.

It had been DMHAS’s intention to consolidate and coordinate most of the services and management activities for GA behavioral health. Before this happened, several modifications to the new structure were required—namely in order to:

1. Adjudicate, process and pay claims. 2. Perform utilization management for certain [additional] services. 3. Coordinate care management activities with the Behavioral Health Units [see below] that perform screening and care
management activities for GA recipients. 5. Assist the Department in developing and implementing a contracting process for eligible behavioral health GA providers. 6. Verify eligibility using information obtained from DSS for GA cash and medical benefits. 7. Provide information to the DMHAS medical director, quality management staff and the quality advisory committee who are responsible for implementing a quality management program plan for GA recipients.”

C. Procurement Process

During this interim period, DSS, not DMHAS, was responsible for a variety of important functions, such as claims payment. Legislation passed in the winter/spring session of 1997, however, mandated that DMHAS assume administration of the behavioral healthcare of the GA population by August 1997. Although it was impossible to achieve this end completely by that date, DMHAS did succeed in controlling several key functions through its interim plan, and shortly began working to implement a structure to establish its new scope. The most important functions needing to come under DMHAS included claims payment, provider contracting and credentialling, and the coordination of care and case management with the BHUs.

In September 1997, DMHAS issued a Request for Proposals (RFP) outlining its requirements for developing a contract with an Administrative Services Organization (ASO) to assist in performing the functions covered in the interim plan with ABH, as well as those yet to come. The RFP outlined DMHAS’s mission, timeframes, evaluative criteria to select an ASO, and general information that related to the ASO contract DMHAS sought to establish. Additionally, the RFP delineated requirements of the bidders in terms of general information, a technical response regarding the scope of work, a financing/budget plan including a cost proposal, and other specific submission criteria. Ambitious in terms of its timetable, DMHAS required the following:
submission of written questions for the bidders’ conference due on September 22; attendance at the bidders’ conference on September 23; all questions to DMHAS due on September 24; letters of intent to deliver a proposal due on September 29; and proposals due on October 10. Additionally, DMHAS aimed to select a vendor by November 1, and have it in place on February 1, 1998.

Seventeen organizations submitted letters of intent to deliver proposals to DMHAS by the deadline. All but two were MBHOs, and thus viable contenders. Yet, by deadline only three proposals were submitted, and one was disqualified for being “incomplete” and “non-responsive” and therefore ineligible for award. Thus, only 2 MBHOs would be evaluated for selection: Value Behavioral Health, Inc. (VBH) of Virginia, and Advanced Behavioral Health (ABH), DMHAS’s interim utilization management entity.

Public mental health and addiction services authorities invest an inordinate amount of resources in establishing and executing a selection process. Much of this is because of the number of lawsuits MBHOs have brought against governments complaining that their selection process was not equitable and that the public agency’s decision demonstrated partiality toward a particular vendor. Considerable detail is included within this section to describe the extensive and meticulous procurement process set up by DMHAS. Additionally, this is important because DMHAS’s decision was ultimately challenged, not in courts as many would have anticipated, but in the political arena.
Throughout the development of the RFP and well into the ASO implementation, DMHAS contracted the assistance of the Technical Assistance Collaborative (TAC), a Boston based organization providing technical assistance to governmental entities implementing managed public behavioral healthcare. With TAC’s assistance, DMHAS developed five steps necessary for reviewing proposals. To accomplish these steps in the review process, DMHAS established seven workgroups, comprised as follows:

1) **Preliminary screeners**, comprised of six DMHAS employees.
2) **Readers**, comprised of eight DMHAS employees and one TAC consultant, each of whom was assigned as a consultant to a member of the selection committee.
3) **Advisors to the selection committee**, comprised of three members of the Transitional Advisory Committee of the State Board for Mental Health and Addiction Services (one member was a consumer of mental health services, one a consumer of addiction services, and one a family member of a consumer).
4) **Consultants to advisors**, comprised of five consumers of mental health services who consulted to the consumer advisors from the State Board of Mental Health and Addiction Services.
5) **Advisors from TAC**, comprised of three consultants serving as advisors to the selection committee.
6) **Selection committee**, comprised of five senior managers from DMHAS.
7) **Reference checks**, comprised of seven DMHAS employees who would report to the selection committee on reference checks of the two bidders.

The five steps for reviewing the proposals were as follows:

1) **Primary Screening**. Using a checklist designed for the process, preliminary screeners reviewed proposals for “responsiveness” based on the criteria established in the RFP.
2) **Review**. Prior to meeting as a group, selection committee members independently reviewed each proposal and summarized input from readers (see below). Advisors from both the State Board of Mental Health and Addiction Services and TAC participated in the selection committee meetings. All advisors were able to give input freely at these meetings; only members of the selection committee assigned ratings, based on consensus, to each section of the evaluative criteria, and then to each proposal as a whole. Additionally, the selection committee developed a listing of agreed upon strengths and weaknesses of each proposal. The selection committee then developed composite scores based on the ratings, assigning relative value to each set of criteria. Each proposal then received a total composite score. All advisors
were present whenever the selection committee assembled. The total cost was listed (per 10,000 users including start-up and 2 full years to follow) as an item following the total composite score on the *Selection Committee's Proposal Score Sheet*, but did not factor into the consensus rating.  

3) **Reference Checks.** DMHAS staff reviewed references and recorded results on a checklist and reported back to the selection committee.

4) **Interview with Bidders.** The selection committee, along with all advisors and the DMHAS Commissioner, interviewed each bidder and documented the group’s evaluation of each bidder’s performance.

5) **Selection Committee’s Recommendation to the Commissioner.** Upon completion of steps 1 – 4, the selection committee reconvened and developed a final recommendation packet concerning the selection. As part of this packet, the selection committee completed final composite ratings that reflected, in addition to the review of the proposals, interviews conducted with each vendor, reference checks, and site visits to the vendors. Site visits focused on the information system technology each vendor could demonstrate in order to collect data and process claims.

Final composite ratings reflected the sets of criteria consistent with initial reviews of the proposals. Vendors were rated according to their understanding of the DMHAS GA system, responsiveness to questions, the strength of their proposed implementation plan, organizational experience and qualifications, and organizational and financial capacity. Heaviest relative values were given to the responsiveness to questions put forth in the RFP and the strength of respective implementation plans.

VBH scored 385 points out of a possible 500; ABH scored 285. VBH proposed costs of approximately $7.3 million; ABH proposed costs of approximately $8.5 million. Based on its review, the selection committee recommended to the Commissioner that the Department enter into negotiations with VBH in order to contract with VBH to perform the scope of work contained in the RFP. The Commissioner then made his decision “based on the selection committee’s recommendation and on the best interest of the State” to enter contract negotiations with VBH. DMHAS then contacted
the two bidders with the Commissioner’s decision, and released their decision to the public.

**D. Political Fallout**

ABH had been established as a private not-for-profit MBHO to provide managed care technologies to local, public behavioral health care agencies. Seed monies for its startup had been furnished by local provider agencies (most of which were DMHAS funded) with an interest in creating an MBHO that would share in the vision of a fully functional non-profit mental health and addiction service provider. Local public behavioral health agencies had been concerned that the state might award an MCO contract to a large and unknown for-profit managed care entity, as had happened in other states. In such a scenario, providers could face reduced roles, or no role at all. Additionally, the Association of Local Mental Health Authorities (ALMHA), formed by the executive directors of the local mental health authorities, had supported the development of ABH as a means to help preserve their continued role in the system.

From the providers’ perspective, the decision to choose VBH meant that a large, for-profit company (with a poor reputation in Connecticut as one of the Medicaid MBHOs) would establish itself in the pivotal role as ASO to DMHAS. It also spelled trouble for ABH. The agency now faced losing its biggest contract as DMHAS’s interim UM entity. Instead of expanding its duties, ABH would be downsizing and laying-off employees. The DMHAS funded provider community reacted explosively toward the proposed contract with VBH. A large state employee union and several provider trade associations formed important lobbying alliances during the election year, and flexed muscle through the Governor’s office and the state Legislature. As a result of strong,
vocal opposition to the VBH contract, contract negotiations between DMHAS and VBH were suspended just prior to signing. Meanwhile, the Governor’s Office and the Connecticut Department of Policy and Management (OPM) brokered a compromise that called for a continuing role for ABH, while allowing DMHAS to move forward with the VBH contract.

The delay in signing the VBH contract meant that DMHAS was unable to implement its new structure on the target date of February 1, 1998. And in the interim, VBH was sold by its parent company, Value Health Inc., to Options, Inc. This new incorporation was named ValueOptions Inc. (VOI). During the winter and spring of 1998, VOI conducted negotiations with ABH, in which VOI agreed to subcontract the UM functions of the operation to ABH. ABH would retain the UM functions it had acquired through the interim plan. ASO implementation planning, which had begun with VBH in December 1997, resumed again with VOI in mid-July 1998. The new target for full implementation of the new structure moved to October 1, 1998.

E. Current Structure

1. Administrative Services Organization (ASO)

Provider Credentialing

As the ASO assisting the Department in managing the behavioral healthcare of SAGA clients, VOI is contractually obliged to perform a multitude of tasks. An important function not covered by the interim plan includes support for the administration of provider contracts. VOI must provide administrative support to DMHAS to develop processes for provider selection, credentialing, rate setting and contracting. Providers who already in 1998 were submitting claim were given until September of 1998 to submit
applications and documentation for credentialing to VOI. The contract establishes a process by which VOI determines credentialing criteria and advises the Department which applicants, including additional providers who have not previously provided services to GA clients, the Department should contract with. The Department’s final authority in choosing providers underscores the administrative, rather than the authoritative role of the ASO. The Department alone enters into the contractual relationship with the provider.

While DSS has determined which clients are eligible for GA, VOI was responsible for developing an “eligibility verification system” one month prior to the date the system became operational (October 1, 1998). The contract stipulates that VOI perform the credentialing provider process on a biannual basis.

Utilization Management

VOI is responsible for performing authorization and reviews of services for GA recipients, and those who have eligibility pending, i.e., those whose formal applications have not yet been submitted to DSS, but whom providers assess as meeting GA eligibility criteria. As previously stated, while VOI is responsible for all parts of the operation, UM has been subcontracted to ABH. Although similar to the UM applied under the interim plan, levels of care subject to review have been expanded to subject all levels of care to UM, further advancing the Department’s objective to manage the behavioral healthcare of GA recipients.

The services subjected to UM by the ASO include sixteen levels of mental health and addiction services. VOI is responsible for operating a toll-free line, based in their Connecticut office, for providers to call to obtain authorizations. Continued stay and
discharge reviews are conducted by the contractor’s clinicians, during the hours of 8:00 am to 5:00 p.m., on a Monday through Friday basis. The contractor must provide prior-authorization reviews twenty-four hours per day, seven days per week. Confirmation of authorization is sent to the provider making the request and to the Behavioral Health Unit (see below) at the time care is authorized.

The following services are subject to UM under the contract:

1. Acute Psychiatric Hospitalization (MH Level IV.2)
2. Medically Managed Inpatient Detoxification (SA Level IV.2D)
3. Medically Monitored Intensive Residential Detoxification (SA Level III.7D)
4. Observation Beds (MH Level II.7, SA Level II.7)
5. Intensive Crisis Stabilization (MH Level II.9)
6. Intensive Residential Treatment (SA Level III.7, III.7E, III.8)
7. Intermediate/Long-term Treatment (SA Level III.5)
8. Long-term Care (SA Level III.3)
9. Transitional Care/Halfway House (SA Level III.1)
10. Partial Hospitalization (MH Level II.5, SA Level II.5)
11. Intensive Outpatient (MH Level II.1, SA II.1)
12. Outpatient (MH Level I.1, SA I.1)
13. Methadone Maintenance (SA Level I.3)
14. Ambulatory Detoxification with On-Site Monitoring (SA Level II.D)
15. Ambulatory Detoxification (SA Level I.D)
16. Methadone Detoxification (SA Level I.2)32

If the Department finds that the ASO has inaccurately authorized treatment, the ASO must pay the costs for the treatment. Inaccurate authorization would occur if the ASO failed “to follow or apply prescribed clinical criteria.” However, exceptions are to be made for Probate commitments, and the ASO must automatically authorize care for the period of time specified by the Probate Court, for GA recipients committed by the Probate court, under state statute, for either psychiatric disabilities or for inpatient alcohol or drug treatment. Additionally, the ASO must conduct a review of discharge plans “prior to discharge.”
Per contract, all calls must be answered within 30 seconds, queuing (on-hold time) must average under 1 minute per call, and the total waiting time per call cannot exceed 3 minutes.\(^37\) The ASO must establish an electronic method of tracking these statistics and must report them to DMHAS. The contractor is also responsible to “monitor a random sample of service center calls to assess clinicians’ skills, tone and professionalism” and report its finding to DMHAS.\(^38\) DMHAS staff also can monitor calls at its own discretion, using VOI’s equipment.

The contract requires that all UM staff be licensed in the State of Connecticut in mental health or addiction treatment and have a minimum of five years experience in the provision of mental health and addiction services. Additionally, UM staff meet minimum training requirements, as specified in the contract, and must be thoroughly knowledgeable of the “Connecticut Client Placement Criteria,” the “Clinical Protocol for Levels of Care for Mental Health,” and “the existing provider service system in each of the Department’s regions.”\(^39\)\(^40\)

The ASO must develop and recommend to the Department “critical, clinical and cost thresholds.”\(^41\) The thresholds would be used to identify individuals who utilized “costly and/or frequent” services. This would help examine “such factors as multiple or lengthy inpatient admissions, rapid inpatient readmissions, and service units or cost limits that exceed established thresholds.”\(^42\) The ASO must establish an appropriate mechanism for reporting these incidents.

As established in the contract, reviews must be completed within specified timeframes: for admission to acute services within ninety minutes, for continued stay and discharge reviews within four hours of the provider’s initial contact or at least four hours
before the authorization expires. The Department incorporated important protocols aimed at protecting clients from poor clinical decisions as they relate to the denial of services. All denials for requested services must be "based on a review made by a Connecticut licensed, board-certified psychiatrist" for mental health services, and "an addictionologist for denials of treatment for substance abuse disorders." Furthermore, the Contractor must have immediate access, twenty-four hours per day, seven days per week, to a psychiatrist who is board certified in Connecticut and by the American Society for Addiction Medicine (ASAM).

VOI must provide training sessions to GA providers, at least annually, on "UM procedures, claims payment procedures, provider profiling criteria, and to respond to questions." Furthermore, the ASO must send a manual to every provider containing the GA ASO procedures and the clinical criteria to be used for utilization reviews. The provider manual must be posted on VOI’s website along with any changes in procedures or clinical criteria.

The Department requires the ASO to review a random set of client charts at provider agencies, equal to five percent of the total number of cases reviewed for each type of service for those clients who have had their care subjected to UM. The ASO must conduct such reviews whenever quality concerns are observed, or when an provider’s outcomes show significant deviation from the averages, "outliers." DMHAS must approve the methodology for selecting and reviewing cases.

Claims Processing and Payment

VOI is responsible for accepting, adjudicating, and paying claims according to the GA ASO contract. DMHAS outlines thirty-six mandates associated with the claims
processing and payment functions. The following is a list of sixteen important mandates listed in this section of the contract. According to the contract, VOI shall:

1. “Adjudicate and pay claims beginning October 1, 1998, for all claims with a service date on or after October 1, 1998, through the termination date of this contract.”
2. “Implement any necessary changes to the fee schedule at a date designated by the Department or within 48 hours of receiving the revised rate information.”
3. “Pay providers for authorized services within 30 days of receiving a clean claim. Claims will not be paid unless GA recipient status has been determined for the time period during which services occurred.”
4. “Accept any claims form approved by DMHAS.”
5. “Receive claims electronically.”
6. “Verify the accuracy and completeness of the claim.”
7. “Have a process that allows providers to check claim status on a timely basis.”
8. “Check claims against any limitations defined in benefit plans...”
9. “Maintain a comprehensive record of all paid services with links back to authorizations, as applicable...”
10. “Process out of plan claims, such as out of state claims, as defined by the Department...”
11. “Receive claims from providers at gross charges and recalculate the payment amount based on the provider’s contract, then give a detailed accounting of the calculation in a format suitable for communicating back to the provider...”
12. “Retain information on paid claims for a minimum of three years after the termination of the contract.”
13. “Produce a weekly payment warrant indicating the amount payable to each provider for review and approval by the Department prior to release of payments. Release payments on a weekly basis.”
14. “Produce a cash flow forecast report on a monthly basis.”
15. “Have the capability of placing individual provider payments on hold...”
16. “...aggregate the claims for multiple recipients on a single provider payment check (also know as “vouchering...”

Claims processing and claims payment apply to the following services:

Mental health and Substance Abuse General Services
1. Emergency Transportation (ambulance)
2. Laboratory Services

Mental Health Services
1. Outpatient
2. Intensive Outpatient
3. Intensive Crisis Stabilization
4. Partial Hospitalization
5. Observation Bed
6. Acute Psychiatric Hospitalization

**Substance Abuse Services**
1. Outpatient
2. Intensive Outpatient
3. Methadone Detoxification
4. Methadone Maintenance
5. Ambulatory Detoxification
6. Observation Bed
7. Partial Hospitalization (Day and/or Evening Treatment)
8. Residential Services – Transitional Care/Halfway House
9. Residential Services – Long-Term Care
10. Residential Services – Intermediate/Long-Term Treatment
11. Residential Services – Intensive Residential Treatment
12. Medically Monitored Intensive Residential Detoxification
13. Medically Managed Inpatient Detoxification

As an Administrate Services Organization, VOI processes payments and issues checks against a DMHAS “controlled” account, “in accordance with a Department approved rate schedule.” As discussed earlier, in ASO arrangements the MBHO is performing an administrative transaction for the “payor,” and is not (unless it is doing so as a result of inappropriate authorizations as discussed above) paying for services from its own account. Within the GA ASO contract at this time, there are no financial incentives for the MBHO to limit or deny care.

**Quality Management and Data Reporting**

VOI is contractually obligated to provide “accurate and timely data and reports that will assist the Department in assuring that all GA recipients receive appropriate, effective and cost efficient treatment.” And VOI is to develop a “quality management plan to assure that the processes and products developed and utilized by the Contractor...
are consistent with the Department’s vision and mission.” Toward this end, the contract permits the Department and VOI to collaboratively develop an acceptable format for the submission of data and reports.

VOI is to review all admission or continued stay reviews which resulted in a complaint or grievance from a GA recipient, his or her family member, advocate or any party “acting on behalf” of the individual. Furthermore, VOI must review any “critical incident or serious adverse treatment response” which occurred during treatment which had been authorized. Under any of these circumstances, the review must occur within two weeks of receiving the complaint, and a report must be issued to the Department within two weeks of completing the review.

The Department, at intervals it selects, also requires VOI to validate the receipt of services for a sample of recipients for whom claims have been paid. The “service validation document must meet with the Department’s approval, and the results of a service validation must be reported to the Department, “by individual and in aggregate, in a timely manner.”

VOI must convene a quality management council, at least monthly, to advise VOI on its performance under the contract. In addition to key representatives from VOI, the council must include at least one mental health and one addiction services consumer (at least one of whom is a member of the State Board of Mental Health and Addiction Services), and at least one provider.

The GA ASO contract specifies data reporting requirements. VOI must provide accurate reports (hard copy and electronic) within fifteen days of the end of the month. “Service user profiles” must capture the profiles of GA recipients who have received
authorized treatment, including demographic information and diagnosis. An additional report must capture information related to each consumer for whom expenditures are in the highest ten percent, and for consumers who have experience four or more admissions to a psychiatric inpatient hospital (Level IV.2) or for Medically Monitored Community Detoxification (Level IV.2) in a one year period. A report is also required on consumers who experience rapid readmissions to psychiatric inpatient, and inpatient or residential detoxification within a seven day period.

Reports summarizing information on all admissions, discharges and readmissions are required. For admissions, information must be sorted by the provider and/or the level of care and must include “number of admissions, average length of stay, median length of stay, total authorized days, number of admission refusals by the provider (with reasons for refusal), number of court petitions, and critical incidents.” Discharge information must include “the reason for discharge (e.g., completed treatment or did not complete treatment and why), sorted by provider and level of care.” Reports on readmission must indicate “number and percentage of individuals readmitted within seven, thirty, and ninety days of previous discharges, sorted by initial discharging provider.”

Of the numerous reports required by DMHAS and outlined in the contract, sixteen are summary reports, in aggregate form, and include:

Authorization reports capturing:
- services requested and services authorized during the reporting period, sorted by provider and level of care,
- cumulative data, by provider and level of care, detailing the number of actual days used as well as the number of days authorized,
- authorizations for clients pending determination of eligibility and for clients with no identified payer source, i.e., “uncompensated care;”
- quality management activities, e.g., resolutions of grievances, critical incidents and use of seclusion and restraints;
2. Complaints report capturing information on the provider, level of care and the nature of the complaint;
3. Appeals report, to be sorted by level of care, including the number of first and second level appeals, number of reversed decisions as a result of the appeal, and the amount of time it took for the ASO to resolve the appeal;
4. Telephonic responsiveness report, summarizing adherence to contractual requirements discussed earlier;
5. Continuity of care reports, sorted by level of care and provider, summarizing the average length of time between services when a client is transitioning between levels of care, (must indicate the percent of consumers who have been admitted to the next level within a three day, seven day and over seven day period);
6. Denials of services, indicating the level of care denied, the provider requesting authorization and the level of care if one was authorized;
7. Average, median and longest length of time from requests for authorization to the first program contact;
8. Number and percent of consumers, by type of service, discharged from inpatient or detoxification and admitted to lower levels of care within three, five, seven and longer then seven day periods;
9. Number and percentage of discharges for “noncompliance,” with no referral to another level of care, due to clients’ refusal;
10. Number of clients, by provider and service type, who were referred to another level of care, but did not attend the first appointment, or attended only one or two appointments;
11. Number of critical incidents, by provider and type of incident, while in treatment or within thirty days of discharge;
12. Number of authorizations, by provider and service type, that occurred at a higher level of care than necessary, because of the unavailability of care at the appropriate level;
13. Financial reports indicating the number and costs of claims submitted, claims paid, and the total year to date expenditures incurred;
14. ASO’s compliance with the performance standard outlined in the contract;
15. Results of chart reviews, sorted by provider, on the use of treatment plans, discharge planning, verification of authorization and billing information, and other information agreed upon by the ASO and DMHAS;
16. Other ad-hoc reports subject to the limitations of the contract.  

Furthermore, the ASO must furnish a report to the Department, every six months, on Provider satisfaction concerning authorization and payment. The Department must approve the “measurement instrument and assessment process,” prior to VOI’s implementation of it.
Appeals Process and Grievance Procedures

The appeals process, which can be used by a GA client or an authorized representative acting on his or her behalf, or a provider, is set up to ensure that a mechanism is in place to appeal decisions related to the ASO’s decision to deny care. The appeal process can either be clinical or administrative in nature.

Clinical appeals concern the ASO’s judgement for denial on the basis of service necessity. The reasons why an ASO may deny care would typically include: inadequate clinical information to substantiate the requested level of care, admission to a lower level of care is appropriate and available, or the provider’s request is not based on an appropriate clinical rationale for admission to the requested service.  

Under the GA ASO contract, the party who wishes to appeal the decision must submit to VOI a “rebuttal” including additional information or justification that demonstrates that the requested level of care is necessary. The first appeal (first level) must be submitted within seven days of the original denial. A physician through VOI who has not participated in the first denial must review this first appeal, and VOI must provide notification of their decision within four hours. If the person who made the appeal is not satisfied with the result of the first appeal, a second-level appeal may be filed within seven days of the decision concerning the first appeal. A second physician through VOI who has not participated in the first denial or the first appeal, must review this second appeal, and VOI must provide notification of their decision within four seven days. A third appeal can be filed with DMHAS who decides all third-level appeals and has final authority in this process.
A provider may choose to file an administrative appeal when a denial is based on “noncompliance with administrative procedures.” Among the examples of provider noncompliance cited in the contract are, not obtaining an authorization for admission or continued stay on time, or for failing to comply with other administrative timeframes, e.g., submitting claims, registering individuals for outpatient treatment or participating in discharge review. In filing an appeal, the provider must submit a rebuttal to VOI substantiating “good cause” or providing additional information within seven days of the decision to deny services. VOI has seven days to respond to the denial. If the provider remains dissatisfied, a second appeal can only be filed with DMHAS. DMHAS retains control of making the final determination, at the second appeal level, and conducts the appeal independently.

VOI is required to develop and implement a grievance procedure, which must be found suitable to the Department, to used by consumers and providers who are unhappy with an action undertaken by VOI which is not covered in the appeal process. A grievance may be filed through use of a toll-free telephone number which is listed, along with the grievance procedure (in both English and Spanish), in the member handbook and in posters to be located at SAGA offices. Furthermore, VOI must appoint, subject to the Department’s approval, a member rights officer who is responsible for investigating, mediating and compiling written reports of the circumstances of grievances, and must maintain records of all grievances.

Under the ASO contract, VOI must also provide “appropriate prevention, education and outreach (PE and O) activities to the GA population a minimum of fifteen hours per month.” Examples of PE and O activities, as specified in the contract, may
include “outreach to homeless shelters, soup kitchens, and other social service programs.” The goal of these activities is to educate beneficiaries and potential beneficiaries of mental health and substance abuse services that can benefit them. VOI is further obligated to participate in consumer forums as requested by the Department, and to promote and conduct “program orientations, speakers bureaus, focus groups, board and committee memberships…”

VOI must assist DMHAS in developing a provider advisory council and must participate in its meetings. It must “support through recruitment and advertising the hiring of persons in recovery,” and must report its progress in this area to the Department on a semiannual basis. The contractor is also responsible for ensuring that individuals with unique cultural needs are referred to providers who can, when possible, speak the same language as the client.

2. Behavioral Health Units

The utilization management entity, discussed above during the interim plan, began operating on August 1, 1998. It was at this same time that DMAS transformed its eleven GA Managed Care Projects into Behavioral Health Unit (BHUs). “As an important adjunct to the utilization management function… DMHAS also recognized the need to have trained professionals located in the DSS SAGA offices.” The primary function of the BHU staff is assessing the GA client’s need for behavioral health services and coordinating care for those clients (care and case management functions are discussed in greater detail below).

While the GA Projects during their initial piloting and development phase were operated by LMHAs, about half of the BHUs are operated by addiction services agencies.
This is more reflective of the contemporary structure of DMHAS as a provider of both mental health and addiction services as opposed to the former DMH which began the development of the GA Projects. Furthermore, prior to August 1, 1998, the GA Projects were only authorized to apply UM functions to mental health services and for dual diagnosis (mental health and substance abuse) services. DMHAS’s decisions to award addiction services agencies with BHUs, along with broadening the UM functions to apply to GA clients with substance abuse problems in the absence of mental illness, reflects the evolving integration of mental health and substance abuse services within the Department. It also illustrates the Department’s movement toward developing a comprehensive managed system of behavioral healthcare for GA clients. Most of the BHUs are operated by DMHAS funded, private, not-for-profits; however, a few of them are components of state operated facilities and are staffed by state employees.

A central goal of the BHU is to increase the GA client’s access to mental health and addiction services by having BHU staff available in the DSS field offices. DSS staff are able to call upon BHU staff to “serve as the initial screening point for GA applicants.” This process occurs statewide. BHU staff assess the client’s needs, formulate an impression of the level of care required, and perform triage functions by making appropriate referrals within the GA provider system. The BHU works closely with the ASO, and informs ASO staff of its recommendations concerning referrals. The ASO can then expect to receive requests for authorizations from providers based on its input from the BHU. BHU staff monitor treatment adherence for all the GA clients within their service area. They are also responsible to provide training to DSS staff on when to refer clients for initial behavioral health screenings.
In addition to making referrals to behavioral health services, BHU staff identify “transitional individuals” as those who will receive the benefit on a short-term basis. Some of these clients may be appropriate to receive Social Security Disability and thus qualify for Medicaid benefits. Others may be assessed as “job ready” and referred to appropriate vocational and employment services. BHU staff make referrals to medical services as appropriate, and have liaison functions with inpatient facilities should their clients be admitted.

Prior to July 1, 1998, GA recipients received a cash benefit in addition to the medical benefit; the cash benefit has been eliminated. This benefit has been eliminated for most GA recipients. When this benefit existed, the BHU was obligated to communicate its assessment concerning treatment adherence to DSS, which would then, if the client was deemed non-compliant with treatment, discontinue the entitlement. Such decisions apparently happened frequently; the Director of one BHU referred to the loss of benefits due to non-compliance “as a common occurrence.” In the current structure with cash assistance no longer in place for every GA client, and non-adherence to treatment continuing to persist to some degree, DMHAS has tied its program offering limited financial supports, the Basic Needs Program, to treatment adherence.

3. Basic Needs Program

A workgroup of DMHAS employees, with an assistant from the Technical Assistance Collaborative convened in January 1998 to design the Basic Needs Program (BNP). DMHAS implemented BNP supports on July 1, 1998. The program is intended to provide basic needs supports to GA clients of DMHAS services who have lost their
cash benefits on June 30. Individuals who are eligible for BNP supports must meet the following criteria:

1. Must be an active SAGA, or Norwich GA, medical benefit recipient;
2. Must not be receiving a SAGA, or Norwich GA, cash benefit;
3. Must be deemed as “engaged” in treatment by the GA behavioral health provider; and
4. Must be in need of supports that cannot be met by existing community resources.

The cash benefit has not been eliminated for every GA client, as those individuals who are deemed, in writing, by a treating physician to be “non-employable” for six months or more, retain the cash benefit. The cash benefit is more per month for these individuals; since they are considered “non-employable,” they are likely candidates for Medicaid. While BNP supports are tailored to meet only the basic needs of an individual, the dollar amount of the supports can exceed the cash benefit, making the BNP supports more desirable for the “non-employable” client whose Medicaid benefit is pending. In theory, DSS must award the cash benefit to “non-employable” clients, which makes them ineligible for BNP supports. However, it appears that in practice, clients have not been compelled to receive cash assistance, allowing them to receive the potentially richer support from BNP.

Application for BNP supports begins with the GA client and his/her substance abuse or mental health provider identifying needs that can be met through the BNP. The provider then completes, with the client, the BNP Assessment and Request Form (ARF). The ARF is submitted to the local BHU. Information required on the ARF includes “client demographics, engagement in treatment, basic needs, vendor information and level of urgency of the request.” Requests are designated by level of urgency and are
considered either “standard” or “urgent.” The provider must send the completed ARF to the local BHU, via facsimile, on the day the ARF is completed.

Urgent supports are capped at a $100 maximum and are available to the applicant within one business day of receipt. Examples of urgent supports include:

- “Urgent food necessary to provide sustenance.
- Urgent shelter to individuals who need quarter to live, sleep and bathe. For example, a person may need assistance with payment for a bed in a shelter program.
- Urgent personal care items for individuals to meet personal hygiene needs or the requirement of an event necessitating the need for such supports. For example, ... a haircut for an [unanticipated] job interview.”
- Urgent clothing for individuals who need appropriate apparel for protection from weather conditions, seasonal changes, or a significant event that is consistent with meeting treatment goals, such as a job interview or treatment session.”

Standard supports include:

- “Clothing to assist an individual with job placement, such as attire for a job interview or particular garments required for the job, such as work boots.
- Assistance with a security deposit to acquire housing or temporary assistance with the rent until the individual can support his/her own housing costs.
- Public transportation to job interview, job training or to assist with a housing search or relocation costs.
- Assistance obtaining inexpensive basic furnishings (bed, used appliances, etc.) for an apartment.”

All the BHUs have vouchers and transportation tokens, supplied through the BNP, to offer clients when considered appropriate.

The local BHU is responsible for reviewing the ARF and determining the client’s eligibility for BNP supports. Local BHU staff must ensure that the request is consistent with BNP program guidelines and that the supports could not be obtained through existing community resources. If the request is urgent, the decision to grant the support
can be made by the local BHU. In order to process standard BNP requests, a “Regional BHU” has been named and a “Regional Review Committee” has been established in each of the five DMHAS regions. Regional BHU staff attend weekly meetings of the Regional Review Committee to approve or deny all standard BNP requests. In addition to reviewing the ARF, the Regional Review Committee considers “overall program goals” and “year to date BNP program budget information” in formulating their decision.  

The Department has contracted with the United Way to purchase administrative services necessary to operate the BNP. These administrative supports include receiving all approved BNP requests from the regional BHU, enrolling the clients into a central database, issuing vouchers to vendors, and, upon receipt of an invoice from the vendor, making the appropriate payment. The United Way then notifies the BHU of the payments it processed.

GA clients eligible for BNP supports and their providers must work with their BHUs to identify vendors in the community from which to purchase services, i.e., grocery, convenience, and clothing stores, pharmacies, landlords, hair salons and barbershops, etc. DMHAS selected the United Way to provide administrative supports because of its familiarity with vendors through other projects it has undertaken, its experience in providing these types of services, and because it has had an already existing infrastructure in place to provide these services.

**Care and Case Management Model**

Historically, DMHAS has provided and funded case management services to mental health consumers only, who met the eligibility criteria for services as defined by
the LMHA and referenced earlier in this chapter. However, since the merger of mental health and addiction services into one state agency in Connecticut, the concept of providing case management services to addiction services consumers had been evolving. Individuals working within the DMHAS system had recognized the value of providing case management services to clients who primarily suffer from addictions. The Department was advancing two initiatives simultaneously, but somewhat autonomously: the development of case management pilot programs (which would parallel the system in place for mental health clients) for persons with addictions (who did not suffer from severe and persistent mental illness), and the Department’s “Care and Case Management” approach for a select group of SAGA clients.

In the spring of 1998, DMHAS convened a statewide workgroup to develop a definition, functions, descriptions of levels of care, and levels of care placement criteria for case management. For the first time, DMHAS requested that material related to case management include both mental health and substance abuse case management. The workgroup produced the following definition of case management for consumers of public-sector behavioral health services in Connecticut:

“Case management refers to the provision of services to meet the multiple needs of persons with severe mental illness and/or substance abuse. Case management services, which are provided in a variety of settings, are support services which assist the client in gaining access to needed treatment services, in addition to medical, social, educational, vocational, housing and other services essential to meeting basic human needs. Case management is a client-driven process aimed at facilitating recovery by involving and sustaining the client in realistic and appropriate activities developed and agreed upon by both the case manager and the client. The degree of severity and duration, and the individual’s level of functioning will determine the intensity and length of time that case management services will be provided to the client.”

The workgroup developed the following list of primary case management functions for consumers of public-sector behavioral health services in Connecticut:

“assessment: determining an individual’s strengths, needs, preferences and risk factors;
planning: developing, with the consumer, a comprehensive service plan, with achievable goals and realistic time lines, which addresses all aspects of the individual’s life;
linking: referring individuals to all required substance abuse and mental health services as well as other community supports;
monitoring: continually evaluating, with the consumer, his or her progress and ongoing appropriateness of services;
advocacy: interceding to assure equity for the individual and for any larger group or class to which the client belongs and linking the client to consumer advocacy groups;
crisis prevention and intervention: identifying triggers for and/or symptoms of relapse, early intervention to prevent further setbacks for the client; and
pro-active outreach: contact with the client, as needed, at a variety of sites in the community.”  

As the case management workgroup was developing the above materials, the DMHAS managed care program was developing its care and case management model for certain GA clients. Care and case management would be reserved for SAGA recipients who had experienced multiple admissions to detox and inpatient psychiatric hospitals. While the development of the case management definition and functions listed above occurred independently from the managed care initiative, the workgroup reviewed the documents produced for the managed care case management initiative to ensure that the material reflected a shared vision. The statewide workgroup included some of the principles outlined by the managed care department in its development of the following ten “Guiding Principles of Case Management” for consumers of public-sector behavioral health services in Connecticut:

1. The intensity of services and frequency of contact is based on the client’s level of functioning as described in the level of care criteria.
2. Case managers assist their clients in obtaining basic supports needed to improve the likelihood of recovery.

3. Creative problem solving and advocacy are essential in helping clients access a system that may not be responsive to their particular needs.

4. Success in working with clients is dependent on a positive working relationship.

5. Collaboration between case managers and other clinical professionals is essential.

6. Case managers provide services according to an overarching treatment strategy consistent with the treatment plans of individual providers.

7. Case managers work with clients to help keep clients engaged in treatment.

8. Coexisting problems such as chronic homelessness, medical problems and legal problems are typically experienced by consumers of case management services.

9. Crisis/relapse prevention and intervention is a focus of case management.

10. Case management programs must recognize the importance of natural support systems for consumers. They should honor the requests of consumers to be discharged from services when consumers have developed and freely participate in support systems that have not been imposed on them.83

DMHAS defines care management as “the process of coordinating the client’s treatment at critical junctures as her or she moves through the various levels of care.”84 It is intended to assure that the client is admitted to the most appropriate level of care, i.e., the lowest level of care at which the treatment objective can be met. Care management demands collaboration on the part of treatment providers to collectively strategize service planning, i.e., developing an “overarching treatment strategy” among multiple providers, ensure smooth transitions among levels of care, and to decrease the likelihood of clients dropping out of treatment.

As part of its current managed system of care for GA behavioral health clients, DMHAS, in September of 1998, implemented care and case management for SAGA recipients who had been experiencing multiple admissions to detox and inpatient psychiatric hospitals. Care and case management services are offered to consumers who
meet the eligibility criteria through the BHUs. The target population includes individuals “who cycle through acute behavioral health services without connecting with lower levels of care for continued treatment.”

The primary goal of providing care and case management to individuals on GA who experience acute treatment recidivism is to increase the client’s potential to succeed in rehab and their ability to function independently. In achieving this goal, DMHAS intends to decrease the GA client’s “overall recidivism within the treatment system.”

The care/case manager must work with the client to achieve the following objectives:

- Improve clinical linkages as a client transitions among levels of care,
- Provide holistic services to maximize the likelihood of a client’s success in treatment,
- Decrease the ineffective use of acute treatment services,
- Provide a system for tracking individuals who experience repeated admissions to acute services throughout their various treatment episodes,
- Ensure successful client treatment outcomes,
- Ensure the client receives the appropriate level of care in an appropriate treatment setting.

DMHAS has identified the following care management services:

- Assessment and referral to the appropriate level of care
- Intake appointment scheduling
- Review of treatment history
- Case planning with treatment providers to assure appropriate issues are being addressed in treatment
- Global treatment planning and notification of the AASO regarding specific treatment recommendations and the expected path of treatment through various levels of care
- Case coordination meetings for clients involved with multiple treatment providers and community supports
- Outreach and/or phone contact to acute service providers to participate in treatment and discharge planning with the client and provider
- Tracking participation in treatment through the ASO and with service providers
- Mediation and resolution with service providers of client related problems and obstacle to recovery

DMHAS has identified the following case management services specific to the BHU’s work with individuals on GA:
• Outreach and engagement attempts with clients in various community settings, including clients home, shelters, soup kitchens, etc.
• Service planning for non-clinical needs (e.g., housing and CEIP referrals)
• Assistance with arranging transportation to treatment and other community supports appointments
• Transportation to essential appointments when no other arrangement is timely or/and practical and such transport can be safely achieved
• Assistance and advocacy in accessing extant community support services
• Assistance in accessing urgent and standard BNP supports
• Face to face supportive counseling
• Referrals and contacts with culturally relevent organizations and individuals (including vocational providers, employers, housing agencies, landlords, healthcare providers, probation/parole officers, crisis intervention services, hospital emergency departments, family members, faith communities, etc.), as needed, to establish and maintain adequate community supports.  

DMHAS has recognized that cost savings can be achieved by providing care and case management services to designated GA consumers and reducing the use of acute services (these services are the most costly in the system). DMHAS intends to reinvest these in developing more extensive community support services, which comprise lower levels of care within the continuum, i.e., case management services, residential programming, and increased day and evening partial hospital programming.

The ASO works collaboratively with the BHU in operationalizing care and case management. As a central function in this process, the ASO must track clients who have experienced multiple admissions into acute services and provides a listing of these clients to the appropriate BHU. Once the BHU has verified the client meets the criteria for care and case management services, the BHU care/case manager is assigned to the client. The care/case manager’s interface with the ASO is essential in recommending authorization of admissions to levels of care within the system. Further collaboration with providers is essential, not only for the planning and delivery of services, but to ensure full utilization of BNP supports to assist the client in achieving their goals.
F. Future Plans

In addition to managing the behavioral health care of GA clients, DMHAS intends to transition other populations it serves to managed care. Over the past few years, Connecticut had intended to transition the behavioral healthcare of Medicare and Medicaid recipients (dually eligibles) to managed care via a carve-out that would be managed by DMHAS. Connecticut had convened a taskforce that included representatives from DSS and DMHAS to study the possibility of obtaining an 1115 waiver from HCFA. Connecticut decided in early-1999 that it would not pursue application to HCFA for a waiver. This decision was made because of the burdensome tasks associated with obtaining and operating programs under HCFA waivers and, as previously discussed, new provisions in the BBA of 1997 allow states to bypass the waiver process by submitting a state-plan amendment to HCFA. By utilizing the state-plan amendment option, Connecticut can secure indefinite approval for their managed care plan rather than the two-year approval issued under a HCFA waiver.

"[Connecticut is] researching now what [approaches] will require a waiver and what won't. I think that the direction we're going in is to gradually incorporate different segments of the Medicaid population into managed care. The dually eligibles (the disabled) and those in long-term care are the larger groups... It is absolutely the goal of the Department to manage the Medicaid dollars for the majority of clients we serve. But, we're not exactly sure which Medicaid populations we're looking for. It will take legislative initiatives to accomplish this. The legislature will decide what parts of Medicaid we get. We don't know for sure."

DMHAS has been preparing to serve additional populations under Medicaid using a regional approach. Toward this end, it has asked all of its funded mental health and addiction services programs to collaboratively form, under guidelines offered by the Department, Integrated Service Systems (ISSs) in each of the five DMHAS regions. To
date the regions have added various structures under this initiative, e.g., a central access unit for all publicly behavioral health services in Region I, and a formally incorporated administrative entity to managed ISS concerns in Region II (and others as well in each of the regions). What remains to be seen is how the various regional structures of an ISS will transition the behavioral healthcare of Medicaid recipients to managed care. To date, the Department has left important specific elements of such systems to each of the regions to explore. These elements include: the degree to which ISSs wish to control their managed care programs versus delegating the operations to an MBHO; models of interfacing with MBHOs (ASO or MCO); and funding arrangements, i.e., risk, capitation, etc.

Regardless of the specific direction Connecticut takes in transitioning the behavioral healthcare services of Medicaid clients to managed care, DMHAS’s initial trial with the GA program will provide useful experience and data in making this transition. Additionally, the ISSs are poised to provide regionally managed and integrated systems of public-sector mental health and addiction services.

References

1 Connecticut first began publicly funded addiction and prevention services through the Connecticut Alcohol and Drug Abuse Commission (CADC). In 1993 CADAC was dissolved as an autonomous entity and its operations were merged into the Department of Public Health (DPH) which then became DPHAS.
2 Connecticut Department of Mental Health and Addiction Services, Local Mental Health Authority Contract. (May 1994)
3 The admission criteria for mental health services, specified earlier by DMH and now DMHAS, reference major disturbances in thought (thought disorders) and mood (affective disorders) by the “Diagnostic and Statistical Manual for Mental Disorders, Fourth Edition, Revised (DSM, 4-R), as schizophrenia, schizoaffective disorder, bipolar disorder, or major depression. While not all individuals eligible for services have one of these exact diagnoses, the majority do, or receives a closely related diagnosis.
4 GA recipients also received a cash benefit, but it was eliminated by the legislature effective July 1, 1998. Beneficiaries who receive services under the new initiative are eligible for supports offered through the
Basic Needs Program (BNP) set up by DMHAS in July 1998. BNP supports are provided, as approved on a per case basis, to clients who are participating in treatment within the DMHAS system and make requests for specific, time limited assistance. Examples include help in paying for transportation, rent, clothing, etc. BNP is discussed in greater detail below.

5 Department of Mental Health and Addiction Services, DMHAS General Assistance Managed Care Program, Legislative Report. (October 1997): 4.

6 Ibid., 5.

7 Ibid., 2.

8 The eleven towns included Bridgeport, Danbury, Hartford, Manchester, Meriden Middletown, New Britain, New Haven, Norwalk, Stamford, and Waterbury.


10 Norwich was the only town that elected to use the political process to allow itself to continue to administer GA benefits.


13 Ibid., 3.

14 Ibid.

15 Ibid., 7.

16 Ibid., 7-8.

17 Ibid., 8.

18 ABH served as a contracted “fiscal intermediary” to pay claim related to services provided in an “institution for mental diseases,” and room and board charges for residential substance abuse treatment.


21 Ibid., 3.


23 The State Board for Mental Health and Addiction Services is an advisory board to the Commissioner of DMHAS and had been established by legislative statute. It was originally developed as the “State Mental Health Board,” prior to the incorporation of addiction services into the Department of Mental Health. The State Board is comprised of an equal number of members of the state’s five regional mental health boards. While the Board’s composition includes some providers of services, it is largely made up of general citizens, consumers, and family members of consumers. The “Transitional Advisory Committee” is a committee of the State Board that has been established to advise the Board on how to best transition from a board which had represented mental health interests to one which represents both members of the mental health and addictions communities.


28 Ibid., 2.


31 Ibid., 12.

32 Ibid., 16.

33 Ibid., 24.

34 In situations where a client is involved with the Superior Court, i.e., court-mandated treatment and court stipulated conditions of probation, the ASO is to utilize the criteria established in the contract in the
authorization of care. The ASO is expected “to work collaboratively with the Department as it communicates with the court system to examine the appropriateness of commitments, the potential of offering more efficient alternatives, and the development of specific alternatives for the court to consider.”


In reviewing discharge plans, the ASO is to consider “relevant biopsychosocial domains”, which must at least include social and vocational rehabilitation, housing and referral to self-help groups. Personal Service Agreement between ValueOptions and the Department of Mental Health and Addiction Services, (5 August 1998): 22.

The ASO contract references the Connecticut Client Placement Criteria (CCPC) and the “Clinical Protocol for Levels of Care for Mental Health.” These are distinct and more substantive documents than the summary version referenced earlier, and are the actual documents to be used by the ASO in performing UM. The ASO must assist DMHAS in its ongoing efforts to review and modify these documents when necessary.


An addictionologist is defined in the contract as “a physician with specialized training in addiction medicine and who is certified by the American Society of Addiction Medicine (ASAM).” Personal Service Agreement between ValueOptions and the Department of Mental Health and Addiction Services. (5 August 1998): 7.


74 Ibid., 9.
75 Connecticut Department of Mental Health and Addiction Services, Basic Needs Program, Provider Guidelines. (June 1998): 5.
76 Because the budget has allowed and the needs have warranted, has been modified recently to $100. Paul Zakarian, interview by author, Manchester Connecticut, 13 March 1999.
77 Ibid.
79 Ibid.
80 Ibid., 6.
82 Ibid.
83 Ibid., 1-2.
85 Ibid.
86 Ibid.
87 Connecticut Department of Mental Health and Addiction Services, General Assistance Program Behavioral Health Unit (BHU) Operating Policies. (November, 1998)
88 Ibid.
89 Ibid.
Approaches in Other States: Iowa, Montana and King County, Washington

While Connecticut has been testing the waters with an ASO arrangement, the application of managed care to various components of public-sector mental health and addiction services has occurred in nearly every state. Medicaid has emerged as the initial vehicle for managed mental health and substance abuse services.

"Medicaid was the first to go online with [managed] general health services. Once this was under control, Medicaid authorities began to look at other services, e.g., behavioral health services. So Medicaid agencies were the ones who initiated development and design of the mental health carve-out."

"Medicaid is the largest source of funding for managed care programs." In nearly one third of all Medicaid programs, the state mental health and/or substance abuse authority either is the lead agency or shares responsibility with Medicaid for administering the program. Compared to the general population, a greater proportion of Medicaid beneficiaries has serious and persistent mental illness. Five percent of the Medicaid population consumes forty-three percent of the dollars spent on mental health services. Clinical and support services for such individuals tend to be more intensive and flexible than for individuals who do not have serious mental illness. This population “doesn’t simply require episodes of care, but instead, long-term support to ensure proper recovery.”

Nearly one hundred public-sector managed behavioral health programs are in place in forty-seven states. Forty-six are integrated health plans (general medical plans are combined with behavioral health). The remainder are “stand-alones” (not associated with medical plans) or carve-outs (behavioral health services are managed separately...
from general medical plans). Some of the carve-outs are partial carve-outs (only specialty mental health and/or addiction services are managed separately from general medical plans). In twenty-seven states the contracts are with private-sector organizations. Of the non-integrated plans (stand-alones, carve-outs and partial carve-outs), over half are managed by public-sector agencies or public/private partnerships.

Private corporations manage most acute mental health and substance abuse services while public/private partnerships manage most specialty long-term services. Typically, managed care entities, including public-sector agencies, are paid on a capitated basis, while most providers are paid on a fee-for-service basis. However, when a service provider acts also as the managed care entity for those services, it is paid through capitation. Over one-third of the programs specific to mental health include coverage for residential, crisis, rehabilitation and support services. While the original trend had been toward privatization, the current trend favors a combination of public and private ventures.

“I think you will see an increase over the next few years of the public-sector managing more programs. Better partnerships are happening, and this will be the model that is used. They [the states] don’t want to have their program be a give-away to the private sector for them to manage.”

While some state mental health and addiction agencies are performing utilization management activities, those agencies do not perform claims payment without the assistance of an MBHO. MBHOs have been involved in every state operating programs in a truly managed care environment, i.e., utilization management integrated with claims payment. Iowa, Montana and King County, Washington have been selected for review within this paper, because those regions represent a range of managed care structures and funding mechanisms, and have achieved varying levels of success. In discussing the
three approaches taken in implementing public-sector managed care programs, the following topics will be considered: contextual data for each state, populations served through state implemented managed care programs, administrative structures of respective plans, including waiver(s) obtained from HCFA, and the financing of the states' plan.

IOWA

In March of 1995, Iowa began managing its public-sector mental health and substance abuse services for mental health consumers and for individuals with coexisting disorders (mental health and substance abuse) through its Mental Health Access Plan, a statewide, mental health stand-alone serving individuals on Medicaid. In September of 1995, Iowa began to manage the substance abuse services for those who do not suffer from mental illness through the Iowa Managed Substance Abuse Care Plan, a statewide, substance abuse stand-alone serving both Medicaid and non-Medicaid individuals. Mental health consumers not receiving Medicaid could seek eligibility under the Iowa County Program. These three plans are discussed in greater detail below.

**Mental Health Access Plan**

Iowa's Department of Human Services has contracted with a private MBHO to administer the Mental Health Access Plan. In 1994, DHS awarded a two-year contract to Medco Behavioral Care Corporation, which later became Merit Behavioral Care Corporation. At that time, Merit was the second largest MBHO in the industry; it has since merged with Magellan Health Services, currently the nation’s largest MBHO. The plan was implemented on March 1, 1995.
The 1915(b) waiver Iowa obtained from HCFA has allowed the state to enroll, on an involuntary basis, adults and children who are Medicaid beneficiaries into the Mental Health Access Plan. This plan targets all individuals who receive Medicaid related benefits, including:

- Aid to Families with Dependent Children (AFDC) or Temporary Assistance for Needy Families (TANF).
- Social Security Disability Income or Supplemental Security Income.
- Both Medicaid and Medicare (dually-eligibles).
- Pregnant women up to 185% of the federal poverty level.
- Infants under 1 year old, up to 185% of the federal poverty level.
- Children ages 6 to 18, up to 133% of the federal poverty level.  

The Department of Human Services' contract with the MBHO to run the Mental Health Access Plan is on a prepaid fully-capitated basis. The capitation rate has been set at eighty-six percent of the cost of Iowa's fee-for-service program. This includes the provision of services, claims payment and other administrative costs. Providers are not at risk and are paid on a previously negotiated fee-for-service basis. Of the amount saved in a given year, approximately one million dollars are reinvested in community-based care to target individuals who use the most intensive services. Of the remaining funds, after the provision of direct services and the reinvestment, eighty percent goes back to the state and twenty percent is kept by the MBHO as profit.

Iowa's carve-out for Medicaid mental health was the second statewide mental health carve-out in the country. When the initial contract with the MBHO was developed, no performance indicators were included. DHS officials did not realize the importance of performance indicators until nearing the end of the first year; and by way of a mutually agreed upon (between DHS and the MBHO) "attachment" to the initial contract, performance indicators were added.  

Added performance indicators included:
Penetration rates—the MBHO would provide services to at least 5% of enrollees per month, on average, and to 15% of enrollees within the contract year.

Functional improvements—a clinical outcomes assessment scale would be developed and implemented to measure functional improvement for a sample of enrollees who have used services under the plan.

Consumer satisfaction—85% of respondents will indicate “some degree of satisfaction” with services they received.

Timeliness with the provision of services and claims processing.

Claims denied as a result of MBHO errors.\textsuperscript{16}

Other performance indicators not yet negotiated between DHS and the MBHO at that time included measures based on authorizations to reflect monthly utilization, measures of collaborative treatment planning conferences, and measures to monitor consumers’ ability to function in the community.\textsuperscript{17}

SAMHSA reported the following outcomes in the Iowa mental health stand-alone.

Time-periods range from prior to implementation of the 1915(b) waiver to one year out (year-one), and to two years out (year-two):

- Inpatient hospitalization (length of stay), before the waiver 11.8, decreased in year-one to 6, and in year two to 5.
- Inpatient hospitalization (readmissions), before the waiver 25.5, increased in year-one to 29.5, and decreased in year-two to 24.6.
- Under the MBHO’s reinvestment program, thirty special projects were funded.\textsuperscript{18}

Nearly one year after operation, DHS and the MBHO reported “having achieved much… to take pride in. Perhaps the most important accomplishment to date is improved access and a related decrease in inpatient length of stay.”\textsuperscript{19} They noted an increased access rate from 5.5% prior to implementation to 7% post implementation.\textsuperscript{20}

The MBHO, in an attempt to enhance community based treatment and community support services throughout the state, asked existing providers to submit proposals for expanding their array of services, including alternative services.\textsuperscript{21} Applications were submitted to provide community support services, including twenty-three hour in-home
observation, sub-acute care, therapeutic foster care, mobile crisis intervention and both in-home and out-of-home respite services.\textsuperscript{22} The results of the initiative, in terms of services offered prior to the implementation of the Mental Health Stand-alone and afterward, were as follows:

**Services pre-implementation**
- Inpatient
- Outpatient
- Partial Hospitalization,
- Day Treatment
- Services of psychiatrists and psychologists\textsuperscript{23}

**Services post-implementation:**
- Outpatient
- Partial Hospitalization
- Day Treatment
- Services of psychiatrists and psychologists
- Twenty-four hour observation
- Intensive outpatient
- Community support
- Mobile crisis intervention
- Residential treatment
- Group home
- Therapeutic foster family
- Respite
- Home-based care
- Crisis stabilization\textsuperscript{24}

The MBHO and DHR concluded:

"It should be noted that this [the increase in the array of services offered] has been done at a savings of 14\% from projected traditional fee-for-service costs, translating to $6 million in savings per year in state and federal funds. Additionally, in the first patient satisfaction survey, 86\% showed satisfaction with [the Mental Health Access Plan]... Prior utilization of services, particularly inpatient services, was a function of what was available. Creating alternative services takes time and resources, but if done properly, is worth the investment... Inpatient utilization has decreased, access to services has increased and the Mental Health Access continues to focus on the high-need patient population, which benefits most greatly from these services."\textsuperscript{25}
By the beginning of year-three of the Mental Health Access Plan—from March 1, 1997 to February 28, 1998—Iowa had developed an impressive range of sixty performance indicators and outcome measures. The indicators fell within four broader categories:

1. *Consumer Involvement and Quality of Life* – 8 indicators
2. *Access and Array* – 16 indicators
3. *Quality and Appropriateness* – 18 indicators
4. *Integration and Interface* – 18 indicators

**Iowa Managed Substance Abuse Care Plan**

At the contracting level, the Iowa Managed Substance Abuse Care Plan integrated the SAMHSA federal block grant funds administered by the Department of Human Services with the Medicaid funds administered by Department of Public Health. Together, the Department of Public Health and the Department of Human Services contracted the same MBHO operating the Mental Health Access Plan to run the Iowa Managed Substance Abuse Care Plan. The plan was implemented on September 1, 1995.

As with the Iowa Mental Health Access Plan, the 1915(b) waiver Iowa obtained from HCFA has allowed the state to enroll, on an involuntary basis, Medicaid beneficiaries into the Iowa Managed Substance Abuse Care Plan. This plan serves all individuals who receive Medicaid benefits, including:

- Aid to Families with Dependent Children (AFDC) or Temporary Assistance for Needy Families (TANF).
- Social Security Disability Income or Supplemental Security Income.
- Both Medicaid and Medicare (dually-eligibles).
- Pregnant women up to 185% of the federal poverty level.
- Infants under 1 year, old up to 185% of the federal poverty level.
- Children ages 6 to 18, up to 133% of the federal poverty level.
For Medicaid beneficiaries, the substance abuse stand-alone, as in the mental health stand-alone, operates on a prepaid fully-capitated basis. The capitation rate is set at eighty-six percent of the upper limit of the 1994 fee-for-service cost. Within this plan, providers also assume no risk and are reimbursed on a fee-for-service basis for services rendered. For non-Medicaid beneficiaries who meet specified eligibility criteria, the substance abuse stand-alone provides services on a standardized sliding-scale fee basis, based on income and family size. For services provided to this population, however, the providers are at risk; though the state does pay a monthly allocation to providers to deliver these services.

In June of 1997, nearly two years after implementation, Iowa State University conducted an independent assessment of the impact of managed care on the substance abuse stand-alone. The following conclusions were reached in this evaluation:

- The number of inpatient detox admissions decreased.
- The number of clients receiving outpatient services increased greatly.
- The clients of the stand-alone were more likely than fee-for-service clients to continue substance abuse.
- Satisfaction remained high, but did not differ significantly from the fee-for-service system or from medical services received through Medicaid.
- Focus groups indicated that the substance abuse stand-alone had increased the range and proximity of services, broadened the client base, implemented improved assessment criteria and developed quality pilot programs.²⁸

**Iowa County Program**

In 1996, Iowa had passed legislation mandating each of its ninety-nine counties to implement managed care programs for Medicaid ineligible adults with mental illness, mental retardation, and/or developmental disorders. New eligibility criteria was set forth in the county plan, but varied from county to county. Now each county would manage and fund services through a Central Point of Coordination (CPC). Both for-profit and
nonprofit organizations could serve as the CPC. The CPC, or its designated entity, has
been established to perform all UM activities. Counties have employed a number of
different models to implement CPCs, including: contracting with an MBHO in Cerro
Gordo County; contracting with other management entities to perform CPC functions in
other counties; and implementing CPCs that perform UM in the remaining counties.
Counties have established a provider network or “lead agencies,” which are nonprofit
consortia of providers who, under contractual arrangements, agree to provide necessary
services to enrollees. 29

A New Plan for Iowa

In March of 1998 Iowa released a final draft of a new plan, the Iowa Plan for
Behavioral Health, beginning January 1, 1999. Under this plan, the Department of
Human Services and the Department of Public Health were given responsibility for
overseeing and monitoring the program. Iowa’s intention has been to serve all
populations previously served by the Mental Health Access Plan and the Iowa Managed
Substance Abuse Care Plan, through a decentralized, regional approach. The program
has integrated Medicaid mental health and substance abuse services into one carve-out.
Annual funding in the five-year contract included $65 million from Medicaid and $15
million from state general funds and federal substance abuse dollars to cover individuals
not on Medicaid. 30 In this contract, Iowa has added an additional eight performance
incentives and ten measures that carry financial penalties. 31

“Financial rewards are given if:

- Consumers participate in at least 96% of joint treatment planning conferences;
- Average time between hospitalizations doesn’t fall below 60 days;
- No more than 20% of children’s inpatient admissions and 15% of adult admissions are involuntary;
• Claims are paid (services are delivered) for at least 15% of plan enrollees;
• At least 2.5% of all service expenditures are for integrated services and support;
• Emergency room presentations fall below 8.5 per 1,000 enrollees;
• More than 90% of patients discharged from inpatient settings receive follow-up care within seven days;
• At least 90% of all inpatient discharge plans are implemented.”

Financial penalties are assessed if:
• Program information isn’t sent to new enrollees within 10 working days;
• Fewer than 86% of discharged patients have documented discharge plans;
• More than 3% of children discharged from inpatient settings go to shelters;
• Fewer than 85% of enrollees denied inpatient admission after an emergency room visits are contacted by the vendor within 72 hours;
• Fewer than 20 treatment planning conferences per month are arranged or participated in by the vendor;
• Fewer than 90% of mental health providers in the past program’s network are in the new network;
• Fewer than 85% of substance abuse providers in the past program’s network are in the new network;
• Less than 85% of claims are either paid or denied within 14 calendar days of receipt, less than 90% in 30 days and 100% in 90 days;
• The vendor takes more than 60 days to certify or not certify a provider applying for network status;
• Provider manuals aren’t provided within 30 days.  

MONTANA

Montana has also implemented a mental health stand-alone, but unlike Iowa provides no managed substance abuse program. Substance abuse services covered by Medicaid remain fee-for-service. The program pools together multiple funding streams: Medicaid, general revenue, state hospital funding and mental health block grant dollars. The Department of Public Health and Human Services’ Addictive and Mental Disorders Division (DPHHS-AMDD) contracts with a private MBHO, Magellan Health Services, to
administer the Mental Health Access Plan. The contract is a five-year, $380 million
dollar contract.

Montana submitted its waiver application to HCFA in May of 1996 and began
implementing its Mental Health Access Plan in April of 1997. Again, the 1915(b) waiver
the State has obtained from HCFA allows the state to enroll, on an involuntary basis,
adults and children who are Medicaid beneficiaries into the Mental Health Access Plan.

This plan serves all individuals who receive Medicaid benefits including:

- Aid to Families with Dependent Children (AFDC) or Temporary Assistance for
  Needy Families (TANF).
- Social Security Disability Income or Supplemental Security Income.
- An optional expansion for pregnant women and children.
- Both Medicaid and Medicare (dually-eligibles).
- State residents up to 200% of the federal poverty level.\textsuperscript{33}

The plan also serves adult residents who are not on Medicaid and who suffer from
severe and persistent mental illness (SPMI) and children with severe emotional
disturbance (SED). Individuals must meet criteria specified by the State to be considered
part of these target populations. Services through the Mental Health Access Plan include:

- Inpatient psychiatric hospitalization.
- Outpatient evaluation and assessment.
- Crisis, e.g., emergency services 24 hours per day, 7 days per week.
- Residential services.
- Rehabilitation services, e.g., individual, group and family therapy.
- Other support services.\textsuperscript{34}

DPHHS-AMDD contracts with the Montana Community Partners (MCP), a coalition
of mental health providers, and the MBHO (Magellan Health Services) to run the Mental
Health Access Plan on a prepaid fully-capitated basis. The capitation rate is based on a
five percent reduction from what these services are estimated to have cost historically.
The amount includes the provision of services, claims payment and other administrative
Montana pays MCP a capitated rate for specified mental health Medicaid services and a fixed sum for the federal mental health block grants and general revenue, mental health dollars (including the Montana state hospital dollars). This funding is integrated at the contract level with MCP. Providers are not at risk and are paid on fee-for-service basis. The MCP can retain fifty percent of the costs saved in a given year before Magellan takes a profit. Magellan’s profits, under this contract, are tied to its performance as assessed by the State: inadequate – 0%, adequate – 2.5%, good – 5%, and superior – 7.5%. However, no profit has been earned to date, and the carve-out has experienced significant losses. In its first year of operation, April 1, 1997 through March 31, 1998, the plan lost $15.7 million, and as of September 1998 Magellan was continuing to sustain losses of approximately $1 million per month.

The Managed Care Access Plan has been plagued by problems since its implementation began. In September 1997, HCFA conducted a review of the plan. HCFA summed up “key recommendations” to “put the implementation and oversight of the Mental Health Access Plan on a productive path.”

2. The State must share with HCFA key information related to the waiver.
3. The State should develop a contingency plan in the event of contractor failure.
4. ...[MCP and the MBHO need] to immediately implement strong measures to assure effective and timely claims processing. The State must monitor this closely and aggressively to ensure MCP’s adherence to the proposed corrective action plans.
5. The State must obtain an understanding of the roles of the various entities involved and make that information public.”

Although HCFA described each of these recommendations as serious, the first two were seen as critically important in that “they threaten continuation of the waiver if the State is found to be in noncompliance.” The HCFA Northwest Regional Administrator
placed particular importance on the State’s lawful obligation to oversee the contract and
the first recommendations:

Even though MHAP is implemented through a contract between the State
of Montana and Montana Community Partners, the State retains
responsibility for ensuring compliance with that contract. The State is not
relieved of its responsibility under 42 CFR 431.10 to administer or
supervise the administration of the plan by virtue of the waiver."40

In addition to monitoring the waiver, HCFA expressed its intent to make
necessary resources available to the State to provide technical assistance. The report did
not mince words concerning the gravity of its findings. “Our current assessment of the
implementation of the waiver is that the waiver is currently in jeopardy of not being
renewed.”41 HCFA characterized the State’s monitoring efforts during the first six
months of implementation as “passive,” asserting that the State relied too heavily on
reports from MCP and its technical assistance consultants, HMA. HCFA concluded that
the State had insufficient staff and resources to conduct effective monitoring. HCFA
noted that the State had been more proactive in ensuring MCP’s completion of a number
of key items, but that these monitoring efforts and attempts to ensure contract compliance
should have occurred at implementation.

“Only more recently has the State taken a more proactive and assertive
stance with MCP in requiring the completion of key items that should have
been in place at the start of the waiver. While the State is to be
commended for its recent actions in demanding corrective action plans
with definitive timelines and the withholding of a portion of the capitation
payment as an incentive to ensure compliance, the State is at fault for not
taking a more active role initially to ensure effective implementation of
MHAP. Earlier monitoring could have exposed systemic problems and
led to earlier corrective action plans and resolution of the problem.”42
HCFA concluded that Montana’s failure to monitor the contract effectively created an adversarial relationship among providers in the managed care program that would be very difficult to repair:

“The lack of monitoring and the negative publicity surrounding the six months of MHAP implementation has had damaging consequences for the relationships between the providers, the State, and MCO. In addition to the monitoring plan, HCFA recommends that the State and MCO collaborate to design and develop a program to build the necessary goodwill with the State’s providers. Managed care will not work effectively with adversarial and distrustful relationships.”

Concerning the second recommendation listed above, HCFA admonished the State for not informing it of the decision to stop payment to MCP for failing to adhere to contractual mandates:

“HCFA is unable to fulfill its responsibility without full cooperation of the State...in providing HCFA with current and continuing updates to implementation and contract administration. ...[Staff of the Northwest Regional Office, Region VIII] are answerable to HCFA’s top administration officials at our Baltimore headquarters as they are to Administration officials at the highest levels in Washington. We absolutely must have current information at all times. This is a particularly critical mandate for the State to understand. MHAP is a controversial, politically sensitive, high profile waiver program that’s been under attack by the public, media and others since implementation. The State’s failure to inform HCFA of its decision to withhold program capitation payments to MCP/CMG was inexcusable.”

HCFA’s third recommendation concerns the development of a contingency plan should it be determined that a contractor has failed to comply with the State’s requirements or the terms of the waiver. The State was given until January 31, 1998 to develop this plan; the HCFA report was sent to them on December 8, 1997. The contingency plan would need to determine whether the scope of the contract was being reduced, an alternative model was being planned, or if the State planned to revert to a Medicaid fee-for-service system. Should MCP or one of its major components opt out
of the contract, the contingency plan would also be necessary. The contingency actually
may have been needed in September of 1998, when officials from Magellan informed the
Governor of Montana of their intentions to terminate the MHAP contract unless the
program’s current financial situation improved within thirty days. Under the terms of the
contract, Magellan was required to give a one hundred eighty-day notice if it intended to
terminate the contract.\textsuperscript{46}

HCFA’s fourth recommendation was based on claims processing backlogs
erperienced during the first six months of operation. HCFA noted that as a result of
unpaid claims, relationships with providers were “severely undermined.” This “directly
impacted access for consumers, as some providers have disenrolled from the program,
resisted enrolling, or struggled financially to the point of cutting caseloads and
staffing.”\textsuperscript{47}

In July, 1998 SAMSHA noted that DPHHS had sought the technical assistance of
a consulting firm that helped develop an “operational plan... with specific deliverables,
deadlines, and financial penalties” to help resolve these problems.\textsuperscript{48} In further attempts
to salvage the plan, DPHHS was seeking increased funding totaling $12.7 million for the
2001 biennium ($8.3 million in federal Medicaid funds and $4.4 million in state general
funds). The rationale for increasing funding included the “anticipated caseload increases,
provider rate increases, and an anticipated revision (in the State’s favor) of the federal
medical assistance percentage rate.”\textsuperscript{49}

In February of 1999, the Montana Joint Appropriations Subcommittee on Human
Services, a powerful legislative subcommittee, decided to cancel the Mental Health
Access Plan.\textsuperscript{50}
Magellan Health services, Inc., the managed behavioral healthcare giant whose covered lives swelled to more than 60 million during the consolidation frenzy of 1997 and 1998, is on the verge of losing its much-debated contract for Montana's mental health carve-out... [This decision] marks a first for the behavioral health industry... The action... has strong backing from the rest of the state legislature...

The Joint Appropriations Subcommittee, through language attached to the state appropriations bill, "would terminate the contract no later than November 1, when funding for the carve-out program would end." The funding for this program in the fiscal year commencing July 1, 1999 was set at $77 million. But state officials have conceded that the program "under its original design" was under-funded by approximately $11 million a year. With both Magellan and state officials agreeing on a mammoth deficiency, one which exceeds fourteen percent, Montana's apparent failure in this program was inevitable. An additional constraint faced by Montana in designing its program was an unreasonable design/implementation timeline. When CMG Health, Inc. was originally awarded the carve-out contract, it had less than five months to meet the April 1, 1997 start-up date.

In an attempt to diminish monetary losses, Magellan has sought more stringent eligibility criteria for its program and has imposed a series of significant reductions in rates paid to providers. Both changes were to have occurred in March and April 1999. The legislature is now focusing on a decentralized approach to managing care and is preparing to introduce legislation requiring DPHHS-AMDD to develop a regional managed care system that would cede control to local providers. Regardless of what new models materialize over the next six months, the legislature has no interest, as presented by one state senator, in continuing to do business with Magellan. "Magellan has zero votes out of 150 Montana legislators to continue this contract. And that's the reality the
executive branch needs to understand." However, according to its president and chief operating officer, Magellan is willing to continue as an ASO or to assist in the transition to a new program. At the end of February, the appropriations subcommittee obtained copies of the contracts used in Maryland, Massachusetts and Connecticut “to examine how an ASO might function under the new system.”

In light of both espoused intentions of state lawmakers and million-dollar monthly deficits, Magellan invoked its “contract exit clause” in late March of 1999. Magellan and state officials agreed to terminate their five-year, four hundred million-dollar contract for the Mental Health Access Plan, with Magellan’s last day for assuming risk falling on May 1, 1999, and its last day as program manager to be June 30, 1999.

Montana is now planning to institute a "regional managed care system," with a projected start-up target between February and July 2000. On June 4, state officials intend to release an RFP. More MBHOs will likely be back in Montana as bidders; for the plan calls for MBHOs to work with provider organizations to establish regional contracts.

**KING COUNTY, WASHINGTON**

The Washington State Legislature enacted the Mental Health Reform Act of 1989, which shifted responsibility for mental health services from the state to county operated mental health authorities, called Regional Support Networks. Most of the counties achieve mandates with no assistance from private-sector corporations, while two counties have enlisted private MBHOs to assist them. Substance abuse services provided to Medicaid recipients are managed by the Division of Alcohol and Substance Abuse and are not part of the managed care program.
The second phase of mental health reform in Washington occurred when HCFA granted a 1915(b) waiver to Washington to establish an Integrated Community Mental Health Program. The State Department of Social Services’ Mental Health Division, which administers the integrated Community Mental Health Program, has contracted with fourteen Prepaid Health Plans that are Regional Support Networks, and is responsible for overseeing and administering the statewide system. In this capacity the State Mental Health Division “sets policy, ensures an accountable system, defines covered lives and minimum services, licenses providers, sets performance standards and outcomes, ensures maximum amount of services and operates state hospitals.”

This plan serves all individuals that are uninsured and underinsured, as well as those who receive Medicaid benefits, including:

- Aid to Families with Dependent Children (AFDC) or Temporary Assistance for Needy Families (TANF).
- Social Security Disability Income or Supplemental Security Income.
- Categorically and medically needy.
- Optional expansion for pregnant women up to 185% of the federal poverty level.
- Children up to 200 percent of the federal poverty level.

Medicaid, federal block grant dollars and state general fund dollars are used to finance the Prepaid Health Plan. The federal block grant and state general fund dollars are used to operate emergency services, intake and to serve the general assistance population. Regional Service Networks are paid on full-risk, capitated basis. The rates were calculated individually for each network. “Savings are reinvested into a system for the creation of innovative programs to assist clients with mental illness.”

By Washington State Statute, “RSNs [Regional Service Networks] are designated as the single point of local responsibility for mental health services… [They are the] purchaser and manger of services.” The consumer and family involvement in the
networks, as specified in the contract, appears to be both substantive and impressive. The contract mandates that consumer majorities comprise the boards that operate the networks. “... 50 percent plus one consumer or family member will be represented...”  
Consumers and family members also have input through Regional Support Advisory Committees.

The State of Washington operates fourteen Regional Support Networks, six of which are multiple county, the remaining eight single county. The networks subcontract with providers to deliver services. King County is one of two counties opting to contract with an MBHO. King County selected United Behavioral Health as its ASO, a San Francisco based MBHO. King County’s Prepaid Health Plan is a managed system of care that replaces the former fee-for-service system. The plan “was designed to increase access to care, client satisfaction, administrative efficiency and create greater accountability for outcomes and quality.”

While the Regional Service Networks are responsible for Medicaid funds, in addition to monies from the state general fund, the State of Washington, in its first attempt to manage its public-sector managed care services, chose to start by having the networks manage outpatient care only. Perhaps King County could have begun more conservatively without the assistance of an MBHO in the design of its program. “However, a number of factors... influenced the County’s decision to go beyond what was minimally necessary and seek a private-for-profit managed behavioral health partner.” The population of King County, which includes Seattle, is 1.3 million, thirty percent of the state’s population. Its Medicaid beneficiaries and providers number more than any other county in Washington. As an urban center, King County is more racially
and ethnically diverse than other areas of Washington. The county has a significant
number of homeless individuals. The County Mental Health Department felt that the
provider network that it contracted with for the provision of nearly 100% of its services,
would not have the capability to continue delivering services well or “even survive in a
managed care environment” without the assistance of a managed care firm. 68

The King County Mental Health Department was intentionally general in its RFP
seeking the procurement of an MBHO. The Department left out specifics because it
wanted to work these details out collaboratively with the MBHO following its selection.

“Unlike most other RFPs, the role and functions for the firm to be selected
were purposefully general; the intent was to engage the firm selected in a
series of discussions that would identify what the major functions of the
managed behavioral health program would be, which of the parties...
[United Behavioral Health and the County] was best suited to do them and
how best to structure the relationship. The providers and community
advocacy groups were brought into the planning process early and
often.” 69

Once King County selected United as its ASO, the eight months leading up to the
startup date were characterized by intense negotiating and planning between the
Department and United. What emerged was a plan that allowed each entity, the
Department and United, to take responsibility for the part of the managed care system
that reflected their respective expertise. 70 United hired almost all its staff for the King
County operation locally. (County and United staffs work in a collaborative manner so
far as to share the office space.)

King County Mental Health Department responsibilities have included policy
development and planning, liaison to State government and retention of financial risk.
The Department has paid an administrative fee to United for its services. The transition
to managed care has required a revision of the Department’s “structure, organization, job
descriptions and duties.”

As the Department’s ASO, United has been responsible for: operating the system-
wide, toll-free access line; overall clinical management; overall customer services
management; holding the contracts with the providers; and operating the case-rate billing
and reimbursement system. As of April 1999, King County RSN Prepaid Health Plan
offers the following outpatient services:

- 24-hour crisis response
- Interpreter services
- Brief interventions
- Case management
- Psychiatric and medical services
- In-home services
- Employment/vocational services
- Homeless outreach and engagement
- Housing/residential services
- Day treatment
- Individual and group therapy
- Family therapy
- Psychiatric consultation to schools
- Medication management
- Cultural consultations and culturally appropriate care
- Education and training opportunities
- Consumer/advocate run services

The State of Washington had previously developed a three-tier system. The state
would pay each county the capitation rate for all eligible Medicaid beneficiaries living in
the county; but the state would be billed for clients who meet the criteria for levels two
and three. Prior to hiring United Behavioral Health, King County had developed a
method of paying for services using a modified version of the state’s tier system and case
rate payments. King County identified six levels of treatment intensity from its 1993 and
1994 service data. It then subdivided each of the States three tiers into two, creating a
six-tier system. The County then linked each tier to one of the service intensity levels. The criteria utilized to identify what tier a client fits into included psychiatric diagnosis as well as required service intensity.

Outcomes for 1998 were updated on April 14, 1999. In terms of access to services, the data reflect an increase in access to services over the previous two years. The data demonstrate a 5.8% increase in the 1998 monthly average of individuals served (children, adults and older adults). The 1998 monthly average of individuals served who were not on Medicaid rose 8.3%. The monthly average of clients served in 1998 was 22,398; 16,727 (74.7%) received Medicaid benefits. The 1998 monthly average for individuals on Medicaid who used services out of the total number of Medicaid recipients (the Medicaid penetration rate) rose 11.7%. The utilization data were also very positive. The total number of crisis outreaches was up 9.2% in 1998 while the total number of inpatient hospitalization days at the state hospital was down 4.2%.

At the present time, the King County Mental Health Division is planning two significant changes to its current system. The County now plans to assume the financial risk for individuals receiving publicly funded inpatient services; and the County is planning a merger between its mental health and substance abuse divisions. On April 7, 1999, the County publicized *Models for Inpatient and Outpatient Mental Health Service Integration in King County* and opened up a “Public Comment Period” from April 7-19, 1999. Within this document, the County Mental Health Division describes two models in detail, one that would utilize “two risk-bearing entities (non-geographically based),” and another that would utilize “one risk bearing entity.” “Neither model includes an ongoing role” for the ASO. “Regardless of which model is implemented,” the King
County Mental Health Division “intends to continue contracting with an ASO during the start-up period.”

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The Consumer's Role in Public-Sector Contracting

“Active involvement in the design, delivery, and evaluation of mental health services is a central tenet of the mental health consumer movement.”¹ The recovery movements for consumers of both mental health and addiction services have important implications for public-sector, managed behavioral health services.

Public-sector managed care can offer consumers significant improvements in the access to and quality of services. Thus, primary and secondary consumers of services (family members and significant others of persons with severe or persistent mental illness and/or long-term substance abuse needs) ought to play a contributing role in the development, implementation and monitoring of managed care contracts. SAMHSA, however, has concluded that this key group of stakeholders goes underrepresented.² Auslander, et. al., discuss the effects the consumer movement has had on the public-sector mental health services. The more salient of these include:

- “Enacting federal and state laws mandating consumer participation in state and local mental health planning activities.
- Recognizing consumers’ rights and establishing systematic procedures to protect these rights.
- Acknowledging the value of consumers as providers of services and developing and funding an array of consumer-run and other alternative services.
- Establishing offices of consumer affairs within many public mental health authorities.
- Creating positions for consumers on boards and committees that guide mental health organizations.
- Increasing awareness of the demonstrated value and importance of involving consumers at the individual, program, and systems level; and educating the public about the experiences of mental illness, its treatment, and the effects of stigma.”³
In order to advocate for adequate resources, consumers need to familiarize themselves with managed care financing structures and administrative processes involved in transitioning to managed care. Whether the transition from a fee-for-service and/or grant-in-aid system to managed care fosters improvement can be discerned in the design, implementation and monitoring of the managed care contract, as well as ensuring that adequate financial resources are in place to purchase high quality, necessary services.

Debates occurring today on how to develop and implement managed systems of care will profoundly affect how mental health and substance abuse services are delivered in the future. Public agencies that conduct an “open process” allow for consumer groups to become aware of their intentions to contract for managed mental health and/or substance abuse services early in the process. SAMHSA concludes that “in addition to the practical rationale and the moral imperative for including consumers in the contracting process, there are solid legal bases for such involvement, on both the state and federal levels” as well:

“Medicaid law requires State Medicaid agencies to form medical care advisory committees...[that] include consumers in their membership. Medicaid agencies must consult [with the committees] ...before implementing major policy or program changes, such as a shift to managed care for consumers with mental illness or drug or alcohol addiction. [Additionally,] the Public Health Service Act requires states to establish state Mental Health Planning Councils to review and provide recommendations to the state on its plan for spending federal mental health block grant funds and to ‘monitor, review and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state.’ If block grant funds are used to finance the managed care plan, the planning council should play a role.”

Consumers can ultimately become involved in pre-contract activities that allow them to participate in initial activities such as design. A critical concern at this stage of contract development for consumers is ensuring that, under the contract, adequate
resources will be in place for the provision of services. Since state and local
governments often rely on managed care companies primarily to save money, the
“consumers’ first priority is to ensure that the provision of a comprehensive system of care
is not compromised or lost.”

State mental health and addiction authorities and providers of services have been
wrestling, to varying degrees, for the past two decades on how to include consumers in
policy and planning as well as the provision of services. Akin to those of the African-
American, lesbian and gay, and persons with physical disabilities, the recovery
movement for persons with severe and persistent mental illness began in the 1960s.

“Mental health consumers began to make their voices heard to rectify the
injustices occurring in large state hospitals. Following
deinstitutionalization, they began organizing to protect themselves against
discrimination in employment and housing, medication abuses, and the
inadequacies in mental health services. Similarly, consumers of drug and
alcohol treatment services have organized to overcome stigma, increase
public understanding that addiction is an illness and not a moral or
character defect, and expand access to services for chemical dependence.
These empowerment efforts grow directly out of the origins of substance
abuse treatment in Alcoholics Anonymous and other twelve-step, self-help
fellowships.”

The strides which have been made in this arena must continue as corporate-sector
managed care companies play significant roles in developing policy and providing
services to public-sector clients.

The need for consumer employees to assist plan members is essential because of
the perspective they offer as individuals who have utilized services. At the forefront of
their concerns is consumer participation in service planning, alternatives to
hospitalization, the provision of transportation, respite services and the need for
individual counseling. Care and treatment philosophies must be centered on recovery.

Auslander, et al., summarize this perspective:

"...many consumers... embrace the view that recovery from psychiatric diagnoses [and addictions to alcohol and other drugs] is possible. Recovery is based on the goal and reality that people heal and go on to lead full lives integrated in their comminutes. Recovery is consumer-defined, consumer-centered, and consumer-driven. The belief that people can recover creates care and treatment that looks quite different from what is designed for people who are expected to remain ill... [Consumer driven] benefit packages and definitions of medical necessity would include a broad array of non-medical, support services such as education and career counseling, permanent housing, ...transportation...self-help, mutual support... rehabilitation services, outreach and crisis services, counseling services, medical services and adjunctive services such as housing and transportation."

Consumer driven services requires consumer oversight of state authorities as they develop budgets for their managed care plan. SAMHSA recommends that if the State is intent on decreasing the overall cost of mental health and/or substance abuse services, the consumer should strive for a cut that does not exceed five to ten percent of current spending levels:

"The goal is to set minimum funding for the managed care contract at a level that will not result in disastrous cuts in services and a poorer service system, from a consumer's point of view, than before."

Once a state has determined the direction and financial structure it will pursue, it will usually look toward how it will control spending or actually decrease costs. However, achieving a decrease in spending for the first year of a managed care contract, while improving quality of care and access to services, might not be possible. Consumers could stress long-term savings, a portion of which should be reinvested into the service system, rather than initial savings. While it is reasonable for the state to pursue cost-containment, the end product must not result in a reduced level and/or quality of
Managed care would most likely improve data reports and lead to a better understanding of true costs, which in the end could lead to more informed decisions on spending levels.

Outlined services in a managed care benefit package do not guarantee that consumers will have access to those services as they are subject to UM. UM focuses on “medical necessity” as the basis for making decisions on approving services. Since mental health and/or substance abuse services often include assistance that is not medical in nature, medical necessity is often referred to as “service necessity.”

Service necessity in public-sector mental health and/or substance abuse services must be broad enough to include services that support recovery including prevention, outreach and rehabilitation, for managed care cannot be successful if it eliminates these services based on the ground that they are not “medical.” The Bazelon Center for Mental Health Law in its series on Protecting Consumer Rights in Public Systems’ Managed Mental Healthcare Policy notes a disturbing trend occurring between states and managed care organizations in contracting as it relates to service necessity:

“Although states frequently provide detailed descriptions of a broad benefit package that covers a wide array of appropriate services, contracts generally provide little, if any guidance to managed care firms regarding appropriate decisions on the necessity of care. Some states have no definition at all of ‘medically necessary.’ As a result, managed care plans are deciding, with little or no public input, requirements or oversight, who will be served, how long they will receive services, which services they will receive and how much money will be spent on their care.”

When the state authority omits definitions of service necessity from its managed care contract, it abdicates its accountability to public-sector consumers of mental health and substance abuse services. “Even where the mental health [and/or substance abuse]
system has been privatized, the ultimate responsibility for its operation still lies with the public agency.” The state must create its own definition of service necessity, and should expect the managed care organizations’ implementation of that definition to include “more detailed and condition-specific criteria.” Therefore, states must require managed care organizations to make their rules and practice guidelines concerning service necessity available to both the state and advocacy groups. This will help to ensure that the plan’s operating criteria meets the state’s expectation concerning the provision of services as it relates to service necessity.

The Bazelon Center for Mental Health Law has produced a detailed guide to assist states in creating a definition of service necessity. The criteria includes: articulating the goals and purpose of services; defining the standard of service delivery; eliminating arbitrary limits, i.e., a maximum thirty outpatient visits or twenty inpatient days per year; implementing a process to determine when services are medically necessary; a process to link disputes to an appeal system for resolving grievances; and a process to impose sanctions on the managed care organization if the plan violates the requirements of the service necessity criteria.

Managed care has been criticized extensively for limiting choice. But, managed care organizations do emphasize choice, and in public-sector mental health and substance abuse services, “real choice has been rare.” In developing managed care contracts, states can introduce choices that are meaningful to consumers. Some managed care companies have endorsed a statement that consumers “shall have a choice of providers within a full continuum of network based services, including recovery and peer support programs.” The contract could contain provisions that facilitate consumer choice.
One area to focus on includes advance directives, including durable powers of attorney and/or appointment of healthcare agents or proxies, in which consumers state their intentions concerning the types and locations of treatment in the event they become incapacitated. Under these provisions, “managed care companies would require providers to refer to these documents in emergencies or when making treatment decisions.”

The managed care contract can require providers to ensure that services are aggressive and flexible enough to meet the needs of consumers who are homeless or incarcerated. Outreach must be in place for providers to make connections to homeless persons and individuals in jail, at soup kitchens, in shelters and in nursing homes. Rapid responses must be available to individuals who have often declined services but may be willing to become involved in treatment for a time defined period because of pressure from family, friends, employers, police or for reasons not apparent to providers. The contract could address this concern via a “provision that non-emergency assessments must be performed within a reasonable timeframe (e.g., forty-eight hours)...” For clients with coexisting disorders, the managed care organization “could be required to integrate mental health and addiction services by requiring collaboration between these clients’ different treatment providers.”

Perhaps one of the most damaging aspects of traditional HMOs is the concept of disenrolling a plan member for failure to comply with treatment, keep appointments or other stipulations of the managed care company. Contracts can disallow disenrollment “on the basis of diagnosis or perceived diagnosis, adverse changes in the enrollee’s health or because of pre-existing conditions.” Other issues the contract should address
concerning disenrollment include: high treatment costs; the inability for a member to pay
deductibles, co-payments or other fees; the failure to complete paperwork or adhere to the
service plan; difficult, uncooperative, or “unpleasant” behavior; or because an enrollee
has “exercised or attempted to exercise his [or her] rights under a grievance or appeal
system.”23

Public-sector services must have the ability to serve clients who comprise the
communities in which they live with regard to culture, language, race and ethnicity.
Therefore, contracts must address cultural competency among providers. “All planning
and delivery of services should be culturally and linguistically responsive to ethnically
diverse populations and the communities where they live.”24

Consumers must be provided with and have ongoing access to grievance
procedures under the managed care plan, and the formal appeal process. The contract
could require the plan to explain grievance procedures and rights regarding an appeal in
easily understood language, and that the managed care organization’s grievance system
be “adequate and responsive,” including same-day decision-making in emergencies, fast
response in urgent situations (e.g., detox), and reasonable responses under other
circumstances (ten days.)25

The contract must avoid giving the managed care organization any incentives to
attempt to have individuals committed to inpatient facilities, e.g., by cost-shifting the
expense of an individual’s treatment to the state authority once they are in a state facility.
The contract should clarify who incurs the expense for involuntary hospitalization and
court-mandated treatment.26
Managed care emphasizes both consumer satisfaction and quality of care. Quality of care is defined best through outcomes measurement. The contract must require processes to gather information from the consumers concerning their level of satisfaction with services and their managed care plan. Outcome measures as well must be based on the consumer’s report concerning feeling safe, mentally healthy and experiencing a good quality of life. Other measures may include “residing in their own home, or living arrangement of their own choosing,” maintaining employment and good physical health, avoiding difficulties with the law, managing their daily lives, and maintaining a positive social support network. Other outcome measures reflect symptom reduction or decreased substance use.

The contract must call for the appointment of consumers to the governing body that monitors and evaluates the managed care plan. This would empower consumers to have the authority to make decisions as part of the board that oversees the particular contract. Consumers may be particularly concerned about the enforcement of penalties levied against the managed care organization for failing to meet critical objectives. Other concerns may include ensuring that audits occur to check the managed care organization's compliance with the contract, particularly in its implementation of service necessity criteria and the review of critical incidents.

By building the proper contract, consumers can enforce quality of services and mode by which they are delivered. In order to ensure that an adequate array of rehabilitative and recovery services are in place, consumers can be empowered to play a role in developing such a contract. With consumer-focused conditions
carefully built into contract, the mission of the public authority, the MBHO and
the needs of the consumer need not be in opposition, but in partnership.

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Summary and Conclusions

Summary

The transition to managed, public-sector mental health and addiction services has reached nearly every state in the country. Because managed care firms have enjoyed successes in building more efficient systems of care, public agencies have turned to them to improve the quality and cost effectiveness of their own systems. Careful planning involving the numerous stakeholders effected by the transition to managed care (e.g., consumers, family members, providers, other state agencies, lawmakers, etc.) is essential to ensuring a smooth transition.

In selecting a managed care model to purchase from a Managed Behavioral Health Organization (MBHO), public authorities must determine the type of assistance it intends to purchase from the MBHO. Two details are of critical importance in selecting a managed care model: the amount of control the state wants to retain for itself or give to the MBHO; and the type of funding structure the state intends to implement under managed care. If the state seeks to retain full responsibility for the payment of services, it would pursue an Administrative Services Organization (ASO) arrangement only. If the state wants its MBHO to assume full responsibility for the payment of services, it would contract with the MBHO to operate at full-risk. The risk behind the latter approach is that the capitation payment to the MBHO remains fixed while the volume of services provided varies. However, when an MBHO assumes risk, it has an increased incentive to control costs in order to operate within budget and/or to make a profit. The amount of risk a managed care entity assumes can be reduced under certain arrangements (e.g., soft-capitation and risk corridors).
Managed care controls costs, in part, by controlling the amount of services used. Utilization Management (UM) is the term used to describe the approach of managed care entities to ensure that only medically necessary services are utilized. Utilization Management requires that providers obtain authorizations before and during (prior and concurrent) treatment episodes in order to be paid for those services. “Medical necessity” or “service necessity” establishes the criteria under which services will be authorized. Consumers of public mental health and/or addiction services can play a critical role in ensuring that contracts establish definitions of service necessity that reflect the consumers’ best interests. In fact, it is often legally required, if not ethically imperative, for public agencies to conduct an open process, which allows for consumer groups to participate in the transition to managed care.

The Healthcare Finance Administration (HCFA) requires states to obtain waivers from the Medicaid rules in order for them to enroll some Medicaid recipients, e.g., beneficiaries of both Medicaid and Medicare (“dually eligibles”), in managed care plans on an involuntary basis. However, state and local governments can transition their fee-for-service or grant-in-aid systems (services paid for through the state or local government’s general fund) to managed care without including Medicaid in this transition. This approach relieves the state from the arduous tasks associated with obtaining a waiver.

Connecticut has created a behavioral healthcare carve-out for its recipients of General Assistance. In 1997, the funding for this program was transferred from the Department of Social Services (DSS) to the Department of Mental Health and Addiction Services (DMHAS). DMHAS then contracted with an ASO to perform provider
credentialling, UM, claims payment, and to generate quality monitoring data. Under its current managed care arrangement, Connecticut has built-in penalties, but no performance bonuses to drive its ASO to achieve good outcomes. DMHAS has added Behavioral Health Units (BHUs) which provide direct services to general assistance clients (case management) and interface with the ASO around care management (ensuring that the client is admitted to the most appropriate level of care). The Basic Needs Program (BNP) had been added to give temporary financial supports (to purchase food, shelter, personal care, clothing, etc.) to clients who had lost their General Assistance cash benefit.

DMHAS additionally directed its funded programs and community facilities to develop Integrated Service Systems (ISSs) in each of its five regions. The ISSs may play a role in administering future behavioral healthcare carve-outs that will serve Medicaid populations. Connecticut will achieve future Medicaid carve-outs through provisions in the federal Balanced Budget Act (BBA) of 1997 and, at this time, does not plan to apply to HCFA for a Medicaid waiver.

In 1995, Iowa enrolled the state's Medicaid clients in its fully capitated Medicaid managed care programs: the Mental Health Access Plan and the Iowa Managed Substance Abuse Care Plan. The Mental Health Access plan achieved $6 million (fourteen percent) savings in one year in state and federal funds and a high rate of consumer satisfaction. The mental health carve-out created and enhanced alternative services, generated improved access and decreased inpatient stay. The substance abuse carve-out decreased the number of inpatient detox admissions and "greatly" increased the number of outpatient services. The “County Program” had also been created as a county-
based, mental health stand-alone for non-Medicaid clients who have met the eligibility
criteria for these services and had been paid for through state dollars and federal block
grants.

In 1999, Iowa launched a new program that integrates all the populations
previously served by the Mental Health Access Plan and the Iowa Managed Substance
Abuse Care plan, through a decentralized regional approach. This program was designed
to integrate the Medicaid mental health and substance abuse services into one carve-out.
Under this new contract, Iowa has added eight new performance incentives and ten new
financial penalties.

In April 1997, Montana implemented a fully capitated statewide Medicaid mental
health stand-alone, the Mental Health Access Plan. The plan ultimately came under fire
from HCFA, providers, consumers, the community and law makers for failing to pay
claims to providers in a timely manner. Additionally, HCFA chastised the Montana
Department of Public Health and Human Services’ Addictive and Mental Disorders
Division (DPHHS-AMDD) for ineffectively monitoring the program and failing to report
significant information to HCFA, including a decision to withhold capitation payments to
the MBHO. The program had been seriously under-funded and the MBHO, Magellan
Health Services, Inc., reported monthly loses of $1 million. Magellan invoked its
contract exit privilege and negotiated a termination to the contract. Montana’s current
plans are to implement a regionally based system. For the interim, administration and
delivery of services are in a precarious situation for both providers and consumers of
services.
In 1997, the State of Washington enrolled its Medicaid beneficiaries into managed care plans. The state implemented a regional approach through fourteen Regional Service Networks (RSNs) to operate a fully capitated outpatient managed care program. King County, Washington contracted with United Behavioral Health as its ASO to co-operate its RSN. In making use of a modified version of the Washington three-tier system, King County demonstrated an overall increase in access to services, an increase in crisis outreaches and a decrease in state-hospital inpatient days. King County is currently redesigning its system of care as it prepares to accept full-risk for inpatient services for its clients.

Conclusions

Public agencies transitioning their mental health and addiction services to managed care improve their chances for success when their objectives are implemented incrementally over several years. Montana’s failure, in part resulted from their attempt to bring nearly all types of services and funding streams together at once, without necessary public oversight and funding reserves.

At this time, Connecticut has not provided its ASO with financial incentives to control costs while increasing the quality of services. As a next step with its GA population, Connecticut should look at providing performance incentives to ValueOptions. The need for such measures is enhanced given the unique relationship between the utilization management entity, ABH, and its providers. Iowa’s experience in using performance incentives as well as its plan to provide regional systems of care should prove useful to Connecticut. In the coming years, Connecticut should also look at
King County's experience in placing inpatient hospital care at full-risk as well as its experience in shifting from an ASO to risk-bearing model.

An underlying aim of this paper has been the examination of the respective missions of non-profit and profit seeking organizations. Individuals working within the non-profit arena (public and private alike) have commonly held the belief that because profit seeking organizations care largely about making money, the quality of services delivered to the consumer must be inferior to the quality of services delivered by non-profit organizations. It is likewise believed that because non-profit organizations care mainly for people, then those organizations will deliver top-quality services.

This paper has found no correlation between quality of care and whether the administrating entity is a non-profit or profit seeking company; in fact, profit status appears to be irrelevant to the question of quality of care. Profit status does seem, however, to have a bearing on efficiency. If for-profit status has no impact on quality, yet is more likely to drive an administrating entity to increased efficiency, it is logical that for-profit companies have a role in health care delivery management.

Existing non-profit mechanisms in place in the public behavioral healthcare delivery system have a crucial place in laying the foundations for an effective transition to managed, public-sector mental health and addiction services. The conditions public authorities put on managed care companies—stipulating that prior to taking profits a percentage is reinvested back into system; tying profit level to performance level—drive these companies to perform in a manner that is beneficial to the consumer. The public agency therefore forces the for-profit sector to be accountable to the primary concern of the consumer: quality of care.
The non-profit, public sector, although partially divested of administrative functions, can continue to ensure that managed care corporations do not treat mental health and addiction services as just another venture in which the bottom line is profits, where profit-driven investors rather than consumers determine quality of services and the manner in which they are delivered. By building the proper contract, consumers can enforce quality of services. In order to ensure that an adequate array of rehabilitative and recovery services—not necessarily medical, yet contributory to recovery—are in place, consumers can be empowered to play a role in developing such a contract. With consumer focused conditions carefully built into contracts, the emerging reality is that profit making and consumer-focus need not be viewed as in opposition, but in partnership.


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