

**NEGOTIATING THE NEW HEALTH SYSTEM:
A Nationwide Study of Medicaid Managed Care Contracts**

Second Edition

**SPECIAL REPORT:
Mental Illness and Addiction Disorder Treatment and Prevention**

Sara Rosenbaum, J.D., Peter Shin, M.P.H., Marcie Zakheim, J.D.,
Karen Shaw, J.D., M.P.H., and Joel B. Teitelbaum, J.D., LL.M.

Kay A. Johnson, M.P.H., M.Ed., Managing Editor

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EXECUTIVE SUMMARY

Introduction

This Special Report of *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts (2d Ed.)* analyzes Medicaid managed care contract provisions related to mental illness and addiction disorders (MI/AD). The analysis is based on 54 contracts and related documents (including 12 managed behavioral health care contracts) which were in effect as of the beginning of 1997.

While this Special Report considers Medicaid contracts, its findings have implications for other public purchasers of managed care services for persons with MI/AD because, like Medicaid, other sources of third-party financing have traditionally supported services and activities that may not be part of the custom of the insurance industry. If these coverage and service practices are not specified in contracts, they may be lost.

Mental illness and addiction disorder coverage and treatment raise important issues in Medicaid policy and Medicaid managed care because of the greater prevalence of these disorders among the low-income population and the large role that Medicaid plays in financing such care. Medicaid accounts for an estimated 14% of all national spending on MI/AD services, and MI/AD services account for between 9.6% and 12.6% of total Medicaid spending. Although expenditures related to the treatment and prevention of mental illness and addiction disorders accounts for a disproportionately high percentage of total Medicaid expenditures, this detail is masked by the fact that by and large, Medicaid recipient and expenditure data are reported by class of beneficiary and service received rather than by diagnosis; as a result, it is not possible, without specialized studies, to evaluate Medicaid spending patterns by diagnosis. Because MI/AD-related costs are so significant to Medicaid, the use of techniques such as managed care to control increasing costs assumes a particularly high degree of importance and makes the study of Medicaid managed care relating to persons with mental illnesses or addiction disorders of even greater consequence.

Finally, while managed care offers an important opportunity to improve and rationalize care for a population with serious illness, the extent to which the managed care industry has geared its services to the Medicaid population is not well-understood. For these reasons, the relationship of managed care to the treatment of beneficiaries with MI/AD and the structure and content of managed care service agreements merit particularly close attention.

Part 1: An Overview of Medicaid Managed Care and the Role of Managed Care Contracts

Among all forms of managed care, Medicaid managed care may be the most complex because of critical differences between Medicaid and the traditional insurance principles on which managed care products are built. Because Medicaid is

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a health care financing program for persons with a higher likelihood of serious illness, it functions as a third-party payer rather than as an insurer. Medicaid coverage is unusually broad and deep; moreover, coverage is available even when recovery to normal functioning is not possible and even when the health problem giving rise to treatment is not an acute illness or injury. Insurance principles, on the other hand, have been crafted over the decades to attract a healthy, working population and to avoid and reduce the “moral hazard” of attracting and covering persons with serious and chronic illnesses. Coverage traditionally has been limited to short-term injuries and illnesses from which recovery can be expected, and treatment is of short duration. Medicaid also operates by special rules where coverage determination is concerned with respect to the standards used to determine coverage, the allocation of the burden of proof, and the process that must be followed in a case in which coverage is denied.

The differences between Medicaid and insurance are starkly demonstrated when Medicaid agencies purchase managed care insurance products for beneficiaries. Medicaid agencies historically have contracted with private (fee-for-service) entities to administer portions of their Medicaid programs; purchasing products from managed care entities, however, is different in that the managed care contracts also involve financial risk. Indeed, Medicaid agencies retain ultimate liability for ensuring that all Medicaid principles and standards are adhered to, even when they utilize private contracts. The terms and wording of the contracts are thus of major significance, because they determine the extent to which a state agency will retain direct liability for Medicaid services (including the depth of covered classes of services) that are not, in fact, included in the managed care contract. An ambiguously-worded contract not only can create residual liability not anticipated by state agencies, but it can create confusion among beneficiaries regarding which entity is liable for coverage. For when Medicaid agencies contract with both general service health care plans and managed behavioral health care plans for “carve-out” services and functions, three sources of liability may exist: the state agency, the general service plan, and the carve-out plan.

Medicaid agencies converting to managed care systems face an additional set of challenges, because Medicaid provides care and treatment for a population that is sicker and poorer, and that has more complex health needs, than the commercially-insured population. Medicaid agencies are also bound by legal and constitutional principles (which, for example, require the agencies’ contracting and monitoring procedures to comply with principles of due process) that apply to public agencies generally. Furthermore, in their use of Medicaid funds to purchase commercial insurance, state agencies increasingly find themselves at the center of a profound public policy debate regarding the extent to which commercial insurance should accommodate itself to the requirements of Medicaid, and the extent to which public financing should continue to compensate for those health care needs among the chronically-ill that commercial insurance does not and cannot fulfill. The magnitude of this public policy debate can become blurred by the day-to-day administrative chores related to managed care purchasing (such as development, preparation, and negotiation of service agreements, capitation and rate-setting, the rapid enrollment of tens of thousands of persons, licensure and certification, and contract compliance oversight).

Part 2: Mental Illness and Addiction Disorder Treatment and Prevention: Key Findings and Trends in Managed Care Contracts

A. General Findings

Twenty-one of the fifty-four contracts reviewed for this Special Report were actually included in the data base for the first edition of *Negotiating the New Health System* because they are multi-year agreements. Nonetheless, analysis of all the contracts for the second edition of the study again revealed important trends.

1. *The number of contracts covering persons with disabilities is rising.* The contracts indicate an increase in the enrollment of persons with disabilities. In the first edition of *Negotiating the New Health System*, for example, we noted that 22 contracts provided for the enrollment of children in foster care and out-of-home placements; in this edition the number of such contracts has risen to 28. We also noted that 31 contracts specified enrollment of one or more categories of persons with disabilities; in this edition the number stands at 38.

2. *Contracts are growing larger and more complex.* In keeping with the trend toward enrolling persons with disabilities, the contracts themselves are growing more complex in their description of contractors' coverage and service duties. Greater attention is being paid to provisions that describe how managed care organizations (MCOs) are expected to relate to other service agencies, and more data collection requirements are being imposed.

3. *States appear to be moving toward greater use of managed behavioral health care arrangements.* This edition of the study contains more carve-out contracts than the first edition, and since data collection for this edition was completed the number of such contracts has increased further still. This growth in carve-out contracts may be attributable to both Ademand@ factors (i.e., the movement of more seriously ill persons into managed care) and "supply" factors (i.e., the growth of a behavioral health care provider market willing to sell services and products to Medicaid agencies).

4. *States are increasingly likely to specify at least some level of treatment and prevention services for mental illness and addiction disorders in their general service agreements.* Analysis of the data shows that each of the 42 general service agreements includes at least some level of coverage for MI/AD services, up from 27 out of 36 such contracts in this study's first edition. In some cases, the coverage in the general service agreement is limited to mental health services that would "ordinarily be furnished by a primary care practitioner within the scope of his or her practice." The magnitude of this coverage is not known, but the issue raises important implications for such coverage in states that use both a general service agreement and a managed behavioral health care agreement.

B. Specific Findings

1. *Enrollment and disenrollment*

Despite the growing trend toward enrollment into managed care of persons with disabilities and special health care needs, only a limited number of contracts make special provision for contractors' treatment of persons who are in a course of treatment at the time of enrollment. Also, nine contracts contain specific provisions regarding the enrollment of children in foster care or out-of-home placements (including those who are under the jurisdiction of the state).

Both general service agreements and, to a lesser (but still prevalent) extent, managed behavioral health care agreements, permit plans to initiate disenrollment of persons who are disruptive. Plan-initiated disenrollment provisions are common in managed care generally and are a feature of the Medicare+Choice program, as well. In some (but not all) states permitting plan-initiated disenrollment of members for disruptive conduct, disenrollments are prohibited if the cause of the disruption is related to the members' health status.

2. *Coverage*

The managed care general service contracts vary tremendously in their coverage of MI/AD services, although the carve-out agreements vary to a lesser extent. Both types of contracts also vary in their approach to defining service and coverage terms, which may lead to major differences in the actual scope of coverage among facially similar contracts. For example, the term "outpatient care" is defined in numerous ways in the reviewed contracts, as are the terms "urgent care" and "emergency care."

The contracts vary enormously in their utilization of standards which contractors must use in making coverage determinations and in their allowance of exclusions that are typical for insurance (but not allowed under Medicaid). Examples of traditional exclusions of otherwise medically necessary contract services include the exclusion of experimental care (state authority to exclude such coverage under Medicaid is circumscribed by tests of reasonableness); exclusion of services furnished by schools (e.g., health care received as part of a special education plan); and exclusion of care furnished by public agencies (e.g., health care received as part of a child welfare plan). Variations in the contracts regarding coverage decision-making standards and exclusions can result in the placement of greater or lesser levels of direct liability on state agencies for services that the contractor deems to be either not covered or excluded from the contract, but which nonetheless are covered under Medicaid itself.

Our analysis of the contracts reveals that in general, state agencies give contractors broad discretion with respect to

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the coverage determination and prior authorization procedures used by the contractors themselves. Few contracts place the burden of proving non-coverage on the contractor, and few provide for continued coverage pending the outcome of a fair hearing if one is requested by the beneficiary.

3. *Network and Access Standards*

Despite the movement of more persons with disabilities into managed care, state agencies continue to vest considerable discretion in their contractors to configure networks and develop more specialized access standards. This practice is particularly prevalent in the area of sub-specialty care. Also, at least some level of self-referral for MI/AD services can be found in 23 contracts, including 8 of the 12 managed behavioral health care contracts. Typically, however, self-referral is strictly controlled in terms of the number of encounters or the types of conditions covered.

States are paying increased attention to the issue of cultural competency, with more contracts addressing the obligations of contractors to develop networks that are culturally sensitive to their members.

4. *Relationship Between Managed Care Organizations and the Rest of the Health System*

While states are paying increased attention to the relationship between managed care organizations and the rest of the health system, cultivating this relationship continues to represent a major challenge. The problem may be particularly acute in the case of the provision of MI/AD services, because plan members with MI/AD-related health care needs may be more likely to be under the care of multiple agencies. For example, foster care children represent a group of members at heightened risk for illness and disability; yet only 2 of the 28 contracts covering such children specifically require managed care organizations to coordinate their services with those offered by other agencies that care for children (e.g., child welfare, special education, and early intervention agencies, and courts). Moreover, even those contracts that do require coordination of services fail to clearly allocate financial responsibility among the MCO and the other agencies and providers.

5. *Quality Improvement, Performance Measurement, Management Information Systems, and Data Reporting*

Despite the challenge of measuring managed care quality and performance (particularly performance over time in the case of serious illness and disability), our review indicates that states are increasingly attempting to expand and intensify quality improvement activities and data reporting. The contracts indicate an effort by states to request data from plans with regard to both the process and structure of care, as well as data regarding health outcomes. While some states have developed quality measurement specifications (possibly as a means for overcoming the relatively generalized performance standards that many of the contract documents contain), the underlying state measures of quality themselves vary greatly.

6. Patient Confidentiality

Patient confidentiality is a major concern for persons receiving MI/AD-related services. Federal regulations establish strict standards regarding the disclosure of information and the release of client records by programs providing alcohol or drug abuse diagnosis, treatment, or treatment referral, and while most of the reviewed contracts contain general references to compliance with “applicable” patient confidentiality requirements under state or federal law, none specifically refer to these regulations.

Part 3: An Analysis of Managed Behavioral Health Care Contracts

Just as there is no single type of managed care contract, there is no single type of managed behavioral health care agreement. States develop many different types of agreements, reflecting different underlying policy purposes. Some of the agreements cover both basic acute care as well as more long-term and intensive services, while others are designed to cover only persons with serious disorders.

Nonetheless, the unique nature of “carve-out” contracts merits special consideration because, in effect, carve-out contracting creates multiple sources of coverage and multiple points of accountability. Unless there is particular attention to detail and the deliberate use of a monitoring system that utilizes performance measures specifically tailored to evaluate performance integration, states risk the danger of creating major gaps in coverage and access due to the legal and operational voids that exist between and among the various contracts at issue.

The use of carve-out contracts effectively creates three tiers of Medicaid coverage and service responsibilities (the Medicaid program itself, the general service managed care contractor, and the managed behavioral health care contractor), all of which must be carefully juxtaposed and measured to avoid access and quality problems. Moreover, these three tiers of Medicaid coverage and service must be reconciled with a fourth tier of coverage and service comprised of health-related housing, social, educational, and other support services that are financed and delivered by or through other agencies and programs other than Medicaid (but for which Medicaid managed care enrollees may be eligible). Indeed, the evidence from our review suggests that managed behavioral health care agreements tend to contain gaps and ambiguities which are of pivotal importance to access and quality, perhaps due to of the complexity of designing an agreement that carves out discrete services and populations.

In any analysis of managed care carve-out contracts, four key issues arise: who is eligible to enroll; which services must the carve-out contractor provide and in accordance with what types of coverage standards; what events trigger entry into the carve-out plan and initiate the plan’s duty to begin serving an individual; and coordination of coverage among plans. The

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contracts reviewed in this study all contain important ambiguities in one or more of these areas, potentially leaving state agencies open to unanticipated residual liability and enrollees vulnerable to significant gaps in coverage. Important service and eligibility terms may be left undefined, and contracts may be unclear regarding the events that trigger the contractor's duty to initiate care. These ambiguities may take on added importance in those contracts in which contractors are paid a percentage of all premiums paid in a service area (rather than on a case-by-case method).

Conclusion

This report reveals greater movement of persons with disabilities into managed care. It also shows that states are struggling with the increasingly complex issues that are raised as managed care systems are built for persons with disabilities and with the challenge of reconciling Medicaid policy with that of insurance. Reconciling the two theories of coverage is particularly important because it is in the financing of care for persons with disabilities that Medicaid policy is so unique. Indeed, the failure to address the issues inherent in the Medicaid/insurance dichotomy can result in a diminution of the very coverage for which Medicaid has been known. Failure to understand the complexities raised by the transformation of Medicaid to a purchaser of managed care also can change long-standing treatment patterns because of the significance of Medicaid on the underlying health care system.

In order to promote the development of quality and appropriate managed care arrangements for beneficiaries, we make the following recommendations:

Efforts should be taken to reduce the discontinuity of Medicaid enrollment. Managed care enrollment depends on stability and continuity to work effectively. The Balanced Budget Act creates new options for states to guarantee 12 months' continuous coverage for children up to age 19. This option should be utilized and also extended to adults who enroll in managed care arrangements;

Efforts should be taken to increase technical assistance to public purchasers in the areas of purchasing specification development and compliance monitoring. Oversight of the quality of publicly-purchased managed care begins with clear and well-articulated purchasing specifications accompanied by well-thought out performance measures and sufficient staff and resources to carry out proper training;

Our final recommendation is to slow down. The headlong rush into managed care is neither wise nor necessary. No population should be pressed into a managed care arrangement that is not ready to enroll that population carefully or provide them with care of adequate quality. This is particularly true of poor people in general, who tend to complain much less than the privately-insured about the quality of their care. The problem with rushing too quickly into managed care is especially great when the lower-income population targeted for such enrollment suffers from physical or mental disabilities

and is being enrolled into companies and plans with little or no experience in the care of low-income persons with considerable health care needs.

INTRODUCTION

This Special Report of *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts (2d Ed.)* presents a comprehensive analysis of the mental illness and addiction disorder-related components of contracts between Medicaid agencies and managed care organizations (MCOs).¹ This analysis examines data extracted from 54 contracts and contract-related documents² (including 12 “managed behavioral health care” contracts³) that were in effect as of the beginning of 1997. All of the data presented in this Special Report can be found in the annotated table volumes contained in the *Second Edition*.

Managed behavioral health care raises some of the most important and complex issues in Medicaid managed care policy. Mental illness and addiction disorders (“MI/AD”), including both acute and chronic illnesses and conditions, are disproportionately prevalent among the Medicaid population. This greater prevalence is attributable in part to Medicaid coverage policy itself (Medicaid explicitly covers persons with significant physical or mental disabilities)⁴ and in part to the fact that low-income status is associated with a higher prevalence of mental illness and addiction disorders.⁵ As a result, even

¹ The Balanced Budget Act of 1997 (BBA) revises Medicaid managed care terminology and classifies as a “managed care organization” any managed care entity (including a federally qualified or state licensed health maintenance organization (HMO) or a health insuring organization (HIO)) that provides both inpatient and outpatient care in exchange for a premium. The term “managed care organization” will be used throughout this Report. For a general overview of the provisions of the BBA and its effects on managed care, see Volume 1 of *Negotiating the New Health System (2d Ed.)*.

² The review includes both contracts and detailed Requests for Proposals, which form the basis for contracts in many states.

³ Many policy analysts and advocates are uncomfortable with the term “managed behavioral health care” because of its potential to infer willful behavior on the part of individuals as the cause of MI/AD-related conditions. We use the term in this study because many state contracts refer to these agreements as such.

⁴ Between 1990 and 1995 the number of Medicaid beneficiaries eligible for coverage on the basis of disabilities or blindness nearly doubled, from 3.7 million persons to nearly 5.9 million persons. Kaiser Family Foundation, *Medicaid Expenditures and Beneficiaries: National and State Profiles and Trends (1990-1995)*, Table 47, (Washington, D.C. 1997). However, Medicaid coverage of these populations has been significantly reduced in recent years. The Balanced Budget Downpayment Act of 1996 (P.L. 104-99) eliminated coverage under Medicaid, Supplemental Security Income, Social Security Disability Insurance, and Medicare in the case of individuals whose basis of disability is addiction or alcoholism. While the Department of Health and Human Services has interpreted this provision to affect only those persons whose disabilities are based solely on their addiction or alcoholism and who have no other impairment that would qualify them for assistance (e.g., AIDS or a serious and persistent mental illness), nonetheless the Act is estimated to have eliminated more than 200,000 individuals from the program. Further, the Personal Responsibility and Work Opportunity Act of 1996 (welfare reform) curtailed SSI coverage for children whose coverage was based on certain mental disabilities. While Medicaid was restored for these children in 1997 by the BBA, Medicaid enrollment patterns among non-cash assistance recipients suggest that many of these children may fail to maintain Medicaid coverage in the absence of welfare receipt.

⁵ See, e.g., D.A. Reiger et al., “One-Month Prevalence of Mental Disorders in the United States and Sociodemographic Characteristics: The Epidemiologic

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those Medicaid beneficiaries whose coverage is not expressly based on a disability may be more likely than the general population to experience more -- and more severe -- mental illness-related problems.⁶

Second, Medicaid coverage and practice policies are of enormous importance to the overall financing of MI/AD services for the Medicaid population. Estimates of national expenditures on mental illness indicate that in 1987, Medicaid accounted for more than 14% of total national spending on mental illness-related care.⁷ Medicaid has been estimated to account for nearly 20% of the total amount of mental health funds implicated in the 1993-1994 national health reform effort.⁸

Given the magnitude of Medicaid's importance to MI/AD-related health care financing generally, as well as the cumulative and interactive effects of multiple sources of health care financing (each of which may be governed by distinct coverage, payment, and performance rules) on the overall performance of the health system, the changes in Medicaid spending patterns resulting from the growth of managed care can be expected to have a considerable impact on the availability, extent, and quality of MI/AD services generally.

Third, MI/AD-related spending is of major financial and structural consequence to the Medicaid program itself. Spending on the treatment and prevention of mental illness and addiction disorders accounts for a disproportionately high percentage of total Medicaid expenditures. This detail is masked by the fact that by and large, Medicaid recipient and expenditure data are reported by class of beneficiary and service received rather than by diagnosis; as a result, it is not possible, without specialized studies, to evaluate Medicaid spending patterns by diagnosis. Those special analyses that do exist indicate that expenditures for MI/AD-related health care needs account for between 9.6% and 12.6% of total Medicaid spending⁹ and between 8% and 11% of all Medicaid expenditures on services other than long term-institutional care.¹⁰ Moreover, many individuals with MI/AD-related health problems have co-occurring physical illnesses and disabilities. When overall expenditures on persons with MI/AD-related health problems is taken into account, the proportion of program funds spent on these individuals rises to an estimated 33% of total program spending.¹¹ (Spending for MI/AD-related services and

Catchment Area Study," *Acta Psychiatr Scand* 88: 35-47 (1993), and citations therein.

⁶ See, e.g., Pamela Loprest and Gregory Acs, "Profile of Disability Among Families on AFDC," The Urban Institute (August, 1996).

⁷ M.P. Freiman, P. Cunningham, and L. Cornelius, "Use and Expenditure for the Treatment of Mental Health Problems," *National Medical Care Expenditure Survey Research Findings* (No.22) (AHCPR, Rockville, MD 1994), cited in A. Jones and D. Salkhever, "Medicaid Alcohol, Drug Abuse and Mental Health Expenditures: National Estimates, 1995" (unpublished report for the Substance Abuse and Mental Health Services Administration, Rockville, MD 1996).

⁸ R. Frank, T. McGuire, D.A. Regier, R. Manderscheid, and A. Woodward, "Health Care Reform and Financing of Mental Health Services: Distributional Consequences," *Mental Health, United States* (Pub. No. (SMA) 94-3000, G.P.O., Washington, D.C. 1994). Cited in Jones and Salkhever, *supra* n. 7.

⁹ G. Wright and J. Buck, "Medicaid Support of Alcohol, Drug Abuse and Mental Health Services," *13 Health Care Financing Review* 1, pp. 117-28 (1991). Cited in Jones and Salkhever, *supra* n. 7. These figures decline somewhat when long-term care is excluded.

¹⁰ Jones and Salkhever, *supra* n. 7.

¹¹ S. Wigdor and S. Foldes, "Utilization of Health and Mental Health Services by Persons Treated for Mental Disorders in the Minnesota AFDC

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populations rose precipitously during the 1980s, increasing, for example, by 129% in California and 167% in Michigan.) Because MI/AD-related costs are so significant to Medicaid, the use of techniques such as managed care to control increasing costs assumes a particularly high degree of importance and makes the study of Medicaid managed care relating to persons with mental illnesses or addiction disorders of even greater consequence.

Finally, the use of managed care arrangements in the care of beneficiaries with MI/AD disorders is growing. Eleven states submitted a total of 12 managed behavioral health care carve-out contracts for review during the 1996-97 collection period covered by this study. More recent data suggest that 20 state Medicaid agencies currently have in place full carve-out managed behavioral health care service agreements,¹² an indication of the rate at which managed care for these populations is increasing. At the same time, state mental health and alcohol and drug abuse treatment and prevention agencies, as well as a growing number of county governments, are also negotiating managed behavioral health care agreements.

Because it merges health care financing and service delivery and creates a potential means for improving accountability for the quality and accessibility of care, managed care represents an important mechanism by which treatment and prevention services for persons with mental illnesses and addiction disorders can be rationalized and strengthened. At the same time, the higher prevalence of these conditions among the Medicaid population has significant ramifications for managed care structure, financing, and performance. With the possible exception of certain specialized companies, managed care organizations (which initially developed as a means of treating a relatively healthy employed population) may have only limited experience in the care of individuals with mental illnesses and addiction disorders. Even those entities that provide managed behavioral health care may, in fact, gear their products to short-term, acute treatment for workers and dependents with MI/AD-related problems, rather than to services for persons with long-term, chronic illnesses and disorders from which recovery may be unlikely.

Medicaid's transformation to managed care merits particularly close observation in the case of persons with mental illness and addiction disorders because of the population's greater level of need, the importance of Medicaid coverage and practice to the overall financing of MI/AD services, the large financial stake in Medicaid represented by these conditions, and managed care organizations' relatively limited level of experience in caring for persons with chronic disabilities. Indeed, an analysis of the structure and content of contracts in the area of mental illness and addiction disorder treatment and prevention has important implications for the study of managed care for persons with chronic illnesses and disabilities generally. The children and adults with chronic mental illness who are being moved into Medicaid managed care may be only the first wave of a new generation of disabled managed care enrollees, as the transformation to managed care begins to rapidly extend beyond non-disabled families with children.

Population," (Unpublished, Minnesota Department of Human Service, Research and Evaluation, Minneapolis, 1991). Cited in Jones and Salkhever, *supra* n. 7.

¹² The Lewin Group, unpublished data (1998). An additional three states have partial carve-out managed behavioral health care contracts. *Id.*

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This Special Report of *Negotiating the New Health System* has been prepared with support from both the Substance Abuse and Mental Health Services Administration (SAMHSA) and The Pew Charitable Trusts. Part 1 provides a general overview of Medicaid managed care and considers the role that contractual documents play in creating the legal framework in which Medicaid managed care operates. Part 2 presents the key MI/AD treatment and prevention-related findings that emerge from our review of the contract data base. Part 3 presents specific findings from a separate and intensive analysis of managed behavioral health care carve-out agreements. The Report concludes with an assessment of the overall implications of this study, as well as with a series of recommendations for strengthening managed care for the MI/AD population.

While this report specifically examines Medicaid managed care contracts, the issues raised are important to publicly financed managed behavioral health care generally, whether financed by Medicaid, federal mental health and alcohol and addiction block grant funds, or state and local revenues. Increasingly, state mental health and alcohol and addiction treatment agencies, as well as county governments, are investing in managed behavioral health care products. Given the discontinuous nature of Medicaid enrollment (with the exception of the elderly and the most seriously disabled, coverage may last on average for less than a year and can be gained and lost repeatedly as a result of even slight fluctuations in income or small adjustments in family living arrangements),¹³ many individuals with MI/AD-related health problems can be expected to move between Medicaid and other sources of health care financing during periods of Medicaid ineligibility.¹⁴ Thus, the policy issues arising from Medicaid managed care can be expected to affect programs financed through other funding streams as well, particularly as states and localities increasingly seek to reconcile health care practice and coverage policies across various payer sources.

The findings from this study also hold important implications for the State Children's Health Insurance Program (CHIP). States that participate in CHIP can elect to administer their programs as a Medicaid expansion, a separate program, or a combination of the two. Where a Medicaid expansion route is chosen, all Medicaid eligibility, coverage, and administration rules apply; consequently, CHIP children enrolled in Medicaid are entitled to all Medicaid coverage, including the unparalleled range of preventive and treatment services available through the Early and Periodic Screening Diagnosis and Treatment

¹³ The National Committee on Quality Assurance (NCQA) estimates that Medicaid managed care enrollment lasts less than 1 year on average, chiefly as a result of involuntary disenrollment arising from the loss of eligibility. *Medicaid HEDIS* (NCQA, Washington, D.C. 1996).

¹⁴ Rapid turnover of Medicaid coverage is expected to become an increasingly significant matter as a result of welfare reform. Although Medicaid coverage rules did not change significantly under welfare reform, the broad changes in national welfare policy can be expected to have a strong impact on access to and coverage under Medicaid, since shortened welfare eligibility periods, the greater use of diversion programs to delay initial entry into welfare, and more active use of sanctions all may combine to more quickly push people off of welfare or inhibit their initial entry. Sara Rosenbaum and Julie Darnell, *An Analysis of the Medicaid and Health Provisions of the Personal Responsibility Work and Opportunity Reconciliation Act of 1996 (Welfare Reform)*, (Kaiser Commission on the Future of Medicaid, Washington, D.C. 1997).

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program (EPSDT), the special component of Medicaid for individuals under age 21.

States that elect to operate separate CHIP programs may offer MI/AD-related coverage and must do so under certain circumstances.¹⁵ Furthermore, even if a state's CHIP plan does not cover MI/AD-related services, the prevalence of MI/AD conditions among children enrolled in CHIP indicates that states administering CHIP through managed care arrangements will need to consider how managed care companies will address health and management needs of enrolled children with MI/AD-related disorders.¹⁶ Since federal contributions to state CHIP programs are subject to aggregate annual limits, most states can be expected to provide CHIP coverage through contracts with managed care organizations operating at full or partial financial risk. Moreover, in states that elect to administer separate programs, children can be expected to move from CHIP to Medicaid and back again as their monthly income fluctuates. In order to avoid mass dislocation of children from their health care arrangements as their source of coverage changes, CHIP and Medicaid are likely to function in close coordination. For all of these reasons, the issues that arise for Medicaid agencies in the design and implementation of managed care systems for special needs children, including children with mental illness and addiction disorders, can be expected to arise in the administration of CHIP.

The findings included in this Report indicate that states are making efforts to design managed care systems that function well for children and adults with serious illnesses and disabilities; however, the findings also underscore the complexity of the undertaking and the large number of potentially serious issues that are receiving inadequate attention as millions of persons are moved into managed care at a precipitous rate. The inadequacies show up with particular force in the case of managed behavioral health care carve-out contracts, which are frequently vague and unclear on even the most basic matters and whose enforceability on fundamental matters of coverage, access, quality, and interaction with the balance of the health care system is commonly open to question. Indeed, the findings from this study suggest that, while managed care is an important tool when properly used, many public purchasers are placing their mental health and addiction disorder treatment and prevention programs into the hands of private companies far more rapidly than either their own contracting abilities or the capabilities of the managed care companies may warrant.

¹⁵ For a general overview of CHIP see S. Rosenbaum, K. Johnson, A. Marcus, C. Sonosky, and C. DeGraw, "The Children's Hour: An Analysis of the State Children's Health Insurance Program," 17 *Health Affairs* 1, pp. 75-89 (Jan./Feb., 1998).

¹⁶ CHIP prohibits discrimination in enrollment based on a child's condition; thus, children with mental illness cannot be excluded from CHIP plans.

PART 1: AN OVERVIEW OF MEDICAID MANAGED CARE AND THE ROLE OF MANAGED CARE CONTRACTS

Among all forms of managed care, Medicaid managed care may be the most complex because of the differences between Medicaid and commercial insurance. Nominally, Medicaid and commercial insurance are similar; both systems offer third-party financing of necessary medical care and provide coverage for a defined set of medical and health benefits. At the same time, Medicaid is radically different from insurance from a legal, structural, operational, and historic standpoint. These differences remain in place from a legal standpoint even in states in which Medicaid agencies purchase commercial, managed care-style insurance and contract for administrative services (either separately or as part of an insurance-risk contract) with commercial managed care insurers.

The distinctions between Medicaid and commercial insurance may come into clearest view on matters related to the care of persons with serious, chronic, and historically uninsurable conditions -- those persons who may never recover to a “normal” state of illness-free health through short-term and acute interventions. Even so, it is in these cases that the nominal similarities between Medicaid and commercial insurance may mask deep divisions until serious problems arise, typically in the area of coverage.

There are fundamental policy reasons for Medicaid’s unique characteristics. These reasons relate to Medicaid’s two essential purposes: (1) coverage of medical and health services for persons with serious and chronic illnesses who are unable to pay for care; and (2) comprehensive medical and health coverage with only the most nominal cost-sharing¹⁷ for persons whose poverty makes even basic health care unaffordable. The medical and health services that Medicaid covers extend well beyond traditional services and can include services and activities that would not be considered “medical” in nature (e.g., ongoing case management, respite care, home adaptation services, room and board, and other non-traditional services). When other sources of funding are added to Medicaid (from programs such as the mental health and alcohol and drug abuse block grants), the Medicaid-supported health care system may offer an enormous range of assistance.

Medicaid’s purposes are very different from that which underlies the commercial insurance market: reasonable financial protection for workers and their families from the high medical costs associated with acute health care problems (from which recovery can be expected). When Medicaid funds are used to purchase commercial insurance, the consequences can be profound for beneficiaries, the health care system, the companies which are expected to provide care, and public

¹⁷ Medicaid eligible children under 18 years of age are insulated from cost-sharing entirely. Section 1916 of the Social Security Act; 42 U.S.C. '1396o.

policy in general.

As state Medicaid agencies convert their programs to managed care arrangements, they face more than the normal set of challenges. Medicaid agencies purchase managed care for a population that is sicker and poorer, with more complex health needs, than the commercially-insured population. Medicaid agencies are also bound by legal and constitutional principles (which, for example, require the agencies' contracting and monitoring procedures to comply with principles of due process) that apply to public agencies generally. Furthermore, in their use of Medicaid funds to purchase commercial insurance, state agencies increasingly find themselves at the center of a profound public policy debate regarding the extent to which commercial insurance should accommodate itself to the requirements of Medicaid, and the extent to which public financing should continue to compensate for those medical and health care needs among the chronically ill that commercial insurance does not and cannot fulfill. The magnitude of this public policy debate can become blurred by the day-to-day administrative chores related to managed care purchasing, such as development, preparation, and negotiation of service agreements, development of capitation and other rates, the rapid enrollment of tens of thousands of persons, development of licensure and certification standards, and development of contract compliance oversight systems.

A. A COMPARISON OF MEDICAID AND INSURANCE PRINCIPLES

1. In general

It is not possible in the space of a relatively short document to do justice to the distinction between Medicaid and insurance principles. Some of the distinctions are well understood: As noted, Medicaid covers low-income persons who typically are outside of the work force because of age, dependent status, or disability, while private insurance is, for the most part, intended to provide a reasonable level of coverage for workers and their families for certain types of health problems; also, Medicaid covers long-term care as well as primary and acute care benefits, while private insurance typically is limited to "major medical" coverage for short-term medical care to treat non-recurring episodes of acute medical illnesses and injuries.¹⁸

To be sure, the notion of what constitutes an insured benefit (i.e., what is included in the premium) has expanded significantly over the past 30 years, as purchasers' coverage expectations have increased and as laws mandating benefit coverage have been enacted.¹⁹ Today, many insurance plans (health maintenance organizations and other managed care organizations,

¹⁸ See Rand Rosenblatt, Sylvia Law, and Sara Rosenbaum, *Law and the American Health Care System* (Ch. 4) (Foundation Press, Old Westbury, NY (1997).

¹⁹ *Id.* (Supplement, 1998).

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in particular) cover at least some level of preventive and primary care for routine health needs (e.g, routine periodic checkups and immunizations, family planning services and supplies, routine pregnancy care, and preventive mammograms).

Despite these changes, commercial insurance principles remain grounded in the concepts of risk management and avoidance of “moral hazards,” a term used by the industry to denote enrollment by individuals with higher health care needs.²⁰ Efforts to avoid “moral hazards” can take several forms: (1) avoidance of certain markets entirely because of the health risks faced by potential enrollees; (2) exclusion from coverage (either entirely or for certain health needs) of individuals with pre-existing conditions;²¹ and (3) benefit limitations that constrain coverage and access to a level of care that may be sufficient to treat only acute illnesses or injuries from which recovery can be expected. While managed care organizations possess unique features, they remain risk-bearing entities that offer prepaid medical care for a fixed price and operate in accordance with the rules and principles of insurance.²² Depending on their contracts, MCOs may offer an expanded class of covered benefits; at the same time, MCOs, as risk-bearing insuring entities, apply commercial insurance principles to decide if an individual member is, in fact, eligible for coverage for one or more benefits enumerated in the contract.

For example, under normal principles of insurance, a “well-child” medical examination would not be considered a medically necessary covered service because the exam is designed to monitor normal growth and development, not to diagnose an illness or injury from which recovery reasonably could be expected. If a commercial insurance contract were simply to cover “physician” services or “medical care”, a commercial insurer could properly deny coverage for a preventive pediatric exam, no matter how beneficial to a child’s health such an exam might be.

However, many insurance contracts today expressly provide for periodic, preventive examinations of children to monitor growth and development (i.e., well-child care). These exams are covered for two reasons: (1) they are considered to be beneficial to children’s overall health; and (2) they are costly. Inclusion in an insurance contract ensures the provision of such services and permits the cost of well-child examinations to be prospectively financed as part of the premium, with the cost of care spread across all enrollees, regardless of whether they have children. In sum, where a contract provision expressly provides for coverage of “non-traditional” services or requires an insurer to use specific and expanded standards and procedures to determine whether coverage is necessary and appropriate, an otherwise uninsurable benefit can become both available and covered.

²⁰ *Id.* (Ch. 4).

²¹ The Health Insurance and Portability Act of 1996 limits somewhat but does not prohibit entirely insurers’ authority to apply pre-existing condition limits and exclusions in both the group and individual health markets. *See id.* (Ch. 2(F)).

²² The relationship between managed care and insurance was underscored in a recent bad faith breach of contract liability case involving the arbitrary denial of out-of-plan coverage. *McEvoy v Group Health Cooperative of Eau Claire*, 570 N.W. 2d 397 (Wis. Sup. Ct. 1997).

2. *Macro-allocation and micro-allocation coverage decision-making: the insurance/Medicaid distinction*

As a non-insurance, third-party financing program, Medicaid pays for many services that commercial insurance does not cover. Some of the differences in coverage and payment are “macro” in nature; that is, they involve distinctions between Medicaid and commercial insurance with respect to entire classes or levels of benefits. Other distinctions are “micro” in nature: they involve the standards and procedures used to determine whether a particular enumerated benefit for an individual is medically necessary and therefore covered. Macro-allocation matters are heavily driven by aggregate cost and broad policy concerns that apply to the entire population of covered persons. Micro-allocation decisions, on the other hand, are heavily fact-driven and are unique to each enrollee. Micro-allocation goes to the heart of the individual entitlement to coverage itself, because it involves the determination of whether a covered individual will actually receive benefits enumerated in his or her insurance policy.

Medicaid’s “macro-allocation” distinction in comparison to commercial insurance is relatively well-understood. For example, Medicaid will, if medically necessary, pay for nursing facility care without prior hospital admission for an acute illness or injury; almost no commercial insurer would do the same. Similarly, Medicaid will cover all medically necessary outpatient mental health care for children without regard to the limitations on the number of visits that might apply to adults, because of the special coverage rules which apply to children under EPSDT.

As important, but more difficult to grasp because of their relatively invisible nature, are the “micro-allocation” (i.e., the individual coverage decision-making) distinctions between Medicaid and private insurance.²³ It is in the area of micro-allocation policy that the most crucial differences between Medicaid and private insurance coverage decision-making often emerge, particularly in the case of persons with chronic illnesses and disabilities who may not recover “normal” functioning. Micro-allocation is especially thorny since it requires consideration of a set of issues that frequently are invisible to the naked eye: the standards and procedures used by the coverage decision-maker to decide if, under a particular set of circumstances, specific services and benefits enumerated in the contract can be considered medically necessary for a particular enrolled individual. Macro-allocation principles determine the *potential* scope of individual coverage; micro-allocation standards and principles determine the *actual* extent of coverage for individual enrollees.

a. Insurer approaches to micro-allocation

In making micro-allocation determinations, insurers typically apply certain principles. First, a service must be medically necessary as defined by the insurer. Second, even if medically necessary, the service must be necessary to diagnose and/or treat a problem that falls within the classes of medical problems covered by the premium (i.e., an illness or injury in an otherwise healthy person and not a chronic disability or condition).²⁴ Third, even if the treatment is necessary to

²³ For a review of macro- and micro- allocation concepts in both insurance and Medicaid, see *Law and the American Health Care System*, *supra* n. 18 (Ch. 2).

²⁴ For a recent article that highlights this “illness/condition” distinction under commercial insurance principles, see “Calling Infertility a Disease, Couples

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address an insurable health problem, it nonetheless may be excluded from the scope of the contract, either explicitly or by implication, and in accordance with the insurer's interpretation of the contract. Common exclusions are treatments which are generally available free of charge in the community or are considered by the insurer to be "educational, social, or judicial" because of the setting or context in which they are delivered or ordered.

In determining if a particular service or procedure is excluded, insurers may be given wide discretion to interpret the scope of the contract. For example, an insurance contract may be silent on what constitutes "experimental", "educational", or "social" services, in which case the insurer has discretion to interpret the terms in accordance with the practice of the industry. The term "experimental" could be defined narrowly to apply only to the items and procedures that specifically are being tested under a controlled scientific trial, thereby leaving covered all other aspects of the clinical trial, as well as any service that is in general use among medical and health practitioners in that specialty as evidenced by practice norms, the opinions of experts, or peer-reviewed literature. A stricter definition of "experimental" would classify as uncovered any treatment that has not affirmatively been shown through controlled, randomized trials to be effective in treating a particular illness or condition. This definition could render most forms of medical care "experimental" since the vast majority of the medical care that Americans receive on a daily basis has not been validated by randomized trials but is furnished based on medical consensus and practice tradition. Indeed, with the exception of immunization and newborn screening for certain metabolic conditions, even well-child care would fail under this strict standard.

In addition to applying certain standards, insurers follow a process that is integral to the coverage determination itself. Some determinations of coverage may take place after a service has been furnished. Indemnity insurance plans, for example, traditionally used a post-utilization review process, with companies determining after the provision of care whether payment would be made. Similarly, under federal law governing Medicare and Medicaid managed care contracts, emergency coverage determinations can now be made only after the provision of emergency services.²⁵

For the past two decades, however, third-party payers (both public and private) increasingly have turned to prior or concurrent authorization procedures for determining coverage. Under prior authorization, the individual coverage determination is made before treatment is furnished. Since, for most persons, most treatment is unaffordable without coverage, coverage determination in a prior or concurrent authorization context becomes tantamount to a treatment decision.

The evidence considered as part of the coverage determination process (whether pre-, post-, or concurrent) lies at the heart of the process. An insurer who considers as evidence only the results of randomized controlled trials, scientific

Battle With Insurers," Esther B. Fein, *The New York Times*, February 22, 1998, Section 1, Page 1 (noting that unless specifically enumerated in the contract, otherwise covered medical and hospital care for infertility is excluded because it is needed to treat a basic condition rather than an illness or injury).

²⁵ 42 U.S.C. §1395w-22(d)(1)(E) (Medicare); 42 U.S.C. §1396u-2(b)(2)(A)(i) (Medicaid).

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studies, and practice standards set by the industry itself,²⁶ and who gives little or no weight to the specific condition of the individual patient, the opinion of the treating physician, or the practice consensus among medical and health professionals in the relevant specialty, could effectively deny coverage for most medical care, either as medically unnecessary or as experimental and therefore excluded.²⁷

An additional critical aspect of the decision-making process is the allocation of burden of proof. An insurer might place on the individual seeking new or continued coverage the burden of proof to demonstrate a given treatment's effectiveness; moreover, were evidence of effectiveness deemed by the insurer to be too weak to justify the continuation of coverage for an ongoing course of treatment, coverage would cease until restored through a subsequent successful challenge by the affected individual to the insurer's decision to terminate or reduce care. Finally, because the challenge would be tantamount to a claim that the contract was breached, the individual would bear the burden of proving coverage.

b. Medicaid and micro-allocation principles and procedures

Medicaid, like commercial insurance, limits coverage to medically necessary care. Furthermore, Medicaid agencies can use coverage review procedures that include prior authorization.²⁸ However, the similarities between Medicaid and private insurance effectively end there.

Under federal law all standards and procedures used by Medicaid agencies must be reasonable and non-discriminatory.²⁹ Certain types of exclusions that are customarily used by commercial insurers (and perfectly permissible as a standard between two private contracting parties), are unlawful under Medicaid. Moreover, state agencies cannot exclude medically necessary coverage for the services and benefits listed in their state plans because they may be defined as “educational,” “social”, or “court-ordered”.³⁰ Furthermore, Medicaid coverage cannot be limited to treatments that are necessary to restore an individual to normal functioning following an illness or injury. Agencies must cover services needed

²⁶ See, e.g., *Healthcare Management Guidelines*, Milliman & Robertson, Inc. (1996). The validity of such industry guidelines as evidence of what should be furnished may be as, if not more, open to question than the opinion of medical practitioners, since the industry stands to benefit directly from the application of these guidelines.

²⁷ See *Adams v Blue Cross and Blue Shield of Maryland*, 757 F. Supp. 661 (D. Md. 1991), overturning a denial of coverage for autologous bone marrow transplant services (the treatment was initially denied as experimental despite evidence of its widespread use in the community of medical professionals, which was the specified evidentiary standard under the Maryland Blue Cross insurance contract).

²⁸ 42 U.S.C. §1396a(a)(30).

²⁹ 42 C.F.R. §440.230(c). An intriguing question is the extent to which principles under the Americans with Disabilities Act (ADA), 42 U.S.C. §12101 et seq., prohibit insurers from arbitrarily denying or reducing coverage based on an illness or condition. To the extent that the ADA in fact reaches such practices, the illness/condition distinction drawn by insurers may, in fact, be unlawful. *Law and the American Health Care System*, supra n. 18 (Ch. 4).

³⁰ 42 U.S.C. §1396b(c).

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to treat both chronic conditions and acute illnesses and cannot require restoration to normal functioning as a precondition to coverage.³¹ Indeed, given the health status of many beneficiaries, such a coverage requirement would defeat the purpose of the program.

As noted, Medicaid agencies are bound by and subject to tests of reasonableness. Their decisions to deny or exclude coverage must demonstrate the reasonableness of the evidence considered in making coverage determinations, which must include the opinion of the treating physician, the overall condition of the individual patient, and evidence of what is considered to be accepted practice among health care professionals.³² In *Reagan v Weaver*,³³ the United States Court of Appeals for the 8th Circuit struck down the Missouri Medicaid program's decision to limit AZT coverage to patients who met certain medical criteria enumerated by the Food and Drug Administration (FDA), regardless of the individual needs of a patient or the opinions of treating physicians. The court stated that:

The Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the attending physician in determining the medical necessity of treatment. In denying AZT * * * the defendants have done nothing to overcome that presumption * * * . In the face of widespread recognition by the medical community and the scientific literature that AZT is the only available treatment for most persons with AIDS, we find that Missouri Medicaid's approach is unreasonable and inconsistent with the [Medicaid] Act. 886 F.2d at 200.

Finally, because Medicaid is means-tested public assistance, the program is governed by constitutional principles of procedural due process.³⁴ As a result, agency determinations to deny, reduce, or terminate coverage in individual cases are not effective until an individual (who desires one) has had a hearing that meets due process requirements, including an impartial decision-maker, the right to present evidence, the right to a written decision, and other elements of fairness.³⁵ Moreover, where an agency decides to reduce or terminate ongoing treatment and the individual requests a hearing in a timely

³¹ In denying Oregon's initial request for approval of its §1115 coverage prioritization demonstration proposal, the Bush Administration ruled that the ADA (which cannot be waived pursuant to §1115) prohibited consideration under Medicaid of whether treatment would improve an individual's quality of life.

³² *Beal v Doe*, 432 U.S. 438 (1977); *Pinnecke v Preiser*, 623 F.2d 548 (8th Cir. 1980); *Reagan v Weaver*, 886 F.2d 194 (8th Cir. 1989).

³³ 886 F.2d 194 (8th Cir. 1989).

³⁴ *Goldberg v Kelly*, 397 U.S. 254 (1970).

³⁵ 42 C.F.R. §431.

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fashion, assistance must be continued pending the outcome of the fair hearing.³⁶ This obligation to continue treatment pending a fair hearing has been held directly applicable to managed care enrollees, since state Medicaid agencies remain obligated to follow constitutional principles even when they hire contractors to administer their programs.³⁷

B. RECONCILING MEDICAID AND INSURANCE PRINCIPLES IN MANAGED CARE CONTRACTS

Medicaid agencies can elect to administer their programs through private contractors acting as simple administrative service organizations or through risk contractors. Regardless of whether the financial risk for the cost of medical care shifts to a company under a managed care service agreement, a state Medicaid agency remains obligated to adhere to federal requirements with respect to health care coverage, access, quality, and administration. Under legal principles of agency, moreover, state agencies remain liable for violations of federal (or state) law by their contractors in the event that their contractors fail to furnish covered care or else furnish care in a manner that does not satisfy legal requirements.

This continued exposure of state Medicaid agencies for coverage and services that are mandated by federal and state law, but omitted from the managed care agreement by the contractor, is easy to overlook because most beneficiaries receive virtually all of the care and services they need (even if they receive their care pursuant to commercial insurance principles).

However, as persons with chronic illness and disabilities increasingly are moved into managed care, the gap between the insurers' approach to treatment and coverage decision-making, as well as overall care management, and federal Medicaid requirements may begin to grow, regardless of whether Medicaid agencies elect to include less than the full array of Medicaid services in their contracts. As a result, the fact that Medicaid managed care enrollees may have two or more layers of coverage (i.e., coverage provided through their managed care plan(s) and coverage provided directly from the state) may become more apparent. State agencies that fail to take into account the distinctions between Medicaid and commercial insurance as they draft their contracts may be left with significant levels of direct financial liability for federally covered services and benefits in the event that a contract turns out to be ambiguous or unclear.³⁸ For this reason the Balanced Budget Act of 1997, as well as subsequent HCFA interpretation of the law, require specificity in managed care contracts,³⁹ in order to avoid the serious and costly problem of unanticipated governmental financial exposure for Medicaid services.

The ramifications of vaguely-worded contracts, however, extend beyond the financial exposure of state and federal governments. Chronically ill and disabled beneficiaries who need Medicaid services not covered or excluded under commercial insurance principles may be unable to secure care, despite the fact that a service is ostensibly portrayed in the

³⁶ *Id.*

³⁷ See *Grijalva v Sbalala*, 946 F. Supp. 747 (D. Ariz. 1996); *J.K. v Dillenber*, 836 F. Supp. 694 (D. Ariz. 1993); *Danids v Wadly*, 926 F. Supp. 1305 (M.D. Tenn. 1996).

³⁸ Under the contract interpretation rule of *contra proferentum* (a contract will be construed against the drafter), service agreements that fail to clarify the scope of coverage (including the standards of coverage and the evidence that must be considered in reaching coverage determinations) would be construed against the agency.

³⁹ 42 U.S.C. §1396v(a)(5)(B)(iv).

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contract as covered when necessary. While some beneficiaries may understand that at least some coverage may still be available directly from the state agency, many others may not (recent amendments to the Medicaid statute require full disclosure by state agencies and commercial plans regarding what is covered by the plan and what is available directly through the state agency).⁴⁰ As a result, beneficiaries simply may forego necessary care or be “ping-ponged” among managed care plans and the state agency while coverage disputes are resolved.

Because of the enormous consequences of ambiguity in the coverage provisions of Medicaid managed care contracts-- to both beneficiaries and to state and federal governments--this report pays particularly close attention to the issue of coverage: the clarity of the contract provisions, the specificity of the coverage principles and procedures that states use to guide contractor decision-making, and the availability of rapid dispute resolution procedures in the event of a coverage dispute. In the case of the managed behavioral health care plans, the separate review found in Part 3, *infra*, is designed to examine these issues in a “carve-out” context, where specificity regarding coordination of coverage between carve-out plans and general plans and the point at which a carve-out contractor’s treatment duties are triggered, as well as coverage specificity, are of great importance.

⁴⁰ 42 U.S.C. §§1396u-2(a)(5)(B)(iv), 1396u-2(b)(1).

PART 2: MENTAL ILLNESS AND ADDICTION DISORDER TREATMENT AND PREVENTION: KEY FINDINGS AND TRENDS IN MANAGED CARE CONTRACTS

Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts (2d Ed.) is a nationwide, point-in-time, descriptive study of contracts between state Medicaid agencies and managed care organizations offering comprehensive medical care, typically on a full- or partial-risk basis.⁴¹ The data from which this analysis is derived were extracted from 54 separate contracts and related documents from 41 states and the District of Columbia that were in use as of the beginning of 1997. Among these contractual documents are 12 managed behavioral health care carve-out documents from 11 states (Iowa maintains separate mental illness and addiction disorder contracts).

Not all of the contracts are new to this edition of the study. Of the 54 contracts included in the data base, 21 were also part of the data base for the first edition of the study, since their terms are multi-year. State agencies requested that we include these contract documents for a second year; in several cases, the agencies supplied us with mid-term modifications and addenda that were incorporated into the data base and are reflected in the volumes of annotated tables that accompany the second edition of *Negotiating the New Health System*. A full description of our methodology, including data preparation and the state submission and review process, can be found in Appendices A and B to this Special Report.

A. TRENDS IN CONTRACTS

Because a sizable proportion of the contract documents are not new and may have been only slightly modified since the first edition of this study was released, the changes between our findings in the first and second editions are not extreme. This is not at all surprising; publicly purchased managed care involves the development of massive, detailed legal documents, a lengthy implementation time period, and a stable performance period that allows for the development and execution of a reliable oversight process. Managed care implementation would be virtually impossible were contracts to change significantly each year, especially in states that use competitive procurement procedures. Moreover, contract terms of short duration might discourage the active involvement of the insurance industry, since market entry is a complex and costly proposition.

Despite the comparability of this year's findings and the findings from the first edition of the study, there are some noteworthy trends.

⁴¹ MCO agreements can be for administrative services only for some or all services enumerated in the contract, with risk retained in the state agency.

1. The number of contracts covering persons with disabilities is rising

In its 1997 report on state Medicaid managed care activities, the National Academy for State Health Policy noted an increase in reported state use of managed care for populations with, or at risk for, disabilities. This trend is evident in the reviewed contract documents themselves. For example, the enrollment table from the first edition of *Negotiating the New Health System* (Table 1.1) identified a total of 22 contracts that were expressly open to enrollment by children in foster care and other out-of-home placements. This edition identifies 28 contracts which are open on a mandatory or optional basis to all, or certain categories of, such children, who have been shown in numerous studies to be at significantly greater risk for both physical and mental disabilities.⁴² (See Figure 2, p. 49) Similarly, the second edition reveals that 38 contracts permit managed care enrollment on either an optional or mandatory basis (i.e., do not expressly exclude enrollment) for either some or all persons with disabilities; in the earlier edition this figure stood at 31 contracts.⁴³

2. Contracts are growing larger and more complex

With the enrollment of more classes of persons with disabilities, it is not surprising that the contract documents are becoming more complex. The growing range of issues addressed in the contract documents is particularly evident in those provisions that address the relationship between managed care organizations and other health, welfare, education, and human service agencies, as well as the courts and the judicial system. As discussed in greater detail *infra*, there is intense variation in how states address these interagency/inter-management issues with respect to the services and responsibilities that fall within both the scope of the managed care contract and the activities of the outside agencies. Nonetheless, the movement into managed care of populations receiving care and treatment from, and/or under the jurisdiction of, multiple agencies has to an unprecedented degree propelled state Medicaid agencies into examining these points of intersection. Undoubtedly, the growth of managed care enrollment of persons with disabilities and special needs also has increased the level of external scrutiny (as well as the level of involvement) by other agencies and programs, for whom managed care may be causing major shifts in the type and level of coverage, the source of care, and the settings and personnel through which care is given.

⁴² See, e.g., Neal Halfon et al., "Development of an Integrated Case Management Program for Vulnerable Children," *Child Welfare* 72:4, pp. 379-96 (1993); N. Hochstadt et al., "The Medical and Psychological Needs of Children Entering Foster Care," *Child Abuse and Neglect* 11, pp. 53-62 (1987); R. Chernoff et al., "Assessing the Health Status of Children Entering Foster Care," *Pediatrics* 93, pp. 594-601 (1994).

⁴³ Of course, this provision indicates those contracts that expressly refer to persons with disabilities. Managed care enrollees may include many persons with one or more disabilities whose basis of Medicaid eligibility nonetheless is other than disability (e.g., a child with a disability whose eligibility is based on her poverty status). As a result, the enrollment chart on page 50 undoubtedly under-represents the actual prevalence of disabled persons in Medicaid managed care plans. The potential for under-representation of persons with disabilities in Table 1.1 of the first edition would be even more pronounced if one were to use the definition of disability found in the Americans with Disabilities Act or the Rehabilitation Act of 1973, rather than the definition used in the Supplemental Security Income Program (SSI) (eligibility for which in most states means automatic Medicaid eligibility as well).

3. States appear to be moving toward greater use of managed behavioral health care arrangements

The use of managed behavioral health care contracts is increasing. For the first edition, which involved the collection of documents during the second half of calendar year 1995, 8 states submitted a total of 9 such agreements for review. For this edition, which is based on contracts collected during the latter half of 1996 and the early weeks of 1997, 11 states submitted a total of 12 behavioral health contracts.⁴⁴ Moreover, it should be noted that the trend toward carve-out arrangements appears to have grown even more pronounced. While submission of contracts is voluntary on the part of states, and thus some states may fail to provide documents, our experience to date has been that states provide us with virtually all “live” contract documents available for review during the collection time period. Thus, we conclude that the apparent growth in the use of managed behavioral health contracts is real and not merely an artifact of a voluntary reporting system.

The growth in carve-out contracting for behavioral health services is probably attributable to several factors. The first is a “demand side” factor: the movement into managed care of more seriously ill populations. As will be discussed at length in Part 3, managed behavioral health care contracts appear to offer broader coverage than general service agreements in certain key areas. This is demonstrated even in cases in which the general services agreements appear to include at least some level of MI/AD services. The increased use of specialized contracts appears to be a logical outgrowth of the trend toward inclusion in managed care of more persons with disabilities. This fact alone probably would help explain the movement toward greater use of specialty managed care products for a higher risk population whose treatment needs may be beyond the skill levels of the general service industry.⁴⁵

As in any health care market, there are probably “supply side” factors, as well, that help explain the use of managed behavioral health care organizations. The growth of this product line may be a reflection of the market power of the specialty industry itself, as well as the underlying provider networks and systems on which the managed behavioral health industry rests. Managed care has altered the relationship between the Medicaid program and the multitude of agencies and providers that depend on its financing. It is likely that the involvement in managed care systems formation by community providers and programs is growing, as local organizations seek to retain a prime contractor relationship with their Medicaid agencies rather than lose the portion of a premium to a general service company.

Furthermore, the managed behavioral health industry is a powerful one, with operations now concentrated in a handful of large companies that are able to offer a wide array of products and more sophisticated management. Given the significance of the MI/AD portion of state Medicaid budgets, as well as the size of other public agency budgets used to support MI/AD-related services, a more aggressive response to the Medicaid market by the industry itself should not be

⁴⁴ One of the states that is newly-represented in the managed behavioral health care data base (Arizona) in fact had a managed behavioral health care contract in effect at the time that collection for the first edition was under way but did not submit the agreement for inclusion in the first edition. It should also be noted that the Washington State behavioral health care carve-out agreement which was submitted by the state and is included in this study does not appear to include inpatient care.

⁴⁵ Of course, states that elect to contract only with general service companies may have numerous contractors that, in turn, subcontract with specialty behavioral health care management firms themselves.

surprising.

4. States are increasingly likely to specify at least some level of treatment and prevention for mental illness and addiction disorders in their general service agreements

In the first edition of *Negotiating the New Health System* we found at least some level of MI/AD coverage in 30 out of 36 general service agreements reviewed. (First Edition, Table 2.1) In this edition we discovered evidence of at least some level of MI/AD-related coverage in all of the 42 general service agreements reviewed. (Second Edition, Table 2.1)⁴⁶ In other words, not only do more contracts cover at least some MI/AD-related care, but such coverage is more prevalent, as well. Thus, at the same time that states are increasingly likely to be using managed behavioral health care carve-out agreements, they are also more likely to be buying general products that include at least some basic level of coverage, suggesting that specific behavioral health care contracts are intended for persons with serious illnesses and disabilities.

Three follow-up observations are worth noting at this point. First, the tendency toward at least some level of MI/AD services in a general service contract is probably consistent with the practice of the industry to provide at least some level of coverage in its commercial products (although the coverage may be through a sub-contract with a specialty managed behavioral health care company). Indeed, it was the disparity in coverage levels between mental illness services and other services that led to enactment of the Mental Health Parity Act of 1996.⁴⁷

Second, and consistent with the first observation, it is not unusual for states to limit coverage for mental illness and/or addiction treatment under their general service agreements to care that would ordinarily be furnished by a member's primary care provider. This type of limiting clause can be found in several contracts, as shown in the annotations that accompany Table 2.1; however, these contracts do not indicate what the state intends by "primary" mental health care, an issue that assumes great significance in states that use carve-out agreements, as discussed below. This type of provision suggests that, as with other forms of primary/specialty care, state Medicaid agencies (and presumably managed care organizations) assume that the individual's primary care provider will be capable of furnishing much of the mental illness or addiction disorder-related treatment and prevention care previously furnished by specialists. For example, mental health care-related amendments effective in 1997 to California's general managed care contract state as follows:

⁴⁶ It should be noted that one state (Montana) that previously included at least some MI/AD services in its general agreement has subsequently eliminated such services and elected to separately contract for all MI/AD services.

⁴⁷ The Mental Health Parity Act of 1996 added provisions requiring parity in the application of certain mental health benefits to both the Employee Retirement Income Security Act of 1974 (Subchapter I, Subtitle B, Part 7C Group Health Plan Requirements (29 U.S.C. §1185a)) and the Public Health Service Act (Subchapter 2-XXV, Part A, Subpart 2-Group Markets Reform (42 U.S.C. §300gg-5)).

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The following mental health services are excluded from the Contract: All Short-Doyle/Medi-Cal (SD/MC) * * * mental health services (inpatient and outpatient); Fee-for-Service/Medi-Cal * * * outpatient mental health services provided by psychiatrists and psychologists; FFS/MC inpatient mental health services.

The Contractor will provide outpatient mental health services within the Primary Care Physician's scope of practice. The Contractor will refer Members who need specialty mental health services to the appropriate * * * mental health provider or to the appropriate SD/MC provider. California Contract Amendment, §6.7.3.3 (1997)

Under this type of provision, a critical issue becomes whether the carve-out contractor has discretion to determine which services fall within a primary care practitioner's "scope of practice," thereby obviating the need for referral care. The ambiguities surrounding the primary/specialty distinction and the scope of discretion given to managed behavioral health care contractors to decide when their services are necessary are discussed at greater length in Part 3. Both issues have particular salience in states that allocate to carve-out firms a percentage of each premium paid for residents of the service area, rather than pay firms on a case-related basis. Such a payment agreement can result in the advance payment of a high-cost specialty supplier who has the discretion to decide if and when its services are needed. While prepayment is, of course, a feature of managed care generally, coverage of primary care acts as a form of check on under-service, since individuals need and demand primary care frequently. The same cannot be said of specialty care, especially in a managed care environment, where the services of specialists are generally discouraged.

B. SPECIFIC FINDINGS

The individual chapters in the volumes of tables accompanying *Negotiating the New Health System* (2d Ed.) present detailed findings in the areas of enrollment, coverage, access, interagency relationships, quality oversight and improvement, consumer protections, and financial and business relationships. This section highlights certain issues within these findings and offers illustrative language from the contract documents.

1. Enrollment and disenrollment

Despite the apparent growing prevalence of children and adults with special health care needs in managed care, the contracts do not suggest the use of specialized enrollment and disenrollment procedures or the imposition of specific

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coverage and care duties on plans that enroll members receiving active care.

For example, as persons with intensive health needs are moved into managed care, it is likely that they will already be receiving medical care at the time of enrollment. Similarly, given the inherently discontinuous nature of Medicaid coverage, it is likely that, regardless of voluntary disenrollment requests from members, there would be significant involuntary disenrollment of individuals receiving ongoing care at the time of membership termination. Neither set of issues received extensive attention in the documents we reviewed.

Seventeen contract documents specifically address plan duties relating to persons receiving ongoing treatment at the time of enrollment. Fewer contracts contain specific provisions related to certain sub-groups of such persons. Seven contracts specifically address the issue of special enrollment procedures for adults or children with mental illness, while four specifically address enrollment of adults and children with addictive disorders. (Table 1.4) Nine contracts contain specific provisions related to the enrollment of children in foster care or out-of-home placements (including those who are in the custody of the state) at the time of their enrollment, a subgroup of enrollees with special health care needs who may be at particularly high risk for illness. For example, Missouri's contract provides as follows:

Children in state custody or foster care placement will be allowed automatic and unlimited changes in plan and provider choice as often as their foster care placement changes necessitate. Missouri RFP, p. 42 (Table 1.4)

While Missouri's contract addresses the treatment of children once they are enrolled in the plan, it does not establish special procedures for their enrollment, such as obligations of the plan to offer foster families additional provider selection assistance, which may be necessary given these children's health care needs. The Iowa substance abuse contract and the New Jersey contract provide examples of the variation in state approaches to contractor duties toward persons receiving care at the time of enrollment. The Iowa substance abuse contract sets forth the following broad obligations, which create general enrollment duties in contractors in the case of certain enrollees:

Inpatient services to enrollees that commenced prior to September 1, 1995, will be the responsibility of DHS (except for the professional component) until such time as the patient is discharged. The Contractor will be responsible for the professional component. *The contractor will make reasonable efforts to be aware of all inpatient services to enrollees to assure continuity of care and the least disruptive transition to managed substance abuse care services subsequent to the discharge*

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from the inpatient facility. Iowa Substance Abuse Contract, p. 7 (Table 1.4) (Emphasis added)

The Iowa contract essentially requires an MCO to familiarize itself with the status of a new enrollee who enters the plan following discharge from a hospital and encourages continuity of care. In contrast, the New Jersey contract sets forth a more specific duty covering a range of services being furnished at the time of enrollment. New Jersey provides as follows:

The contractor shall, for new enrollees, honor plans of care, prescriptions, durable medical equipment, medical supplies, prosthetic and orthotic appliances, and any other ongoing services initiated prior to enrollment with the contractor until the enrollee is evaluated by his/her primary care physician and a new plan of care is established with the contractor. New Jersey Contract, p. 44 (Table 1.4)

The New Jersey contract thus creates a specific and measurable duty in a contractor to adhere to pre-existing plans of care until a new primary care relationship has been established and a new plan of care is put into effect.

In the first edition of *Negotiating the New Health System* we noted that many contract documents permit plans to request disenrollment for cause in the case of enrollees who engage in disruptive or inappropriate behavior. This practice is also addressed in many of the documents included in this edition (Table 1.7), although inclusion of such a plan option is relatively less common in the managed behavioral health care carve-out agreements, but present nonetheless (see Table 1.7). Plan-initiated disenrollment provisions are not unusual; indeed, the Balanced Budget Act specifically permits Medicare+Choice plans to disenroll Medicare members “who engage in disruptive behavior” as defined in standards set by the Secretary of the Department of Health and Human Services.⁴⁸

At the same time, however, the unrestricted right on the part of plans to initiate disenrollment requests when they consider behavior to be “disruptive” could potentially fall with disproportionate weight on individuals who attempt to exercise their rights under a plan. Even more significant in the context of this study, a broadly drafted “disenrollment for cause” provision could lead to the disenrollment, without reasonable accommodation, of individuals whose conduct is the product of a mental illness or addiction disorder.

⁴⁸ Section 1851(g)(3)(B) of the Social Security Act. Standards are expected to be issued in 1998.

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States offer contrasting approaches to this issue. The Nebraska mental health agreement, for example, permits its behavioral health contractor to request from the Department of Social Services a disenrollment for “just cause” as permitted under the Nebraska Administrative Code.⁴⁹ The Florida mental health agreement, on the other hand, expressly prohibits contractors from disenrolling members for cause, although it does allow the contractor to “change the enrollee’s direct service mental health care provider.” (Table 1.7) Thus, while the Florida contract appears to indicate an expectation on the state’s part that a specialty company will have mechanisms for addressing issues related to particularly difficult clients, the Nebraska contract includes provisions permitting plans to seek the removal of such persons from the plan itself.

2. Coverage

As discussed in Part 1, coverage lies at the heart of the managed care agreements. Therefore, a discussion of coverage actually raises several distinct issues and sub-issues. Macro-allocation issues focus on the classes and general extent of services and benefits that are covered by Medicaid and included in the contract. Thus, for example, whether or not inpatient crisis care is a covered benefit is a macro-allocation issue, as is the question of whether the contract allows an MCO to place an aggregate limit on the number of inpatient crisis episodes it will cover in a year. Micro-allocation matters, on the other hand, encompass the process of coverage determination and the standards which contractors must apply in reaching individual coverage determinations, including the use of prior authorization, evidentiary and burden of proof issues, and the question of continued assistance in situations in which the determination involves the termination or reduction of ongoing treatment.

Depending on how broadly the contract is drafted, a state agency may remain directly liable for some degree of care. For example, if a state’s contract either expressly or by implication (e.g., through silence) permits the contractor to place aggregate limits on inpatient crisis episodes, the state Medicaid agency may remain directly liable for additional episodes of crisis care. This would be particularly important when children are involved, due to the EPSDT program’s prohibition on flat limits that, while potentially permissible in the case of adults, deprive children of medically necessary care.⁵⁰ Similarly, if a state’s contract does not require an MCO to continue benefits at pre-reduction or pre-termination levels during the pendency of a decision in a fair hearing that has been timely requested by the recipient, under due process requirements the state presumably would remain directly liable for the cost of such coverage.

⁴⁹ The Nebraska Administrative Code provides: “In the following situations DSS approval is required before disenrollment occurs: (1) Fee for service Medicaid is determined to be more cost effective for the client’s needed services; (2) Extreme circumstances/hardships exist; (3) The client is not benefiting from participation in [the plan]; or (4) Other similar situations.” These provisions appear to give the plan the right to initiate a disenrollment request in a wide variety of circumstances, including a general inability to manage or handle a member who is being “disruptive” and thereby creating “extreme circumstances” or “not benefiting” from managed care.

⁵⁰ Of course, where the state agency considers its contract to prohibit such limits, it may have a breach of contract claim against the MCO for failing to cover medically necessary care.

a. Macro-allocation: classes and extent of coverage for beneficiaries as a group

The Medicaid program allows states to cover an extremely broad range of preventive, acute, and long-term services for persons with MI/AD in virtually any therapeutic setting allowable under state law. In the first edition of this study we reported wide variation in the scope of coverage within the service agreements. Table 2.2 in the accompanying volumes shows that this variation continues. Variation in coverage is particularly pronounced in the general service agreements, with more consistent scope of coverage patterns in the behavioral health care carve-out arrangements, as discussed in Part 3. Not surprisingly, perhaps, the greatest variations involve long-term residential and non-residential treatment and other longer-term management services for individuals with more severe problems. The most commonly covered services are outpatient care, inpatient crisis care, case management, screening, and referrals. Some contracts specify that in setting coverage limits the contractor must adhere to those limits that are included in the state plan; most contracts are silent on this point, however, thereby implicitly permitting the contractor to limit overall coverage to levels below that which the state program actually permits. New Jersey's contract offers an example of a provision that has been drafted to avoid such residual exposure:

The health care services listed [in the agreement] shall be provided by the contractor to enrollees as covered benefits rendered under the terms of this agreement. Provision of these services shall be equal in amount, duration and scope as established by the Medicaid program, in accordance with medical necessity without any predetermined limits, unless specifically stated, and as set forth in the Medicaid Provider Manuals. New Jersey contract, p. 130 (Table 2.1)

There may be many reasons why state contracts vary so greatly on the basic issue of which classes of services are included in the agreements. Some state Medicaid plans may not cover a service at all for the general population, and the state may not have elected to use its authority under federal law to furnish greater levels of benefits to MCO enrollees.⁵¹ Other state agencies may decide to retain direct coverage responsibility for certain services included in the state plan (e.g., inpatient psychiatric care for children under age 21, pharmacy services, or other services left in the fee-for-service system and not subject to contractor management rules). Still other states may create three tiers of coverage: their own continued direct coverage of certain benefits, other benefits included in a general service agreement, and additional services placed in a managed behavioral health care carve-out agreement. In any given state, all three factors can be at work: that is, the state may not cover certain services at all, retain direct liability for other services, and place still other services in one or more general or specialized managed care contracts. As a result, a true interstate comparison of the actual scope of mental illness and

⁵¹ Section 1902(a)(10)(E) of the Social Security Act; 42 U.S.C. §1396a(a)(10)(E).

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addiction disorder treatment and prevention services is possible only by examining all three possible sources of coverage (i.e., the state plan, the general agreement, and the carve-out agreement).

Few of the contracts examined in this collection round specify which services covered under the state Medicaid plan are in which location (i.e., the state plan, a general agreement, or a specialty agreement) and the extent of coverage in each location. This lack of specificity regarding the location of services can be expected to change, however, as a result of previously-mentioned provisions in the Balanced Budget Act of 1997. The need to provide beneficiaries with greater specificity regarding which services are plan services and which remain services of the state agency may result in greater clarity in the contracts, as well.

While the full range of state variation in coverage is beyond the scope of this Report, the contracts offer important insight into how states approach different coverage issues, with respect to both classes of coverage and service definitions (a crucial aspect of articulating coverage limitations). An example of this variation can be found in coverage of outpatient care. The term “outpatient care” encompasses a potentially enormous range of services and procedures, from a simple office visit with a medical professional to comprehensive day treatment programs furnished by clinical providers offering a bundled array of interventions and procedures for persons with mental illness or addiction disorders. All possible variations on the term can be found in the contracts. For example, California, which as noted previously offers very little MI/AD care under its general service agreement, defines outpatient care as follows:

The Contractor will provide outpatient mental health services within the Primary Care Provider’s scope of practice. California Contract Amendment, §6.7.3.3 (Table 2.2)

Illinois, on the other hand, which at the time of our study did not use a carve-out agreement but covered a fair amount of MI/AD-related care under its general service agreement, uses the term “outpatient care” to describe the following set of services:

Contractor will be responsible for mental health services and rehabilitative services relating to the abuse of or addiction to alcohol and drugs not to exceed in the aggregate twenty (20) outpatient visits per Contract Year * * * of which no more than twenty (20) * * * visits * * * may be used for rehabilitative services relating to the abuse of or addiction to alcohol and drugs; and detoxification and treatment for medical complications of abuse of alcohol or drugs on either an outpatient or inpatient basis, whichever is medically determined to be appropriate. Illinois Contract, p. 12 (Table 2.2)

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The Illinois definition suggests that the term “outpatient care” is expected to include both services furnished by independent medical practitioners as well as comprehensive rehabilitation care. The contractor is not bound under this provision to actually offer any comprehensive outpatient rehabilitation care, but if it does, its responsibility is limited to 20 visits.

Urgent and emergency care services present important examples of the potential influence of service definitions on the scope of the service itself. The Balanced Budget Act of 1997 contains a new statutory “prudent layperson” definition of emergency conditions. This definition requires state contracts with managed care organizations⁵² to cover emergency services (which are defined in the law as services that are “needed to evaluate or stabilize an emergency medical condition”⁵³) that are needed by persons with “emergency medical conditions.” The term “emergency medical condition” is defined as:

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; or (ii) serious impairment to bodily functions; or (iii) serious dysfunction of any bodily part.⁵⁴

The annotations in Table 2.6 illustrate the significance this change will have on future contracts. Virtually all of the definitions in the contracts analyzed fail to reference a prudent layperson, thereby leaving the question of coverage to be determined in accordance with the more restrictive professional judgment standard in those states that have not yet enacted their own “prudent layperson” statutes applicable to Medicaid managed care arrangements.⁵⁵ Moreover, several contracts fail to provide for an “immediate” access standard in the case of an emergency, and instead are drafted in a manner that arguably allows for a lesser level of performance. The Nebraska mental health contract provides an example of a provision that would appear to permit emergency response time that is less than immediate:

⁵² Whether the new prudent layperson standard applies only in states that provide managed care as a state option or also to states that administer their programs under §1915(b) waiver authority is unclear at this point because of ambiguities in the manner in which the BBA was drafted. For a general discussion of the managed care provisions of the BBA, see the Overview volume to the Second Edition of *Negotiating the New Health System*. See also, Andy Schneider, *Overview of Medicaid Managed Care Provisions in the Balanced Budget Act of 1997*, The Kaiser Commission on the Future of Medicaid (Washington, D.C. 1997).

⁵³ 42 U.S.C. §1396u-2(b)(2)(B)(ii).

⁵⁴ 42 U.S.C. §1396u-2(b)(2)(C).

⁵⁵ According to Ken King, Director, Chapter and State Relations, American College of Emergency Physicians, there were 16 states with their own “prudent layperson” statutes at the time of this writing.

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[Contractor] shall arrange for the provision of all Emergency Medical Services * * * 24 hours each day, 7 days a week. [Contractor] shall ensure that its Providers have a phone number that Clients or individuals acting on behalf of a Client can call at any time to obtain emergency * * * care. This number must have access to individuals with authority to authorize treatment as appropriate. A response to such call must be provided within 30 minutes. Nebraska Mental Health Contract, p. 11 (Table 2.6)

Under this provision, while the contractor itself must be available 24 hours a day, and must “respond” to emergency requests within 30 minutes, there is no actual requirement that emergency medical care be covered on an immediate basis. Indeed, this contract would appear to permit prior authorization of emergency care. Assuming that an individual is suffering from what a prudent layperson would consider to be a life-threatening emergency requiring immediate attention, the Nebraska contract nonetheless would authorize the contractor to deny payment for care without prior authorization. Furthermore, the contractor would have no obligation to make care available immediately.⁵⁶

b. Micro-allocation: coverage procedures and standards for individual enrollees

Micro-allocation aspects of contracts embody numerous sub-issues: the insurer’s authority to exclude certain otherwise-covered services; the procedures that must be used to decide coverage initially; the standard that the decision-maker uses in determining an individual’s entitlement to coverage; the evidence that the decision-maker must take into account in making the coverage determination; the allocation of the burden of proof in the coverage determination; and the availability of continued assistance in the event of an appeal of an initial decision to terminate or reduce coverage for ongoing treatment.

Exclusionary clauses. As noted in Part 1, insurance contracts typically either contain express provisions permitting the insurer to exclude certain otherwise-covered treatments, or else broadly delegate to the insurer the authority to determine

⁵⁶ It should be noted that where a state agency’s contract contains provisions that are inconsistent with applicable state or federal law (that has not been waived), the provision would be without legal meaning, since administrative agencies have no legal authority to overrule state or federal law in their contracts. See *MedCare HMO v Bradley*, 777 F. Supp. 1460 (N.D. Ill. 1992) (overturning a contract-at-will clause in a state contract with a managed care organization as inconsistent with state law); *J.K. v Dillenberg*, 836 F. Supp. 694 (D. Ariz. 1993) (prohibiting state from disclaiming its federal responsibilities by contracting out its obligations to a private agency).

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if a service is “medically necessary and appropriate,” thereby implicitly permitting such exclusionary clauses to be imposed.⁵⁷

Where the insurer is permitted to exclude coverage of services and benefits that are not excluded from Medicaid itself, the state agency would remain directly liable for treatment.

While insurers typically exclude experimental treatment, Medicaid limits the authority of state agencies to exclude a service by declaring it “experimental.” Where exclusionary powers are given to insurers in the area of experimental care but no boundaries are created regarding how an experimental determination is to be made, the state agency can be left directly liable for coverage. None of the contracts reviewed set boundaries on the interpretation of experimental treatment similar to those found in *Reagan v Weaver* and the accompanying cases cited in Part 1 (see p. 14).

Other common insurer exclusions are services that are otherwise covered but that are deemed necessary through an educational program, social service program, or as a result of a court or agency order. Insurers typically also exclude services that are available to the public on a free or reduced-cost basis. Many of these exclusionary clauses are highly relevant to MI/AD-related services because of the nature of the patient population (i.e., multiple needs individuals under the care of numerous programs and agencies), and the nature of the services and programs involved.

There are numerous examples of situations in which Medicaid requires coverage of services and activities that insurers would traditionally exclude. For example, the Medicaid statute specifically prohibits agencies from excluding coverage of medically necessary care simply because it is needed as part of a child’s individualized education plan or family service plan under the Individuals with Disabilities Education Act (IDEA).⁵⁸ Similarly, there is no authority in the statute for a state agency to deny coverage of a covered benefit simply because it has been deemed necessary by a court. While the agency would have the authority to consider the necessity of such care, the fact that it is court-ordered cannot serve as a sole basis for denial.

Most contracts are silent on the issue of exclusions. (See Table 2.8) Those that do address the issue tend to either accord contractors considerable leeway to make the decision regarding exclusion or else exempt the procedure or service from the contract altogether and leave the matter as a direct state agency responsibility. For example, the Florida mental health contract has extensive provisions detailing the coverage obligations of its contractors in the case of children who are in foster care or other out-of-home placements (see annotations to Table 2.8). The following excerpt illustrates the detailed nature of the specifications and how Florida has elected to allocate coverage responsibilities:

The contractor is not responsible for physician services provided as a component of therapeutic foster care

⁵⁷ Recent court decisions from the arena of employee health benefit plans and commercial insurance suggest that insurers may be moving to more explicit exclusionary clauses since, under the doctrine of *contra proferentum*, ambiguities in the contract would be construed against the insurer. See generally *Law and the American Health Care System*, *supra* n. 18 (Ch. 2(E) and 1998 Supplement).

⁵⁸ 42 U.S.C. §1396b(e).

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. These services will continue to be provided by HRS *** Department of Alcohol, Drug Abuse and Mental Health *** [T]he plan will not be responsible for the provision of room and board or any psychotherapeutic services (with the exception of [certain services]) *. For any child receiving services through the plan, the plan must participate in all HRS or school staffings which may result in the provision of services for which the plan is responsible****. The contractor shall provide court-ordered evaluation and expert witness testimony required by children who are [members of the plan]. Case management of children in the plan is to include involvement of persons, schools, programs, networks and agencies which figure importantly in the child=s life. **** [The contractor will] provid[e] court ordered mental health evaluations for its enrollees as required by, and within the time limits set by, the courts. The contractor shall also provide expert mental health testimony for its enrolled recipients (with the exception of children in specialized therapeutic foster care and residential treatment) as ordered by the courts. Florida Mental Health RFP, pp. 24-6, 33 (Table 2.8)

Coverage determination procedures (utilization review and prior authorization). The process by which coverage is determined is integral to the issue of coverage determination. This is particularly true in the case of managed care, where the process of reviewing the necessity of care for many procedures (especially those that are considered by the contractor to be specialty care) occurs prior to the receipt of services (i.e., prior authorization). In prospective utilization review situations, coverage determinations become treatment decisions, and the need for procedural safeguards increases.

In addition to the threshold question of whether prior authorization is permissible at all for certain procedures (e.g., emergency care), the general issue of utilization review raises numerous sub-procedural issues including the evidence that must be considered during the process, the qualifications of reviewing personnel, recipient and practitioner access to prior authorization procedures, timelines for prior authorization, and the manner in which the determination must be communicated (e.g., written versus oral; with a written explanation of the basis for the decision). Federal Medicaid regulations set forth extensive utilization review requirements for both inpatient care and outpatient prescribed drugs (see the discussion of drug coverage, *infra*). Most state contracts, however, leave the structure of the contractor's utilization review program to its discretion, providing limited or no guidance on minimum elements or performance standards. Hawaii's contracts offer an example of broadly worded specifications that would appear to create no unqualified and enforceable obligations:

Utilization Review: The [quality assurance plan] shall include a written description of the plan's utilization management program to determine whether the level, type and cost of benefits provided are appropriate to the recipients. The program shall include evaluating necessity, the criteria used and the process used to review and approve the provision of

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behavioral health services. The focus of the utilization management program is to detect under utilization and over utilization. The pre-authorization and concurrent review requirements shall be documented. Hawaii Behavioral RFP, pp. 25-6, 28 (Table 3.5)

The standard of coverage. The standard of coverage is the general standard that a buyer expects its contractors to apply when making coverage determinations. This standard is commonly referred to as the “medical necessity” standard. Table 2.7 in the annotated table volumes shows those contracts that specifically define the term “medical necessity.” As the table suggests, a number of contracts, particularly the managed behavioral health care carve-out agreements, are silent on this definitional issue, leaving to the contractor the discretion to fashion its own standard.

The definitions of medical necessity found in Table 2.7 vary in their structure and specificity. For example, Iowa’s substance abuse contract offers relatively extensive direction to the contractor regarding coverage decision-making:

Determination of coverage under Medicaid funding arrangement is based on logic which examines five (5) variables including the presence of service necessity as determined by the ICPC and for PMIC Substance Abuse Services, the PMIC Admission and Continued Stay Criteria, authorization by the contractor for rendered services at levels IV, V, V - PMIC, VI, and VII as defined by the ICPC and for PMIC Substance Abuse Services, the PMIC Admission and Continued Stay Criteria, by the contractor, the provider of such services, the diagnosis, and the type of services provided.

1. Services are covered at levels I, II, and II when provided by a qualified (participating) provider and when services are medically necessary according to the Iowa Client/Patient Placement Criteria.
2. Services are covered at levels IV, V, V - PMIC, VI, and VII when provided by a qualified (participating) provider when services are necessary according to the ICPC and for PMIC Substance Abuse Services, the PMIC Admission and Continued Stay Criteria, and when services are authorized by the contractor.
- 3a. Covered Diagnoses. The following ICD-9 and DSM-IV diagnostic code series are considered to be covered when services are billed or reported under an approved CPT-4 procedure code, are necessary, and are provided by a participating Medicaid provider, except as noted under II.B.3.b

Exception: PMIC Substance Abuse Services are covered regardless of billing diagnosis when the admission diagnosis is one of the following:

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- 291 Alcoholic Psychoses
- 292 Drug Psychoses
- 303 Alcohol Dependence Syndrome
- 304 Drug Dependence
- 305 Non-Dependent Abuse of Drugs * * * . Iowa Substance Abuse Contract, Attachment 1/1/96, pages 3-4 (Table 2.7)

3. DEFINITION OF TERMS...

Service Necessity:

The requirement that the goods and services provided or ordered must be, pursuant to the criteria of the ICPC:

1. Appropriate and necessary to the symptoms, diagnoses or treatment of a substance abuse disorder;
2. Provided for the diagnosis or direct care and treatment of a substance abuse disorder;
3. Within standards of good practice within the substance abuse service area;
4. Not primarily for the convenience of a plan member or a plan provider; and
5. The most appropriate level or supply of service which can safely be provided. Iowa Substance Abuse Contract, page 5 (Table 2.7)

The Maine contract, on the other hand, provides a very broad definition of medical necessity that is designed to cover all conditions and procedures, giving contractors no guidance on questions of coverage determinations:

1. MEDICALNECESSITY...A1. MEDICALNECESSITY... For purposes of this initiative, medical necessity is defined as health care services which are reasonable and necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury. Maine RFP, page 37

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There are important differences in these two approaches. The Iowa contract provides specific guidance on the protocols that are to be applied in determining the medical necessity of care at various levels and stages of treatment. The standard also establishes an accepted practice standard of coverage that is specific to the substance abuse practice area (i.e., the specialty of substance abuse treatment) as opposed to general standards of treatment. Further, the contract limits coverage to services needed to diagnose and treat a disorder (except, of course, to the extent that the agreement specifically enumerates in the contract specific preventive services for individuals without symptoms of a disease or disorder).

The Maine contract, on the other hand, gives the contractor more latitude to select the specific protocols that it will apply in making medical necessity determinations. Moreover, unlike Iowa, the Maine contract does not specify that the coverage protocols be specific to the specialty area for which treatment is being furnished. However, unlike Iowa, the contract does provide a standard that requires the contractor to consider not only the remedial but also the preventive effects of the proposed treatment on the individual.

Evidentiary requirements and the burden of proof. As previously noted, because Medicaid is a need-based program subject to constitutional protections, due process considerations require that Medicaid agencies, in individual coverage decision-making, have reasonable factual evidence before denying, terminating or reducing medical assistance and that the evidentiary standard not be arbitrary (i.e., not exclude evidence of current medical practice, the opinion of the treating physician or health professional, or the individual needs of the beneficiary).⁵⁹ Thus, Medicaid agencies must act on reasonable evidence and have the burden of proving non-coverage. More than 30 years of judicial decisions striking down agency determinations that do not conform to these evidentiary and burden of proof standards and that create irrebuttable presumptions against coverage by excluding the very evidence that would justify coverage demonstrate that such determinations are unlawful. It is thus in states' strong interests to develop contract specifications related to coverage that are coextensive with their own obligations in order to guard against improper decision-making and significant residual, direct liability for services denied or excluded by a contractor.

As a general matter, the contracts are silent on the issue of evidentiary matters and burdens of proof. A number of states include with their medical necessity clauses standards that require contractors to take into consideration what constitutes accepted medical practice among health professionals. Other states are silent on the weight (if any) to be given to evidence of accepted practice, evidence supplied by the treating health professional, and evidence arising from the individual's condition. At least one state (Nebraska) explicitly incorporates into its contract an evidentiary standard that would permit a contractor to exclude as irrelevant much of the evidence that courts have commonly insisted upon when reviewing agency denials of coverage:

⁵⁹*Goldberg v Kelly*, 397 U.S. 254 (1970).

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1.19 The terms “**Medical Necessity**” and “**Medically Necessary**” with reference to a covered service means health care services and supplies which are medically appropriate and (1) necessary to meet the basic health needs of the Client; (2) rendered in the most cost-effective manner and type of setting appropriate for the delivery of the Covered Services; (3) *consistent in type, frequency and duration of treatment with scientifically based guidelines of national medical, research or health coverage organizations or governmental agencies*; (4) consistent with the diagnosis of the condition; (5) required for reasons other than the convenience of the Client or his or her Physician; (6) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency; (7) *of demonstrated value*; and (8) a no more intense level of services than can be safely provided. *The fact that the Physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness or mental illness does not mean that it is Medically Necessary.* Services and supplies which do not meet the definition of medical necessity set out above are not covered. Nebraska Mental Health Contract, p.5 (Table 2.7) (Emphasis added)

The Nebraska contract thus permits an MCO to exclude from coverage decision-making all evidence that is not derived from standardized guidelines developed either through scientific studies or “health coverage organizations” (that presumably could be industry-owned). The patient’s individual needs as well as the opinions of the treating physician are either not identified as evidence or else are identified as irrelevant evidence. Under Medicaid coverage principles, as stated in *Reagan v Weaver*, a contractor that denies coverage based on this formula could do so by excluding evidence that courts have historically held to be statutorily mandated, thereby failing to meet the burden of proof requirements that apply to Medicaid agencies when they deny, reduce, or terminate care.⁶⁰

State authority to override plan coverage determination procedures. A number of states retain discretion (beyond the formal fair hearing process) to override contractors’ initial coverage determinations for one or more services, thereby permitting the state to substitute its judgment regarding the terms of the contract or specific coverage situations for that of the contractor.

c. Coverage decision-making and prescribed drugs

Because of the importance of prescribed drugs to the treatment and management of mental illness and addiction

⁶⁰*Reagan v Weaver*, 886 F.2d 194 (8th Cir. 1989).

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disorders, we have separately analyzed the micro-allocation and macro-allocation issues inherent in the coverage of prescribed drugs. Specific macro-allocation issues considered were the inclusion of drugs in the contracts at all, the permissibility of formularies and minimum standards for formularies where in use, and provisions pertaining to the permissibility of therapeutic drug substitution practices by contractors. Micro-allocation issues include specific rules applicable to drug coverage determinations for individual enrollees in the case of off-formulary drugs, including the use of prior authorization.

Table 2.1 indicates that nearly all states provide at least some level of drug coverage in their managed care agreements, although drug program authority and responsibility may be distributed between the state and its contractors depending on the drug itself, the state's willingness to contract for drug coverage, and the contractor's willingness to furnish drug coverage.⁶¹

The managed behavioral health care plans vary in how they address drugs. Five of the 12 managed behavioral health agreements appear to include coverage of at least certain prescribed drugs (Arizona, Hawaii, Massachusetts, Pennsylvania, and Washington State). Certain states (Oregon, New York) appear to place at least a portion of their drug coverage in their general service agreements and none with their behavioral health contractor. The Iowa carve-out contracts (both mental health and substance abuse), while not providing for coverage of prescription drugs, do cover the management of certain drugs (e.g., Clozapine and Methadone). Florida's carve-out contract addresses prescription drug coverage only to the extent that it notes that such drugs are only available on a fee-for-service basis, and neither Nebraska nor Utah address prescription drugs in their carve-out contracts.

Federal law sets forth minimum requirements regarding the sufficiency of drug coverage by state Medicaid agencies, including standards for the development of formularies, requirements related to the emergency dispensing of off-formulary drugs, procedures for gaining access to off-formulary drugs, identification of certain drugs that are subject to restrictions, and formulary updating.⁶² The safeguards applicable to state agency formularies do not apply in the case of covered outpatient drugs dispensed by Medicaid managed care organizations.⁶³ However, as with all Medicaid services and benefits, HMO drug programs would be subject to the same tests of reasonableness generally applicable to items and services covered under the program. Therefore, the safeguards expressed in the statute for state-administered formularies (i.e., reasonable coverage based on expert judgment, updating access to non-formulary drugs, and emergency dispensing requirements) could be considered guideposts for MCO contracts.

For the most part, states accord contractors broad discretion regarding drug coverage decision-making; only 18

⁶¹ See, e.g., Massachusetts contract annotations (Table 2.2), which permit the state to evaluate inclusion of drugs on a case-by-case basis.

⁶² §1927(d) of the Social Security Act; 42 U.S.C. §1396r-8d.

⁶³ §1927(j) of the Social Security Act; 42 U.S.C. §1396r-8(j). The exemption specifically applies to organizations with risk contracts under §1903(m). Therefore, administrative services contracts with MCOs that do not involve the devolution of financial risk seemingly would be bound by the terms of §1927(d), as well as other provisions of the statute relating to prescribed drugs.

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contracts set forth minimum specifications for formularies. (Table 3.9) For example, Delaware’s contract provides:

The Diamond State Health Plan will provide standard benefits similar to the acute care benefits that are currently provided under Delaware’s Medicaid program. At a minimum, MCOs must agree to assume responsibility for all covered medical conditions within the Basic Benefit Package for each client. Delaware Contract, unnumbered page (Table 2.1)

Under this general provision, a contractor would not be bound to use the state’s formulary or drug coverage standards as long as its coverage is “similar”; this term is not defined, however, nor is there an indication of how the state expects to measure contractor compliance with a “similar” standard, assuming that such a standard can be articulated.

Unlike Delaware, South Carolina expressly addresses the issue of formularies. However, the South Carolina contract is virtually as broad regarding contractor discretion over access to prescribed drugs and formularies:

Service limits such as a drug formulary may be implemented; however there must be a mechanism to cover drugs outside the formulary if they are determined to be medically necessary in the treatment of a particular Medicaid HMO Program member. South Carolina Contract, p. 14 (Table 3.9)

The South Carolina provision requires a “mechanism” for covering non-formulary drugs, but permits the plan full discretion in how the determination of medical need is to be reached and does not require emergency dispensing or formulary updating.

Colorado’s prescribed drug specification appears to provide contractors with greater leeway to impose absolute and general exclusions on drug coverage than would be permissible in the case of state Medicaid programs themselves under general principles of reasonableness. In *Reagan v Weaver*, the United States Court of Appeals ruled unlawful state drug coverage limitations that flatly and irrebuttably excluded all uses of FDA-approved drugs other than those uses approved by the FDA and administered in accordance with FDA treatment guidelines, because such a coverage standard effectively excluded all evidence of current medical practice, patient need, and recommendations of the treating physician.⁶⁴ The Colorado contract, however, permits its contractors to limit their drug coverage to:

Drugs and medicines published as “Covered Drugs” as listed by the Department which have been approved for use in the United States by the Food and Drug Administration (FDA) and only to the extent that they are used to treat a condition which the FDA has determined that

⁶⁴ 886 F.2d 194 (8th Cir. 1989).

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the drug or medicine is medically appropriate, following FDA approved routes of administration. Colorado Contract, pp. 19A, 21

Therapeutic substitution of one formulary drug for another poses major issues for both beneficiaries and providers, because of questions regarding what constitutes a “therapeutic equivalent” and the limits that should be placed on substitution authority. None of the contracts reviewed established standards governing the practice of therapeutic substitution of drugs, although a number of contracts do contain general directives on formularies.

The Missouri and New Jersey contracts both address many of the issues that can arise in a prior authorization system for prescribed drugs; both states have elected to parallel the requirements of the Medicaid statute. The Missouri contract provides as follows:

Under the current Missouri Medicaid Pharmacy Program, nearly all products of manufacturers participating in the national rebate program are reimbursable * * * . Everything that is covered under the Medicaid Pharmacy Program either without restriction or through prior authorization must be covered by the plans either without restriction or through prior authorization. However, it is not essential that plans cover pharmaceutical products without restriction to the same extent that the fee for service program does. Plans may have a more extensive list of drugs requiring prior authorization but plans may not exclude from coverage any products not excluded under the current Medicaid Pharmacy program. * * * Products available under the Medicaid Pharmacy program must be made available regardless of whether or not the prescriber is in the plan’s network, but plans may require that prior authorization be obtained for prescriptions generated by an out of plan prescriber. Any drug prior authorization program must meet the following criteria: Plans must provide response by telephone or other telecommunication device within 24 hours of a request for prior authorization. Plans must provide for the dispensing of at least a 72-hour supply of a drug product that requires prior authorization in an emergency situation. Approvals must be granted for any medically accepted use. Medically accepted use is defined as any use for a drug product which is approved under the Federal Food, Drug and Cosmetic Act, which appears in peer-reviewed literature, or which is accepted by [certain enumerated] compendia * * * . In addition plans must have a mechanism whereby drugs can be prior-authorized if a member is out of a plan’s service area and there is a time lag between the date of a members effective enrollment and that member’s assignment to a primary care provider. Missouri 1997 RFP, p. 137 (Table 3.9)

3. Network and Access Standards

a. Provider network composition and access standards

Despite the increased number of contracts potentially covering disabled populations who generally have more specialized health care needs, state agencies continue to vest considerable discretion in contractors to tailor their networks and access standards to meet these emerging needs. Traditionally, state Medicaid programs have maintained only limited involvement in the area of provider availability and competency. This limited involvement is reflected in the reviewed contracts, a finding consistent with that of the first edition of this study. In general, states delegate to their contractors broad discretion to develop the provider networks that will furnish covered services, although most contracts contain access standards which must be met.

Most of the contracts reviewed contain at least some specifications regarding the composition and capabilities of provider networks. Twenty-eight contracts, and nine of the twelve managed behavioral health care contracts, contain some level of detail regarding the characteristics and competence of network providers who furnish MI/AD-related services. (Table 3.1) However, as a general matter the contracts designate broad authority to contractors to select and credential providers, proscribing only narrow descriptions of the competency and skill levels of the professionals, agencies, and institutions that will furnish care under the contracts. Presumably, the limited performance specifications for network composition and qualifications (particularly in the case of managed behavioral health care carve-out agreements) is a result of state agencies' belief that network design and development represent an area in which managed care organizations are uniquely qualified due to the nature of the business. Whether or not this expectation is correct in the case of more severely and chronically ill low-income populations is perhaps open to question, since these are not the populations whom managed care organizations traditionally have served.

State approaches to the issue of provider network specifications vary tremendously. For example, Hawaii's behavioral health contract specifies as follows:

All providers of service shall meet applicable state and federal regulations, licensing, certification and recertification requirements * * * . [Minimum network requirements include] Outpatient behavioral health services * * * Mental health rehabilitation services * * * [and] Behavioral health specialists such as psychiatrists who * * * have admission and treatment privileges in a general acute care hospital or psychiatric facility. Hawaii Behavioral Health RFP, pp. 16-7 (Table 3.1)

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Read as broadly as possible, the Hawaii contract would permit a company to assemble a network consisting of psychiatrists and hospital-based rehabilitation programs. Iowa's mental health contract specifies simply that,

The Contractor shall provide at least as much access to medically necessary covered services as currently exists within Iowa's Medicaid fee-for-service delivery system. This shall be measured against current Medicaid provider enrollment. Iowa Mental Health Contract, p. 17 (Table 3.1)

The Iowa contract may in fact establish a stricter standard for networks than the one used by Hawaii, since the Iowa agreement uses provider participation in the fee-for-service system as a benchmark for measurement. To the extent that the Iowa Medicaid fee-for-service plan offers beneficiaries a broader choice of providers than psychiatrists and hospital-based programs, the benchmark would function as a measurable check on networks that could be viewed as overly narrow in their membership. On the other hand, as the fee-for-service system disappears, it is not clear how long this benchmark will be a viable one.

Florida takes a significantly different approach in its managed behavioral health service agreement, setting forth relatively extensive specifications in its mental health contract regarding provider composition:

The contractor shall have access to no less than one fully accredited psychiatric community hospital bed per 2000 prepaid members, as appropriate for both children and adults. * * * The contractor's staff shall include at least one board certified adult psychiatrist or one who meets all education and training criteria for board certification, to be available within thirty minutes typical travel time of all enrolled recipients. The contractor's staff shall include at least one board certified child psychiatrist, or one who meets all education and training criteria for board certification, to be available within thirty minutes typical travel time of all enrolled recipients. * * * The contractor's array of direct service mental health care providers for adults and children must include providers that are licensed or eligible for licensure and demonstrate two years of clinical experience in the following specialty areas: (1) adoption; (2) separation and loss; (3) victims and perpetrators of sexual abuse; (4) victims and perpetrators of physical abuse; (5) court ordered evaluations; and (6) expert witness testimony. * * * The contractor shall provide staff appropriately trained and experienced to provide psychological testing. The contractor shall provide staff appropriately trained and experienced to provide rehabilitation and support services to persons with severe and persistent mental illness. * * * Upon the initial request for services the contractor shall

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provide the enrollee with the name of the assigned mental health provider and an appointment with the provider which is within the required access times indicated [in the contract]. * * * To demonstrate the plan will have the staffing resources necessary for the provision of services, complete and attach * * * PMHP Service Provider Staffing Table, denoting for each county in the service area the number of actual and proposed FTE psychiatrists, child psychiatrists, mental health care case managers, psychologists, psychiatric nurses, licensed certified social workers; other licensed mental health professionals * * *. Florida Mental Health RFP, pp. 28-9, 38, 85 (Table 3.1)

Beyond the issue of network membership and capabilities is the issue of patient access to the network. Nineteen contracts address access-time standards in the area of MI/AD services. (Table 3.7) In many instances, the state delegates to the contractor relatively broad authority to establish access standards for routine, urgent, and emergency care for certain MI/AD services; in other circumstances the standards are specified. Both of these approaches are illustrated by the following excerpts:

Contractor shall define access requirements for routine, urgent and emergency care for chemical dependency services. Pregnant women, not in treatment, shall be included in the definition for urgent care; intravenous drug users shall be included in the definition of routine care. Oregon Contract, p. 11 (Table 3.7)

The MCO provider network must provide face-to-face intervention within one hour for emergencies * * * within seven days for routine appointments and for specialty referrals. Pennsylvania Behavioral Health RFP, p. 69 (Table 3.7)

b. Self-referral to mental illness and addiction disorder providers

Self-referral to certain providers is an issue that has received increasing attention in the public policy debate concerning managed care patient protection. Fifteen general agreements and eight behavioral health care contracts address the issue of self-referral to providers of MI/AD services. In a number of instances self-referral is limited to emergency care. In other instances enrollees are permitted a specified number of self-referrals, typically for assessment and counseling purposes. The Nebraska mental health contract provides as follows:

Through the client assistance program provide direct access to [MI/AD] providers by self

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referral as well as PCP referral, state agency referral, and referral by school health personnel for up to five (5) visits per Client on an annual basis. Nebraska Mental Health Contract, Addendum A (Table 3.4)

The New York RFP and Oklahoma contract permit one annual self-referral (including school referrals for children).

c. Cultural competency

A central concern in the delivery of health care is the cultural competency of medical and health professionals. The ability to furnish care in a culturally competent fashion is essential not only to overall patient satisfaction but to the ability to properly diagnose, treat, manage, and prevent illness and disability within a defined population. Increasingly, cultural competency is an issue that is addressed in managed care contracts.

Table 3.6 indicates that 29 contracts, including 9 of the 12 behavioral health care contracts, address the issue of cultural competency; of these contracts, 10 attempt to define the term “cultural competence.” Nebraska’s managed behavioral health contract offers an interesting example of a cultural competency provision. The agreement not only attempts to establish a performance measurement for cultural competency; it permits certain enrolled individuals to pursue specific remedies if they are unable to locate MI/AD care that they consider to be culturally competent:

[Contractor] shall encourage and foster cultural competency among Providers. [Contractor] shall permit Clients to choose Providers from among [its] Network based on cultural preference. [Contractor] shall permit Client to change Providers based on cultural preference. Clients may submit grievances to [Contractor] and/or the Department related to inability to obtain culturally appropriate care, and the Department may, pursuant to such grievance, permit a Client to use [a] Fee-for-Service [provider] in a county where [contractor] does not enroll all MHSAS professionals. * * * Cultural competence shall be measured by the Department in its Client satisfaction survey program. [Contractor=s] performance goal for the first two years of the contract is 80% satisfaction.⁶⁵ Nebraska Mental Health Contract, Addendum A (Table 3.6)

⁶⁵ An interesting question is whether the 80% satisfaction measure is of all enrollees or of that subgroup of enrollees who fall into one or more culturally diverse categories. To the extent that the satisfaction measure is of all enrollees (and the language appears to suggest this result), the needs of a small cultural minority could be masked by the satisfaction of the majority. Nonetheless, Nebraska is unique in its attempt to measure satisfaction with its cultural competency requirements.-

4. Relationship Between Managed Care Organizations and the Rest of the Health System

A critical issue in the treatment of persons with mental illness and addiction disorders is the extent to which managed care organizations are required to interact with other programs and agencies which are involved in the treatment and management of such individuals. Individuals with MI/AD-related conditions are likely to be receiving other types of health and related services that bear directly on the care they receive from their managed care plans. Moreover, agencies and programs often depend on Medicaid-covered services to help finance related care. In the first edition of this study we examined the extent to which contracts specified the establishment of relationships between MCOs and other agencies and programs and concluded that states face major challenges in attempting to define these relationships. This edition underscores that this area is one that commands the continued attention of program administrators and policy makers.

Table 4.1 illustrates the wide variation in states' approaches to the issue of interagency relationships. The most commonly addressed areas are public health practices (e.g., responsibilities of the contractor to offer, through local health agencies, direct observed therapy services for persons with tuberculosis) and generalized coordination requirements with state and local mental health and substance abuse programs. Thirty-three contracts contain at least some level of specification related to managed care activities that have public health implications in the areas of prevention and surveillance of communicable disease, while 24 contracts specify relationships with substance abuse agencies and 36 address the relationships between managed care organizations and mental health agencies. Further, 10 of the 12 managed behavioral health care contracts address MCO relationships with either mental health or alcohol and substance abuse agencies (or both). The nature and extent of these specified relationships, however, varies significantly. Far fewer contracts address MCO relationships with other types of organizations, such as agencies for children with special health care needs, child welfare agencies, early intervention agencies, and juvenile justice agencies. Wisconsin's contract offers an extraordinarily extensive and detailed set of specifications relating to the relationships between managed care organizations and other agencies, as excerpted below:

The HMO shall sign an MOU with the agencies noted below which includes the minimum requirements listed below:

[County corrections boards] * * * specifying, at a minimum, the conditions under which the HMO will either reimburse the Board(s) or another contract provider, or directly cover medical services, including, but not limited to, examinations ordered by a court, specified by the Board's designated assessment agency in an enrollee's driver safety plan * * *. It is the responsibility of both the HMO and the Board to assure that courts order the use of the HMO's providers. If the court orders a non-HMO source to provide the treatment or evaluation, the HMO is liable for the cost up to the full Medicaid rate if the HMO could not have provided the service through its own provider arrangements. If the service was such that the HMO could reasonably have been expected to provide it through its own

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provider arrangements, the HMO is not liable. The MOU shall further specify reimbursement arrangements between the HMO and the Board's provider for assessments performed by the Board's designated assessment agency under * * * Intoxicated Driver Program rules. * * * *

Court Related AODA Services: The HMO shall be liable for the cost of providing all medically necessary AODA treatment, as long as the treatment occurs in an HMO-approved facility or by an HMO-approved provider prescribed in the subject's Driver Safety Plan. * * * The medical necessity of services specified in this plan is assumed to be established, and the HMO shall provide those services unless the assessment agency agrees to amend the enrollee's Driver Safety Plan. This is not meant to require HMO coverage of AODA educational programs. Necessary HMO referrals or treatment authorizations by providers must be furnished promptly. It is expected that no more than five days will elapse between receipt of a written request by an HMO and the issuance of a referral or authorization for treatment. Such referral or authorization, once determined to be medically necessary, will be retroactive to the date of the request. After the 5th day an assumption will exist that an authorization has been made until such time as the HMO responds in writing.

[Adult welfare] The HMO must assign an HMO medical representative to interface with the case manager from the Targeted Case Management * * * agency. This HMO representative shall work with the case manager to identify what Medicaid covered services, in conjunction with other identified social services, are to be provided to the enrollee. The HMO is not required to pay for medical services directed outside of their provider network by the case manager unless prior authorized by the HMO.

[Child welfare] The HMO shall arrange for the provision of examination and treatment services by providers with expertise and experience in dealing with the medical/psychiatric aspects of caring for victims and perpetrators of child abuse and neglect and domestic violence. Such expertise shall include the identification of possible and potential victims of child abuse and neglect and domestic violence, statutory reporting requirements, and local community resources for the prevention and treatment of child abuse and neglect and domestic violence. The HMO shall consult with human service agencies on appropriate providers in their community. * * * The HMO shall further assure that providers with appropriate expertise and experience in dealing with perpetrators and victims of domestic abuse and incest are utilized in service provision.

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[Court-related children's services] The HMO shall be liable for the cost of providing assessments under the Children's Code * * * and shall be responsible for reimbursing for the provision of medically necessary treatment if unable to itself provide for such treatment ordered by a juvenile court. The medical necessity of court-ordered services is assumed to be established and the HMO may not withhold or limit services unless or until the court has agreed. Wisconsin contract, pp. 37, 81-2 (Table 4.1)

Children in foster care and other out-of-home placements may be particularly in need of coordinated services among several different agencies. The social and medical risk status of such children is well-documented, and it is common for numerous agencies to be involved in their care. Proper treatment and management is made even more difficult as a result of the unstable living arrangements of many of these children, moving from home to placement and then among different placements.

Figure 1 (p. 50) identifies 28 contracts that appear to require or permit the enrollment of children in foster care and other out-of-home placements on either a mandatory or optional basis. The Figure also identifies those states whose contracts contain at least some specification regarding contractor obligations to "coordinate" their activities with those of other agencies and programs. The term "coordination" is in-and-of-itself extremely vague, since it can be as limited as sending informational materials or as extensive as joint case plan development, coordinated payment procedures for services covered by the MCO and included in a child welfare case plan, involvement of certain agencies in an MCO's provider network, exchange of certain data and medical records, and so forth.

Even on the threshold question of coordination, however, state contract provisions vary significantly on the issue of whether they specify any provisions related to the issue and on the scope of coordination required, if so specified. For example, the Florida managed behavioral health care contract specifically exempts from the scope of the agreement physician services furnished as part of therapeutic foster care. The Minnesota contract, which excludes certain children in foster care from enrollment, contains a unique provision requiring health plans to develop transitional treatment arrangements for children who enroll in the plan following a period of exclusion due to their foster care or out-of-home status:

The health plan is * * * required to develop a transitional plan for children who have previously been excluded from [managed care] because they have been involved in the child protection system, placed in foster care, or diagnosed as severely and emotionally disturbed. While excluded * * * a treatment regimen may have been initiated for those children who are assessed as having behavioral or other mental health problems. However, because the duration of the exclusion * * * will vary from one child to the next, some of these children

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may be enrolled in the health plan before their treatment plan is completed. As part of the treatment plan the health plan should participate in county child protection conferences to assure proper communication and coordination between the county social services agency and the health plan regarding the specific needs of each child. Minnesota contract, Appendix I, pp. 1, 6 (Table 2.8)

Figure 1. Treatment Plan Coordination Provisions Contained in Contracts that Provide for Enrollment of Children in Foster Care and Other Out-of-Home Placements

States whose contracts cover some or all children in out of home placements	Individualized Education Plan	Individualized Family Services Plan	Child Welfare Agency Plan	Court-Ordered Treatment Plan
CO	√			
DE				
FL (general)			√	√
FL (behavioral)			√	√
IN				
IA (subst. abuse)			√	√
ME				√
MS				
MO	√	√	√	√
MT				
NE (general)				
NE (behavioral)				√
NH	√	√		
NM			√	√
NY (general)				
NC				
OH				
OR (general)				√
OR (behavioral)				
PA (general)	√	√	√	√
PA (behavioral)	√		√	√
SC		√	√	√
TN			√	√
UT (general)				√
UT (behavioral)			√	

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States whose contracts cover some or all children in out of home placements	Individualized Education Plan	Individualized Family Services Plan	Child Welfare Agency Plan	Court-Ordered Treatment Plan
VT				√
WA (behavioral)				
WV			√	

Source: *Negotiating the New Health System (2d Ed.)* (Vol. 2, Tables 1.1 and 2.8)

5. *Quality Improvement, Performance Measurement, Management Information Systems, and Data Reporting*

Quality improvement, performance measurement, and data reporting requirements are central elements of managed care contracts, as are the management information systems that make managed care an achievable goal. The payment structure of managed care, and the service accountability goals that managed care creates, make quality improvement and performance measurement critical activities for managed care purchasers. Developing, using, and interpreting quality of care measures is especially challenging in Medicaid, because periods of enrollment are quite short on average, making it difficult to use traditional quality measurement tools. Moreover, while the picture is improving somewhat, there are few quality measures that relate effectively to the structure, process, and outcome of care for persons with serious and chronic illnesses and disabilities.

Despite the challenge of measuring managed care quality and performance (particularly performance over time in the case of serious illness and disability), our review indicates that states are making an effort to expand and intensify quality improvement activities and data reporting. Some states have developed quality measurement specifications, possibly as a means for overcoming the relatively generalized performance standards that many of these documents contain. We have reproduced selected measurement specifications in Appendix A to this volume.

The challenges in monitoring quality and fashioning effective quality measurements arise, in part, from several factors: vague performance standards; the difficulty of articulating clear performance measures; and problems related to the collection of valid and reliable data. To facilitate the collection and storing of necessary data, states require their contractors to maintain management information systems (MIS) as part of their overall quality improvement activities. However, states vary significantly in the degree of MIS specification they build into their contracts.⁶⁶ Florida's mental health RFP, for example, contains relatively specific performance specifications for contractors' MIS systems:

⁶⁶ For an excellent overview of purchasing expectations relating to MIS systems and other matters, see Health Systems Research, Inc., *Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers* (December, 1997 Draft, Washington D.C.)

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- A. Maintain client service, utilization, and expenditure profiles, and current and historical data with beginning and ending dates.
- B. Conduct claims processing and payment for all subcontracted providers.
- C. Maintain data documenting service utilization by service, enrollee, designated groups of recipients, and providers for Clorazil, targeted care management, and OBRA children's services.
- D. Maintain data documenting management, administrative, and service costs.
- E. Maintain data sufficient to reconcile capitation payments at the end of each reconciliation period for targeted case management and OBRA children's services.
- F. Maintain data sufficient to document services authorized but not yet claimed by direct service provider and by enrollee.
- G. Maintain critical incident data.
- H. Maintain clinical and functional client outcomes data.
- I. Maintain data documenting costs for compiling cost reports, if the contractor will use a risk corridor * * * . Florida mental health RFP, pp. 65-6.

Iowa's mental health contract contains similar specifications.

Impact of the Balanced Budget Act on Quality Improvement, Data Reporting, and Information Management. The Balanced Budget Act of 1997, which is reviewed in detail in Volume One of *Negotiating the New Health System (2d Ed.)*, established a series of new statutory requirements, applicable to MCOs, in the area of quality improvement. Many of these requirements parallel existing administrative requirements for HMOs established by the Health Care Financing Administration. In brief, the BBA quality improvement provisions require states which contract for MCO services to develop quality improvement strategies that include access standards, standards to measure quality (including an examination of grievance procedures and marketing and information standards), and monitoring procedures. In addition, states must provide for annual external, independent quality reviews of the outcomes of, and access to, items and services under the contract.⁶⁷

As discussed, virtually all of the contracts reviewed in this study contain some access standards, although the degree

⁶⁷ 42 U.S.C. §1396u-2(c).

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of specificity required by the state varies. Moreover, many contracts do not define the measurement of each access standard. In other words, a state contract may specify that urgent care services must be furnished within 48 hours of request, but the contract may fail to outline how the state intends to measure contractor compliance with the standards, the procedures by which the contractor will conduct a self-assessment of its performance, or the data that the contractor must supply the state for monitoring purposes. Because of due process considerations that are implicated when a public purchaser seeks either to impose intermediate sanctions or to terminate a contract for failure to comply with performance requirements, ambiguities in performance measurement and data collection can lead to serious enforcement problems.⁶⁸

Table 5.1 in the annotated table volumes provides an overview of the quality improvement provisions of state contracts. This table indicates that states that contract with both general and behavioral health care plans take variable approaches in their quality improvement provisions. For example, while Florida’s general and behavioral health care contracts contain parallel quality improvement provisions, other states with both general and behavioral health care contracts use different contractual approaches to quality improvement. New York specifies more quality improvement elements in its managed mental health care contract than in its general service agreement, while Massachusetts and Utah specify fewer. Figure 2 (which is an amalgam of information found in Tables 5.1, 5.2, 5.3, and 6.2 in the tabular volumes) identifies the extent to which state managed behavioral health care carve-out contracts contain specific provisions related to quality improvement, including system elements, general and MI/AD-specific data reporting, and grievance procedures.

Figure 2. Quality Assurance, General and MI/AD-specific Data Reporting, and Grievance Procedures

AZ	FLM	HI	IA	MA	NE	NY	OR	PA	UT	WA
BH	H	BH	MH SA	BH	MH	MH	MH	BH	MH	MH

TABLE 5.1 QUALITY ASSURANCE

Internal QA system	-	-	-	-	-	-	-	-	-	-
External review of provider performance	-	-	-	-	-	-	-	-	-	-
Clinical studies	-	-	-	-	-	-	-	-	-	-
Clinical guidelines	-	-	-	-	-	-	-	-	-	-

⁶⁸ Furthermore, the BBA prohibits states from terminating contracts until a managed care organization has had a pre-termination hearing. 42 U.S.C. §1396u-2(e)(4)(B). This degree of provider protection in federal law (which is also extended to HMOs and Provider Service Organizations participating in Medicare, §1857(h)(B) of the Social Security Act) is unprecedented, although some states had established this level of provider protection under state law. See *MedCare HMO v Bradley*, 788 F. Supp. 1460 (N.D. Ill. 1992).

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	AZ BH	FLM H	HI BH	IA MH SA	MA BH	NE MH	NY MH	OR MH	PA BH	UT MH	WA MH
Profiling provider performance	-	-	-	-	-	-	-	-	-	-	-
Evaluation of grievances and complaints		-	-			-	-	-	-	-	
Corrective action plan	-	-		-	-	-	-	-	-	-	-

TABLE 5.2 GENERAL DATA REPORTING

Access data	-					-	-		-		
Complaints and grievances	-	-	-	-	-	-	-	-	-	-	-
Encounter data	-		-	-		-	-	-	-	-	-
Financial data	-	-	-	-	-	-	-	-	-	-	-
General authorization	-	-		-			-	-	-		-
Outcomes data	-	-							-		
Performance data	-		-			-	-		-		
Utilization data		-	-					-	-	-	
Other	-	-		-	-	-	-	-	-	-	-

TABLE 5.3 MENTAL HEALTH AND SUBSTANCE ABUSE DATA REPORTING

Care process and outcome data for mental health and substance abuse treatment		-	-	-	-	-	-	-	-	-	
Discharge data for addictive disorder			-						-		
Hospitalization for addictive disorder			-		-				-		
Hospitalization for mental illness			-	-	-			-	-	-	
Identified substance abuse				-	-						
Identified domestic abuse		-									

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	AZ BH	FLM H	HI BH	IA MH SA	MA BH	NE MH	NY MH	OR MH	PA BH	UT MH	WA MH
QA/Utilization measures for mental health/substance abuse treatment	-		-	-	-	-		-	-	-	-
Other		-		-	-	-		-			

TABLE 6.2 BENEFICIARY GRIEVANCE PROCEDURES

Internal grievance process	-	-	-	-	-	-	-	-	-	-	-
Time lines for grievance response		-	-	-	-	-	-	-	-	-	-
Expedited grievance process	-					-		-	-	-	-
External appeal to state	-	-	-	-	-	-	-	-	-	-	-

- Means that an issue was addressed in the contract or RFP.

6. Patient Confidentiality

An important issue in health care for persons with mental illness and addiction disorders is patient confidentiality. Federal regulations applicable to all programs (defined as individuals or entities (other than general medical care facilities) who hold themselves out as providing, and do provide, alcohol or drug abuse diagnosis, treatment, or referral for treatment)⁶⁹ establish strict standards regarding the disclosure of information and the release of client records. While most contracts contain general references to compliance with “applicable” patient confidentiality requirements under state or federal law, none specifically refer to these regulations.

C. PERFORMANCE MEASUREMENT

A general issue under all of the contracts is the extent to which the enumerated specifications create clear expectations that can be measured, monitored, and enforced. The hundreds of thousands of annotations contained in the annotated volumes of *Negotiating the New Health System* (2d Ed.) indicate that, in many cases, expectations are hortatory in nature (e.g., “Contractor shall make its best effort to learn about a patient’s pre-discharge course of treatment”), and do not create a standard that is capable of being measured, monitored, and enforced.

⁶⁹ 42 C.F.R. §2.11.

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This issue of enforceable expectations is important to the overall management of contracts, since fundamental concepts of due process dictate that a sanction against a managed care company for poor performance or non-performance must be based on failure to perform in accordance with clear performance standards that can be reasonably and validly measured.⁷⁰ Throughout our research, we have consistently observed an absence of clear and articulated measures for reviewing the extent to which contractors are in compliance with performance specifications, as well as a failure to specify the data that contractors will be expected to submit to demonstrate their compliance.

This lack of measures may be an indication of the difficulty of developing specific process, structure, and outcome measurements. It also may signify that many of the underlying standards themselves may be too vague to permit fair measurement. Where the latter is the case, a significant question becomes whether the specification itself is worth including in the contract if, in fact, it is immeasurable. To the extent that provisions are included to provide a general sense of what a purchaser wants, there may be better means for communicating generalized desires. A contract is a legal document that creates an enforceable promise; it should not function as a broad set of observations about how the health system should operate. To the extent that contracts lack enforceable performance measures, they become unenforceable assemblages of written materials that provide little support to patients and little guidance to contractors about the buyer's expectations. Indeed, such contracts tend to create a cynicism about the very act of setting legal standards and protections itself.

⁷⁰ See *MedCare HMO v Bradley*, 788 F. Supp. 1460 (N.D. Ill. 1992), wherein the court enjoined the state of Illinois' termination of a managed care contract pending notice and an administrative evidentiary hearing. The court in *MedCare* ruled that the state could not even offer beneficiaries the option of voluntarily leaving the failing HMO during the pendency of the hearing because of the company's property interest in their continued membership. It is evident, therefore--putting aside issues of money--that protecting the health and welfare of beneficiaries compels states to develop effective monitoring and enforcement schemes that can withstand due process challenges from substandard companies who are subject to sanctions.

PART 3: AN ANALYSIS OF MANAGED BEHAVIORAL HEALTH CARE CONTRACTS

Throughout this Report we have discussed the arrangements within general service agreements for the treatment and prevention of mental illness and addiction disorders, as well as the content and structure of specific managed behavioral health care contracts. However, the unique nature of “carve-out” contracts -- that is, contracts that cover a discrete subset of all Medicaid services and/or serve a discrete portion of the population -- merits additional consideration. While drafting a single managed care agreement is, by itself, complex, using multiple agreements is even more so; carve-out contracting, in effect, creates multiple sources of coverage and multiple points of accountability. Unless there is particular attention to detail and the deliberate use of a monitoring system that utilizes performance measures specifically tailored to evaluate performance integration, states risk the danger of creating major gaps in coverage and access due to the legal and operational voids that exist between and among the contracts.

The use of carve-out contracts effectively creates three tiers of Medicaid coverage and service responsibilities (the Medicaid program itself, the general service managed care contractor, and the managed behavioral health care contractor), all of which must be carefully juxtaposed and measured to avoid access and quality problems. Moreover, these three tiers of Medicaid coverage and service must be reconciled with a fourth tier of coverage and service for which managed care enrollees may be eligible, comprised of health-related housing, social, educational, and other support services that are financed and delivered by or through other agencies and programs other than Medicaid.

While the dozen managed behavioral health care agreements reviewed in this Report can be grouped under the rubric of carve-out contracts, in fact the agreements vary enormously with respect to both the range of individuals covered and the extent of coverage included in each contract. Figures 1 and 2, *supra*, capture some of the differences in these contracts; the variations, however, go well beyond coverage for children in foster care or out-of-home placements and requirements for data reporting, quality assurance, and grievance procedures. Indeed, the variations underscore the fundamentally different ways in which states utilize managed behavioral health care agreements and the diverse roles which such agreements may play within a state’s Medicaid program. Moreover, the evidence from this review suggests that managed behavioral health care agreements tend to contain gaps and ambiguities which are of pivotal importance to access and quality, perhaps due to of the complexity of designing an agreement that carves out discrete services and populations.

Managed behavioral health care carve-out agreements raise four central questions. The first question involves the population eligible for enrollment under the agreement. A managed behavioral health care agreement can cover all or a subset of individuals eligible for enrollment into the general managed care system in the service area. Common subset classifications may be fashioned by diagnosis or by the scope of coverage available through the general service agreement. Examples of subsets of eligible persons include individuals whose mental or addiction disorders are severe and persistent

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or individuals who are members of general plans that do not offer mental illness and addiction disorder prevention and treatment benefits for persons with more intensive health needs.

A second critical question concerns the range of services to be offered by or through the managed behavioral health care contractor. Contractors may offer some or all MI/AD-related services covered under the state plan, as well as other services (i.e., physical health care) for populations receiving managed care services exclusively through a specialized provider.

Disparities in service provision, however, go beyond the range of services offered by the behavioral health care contractor. Even where the contractor offers all Medicaid covered services, further variation can be found in the depth and scope of coverage. For example, the contractor may offer all classes of MI/AD-related outpatient care covered under a state Medicaid plan but only up to a certain level (expressed in dollars, episodes of treatment, or duration of treatment), with additional coverage available directly through the Medicaid program.

A third crucial issue addresses the manner by which the carve-out contractor's diagnosis and treatment service duties are initiated. Managed behavioral health care is a specialized service in the world of managed care and, similar to other specialized services, must be initiated through a triggering event (such as a referral for services). Managed behavioral health care contractors are entities that provide such specialty care. As such, their duties to begin assessing and treating eligible persons must also be triggered by some event (e.g., referral from a primary care provider; referral from a school, community program, court, or other agency; referral from a provider of specialized physical health services; a self-referral; or a combination of triggering events). Therefore, it is essential to know both who can initiate care and, as importantly, the obligation of the contractor to respond to the initiator.

A fourth critical issue addresses the manner in which the behavioral health care contractor is required to relate to other parts of the health care system, including the general contractor, other programs and agencies, and the Medicaid agency itself. Gauging the relationships between managed behavioral health care organizations and the rest of the health care system is particularly important in the case of individuals with dual, or multiple, diagnoses. It is common for persons with mental illness to also have an addiction disorder; similarly, many individuals with mental health problems also have co-occurring physical conditions that must be managed. In cases such as these, the management of one condition can significantly affect the successful management of the patient's other condition. Thus, delineating the duties of managed behavioral health care plans with respect to the treatment and supervision of persons with multiple health problems is exceedingly important. Further, coordination of care is of importance in situations where part of the medical treatment an individual needs for a particular diagnosis is accessed and provided through multiple plans. This scenario is especially likely to occur in the case of prescribed drugs, which may be dispensed and controlled by the managed care enrollee's general plan but coordinated by the behavioral health care contractor.

As noted in the first part of this Report, drafting contracts poses a major challenge, since silences and ambiguities can lead to gaps in coverage, confusion over roles and responsibilities, and ultimately to the diminished enforceability of the contract itself. The contract must be clear enough on its face to avoid possible conflicting interpretations, and this is

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especially true when the drafter is a public agency, because basic concepts of due process limit the agency’s ability to subsequently and unilaterally clarify or amend provisions of the agreement. A close analysis of the structure and content of the managed behavioral health care agreements included in this document reveals important ambiguities in the manner in which the four central questions raised by such contracts are addressed and, therefore, the manner in which the behavioral health care contractors’ duties are triggered, articulated, and enforced.

A. WHO IS ELIGIBLE FOR ENROLLMENT

The contracts take a wide variety of approaches in classifying eligible persons, as shown in Figure 3.

Figure 3. Persons Eligible for Enrollment in Managed Behavioral Plans

Managed Behavioral Health Contract	Classes of Persons Eligible to Enroll
Arizona	Medicaid-eligible persons and members under age 18 and 21 years of age and older; seriously mentally ill persons (as determined by the plan) and members age 18 and older
Florida	All Medicaid recipients in managed care eligible categories who are not enrolled in an HMO
Hawaii	QUEST and ABD adult recipients 18 years and older, not confined to a nursing facility, who have been determined by an independent clinical evaluation to have a serious and persistent mental illness
Iowa (substance abuse)	All Medicaid eligible persons other than persons over age 65, the spend-down medically needy, persons in NFs, ICFs (MR and MI), children in psychiatric hospitals, persons treated at certain residential facilities, and certain non-Medicaid-eligible, publicly financed persons
Iowa (mental health)	Persons with certain ICD-9 Code diagnoses who are FIP and FIP-related Recipients, SSI and SSI related recipients under age 65, medically needy persons with no spend-down. Excluded persons are persons enrolled in an HMO, persons age 65 and older, persons in a state mental institution unless placement was initiated by the contractor, residents of ICF/MRs, children in psychiatric hospitals, persons who are spend-down medically needy
Massachusetts	Managed care eligible persons not enrolled in an HMO that offers mental health benefits
Nebraska	Persons identified by the state agency
New York	Persons who (1) are eligible for Medicaid, Aspecifically SSI Cash, SSI Medicaid, and AFDC Medicaid; and (2) are currently receiving inpatient, outpatient (clinic, continuing day treatment, and or intensive psychiatric rehabilitative treatment) or community support services, and (3)

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Managed Behavioral Health Contract	Classes of Persons Eligible to Enroll
	are not currently receiving licensed outpatient treatment in non-state-operated programs; and (4) are either 18-21/22 or 65 and over if residing in an inpatient psychiatric center, or age 18 or over if admitted to an outpatient psychiatric program. Persons are considered to be currently receiving services in a state-operated psychiatric center if they are admitted to the program on the date of their enrollment
Oregon	Persons eligible for managed care who are found to have, or are suspected of having, a mental health condition specified in the most recent prioritized list of integrated health services (prioritized list of services)
Pennsylvania	All managed care enrollees living in certain counties
Utah	All managed care enrollees living in certain counties
Washington State	(Tier 1) All Medicaid recipients living in certain geographic areas; (Tier 2) all recipients who are severely emotionally disturbed (for children) or chronically mentally ill or seriously disturbed and at risk for becoming chronically mentally ill (Contractor submits definition of seriously disturbed and “at risk of becoming chronically ill”); and (Tier 3) all Tier 2 persons who are high utilizers of inpatient psychiatric care, have experienced one or more jail or juvenile detention episode within the 12 months preceding enrollment, or are or were homeless within 12 months preceding enrollment.

Source: *Negotiating the New Health System (2d Ed.)*, Vol. 2

The variations in Figure 3 emphasize the differences in state policy goals which underlie the use of specialized managed behavioral health care organizations. Some states, such as Hawaii and Oregon, utilize managed behavioral health care plans for persons with severe illnesses or who are diagnosed with certain conditions. More common, however, are the states that use specialty plans for persons who need both basic mental health care and longer-term treatment. For example, Utah, Pennsylvania, Massachusetts, Washington State, and Florida appear to enroll persons with basic needs, as well as individuals with more advanced problems. Further, Massachusetts and Florida enroll into their specialty plans those individuals who are not members of an HMO that offers mental health services, thereby providing all such needs to those individuals through the specialty plans.

Also important are the differences in the manner by which enrollment is triggered for persons with certain disorders. For example, both Nebraska and Hawaii reserve the right to identify and enroll certain persons in the plan. Washington State, on the other hand, permits contractors to set their own definitions and eligibility criteria.

B. THE RANGE OF SERVICES PROVIDED AND THE DEPTH AND SCOPE OF COVERAGE

Figure 4 shows the range of classes of benefits furnished by managed behavioral health care plans. However, standing alone this Figure masks substantial further disparities in coverage. Such disparities show up in the service definitions themselves, the definitions of medical necessity that are used to determine coverage, and the amount, duration, and scope of the covered benefits (all of which have been reviewed at length in Part 2). For example, while the Massachusetts contract contains extensive definitions of covered services, leaving little discretion to the behavioral health care contractor, most of the other contracts simply list covered services, thereby vesting the contractor with significant discretion to define each covered benefit. Examples from the Massachusetts and Pennsylvania contracts are as follows:

1. DMA Covered Services

A. Inpatient Services -- shall mean twenty-four hour services which provide intervention for mental health or substance abuse diagnoses or both.

1. Enhanced Level III detoxification for Pregnant Women -- shall mean short term medical treatment for substance use withdrawal, medical assessment and intervention, including both medical and social components, to ensure quality substance abuse treatment and obstetrical care to pregnant women.

2. Inpatient Mental Health Services -- shall mean hospital services to stabilize an acute psychiatric condition which: (1) has a relatively sudden onset; (2) has a short, severe course; (3) poses a significant danger to self or others; and/or (4) has resulted in marked psychosocial dysfunction and/or grave mental disability.

3. Inpatient Substance Abuse Services (Level IV) -- shall mean hospital services which provide a planned detoxification regimen of 24-hour medically directed evaluation, care and treatment for psychoactive substance abusing individuals in a medically managed inpatient setting.

4. Level III Detoxification -- shall mean inpatient substance abuse services that provide short term medical treatment for substance abuse withdrawal, individual medical assessment, evaluation, intervention, substance abuse counseling, and post-detoxification referrals. These services may be provided in licensed freestanding or hospital-based programs. Massachusetts Behavioral Health Contract, Appendix C

In Plan Services --

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- (1) inpatient psychiatric hospital services, except when provided in a state mental hospital
- (2) inpatient drug and alcohol detoxification * * *
- (4) inpatient drug and alcohol rehabilitation; * * *
- (8) residential treatment services for children and adolescents. Pennsylvania Behavioral Health Contract, Part IV (Work Statement), p. 51

Figure 4. Mental Health and Substance Abuse Services

	AZ BH	FL MH	HI BH	IA MH SA	MA BH	NE MH	NY MH	OR MH	PA BH	UT MH	WA MH
Care coordination/case management	-	-	-	-	-	-	-	-	-	-	-
Crisis management	-	-	-	-	-	-	-	-	-	-	-
Family therapy	-	-	-			-	-		-		
Individual therapy	-	-	-	-	-	-	-	-	-	-	
Group therapy	-	-	-	-	-	-	-	-	-	-	
Hospital detoxification					-	-			-	-	
Inpatient services for persons under 21	-	-	-	-	-	-	-	-	-	-	
Long-term residential	-	-		-	-	-	-	-	-		
Medication management	-	-	-	-	-				-	-	-
Non-hospital residential detoxification						-			-		
Outpatient treatment		-	-	-	-	-	-		-	-	-
Partial day treatment programs	-	-	-	-	-	-			-	-	
Prescribed drugs	!	!	!	!	!				!		!
Preventive health services		-				-		-	-		

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	AZ BH	FL MH	HI BH	IA MH SA	MA BH	NE MH	NY MH	OR MH	PA BH	UT MH	WA MH
Referrals	-	-	-	-	-	-	-	-	-	-	-
Screening, assessment and diagnosis	-	-	-	-	-	-	-	-	-	-	-
Short-term residential (includes hospital)	-	-	-	-	-	-	-	-	-	-	-
Transportation	-	-	-	-	-	-	-	-	-	-	-
Other	-	-	-	-	-	-	-	-	-	-	-

C. EVENTS THAT TRIGGER THE CONTRACTOR’S DUTY TO SERVE MEMBERS

The contracts exhibit wide variation in their articulation of when and how a managed behavioral health care organization’s duties to furnish covered benefits are triggered. Most of the agreements lack a clear statement regarding the obligations of contractors to initiate care sought from the behavioral health care plan by each possible avenue through which such a referral can occur (i.e., a self-referral, a referral from a primary care provider, a referral from a physical health specialist, or a referral from an agency, court, or other program). While several of the contracts address one or more of these avenues of entry, none address all of them. The Arizona contract comes closest to the imposition of a blanket duty to initiate care, as illustrated by the following provision:

ADHS shall ensure that all members who are referred for behavioral health services receive a screening and evaluation, including an assessment for case management needs, within one week of referral. Arizona Behavioral Health Contract, p. 9

Even in this instance, however, the term “referral” is unclear, leaving open to interpretation what constitutes a “referral”. Without an unambiguous and unequivocal statement regarding the events that trigger a duty on the part of the contractor to initiate care, it is possible that a contractor could be paid for an amount and level of care that significantly overstates its actual obligation to furnish care. Excess payment may be especially likely in those agreements in which the contractor is paid a certain capitation amount for each member in its service area regardless of the amount of actual care provided.

D. COORDINATION OF CARE WITHIN THE HEALTH CARE SYSTEM

Similar to the ambiguity regarding the events that trigger a contractor's duty to initiate care, the behavioral health care contracts are frequently unclear with respect to the obligations of contractors to coordinate services and payment for care with general service contractors, other programs and agencies, and the Medicaid agency itself. Conversely, many of the general service agreements in states with carve-out behavioral health care plans also lack clearly articulated standards for coordination of coverage. This is an especially important issue in circumstances regarding dual, or multiple, diagnosis, where a determination may be needed regarding what constitutes the primary diagnosis to properly allocate coverage, treatment, and management responsibilities.

Iowa is unique in its approach of maintaining separate managed care contracts for addiction disorder and mental illness. Each contract contains a provision regarding coordination of care for persons with dual MI/AD diagnoses, as illustrated by the following excerpt:

Some individuals who would otherwise be eligible persons may be diagnosed as mentally ill as well as substance abusers. If the primary diagnosis is mental illness, the individual will not be an eligible person for covered services under [this contract]. If the primary diagnosis is a substance abuser, the individual will be an eligible person under [this contract] and the contractor shall arrange and pay for any necessary mental health treatment. The primary diagnosis shall not be determined merely by the provider's designation but shall be determined based upon clinical criteria to be developed jointly by the contractor, the Departments and the [mental health contractor]. If a definitive primary diagnosis cannot be made for any reason, the primary diagnosis will be deemed to be mental illness. Iowa Substance Abuse Contract, p. 22

More common, however, is the use of blanket phrases in both general and specialized service agreements, such as the following provision from the California contract that creates a broadly-worded expectation, compliance with which may be impossible to measure:

The Contractor will case manage the physical health of the member and coordinate services with the mental health provider of the member. California Contract, pp. 88-9 (Table 2.2)

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Coordination of coverage, treatment, and payment policies is especially important in situations in which prescribed drugs and health care are covered through separate contracts. Mechanisms are needed to ensure that drug prescriptions written by a behavioral health care provider are dispensed in an appropriate fashion by the general service plan. Moreover, in the case of persons with co-occurring conditions--who may be taking multiple medications that can have deleterious interactive effects--procedures are needed to ensure proper management of both sets of prescribed drug treatments. While failings in drug management are commonplace in the fee-for-service system, management expectations are low under such systems. On the other hand, coordination expectations are greater for managed care systems, under which significant amounts of funds are expended to achieve precisely these types of improvements in quality.

Despite the importance of cross-program coordination between general service and behavioral health care contracts, we were unable to identify examples of quality performance indicators developed to measure structure, process of care, or outcomes in the case of persons with co-occurring conditions or individuals whose treatment requirements involved securing covered services from different plans.

CONCLUSION

As managed care enrollment reaches further into the Medicaid population, fundamental questions regarding the care and treatment of persons with disabilities arise. The Medicaid program has had an enormous impact on access to care among the poor and the very sick. It stands today as the nation's most important health care financing program for low-income, chronically ill, and disabled Americans, and in no area is it more important than in the care and management of persons with mental and addictive disorders.

As beneficial as Medicaid has been, it has also suffered from serious limitations. Historically, the most notable of these limitations has been the difficulties which beneficiaries experience in securing access to both primary and specialized care. By developing systems of integrated care that establish a contractual duty to serve members, managed care arrangements can help ameliorate this long-standing problem in the program while giving purchasers a greater ability to improve the quality of care and promote accountability.

At the same time, managed care presents extraordinary challenges, particularly for state Medicaid agencies and other public agencies involved in the care of Medicaid beneficiaries. The challenges begin with a population that is poorer, sicker, and more likely to reside in communities with inadequate health care systems on which managed care companies can build their "virtual health systems." Moreover, because Medicaid managed care arrangements operate as closed systems with almost no out-of-plan coverage allowed for contracted services, state agencies are under considerable pressure to develop plans that function in a timely and high-quality fashion. Unlike more affluent persons, Medicaid managed care enrollees have no ability to step outside of their managed care networks for point-of-service care in the event that in-plan care is inaccessible or of poor quality. New provisions in the Balanced Budget Act which allow state agencies to lock in enrollees for up to 12 months following an initial 90-day open enrollment period,⁷¹ thereby increasing the amount of time that beneficiaries may be required to remain in a plan, will further intensify the pressure for strong oversight.

A second major problem is the underlying discontinuity of Medicaid coverage itself. This instability makes the use of management techniques by plans and oversight techniques by agencies very difficult. This is a problem that we identified in the first edition of the study, and it remains as serious today. Amendments to the Medicaid program in the Balanced Budget Act permit states to guarantee a 12-month eligibility period for children under age 19; this option represents not only a vital coverage guarantee for children but also a potentially important tool for improving managed care operations and oversight. Even if all states were to take advantage of this option for children, however, there is no similar option for adults.

Unstable Medicaid coverage has always been a problem with the program. The 1996 welfare reform legislation, by tightening the eligibility rules for cash assistance programs on which Medicaid coverage continues to rest, increases the

⁷¹ 42 U.S.C. §1396u-2(a)(4)(A)(ii).

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opportunity to lose Medicaid while simultaneously reducing the opportunity to qualify for coverage. The increased potential for short or delayed enrollment has implications for the use of managed care which, like all insurance, depends on a stable and relatively healthy population for its financial viability.

A third major problem is the relative lack of managed care organizations with experience in the management of chronically ill and high-risk populations. The growth of managed health care systems is attributable to, and based upon, the provision of service to the employed population, not to Medicaid recipients. As more Medicaid-eligible disabled persons are enrolled in managed care, however, the potential effects of inexperience become more serious.

Increasing attention has been paid in recent months to early signs of an exodus from Medicaid managed care by a number of private companies. This indeed represents a potential problem with regard to the quality of care, since it lowers the pool of experienced managed care companies available to Medicaid programs.⁷² At the same time, it is not readily evident that large corporations with a history of insuring an employed population are capable of offering Medicaid agencies the added qualifications and capabilities that are needed to manage the care of a disabled population. Moreover, the departure of certain private companies from managed care should not be permitted to operate as a signal to relax purchasing specifications, but should instead call for structural and rate improvements that might strengthen, rather than diminish, industry involvement.

A fourth problem, and one that is evident from the contracts reviewed for this Report, is that in their effort to bring high-quality oversight tools to managed care, Medicaid agencies operate at a double disadvantage. First, there are very few outcome measures against which performance can be gauged, and the relative few that exist are very difficult to apply to the Medicaid population because of the short periods of enrollment created by the coverage “churning” phenomenon noted above. Second, very little is systematically known about what constitutes a “quality health care input”; that is, while there is a great deal of empirical evidence of appropriate management techniques for a higher-risk population, there have been little rigorous analyses of the information that is available. In such a situation, agencies face difficulties establishing detailed specifications regarding the form and manner in which care should be delivered, the factors that should go into coverage determinations, or the factors that should go into the selection of a provider network. The lack of evidence can be seen in the widely variable contracts analyzed in this study, as well as the extent to which many states have elected to delegate certain functions to the companies in the hope of moving toward a standard of care.

In the absence of a strong evidentiary data base from which to fashion a managed care system for a low-income, sicker population, state Medicaid agencies are faced with a greater potential for error in the amount and level of care they buy. This error can occur in one of two basic directions: the provision of excessive and inappropriate care which is of marginal utility; or the under-provision of medically necessary care by entities that increasingly, in a Medicaid context, perceive the financial risks as high and the financial rewards as low. Medicaid agencies need to guard against both types of

⁷² See, e.g, Harris Meyer, *AMedicaid: States Serve Up a Real Turkey*, *Hospitals and Health Networks*, pp. 22-8 (Nov. 20, 1997).

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problems; yet while managed care companies may be appropriate agents for the first problem area, they clearly cannot be assigned the sole responsibility of guarding against the second problem, because of their direct financial interest in reducing the cost of care. Moreover, the sheer magnitude of the effort needed to monitor under-service or poor quality care in a timely fashion makes it exceedingly difficult for agencies to develop alternative oversight capabilities and the resources necessary to do a proper job. Finally, state agencies experience enormous pressure from their legislatures to keep premiums down, particularly in those states where stories of excessive profits have emerged. In those instances, there may be increased pressure to cut care as contractors watch their premiums stagnate or decline.

An additional problem facing Medicaid managed care is a consequence of the extent to which Medicaid funds permeated the pre-managed care health system. Medicaid is the nation's single most important source of health care financing for persons with chronic illnesses and disabilities. The chronic care services financed with Medicaid go well beyond specific classes of benefits such as nursing home and home health care. As discussed in Part 1, the impact of Medicaid can be felt in the greater levels of coverage for primary and acute care for persons with chronic illnesses and disabilities as compared with the levels of coverage available under traditional insurance principles. Medicaid's impact can also be seen in the broader definition of the types of health care covered by Medicaid, as well as the care in community and alternative settings that Medicaid historically has financed.

When states transform their Medicaid budgets from open, fee-for-service payment arrangements into closed, premium-based, commercial insurance arrangements without taking these basic differences into account, several consequences can follow. First, unless the managed care contract for coverage and service is drafted to track the principles of Medicaid rather than commercial insurance, important services can be lost as companies apply commercial principles to Medicaid managed care. Much of *Negotiating the New Health System* is devoted to an exploration of this phenomenon.

Second, in fashioning their networks, managed care companies may, in the absence of express contract specifications, avoid providers and service settings that are perceived by the companies to be inconsistent with traditional notions of coverage and patient management in an insured setting.⁷³ The result can be the loss to Medicaid beneficiaries of entire classes of providers and programs, particularly providers and programs that offer "soft" services that are empirically believed to be of importance for the care of persons with disabilities but for which there is no "hard" evidence. In an age of evidenced-based medical necessity, empirical data tend to hold relatively little value for managed care companies. In the absence of express contract provisions that override the fundamental beliefs and operational approaches of insurers, this empirical world of health care may be lost before its value can ever be rigorously evaluated.

The challenge of managed care in Medicaid is to reconcile insurance principles with the structure of Medicaid coverage so that important types of coverage are not lost. Even more fundamentally, the challenge for Medicaid agencies, and other public agencies involved in the design of managed care systems, is to decide how much discretion to vest in

⁷³ The problem of network involvement among health providers serving low-income patients is documented in "Selection and Exclusion of Primary Care Physicians by Managed Care Organizations," A.B. Bindman et al., *JAMA*, Vol. 279, No. 9, pp. 675-79 (1998).

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contractors to reshape the very nature of health care for persons with chronic illnesses and disabilities. The decisions made by managed care companies regarding the extent to which contract services will be covered, the settings in which care will be furnished, the agencies with which they will coordinate their activities, and how they will relate to the rest of health system generally will, in the long run, reframe health coverage for persons with disabilities. To the degree that contractors have a great deal of experience with disabled populations, extensive discretion is justifiable. To the degree that such experience is lacking, such extensive delegation might be more carefully scrutinized.

In the first edition to our study we recommended the careful and considered development of coverage and performance standards for Medicaid managed care contracts, as well as ongoing technical assistance aimed at translating these standards into the clearest language possible. As managed care enrollment of persons with disabilities grows, and state discretion to implement managed care systems for special needs beneficiaries increases, we believe that these recommendations take on added importance. Managed care, if carefully structured, can lead to a major improvement in the operation of the health care system. The investment of time, resources, and effort that will be needed to create a generation of well-structured, adequately-financed managed care initiatives is fundamental in our view not only to Medicaid but also to Medicare, the Children's Health Insurance Program and, finally, to employment-based health coverage, which increasingly is responsible for the coverage and care of persons with disabilities.

In order to promote the development of quality and appropriate managed care arrangements for beneficiaries, we make the following recommendations:

First, efforts should be taken to reduce the discontinuity of Medicaid enrollment. Managed care enrollment depends on stability and continuity to work effectively. The Balanced Budget Act creates new options for states to guarantee 12 months' continuous coverage for children up to age 19. This option should be utilized and also extended to adults who enroll in managed care arrangements;

Second, intensive technical assistance for public purchasers in the areas of purchasing specification development and compliance monitoring is crucial. Oversight of the quality of publicly purchased managed care begins with clear and well-articulated purchasing specifications accompanied by well-thought out performance measures and sufficient staff and resources to carry out proper training. The Department of Health and Human Services should expand its role in assuring that state Medicaid agencies and other public purchasers receive the training and support they need and that integrated, multi-disciplinary working groups are formed to develop specifications and technical support materials for key populations and health care needs. Federal financial contributions for these activities should be increased to 100%;

Our final recommendation is to slow down. The headlong rush into managed care is neither wise nor necessary. No population should be pressed into a managed care arrangement that is not ready to enroll the population carefully or provide them with care of adequate quality. This is particularly true of poor people in general, who tend to complain much less than the privately-insured about the quality of their care. The problem with rushing too quickly into managed care is

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especially great when the lower-income population targeted for such enrollment suffers from physical or mental disabilities and is being enrolled into companies and plans with little or no experience in the care of low-income persons with high health care needs. Public agencies should be permitted to move as carefully as they believe the need dictates, particularly given the dramatic decline in growth rate of Medicaid spending, both per patient and in the aggregate. Now is the ideal time to build a quality managed care system with care and attention.