

Ensuring Access to Behavioral Healthcare through Integrated Managed Care: Options and Requirements

This paper is an update of an earlier paper titled, Increasing Access to Behavioral Healthcare: Managed Care Options and Requirements

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I. CONTEXT AND PURPOSE

Since this paper was first issued in 2011, major provisions of the Patient Protection and Affordable Care Act (ACA) were implemented and the ACA's triple aim to improve health, enhance the patient experience of care, and reduce the per capita cost of total health care is increasingly driving health care design and delivery. This update reflects new contracting realities, the rapid expansion of Medicaid managed care, and arrangements emerging from programs testing different financing and administrative alignments for Medicare-Medicaid enrollees.

The move toward integrated medical and behavioral health has only intensified with the introduction of state partnerships by the Centers for Medicare and Medicaid Services (CMS) to demonstrate models that align the financial and organizational incentives of Medicare and Medicaid for enrollees who are eligible for both programs. Many of these Medicare-Medicaid enrollees (MMEs, also referred to as “duals”) are under the age of 65 and eligible on the basis of disability, and have higher average costs than Medicare-only or Medicaid-only enrollees. Many of these individuals also have both multiple behavioral health conditions and chronic diseases.

In addition, the ACA provision that includes mental health and substance use disorder services as part of essential health benefits, and the implementation of the Mental Health Parity and Addiction Equity Act (MHPAEA) and its final regulations, place greater emphasis on the provision of substance use services (SUD) within Medicaid. While traditional Medicaid is not required to comply with parity provisions, managed care plans serving Medicaid expansion populations in the 28 states expanding Medicaid eligibility must comply. Some states, like New Hampshire, are choosing to implement a standard benefit for both traditional and expansion populations, which requires creating a full Medicaid SUD benefit for the first time. SUD treatment is considered in all areas of this document.

While integrating clinical care and services is an important goal for improving Medicaid and Medicare-Medicaid systems, states cannot achieve true integration of clinical services in managed care arrangements simply by contracting with a managed care entity. Clinical integration requires access to appropriate personnel, services, and supports that are paid for and aligned within the managed care approach. The Medicare-Medicaid demonstration programs, moreover, must address a wide range of disabilities and complex health conditions, which requires a broad range of services and provider capabilities. In addition, different managed care arrangements have very different impacts on Medicaid enrollees with the most serious mental illnesses, emotional disturbances, substance use disorders, and other disabilities.

This document systematically reviews the capabilities of different managed care approaches in meeting the needs of these populations. It also provides resources for advocates to educate policymakers and ensure that this vulnerable population's special needs are addressed throughout the transition to managed care. This document outlines aspects of plan design, provides model contract terms that states may incorporate into integrated managed care contracts, and identifies relevant performance measures. In addition, this document provides questions that states and advocates can ask potential managed care providers to help elicit information about their approach to manage behavioral health services, and their experience working with people who have serious mental health and addiction problems. Finally, a new chapter addresses the special needs of Medicare-Medicaid enrollees and provides recommendations on additional requirements to ensure that plans serving this group provide appropriate care and access to Medicare and Medicaid-covered services.

This document is intended to influence each state's managed care RFPs to ensure that managed care arrangements provide for an adequate array and intensity of levels of care and providers. It is recommended that interested parties use this document well in advance of developing or releasing a managed care RFP.

II. APPROACHES TO MANAGED CARE: MBHOs Compared to MCOs

Serious mental illnesses and substance use disorders can lead to high levels of impairment in many areas of functioning and require a special approach to integrated services for this population. Typical acute episodic care models cannot provide the care coordination, care management, and social supports that are needed to truly improve health and reduce expenditures for this group. The complex behavioral problems, co-occurring medical problems, limited family resources, and difficult living conditions of adults with serious mental illness (SMI) or substance use disorders (SUD), and children with serious emotional disturbance (SED) require specialized strategies to ensure access to coordinated and effective behavioral and medical care.

While all managed care approaches have advantages and disadvantages, the serious, persistent, and pervasive needs of children with SED and adults with SMI or serious addiction warrant a focused approach. The two common approaches to managed care for children and adults with serious mental health or substance use disorders are known as “carve in” and “carve out.”

Carve In: Integrated managed care approaches include physical health and behavioral health benefits in the same health plans. This means that a managed care organization (MCO) is contracted under a capitated rate to manage both medical and behavioral health services. In most states, there are multiple MCOs to allow Medicaid enrollees a choice of health plans. Though these contracts are considered carve ins, or integrated, it is common for MCOs to subcontract with a specialty managed care organization to manage behavioral health services. This organization might be the behavioral health division of the same company, or it might be part of a wholly separate business organization. Either way, the Medicaid agency addresses behavioral health concerns through the MCO, but patients and providers are likely to deal directly with the subcontracted behavioral health organization to access services, obtain authorizations, and get paid.

Carve Out: An alternative to integrated managed care is to carve out Medicaid behavioral health services from MCO contracts. Behavioral health services can either remain in the Medicaid fee-for-service system or a specialized Managed Behavioral Health Care Organization (MBHO) is contracted to manage them. States have contracted with MBHOs on both capitated and administrative only (ASO) bases. An ASO is paid an administrative fee for its management services and reimbursed for the costs of the behavioral health services it purchases. In this way, it is not at financial risk for the costs of services, and therefore has less incentive for restricting care or seeking efficiencies in other ways. Often, there is just one MBHO for a state or per region, though some localities offer a choice of carve out plans: for example, Wayne County, Michigan.

MBHOs and MCOs have different capabilities and experiences providing the types of care and care management needed by populations with serious mental illness and addictions disorders or SED. This document analyzes each system across the following parameters:

- A. Outreach and Access
- B. Benefits
- C. Treatment Planning and Care Coordination
- D. Consumer Involvement in Policy Making and Service Delivery
- E. Contracts
- F. Quality and Cost Outcomes
- G. Medical Care for Vulnerable Populations

References are provided to relevant sections of Chapter III which address aspects of plan design, contact specifications, and includes performance measures that address the issues discussed.

1. MCOs vs. MBHOs: Outreach and Access

Some individuals with SMI or SUD are reluctant to enter treatment. Assertive outreach is needed by treatment organizations to support these individuals in their homes and other community locations. In addition, treatment organizations must build a relationship to engage these individuals in services. This requires skill, respect, time and flexible funding. Many of these individuals also require frequent monitoring to maintain stability. Many MBHOs are experienced in working with community mental health and addiction treatment providers to engage families whose children have SED, and adults with SMI or SUD into MH or SUD services. However, most MCOs lack assertive outreach providers in their networks and are more accustomed to using telephonic outreach, which is far less effective for people with SMI or serious SUD. (See III.2.B.)

Community behavioral health providers offer multi-disciplinary and comprehensive services, and are the anchors of networks serving children with SED and adults with SMI or serious SUD. Community behavioral providers create multi-disciplinary care teams that include psychiatrists, psychiatric nurses, psychologists, Masters-trained clinicians with licenses or working toward licenses, addiction counselors, and direct care and peer/recovery support staff. Their care teams provide and coordinate the range of psychotropic medications and clinical and support services needed to treat these illnesses and support the clients. Many have well-established relationships with children with SED and adults with SMI or SUD. MBHOs generally credential and contract these providers as an organization. In contrast, MCOs do not always include community behavioral providers in their networks. When they do, they often individually credential only licensed clinicians with 3 years of experience, thereby excluding important case management, peer/recovery support, and other supportive services needed by people with SED or SMI. Often MCOs do not recognize SUD credentials unless the individual also has Master's-level clinical training. Alternatively, MCOs may only cover traditional outpatient services and pay at rates for traditional outpatient care, but do not cover the additional costs of services for engagement, outreach, and care coordination. (See III.1.C. and III.2.C.)

2. MCOs vs. MBHOs: Benefits

The managed care benefit package should include the broad range of services and medications, including those needed as an alternative to more restrictive and expensive hospital and residential care, for which children with SED and adults with SMI or serious SUD are typically at risk. These services should include community crisis stabilization, community case management, rehabilitation and skill building, family and consumer education, assertive community treatment intensive outpatient, partial hospitalizations, peer support, and other recovery oriented services.¹

If MBHO benefits do not include these services, contracts will likely to require active collaboration with services funded by other payers. Many MBHOs have considerable experience in designing and procuring these alternative services, and manage them on a continuum of care. Moreover, a single, geographically-based MBHO may have the volume to define and procure a service – such as mobile psychiatric intervention – and reap the savings in reduced emergency room and inpatient care. Collaboration is less likely to occur when the needs of the population are spread over different health plans, unless the state requires it as in the case of Massachusetts, when it established a new set of system of care services for children with SED.

In contrast, MCO benefits often cover only acute service and currently have few contractual requirements to coordinate with services provided outside of their network. For instance, few MCOs use community crisis stabilization, meaning that their members must rely on emergency departments, psychiatric hospitalization, and inpatient detoxification, which are more disruptive to clients and far more expensive. For example, the Massachusetts carve-out program is a state-of-the-art service innovation for high risk clients

and includes family support, wraparound services, and structured outpatient services for addiction. While Massachusetts HMOs are now required to cover many of these services under mental health parity, HEDIS data show that intermediate services (where many of these more intensive community services are classified) are used far less by MCOs than by the Massachusetts MBHO. (See III.1.C.)

Flexible prior authorization requirements are also critical to provide needed services that save money and produce better outcomes, even when services are outside the standard benefit. Many MBHOs have flexible prior authorization requirements that routinely allow them to authorize such services which increases access for individuals with unique and complex needs, and reduces the administrative burden of the authorization process. An example of flexible authorization processes is the ability of most MBHOs to authorize wraparound services for children with SED, which eases and supports the child's transition from a residential setting to home, school, and community.

In contrast, most MCOs authorize services using traditional medical necessity criteria. These plans generally require considerable justification to use a non-traditional service, even when it saves money associated with more intensive services. For example, in Massachusetts, behavioral health services are the most frequently requested services for external review since 2001, accounting for 37% of such requests in 2010. HMO behavioral health decisions are overturned or partially overturned by external review more frequently than other MCO appeals that go to the Department of Public Health.² (See III.2.D.)

When considering how to provide the full range of services needed by children with SED or adults with SMI, it is often necessary to pull from multiple funding streams. Statewide and regional MBHOs are more easily financed from multiple funding streams, while this is much more difficult with MCO capitation rates. For example:

- Arizona continues to combine Medicaid funding for behavioral health services paid on a capitation basis with other state and federal block grant funds. It is in the process of procuring two Regional Behavioral Health Authorities (RBHAs) to serve as the single point of authority for all citizens meeting clinical and financial eligibility criteria for public behavioral health services.³ With this re-procurement, Arizona is also adding Medicaid and Medicare funding for the physical health services of Medicaid and Medicare-Medicaid enrollees with serious mental illness, with the expectation that the RBHAs will manage and coordinate both behavioral and medical care for this population.
- Massachusetts has combined funding from the Department of Mental Health with Medicaid for its MBHO to finance psychiatric emergency service teams.
- A number of children's managed care programs incorporate Medicaid funding with funding from the child welfare agency and/or the juvenile justice agency to finance wraparound services for children with SED. As one example, Wraparound Milwaukee is funded by the Bureau of Milwaukee Child Welfare, the County's Delinquency and Court Services, Behavioral Health Division, and the State Division of Health Care Financing (the state Medicaid agency) to serve children and adolescents who have serious emotional disorders, and who are identified by the Child Welfare or Juvenile Justice System as being at immediate risk of residential or correctional placement or psychiatric hospitalization.⁴

Psychotropic medications are crucial in the effective treatment of mental health disorders. Medicaid and MBHOs have traditionally covered a wide range of atypical antipsychotics, though access to these costly medications is sometimes limited during times of state budget stress. It often takes considerable time for

psychiatrists to find effective medications, dosages, or combinations of medications that work appropriately for individuals with serious mental illnesses. Sometimes a trial of less expensive medication alternatives must be conducted prior to prescribing a more expensive, yet effective option. However, once such a trial has been completed, another trial should not be required simply because of a change in the MCO. Due to expense, some of these medications are not appropriate for co-insurance in which the member pays a percentage share of the medication's cost. A better alternative is to use a fixed co-pay set at an affordable price for members with limited incomes.

Medication also important for treating substance use disorders. Methadone treatment is evidence-based and shown to be effective for individuals with opioid addictions. Buprenorphine allows for office-based outpatient withdrawal management. These treatments face different barriers than those for mental health: Methadone can be expensive, not because of the price of the medication, but because of the cost of extended daily dosing services, and it is not yet covered in all state Medicaid plans. Administering buprenorphine requires that physicians become certified, and relatively few physicians have undergone the certification process. States may wish to review the evidence and experiences of other states that cover methadone. States may also want to require MCOs to include all physicians certified to administer buprenorphine in their networks. (See III.1.F.) An additional medication option is injectable Naltrexone. Injectable Naltrexone has no diversion potential, requires less frequent administration, and ensures medication adherence due to its delivery mechanism. When possible, this medication should be treated as a pharmacy benefit to ease administrative burdens for prescribers and treatment organizations.

3. MCOs vs. MBHOs: Treatment Planning and Care Coordination

To develop treatment plans, managed care entities must work with children with SED, adults with SMI or SUD, and disabled populations who have complex and serious needs that require a high level of expertise. Many MBHOs have considerable experience designing and implementing initiatives for children with SED and people with SMI or serious SUD using stages of change, recovery strategies, person-based planning, and evidence-based practices. For example, Community Mental Health Centers in Michigan have contracted with the state's Medicaid agency to prevent inpatient hospitalization of foster children with SED, by providing intensive treatment and wrap-around services in the community. Preliminary outcomes show that 97% of participants were served by community resources at an average treatment cost of just \$69 a day, far less than hospital care. They also experienced clinically significant improvements in average scores on the Child Adolescent Functional Assessment Scale (CAFAS).

In contrast, MCOs are seldom required to undertake special initiatives for this population. While states often contract with MBHOs to offer training on treatment needs for people with SED or SMI, or to implement specialty services in their networks using evidence-based practices, few MCOs work with high-need populations with mental health problems and disabilities. MCOs are not as effective at managing behavioral health. A study from the Health Employer Data and Information Set (HEDIS) for 384 HMOs, found that MCOs scored significantly lower on quality of care for mental health than for physical health.⁵ (See III.2.D.)

Managed care entities need to promote access to community-based support services for members with complex needs, such as co-occurring substance abuse, medical conditions, and/or housing problems. Many MBHOs contract for face-to-face assistance for children with SED and adults with SMI. Community case managers assist in accessing and coordinating social support services, such as housing, education and income support, that may fall outside of covered benefits. For example:

- Westchester County, NY measured the 2008 Medicaid mental health costs of Case Management and Assertive Community Treatment (ACT) populations in counties participating in a Care Coordination Program to the same populations in 6 comparison counties. It found that clients receiving care coordination had 92% lower inpatient service costs; 42% lower outpatient service costs; and 13% lower community support costs. The per person cost increase from 2003 – 2008 was 15% for counties with care coordination and 24% for comparison counties.⁶
- The cumulative rate of increase between 2003 and 2008 for Medicaid costs for case management recipients was 8% for Erie County and 13% for Monroe County, both of which were managed by a specialized behavioral health organization. These are compared to a 20% increase for individuals in the classification of NYS SSI/ Disabled-Rest of State.⁷

In contrast, most examples of MCO care coordination are telephonic and generally focus on coordinating medical and related services for conditions such as diabetes, cardiovascular disease, and COPD. For example, almost half of the New York high-risk cases identified by a criminal justice review panel were disengaged from care and for Medicaid-managed care individuals, there was “no case in which an MCO care manager was aware of or attempting to coordinate mental health services for a disengaged individual.”⁸

4. MCOs vs. MBHOs: Consumer Involvement in Policy Making and Service Delivery

Peer/recovery-coach delivered services are proven beneficial and cost effective for families of children with SED and for adults with SMI and SUD. Peer organizations are often small and have much more limited administrative capacity than health care providers, requiring different payment and management approaches than other network providers. Many MBHOs were instrumental in developing and supporting peer service models, including sponsoring the development of peer run organizations. For example, in Massachusetts, Value Options MBHO was required to contract with a consumer-run organization to implement a Consumer Satisfaction Team. This eventually grew into a new organization led by mental health consumers. Iowa’s Medicaid behavioral health care management contractor, Magellan Health Services, used cost savings designated for community reinvestment to evaluate the effectiveness and cost of peer support services. Peer support is now reimbursable through Medicaid. Currently, 11 of the 44 community mental health centers in Iowa have or are in the process of gaining peer support programs through grants or direct reimbursement.⁹ In contrast, MCOs are not experienced in working with this type of organization.

Including families and adult consumers in program decision making has clearly demonstrated value and benefits, and has resulted in better services. Many MBHOs have established advisory groups that include family and consumer representatives, or involve families and consumers in planning and implementation in meaningful ways. For example, New Mexico’s Behavioral Health Collaborative has an Office of Consumer Affairs responsible for training, program development and advocacy, and funding and participation/information dissemination. In contrast, few MCOs have active input from behavioral health consumers. (See III.2.H.)

5. MCOs vs. MBHOs: Contracts

State contracts with managed care entities should include financial incentives to improve care for people with SMI, SUD, and other vulnerable populations. MBHO contracts are generally more accountable than MCO contracts. They include more detailed specifications for managing behavioral health care in vulnerable populations. State mental health and Substance Use Single State Authorities often participate in developing performance specifications for MBHO contracts that require extensive measures of access and qual-

ity of care for SMI. For example, see Washington State's report on its county-based MBHOs on its MHD-PI website, System for Communicating Outcomes, Performance & Evaluation (SCOPE). In addition to standard measures of utilization and hospitalization, the state reports measures of effective engagement in MH and SUD care, and outcomes affecting employment and homelessness. New York State not only requires that managed care providers for its Health and Recovery Plan (HARP) measure employment and housing outcomes, but these constructs are also incorporated into performance measures.¹⁰ In contrast, MCOs are seldom measured or incentivized for their service to people with SMI or SUD. They are not generally required to report separately on behavioral health or on services for people with SED, SMI, or serious SUD. Limited reporting on behavioral health care places difficulties on states to determine changes in access or quality. If MCOs subcontract to an MBHO provider to manage behavioral health benefits, the state is often restricted from reviewing the terms of that agreement. (See III.2.L. and III.3.)

6. MCOs vs. MBHOs: Quality and Cost Outcomes

In planning a managed care initiative, states should consider each arrangement's demonstrated ability to improve behavioral health care for disabled Medicaid populations. MBHOs have improved access to community-based care and alternative services, and have increased the time that members spend living in the community rather than in restrictive inpatient settings, or involved with the criminal justice system. For example, in 2010, over 2 million people were enrolled in Pennsylvania's Behavioral HealthChoices, a county-based MBHO initiative. Both for-profit and not-for-profit health plans serve the entire state and have expanded service access, quality, innovation, and integration. The state reports that in the 12 years since the program began, the use of community-based behavioral health services has increased, while realizing a major reduction in inpatient use.¹¹ From 2009 to 2010 in Pierce County, Washington, Optum Health reported that its behavioral health plan achieved a 26% increase for 1 year in the number of Medicaid recipients served; a 19.5% reduction in hospitalization; a 32% reduction in readmission rates, and a 38.2% reduction in inpatient bed days.¹² In Massachusetts and Iowa, expanded Medicaid SUD benefits coupled with implementing managed care, has expanded access at a reduced overall cost for SUD treatment.¹³ States should also consider which type of arrangement demonstrates an ability to save money on behavioral health care for disabled Medicaid populations. MBHOs have taken on risk (such as reducing hospitalization costs) and succeeded. Others have won performance incentives based on improving access or care. For example, Pennsylvania's Behavioral HealthChoices MBHOs have generated \$4 billion in savings from 1997-2007. Behavioral Medicaid costs were managed well below the projected fee-for-service levels. In one county, there was a major decline in the proportion of Medicaid expenditures going to inpatient care, from 38% in 1998 under a FFS system to 16% in 2008.¹⁴ ValueOptions reports a 50% reduction in outpatient and ER visits, and a 71% reduction in psychiatric inpatient admissions for Massachusetts Medicaid enrollees, on average, over a 3 year period.¹⁵ As of 03/31/12, Value Options Maryland has provided utilization management and claims adjudication services for behavioral health care delivered by the State's Public Mental Health System network of providers. During that time, PMPM costs have declined each quarter, arriving at a PMPM global cost of care that is \$4.89 lower than that at contract inception. This equates to savings of approximately \$46 million over 3 years.¹⁶

Regional behavioral health organizations (BHOs) in Colorado were paid on a capitated basis for the past 14 years to manage Medicaid behavioral health care. They have contained increases in their capitation rate to 13.8% over this period, far less than the 33% cost of living adjustments made to community providers, the overall inflation rate of 44% (regional Consumer Price Index) and the inflation rate for medical care of 82% (regional medical consumer price index).¹⁷

MBHOs have also demonstrated the capacity to assist with reinvestment. In some states, a portion of savings generated by MBHOs was reinvested into expanding alternative services, such as peer providers. Pennsylvania's HealthChoices program has contained the costs of Medicaid behavioral health services at 30% lower than the projected spending would have been under fee-for-service, and, over its 12 year life, produced \$446M in savings that were reinvested into critically-needed housing and other community services.¹⁸ In Iowa, Magellan invests 2.5 percent of the money received from the state into the Iowa Community Reinvestment Fund which is used to support family and peer services, Assertive Community Treatment, and provider quality improvement.¹⁹

In contrast, when MCOs subcontract with an MBHO to manage their behavioral health benefit, administrative costs are high. This adds additional administrative costs to the average 13% of revenues that MCOs spent on administration, plus profits for large group plans in 2012.²⁰ Both administrative and service costs of subcontracted MBHOs are often counted as medical costs, understating the true cost of managed care administration. States cannot easily determine whether MCOs have generated savings for behavioral health services, because behavioral and physical service costs are not clearly delineated in MCO reporting. (See III.1.D.)

7. MCOs vs. MBHOs: Medical Care for Vulnerable Populations

Delivering effective behavioral health treatment produces a cost offset (reduction) in medical costs. MBHOs are demonstrated to deliver such services in a way that reduces costs. Studies beginning as early as 1967 provide strong evidence that provision of mental health and substance abuse treatment for individuals reduces medical costs.²¹ A study of high cost Missouri Medicaid enrollees with serious mental illnesses and high total (medical and behavioral health) Medicaid costs, found that total health costs per user declined steadily after initiating community mental health case management. This decline included the costs of the case management service provided by community mental health providers.²² A 2010 report found that in Washington state, "...treatment penetration ...for substance use disorders... has coincided with a significant relative reduction in rates of growth in medical and nursing facility costs for Medicaid Disabled and GA-U [now Disability Lifeline] clients with substance use problems. The ...expansion... in substance use disorder treatment... achieved an impressive return on investment estimated to be two dollars in...costs saved per dollar invested..."²³

In addition, some MBHOs have worked with community behavioral health care providers that have demonstrated improvements in the physical health care of their clients. The primary health provider for most individuals with SMI is the community mental health center. Many currently offer active case management that includes a liaison to primary care and some have co-located primary care in their sites. MBHOs' greater experience working with community behavioral health providers makes them an important partner for delivering integrated primary and behavioral health care and wellness for this unique population.

Integrated primary and behavioral services delivered in behavioral health sites have a demonstrated ability to implement programs that improve physical health and cost outcomes for individuals with SMI. For example, a medical care management intervention for people with SMI delivered at an urban community health center, increased linkage to primary care providers, increased participation in recommended preventive services, and increased evidence-based services for cardio-metabolic conditions and lower cardiac risk scores when compared to a control group that did not receive the intervention.²⁴ The Veterans Administration placed primary care services in a specialty MH clinic and significantly increased the rates and number

of visits to medical providers, reduced likelihood of ED use, significantly improved quality of routine preventive services, significantly improved scores on SF-36 Health Related Quality of Life, and was cost-neutral (i.e., primary care costs offset by reduction in inpatient costs).²⁵

Improvements in care for people with SUD are also found in integrated care. Researchers compared patients who received at least 6 months of continuous methadone treatment and at least 2 visits for medical care provided on site at the methadone program to patients who did not receive at least 2 medical visits to the program. The group receiving integrated care had the highest average costs, followed by those receiving only long-term methadone treatment. However, the number of emergency visits and acute hospitalizations decreased for the integrated care group, suggesting that investing in integrated methadone and medical care is “money well spent,” because it generates improvement in overall health status.²⁶

Many adults with SMI do not receive well-coordinated medical care. Few primary care practices have experience working with people who have SMI, children who have SED or other disabilities, nor do they currently have the resources to address their special needs. To date, MCOs have not been successfully engaging people with SMI or other significant mental health and substance use disorders into treatment, resulting in costly use of emergency and inpatient services. For example, over 25% of NY Chronic Illness Demonstration Project enrollees did not have a primary care visit in the baseline 12-month period, and over 70% did not have a specialty care medical visit.²⁷ Almost half of the New York Medicaid Managed Care high-risk cases were disengaged and there was “no case in which an MCO care manager was aware of or attempting to coordinate mental health services for a disengaged individual”.²⁸ In New York State, 2007 data reveals that \$814 million was spent on what are called “potentially preventable (hospital) readmissions (PPRs),” namely people who had a hospital stay that either did not leave them well enough to avoid readmission, or they lacked good community-based follow up, became acutely ill again and received another (potentially unnecessary and expensive) inpatient stay within 30 days. Of the \$814 million, almost half (\$395 million), was incurred for medical admissions (e.g., heart disease, diabetes, pneumonia, trauma) for people with mental health and substance use disorders. Those readmitted for mental health and drug abuse stays alone, totaled \$270 million. Thus, taken together, \$665 of the \$814 (more than 80 percent) was spent, perhaps unnecessarily, on people with mental and substance use disorders, principally for behavioral health conditions.²⁹ (See III.2.G.)

III. CONTRACT TERMS FOR CONSIDERATION IN INTEGRATED MANAGED CARE

This analysis highlights the differences between two common managed care approaches and the consequences of failing to address the special engagement, care coordination, and treatment needs of individuals with serious mental illness, addictions disorders, and SED during the transition to managed care. As states pursue integrated approaches to managed care, states must consider the following contract terms and performance measures included in RFPs and contracts.

Carve-out Managed Behavioral Healthcare Organization (MBHO) contractors clearly understand the special needs of people with behavioral health conditions. However, managed care organizations (MCOs) have often not had the opportunity to work with these populations in a Medicaid health plan. MCOs might pay more attention and dedicate the right levels and kinds of resources to serve children with SED and adults with SMI or SUD, if they had similar levels of specificity in their contract requirements and incentives as in many of the MBHO contracts. If states elect to integrate behavioral health benefits for people with SED, SMI, or SUD into MCO plans, the following contractual requirements should be considered to ensure that the needs of children with SED and adults with SMI or SUD are adequately addressed.

This document contains recommendations related to the design, contracting and oversight of integrated Medicaid managed care plans to responsibly manage both primary and behavioral health care for individuals with SMI or SUD and children with SED. These recommendations encompass:

1. Aspects of plan design
2. Contract specifications
3. Performance measures
4. Questions for MCOs interested in bidding on such managed care plans.

1. Plan Design

A. Identify people with SED, SMI, or serious SUD

Most Medicaid systems do not include an identifier for people with SED and SMI. To better plan, monitor, and manage care for this group, states should establish methods to identify these individuals, set rates for their care and track their care afterwards.

- States can share data from state mental health authorities or community mental health centers responsible for determining a designation of SED or SMI.
- States can mine their data to develop diagnostic and use indicators of people with SED or SMI.
- States can require enrollment brokers to use screening tools to help identify such individuals at the point of enrollment.
- States can require MCOs to propose and implement a process to identify individuals once they are enrolled in an MCO.

There is no formal, widely used designation of serious SUD similar to that of SMI for mental illness. However, the state of New York has defined a population with functionally limiting SUD, and with risk factors related to SUD via the prior year's claims history. Risk criteria include: two or more services in an inpatient or outpatient chemical dependence detoxification program; one or more inpatient stays with an SUD

primary diagnosis or with an SUD-related medical diagnosis related group (DRG) and a secondary diagnosis of SUD; two or more emergency department visits with a primary SUD diagnosis or an SUD-related medical DRG and a secondary SUD diagnosis. States could also develop their own criteria.

B. Develop risk adjustment and payment mechanisms to counter risk of adverse selection of people with SED, SMI or SUD, and other high-need members³⁰

A higher than average cost of care for children with SED and adults with SMI or SUD creates an incentive for MCOs to discourage their enrollment. States can use a number of mechanisms to adjust for this risk and counter this incentive.

- States can set higher rates for higher cost groups that adequately compensate for the care. Different capitation rates can be set for different subpopulations, or an enhanced payment can be offered to manage care for people assessed to meet a certain standard of need.
- States can negotiate agreements to share risk if costs of care exceed an expected benchmark (and to share savings above a certain amount).
- States can develop risk adjustment arrangements that shift funds from MCOs that enroll a disproportionate number of high-need individuals from those who have enrolled fewer individuals. This allows payment adjustments based on the plan's actual enrollment.
- Risk sharing mechanisms should be carefully analyzed and monitored to ensure unintended and undesirable incentives are not created.
- States should require MCOs to accept all members who seek to enroll, and prohibit MCOs from refusing to enroll individuals with an adverse change in their health status, utilization patterns, cost of care, missed appointments, inability to pay, submission of grievances or appeals, or behavior related to their special needs.^{31, 32}

C. Design MCO plan benefits to include an appropriate range of services for people with SED, SMI, and SUD.

Benefits should include community-based services to prevent more restrictive and expensive hospital and residential care to the degree allowed by the state Medicaid plan. At a minimum, services should include the continuum of care described by SAMHSA³³ and included in the Medicaid state plan, or can be financed by cost savings. Services for Medicaid expansion enrollees must meet parity standards and include essential benefits such as MH and SUD inpatient and outpatient care. MCOs should be required to support links between Medicaid services and health and other supportive services provided outside of the managed care benefit.

- Health homes
- Prevention and wellness services
- Engagement services
- Outpatient and medication assisted treatment
 - Community supports and recovery services
 - Intensive support services
 - Other living supports
 - Other of home residential services
 - Acute intensive services

States should:

- Identify desirable evidence-based practices and require MCOs to include these practices in their network. MCOs should pay for services at rates that fully compensate for the costs of providing services.
- Consider whether it would be beneficial to braid other funding streams for mental health services with Medicaid financing to enable health plans to manage a more complete set of services for individuals with SED, SMI, or SUD. If so, states should require MCOs to develop methods to track different eligibilities and funding sources. States should monitor MCOs to ensure compliance.
- Exclude from the capitation payment, relatively new services without a well-established utilization pattern, or for services used at higher than historical rates, such as long-term services and supports that discourage institutional care. Instead, states can directly reimburse MCOs for all funds spent on these services until a valid basis exists to include such funds in the capitation. Doing so removes risk for the costs of service expansion from the MCO while eliminating the associated incentives to restrict use of the services.
- Require MCOs to cover and reimburse primary-care practitioners that identify and treat individuals with mental health and substance use disorders, and cover practitioners for prescribing/administering medications for MH and SUD.

D. Establish separate capitation rates for behavioral health services to include a more specific rehabilitative focus and require separate financial reporting.

Establishing a separate capitation rate for behavioral health services ensures that adequate resources are available to cover both traditional behavioral health inpatient and outpatient services, and include the broader spectrum of rehabilitation services needed by individuals with SED, SMI, or SUD. Separate reporting requirements for the behavioral health-specific payment will hold MCOs accountable for managing behavioral health resources.

- Ensure that the capitation calculations include primary care services to identify and treat MH and SUD, and specify if calculations are counted against the MH capitation or the medical capitation.

E. Design mechanisms to discourage MCOs from shifting costs of people with SED, SMI, or SUD to other payers, including state hospitals, education and correctional systems, among others.

Any managed care entity has an incentive to shift costs by encouraging members to use services purchased by other payers instead of using covered health services. For example, if state hospital care is paid for by the state mental health authority, MCOs have an incentive to encourage referral for state hospital services, rather than provide stabilization services in the community.

- States can monitor the MH and SUD conditions of Medicaid enrollees using state hospital, school, or correctional services, and identify patterns that indicate cost shifting.
- States can hold MCOs responsible for paying for some or all of state hospital care, nursing home care, home-health care or court-ordered services.
- Alternatively, states can establish control over admissions to such programs, monitor the rate at which MCO clients use such services, or require MCOs to measure use of out-of-plan services. States can establish incentives for MCOs to develop plans of care that minimize the use of out-of-plan services.

F. Behavioral health pharmacy coverage

States can include behavioral pharmacy coverage in MCO benefits, or contract for a separate pharmacy manager. Either way, states should:

- Provide robust coverage for medications critical to treat people with serious mental illness.
- Cover all medications approved to treat alcohol and opioid dependence.
- Require that formularies include an effective array of psychotropic medications needed by people with SED or SMI, and lessen restrictions to the formulary used in Medicaid fee-for-service or Medicare Part D.
- Require continuity of care policies that allow consumers to maintain medication access during transition periods.
- Ensure that policies for co-pays and authorizations are not barriers to access, including avoiding use of co-insurance for high cost medications.
- Require that MCOs use protocols to identify potentially dangerous doses or combinations of medications and implement a program to work proactively with prescribers to address serious medication issues. However, MCOs should always honor prescribers' decisions on medications.
- Include injectable mental health and addiction medications as pharmacy, rather than medical benefits.

G. States should specify if subcontracting for behavioral health is acceptable

States should:

- Consider if MCOs are permitted to subcontract to an MBHO provider to manage behavioral health benefits. Alternatively, states may elect to require the specialty carve-out, as Tennessee has done. If allowed, the states should specify what behavioral health services must be included in the carve-out benefit. States should also specify the allowable terms of that agreement, or require prior approval of such agreements, including payment rates. Payment rates should be established at a level consistent with the state's actuarial assumptions for behavioral health.

2. Contract Specifications

A. Consumer Choice and Protections

States should:

- Ensure that individuals with SED, SMI, and SUD have assistance from skilled advisors to assist them in making an informed choice between available MCOs.
- Ensure members have the unrestricted right to change MCOs on a monthly basis, up to a certain number of times per year. Any further changes should occur with the consult of an independent or state consumer-rights advocate.
- Require MCOs to fully inform members of their rights in an easily readable format. Include rights to grievances and appeals, to change health care providers, to be treated in the least restrictive setting, to have expedited reviews when the situation is urgent or an emergency, and the right to consent to all treatment.³⁴

- Require MCOs to offer individuals with SED, SMI or SUD the same rights to behavioral health services from out-of-network providers that all other member's access for general medical care.
- Consider requiring MCOs to allow an extended transition period (one to two years) for members whose providers are unwilling to participate in the MCO's network.
- Require MCOs to offer members with SED, SMI, or SUD a choice of community providers and a choice of case managers.³⁵
- Prohibit MCOs from denying a member an appropriate service if the member has refused another service.³⁶

B. Outreach and Access

States should:

- Designate an enrollment broker and/or the MCO to assist members in fulfilling renewal process requirements to maintain their Medicaid eligibility.
- Establish a clear requirement for MCOs to serve members who are resistant to behavioral or medical care, and continue to reach out to them creatively and assertively.
- Require MCOs to purchase "assertive outreach" from community behavioral health providers to engage people with SMI or SUD and do not receive regular treatment.
- Require MCOs to track and follow up on individuals after discharge from an inpatient or other 24-hour setting, and assist them in accessing needed community services.

C. Community and Provider Education on Opioid and Non-Opioid Drug Use

States should require MCOs to:

- Provide information to providers on the medical consequences of substance use disorders, including neonatal abstinence syndrome, and potential infection with human immunodeficiency virus and viral hepatitis.
- Direct the prescriber to educational resources on appropriate prescribing of controlled substances.
- Provide education on non-opioid interventions for pain, including non-pharmacological interventions.
- Ensure availability of non-opioid interventions for pain, including non-pharmacological interventions.
- Start a campaign to inform individuals about available resources to aid in recovery from substance use disorder.
- Encourage individuals with, or seeking recovery from substance use disorder to enter the health care system.
- Provide substance use recovery support services to high school and college students.
- Focus prevention efforts on teenagers, college students, and college-age individuals. Develop digital campaigns and a community education toolkit.

- Develop adult-focused awareness efforts, including older adults, for prescription medication disposal, opioid and heroin abuse, signs of overdose, and the use of naloxone for reversal.
- Develop research-based community online education and social media material with an accompanying toolkit for parents and other caretakers of teens, to educate parents about opioid and heroin abuse, how to intervene if a parent thinks their teen is abusing opioids or heroin, the signs of opioid or heroin overdose, and the use of naloxone to prevent death from opioid or heroin overdose.

D. Network

States should:

- Require MCOs to include community mental health and specialty addiction agencies in networks, and to develop streamlined methods to credential relevant organizations, and allow all clinicians to serve the plan's members.
- Require MCOs to include providers with expertise in the needs of children subjected to abuse and/or neglect.
- Require MCOs to include in their networks, all willing physicians who are certified to administer buprenorphine, unless they do not meet other minimum standards.
- Require MCOs to recognize the state's licensing standards for MH and SUD services as necessary and sufficient to enter the network.
- Require MCOs, when appropriate for the service or populations, to develop efficient methods³⁷ to credential Masters-level clinicians not yet licensed or have 3 years of experience, including substance abuse counselors, direct care, and peer/recovery staff.
- Develop appropriate standards to measure behavioral health network adequacy for network providers whose panels are full and are not accepting new clients, and ensure timely access to emergent, urgent and routine care.
- Require MCOs to provide 24-hour psychiatric crisis stabilization services and prompt access to detoxification services.
- Require MCOs to contract with community-based providers to coordinate referrals for community-based support services for members with SED, SMI, and SUD, including education, housing, and income support that may fall outside of covered benefits.
- Require all MCOs to include certain services in their networks and pay a fair rate if those services are intended for all Medicaid members, and if volume is needed to maintain sufficient capacity. Examples include community crisis stabilization, intensive outpatient, or Assertive Community Treatment.
- Include peer/recovery-coach delivered services on the continuum of behavioral health services for people with SED, SMI and SUD through standard benefits, braided funding or by referral.
- Specify that MCOs develop appropriate business relationships with peer/recovery organizations, providing modified payment and additional management support when necessary.
- Require MCOs to develop and pay for community mental health centers and require SUD providers to offer active care coordination services that include a liaison to primary care and/or health homes.

- Require health homes serving patients with SED, SMI, or SUD to use care coordination resources to collaborate with community mental health centers and SUD treatment providers.
- Require MCOs to contract with primary care practices such as Community Health Centers and behavioral health providers with co-located primary care that currently treat individuals with SED, SMI, and SUD.
- Require MCOs to develop plans to increase the network of primary-care providers who are prepared to welcome and serve people with SED and SMI.
- Require MCOs to include all physicians who are certified to administer buprenorphine or naloxone into their network.
- Require MCOs to encourage and pay for MH and SUD screening, brief interventions, and medication management in primary care.
- Prohibit MCOs from setting rules for payment that inhibit co-location and integration of primary care and behavioral health care, such as prohibiting billing of two services on the same day.
- Prohibit MCOs from excluding or discriminating against providers that serve high-risk populations.
- Require MCOs to pay behavioral and primary care providers at rates that adequately cover their costs and are sufficient to maintain their participation in the network.
- Require MCOs to pay for tele-health services whenever needed to expand access to healthcare.

E. Service Authorization

Historically, behavioral health benefits are more limited and managed more stringently than medical/surgical benefits. However, the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA) requires health plans to cover mental health and substance abuse services with financial or numerical limits and non-quantitative treatment limits that are no more restrictive than those applied to medical/surgical care. (Medical necessity criteria and service authorization practices are considered to be non-quantitative treatment limits.) MHPAEA is applicable to Medicaid expansion services, but not necessarily to traditional Medicaid. Medicaid managed care is covered to the extent that a State Plan covers behavioral health services. States can use MHPAEA provisions to help ensure that Medicaid managed care plans use appropriate service authorization practices to ensure access to behavioral health therapies that are safe, effective, and able to achieve superior outcomes, at least within the scope of services covered in the State Plan. States should:

- Require MCOs to prepare a parity compliance plan for state approval that includes specific assurances that MH and SUD services are administered at parity with medical services, as specified by the final regulations of the Mental Health Parity and Addiction Equity Act of 2008.
- Ensure transparency by monitoring MCOs' compliance with MHPAEA provisions that require MCOs to disclose standards for both behavioral health and medical/surgical service approval plans, and allow members to compare the plan's relative restrictiveness.
- Require MCOs to develop flexible prior-authorization policies for wraparound services and services outside the benefit package, when such services are likely to save money or produce better outcomes.

- Consider establishing a standard of “psychosocial necessity” instead of “medical necessity” for the supportive services needed by individuals with SED, SMI, and SUD. States should develop methods to monitor the implementation by MCOs.
- Require MCOs to staff its service authorization functions with behavioral health professionals experienced in care for disabled populations and able to discuss treatment plans with provider clinicians on a peer to peer basis.
- Require MCOs to allow billing for more than one behavioral health or primary care service on the same day (to allow members to use time and transportation efficiently).
- Require MCOs to individualize authorization decisions rather than implement de facto maximum lengths of stay in a specific service.³⁸
- Require that MCO’s guidelines for placement or discharge incorporate homelessness, lack of family supports and coexisting medical conditions.³⁹
- Monitor lengths of stay and utilization indicators to identify patterns of overly-restrictive authorization practices.

F. Appeals

The ability to appeal health plan denials of service is a critical right. Given the significance of specialized services, specific mediations, and existing treatment relationships to effectively manage a client’s condition, appeals must provide timely resolution of service denials. Because people with serious mental illness or addictions may have difficulty advocating for themselves, the process must be easy to access and understand. Provisions for providers or advocates to assist patients should be implemented. States should:

- Require MCOs to notify members promptly of their rights to appeal.
- Review plan notices to ensure that they are easy to understand for the literacy levels and language groups commonly found in the covered population.
- Allow family members, friends, advocates, or providers to assist the client during the appeals process.
- Ensure that the requirements of the appeals process do not impose difficult barriers for persons of low income.
- Monitor responses to appeals to ensure that timelines are consistently met and procedures followed.
- Analyze appeals and complaints to identify and address any systemic issues.

G. Staffing

States should require MCOs to have:

- A minimum level of managers and staff with extensive experience working with individuals with SED, SMI, and SUD to ensure their ability to effectively manage and improve care.
- Dedicated personnel to work on clinical and administrative functions for behavioral health.

H. Treatment Planning and Care Coordination

The complexity of treating serious mental illness, co-occurring substance use disorder and chronic conditions, and effectively addressing social needs for housing, transportation, and employment requires individualized approaches to care management. Decisions regarding managing care and assessing risks and benefits of any mental or behavioral health therapy or medication, must be made by the treating health care provider in consult with the patient. In addition, due to the vulnerability of individuals with serious mental health conditions, continuity of care is critical for members whose condition has stabilized. Standards that require fail first policies for services or medications and thereby require a member to terminate services, should be suspended. Continuity of care must be assured for members to continue services and continue medications that have proven effective in managing the member's behavioral health condition. Policies that allow members to continue care with out-of-network providers for extended periods are also necessary. States should:

- Explicitly define recovery for individuals with SMI and SUD and resiliency for children with SED, and require MCOs to promote recovery and resiliency in treatment planning.
- Require MCOs to authorize health care professionals and patients to make shared decisions for the appropriate approach to manage care and assess risks and benefits of mental or behavioral health therapy and medication.
- Require MCOs to establish policies to waive any fail first processes or formulary limitations for services or medications for members with serious mental illness, whose current service plan is demonstrated to keep them stable.
- Do not allow MCOs to impose time limits on medications used for treating opioid or alcohol dependence.
- Require MCOs to invite service providers treating members into their networks.
- Require MCOs to develop single case agreements with out-of-network providers to maintain continuity of care for extended periods.
- Require MCOs to establish liaisons and negotiate protocols with state agencies such as the mental health authority, the single state agency for substance use disorders, the child welfare agency, and correctional agencies to coordinate treatment planning, discharge and other key aspects of care for shared clients. Protocols must be efficient for state agency staff who must interact with more than one MCO.
- If these agencies pay for services that constitute a portion of the continuum of care for individuals with SED, SMI or SUD, protocols should address managing both access to and transition from these services.
- Require MCOs to negotiate a written agreement with local law enforcement agencies to ensure the smooth transfer of enrollees who are assessed to be a danger to self or others.⁴⁰
- Require MCOs to work closely with Community Mental Health Centers and SUD treatment providers to develop care management programs for individuals with SED, SMI, and SUD with complex needs. Protocols should include identifying such individuals, timelines to assess and develop a care plan, coordinating between MCO care managers and treatment providers, and evaluating the program.⁴¹

- Require MCOs to develop policies and procedures that ensure warm handoffs when a client transitions from one level of care (e.g., inpatient) to another (e.g. community-based medication management and rehabilitation), or when a client requires access services outside of his or her established health home, including medication.

I. Medical Care for People with SED, SMI and SUD

Individuals with SMI and SUD are at higher risk for certain co-occurring disorders. For example, those who are prescribed atypical antipsychotic medications may experience major weight gain and changes to metabolism that increase the risk of diabetes and high cholesterol.⁴² In addition, individuals with SMI smoke at much higher rates than those without mental illness. Nearly half of cigarettes smoked are smoked by people with mental illness, and the rates of smoking have not fallen. Smoking cessation methods have not been as successful for them as hoped.⁴³ These and other health problems, combined with limited access to medical care, result in a lower life expectancy of 25 years than for individuals with similar demographic characteristics in the general population.⁴⁴ People with both SMI and SUD die 37 years earlier. People with SUD also have heightened medical risks. Heavy alcohol use is associated with liver disease and coronary artery disease, while cocaine use can trigger heart disease, and abuse of injection drugs increases the risk of hepatitis C and HIV/AIDS.⁴⁵ Given these significant medical needs and poor health outcomes, it is imperative that integrated managed care plans include strong incentives to address barriers to medical care. States should:

- Require MCOs to enroll members with SED, SMI, or SUD in health homes when they meet the chronic illness criteria specified by the state's health home plan.
- Consider requiring MCOs to develop a strategy (for state approval) to create a health home for people with SED, SMI, or SUD and another chronic conditions. Health homes must address medical and behavioral needs in an integrated way. This includes expanding co-located primary care in behavioral health settings, training primary care practices to better work with individuals who have SMI or SUD and children who have SED or other disabilities. Include additional resources for assertive outreach, engagement, shared information systems, and care coordination.
- Require MCOs to develop methods to compensate primary care providers for the time spent working with members with mental health or substance use problems.
- Encourage self-management programs for individuals with SED, SMI, and SUD to address both physical and mental wellness, including smoking cessation and weight loss. Self-management should be available to all, as outside plans or provided as a part of the MCO benefit.
- Require MCOs to work with primary care and behavioral providers to develop standard evidence-based guidelines to best meet the needs of clients with SED, SMI, or SUD, and establish common expectations and practices that enhance coordination and communion between primary and behavioral health providers.⁴⁶
- Encourage MCOs to incentivize primary and behavioral health providers to deliver well-coordinated care.⁴⁷ For example, MCOs can require that contracted primary care providers share physical health data for shared clients with community behavioral health providers.
- Develop measures to monitor the provision of medical care for members with SED, SMI, or SUD.

J. Consumer Involvement

States should require MCOs:

- To have formal advisory or governance bodies that include family and consumer representatives of individuals with SED, SMI, and SUD, as well as behavioral health providers. The state should monitor policy making, program development, and quality improvement for these groups.
- To assess the satisfaction of members with children who have SED, and members with SMI or SUD, use methods that ensure high response rates and valid data, such as surveys and interviews of consumers.
- To stratify complaints and grievance data and include data for behavioral health issues and data for clients with SED, SMI and SUD.

K. Cultural Competency

States should:

- Require MCOs to ensure availability of bilingual providers and trained interpreters in the languages used for at least 5% of Medicaid enrollees.
- Require MCOs to assess the completeness and accuracy of information on member race and language and implement improvements as necessary.
- Establish performance expectations to reduce significant disparities in health access experienced by groups enrolled in Medicaid.
- Make key performance reports available and stratified by racial and ethnic group.

L. Information and Billing Systems

States should:

- Require MCOs to develop efficient and effective information systems to document and monitor the implementation of treatment plans for people with complex conditions to include services outside of the benefit.
- Require that MCOs use efficient, timely and user friendly processes for authorization and billing to minimize the burden on providers, and monitor those processes.
- Require that any behavioral health subcontractor meet the same expectations as the MCO, and report the same indicators of payment timeliness and appeals resolution.
- Reserve the right to require that MCOs collaborate on common authorization, billing and credentialing processes and protocols to standardize information across plans, and simplify the administrative processes for providers participating in multiple networks.

M. Contracts and Oversight

States should:

- Clearly define the terms recovery and person-centered planning for people with SED, SMI or SUD, and set measurable goals to implement these principles within the managed care program, and include in procurement documents and the contract.
- Require prospective MCOs to describe in their proposals how to implement recovery principles and person-centered planning in the provider network.

- Include consumer and caregiver representatives in the selection process to help rate proposals on implementation plans for recovery orientation and person-centeredness.
- Require Medicaid agencies to involve state mental health authorities and single-state agencies for substance abuse when developing performance specifications for access and quality of care for individuals with SED, SMI, and SUD.
- Designate a Medicaid staff member with training and experience in providing treatment for SED, SMI, and SUD to oversee the MCOs' contractual requirements to provide behavioral health services. Ensure that staff capacity is sufficient to monitor the size and number of MCOs in the state.
- Consider including financial incentives to improve care for individuals with SED, SMI, and SUD.
- Set a minimum standard for medical loss that specifies a methodology that separately measures and appropriately counts the administrative costs of any subcontracted MBHOs.

N. Quality Improvement

States should:

- Require all MCOs to incorporate recovery strategies, person-centered planning, youth and family-driven care and evidence-based practices into their services for individuals with SED, SMI, and SUD.
- Require MCOs to report on and improve access to community-based care and intermediate services, and to increase the time that members with SED, SMI, and SUD spend living in the community, rather than restrictive inpatient settings, homelessness, or criminal justice system involvement.
- Require MCOs to promote recovery goals such as stable housing and full employment for individuals with SED, SMI, and SUD, and report on goal attainment.
- Carefully monitor the quality of behavioral and medical care delivered to individuals with SED, SMI, and SUD by its MCOs. As noted previously, this reporting requires both the state and MCOs to develop methods to identify and track individuals with SED, SMI, and SUD in enrollment and utilization records, and in collecting recovery-related measures not found in claims.
- Set expectations for improvements to access to primary care and to manage chronic medical conditions among individuals with SED, SMI and SUD.

O. Cost Savings and Reinvestment

States should:

- Clearly communicate expectations to define behavioral services and physical health services, and require all MCOs to report on costs and utilization with these definitions to ensure comparable data usage.
- Establish methods to measure behavioral health expenditures and require that MCOs meet minimum spending targets for services.
- Require MCOs to report on the medical care costs for individuals with SED, SMI, and SUD and other chronic conditions, to better understand medical cost offsets produced by behavioral health treatment.
- Require a portion of cost savings from improved care of members with SED, SMI and SUD to be reinvested in community services, with assistance from state Medicaid officials and consumer advisory groups to identify reinvestment priorities.

3. Performance Measures

A. Measures of Behavioral Health Service

ACCESS

- Timeliness of access to primary care and specialty care measured by surveys (e.g., Consumer Assessment of Healthcare Providers and Systems (CAHPS), other surveys)
- Analysis of network's compliance with geoaccess standards
- Behavioral network sufficiency, taking into account closed panels
- Screening for clinical depression and follow-up (NQF, 0418)
- Initiation of alcohol and other drug dependence treatment (HEDIS)

SERVICE UTILIZATION

- Percent of members using outpatient mental health care (HEDIS)
- Percent of members using intermediate mental health care (HEDIS)
- Percent of members using inpatient mental health care (HEDIS)
- Percent of members using emergency rooms and alternative psychiatric crisis services, all members, SMI and SED members, members with SUD (MassHealth, 2008)
- Rate of diversions from inpatient
- Biweekly or monthly report of SMI and SED members who no longer meet inpatient level of care, but cannot be discharged (MassHealth, 2008)
- Percent of members receiving screening and brief counseling for substance use

QUALITY

- Experience of care (CAHPS or other survey)
- Percent of members with SMI or functionally limiting SUD assigned to the plan who are retained for six months
- Improving or maintaining mental health over two years (CMS)
- Post-discharge continued care plan 1) created; 2) transmitted to the next level of care provider on discharge (NQF, 0557 & 0558)
- Percentage of hospital-discharged patients contacted by the MCO hospital liaison or a designated provider by phone or in person within 2 days of discharge. (Modified from Rhode Island Health Home Quality Measures)
- Percentage of members with follow-up within 7 days and 30 days of discharge from a mental health hospitalization (HEDIS)
- Percentage of member with follow-up within 7 days and 30 days of discharge for a hospitalization for alcohol or chemical dependency detoxification (NYState, 2012)
- Rate of (avoidable) psychiatric readmissions

- Appropriateness of drug regime (# of scripts with contra-indicated doses or drug combinations) (Bella et al, 2009)
- Adherence to mood stabilizers for individuals with bipolar I disorder (RAND)
- Proportion of schizophrenia patients with long-term utilization of antipsychotic medications (RAND)
- Adherence to antipsychotic medications for individuals with schizophrenia (HEDIS)

RECOVERY MEASURES

- Number of members with SMI or functionally limiting SUD who maintain stable housing (Illinois and Virginia Dual demonstration)
- Number of members with SMI or functionally limiting SUD who maintain or gain employment (adapted from IOM)
- Number of days worked without absence (IOM, 1997)
- Average attendance in school for children and adolescents (IOM, 1997)
- Percent of clients with SMI who live independently in the community (IOM, 1997)
- Percentage of members treated for SUD whose substance-free status is validated through breath and urine testing (IOM, 1997)

ADMINISTRATIVE MEASURES

- Adoption and use of Medicaid e-prescribing in ambulatory settings (NQF, 0486)
- Adoption of health information technology (NQF, 0488)
- Ability of providers with HIT to receive laboratory data electronically as discrete searchable data (NQF, 0489)
- Percent of health home patients whose charts include documentation of physical and behavioral health needs (Rhode Island Health Home measures)

B. Measures of primary and medical care for people with SMI and SED

Some of these measures may be used for all plan members. We recommend they be stratified for people identified with SED, SMI, and SUD.

ACCESS

- Members with a usual source of primary care
- Member visits to provider identified as the usual source of care (National Quality Forum)
- EPSDT Composite for children (HEDIS)
- EPSDT Composite for adolescents (HEDIS)
- Difficulty speaking with provider due to language (CAHPS)
- Respect from providers (CAHPS)

- Access to interpreter (CAHPS)
- Ratio of primary care providers to members by geographic area (Bailit, 2011)

UTILIZATION

- Emergency department utilization (HEDIS)
- Risk Adjusted length of hospital stay (NQF)

QUALITY

- Tobacco use assessment and tobacco cessation intervention (NQF, 0028)
- Annual assessment of weight or BMI, glycemic control, and lipids for individuals with Bipolar I Disorder (RAND)
- Diabetes screening of individuals with schizophrenia or bipolar disorder and antipsychotic use (HEDIS, 2013)
- Diabetes monitoring for individuals with schizophrenia and diabetes (HEDIS, 2013)
- Cardiovascular monitoring for individuals with schizophrenia and cardiovascular disease (HEDIS, 2013)
- Cholesterol Management For Patients With Cardiovascular Conditions (HEDIS)
- Comprehensive Diabetes Care (HEDIS)
- Medication possession ratio (proportion of days a patient takes medication, based on the intervals between refills) (Oestrich & Clayton, 2009)
- Medication gap (average days between refill of prescription) (Oestrich & Clayton, 2009)
- Hospitalization rates for preventable or avoidable visits (Bella et al, 2009)
- Avoidable emergency department utilization (National Quality Forum) (Medi-Cal, 2010)
- Mortality rates for individuals with MH and/or SU conditions
- Rate of smoking screening and counseling
- Increase in level of physical activity
- Weight loss
- Beneficiaries changed managed care plans within 60 days (Bailit, 2011)

C. Measures of primary and behavioral health integration for people with SED or SMI

- Linkage to primary or specialty care for physical health (Bella et al, 2009)
- Degree of MH/SU integration with primary care: % of healthcare homes with access to MH/SU primary care through a team, co-location, a system, or through referrals (Wash DSHS, 2010)
- Percent of practices that have adopted Electronic Health Records (EHRs) that can be accessed by primary and MH/SU care. (Wash DSHS, 2010)
- Evidence of comprehensive screening (in all three domains - physical, MH, SU) (Wash DSHS, 2010)

- Percentage of individuals screening positive who have further assessment in domain screened (Wash DSHS, 2010)
- Evidence of joint assessment, jointly developed plans of care (Bella et al, 2009)
- Linkage to community behavioral health for mental health (Bella et al, 2009)

D. Administrative Measures

- Percentage of authorization requests approved, modified or denied by service type (Bailit, 2011)
- Average length of time to make an authorization determination by service type (Bailit, 2011)
- Average time to payment of clean claims
- Per enrollee spending stratified by physical and behavioral health care

4. Questions for MCOs

State Medicaid agencies, state legislators, behavioral health providers and advocates may have opportunities to meet with managed care companies competing for managed care opportunities. The following questions can help elicit relevant information about a company's experience managing behavioral health care for people with SMI, SED, and serious SUD, and the strategies and approaches they intend to use. Advocates may wish to recommend that the state incorporate some of these considerations into its proposal review process.

1. Are you accredited by NCQA?
2. Do you publicly release all of your HEDIS results?
3. Do you subcontract with an MBHO for management of behavioral health benefits? If so, which MBHOs do you use in what plans, and are they at risk?
4. What is your experience managing care for Medicaid enrollees, for Medicaid disabled enrollees, for adults with serious mental illness or substance use disorders or youth with serious emotional disturbance?
5. What kinds of mental health rehabilitation services are included in your benefits? How do you credential rehabilitation service providers?
6. What peer services are included in your benefits?
7. What is the average wait time for a member to get an appointment with a psychiatrist? For a child to get an appointment with a child psychiatrist?
8. What performance improvements has your company achieved for people with serious mental illness or substance use disorders, or for treatment of mental illness or substance use disorders overall?
9. How has your company promoted access to dual diagnosis treatment for people with both mental health and substance use disorders?
10. Has your company implemented person-centered care in any of your health systems? Please describe what services and populations were involved. How did you measure progress? What were the results?

11. How do you define recovery? Are your clinical staff trained on recovery principles? How have you incorporated recovery principles into one of your programs? What were the results?
12. What is your average turnaround time for clean claims? What is the average turnaround time for any behavioral health subcontractor?
13. What are your penetration rates for use of behavioral health services for your Medicaid populations?
14. What outpatient and rehabilitative mental health services require prior approval? How many visits are approved at one time? What percentage is approved?
15. What are the qualifications of personnel who interact with network mental health providers to authorize care?
16. How have you changed your authorization process for mental health and substance use disorder services to comply with the Mental Health Parity and Addiction Equity Act? Has there been any change in penetration rates or units of service used per member?
17. How do you set payment rates for outpatient mental health care?
18. How do you select members for participation in special care coordination programs? (probes: intensive use of services, indicators of chronic conditions that aren't optimally treated) Have people with serious mental illness or addictions been included in these efforts? How are mental health and substance use disorder services included in treatment plans?
19. What have you done to promote better coordination between your primary care network and your behavioral health network?

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IV. ADDITIONAL CONSIDERATIONS FOR MANAGED CARE FOR PEOPLE WITH BOTH MEDICARE AND MEDICAID COVERAGE

1. Medicare-Medicaid Enrollees and Federal Demonstration Programs

A. About Medicare-Medicaid Enrollees

Nineteen states are working with the Centers for Medicare and Medicaid Services (CMS) to develop methods to demonstrate better alignment of the financing and incentives of Medicare and Medicaid for people enrolled in both.⁴⁸ Many of the proposed demonstrations will employ capitated managed care approaches. The approximately 9.6 million Medicare-Medicaid enrollees (MMEs) are among the most vulnerable and highest cost enrollees in the Medicaid and Medicare systems. They accounted for 14% of Medicaid enrollment and 36% of Medicaid expenditures in 2010.⁴⁹ They also accounted 21% of Medicare enrollment and 33% of Medicare spending in 2009.⁵⁰

MMEs have high rates of mental disorders; the treatment records of 23% show evidence of diagnosed depression, 22% show affective and other serious mental health disorders, and 6% show schizophrenia. Twenty percent show evidence of one or more mental health and/or cognitive disorder, and 38% show both a physical and a mental health or cognitive disorder. The group also includes a significant subpopulation of individuals with intellectual and developmental disabilities. A total of 85% have a chronic physical condition. The most prevalent of which are: osteo or rheumatoid arthritis (62%), diabetes (35%), and pulmonary disease (28%).⁵¹ Because of these multiple chronic conditions and disabilities, MMEs are more likely to use Long Term Services and Supports than Medicaid-only enrollees. In 2009, 15 percent received care in a long-term care facility, such as a nursing home, and 65% of Medicaid spending for MMEs was for long-term care services. This includes not only 24-hour care facilities, but also community-based services provided on a long-term basis to help with health care and functioning.⁵²

Because of the complexity of the dual benefit, Medicare-Medicaid enrollees are often excluded from Medicaid or Medicare managed care plans. However, some managed care programs do enroll them. Insurers can develop Special Needs Plans (SNP) for defined, high-need Medicare subpopulations. SNPs can also be developed specifically for MMEs (Dual Eligible Special Needs Plans, or D-SNPs). For these plans, only Medicare benefits are managed; MMEs access their Medicaid services as usual. On the Medicaid side, some states have enrolled MMEs into Medicaid managed care plans, in which case they get their Medicare benefits as usual. Minnesota has pioneered a managed care model in which Medicaid MCOs serving dual eligibles must also be certified as Medicare D-SNPs, but there are few other well-tested examples of models to coordinate Medicare and Medicaid for MMEs.

B. About Medicare-Medicaid Financial and Administrative Alignment Demonstrations

Differences in the financing and administration of Medicare and Medicaid means that Medicare and Medicaid services are not always optimally aligned to work well together. For example, states are incentivized to invest in Medicaid community-based Long Term Services and Supports (LTSS) that can prevent or reduce the use of long-term institutional care, because the state Medicaid program shares in any savings created. However, those services might also benefit individuals at risk of repeated use of emergency and inpatient care. In this case, the Medicare program would realize most of the savings, as Medicare is the primary payer for inpatient and emergency care. Since states cannot realize the savings, they may not invest in services

that would benefit MMEs and the health care system as a whole. In addition, the coverage of different services under different health care systems and payment methods means that enrollees may have a difficult time understanding the services they can use and how to access them. As a result, the system as a whole is not operating optimally to provide lowest cost care in the least restrictive environment.

To address this issue, the Affordable Care Act included a provision directing CMS to work with states to develop demonstrations to integrate care and align financing and/or administration for Medicare-Medicaid enrollees. The demonstrations assume that significant cost savings are possible from better managing care for this high need, high cost group currently served in unaligned systems. The six capitated models approved by CMS are proposing to save from 0.5% to 1.5% in the first year, rising to 3% to 5.5% in the third and final year.⁵³ These savings will be taken from a reduction in the capitation rates. However, many also have a form of risk sharing to protect MCOs from losses due to members with extraordinary health care costs. Some models will use managed fee-for-service models and will realize savings retroactively from reduced expenditures.

C. Participating States and Covered Populations

Massachusetts and Minnesota were the first to reach agreement with CMS and initiate their demonstrations. California, Illinois, New York, Ohio, Virginia and Washington were next to reach agreement. The law authorized demonstrations covering up to 2 million dual eligibles, and the eight approved programs listed above, cover 1.1 million. None of the demonstrations are statewide. Four additional agreements were reached between CMS and Colorado, Michigan, Texas and South Carolina. Six additional demonstration proposals are being considered, plus a second proposal each from New York and Washington, both of which address different models or different populations.⁵⁴

Six of the eight initially approved proposals are capitated models, Washington's is a managed fee-for-service model, and Minnesota is testing administrative alignment in its existing Medicaid MCOs that are also D-SNPs. Four of the demonstrations will enroll adult MMEs in specified counties or regions. Massachusetts's demonstration focuses on non-elderly adults, most of whom will be eligible on the basis of disability. Minnesota's administrative alignment demonstration is limited to dual eligibles who are over age 65. New York and Washington each have designated a high risk, high need group. All the capitated demonstrations have excluded individuals with intellectual disabilities, but New York is proposing a second demonstration specifically for that group.

Beneficiaries in capitated demonstrations will have the right to opt out of the demonstration program at any time. Most demonstrations begin with a period of voluntary enrollment during which eligibles can select among plans, followed by a period of passive enrollment, during which MMEs in the target population are assigned to a plan using algorithms to maximize their continuity with current providers. Several states are seeking to make enrollment in Medicaid managed care mandatory for any MMEs who opt out of their state's demonstration program.

D. Challenges Unique to the Medicare-Medicaid Demonstrations

Unlike specialized behavioral health carve outs, the MME demonstration programs are expected to provide both medical and behavioral health services for their many members with SMI and SUD, as well as for other elderly and/or disabled individuals with multiple health and behavioral health conditions. Plans must not only be expert in meeting the behavioral health needs of individuals with SMI or SUD, but also in coordinating their medical care for commonly co-occurring conditions such as hypertension, COPD, and diabetes. In

addition, plans must be able to manage the supportive services needed by people with physical disabilities and the medical care for people with multiple disabling medical conditions. This is a group with a significant share of highly vulnerable members with complex conditions. There may be only one practitioner who can effectively address their combination of conditions. Individuals with physical disabilities have sometimes worked many years to find practitioners that will work with them effectively to address their needs. There is considerable value in maintaining continuity with providers who are familiar with a member's complicated health history when the member prefers to do so. Disruptions in care of even one condition can have a cascading effect that causes other conditions to destabilize, resulting in health crises and hospitalization or institutionalization.

Due to their disabilities and complex health conditions, many MMEs rely on long-term services and supports, both institutionally and community based. There is considerable benefit for both members and payers in using community LTSS and home and community based waiver services to minimize the need for out of home institutional care. Most demonstrations have included these services in the demonstration program's benefits. Some have specifically allowed plans to create additional diversionary services (within the capitation) when needed to best prevent or shorten inpatient or institutional care. Some have required "conflict free" community-based care coordination that is independent of the providers of home and community based services.⁵⁵ This arrangement neutralizes any incentive for care coordinators to make referrals to the services provided by their own organizations. However, it may pose a challenge for behavioral health, where there may be only one organization in a county with the expertise needed to plan long-term services and supports for people with serious mental health or substance use disorders.

Finally, health plans have considerable challenges in effectively coordinating the largely separate Medicare and Medicaid health systems. This requires educating not only their own staff but also their network providers and their members on the services available and how to access them.

2. Special Contract and Implementation Considerations for Medicare-Medicaid Demonstration Programs

Most of the considerations described for Medicaid managed care will apply to Medicare-Medicaid enrollees with SMI or SUD enrolled in capitated Medicare-Medicaid demonstration programs. However, the special characteristics of the dual-eligible population and of the Medicare-Medicaid alignment mean that additional issues must be considered. Because there is not a long history of dual eligible managed care projects, we have not attempted to document the strengths and weaknesses of different models. Rather, we discuss the key considerations pertaining to each topic, and suggest targets for advocacy or contract specifications.

A. Planning and implementation process

In order to effectively address the concerns and needs of the many disability groups that participate in a Medicare-Medicaid alignment demonstration, states must conduct a broad ranging public planning process that includes Medicare-Medicaid enrollees, advocacy groups, and providers. Both states and participants should recognize that it may be challenging to manage discussions with participants whose concerns and considerations may not overlap. For example, MMEs with SMI and their providers face unique challenges that may not be the same as those facing MMEs with a physical disability and their independent living providers. Since these groups don't often meet together, they may use the same terminology to mean different things. In addition, special efforts may be needed to ensure that all groups attending have the opportunity to express their own concerns and suggestions. For example, in one planning meeting in Massachusetts,

advocates for people with physical disabilities were active participants and frequently referred to themselves as people with disabilities. However, people representing MMEs with SMI and intellectual disabilities did not speak about their experiences.

States should:

- Conduct multiple public meetings throughout the planning process in all the regions of the state planned to participate in the demonstration.
- Publicly share draft plans and be prepared to revise them based on feedback.
- Establish a broad based and representative advisory group including all disability groups and providers that will participate in the demonstration, and confer with them frequently during the planning process.
- Ensure that stakeholders from all groups have an equal chance to participate in public processes.

In addition, advocacy and provider groups for people with disabilities would benefit from meeting in advance of and during the public process to get to know each other, and better understand each group's key issues and concerns and to identify common priorities.

B. Target population

States have multiple ways to select a target population, including by age, disability status, geography, and institutional status, or other indicators of risk or cost. This decision will be based on the state's goals for the program and which populations it believes will most benefit from better coordinated Medicare and Medicaid services. The state should also consider the characteristics of the different service systems serving Medicare-Medicaid enrollees and their readiness to participate in a managed care model. For example, programs targeting elderly MMEs should involve or collaborate with Aging Service Access points, while those targeting populations with SMI will need to include community mental health centers in the network.

States should:

- Conduct in depth analyses of the service patterns and costs of the designated target population to learn what services they are currently using and identify the potential for improvements in care.
- Gather input from all providers currently involved in the care of the target population, whether in the Medicare or Medicaid system or outside of it.
- Assess the readiness of the existing service system to make desired changes, and design phased approaches if necessary, especially for providers that are not currently part of the health system.

C. Consumer choice and protections

Because of the vulnerability of many Medicare-Medicaid enrollees and the complexity of administering dual benefits, an even higher level of consumer choice and protections are recommended to be built into dual demonstration programs.

ENROLLMENT, OPT OUT AND CHOICE

Many MMEs are expected to be passively enrolled in dual eligible demonstrations. Most will be offered the opportunity to voluntarily enroll and select their plan. However, those that don't voluntarily enroll will be passively enrolled, using intelligent algorithms that match them to plans with the providers they currently use. While there are considerable requirements for notifying Medicare-Medicaid enrollees

about the new demonstration and their opportunity to enroll, states expect that many will be enrolled passively and may not know that this has happened. States should:

- Use their enrollment broker, navigator, or community health worker resources to actively reach out to potential enrollees and help them understand their options, the potential benefits to them, and how to enroll and how to opt out.
- Require MCOs to have robust communication and member service functions that can communicate clearly in multiple languages with members and respond promptly to their questions.
- Require MCOs to have an urgent response capacity that can intervene if the transition has resulted in a risky situation for any member.
- Ensure that the administrative processes of the state and CMS can promptly reinstate any Medicare-Medicaid enrollees who opt out of the demonstration into traditional Medicare and Medicaid.

CONTINUITY OF CARE

Given the vulnerable state of some enrollees who will be transitioning to a dual demonstration, it is imperative to ensure continuity of care. The National Senior Citizens Law Center (NSCLC) has reviewed the first six Memoranda of Understanding negotiated between states and CMS and made the following recommendations. States should:

- Expansively define current providers for whom continuity is allowed. Some states have not defined the term, allowing a broad construction of its meaning. If it is more narrowly defined, the NSCLC recommends a definition no more restrictive than having at least 1 visit in the year prior to the date of enrollment.
- In addition to the right to continue with a specific provider, ensure rights for continuity of services during a transition period. If a member has a scheduled surgery or needs to start physical therapy, these plans should be honored, even if the provider is new to the member. Since Medicare does not use prior authorization processes, it is not sufficient to require that prior authorizations be honored. The following language covers both Medicaid and Medicare services.
 - Require demonstration plans to pay for services that would have been covered if the individual were in Medicare or Medicaid fee for service, are part of a current care plan, and have been scheduled, ordered, prescribed, or initiated.
- Include all types of providers and services in these continuity rights.
 - Require at least 90 days of coverage for supply and repair of durable medical equipment, prosthetics, orthotics, and supplies from out of network providers (per current Medicare managed care rules).
- Apply continuity protections to any newly covered services. For example, if dental coverage is newly covered in the dual demonstration, the plan should pay for any dental work already in process from the date of enrollment.
- Require that plans maintain at least current level of service for direct care services for at least one year. Services include personal care, waiver nursing, home care, respite care, community living, adult day health, social work counseling, and independent living. Where assessment and determination of service needs reside with an independent organization, states may wish to establish different standards.

- States have defined different transition periods, ranging from 90 days to one year; the NSCLC recommends a transition period of a year. Some states have set different periods for different services. Ohio has not set a time period, but has required that previous scheduling, authorizations, and orders be honored and that plans allow courses of treatment to be completed.
- States should require plans to enter into single case agreement^I for a specific member with their health care provider when circumstances warrant.
- The transition period should not be shorter than the designated period unless a new enrollee has received a full assessment, has a care plan that he or she has agreed to, has access to needed providers, and agrees to the shortened period.
- Continuity for individuals in long-term care facilities or assisted living waiver services should be provided for the full term of the demonstration, even if the facility is not in the plan's network. To do so, the state must set provisions requiring adequate payment.
- Enrollees and their providers must be notified in clear language about the enrollee's rights and the providers' options. Notifications should occur in all relevant languages, especially when an enrollee is first enrolled and when a continuity period is coming to an end. States should consider telephonic outreach for some enrollees.
- Establish clear requirements for plans to actively recruit current Medicare and Medicaid providers into their network, and to establish clear and user friendly processes for providers to get authorized, bill, and be paid for non-network services.
- Monitor plan readiness to recruit non-network providers and manage non-network services, and monitor operations to ensure that administrative barriers are not impeding participation of non-network providers.

COMPLAINTS AND APPEALS

Medicare and Medicaid have different appeals processes and timelines, making it challenging to create an integrated process that combines the required features of each. However, doing so is necessary to ensure that members have prompt access to the full range of services available to them through the two programs. The NSCLC review of the first six Memoranda of Understanding resulted in these recommendations for an integrated appeals process.⁵⁶

The state should:

- Clearly define what services are considered to be covered by both programs in their plan contracts.
- Develop an integrated review process, or closely coordinate the separate processes to promote efficiency and timely decisions. Currently, states take a variety of approaches. Some states maintain separate external review processes performed by the Medicare Independent Review Entity (IRE) for Medicare services and the Medicaid Fair Hearing Board. Some services are covered under both Medicare and Medicaid, meaning that they could be appealed under both programs. Some states allow such appeals to go forward simultaneously, while others require that the Medicare IRE render a decision first.

I A single case agreement is an agreement between a health plan and a provider for reimbursement of health services for a specific health plan member. This agreement does not make the provider part of the health plan's network.

- Consider following the example of New York State, which has established an integrated appeals process at every step. Following an appeal directly to the plan, the member's appeal is considered by an administrative hearing officer trained in and responsible for considering both Medicare and Medicaid benefits and rules. The next stage appeal is to the Medicare Appeals Council, where federal hearing officers will also consider both Medicare and NY Medicaid rules and guidance. The final stage available to a member is federal district court.
- Timelines for plan response to initial appeals range from 15 to 30 days. The NSCLC recommends a 15 calendar day response period.
- Allow members to have an oral presentation of facts and an in-person hearing at the plan level to facilitate physician-to-physician communication, consistent with current Medicare managed care guidance.
- Forgo the option to recoup the cost of services appealed when received during the appeals process. Given the limited income of Medicare-Medicaid enrollees, the risk of having to repay may discourage members from exercising their appeal rights.
- Consider phasing in faster Medicare and Medicaid time frames for external appeals, like Ohio.

Because this population is particularly vulnerable, it is also important that they have access to effective complaint resolution for matters other than appeals of service authorization. Some states do this by establishing an independent ombudsman, or by designating the ombudsman to serve members of the demonstration. Other states assign this responsibility to staff in their Medicaid agency.

Either way, states should ensure that:

- The designated agent responding to complaints is appropriately trained and empowered to assist members to address enrollment, service, communication, or other problems.
- This agent keeps records of complaints and analyzes them to identify systemic problems requiring policy-level interventions or problems with the performance of an MCO or enrollment broker warranting corrective action.

CONFIDENTIALITY

The state needs to ensure that the additional confidentiality provisions pertaining to mental health and substance use disorder diagnosis and treatment information are addressed by its MCOs, and that the MCOs have strategies to address the barriers that confidentiality provisions can cause in collaboration between behavioral health and medical providers.

OVERSIGHT OF ABUSE AND NEGLECT

A high proportion of Medicare-Medicaid enrollees are in institutional care or dependent on the assistance of caregivers coming to their homes, so the potential risk of abuse, neglect, or exploitation must be recognized and addressed. The state should:

- Require MCOs to establish or participate in a state operated system to respond to, identify, and prevent abuse, neglect, and exploitation.
- Closely monitor this system and identify any patterns that can be addressed by systemic interventions or corrective action plans.
- Provide members with easy to understand information about their rights and how to submit a complaint and require institutional and community-based providers to distribute or post this information.

D. Care delivery model

The variety of health conditions, disabilities, ages, and cultural groups in the Medicare-Medicaid population requires that MCOs create a person-centered assessment and care planning process driven by the priorities and goals of each individual. While this model is often familiar to behavioral health organizations who have worked with it over a period of years, medical providers have less or no experience with this model. Several ways of performing this function can be used. Some states have assigned this responsibility to newly created Medicaid health homes that will be in part of the MCO networks. Others require the use of an independent (also known as conflict free) care coordination organization that does not have a stake in referring to their own organization for services. Washington State has designated its Area Agencies on Aging to provide this function. Massachusetts has established health homes, but also requires an independent living LTSS coordinator from a community-based organization be contracted to perform LTSS planning. States should:

- Define person-centered care and include specifications in the MCO contract outlining the characteristics of the assessment and service planning process. Provide training or require MCOs to train their own staff and their provider network on the nature of person-centered planning, the process, and their own roles in collaborating to carry out person-centered planning.
- Consider designating community organizations with the appropriate experience in person-centered planning and care coordination to perform this function and require MCOs to contract with them for this service.
- Require MCOs to clearly designate how members can select their own personal care attendants, including family members, and monitor this service to ensure that members are satisfied.
- Require that MCOs provide extra support during transitions from 24-hour settings to community settings, or at any other time that a member may need extra support to maintain health.
- Develop measures of member ratings of the person-centeredness of their plans and services.

E. Benefits

The benefits of integrated Medicare and Medicaid care can be best realized if all Medicare and Medicaid covered benefits are included in the dual eligible plan with sufficient resources for planning and coordinating them. States should:

- Design their benefit to be as inclusive as possible.
- If an existing service in the state, such as peer services, is not yet a covered Medicaid benefit, provide additional funding for this purpose outside of the capitation, or require MCOs to establish close liaisons with the agency that purchases these services.
- Require MCOs to designate a liaison to other state or county agencies that provide housing, income support, food assistance, and other services needed by Medicare-Medicaid enrollees and to meet regularly to facilitate coordination of services.
- Require MCOs to designate a liaison and to negotiate protocols with the courts, prison, and jails for members being diverted from or released from prison.
- Ensure that MCOs provide access to and pay for specialized crisis intervention services for both psychiatric and medical care.

F. Financing

Financing methods should be adequate and appropriate to meet the needs of enrolled members. They should appropriately incentivize community care over institutional care. States should:

- Include nursing homes in the capitated rate, and hold MCOs responsible for the entire stay.
- Pay the same rate for members in community care as for those in nursing home care (though different rate categories may be established for other reasons).
- Share savings from appropriate reductions in institutional care and increases in community care with the MCO as long as quality standards have been met.
- Require MCOs to reduce and eliminate wait lists for community services.

G. Provider network

As indicated in the discussion on continuity of care, Medicare-Medicaid enrollees need a comprehensive and highly skilled provider network that is ready and willing to participate in person-centered care.

States should:

- Establish minimum standards for network adequacy for basic medical services and for the specialized LTSS needed by this population.
- Consider requiring MCOs to contract with all providers of specialized LTSS, such as community mental health centers and home health providers, as long as they meet requirements for quality and coordination of care.
- Require the MCOs to facilitate coordination between acute and long term care as well as between primary care, medical specialty care, and behavioral health care.
- Devise and monitor measures of network adequacy and coordination.
- When appropriate, require MCOs to develop alternative credentialing standards for peer services and certain supportive services.

H. Organizational structure and staffing

States should:

- Set standards for MCO minimum staffing that ensure the breadth of expertise needed to manage care for this complex group.
- Consider requiring that staff performing certain functions be sited within the state or the region to be served.
- Require each MCO to establish a formal advisory group that includes members and caregivers with a range of conditions or disabilities as well as medical, behavioral health, and long-term service and support providers. The group should meet no less than quarterly, and the state should monitor notes of the meetings and actions taken in response to their advice.

I. Performance and QI

States should:

- Require a robust quality improvement system.
- Depending on the number of plans and the areas they serve, consider setting some quality improvement goals that pertain to all plans.
- Require detailed reporting on a comprehensive range of quality and performance measures to allow monitoring of compliance with contractual requirements and quality of care.
- Maintain sufficient state staff with the appropriate qualifications to perform monitoring and oversight.
- Involve members, caregivers, and providers in a Quality Improvement group advising the state in interpreting results and determining priorities for follow-up.

J. Utilization management

States should:

- Require MCOs to develop flexible utilization management processes that facilitate person-centered care for members with chronic diseases. This could include standing referrals to specialists and automatic authorization of care plans developed by independent care coordinators, health homes, or multi-disciplinary care teams.
- Monitor MCO utilization to ensure its flexibility and support for person-centered care.

3. Additional Resources for Advocates

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