NATIONAL COUNCIL
FOR COMMUNITY BEHAVIORAL HEALTHCARE

Increasing Access to Behavioral Healthcare

Managed Care Options and Requirements

JULY 2011

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The National Council for Community Behavioral Healthcare (National Council) is the unifying voice of America's behavioral health organizations. Together with our 1,950 member organizations, we serve our nation's most vulnerable citizens — more than 6 million adults and children with mental illnesses and addiction disorders. We are committed to providing comprehensive, high-quality care that affords every opportunity for recovery and inclusion in all aspects of community life.

The National Council advocates for policies that ensure that people who are ill can access comprehensive healthcare services. We also offer state-of-the-science education and practice improvement resources so that services are efficient and effective.

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This full report has been prepared under the auspices of the National Council for Community Behavioral Healthcare. Comments are welcomed and should be directed to the National Council offices at 1701 K Street NW, Suite 400 Washington, DC 20006-1526.

I. Context and Purpose

The ongoing recession has put tremendous pressure on state spending at a time when revenue increases are politically unpopular. Medicaid is a major state responsibility, and states are looking for predictability and cost containment. States are increasingly considering integrated managed care approaches that consolidate the financing for managing Medicaid physical and behavioral health services. To save money, they are trying to bring their higher cost enrollees – those who are disabled – into managed care. However, financial integration does not automatically lead to clinical integration. Previous experience has shown that financial integration of behavioral and physical health services without strong clinical requirements has reduced access to specialty behavioral healthcare services and not improved care for affected beneficiaries.

Integration of clinical care and services is an important goal for improving Medicaid systems. Integrated health care delivery has been demonstrated to improve care and reduce costs[1] by ensuring that people with chronic conditions have ready access to both primary and behavioral health care with close coordination between them, as in the concept of patient centered medical homes. Integrated care centered in behavioral health organizations has begun to bring primary care and other medical services to adults with serious mental illnesses (SMI) and substance use conditions. Offering primary care in a behavioral health setting is particularly important because this group has suffered for years with compromised access to primary and other medical care, contributing to their high levels of chronic illness and early death.[2]

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. Moreover, different kinds of managed care arrangements can have a very different impact on Medicaid enrollees with the most serious mental illnesses and emotional disturbances. This document systematically reviews the capabilities of different managed care approaches in meeting the needs of this population. It also serves as a resource for advocates to use in educating policymakers and ensuring that this vulnerable population's special needs are addressed throughout the transition to managed care.

II. Approaches to Managed Care: MBHOs Compared to MCOs

Serious mental illnesses can lead to high levels of impairment in many areas of functioning, requiring a special approach to integrated services for this population. Typical acute episodic care models cannot provide for the care coordination and care management that is 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 SMI and children with serious emotional disturbance (SED) require specialized strategies to ensure that they have 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 warrant a focused approach. The two common approaches to managed care for children with SED and adults with SMI 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 to have 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.

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) can be contracted to manage them. States have contracted with MBHOs on both capitated and administrative only (ASO) bases. Often, there is just one MBHO for a state or per region, though some localities offer a choice of carve out plans; for example, in Wayne County, Michigan.

MBHOs and MCOs have different capabilities and experiences with 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

A. MCOs vs. MBHOs: Outreach and Access

Some individuals with SMI are resistant to using mental health services and medications. Providers need to provide assertive outreach to these individuals in their homes and other community locations to build a relationship in order to engage them in services. This requires skill, respect, time and flexible funding. Providers also need to provide frequent monitoring to help such individuals maintain their psychiatric stability. **Many MBHOs are experienced in working with community mental health providers to engage families whose children have SED and adults with SMI into mental health services. Most MCOs lack these kinds of providers in their networks and are more accustomed to using telephonic outreach, which is not likely to be effective with people with SMI.**

Community behavioral health providers, offering multi-disciplinary and comprehensive services, are the anchors of networks serving children with SED and adults with SMI. Community behavioral providers create multi-disciplinary care teams that include psychiatrists, psychiatric nurses, psychologists, masters trained clinicians with licenses or working toward licenses, and addiction counselors, and direct care and peer support staff. Their care teams provide and coordinate the range of clinical and support services needed to treat these illnesses and support the clients and have established relationships with many children with SED and adults with SMI. **MBHOs generally credential and contract with 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 support, and other supportive services needed by people with SED or SMI**

B. MCOs vs. MBHOs: Benefits

The managed care benefit package should include the broad range of services to prevent use of more restrictive and expensive hospital and residential care that children with SED and adults with SMI need. These services should include community crisis stabilization, community case management, rehabilitation and skill building, family and consumer education, assertive community treatment, peer support, and other recovery oriented services.[3]

If MBHO benefits do not include these services, their contracts are likely to require active collaboration with services funded by other payers. **Many MBHOs have considerable**

experience in designing and procuring these alternative services, and managing them in 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. This is less likely to occur when the needs of the population are spread over different health plans.

In contrast, MCO benefits often cover only acute services and MCOs currently have few contractual requirements to coordinate with services provided outside of their network. For instance, few MCOs use community crisis stabilization, meaning that they must rely on emergency departments, psychiatric hospitalization, and inpatient detoxification which are more disruptive to clients and more expensive. For example, the Massachusetts carve out program has developed state of the art service innovations for high risk clients, including 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 alternative service utilization (where many of these more intensive community services are classified) are used far less by MCOs than by the Massachusetts MBHO.

Flexible prior authorization requirements are also critical to allowing for the provision of needed services that will save money or produce better outcomes, even when such services are outside of the standard benefit. **Many MBHOs have developed flexible prior authorization requirements that allow them to authorize such services routinely**. This 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 to ease and support the child's transition from a residential setting to home, school and community.

In contrast, most MCOs are experienced only with authorizing services using traditional medical necessity. These plans generally require considerable justification to use a non-traditional service, even if it will save money over more intensive services. For example, in Massachusetts, behavioral health services have remained the most frequent source of requests 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 that other MCO appeals that go to the Department of Public Health.[4]

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 can more easily be financed from multiple funding streams; while this is much more difficult with MCO capitation rates**. For example:

- Arizona combines Medicaid funding paid on a capitation basis with other state and federal block grant funds managed by five Regional Behavioral Health Authorities (RBHAs) that serve as the single point of authority for all citizens meeting clinical and financial eligibility criteria for public behavioral health services.[5]

- Massachusetts has combined funding from the Department of Mental Health with Medicaid for its MBHO to finance psychiatric emergency service teams.

- New Mexico has combined funding from all state agencies for mental health and substance abuse for management by an MBHO.

- 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 Heath 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.[6]

C. Treatment Planning and Care Coordination

Managed care entities need to be able to work with children with SED, adults with SMI, and disabled populations who have complex and serious needs requiring a high level of expertise to develop treatment plans. **Many MBHOs have considerable experience designing and implementing initiatives for children with SED and people with SMI using 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 for 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 have often contracted with MBHOs to offer training on treatment needs of 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 as they are for physical health. A study of data from the Health Employer Data and Information Set (HEDIS) for 384 HMOs, found that they scored significantly lower on quality of care for mental health than for physical health.[7]

Managed care entities need to promote access to community based support services for plan 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 them 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 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.[8]

- 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.[9]

In contrast, most examples of MCO care coordination are telephonic and generally focus on coordination of medical and closely related services for conditions such as diabetes, cardiovascular disease, and COPD. For example, almost half 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"[10]

D. Consumer Involvement in Policy Making and Service Delivery

Peer delivered services have proven beneficial and cost effective for families with children who have SED and for adults with SMI. 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 have been instrumental in developing and supporting the use of 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. From this beginning, peer support has become 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.[11] **In contrast, MCOs do not have experience working with this type of organization**.

Involving families and adult consumers in program decision making has clearly demonstrated value and benefits, resulting in better services. **Many MBHOs have established advisory groups that include family and consumer representatives, or have involved 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, funding and participation/information dissemination. **In contrast, few MCOs have active consumer input from behavioral health consumers**.

E. Contracts

State contracts with managed care entities should include financial incentives for improving care for people with SMI or other vulnerable populations. **MBHO contracts are generally more accountable than MCO contracts**. They include more detailed specifications for managing behavioral health care of vulnerable populations. State mental health authorities are often involved in developing performance specifications for MBHO contracts that require extensive measurement of access and quality of care for SMI. For example, see Washington state's reporting on its county based MBHOs at http://www.mhd-pi.com/Reports/. In addition to standard measures of utilization and hospitalization, outcomes such as employment and homelessness are measured. MBHOs provide states with considerable information about this population, how they are being served, and their outcomes of care. For example, see Colorado's reporting on individuals served in its regional MBHOs at http://www.cdhs.state.co.us/dmh/de_orchid.htm.

In contrast, MCOs are seldom measured or incentivized for their service to people with SMI. They are not generally required to report separately on behavioral health or on services to people with SED or SMI. Limited reporting on behavioral health care makes it difficult for 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 review of terms of that agreement.

F. Quality and Cost Outcomes

In selecting a managed care arrangement, 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**. They have increased the time that members spend living in the community rather than being 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 over the 12 years since the program began, it has increased use of community-based behavioral health services, and realized a major reduction in inpatient use.[12] 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.[13]

States should also consider which type of arrangement has a demonstrated ability to save money on behavioral health care for disabled Medicaid populations. **MBHOs have taken on risk (such as for 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 for 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] Regional behavioral health organizations (BHOs) in Colorado have been 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).[16]

MBHOs have also demonstrated the capacity to assist with reinvestment. In some states, a portion of savings generated by MBHOs have been reinvested into expanding alternative services, such as peer providers. Pennsylvania's Health Choices 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, has produced $446M in savings that were reinvested into critically needed housing and other community services.[17] In Iowa, Magellan invests 2.5 percent of the money received from the State in the Iowa Community Reinvestment Fund which is used to support family and peer services, Assertive Community Treatment, and provider quality improvement.[18]

In contrast, when MCOs subcontract with an MBHO to manage their behavioral health benefit, administrative costs can be high. This adds additional administrative costs to the average 12.6%[19] of revenues that MCOs spend on administration plus profits. Both administrative and service costs of subcontracted MBHOs are often counted as medical costs, understating the true cost of managed care administration. States can't easily determine whether MCOs have generated savings on use of behavioral health services, because behavioral and physical service costs often aren't clearly delineated in MCO reporting.

G. Medical Care for Vulnerable Populations

Delivering effective behavioral health treatment produces a cost offset (reduction) in medical costs. **MBHOs have been demonstrated to deliver such services in a way that reduces costs.** Studies beginning as early as 1967 have provided strong evidence that provision of mental health and substance abuse treatment for individuals reduces their medical costs.[20] 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 initiation of community mental health case management. This decline included the costs of the case management service provided by community mental health providers.[21] 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…"[22]

In addition, some MBHOs have experience working with community behavioral health care providers that have demonstrated the ability to improve the physical health care of their clients. The primary health provider for most individuals with SMI is their community mental health center. Many already offer active case management that includes liaison to primary care. Some have co-located primary care in their sites. MBHOs' greater experience working with community behavioral health providers to serve people with SMI 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 people 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, participation in recommended preventive services, use of evidence based services for cardio-metabolic conditions and lower cardiac risk scores than a control group that did not receive the intervention.[23] The Veterans Administration placed primary care services in a specialty MH clinic and found that it significantly increased the rates and number of visits to medical providers and 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).[24]

Many adults with SMI do not get 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 needed to address their special needs. **To date, MCOs have not been successful in engaging people with SMI or other significant mental health and substance abuse needs 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.[25] Almost half 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".[26] 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 so that they became, again, acutely ill and received another (potentially unnecessary and expensive) inpatient stay within 30 days. Of the $814 million, almost half ($395 million), was for medical admissions (e.g., heart disease, diabetes, pneumonia, trauma) of 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 disorders, principally for the serious medical illnesses that they frequently suffer.[27]

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 or addictions disorders and SED during the transition to managed care. As states pursue integrated approaches to managed care, they should consider the following contract terms and performance measures for inclusion in RFPs and contracts.

MCO Contractual Requirements
Quality Behavioral Health Care

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. They may pay more attention and dedicate the right levels and kinds of resources for serving children with SED and adults with SMI if they have similar level of specificity in their contract requirements and incentives as many of the MBHO contracts. If states elect to integrate behavioral health benefits for people with SED or SMI into MCO plans, the following contractual requirements should be considered to ensure that the needs of children with SED and adults with SMI are adequately addressed.

This document contains recommendations related to the design, contracting and oversight of integrated Medicaid managed care plans responsible for management of both primary and behavioral health care for populations including adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). These recommendations encompass:

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

1. Plan Design

A. Identify people with SED and SMI

Most Medicaid systems do not include an identifier for people with SED and SMI. In order to better plan, monitor and manage care for this group, states should establish methods for identifying these individuals, setting rates for their care and tracking their care thereafter.

- States can mine their data to develop diagnostic and utilization indicators of people with SED or SMI.
- They can use screening tools to help identify such individuals at the point of enrollment.
- States can require MCOs to propose and implement a process for identifying such individuals once they have been enrolled in an MCO.

B. Develop risk adjustment and payment mechanisms to counter risk of adverse selection of people with SED and SMI, and other high need members. [28]

The greater than average cost of care of children with SED and adults with SMI 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 they need. 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. This allows payments to be adjusted based on plans' actual enrollment.
- Any risk sharing mechanism should be carefully analyzed to ensure that it does not inadvertently create unintended and undesirable incentives.
- States should require MCOs to accept all members who seek to enroll in the plan and should prohibit them from disenrolling an individual for 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.[29, 30]

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

These should include the community based service people need to prevent the use of more restrictive and expensive hospital and residential care to the degree allowed by the state Medicaid plan. At a minimum, these services should include the continuum of care described by SAMHSA[31] to the degree that they are included in the Medicaid state plan or can be financed by cost savings. MCOs should be required to support linkage between Medicaid services and those 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 consider whether it would be beneficial to braid other funding streams for mental health services with its Medicaid financing so that its health plans can manage a more complete set of the services needed by people with SED or SMI. If so, states should require MCOs to develop needed capacities to track different eligibilities and funding sources and states should monitor MCOs to ensure it is being done properly.

D. Establish separate capitation rates for behavioral health services in order to include a more specific rehabilitative focus and to 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 the broader spectrum of rehabilitation services needed by people with SMI and SED. The separate reporting that will be required for the behavioral health specific payment helps to hold MCOs accountable for their management of behavioral health resources.

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

Any managed care entity has an incentive to shift costs[32] by encouraging members to use services purchased by other payers. For example, if state hospital care is paid for by the state mental health authority, MCOs experience an incentive to encourage referral for state hospital services, rather than provide stabilization services in the community.

- States can make MCOs responsible for paying for some of all of state hospital care, nursing home care, home health care or court-ordered services to establish appropriate incentives.

- Alternatively, states can establish control over admissions to these programs, monitor the rate at which MCO clients use such services, or establish incentives for MCOs to develop plans of care that minimize the use of out-of-plan services.

F. States can include behavioral pharmacy coverage in MCO benefits, or contract for a separate pharmacy manager.

- Either way, states should require that formularies include an effective array of psychotropic medications needed by people with SED or SMI and be no more restrictive that the formulary used in Medicaid fee for service. States should also ensure that polices for co-pays and authorizations are not barriers to access.

- States should require that MCOs have protocols to identify potentially dangerous doses or combinations of medications and have a program to work proactively with prescribers to address them. However, MCOs should always honor prescribers' decisions on medications.

G. Specify if subcontracting for behavioral health is acceptable

- States should consider whether to allow MCOs to subcontract to an MBHO provider to manage behavioral health benefits. Alternatively they may elect to require the specialty carve-out, as Tennessee has done. If allowed, the state 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

Consumer choice and protections

States should:

- ensure that people with SED and SMI have assistance from skilled advisors who can 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 would be 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. This should include their 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 emergency, and the right to consent to all treatment.[33]

- require MCOs to offer people with SED or SMI the same rights to get behavioral health services from out-of-network providers that other members have for general medical care.

- require MCOs to offer members with SED or SMI a choice of community providers and a choice of case managers. [34]

- prohibit MCOs from denying members an appropriate service if they have refused another service.[35]

Outreach and Access

States should:

- 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 who are not receiving regular treatment.

- require MCOs to track and follow up on individuals after discharge from an inpatient setting to assess whether they are receiving needed services.

Network

States should:

- require MCOs to include community behavioral providers in their networks, and to develop streamlined methods for credentialing them as an organization, allowing all their clinicians to serve the plan's members.

- require MCOs to include providers who have special expertise in the needs of children who have been abused or neglected.

- require MCOs to recognize the state's licensing standards for behavioral health services as necessary and sufficient for entry into the network.

- require MCOs, when appropriate for the service or populations, to develop efficient methods[36] to credential: Masters clinicians who have not yet earned licenses or had 3 years of experience; substance abuse counselors; direct care and; peer support staff.

- develop appropriate standards to measure behavioral health network adequacy in a manner that accounts for network providers whose panels are full and are not accepting new clients and that ensures timely access to emergent, urgent and routine care.

- require MCOs to contract with community based providers to make and help coordinate referrals for community based support services for members with SED and SMI, such as education, housing and income support, that may fall outside of covered benefits.

- require all its 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 might include community crisis stabilization or Assertive Community Treatment.

- include peer delivered services in their continuum of behavioral health services for people with SED and SMI through its standard benefits, braided funding or by referral.

- specify that its MCOs develop appropriate business relationships with peer organizations, using modified payment and providing additional management support when necessary.

- require MCOs to develop and pay for community mental health centers to offer active care coordination services that includes liaison to primary care.

- require MCOs to contract with primary care practices such as Community Health Centers and any behavioral health providers with co-located primary care which currently work with people with SED and SMI.

- require that MCOs to develop plans for state approval to increase the network of primary care providers who are prepared to welcome and serve people with SED and SMI.

- 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 telehealth services whenever needed to expand access to needed healthcare

Service Authorization

States should:

- require MCOs to develop flexible prior authorization policies for authorization of wraparound services and services outside of 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 people with SED and SMI. States should develop methods to monitor how it is being implemented by MCOs.

- require MCOs to staff its service authorization functions with behavioral health professionals experienced in care for disabled populations who are able to discuss treatment plans with provider clinicians on a professional basis.

- require MCOs to allow billing for more than one service on the same day to allow members to use time and transportation efficiently.

- require MCOs to individualize authorization decisions and not create de facto maximum lengths of stay in a specific service[37]

- require that MCO's guidelines for placement or discharge taken in account homelessness, lack of family supports and coexisting medical conditions[38]

Staffing

States should require MCOs:

- to have a minimum level of managers and staff who have extensive experience working with people who have SED and SMI to ensure their ability to effectively manage and improve their care.

- to have dedicated personnel to work on clinical and administrative functions for behavioral health.

Treatment Planning and Care Coordination

States should:

- explicitly define recovery for people with SMI and resiliency for children with SED and require MCOs to promote them in treatment planning.

- require MCOs to negotiate protocols with state agencies such as the mental health authority, the child welfare agency and correctional agencies for coordinating treatment planning, discharge and other key aspects of care for shared clients. These protocols must be efficient for state agency staff who will have to deal with more than one MCO.

- If these agencies pay for services that constitute a portion of the continuum of care for people with SED and SMI, these protocols should address how access to and transition from these services will be managed.

- require MCOs to negotiate a written agreement with local law enforcement agencies to ensure smooth transfer of enrollees who are assessed to be a danger to themself or others.[39]

- require MCOs to work closely with Community Mental Health Centers to develop care management programs for individuals with SED and SMI who have the most complex needs. The program must include protocols for identifying such individuals, timelines for assessing and developing a care plan, coordination between MCO care managers and treatment providers, and evaluation of the program.[40]

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

Medical Care for People with SED and SMI

States should:

- require MCOs to enroll members with SED or SMI in health homes when they meet the chronic illness criteria specified by the ACA.

- require MCOs to develop a strategy for state approval to create a health home for people with SMI that has the capacity to address their medical and behavioral needs in an integrated way. This could include expansion of co-located primary care in behavioral health settings, training for primary care practices to better work with people who have SMI, children who have SED or other disabilities, and additional resources for assertive outreach, engagement, shared information systems, and care coordination.

- require MCOs to develop methods for compensating primary care providers for the extra time needed to work with members who have or may have mental health problems.

- encourage the development of self-management programs for people with SMI and SED to address both physical and mental wellness, including smoking cessation and weight loss. These should either be available to all outside of the 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 and SMI and establish common expectations and practices between primary and behavioral health providers.[41]

- encourage MCOs to incentivize primary and behavioral health providers to deliver well coordinated care.[42] This can be done, for example, through MCOs requiring that contracted primary care providers share physical health data for shared clients with community behavioral health providers.

Consumer Involvement

States should require MCOs:

- to include family and consumer representatives of people with SED or SMI on their advisory groups. The state should monitor how these groups are involved in policy making and program development.

- to assess the satisfaction of SMI and SED members, oversampling them and using methods, such as survey interviews conducted by consumers, that have been demonstrated to result in a good response rate and valid data.

- to stratify their complaints and grievance data by behavioral health issues and clients with SED and SMI.

Cultural competency

States should:

- require MCOs to ensure availability of bilingual providers and trained interpreters in the languages present in at least 5% of Medicaid enrollees.
- establish performance expectations for reducing any significant disparities in health access experienced by groups enrolled in Medicaid
- make available key performance reports stratified by racial and ethnic group.

Information and billing systems

States should:

- require MCOs to develop efficient and effective information systems that can document and monitor the implementation of treatment plans for people with complex conditions that includes 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 should monitor those processes.
- reserve the right to require MCOs to collaborate on common authorization, billing and credentialing processes and protocols so that information is standardized as much as possible across plans, and the administrative processes are simplified for providers participating in multiple networks.

Contracts

States should:

- require Medicaid agencies to involve state mental health authorities in developing performance specifications for access and quality of care for people with SED and SMI.
- consider including financial incentives for improving care for people with SED and SMI.
- set a minimum standard for medical loss that specifies a methodology that appropriately counts the administrative costs of any subcontracted MBHOs.

Quality Improvement

States should:

- require all MCOs to incorporate recovery strategies, person-based planning, youth and family driven care and evidence based practices into their services for people with SED and SMI.

- require MCOs to report on and improve access to community based care and alternative services and to increase the time that members with SED and SMI spend living in the community rather than being in restrictive inpatient settings or involved with the criminal justice system.

- carefully monitor the quality of behavioral and medical care delivered for people with SED and SMI by its MCOs. As noted previously, this kind of reporting requires both the state and MCOs to develop methods of identifying and tracking people with SED and SMI in enrollment and utilization records.

- set expectations for improvements in access to primary care and management of chronic medical conditions among people with SMI.

Cost Savings and Reinvestment

States should:

- clearly define expectations about what is considered a behavioral service and what is considered a physical health service, and require all its MCOs to report on their costs and utilization using these definitions so that the data are comparable.

- establish methods for measuring the behavioral health expenditures and require MCOs to meet funding targets for these services.

- require MCOs to report on the medical care costs for people with SMI and SED, as well as other chronic conditions, to better understand medical care offsets produced by behavioral health treatment.

- require a portion of cost savings from improvements in community behavioral care to be reinvested in community services, with state Medicaid officials and consumer advisory groups assisting to identify priorities for reinvestment.

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
- Initiation of alcohol and other drug dependence treatment (HEDIS)

Service utilization

- Percent of members using outpatient mental health care (HEDIS)
- Percent of members using alternative 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 (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)

Quality

- Experience of care (CAHPS or other survey)
- Percentage of members with follow-up within 7 days of discharge from a mental health hospitalization (HEDIS)
- Rate of (avoidable) psychiatric readmissions
- Appropriateness of drug regime (# of scripts with contra-indicated doses or drug combinations) (Bella et al, 2009)
- Adherence to psychotropic drug regime (Bella et al, 2009)
- Number of members with SMI 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 SU whose substance-free status is validated through breath and urine testing (IOM, 1997)

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 SMI and SED.

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

- 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 cessation
- 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

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 people with serious mental illness 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 for treatment of mental illness overall?

9. How has your company promoted access to dual diagnosis treatment for people with both mental health and substance use disorders?

10. What is your average turnaround time for clean claims?

11. What are your penetration rates for use of behavioral health services for your Medicaid populations?

12. What outpatient and rehabilitative mental health services require prior approval? How many visits are approved at one time? What percentage are approved?

13. What are the qualifications of personnel who interact with network mental health providers to authorize care?

14. How do you set payment rates for outpatient mental health care?

15. 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 been included in these efforts? How are mental health services included in treatment plans?

16. What have you done to promote better coordination between your primary care network and your behavioral health network?

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