Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MANDATORY MANAGED CARE

Early Lessons Learned by Medicaid Mental Health Programs

JUNE GIBBS BROWN
Inspector General

JANUARY 2000
OEI-04-97-00343

OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To describe early lessons learned by State Medicaid programs converting mental health services to persons with serious mental illnesses from a fee for service system of care to mandatory managed care.

BACKGROUND

States are increasingly converting their Medicaid programs from fee for service models to managed care models. Nearly every State has implemented, or is planning to implement, mandatory managed care for Medicaid beneficiaries who require mental health services.

We surveyed seven State Medicaid programs that were among the first to mandate managed care mental health services for persons with serious mental illnesses. In this report, we highlight early lessons learned by the first five States that converted to mandatory managed care. We also included two States that recently converted to mandatory managed care. We included these two States because the Health Care Finance Administration identified them as having particularly innovative programs.

Most of the practices we highlight were considered to be successful by State Medicaid staff in more than four of the seven States we studied. Those early States laid the ground work for other States that followed. Even within the group of seven, the first States who converted in 1991-1992 were models for those that followed.

EARLY LESSONS LEARNED

The implementation successes and problems reported by the seven States we studied can be helpful for other States that are considering mandating managed care for mental health, or any other speciality services. We did not determine the effectiveness of the lessons learned reported by the States. We believe, however, that such information can be helpful to States starting mandatory managed care programs, transitioning from fee for service, and providing access to out-patient services.

Starting Managed Care Programs

- Separate mental health services from other health services
- Phase In conversion
- Exclude Drug formulary from managed care system
- Use existing public health system
- Keep contract language specific

Transitioning From Fee For Service

- Provide community education early and often
- Involve beneficiaries in conversion process
- Involve beneficiaries and family in treatment planning
- Ensure timely payment of providers

Providing Access to Care

- Eliminate co-payments
- Assign health care coordinators
- Allow any accredited provider to participate
- Encourage liberal prior authorization policies
- Initiate outreach programs
- Develop rural services
- Initially share financial risk to encourage development of services

CONCLUSION

States have become more efficient in their managed care mental health programs. Each State learns from the successes and mistakes of its predecessors. The continued sharing of lessons learned could greatly benefit other States that are considering converting to mandatory managed care, and those preparing for contract renewal.

AGENCY COMMENTS

Both HCFA and SAMHSA commented on our draft report.

HCFA stated that the report provided good, first-hand information on changes to Medicaid mental health services resulting from mandatory managed care enrollment during the first few years.

SAMHSA questioned whether the lessons learned should be referred to as "findings." They said the word "findings" may cause the reported experiences of the seven States to be construed as scientific data. We agree that our results are not "scientific" in the sense commonly used by SAMHSA in its grant programs. On the other hand, we did gather the early experience of States in a systematic way and presented a broad spectrum of assessments of the relevance and significance of these early efforts. For this reason, we believe the use of the work "findings" is appropriate. However, because of SAMHSA's concerns, we have renamed this section "Early Lessons Learned" in order to reduce any misunderstanding within the research community about the nature of our findings. We also included in this report, a section on advantages and limitations of our methodology in order to emphasize that our results are based on a case study approach.

SAMHSA also expressed concern that none of our selected States had integrated programs and that we

therefore could not present a balanced comparison of integrated and carved out mental health systems of care. However, our purpose was to describe the lessons learned by States that were the first to implement mandatory managed care. None of these States utilized an integrated system of care. Therefore, we could not compare these different systems

Additionally, SAMHSA expressed concern that we may not have adequately included the views of State mental health staff and stakeholders. As shown in our methodology, we considered input from such groups as highly important. To illustrate, we interviewed at least 37 State mental health staff and stakeholders.

We also made several technical changes suggested by SAMHSA.

The full text of HCFA and SAMHSA comments are in Appendix B.

INTRODUCTION

PURPOSE

To describe early lessons learned by State Medicaid programs converting delivery of mental health services to persons with serious mental illnesses from a fee for service system of care to mandatory managed care.

BACKGROUND

States are increasingly converting their Medicaid programs from traditional fee for service models to managed care models. As of June 1998, over 16.5 million Medicaid beneficiaries were participating in some type of managed care program. This represents over 53 percent of the Medicaid population[1].

Nearly every State has implemented, or is planning to implement, mandatory managed care for Medicaid beneficiaries who require mental health services. As of July 1998, 36 States have implemented mandatory mental health managed care programs.[2] The first seven States all implemented mandatory managed care between 1991 and 1995. They laid the ground work for other States that followed. Within the group of seven, the earlier ones that converted in 1991-1992 were models for those that followed.

Mental Illnesses

Adults, age 18 and over, who currently or any time in the past year have had a diagnosable mental, behavioral, or emotional disorder that results in functional impairment which substantially interferes with or limits one or more major live activity is defined as seriously mentally ill.[3] The annual prevalence of serious mental illness in the United States is estimated to be about 5 percent, or 10 million people.[4] Some of the more commonly recognized disabling types of serious mental illnesses include schizophrenia, bipolar disorder, major depression, obsessive-compulsive disorder, and panic disorder.

Children, up to age 18, with the same diagnosis, are classified as seriously emotionally disturbed. An estimated 1 in 10 children are reported to have a serious emotional disturbance at any given time.[5] In fact, the estimated prevalence rate of serious emotional disturbances for children - about 9 percent - is higher than the prevalence rate of serious mental illnesses for adults.[6]

In addition to the disorders that effect adults, children with a serious emotional disturbance may also be commonly diagnosed with attention deficit disorder, autism, pervasive development disorder, or Tourette's syndrome.

METHODOLOGY

We reviewed the mental health managed care programs for seven States . They were Arizona, Massachusetts, North Carolina[7], Utah, Washington, Iowa, and Colorado. We highlight successful practices of the first five States with mandatory managed care programs for persons with serious mental illnesses for at least 3 years as of April 1997.[8] Likewise, we included successful practices of two States, Iowa and Colorado that the Health Care Finance Administration identified as being particularly innovative programs.[9] Most of the practices we highlighted were considered to be successful by State Medicaid staff in more than half of the seven States we studied. For comparison purposes, we provided a general description of each selected State program in appendix A.

To identified successful practices, we interviewed Medicaid staff in each selected State. We also interviewed selected managed care organization officials, mental health care providers, and mental health stakeholders. We asked them to describe the positive and negative experiences of managed care implementation.

Advantages and General Limitations

We used a case study approach in analyzing the early lessons learned by Medicaid mental health programs. The advantage of this approach was that it allowed us to gain first-hand experiences from State officials, managed care organization representatives, mental health providers, and stakeholders. Our methods have general limitations in that the States or sites selected may not be typical, and we did not verify the testimonial information they provided to us. The information is also limited, because it reflects operations that occurred over a 2 to 3-year time period starting with each States first year contract. We are aware that State Medicaid managed care systems have continued to evolve with each new contract and waiver renewal, and that the structure of our surveyed States today may be quite different from their initial managed care contracts.

Despite the general limitations of our inspection, we believe this report provides good, first-hand information on the early lessons learned by Medicaid mental health programs implementing mandatory managed care programs. This type of information could be most useful when first implementing a new system of care.

Definitions

Seriously Mentally Ill - For purposes of this report, the serious mentally ill population refers to both adults and children, unless otherwise stipulated.

Stakeholders - For the purpose of this report, stakeholders include persons with a serious mental illness, family members of persons with a serious mental illness, and State and national mental health organizations representing persons with serious mental illnesses.

Companion Reports

We issued a companion report titled Mandatory Managed Care - Changes in Medicaid Mental Health Services (OEI-04-97-00340). That report provides an early look at the changes that mandatory managed care had on State Medicaid mental health services for persons with serious mental illnesses.

We also observed that children often face different challenges accessing mental health care than do adults. These differences are presented in a companion report titled Mandatory Managed Care - Children's Access to Medicaid Mental Health Care (OEI-04-97-00344).

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We did our field work between May 1997 and July 1997. While conditions regarding mental health services in managed care settings may have changed since then, our report reflects conditions and patterns of care in the first few years of converting fee for service programs to managed care. Wherever possible we have updated our background information. We conducted the inspection in accordance with Quality Standards for Inspections issued by the President's Council on Integrity and Efficiency.

Early Lessons Learned

Within broad Federal guidelines, State Medicaid programs determine who is eligible for Medicaid benefits, as well as what services are provided. Given the ability of each State to tailor their programs to best fit their individual needs, it is understandable that no two State Medicaid programs are exactly alike.

The overall uniqueness was evident in all seven State Medicaid mandatory mental health managed care programs we studied. However, we identified several common implementation characteristics that Medicaid staff in most of the seven States said were particularly successful. According to Medicaid staff, the strategies highlighted below were used when starting a managed care program, transitioning from fee for service, and providing access to care for persons with serious mental illnesses.

Starting Managed Care Programs

Separate Mental Health Services From Other Health Services

All seven States separated or "carved out" their mental health services from their general health services. By carving out mental health services, States helped ensure provision of care by specialized managed care organizations that are experienced with the challenges of treating serious mentally ill populations. The seven States said that general health care managed care organizations were not typically structured to handle the complex, long-term challenges presented by Medicaid serious mentally ill populations.

Phase In Conversion

Four of the seven States surveyed chose to first test mandatory managed care in a portion of the State. These States reported fewer implementation problems than did States that immediately implemented State-wide programs without testing. States that implemented State-wide experienced delays in converting and enrolling beneficiaries, lack of up-to-date eligibility information, cumbersome prior authorization procedures, and delays in paying providers. Smaller test sites allowed States to resolve such service and logistical problems prior to State-wide implementation.

Exclude Drug Formulary from Managed Care System

States did not include the cost for prescription drugs in their managed care contract. This was done primarily because States were unsure of how to accurately determine the cost for this benefit. Without reliable cost information, States said they could not correctly set the capitation rate for this benefit. States believed that if they did not set the capitation rate for prescription drugs at the correct level, managed care organizations would have an incentive to restrict access. Therefore, excluding prescription drugs from managed care contracts would protect beneficiaries. Beneficiaries continued to receive their prescription drugs through the traditional fee for service system.

Use Existing Public Health System

Most States contracted with their established public health providers, typically Community Mental Health Centers (CMHCs), who formed non-profit managed care organizations to bid on contracts. States believed that contracting with existing CMHCs would allow them to keep the existing public mental health system in place, allow for a more seamless conversion, and minimize the impact of change on beneficiaries. They also generally thought that existing CMHCs had more experience providing services to the Medicaid beneficiaries with serious mental illnesses.

Keep Contract Language Specific

In hindsight, most States acknowledged that their first managed care contracts were weak and not as specific as they should have been. States learned from their experience and strengthened contract language in subsequent contract renewals. It is important that States not be naive about contracts. If something is not specified in the contract, it will not happen unless States are willing to pay more for it.

Transitioning from Fee For Service

Provide Community Education Early and Often

States recommended educating and advising beneficiaries of pending system changes as early, and as often, as possible. These efforts should start during initial planning, and continue well after managed care implementation. States found such early outreach efforts well worth the effort and cost.

Involve Beneficiaries in Conversion Process

Most States involved beneficiaries and family members in planning and developing their mental health managed care programs. Beneficiaries who were involved early in the contracting process felt the most in control and were the most receptive to the managed care conversion.

Involve Beneficiaries and Family in Treatment Planning

Family members and beneficiaries often felt that they were not always respected or looked upon as a resource when providers and managed care organizations developed treatment plans. These groups wanted more involvement in treatment plans. Managed care organizations that solicited and incorporated input from family members and beneficiaries on treatment plans received more favorable comments regarding their managed care programs.

Ensure Timely Payment of Providers

During the initial stages of conversion to managed care, providers often waited long periods of time without receiving payment for mental health services rendered. This problem was more prevalent in those States that implemented mandatory managed care State-wide. Payment delays caused a lot of animosity among providers. It creating a financial hardship for some providers, particularly the traditional public providers who did not have capital reserves to withstand long payment delays. As an inducement to encourage timely payment of providers, one State included financial incentives and penalty clauses in the managed care organization contract.

Providing Access to Care

Eliminate Co-payments

All States that had a fee for service co-payment requirement eliminated it when they converted to managed care. States reported co-payments are typically used to discourage, or limit, use of services, and may have served as a barrier to out-patient treatment for Medicaid beneficiaries under the prior fee for service system. States believed discouraging use of services by charging a co-payment is inconsistent with the goals of public health programs, which is to provide services to those in need. While the eliminated co-payment was typically only a few dollars per visit, any fee can be a strong barrier to care for Medicaid beneficiaries.

Assign Health Care Coordinators

To improve access to services and coordination of care, some States created health care coordinator positions. Each new Medicaid beneficiary would be assigned to a health care coordinator. Mental health stakeholders viewed health care coordinators as a proponent for services and care, rather than a gatekeeper, or someone who limits care. They not only assisted with obtaining mental health services, but they helped coordinate general health services, which is often a challenge for beneficiaries in a carved out health care system.

Allow Any Accredited Provider to Participate

Two States used "any accredited provider" language in their managed care contracts. This meant that any provider, that met the managed care organization's accreditation requirements and accepted the managed care organization's reimbursement rates, was eligible to participate in the managed care system. By requiring that managed care organizations not restrict provider participation, States were able to expand beneficiary choice of providers, as well as increase system capacity by expanding the managed care organization's provider base.

Encourage Liberal Prior Authorization Policy

States believed that pre-authorizing a set number of initial out-patient services reduced administrative bureaucracy and costs, and improved timeliness of services. Providers were also more satisfied with managed care when they were given this flexibility. Requiring each individual service to be approved in advance proved to be cumbersome and labor intensive for both providers and managed care organizations.

Initiate Outreach Programs

One State said they increased the number of beneficiaries accessing mental health services by requiring beneficiary out reach programs. The State required managed care organizations to contact new Medicaid enrollees and to periodically send a newsletter or program information to all enrollees. This initiative was highly touted by the State as a reason they were able to increase the percentage of Medicaid enrollees accessing mental health services

Develop Rural Services

Several States encouraged the development of rural programs by providing a higher capitated rate for these areas. Rural areas present special problems because an adequate number of providers and services are often not close by. Populations are often not large enough to spread the risk to make capitation feasible.

Initially Share Financial Risk to Encourage Development of Services

To ensure that new managed care organizations were ready to provide needed out-patient services, several States initially shared the financial risk for services with managed care organizations. This allowed managed care organizations to develop adequate services and programs. It also allowed States to test their newly set capitation rates for accuracy without risking the financial stability of the managed care organization. This sharing of risk was particularly helpful to newly created non-profit organizations which did not have financial reserves to sustain extended operational losses. States also felt that initially sharing financial risks would reduce the incentive for providers to restrict services.

CONCLUSION

States have become more efficient in their managed care mental health programs. Each State learns from the successes and mistakes of its predecessors. The continued sharing of lessons learned will greatly benefit other States that are considering converting to mandatory managed care, and those preparing for contract renewal.

AGENCY COMMENTS

Both HCFA and SAMHSA commented on our draft report.

HCFA stated that the report provided good, first-hand information on changes to Medicaid mental health services resulting from mandatory managed care enrollment during the first few years.

SAMHSA questioned whether the lessons learned should be referred to as "findings." They said the word "findings" may cause the reported experiences of the seven States to be construed as scientific data. We certainly agree that our results are not "scientific" in the sense commonly used by SAMHSA in its grant programs. On the other hand, we did gather the early experience of States in a systematic way and presented a broad spectrum of assessments of the relevance and significance of these early efforts. Keeping in mind the source and nature of the information, it seems prudent to try to learn as much as possible from what these seven States have done so far. It was our hope, as SAMHSA has put it, that "the lessons learned by the seven States are valuable for ongoing implementation by other States." Nevertheless, because of SAMHSA's concerns, we have renamed this section "Early Lessons Learned" in order to reduce any misunderstanding within the research community about the nature of our findings. We also included in this report a section on advantages and limitations of our methodology in order to emphasize that our results are based on a case study approach. We believe our discussion on our study advantages and limitations will help readers understand what can and cannot be inferred from our field work.

SAMHSA also expressed concern that none of our selected States had integrated programs and that we therefore could not present a balanced comparison of integrated and carved out mental health systems of care. However, our purpose was to describe the lessons learned by States that were the first to implement mandatory managed care early. None of these States utilized an integrated system of care. Therefore, we could not compare the different systems

Additionally, SAMHSA expressed concern that we may not have adequately included the views of State mental health staff and stakeholders. As shown in our methodology, we considered input from such groups as highly important. To illustrate, we interviewed at least 37 State mental health staff and stakeholders.

We also made several technical changes suggested by SAMHSA. For example, we clarified Appendix A to show services that were excluded from risk by managed care organizations during their first year contracts.

We present the full text of HCFA and SAMHSA comments in Appendix B.

APPENDIX A

Summary: First Year Medicaid Managed Care Mental Health Contracts

State	Start Date	Waiver Type	Type of Managed Care Organization	Coverage	Initial Area Covered	
AZ	Jan 1992	1115	Non-profit, public sector, CMHCs*	Adults and Children	Statewide	
CO	Aug 1995	1915(b)	Most areas non-profit, public sector CMHCs. Two rural areas - partnership between public sector CMHCs and private, for-profit companies	Adults and Children	6 test areas. Excluded largest metro area	State hospital & drugs
IA	Mar 1995	1915(b)	one private for-profit company for whole State	Adults and Children	Statewide	State hospital & drugs
MA	Jan 1992	1915(b)	one private for-profit company for whole State	Adults and Children	Statewide	State hospital & drugs
NC	Jan 1994	1915(b)	Non-profit, public sector CMHCs	Children Only	11 counties, approx 25% of state	Outpatient care
UT	Jul 1991	1915(b)	non-profit, public sector CMHCs	Adults and Children	8 of 11 areas. 80% of Medicaid population	State Hospitals
WA	Jul 1993	1915(b)	Non-profit public sector system	Adults and Children	6 of 14 areas. 66% of Medicaid population	In-patient care

* Community Mental Health Centers

APPENDIX B

Agency Comments

Health Care Financing Administration (HCFA)
Substance Abuse and Mental Health Services Administration (SAMHSA)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: OCT 14 1999

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash
Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Mandatory Managed Care: Changes in Medicaid Mental Health Services," (OEI-04-97-00340); "Mandatory Managed Care: Children's Access to Medicaid Mental Health Services," (OEI-04-97-00344); and, "Mandatory Managed Care: Early Lessons Learned by Medicaid Mental Health Programs," (OEI-04-97-00343)

Thank you for the opportunity to review and comment on the three draft reports on mental health services in mandatory Medicaid managed care programs. The reports examine changes in services, children's access to care, and early lessons learned. We appreciate the effort that went into these reports. The reports provide good, first-hand information on the changes to Medicaid mental health services resulting from mandatory managed care enrollment during the first years of these programs.

Medicaid managed care initiatives are designed to control escalating costs, expand coverage and access to services, and improve quality of care. States face the challenge of designing and monitoring mental health programs that provide Medicaid beneficiaries with the care that they need while reducing or containing growth in costs. States set standards in their contracts for determining appropriate levels of services, using broad definitions of medical necessity, and limiting the use of prior authorization requirements for access to outpatient care. Also, states generally expand the range of community-based mental health services covered, compared with fee-for-service programs. Most carve-out plans use several approaches to quality assurance, including conducting patient satisfaction surveys, establishing and monitoring standards, and having consumer committees.

Two of the three above-subject reports contain recommendations. Our specific comments to those recommendations are attached.

Attachment

IG	✓
EAIG	
PDIG	✓
DIG-AS	
DIG-EI	✓
DIG-OI	
DIG-MP	
OCIG	
ExecSec	✓
Date Sent	10-15

DEPARTMENT OF HEALTH & HUMAN SERVICES

Substance Abuse and Mental Health Services Administration

Center for Mental Health Services
Center for Substance Abuse Prevention
Center for Substance Abuse Treatment
Rockville MD 20857

AUG 16 1999

TO: June Gibbs Brown
Inspector General

FROM: Administrator

SUBJECT: Draft Reports on Mental Health Services in Medicaid Managed Care Programs

Thank you for the opportunity to review and comment on the following three draft reports from your Office of Evaluations and Inspections:

- Mandatory Managed Care: Changes in Medicaid Mental Health Services (OEI-04-97-00340)
- Mandatory Managed Care: Early Lessons Learned by Medicaid Mental Health Programs (OEI-04-97-00343)
- Mandatory Managed Care: Children's Access to Medicaid Mental Health Services (OEI-04-97-00344)

These reports are based on case studies of seven states and their experiences with implementing mandatory managed care for Medicaid beneficiaries, with a particular focus on how it affects access to and quality of mental health services. Each report discusses its findings, and in some cases, recommendations, to States involved in implementing mandatory managed care for Medicaid-funded services.

While we very much appreciate the difficulty in conducting short term program evaluations, particularly in an environment of newly emerging, dynamic and complex health systems changes, and believe that a number of the report's recommendations are useful, we are concerned about the conclusions which the public, the Department, and the Congress may draw from these reports. Our concerns are summarized under the following general areas:

Findings and Recommendations. Generally speaking, the research upon which the reports are based is neither scientific nor comprehensive. The investigators, themselves, state that there is a great deal of variation among States in terms of how they have chosen and are choosing to implement changes to their Medicaid programs. In addition, the participating States have not had an opportunity to collect outcome data on the effectiveness of these services. While the lessons learned from these seven States' experiences are valuable to the ongoing implementation efforts of other States, we would hesitate to refer to some of these lessons as "findings" that may be construed as scientific data or to make general recommendations to the field based on these results.

Office of the Administrator—Office of Applied Studies—Office of Communications—Office of Equal Employment Opportunity & Civil Rights—Office of Managed Care—Office of Minority Health—Office of Policy & Program Coordination—Office of Program Services

Two findings in particular seem to lack a balanced perspective. The first finding, in the report on *Changes in Medicaid Mental Health Services* (page 9), is that managed care has expanded available services. This is a broad statement that, for a number of reasons, does not appear to be based on a sound evaluative approach.

First, the statement is based on documents from only four of seven states. Two of these were specifically chosen by the Health Care Financing Administration as having generally recognized innovative programs.

Second, the statement is based on the fact that out of a very small sample of programs, just over half reported increased utilization (ranging only from one to two percent) after conversion to managed care. One would presume this means that the overall penetration rate increased during some specific time period. It is not clear, however, if this is for all services or only a subset of services (e.g., outpatient services). Also, it seems doubtful that a one to two percent increase is statistically significant.

Third, even if penetration rates did increase in these four States it does not mean that Medicaid beneficiaries were receiving higher quality care and were experiencing improved outcomes from those services. The report notes that no State had working outcome measures in place.

Fourth, all seven States claimed dramatic declines in inpatient costs. One would assume this was the result of decreased utilizations. Two States said there was a reduction of 40 to 50 percent in available psychiatric beds. Commonly, according to State Medicaid staff, average length of stay was reduced by as much as 50 percent. Was this dramatic decline in inpatient utilization factored into the apparent increase in mental health services utilization?

Finally, it was noted that psychiatric hospital re-admission rates were generally higher under managed care, ranging from four to nine percent, and that stakeholders in several States expressed concern that lower average length of stays and increased re-admission rates may indicate that persons with serious mental illnesses are being released from in-patient care too quickly. This seems to be a noteworthy finding in and of itself.

The second troublesome finding, in the report on *Early Lessons Learned by Medicaid Mental Health Programs* (page 5), is that it is best to separate mental health services from other health services. We believe it is misleading to characterize this as a "finding." Finding generally refers to a conclusion reached after investigation or examination. For several reasons, this does not appear to be the case here.

First, all of the States studied were carve outs. There was no examination of integrated programs. While the seven States all may have indicated that such an arrangement worked well in terms of administration and implementation of a managed care arrangement, no comparison was conducted with other States that did not choose to carve out such services, nor is there any outcome data to indicate that such an arrangement resulted in more effective services. A more thorough comparative analysis would seem to be required in order to reach a reasonable basis for conclusion.

Second, while there certainly are benefits to carve-out programs, there is no balanced discussion of the potential problems of carve-out programs. For example, how do you integrate and coordinate care to meet both the physical and mental health care needs of the client and treat, in a comprehensive manner, persons with co-occurring mental health and substance abuse disorders?

Third, the report also states (page 1) that there was no attempt to "determine the effectiveness of the lessons learned reported by the States." Again, with this in mind, we do not believe it is appropriate to characterize this and other "lessons" as "findings." It tends to give them an air of authority that is not justified by the evidence.

New Services. In the report on *Changes in Medicaid Mental Health Services* (pages 9 and 10), the findings refer to new services or "innovative interventions" that have expanded the scope and flexibility of outpatient services. In addition, the report claims that these services or interventions would not or could not have been offered under the previous fee-for-service program.

We believe that these statements are misleading, at best. To our knowledge, providing services through a managed care arrangement does nothing to change the eligibility of a service or "intervention" for Medicaid reimbursement. At least two of the services identified, residential services and vocational services, generally are not coverable under Medicaid. It is possible that States may have obtained permission to offer an otherwise uncoverable service under an 1115 waiver. However, if that is the case, the reason should be attributed to the waiver, not to managed care. It is important that the OIG clarify these issues and independently determine that States are meeting applicable statutory and regulatory requirements. States should not be given the impression that managed care allows them to circumvent or ignore Medicaid limits on service coverage.

Data. In the report on *Children's Access to Medicaid Mental Health Services* (page 7), it is stated that "detailed data was almost nonexistent." Other parts of this report, however, cite statistics that assume that States do have such detailed data (e.g., changes in inpatient utilization). If States do not have detailed data, where do such statistics come from and how credible are they? Also, we would assume that the lack of detailed data is a serious handicap for state administrators and federal reviewers in their management and oversight responsibilities. If this is true, it would seem that this also should be a major finding of the report.

Involvement of State Mental Health Stakeholders. It is not clear to what extent State mental health staff and officials and mental health planning council members were involved in the interviews conducted as part of this study. The primary focus of the study at the State level appears to be on the State Medicaid agency. Although the investigators do make mention of including State mental health staff and stakeholders in the study, it is not evident to what degree this occurred. From a State systems perspective, we believe that it is critical that such important State stakeholders not only be included in such evaluations, but that State Medicaid agency staff be strongly encouraged to work in partnership with their State Mental Health Authorities to ensure access and quality services for those with serious mental illnesses.

Finally, on an editorial note, each of the reports contains an Appendix A, a chart entitled "Summary: First Year Medicaid Managed Care Mental Health Contracts." According to the chart, the State of North Carolina's 1915(b) waiver program excludes outpatient care from its covered mental health services. Based on the information available to us on North Carolina's waiver program, outpatient services are covered. We suggest that the OIG confirm this information for accuracy and make changes if necessary.

In summary then, SAMHSA would recommend that the OIG proceed cautiously in making general statements of findings or recommendations to States without consideration or mention of these important concerns and limitations.

If you have any questions on these comments or need additional information, please contact Robert Willcoxon, SAMHSA GAO liaison, on 443-4543.

Nelba Chavez, Ph.D.

ENDNOTES

1. National Summary of Medicaid Managed Care Programs and Enrollment, Medicaid Managed care Enrollment Report, The Health Care Financing Administration, June 30, 1998

2. State Profiles on Public Sector Managed Behavioral Health Care and Other Reforms. Managed Care Tracking System, Substance Abuse and Mental Health Services Administration, July 31, 1998

3. Federal Register, Volume 58, Number 96, May 20, 1993 page 29425

4. The 12-Month Prevalence and Correlates of Serious Mental Illness (SMI) Mental Health, United States, 1996. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1996

5. Prevalence of Serious Emotional Disturbance in Children and Adolescents. Mental Health, United States, 1996. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 1996

6. ibid

7. In February 1999, North Carolina requested to withdraw its 1915(b) waiver extension of the Carolina Alternatives Program. The State proposes to move all recipients back to a fee for service system on or before June 30, 1999.

8. Oregon and Tennessee have been under managed care for a minimum of 3 years, but did not phase in their seriously mentally ill populations until January 1995 and July 1996 respectively. North Carolina's waiver only applies to children.

9. Iowa implemented March 1995. Colorado implemented July 1995.