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**OFFICE OF
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MANDATORY MANAGED CARE

Changes in Medicaid Mental Health Services



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EXECUTIVE SUMMARY

PURPOSE

To provide an early look at the changes that mandatory managed care had on State Medicaid mental health services for persons with serious mental illnesses.

BACKGROUND

States are increasingly converting their Medicaid programs from traditional 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. The increased use of this emerging form of care has generated interest within the Substance Abuse and Mental Health Services Administration and the Health Care Financing Administration, particularly care for persons with serious mental illnesses.

We used a case study approach for reviewing mandatory mental health managed care programs in seven States. We integrated, compared, and summarized documentary and testimonial evidence obtained from State Medicaid managed care offices and mental health departments. We also interviewed managed care organization officials, mental health providers and stakeholders. We did not validate the testimonial evidence, but we believe it provides a first hand view of this emerging form of care by program operators and stakeholders who have a strong interest in program effectiveness.

FINDINGS

Services Expanded

Managed care allowed States to offer more specialized and creative out-patient services. Further, States said overall use of mental health services increased. Four of 7 States documented increased utilization ranging from about one to 2 percent after conversion to a managed care system.

Costs Reduced

States converted to managed care primarily to reduce skyrocketing mental health costs. States reduced cost by setting limits for mental health costs in managed care contracts. They also achieved program savings by shifting care from in-patient to out-patient settings.

Stakeholders, however, expressed concern that lower average length of stays and increased readmission rates may indicate that persons with serious mental illnesses are being released from in-patient care too quickly.

Health Impact Not Quantified

No State had working outcome measures in place. Beneficiary satisfaction surveys and grievances may inaccurately reflect the level and quality of care received.

Savings Not Always Used to Improve Mental Health Services

Consistent with existing regulations, States returned “off the top” savings to the State’s General Fund. States also used savings resulting from managed care operations to expand services to non-Medicaid eligible persons, and to help fund managed care administration. However, four States did not have the appropriate Medicaid waiver to use operational savings in this manner.

RECOMMENDATIONS

While States reported that managed care programs have expanded out-patient services, and reduced costs, the overall effect on the health of persons with serious mental illnesses was not quantified. However, resolution of several important concerns could significantly improve Medicaid mental health programs as more States convert to mandatory managed care. Accordingly, we recommend that:

- < HCFA work with SAMHSA to develop outcome measurement systems that can be used as a condition of waiver approval.
- < HCFA encourage States to establish independent, third-party mental health systems for conducting beneficiary satisfaction surveys.
- < HCFA ensure that States obtain the required 1115 waiver before using savings from managed care operations to expand services to non-Medicaid populations.

AGENCY COMMENTS

Both HCFA and SAMHSA commented on our draft report.

HCFA disagreed with our draft recommendation to require States to develop outcome measures as a condition of waiver approval. While recognizing the importance of outcome measures, HCFA said no reliable and cost-effective outcome measurement system currently exists and that requiring States to develop such a system would stall the waiver process. We continue to believe that without an outcome measurement system States and HCFA have no way of determining the effectiveness of managed care services. However, based on HCFA comments we modified our draft recommendation to encourage HCFA and SAMHSA to work together to develop outcome measurements that can be used as a condition of waiver approval.

HCFA agreed that States need to improve systems for measuring and promoting beneficiary satisfaction, and that the neutrality of people involved in the complaint process is important. However, they disagreed with our recommendation to require the use of such third parties in State appeal and grievance systems. They noted that appeal and grievance systems were mandated in the Balanced Budget Act of 1997. We recently started an evaluation of these systems; therefore, we are holding in abeyance our draft recommendation until we complete the evaluation of State Medicaid managed care grievance and appeal systems.

HCFA disagreed with our recommendation that States have an approved 1115 waiver before using savings resulting from managed care operations to expand services to non-Medicaid populations. HCFA stated that no such waivers are required since States can use their own share of savings to provide additional services of any kind including services for non-Medicaid eligible persons. We agree with HCFA that States are free to use “off the top” State savings to fund services for non-Medicaid eligible persons. However, we are referring to savings within the managed care program itself, including the Federal share of these savings. Our understanding is that use of such savings for that purpose would require a 1115 waiver. We modified the text of our report to make this distinction clearer.

SAMHSA commented that a number of our recommendations were useful, but expressed concern about our drawing conclusions from what they believe is a study method that is not “scientific”. We wish to emphasize that we used a case study method for our inspection. In describing our methodology we included a detailed explanation of the advantages and limitations of our case study approach. The limitations which we point out are similar to those described by SAMHSA. Our goal, however, was to take advantage of the early experience of some States to guide implementation of other States who are using a managed care approach for mental health services. We are confident that our readers will interpret our findings in the context of the methodology which we described. SAMHSA’s thoughtful comments will also help our readers avoid the pitfalls of over generalization.

SAMHSA expressed concern about States offering mental health services under Medicaid managed care that are not authorized under traditional fee for service Medicaid. It was not the purpose of this study to determine if States were complying with Medicaid rules regarding allowable services. Rather, we were more interested in the general trends and practices of mental health services in a managed care environment.

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 provide an early look at the changes that mandatory managed care had on State Medicaid mental health services for persons with serious mental illnesses.

BACKGROUND

States are increasingly converting their Medicaid programs from traditional fee for service models to managed care models. As of June 1998, more than 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 increased use of this emerging form of care has generated interest within the Substance Abuse and Mental Health Services Administration and the Health Care Financing Administration, particularly care for persons with serious mental illnesses.

Within the Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration (SAMHSA) is responsible for improving quality and availability of prevention, treatment, and rehabilitation services for mental illnesses. The Health Care Financing Administration (HCFA) is responsible for administering the Medicaid program through the various States.

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 life activities 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.

Managed Care

Managed care is a broad term used to describe a variety of approaches for delivering health care. Managed care is characterized by an emphasis on preventive care, elimination of unnecessary services, negotiated price discounts, smaller co-payments and deductibles, and substitution of lower-cost services for higher-cost services. Historically, it has been commonly found in private sector health insurance programs.

Typically, managed care involves paying a contractor a fixed, or capitated, amount per month, per patient to provide all agreed upon health care. The contractor, commonly referred to as the managed care organization, then bears a financial risk of ensuring that all medically necessary services are provided. To remain solvent, a managed care organization must ensure that the cost of services does not exceed the total capitated amount.

Managed care is a sharp contrast to the traditional fee for service delivery system where providers are reimbursed for each authorized service. In a fee for service system, consumers have open access to services, within limits set by their insurance.

Medicaid Managed Care “Carve Outs” Preferred for Mental Health Care

“Carve out” is a term used to describe a health care service or population that has been separated, or carved out, from other general health services or populations. When State Medicaid programs convert to managed care, they typically chose to separate, or carve-out, mental health delivery systems from other general health services. All States in our study used a full or partial carve-out arrangement to deliver mental health services to Medicaid beneficiaries. Theoretically, carve outs allow health plans to offer Medicaid beneficiaries access to the best available specialists, treatments, and technologies.

Carve outs also reduce risk to managed care organizations by separating speciality treatments that typically require a high level of care and cost. Carving out high-cost services and providing a higher capitated rate for individuals requiring those speciality services is intended to reduce incentives for managed care organizations to limit services. A carve out also enhances the ability of Medicaid agencies to ensure that funding is used to provide speciality services because funds are separated from general health funding.

Mandatory Medicaid Managed Care

Historically, State Medicaid programs could only offer managed care as an option to traditional fee for service. States could not mandate managed care enrollment without first obtaining a

waiver from HCFA. The most common waiver requests are those permitted by Section 1915(b) and Section 1115 of the Social Security Act.

- < Section 1915(b) permits waiver of the Medicaid freedom-of-choice provision. This waiver allows States to mandate enrollment in managed care plans. This type of waiver is used more commonly than Section 1115 waivers. Of the 36 States that have implemented mandatory managed care as of July 1998, 27 have 1915(b) waivers.⁷
- < Section 1115 permits large-scale demonstration projects, waiving numerous aspects of Federal Medicaid law. Those aspects include rules on eligibility, benefits, provider qualifications, payment rules, and administrative requirements.

In order for a State to receive either of these waivers, they must document that managed care costs will not exceed those had the program continued under its present fee for service reimbursement system.

Certain provisions of the Balanced Budget Act of 1997 were intended to allow States to implement mandatory managed care without a waiver under certain conditions. However, the complexity of carving out and mandating managed care for all populations with serious mental illnesses still generally requires a waiver.

METHODOLOGY

State Selection

We reviewed mental health managed care programs for seven States. They were Arizona, Massachusetts, North Carolina, Utah, Washington, Iowa, and Colorado. We selected all States (five) that had been under a mandatory managed care program for persons with serious mental illnesses for at least three years as of April 1997.⁸ We selected the remaining two States, Iowa and Colorado, at the request of HCFA. Although Iowa and Colorado had only been under managed care for about two years at the time of our inspection,⁹ HCFA staff said they were generally recognized as having innovative programs.

The mental health managed care programs operated by the seven selected States were similar in many respects, but they also differed in some notable ways. For example, each State program, except one, included adults and children. The one exception, North Carolina, included only children.¹⁰

The State programs also represented a mixture of managed care contracts. Four States contracted with only non-profit managed care organizations. Those managed care organizations were formed by existing public mental health providers. Two of the remaining three States contracted with for-profit managed care organizations. The final State contracted with a combination of non-profit and for-profit managed care organizations.

Finally, the States implemented mandatory managed care programs in a variety of ways. For example, four States initially only implemented programs in selected counties and regional communities--test geographical areas. The remaining three implemented State-wide programs.

For comparison purposes, we provided a general description of each selected State first year program in Appendix A.

Document Review

At each selected State, we reviewed key Medicaid and mental health program documentation showing program implementation, status and operations impact on persons with serious mental illnesses. To illustrate, we analyzed the first year managed care contract for each selected State. We also analyzed request for proposals, managed care waiver requests, State progress reports, internal and external studies and reviews on program operations, beneficiary satisfaction survey results, complaint and grievance reports, in-patient care data and reports, mental health program costs, and records on beneficiary utilization.

We also conducted an Internet search to identify managed care research involving persons with serious mental illnesses. Finally, we reviewed professional journals, studies and publications on State Medicaid programs and mental illnesses.

Interviews

We interviewed 23 State Medicaid managed care department and mental health office staff in our survey. From those officials, we obtained an understanding of individual State implemented and operated Medicaid programs. Finally, we obtained the views of State Medicaid and mental health staff on program changes for persons with serious mental illnesses.

Also, we interviewed 16 managed care officials, and mental health care providers, as well as 21 mental health stakeholders to obtain their views on program operations. We were particularly interested in their views on the impact of converting State mental health programs from a fee for service system to a mandatory managed care system. We selected managed care organization officials, mental health providers, and stakeholders based on recommendations from State Medicaid staff.

Advantages and General Limitations

We used a case study approach in analyzing the changes in services on persons with serious mental illnesses. 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.

The differences in individual State programs, and inconsistent data reporting limited our ability to generalize across State programs. For example, each State Medicaid program collects and reports data differently. To illustrate, one State tracks psychiatric hospital readmission rates within 30 days of release, but another State used a 90-day criteria. However, where utilization data was available, it is included in our report.

Finally, a few mental health stakeholders asked us to include in our study an analysis of several general mental health concerns, such as housing, formulary restrictions, and involuntary commitments. Such issues have existed for years under previous, traditional fee for service systems, and will likely exist under new managed care systems. We believe they are valid, important issues, but we did not include them in the scope of this study. Such issues are not the result of State Medicaid conversion to mandatory managed care. Further, we expect to continue our analysis of mental health care in the future. These and other important issues are likely topics for those inspections.

Despite the general limitations of our inspection, we believe this report provides good, first-hand information on the changes to Medicaid mental health services resulting from mandatory managed care enrollment. This type of information could be useful when first implementing a new system of care.

Definitions

Seriously Mentally Ill - For purposes of this report, the seriously 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. The organizations include such groups as the National Alliance for the Mentally Ill, The American Psychiatric Association, and The Federation of Families for Children's Mental Health.

Companion Reports

This report is one of three on mandatory managed care and Medicaid mental health services. It provides an early look at the changes that mandatory managed care had on State Medicaid mental health services for persons with serious mental illnesses.

While doing this study, we observed several common program characteristics and implementation practices that we believe would be valuable to other State Medicaid programs that plan to convert to a mandatory managed care system for mental health services, or any

other specialty services. We present the common characteristics and practices in a companion report titled Mandatory Managed Care - Early Lessons Learned by Medicaid Mental Health Programs (OEI-04-97-00343).

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

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.

FINDINGS

Services Expanded

New Services

All States told us that managed care allowed them to offer more specialized out-patient services than they could offer under their prior fee for service system. State Medicaid officials, along with several mental health stakeholders, described several examples of successful new services as a result of converting to managed care. The examples are highlighted below.

- < **Residential Services:** Services typically involve a group home concept that encourages and develops independent living.
- < **Vocational Services:** Vocational services involve job training and placement. Such services increase financial stability, self-esteem, and independent living. Also, employment opportunities have been found to reduce hospitalization, shorten in-patient lengths of stay, and reduce the need for clinical services in general.
- < **Respite Care Services:** Respite services provide temporary care for beneficiaries so that primary care givers may have time away and relief from stress.
- < **In-Home Programs:** These programs assist and support beneficiaries to function independently in their own home. The services are available 24 hours daily for persons who agreed to the program as an alternative to in-patient care.
- < **Club House/Day Services:** This program is intended to provide a structured day for beneficiaries. It is often run by beneficiaries with minimum provider oversight. The program objective is to develop and encourage independent living and responsibility.
- < **Personal Services:** The objective is to assist beneficiaries with personal care and daily living activities, such as shopping, cleaning, banking, and picking up prescriptions.
- < **Evaluation and Treatment Centers:** These are low-cost, in-patient care facilities that are limited to less than 16 beds. Stays are typically short-term. The objective is to return beneficiaries to a community setting as quickly as possible.

State officials cited the flexibility to provide services such as those described above as one key advantage of managed care over their previous fee for service system. They said that such services generally would not have been offered by States under fee for service.

Innovative Interventions

The flexibility afforded by managed care allow States to be more creative in how they strive to improve the mental health of Medicaid beneficiaries. To illustrate,

- < One State provided residential phone service for a beneficiary in an isolated, rural area. The phone allowed the person to easily call managed care providers and support networks. Thus, State officials told us that the phone helped prevent costly visits to the hospital emergency room.
- < Another State built a fence around the home of a person with a serious mental illness. The fence reduced paranoia episodes and allowed the person to feel more secure in his home. As a result, the person was able to remain actively employed in the community and out of the hospital.

Medicaid funding for innovative interventions such as the above two examples would not have been possible under the previous fee for service system, according to State Medicaid officials.

Increased Use

The seven States in our study told us that converting to managed care increased overall use of mental health services. Four of the seven States documented that the number of Medicaid beneficiaries who used mental health services increased about 1 to 2 percent after conversion. This increase was corroborated by States that initially converted to mandatory managed care in test areas (counties and regions). They said the increased use of mental health services in the test areas was greater than that in counties and regions that continued to use fee for service systems.

Historically, Medicaid mental health fee for service systems centered around expensive in-patient treatment. Managed care shifted the focus towards more community-based, out-patient care. Community-based out-patient care is generally acknowledged by both State Medicaid officials and stakeholders as being less costly, and more effective than in-patient care for the long-term treatment of persons with serious mental illnesses. While States reported decreased use of in-patient care, they reported larger increases of out-patient care.

Importantly, several States noted that the time beneficiaries had to wait to receive services was less under managed care than it was under their prior fee for service plan. For example, one State reported a 25 percent decrease in the number of beneficiaries that were required to wait 2 weeks or more for out-patient services.

Costs Reduced

Contracted First Year Savings

Medicaid officials in all seven States said their primary reason for converting to managed care was to reduce skyrocketing mental health costs. For example, one State reported that Medicaid mental health costs had increased by almost 20 percent annually over the past several years under fee for service. State Medicaid staff told us they could gain better control over Medicaid mental health costs by contracting with managed care organizations under capitated arrangements.

One way that States gained control over costs was by setting the contracted capitation rate lower than the anticipated fee for service rate. For example, one State stipulated that contract bids could not exceed 95 percent of the anticipated fee for service rate. Four of the seven States we studied said such “off the top” savings from setting contract limits ranged from 4 to 12 million dollars in the first year¹¹. The remaining three States allowed contracted rates to match expected fee for service levels. Therefore, while not realizing a cost savings, they said their costs remained stable.

Reduced In-Patient Care Lowered Costs

The seven States we studied all claimed dramatic declines of in-patient (hospitalization) costs. Under their previous fee for service systems, State Medicaid staff said in-patient costs typically represented over half of their mental health service expenditures. Most of the State Medicaid staff said that they cut the percentage of in-patient costs nearly in half by converting to managed care. For example, one State Medicaid official said that in-patient care costs were reduced from 51 percent of mental health costs to only 17 percent one year after conversion to managed care.

The States managed care programs achieved cost reductions largely by shifting care from in-patient to out-patient settings. The decrease of in-patient use allowed States to completely close some State psychiatric hospitals and significantly reduce total available beds for mental health care. Medicaid staff in two States, for example, said they experienced a reduction of 40 to 50 percent in available psychiatric hospitals beds.

Finally, State managed care organizations achieved cost savings by reducing hospital length of stay. Commonly, State Medicaid staff told us the average length of stay was reduced by as much as 50 percent after converting to managed care. Medicaid staff in one State, for example, said their average length of stay dropped from about 12 days to 6 days after converting to managed care. Staff in another State reported a drop from about 30 days to under 20 days.

Conversely, State Medicaid staff noted that the psychiatric hospital re-admission rate was generally higher under managed care than it was under their previous fee for service system.

Increases in re-admission rates generally ranged from about 4 to 9 percent, although one State saw no noticeable increase.

Stakeholders generally agreed with State Medicaid staff on the effectiveness of out-patient treatment. However, stakeholders in several States expressed concern that possibly too many hospital beds are being eliminated too quickly from the public mental health system. Further, these stakeholders 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.

Health Impact Not Quantified

No Systematic Measures of Clinical Outcomes

Is managed care improving the health of persons with serious mental illnesses? This is a very serious and important question for HCFA, SAMHSA, States, managed care organizations, and stakeholders. However, none of the States included in our study had working outcome measures in place before or after they converted to managed care. Even basic utilization data, such as lengths of hospital stays, and number of visits, was inconsistently reported by States. Therefore, HCFA and States have no systematic way to determine the impact of managed care on the health of persons with serious mental illnesses.

However, State officials, mental health providers, and stakeholders in all States said they believe that overall mental health care has improved as a result of converting to mandatory managed care. Supporters of managed care could supply only anecdotal evidence. Likewise, critics of managed care presented similar anecdotal evidence for their views. Given the lack of supporting, compelling evidence from either supporters or critics, there is little quantifiable proof on whether mental health care has gotten better or worse.

One way to determine if a patient's health improved is to analyze the results achieved by a specific type of treatment or system of care. This is commonly referred to as measuring clinical outcomes. Clinical outcomes are critical when trying to determine if services and programs are effective. However, clinical outcomes are also the most difficult type to determine, particularly when it involves serious mental illnesses because each person's treatment plan is unique, and it is often difficult to determine which intervention brought about improvement. Further, mental illness may be influenced by environmental factors, such as poverty, and family situations.

Medicaid staff in all States that participated in our study said they need to develop and implement clinical outcome tracking systems. They also said they were in the process of developing and testing such systems. According to the State officials, once their systems are completed, they will be able to gather and study data to determine clinical outcomes for persons with serious mental illness.

In the interim, States use various service indicators to judge the quality of managed care. For example, they include specific standards in their managed care organization contracts such as re-admissions rates, speed in which phones are answered, and the timeliness in which payments are made to providers. Some States also specify bonuses and penalties in their managed care contracts to encourage meeting the standards. State officials agree, however, that while such measures are important, they do not allow States to determine if people with serious mental illnesses are getting better faster, and staying well longer.

Beneficiary Satisfaction Measures May Be Misleading

Where available, we compared the results of managed care organization beneficiary satisfaction surveys with results of similar surveys conducted by States prior to their conversion to managed care. Our comparisons showed no significant changes in satisfaction resulting from implementation of managed care. Medicaid beneficiaries seemed generally satisfied with care and services both before and after the States converted to managed care.

Stakeholders, however, expressed concern about the results of managed care organization conducted beneficiary satisfaction surveys. Stakeholders argued that the surveys may be an inaccurate reflection of the experiences and opinions of managed care organization beneficiaries with serious mental illnesses. The stakeholders gave several examples to illustrate their concern.

First, managed care organizations were generally responsible for conducting all surveys of persons with serious mental illnesses to determine managed care service satisfaction. The managed care organizations were typically required to report survey results to the States. Because the managed care organization that provided the services also conducts the survey, stakeholders said that persons with serious mental illnesses were often afraid to criticize the services they received. They noted that in most instances, persons with serious mental illnesses had no where else to go for needed services.

Second, persons with serious mental illnesses, due to the very nature of their illness, were often not able to accurately comment on the level or benefits of care they received. Further, in some instances, they were not aware of services or treatment options available to them.

Finally, stakeholders noted that persons with serious mental illnesses were often unable to complete survey instruments independently. In some such instances, they said it was common practice for providers to assist beneficiaries in completing surveys. Therefore, according to the stakeholders, it was unlikely that beneficiaries would openly criticize providers who were helping them complete a survey.

Several States have tried to lessen stakeholder concern about “the fox guarding the hen house” by creating Ombudsman programs, and by contracting with consumer groups to conduct satisfaction surveys. In States where satisfaction surveys were conducted by parties other than

managed care organizations, stakeholders said consumers were more comfortable voicing their true opinions without fear of reprisal, whether real or perceived.

However, even in States that used third parties to conduct satisfaction surveys, stakeholders still questioned their impartiality when the third party relied on funding from the managed care organization.

Grievances May Not Be a Reliable Measure

Grievances may not be a reliable measure of health impact for two reasons. First, States told us they received very few formal grievances. Therefore, they assumed that beneficiary care was adequate. In fact, Medicaid officials in one State said that they had never received a complaint about mental health care provided by a managed care organization.

Generally, complaints or grievances that arose were resolved at the managed care organization level. Typically, managed care organizations have first level responsibility for handling consumer and provider grievances. If managed care organizations cannot satisfactorily resolve a grievance, the consumer can elevate it to the State.

Second, stakeholders expressed an overall feeling that beneficiaries rarely used the grievance process. They said beneficiaries were not fully aware of their grievance rights and procedures. Stakeholders complained that grievance procedures for managed care organizations were not always well publicized. They told us that although beneficiaries typically were given brochures explaining grievance procedures, they seldom read or understand the information. Stakeholders also believed that beneficiaries did not file grievances because they were afraid it would effect the services they receive.

In general, providers filed more complaints and grievances than did beneficiaries. Further, most of the complaints and grievances were filed against for-profit managed care organizations rather than non-profit managed care organizations. In most instances, the complaints and grievances involved financial issues or perceived limits on provider authority to provide service.

To add credibility to the grievance process, two States added a contract provision that required an independent Ombudsman program to assist beneficiaries who had complaints and grievances. This was expected to improve beneficiary support and education. However, stakeholders argued that if an Ombudsman program is used it should be funded directly by the States.

The complaint and grievance procedures under managed care were similar to the prior fee for service systems. Beneficiaries brought few formal complaints or grievances to the State. They were resolved at the lowest possible level--usually the provider. However, there was one important difference, beneficiaries had an option. They could vote with their feet, and go to another provider. This is not always an option for beneficiaries receiving services through a mandatory managed care system.

Savings Not Always Used to Improve Mental Health Services

“Off The Top” Contract Savings Were Returned to State General Fund

Four States achieved cost savings by setting contract limits for managed care. They returned these savings to the State General Fund. The State then re-directed the savings to other State activities.

While Federal requirements do not limit the use of such “off-the-top” program savings for other purposes, the practice of using the fee for services to managed care conversion process as an opportunity to reduce mental health program costs was a great concern to stakeholders, such as State officials for the National Alliance of the Mentally Ill. The stakeholders preferred awarding managed care mental health contracts at 100 percent of the estimated fee for service level. They argued that this would allow States to expand alternative programs for persons with serious mental illnesses.

However, State Medicaid officials viewed the reductions as a necessary action to roll back overall mental health costs that for years had skyrocketed out of control under the fee for service system. By effecting large cost reductions through the contracting process, States reduced their overall mental health costs, as well as matching Federal expenditures. Further, neither stakeholders nor State officials have shown a deterioration in service for people with serious mental illnesses after the conversion.

Three States did award contracts at 100 percent of estimated fee for service levels. Those States seemed to enjoy higher support by stakeholders for their managed care conversion.

Savings Resulting From Managed Care Operations Were Used to Expand Non-Medicaid Services

Five of seven States reported operational savings. Operational savings result when money paid to a managed care organization to provide care is not spent during the course of the year. This residual money is considered to be savings resulting from managed care operations. States said that operational savings result from implementation of managed care practices such as greater use of out-patient care and reductions in length of hospital stays, or from less than anticipated utilization of services.

According to State Medicaid staff, managed care organizations in four of the States used such operational savings to expand services to non-Medicaid eligible populations. The other State deposited its operational savings into the General Fund.

Using such operational savings to expand services to non-Medicaid persons is permitted by waiver under Section 1115 of the Social Security Act. However, States are first required to ensure that all necessary services are provided to Medicaid beneficiaries. Of the four States in

our study that reported using operational savings to expand services to non-Medicaid populations, only one had the required Section 1115 waiver.

The other three States that expanded services to non-Medicaid populations, and the one State that returned operational savings to the State General Fund, only had a 1915(b) waiver. However, a 1915(b) waiver does not allow States to use operational savings to provide services for non-Medicaid populations. It only allows States to use operational savings to provide Medicaid beneficiaries with additional services. Using managed care operational savings to provide services to non-Medicaid populations or depositing such savings in the State General Fund are not inappropriate when the original funding included Federal dollars.

Another issue is that States provided little oversight on how managed care organizations used operational savings. In addition to using such savings to expand services to non-Medicaid populations, some managed care organizations used operational savings for administrative purposes. For example, some used the savings for financial reserves, administrative salary increases, mortgage payments, and facility development. State request for proposals gave only general guidance over how savings could be used. Typically, no prior approval was required, and spending of operational savings was left up to the discretion of the managed care organization.

RECOMMENDATIONS

While States reported that managed care programs have expanded out-patient services, and reduced costs, the overall effect on health of persons with serious mental illness was not quantified. However, resolution of several important concerns could significantly improve Medicaid mental health programs as more States convert to mandatory managed care. Accordingly, we recommend that

HCFA work with SAMHSA to develop outcome measurement systems that can be used as a condition of waiver approval. Most State contract request for proposals require managed care organizations to develop and implement an outcome measurement system. However, at the time of our study, no State could produce any measurement results.

We recognize how difficult the development of outcome measures can be, particularly in the area of mental health where it is often difficult to determine which intervention brought about relief. Also, the lack of standardized data reporting and tracking systems can make determining successful practices difficult. However, as difficult as it is to develop working outcome measurements, HCFA should continue to work with SAMHSA, States, and stakeholders to develop and implement working outcome measurement systems.

HCFA encourage States to establish independent, third-party mental health systems for conducting beneficiary satisfaction surveys. Funding should come from the State Medicaid program rather than directly from managed care organizations, so that the program can operate more independently. Such a program will improve consumer confidence, and promote more open, honest feedback.

HCFA ensure that States obtain the required 1115 waiver before using savings resulting from managed care operations to expand services to non-Medicaid populations. Three States that only had a 1915(b) waiver used operational savings to expand services to non-Medicaid populations. Another State returned operational savings to its General Fund based only on a 1915(b) waiver. State General Funds can be used for various activities such as building roads or providing mental health services to non-Medicaid populations. However by statute, a 1115 waiver is needed to use savings from managed care operations to expand services to non-Medicaid populations.

AGENCY COMMENTS

Both HCFA and SAMHSA commented on our draft report.

HCFA disagreed with our draft recommendation to require States to develop outcome measures as a condition of waiver approval. While recognizing the importance of outcome measures, HCFA said no reliable and cost-effective outcome measurement system currently exists and that requiring States to develop such a system would stall the waiver process. We continue to believe, however, that without an outcome measurement system, States and HCFA have no way of determining the effectiveness of managed care services. However, based on HCFA comments we modified our recommendation to encourage HCFA and SAMHSA to work together to develop outcome measurements that can be used as a condition of waiver approval. Further, Section 438.340 of the proposed managed care regulation for the Balanced Budget Act of 1997 requires States to develop outcome measures.

HCFA agreed that States need to improve systems for measuring and promoting beneficiary satisfaction, and that the neutrality of people involved in the complaint process is important. However, they disagreed with our recommendation to require the use of such third parties in State appeal and grievance systems. They noted that appeal and grievance systems were mandated in the Balanced Budget Act of 1997. We recently started an evaluation of these systems; therefore, we are holding in abeyance our draft recommendation until we complete the evaluation of State Medicaid managed care grievance and appeal systems.

HCFA disagreed with our recommendation that States have an approved 1115 waiver before using savings resulting from managed care operations to expand services to non-Medicaid populations. HCFA stated that no such waivers are required since States can use their own share of savings to provide additional services of any kind including services for non-Medicaid eligible persons. We agree with HCFA that States are free to use “off the top” State savings to fund services for non-Medicaid eligible persons. However, we are referring to savings within the managed care program itself, including the Federal share of these savings. Our understanding is that use of such savings for that purpose would require a 1115 waiver. We modified the text of our report to make this distinction clearer.

SAMHSA commented that a number of our recommendations were useful, but expressed concern about our drawing conclusions from what they believe is a study method that is not “scientific.” We wish to emphasize that we used a case study method for our inspection. In describing our methodology we included a detailed explanation of the advantages and limitations of our case study approach. The limitations which we point out are similar to those described by SAMHSA. Our goal, however, was to take advantage of the early experience of some States to guide implementation of other States who are using a managed care approach for mental health services. We are confident that our readers will interpret our findings in the context of the methodology which we described. SAMHSA’s thoughtful comments will also help our readers avoid the pitfalls of over generalization.

SAMHSA expressed concern about States offering mental health services under Medicaid managed care that are not authorized under traditional fee for service Medicaid. It was not the purpose of this study to determine if States were complying with Medicaid rules regarding allowable services. Rather, we were more interested in the general trends and practices of mental health services in a managed care environment.

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 the increase of both out-patient, and overall service utilization under managed care. We also 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.

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

Agency Comments

Health Care Financing Administration (HCFA)

Substance Abuse and Mental Health Services Administration (SAMHSA)



DATE: OCT 14 1999

TO: June Gibbs Brown
Inspector General

FROM: Michael M. Hash *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	<input checked="" type="checkbox"/>
E/AG	<input type="checkbox"/>
PD/AG	<input type="checkbox"/>
DIG-AS	<input checked="" type="checkbox"/>
DIG-EI	<input checked="" type="checkbox"/>
DIG-OI	<input type="checkbox"/>
DIG-MP	<input type="checkbox"/>
OCIG	<input type="checkbox"/>
ExecSec	<input checked="" type="checkbox"/>
Date Sent	10-15

Comments of the Health Care Financing Administration on
the Office of Inspector General Report: "Mandatory Managed Care: Changes in
Medicaid Mental Health Services," (OEI-04-97-00340)

OIG Recommendation

The Health Care Financing Administration (HCFA) should require states to include the development of outcome measurement systems as a condition of waiver approval.

HCFA Response

Although, we concur with the intent of the recommendation, we disagree with the recommendation. We believe this recommendation does not take into account the current state of the art in outcome measurement. The development of outcome measurement systems is extremely important, and the Department of Health and Human Services, along with other Federal and state agencies, and private sector researchers are working to achieve this goal. But, despite these efforts, valid, reliable, and cost-effective outcome measurements are generally not yet available; particularly in the behavioral health area.

If complete systems of such measures were made a prerequisite for waivers, no waivers could be granted at the present time. Moreover, requiring the states alone and individually to undertake development of such systems would likely involve costly duplication of effort and would overlook the importance of contributions by the Federal government and private entities to this development effort. As soon as we have the criteria, we will work with states to ensure that appropriate measurements for mental health services are utilized.

OIG Recommendation

HCFA should encourage states to establish independent, third-party mental health systems for conducting beneficiary satisfaction surveys, and for resolution of complaints and grievances when managed care enrollment is mandated.

HCFA Response

Although we concur with the intent of the recommendation, we disagree with the recommendation. We believe the recommendation should be framed somewhat less restrictively and should reflect changes in the program since your work was initially done.

We agree that HCFA should encourage states to improve their systems for measuring and promoting beneficiary satisfaction. Most states, in fact, currently use independent parties to conduct beneficiary satisfaction surveys. We also agree that an important consideration is the neutrality of people and organizations conducting surveys and certainly, in most cases, resolving complaints and grievances. The Medicaid regulations at CFR 434.32 require managed care organizations to establish a grievance process. This is true not only in mandatory enrollment situations as described by the OIG, but also in voluntary arrangements as well. The Balanced Budget Act of 1997 managed care regulation currently under development was published as a notice of proposed rulemaking in September 1998. When published, the regulation will strengthen the requirements for a grievance process and keep in place the statutory requirements for a state's fair hearing process. Again, this would apply to all managed care arrangements, whether voluntary or mandatory, and not only in mandatory arrangements as the report recommends.

OIG Recommendation

HCFA should ensure that states obtain the required 1115 waiver before using mandatory managed care program savings to expand services to non-Medicaid populations.

HCFA Response

We do not concur. This recommendation is based on an incorrect understanding of the statute. If states want to expand Medicaid eligibility to individuals who would not otherwise be considered Medicaid-eligible, and they want to pay for Medicaid services for these individuals using Federal funds, they must request authority to claim costs not otherwise matchable. The Secretary may grant these waivers pursuant to her authority under section 1115 of the Social Security Act.

The OIG report outlines a very different scenario. In the states visited by the OIG, the Medicaid program purchases services through a managed care arrangement that costs less than the previous fee-for-service arrangement. Such an arrangement saves money for both the state and Federal governments. The states then use part of the state share of the savings to fund additional services, some of which are provided to non-Medicaid eligible persons. In general, there are no Federal requirements attached to the use of these state savings. Section 1115 waivers are not required in this instance.



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, SAMEISA 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 Wilcox, SAMEISA GAO liaison, on 443-4543.


Neiba Chavez, Ph.D.

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. 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
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.
9. Iowa implemented March 1995. Colorado implemented July 1995.
10. 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.
11. One State reported first year cost savings of about \$47 million. However, this included both mental health and substance abuse managed care savings. The State was unable to report mental health cost savings only.