Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers

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Foreword

During this time of financial uncertainty and change in the Nation's health care systems, the Center for Substance Abuse Treatment (CSAT) is proud to provide the substance abuse and mental health fields with this Technical Assistance Publication (TAP), *Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers.* The document is a comprehensive guide for public purchasers and others interested in influencing the development of requests for proposals (RFPs) and contracts in managed behavioral health care. Experts in both the substance abuse and mental health fields collaborated in its development.

It is generally agreed that strong contracts between purchasers of health care services and managed care organizations (MCOs) form the foundation upon which managed behavioral health systems are built. Unfortunately, some public purchasers have left themselves and their clients vulnerable to poor quality services and restricted access due to poorly conceptualized and poorly written RFPs and contracts. This guide provides information that will help public purchasers develop RFPs and contracts for managed behavioral health care so as to achieve programmatic success. Although this guide is intended to assist public purchasers in their managed care contracting efforts it should not be used as a substitute for expert legal or financial guidance. Any recommendations put forth here should be carefully considered by purchasers and adapted with appropriate guidance to meet the needs of the specific State or locality.

This TAP is targeted most specifically to State and county substance abuse and mental health authorities, State Medicaid authorities, and other payers and purchasers of managed mental health and/or substance abuse services. CSAT hopes, however, that substance abuse and mental health treatment providers, MCOs, consumer groups, advocacy groups, academicians, and researchers will find the document an informative discussion of the essential elements of managed care contracting for substance abuse and mental health services.

This document was developed by CSAT using national experts as an advisory panel. Once published, TAPs generally are not revised, and the development process ends. Traditional ways of developing and disseminating knowledge are changing, though, and CSAT recognizes that a document on a topic as dynamic as managed care contracting must be very accessible and continually updated if it is to continue to be useful. Therefore, CSAT has made this TAP available on the Internet and plans to update the information contained within it on a regular basis. Internet accessibility will provide readers of this TAP with a mechanism for asking questions, contributing new material, and providing ongoing feedback on the guide. We hope that this document will serve as a model for developing and disseminating essential information in an online, interactive, and continually updated manner.

CSAT invites you to use this guide to better understand how to develop RFPs and contracts for managed behavioral health care systems that live up to their promise of providing state-of-the-art services to people with mental health and addictive disorders. We further invite you to use your knowledge and experience to contribute to its continual evolution so that it may better serve others.

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This document reflects the efforts of many contributors: national experts in the fields of substance abuse, mental health, Medicaid, child welfare, consumer advocacy, and the attorneys who represent these fields. The need for managed care contracting information in State and local agencies and the desire to make this document a state-of-the-art guide to contracting for managed care services for people with addictive and mental health disorders brought together individuals and organizations from diverse fields, with affiliations in Federal, State, county, and local governments and in both the public and private sectors.

Oversight, guidance, and support for this publication was provided by a Development Panel made up of experts in managed care contracting for substance, abuse, mental health, and medical services from across the country. Development Panel members attended the initial concept meeting, developed outlines, drafted chapters, offered consultation, and provided comments throughout a long and challenging development process. They were very generous with their time, and their knowledge and dedication helped ensure that this document would have a practical application to public managed care contracting. A special debt of gratitude is owed to Development Panel members Sara Rosenbaum, who provided substantive knowledge of the legal aspects of managed care contracting, contributed the bulk of the sample contract language, and reviewed the entire document for accuracy; Paul Litwak, who played a formative role throughout the project and contributed substantially to the chapters on developing a managed care initiative and management information systems; Rick Ramsey, who played an active leadership role throughout and contributed to many chapters; Robert Mirel and Steve Wood, who made invaluable contributions to the chapter on management information systems; Neal Cash, for sharing his first-hand experience with provider-sponsored networks; and Richard Dougherty, Haiden Huskamp, and Tony Broskowski, for sharing their expertise on financial issues.

Important contributions were also made by the staff and constituents of several national organizations and government agencies, including the National Association of State Alcohol and Drug Abuse Directors, the National Association of State Mental Health Program Directors, the National Association of County Behavioral Health Directors, the American Public Welfare Association, and the Health Care Financing Administration. These stakeholders provided guidance early in the development process, making recommendations concerning what they sw s the most-needed information as they confront the challenges associated with developing managed care contracts.

More than 50 field reviewers representing the mental health, Medicaid, substance abuse, and managed care fields offered extensive feedback on the document and in many ways shaped its focus. The collective input form these individuals-was invaluable.

Finally, thanks go to the dedicated staff of Health Systems Research, Inc., including Project Director Stephen Moss, William Ford, Kathy Jacquart, Dhlia Shaewitz, Cathy Corder, and Daniel Kent; and to consultant editors Constance Gartner, Betsy Earp, Kerry Kemp, and Carolyn Davis.

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CHAPTER I

Introduction

Key issues in this chapter:

- The managed care trend
- Challenges for managed care initiatives in the public sector
- The critical importance of a good contract

In recent years, State Medicaid agencies and other public sector entities--in particular, State, county, and local substance abuse and mental health authorities--have increasingly been taking the initiative to purchase substance abuse and mental health managed care services from private sector organizations or specialized nonprofit agencies. Developing requests for proposals (RFPs)[(1)] and then contracting for outside managed care services is a significant vehicle for introducing managed care into the public sector while responding to complex financial and political pressures. In most States, the State Medicaid agencies or other public purchasers have already begun contracting with managed care organizations (MCOs), and in many other States managed care initiatives are under way or are being considered.

- Uses and limitations of this guide

This document is a practical guide for public purchasers and others involved in the design and development of managed care initiatives involving substance abuse and/or mental health services. The Center for Substance Abuse Treatment (CSAT), the Center for Mental Health Services, and their parent agency, the Substance Abuse and Mental Health Services Administration (SAMHSA), developed this publication to help State Medicaid agencies, State substance abuse and mental health authorities, and other public purchasers translate rapidly evolving policy goals into effective RFPs and contracts that are the basis for sound managed care initiatives. To develop this document, CSAT, the Center for Mental Health Services, and SAMHSA sought guidance and direction from an expert panel and field reviewers that included State Medicaid agencies, substance abuse and mental health authorities, managed care contracting experts, health care attorneys, providers, and consumers.

Chapters II through VIII of this guide describe several important issues pertaining to contracts for managed behavioral health care:

Chapter II discusses the process of designing, procuring, and implementing a managed care system--from preliminary design, through development of an RFP, through the signing and subsequent monitoring of the contract.

Chapter III considers the essential decisions concerning the services to be covered in a managed care plan, medical necessity, and the impact of funding streams on coverage.

Chapter IV examines the establishment and maintenance of provider networks, including network design, selecting network providers, ensuring enrollees' access to services, subcontracting with network providers, establishing provider standards, and monitoring provider performance.

Chapter V concentrates on the key features of a management information system (MIS) that would be most effective in a managed care system, including data requirements and hardware and software needs.

Chapter VI addresses issues pertaining to quality of care, including measures of quality, accreditation standards, report cards, measures of consumer satisfaction, and internal and external quality management systems for MCOs.

Chapter VII examines different aspects of financing in a managed care environment, including such topics as risk-sharing arrangements, incentives and sanctions, third-party reimbursement, copayments and deductibles, cash flow management, reinvestment requirements, and financial reporting.

Chapter VIII provides an examination of important consumer protection issues, including various consumer rights and the complaints, grievances, and appeals process.

At the end of the document, there is a resource list with the names, addresses, and phone numbers of a variety of organizations involved in the fields related to managed behavioral health care. There is also a comprehensive glossary of terms.

A. The Managed Care Trend

In a single generation, we have witnessed a major transformation of the public and private health insurance system in the United States. Twenty-five years ago, thousands of small and mid-sized public and private health care providers sold health services to individuals with commercial health insurance, charging what they believed was appropriate and rendering treatment in accordance with individual professional judgment. The insurance companies then paid the health care providers' bills (either fully or nearly completely) and did not question the providers' practice style. Medicaid and Medicare operated in a similar fashion.

Today more than three-quarters of commercially insured persons, more than 12 percent of Medicare beneficiaries, and almost 40 percent of Medicaid beneficiaries get their health coverage from managed care enterprises that combine the financing of health care services with their delivery. Managed care entities affiliate with networks of hospitals, community-based organizations, pharmacies, physicians, and/or other health care professionals and limit payment for covered services to services provided through those networks. The selection of providers for an MCO's network is primarily the responsibility of the MCO, although the purchaser of managed care services can influence these choices. For providers, membership in an MCO's network is dependent upon both an adherence to the MCO's practice requirements and the acceptance of financial risk and/or stringent payment controls.

Managed Care and Managed Care Organizations

Managed care, broadly defined, is a comprehensive approach to health care delivery that encompasses planning and coordination of care, monitoring of care quality, and cost control. Methods for managing care may include the development and implementation of criteria for level of care assignments and medical necessity determinations. Other methods for managing care may include use of standardized pretreatment assessment and treatment planning methods supported by practice pattern analysis and provider profiling, and outcomes management. Managed care encourages development of and referral to a complete continuum of care, and use of prior authorization and concurrent review for ongoing care management. Finally, managed care includes new systems of financing health care delivery, such as putting providers at risk for the cost of service delivery. (The above definition is derived from Freeman and Trabin [1994].)

Managed care organizations are organized systems of health care that integrate the provision of paying for health services with the provision of health care services. Because MCOs operate in accordance with good business principles and expectations, their role is largely to control spending levels within clearly established financial parameters. MCOs typically develop and implement criteria to determine assignment of enrollees to the appropriate level of care based on assessed medical and clinical need. MCOs include a wide variety of for-profit and nonprofit organizations, including health maintenance organizations (HMOs), prepaid health plans (PHPs), and other health care systems that provide a full range of health care services, organizations that specialize in the management of substance abuse and mental health services (usually called managed behavioral health care organizations, or MBHOs), government entities (e.g., counties), and organized networks of health care providers.

A growing number of State, county, and local agencies are now developing or contracting with MCOs to manage substance abuse and/or mental health (i.e., behavioral health) services for their populations. Approximately 20 States have implemented some form of managed behavioral health care for Medicaid recipients, serving approximately 5 million enrollees, and the number continues to climb. Many MCOs, which formerly focused only on private sector health care, are eager to enter this emerging and lucrative market in the public sector.

Many State, county, and local agencies have successfully reorganized their infrastructure to implement certain managed care principles and technologies. Yet numerous agencies have chosen to contract externally with MCOs to manage the delivery of some or all substance abuse and mental health services. In many cases, the movement toward the purchase of behavioral health care is part of a broad trend to transfer the management and delivery of Medicaid, Medicare, and other publicly funded services to MCOs.

As State, county, and local agencies have come to realize the potential value of contracting with MCOs, many have developed specific goals for improving their systems through managed care. These goals often include the following:

To improve coordination of and access to a full continuum of substance abuse and mental health treatment and prevention services;

To improve the quality of services for populations that have substance use and/or mental health disorders;

To allocate limited financial resources more efficiently and effectively;

To improve the predictability of costs, thereby increasing the accuracy of budgets;

To integrate the delivery of general medical and primary health care with behavioral health care;

To expand coverage to a larger proportion of the population; and

To increase accountability for and systematically improve consumer outcomes.

Well-designed managed care systems can best achieve these goals when purchasers and MCOs clearly understand the needs of the population served, the unique requirements imposed by the fiscal and political environment, and the most effective managed care practices. To meet these conditions, purchasers must use the contract development process and the contract to maximize their control over the design, award, operations, and outcomes of the managed care system.

B. Challenges for Managed Care Initiatives in the Public Sector

There are several challenges faced by those attempting to build successful managed care initiatives in the public sector:

The populations served by Medicaid and other public sector service systems tend to be poorer and sicker than populations with commercial insurance, and MCOs may have little experience with these populations.
Federal, State, and local substance abuse and mental health authorities have little experience with managed care practices and must operate under statutory and regulatory limitations not found in the private sector.
Many State and local service delivery systems are fragmented, in part because different agencies handle different populations, and separate funding streams for designated populations have created different sets of structures and incentives.

The populations served by public sector service systems pose unique challenges to the success of managed health care initiatives because public sector populations generally require a far broader range of services than individuals with commercial health insurance and also tend to make greater use of "wraparound" services, such as child care, housing assistance, and vocational training. Many people served in the public sector are poor, elderly, undereducated or uneducated, and/or members of disadvantaged ethnic or linguistic minorities. Many of them seek services only when they are already at a late stage of disability. Individuals depending on publicly funded treatment often have the most debilitating addictions and/or the most serious mental illnesses, as well as co-occurring medical complications. Furthermore, the public sector population includes children with the most serious emotional disorders requiring a broad range of specialized services.

MCOs seeking to contract with public sector agencies often have worked exclusively with commercially insured populations consisting primarily of employed adults and their families. The approaches and regimens developed by these MCOs may not fit the special behavioral health care needs of the public sector population. Meeting the ongoing rehabilitation and recovery needs of individuals with the most serious substance abuse and mental health disorders is expensive, and some services do not meet the sometimes restrictive "medical necessity" criteria imposed by MCOs (see medical necessity discussion in Chapter III). In addition, many MCOs may have limited experience with the types of prevention services mandated for individuals served by public sector systems.

Differences between traditional public service systems and private sector methods of operation pose another challenge to public sector managed care initiatives. As Federal, State, and county substance abuse and mental health authorities move away from their former roles as administrators of grants and contracts into new roles as purchasers of managed systems of care, they must work within governmental limitations that are not found in the commercial sector. These include legislative and statutory restrictions, such as mandated services for special populations, restrictions on what types of providers can be utilized, set percentages of funding that must be spent in certain areas (e.g., prevention services) or for specified populations (pregnant women), and underfunding.

Another challenge to a successful managed behavioral health care system is the fragmentation of service delivery systems that characterizes many State and local systems and causes duplication of and gaps in the service continuum. This fragmentation is due in part to a lack of coordination between agencies and separate funding streams that are designated only for specific populations. This lack of integrated services has additional implications for cost and quality of care for individuals with the most severe illnesses, such as seriously and persistently mentally ill persons. Complicating matters further is the fact that many individuals in public substance abuse and mental health

treatment are also served by other public agencies and systems, some of which, like the child welfare system, are setting up their own service management systems.

C. The Critical Importance of a Good Contract

Sound contracts are at the foundation of successful public sector managed care initiatives, which are likely to consume literally billions of dollars in public financing. A contract defines the expectations of the purchaser, the obligations of the MCO and its network of providers, and the rights of consumers. A contract embodies legally enforceable sets of promises that are crucial to accountability. Therefore, it is essential that the contract clearly state what duties are delegated to the MCO and what duties remain with the public purchaser of managed care services.

Public sector managed care contracts are collectively forming a critical component of the legal framework in which public services are delivered. To some degree, the contract and its associated documents (such as RFPs) are the *only* existing legal framework (Rosenbaum et al., 1997). Because a contract, by definition, constitutes a legally enforceable promise, virtually every issue addressed in it has legal implications in terms of whether the promise is worded in a way that can be enforced by a court of law.

When a contract is poorly drafted, the financial consequences can be enormous, because under the principles of contract law, a contract will be interpreted by the courts against the drafter. In the case of public managed care procurements under Federal and State law, the public agency is the drafter. An unfavorable court ruling can leave the agency legally and financially exposed for services that it assumed were part of the contract but that in fact fall outside the scope of the agreement because of vague or erroneously drafted terms.

The contract is the means by which compliance with applicable Federal and State mandates and regulations can be established. The Federal laws and regulations governing Medicaid, the Federal Community Mental Health Services (CMHS) Block Grant (Public Law 102-321; 42 U.S.C. §300x-7-§§300x-8), and the Substance Abuse Prevention and Treatment (SAPT) Block Grant (Public Law 102-321; 42 U.S.C. §300x-21-§§300x-35), for example, specify requirements for coverage; if the responsibility for meeting these requirements is not specifically delegated to the MCO in the contract, that obligation remains with the purchaser and may result in unanticipated costs.

In addition, contracts can address such issues as: the relationship between the contract and the RFP; the relationship between the contract and local, State, and Federal law; the MCO's subcontracts with providers; indemnification; the MCO's accountability and reporting responsibilities; and conditions of contract termination in the event of nonperformance. These issues are discussed in later chapters of this document.

A recent analysis of dozens of State Medicaid contracts covering prevention and treatment services for mental and addictive disorders showed that most had significant weaknesses that may leave the purchaser at financial risk and consumers at clinical risk (Rosenbaum et al., 1997). These weaknesses can be attributed to many factors. Strong contracts for managed care are intricate and difficult to write. Purchasers must define a benefit package that meets the special needs of diverse populations and then clearly describe the package in specific contract language. In many cases, the purchaser must translate oftentimes arcane regulatory language into precise, legally binding contract provisions. In addition, under a managed care system, the purchaser must address numerous gray areas that are not covered by existing State regulations. Therefore, strong contracting expertise, an understanding of Federal and State laws and regulations, and public input in the contracting process are crucial as purchasers develop contracts that provide effective services and minimize the purchaser's financial risk.

D. Uses and Limitations of This Guide

Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers is intended to provide guidance from both policy and legal perspectives on developing RFPs and contracts between public purchasers and MCOs. This guide is designed to provide *strategies* for managed care contracting efforts but does not *prescribe* how these efforts should be developed. Although targeted primarily toward State and county substance abuse and mental health authorities, Medicaid agencies, and other public purchasers of managed care services, this document will prove useful to treatment providers, MCOs, academicians, researchers, consumers, and other stakeholders who will find that it addresses the most pertinent issues in managed behavioral health care contracting. The reader of this document can gain the following:

Familiarity with designing and procuring, and implementing managed care systems, including a review of options for consideration, problems that may be encountered, and key legal issues;

Knowledge of RFP and contract issues related to sound clinical care, network development, quality assurance, management information systems, financing, and consumers' rights; and

Understanding of the importance of developing a comprehensive set of well-conceptualized and well-written RFP and contract provisions to provide a strong structure for public sector managed care initiatives.

Given the rapid evolution of managed care and the many variations with which States and localities are experimenting, no single approach to behavioral managed care contracting can be recommended for all public purchasers. This guide suggests a number of specific issues that purchasers may wish to consider when developing RFPs and controls for behavioral managed care initiatives. Purchasers are cautioned that this document is no substitute for expert legal and other analytic consultation in developing RFPs and contracts; and it does not eliminate the need for legal, actuarial, or other expert assistance (e.g., clinical matters, organizational public policy) in designing the RFP, conducting the procurement, or negotiating the contract. Purchasers are strongly urged by the project's Development Panel to secure the assistance of legal counsel and of actuarial, financial, and managed care experts throughout the design, procurement, and contract implementation processes.

Managed behavioral health care contracting in the public sector is changing rapidly, and to be responsive to public sector purchasers as the field continues to change, *Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers* is designed as a "living" document. Publishing the guide in a looseleaf modular format makes it possible to periodically update key content areas and contract language to reflect state-of-the-art expertise. In addition, readers will have access to an interactive, electronic version of this guide, located on CSAT's Web site *(www.treatment.org)*.[2]

The electronic version will contain linkages to other Web sites that will allow readers to explore related contracting issues in more depth. Readers will also be able to review contracts developed by public purchasers, exchange information in an online "chat room," and submit comments and local examples of contract-related experiences, which may be included in later revisions of the document.

1. An RFP is a solicitation document issued to obtain offers from contractors that propose to provide products or services under a contract to be awarded using the process of negotiation.

2. Readers may find it helpful to note that specific examples of contract language used in States' Medicaid managed behavioral health care contracts are available through the SAMHSA Web site: *www.SAMHSA.gov*

CHAPTER II

Designing, Procuring, and Implementing a Managed Care System

Key issues in this chapter:

- Designing a managed care system
- Procuring managed care services
- Implementing a managed care system

Although some States and localities permit any managed care organization (MCO) that can satisfy its conditions and is willing to provide care at the purchaser's stated price to participate in their managed care system, others acquire managed care services through a competitive procurement process. In a competitive procurement process, MCOs are selected on the basis of their technical qualifications and the price they charge for the service package. Legal principles dictate that competitive procurements, which may involve tens or hundreds of millions of dollars worth of business, be fair and open.

As a result, competitive procurements create complex organizational and legal tasks for purchasers as they move toward acquiring behavioral managed care services. MCOs treat competitive procurements as an extremely serious legal matter and do not hesitate to challenge a process they consider tainted.

As discussed in this chapter, writing and negotiating a managed care contract is actually one of the later phases in a complex design and procurement process. In most circumstances, the final managed care contract is based on the results of several efforts:

> Preparation by the purchaser of a request for proposal (RFP)--that is, a solicitation document issued to obtain offers from contractors that propose to provide products or services under a contract to be awarded using the process of negotiation;
>
> The submission of proposals by bidders;
>
> Selection of the successful bidder; and
>
> Negotiations between the purchaser and the successful bidder that take place after the contract has been awarded but not yet signed.

Public purchasers of managed care, and the environments within which they operate, vary tremendously, and these differences have a substantial influence on design, procurement, and implementation of a managed care system. The public purchaser itself--for example, the State Medicaid agency or State substance abuse or mental health authority--may have highly variable purchasing power depending on the size, scope, and expenditure level of the program under which it operates. Differences in the local availability of clinical services and financial and staff resources may affect the procurement process. The political environment, population demographics, and geographic factors also affect the procurement process. Thus, each purchaser of managed care faces a unique set of challenges.

This chapter uses an adaptation of the 10-step model developed by the Federal Center for Mental Health Services to address issues at various stages in managed behavioral health care procurement process (Dougherty, 1996). It also identifies some of the types of legal challenges a purchaser may face when developing a managed care system. As illustrated in Exhibit II-1, the 10 steps in the model used to organize the discussion in this chapter can be grouped into three major stages: (1) designing a managed care system; (2) procuring managed care services (includes issuing an RFP, selecting a vendor, and awarding a contract); and (3) implementing a managed care system (includes implementing the contract and subsequent monitoring and evaluation).

Exhibit II-1.

A 10-Step Process for Designing, Procuring, and Implementing a Managed Care System

STAGE 1: Designing a Managed Care System

Step #1: Assemble the development team

Step #2: Develop the initial system design

Step #3: Analyze historical costs and project future costs of the initial design

Step #4: Determine optimal financing mechanisms, payment methods, and financial risk level

Step #5: Build stakeholder consensus

STAGE 2: Procuring Managed Care Services

Step #6: Write the RFP

Step #7: Establish fair and legally sound procurement and evaluation procedures

Step #8: Select a vendor, negotiate issues of contention, and award the contract

STAGE 3: Implementing a Managed Care System

Step #9: Sign, implement, and administer the managed care contract

Step #10: After procurement, monitor, audit, and evaluate performance under the managed care contract

Understanding the tasks and challenges of each stage is essential to designing a clinically sound and cost-effective managed care model, establishing a successful and legally defensible RFP and contract development process, and implementing an effective managed health care system.

A purchaser can expect that political pressures from stakeholders will be brought to bear on the process. Some political pressures are likely to come from within the purchaser's agency and others from external government agencies or officials. There are also likely to be pressures from consumers and their families, local health care providers, and MCOs. A purchaser should weigh the amount of influence each of these entities should have on the design of the managed care system, because politics can irreparably taint the entire managed care procurement process. If adequate safeguards are not taken, political pressures both from within the agency and from outside sources may affect selection of the vendor and allow legal challenges from unsuccessful bidders. Purchasers must carefully monitor the managed care selection process to ensure that no State, Federal, or other procurement laws are violated.

Stage 1: Designing a Managed Care System

Key steps in this stage:

- Step #1: Assemble the development team
- Step #2: Develop the initial system design
- Step #3: Analyze historical costs and project future costs of the initial design
- Step #4: Determine optimal financing mechanisms, payment methods, and financial risk level
- Step #5: Build stakeholder consensus

The first steps for a purchaser in developing a managed care system are assembling a competent development team and developing an initial system design that addresses coverage, service delivery, access, networks, quality assurance, measures of performance, and other key components of the final system. The next steps are analyzing historical costs and projecting future costs of the system design and determining optimal financing mechanisms, payment methods, and risk levels. Soliciting and incorporating stakeholder input, and moving toward consensus, are crucial parts of the design process from its outset to its conclusion.

Step #1: Assemble the Development Team

Assembling a competent development team at the outset of the design process is essential. Team members and other collaborators must collectively bring to the procurement process the appropriate training and expertise to design a managed care system that will best meet the needs of the populations to be served.

Tasks for which the development team is responsible include analyzing financial data and projecting the new system's future costs, establishing financing and payment mechanisms, and proposing strategies for the use and management of risk.

a. Qualifications of the Development Team

Development team members should be carefully selected on the basis of their individual skills and potential contributions. Key attributes include a detailed understanding of the needs of the enrollee population; writing, analytic, and financial abilities; a clear understanding of the opportunities, risks, and challenges inherent in developing a managed care system; an understanding of the needs of the stakeholder community; an understanding of the service delivery system; and the capacity to be absolutely discreet. The purchaser's development team should generally be small--some would say a core of six to eight members--but should be able to call on other individuals as needed. These other experts can be brought into the planning process when they can make an important contribution. Too large a core group will increase the risk of inappropriate disclosures that can taint the procurement process.

The development team should also identify staff members from various agencies with interest or expertise in the services to be purchased. For example, when the purchaser is a State Medicaid agency, the team may immediately want to bring in staff from the State substance abuse and/or mental health agencies because of the relevance of their expertise in the delivery of these services and their familiarity with the organizational and political matters that may arise during the overall process. The team should be given sufficient time and resources to participate in the planning and implementation process.

b. Qualifications of the Development Team Leader

The leader of the purchaser's development team should have a thorough understanding of the purchaser's needs and staff resources and be able to assemble and manage a very strong team. The team leader should be the senior executive of the purchasing entity or another person designated by the purchaser. The team leader has tremendous responsibilities for the success of the procurement. He or she should have managed care experience or extensive training in issues concerning managed care, as well as sufficient authority to shape and lead the development team in issues of importance to the purchaser. Ideally, the team leader either should have a background in procurement law or should appoint a legal advisor to the team at its inception. The stronger the team is in the area of procurement law, the more likely the purchaser will withstand a legal challenge to the procurement, a reality in any purchasing endeavor of this magnitude.

c. Qualifications of Bid Evaluators

Bid evaluators are also critical contributors to the procurement process. The purchaser must rely on the evaluators to assess bidders in a fair and impartial manner and make recommendations to the selection team.

The purchaser will need to know that the evaluators:

- Possess sufficient background and evaluation skills;
- Are free of conflicts of interest in relation to the bidders (and that they have fully disclosed any information regarding their contacts with bidders before and/or during the selection process);
- Are fair and impartial;
- Understand the scoring processes and tools used in the evaluation process;
- Are given sufficient time to adequately evaluate all the bids submitted.

The purchaser should take into account all possible issues that could affect the purchaser's confidence in the bid evaluator panel's recommendations. (These issues are discussed further in Step #7 below.)

d. The Use of Expert Consultants

Expert consultants can significantly increase the chances of a successful process. The team should consider the use of expert consultants who are able to bring a wealth of expertise from other managed care efforts but do not pose a conflict of interest. The consultants should be chosen carefully, and their references and reputations regarding ethics, expertise, and judgment should be thoroughly reviewed. Using consultants does not in any way diminish the knowledge or talents of staff involved with the effort.

e. Legal Precautions

Purchasers who design a managed care system may have little or no direct legal expertise in procurement, but many factors in the procurement process put the purchaser at legal risk. Thus, legal experts are essential to the core team to scrutinize the plan's design and identify any possible legal ramifications of policy decisions.

In a legally defensible design and procurement process, information is shared fairly among all prospective bidders and the process contributes to the procurement of quality services at a fair price. Any failure on the part of the purchaser or purchaser's agents to be even-handed, or any act that raises questions of fairness, can result in a legal challenge. A legal challenge can be very expensive and troublesome for a purchaser even if it is ultimately unsuccessful.

To avoid such a challenge, the purchaser should adopt strict standards regarding how team members, as well as evaluators, expert consultants, and others, may interact with other employees of the purchaser, potential bidders, and the general public. Any contact between the bidder and the purchaser's employees and evaluation team opens the door for legal problems. The purchaser can avoid some problems by setting forth standards for these communications in the RFP and adhering to them strictly. Guidelines concerning communications with bidders should be developed for purchasing agency staff, also. All communications with bidders should be noted, and any information given to one bidder should be given to all. If the procurement is challenged, such documentation will provide support for the purchaser's argument that all bidders were treated equally and fairly.

From the outset, the purchaser should clearly describe the ground rules to be followed by purchaser staff, consultants, and advisors during the procurement process, including situations to be avoided (e.g., paying or accepting payment for meals, gifts over a specified amount, tickets to events) and policies to guide communications with potential bidders and other interested groups. All team members, stakeholders, and consultants should understand and be held accountable for these policies. During the pre-RFP period, prospective bidders often send teams to work in the State and may spend considerable time and money acquainting themselves with all players and potential partners. Because of the large size of managed care contracts, the temptation for prospective bidders to do more than assess "the lay of the land" during this period is very strong. Contacts during this time by the purchaser's staff, consultants, or advisory committee members should be carefully monitored to avoid the appearance or reality of conflict of interest.

The purchaser should obtain complete disclosure from all involved consultants and consultant groups regarding their ownership and any formal and informal relationships to MCOs. A consultant or consultant group that has direct interactions with an MCO should be disqualified. Similarly, a consultant or consultant group that has indirect interactions with an MCO--for example, provides services to a firm designing a management information system (MIS) for the MCO--should also be disqualified.

The development team's membership may change or team members may leave the agency during the design process, and the purchaser should take steps to protect the confidentiality of any relevant material and concepts. These protections may be in the form of confidentiality statements signed by employees or requirements in the RFP for bidders to disclose hiring or any use of a former employee of the purchaser.

f. Use of a Final Design Team

Although team members may change, at some point a final group must be formed to make recommendations to the purchaser on the scope of services and benefits. Forming a final design team with limited membership may help the purchaser guard against conflicts of interest and protect the legitimacy of the procurement process because communications will be limited to a select few.

g. Stakeholder Involvement With the Team

Representatives from relevant public agencies, stakeholder groups other than bidders, potential bidders, actual or potential subcontractors to bidders, and consumers and their families should have the opportunity to provide input during the design phase and to develop a strong stake in the plan. The timing of stakeholder involvement will vary according to circumstances, but it should generally begin very early so that stakeholders understand the rationale behind decisions and the opportunities and challenges of the evolving plan.

Step #2: Develop the Initial System Design

a. Clarifying Objectives

An essential step in the initial design phase is an analysis of the strengths and weaknesses of the current system and the identification of goals and objectives for the managed care initiative. These can be expected to vary according to local circumstances. The goals and objectives of managed care initiatives often include, but are not limited to, the following:

Containing or reducing costs for substance abuse and mental health services;

Privatizing public services or redefining the role of government;

Expanding coverage to new populations;

Improving access to services;

Achieving parity between physical and behavioral health benefits.

Improving the allocation of resources;

Shifting utilization patterns or level of care patterns;

Integrating separate funding or service systems;

Redressing historical underfunding of public substance abuse and mental health services;

Protecting special populations and funding dedicated to these populations;

Correcting financial or managerial corruption; and

Resolving conflicts between government jurisdictions regarding the provision of services, funding streams, populations served, or outcomes measured.

Clarifying the objectives for redesigning or restructuring the existing system requires a systematic assessment of the purchaser's needs and capabilities and the identification of problems and strengths in the current system. The team can then target opportunities for improvement, consider solutions, discuss potential barriers to success, establish measurable short-, intermediate-, and long-term goals, and select indicators to measure success. Because the design of the new system will have far-reaching ramifications, planners should ensure that this phase of the process is not hurried or skewed by political demands. It is equally important that this phase include stakeholders, such as representatives of other key agencies, providers, and consumers and their families.

b. Using Requests for Information (RFIs) To Enhance Design

Purchasers are increasingly using RFIs to solicit input from all interested individuals on the design of the managed care plan--from consumers to providers to other agency heads to MCO bidders. Developing and disseminating an RFI can be a very useful strategy for purchasers in the early stages of the design process. Stakeholders tend to take

a great interest in RFIs and often provide a substantial amount of useful input. Responses to the RFI may offer detailed suggestions about system design and can also help the purchaser anticipate unforeseen problems and opportunities. However, purchasers should consider advice from bidders cautiously and take great care to avoid even the appearance of any impropriety or conflict of interest. (The use of RFIs is discussed further in the section on the "Bidder Qualification Process" in Step #6 below.)

How a purchaser uses the information supplied by outside entities has the potential to lead to a legal challenge of the purchaser's procurement. Designing a managed care system to incorporate or address issues that have been supplied by bidders in responding to an RFI may lead to a dangerous legal pitfall. Should the purchaser make changes in the managed care plan that appear to favor one particular bidder, legal challengers may argue that certain bidders had an unfair advantage. Thus, if an RFI is used, it must be structured to allow the purchaser to receive comments from all interested parties but to reserve final judgment about the comments received until all responses are in--with an eye toward avoiding the appearance of favoritism.

Although an RFI can provide the purchaser with valuable information, the RFI process adds additional time to the design effort. The purchaser should build the timeframe for the RFI into the procurement timetable and cost estimations. Failure to allow for delays that may be caused by this process and attempting to get a managed care system up and running in a shorter timeframe increases the possibility that mistakes will be made. Such shortcuts often set the stage for legal problems.

Step #3: Analyze Historical Costs and Project Future Costs of the Initial Design

Analyzing historical costs to accurately project future costs is a crucial task for the development team, because potential bidders will rely heavily on these projections in developing their bids. Accurate data are necessary for bidders to develop well-informed pricing proposals--unless the purchaser is setting the rates without asking for bids (see below, Step #4). Analyzing historical costs may be difficult because of insufficient data; in traditional systems, individuals are often not tagged by a unique identifier and thus their costs in different systems cannot be determined. The expertise of actuaries or others experienced in analyzing variance levels is necessary to determine whether historical unit cost data can be relied upon for estimating future rates. These analyses generally involve compiling claims data or other reimbursement data from a representative time period.

For programs funded with non-Medicaid funds--for example, with Community Mental Health Services (CMHS) Block Grants, Substance Abuse Prevention and Treatment (SAPT) Block Grants, or discretionary State funds[(1)] -- historical cost data will generally not be available in the same claim-based format as the Medicaid data. To the extent possible, data for programs with non-Medicaid funding should be summarized in a format similar to that of Medicaid data to make it easier to collate. The summaries should be done by staff who can understand the information fields used in other insurance claims, State reports, or utilization reports.

An ongoing effort to gather information in the data collection and analysis phase is needed to assure the development team that the problems identified have been properly understood and that the goal of the initiative is properly targeted. All data related to cost analysis and projections should be checked by several individuals in the field for accuracy and completeness before release. Assistance from actuaries, health economists, or highly trained claims data staff is essential. If the data are inaccurate or if some component is missing, the payment rates will likely be inadequate and could provide the basis for later lawsuits.

Financing and risk in managed care contracting are discussed at length in Chapter VII. One of the points made in that chapter is that there is a continuum of risk-transfer financing models for managed care contracts. The different risk-transfer financing models--including a global budget, capitation payment arrangements, case-rate payments, and fee-for-service payment--apportion the major types of financial risk between the purchaser of managed care and an MCO in very different ways.

Various approaches to establishing capitation payment rates are discussed in Chapter VII. RFPs that call for managed care entities submitting bids to propose a capitation rate generally require claims data that include the number of recipients for each service type by any applicable eligibility category (e.g., families formerly covered by Aid to Families With Dependent Children or Supplemental Security Income recipients); costs; units of services; and any other relevant pricing factors. Determining the number and types of eligible recipients is essential to the establishment of a capitation rate. In non-Medicaid initiatives, where accurate numbers of eligible residents may be difficult to obtain, the number of individuals who are eligible for services can be estimated from census data or from data from epidemiological studies.

The purchaser's development team must understand clearly which covered benefits and services will be included in the contract and which will remain the direct financial and coverage obligation of the purchaser. A Medicaid managed care contract, for example, may cover short-term hospitalization for children with mental illness but not long-term stays; in this situation, some portion of a seriously ill child's hospitalization would remain the direct obligation of the State, because under Medicaid law the child is entitled to medically necessary hospitalization regardless of the fact that the managed care contract covers only a portion of the necessary care. Thus, the State Medicaid agency should retain sufficient funding to pay for these services that are required by law but that are not included in the managed care contract.

The development team also must know the cost per unit of service that is included in the contract. Publicly funded systems have historically paid an all-inclusive rate to many classes of providers. Few data exist about the costs of subcomponents of "bundled" services, which has led to wide cost variations among providers, even when claims data are available. The problem of the bundled rate may make development of reliable rates for managed care impossible until the service can be unbundled and data collected on the cost and utilization of the service subcomponents. Purchasers should consult with actuaries or other financial experts about whether available historical cost data are reliable measures of the cost of future capitation arrangements.

To identify trends in utilization and enrollment reflecting changes in the economy, eligibility levels, and services, it is best to use 3 or more years of data. The more precise the count of covered individuals, the more accurate the cost estimates will be and the more on target the final payment rate is likely to be.

The purchaser should call upon actuaries to ensure the purchaser that the rates to be paid to the MCO are sufficient to support the desired level of utilization in the managed care system and the associated costs. When a large proportion of the data needed to establish payment rates is not current, are inaccurate, or otherwise perceived to be weak, one option is for the State or county to share some of the financial risk with the MCO (see Chapter VII). Another option is to consider methods of financing (e.g., interim payments with cost settlement) other than risk-transfer payment until adequate baseline data can be developed.

Actuarial analyses of historical data must also take into account anticipated savings from implementation of the managed care plan, including reductions in the cost of certain services (e.g., medical/surgical costs) by increasing the availability of another service (e.g., substance abuse prevention or treatment). Oregon officials, for instance, calculated the anticipated savings in medical services that would result from an increase in the availability of substance abuse services, and then used this information to affect actuarial results and significantly improve the priority of substance abuse services in that State's health care reform initiative.

The Inclusion of Service Utilization Data in an RFP

When possible, the purchaser's development team should determine whether there is relevant quantitative information on the utilization of the current health services delivery system and should include this information in the RFP for managed care services. Quantitative information on the utilization of services should include a full set of descriptive statistics if possible, including the minimum value, the maximum value, the values for each percentile (e.g., the value for the 10th percentile; the 90th percentile), the standard deviation of the set of values, and the number of values the data set comprises. Averages can be deceptive if the distribution of values is highly skewed (as is often the case in health care). The average number of outpatient visits across all users may be six--but that number could result from a combination of a large number of early treatment dropouts and an equally large number of clients with high rates of service utilization. The resulting mean would be misleading. Units of service per unit of time is also a useful statistic--12 visits provided intermittently over 26 to 52 weeks (episodic drop-in behavior) are not the same as 12 visits provided in a focused way over 8 to 12 weeks (e.g., intensive outpatient care).

Purchasers should be aware that transferring historical cost data directly into future capitation rates without adjusting for these cost savings can result in overallocation of resources for managed care services, and high profit margins for MCOs.

If key data are missing, or if it is necessary to make too many assumptions to cover missing data fields, then planners should consider adjusting the timeframes of the initiative until adequate information can be developed, collected, and analyzed. One option sometimes used by States and counties in this situation is initially to establish a contract with an MCO or other organization to provide specified administrative services only (ASO) in a contracting arrangement

that passes no financial risk for the cost of health services to the organization providing administrative services (see Chapter VII). Such an arrangement can help institute needed management reforms and permit collection of baseline data for a year or more before some or all system funds are put into a risk-bearing arrangement.

In order to develop a reasonable cost proposal, bidders may find information on the following useful:

Incidence and prevalence of substance use and mental health disorders;

Utilization rates by service type;

Acute inpatient readmission rates;

Length of stay per admission per level of care;

Outpatient sessions per defined treatment episode;

Analysis of utilization patterns, including high users of services and their associated costs;

Descriptions of the demographic, diagnostic, and utilization characteristics of high users;

Analysis and identification of gaps in the treatment continuum, including input from consumers and advocates;

Description of known needs and demands for services;

Designation of clinical and financial responsibility for pharmacy, laboratory, and emergency room costs; and

Identification of service costs that have been supplemented by the following:

- Foundation and other philanthropic sources;

- Federal, State (e.g., Department of Corrections), and local funds and whether or not these arrangements will apply to the MCO;

- Interagency agreements; and

- Identification of barriers to current treatment or planned treatment services (waiting lists, pharmacy integration, exclusionary diagnoses).

Step #4: Determine Optimal Financing Mechanisms, Payment Methods, and Financial Risk Level

The managed care purchaser's selection of financing and payment methods should be decided based on the goals and objectives of the managed care program. A purchaser whose main priority is to increase accountability, enhance quality, and/or improve efficiency, for instance, might establish a flat payment fee and then challenge bidders to compete based on access and quality of care issues. A purchaser whose main priority is to maximize cost savings and strictly control its financial risk, on the other hand, may want to use financially competitive processes and risk-transfer payment systems.

When a quality competition is used alone, (i.e., prices are set and bidders compete on the basis of quality of care), the purchaser must be exceedingly clear about the standards it uses to differentiate one bidder from another because price effectively has been removed as a competitive factor. When the competition includes both price and quality, the purchaser may want to establish clear internal evaluation safeguards so that the award does not automatically go to the lowest bidder. Even in States in which procurement law requires the award of a contract to the lowest bidder, such a law applies only to the lowest *qualified* bidder. This legal caveat permits the buyer to use measures of quality to select its bidder, even when price may be a driving issue. A purchaser using price competition should know from its

actuaries what the lowest reasonable price is and should design a bid evaluation system that makes price only one of several components. When price competition is used, purchasers must recognize that in some systems or for some populations, the chances of obtaining significant savings may be very slim owing to prior cost reductions, the inherent cost of treatment for the target population, or other factors such as extremely low budgets for services.

One of the most substantial challenges for the purchaser's development team is to balance the purchaser's objectives and strategic alternatives with financial incentives that best fit the situation. One method that States have used to solicit price reductions has been to award their default enrollment population (i.e., individuals who are required to select a plan but fail to do so after being given the opportunity to make an informed choice) to the lowest bidder. Other States have used arrangements that have involved the separate bidding of the State's default business.

Step #5: Build Stakeholder Consensus

One of the first tasks of the development team is to create and implement a strategy that solicits the input of stakeholders early in the managed care system design process to build a sense of collaboration and partnership and identify troublesome issues. Any managed care initiative undertaken in the public sector will have a substantial clinical, financial, and political impact on a wide variety of individuals and organizations including the following:

- The public purchaser (e.g., a State Medicaid agency; a State, county, or local substance abuse or mental health authority; an American Indian or Alaskan Native tribe or tribal organization);
- Managed care entities (e.g., managed behavioral health care organizations, HMOs, counties, provider-sponsored organizations);
- Health care providers (e.g., treatment agencies, individual providers, State and county direct service employees, hospitals, nursing homes);
- Consumers and their families (e.g., individuals, families, guardians);
- Consumer advocates;
- Government agencies (e.g., legislative committees, child welfare and special education, social services, corrections, housing agencies, State vocational rehabilitation agencies, State and county substance abuse and mental health agencies); and
- Regulators and policymakers.

If stakeholders such as these are to be involved in basic design decisions, the purchaser must take steps to guard against conflicts of interest, as noted above. MCOs may face serious antitrust consequences if they organize to provide a collective response to a State's request for comments. Involving health providers in the design of the managed care system may raise some of the same conflict-of-interest and antitrust issues that arise with MCOs.

The purchaser's development team may want to create an advisory group consisting of representatives of various stakeholder groups who have the ongoing opportunity to make suggestions, voice concerns, and/or participate in the process of decisionmaking. Some modest financial support may be necessary to involve certain low-income stakeholders. It may also be advisable to meet with some stakeholders separately to discuss issues of concern to them, such as design elements related to children in foster care. When assembling an advisory group, conflicts of interest are natural and inevitable and are best discussed openly and directly.

Consumers and family members or guardians can offer an especially valuable perspective during the early design and planning phase of the managed care initiative. Many consumers and their families have become very resourceful in obtaining information and services on their own because they have all too often encountered a lack of resources, fragmented systems, and providers who are ill informed about their needs. As a result, some consumers and family members may be more knowledgeable about treatments, services, and system problems than are purchasers, providers, MCOs, or other stakeholders. (A more detailed examination of the optimal roles of consumers is presented in Chapter VIII.)

In some cases, achieving consensus from a wide variety of stakeholders about the underlying principles and operations that will guide the managed care initiative is very difficult or impossible. Conducting public meetings or hearings and providing the larger community with an opportunity to comment on drafts of documents is one way to help build consensus. A balance must be struck, however, between ensuring the opportunity for sufficient input and creating unnecessary burdens for the development team. Soliciting input from potential competitors and their subcontractors is particularly challenging since the manner in which this occurs can affect the legality of the entire procurement. Regardless of the methods used to build consensus, purchasers should be cautioned that the failure to solicit early input from key stakeholders in a meaningful way can create very serious problems throughout the design, procurement, and implementation phases. In some cases, lack of consensus has derailed otherwise well-designed programs.

Special Issues Encountered in the Design Stage

The primary tasks of the design stage have been outlined above. In the discussion that follows, issues pertaining to decisions about major aspects of the managed care system design phase are highlighted:

Decisions about eligibility criteria;
Decisions about enrollment strategies;
Decisions about disenrollment protections;
Decisions about what services to cover in the benefits package; and
Decisions about joint purchasing of services (i.e., whether to purchase substance abuse services and mental health services separately or jointly) and decisions about the degree to which managed behavioral health care is to be integrated with general health care (i.e., whether it is to be "carved in" with general health care or "carved out").

Given the current trend toward more integrated systems, it may be advantageous to develop models of managed care systems that will facilitate greater coordination of Medicaid and other funding streams (see discussion of funding streams in Chapter VII). One challenge would be to determine the range of services and level of access that the purchaser would like to provide and then to identify the funding streams that can be accessed when creating that package.

Combining funding streams for managed care initiatives is a very challenging task. The Medicaid program, for example, is subject to numerous statutory requirements that do not disappear simply because a State Medicaid agency decides to use a private contractor to perform some of its functions. In trying to pool funds from two or more sources, consideration should be given to the fact that eligibility rules, enrollment practices, and services covered vary tremendously across different government-funded programs. Also, the statutory and regulatory provisions vary across government programs and are very different from each other and from the provisions governing Community Mental Health Services (CMHS) and Substance Abuse Prevention and Treatment (SAPT) Block Grants (for further discussion, see Chapter III).

a. Decisions About Eligibility Criteria

The criteria that will be used to determine who is eligible for managed care services may be based on a host of clinical, financial, and political considerations that vary in different States, counties, and localities. The development of a managed care system can be an opportunity to establish more uniform policies on eligibility for services to special populations that require access to multiple government-funded programs. The attempt to streamline processes and coordinate care within Medicaid could include a consolidation of access requirements under the direction of a case manager. Targeted case management is a mandatory Medicaid benefit for Medicaid-eligible children and an optional benefit for adults. At the very least, designers will want to ensure the development of policies that promote efficient referral between the managed behavioral health program and other government-funded service delivery systems. Some factors upon which eligibility can be based include the following:

Insurance status;

Diagnosis (i.e., level of functional impairment);

Severity of illness;

Risk factors;

Income and/or asset level;

Age;

Geographic variables;

Specific clinical subtypes;

Disability status; and

Involvement in specified systems or groups (e.g., criminal justice system, child welfare system).

Once the eligibility criteria have been established, it will be possible to develop a thoroughly researched estimate of the number of likely subgroups, the number of eligible individuals in each, and their probable geographic distribution. If the estimated number of eligible persons or their distribution is unacceptable because of cost or other considerations, the purchaser may decide to adjust the eligibility criteria.

The final eligibility criteria and estimate of the size of the eligible population will enable potential bidders to submit informed proposals. Great care should be taken to ensure that eligibility data are as accurate and complete as possible. In some situations, certain eligibility groups may have access to services not available to other groups, for example, when another entity is sharing the cost of designated services (e.g., educational training, social skills training). That may be the case particularly when the same contract is used to enroll Medicaid beneficiaries and persons whose enrollment is sponsored by other programs (e.g., the CMHS Block Grant), because Medicaid beneficiaries may be entitled to a far broader array of services.

Managed Care Initiatives Involving Children's Services

Decisions about the purchase of child, adolescent, and family services are often complicated due to the complex needs of these consumers, and the frequent use of multiple funding streams. In managed care initiatives that involve children's services, the regulation of MCOs is sometimes shared by a collaborative purchasing coalition made up of the government agencies and foundations that financially supported the system of care before managed care was implemented. Thus, for instance, the Federation of Families for Children's Mental Health has advised purchasers to establish interagency agreements that detail protocols for sharing responsibilities and costs related to care coordination for children and families who require access to multiple systems at the same time.

Since 1992, the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) and the Child, Adolescent, and Family Branch of its Center for Mental Health Services have supported the development of community-based systems of care for children with emotional disturbances and their families. In addition, SAMHSA's Center for Substance Abuse Prevention (CSAP) has funded several community action grants that are intended to foster collaboration and cooperation across State and county agencies to prevent the onset of substance abuse among adolescents and their families.

These and related efforts have supported strong coordination and integration of child and family services in locally based comprehensive systems of care. Such services include health care services; services for mental, emotional, and substance use disorders; child welfare services; schools and other educational services; and juvenile justice services. To assist the MCO, governmental agencies, and the provider network gain access to diverse and unencumbered funds that can be used to manage a coordinated system of care for children and their families, the purchaser of managed behavioral health care services may want to consider using an entity skilled in identifying such funds.

b. Decisions About Enrollment Strategies

The development team must decide whether enrollment in managed care can be required, allowed, or prohibited for particular subgroups. Because of the clear financial consequences of providing services to someone no longer eligible for services, it also is important to specify how promptly the MCO can disenroll members.

Eligible individuals can join a managed care plan in person, over the telephone, by mail, or by the recommendation of a designated enrollment counselor. Typically, they enroll in a managed care plan in one of two ways. The first is to enroll in a specific plan and complete the enrollment process within the timeframe established by the State (e.g., 45 days from a designated date). The second, for individuals who enroll late or do not make an enrollment selection, is to be randomly assigned to a plan (autoenrolled) with no personal input into the enrollment decision.

People suffering from severe mental and/or addictive disorders may have substantially greater difficulties than healthier people in meeting a short deadline and therefore are likely to be overrepresented in autoenrolled groups. If these individuals are helped by guardians or caseworkers, they may not have as much difficulty in meeting the deadline.

Dissemination of information about enrollment is critical, and active outreach efforts to enroll eligible individuals should be planned. Outreach may be most needed with populations that are legally vulnerable, such as illicit drug users and drug-addicted women with children.

Default enrollment may increase the chances that individuals actively receiving services for mental or addictive disorders will be forced to terminate treatment because their usual provider(s) is not a member of the assigned plan. Such disruptions in the treatment process can lead to significant therapeutic losses and confusion, increased difficulties in treatment compliance, and uncertain transitions to new and unfamiliar providers.

Purchasers can avoid this problem by adding contract provisions for out-of-plan referral benefits or for highly specific, time-limited transfer activities. In such instances, purchasers may want to develop detailed transition policies for those in treatment, during enrollment or disenrollment, transfers, or at re-enrollment. For example, the MCO could be required to authorize out-of-network payments for a designated period of time for individuals who must continue care while making the transition to new service providers. Purchasers can ameliorate the impact of involuntary default assignments by assigning certain providers or outreach workers to search for individuals who have not made selections, ensuring that every reasonable effort is made to contact them and help them select an appropriate provider.

The child welfare system operates on a no-reject, no-eject policy. Purchasers of child welfare managed care services must be sensitive to the potential impact of the autoenrollment requirement inherent in the statutory mandate to serve and protect all children deemed abused and/or neglected. However, once a child is enrolled in a plan, it is permissible to offer the child different benefits or services intended to protect and facilitate permanency for the child and family in a timely manner.

Another enrollment issue arises when purchasers contract for behavioral health services with more than one plan, providing enrollees with several options for substance abuse and mental health services. When many MCOs compete for enrollees, there may be incentives for adverse selection, meaning that plans may compete for the healthiest people and try to avoid enrolling people with the most expensive treatment needs. This practice is referred to as "cherry picking." It is relatively easy for an MCO to cherry pick among persons with mental and addictive disorders--for example, the MCO could adapt policies to decrease the number of individuals with high rates of mental health care utilization based on the knowledge that the use of mental health services in a year is highly predictive of high levels of physical health service use in that year and of high mental health service use in the next year. Thus, purchasers who develop contracts with several MCOs that will compete for a finite pool of enrollees should create strong protections against cherry picking.

Purchasers must also take into account changes in public policy that affect eligibility and enrollment procedures, such as the new Supplemental Security Income (SSI) eligibility criteria for children, as contained in the Personal Responsibility and Work Opportunity Act of 1996.

Depending on the circumstances, purchasers may want to consider using health benefits managers or enrollment brokers who implement and manage the enrollment function. Examples of the use of health benefits managers are found in Pennsylvania, Massachusetts, Maryland, and Nebraska. If a health benefits manager is used, the prime contract between the purchaser and the MCO should clarify who pays for this service, how disagreements between the MCO and health benefits manager are resolved, health benefits manager responsibilities and restrictions, the

MCO's responsibilities for providing the health benefits manager with information, and the processes by which the MCO and the health benefits manager are to communicate (Horvath and Kaye, 1995). A health benefits manager can reduce cherry picking or other hazards of aggressive MCO marketing and reduce the use of default assignment by actively seeking out eligible individuals and assisting them in making the best choice based on their circumstances.

Enrollment practices should be closely monitored. If significant enrollment problems occur, such as those described above, enrollment may need to be suspended. A suspension option should therefore be incorporated into the contract. Since such a suspension has serious financial consequences for the MCO and service consequences for individuals, this option should be used only if there appears to be no other recourse.

In sum, several issues are inherent in any voluntary enrollment situation. To prevent an MCO from cherry picking, some type of independent entity is often needed to ensure a degree of control over who is, or is not, determined eligible. Care must also be taken when transitioning individuals already in treatment into the MCO provider network. This may require authorization of services with the enrollee's current provider and/or establishment of timelines for transition planning. These strategies can be very important for vulnerable populations to ensure that an individual's condition does not deteriorate because medications or other key services are not accessible during the transition to a new system.

c. Decisions About Disenrollment Protections

Individuals with substance use and mental health disorders need contractual protections from disenrollment because they often receive services through managed care systems that are permitted to disenroll them for noncompliance. Some MCOs have used various operational definitions of noncompliance to contain costs, such as failing to follow instructions, being generally uncooperative, or failing to regularly keep appointments.

The nature of substance use and mental health disorders makes it likely that some individuals who have these disorders will not comply with either general health or behavioral health service requirements. Many consumers with behavioral health problems are noncompliant with treatment due to symptoms of their illnesses or side effects of their medications. Court-ordered clients and other involuntary recipients of care may also be vulnerable to charges of noncompliance.

The incentive to disenroll people with substance use and mental health disorders for cause is great, because these individuals tend to have very high health care utilization rates. Individuals with alcoholism use health care services at two to four times the rate of the general population, and family members of individuals with alcoholism use health care services at a rate two to three times that of the general population.

The purchaser of a managed care system can discourage the clinically unsound practices of disenrolling people with mental and substance use disorders for noncompliance. One way is to require that the MCO obtain the purchaser's approval before disenrollment for cause can occur (this approach was used in Oregon for substance use treatment enrollees). Another way is to offer specialized enrollment procedures for different categories of individuals (such as those currently hospitalized or non-English-speaking individuals), provide opportunities for families to enroll in a plan as a family unit and be eligible for a package of benefits and coordinated case management services, or develop effective stop loss policies or risk corridors (see chapter VII) that place limits on the amount of losses that can occur. The purchasers may wish to contractually prohibit some or all "cause-based" disenrollments initiated by the MCO.

The capacity to offer portability of coverage to enrollees is a critical decision for public purchasers if they wish to minimize disruption in services when enrollees move. Decisions about portability may influence design considerations that affect location of services, such as the choice between statewide and regional networks. (Chapter VIII provides a more detailed examination of disenrollment and contract development options.)

d. Decisions About Covered Services

In addition to determining who is eligible for the program, the development team must articulate clinical and other services to be included in the benefits package. Before this can be done, the purchaser must assess the adequacy of available funding. Furthermore, because managed care adds an extra layer of administrative costs compared with an unmanaged system, there is less funding available for clinical services. Thus the purchaser must analyze the eligible population, expected use patterns, and the costs of supporting those patterns and begin to make fundamental decisions about what types of services to offer and how access to those services will be managed.

This step requires the development of precise service definitions, which may never have been done before, and the inclusion of these definitions in the RFP and the contract. The package generally describes the following aspects of coverage (Rosenbaum et al., 1997):

> The categories and types of covered and excluded services, providers, and populations, including a description of coordination issues between covered and excluded services;
>
> Permissible limits on the amount, duration, and scope of services;
>
> Benefit and service definitions; and
>
> Definitions and standards for determining medical, clinical, and psychosocial necessity and other means of determining eligibility for a unit of service.

The benefit package is the heart of the system. In the case of Medicaid, States remain financially liable for services that are included in the State plan but are not covered in the contract. If services are not described well, MCOs can make excessive profits because they are contractually liable for fewer services than the premium assumes. Poorly described services can also result in unanticipated costs for the State (see discussion in Chapter III). The types and extent of covered services may vary considerably between plans due to differences in existing service structures, regulatory guidelines for units of service (e.g., Title IV-E dollars in the children's system may be used to pay for board and maintenance only), budget considerations, and available funding streams in a given State or county. Requirements attached to funding streams can have a profound impact on the services that can be purchased. See Chapter III for a more detailed explanation of issues pertaining to covered services.

e. Separate vs. Joint Purchasing of Services and "Carve-In" [2] vs. "Carve-Out" Models

Embedded in decisions about which services to include and the criteria for determining eligibility are four options that may have some of the greatest long-term ramifications for the evolving system:

> Whether the purchaser opts to buy mental health services only, substance abuse services only (treatment and/or prevention), or both;
>
> Whether to blend behavioral health services with physical health services in a carve-in (integrated health care) purchase, separate these services from general health care and build a "carve-out" system, or build a carve-out system with planned and effective coordination between medical and behavioral health;
>
> Whether to blend behavioral health services with services from other systems of care in a comprehensive delivery package (e.g., for children and their families); and
>
> Whether or not to carve in, carve out, and/or phase in coverage for specified subgroups (e.g., children and/or families, adults with severe mental illness, all SSI recipients).
>
> Empirical data may drive decisions about those options to some extent, but the four decisions are often largely based on the fundamental beliefs and system philosophies of the development team and other decisionmakers about how health care systems are optimally organized. While an in-depth discussion of these design decisions is beyond the scope of this document, some of the key points for consideration are identified below.

Joint or Separate Purchase of Substance Abuse and Mental Health Services. A far-reaching design decision is whether to combine the purchase of substance abuse and mental health services in the RFP under the umbrella of behavioral health or whether these two specialty services will be purchased separately. Jointly purchased substance abuse and mental health services can be managed very closely as one program or alternatively, managed as distinct and separate programs. Many factors can drive the decision to separate, combine, or coordinate the service packages of these disciplines, including the existing organizational structure of

government, the relative cost of each benefit, political and personal relationships between officials and departments, conceptual viewpoints of leading decisionmakers, the readiness of either system to be effectively managed, and the perspective and strength of advocacy groups (Moss, 1995).

The relationship between the substance abuse and mental health fields is complex. Professionals in both fields often have deeply held sentiments and philosophies about the most appropriate way to structure the functional relationship between the systems. Views can differ substantially with respect to the most appropriate governmental organization structures, treatment philosophies, and optimal business relationships with each other in a managed care marketplace. These views can play a large role in all levels of decisionmaking. There are also substantial differences between the two fields in the areas of health care conditions addressed, the emphasis on treatment and prevention services, and the provider systems used.

A significant factor encouraging greater coordination of services is the large number of persons with co-occurring mental and substance use disorders found in both treatment systems, but especially the mental health system. Results of such studies as the Epidemiologic Catchment Area study of the National Institute of Mental Health and the National Comorbidity Survey suggest that there are approximately 10 million Americans with co-occurring substance use and mental disorders (Regier et al., 1990).

Possible advantages and disadvantages of purchasing substance abuse and mental health services together are listed in Exhibit II-2.

Exhibit II-2.

Joint Purchase of Substance Abuse and Mental Health Treatment Services:

Potential Advantages and Disadvantages

Potential Advantages	Potential Disadvantages
Increased efficiencies in management, administration, financing, and other operations;	Loss of the distinct identity, treatment philosophies, and/or practices of the smaller substance abuse treatment system within the larger mental health system;
Increased use of common information system infrastructures and data elements;	Lack of substance abuse treatment experience/expertise among senior leaders of the combined departments and lack of mental health expertise and training among substance abuse caregivers and counselors;
Fewer incentives for cost-shifting in treating those with co-occurring mental and addictive disorders;	Greater likelihood that those with substance use disorders will be treated by those trained in mental health but not substance abuse;
Stronger and more collaborative political influence for both systems;	Lack of experience, understanding, or focus on substance abuse prevention services;
Greater compatibility with existing structures of managed behavioral health care organizations;	Increased barriers in providing a larger, more diversified benefit package of alcohol and other drug services;
Greater capacity to meet the needs of individuals with a dual diagnosis of a mental disorder and a substance use disorder.	Decreased emphasis on specialized treatment for addiction disorders;
	Loss of distinct cost data for both substance abuse and mental health services.

Carve-In and Carve-Out Models. Purchasers must make decisions regarding the degree to which managed substance abuse and mental health services are to be integrated with general health care. Most often, managed behavioral health care is carved out from general health care and managed care separately. This usually occurs in one of two ways: (1) a purchaser contracts directly with a managed behavioral health organization (MBHO) to manage the substance abuse and mental health services; or (2) full service MCOs subcontract these services to MBHOs.

Officials in New Mexico, for example, wished to foster integration between behavioral and general health care services but feared that behavioral health dollars might be siphoned away to fund general health care. Consequently, they developed a modified carve-in model that requires HMOs to contract with an independent MBHO for the management of behavioral health services but establishes mechanisms to create an impenetrable barrier between general health and behavioral health dollars.

The decision about whether to develop a carve-out model or a more integrated carve-in model is affected by several factors that vary substantially from purchaser to purchaser. These include the general makeup of the existing health care system, the market penetration of managed care, the availability of HMOs or full-service MCOs in the local health care environment, the ability of these organizations to meet appropriately the behavioral health needs of the eligible population, cost considerations, and the opinions and perspectives of key decisionmakers.

It should be noted, however, that a recent survey of 11 large full-service HMOs showed that all but two provided substance abuse and mental health services by purchasing services from wholly-owned behavioral health subsidiaries or independent vendors (Rudd, 1997). Even the two HMOs that provided some services inhouse used outside contracted vendors for Medicaid enrollees. Designers should carefully consider the type and degree of integration desired if carve-in models are being considered, since often the HMO will carve out behavioral health services.

Ensuring that behavioral health services are effectively linked with primary health care remains a substantial challenge in designing managed care systems. Regardless of whether they choose a carve-in or carve-out model, purchasers must develop parameters in the contract that specify any primary care linkages, including performance standards that monitor the degree to which expectations are met. Purchasers opting to buy substance abuse and mental health services using an integrated carve-in model should closely monitor both substance abuse and mental health benefits to ensure that the utilization of these services is comparable to the utilization of physical health benefits provided in the package. Purchasers of substance abuse and mental health carve-outs should devote substantial resources to ensuring that there is an adequate link to primary health care services.

The potential advantages and disadvantages of the carve-in model for substance abuse and mental health benefits are shown in Exhibit II-3; the potential advantages and disadvantages of the carve-out model are shown in Exhibit II-4.

Exhibit II-3.

Carve-In Model: Possible Advantages and Disadvantages[3]

Possible Advantages	Possible Disadvantages
Potential for improved coordination and linkages of general health care and behavioral health services;	Increased likelihood of underfunding and de facto marginalization of substance abuse and mental health services;
Increased efficiency, including simplified contracting	Insufficient experience of HMOs (where carve-ins are

and rate-setting processes; Potential for more integrated, coordinated, and "holistic" treatment of consumers; More achievable and measurable general health care cost offsets that may be more easily reinvested in behavioral health services; Promotion of consumer choice by managed care plans that contract with multiple full-service HMOs; Improved access to primary health care services; Increased opportunity for prevention, early assessment, and brief intervention.	generally found) with services needed by public sector populations; Danger that HMO(s) will base resource allocations for public behavioral health services on inadequate historical levels rather than on clinical need; Tendency of primary care physicians, acting as gatekeepers, to underdiagnose and/or undertreat addictive and mental disorders; Significant portions of dollars assigned for behavioral health services may be inappropriately diverted to fund physical health care needs; Primary care physicians may be inexperienced in screening for, assessing, and/or treating addictive and mental disorders.

Exhibit II-4.

Carve-Out Model: Possible Advantages and Disadvantages

Possible Advantages	Possible Disadvantages
Increased ability to meet the complex needs of individuals requiring specialized treatment for mental and addictive disorders; Dedicated funds for behavioral health services can establish a "floor" for spending and protect funds from diversion to general health care; Predictability of spending for behavioral health services; Increased confidentiality in practice because clinical records, billing systems, and treatment systems are separate from those of general health care systems; More specialized services designed explicitly to meet the needs of the target population; Usually a greater level of clinical experience and expertise regarding the prevention and treatment of mental and addictive disorders.	Decreased capacity to coordinate and link behavioral health services with general health services; Greater administrative costs than if administration was combined with a larger health care organization; Unavailability of onsite, naturally occurring cross-training opportunities; Greater likelihood of consumers' being limited to a choice of one or just a few plans; Possible limitations on access to innovative, more costly medications if the pharmacy benefit is covered in a separately managed primary health contract; Increased ambiguity regarding how to fund laboratory and pharmacy services, when and how to assign risk for these services, and how to establish clear accountability; Increased coordination and linkage problems for more complex cases where various case managers and services may be involved; Greater likelihood of consumers not following more complicated referral procedures.

Stage 2: Procuring Managed Care Services

Key steps in this stage:

- Step #6: Write the RFP
- Step #7: Establish fair and legally sound procurement and evaluation procedures
- Step #8: Select a vendor, negotiate issues of contention, and award the contract

The procurement of managed care services is likely to be a highly politicized process and is a complex legal process. A procurement process that is smooth, includes all viable bidders, and is legally defensible will lead to the development of a sound contract and a high-quality managed care system. In this stage of the process, it is especially important that the purchaser's team leader make every effort to control team members' communications with others and to avoid conflicts of interest and the appearance of such conflicts.

It is also important that the procurement process conform to applicable laws and regulations. All States must comply with relevant Federal laws, but each State has specific requirements--such as general purchasing rules and required contract language--that will affect the development of the RFP and contract provisions and, in many cases, the entire procurement process. State insurance and HMO regulations, which vary widely, may also dictate the structure and content of the RFP and contract. These laws and regulations often address fiscal solvency, network requirements, reporting requirements, certificates of authority to operate within the State, and so forth. Other laws address consumer protections, such as specific grievance procedures, marketing rules, definitions of emergency care, and quality of care issues.

It is essential that planners ascertain relevant State requirements early in the process of planning a managed care initiative and that any necessary amendments to State law be accomplished so that they can be reflected in the RFP and finalized before contract startup (Horvath and Kaye, 1995; Rosenbaum et al., 1997). Planners should also assess the need for changes in legislation and/or regulations that will make desired reforms possible. New legislation is often necessary for Medicaid waivers, changes in procurement, licensure, or government personnel approvals before it is possible to implement the changes planned.

Step #6: Write the RFP

The requirements spelled out in the RFP form the philosophical and operational basis for the contract, while simultaneously protecting the clinical, legal, and financial interests of the purchaser. A study by the National Alliance for the Mentally Ill clearly showed that there is a great need for carefully constructed RFPs (Huskamp, 1996). Bidders tailor proposals specifically to the RFP requirements, and RFP responses may well become attachments to the managed care contract. (Sample specifications, characteristics, and components contained in a standard RFP are presented in Appendix A.)

A clear definition of the reform goals planned for under the contract and the problems to be addressed should be clearly stated in the RFP. Because the primary purpose of an RFP is to generate sufficient information to facilitate selection of the best bidder(s) to manage enrollee care, a primary objective of any RFP is to define a system that is reasonable enough to attract a sufficient number of responsible, qualified bidders. The RFP should outline financially reasonable terms that address the legitimate interests of all parties. Neither the purchaser, the MCO, nor consumers win if competent companies don't bid because the program requirements and/or RFP terms are seen as unreasonable, or if the contracted MCO becomes financially unable to meet enrollees' needs because of inaccurate data in the RFP. Although the contract must protect the legal rights of the purchaser, the goal is not necessarily to gain complete legal advantage over a vendor or over other types of outside or internal partners. One-sided RFPs and contracts may not attract desirable bidders.

Procurement Proceedings

If a State administrative procedures act does not provide for review of the purchaser's procurement proceedings, and if Federal money is used for the managed care plan, the Federal Administrative Procedures Act, and potentially the Medicaid statute itself, give bidders a cause of action to challenge the award made by a State. A purchaser should review the provisions of the Federal Administrative Procedures Act to ensure that all guidelines are followed before undertaking a procurement. There is a substantial case law that interprets both the Federal acquisition regulations and the Federal Administrative Procedures Act. A purchaser should consult legal counsel to address these acts and regulations that may affect the procurement process. A subsequent box highlights influential cases in which State procurements were challenged by losing bidders.

a. State Bidding Procedures

Prior to final design of the managed care program, a purchaser should review State bidding procedures to ensure compliance. For example, State law may address required preferences for minority and small businesses. State law may also address preferences for "home State" businesses. Purchasers must review all aspects of the bidding procedure to ensure that any required preferences or scoring techniques are followed. This includes a review of any legislation that may relate to the selection process. A purchaser should be mindful of legislative directives, as dissatisfied bidders may use legislative language to try to prove that a procurement did not proceed according to State directives.

b. State Administrative Procedures Act

Bidding procedures that are affected by State law may be subject to a State's administrative procedures act, which ensures that State functions are carried out in accordance with concepts of due process. Generally, a State's administrative procedures act may permit judicial review of discretionary acts (i.e., procurement) performed by a State agency. If the procurement conducted by the purchaser falls within the confines of discretionary acts, it may be subject to judicial review.

A legal challenge of a procurement based on a State's administrative procedures act may lead the court to examine whether the procurement conducted by the State agency was conducted arbitrarily or capriciously. In the context of this guide, the term "arbitrary and capricious" refers to procurements in which the standards to be applied were either unclear or unfairly applied or the process was tainted by conflicts, or both. The result is considered arbitrary and capricious because the standards were meaningless and/or because the process was unfair. The court may also examine whether the purchaser can produce adequate evidence to substantiate the selection of a particular vendor. Thus, the purchaser must fully document procurement procedures and selection criteria to ensure sufficient evidence to support its final decision.

c. Federal Procurement Law

If a purchaser is using Federal money to operate the managed care plan, not only State procurement laws but Federal procurement laws may apply. Special Federal acquisition regulations from the *Code of Federal Regulations* should be referenced by the purchaser.

d. Precision and Specificity of the RFP and Contract

Determining the optimal level of detail in the RFP and contract is a fundamental decision for the purchaser. At one end of the spectrum, purchasers may wish to be very prescriptive in order to clearly convey in objective, measurable ways their expectations of the MCO. Some argue that, in the attempt to prevent the MCO from inept or avaricious behavior, this level of prescriptive detail will eliminate creativity or input from the MCO. If the RFP is too detailed and prescriptive, the responder need only "parrot" the questions in their response. Those advocating for more broadly worded contracts believe that the customer would be better served by engaging the services of a legitimate and ethical MCO and then working out the details of the program collaboratively.

Some purchasers may want one RFP process that leads to two contracts with the selected MCO in order to prevent the RFP from being overly detailed and prescriptive. One contract period would be for planning and development and

the other for operations. To be most helpful, the RFP should describe particular programmatic and policy issues that the purchaser has identified. Formats that request the responder to delineate a plan to deal with the programmatic and policy issues provide the opportunity for vendors to differentiate themselves for the customer.

The purchaser's critical task is clearly to articulate specifications of overriding importance and to include with each of these specifications a mechanism for measuring the MCO's performance. When the State/purchaser does not have sufficient information to give precise direction to its contractor, it is perfectly acceptable to permit the contractor to develop its own approach, as long as the purchaser understands that in such a situation it is effectively defaulting to the industry or contractor standard. For example, a purchaser may want extreme clarity about which services are covered and which are not. On the other hand, the purchaser may elect to give the seller broad latitude to select the provider network.

Case Histories in Managed Care Procurement

Possibly the three most influential cases involving a State's procurement of managed care occurred in Ohio, Iowa, and Colorado. There have been challenges in other States (Wyoming, Colorado, Massachusetts, and the District of Columbia, for example), but the Iowa, Ohio, and Colorado cases address topics of concern to all potential purchasers, especially since they are reported cases that may be used by both purchasers and bidders in support of their respective positions. When the purchase of managed care services includes Federal dollars, the purchaser also should be aware of all Federal regulations that govern procurement processes. A key regulation is Part 74 of 45 C.F.R., which requires "free and open competition of the procurement." This regulation was found applicable in a successful court challenge in 1996 in Iowa and in 1997 in Ohio.

Ohio case--In the Ohio case, *Value Behavioral Health, Inc. v. Ohio Department of Mental Health* (966 F. Supp. 557 (S.D. Ohio 1997)), one of the Nation's largest managed behavioral health care organizations (MBHOs) challenged Ohio's selection of a partnership involving another large MBHO. The Ohio decision is important as it appears to support the proposition that a bidder may have a Federal right of action to challenge a procurement and is not limited to State-created remedies. The court held that potential contractors have a Federal right to expect a fair process when a Medicaid contract is let and thus, when the process used by the State was alleged to be unfair (in this case the record suggested *ex parte* communications), the aggrieved bidder could claim a right to Federal review of the State's procedures. This case is also an important tool in teaching purchasers what types of communications may be allowed with bidders prior to finalization of a contract, including contacts after the vendor has been selected but has yet to sign a contract. In this case, the dissatisfied bidder alleged that the preliminary winner was permitted to alter elements of its bid to bring its proposal into conformity with the State's expectations. A lesson learned from this court action is that contact after the award but prior to finalization of a contract should be limited.

The MBHO's suit against the state, currently under appeal, was successful in overturning the award. As a result, the Ohio project has been suspended and neither company is managing the care. This Ohio case is significant as it created a Federal cause of action, opening the Federal courts to litigation from disgruntled bidders for Medicaid contracts. The ruling also required that a Federal monitor oversee future State procurements in all areas of State business. Twenty-four States have joined Ohio in the appeal of this decision.

Iowa case--The Iowa decision provides insight about conflict of interest and scoring techniques. *MEDCO v. State of Iowa* (553 N.W. 2d 556 (Iowa 1996)) involved the State's use of a managed care consultant who had a conflict of interest (ownership by the same company that owned a bidding MCO). Even though the consultant recused itself, the fact that the State used a different consulting group suggested by the disqualified consultant was sufficient to taint the process. In addition, the case involved issues that emphasize that a purchaser must be certain that any scoring tool adequately reflects the capabilities of the bidder as it relates to the specifications of the RFP. Likewise, the purchaser must be certain that the scoring of any such tool by evaluators adds up as the evaluator indicates.

Colorado case--While State laws differ, conflicts of interest concerning procurement may be affected by Federal law. An interesting case concerning conflicts of interest took place in Colorado (*QualMed. Inc. v. Office of Civilian Health and Medical Program of the Uniformed Services*, 934 F. Supp. 1227 (D.Col. 1996)). The results of this case show that a bidding entity must also take all reasonable steps to mitigate conflicts of interest. Further, a bid must be evaluated based on the merit of the proposal and its consistency with the evaluation criteria.

If the purchaser negotiates with a vendor to fill in gaps or address issues that should have been included in the RFP during the negotiation phase, there may be legal impediments to the addition of services to the vendor's bid. If the purchaser negotiates for more or different services than originally outlined, legal challengers may argue that the purchaser did not follow procurement guidelines or the law.

RFPs that provide detailed program definitions, specific contractor requirements, and expected outcomes will more readily be incorporated into the contract. Because the RFP and the proposal submitted by the winning contractor are often wholly or partially incorporated into the contract, the importance of these documents should not be underestimated. In some cases, the RFP, with the proposal and other attachments referenced, becomes the contract itself (Rosenbaum et al., 1997). In such cases, the contents of the RFP should explicitly mirror the contract that purchasers expect will eventually be signed.

The RFP must specify the format and content of the proposal. In general, the RFP must provide a clear and detailed picture of the evolution and structure of the health care system, the short- and long-term goals of the new managed care program, the population(s) to be covered, and the values that underlie the public system. It must be comprehensive and include detailed descriptions of eligibility and enrollment of consumers, access requirements, the nature of the program, the scope of the benefit plan, and consumer rights. It also should outline the processes to be followed in terms of managing utilization and quality, standards for the provider network, the system of grievance and appeals, and how claims are to be paid.

The purchaser must outline the methods and standards for payment of the contractor, including rate-setting methods, requirements for the management of funds, and banking and accounting requirements. Measures of performance should be included with each specification, and the contract should have rules that impose intermediate sanctions in nonperformance. In addition, the purchaser must define the minimum qualifications of the contractor, including financial condition, independence requirements, licensure, and other experience. This definition is necessary because the firms in this industry change so frequently that information that is valid one month may easily be out of date the next. In addition, there should be provisions concerning what should happen if there is a change in vendor ownership. Some purchasers, to protect the consumer and the public trust, may wish to define allowable limits on profits and/or to establish guidelines for how a defined percentage or amount of profits are to be reinvested in the system.

The RFP should also include definitions and levels of service and should indicate the expected timeframe and transition requirements for implementing the program. It must also describe the process by which some bidders are asked to submit their "best and final" offers if these are allowed in the State; this process must be carefully documented and able to withstand a legal challenge. Purchasers must understand that some private sector firms are accustomed to substantive, last-minute financial negotiations done in the purchaser's best interest. In the public sector, the opportunity for such changes usually must be provided to all finalists and not just to one favored entity, as is often done in the private sector. Vendors who have been selected for best and final offers will generally not press for equitable treatment of their competitors; ensuring fairness and even-handed treatment is the responsibility of the purchaser, as several State courts have found.

The development team should use the most knowledgeable staff and/or consultants available to form a writing team for the RFP. This often involves a chief drafter and a small group to review drafts and provide comments and input. After a thorough review of model contracts, RFPs, and other State procurement documents, the writing team should begin by developing a general outline for the RFP subject to review and approval by the development team. Stakeholders may also be allowed to provide input on the outline and/or language at this early stage of the process. Consultants with expertise in RFP preparation and other skilled writers are potential resources that the purchaser should use wisely. Because the RFP is often incorporated into the contract, RFP provisions should be drafted in precise language that is not subject to different interpretations. Attorneys can be helpful in this drafting process. However, the State must take care to fully brief any writers or consultants on all of the key decision points, if these individuals have not been part of the planning process. Purchasers may also find it useful to write the RFP and the draft contract at the same time. Any contract language required in State or local regulations should be included in the RFP, including requirements for Medicaid (if applicable). Contract requirements for Medicaid-covered services are outlined in the applicable Medicaid regulations (45 C.F.R. Part 74) and are further described in the Medicaid Manual in Section 2087. These sections should be reviewed for possible inclusion in RFPs and resulting contracts.

e. Bidder Qualification Process

As discussed earlier in this chapter, prior to issuing the RFP, it is often advisable to issue an RFI for review and comment by all interested parties. One purpose of this short evaluation is to ascertain the number of interested

bidders and to develop a mailing list of qualified bidders. Thus, the purchaser must decide how to qualify bidders. Ideally, key stakeholders should come to a consensus on these criteria. Bidders who fail to meet qualification criteria via the RFI process should be acknowledged but excluded from the bidding process. Failure to conduct the RFI process may lead to an excess of unacceptable proposals to evaluate and costly use of staff or consultant time. Some State vendor selection processes that have ended in litigation could have been solved by eliminating some less qualified competitors at the outset. Qualification requirements have been widely used in the private sector and include organizational features such as the following:

Auspices (for profit or not for profit), independence, and ownership;

Geographic location;

Minimum financial disclosure/financial resources baseline;

Minimum years in operation;

Acceptable references from key clients in similar States;

Minimum size, including covered lives, network size, and revenue;

Minimum management information system capability;

Acceptable audited financial statements;

Accreditation;

Evidence of current liability insurance and history of malpractice litigation;

Minimal prior litigation history; and

Evidence of stable organizational leadership and ownership.

Managed care vendors that pass these tests and sign confidentiality and conflict-of-interest statements can safely be sent RFPs. Although potential bidders frequently ask for exceptions to allow them to enter the process after it has begun, such exceptions should rarely be made.

f. Letters of Intent and Transmittal

Submission of a letter of intent to compete in the RFP process should be a prerequisite for the submission of a proposal if this is part of the established process in the State. The letter of intent provides the purchaser a written opportunity to:

Identify all potential bidders;

Manage all contacts by potential bidders with officials within the agency; and

Produce accurate records of distribution of material from the purchaser to the bidders.

The letter of intent must have an original signature. Depending on State law, proposals may not be accepted from bidders who fail to submit a letter of intent by the date established in the RFP. The letter should contain the bidder's name, title, mailing address, telephone number, statement of intent to compete for the contract, and authorizing signature. Senior team members should be available throughout the entire process to answer procedural questions.

In addition, each bidder's transmittal letter should contain assurances for the purchasing agency. (The recommended statements and assurances that a bidder's transmittal letter should contain are presented in Appendix B of this guide.)

Step #7: Establish Fair and Legally Sound Procurement and Evaluation Procedures

a. The Selection Committee

The selection committee that reviews the submitted proposals should be small enough for effective functioning and may include key internal staff, representatives from the appropriate State (or county) substance abuse and mental health authorities, consumer and family representatives, and outside consultants. This committee is usually chaired by the manager responsible for program operations or a designated senior staff member. The selection committee's responsibilities and goals may vary but may include selecting acceptable and unacceptable candidates, ranking of acceptable applications, identifying strengths and weaknesses, conducting orals, reviewing references, development of a unanimous recommendation, and/or making recommendations to the decisionmaker. Although often there are pitfalls associated with outside evaluation, the existing stakeholder advisory group or a similar group can provide input to the selection committee. Caution should be exercised because some of those who offer input may be providers associated with the MCO or others with conflicts of interest.

The purchaser may wish to consider liaisons with other government agencies. For example, a child welfare liaison may be needed to ensure the adequacy of MCOs' plans with regard to care coordination pathways for children and families involved with both the child welfare department and the Medicaid managed care program. This decision is particularly critical for States in which some child welfare services have been paid for with Medicaid funds. In such cases, there is a need to ensure continuity in the content and range of services, and these design issues are probably best reviewed by a child welfare professional.

b. Validity of Tools Used in the Evaluation Process

When the selection committee is charged with recommending and/or selecting the successful bid, the validity of the evaluation tool, analysis guidelines, and scoring process is critical. These tools should be developed and published before the RFP is issued. In particular, the evaluation tool is critical in determining the successful bidder. The tool should be designed to fairly and adequately score the bids submitted. It should not be so complicated that the evaluation panel cannot understand and use it. During the RFP process, the development team should have the evaluation tool reviewed by appropriate legal and technical experts. Generally, rankings and scores on specific areas of a bidder's proposal should be based on consensus score; individual scoring should be used only for notes and planning purposes.

Evaluators should be instructed to keep exhaustive notes so that their ratings of bidders can be understood and compared for uniformity of approach. For example, when evaluators rank one bidder high and another low on network, their notes should reflect what was meant by a "good" network (e.g., many providers located in areas of high need, an adequate array of specialists, the inclusion of network members with special skills in treating non-English-speaking members). Evaluators should receive exhaustive guidance from the purchaser regarding the criteria they will be expected to apply in evaluating each element of the contract.

All notes and documents created during the selection process, such as ratings, rationales, advisory presentations, and areas of disagreement when unanimity cannot be achieved, should be kept and presented to the director of the purchasing agency. These documents should be reviewed for accuracy by legal counsel as well as procurement staff and should become part of a permanent record. Purchasers should be aware that some RFPs and Federal and State laws allow for a review by the purchasing agency of the decision to select a particular bidder. This also allows a dissatisfied bidder to review the agency's decisionmaking process. In the bidder review, all applicable administrative procedures used by the purchaser may be subject to scrutiny, and score sheets, evaluation tools, and even personal notes may be accessible to an unsuccessful bidder.

c. Conducting a Fair Procurement

Litigation challenging the legality of procurement processes is becoming increasingly common (see "Case Histories in Managed Care Procurement" on page 39). Because purchasers usually select only one vendor in a procurement, competition between MCOs can be intense. Many MCOs are attempting to establish or strengthen their market position. Moreover, proposal development by an MCO is very expensive. Consequently, losing bidders may have

multiple incentives to litigate if they believe they have any chance of success. If they are successful, they may be awarded the contract or at least have another opportunity to compete if the contract is rebid. In addition, the ability to delay a competitor's startup may enhance their own market share. In a Medicaid procurement process, the legal implications of program design center on "free and open competition" as discussed in the Federal acquisition regulations (48 C.F.R. §9.504).

The procurement process is not completely quantifiable, and where there is room for interpretation, there is room for challenge. MCOs are under tremendous financial pressure to win contracts, and challenging a contract award can result in a profitable reversal of a decision. As noted above, unsuccessful bidders in several States (e.g., Iowa, Montana, Colorado, and Ohio) have challenged the legality of the procurement process for Medicaid managed behavioral health care contracts. These challenges have led to costly litigation and delays and project revocation. In finding reasons to challenge the process, aggressive MCOs can often capitalize on State officials' relative lack of knowledge, expertise, and skill in conducting procurements of this magnitude. The fundamental lesson learned in these various lawsuits has been the need for using well-trained staff and precise procurement procedures from the beginning of the process.

Avoiding Lawsuits: Ensuring a Fair and

Legally Sound RFP Procurement Process

The RFP should be carefully written and reviewed by knowledgeable persons outside the writing team to ensure that it does not inadvertently contain features that would bias the selection process.

The RFP should designate an issuing officer, the only person a bidder or potential bidder may contact once the RFP is issued. Unauthorized contacts should lead to enforceable disqualifications.

The RFP should restrict how long communication can continue during the procurement process by announcing an end date for communication between bidders and the issuing officer.

If the issuing officer is successfully challenged, a fully briefed understudy must be available to take over.

The purchaser must establish standard protocols for contacts and document all contacts between each bidder and the issuing officer.

It is usually important to involve unbiased outside consultants in the vendor evaluation and decisionmaking process (subject to the same procurement requirements and conflict-of-interest provisions as the rest of the parties involved) to ensure that the team has a sufficient knowledge base related to managed behavioral health care, contract negotiation, actuarial issues, and general financial expertise.

Conflict of interest should be concretely and specifically defined in all documents and vendors should be made aware of the definition and of the State's requirements.

Even the appearance of any conflict of interest on the part of any key participants in the process, including State staff, advisory committee members, and/or external consultants must be avoided.

All individuals involved with key decisions should sign conflict-of-interest disclosure forms before they are involved in the process. Staff or committee members who are found to violate the conflict-of-interest requirements must be removed before final procurement decisions are made if litigation is to be avoided.

The schedule of all events, including a bidders' conference, should be announced well ahead of time to allow adequate time for responses.

The team should ensure that only designated staff or consultants are available to respond to questions raised

following the bidders' conference.

A summary of the bidders' conference with detailed written responses to the questions asked should be promptly forwarded to all those who attended.

The purchaser's intent should be clear from the outset regarding selection of one or more bidders to negotiate with and the extent to which proposals may be modified during negotiations, such as best and final offers.

Strict confidentiality about the evaluation process should be maintained, unless information is broadly distributed.

All known procedural requirements found in statutes, regulations, or the RFP itself should be strictly adhered to, including the use of State procurement agencies or officers/auditors normally involved in large purchases.

The purchaser should generally assume that any RFP award will be challenged. Such an assumption will encourage scrupulous behavior and ensure that the purchaser seeks early and ongoing legal advice.

Step #8: Select a Vendor, Negotiate Issues of Contention, and Award the Contract

Once a bidder has been selected, a number of issues must be addressed before the contract is finalized. Most are related to reconciling the RFP, the MCO's proposal, and the frequently divergent "understandings" that have developed between key individuals but not recorded. The resolution of these and other issues can lead to best and final negotiations that usually take 1 to 2 months, sometimes longer. Best and final negotiation parameters should be clearly addressed in the RFP, because legal issues abound when bids or the RFP are altered. These negotiations may or may not be possible depending on the procurement laws in the State. When not allowable, it is possible to build a "clarification process" of technical issues before award of a contract. For instance, before the award, the purchaser can require oral and written clarification of technical issues or a carefully planned visit to a site where the MCO is operating to observe operations and/or discuss issues.

Any final negotiations should ensure that the contract between the purchaser and the MCO provides a solid clinical, operational, and legal foundation upon which the managed care system can be built. All responsibilities identified and agreed to by both parties should be precisely described, because legal disputes between the contractor and the purchaser will be decided on the basis of these provisions and will generally hold the drafter (i.e., purchaser) responsible for clarifying its requirements (Bazelon Center for Mental Health Law, 1995; Horvath and Kaye, 1995).

To support the contractor's adherence to the implementation schedule and a smooth transition, detailed objectives and requirements should be included in the RFP, the contractor's proposal, and the contract. Contractors usually begin work immediately in order to be fully operational in a relatively short time. The purchaser should allow at least 3 to 4 months from the contract award before operations formally begin. In anticipation of a signed contract, memoranda of understanding between the purchaser and the contractor are sometimes developed to provide a formal understanding of preparation processes and activities (e.g., development of management information systems, staff recruitment). The purchaser and the contractor should assign project officers to conduct activities during the implementation process. It may also be useful to place performance guarantees around the efficiency of the contractor's implementation process. Doing so, however, assumes that State personnel have fulfilled their scheduling and resource commitments to the contractor.

In general, the managed contract should achieve the following goals:

Form an operational basis for the relationship between the purchaser and contractor;

Define the specific responsibilities of all parties;

Establish clear standards for the discharge of these responsibilities;

Establish incentives for performance and sanctions for noncompliance;

Define and establish the payment mechanism(s);

Establish the financial basis for the relationship, what will be delivered, what will be paid, and under what schedule;

Delineate the goals and philosophy of the program, as well as its key operational and policy components;

Provide structures to resolve disputes, enforce contract provisions, and apply damages;

Protect the rights of enrollees and providers;

Establish a timetable for discharge of key responsibilities during the implementation period, including appropriate incentives and sanctions tied to deliverables;

Establish organizational and staffing requirements;

Establish a process for operations;

Establish a set of performance measures and minimum standards;

Establish specific fees for specific tasks, as appropriate; and

Specify requirements for making the system culturally accessible.

The remaining chapters of this document discuss options for meeting these specific goals.

Stage 3: Implementing a Managed Care System

Key steps in this stage:
- Step #9: Sign, implement, and administer the managed care contract
- Step #10: After procurement, monitor, audit, and evaluate performance under the managed care contract

Step #9: Sign, Implement, and Administer the Managed Care Contract

A purchaser should not underestimate the challenge involved in implementing a managed care system. Multiple activities must occur to prepare for the transition.Before proceeding, however, a purchaser should consider any events that may have changed the landscape since the RFP was developed. For example, if any health care legislation was implemented during that time that affects eligibility, the purchaser may want to renegotiate expectations about enrollment and claims targets. It is essential that any renegotiation consideration be informed by legal counsel, as this may put the entire procurement process into question and invalidate the selection. The purchaser should consult with its peers, such as those in child welfare, to clarify relevant issues prior to implementation of a managed care initiative.

During the first weeks and months of the managed care initiative's implementation, the purchaser will be setting a precedent for the manner in which it will handle its relationship with the MCO. For that reason, it is important to manage the implementation process thoughtfully. Weekly project management meetings in which problems are discussed and deliverable tasks are assigned and monitored can provide a solid framework upon which to build the relationship.

Like the RFP, the contract should include detailed implementation plans. The bidder's response to the RFP regarding program implementation should provide a useful plan of tasks and timeframes for making the transition to the new system. In addition, bidders should be required to provide a detailed and specific workplan when they become finalists. The purchaser should examine each bidders' workplan to determine its feasibility and reasonableness, and the purchaser should then provide input and convey acceptance of a final workplan in writing. The most immediate tasks faced by the MCO may include adaptations to the existing claims system; grandfathering of existing contracts; development of a deliverable schedule; development, refinement, or expansion of MIS capacity; and recruitment or reassignment of staff.

Although the responsibilities and timeframes for the transition period should have been covered by the RFP and the successful bidder's response to the RFP, there is sometimes a need to develop a written agreement during the transition from award to contract signing. As mentioned earlier in this section, a memorandum of understanding with the MCO can provide the necessary legal framework for implementation preparation to begin while the details of a contract are finalized. The memorandum of understanding should summarize key points of agreement and include the stipulation that the MCO covers startup costs if negotiations fail. Points of contact should be identified by both the purchaser and the MCO, including project officers who are authorized to bind each party to agreements and decisions. Some States see startup costs as an investment made by the MCO. In these cases, the State's payment is in the form of capitation only after the program is operational. The rationale behind this model is that it provides a very strong incentive for the MCO to get the program up and running. A memorandum of understanding should be carefully reviewed by legal counsel as it is a binding contract and can create substantial problems if no contract is finalized.

During negotiations, the purchaser may choose to revisit the issue of staff credentialing and to monitor the hiring process to ensure that the MCO staff reflect both the anticipated level of competence and the diversity of the population being served. This is the time to make sure that specialists, in areas such as child and family, and substance abuse are on board or being pursued by the MCO. To ensure continuity of coverage for enrollees during the transition to the managed care plan, purchasers may direct MCOs to develop and utilize short-term provisional contracts with current providers as needed to allow sufficient time for contracting and credentialing and to facilitate smooth and clinically appropriate transitions for consumers.

Preoperational tasks include developing educational materials for recipients (consumer and family advocacy organizations such as the Federation of Families for Children's Mental Health [FFCMH] and State-level affiliates of the National Alliance for the Mentally Ill [NAMI] can assist); establishing a provider network; developing training and instructional materials for providers and their staff; establishing and testing of the enrollment process; installing a management information system (MIS); installing telephone systems; establishing intake and referral procedures, and hiring and training staff.

Other tasks and deliverables that can be undertaken at this time include the following:

Making final decisions about MCO staff;

Testing functions and features of the MIS;

Making final decisions about software used to analyze geographic access to services based on population distribution;

Performing a readiness review to look at staff, enrollee services, the claims processing system, and the ability to transmit data to the purchaser;

Developing written material such as consumer-reviewed enrollee handbooks , marketing information, and provider handbooks; and

Preparing reports on ongoing meetings between the MCO and the purchaser and other key groups (i.e., CEO meetings, marketing staff meetings, medical director meetings, advisory group meetings, and chief financial officer meetings).

A file of deliverables, recorded receipt dates, and completion levels should be maintained throughout the project. This record should be set up as the repository of all materials that might be relevant if the purchaser wants to implement penalties for inadequate performance or, in severe cases, terminate the contract.

Step #10: After Procurement, Monitor, Audit, and Evaluate Performance Under the Managed Care Contract

Three different and distinct activities are crucial in the postprocurement review period: monitoring, auditing, and evaluating. Each of these activities has a different but essential role in the review process. (Monitoring and quality assurance issues are discussed at greater length in Chapter VI.)

a. Monitoring

Necessary formal monitoring strategies include regular reporting, formal and informal site visits, ad hoc requests for information from the MCO, and information gathered from staff providers and external agencies. Formal monitoring meetings or visits should be scheduled in advance and focus on specific areas of project performance. The purchaser should use these processes to set a clear precedent for the MCO to expect followup on deliverables and a sharp focus on completing tasks in a timely manner. Informal monitoring might include casual conversation, attendance at provider meetings, and involvement in consumer and family advocacy meetings. Observation of MCO activities, to witness firsthand the MCO's manner in a variety of situations, can be extremely helpful in anticipating and managing problematic issues.

In addition, the purchaser should specify required reports and establish a schedule for receipt and response to those reports. Purchasers should be cautious not to overwhelm the MCO with report requests. Reporting requirements should be realistic in scope and based on information that the purchaser will actually use, consistent with the ability of the MCO's MIS to generate the reports. These requirements should also be sensitive to the burden that reporting requirements can place on providers, recipients, and the MCO.

The purchaser may also consider a role here for other government agency liaisons. For example, a child welfare liaison may meet regularly with the MCO and the purchaser to monitor the implementation of mutually agreed-upon care, such as coordination pathways for children and families involved with both the child welfare and the Medicaid managed care programs.

b. Auditing

Unannounced audit activities include formal reviews in which programmatic and financial data are collected in a systematic manner following predetermined protocols. While financial audits should be conducted by a certified public accountant, programmatic audits may be conducted by the purchaser directly or by an independent quality review organization, such as the National Committee on Quality Assurance. Some advantages of independent audits are the perceived objectivity of the findings and the ability to compare the MCO's performance with that of other MCOs.

The purchaser may want to audit the potential for cost shifting early in the project. For example, have child welfare costs increased as Medicaid spending on inpatient care decreased? Has Medicaid spending on outpatient care increased and child welfare expenditures for community-based care decreased as the managed care effort offers more intensive outpatient services for all children? Have State mental health hospital costs risen due to overly restrictive clinical practices by the MCO? Monitoring for potential cost shifting should be planned well in advance. The process requires significant time to negotiate because of the need to develop data exchange agreements and protocols

among government agencies and with private vendors. Health economists are not used to examining societal cost offsets, as would be called for here, and the selection of an experienced and knowledgeable auditor is critical.

c. Evaluating Performance

Evaluations of the MCO's performance should be performed on an ongoing basis and, if possible, should be based on a valid set of baseline data. The evaluations should be designed to provide the purchaser with useful data, without being too resource intensive, and should be an integral part of a larger overall monitoring system. While evaluation projects can be large or small, purchasers should bear in mind that the cost of such projects may be minor when compared with the overall cost of the project.

Evaluations during the postprocurement period should focus on the most critical issues that are measurable and that can generate information in a fairly short period of time. Longer term program evaluations, such as those required by the Health Care Financing Administration (HCFA) at the end of any 2-year Section 1915(b) Medicaid waiver and those that are an integral part of any Section 1115 Medicaid waiver, are generally used to determine whether the waiver program has met access, quality, and effectiveness objectives and is therefore eligible for renewal.

For waiver renewal evaluations, the purchaser may want to consider obtaining consultation or services from independent contractors with evaluation expertise who can provide an objective, scientific assessment of purchaser-determined access, quality, or outcome measures in the new system and help identify and solve implementation problems. Purchasers may want to contract with an evaluator entity early in the project and begin to design the evaluation model. Whenever possible, ongoing evaluation efforts should be blended with larger, long-term studies.

Purchasers should be very careful, however, in choosing such technical assistance, especially for Medicaid evaluations. Only a few universities and research firms have experienced conducting large-scale evaluations of Medicaid medical and behavioral health programs. It may be advisable to check with appropriate Federal resources to ascertain the location of the centers with experience doing such evaluations. Regardless of the approach used by the purchaser to evaluate the MCO's performance, the monitoring and evaluation of consumer and system outcomes should begin early in the process and continues.

[1.] Medicaid managed care purchasing is governed by detailed Federal statutory and regulatory requirements, so purchasers of behavioral managed care services are cautioned against combining several sources of public funding into a single procurement unless all funds are subject to Medicaid requirements. Even in this situation, non-Medicaid sources of funding, such as the CMHS and SAPT Block Grants, may have their own requirements regarding use of funds (for further discussion, see Chapter III).

[2.] In some contexts, the term "carve-in" technically refers to a reintegration of previously carved out services, back into an integrated health care model. In this document, the term carve-in refers to an integration of behavioral health care services with general health care, whether or not they were previously carved out.

[3.] These features apply only to managed care systems that do *not* subcontract for behavioral health services.

CHAPTER III

Coverage

Key issues in this chapter:

- Coverage options under managed care: defined benefits vs. defined contributions
- Developing service definitions
- Defining and operationalizing medical necessity
- Funding streams and their impact on coverage

A central issue in preparing requests for proposals (RFPs) and contracts for managed care is defining the scope of the coverage agreement between the purchaser and the managed care organization (MCO). In the absence of express contract language establishing variations from insurance custom and practice, the coverage a purchaser receives from an MCO generally will be consistent with these customary standards. If the purchaser of defined benefits wants a different level of coverage or coverage furnished in accordance with different standards, the RFP and contract must explicitly state the purchaser's requirement. Otherwise, the expectation may be held to fall outside the scope of the agreement and will remain the "residual" responsibility[(1)] of the purchaser. Silence or ambiguity in the contract will be construed by the courts against the agency that issued the contract--i.e., the purchaser.

Because of resource limitations and political issues, many managed behavioral health benefit plans developed for the public sector include only a portion of the full range of services needed to prevent, treat, and provide rehabilitation for mental and addictive disorders. Thus, in many States, the responsibility for delivery of behavioral health services is divided between the purchaser and the MCO(s). Without careful planning and delineation of service responsibilities, this splitting of the full continuum of care can lead to cost shifting, a fragmented delivery system, and lack of any meaningful accountability.

MCOs operate in a competitive environment and generally are eager to satisfy purchasers' needs and desires; however, they typically have multiple "books of business" and thus may be reluctant or unwilling to tailor their operations and their standard benefit package. A State Medicaid agency or other public purchaser charged with service responsibilities beyond those that any MCO is willing or able to assume retains residual coverage responsibilities and must ensure that it has sufficient funds to properly execute these responsibilities.

Special industry practice guidelines offer a particularly good view of what the managed behavioral health care industry considers standard coverage. Accreditation guidelines also offer insight into what is currently considered standard operating practice for the industry. Purchasers making coverage determinations should familiarize themselves with these documents so that they can better understand the extent to which their purchasing expectations align with or depart from industry standards.

This chapter covers several topics of importance to developing and defining the scope of a coverage agreement between a purchaser of managed behavioral health care and an MCO:

Coverage options under managed care--namely, defined benefit contracts and defined contribution contracts;

Developing definitions for services to be covered--including preventive, treatment, rehabilitation, and ancillary social and rehabilitative support (or "wraparound") services--and incorporating these definitions into the contract;

Defining the critical concept of medical necessity in public sector managed care contracts and operationalizing this concept through means such as MCOs' utilization management (UM) practices; and

Writing contracts to ensure that coverage complies with Federal statutory and regulatory provisions governing the various funding streams used to purchase behavioral managed care services--in particular, Medicaid and the Substance Abuse Prevention and Treatment (SAPT) Block Grant (Public Law 102-321; 42 U.S.C. §§300x-21-300x-35) and the Community Mental Health Services (CMHS) Block Grant (Public Law 102-321; 42 U.S.C. §§300x-7-300x-8).[2]

A. Coverage Options Under Managed Care: Defined Benefits vs. Defined Contributions

Purchasers can contract for the provision of coverage to enrollees in two ways. They may either buy a defined set of benefits or they may elect to buy a defined contribution.

Defined benefit contracts specify a defined set of benefits that managed care enrollees are eligible to receive. A contract for a Medicaid managed care initiative is typically a defined benefit contract.

Defined contribution contracts entitle no individual enrollee to any particular service; the MCO's duty is to the covered group as a whole. A managed care contract using State block grant funds is usually a defined contribution contract.

1. Defined Benefit Contracts

Managed care products customarily consist of a defined set of benefits that enrollees are eligible to receive if the benefits are determined to be "medically necessary." Several factors affect the definition, scope, and "usability" of a defined benefit in practice.

Under certain circumstances, an MCO may wish to exclude coverage for a defined covered benefit because the MCO considers delivery of the service to be the responsibility of another entity and not a medical treatment. For example, the MCO may wish to exclude a type of treatment ordered by a court or recommended in a student's Individualized Education Plan. An MCO may also wish to exclude a covered benefit if it is considered experimental under the MCO's definition (Rosenblatt, Law, & Rosenbaum, 1997).

An MCO may also want to deny coverage if the requested service is for a condition that does not fall within the traditional range of insurable risks--that is, if it is not seen as medically necessary for the restoration of normal functioning after an illness or injury. Thus, treatments for chronic disabling conditions with little chance of improvement may be denied altogether as not covered. More commonly, the service requested may be covered by the MCO, but only up to a certain amount (e.g., 20 outpatient mental health visits per year) in order to avoid covering services for consumers who may have chronic and incurable disorders and high needs for services.

Because of the structure of the Medicaid program and its requirements of State agencies, a Medicaid managed care contract must be drafted as a defined benefit agreement,[3] although the contract may contain memberwide service goals and outcomes, as in a defined contribution agreement. An example of such goals are the measures included in the Health Plan Employer Data and Information Set (HEDIS 3.0) developed by the National Committee for Quality Assurance (NCQA) (NCQA, 1997), which are discussed in Chapter VI of this document. A State may also use funds from the SAPT and CMHS Block Grants to purchase defined benefits. However, unless the State elects to use significant funds for relatively few members or adds appreciably to the block grant allotment out of its own funding, it is likely that a benefit package financed with block grant funds will be far narrower than one sponsored by Medicaid.

Finally, the MCO retains the discretion (and the duty under most contracts) to make medical necessity determinations. In the absence of an explicit contractual agreement to the contrary, an MCO will apply its own set of criteria in medical necessity determinations.

2. Defined Contribution Contracts

A purchaser may elect to buy a defined contribution benefit rather than a defined service benefit. A defined contribution contract entitles no individual member to any particular service; instead the MCO owes a duty to the

covered group as a whole. For example, a defined contribution plan is similar to the State's giving a grant to a community mental health center (CMHC) or addiction treatment center in exchange for performing a specified set of services. The clinic's service obligation is toward the residents of its service area as a group, and there is no enforceable individual right to any level of benefit.

The difference between a community clinic grant and a defined contribution managed care plan is that in the former case, the contractor's duty is generally to all the individuals in its service area, while in the latter case, the grantee's duty is confined to its members. In both cases, however, the purchaser asks the seller to take on certain broad tasks for the group as a whole and/or to accomplish certain goals for the eligible population. The purchaser may impose limitations on how the goals are reached (e.g., "Do not spend less than 20 percent of the funds on preventive services, as defined in this agreement").

In the case of a community clinic grant, however, the grantee may be forced to reduce or alter services if patients consume a greater than expected level of care or if there is an unanticipated increase in the number of community residents seeking care. This is not true in a defined contribution managed care contract; a contractor is at risk for fulfilling the duties it assumed for the term of the agreement. The purchaser cannot, however, expect the contractor to furnish additional services for the same payment, nor can it expect the contractor to alter its service mix in order to reach additional residents of its service area who are not members of the plan.

The State may also use block grant funds to purchase a defined contribution plan under which it pays a certain amount per member per month to finance general activities for members. Under such a plan, performance is best measured by broad intermediate service goals and overall health care outcomes, such as receipt of preventive services by a certain proportion of all members, or a percentage decline in school absentee rates among plan members who are children with a serious emotional disturbance. In addition, a State could use its block grant funds to provide at least some level of benefit or contributed coverage to enrollees during periods when their Medicaid eligibility lapses. Finally, block grant funds also might be used to finance activities that do not constitute medical assistance under the Medicaid statute or for which payment is prohibited (e.g., services to residents of institutions for mental disease [IMDs]).

B. Developing Service Definitions

The purchaser of managed behavioral health care services must precisely define the substance abuse and/or mental health services to be covered by the MCO. In a study of State Medicaid managed care contracts, Rosenbaum and her associates (1997) found that different terms are often used to describe the same types of services and that there is inconsistency among the States in their definitions of federally defined services. Given such variability in definitions of substance abuse and mental health services and the fact that the terms for services are often used inconsistently across regions and by behavioral health professionals, it is essential that the purchaser of managed care services clearly define the substance abuse and/or mental health services it wants to cover in both the RFP and the contract.

A purchaser can either develop its own definitions of substance abuse and/or mental health services or reference other documents with definitions. The substance abuse and mental health fields have both made efforts to define services (see definitions of both types of services in Appendix C). In addition, purchasers may seek assistance from a variety of Federal and State agencies, national associations, and credentialing organizations for assistance in developing definitions of substance abuse and mental health services: the Council on Accreditation of Services for Families and Children (COA), the Family Treatment Association (FTA), the National Association of State Mental Health Program Directors (NASMHPD), the National Alliance for the Mentally Ill (NAMI), the Federation of Families for Children's Mental Health (FFCMH), the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and the American Public Welfare Association (APWA), the Joint Commission on Accreditation of Health Care Organizations (JCAHO), and the Committee for Accreditation of Rehabilitation (CARF).

It is usually safest for a purchaser to adopt very precise descriptions of substance abuse and mental health services, but the definitions should not unduly impede or prohibit the MCO and its provider network from delivering individualized, person-centered care in a flexible and creative manner, especially in risk-based payment systems. All service definitions developed by an MCO should be subject to the purchaser's approval prior to implementation.

1. Typologies of Substance Abuse and Mental Health Services

For purchasers considering what types of substance abuse and mental health services to include in a managed care contract, two existing typologies of services--one published by the Institute of Medicine (IOM) and the other by the American Society of Addiction Medicine (ASAM)--may offer a useful conceptual framework.

a. The Institute of Medicine's (IOM) Typology

The Committee on Prevention of Mental Disorders (IOM, 1994) proposed a classification system for the full spectrum of services addressing mental disorders, including addictive disorders. This typology has been adopted by the National Institute on Drug Abuse (NIDA) and the Center for Substance Abuse Prevention (CSAP), among other organizations, and is rapidly gaining adherents among State agencies. (See Appendix C for SAPT primary prevention definition.)

The IOM typology divides services into the following three categories:

Preventive interventions;

Treatment interventions; and

Maintenance interventions.

Preventive interventions are services designed to reduce the probability of development of clinically demonstrable substance abuse and mental health problems. They consist of (1) *universal interventions* targeted to a population group that has not been identified on the basis of individual risk (e.g., substance abuse prevention curricula required of all public school students); (2) *selective interventions* targeted to individuals or a subgroup of the population whose risk of developing clinical problems is significantly higher than average (e.g., bereavement support groups for low-income widows and widowers, life skills programs for chronically truant students); and (3) *indicated interventions* for individuals with minimal but detectable signs or symptoms foreshadowing mental or substance use disorders (e.g., parent-child interaction training for children identified as having persistent conduct problems).

Treatment interventions are therapeutic services designed to reduce the length of time a disorder exists, halt its progression of severity, or if not possible, increase the length of time between acute episodes. The IOM typology divides treatment into the categories of (1) case identification; and (2) treatment for the identified disorder, to include interventions to reduce the likelihood of future co-occurring disorders.

Maintenance interventions are generally supportive, educational, and/or pharmacological in nature and are provided on a long-term basis to individuals who have met DSM diagnostic criteria and whose underlying illness continues. The two components of maintenance interventions are (1) the provision of rehabilitative aftercare; and (2) support of patients' compliance with long-term treatment to prevent recurrence of acute incidents.

Public purchasers of managed care have most frequently purchased services labeled treatment services in the IOM continuum, but an increasing number are purchasing prevention and maintenance services. Thus, for example, public sector agencies have negotiated separate arrangements with such community-based organizations as Oxford houses, halfway houses, and support groups to provide maintenance interventions for individuals recovering from drug addiction. Similarly, the public sector frequently has maintained contracts or grants with community-based providers to undertake preventive interventions through outreach to the general population or to high-risk individuals. These arrangements can be funded separately but coordinated with the MCO, or can be included as part of the defined benefit package. In either case, purchasers may benefit by analyzing the costs and potential benefits of providing adequate funding for certain preventive and maintenance interventions, in addition to treatment.

b. The American Society of Addiction Medicine's (ASAM) Typology

The substance abuse field has made substantial progress over the past decade in developing a formal structure that systematically organizes commonly used treatment interventions. In an ongoing effort to establish national standards for defining (1) a continuum of substance abuse prevention, treatment, and rehabilitative services; and (2) a set of admission, continuing care, and discharge criteria for each level of service intensity, ASAM, with nationwide input from treatment professionals and others, has been developing *Patient Placement Criteria for the Treatment of Substance-Related Disorders.* The second edition of this publication, referred to as ASAM PPC-2, was published in 1996 (ASAM, 1996).

The criteria in ASAM PPC-2 are the most widely used and comprehensive national guidelines for placement, continued stay, and discharge of patients with alcohol and other drug problems. ASAM PPC-2 specifies five levels of treatment services:

Pretreatment;

Level I, Outpatient Services;

Level II, Intensive Outpatient/Partial Hospitalization Services;

Level III, Residential/Inpatient Services; and

Level IV, Medically Managed Intensive Inpatient Services.

ASAM PPC-2 also describes a range of resources to be used by individuals at each level depending on continual assessment of six dimensions: the individual's need for detoxification services, medical complications, emotional/behavioral complications, treatment acceptance or resistance, relapse potential, and recovery/living environment.

To delineate various intensities of services within a particular level, ASAM PPC-2 introduced the concept of "gradient intensities." Thus, for example, a residential or inpatient program (Level III) with ready availability of onsite psychiatrists, a nursing staff, and a high staff-to-consumer ratio might be categorized as Level III.7. Another Level III residential program with minimal on-call medical support might be categorized as Level III.1. ASAM PPC-2 also addresses the increasing need to separate or "unbundle" the treatment modality and intensity of service from the treatment setting. Thus, for instance, detoxification, which was once regarded as an inpatient procedure, can be administered in a variety of settings at all levels of care, ranging from hospital-based programs to outpatient clinics and even in the home.

ASAM PPC-2 is copyrighted, and purchasers should beware that ASAM historically has denied all requests to modify the criteria. ASAM's literature has made it very clear that the organization intends to maintain and protect its copyright in order to safeguard the integrity of the text. States and other entities may publish supplemental material to augment the criteria in ASAM PPC-2 but may not identify such material as ASAM criteria.

2. Wraparound or Ancillary Services

Individuals with mental or addictive disorders served in the public sector often require a wide range of social and rehabilitative support services, commonly referred to as wraparound or ancillary services (see Exhibit III-1), and it is critical to address these services in the RFP and contract for managed care. Ensuring the availability of transportation, child care, employment-related services, and other ancillary services is challenging because such services are usually not funded as health care services; such services generally are funded, managed, and under the jurisdiction of several agencies in different government departments, a situation that can result in significant barriers to access.

The purchaser should analyze the current systems of care to determine how existing wraparound services can be accessed and how the managed care initiative can be used to improve service access and coordination. In Medicaid initiatives, the purchaser may consider establishing contractual arrangements with wraparound service providers and paying for some of these services with the Medicaid optional services called rehabilitation services and targeted case management.

Consumers' complex service needs can be very challenging (see case example in box), and the purchaser must carefully consider the optimal arrangements for meeting these needs. Many questions must be answered: Will the most frequently required wraparound services be included in the RFP? Is there sufficient funding to support these services? Is the MCO responsible for providing case management to help enrollees gain access to needed services? If so, is this cost included in the payment to the MCO? The overriding question is whether well-conceptualized and well-written contracts, combined with strong financial incentives and an MCO's capacity to track and manage services, can create the foundation necessary to successfully coordinate needed services and eliminate fragmentation.

Exhibit III-1.

Ancillary Social and Rehabilitative Support (or "Wraparound") Services

Ancillary social and rehabilitative support services for individuals with substance abuse or mental health disorders are often referred to as "wraparound services." The appropriate mix of wraparound services for an individual should be individually determined as part of the individual's treatment plan. The services listed below are commonly regarded as wraparound services.

Transportation

Child care

Assistance with housing (e.g., Section 8 rental subsidies)

Vocational training, job counseling, and other employment-related services

Primary health care, with screening for human immunodeficiency virus (HIV), tuberculosis, and other infectious diseases

Educational support services

Legal consultation and counseling services (e.g., custody, landlord rights, divorce disputes, etc.)

Financial counseling and/or assistance

Domestic violence support services

Nutrition education

Parenting courses and training

Child/adolescent support services:

- After school programs

- Teen centers

- Mentoring programs

- Recreational programs

- Arts and cultural enhancement

Although some of these services may be covered by health care plans, more often they are funded in other ways.

The purchaser may use the opportunities inherent in managed care initiatives to lower interagency barriers or to broaden its definition of health care and include financing for selected wraparound services in the managed care plan. In most States, experienced community-based providers are well positioned to provide wraparound services because they have been serving this population for years and have developed coordination mechanisms to overcome interagency barriers. This is particularly true in rural areas where substance abuse treatment agencies and mental health programs are often in the same or adjacent facilities.

Wraparound Services: Case Example

To understand the potential impact of wraparound services on outcomes, consider a young woman seeking treatment who is dependent on cocaine and alcohol and intermittently suicidal. She is a high school dropout with two preschool children. She has no adaptive support system, is in a violently abusive relationship, has no transportation, and is facing drug-related criminal charges. Treatment provided without consideration of her circumstances is unlikely to be successful.

A comprehensive treatment plan would need to address her multiple needs to support her mental health and/or substance abuse treatment. For instance, arranging for transportation and child care services would enable her to continue in dual diagnosis treatment, and domestic violence support services would help her address her abusive relationship. To achieve an optimal outcome for her and her children, she may also need legal aid to represent her in court, parenting training to help her build skills as a mother, housing in a "clean and sober" environment, educational services to assist her in obtaining a GED, job placement services, and primary health care services for her and her children.

If the purchaser desires this level of coordination and comprehensiveness, the RFP and contract should clearly address expectations in terms of process, desired outcomes, and the means by which these will be monitored.

Wraparound Services. Purchasers may wish to address the following in RFPs and contracts:

Identify wraparound services to be financed within the benefit package.

Establish expected utilization rates for wraparound services and the means for monitoring this utilization.

Specify who is responsible for financing the cost of these services.

Direct the MCO to develop a plan for purchaser review and approval to improve and coordinate access to wraparound services.

Specify wraparound services to which the MCO should systematically build access.

Identify specific agencies, government departments, and other relevant organizations with which the MCO should coordinate services.

Direct the MCO to develop detailed memoranda of understanding, in active collaboration with the purchaser and with purchaser-specified agencies regarding wraparound services.

Describe network providers' responsibilities for providing and/or referring to wraparound services.

Describe systems to monitor, measure, and evaluate successful access to and coordination of these services.

C. Defining and Operationalizing Medical Necessity

The determination of medical necessity is the process by which a specific service is judged to be necessary in the clinical care of a patient. Services judged necessary are eligible for reimbursement by the payer. Such determinations often have a subjective component, and differences in interpretation of this concept can be conceptualized along a continuum. At one end is a strict biological interpretation of medical necessity that excludes most psychosocial factors from consideration and does not recognize several prevention, remediation, rehabilitation, and recovery service needs. At the other end, psychosocial factors are seen as essential considerations in determining whether a service is necessary. For a discussion of issues related to medical necessity in managed mental health services, see Ford (1998).

1. Importance of Defining Medical Necessity for Public Sector Populations

Purchasers of managed behavioral health care for public sector populations with needs for multiple types of services must understand the importance of the concept of medical necessity and thoughtfully integrate this understanding into the RFP and managed care contract. How the contract addresses medical necessity and clarifies the application of this concept in clinical decisionmaking will have a profound impact on access to and quality of treatment. In addition, any ambiguity in the contractual definition of medical necessity can leave the purchaser clinically and financially liable for certain types of care. Clinically inappropriate interpretations of medical necessity driven by purchaser imprecision in contract language, insufficient understanding of enrollee needs, or a need to achieve short-term cost savings have sometimes led to unsound restrictions on access to substance abuse and mental health services and a fragmented and incomplete approach to client care.

In past contracts for managed care, most States and counties have provided only basic descriptions of what they consider to be medically necessary services, using language modeled on private contracts for managed behavioral health care. This approach grants MCOs considerable discretion in determining when a covered service will be deemed appropriate for a particular individual. Purchasers who wish to more clearly influence how medical necessity is operationalized can use the RFP and contract to specify who may make medical necessity determinations, the basis for making determinations, the role of scientific evidence, public and proprietary clinical practice protocols, the relevance of the provider's clinical judgment, and the extent of retention of judgment permitted to the MCO. An emerging approach is to adopt a broad description of medical necessity, drawing from existing State and/or county rules about when a publicly funded service is reimbursable. This approach helps ensure that an MCO will not limit access by using a strict biological interpretation of medical necessity (Bazelon Center for Mental Health Law, 1997; CSAT, 1995c).

In a few States, some MCOs view court-ordered services as not medically necessary. The contract should address the process to be followed when an MCO is ordered by the court to provide treatment that the MCO believes is inappropriate.

Medical Necessity and the Courts

Medical necessity determinations and utilization management (UM) policies that emphasize cost cutting over quality of care can severely restrict needed services and, occasionally, lead to tragic outcomes. Much criticism has been leveled at how MCOs make medical necessity determinations, which are seen as overly restrictive. Over the past three decades, several lawsuits have been presented to the courts to make decisions about the appropriateness of medical necessity determination (AHCPR, 1995; Bergthold, 1995).

In a study of such cases, Sage (1995) found that consumers prevailed about 60 percent of the time, while insurers prevailed 40 percent of the time. Analysis of these cases suggested that medical necessity criteria developed with meaningful public, consumer, and provider input and using "well-developed decisionmaking processes" can help purchasers ensure that coverage decisions are not seen as "arbitrary" and thus leave them legally vulnerable (AHCPR, 1995). Courts were found generally to uphold medical necessity determinations if the MCO had a carefully thought-out definition of medical necessity, explained it to the consumer, had several levels of internal appeals, followed the appeals process carefully, and gave consumers the opportunity to participate in the development and refinement of the managed care initiative.

2. Evidentiary Issues in Medical Necessity Decisionmaking

Evidentiary issues are a central aspect of medical necessity decisionmaking. Traditionally, review of the appropriateness of medical coverage has included consideration of accepted standards of medical practice, other evidence of usual and customary practice, and the recommendations of a patient's treating health professional. The use of evidence from controlled randomized clinical trials has been considered relevant in determining whether to move a specific treatment from experimental to accepted practice status, but such evidence has traditionally played very little role in medical necessity determinations (in part because few medical treatments have been evaluated for efficacy in randomized clinical trials). However, in recent years, leaders in the managed care industry have increasingly promoted a concept known as "evidence-based medical necessity." See Eddy (1994, 1996) for further discussion.

a. The Concept of Evidence-Based Medical Necessity Determinations

The concept of evidence-based necessity determinations was developed in response to mounting evidence of widespread and potentially unjustifiable variation in medical practices. In evidence-based medical necessity determinations, no weight is given to informal clinical experience, the standards of health professionals, and the opinion of an individual's treating physician. Instead, the decisionmaker relies on evidence gleaned from controlled randomized clinical trials, with coverage based on quantitative evidence of efficacy resulting from the trials.

Despite the appeal of making decisions on the basis of evidence-based medical necessity, the related issues are quite complex and can be troublesome upon closer examination. Even when the task at hand is to determine whether a certain practice is experimental or accepted, courts have frowned on a decisionmaker's relying solely on quantitative data, particularly when the coverage agreement itself calls for consideration of existing community practice standards in determining the extent of coverage.(4) When the coverage at issue involves a customarily accepted procedure, application of evidence-based decisionmaking effectively would result in denial of benefits. Because there are so few data on which to base coverage determinations, it is possible that application of evidence-based decisionmaking would in fact eliminate coverage for most care and services. At some point, the test, if unjustifiable because of the absence of quantitative data, might be considered unreasonable under the Medicaid coverage standards described later in this chapter.

b. An Evidence-Based Medical Necessity Test in a Contract

At least one State--Nebraska--has specifically incorporated evidence-based tests of medical necessity in its Medicaid managed care contract (Rosenbaum et al., 1997). The portions of the contract highlighted in bold below (items 3 and 7) are references to evidence-based tests of medical necessity:

> *The term "medical necessity" and "medically necessary" with reference to a covered service means health care services and supplies which are medically appropriate and (1) necessary to meet the basic health needs of the client; (2) rendered in the most cost effective manner and type of setting appropriate for the delivery of the covered services;**(3) consistent in type, frequency and duration of treatment with scientifically based guidelines or national medical, research or health coverage organizations or governmental agencies;** (4) consistent with the diagnosis of the condition; (5) required for reasons other than the convenience of the client of his or her physician; (6) no more restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;**(7) of demonstrated value;** and (8) a no more intense level of services than can be safely provided. The fact that the physician has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular injury, sickness or mental illness does not mean that it is medically necessary.*

The Nebraska medical necessity standard cited above applies to all requests for coverage; it is not restricted to cases in which the decisionmaker is called on to decide whether the treatment in question is experimental. Moreover, under the Nebraska standard, a party claiming that a service is medically necessary is effectively required to offer evidence from national organizations or agencies that the sought-after service is consistent with the work of national agencies and is of demonstrated value. The decisionmaker also is free to disregard the opinion of the treating physician.

The Nebraska contract is unique because it expressly incorporates an evidence-based medical necessity test. However, such tests may be used increasingly by MCOs. Because the legality of an evidence-based medical necessity in a Medicaid context has not yet been measured, permitting its use either expressly or through silence on the matter may create an unanticipated liability on the part of the State in the event that the test is found to violate Medicaid reasonableness rules. For instance, since there is very little quantitative evidence where medical care is concerned, it is possible that a court might invalidate the approach as an unattainable standard of proof. To the extent that a State does decide to permit use of the test under at least some circumstances (e.g., when the service in question is considered experimental, or for certain services that are of high cost and marginal utility), the State may want to retain the authority, as discussed above, to override specific coverage decisions under its own evidentiary test. Moreover, the State may want to provide that regardless of the test used by the company, any administrative or judicial decision ordering a State to provide coverage will also bind the MCO to the extent that the service at issue falls into one of the coverage listings in the contract.

3. Drafting Medical Necessity Contract Provisions

In drafting medical necessity provisions of a managed care contract, purchasers will have to address the following critical questions:

Will the MCO be required to use the purchaser's existing standard of coverage for determining medical necessity or some other standard developed by the State for the contract?

Will the purchaser retain the right to reverse the MCO's determination when review under its own standards finds that the service is necessary?

What evidence will the MCO be required to consider, and what process will it be required to follow, in making coverage determinations?

Will the MCO be bound to pay for contract services that are determined to be covered by a court in a judicial proceeding?

These issues are discussed in the sections below.

a. The Standard of Coverage

A State may elect to require the MCO to apply specified definitions of medical necessity. For example, the California contract incorporates into the agreement the State's relatively strict existing standard of medical necessity, which has been upheld in the case of adult services in Medicaid litigation (Rosenbaum et al., 1997). The California standard is as follows:

> *Medically necessary means reasonable and necessary services to protect life, prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.*

Alternatively, a State could elect to direct the MCO to follow more comprehensive practice guidelines and treatment protocols that have been developed to guide the conduct of health care professionals in specific areas of practice. Assuming that the benefits that are needed to institute such programs are covered under the State's contract, these protocols and guidelines might be considered as specifications regarding the treatment of persons with these conditions.

The Federal Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program provides for coverage of preventive services to children covered by Medicaid. The EPSDT program also specifically provides for coverage to "ameliorate" an illness or condition. Pennsylvania's 1996 RFP contains a comprehensive definition of medical necessity that would satisfy the Medicaid reasonableness test for both children and adults (Rosenbaum et al., 1997). Following the language of the EPSDT program closely, the Pennsylvania RFP stipulates that one of the following standards must be met:

> *The service or benefit is reasonably expected to prevent the onset of an illness, condition, or disability.*
>
> *The service or benefit will, or is reasonably expected to, reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury or disability.*
>
> *The service or benefit will assist the individual to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and those functional capacities that are appropriate for individuals of the same age.*

b. Purchaser Authority To Review the MCO's Determinations

When a purchaser has particular concerns about an MCO's coverage of certain benefits, one approach may be to provide in the contract as follows:

> *The agency reserves the right to review Contractor's coverage determinations with respect to the services and items which, under the State's interpretation of this agreement, are enumerated under this contract; and furthermore, to require that the Contractor provide coverage in those instances in which, in the opinion of the State, coverage is medically necessary in accordance with standards and procedures used by the State.*

This type of provision is common in MCO contracts. While presumably such a provision is used somewhat sparingly, it serves as an important "backstop" for the coverage determination process.

c. Evidence and Processes in Making Determinations

In making a medical necessity determination, the decisionmaker considers certain evidence and uses certain procedures. Such procedures and their timelines can be highly important. For example, an MCO might require prospective or concurrent review of services furnished outside the scope of normal clinical activities. In certain instances, however, the use of prior authorization is expressly prohibited by Federal law. For example, MCOs cannot subject emergency services to prior authorization requirements, and State Medicaid agencies (and therefore their contractors) cannot require prior authorization for EPSDT periodic or as-needed screens for children. Furthermore, the Medicaid statute contains certain rules regarding limitations on coverage of drugs. States may use prior authorization for outpatient drugs but only if the prior authorization system is able to provide for a 24-hour response by telephone or telecommunication device. Moreover, with the exception of certain drugs enumerated in the Medicaid statute, the agency must provide for "the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation" (42 U.S.C. 1396r-8(d)(5)).

To ensure compliance with these requirements, contracts should identify instances in which prior authorization cannot be used or where interim services (as in the case of prescribed drugs) must be made available.

d. Coverage in the Event of Administrative or Judicial Order

A State may want to protect itself in the event that an MCO makes a medical necessity determination that denies coverage for a class of service listed in the contract and either a court or an administrative agency rules that the service is required to be covered under Federal law or the State plan. The State might consider inserting the following clause into the contract:

> *In the event that the State is ordered by a court or an administrative agency to cover a service which, under the State's interpretation of this agreement, falls within one or more classes of services or items covered under this agreement, Contractor shall be responsible for payment for such service under such terms and conditions as may be prescribed by the court or agency.*

Drafting Medical Necessity Contract Provisions. Purchasers may wish to address the following in RFPs and contracts:

Ensure that all terms in the definition of medical necessity are operationally precise to avoid any ambiguities in the interpretation by the MCO.

Ensure that the definition provides clear direction to the MCO regarding utilization review policies and procedures, including the procedures for members to file grievances and appeals.

Establish that medical necessity determinations should include consideration of psychosocial factors.

Ensure that medical necessity definitions and criteria in the prime contract are included in subcontracts with network providers.

Establish the purpose of providing particular services (e.g., assess, diagnose, treat symptoms; prevent progression; rehabilitate; promote recovery) and its relationship to medical necessity determinations.

Establish standards for service delivery (i.e., need for an individualized service plan, consumer involvement in treatment planning, consumer choice of service, cultural relevance, least restrictive setting, continuity of care, confidentiality, consistency with national standards of practice, referrals to other appropriate agencies, etc.).

Ensure that services accommodate the needs of persons with disabilities (physical and mental) in accordance with the Americans With Disabilities Act.

Proceed cautiously in establishing requirements for demonstrated effectiveness or cost effectiveness.

Reference external criteria, such as formal patient placement criteria, for establishing medical necessity standards.

Ensure that medical necessity criteria and definitions of services for children and adolescents are age appropriate, given the many different factors related to providing care to children (i.e., role of the family, developmental stages and rapid changes as children age, need for parental or guardian consent for treatment, different goals for treatment, greater need for early intervention and prevention of future disability, etc.).

Ensure that medical necessity criteria take into account exceptions to regulations on access, such as dangerous disease clauses for teenagers interested in obtaining certain types of medical and mental health support services without parental or guardian consent.

Ensure that the final step in the clinical appeals process is a review by the purchaser (or delegated State or county agency) so that any inappropriate decisionmaking processes can be understood and addressed directly (rather than only through subsequent policy changes or contract revisions).

4. Processes for Operationalizing Medical Necessity: Utilization Management and Clinical Practice Guidelines

Even when a purchaser of behavioral managed care services provides clear definition and guidance regarding medical necessity in the contract, the interpretation of this definition in daily practice is ultimately what determines the services received by enrollees. Two fundamental processes by which medical necessity is interpreted and operationalized--utilization management (UM) and clinical practice guidelines--are discussed below.

a. Utilization Management (UM)

UM is the means by which an MCO monitors and manages service utilization by enrollees. Utilization patterns can be managed in several different ways. The most common UM methods include: (1) using utilization review staff to monitor the appropriateness of admission into particular levels of care and the duration of treatment at that level of care; (2) delegating UM to network providers; and (3) using a database of profiles of network providers describing their patterns of delivering care.

It should be noted that the UM process in public sector managed care differs from the UM process as defined in commercial managed care contracts. Public sector UM typically includes some case management services in addition to field or provider-based case managers whose job it is to improve the delivery system. In the commercial sector, UM generally relies on the consumer's calling the MCO for authorizations of care; in the public sector, however, authorization for care is typically pursued by a provider on behalf of a consumer who is too impaired to pursue authorization.

Public purchasers can use the contract to influence UM functions. For example, they may wish to contractually address the qualifications of utilization reviewers, their supervision and the qualifications of the supervisor, and the range of their authority (e.g., a physician may be required to deny authorization).

Purchasers of managed care services may want to encourage, mandate, or reserve approval rights for the MCO's use of patient placement criteria and clinical practice guidelines. Such guidelines are, in effect, the operational definitions of medical necessity on which assessment, placement, and treatment decisions are based. A purchaser may require the MCO and network providers to adhere to purchaser-approved sets of guidelines and to be capable of producing auditable trails of data used in making individual UM decisions. Such data can form the basis for measuring performance and outcomes.

b. Clinical Practice Guidelines

Clinical practice guidelines, sometimes referred to as practice or treatment protocols, provide systematic recommendations for treating specific health disorders, with the goal of standardizing treatment and increasing the likelihood of good outcomes. Purchasers and MCOs often require providers to adhere to specific guidelines that they believe to be consistent with their medical necessity practices. These guidelines are usually based on some

combination of current research findings and expert opinion. For example, the American Psychiatric Association has recently begun to publish a series of clinical practice guidelines, including those for substance use disorders, depression, eating disorders, and schizophrenia.

The Federal Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA) has developed a series of Treatment Improvement Protocols (TIPs) to facilitate the transfer of state-of-the-art guidelines for the treatment of alcohol and other drug abuse from acknowledged clinical, research, and administrative experts. Using a Federal resource panel to review the state-of-the-art in treatment and program management, recommendations from this panel are sent to a second non-Federal consensus panel of experts. A chair for the panel is appointed and is responsible for ensuring that the resulting protocols reflect true group consensus. This group meets and makes recommendations, defines protocols, and arrives at agreement on protocols. These recommendations are then reviewed by a third group whose members serve as expert field reviewers. Once their recommendations and responses have been reviewed, the chair approves the document for publication. CSAT has published over 25 TIPs on topics ranging from State methadone treatment guidelines to treatment for HIV-infected alcohol and other drug abusers. These TIPs may be ordered by contacting the National Clearinghouse for Alcohol and Drug Information at (800) 729-6686 (*www.health.org/*) or for TDD, (800) 847-4889; through the National Library of Medicine (*http://text.nlm.nih.gov/*); or through the CSAT Treatment Information Exchange forum (*www.samhsa.gov/csat/*).

Some MCOs have also developed practice guidelines that are specific to the diagnostic categories in the American Psychiatric Association's *Diagnostic and Statistical Manual*, 4th edition (DSM-IV).

Operationalizing Medical Necessity. Purchasers may wish to address the following in RFPs and contracts:

Specify the process by which the purchaser will monitor the MCO's implementation of medical necessity.

Require the MCO to solicit the input of providers and consumers and their families when developing and refining utilization management (UM) guidelines.

Require that the MCO's guidelines be published and available for public review and comment.

Require purchaser approval of UM guidelines.

Require the development of written policies and procedures governing all aspects of the UM process and require that the UM agent maintain and make available a written description of these procedures to enrollees and providers.

Establish guidelines regarding any restrictions on financial incentives to the UM agent to deny or curtail approvals for services.

Require that guidelines be developed and used for screening and diagnosis, remediation, treatment, and rehabilitation for children eligible for the EPSDT program under Medicaid and that the guidelines also address long-term care issues for children, including access to medications.

Require the provision of rehabilitation and supportive services for persons with severe and persistent mental illnesses, chronic substance use disorders, and co-occurring mental illnesses and substance use disorders.

Establish the right of the purchaser to audit performance and to ensure that guidelines and UM criteria are being used appropriately.

Ensure that UM procedures are individualized to consumers' needs and are not allowed to create de facto limits on lengths of any specific treatments (for managed care systems without formal upper limits on specified services imposed by the payer).

Require sufficient provision of training in the use of the UM guidelines to UM clinicians, providers, designated representatives, government officials, consumer representatives, primary care representatives, and specified others.

Establish minimum requirements for UM staff in terms of education, professional experience, training, and/or relevant life experiences.

Require that the UM guidelines be consistent with other purchaser-specified guidelines.

Require that the guidelines for placement or discharge reflect an understanding of conditions relevant to public sector populations, including homelessness, inadequate or pathological family/social support systems, and coexisting medical conditions.

Specify whether the MCO's UM program must be accredited by the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Committee (URAC).

D. Funding Streams and Their Impact on Coverage

Funds from a variety of Federal and other sources (see Exhibit III-2) can be used to purchase and/or support substance abuse and mental health services for adults and children. There are requirements attached to each source of funds that can have a significant impact on the services that can be purchased. When a public purchaser contracts with an MCO to deliver managed behavioral health care services using funds from one of these sources, it may delegate responsibility for complying with all relevant requirements to the MCO. For that reason, it is essential that purchasers understand the requirements attached to various funding streams.

Most current managed care initiatives in the public sector use Medicaid funds; and Medicaid managed care purchasing is governed by detailed Federal statutory and regulatory requirements. Increasingly, however, Federal CMHS and SAPT Block Grants are being used to fund managed behavioral health care services.[5] The statutes and regulations governing Medicaid impose very different duties on States and create dramatically different rights and expectations in the individuals who are assisted than do the statutes and regulations governing the two block grant programs. Whenever a State or county agency enters into a service agreement with a private company to perform Federal statutory duties, it retains the duty to adhere to Federal law. Thus, a State agency must ensure that any MCO with which it contracts performs the agency's duties under each program in a manner consistent with Federal legal requirements.

Exhibit III-2.

Sources of Funds That May Be Used To Purchase Public Behavioral Health Services

Medicaid

Substance Abuse Prevention and Treatment (SAPT) Block Grant

Community Mental Health Services (CMHS) Block Grant

Medicare

Research-based demonstration grants for secondary prevention from Federal agencies that include the Centers for Disease Control and Prevention, the National Institute on Drug Abuse, the National Institute on Alcoholism and Alcohol Abuse, the National Institute of Mental Health, the Center for Substance Abuse Treatment, the Center for Substance Abuse Prevention, and the Center for Mental Health Services

Child-welfare-related funding

- Title IV-E, IV-B, and IV-A

- Special education funding through the Individuals With Disabilities Education Act

- Juvenile justice and corrections funding such as the Office of Juvenile Justice and Delinquency Prevention Community Block Grant

Early intervention funding under the Individuals With Disabilities Education Act and from the Maternal and Child Health Bureau

Housing and Urban Development rental assistance and housing development programs

Rehabilitation Services Administration funding for State vocational rehabilitation programs

State general revenues

State Medicaid matching funds

County and local contributions; for example, special appropriations for public substance abuse and mental health services such as mil taxes (common in counties); and sales taxes on tobacco or alcohol (California)

Agency matches

State funding for behavioral health services

Charitable contributions

The statutes and regulations governing funding streams have a great deal of influence on the day-to-day operations of MCOs and services provided. Recent statutory changes have radically reshaped the way that government programs pay for and deliver health and human services; these changes will have a significant impact on the design and implementation of managed care initiatives in the public sector. Thus, for example, purchasers of behavioral health services must consider new Supplemental Security Income (SSI) eligibility issues that have resulted from welfare reform because they affect eligibility for Medicaid services. They also must consider reforms that introduced the possibility of contracting with for-profit organizations to deliver children's residential treatment services.

In States that use Federal Medicaid funds and the SAPT and CMHS Block Grants to purchase managed care, an enrollee may move from Medicaid sponsorship to sponsorship under one or both block grant programs over the course of a single period of enrollment. (Medicaid coverage is quite unstable; in the absence of "bridge" financing, a member will be involuntarily disenrolled following the loss of Medicaid.) Moreover, an individual's coverage may be financed by more than one sponsor; for example, SAPT Block Grant funds may be used to finance the portion of the premium that covers services not allowable under Medicaid, such as services to residents of IMDs.

It is important to note that purchasers of managed care services paid for from pooled funding should carefully research the legal obligations entailed in delegating full control and/or risk to a private entity for discrete types of public sector services. Some regulations restrict the role of private entities in the administration of certain Federal programs, like child welfare. When possible, purchasers may want to consider the desirability of applying for waivers or modifying State Medicaid plans to lift these restrictions.

Purchasers also must be aware of the funding ramifications that exist under the Individuals With Disabilities Education Act. Children with an Individualized Education Plan under this act are entitled to a full spectrum of community-based services to help them attain their academic potential. Other relevant regulations for children, such as permanency planning, generally support managed care principles in that they encourage short lengths of stay in out-of-home placements. Avoidance of institutional care is a priority, and there is emphasis on family strengthening, family reunification, and community-based, family-driven service delivery.

1. Medicaid

Medicaid is a Federal entitlement program authorized by Title XIX of the Social Security Act and operated by participating State and territorial governments that provides medical benefits for eligible aged, blind, disabled, and

low-income persons. Subject to broad Federal guidelines, States determine who is eligible, benefits covered, rates of payment for providers, and methods of administering the program. The costs of the Medicaid program are shared by the Federal Government and the States. It is important to note that Medicaid is always the payer of last resort. Medicaid, insurance coverage, and other funding are to complement/supplement Medicaid payment. These other sources of funds for which a Medicaid recipient is eligible must discharge liability before a claim for payment will be accepted by Medicaid.

a. Medicaid Coverage Requirements

States are required by Federal law and regulations to provide Medicaid beneficiaries coverage for specified services. Minimum coverage requirements vary depending on whether a beneficiary is "categorically needy" (i.e., qualifies for Medicaid because he or she meets certain income and other requirements) or "medically needy" (i.e., qualifies for Medicaid because he or she meets certain medical requirements) (42 U.S.C. §1396a(a)(10)). The discussion here focuses on required coverage for categorically needy Medicaid beneficiaries, who constitute the bulk of Medicaid managed care enrollees. (Most medically needy Medicaid beneficiaries use the program as a catastrophic coverage program for long-term care.)

Mandatory Medicaid services for categorically needy beneficiaries are identified in Exhibit III-3A; Medicaid services that States may cover at their option are identified in Exhibit III-3B. The Medicaid law requires that the amount, duration, and scope of a service be sufficient to achieve its stated purpose. If Medicaid funds are used for managed care, this standard requires the explicit delegation of this responsibility to the MCO. If the State does not explicitly delegate this responsibility, it may unknowingly retain residual clinical and financial liability--and enrollees may not get services to which they are entitled.

Exhibit III-3A. **Mandatory Medicaid Services Used To Provide Substance Abuse and** **Mental Health (SA/MH) Services and Relevant Federal Regulations**	
Inpatient hospital services 1905(a)(1) 42 C.F.R. 440.10 (excluding institutions for mental disease [IMDs])	May be used to provide inpatient psychiatric services or American Society of Addiction Medicine (ASAM) Level IV addiction services.
Outpatient hospital services 1905(a)(2) 42 C.F.R. 440.20	May be used to provide a variety of outpatient behavioral health services in hospital settings.
Physician services 1905(a)(5) 42 C.F.R. 440.50	May be used to provide various psychiatric services, including medication management and psychopharmacological assessment.
EPSDT (Early and Periodic Screening, Diagnosis, and Treatment) services for children 1905(a)(4) 42 C.F.R. 440.40b	May be used to provide a wide range of SA/MH services (antidiscrimination provisions state that general services--including SA/MH services--must be covered) for eligible children, including the following requirements: Periodic assessments of a child's "mental health development"; Provision of necessary diagnostic services; and Appropriate SA/MH treatment services to address issues identified in EPSDT screens. May also be used to provide transportation vouchers to assist families and their

	children in accessing treatment.

Exhibit III-3B. Optional Medicaid Services Used To Provide Substance Abuse and Mental Health (SA/MH) Services and Relevant Federal Regulations	
Rehabilitative services 1905(a)(13) 42 C.F.R. 440.130	May be used to provide a broad and flexible range of services, including assessments; psychosocial rehabilitation services; day treatment; life skills training; drug abuse treatment; training and education on medication issues; and crisis intervention services. These may be provided in any setting, including homes, schools, clinics, and/or group homes.
Clinic services 1905(a)(9) 42 C.F.R. 440.90	May be used to provide a broad range of SA/MH services, including individual, group, and family counseling; physician services; medication management; and emergency/crisis services from a wide variety of agencies and clinics.
Inpatient psychiatric services for individuals under age 21 1905(a)(16); 1905h; 42 U.S.C. 1369d; 42 C.F.R. 441.151-182; 42 C.F.R. 440.160	May be used to provide services in IMDs for children and adolescents with serious emotional disturbances who require acute inpatient care to ensure their safety and/or address serious SA/MH problems.
Services of other health professionals 1905(a)(6) 42 C.F.R. 440.60	May be used to purchase services of other health care professionals, such as psychological testing or psychiatric social work services.
Prescription drugs 1905(a)(12) 42 C.F.R. 440.120	May be used to provide psychotropic medications, methadone/LAAM, and other prescription drugs used in the somatic treatment of behavioral health disorders. May be used to provide case management services to assist enrollees in gaining access to needed medical, social, educational, and other services that are called for in the treatment plan. May be targeted to high-risk geographic areas and population groups.
Targeted case management services 1905(a)(19); 1915g	
Personal care services 1905(a)(4)	May be used to provide services for individuals who require this type of support, such as those suffering from severe psychiatric disorders or those debilitated by HIV/AIDS.

Certain services are particularly complex, because although they are described as a single benefit, they are actually a "bundled benefit," each component of which is a service requirement. Examples are Medicaid's mandatory EPSDT benefit for children under 21 and mandatory services provided by federally qualified health centers and the rural health clinics (see Exhibit III-4). Both of these benefits have direct implications for children and adults with mental illness and addictive disorders.

Exhibit III-4.

Mandatory Services Under Medicaid's EPSDT Program for Children and Services Provided by Federally Qualified Health Centers and Rural Health Clinics

Mandatory Services Under Medicaid's EPSDT Program for Children (42 U.S.C. §1396d(r))

- Periodic and as-needed screening services, including a comprehensive health and developmental history; a comprehensive unclothed physical examination; appropriate immunizations according to the Federal schedule established by the Centers for Disease Control and Prevention (CDC); laboratory tests, including testing for elevated blood lead levels; and health education, including anticipatory guidance
- Vision care, including periodic and as-needed exams, diagnosis, and treatment, and eyeglasses
- Dental care to relieve pain and infections, restore teeth, and maintain dental health
- Hearing services, including periodic and as-needed exams, diagnosis, and treatment (including hearing aids)
- All medically necessary health care, diagnosis, services, treatment, and other measures described in 42 U.S.C. §1396d(a)) to "correct or ameliorate physical and mental illnesses and conditions discovered by the screening services," whether or not such services are covered under the State plan

Mandatory Services Provided by Federally Qualified Health Centers and Rural Health Clinics (42 U.S.C. §1395x(aa))

Physicians' services and services and supplies incident to a physician's services
Services furnished by physician assistants or nurse practitioners, clinical social workers, and clinical psychologists
Home health and intermittent nursing care in areas designated as having a shortage of such services

The rules that apply to Medicaid coverage make the transition to managed care particularly challenging. Medicaid is a third-party financing program; it is not an insurance program, nor does it operate by insurance rules. When purchasing Medicaid managed care, however, State Medicaid agencies use their funds to buy coverage from MCOs that, in the absence of regulatory or contractual modifications, operate according to standard and somewhat restrictive insurance principles rather than the broader and deeper coverage rules that govern Medicaid.

Because States retain full residual liability for all Federal administrative and coverage obligations, their choice is either to require MCOs to carry out these obligations as required under law or to retain a significant level of residual and direct responsibility for covered care and services. States and counties throughout the country are struggling with these issues. Moreover, contracts that are unclear or ambiguous about the allocation of responsibilities can lead not only to less coverage for enrollees, but also to an unanticipated

level of direct responsibility on the part of the State for benefits that are covered under the State plan but that inadvertently are not addressed in the contract (Rosenbaum et al., 1997).

b. Definition of Emergency Services

The State of Florida has attempted in its mental health contract to develop a specific definition of emergency tailored to individuals with serious mental illness (Rosenbaum et al., 1997):

> *Emergency mental health services are those services required to meet the needs of an individual who is experiencing an acute crisis which is at a level of severity that would meet the requirements for involuntary hospitalization pursuant to [Florida law] and who, in the absence of a suitable alternative, would require hospitalization.*

Note that regardless of the definition, in the case of a particular individual, it is the MCO that decides what meets the definition. The MCO's decision about this is a coverage determination and thus triggers both HMO grievance and Medicaid fair hearing provisions.[(6)]

In deciding coverage cases, courts look to the Federal definition of services to gauge whether a limitation is reasonable. Therefore, it is important for purchasers to incorporate applicable Federal definitions into their contract with an MCO so that, in the event of a coverage dispute, the MCO's liability will be coextensive with that of the State and the State can seek recovery in the event that it is ordered to pay for a service.

c. Medicaid's Test of Reasonableness

Under Federal law, States are prohibited from using Federal Medicaid funds to pay for "medically unnecessary" care (42 U.S.C. §1396a(a)(30)). Federal regulations do not define what is medically unnecessary, although they do place certain limitations on a State's discretion to establish its own version of medical necessity standards in establishing benefits. The regulations apply to the definition of medical necessity for a specific benefit and is not applicable to a medical necessity determination of an individual enrollee. The regulations establish a test of "reasonableness" for Medicaid coverage, with reasonableness defined in direct relation to the purpose of the benefit for which coverage is sought. The regulations provide as follows:

> *Each [covered] service must be sufficient in amount, duration and scope to reasonably achieve its purpose; . . . The Medicaid agency may not arbitrarily deny or reduce the amount, duration or scope of a required service because of the diagnosis, type of illness or condition (42 C.F.R. §440.230 (1997)).*

As can be seen, the regulations also prohibit the use of coverage limitations that would result in discrimination in the provision of care on the basis of a condition. Medicaid does not permit the types of distinctions between recoverable illness and nonrecoverable chronic conditions that are a traditional part of insurance theory and practice.

In its structure and operation, Medicaid is meant to function as a program not only for healthy low-income persons but also for persons who have chronic disabilities. Therefore, the rules that govern private insurance decisionmaking have only limited application to Medicaid. Thus, for example, a State Medicaid agency cannot deny the services of a nursing facility to an infant after surgery for a severe congenital condition from which a full recovery might never occur, while permitting such coverage for a 50-year-old recovering from a stroke.

Medicaid's unique approach to coverage is particularly notable in the case of children. Over 30 years, Medicaid's test of reasonableness has been interpreted by courts to require a preventive standard of coverage in the case of children entitled to benefits under the EPSDT. Because the purpose of EPSDT is to finance early diagnosis and treatment of physical and mental conditions before they become serious, limitations that restrict coverage to cases of severe or extreme necessity have been ruled unlawful in the case of children (Rosenblatt, Law, and Rosenbaum, 1997). For example, restricting dental care except in emergency situations or providing medical benefits only when an individual is severely ill is unlawful. Consequently, coverage limitations that would be permissible in the case of adults are not permissible for children if the result is to reduce medical assistance to a level that would defeat the preventive purpose of the EPSDT benefit.

Finally, courts have ruled that at least in the case of adults, the Medicaid program's medical necessity test of reasonableness permits the imposition of across-the-board limitations on coverage of benefits as long as the resulting benefit is sufficient to satisfy the needs of the great majority of recipients. Thus, for example, limiting physician visits to three per month except in emergency situations has been upheld, as have across-the-board limitations on inpatient hospital coverage (Rosenblatt, Law, and Rosenbaum, 1997). However, such across-the-board limitations are not allowed in the case of children, who are entitled to all services determined to be medically necessary regardless of limits that otherwise would apply to adults (42 U.S.C. §1396d(r)).

d. Issues in Medicaid Coverage

To meet the challenges raised by the coverage provisions of the Federal Medicaid statute, a State must address several issues. Each of the issues listed below is discussed in the following sections.

Classes of covered services. The State must decide which classes of covered services will be included in the contract and which will remain the direct responsibility of the State agency.

The amount, duration, and scope of contract services. The State must decide what across-the-board limits are permitted on covered classes of services, particularly those services for which such across-the-board limits are impermissible under Federal law and for which the State therefore would retain residual coverage responsibility.

Service definitions. To guard against unanticipated residual responsibilities, the State must ensure that the coverage definitions used in the contract (or by the MCO) are consistent with the definitions that exist under Federal Medicaid law.

Medical necessity. The State must consider the definition of medical necessity used by the MCO in order to determine whether the definition will or could create unanticipated residual responsibilities for the State because of Medicaid requirements. If it does, the State must decide the extent to which it wants to modify the MCO's definition or retain the authority to override certain coverage determinations by the MCO.

Limitations and exclusions. The State must consider whether the limitations and exclusions generally used by the MCO can or could result in the exclusion of services that are covered under Federal Medicaid law and, if so, whether to override them in the contract. Conversely, the State must ensure that the MCO honors the exclusions that exist in the Medicaid statute, such as the IMD exclusion.

Classes of covered services. In developing a contract for Medicaid enrollees, a State must decide which of the classes of covered services included in its plan will also be included in its contracts. When a single service in the State plan is in fact a bundled service, care must be taken to distinguish which elements of the bundled service will be included in the contract and which will be left as the direct responsibility of the State. The EPSDT benefit is a particularly good example of a benefit that includes numerous service subcategories. Many State contracts contain significant ambiguities regarding the scope of the MCO's duties, or else they appear to leave many covered categories of services uncovered, and thus the responsibility of the State (Rosenbaum et al., 1997).

The following is an example of an ambiguous definition of the classes of EPSDT services. This example is taken from a request for information (RFI) issued by the State of Maine (Rosenbaum et al., 1997).

> *The preliminary comprehensive benefit package places a special emphasis on preventive care, including EPSDT services. EPSDT is a federally mandated program of informing/outreach activities and benefits targeted to Medicaid beneficiaries up to age 21. An effective EPSDT program assures the health problems found are diagnosed and treated early before they become more complex and their treatment more costly. MCOs will be required to have written policies and procedures for an EPSDT program. This should include conducting EPSDT screens on all members age 21 to identify health and developmental problems.*

Under this definition, it is impossible to tell which screening services (periodic or as needed) are covered. It is also not possible to tell which classes of covered services are covered under the contract other than "screens" a term which itself is ambiguous. Nor is it possible to tell which screening elements are required at

each screen. On the other hand, the Massachusetts contract contains detailed appendices that list each category of screening (periodic and as needed), diagnostic, and treatment service that is the responsibility of each participating contractor and each required element of the EPSDT screen (Rosenbaum et al., 1997).

In the treatment of complex conditions such as mental illness or addiction, care should be taken to include every class of service that is covered under the plan and that conceivably could be part of an appropriate treatment regimen. This is not to suggest that services should be covered up to an unlimited level, but only that no essential class of service should be omitted from the contract unless this is the intent of the drafter. Rosenbaum and her colleagues (Rosenbaum, et al. 1997) noted wide variation in the classes of covered services related to the treatment of mental illness and addiction. The variations in coverage include services that are covered in virtually all State plans. The wide variation suggests a lack of consensus among States regarding the classes of services that might be used to diagnose, treat, and prevent such conditions. The variation also suggests that States are willing to leave as a direct benefit certain services that are necessary for the treatment of mental and addictive disorders (e.g., prescribed drugs, long-term residential care or inpatient psychiatric care for children with severe mental illness). This variation also leaves it to the MCO industry to determine whether certain classes of services (e.g., preventive health services) should be offered to individuals with these conditions.

Amount, duration, and scope of covered services. Contracts that permit across-the-board limitations on one or more covered services should clearly identify and describe these limitations. Thus, for example, in the case of nonhospital residential detoxification, the Connecticut Medicaid contract specifies that (Rosenbaum et al., 1997):

> *Services under the Medicaid program shall be for alcohol dependent individuals and shall be limited to (1) the acute and evaluation phase of the treatment program and (2) a 10-day period for each occurrence.*

The Connecticut contract expressly omits detoxification for individuals who are dependent on substances other than alcohol. Moreover, the contract limits coverage for persons with alcohol dependency to one short-term treatment per occurrence. To the extent that the State Medicaid plan covers additional levels of treatment, payment for such service would be the responsibility of the State. For instance, this additional payment responsibility might arise in the case of alcohol-addicted children, whose treatment would be considered an EPSDT service and thus not subject to such across-the-board limits if the resulting limitations reduced coverage below medically necessary levels.

Service definitions. As noted, the Federal Medicaid statute and regulations contain numerous examples of service definitions. When a contract deviates from Federal law in defining a service, the State retains residual coverage responsibility up to the Federal definition. For example, the District of Columbia's contract defines maternity coverage as follows (Rosenbaum et al., 1997):

> *Prenatal care, examination, tests and education, hospital and delivery services, newborn care, and postpartum care.*

This definition departs from the Federal definition in its omission of pregnancy-related services. Thus, services for women whose eligibility is based on their pregnancy could be limited to prenatal, delivery, and postpartum care; the contractor could conceivably eliminate coverage of services to treat an underlying health problem or an addiction. If a State intends to retain such direct responsibilities, such an omission makes sense. But when the State has calibrated its premium to the Federal definition, the omission leaves the State vulnerable to additional and unanticipated costs.

Medical necessity. As noted, State Medicaid agencies have had to develop medical necessity standards, because Federal Medicaid funds cannot be used for medically unnecessary services. The issue of medical necessity within Medicaid constitutes one of the most difficult challenges in shaping a Medicaid contract with an MCO. Insurance approval of reimbursement for services provided is generally based on proven eligibility and demonstrated medical necessity. When medical necessity is inappropriately applied, it can lead to problems of access to and duration of treatment services, access to prevention, remediation, rehabilitation, and chronic care, and to nontraditional services and service providers. The issue of medical necessity is discussed at length earlier in this chapter.

Limitations and Exclusions. As noted, insurance plans traditionally limit or exclude coverage for certain types of services, even when they fall into a covered category of service and are otherwise considered medically necessary. Three important categories of such services for individuals with mental illness or addictive disorders are court-ordered care, services provided in schools, and services provided in accordance with a written plan of treatment prepared by a child welfare agency, an early intervention agency, or another agency with a legal obligation to provide or arrange for services. States vary widely in their approaches with respect to coverage of these services, with some electing (either intentionally or as a result of failing to override the industry practice) to retain a direct obligation to pay for the service, and others providing for coverage by the MCO.

In the case of members enrolled in multiple treatment systems, contracts should reflect the State's express decisions regarding whether to require the MCO to provide services that are enumerated in the contract and that are found to be necessary by another agency. The contract language should delineate for the contractor: (a) the extent to which the contractor will be required to cover a particular service or a service furnished in a particular setting, (b) the right of the contractor to exclude certain services; and (c) the extent to which the contractor is bound by the opinion of the agency ordering provision of the service. For example, it is not enough to merely state that an MCO must cover services specified in an Individualized Education Plan. If the State wishes to make the school district's decision to provide a service legally binding on the MCO, it must specify this in the contract. If, on the other hand, the State simply wants the MCO to take the other agency's views into account in reaching its coverage determination, then this fact needs to be specified.

Delaware has decided to specifically limit the contractor's responsibility for services related to education and early intervention that are covered under the State Medicaid plan (Rosenbaum et al., 1997). Delaware's RFP states the following:

> *The MCO will be responsible for: (a) encouraging PCPs [primary care physicians] to participate in multidisciplinary assessment teams and coordinating assessments and services with the Department of Health and Social Services; (b) reimbursement of necessary treatments and medically necessary early intervention services identified during the assessment process and approved by the child's PCP.*
>
> *The MCO will not be financially responsible for therapy services (PT, OT, SP) included in an Individual Family Service Plan and provided in the public school setting. However, MCOs will be required to coordinate with [the Department].*

This provision permits the MCO to limit coverage to services that it (rather than the early intervention agency) approves, and excludes liability altogether for school services, direct payment responsibilities which are retained by the State. (The Medicaid statute prohibits denial of coverage for services on the grounds that they are included in a child's Individualized Education Plan or Individual Family Service Plan (42 U.S.C. 1396b(e)).

Coverage Under Medicaid. Purchasers may wish to address the following in RFPs and contracts:

Ensure that the delegation of Medicaid amount, duration, and scope requirements are clearly delineated.

Clarify whether the contractor carries out all Federal administrative and coverage obligations.

Ensure that there are no coverage limitations in the contract that would result in discrimination in the provision of care on the basis of a medical condition.

Ensure that if coverage limitations appear in the contract they will still be sufficient to meet the needs of the great majority of recipients.

Ensure that any across-the-board limitations are clearly identified and defined.

Ensure that there are no across-the-board limitations for children.

Ensure that the contract definition of medical necessity does not create unanticipated residual responsibilities for the State.

Ensure that MCO exclusions are consistent with Federal Medicaid law.

Ensure that the contract includes applicable Federal definitions so that MCO liability is coextensive with that of the State.

Ensure that contract language reflects the MCO's responsibility to cover services which arise from the actions of third parties.

2. The Substance Abuse and Mental Health Block Grants

The Substance Abuse Prevention and Treatment (SAPT) Block Grant (42 U.S.C. §§300x-21- 300x-35) and the Federal Community Mental Health Services (CMHS) Block Grant (Public Law 102-321; 42 U.S.C. §§300x-7-300x-8) programs provide funding to States to support activities related to the diagnosis, treatment, and prevention of mental illness and addictive disorders. Unlike Medicaid, these block grants do not establish an entitlement to coverage for eligible persons. The laws specify broadly how the block grant funds are to be used, but they give States considerable latitude in determining how best to serve the targeted populations.

Neither statute prohibits agencies from providing care through Fisk-transfer contracts with for-profit companies. Regardless of whether a State contracts with an MCO for certain benefits or services, State and county substance abuse and mental health agencies are responsible for ensuring that funds are spent in compliance with Federal law. Key provisions of the CMHS and SAPT laws that are relevant to managed care contracting are outlined below.

a. The Substance Abuse Prevention and Treatment (SAPT) Block Grant

Much as the CMHS Block Grant does, the SAPT Block Grant law (Public Law 102-321; 42 U.S.C. §§300x-21-300x-35) has certain minimum service requirements:

Not less than 35 percent of the grant can be spent on prevention and treatment activities related to alcohol, and not less than 35 percent on activities related to drugs.

Not less than 20 percent can be spent on substance abuse education and counseling and other risk reduction services, with priority given to population groups at risk for substance abuse.

A minimum portion of a State's Federal allocation must be spent on treatment for pregnant women and women with dependent children (this provision can be waived in States that can demonstrate that they are providing an adequate level of treatment services as indicated by a comparison of the number of such women seeking services with the available service capacity).

The statute specifies treatment timelines for individuals requesting treatment for injection drug use; an individual must be admitted to treatment within 14 days after the request, or 120 days in the event that treatment programs funded under the act have reached capacity (42 U.S.C. §300x-23(a)). In the case of pregnant women, stricter treatment timelines are established, and preference is given to them when facilities have limited capacities (42 U.S.C. §300x-27).

The statute requires entities receiving funds to routinely make available tuberculosis services to each individual receiving substance abuse treatment. The term "tuberculosis services" means counseling, testing and providing such services (42 U.S.C. §300x-24(a)).

The statute requires designated States to carry out one or more projects to make available to individuals early intervention services for HIV disease at the sites at which individuals are undergoing treatment for substance abuse. The term "early intervention services for HIV disease" refers to appropriate pretest counseling; testing to confirm the presence of HIV; tests to diagnose the extent of the deficiency in the immune system; tests to provide information on appropriate therapeutic measures for preventing and treating conditions arising from the disease; and appropriate posttest counseling. The term "designated

States" refers to States with an AIDS case rate of 10 or more such cases per 100,000 individuals (as reported to and confirmed by the Director of the Centers for Disease Control and Prevention for the most recent calendar year for which such data are available). The law exempts a State from having to offer these services through at least one rural site if there is "insufficient" demand (42 U.S.C. §300x-24(b)).

The statute contains third-party liability recovery provisions that prohibit payment if payment has been made or can reasonably be expected to be made under Medicare or Medicaid programs or another insurance program (42 U.S.C. §300x-31(a)).

The SAPT Block Grant places several important limitations on a State's discretion to contract with an MCO for the delivery of services financed in whole or in part with block grant funds. Unlike the CMHS Block Grant (see below), the SAPT statute does not delineate "qualified providers," nor does it mandate an open-door policy. However, the law does provide for minimum service allotments (e.g., for pregnant women). This provision limits a State's ability to use funds to sponsor enrollment of other individuals unless the State can document that other funds are available to adequately serve the target population.

The SAPT Block Grant has other restrictions. Funds may not be used to pay for inpatient hospital services, to make cash payments to intended recipients of services, to make capital or major equipment improvements, to satisfy non-Federal spending requirements under any other Federal program, or for care and services not authorized under the Ryan White Act. Finally, the SAPT Block Grant also places a 5 percent limitation on a State's use of Federal funds for administrative purposes, and these limitations would have to be reflected in the administrative payment components of the premium.

Purchasers can review services and activities included in the benefit plan and then make a determination about the components of the SAPT statutes and regulations that are relevant. Several States (e.g., Iowa, Minnesota, Oregon, Colorado, Montana, and Maryland) have experience developing RFPs, reviewing contractor proposals, negotiating and awarding contracts, and monitoring MCO performance in relation to SAPT Block Grant funds. (Appendix D provides an example of SAPT Block Grant funding contract language used by Colorado.)

b. The Community Mental Health Services (CMHS) Block Grant

The Community Mental Health Services Act (Public Law 102-321; 42 U.S.C. §§300x-7-300x-8) specifies that Federal CMHS Block Grant funds should be allocated to meet the needs of adults with a serious mental illness and children with a serious emotional disturbance (see definitions in Appendix E), but it does not regulate how States should spend CMHS Block Grant funds. This law gives the Federal Government less authority over States in terms of shaping contracting practices than the SAPT Block Grant law does.

To establish a framework for how CMHS Block Grant funds should be used, the Federal Center for Mental Health Services developed a set of 12 "criteria" or goals. When States use CMHS Block Grant funds to purchase mental health services from an MCO, they must determine which CHMS criteria apply and ensure that the contract clarifies how the MCO will address the criteria. The Center for Mental Health Services enters into contracts with teams of experts to monitor use of CMHS Block Grant funds by the MCO and its network providers. The Center for Mental Health Services has recently consolidated its 12 criteria for how CMHS Block Grant funds should be used to five criteria. Complying with the new set of criteria is optional until current reauthorization legislation takes effect and mandates compliance by fiscal year 1999 (see Appendix F for a list of the 12 old and 5 new criteria).

The Center for Mental Health Services emphasizes that services should be targeted to populations based on the presence of functional impairment that substantially interferes with or limits the performance of one or more major life activities, in addition to a qualifying diagnosis. As examples of target populations, the Center for Mental Health Services cites the most seriously disturbed adults with serious mental illness and children with a serious emotional disturbance and their families, individuals with schizophrenia and major mood disorders, and individuals with serious mental illness who are homeless or involved with the criminal justice system.

The Community Mental Health Services Act sets forth a series of limitations on how CMHS Block Grant funds can be used:

The State must spend funds on "adults with a serious mental illness" and "children with a serious emotional disturbance" (42 U.S.C. §300x-1(a)). The Secretary of Health and Human Services is required to define these populations in regulations (see definitions in Appendix E).

Minimum allocation requirements for services to children with serious emotional disturbances must be met.

The contract must be developed as part of a "plan for the development and implementation of an organized community based system of care," which includes "quantitative targets" regarding the number of individuals to be served and the services provided.

At a minimum, the contract arguably must provide case management as a service benefit, since case management is the one service that is identified as required in the State plan (42 U.S.C. §300x-1(b)(7)). (Of course, the State could carve out case management and continue to purchase these services from noncontractor providers, but presumably case management services are at the core of this type of contract.)

The contract must be part of an overall plan that includes at least some level of service to persons who are homeless.

The contract must be part of a plan that "provides for a system of integrated social services, educational services, juvenile services, and substance abuse services for children with serious emotional disorders, along with mental health services."

The contract must be part of a plan that targets defined geographic areas for service.

Most notably, perhaps, States are restricted to providing services with funds appropriated under the law "only through appropriate qualified community programs (which may include community mental health centers [CMHCs], child mental health programs, psychosocial rehabilitation programs, mental health peer-supported programs, and mental health primary consumer directed programs)" (42 U.S.C. §300x-2(b)).

To the extent that CMHCs are part of a State's treatment system, the centers must meet certain minimum qualification criteria (42 U.S.C. §300x-2). These criteria include certain minimum service requirements within a geographically defined service area, including outpatient services for target populations, 24-hour-a-day emergency care services, day treatment, and preadmission patient screening services. Services must be provided (within the limits of the capacities of the centers) to any individual residing or employed in the service area of the center "regardless of ability to pay."

As broadly as it is drafted, the Community Mental Health Services Act appears to place some limitations on a State's discretion to spend service funds through managed care contracts. First, it appears to limit services to those provided through qualified community programs. This requirement appears to limit a State to drafting contracts in which Center for Mental Health Services-financed services are offered through a network that consists only of providers with appropriate "community program" attributes, as the term is used in the statute. This restriction does not exist in Medicaid managed care contracting, where freedom of choice on the part of plans is a primary component of the law.

Second, the act appears in effect to limit a State to drafting contracts to provide services to uninsured persons rather than to provide supplemental services to Medicaid beneficiaries. This is because the required services that must be furnished by qualified community programs are all currently or potentially reimbursable under Medicaid. It is possible, of course, that a State's Medicaid plan would not cover these basic services, although when unbundled, virtually all of the minimum services represent mandatory Medicaid services (i.e., they consist of physician services, outpatient hospital care, emergency hospital care, and services for children). Consequently, since CMHS Block Grant-sponsored managed care contracts must cover these services if a State is to be in compliance with Federal requirements, then presumably block grant funds would be used to buy enrollment for uninsured persons rather than to fill service gaps for Medicaid beneficiaries (unless, of course, the overall funding made available through the block grant surpasses the amount needed to make the required services available in the contractor's service area).

Finally, reconciling the "open-door" policy of the Community Mental Health Services Act with the fundamental principles of managed care is not a simple task. The statute requires CMHCs to serve all residents in their service area without regard to their ability to pay. On the other hand, a managed care service agreement by definition covers specific members, not a geographic area. An open-door policy is fundamentally inconsistent with the notion of plan membership and risk contracting.

Contracts sponsored with CMHS Block Grant funds could be financed through a small amount of funding set aside for use to purchase membership. It would appear, however, that the State would have to retain funds to pay CMHCs

directly in order to sustain their required open-door policy to nonmembers. In the alternative, the State's contract could include a charitable services provision that effectively requires the MCO to maintain its CMHC provider network members in "open-door mode" with respect to the mandatory minimum services enumerated in the statute. Because this type of requirement would be fundamentally inconsistent with the principles of managed care, its utility is questionable.

In addition to these considerations, certain State expenditures under the CMHS Block Grant statute are not permissible. Impermissible activities include inpatient care, cash payments to intended recipients of care, purchase or improvement of land or other major capital construction or equipment purchase, or to supplant non-Federal spending requirements. Thus, a contract should specify these activities as excluded from the scope of the agreement.

While the CMHS Block Grant statute and regulations are often ambiguous, they do contain a prohibition against using block grant funds "to provide financial assistance to any entity other than a public or nonprofit private entity." In addressing questions regarding the use of these funds to purchase services from a for-profit company, legal counsel from the Substance Abuse and Mental Health Services Administration (SAMHSA) has determined that the contracts would appear to be appropriately referred to as a "procurement contract," rather than a form of "financial assistance." Consequently, when a purchaser is seeking to acquire the services of a managed care company to carry out functions that it would otherwise perform under the block grant, the statutes would not appear to act as a bar to contracting.

Finally, States are prohibited from spending more than 5 percent of their CMHS Block Grant funds on administrative expenses. MCOs' administrative costs are considerably higher than this. Thus, in drafting a managed care contract, a State should clarify that the portion of the premium used by the MCO to administer the plan is derived from separate State funds rather than from the Federal allocation.

SAPT and CMHS Block Grants. Purchasers may wish to address the following in RFPs and contracts:

- Specifically identify all statutory and regulatory requirements of the block grant that the MCO is obligated to fulfill, including how relevant criteria are to be addressed.
- Establish the MCO's reporting responsibilities so that reports will be sufficient to fulfill the purchaser's monitoring responsibilities and Federal oversight needs.
- Define the MCO's responsibility for any administrative fees related to the management of the grant.
- Specify a plan for mediating the differences between the confidentiality regulations of CSAT, the Center for Mental Health Services, and Medicaid, noting that the CSAT guidelines are the most stringent and therefore are the easiest to adhere to universally when administering an integrated system.
- Determine whether block grant requirements will be met in the aggregate or on a statewide basis or passed on to providers in subcontracts.
- Specify that all services purchased by the MCO with identified block grant funds must be provided by public agencies or private nonprofit entities.
- Require that the MCO make a separate accounting for these funds to allow the purchaser to determine and demonstrate they were expended in accordance with Federal requirements.

[1.] Residual responsibility is a hallmark of Medicaid managed care purchasing. Since the Medicaid program is far broader and deeper in its coverage than any traditional insurance product, no matter how comprehensive, there are some responsibilities that no MCO is willing or able to take on. These responsibilities, which remain with State Medicaid program purchasing services from the MCO, are called "residual" responsibilities.

[2.] As discussed later in this chapter, Medicaid and theSubstance Abuse Prevention and Treatment (SAPT) and Community Mental Health Services (CMHS) Block Grants have their own requirements regarding use of funds.

[3] One State, Oregon, received waivers of Federal Medicaid coverage rules under Section 1115 of the Social Security Act in order to conduct a demonstration under which plans are paid a defined contribution for their services and may vary the Federal Medicaid benefit package in accordance with a special State priority-setting system. No other State's Section 1115 demonstration includes waivers of the defined benefit structure of Medicaid, although certain States may provide fewer defined benefits for their demonstration-eligible populations (Rosenbaum and Darnell, 1997).

[4] See, for example, *Adams vs. Blue Cross/Blue Shield of Maryland* [757 F. Supp. 661 (D. Md., 1991)].

[5] Because of Federal statutory and regulatory requirements governing Medicaid managed care purchasing, purchasers of behavioral managed care services are cautioned against combining several sources of public funding into a single procurement unless all funds can be subject to Medicaid requirements. Even in this situation, non-Medicaid sources of funding, such as the CMHS and SAPT Block Grants, have their own requirements regarding use of funds.

[6] A State agency may require first exhausting a plan's grievance process. All Medicaid beneficiaries, regardless of their managed care status, however, are entitled to a fair hearing when they are aggrieved by any decision of the State. Since the MCO is making decisions on the State's behalf, enrollees in a managed care plan have the right to a fair hearing. The State's duty to provide a constitutional-level fair hearing is not delegable to an informal grievance system that is part of the plan (*Wadley v. Daniels*, 926 F. Supp. 1305; (M.D.Tenn., 1996); *J. K. v. Dillenberg*, 836 F. Supp. 694 (D. Ariz., 1993)).

CHAPTER IV

Contracting for Network Services

Key issues in this chapter:

- Specifying the capacity and composition of the MCO's provider network
- Selecting providers for the network
- Ensuring enrollees' access to network services
- Subcontracting with providers
- Establishing qualification standards for provider staff
- Monitoring providers' performance

The basis of a managed care initiative is often the delivery of contracted services through a network of participating providers, so careful selection of providers in the network is critical. A fundamental feature of virtually all State and county contracts with managed care organizations (MCOs) is the MCO's ability to demonstrate an adequate provider network. However, some States and counties permit the MCOs that win the contract to finalize their provider networks between the time of contract award and actual implementation.

This chapter discusses several aspects of the development of effective provider networks:

- Specifying the capacity and composition of the MCO's provider network;
- Selecting providers for the network;
- Ensuring enrollees' access to network services;
- Subcontracting with providers;

- Establishing qualification standards for provider staff; and
- Monitoring providers' performance.

A.Specifying the Capacity and Composition of the MCO's Provider Network

1. Provider Network Capacity

An effective contract will ensure that the MCO's provider network has the capacity to provide enrollees with access to the full range of contracted services. In Medicaid managed care initiatives, this feature is mandatory for compliance with Federal Medicaid law. The concept of "sufficient capacity" of a network is difficult to define, however, and will certainly evolve over time. Generally, sufficient capacity can best be understood by examining the strengths and weaknesses of the current provider system, identifying gaps in services and/or in management capability, and soliciting input from consumers and their families, providers, advocates, related agencies, and other stakeholders. This approach will provide the information necessary to build an infrastructure that can support the goals of the initiative in many areas (e.g., data systems; management, clinical, and financial controls).

There are several means by which the issue of sufficient capacity can be addressed. Under Federal Medicaid law, it is the State's duty to ensure adequate access and capacity regardless of the type of arrangement the MCO has with the network. Most purchasers address one or more dimensions of capacity and access in their contracts (Rosenbaum et al., 1997). Purchasers can use the request for proposal (RFP) to give bidders comprehensive information related to capacity needs; this approach is likely to lead to proposals that are relatively consistent with the purchaser's expectations and lay the foundation for capacity-related provisions in the contract. Alternatively, the purchaser may require the MCO to submit a capacity-development plan for purchaser approval.

The benefit package provides the foundation upon which capacity requirements can be determined and should guide the MCO's decisions about the composition of the provider network. Other factors to be considered include current capacity of service programs and existing systems; population-specific utilization patterns, if known; areas of insufficient capacity; anticipated changes in utilization upon implementation of managed care; environmental, geographic, and cultural/ethnic variables that may affect service access; and plans for equalizing service resources and enrollee access across regions. The RFP and the contract should specify the purchaser's desires for geographic access, access to timely appointments, and access to a full range of appropriate providers and should describe the mechanisms that will be used to monitor access. (Capacity standards may have to be adapted for rural and frontier areas, as geographic access is more difficult to achieve.)

Provider Network Capacity. Purchasers may wish to address the following in RFPs and contracts:

Establish access standards that can be quantified and monitored, and require the MCO to demonstrate the capacity to provide and monitor access as defined by the purchaser.

Require the MCO to have full capacity available on the contract start date, or stipulate that specified services may be phased-in on an approved timetable and/or on a regional basis.

Specify the MCO's responsibilities for addressing unexpected capacity demands, such as unforeseen gaps in services, disasters, and newly emerging needs.

Establish allowable variations in minimum capacity due to regional factors (such as urban versus rural capabilities), available modalities of care, and/or other purchaser-specified factors.

Establish conditions under which enrollees are permitted to use out-of-network providers.

Network Services in a Rural Environment*

Although 23 percent of the U.S. population lived in rural areas at the time of the last census (U.S. Bureau of the

Census, 1988, 1989), most MCO experience has been developed and refined in urban and suburban environments. The accessibility of behavioral health care services in rural areas is often severely compromised because of a limited supply of providers, inadequate ancillary services, and substantial distances for enrollees to travel to obtain treatment services.

Developing optimal network services in rural areas requires creativity, innovative strategies, and, increasingly, communication technologies. Strategies may include the following:

- Systematic training of local health care providers in screening, assessing, referring, and treating mental and addictive disorders;
- Increased use of "telemedicine" approaches: video systems, computer-based video hookups, and electronic mail communication to strengthen linkages of rural residents with professional help in urban areas;
- Mobile units and "circuit-riding" providers who regularly visit small town clinics; and
- Clinically staffed 800 numbers to provide information, screening, assessment, referral, triage, and crisis counseling.

Each rural environment offers unique opportunities and challenges in developing the most effective network systems. Purchasers that have a significant number of enrollees in rural areas should ensure that the RFP and contract specifically address the ways in which the MCO and its provider network will creatively approach the challenges of meeting the behavioral health care needs of rural residents.

*According to the U.S. Bureau of the Census, a rural area is a county without a central city or without two cities of 50,000 or more in population, or a county or town with areas of open country and fewer than 2,500 people.

2. Composition and Structure of the Provider Network

Purchasers can also use the RFP and the contract to shape the overall composition, structure, and characteristics of the provider network. Requirements may vary substantially based on the goals of the managed care initiative and unique characteristics of the enrollee population to be served. For example, a purchaser with a large percentage of enrollees from one or more ethnic groups may wish to require the development or expansion of culturally specific services and/or the active utilization of traditional community-based organizations with experience serving those groups. Similarly, a purchaser with a significant percentage of enrollees in rural areas may want to be explicit in the RFP and the contract in terms of rural network needs (see box above).

Adults with severe and persistent mental illness (SPMI) and children with serious emotional disorders (SED) are two other subpopulations who have very specific network needs. These include providers with specialized training and experience, coordination with accessible providers of clinically important wraparound support services. Effective mechanisms for referral to such nonreimbursable but necessary services consistently improve treatment outcomes, and network developers may wish to create a more seamless system of care by establishing cost-sharing arrangements with key agencies to help enrollees obtain these services.

Network Composition. Purchasers may wish to address the following in RFPs and contracts:

Describe the required clinical and administrative capacity of the network, including providers' capabilities and their capacity to accept new referrals, as well as licensure, credentialing, board certification, and accreditation requirements.

Establish minimum guidelines for providers' competence and experience in serving the covered enrollee population.

Establish the means by which consumers will most successfully obtain needed wraparound services.

Establish whether providers must meet Medicaid or other regulatory requirements regarding certification, licensure, accreditation, and/or eligibility for reimbursement.

Establish the network strategy for meeting the cultural- and gender-specific needs of consumers.

Ensure that emergency service teams have expertise in assessing adults with substance use disorders, children, and other purchaser-specified populations.

Ensure that Medicaid management services include child experts, and that mechanisms are in place for reporting child abuse, institutional abuse, and domestic violence.

Ensure that there is an adequate safety net so that children and families have a choice of providers in a given region.

Specify the desired processes and relationships between the MCO and services provided by State or county employees (e.g., State psychiatric hospitals).

Establish minimum thresholds regarding desired credentialing standards.

Permit (as is done in Colorado) or prohibit (as is done in Massachusetts) the MCO from directly delivering care using its own staff or programs.

Establish measurable expectations regarding the degree of coordination of substance abuse and mental health treatment services with primary health care services.

Establish any necessary antitrust controls, both prior to and after contracts are developed with providers.

Establish minimum requirements regarding strong functional linkages to housing and rehabilitation providers when serving adults with SPMI.

Establish an ongoing mechanism for measurement and monitoring of the adequacy of network composition and capacity.

B. Selecting Providers for the Network

1. Selection of Providers

The selection of providers for an MCO's network will largely determine the accessibility, range, and quality of services the MCO provides. The provider selection process can vary substantially depending on a number of factors:

Whether a competitive procurement process is being established;

Whether an MCO bidding on the contract is allowed directly to provide services with its staff and programs (e.g., staff model health maintenance organizations [HMOs]);

Whether an MCO develops a business and/or legal partnership with a local provider organization(s);

Purchaser philosophies, experience, and perspectives;

Availability, willingness, and capacity of providers to serve the target population in a defined area; and

Clinical philosophy and approach of the MCO.

If the purchaser wishes to establish minimum requirements for the process of selection and deselection, it must do so in the contract. Federal Medicaid standards do not create any substantive requirements in this area, other than a general prohibition against arbitrary discrimination against certain classes of providers (see discussion below), although Federal Medicaid law extensively protects the MCO's selection and deselection process itself. In a number

of States, courts have enjoined MCOs from arbitrarily denying admission to networks or deselecting network members (see cases cited in Chapter 2 of Rosenblatt, Law, & Rosenbaum, 1997).

MCOs are increasingly developing partnerships with local provider organizations to bid on public sector contracts. These partnerships are often formed long before the RFP is released. When development of such partnerships is likely, the purchaser may want specifically to require the providers to comply with applicable specifications in the RFP and contract regarding selection of individual providers. In addition, the MCO must be able to show the purchaser that it has demonstrated due diligence in considering a range of area providers in its selection process.

In many situations, however, network providers are selected in a highly visible competitive procurement process that is likely to be closely monitored by stakeholders. Competitive selection processes must effectively incorporate several, often conflicting, factors, including estimates of capacity needs, desired characteristics of the network providers, clinical needs of the enrollees, regional considerations, stakeholder input, and usually a host of political, legal, and/or business factors.

Competing in the network provider selection process may be the first time that providers from the public and private sectors compete openly with one another. The purchaser should ensure in the contract that the MCO's process for selecting providers is conducted in an open and objective manner that can withstand public, clinical, and legal scrutiny and is in the best interests of the enrollee population. Since the MCO is effectively undertaking a procurement of publicly financed services on the purchaser's behalf, certain aspects of the State's procurement laws apply. Purchasers should generally consult with legal counsel if they allow the MCO to select provider networks through a competitive procurement.

The purchaser must often balance the desire to protect current service providers and to have a broad network with the goals of obtaining favorable financial and clinical arrangements with providers. In general, the greater the number of providers actively participating in a network, the more difficult it is for the MCO to monitor practice patterns, to carry out credentialing activities, and to negotiate substantial discounts that rely on patient referral volume.

One of the most important factors in the MCO's selection of providers is whether the MCO uses a competitive process, a noncompetitive process, or a combination of both to procure some or all network services. Although MCOs generally use competitive processes to lower costs, to limit the network of providers, and to increase accountability, some MCOs choose a noncompetitive procurement when services are not widely available. These may include specialty services, services for which there is no excess capacity, services that require widespread local availability (e.g., outpatient services), and other situations in which there is little likelihood of achieving savings, increasing efficiency, and/or improving quality via a competitive process.

Another factor that promotes noncompetitive procurement is "any willing provider" legislation that has been enacted in several States in order to support participation of local and private providers and practitioners. Such legislation stipulates that MCOs must contract with any provider who is "willing to meet the terms and conditions of the payment contract." Purchasers should be aware that MCOs can minimize the impact of such legislation by creating "tiered" networks in which "preferred" providers are sent the bulk of cases and mandated provider applicants are technically included in the network but receive few, if any, referrals. While such practices may support purchaser and MCO goals of clinical and financial control, efficiency, or geographic access, they may violate the law's intention to maintain open networks with broad access. If a purchaser is particularly concerned about access for certain types of providers, it should specify inclusion of those providers in the contract and include standards, measures, and sanctions for nonperformance.

Selection of Providers. Purchasers may wish to address the following in RFPs and contracts:

- Specify whether the MCO should use a competitive, noncompetitive, or mixed process to procure services, either for all services, or by levels and/or types of care.

- Establish implementation plans with timelines for procuring network services systemwide, by region, and/or by level of care.

Require the MCO to solicit input from consumers and their families and other stakeholders on provider selection procedures and criteria.

Ensure that MCO solicitation practices are consistent with applicable State and/or Federal laws.

Require the development of comprehensive performance expectations for all procured services.

Ensure that selected network providers meet overall and regional capacity needs for all covered services and special populations.

Establish formal, objective, and documentable procedures and criteria for MCO review of providers' proposals for network membership.

Establish a formal review and appeals process so that providers can address perceived inequities in the solicitation process.

Require provider grievance and appeals procedures, with appeal to the purchaser if unresolved, concerning financial arrangements, referrals, use of utilization management (UM) or utilization review (UR), and advocacy for consumer services.

Require that the MCO contract only with specified classes of providers, such as those that are fully licensed and board certified; State-approved vendors, practitioners, and facilities; federally qualified health maintenance organizations (HMOs); and community mental health centers.

Require that a specified percentage of enrollees be referred to community-based organizations for a defined period of time.

Address whether the MCO can transfer legal liability to the provider for any actions that result from MCO decisions, and vice versa.

Because "gag" clauses are now banned, prohibit any contract provisions between the MCO and the provider that prevents the health care provider from disclosing to enrollees any information that the provider believes to be appropriate about possible courses of treatment and/or provision of tests.

2. Types of Providers

The RFP and the contract can prohibit or encourage the selection and utilization of certain types of providers in the network. A wide range of providers deliver substance abuse and mental health services and can be viable candidates for inclusion in an MCO's provider network. These may include traditional nonprofit and other community-based organizations, public health care institutions, for-profit health care organizations, provider-sponsored networks, State- or county-funded agencies, institutions that provide direct services, hospital-based systems, primary health care providers, school-based clinics, group practices, individual practitioners, and consumer-run organizations. Three types of providers are increasingly involved in managed care initiatives and/or addressed in managed care contracts: community-based organizations (CBOs), public institutions, and provider-sponsored networks.

a. Community-Based Organizations (CBOs)

Given the complex needs of many enrollees in public sector managed care initiatives, purchasers may wish to promote the active involvement of CBOs to provide substance abuse and mental health services. These organizations have historically been the linchpin of public sector services and usually have substantial experience providing services to some of the most challenging public sector consumers. At least 26 States that maintain full-service managed care Medicaid agreements address to some degree the issue of the safety net and of inclusion of traditional providers in their contracts with MCOs.[(1)]

In recent years, managed behavioral health care organizations (MBHOs) have increasingly made efforts to develop partnerships with CBOs when bidding on contracts and have recruited administrators with strong public sector experience into their organizations. However, some MCOs are more inclined to establish or maintain contracts with

network provider systems that are designed for commercially insured populations (Rosenbaum et al., 1997) or that have administrative and/or clinical staff with little or no public sector experience. This sometimes raises concerns that an MCO will not include a sufficient number of CBOs in the network and that this may negatively impact the consumers' level of functioning.

Purchasers can use the RFP and contract to promote or require the inclusion of CBOs that have historically served clients whose care was supported by public funds. As with the selection of any provider, the purchaser's desire to include community providers needs to be balanced with an equal concern for the quality of services the provider is capable of delivering. Purchasers should appreciate that many CBOs provided a safety net for the public sector before it was profitable to do so. They may therefore have insufficient funds to invest in improving buildings, developing more sophisticated management information systems (MIS), hiring high-salaried staff, and so forth. CBOs can be highly vulnerable in the transition to a competitive marketplace. Given this situation, purchasers and MCOs sometimes face challenging dilemmas about the adequacy of some CBOs to function in a new managed care initiative. Purchasers should be sensitive to the fact that mandated inclusion of providers who are ill-prepared to function in a specific initiative may result in substandard service, and appropriate safeguards should be established. To help address this issue, the Federal Center for Substance Abuse Treatment (CSAT) has recently established a contract to provide technical assistance and training to CBOs across the country regarding improving business practices and successfully adjusting to a more competitive business environment.

Purchasers who want to ensure that CBOs are included in the MCO's initial provider network and receive adequate referrals can require that certain providers or categories of providers be included in the network as "essential community providers" (ECPs), usually for a defined period of time. The basic principles underlying this inclusive approach are that many CBOs with extensive experience treating the enrollee population should be given the opportunity to adapt to the managed care environment and that consumers of substance abuse and mental health services should not be expected to make abrupt transitions to new providers.

b. Public Institutions

Many purchasers may wish to include State or other public institutions, such as State hospitals, in the MCO's provider network and to "re-engineer" their public system to ensure that government-operated services are one component of the new managed care system. It may be the goal of other purchasers to restructure the service delivery system or to reduce reliance on certain providers or modalities (e.g., State hospitals, long-term residential placements for children). The purchaser may use the contract to construct provider networks consistent with these goals. State laws vary on whether public institutions can provide services as part of a managed care network. Purchasers should exercise due diligence, investigate and protect themselves from liability at unaccredited State facilities.

Nearly half the States surveyed by the Bazelon Center for Mental Health Law (1997) indicated that they include, or plan to include, public institutions in their managed care initiatives. There are many ways to include these institutions, including fee-for-service arrangements. Almost all State hospitals are accredited as a requirement for receiving Medicaid reimbursement. Nonetheless, there may be pitfalls depending on State laws, and purchasers should address several questions before requiring inclusion of public institutions in an MCO's network.

Inclusion of Public Institutions in an MCO Network:

Questions To Ask

Does some or all of the public mental health or substance abuse treatment system operate under court supervision, court mandates, or consent agreements that may affect the ability to participate in managed care restructuring?

Does State law allow a State institution to participate in a competitive market?

Does the institution have to be accredited or licensed?

Does the institution have substantial consumer lawsuits outstanding?

Can State or county employees be held accountable by a private sector MCO?

Can State hospitals accept risk-sharing performance contracts from MCOs?

Is the legislative appropriation to the State hospital included in or affected by the MCO contract?

Will the State institution offer services for "free" or be reimbursed by the MCO on a fee-for-service or a risk-sharing basis?

Will the public institution accept patients for admission after covered benefits are exhausted?

How will case management be coordinated between the public institution and the MCO?

Does State procurement law limit the participation of a public institution in a provider-sponsored organization that seeks a managed care contract?

c. Provider-Sponsored Networks (PSNs)

A PSN is a group of providers who have affiliated to pool administrative, financial, and/or clinical resources to improve efficiencies and strategically enhance their position in the health care marketplace. Providers that wish to establish PSNs must be careful about antitrust and restraint of trade issues and should engage the services of legal counsel early in their deliberations. Purchasers can use the RFP and the contract to prohibit, encourage, or mandate the involvement of PSNs in the management or provision of treatment services. PSNs often seek a legal partnership with an MCO, hospital, or other health care organization to strengthen their financial position. Because State laws vary concerning the regulation and legal framework under which PSNs may be formed and operated, purchasers should ensure that the RFP and contract reflect a full understanding of these issues.

Types of Providers. Purchasers may wish to address the following in RFPs and contracts:

Establish requirements for the MCO to use certain types of providers (e.g., State hospitals, federally qualified HMOs, State or nationally certified substance abuse counselors or prevention service providers, or nonprofit community-based organizations).

Establish requirements for the MCO to establish procedural linkages to certain types of providers for specific services (e.g., acceptance of screening evaluations from specific categories of community-based prevention service providers; referral and transfer to a State- or community-provided list of service providers for aftercare).

Establish capitalization requirements that do not functionally prohibit community-based, nonprofit organizations from submitting bids.

Establish clinical, administrative, and/or financial requirements that support active involvement of community-based organizations (CBOs).

Clarify the capacity to establish, as needed, different financial arrangements for similar types of State- or county-operated programs.

Confirm that the purchaser is able to assume legal liability for clinical decisions made by the public institution, possibly requiring special indemnification arrangements and/or reinsurance.

Designate specific provider organization(s) to be included and used in the provider network, including consumer-run and peer-support programs, if desired.

Address any issues related to labor unions and/or exclusions regarding outsourcing.

Create the operational definition, and define the privileges and expectations of an essential community provider (ECP).

Define the types of agencies and/or the criteria that can qualify as an ECP.

Establish mechanisms to monitor referral and utilization of the services of ECPs.

Establish a minimum amount or percentage of referrals or overall service utilization to occur in ECPs.

Establish timeframes for ECP status to terminate.

Establish any special means by which ECP performance will be measured.

Require the MCO to provide training and/or technical assistance to CBOs, as needed and approved by the purchaser.

Define the referral relationship between the MCO and the public institution.

C. Ensuring Enrollees' Access to Network Services

One of the most important responsibilities of a public purchaser of managed care is to ensure that enrollees in managed care systems have prompt and easy access to network services. Such access is a hallmark of a high-quality health care system. The Health Care Financing Administration (HCFA) requires a demonstration of access for Medicaid managed care systems operated under Medicaid waivers.

Ensuring access to services for individuals who rely on public sector service systems can be very challenging. Individuals served by public sector systems often lack the resources to obtain services from complex and bureaucratic health care systems, and their mental and/or addictive disorders often exacerbate access problems. Many of them also lack transportation and/or child care. For reasons such as these, individuals in the population served by public sector systems often require specialized support to gain access to health care and ancillary services they need. A well-designed managed care system can coordinate services and facilitate the movement of enrollees through the clinical care system, creating an opportunity for purchasers to significantly increase access for their vulnerable populations by identifying the components of access that are most likely to be meaningful to consumers.

Determining what constitutes good access and developing reliable measures of access is also very challenging. Performance measures are usually based on quantifiable data, so evaluations are often limited by what is easily quantifiable, limiting their range and meaningfulness.

The fundamental components of access that are most likely to be relevant to enrollees are summarized below, along with points to consider when developing RFPs and contracts.

1. Components of Access

a. Information/Education Needs

Enrollees, providers, and MCO employees require comprehensive and up-to-date information about the services that are available and how to use them. It may be necessary to make this information available in several languages and to ensure that it is written at a basic reading level. The methods by which this information is conveyed to enrollees varies. Consumer handbooks, brochures, pamphlets, and posters are often used, although educational strategies for those who can't read should also be developed.

Information/Education Needs. Purchasers may wish to address the following in RFPs and contracts:

Specify the degree to which the purchaser, the MCO, or both, are responsible for ensuring the availability of information to all enrollees, network providers, and other interested parties.

Require a handbook that provides guidance to clinicians and provider organizations on difficult or unfamiliar situations.

Specify the type of information to be provided at enrollment and re-enrollment, such as services covered (including services for specialized populations), exclusions, limitations on coverage, explanation of a 24-hour toll-free line, grievance procedures, disenrollment criteria, procedures for determining the appropriate treatment level, access to representation, and other enrollee rights and privileges.

Require that information (including consumer handbooks) is free of technical jargon, formatted in an easy-to-read style, and available in the primary languages of the enrollee population.

Specify the reading level at which the information should be written.

Require the MCO to develop and maintain an up-to-date list of all organizations, clinicians, and other service providers in the network, including names, addresses, telephone numbers, specialties, license numbers, and other relevant information.

Clarify how enrollees are to access and use primary health care services and medications, how these services will be coordinated with behavioral health services, and how access and utilization of these services will be monitored and tracked by the MCO.

Require an easily accessed enrollee services unit to provide enrollees with information, answer questions, give recommendations, and resolve complaints.

Require that essential materials be adapted to meet the needs of those with disabilities (e.g., audiotapes upon request, large-print versions of consumer materials).

b. Ease of Initial Access

The ease with which an enrollee can initially access services is a fundamental component of access. Rosenbaum et al., (1997) found that some enrollees in managed care systems sometimes have to negotiate with as many as three different entities to obtain initial services (e.g., outpatient assessment, detoxification). Increasingly, MCOs are allowing direct access/self-referral for certain types of initial services.

A number of States maintain strict specifications with respect to initial access in order to ensure that MCOs begin serving enrollees promptly. Ensuring that MCOs serve enrollees promptly is particularly important given the relatively brief periods of enrollment that many beneficiaries may face because of interrupted Medicaid eligibility, a problem that has grown since the enactment of the 1996 welfare reform legislation.

Particularly crucial may be the establishment of minimum performance standards for the selection of a primary care provider, including access to lists of participating providers that are kept up to date and that contain addresses and telephone numbers; assistance in selection; timelines for selection; requirements to honor patients' choice of providers; and permissible procedures for situations in which patients fail to select providers. In the absence of specifications, an MCO may devise its own procedures, including large-scale assignment of nonselecting patients to providers with whom the MCO has negotiated additional discounts. This practice of auto-assigning patients to certain providers may result in the disruption of care in the case of persons who have chosen an MCO because their provider is a member.

Most States do not require that MCOs honor patients' choice of a primary care provider. Instead, they permit the MCO some discretion in deciding whether or not to assign the patient to his or her provider of choice. The Massachusetts contract establishes particularly stringent specifications for the assignment of patients (Rosenbaum et al., 1997):

In the event that the Contractor is unable to elicit a PCP [primary care provider] selection from an enrollee, the Contractor shall assign a PCP to such enrollee within two business days of obtaining enrollment information . . . Such PCP assignment shall meet the following criteria:

a. The PCP shall be within a 15-mile radius and/or 30 minutes' traveling time from the enrollee's home address. Within urban locations this shall take into account walking and public transportation.

b. The contractor shall determine whether the assigned enrollee had previously received services under the Contractor's plan, within the last two years, under either Medicaid or a commercial membership, where the recipient had a minimum of two claims with a PCP during that two-year period.

-If the enrollee received a minimum of two services from a PCP in the Contractor's plan, the HMO shall automatically assign the enrollee to the PCP.

-If the enrollee did not have a pre-existing relationship with a PCP who participates in the contractor's plan, the Contractor shall determine an alternate methodology to automatically assign enrollees to a PCP.

Ease of Initial Access. Purchasers may wish to address the following in RFPs and contracts:

Specify the model(s) of initial access to services to be used by the MCO.

Specify whether behavioral health care services can be accessed directly without going through a primary care provider.

Require the MCO to have a 24-hour, toll-free service line available 7 days a week that provides information, assessment, crisis intervention, and referral services and that has sufficient capacity to meet the needs of non-English-speaking enrollees.

Establish how enrollees are to access emergency services.

Establish how initial access systems will be measured, monitored, and evaluated.

Specify how access systems will accommodate enrollees with disabilities (e.g., visually or hearing impaired) or who have low levels of literacy.

Specify the types of authorization (e.g., pre-authorization, postauthorization, no authorization) that are required, allowed, or forbidden.

c. Geographic Proximity

Many publicly insured individuals do not have reliable access to transportation, and the travel time or distance to service locations may be prohibitive. While most States specify geographic access standards for primary care, far fewer do so for specialty care.[(2)] Purchasers can develop contract provisions defining the maximum times and/or distances considered acceptable, possibly establishing different standards for some types of services, and can address the availability of or responsibility for transportation services. Ideally, these provisions should be consensus-derived and/or part of negotiations. State Medicaid plans must assure that beneficiaries have transportation to medically necessary care, although how this transportation service is implemented varies widely from State to State. Some States do include at least some level of transportation in their contracts as a required service, particularly in cases in which MCOs are operated by community programs that customarily offer transportation services.

A Florida Medicaid contract sets the following access standards for mental health providers (Rosenbaum et al., 1997):

The Contractor shall make available and accessible facilities, service locations, and service sites and personnel sufficient to provide the covered services (specifically, nonhospital, outpatient, emergency, and assessment services) throughout the geographic area within thirty minutes typical travel time by public or

private transportation of all enrolled recipients. (The typical travel time standard does not apply to waiting time for public transportation; it applies only to actual time in transit.)

Geographic Proximity. Purchasers may wish to address the following in RFPs and contracts:

Specify the maximum allowable travel times and distances (or number of bus transfers) enrollees may be required to travel to specified levels of care and services.

Require the MCO to develop strategies for ensuring transportation services by providing these services directly, assigning transportation responsibility to network providers in specified circumstances, or subcontracting this service to a transportation firm (possibly including a maximum cap on the MCO's financial responsibility in this area).

Establish special access standards for services that are highly specialized and/or for which there is a limited choice of providers.

Establish access requirements for rural or frontier areas based on mileage, time restrictions, or other relevant variables depending on the environment.

Require use of software packages designed to assist in the actual measurement of and monitoring of geographic access.

d. Timeliness of Access

Enrollees' motivation to address their behavioral health problems is often fleeting, and a delay in access can result in a missed opportunity to initiate treatment. The purchaser can establish standards for promptness of service delivery in a variety of areas. For instance, the purchaser may wish to establish maximum waiting times for routine, urgent, and crisis/emergency care; specify the response time for the toll-free consumer service line (e.g., customer service line answered within four rings or 30 seconds); stipulate that customer service line staff be familiar with the plan, benefits, and network providers to facilitate assessment; and mandate that trained staff be available around the clock for crisis intervention and assessment. Nearly all States establish timelines for emergency services; fewer do so for other forms of care. Twelve States establish time standards for mental health services.[(3)] Typical service timeframes used by States are same day/immediate service for emergencies with 24-hour-per-day, 7 day-per-week availability by the contractors, 24 to 48 hours for urgent care, preventive (non-symptomatic) services within 45 days of request, and non-urgent symptomatic office visits within 2-7 days of request. Massachusetts establishes certain timeframes for selected services for addiction disorders (Rosenbaum et al., 1997):

With regard to acupuncture detoxification, the Contractor shall provide, *where Medically Necessary, up to six (6) treatments per week for the first two (2) weeks of treatment and up to three (3) treatments per week after the first two (2) weeks.*

With regard to methadone maintenance therapy, the Contractor shall provide, where Medically Necessary, one (1) dose per day and up to four (4) methadone counseling sessions per week.

Washington State's contract requires contractors to be able to furnish outpatient crisis mental health service to enrollees *"24 hours a day, seven days a week."* The contract specifies that *"all other services shall be available during regular business hours and without undue delay."* Vermont requires plans to make initial mental health services available within 5 working days for treatment of a non-emergency, non-mental-health problem (Rosenbaum et al., 1997).

New York's RFP contains relatively extensive service timelines for mental health services (Rosenbaum et al., 1997):

The plan will have 24-hour availability of crisis care . . . [and] availability of psychiatric consultation coverage 24 hours each day to do triage and provide consultations on medication reactions, etc. . . . [The plan will have] seven days, 24-hour access to support and counseling by trained peers and/or other staff, provided in the enrollee's home with the goal of reducing distress while allowing the person to stay in familiar surroundings.

Timeliness of Access. Purchasers may wish to address the following in RFPs and contracts:

Specify the required degree of promptness of telephone services, such as the number of rings or seconds allowable before a call is answered by a person, the maximum amount of time callers may spend on hold, and call abandonment rates.

Require the MCO to have urgent and emergency/crisis services available within specified periods of time.

Establish maximum times between initial telephone (or other contact) and first face-to-face contact for routine, urgent, and crisis/emergency care.

Specify the supervision requirements and level of training and capabilities required of staff who answer consumer service lines.

Establish whether the MCO may use an automated attendant answering system.

Establish maximum allowable times for MCO authorizations and reauthorizations, or allow a certain level of service before authorization must be obtained (e.g., eight outpatient visits).

Establish policies concerning waiting lists for clinical services, including whether such lists are acceptable and for how long.

Clarify access requirements for designated services (e.g., detoxification).

e. Cultural and Linguistic Competence

The relationship between culture, language, and health care is complex and inextricably linked to health outcomes. Most States address this issue to at least some degree. In States or counties where enrollee populations include significant cultural, ethnic, and/or linguistic diversity, it is imperative that the MCO establish systems designed to facilitate access to services for diverse groups.

For instance, the Florida mental health contract requires staffing patterns that reflect the racial and ethnic composition of the community in which the plan is located and requires that services be provided in the language spoken by the enrollees. The contract specifies that the contractor must supply the State with a list of all Spanish-speaking and Spanish-literate staff (Rosenbaum et al., 1997).

Wisconsin has one of the most extensive sets of provisions regarding the language and cultural appropriateness of care, as shown below (Rosenbaum et al., 1997):

Provide interpreter services for enrollees as necessary to ensure availability of effective communication regarding treatment, medical history or health education. Furthermore, the HMO must provide 24 hour a day, 7 day a week access to interpreters conversant in languages spoken in the HMO's service area, including at least Spanish and Hong. Also, upon a recipient or provider request for interpreter services in a specific situation where care is needed, the HMO shall make all reasonable efforts to provide an interpreter in time to assist adequately with all necessary care, including urgent and emergency care. The HMO must routinely document all such efforts.

This documentation must be available to the Department at the Department's request. Professional interpreters shall be used when needed where technical, medical or treatment information is to be discussed or where use of a family member or friend as interpreter is inappropriate. Family members, especially children, should not be used as interpreters in assessments, therapy, and other situations where impartiality is critical. The HMO will maintain a current list of interpreters who are on "on call" status to provide interpreter services.

HMO shall address the special health needs of enrollees who are poor and/or members of a minority population group. HMO shall incorporate in its policies, administration, and service practice the values of (1) honoring members' beliefs, (2) being sensitive to cultural diversity, (3) fostering in staff/providers attitudes

and interpersonal communications types which respect enrollees' backgrounds. HMO shall have specific policy statements on these topics and communicate them to subcontractors . . .HMO shall encourage and foster cultural competency among providers. HMO shall permit enrollees to choose providers from among the HMO's network based on cultural preference. HMO shall permit enrollees to change primary providers based on cultural preference. Enrollees may submit grievances to the HMO and/or the Department related to inability to obtain culturally appropriate care, and the Department may pursuant to such grievance permit an enrollee to disenroll and enroll into another HMO . . . .

Culturally appropriate care is care by a provider who can relate to the enrollee and provide care with sensitivity, understanding and respect for the enrollee's culture.

Cultural and Linguistic Competence. Purchasers may wish to address the following in RFPs and contracts:

Establish standards for cultural and linguistic competence required by the MCO and its provider network, including degreed and nondegreed professionals who reflect the cultural and linguistic makeup of the enrollee population.

Establish standards for translation and interpreter services for customer service telephone and direct service providers.

Require the MCO and/or provider to develop cultural competence plans.

Specify cross-cultural training requirements.

Provide guidelines or specific requirements for minority providers.

Require the MCO to monitor compliance with any legal or contractual requirements for cultural competency, and establish standards, measures, and means for enforcing compliance.

Require the MCO to develop and implement standards to systematically evaluate providers' cultural competency.

Require the MCO to provide enrollees with written information about access and services in specified languages.

Require specialized outreach to certain populations.

Require the MCO to develop strategies to accommodate the specific cultural/ethnic-related needs of consumers with disabilities.

Require the MCO to develop strategies to accommodate consumers who are deaf or hearing impaired.

Ensure the availability of linguistic capabilities upon consumers' request.

f. "Gatekeeper" Competence

Managed care systems by definition incorporate some version of a "gatekeeping" function to ensure that services are provided in the most appropriate and efficient manner and to protect against unnecessary utilization of expensive services. How this function is implemented varies substantially. It may involve primary care providers' screening and referring before services are deemed appropriate and reimbursable, phone-based utilization reviewers, MCO- or provider-based utilization management teams, care managers, and so forth. Regardless of the setting or model used, the competence of individuals performing the gatekeeping function is crucial because they must be capable of accurately assessing needs and triaging consumers to the most appropriate set of services. The gatekeepers must be well trained in and sensitive to the complex biopsychosocial aspects of mental illness and addiction.

Gatekeeper Competence. Purchasers may wish to address the following in RFPs and contracts:

Specify how primary care physicians are to conduct screening and assessment for mental and addictive disorders or for risk factors associated with these disorders.

Specify the gatekeeper's responsibilities to inform the primary care physician of the patient's treatment plan, in accord with confidentiality requirements.

Specify minimum qualifications, training, and experience in substance abuse and mental health assessment and treatment for those who perform a gatekeeper function.

Establish guidelines for screening and assessment tools to be used in gatekeeping functions.

Establish separate standards for those performing gatekeeping functions for different specializations, such as mental disorders, substance use disorders, children and so forth.

Establish restrictions on or limitations for financial incentives of gatekeepers that may unduly affect decisionmaking.

Specify availability, consultation, or determination of utilization management decisions by a physician or by a psychiatrist.

g. Outreach Capabilities

Improving access for hard-to-reach populations may often require outreach services. These services may be directed to addicted pregnant women, homeless individuals with mental and/or addictive problems, injection drug users, severely mentally ill individuals, or others who are unlikely to seek out treatment on their own and whose untreated illnesses entail high social and other costs. Some purchasers prefer to contract with agencies other than MCOs to do outreach for hard-to-reach populations. If the MCO is to conduct outreach, the contract should be very specific as to what is required and also ensure that the MCO is held accountable for outreach work at the rate anticipated.

Outreach Capabilities. Purchasers may wish to address the following in RFPs and contracts:

Identify target population groups for outreach.

Specify requirements for the MCO to conduct outreach, particularly outreach to vulnerable populations (such as people who are homeless) or difficult-to-reach groups (e.g., rural, specific ethnic/cultural populations).

Require the MCO to develop outreach staff guidelines and standards.

To clarify both what is expected and what is not, establish requirements for outreach in specific terms (e.g., how many staff should be devoted to outreach, in what locations and to which populations, and how outreach should be conducted).

Establish measures for performance of outreach functions.

Stipulate appropriate incentives to encourage the MCO's outreach efforts.

Establish acceptable penetration rates (i.e., access to services).

Clarify how outreach efforts will be monitored.

2. Measuring Access

Several organizations have developed and continue to refine standards that measure different aspects of access. These standards are likely to form the base upon which access within the field will be built. The accompanying box outlines the standards established by these organizations. Purchasers are strongly encouraged to be specific in the

RFP and contract about their expectations concerning performance of the contractor. These expectations should have measures attached to them, standards to which the contractor will be held accountable, incentives and sanctions for reaching or failing to reach the standards set, and provisions that the contractor use new measures and standards at periodic intervals (e.g., annually or at contract renewal). There should be expectations in the RFP/contract about rates of use by population and a means for tracking utilization and access rates in fairly real time (e.g., monthly reports at least) and means for auditing use rates to assure that expectations are being met and that the data reported are accurate.

Standards for Measuring Access to Behavioral Health Services

National Committee for Quality Assurance (NCQA)

NCQA's *Health Plan Employer Data and Information Set* (HEDIS 3.0) (NCQA, 1997) measures waiting time and overall availability by geographic access of mental health and chemical dependency providers.

American Managed Behavioral Healthcare Association (AMBHA)

AMBHA's *Performance-Based Measures for Managed Behavioral Health Care Programs* (PERMS 1.0) (AMBHA, 1995) assesses the penetration rate, utilization, and call abandonment rate.

Digital Equipment Corporation (DEC)

DEC's standards (1995) are similar to those of HEDIS but specify the expected level of access (IOM, 1996).

D. Subcontracting With Providers

One of the MCO's fundamental responsibilities is to execute and administer service contracts with providers. Like the prime contract between the purchaser and the MCO, the MCO's subcontract with providers establishes specific clinical, financial, and operational responsibilities. The purchaser may wish to include substantive contractual requirements about the content and/or structure of such subcontracts, require their approval by the purchaser, require the MCO to show evidence of due diligence in soliciting providers, and mandate that the fundamental content of subcontracts between the MCO and providers be made public in the same manner as the prime contract is made public.

1. Devolution of Responsibilities in the Prime Contract to the MCO's Subcontracts With Providers

The importance of extending the relevant terms of the prime contract to the MCO's subcontracts with providers to ensure the legal devolution (delegation) of many service and performance duties from the MCO to providers cannot be overemphasized. The providers in the MCO's network are not parties to the prime contract between the purchaser and the MCO and are therefore not bound by it unless the MCO-provider contract so states. For example, many prime contracts require the MCO to develop practice guidelines regarding quality of care; however, these same contracts may neglect to require the MCO-provider contract to address this issue. As a consequence, the MCO may not distribute the agreed-upon guidelines to providers, and the providers are under no contractual obligation to follow them. To ensure that network providers are contractually obligated to provide services in a manner consistent with the prime contract, the purchaser may require the MCO to bind providers by the relevant terms of the prime contract.

In addition, at a minimum, to guard against the potential for underservice, the contract should specify that the MCO must provide evidence that it has communicated to its subcontractors the classes of benefits that will be covered, the

standards and procedures for making coverage determinations under the agreement, and a full explanation of the benefits that can be secured for enrollees both through the contract and outside of the contract. One of the great challenges for a managed care purchaser is ensuring that all subcontractors are aware of its agreement with the contractor. This is especially true in the case of Medicaid managed care agreements, in which the terms of the master contract may depart significantly from those found in service agreements in the private sector.

Devolution of Responsibilities. Purchasers may wish to address the following in RFPs and contracts:

Require the MCO to have signed subcontracts with providers in place before the plan is implemented.

Establish guidelines regarding the use of provisional contracts or some other transitional arrangement if necessary (with appropriate malpractice coverage and indemnification provisions) to facilitate contracting, credentialing, and clinically appropriate transitions for enrollees during the implementation of the managed care plan.

Ensure the delegation of all relevant service and performance duties from the prime contract to the subcontract.

Require purchaser approval of all MCO-provider contract language related to the devolution of prime contract terms to the provider.

Require the MCO to monitor prime contract terms and ensure compliance of prime contract requirements by the subcontractors.

Require the MCO to train providers to ensure clear understanding of the purchaser's contract with the MCO and consequent provider obligations.

Require purchaser approval of a standard subcontract base language that clearly reflects the delegation of responsibilities (e.g., performance standards, recommendations for network membership, medical necessity criteria, quality assurance, consumer protections, and grievance and appeals procedures).

Require that all subcontracts, provider performance standards, and practice guidelines be publicly available.

Require compliance with 42 C.F.R. 434.70 and 434.67, whereby the MCO may operate a physician incentive plan only if it is consistent with the act's provisions.

Establish any requirements regarding timelines and processes for the recontracting and reprocurement of providers.

Ensure that provider contracts are available to the public and that information on financial incentives that might influence care is also publicly available.

Establish mechanisms for the purchaser to audit compliance of the MCO with its practice guidelines and utilization review criteria.

2. Provider Payment Requirements

Another essential component of the contract is the MCO's payment terms and conditions with regard to network providers. Purchasers may wish to support the ongoing financial viability of network providers by contractually establishing fair, efficient, and monitorable compensation methods.

Provider Payment Requirements. Purchasers may wish to address the following in RFPs and contracts:

Require the MCO to have signed subcontracts with providers in place prior to the start date of the MCO contract.

Require the MCO to specify clear payment terms and conditions in the MCO-provider subcontract (e.g., rates, timeframes for payment, assumption of risk, copayments, deductibles, and service definitions).

Establish timelines for payment of providers (especially important during the startup period when providers may not have adequate cash reserves)-- e.g., 90 percent of invoices be paid within 45 days.

Establish fees and schedules of services for fee-for-service arrangements.

Require the MCO to report any revenue paid to the providers from copayments or charges for noncovered services, or other sources.

Require the MCO to seek purchaser approval regarding subcapitation to providers, rate-setting policies, or other purchaser-specified reimbursement-related issues.

Require the MCO to pay claims for dates of service beginning on the date of contract implementation.

Require reporting on all third-party payment activities, or alternatively, encourage the MCO to collect third-party liability payments by designating a percentage to be retained by the MCO for its efforts (e.g., 25 percent).

Require MCOs to develop fair payment terms and efficient and monitorable processes in the MCO-provider subcontract.

Determine all financial responsibilities for consumers already in treatment when the contract starts.

3. Grievance and Appeals Procedures for Providers

Rosenbaum and her colleagues' analysis of State Medicaid managed care contracts found that most contracts, through omission or insufficiently precise language, created a situation in which MCOs held considerable power over providers, giving the providers no recourse to address what they may have considered unfair practices (Rosenbaum et al., 1997). To ensure that network providers have viable options for addressing issues with the MCO, a purchaser of managed care services may require the MCO to include dispute resolution, grievance, and appeals procedures for providers in the MCO-provider subcontract. Such provisions should clearly describe procedures, identify who bears the cost of the procedures, and protect the rights of providers who challenge MCO practices. Policy and legal issues abound, and purchasers should ensure that the arbitration-grievance procedures comply with all relevant county, State, and Federal laws and regulations.

Grievance and Appeals Procedures for Providers. Purchasers may wish to address the following in RFPs and contracts:

Require the MCO to develop provider grievance and appeals procedures with levels of appeal available within the MCO and, ultimately, an appeal to the purchaser or its designee (e.g., the State mental health or substance abuse authority).

Require the MCO to generate written documentation supporting a decision to eliminate or suspend a provider from the network, to be available to the purchaser and provider upon request, ensuring confidentiality when necessary.

Ensure that providers have access to grievance and appeals procedures, both with the MCO and with the purchaser.

E. Establishing Qualification Standards for Provider Staff

Another MCO responsibility is to establish, monitor, and enforce standards for training, experience, qualifications, and continuing competency of staff who provide services within their networks. A purchaser can use the prime contract to

establish qualification standards for network provider staff for implementation by the MCO, or the purchaser can require the MCO to propose a set of standards for the purchaser's review and approval.

1. General Staffing Guidelines

Staffing guidelines, such as those specified by the National Committee for Quality Assurance (NCQA) in its behavioral health accreditation standards, can be used to establish minimum requirements in such areas as education, training, experience with the defined population, cultural competence, and licensing and certification. Although these standards are very helpful, it has been argued that they are too oriented to private sector systems and must be supplemented to be useful in public sector systems (Bazelon Center for Mental Health Law, 1997). Requiring accreditation of the MCO is also a way in which minimal credentialing standards for staff can be assured. All licensing and certification standards must be consistent with all applicable local, county, State, and/or Federal requirements.

In determining staff qualifications, purchasers may want to be careful not to be overly restrictive in order to allow for staffing patterns that make optimal use of licensed professional, certified, and "experientially trained" staff. A significant percentage of direct service staff in the substance abuse field, for example, are people in recovery who have not pursued academic degrees but are nonetheless highly effective in certain clinical settings (e.g., detoxification, outreach). Overly restrictive standards might prohibit the use of such staff in publicly funded substance abuse services. Similarly, staff qualification requirements should not restrict valuable opportunities to include students, volunteers, and consumers, as long as they are adequately supervised by licensed professionals. (The 1997 NCQA manual includes new language to allow credentialing of programs that have unlicensed staff with licensed supervisors.) These staff can be used well in staffing patterns that achieve treatment goals in ways that are innovative, clinically sound, and cost effective. Use of such staff requires clear policies on appropriate functions, malpractice protection, and appropriate fee structures.

General Staffing Guidelines. Purchasers may wish to address the following in RFPs and contracts:

Specify that the purchaser retains the right to approve all staff standards and any exceptions to those standards before implementation.

Require the MCO to be appropriately accredited, or to use the credentialing standards of NCQA accreditation as a base and then set additional standards to reflect public sector realities.

Establish the staffing requirements for managing and/or providing substance abuse treatment and prevention, both for those experientially trained and for those with academic training and/or licensure.

2. Credentialing and Credential Verification

Establishing credentialing standards for providers allows the purchaser to ensure the qualifications of professional, licensed, and certified staff within the network. Credentialing is a review process based on specific criteria, standards, and prerequisites to approve a provider or professional who applies to provide care in a number of health care settings, including hospital, clinic, medical group, health plan, or in private practice. Credentialing activities generally include review of original documents submitted by the provider, including contacting references, verifying licensure, and reviewing and verifying insurance and malpractice history. These activities may be carried out by the MCO or contracted out to an organization that specializes in such tasks. Due to the liability risk of credentialing in a manner not consistent with industry standards, which are set mainly by NCQA and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), purchasers should exercise caution in the degree to which they vary from these established standards.

Credentialing. Purchasers may wish to address the following in RFPs and contracts:

Direct the MCO to develop, implement, and/or oversee credentialing policies and capabilities of network providers and MCO staff.

Require purchaser approval of the credentialing policies and process.

Identify which categories of providers are to be credentialed and methods by which this will take place, and set timeframes for the credentialing process.

Establish the credentialing standards to be used, such as those drafted by NCQA, JCAHO, CARF, CAO, or other accrediting organization.

Ensure that the standards used are consistent with any State, county, or local requirements.

Require the MCO to utilize State counselor certification or credentialing as a staffing standard.

Require the MCO to oversee and closely monitor any credentialing work that is contracted out.

Establish requirements for credentialing group providers, as contrasted to standards for credentialing individual providers.

Require the MCO to provide primary source verification of documentation regarding MCO staff experience and training, as well as network providers.

Direct the MCO to include providers with specialized training and experience in specialty areas (e.g., substance abuse, children, eating disorders).

Establish whether the MCO and its providers must accept referrals of enrollees involved with the courts or the criminal justice system or referrals that present conditions outside their licensure or competency to treat.

Establish a volume or amount of funds that must be provided through essential community providers (e.g., Oregon substance abuse services).

Require that substance abuse and mental health service providers establish and maintain formal relationships with each other and with primary health care providers and with social services and supportive services organizations.

3. Clinical Specialties

The purchaser may wish to require that a sufficient number of staff throughout the network have training, board certification, and/or experience in various specialties. For instance, the purchaser may want the MCO to have expertise in-house and within its network to manage the treatment of children with severe emotional disturbances who require the services of board-certified child psychiatrists and child psychologists.

The degree to which purchasers choose to address clinical specialty issues will vary depending on the needs of the enrollee population, the availability of specialists, utilization of specialists in the current system of care, and the purchaser's attitudes about the importance of using specialists. Purchasers may wish to require the MCO to submit a specialty services plan for purchaser approval, specifying standards for certain specialties and/or identifying the types of programs that should have specialists on staff or readily available.

Clinical Specialties. Purchasers may wish to address the following in RFPs and contracts:

Require the MCO to submit a specialty services plan for purchaser approval.

Specify which clinical specialties are required within the network, including waivers or adjustments for rural and frontier areas when appropriate.

Establish the settings, situations, and/or programs that should have such specialties.

Specify which board certifications are required for physicians, psychologists, and others, both in the MCO and in designated settings and situations.

Establish and provide means to monitor access to specialists.

Require the MCO to systematically upgrade and improve specialist capabilities throughout the system, taking into account the potential limitations of specialist availability in rural and frontier areas.

4. Consumer Employment

Employment of consumers of mental health services and their families and individuals in recovery from addiction can be an important element in an effective staffing system. Consequently, the purchaser may wish to develop standards that promote the training, hiring, employment, and supervision of those with mental disorders, those in recovery from addictive illnesses, and family members of children with emotional disorders, both in the provider network and within the MCO. The purchaser may also wish to promote contracts for services with consumer-sponsored organizations.

Consumer Employment. Purchasers may wish to address the following in RFPs and contracts:

Establish guidelines for the use of consumer-based provider systems (e.g., consumer support groups or drop-in centers).

Establish consumer and family employment goals for internal MCO and/or provider operations.

Direct the MCO to systematically promote, monitor, and improve the recruitment, training, and hiring of former or current consumers and family members by network providers.

Establish minimum standards for length of sobriety required for clinical staff and for systems to respond to relapse or psychological deterioration among staff.

Require compliance with all applicable State or county laws regarding health status including substance use/sobriety by recovering employees.

F. Monitoring Providers' Performance

Monitoring, evaluation, and improvement of network providers' performance by the MCO is a crucial and ongoing task of network management. Effective monitoring and management of providers' performance by the MCO can give the purchaser much critical information. The purchaser may therefore wish to include guidelines and specifications in the contract regarding how this monitoring process should occur and the standards by which the MCO's monitoring strategies will be evaluated. Chapter VI includes an analysis of important issues related to performance monitoring and quality assurance, and these topics are only briefly discussed here in relation to network monitoring.

MCOs use a wide variety of strategies to monitor and manage performance of the providers in their networks, which may include placing MCO staff at treatment sites, making intensive site visits, conducting consumer satisfaction surveys and focus groups, and requiring internal reporting by utilization management staff. Increasingly, however, provider monitoring relies on data-based provider profiling, in which systematic profiles of providers are created using a series of specific measures. In claims-based fee-for-service arrangements, a substantial amount of useful information can be developed from which provider profiles can be generated. The profiles can be used to compare the performance of providers of similar services. They can also be used to design quality improvement programs, distribute incentives or enact sanctions, establish corrective action plans, and/or provide the basis for continued measurement in the network.

Monitoring Providers' Performance. Purchasers may wish to address the following in RFPs and contracts:

Require the MCO to submit a formal network monitoring, development, and management plan for purchaser approval, including procedures for corrective action plans and systematic follow-ups.

Establish clear specifications to support purchaser monitoring and evaluation of specified MCO network management functions (e.g., a report card).

Describe any MCO requirements regarding training of network providers (e.g., utilization management, best practices, or management information service development).

Implement a tracking system to measure providers' progress.

Describe the role of consumers and family members in monitoring provider performance.

Describe required provider profile measures and evaluation criteria.

Describe software capabilities that would best meet desired provider-profiling needs.

Require that profiling measures and procedures be available to providers and the public.

Specify any provider reporting requirements (e.g., State client data systems, outcome reporting systems, or data on placement patterns).

Ensure that providers are given feedback on quality and performance data.

Require documentation of actions taken to resolve quality concerns.

[1.] For a detailed analysis of this issue, see table 3.1 with State Medicaid managed contract provisions addressing this issue in Rosenbaum et al. (1997).

[2.] For a detailed analysis of this issue, see table 3.8 with State Medicaid managed contract provisions addressing this issue in Rosenbaum et al., (1997).

[3.] For a detailed analysis of this issue, see table 3.7 with State Medicaid managed contract provisions addressing this issue in Rosenbaum et al., (1997).

CHAPTER V

The Management Information System

Key issues in this chapter:

- The managed care purchaser's expectations of an MIS
- Characteristics of an "ideal" MIS for a managed care system
- Data generated by stakeholders in a managed care system
- Basic MIS operational features
- Confidentiality considerations
- Ownership and use of

Information management is an essential element of any managed care system. Advances in hardware and software make it possible to apply technology effectively to support creation of "patient-centered" service systems. Whether the purchaser is planning to use the managed care organization's (MCO's) management infor-mation system (MIS) to manage the care system or instead will be purchasing and implementing an MIS in house, it should give careful consideration in both the request for proposal (RFP) and the contract to a number of issues.

Many purchasers assume that because they are acquiring the services of an MCO, they can rely on the MCO to provide the necessary MIS support. This is not always the case. The purchaser must identify its needs as clearly as possible in the RFP and contract and then evaluate the bidders' ability to meet those requirements. If the purchaser of managed care plans to use the MCO's MIS, it must make a concerted effort to determine whether the MCO's MIS will be adequate. For these reasons, the RFP, and especially the contract, must clearly state all the required functions of the MIS. Lack of attention to detail regarding MIS-related issues can be a costly and disappointing mistake, as it is very difficult and expensive to make changes to a contractual relationship after the fact. If the purchaser is planning to purchase and implement an MIS on its own, the RFP and contract with the MCO should clearly indicate this.

data

- Technical requirements for an MCO's MIS
- Procurement of an MIS by a purchaser for its own use

This chapter focuses on contractual issues related to the exchange of information and the application of technology to support a public managed care initiative. It addresses the following MIS-related topics:

- The managed care purchaser's expectations of an MIS;
- Characteristics of an "ideal" MIS for a managed care system;
- Data generated by stakeholders in a managed care system;
- Basic MIS operational features;
- Confidentiality considerations;
- Ownership and use of data;
- Technical requirements for an MCO's MIS; and
- Procurement of an MIS by a purchaser for its own use.

A. The Managed Care Purchaser's Expectations of an MIS

The process of selecting an MCO to operate a managed behavioral health care program is much different from the process of selecting a vendor to supply technology to a State or county government for a managed care system. The legal requirements and contract terms governing the exchange of information between purchasers, MCOs, and providers are different from the legal requirements and contract terms governing a State's purchase of technology from an MIS company.

The requirements of a contract between a purchaser and an MCO will vary depending on the degree of influence the purchaser wishes to exert on the way the system is used. The primary concern of some public purchasers may be to ensure that the MCO provides information that allows the purchaser to monitor and evaluate the MCO's performance and to provide reports to the Federal Government and other authorities. Other public purchasers may want to direct the way the MCO manages communications between providers, the MCO, and the purchaser.

As discussed later in this chapter, several basic MIS operational issues related to information processing must be addressed before the managed care system is established. Provisions governing these MIS operating issues (e.g., exchange of information required to verify eligibility), along with a few fundamental legal considerations related to the exchange of information (e.g., as protection of patient confidentiality) are common to all managed care contracts. These MIS operational issues arise regardless of the purchaser's role in the day-to-day operations of the MIS.

B. Characteristics of an "Ideal" MIS for a Managed Care System

To best support an efficient and clinically effective managed care program, an "ideal" MIS should be a "person-centered," integrated, and "operational" system. The discussion of an ideal MIS here is intended to illustrate the optimal use of technology to support managed care initiatives. It is not intended to suggest that acquisition of a system having all of the characteristics discussed is necessary for an effective managed care system.

The ideal MIS is a system that could be used by providers, provider-sponsored service systems, MCOs, or government organizations, or by all four working in collaboration with one another. The system is intended to be a truly integrated system with the capacity for many organizations to share the information required to perform

interdependent functions. The system should integrate different types of information (e.g., clinical, social, financial, and administrative), interactively process changes in data elements to trigger action in accordance with user-defined parameters (e.g., fax, request for treatment report, outcomes measurement, clinical consultation), intelligently "push" information to users, and allow individual users to view information and enter and edit data.

The ideal MIS also should reinforce cooperative relationships among the purchasers, the MCO, and provider organizations. The system will support risk-sharing arrangements in which providers assume clinical responsibility and financial risk associated with service decisions. This places day-to-day decisionmaking in the hands of those who know the consumers best. It also places financial incentives as close as possible to direct service providers, lessens time and resources devoted to MCO utilization review of providers' treatment decisions, reduces conflict between the MCO and providers, and minimizes distribution of confidential information.

1. A "Person-Centered" MIS

The ideal MIS will support individualized treatment planning and continuity of care as a person moves in and out of treatment and from program to program. Whereas a "program-centered" MIS will focus only on the performance of a particular function and will "lose" consumers as they pass from one program to another, a "person-centered" MIS will be able to capture all clinical, social, and financial information related to an individual consumer and track the person across the full continuum of services and programs. (An integrated MIS will be able to group data by program--or by any other function--as a secondary feature of a person-centered MIS.)

2. An Integrated MIS

The MIS must create a comprehensive data set containing the relevant information collected from various domains--enrollees, the MCO, and network providers. The data set should include clinical, demographic, financial, utilization management, and any other data produced from the operation of the system. Different users of the system--clinicians, utilization managers, financial analysts, and evaluators--need to look through different windows that allow them to view and manipulate information in the way that best meets their needs. The system must be capable of integrating data from different domains within the data structure and arranging the information in ways that are useful to those with different roles, tasks, and technical expertise.

3. An "Operational" MIS

In the past, the primary function of an MIS was to provide data (e.g., periodic reports or budget information) for retrospective analysis that would help administrators and others carry out planning functions. Essentially, the MIS was used as an electronic filing cabinet. Although retrospective analysis continues to be critical, current MIS designers are aiming toward more "operational" systems.

In an "operational" MIS, data collected in the performance of routine tasks are integrated and made available on a real-time basis so the data are accessible and usable by staff. An operational system is designed to support the daily workflow of the system, facilitate the exchange of information between organizations and people who perform complementary functions, and facilitate performance of specific tasks. For example, a utilization manager may use the MIS to review a person's previous episodes of care, receive information from the treating clinician regarding the person's progress, and review the cost of services to date relative to the benefits available. All the data required to make such decisions are current and available on the MIS without the need for research or special procedures. Additionally, the system might include clinical decision support technology to alert the utilization manager to the need for a medical consultation about a possible adverse medication interaction, then automatically alert the consulting physician and route the consumer's file for review. In this way, the MIS saves time, increases efficiency, and enhances accountability, leading to improved clinical service.

C. Data Generated by Stakeholders in a Managed Care System

Within a service system, the information that must be available to support the work of a direct provider of treatment mirrors that required by an MCO. Both require information about benefit plan design, member eligibility, provider credentials, reimbursement terms, authorization of payment for specific services, clinical outcomes, and financial performance. Both require information from enrollees regarding clinical and social history, expressed needs, functional status, and diagnostic tests. Both providers and MCOs may accumulate highly confidential information regarding a person's status as a patient, personal history, diagnosis, and treatment plan. In a fully integrated system,

a common data set will be established, and data will be exchanged in a manner that facilitates clinical operations. However, such exchanges increase the risk of violation of consumer confidentiality. (This issue is discussed further in Chapter VIII.)

It is important to note that the nature of the information processing requirements of MCOs and providers has changed over time. In the early days of managed behavioral health care, MCOs and providers had a fairly adversarial relationship. MCOs were focused on cost control and engaged in utilization review of treatment decisions for the purpose of cost containment. They did not share information, decisionmaking, or financial risk with providers. Provider-sponsored service systems did not exist. Recently, however, MCOs and provider organizations have moved toward more collaborative relationships. Local provider systems increasingly work in partnership with MCOs and perform managed care functions such as utilization review. MCOs and provider systems sometimes share financial risk and work from a common set of clinical decision support protocols. Both provider systems and MCOs are under increased pressure to demonstrate clinical effectiveness and control costs.

Exhibit V-1 lists the types of data supplied by the MCO, providers, and enrollees in the course of operation of a managed care program. Purchasers also supply some information (eligibility data, benefit limits) essential to managed care operations. Purchasers also generate information essential to analysis of the success of the managed care program (actuarial projections, payments to MCOs, clinical grievance reports, and audit reports).

Exhibit V-1.

Some Key Sources and Types of Data in a Managed Behavioral Health Care System

MCO-Supplied Data	Provider-Supplied Data	Enrollee-Supplied Data
Claims payment	Billing	Eligibility information (such as a Medicaid card)
Financial accounting	Clinical records	Clinical history
Financial trend analyses	Treatment plans, including diagnoses	Social information (family and work)
Triage and referral records	Authorization information from the MCO	Expressed needs, including symptoms
Utilization review and authorization of payment	Disease management information from the MCO	Information on functioning status
Case management	Clinical credentials	Testing data
Physician review	Licensure and accreditation information	Outcomes reports
Clinical appeals	Outcomes and consumer satisfaction data per managed care program requirements	Satisfaction surveys
Disease management protocols (if any)	Serious incident reports	• Complaints, grievances, and appeals
Credentials verification	Any performance indicators received from the MCO	
Outcomes data accumulation and analysis		
Incident reports		

Resolution of grievances MCO internal operations quality assurance data (response time and consumer satisfaction) Trend analysis and provider performance (clinical efficacy and financial "value")		

D. Basic MIS Operational Features

The contract between a public purchaser of managed care and the MCO must address "nuts and bolts" operational questions about the data to be supplied, who will supply it, how the data will be exchanged, what data will be maintained, and how the data will be kept secure. The contract must enable the MCO to support daily operations and monitor the integrity of the service system and the performance of network providers. The purchaser must ascertain whether the MCO has the capacity to perform required functions by ensuring that the contract provides for the continued management and improvement of essential functions. This section reviews 13 basic MIS operational features that must be addressed regardless of the purchaser's role in the day-to-day operations of the MIS.

1. Management of Eligibility Information

The MCO, network providers, and the purchaser share a strong interest in maintaining a current roster of individuals eligible for coverage under the plan. The set of individuals eligible to receive services is likely to change frequently, and the purchaser controls this information. The managed care contract should include provisions describing the manner and frequency with which the purchaser will provide eligibility information to the MCO. Such information is usually provided through a tape-to-tape transfer every 30 days, but updates could be provided more frequently. In Medicaid programs, eligibility can change frequently, and these changes need to be reflected in the eligibility records. These data may be provided electronically through a direct download of data from the State Medicaid agency to the MCO. Alternatively, the MCO or a provider may install a special computer terminal in its offices with direct access to the eligibility database maintained by the purchaser. Different approaches will be used depending on the technical capabilities of purchasers and MCOs. Often, the optimal approach is not used because the cost of establishing direct electronic linkages between the State system and the MCO is prohibitive. These issues should be considered when establishing the startup budget for the managed care system.

The choices made for transferring and maintaining information on eligibility will have an impact on the financial terms of the agreement. Providers, the MCO, or the purchaser may have financial responsibility for mistakes in verification of a person's eligibility. (Some MCO-provider contracts disclaim responsibility for verification of eligibility until claims are paid--effectively transferring to the provider the financial risk of treatment of an uninsured person.) The purchaser may wish to hold the MCO financially responsible by requiring verification of eligibility at the point of initial contact--that is, by the intake and case management staff. If electronic access to current eligibility data is not available, it is difficult to transfer that risk to the MCO.

The MCO should have a strategy for systems control of eligibility determination and for tracking eligibility over the course of treatment. Such a strategy requires software to support the collection and maintenance of enrollee information. The MCO must ensure that the enrollee is uniquely identified (see section below on confidentiality considerations). As disputes may arise based on eligibility for specific services at a particular time, the MCO must maintain eligibility records detailing the service array and eligibility criteria for a period of time defined by the purchaser.

Management of Eligibility Information. Purchasers may wish to address the following in RFPs and contracts:

Identify eligibility information management as a required capability, setting the proposed solution as a minimum standard for contract compliance.

Define the manner in which eligibility information will be provided to the MCO and to the providers.

Define any work to be done during the startup phase of implementation of the plan, including custom programming by the MCO and/or the purchaser, milestones for completion of work, and compensation (if any) for startup costs.

Allow for changes to and upgrades of the MCO's eligibility information management capability.

Specify for whom and when (such as at the enrollee's first contact) eligibility can be determined.

Specify a time period for which the MCO must maintain electronic records of eligibility determinations, so that the purchaser can review dispute resolutions.

If the MCO will be asked to implement algorithms in software that calculate eligibility, reference these algorithms as an addendum to the contract, subject to change by the purchaser on notice and within a specific timeframe.

Require the MCO to use a unique purchaser-defined identifier for each enrollee.

Specify a timeframe within which the MCO must respond to providers regarding the eligibility of an individual presenting for treatment.

2. Provider Credentialing

The MCO's MIS should maintain data on the credentials of individuals providing services to consumers. The purchaser may require that the MCO verify providers' credentials with "primary sources" such as licensing bodies, educational institutions, and malpractice insurance carriers. Primary source verification of provider credentials is required by the National Committee on Quality Assurance (NCQA) and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), both of which accredit MCOs.[1] In addition, the MCO should maintain data on each provider's expertise, office locations, hours of operation, specialized programs, and so forth, to facilitate referrals by case managers and intake staff.

The purchaser may wish also to require the MCO to demonstrate that all provider information has been verified periodically. The purchaser may require online access to the MCO's provider database to verify provider information and credentialing.

Provider Credentialing. Purchasers may wish to address the following in RFPs and contracts:

Require the MCO's MIS to maintain data on individual providers' (1) licensure status; (2) professional affiliations; (3) hospital privileges (if applicable); (4) education and training; and (5) board certification.

Require primary verification of credentials.

Require the MCO's MIS to maintain data on individual providers' (1) office locations; (2) basic demographic information (e.g., age, gender, staff characteristics, cultural/ethnic background); (3) days and hours of operation; (4) intake and/or contact number; (5) fee structure (e.g., sliding scale); (6) Medicare/Medicaid participation; and (7) scheduling availability.

Require the MCO's MIS to maintain data for individual providers on (1) services provided; (2) specialization by patient age group, disorder, gender and/or sexual orientation; (3) specialty programs; and (4) treatment patterns.

Require the MCO's MIS to maintain data for individual providers on (1) malpractice insurance coverage; and (2) reported incidents.

3. Exchange of Data Between Providers and the MCO

The MCO is often involved in the referral of enrollees to different levels of care, monitoring treatment for appropriateness and medical necessity, and monitoring the quality of care delivered by network providers. Much of the information required to fulfill these responsibilities will come from providers. This raises privacy and confidentiality

issues, which are discussed briefly in the section below on confidentiality considerations and in more detail in Chapter VIII.

Purchasers should specify the basic information about all enrollees that must be gathered by the MCO. This information is required to satisfy the State's need to monitor the success of the managed care program and its obligations to report to the Federal Government and others. At a minimum, this information would include a unique enrollee identifier, diagnosis, treatment provided by billing (or CPT) code, and fees paid for treatment. In addition, the MCO could be required to secure a sample of data so that clinical outcomes and consumer satisfaction can be analyzed.

The RFP should solicit information from potential vendors on their ability to gather and manage essential information. Means of information exchange may be over the telephone, through written reports, via fax, or through electronic transfer of data between a provider and the MCO. In assessing the viability of the system proposed by the MCO, the purchaser should consider practical issues, such as the cost to providers of compliance with the MCO's system and the availability of the required technology.

It is also important to determine whether the system proposed by the MCO actually works. There is often a huge gap between a written description of a system's technological capabilities and how the system works in real life.

Purchasers should consider whether or not they wish to establish technology standards that mandate that MCOs and providers exchange information in a particular manner. The ideal MIS would require the MCO and provider organizations to maintain the technical ability to exchange data electronically. Data exchange can be done in a variety of ways. Ideally, the providers and the MCO would have access to a common software system that integrates clinical and financial data. The capacity of provider organizations to participate in electronic data exchange should be considered by purchasers.

Exchange of Data Between Providers and the MCO. Purchasers may wish to address the following in RFPs and contracts:

Specify the core set of information that must be gathered by the MCO for all enrollees, including a unique client identifier, diagnosis(es), treatment provided by billing (or CPT) code, and fees paid for treatment.

- Require the MCO to systematically obtain data that can be used to analyze consumer satisfaction, clinical processes, and clinical outcomes.
- Establish technology standards mandating that MCOs and providers exchange information in a particular manner.

Require that the MCO use a software system that integrates clinical and financial data.

Require the MCO to build the capacity of provider organizations to participate in electronic data exchange.

4. Standardization of Clinical Assessments

A standardized clinical assessment containing key indicators of enrollees' functioning and status should be used whenever possible. The MIS must be capable of maintaining and managing assessment data that supports initial placement, continuing-stay reviews, and attainment of desired outcomes. In several currently available systems, the assessment interview is conducted with the assistance of a computer, and the entire assessment is captured electronically. While not entirely necessary, raw data from the assessment relating to clinical status and level of care could be maintained on the MIS so that the MCO or purchaser could use those data for analysis. The MIS requirements to support this activity include collection and maintenance of data on clinical criteria and assessment events as well as analytic and online data retrieval capabilities.

Standardization of Clinical Assessments. Purchasers may wish to address the following in RFPs and contracts:

Require that key data elements from assessments be maintained on the MIS.

Require that the MIS be capable of retrieving these data as needed.

Require that the MIS maintain data from discrete assessments for use in comparative analysis.

5. Outcome Evaluation

A managed care program must be evaluated in terms of the value it offers--that is, the extent to which it provides appropriate, high-quality services at a reasonable price. Judgment of the effectiveness of a managed care program solely on the basis of cost may lead to the denial of necessary treatment. As noted in Chapter VI, managed care systems are increasingly making efforts to evaluate clinical outcomes and managed care consumers' satisfaction with the care and services they receive.

Typically, outcomes programs will measure changes in clinical status as measured by standard clinical assessment tools and indicated by critical events (relapse, readmission to inpatient treatment) and functional status (ability to work, attend school, and maintain family relationships), as well as consumer satisfaction. Outcome measurement includes baseline measures using standardized assessment tools and followup assessments during and after completion of treatment.

The RFP should solicit input from vendors about the design of the outcomes measurement system. The contract should then require the MCO to collect and store outcome data. It should specify measures to be used, sampling methodologies, the manner in which data will be accumulated, analyses to be conducted, reports to be provided by the MCO, and raw data to be shared with the purchaser. With regard to information processing, the MCO contract should identify the manner in which enrollees, providers, and MCO staff will supply data. It is usually necessary to transfer data from various sources (claims processing, clinical case management, provider assessments, consumer self-evaluation, and satisfaction reports) to establish and maintain an outcomes database. The contract should specify that such a database will be established and should set a schedule for updating it. The contract should address questions related to the transfer of data from the MCO to the purchaser and specify standard data analyses and reports to be shared with the purchaser, providers, and recipients.

Outcome Evaluation. Purchasers may wish to address the following in RFPs and contracts:

Establish the fundamental MIS requirements needed to support evaluation of clinical outcomes and consumer satisfaction.

Develop or refine the capacity to measure changes in clinical status as measured by standard clinical assessment tools and indicated by critical events (relapse, readmission to inpatient treatment) and functional status (ability to work, attend school, and maintain family relationships).

Establish baseline measures in key areas using standardized assessment tools and followup assessments during and after completion of treatment.

Establish minimum capacity requirements for the MCO to collect and store outcome data.

Specify the measures to be used, sampling methodologies, manner in which data will be accumulated, analyses to be conducted, reports to be provided, and raw data to be shared with the purchaser.

Identify the system and processes through which enrollees, providers, and MCO staff will supply data.

Establish and maintain a database to which data from various sources (e.g., claims processing, clinical case management, provider assessments, consumer self-evaluation, and satisfaction reports) can be transferred.

Specify a standard set of data analyses and reports designed to be shared with the purchaser, providers, and recipients.

6. Utilization Management and Treatment Authorization Process

Service authorization allows for the individual management of each case by MCO staff. The MCO's MIS must efficiently support utilization management (UM) personnel in monitoring treatment and outcomes, performing periodic continuing-stay reviews, authorizing payment, and effectively managing the care of enrollees. Providers must be informed about the authorization for each case to support billing and establish limitations on funding for treatment. Purchasers may require that recipients also receive hard copies of service authorizations.

Utilization Management and Treatment Authorization Process. Purchasers may wish to address the following in RFPs and contracts:

Require that the MCO's MIS links utilization data with clinical data.

Ensure flexibility to record and easily access text describing clinical issues.

Ensure capacity to input complex clinical data in an efficient manner.

Ensure that clinical standards used to determine appropriate utilization be available electronically.

Ensure that the MIS has the capability to verify that standards have been applied appropriately.

Ensure that the payment authorization process uses precertification and continuing-stay determinations as criteria for payment.

Ensure capacity to provide recipients and providers with hard copies of authorization decisions.

7. Case Management

Case managers (also called service coordinators) work with individuals to ensure that they gain access to all necessary services and that services they receive from different providers are coordinated. The MIS should give the case manager access to the information needed to coordinate care, and the contract should specify the manner in which this information will be provided. MIS requirements to support case management involve the collection and maintenance of substantial information about the needs of the individual, resources available from the provider network, the individual's treatment plan, comments from treating providers, and information on the benefits remaining under the terms of the plan. The case manager needs timely access to this wide variety of information. Case management functions can be performed by the MCO, providers, or specialized personnel. Case managers may also need information about the availability of wraparound services to meet the client's needs (see Chapter III).

Case Management. Purchasers may wish to address the following in RFPs and contracts:

Establish MIS requirements to support case management functions involving the real time collection and maintenance of substantial information about the needs of the individual, the individual's treatment plan, and comments from current service providers.

Establish MIS requirements regarding access standards for obtaining all necessary information about service providers and other resources available from the provider network and about wraparound services.

Establish minimum requirements regarding the maintenance of up-to-date information on the benefits remaining under the terms of the plan.

Establish minimum requirements regarding the different case management functions that can be performed by the MCO, providers, or specialized personnel.

8. Services Tracking

It is essential that the MCO develop a method to capture information on the provision of services to eligible enrollees. These data must be accumulated regardless of whether the MCO pays a provider a fee for each service event or uses some other payment method (see Chapter VII). Service events must be comparable throughout the service system so that standardized measures of intensity and patterns of service provision and associated costs can be determined. Data on service events are used to identify services individual consumers are receiving, allow analysis of patterns of treatment by different providers, support clinical outcomes research and quality assurance efforts, and support the purchaser's reporting responsibilities.

Services Tracking. Purchasers may wish to address the following in RFPs and contracts:

Require the MCO to use a standardized method to collect service event data that supports comparison of these events across the provider network.

Require that the method used for collecting service event data supports the analysis of clinical practice.

Specify standards for service event data (particularly important if the purchaser contracts with more than one MCO). Include definitions of services, units of measure regarding time and frequency, and the format for data collection.

Require that service tracking data be available to case management staff.

Require that the MCO be able to associate costs with each category of service provided.

Require that the MIS maintain detailed data on service events for a purchaser-specified period of time sufficient to allow for retrospective analysis by the purchaser and authorized research organizations.

Require that the MCO transmit service event data to the purchaser and specify the formats and frequencies of transmittals.

Require the MCO to ensure that the transfer of records complies with Federal confidentiality statutes and regulations (42 C.F.R. Part II).

9. Claims Processing

Claims processing supports the flow of funds to the provider network from the MCO; it also supports service monitoring and cost analyses. As a provider system must have cash flow to operate effectively, claims processing is a critical issue.

The purchaser may retain financial risk associated with provision of service beyond the scope of the managed care contract. For example, the purchaser may be responsible for payment for a service that is not covered under the managed care plan, continued treatment after the limits of coverage have been exceeded, or payment for service to individuals who are not eligible for treatment under the managed care program. The MCO may have agreed to accept full financial risk through a capitation contract, or risks associated with achievement of performance targets. The MCO and provider-sponsored service systems may have agreed to share financial risk associated with treatment of a subset of the eligible population.

Adjudication of claims in a managed behavioral health care system is a complex enterprise, heavily dependent upon the MIS. Many MCOs have encountered difficulties in the efficient handling of claims payments. Proper claims adjudication requires the system to have access to information about the following:

Coverage available under the managed care plan, which requires detailed tables to allow precise definition of covered services; limitations of payment by service (i.e., 20 outpatient visits, 30 days of inpatient treatment); excluded services (e.g., "Rolfing" therapy, biofeedback); and annual or lifetime limits on coverage;

Consumer eligibility status at the time of treatment (by referencing the eligibility files);

Provider status as a member of the network, qualifications to provide services for which claim was submitted, affiliation with larger provider organization or service system, tax identification, payment address (by referencing the provider database and credentialing files);

Fee schedule for payment for services rendered (by referencing the benefit plan and provider files);

Utilization review authorization of payment for service rendered, by reference to number of units of treatment, level of care, and period of time during which treatment was to be provided (by referencing the utilization review files);

Coordination of benefits (by referencing the eligibility files and records of alternative coverage); and

Fund to be charged (by referencing MCO financial accounting files).

Claims processing software is among the most expensive that an MCO will maintain. The RFP should solicit information from the vendors on the software system that will be used to support this function. The MCO's claims system should be able to exchange information electronically with its clinical management system to ensure proper adjudication of claims and to apprise case managers, providers, and enrollees of financial resources available to support planned treatment.

Claims Processing. Purchasers may wish to address the following in RFPs and contracts:

Ensure that the MCO has the capacity to accept claims from providers in a variety of forms--i.e., via paper, electronic media, and electronically (EDI, or electronic data interchange, a telecommunication standard).

Specify a timeframe for the processing of claims that will ensure cash flow to the provider network and possible penalties for noncompliance.

Specify that claims processing data be available and able to be readily formatted into desired reports.

Require that claims processing data be transmitted to the purchaser in an acceptable form that meets the requirements for the purchaser's analysis and external reporting.

Require that the MCO support providers' electronic monitoring of claims received, processed, and adjudicated.

10. Implementation of Performance Criteria

The purchaser must establish performance criteria to measure the MCO's effectiveness in implementing and managing the contract. Once criteria are established and key performance indicators are determined, the purchaser must ensure the capabilities of the MCO's MIS to collect, manage, and maintain these critical data. Because much of the information must be collected from network providers, the MCO should be required to show how the information will be collected and managed and how accuracy will be maintained via review activities (e.g., audits).

Implementation of Performance Criteria. Purchasers may wish to address the following in RFPs and contracts:

Specify standards for the evaluation of performance measures.

Identify key data elements needed to derive the measures.

Identify algorithms used to calculate the measures.

Indicate the method of transfer of data between the provider and the MCO.

Identify facilities needed by the MCO and the provider to collect, transmit, manage, and secure the data.

Specify time intervals for transmission of or availability of data.

Specify the reports required and the time intervals for submission of such reports to the purchaser.

11. Reporting

The MCO should be expected to produce a wide variety of reports to support management decisionmaking, quality management, and quality improvement. The contract should specify the nature of the reports the MCO will be required to prepare, the schedule for preparation of reports, and the groups to whom various reports will be distributed.

Different reports may be prepared for the purchaser, network providers, enrollees, and the public. For example, the purchaser may require comprehensive reports regarding all aspects of operation of the managed care program. Such reports would include claims data, estimates of claims incurred but not yet reported, patterns of utilization at each level of care, utilization by provider or provider system, utilization by age category, utilization by diagnostic category, readmission rates, clinical outcomes indicators, consumer satisfaction, and so forth.

The purchaser may require the MCO to share information with network providers to create a "feedback loop" regarding each provider's patterns of treatment and cost of service relative to other providers. A feedback loop is particularly important if the MCO makes "economic credentialing" a condition of continuing provider participation in the network (see Chapter IV).

The MCO may be required to prepare a standard "report card" on its own performance, as measured by consumer satisfaction, number of people receiving treatment, pattern of treatment across the entire network, and clinical outcomes. The MCO may also be required to produce similar information on specific providers or case managers to assist enrollees in their choices.

The RFP should solicit information from bidders on the manner in which they will produce reports and ask them to submit sample reports. Many MCOs use software programs that are specifically designed for statistical analysis of data and production of complex reports. The MCO should be able to produce a number of standard reports upon demand and have the flexibility to produce custom reports.

Reporting. Purchasers may wish to address the following in RFPs and contracts:

Specify the standard reports that will be required.

Attach samples of standard reports to the contract as exhibits.

Include the schedule for production of standard reports.

Describe the scope of distribution of standard reports.

Specify timeframes for production of custom reports requested by the purchaser and any charges by the MCO for custom reports.

Identify data that will be maintained and available for the purpose of producing custom reports, including any aggregation formulas to be applied in analyzing data.

Allow modification of reporting requirements as needed, subject to adjustment of MCO fees in the event that the purchaser demands material changes.

12. Quality Assurance

As discussed in detail in Chapter VI, an effective quality assurance program is an essential aspect of an MCO's operations. Quality management requires regular review of operations and outcomes to determine the effectiveness of services and to ensure that avoidable treatment omissions are not made. A comprehensive, integrated MIS is an excellent tool for implementing such a program.

Quality Assurance. Purchasers may wish to address the following in RFPs and contracts:

Require that the MIS maintain assessment and outcome data electronically for a specified period.

Ensure the capability of the MIS to compare baseline assessment data with periodic reassessment data.

Require the MCO to implement software-driven triggers that alert quality management staff to out-of-the-ordinary occurrences for enrollees or providers or to predetermined markers of quality (e.g., insufficient followup after inpatient hospitalization).

Require the MCO to report actions taken as a result of quality assurance triggers.

13. Incident Reporting

Reporting and tracking critical incidents, such as assaults, suicides, and homicides, is an important aspect of the quality management function of the MCO. Timely reporting of critical incidents should be mandated in the contract with appropriate timeframes and level of detail to be reported. Contract provisions addressing MIS needs in this area are related to the MCO's ability to accept electronic input from providers of the incident report, maintain and analyze data on the occurrence of these incidents, report them to the purchaser on a timely basis, and provide the purchaser online access to current information. RFP and contract provisions should address all of these issues.

Incident Reporting. Purchasers may wish to address the following in RFPs and contracts:

Require the MCO to have the capacity to report and track critical incidents.

Require the MCO to have the capacity to maintain and analyze the occurrence of these incidents, report them to the purchaser on a timely basis, and record input by providers.

E. Confidentiality Considerations

One of the most important elements and expectations of the therapist-patient relationship is confidentiality. Only an individual who pays cash for all clinical services, however, can reasonably expect that the therapist will not reveal anything about the patient to third parties, including the fact that he or she is receiving treatment. This expectation of confidentiality is embodied in State and Federal law. Exceptions are allowed only in circumstances in which a patient gives the therapist reasonable cause to believe that the patient is likely to harm himself/herself or a third party, or cases of suspected abuse or neglect. (See Chapter VIII for a discussion of laws governing confidentiality of clinical information.)

When a third party is obligated to pay for the patient's treatment, confidentiality issues are not as clear cut. Even in a fee-for-service system, an insurance carrier or government agency has access to information indicating that an identified individual received a particular type of treatment. Federal regulations governing substance abuse records *strongly* protect the confidentiality of this information by requiring that patients authorize its release to third-party payers. State laws govern confidentiality of information relating to mental health treatment. Most State laws allow release of information without specific written authorization to the extent necessary to enable payment of health benefits (e.g., see New York State Mental Hygiene Law §33.13).

The risk of breaches of confidentiality are far greater in the context of managed care. Under managed care systems, a third party may demand access to highly personal information for the purpose of deciding that treatment is "medically necessary" and therefore reimbursable (see discussion of medical necessity in Chapter III). This creates a conflict for providers, who wish to protect the confidentiality of those being served but who know that if personal information about consumers is not shared, the MCO will not reimburse the provider for services rendered. There are many situations in which consumers have terminated treatment rather than allow their deepest secrets to be shared with third parties. Thus, it is important that MCOs be required to establish policies and procedures requiring network providers to inform patients about their confidentiality rights. It is also important that a standard form, approved by the purchaser, be used by an MCO's providers to inform patients of their rights and to secure a patient's permission to release confidential information.

The issue of confidentiality is particularly critical in the context of an MIS because confidential information may be released to the MCO. In a fully integrated service system, using the "ideal" MIS, confidential information may be passed electronically among a number of parties. Confidential information could even be stored on server computers that are accessible through the Internet.

To ensure confidentiality of clinical information, each enrollee should be given a unique identifier--that is, an alphanumeric code designed so that no two people in the system have the same identifier and so that all clinical data collected for an individual can be compiled--which is virtually indecipherable. Such an identifier may be the only means of ensuring confidentiality, because data and information from the MCO's and providers' files can be shared across networks with case managers and other State systems. In a system for substance abuse and mental health treatment records, it is critically important that unique identifiers be used, that they be secure, and that they are not easy to decipher. The use of entire identifiers such as a Social Security number or name should be avoided. Nevertheless, claims adjudication usually requires the use of name or social security number for accumulating benefits properly and for sending an explanation of benefits to enrollees.

Confidentiality Considerations. Purchasers may wish to address the following in RFPs and contracts:

Require the MCO to establish policies and procedures requiring network providers to inform patients about their confidentiality rights.

Require the MCO to adopt a standard form, approved by the purchaser, that can be used by its providers to inform patients of their rights and to secure a patient's permission to release confidential information.

Require the MCO to maintain policies and procedures to ensure that identifying and clinical information about patients is not shared within the MCO, except as necessary to enable the MCO to carry out clinical functions.

Require the MCO's MIS to have security clearances built in to limit access to patient identifying information and clinical information to only those persons whose job requires such access.

Require the MCO to establish a virtually indecipherable unique identifier coding system for enrollees that permits the sharing of data collected on enrollees while preserving their confidentiality.

Require that MCO reports not include any information that identifies individual patients (with the exception of reports on critical incidents or purchaser audits of individual records).

Require that to the extent that the MCO's managed care system requires the electronic exchange of confidential information over the Internet or other public data transfer systems, all files will be encrypted, using an encryption system that is commercially available and approved by the purchaser.

Require that any servers maintained by the MCO will have "firewalls" built in and require multiple levels of security clearances to protect against breaches of security and leakage of confidential information.

Require that the MCO agree to abide by all applicable provisions of State and Federal law relating to the release of confidential information in the same manner as the direct provider of treatment services.

Require that the MCO notify a consumer in the event of any subpoena of confidential information about him or her to give the consumer the opportunity to seek a court order prohibiting the release of confidential information.

Require that the MCO have all its employees sign agreements to be bound by the provisions protecting the confidentiality of information about patients, including information about the consumer's identity.

Require that the MCO will pay liquidated damages in an agreed-upon amount for every breach of confidentiality discovered by the purchaser.

Require that the MCO and its network providers maintain compliance with the Federal substance abuse confidentiality regulations.

F. Ownership and Use of Data

An MCO will accumulate a vast amount of data about the delivery of substance abuse and mental health services in the State or county. These data will have value to the MCO, because they can be used to improve operations. The data may also have potential value to third parties, such as large drug companies, which could learn about the impact of use of their medications in treatment. Drug companies may also want information about prescription patterns by individual providers to be used for direct marketing purposes.

Purchasers should protect against the unauthorized use of data generated in the course of operation of their managed care program. The contract should indicate that the data generated in the course of administration of the program is the property of the purchaser. The MCO may be allowed to use the data for internal purposes.

It is important to distinguish between data that apply specifically to the purchaser's managed care program and data that are accumulated by the MCO in the ordinary course of its business. For example, the MCO may have a list of network providers, including their areas of specialization, office locations, and so forth. These data may belong to the MCO. On the other hand, data about the cost of treatment of enrollees are clearly the property of the purchaser.

The following provides example text for contract language covering the ownership of data:

Purchaser shall be and remain the sole and exclusive owner of any and all data pertaining to the operation of the managed care program(s) that are operated by the MCO on behalf of the Purchaser. (Such data are hereafter referred to as the "Purchaser Data.") This includes all Purchaser Data entered into the MCO's MIS System (including without limitation, all Client information, Eligibility data, Claims reports, Utilization reports, and any information from Purchaser's present data processing and information system which shall be transferred and converted, pursuant to the Implementation Plan, to operate on the MCO's MIS System). Neither the MCO nor any of its employees, agents, consultants, or assigns shall have any rights in any of the Purchaser Data in any form including, but not limited to, raw data, stripped data, cumulated data, usage information, and statistical information derived from or in connection with the Purchaser Data. The parties agree that the Contractor shall promptly download for and provide to the Purchaser, at no cost to the Purchaser, all such Purchaser Data in an electronically accessible form upon the termination of this Agreement. This provision shall survive the term or termination of this Agreement (Litwak, 1997).

Ownership and Use of Data. Purchasers may wish to address the following in RFPs and contracts:

Identify data that belong to the purchaser (such as claims data, standard reports, custom reports, and service utilization data). Also identify any data that will remain the property of the MCO.

Prohibit any release of the purchaser's data to third parties without the written permission of the purchaser.

Prohibit any publication of analyses of purchaser's data without the written permission of the purchaser.

Prohibit any commercial use of purchaser's data.

Prohibit aggregation of the purchaser's data with other data maintained by the MCO, except for the purpose of academic research relating to public health and operation of substance abuse and mental health treatment systems.

Prohibit any release of data in any form that tends to allow third parties to learn the identity of patients or reveals confidential information about patients.

G. Technical Requirements for an MCO's MIS

Unless a purchaser is attempting to develop an ideal information processing environment for managed care programs in its State or county or is acquiring an MIS for its own use, it need not attempt to control the exact manner in which the MCO operates its MIS. Nonetheless, it is necessary for the purchaser to be assured that the MIS used by the MCO will function properly and comply with contractual requirements. The purchaser has the right to identify a number of technical requirements that the MCO's MIS will be expected to meet. Some of the technical requirements are discussed below.

1. Industry Standards and Open Architecture

In determining the acceptability of an MCO's MIS, the concept of "open architecture" is central. The information systems industry has defined very specific standards for systems design supporting transfer of data and communication protocols between computers. The standards determine the ways that data are structured and communicated, that hardware and software operate, and that security of data is maintained. When a system adheres to industry standards, it can be said to have an open architecture.

In general, for purposes of the contract, the purchaser should ensure that the MCO's MIS meets industry-established standards and has the ability to negotiate and experiment with new or more refined standards. In setting standards, the purchaser should obtain inhouse or other consultation, especially in determining whether and when standards for systems design should conform to those used by State and other agencies in the geographic area. Because purchasers may contract for services with several MCOs, it is crucial that the purchaser can communicate in the same way with each and that the data the MCOs collect are standardized for analysis and comparison.

Industry Standards and Open Architecture. Purchasers may wish to address the following in RFPs and contracts:

Ensure the MCO's MIS adheres to industry standards for open architecture.

If contracting with several MCOs, standardized methods of communicating are used and standardized data are collected.

2. Access to Data

To carry out the monitoring function, the purchaser must have access to data on the ongoing operations of the MCO and network providers. By means of contract provisions, the purchaser should require that all data contained in the MCO's MIS be easily retrievable either by direct access or by standard format extractions.

a. Direct Access

Many purchasers have begun to require direct online access to data maintained on the MCO's MIS. If this is desired, the contract should identify all data sets and elements to which such access is required, including a definition of screens, reports, and specific files. For example, at a minimum the purchaser should have appropriate access to utilization data (such as the number of persons served), and cost data (such as the per person cost per 1,000 enrollees or costs per service unit).

However, most MCOs regard such data as proprietary and will wish to restrict online access in certain areas. In this case, it is important that the purchaser require the MCO to have an MIS that is sophisticated enough to allow the purchaser access to specified data sets while protecting the rest of the system. As security is a significant issue, substantial restrictions on direct access may be appropriate for some purchaser staff (see below).

b. Standard Format Extractions

Without requiring direct access to the MCO's MIS, the purchaser can require that defined data sets be made available at certain specified intervals or on demand in a manner that meets the file format requirements of the purchaser's MIS. Typical industry standard file formats to electronically exchange text include ASCII text, C-ISAM, or DBMS-specific constructs available from independent manufacturers. The purchaser must then specify the data to be provided in these files and the method of communication (i.e., electronic transfer via standard tape sent by courier or transfer through a specified telecommunications structure).

Access to Data. Purchasers may wish to address the following in RFPs and contracts:

Specify all data sets and elements for online access.

Specify file formats for standard format extractions of data.

3. Data Storage Requirements

The MCO must have the capability to provide online access to sufficient data to perform necessary operational functions and analyses. Rather than specify the amount of storage required in terms of hardware capacity for the MCO's MIS, the purchaser should require the MCO to demonstrate that its hardware provides a sufficient capacity to store data online for a defined period. The MCO will know the size of the data set based on the number of members served, the transactions recorded, and system maintenance storage. When the purchaser specifies a period of time for which these data must be available, the MCO can calculate the amount of storage required.

Online availability of data is often required for the current fiscal year and for a defined period before and after the fiscal year to allow for necessary comparative analysis and evaluation. For example, a purchaser may require online storage of 2 years' worth of data (i.e., not archived). Given some defined period, the MCO will be able to calculate its hardware requirements. Archived information should be accessible within a timeframe defined by the purchaser, and the system must be capable of accommodating loading and use of archived data by auditors and other evaluators.

Data Storage Requirements. Purchasers may wish to address the following in RFPs and contracts:

Require the MCO to demonstrate that its hardware provides sufficient capacity to store data online for a defined period.

Specify the timeframe for retrieving archived data.

4. Data Backup

The purchaser should require the MCO to protect against loss of the purchaser's data. It can do this by requiring daily, weekly, and monthly backups by the MCO of portions of the data used to operate the managed care program. Backup data should be maintained offsite at a secure location. Similarly, the purchaser should require the MCO to ensure that it maintains offsite backup copies of the software systems used in its operations.

Many purchasers also require MCOs to maintain backup power generators in the event of a power failure, or to establish redundant operating systems at multiple locations to ensure that service to enrollees is not interrupted.

Data Backup. Purchasers may wish to address the following in RFPs and contracts:

Specify backup requirements for data.

Specify backup power requirements for the MCO's MIS.

5. Security Standards

Security is a primary concern in networked systems. Both MCO employees and third parties (including employees of the purchaser) must give careful consideration to security regarding access to the MCO's MIS. The contract should include provisions requiring strict enforcement of industry security standards and technology. Because of the confidential nature of information about behavioral health care treatment, only authorized persons should have access to data about patients. The contract should require the MCO to demonstrate its capability to adhere to industry-established security standards, with multiple levels of security clearance related to user category and point of access. Security clearances should be tied to specific system functions, data elements, screens, and reports.

Security Standards. Purchasers may wish to address the following in RFPs and contracts:

Require adherence to industry security standards and technology.

Specify security clearances tied to specific system functions, data elements, screens, and reports.

6. Telecommunications Capabilities

Telecommunications is a critically important part of the managed care information processing system. The RFP should solicit information about the telecommunications capabilities of the bidders. The MCO telecommunications system should be capable of handling a large volume of telephone calls, appropriately transferring calls within the MCO system, and monitoring the source of calls, the number of rings before a call is answered, the "call abandonment" rate (hang ups before a call is answered), and the duration of calls by MCO employees. The MCO should be able to provide detailed reports in each of these areas. This information can be invaluable in monitoring the responsiveness of the MCO to enrollees and providers and the nature and quality of the work performed by the MCO's clinical staff.

Many MCOs are now connecting telephone switching systems with computer systems. When the phone rings, the computer automatically calls up records that tie to the phone number of the caller. This allows more personal interaction with the caller. If the caller is transferred to another staff member of the MCO, the computer file is automatically transferred as well.

The RFP and contract should establish minimum criteria for the telecommunications capability of the MCO. In addition, they should define expectations related to the transfer of electronic data between the purchaser and the MCO, between the MCO and network providers, and specified government agencies. Some purchasers may require MCOs to maintain dedicated high-speed telecommunications lines for that purpose. The MCO's telecommunications system should be installed and tested well before the startup date of the managed care program.

Telecommunications Capabilities. Purchasers may wish to address the following in RFPs and contracts:

Require that the MCO's MIS meet industry-established standards and be able to negotiate and experiment with new or more refined standards.

Require that all data contained in the MIS be easily retrievable either by direct access or by standard format extractions.

Require that hardware provides a sufficient capacity to store data online for a defined period.

Require that archived information be accessible within a timeframe defined by the purchaser.

Require that the archiving system be capable of accommodating the loading and use of archived data by auditors and other evaluators.

Require protection against loss of the purchaser's data through a purchaser approved backup schedule.

Require adherence to industry-established security standards, with multiple levels of security clearance related to user category and point of access.

Establish minimum criteria for the telecommunications capability, including the capability of handling (and reporting on) the management of a large volume of telephone calls, including appropriately transferring calls within the MCO system, monitoring the source of calls, the number of rings before a call is answered, the "call abandonment" rate (hang ups before a call is answered), and the duration of calls by MCO employees.

Establish minimum expectations related to the transfer of electronic data between the purchaser and the MCO, between the MCO and network providers, and the MCO and specified government agencies.

Require dedicated high-speed telecommunications lines for the transfer of electronic data.

H. Procurement of an MIS by a Purchaser for its Own Use

This chapter is not intended as a comprehensive guide for purchasers wishing to acquire an MIS for their own use or as a standard for use by providers in their jurisdiction. However, some State and county governments may be interested in acquiring an MIS to enable them to play an active role in the operation of a managed substance abuse and mental health service system.

Federal financial participation in the cost of design and procurement of "Automatic Data Processing" (ADP) systems used to manage public assistance programs (including Medicaid) is available to State and county governments. Procedures for Federal approval of MIS plans developed by States and counties, and conditions of Federal participation are described in the *Code of Federal Regulations* (45 C.F.R. 95.601 et. seq.).

Federal funds are available to offset the cost of MIS planning, MIS design, and procurement of MIS software and equipment. The Health Care Financing Administration must approve in advance any plans involving an Medicaid expenditure greater than $5 million dollars ($5,000,000.00).

Federal regulations require that States or counties will have all ownership rights in all software or software modifications (including documentation) that is custom developed for the State or county, and for which Federal financial participation is claimed. In addition, the Federal Government reserves a royalty free, perpetual license to use the software to support Federal operations. These requirements do not apply to pre-existing software sold to the State or county at established prices. Federal financial participation is not, however, available to offset the cost of purchasing proprietary software "developed specifically for the public assistance programs covered under this section."

The "ideal" MIS described in this chapter is attainable. It requires a cost commitment, a great deal of planning, and a commitment to install the system in cooperation with key agencies and provider organizations over an extended period of time. However, the more sophisticated the system is, the more difficult it will be to attain the ideal. Complex systems will be more dependent on data standards. Nevertheless, most of the objectives of the ideal system are obtainable.

Reliable software designed to support "mission critical" functions is usually the hardest piece of the MIS to find. Mission critical functions are functions that enable an organization to complete essential work processes. The capabilities necessary include recording essential clinical information about service recipients, maintaining financial information about the mental health and/or substance abuse health benefit plan, accessing and analyzing data about the service system, and allowing those who work together in the service system to communicate effectively and work more efficiently. In addition to meeting technical requirements, the software licensing agreement should include the elements shown in Exhibit V-2.

Though mission critical software is an important component and may be quite expensive, software represents a fraction of the cost of implementing a complex MIS. Hardware, local and wide area network communications systems, training, and local system maintenance are the most expensive to develop and maintain. Implementation planning and the technical ability to maintain systems locally are critically important to successful deployment of a new MIS.

Procurement of an MIS. Purchasers may wish to address the following in RFPs and contracts:

Require software vendors to use an "open systems" architecture to allow easier exchange of data with other systems.

Require software vendors to use a system built on a relational database to ensure that it can be scaled upwards to meet the requirements of the purchaser.

Require software vendors to be in compliance with JCAHO, American Hospital Association, and other accreditation standards applicable to health care software systems.

Require software vendors to be in compliance with various generally accepted standards for software design, including: HL7, OLE 2.0, MAPI 1.0, TAPI 2.0, and SAPI 1.0 standards.

Require software vendors to maintain the ability to generate all reports required by the NCQA, including HEDIS (the Health Employer Data and Information Set) 3.0 and successors.

> Require the software vendor's software license agreements include appropriate provisions pertaining to the scope of the license, acceptance testing, performance standards, ownership of the product, maintenance, indemnification, data integrity, year 2000 functionality, documentation, and "help" systems.

The decision by a State or local governmental agency to purchase an inhouse MIS rather than to purchase the MIS services of an MCO is a critical one. The purchase of an inhouse MIS means that all of the functions described in this chapter should be considered during the procurement of a vendor to provide software, hardware, and/or telecommunications products and support. The purchase of an inhouse MIS puts much more control of the process into the hands of the purchaser but also brings with it accountability and responsibility for the end result.

Exhibit V-2.

Software Licensing Agreement: Key Elements

The software licensing agreement should include the following elements:

Scope of license. This can be based on references to the number of users of the software, the number of workstations, the number of servers upon which a networked software system is installed, or by reference to the scope of activities of the purchaser. Other than price, this is the most critical financial component of the agreement.

Acceptance testing. The purchaser should have the opportunity to test the software to be sure that it meets agreed-upon performance standards before being obligated to pay the full price for the product.

Performance standards. The system should meet minimum standards for speed of data processing and changing of software screens, given the purchaser's hardware, network, and communications configuration.

Ownership of the product. Protection for the purchaser should be ensured in the event that a third party claims that the software vendor misappropriated intellectual property.

Maintenance. An agreement by the vendor to repair "bugs" promptly and to respond to problems experienced by the purchaser in accordance with their severity should be included.

Indemnification. Indemnification of the purchaser against the vendor's violation of the trade secrets or other intellectual property rights of third parties, as well as violation of the Health Insurance Accountability and Portability Act of 1996, should be included.

Data integrity. The purchaser should receive assurances that the software will not corrupt the integrity of the purchaser's data.

Year 2000 functionality. The purchaser should be protected against inaccurate functioning on or after January 1, 2000.

Documentation. Complete and accurate documentation of all software functionality should be included.

"Help" systems. Both written and electronic "help" systems for users should be included.

[1.] JCAHO accreditation and NCQA review are voluntary. The purchaser may wish to require primary source verification independently.

CHAPTER VI

Quality Management

Key issues in this chapter:

- Framework for evaluating quality: structural, process, and outcome measures
- Accreditation of MCOs and other providers
- Report cards on MCOs
- Measures of consumer and family satisfaction
- Quality management systems for MCOs

Although cost containment has been the dominant catalyst behind the move to managed care systems, there is now strong and growing interest in evaluating and improving the quality of care. Quality of care has been defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge (IOM, 1990a).

Driving the new interest in quality of care are improved methods for assessing quality; increased competition for contracts; concern about the effects of incentives in managed care contracts for undertreatment and restricted access; and a growing demand for accountability by Federal, State, and county governments (IOM, 1996; Meyer, 1997; Rosenbaum et al., 1997).

Quality standards can vary, but there is a consensus emerging about the aspects of service delivery and treatment outcomes that should be measured to assess the system of care. The measures and mechanisms chosen in different managed care initiatives to assess and improve the quality of care and increase the accountability of managed care organizations (MCOs) will vary substantially depending on the circumstances (IOM, 1996).

A purchaser of managed care can use a well-written contract to establish what standards of quality it expects from an MCO and to specify how quality will be defined, monitored, and managed. One of the most notable developments in purchaser contracting practices in recent years is the increased reliance on establishing minimum standards of MCO performance and the development of measures to determine whether MCOs are meeting those standards. The following language from a contract between the State of Massachusetts and a health maintenance organization (HMO) illustrates how a purchaser may provide an MCO with detailed contract language on both the standard it expects the MCO to meet and the measure that the purchaser will use to determine whether the MCO is meeting the standard (Rosenbaum et al., 1997):

Standard: *"The HMO shall maintain an ongoing formal process to develop and adopt clinical practice guidelines for conditions which have traditionally exhibited high cost and/or high variation among Provider treatment methodologies. Guidelines should combine the best available scientific evidence, outcomes, and expert opinion in the specialty for which the guideline is being developed and should be developed in conjunction with the Provider network to assure maximum acceptance. The HMO shall further demonstrate that such protocols have been implemented and that measurement of compliance with the guidelines is occurring.*

Measure: *The HMO shall select two clinical practice guidelines, including at least one of the following: asthma management, prenatal care, substance abuse or pregnancy, and a second guideline of the HMO's choice. For each of the two clinical guidelines selected, the HMO shall document: (a) the process for the development and dissemination of clinical practice guidelines to participating Providers and members; (b) how the HMO incorporates scientific evidence, expert opinions, and the opinions of network providers and expert clinicians outside of the network into such guidelines; and (c) an ongoing evaluation process for the purpose of updating and revising the clinical practice guidelines, as indicated by current medical practice standards."*

This chapter presents a framework that may help purchasers in thinking about quality. It also discusses issues that purchasers should consider when developing provisions related to quality management in requests for proposals (RFPs) and contracts. The chapter covers the following topics:

- Framework for evaluating quality: structural, process, and outcome measures;
- Accreditation of MCOs and other providers;
- Report cards on MCOs, such the National Committee for Quality Assurance's (NCQA) Health Plan Employer Data and Information Set (HEDIS 3.0);
- Consumer and family satisfaction measures; and
- Internal and external quality management systems for MCOs.

A. Framework for Evaluating Quality: Structural, Process, and Outcome Measures

When purchasers are developing their strategies for using a contract with an MCO to ensure a certain level of quality, they may find Donabedian's conceptual framework for evaluating the quality of care useful (Donabedian, 1980, 1982, 1985). Donabedian identified three distinct categories of measures used to evaluate the quality of care: (1) structural measures; (2) process measures; and (3) outcome measures.

Process measures are currently the dominant type of quality measures in managed behavioral health care contracts. As discussed below, however, there is growing interest in the use of outcome measures, and MCOs are increasingly allocating resources to outcome measures to maintain a competitive position in the industry. There is less emphasis on the use of structural measures of quality in managed behavioral health care contracts than on the use of either process or outcome measures. The use of each of these three types of measures of quality in managed behavioral health care is discussed further below.

Framework for Evaluating Quality: Structural, Process, and Outcome Measures

- **Structural Measures**

  Measures pertaining to the capacities, technologies, and infrastructure that make up the structure of care (e.g., management information system, number and types of staff, types of facilities, size and composition of an MCO's provider network)

- **Process Measures**

  Mesures pertaining to the administrative, clinical, and other processes by which care is provided

- **Outcome Measures**

  Measures pertaining to the orucomes of care(e.g.,reductions in drug use, amelioration of symptoms of depression)

SOURCE: Donabedian,1980,1982,1985.

1. Process Measures of Quality

Process measures of quality--which in the field of behavioral health care are frequently referred to as "performance measures"--are generally of three main types: (1) measures of administrative processes (e.g., an MCO's customer service practices, and claims payment proficiency); (2) measures of clinical processes (e.g., an MCO's compliance with patient placement criteria, provision of relapse prevention training, continuity of care); and (3) measures of financial/utilization processes (e.g., population penetration rates, utilization patterns, and claims targets) (Oss, 1994).

Process measures typically measure activities that are *believed* to lead to positive outcomes. The use of process measures is based on a belief that improving the process of care will yield improved outcomes. Purchasers should recognize, however, that not all process measures relate to, or even correlate with, outcome measures. Although the managed behavioral health care industry is attempting to develop a consensus on the most valuable process

indicators to use (see the April 1997 issue of *Behavioral Healthcare Tomorrow*), little research has been directed toward the relationships between specific process measures and actual outcomes. Furthermore, little is known about the efficacy of process measures to predict outcomes consistently across patient groups (McLellan et al., 1996).

Some of the potential benefits and limitations of process measures of quality are identified in Exhibit VI-1. To be most useful, process measures must be based on reliable, accurate, and complete data and relate clearly to the outcome being sought. If process measures are used properly, they can provide purchasers of managed substance abuse and mental health services, MCOs, consumers, and others with valuable information that can facilitate efforts to monitor, evaluate, and improve the quality of care.

Exhibit VI-1.

Process Measures: Benefits and Cautions

Potential Benefits	Cautions/Limitations
Measures provide operational and measurable representations of performance. Measures establish a base upon which to set standards to be attained by the MCO. Measures increase overall accountability of the MCO. Measures create opportunities to monitor and improve performance over time. Measures provide a vehicle for implementing quality improvement initiatives or corrective action plans. Measures provide a structure for financial incentives and sanctions. Measures establish a framework for comparing performance in specified areas across health care systems. Measures provide useful information to individuals and businesses to aid in their	Measures can easily be based upon data that are not complete, accurate, reliable, and/or valid. Measures based on data from an MCO's management information system (MIS) are subject to distortion, misinterpretation, and, in some cases, misrepresentation. The validity of many measures may be questionable; some measures may be imperfect representations of the issues they attempt to address. Case-mix risk adjustments, critical in accurately interpreting process and outcomes measures, are seldom included.

2. Outcome Measures of Quality

Outcome measures of quality have begun to receive much attention in the behavioral health care field. Although there is much evidence to support the effectiveness of prevention, treatment, and rehabilitation for substance abuse and mental health disorders (Hubbard, 1989; IOM, 1990a; McLellan et al., 1996; Simpson & Sells, 1990) evidence developed in other States or systems of care is often not perceived by State legislatures and the public as applicable to local systems of care. Consequently, the purchasers of behavioral health care services are often challenged to

defend the expenditures to a skeptical legislature and public and to demonstrate that such services are resulting in positive outcomes and measurable societal benefits. Furthermore, some MCOs are beginning to propose outcome-based reimbursement arrangements as a means to circumvent what they perceive to be purchasers' overemphasis on price factors (Meyer, 1997).

Neither the mental health nor the substance abuse fields have achieved a high degree of consensus about specific outcome measures to use and what indeed constitutes treatment success.[(1)] Thus, for example, the addiction treatment field continues to struggle with the controversial issue of whether treatment goals for persons with substance use disorders should be directed toward abstinence from all substance use or whether reduced use can be a viable goal for some populations.

In the mental health field, a similar struggle is sometimes noted over whether symptom reduction or symptom recovery ("cure") should be the ultimate goal for those with mental illnesses. For an adult with severe mental illness, individually determined goals might include securing a job, regular housing, enough income to live on, and a social network. For a child with a serious emotional disturbance, goals might include an improved level of functioning in school, at home, and with peers. For an individual with severe substance dependence, goals may include decreased quantity and frequency of substance use, reduced symptoms, reduced involvement with the criminal justice system, lower medical costs, and improved vocational or employment status (as currently measured in the States of Minnesota, California, and Oregon) (McLellan et al., 1996).

Exhibit VI-2 lists some research-based behavioral health care outcome measures from an Institute of Medicine (IOM) report *Managing Managed Care* (IOM, 1997). (Appendix G lists examples of other potential outcome measures in behavioral health care, along with several potential process measures.)

Exhibit VI-2. Research-Based Behavioral Health Care Outcome Measures

1. Percentage of individuals who show reductions in symptoms;

2. Percentage of patients who show improved functioning;

3. Number of patients who return to work;

4. After return to work, average number of consecutive days worked without absences;

5. For children and adolescents, number who return to school;

6. For children and adolescents, average number of consecutive days in attendance at school;

7. Number of clients returning to earlier levels of treatment;

8. Number of clients who are able to live independently in the community;

9. Number of clients whose substance-free status is validated through regular breath and urine testing; and

10. Number of clients who increase participation in community activities.

SOURCE: IOM, *Managing Managed Care: Quality Improvement in Behavioral Health,* 1997.

The purchasers of managed behavioral health care should be prepared to include a well-defined plan for outcome measurement in the contract. Given that the development and use of outcome measures in managed behavioral health care systems are still in the early stages, a purchaser should use caution in selecting the outcome measures. Furthermore, the cost of obtaining outcome data must be weighed against the value of the data. Factors to take into

consideration include the validity of the data and the reliability and accuracy of the information they provide, costs of data collection, its utility for making corrective decisions, and consistency with confidentiality requirements. In addition, outcomes must be selected that can be precisely measured, such as psychiatric hospitalization readmission rates, or the percentage of increase in school attendance among children, or a decrease in criminal justice system involvement. If available resources are very limited, the purchaser may wish to consider implementing the outcome measurement system in stages; building on it as resources become available and experience is acquired.

A Resource for Information on Outcomes Monitoring

Purchasers interested in developing outcome-measurement systems for substance abuse and mental health treatment services may wish to review the Treatment Improvement Protocol (TIP) developed by the Center for Substance Abuse Treatment (CSAT) titled *Developing State Outcomes-Monitoring Systems for Alcohol and Other Drug Treatment* (CSAT, 1995a). This TIP describes useful principles and techniques for designing outcomes-monitoring systems, establishing policies and viable infrastructures for monitoring and evaluating the outcome measures designed, and selecting a feasible number of outcome measures that best reflect the goals of the contract. Examples of outcomes-monitoring systems developed in various States are described in the TIP.

In selecting outcome measures, the purchaser should be aware that different stakeholders--for example, the legislature, the courts, the health care system, consumer and family groups, various social and public health agencies--may take a substantial interest in the types of outcome measures used. Their goals and expectations, which often vary dramatically and may conflict, can result in strong pressures on the purchaser of managed behavioral health care services to devote finite resources to an expansive, all-inclusive set of measures that does not include a measure of whether individuals receiving care actually get better.

Clinical outcomes for individual patients (e.g., improvements in cognitive functioning, reduction in cocaine use) may not be of primary interest to some stakeholders. In an analysis of outcomes desired by various stakeholders, McLellan and Weisner (1996) found that few stakeholders sought "direct" treatment outcomes; rather, they called for broader societal benefits such as "reduced crime, improved health status, prevention of human immunodeficiency virus infection, reduction of unsafe sexual practices, improved employment, and improved family functioning." Because measurement of outcomes is a complex undertaking and can require significant financial and staff resources, only a limited number of measures may be feasible. Alternatively, purchasers may want to limit the tracking of certain outcomes to specific population groups rather than all enrollees.

3. Structural Measures of Quality

Structural measures of quality refer to a wide range of "tangibles" that are part of the health care system and are believed to be positively related to outcome, or at least increase the chances that outcome will be positive. Structural measures of quality include capacities, technologies, and infrastructure that, when present, would be perceived by most to be related to higher quality processes and outcomes of treatment. Thus, for example, better facilities, telecommunications, office equipment, a management information system (MIS), and staffing in a hospital would seem to enhance the institution's capacity to provide high-quality services, all things being equal.

Licensing of facilities usually relies heavily on structural measures of quality. Requirements concerning the size of rooms and hallways, sanitation, medical records, fire detection, staffing, etc. ensure that the physical facilities and clinical support systems are adequate to support the program. Although meeting these requirements does not ensure a good treatment outcome, not meeting them could potentially create conditions that would ensure a poor outcome, for example, an undetected fire. Accreditation standards (discussed later in this chapter) also consider structural features, such as staff training, staff size, medical record organization and content, infection control, and quality assurance/improvement systems. These standards are extremely important in encouraging the development of systems that will actually improve outcome.

Facilities and programs are increasingly understanding the value of nicely landscaped grounds, good lighting, and decorative art. These structural features help create the perception, or an expectation, that the program has the potential to provide quality outcomes. These "placebo" effects may be quite effective at improving the potential for good outcomes.

Purchasers should specify what structural measures will be required as part of the managed care system under development. For example, having comparable facilities for serving private- and public-pay clients, living in different areas, might be required.

4. Quality Measures for Substance Abuse and Mental Health Services: Similarities and Differences

It is important for purchasers of managed behavioral health care services to distinguish between quality measures that can be applied effectively to both substance abuse and mental health populations and those that are appropriate for one population or the other (as well as those that are appropriate for children). While many process and outcome measures can be applied both to mental health and to substance abuse treatment, an optimal set of measures for individuals with severe mental illness will differ in many ways from a set of measures for individuals with addictive illness. Similarly, the most appropriate measures for children and adolescents may be quite different from those used for adults.

An IOM committee that studied managed behavioral health care identified the following general outcome areas that can be applied to a broad cross-section of consumers of both substance abuse and mental health treatment services (IOM, 1996): improvement in employment or vocational status, medical status, family and social functioning, legal problem status, cognitive functioning, and quality of life.

Expected outcomes and the processes necessary to achieve given outcomes may differ depending on an individual's diagnosis, the severity of the problem, the drug(s) of abuse, age, and the stage of illness or recovery. Thus, for example, the purchasers should not expect all process and outcome measures to be equally applicable for severely mentally ill adults, individuals with long-term heroin addiction, adults with major depression, children with severe emotional disturbances, and adolescents with comorbid mental and addictive disorders.

Structural, Process, and Outcome Measures of Quality. Purchasers may wish to address the following in RFPs and contracts:

Include the input of consumers when establishing measures that are relevant to them; patient satisfaction data alone are insufficient and easily "gamed" by surveyors.

Ensure that outcome measures are measurable and limited enough so they can be tracked and used to improve treatment.

Identify, precisely define, and/or provide all performance measures that the MCO is required to develop and/or implement (e.g., claims paid, clinical records, satisfaction, and per capita cost analysis).

Specify performance measures and standards to which incentives or sanctions are attached.

Clarify purchaser quality monitoring activities, including reviews of performance measures, clinical records, grievance and appeal data, enrollment/disenrollment data, terminations, utilization and financial data, and management systems and procedures.

Require that the MCO have or develop the technological capacity to fulfill all contractually stipulated responsibilities related to the collection and measurement of performance indicators and outcome measures.

Define the process by which disagreements, misinterpretations, or ambiguities about measures will be resolved.

Delineate the MCO's responsibilities about the integrity of the data and reporting requirements.

Establish standards for validation and verification of reported performance data.

Require compliance with State and/or Federal reporting requirements.

Specify the processes and mechanisms by which the quality management staff and structures of the MCO and purchaser will communicate.

Require that funds be set aside by the MCO to conduct outcome studies.

Specify the required capabilities, flexibility, and resource intensity of the MCO's outcomes measurement system.

Require the MCO to collect, analyze, and develop periodic reports with data on specified outcomes for specific subpopulations.

Specify appropriate outcome measures for different populations (e.g., persons with long-term mental illness, individuals who are homeless and abuse substances, children with severe emotional disturbances).

Require that the MCO collaborate with the State, county, and/or local mental health and/or substance abuse authorities in outcome-related evaluation initiatives.

Require that the MCO make staff, data, and other relevant resources available to the evaluators representing the purchaser.

Establish guidelines for phasing in outcome measurement, using established baseline measures wherever feasible.

B. Accreditation of MCOs and Other Providers

The purchaser of managed behavioral health care services must decide whether to require an MCO to have specific accreditation to be eligible to bid for the contract and whether to require accreditation for all or some types of network providers. A number of organizations systematically assess the clinical and administrative operations of individual providers, MCOs, and other health care delivery systems and institutions and accredit them if they comply with predetermined standards. Many of the standards used in accreditation are structural measures of quality (see earlier discussion in this chapter). Public and private payment programs often require accreditation as a condition of payment for covered services.

The activities of four of the most well-known national accrediting organizations that review behavioral health care organizations--the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the National Committee for Quality Assurance (NCQA), the Commission on Accreditation of Rehabilitation (formerly the Commission on Accreditation of Rehabilitation Facilities, or CARF), and the Council on Accreditation of Services for Families and Children (COA)--are described in Exhibit VI-3.[(2)] In many cases, accreditation by these organizations has become a necessary, but not sufficient, requirement to be competitive in a managed care environment. However, very few MCOs serving persons with substance abuse and mental health disorders have been accredited by these organizations.

Exhibit VI-3.

National Accreditation Organizations

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): Accreditation Programs and Services: Behavioral Health Care Accreditation Program One Renaissance Boulevard	Accredits staff model delivery systems in organizations providing mental health, substance abuse, and mental retardation/developmental disabilities services. Developed accreditation guidelines for wide variety of network-based services systems, such as MCOs, health maintenance organizations (HMOs), preferred provider organizations, and provider-sponsored networks.

Oakbrook Terrace, IL 60181 Phone: (630) 792-5791 Fax: (630) 792-5644 Website: *www.jcaho.org*	Currently evaluates and accredits more than 15,000 health care organizations.
National Committee for Quality Assurance (NCQA): Behavioral Health Accreditation Program 2000 L Street, NW, Suite 500 Washington, DC 20036 Phone: (202) 955-3500 Fax: (202) 955-3599 Website: *www.ncqa.org*	Accreditation focuses primarily on the highest organizational levels of an MCO's structure. Develops quality standards and promotes improvement in quality of care provided in managed care plans and has recently issued accreditation standards for behavioral health care.

Exhibit VI-3.

National Accreditation Organizations (cont'd.)

Commission on Accreditation of Rehabilitation (CARF) (Formerly the Commission on Accreditation of Rehabilitation Facilities) 4891 East Grant Road Tucson, AZ 85712 Phone: (520) 325-1044 Fax: (520) 318-1129 Website: *www.carf.org*	Accredits individual substance abuse programs, mental health programs, and community-based rehabilitation programs treating individuals with chronic mental and addictive disorders. Built on strong consumer-centered philosophy that encourages active consumer involvement in all activities, including collaborating in the development of individual treatment plans. Developed program standards regarding access issues. As of June 1997, over 13,000 programs accredited.
Council on Accreditation of Services for Families and Children (COA) 120 Wall Street, 11th Floor New York, NY 10005	Created quality standards for more than 50 types of services more closely related to behavioral health care and social services than to the medical model of delivery. Services include individual outpatient programs, day treatment programs, developmental disabilities services, day

Phone: (212) 797-3000 Fax: (212) 797-1428 Website: *www.nn4youth.org*	care/foster care for children, and numerous others. Accredits about 3,000 social service programs and 1,000 behavioral health programs .

Apart from national accrediting organizations, States accredit and license organizations, such as those based on the PACT (Program for Assertive Community Treatment) model, consumer-run clubhouses, and those providing partial hospitalization, intensive outpatient, and intensive case management services for persons with severe mental illnesses and substance abuse disorders. Accreditation of these organizations generally involves systematic assessments of clinical and administrative structures. In some cases, jurisdictions have moved to or are experimenting with national accreditation as a replacement for State or local licensing (e.g., Michigan, North Dakota pilot program, and the Veteran's Affairs mandate for CARF accreditation for all behavioral health and vocation programs under their Prescription for Change initiative).

Mandating the accreditation of MCOs and/or service providers may have both benefits and drawbacks for a purchaser of managed substance abuse and mental health services. The obvious advantage of requiring MCOs and/or service providers to obtain this "seal of approval" is that it provides reasonable assurance that the clinical and administrative operations of the accredited organization have met basic standards of quality in terms of process and outcomes. However, several problems related to current accreditation practices have been noted (Horvath and Kaye, 1995; IOM, 1996; Bazelon Center for Mental Health Law, 1997):

The costs of going through an accreditation process can be prohibitive, especially when personnel costs and time are considered and requiring accreditation could eliminate viable MCOs or programs from bidding on the contract.

There is redundancy among accreditation standards from different accrediting agencies. National MCOs, managed behavioral health organizations (MBHOs), and other health care delivery systems often obtain accreditation from several different agencies to meet the requirements of various purchasers, which results in costly duplication of effort.

Private accreditation standards are frequently vague and do not take into account many issues particularly important in the public sector (e.g., access, grievance procedures, and enrollee rights); additional standards may need to be developed.

Accreditation standards often duplicate State licensing requirements.

Current accreditation standards for behavioral health care are generally less refined than general health care measures and often emphasize structural and administrative process issues that do not adequately address the quality of clinical services.

In response to these and other issues, the Institute of Medicine (IOM, 1996) has questioned the utility and validity of accreditation in the current health care environment and has encouraged accreditation agencies to focus their standards on the most relevant issues, to examine the use of "deeming" (accepting another entity's standards and/or review process in place of one's own in some or all areas), and to consolidate the multitude of accreditation standards from various organizations to reduce overlap and redundancy.

Accreditation. Purchasers may wish to address the following in RFPs and contracts:

Specify whether the MCO, network providers, and/or subsets of network providers must be accredited.

Specify the type or types of accreditation required.

Establish any timeframes within which an organization(s) must obtain accreditation, if not already accredited.

Specify the consequences of losing accreditation, having the accreditation downgraded, or not achieving it within a specified period.

Ensure compliance with relevant State licensing requirements and other applicable standards for MCOs, HMOs, and substance abuse and mental health treatment providers.

Specify policies regarding "deeming," and clarify how providers can request that an existing accreditation be deemed acceptable.

C. Report Cards on MCOs

Purchasers are increasingly using "report cards" to monitor the performance of MCOs. Report cards present systematically organized data on standardized sets of measures, often with associated minimum standards, about MCOs and/or health care providers. Purchasers, MCOs, consumers, and others can then examine and compare objective information about the clinical and administrative processes of different MCOs.

Widespread use of report cards on MCOs promises to increase standardization of measures and data-gathering procedures across a variety of behavioral health care systems. It should be noted, however, that most report cards are designed for adult services rather than services for children or adolescents.

Report cards can be developed by any purchaser or organization. Four nationally recognized report cards that are increasingly being used by purchasers to assess the quality and performance of those MCOs managing behavioral health care services are these (see Exhibit VI-4):

The Health Plan Employer Data Information Set (HEDIS 3.0) prepared by the National Committee for Quality Assurance (NCQA);
Performance-Based Measures for Managed Behavioral Health Care Programs (PERMS) prepared by the American Managed Behavioral Healthcare Association (AMBHA);
County Behavioral Healthcare Measures prepared by the National Association of County Behavioral Health Directors (NACBHD); and
The Mental Health Statistics Improvement Program (MHSIP) prepared by the Center for Mental Health Services (CMHS).

Industry norms such as HEDIS and PERMS are developed on the basis of data from the existing administrative database (e.g., telephone answering rates) that does not necessarily include data on certain types of outcomes that may be important to purchasers. Improvements in social functioning or employment, for example, are not part of an administrative database. Should a purchaser want to obtain data on these types of outcome measures, it must be willing to invest in both infrastructure development and the collection of data. The acquisition of standardized and reliable information about these outcomes would require a significant commitment and investment on the part of the purchaser.

Exhibit VI-4.

Four Nationally Recognized Report Cards

Health Plan Employer Data Information Set (HEDIS 3.0) **National Committee for Quality Assurance (NCQA)**	The most widely used set of general health care performance standards. Incorporates measures designed for Medicaid and other populations. Includes 71 measures in the reporting set of measures (to be reported in 1997), plus 33

2000 L Street, NW, Suite 500 Washington, DC 20036 Phone: (202) 955-3500 Fax: (202) 955-3599 Website: *www.ncqa.org*	measures in a "testing set". Categorized into eight domains: accessibility, treatment effectiveness, stability, satisfaction, cost, degree of informed choices, use of services, and descriptive information. A handful of behavioral health measures are in the reporting set and more are in the testing set, including: - Outpatient followup after hospitalization, - Number of providers accepting new patients, - Utilization of different specified levels of care, - 90-day inpatient readmission rates, - Several related items in a health plan member satisfaction survey. Precisely defined measures and standards.
Performance-Based Measures for Managed Behavioral Healthcare Programs (PERMS) **American Managed Behavioral Healthcare Association (AMBHA)** 700 13th Street, NW, Suite 950 Washington, DC 20005 Phone: (202) 434-4565 Fax: (202) 434-4564 Website: *www.ambha.org*	Includes 23 industry-standardized measures designed specifically for substance abuse and mental health treatment. Measures access, consumer satisfaction, and quality. Quality measures include systems effectiveness for substance abuse treatment and continuity of care for patients in treatment and detoxification. Precisely defined measures.

Exhibit VI-4. (cont.)

Four Nationally Recognized Report Cards

County Behavioral Healthcare Measures **National Association of County Behavioral Health Directors (NACBHD)** 6000 Lamar Street, Suite 130 Mission, KS 66202 Phone: (913) 384-3535	Developed to monitor and improve the quality of substance abuse and mental health services. Designed to be particularly relevant to service delivery at the county level. Categorized into five domains of three to five measures each, with recommended tools to obtain those measures: - Access, - Consumer satisfaction, - Consumer outcomes,

Fax: (913) 591-5653 Website: *www.naco.org/affils/afflpres.htm#16*	- Intersystem outcomes, and - Utilization.
Mental Health Statistics Improvement Program (MHSIP) **Center for Mental Health Services (CMHS)** Parklawn Building, Room 15-105 5600 Fishers Lane Rockville, MD 20852 Phone: (301) 443-0001 Fax: (301) 443-1563 Website: *www.mentalhealth.org*	Measures for comparing and evaluating access, appropriateness of treatment, outcomes, and prevention in the delivery of mental health services to persons with severe mental illness. In testing and development in 20 States. Instrument reflects significant consumer input into design and content.

D. Measures of Consumer and Family Satisfaction

Measurement of consumer and family satisfaction with behavioral health care services is increasingly becoming an integral component of quality monitoring efforts. Purchasers are therefore including these measurements as a quality-monitoring tool in contracts with MCOs. Indeed, the voices of consumers, their families, and others who support consumer recovery can provide valuable information to the purchaser about the strengths and weaknesses of an MCO and its network of providers. Consequently, a growing number of purchasers are attaching financial incentives or sanctions to MCO performance in this area (Petrila, 1996; Ruggeri, 1994).

Assessment of consumer satisfaction can empower consumers and send a strong message to providers that such a focus is valued. Yet despite the value of consumer satisfaction measures for assessing quality, the purchaser should be aware that many challenges are associated with such measures and that findings related to satisfaction may need to be interpreted with caution. Some evidence suggests that even when MCOs primarily serving Medicaid beneficiaries have weaker ratings on performance measures for quality and access, enrollees are still as likely to indicate satisfaction with these plans as are individuals enrolled in private insurance plans that have significantly higher performance ratings (Rosenbaum et al., 1997).

A recent literature review of the measurement of consumer satisfaction summarized the challenges currently associated with measurement of consumer satisfaction. These challenges are identified in the box below.

Challenges in Measuring Consumer Satisfaction

There is no widespread consensus about the definition and appropriate measurement of satisfaction.
Very complex relationships exist between consumer satisfaction and quality of care,

consumer demographics, provider profiles, and treatment outcomes.
Design and implementation of surveys for special populations (such as those with substance abuse and mental health problems treated in the public sector) are far from exact sciences.
Tools used to measure satisfaction with behavioral health treatment have been less rigorously evaluated for reliability and validity than tools for general health care.
Satisfaction surveys often yield high and undifferentiated levels of satisfaction.
Consumer responses are sensitive to the method of administration and can be affected by social desirability (the tendency of respondents to answer in a way that would please the person administering or issuing the survey).
Survey questions and results are often more a reflection of basic access (e.g., answering phones) and administrative efficiency of the MCO than of the quality of clinical services.
Surveys require sufficient brevity to generate adequate response rates, yet they must be specific enough to suggest actions that may be taken to improve the particular situation.
Some researchers have found no relationship between consumer satisfaction and quality of care and some have even found an inverse relationship.

Given the challenges of conducting consumer satisfaction surveys, many purchasers are now including alternative mechanisms to assess the experience and satisfaction of enrollees with the MCO and its network providers. These include focus groups, in-depth interviews from samples of enrollees, and face-to-face surveys using consumers or family members as interviewers. Consumer satisfaction teams can also be used. These teams, which are consumer-run programs, serve as a monitoring and feedback mechanism in the system and can be given the authority to provide feedback to upper management of the MCO and/or purchaser. In addition, there is a current effort to adapt for behavioral health care the Consumer Assessment of Health Plan Study of the Federal Agency for Health Care Policy and Research (AHCPR).

The purchaser may also wish to consider periodically assessing, or having the MCO assess, the satisfaction and opinions of key providers in the MCO's network as well as other organizations with which the MCO has an ongoing relationship. In the private sector, such mandated provider surveys are generally conducted by external parties. Surveyed organizations may include network providers; State and county mental health, substance abuse, social service, and other government agencies; consumer and family advocacy groups; and any other organization whose perspective would help illuminate the strengths and weaknesses of the MCO's performance. If the purchaser wants the MCO to conduct the surveys, the purchaser should define its role in approving the surveys and controlling how survey results can be used in marketing initiatives.

Measuring Consumers' Satisfaction. Purchasers may wish to address the following in RFPs and contracts:

Require the MCO to include input from providers, consumers, families, and other stakeholders in the development, implementation, evaluation, and refinement of satisfaction measurement systems and tools.

Require that all satisfaction measurement tools and processes have the approval of the purchaser before implementation.

Ensure that any surveys used, and processes followed, are methodologically sound (e.g., use adequate sampling and weighting techniques).

Determine the frequency of surveys based on the intended use of the information.

Specify that a standardized base of questions, data elements, and measurement processes (including guidance on sample size, timeframes, and response rate) must be used on surveys and other tools to facilitate comparisons

across all levels of care (additional questions and data elements for different levels can be added to this base to allow programs and health care systems to individualize their tools).

Require the MCO to supplement any surveys it conducts with additional, possibly more meaningful, mechanisms for understanding consumer views, such as focus groups or in-depth interviews conducted by family members or consumers.

Require the use of nationally standardized report cards (e.g., HEDIS, PERMS) or the use of selected consumer-oriented measures, to allow comparison to other health care systems.

Require periodic assessment of complaints, disenrollments, and requests to change facilities and providers.

Require systematic followup of survey findings, including identification and investigation of sources of dissatisfaction, development and implementation of a corrective action plan, dissemination of findings to providers, enrollees, and legislative oversight committees, and a reevaluation of the survey process.

Require regular reviews of the MCO's performance by conducting unbiased surveys of providers and other stakeholders.

Ensure that providers and enrollees who provide negative feedback about the MCO are not threatened or penalized in any manner for their action.

E. Quality Management Systems for MCOs

A promising strategy for establishing and maintaining a managed care system based on quality principles is to use the RFP and contract to ensure that the MCO has a well-supported internal quality management (QM) system. The resources supporting and sophistication of an MCO's internal QM efforts vary tremendously among MCOs. However, MCOs are increasingly adhering to NCQA's comprehensive standards for QM. NCQA's accreditation summary reports provide detailed guidance to MCOs who seek accreditation.

1. Internal Quality Management

All Medicaid managed care contracts require the MCO to have an internal QM system. Rosenbaum et al. (1997) found that most State Medicaid programs set out extensive specifications for the structure and performance of such systems, not leaving it to the MCO's discretion.[3]

Purchasers of managed behavioral health care should make sure that the RFP and contract clearly state the expectations, capabilities, and responsibilities of the QM system, even in cases where the details for developing and/or refining the MCO's internal QM system are primarily the responsibility of the MCO. Provisions requiring mandatory compliance with NCQA's standards will give the purchaser leverage to require changes in the MCO's internal QM system if needed. Other contract provisions may require the establishment of an MCO QM team; require an independent quality review council composed of providers, consumers, and other stakeholders; or require the MCO to develop and maintain a continuous quality improvement program.

Internal Quality Management. Purchasers may wish to address the following in RFPs and contracts:

Require the MCO to create a quality management team, accountable to the governing body of the organization.

Develop, implement, and systematically refine a comprehensive quality management plan that is consistent with the RFP and all applicable State and Federal requirements.

Incorporate a process for continuous improvement of quality across QM activities.

Establish a system to monitor the completeness, accuracy, and appropriateness of service authorization decisions and ensure compliance with the utilization control requirements of the U.S. C.F.R. 456.

Develop a comprehensive set of procedures for network providers and specify the MCO's responsibilities for management and reporting of serious incidents (i.e., deaths, suicide attempts, injurious assaults on provider premises, use of seclusion or restraints, medication errors, felony arrests, and convictions).

Develop and implement systematic procedures for monitoring, managing, and improving the quality of individual network providers and of the provider network as a whole.

Require the MCO to establish, facilitate, and empower a community-based monitoring council that includes providers, consumers, and family members.

Require the MCO to actively cooperate with any external quality monitoring team as it develops, implements, and monitors quality improvement goals, objectives, and activities for the provider network and the MCO.

2. External Quality Management

Some purchasers may opt to supplement the MCO's QM program with an external agency that specializes in monitoring and auditing quality in health care settings to increase credibility and accountability (Huskamp, 1996).[(4)]

HCFA requires that all States administering Medicaid managed care waiver programs under Section 1915 or Section 1115 of the Social Security Act provide for external quality assurance oversight.

[1.] In September of 1997, the American College of Mental Health Administration (ACMHA), concerned that the rapid proliferation of process/performance measures and strategies is counterproductive for the behavioral health care field, held a summit in Santa Fe, New Mexico, to address outcome measurement. Representatives attended from such organizations as the Substance Abuse and Mental Health Services Administration (SAMHSA), the Institute of Medicine (IOM), the National Alliance for the Mentally Ill (NAMI), the Commission on Accreditation of Rehabilitation (CARF), the National Committee for Quality Assurance (NCQA), the American Managed Behavioral Healthcare Association (AMBHA), and the National Mental Health Association (NMHA). Participants were divided into working groups reflecting the following domains: prevention, access, process/performance, outcomes, and structure. Over the course of 2 days, each group produced a set of core values for each domain, with recommendations for next steps. Participants are actively collaborating with key agencies to refine the work initiated at the summit.

[2.] For more information, see the Institute of Medicine report (1996).

[3.] For a detailed analysis of this issue, see Table 5.1, Rosenbaum et al. (1997), which presents State Medicaid managed contract provisions addressing quality assurance.

[4.] The Health Care Financing Administration (HCFA) mandates that all State Medicaid waiver programs provide for external quality assurance programs to assist in managing, collaborating with, and/or monitoring the MCO's quality improvement systems without any vested interest in the outcome.

CHAPTER VII

Financial Issues

Key issues in this chapter:

- The shifting of financial risk from the purchaser to the MCO
- Applying incentives and sanctions to MCOs

Public purchasers often have a variety of goals when developing, implementing, and overseeing a managed care program for mental health and/or substance abuse services--typically, some combination of containing or reducing costs, expanding access to services, and improving the quality of care. Although a managed care organization (MCO) may share many of the purchaser's goals, it operates under a different set of incentives and consequently may have some very different goals. The vehicle by which the purchaser defines its goals and objectives is the contract; but the structure required to achieve those goals is a carefully designed financing and payment system.

- Dealing with third-party payments
- Making decisions about copayments and deductibles
- Managing cash flow
- Specifying reinvestment requirements for MCOs
- Requiring financial reports by MCOs

The development of a financing and payment system to achieve the purchaser's goals and objectives in a managed behavioral health care contract can be one of the greatest challenges a purchaser faces. The selection of approaches ought to be strongly influenced by the purchaser's primary goals and objectives.

This chapter provides an overview of the key financial issues and options that a purchaser of managed substance abuse and mental health services should address when developing requests for proposals (RFPs) and contracts:

The shifting of financial risk from the purchaser to the MCO;

- Applying incentives and sanctions to MCOs;
- Dealing with third-party payments;
- Making decisions about copayments and deductibles;
- Managing cash flow;
- Specifying reinvestment requirements for MCOs; and
- Requiring financial reports by MCOs.

A. The Shifting of Financial Risk From the Purchaser to the MCO

Traditionally, "risk" in insurance means the cost of the health services. The entity paying for the service is said to assume the risk for that service. The shifting of financial risks from the purchaser of managed care to an MCO or a provider is one of the defining characteristics of managed care and represents a major departure from the traditional fee-for-service system that has dominated health care in recent decades. Under the traditional fee-for-service payment system, the purchaser reimburses providers for services *after* their provision; furthermore, the purchaser assumes the bulk of four major types of financial risk: namely, risks due to variation in (1) rate of membership and enrollment, (2) the cost of producing units of health services, (3) the volume and type of units used, and (4) service users per 1,000 enrollees (see Exhibit VII-1). In managed care contracts, the purchaser prospectively pays--that is, pays in advance--a negotiated fee to an MCO to provide all medically necessary covered services to an individual or defined population for a treatment episode or an established period of time. Depending on the type of prospective payment arrangement the purchaser selects--a global budget, capitation payment, or case-rate payment--the purchaser thus transfers or shifts some of the four types of financial risk to the MCO.

Exhibit VII-1.

Four Major Types of Financial Risk Borne by Purchasers and/or MCOs

Risk due to variation in the rate of membership and enrollment (e.g., 8% increase in membership);

Risk due to variation in the cost of producing units of services (e.g., 6% decrease in operating cost);

Risk due to variation in the volume and type of units used (e.g., 12% increase in outpatient use);
Risk due to variation in service users per 1,000 enrollees (e.g., 14% decrease in user rate).

The purchaser usually begins with all or most of the four major types of financial risk described above. There is broad continuum of models available for the transfer of financial risk from the purchaser to the MCO and its network: (1) a global budget; (2) capitation payment (full or partial); (3) case-rate payment; and (4) fee-for-service payment. (These models are discussed in detail later in this chapter. See also Table VII-1 on page 178.)

Once the purchaser has transferred financial risk to an MCO, the MCO may in turn pass some of the financial risk on to others (e.g., to physicians or other providers in the MCOs provider network, or to consumers). This practice is known as risk transfer.

The structure of the contractual financial risk-transfer arrangement between a purchaser and an MCO must be carefully negotiated and clearly understood by the parties so that unexpected service costs or savings risks are predictably born by the appropriate party. Failing to clearly identify the risks in a risk-transfer arrangement may cause unexpected cost shifting between providers and MCOs or between different components of the same organization. Although the purchaser can tailor a managed care contract with risk transfer to create the desired constellation of incentives for the MCO, any contract that exposes the purchaser to risk should be carefully reviewed by legal counsel to ensure that all risks are properly balanced as intended by the parties.

To establish the necessary foundation for devising the optimal risk-transfer strategy in a managed care financing package, a purchaser must thoroughly analyze the strengths, weaknesses, and the unique attributes of the particular environment (such as the financial resources available, the capacities of the existing provider pool, the demographic and utilization characteristics of the eligible population). The capacity to bear financial risk varies widely among MCOs and providers, and it is imperative that public purchasers of managed care not assign risk to any MCO or providers that lack sufficient capacity to absorb and manage that risk.

The following section will present methods of managing risk, issue related to risk-transfer financing, and risk-transfer financing models.

1. Managing Financial Risk

There are several approaches that can be used by purchasers to assist in managing the financial risk: (1) limits on profits and losses; (2) specifications for reinvestment of excess savings; and (3) requirements for risk reserves/reinsurance.

a. Limits on Profits and Losses

The purchaser may contractually limit the profits and/or losses an MCO may experience. In the case of profit limits, the purchaser must determine early the amount of profit it is willing to allow the MCO to make and how this profit may be achieved. The contract documents between the parties should address the degree to which each party keeps any MCO profit in excess of the agreed-upon amount. A purchaser can also limit the level of MCO profits or losses, based on a percentage of the budget. Thus, for example, a purchaser might place a cap on total profits or losses of 10 percent of the total payment; then, no matter how far above or below the target the MCO's actual costs were, the MCO would not incur a loss or profit of more than 10 percent of the total payment.

Alternatively, a purchaser may choose to limit the losses an MCO will incur. This approach can serve three important purposes:

It reduces financial incentives for an MCO to provide insufficient services (because the purchaser will share some of the costs of care above a target claims level);
It protects an MCO from extreme financial risk, so there is less concern about the financial viability of the MCO; and

It reduces the incentive for an MCO to include a "risk premium" (i.e., higher payment for assuming risk) in a competitive bid by shielding the MCO from some potential financial risk.

One approach to lessen an MCO's incentives to undertreat is the use of stop-loss arrangements (also referred to as "catastrophic stop-loss"), under which losses are capped at a specified level. Two types of stop-losses exist: (1) an aggregate-level stop-loss, and (2) an individual-level or per-case stop-loss:

An aggregate stop-loss is identical to a cap on the MCO's losses mentioned above and creates similar incentives.

Under a per-level case stop-loss, a limit on expenditures per consumer per time period (often a year) is set. After the consumer's costs reach that level, the purchaser pays 100 percent of that enrollee's claims costs for the rest of the year. For example, if an individual stop-loss of $30,000 per year is set, the purchaser is responsible for any costs for an enrollee that exceed the stop-loss amount. An individual stop-loss reduces the incentive for an MCO to restrict services provided to individuals with the most severe illnesses, since the purchaser shares responsibility for the costs of the most expensive cases. Rather than pay 100 percent beyond the designated expenditure limit, the purchaser may opt for a risk-sharing arrangement with the MCO. In this case, the purchaser would pay, for instance, 90 percent of the costs and the MCO would pay 10 percent of the costs beyond the expenditure limit. The purpose of such an arrangement is to impose some incentive on the MCO to manage care even after the expenditure limit has been reached.

b. Specified Reinvestment of Excess Savings

Purchasers may require that MCOs reserve a specified portion of savings for reinvestment in the public system. Doing this tempers the incentive to limit access, withhold care, or compromise quality to contain expenses, because the MCO has less to gain financially from such practices. It is important that the contract specifically address the mechanisms and procedures to be used by the MCO to account for savings and reinvestment activities.

If the parties require a reinvestment of funds into the delivery system, careful attention should be paid to Federal funds. The Federal Government may assert that it is entitled to the portion of profits or savings of the managed care plan attributable to the Federal funds. The contract should carefully reflect the intent of the parties and, in the case of Medicaid funds, provide written assurances from the Health Care Financing Administration (HCFA) concerning any such surplus or reinvestment. (Reinvestment requirements are discussed in more detail later in this chapter.)

c. Requirements for Risk Reserves/Reinsurance

The purchaser must determine whether it will require the MCO to maintain a sufficient sum of money to cover any reasonable costs that may be incurred (risk reserves), or to obtain reinsurance to protect the financial integrity of the managed care program. Some States' insurance regulations may require the MCO to maintain a predetermined amount of risk reserve or to purchase reinsurance. If so, the purchaser must explore the applicability of these insurance rules and regulations to the managed care program.

In some cases, purchasers may require the MCO to purchase reinsurance or may determine through the RFP process whether the MCO plans to purchase such insurance. Under a typical reinsurance arrangement, the reinsurance policy pays all claims costs above a certain threshold. This arrangement does shield the MCO and the purchaser from a portion of the financial risk for claims, but it also increases direct costs for the purchaser who ultimately pays for the cost of reinsurance.

Also, how risk reserves are identified and evaluated in the RFP is of critical importance. For instance, are the risk reserves part of administrative expenses? Do the risk reserves revert to the purchaser upon termination? A good example of problems relative to risk reserve issues is found in the recent Ohio procurement challenge (see *Value Behavioral Health, Inc. v. Ohio Department of Mental Health,* 966 F. Supp. 557 (S.D. Ohio 1997)).

2. Issues in Risk-Based Payment

There are several issues related to risk transfer financing that should be considered, including: (1) cost shifting; (2) MCO risk sharing with providers/subcontractors; (3) separating service costs from administrative costs; (4) duration of risk-based contracts; and (5) setting appropriate payment rates.

a. Cost Shifting

Giving different health care organizations responsibility for different subpopulations with different payment rates can encourage substantial cost shifting. Thus, for instance, recent analyses in Missouri have found that the relatively low-cost population of enrollees in the Aid to Families With Dependent Children program is overrepresented in health maintenance organizations (HMOs), while the high-cost severely and persistently mentally ill population is overrepresented in community mental health centers (CMHCs) (Broskowski, 1997). For these reasons, many observers believe that only a single organization is appropriately positioned to be responsible for achieving the optimal balance of resources for a diverse population.

b. MCO Risk Sharing With Providers/Subcontractors

A fundamental financial decision of the purchaser is whether, or to what degree, to allow the transfer of financial risk from the MCO to the providers through subcontracts. Whatever risk is transferred must be carefully monitored by the purchaser, as there is the potential for the MCO to transfer an unreasonably large component of the risk to other parties.

The purchaser must make clear its policies about transferring financial or other risks from the MCO to providers in the contractual agreement. The purchaser should contractually ensure that the obligations and responsibilities in the prime contract between the purchaser and the MCO devolve to all provider subcontracts. In addition, the purchaser should retain the ability to oversee the amount of risk that is transferred to providers and subcontractors. Doing this is particularly important in Medicaid managed care contracts because of the Federal prohibitions against illegal physician incentive plan arrangements. These prohibitions outlaw the use of physician incentive plans that create excessive risk, which HCFA has defined as risk levels that surpass 25 percent of the physician's anticipated revenues.

Purchasers should be aware that a wide-open policy regarding the transfer of financial risk in subcontracts with providers can result in the MCO's transferring virtually all of the risk associated with the provision of care to providers, thus assuring the MCO of a predictable profit. This situation can be dangerous, because most providers are not likely to have large capital reserves and thus are not likely to be able to absorb large cash flow fluctuations or periods of unusually high utilizations; when such providers bear the bulk of the financial risk, their incentives to withhold or minimize services during a financially difficult time could be great.

Federal Law and Physician Incentive Plans

Federal law prohibits MCOs with Medicaid contracts from operating "physician incentive plans" that fail to meet Federal requirements. Federal requirements for physician incentive plans are as follows (U.S.C. §1903(m)(2)(A)(x)):

A plan may not make any specific payment either directly or indirectly to a physician or a physician group as an inducement to reduce or limit medically necessary care for an enrollee.

If a plan places the physician or physician group at substantial financial risk (greater than 25 percent of the physician's anticipated income under the agreement) then the organization must provide stop-loss that takes into account the size of the physician practice and the number of enrollees.

A plan must conduct periodic surveys of enrollees (both current and previous) to determine access and satisfaction.

A plan must file sufficient information with the Secretary of Health and Human Services and the State to permit a determination as to whether it is in compliance with Federal requirements.

It also should be noted that the purchaser exerts control over a managed care program mainly through the MCO, which is subject to financial and possibly insurance regulation; the purchaser's ability to monitor a subcontracted provider's financial position and service management practices is far more limited (Rosenbaum et al., 1997). To reduce the risks of substandard care, purchasers should consider including monitoring and performance standards for subcontractors in the prime contract. Specific contractual terms can allow the purchaser to review, modify, and terminate subcontractual terms, conditions, and relationships. Regardless of any subcontracts entered into by the MCO, the prime contract should require the MCO to remain financially liable for the delivery of the goods and services negotiated in the contract throughout its term.

Largely because many providers' management information systems (MIS) are detailed financially but not clinically, providers with at-risk subcontracts are sometimes unable to develop detailed and accurate reports on the delivery of care and financing to the contracting MCO. The MCO, in turn, may be unable to obtain much detail on capitated providers' levels of service or utilization and/or quality management activities, leaving both the purchaser and MCO with few or no data upon which to base evaluations, establish accountability, and/or improve quality. Consequently, purchasers should be very attentive to the capacity of providers to assume risk and build and/or manage sophisticated MIS when considering strategies regarding subcontracts. Purchasers may also want to require on-line use of the provider of the MCO's MIS, if it is sufficiently comprehensive (see Chapter V).

If the contract lacks specificity about risk transfer to providers, MCOs may create financial incentive structures that encourage inappropriate limits on services. Purchasers may wish to limit or prohibit risk-transfer or incentive-based arrangements and require MCOs to offer (or require the purchase of) stop-loss insurance for network providers (Rosenbaum et al., 1997). Many States place limits on the level of risk that can be assumed by providers without insurance licenses. Both of these mechanisms maintain at least some degree of financial risk with the MCO, where it can be more adequately monitored.

It should be noted that despite the many challenges associated with providers absorbing too much of the financial risk, many purchasers, MCOs, and/or providers are interested in establishing, or are required by legislation to establish, risk-transfer contracting arrangements between MCOs and providers. Providers may be interested in establishing a risk-transfer arrangement in return for flexibility in making decisions about treatment and about service mix, accessing capitation payments up front to permit investment, and developing rollover authority to build up reserves.

Letting providers have a stake in the quality and quantity of care (i.e., sharing risk with the MCO) has many associated risks but also may have benefits. Increasing numbers of providers are interested in and capable of assuming risk. Providers can act more creatively and rapidly to intervene on a patient's behalf when they do not have to deal with the time- and resource-consuming aspects of an external authorization process. Creative and prompt responses are generally more likely to produce better outcomes at lower costs (e.g., a relatively minor intervention at a moment of crisis can be far more effective than a more expensive and intensive intervention days afterward).

c. Separating Service Costs From Administrative Costs

For each type of financial risk-sharing arrangement mentioned above, a purchaser can choose to separate payments for administrative costs and for service costs (e.g., under a pure capitation contract, a purchaser can pay a per capita rate for administrative costs and a separate per capita rate for service costs). The purchaser can also choose to use different types of risk-sharing arrangements for each type of cost. For example, a purchaser could use a pure capitation arrangement or global budget for administrative costs and use a partial capitation arrangement for service costs. This combined arrangement would provide strong incentives to control administrative costs, but would temper somewhat the financial incentives to reduce service provisions that are inherent in a global budget or full capitation arrangement for service costs. Separating payments in this manner allows purchasers to keep a more careful watch over the different types of costs and to more precisely target incentives for each.

Administrative services only (ASO) contracting arrangements are common in employer-sponsored health plans, but the use of this model is relatively new in the public sector. Several public purchasers now use ASO contracts, including Maryland's public mental health system, San Diego County's mental health system, and portions of Florida's Medicaid behavioral health program. Under an ASO contract, the purchaser pays the MCO (or an entity providing one or more standard managed care services), a set of performance-based fees to perform specified administrative or management functions, passing no financial risk for health service costs to the MCO.

For example, a purchaser may pay an MCO a designated fee per enrollee per month to provide such services as recruiting and maintaining a provider network, processing claims, completing financial reports, conducting utilization management activities, and/or providing various quality management functions. Under this arrangement, the MCO bears no financial risk for the cost of health services.

At first glance, an ASO model appears to provide no risk to the purchaser and the MCO. Frequently, however, the purchaser will also put the ASO administrative fees at risk or include financial incentives and/or sanctions tied to key measures (e.g., timely processing of claims, percentage of claims that are fully filled out, error-free, and able to be processed upon submission). Consequently the volume, complexity, and quality of the submitted claims can have a significant influence on the MCO's risk. Clearly written provisions can be especially important as they relate to claims and the definition of a "clean" claim.

An ASO contract provides minimal financial incentives[(1)] to an MCO to control health service costs because the MCO is not responsible for these costs and there is no limit or target set on spending for covered services. Thus, an ASO contract arrangement may make it difficult for the purchaser to control costs or to accurately predict annual expenditures for budgetary purposes. Purchasers also should be aware that an ASO arrangement can discourage needed investments in quality-improving technology for the purchaser's management information system (MIS) unless the system is set up in such a way as to provide incentives for building or refining the purchaser's MIS. Purchasers should ensure that the ASO contract does not create several opportunities for bundling additional costs (e.g., quality improvement efforts in MIS performance) into the administrative fee and thus artificially inflating administrative expenses.

ASO arrangements can provide purchasers an opportunity to gain valuable experience with managed care practices and technologies, to buy and/or learn how to best use available technologies, and/or to obtain crucial data that facilitates accurate estimates of future utilization. An ASO arrangement can eventually evolve into a purchaser-based management services organization, in which the purchaser assumes responsibility for many or all of the ASO functions.

d. Duration of Risk-Sharing Contracts

Purchasers should not underestimate the importance of the time period used in the contract. In general, quality improvement initiatives take a fair amount of time to have their influence felt in the system and will usually not be pursued if there is not a long-term mutual commitment between the involved parties. For instance, 1-year contracts provide strong incentives for MCOs and others involved in risk-transfer arrangements to seek quick, short-term gains, while longer-term contracts with built-in renewability options are more likely to encourage the development of quality-driven, systemic improvements that will produce savings. While 1-year contracts make sense when purchasers seek technology or supplies ("keep shopping for a better vendor"), they can be quite destructive for a commodity like health, that by its very nature requires a long-term perspective.

e. Setting Appropriate Payment Rates

The actuarial science of setting appropriate public sector capitation rates for behavioral health is still in its earliest stages, available data used to develop rates is often very weak, and actuaries must depend on the validity of numerous assumptions throughout the development process. Rate setting, as a result, seems to be proceeding largely by trial and error, leaving some systems seriously underfunded. Providing relevant information to the actuaries can influence their assumptions and is a key task for those involved in this process. An inappropriately low rate will inevitably lead to significant problems for consumers, providers, MCOs, and ultimately, the purchaser.

3. Risk-Transfer Payment Models

Many States, counties, and regional authorities have now begun to develop and refine risk-transfer payment systems with MCOs. These include Massachusetts, Oregon, Iowa, Colorado, Washington, Utah, Nebraska, Ohio, and San Diego County.

A continuum of financial risk-sharing arrangements for managed care contracts--including a global budget, capitation payment, case-rate payment, and fee-for-service payment--is shown in Table VII-1 below. These arrangements allocate the four major components of financial risk--that is, risk due to variation in the rate of enrollment, in the cost of producing services, in the volume and types of units used, and in service users per 1,000 enrollees--between the purchaser of managed behavioral health care services and an MCO in very different ways.

a. A Global (or Fixed) Budget

A payment arrangement that transfers full financial risk for the components of financial risk mentioned earlier from the purchaser of managed care to an MCO (or from an MCO to a network provider) is a global (or fixed) budget. Under this model, the purchaser of managed care pays a fixed dollar amount to the MCO both to administer the managed care program and to provide all services for which the MCO is responsible. No matter how high the costs of providing care to enrollees are, or how many additional enrollees join or leave the plan in a given year, the MCO is paid the agreed-upon global budget payment.

Table VII-1.

Risk Transfer Payment Models

Payment Model	Variations	Comments
Global Budget (Payment for total population)	**No excluded services** **Limited excluded services**	Under a global budget arrangement, the MCO is at full risk for all of four components of financial risk--(1) variation in the rate of membership and enrollment; (2) variation in the cost of producing services; (3) variation in the volume and types of units used; and (4) variation in service users per 1,000 enrollees.
Capitation Payment (Payment per enrollee)	**Full capitation** No risk/reward corridor Risk reward corridor **Partial capitation** No risk/reward corridor Risk reward corridor	Full capitation payment arrangements involve payment to an MCO of a predetermined fixed fee per capita to provide all necessary services for a defined population of enrollees. The MCO is at financial risk for variation in the cost of producing services, as well as for variation in the volume and type of services and variation in users per 1,000 enrollees. It is not at risk for variations in rate of enrollment. Partial capitation refers to situations where one part of the population is capitated and the other is not.
Case-Rate Payment (Payment per user of services)	**Period of time** **Episode of care**	Under case-rate payment arrangements--involving payment to the MCO (or provider*) of a fixed "case rate" per user to provide a defined set of services as needed to a specified group of users--the MCO is at financial risk for both variation in the cost of producing services and for variation in the volume and type of services required by the individual
Fee-for-Service Payment (Payment per unit of service)	**Bundled services** Discounted Not discounted	Under fee-for-service arrangements, the MCO is not at financial risk for any of the four types of risk. The purchaser, however, assumes all of the risk. An MCO paid through a global budget, capitation, or case-rate may pay providers using a form of fee-for-service. In this case, the

	Not bundled services Usual and customary charges Billed charges	MCO is at risk.

*As discussed later in this chapter, case rates are used most often to pay service proviers, either when they are functioning as an MCO or when they are subcontracting to an MCO.

Note, however, that if a public purchaser is held financially responsible for any shortfall in the global budget (as is currently the case in some jurisdictions), the planned global budget process becomes largely irrelevant.

A global budget arrangement allows the purchaser of managed behavioral health care to predict with certainty the level of expenditures on mental health and/or substance abuse services in a given year. Global budgets are often used when the number of eligibles is unknown and are usually based on the prior year's costs, less a predetermined percentage for savings. They are more especially likely to be used when the purchaser is a State or county substance abuse and mental health authority.

A global budget creates very strong incentives for an MCO to control costs and improve the efficiency of its service delivery and administrative practices, especially if the MCO is to retain all savings as profit or as new operating capital. However, the very strong incentives to the MCO to achieve savings can encourage the entity to provide less than the therapeutically appropriate level of care or to reduce overall access to care, particularly when enrollment is greater than expected.

Examples of Public Purchasers Using a Global Budget

California State contracts with counties for mental health services

Massachusetts For mental health acute inpatient treatment for seriously mentally ill persons without insurance

Montana Fixed budget for non-Medicaid eligibles and capitation for Medicaid eligibles

Iowa For substance abuse services to non-Medicaid citizens

A fixed budget places the MCO at the highest level of financial risk. If managed care enrollment is higher than expected and/or claims costs greatly exceed the amount in the global budget, the financial viability of the managed care initiative may be put in jeopardy. For an MCO with low financial reserves, the result could be very serious financial difficulties or insolvency. The risk of insolvency is particularly great for small regional MCOs or providers whose budget is dependent on the managed care contract. The loss of such a contract could lead to serious financial troubles. Several States have seen their CMHCs suffer such a misfortune when they have acted as underfunded MCOs.

Because an MCO may assume a relatively high degree of financial risk under a global budget arrangement, the MCO is likely to seek higher payment rates from the purchaser for assuming this risk.[2] Thus, a global budget arrangement may actually result in higher overall costs for the purchaser, especially if the purchaser has insufficient data to accurately estimate need, utilization, and costs. Because of the potentially higher costs of a fixed-budget arrangement, some purchasers have chosen to use a global budget arrangement for selected services or populations only and to use other payment strategies to pay for other types of services or groups of recipients.

The greatest legal concern in a global budget arrangement is ensuring that the MCO can safely assume the risks associated with it. In determining the rates that are to be paid to the MCO, the purchaser should consider including provisions in the contract to allow for renegotiation of the rates in the event the amount reimbursed proves to be unrealistically low or high. Allowing some renegotiation options may allow a managed care program to remain a viable option for the purchaser if the MCO is on the verge of bankruptcy, pushing risk too far down to the provider pool, or is taking too much profit from the system.

b. Capitation Payment

Under a fully capitated, full-risk arrangement, the purchaser pays the MCO a monthly per capita rate to cover all costs associated with providing behavioral health care services to a population of enrollees. The per capita rate for each enrollee is fixed, regardless of whether an enrollee uses any services. It may be set by the purchaser in advance or determined in the context of a competitive bidding process. The MCO assumes all financial risk for variation in the cost of producing services but assumes no risk for variation in enrollment. The latter risk is assumed by the purchaser, who pays an additional per capita payment for each additional enrollee, or who pays less in aggregate if enrollment reverses.

Fully capitated payment arrangements are like a fixed-budget arrangement in that they provide a strong incentive to control costs and improve efficiency. Although full capitation can create strong, short-term financial incentives to unduly restrict enrollee access and use of services, it also can provide equally strong incentives for the MCO to provide high-quality services and to secure effective linkages with other types of service providers to support positive outcomes. The strength of the contract access monitoring and quality monitoring mechanisms, and effective use of incentives and sanctions will in large part determine the way in which a full capitation payment system impacts the success of the managed care initiative.

Purchasers should understand that accurately estimating capitation rates is an actuarial art, not a science. Errors in judgment or erroneous assumptions are common and can cause an otherwise well designed program to fail due to insufficient capitation rate(s). In attempting to establish the most valid rates, different purchasers have used different approaches. One option to use when there is insufficient data to make highly accurate estimates for capitation rates is to develop a "floating" capitation rate that is adjustable based on the actual utilization data in the new system. See Exhibit VII-2 for three different approaches to arriving at capitation payment rates.

Exhibit VII-2. **Three Approaches to Establishing Capitation Payment Rates***	
Approach #1: Specify in the RFP the exact capitation rate to be paid.	Under this approach, the purchaser announces the rate in the RFP. This approach allows the purchaser to maintain responsibility for establishing the most appropriate rate instead of allowing market forces to determine the rate. Only those MCOs interested in accepting the contract at the specified rate will submit bids. Interested MCOs compete not on price, but on other criteria determined by the purchaser such as administrative fees, provider networks, quality assurance mechanisms, and outcomes management capacity. The challenge for the purchaser is setting an appropriate capitation rate that both attracts qualified plans and meets the purchaser's fiscal goals. If the capitation rate in the RFP is too high, the purchasers' expenditures will end up being higher than necessary and generate excessive profits for the MCO. (The

	purchaser may, if it chooses, require the MCO to reinvest excessive savings in the care system, mitigating the risk of a "too-high" rate.) If the specified capitation rate is too low, many qualified MCOs may choose not to submit a bid, and those that do bid may later begin to restrict access or provide lower quality services to maintain financial viability.
Approach #2: Specify the maximum capitation rate and allow bidders to bid this amount or a lower amount.	Under this approach, the purchaser sets a maximum capitation rate and allows MCOs to bid at this capitation rate or less. Setting a maximum rate allows the purchaser to limit maximum expenditures, retaining some control over future costs while simultaneously allowing for competition among MCOs with respect to price, potentially resulting in lower costs. Because the market is highly competitive, some MCOs may deliberately underbid to obtain greater market share, resulting in a greater danger of undertreatment or other quality-of-care problems.
Approach #3: Provide no guidance on preferred capitation rate in the RFP and allow MCOs to bid a rate of their choice.	Under this approach, the purchaser allows full market competition among the bidders with respect to the capitation rate. Again, increasing competition can result in the lowest cost to the purchaser and possibly the greatest levels of service innovation. The purchaser must be careful, however, not to agree to a capitation rate that is below a level that would ensure appropriate provision of services. (This option is technically not possible under Medicaid waivers, which are subject to upper payment limit restrictions.) The purchaser must also decide how to weight a low capitation rate, given other considerations, such as access and quality.
*These approaches can also be used for negotiating a variety of different payment structures.	

The contractual agreements between the parties should identify the following: (1) MCO per capita fees and claims target; (2) the risk-sharing ratio; and (3) the risk-free corridor.

MCO per capita fees and claims target. Often, a per capita fee paid to the MCO is specified in the contract as a portion of the total capitation rate. This fee covers the administrative costs of the contract and should include overhead and any applicable profit. The contract then specifies a per capita claims target for substance abuse and mental health services covered under the plan. The claims target is based on the benefit plan and average per-person claims expenditure for the population, as well as the utilization management rules used. To establish a claims target, purchasers can start with previous average per capita spending levels and adjust these levels using numerous assumptions about the appropriate or desired impact of the managed care program on expenditures for mental health and/or substance abuse services. If the purchaser wants to create a stronger incentive for the MCO to limit costs, it can choose a lower target; to create a weaker incentive to limit costs but a stronger incentive to improve access and quality, the purchaser may select a higher target.

Risk-sharing ratio. Once a claims target has been set, the purchaser defines a risk-sharing ratio that specifies how the costs of claims above the target--or savings, if expenditures are below the target--will be shared by the MCO and the purchaser. As an example, a 50:50 sharing ratio for savings requires the two parties to share equally in any savings or losses if expenditures are below or above the targeted capitation amount. To create a stronger incentive for cost containment or reduction, a purchaser can choose a sharing ratio that allows the MCO a greater share of savings and assigns the MCO greater responsibility for losses (e.g., 90:10, under which the MCO keeps 90 percent of savings and assumes 90 percent of losses). To temper the incentive to restrict service provision, a purchaser could choose a sharing ratio that places less responsibility for losses on the MCO and allows the MCO a greater share of savings (e.g., the MCO keeps 50 percent of the savings, but assumes only 25 percent of the losses). This is known as asymmetrical risk. Above or below the set rate, other financial arrangements prevail (refer to the section on stop-loss arrangements below).

Risk-free corridor. Many purchasers also use a risk-free corridor above or below the claims target to specify a portion of the claims risk for which the MCO is not responsible. For example, if the target is $10 per enrollee per month and the risk-free corridor is ± 5 percent, the MCO is not responsible for claims costs between $10 and $10.50 and cannot keep any savings between $9.50 and $10.00. (The purchaser gains or loses the $.50.) The use of risk-free corridors acknowledges that the development of capitation rates is not a perfect science, and that, as long as the MCO's claims costs fall within a particular range around the target, the negotiated fee will still be paid without penalty or bonus. This arrangement, which has been used in many private sector managed behavioral health organization (MBHO) contracts, can minimize the need for extensive negotiations when costs are reconciled at the end of the fiscal year.

c. Case-Rate Payment

Case rates are used most often to pay service providers, either when the service providers are functioning as an MCO or when they are subcontracting to an MCO. Under the case-rate model of payment, the purchaser of managed care pays a fixed rate for each "case," that is, each designated individual who enters the system and uses services.

The case-rate approach to payment was developed in part because of the difficulty of accurately estimating service users per 1,000 enrollees. The case rate is calculated by estimating the expected average expenditures for service users only. Thus, a case rate is typically higher than a full capitation rate, because a pure capitation rate is calculated as an average of expected expenditures over a population of enrollees that includes both service users and nonusers.

Calculating case rates. The following basic formula can be used to develop a baseline case rate for a defined event:

Case rate per defined event = (Cost per day/visit) × (Mean length of stay/mean

frequency of visits)

This baseline rate can then be adjusted as desired by included service(s), definition of the episode or time, user characteristics, region, and so forth. When setting case rates, the purchaser should make every effort to obtain all relevant national and regional data to begin to establish norms. Determining what case rates to pay is difficult given the paucity of national cost and utilization data on both substance abuse and mental health services. The paucity of data is particularly acute in the addiction field.

In the context of managed behavioral health care, case rates can be formulated to cover either a defined episode of care or a defined period of time (see Table VII-2):

- ***Case rate for a defined episode of care:*** The case rate covers a precisely *defined episode of care* for an individual with either a *single* level of care (e.g., a detoxification or intensive outpatient treatment episode) or *multiple levels* of care (e.g., detoxification plus outpatient services). Case rates for discrete treatment episodes (e.g., detoxification) are the easiest to design. Alternatively, an episode of care can begin with an acute treatment experience (generally requiring continuing care afterwards) and continue until the consumer has no treatment episodes for a specified period (e.g., 8 to 12 weeks).

- ***Case rate for a defined period of time:*** The case rate covers a *defined period of time* (e.g., 6 months, 1 year) for an individual with *multiple* levels of care (e.g., all covered levels of care per individual per year). Precise definitions are needed regarding all responsibilities. For instance, a provider could be responsible for the provision of all detoxification and outpatient treatment for a specified individual for 1 year.

Whether based on an episode of care or a period of time, case rates can be based on either a *single case rate* unadjusted for level(s) of care, severity of illness, or region; or a *stratified case rate* adjusted by a defined variable or variables (e.g., level of care, severity of illness, region, or all combined).

Table VII-2.

Illustration of Two Approaches to Designing Case Rates

	Rate for Defined Episode of Care Examples	Rate for Defined Period of Time Examples
Single case rate (applies to all users)	$1,000 per ASAM Level III.1 detoxification episode (base payment)	$2,500 for all detoxification and outpatient services for 1 year (base payment)
Stratified case rates that vary by:		
Level of care/type of service used	$1,100 per ASAM Level III.7 detoxification ($100 increased fee over base payment for a higher level of care)	$3,200 for all ASAM Level IV detoxification and outpatient services for 1 year ($700 increased fee over base payment for a higher level of care)
Severity of condition/illness	$1,150 per ASAM Level III.1 detoxification for a pregnant woman ($150 increased fee over base payment for a higher level of care)	$4,500 for all detoxification and outpatient services for an individual who is seriously and persistently mentally ill (SPMI) and addicted for 1 year ($2,000 increased fee over base payment for a higher level of care)
Region	$1,040 per ASAM Level III.1 detoxification in Region 4 ($40 increased fee over base payment for Region 4)	$2,700 for all detoxification and outpatient services for an individual in Region 2 for 1 year ($200 increased fee over base payment for a higher level of care)
Combined: level, severity, & region	$1,290 per Level III.7 detoxification for a pregnant woman in Region 4	$5,400 for all ASAM Level IV detoxification and outpatient services for an individual with SPMI and addicted in Region 2 for 1 year

Distinctions between case rates for substance abuse and mental health services. In considering case rates, it is important to make a distinction between case rates for mental health services, case rates for substance abuse services, and case rates for combined behavioral health services. In comparison with substance abuse services, mental health services (both for Medicaid and non-Medicaid funded services) generally can be more easily blended

into actuarial processes and development of case rates. In comparison to substance abuse, mental health cases generally:

- Are associated with less frequent admissions, discharges, and readmissions (and thus have more predictable treatment costs);

- Involve more medical personnel and related medical services and are thus more comparable with case-rate experience in the medical sector;

- Have more frequently been offered in the context of managed care; and

- Are more likely to have more predictable expenditures because of the larger database on mental health services.

The case-rate data established for mental health services may prove neither valid nor helpful when trying to establish appropriate case rates for substance abuse services.

Monitoring and managing case rates. Purchasers should be aware that a case-rate system can encourage an increase in outreach services, thereby increasing access of certain subgroups into the service system, because the MCO or provider receives a full case-rate payment for each service user. A case-rate system provides strong economic incentives for the MCO or provider to identify people who need mental health and/or substance abuse treatment, some of whom might not have been enrolled or diagnosed in the same way if the MCO or provider were under a different payment system. Careful monitoring of service patterns is therefore a crucial component of effectively managing this type of payment. Similarly, MCOs and providers have incentive in a case-rate system to restrict ongoing care.

In unregulated, unmanaged circumstances, there is also considerable danger that an MCO or provider will seek out individuals who are users but have the least severity of illness (see Chapter II on enrollment). Purchasers must analyze the inherent incentives of each case-rate variation and take steps to avoid problems (e.g., independent gate keepers, random assignments, case mix adjustments).

One way for a purchaser to guard against inappropriate identification of cases is to perform periodic clinical audits of cases to assess service appropriateness, and/or create guidelines or criteria that enrollees must meet to enter the service system (e.g., no case-rate payment will be given for detoxification if this service is not followed by other services). If MCOs and providers with case-rate arrangements have an incentive to enter enrollees in the treatment system, but not necessarily to keep them there or ensure that the appropriate type or amount of services are provided, such clinical audits would identify them, putting them at high risk of losing their contracts in the future.

Other strategies that a purchaser can use to provide an incentive for MCOs or providers to give enrollees appropriate care under case-rate payment arrangements include blending some degree of fee-for-service reimbursement into the model. For instance, the entity could be paid on a fee-for-service basis until the reimbursable amount totaled the amount of the case rate. Alternatively, the purchaser could pay for discrete amounts of services (e.g., pay for first five outpatient visits, then for the next five, etc.) up to the case rate.

Case-rate contracts can cover both administrative and service costs, or they may be structured to cover only service costs, with administrative costs paid for separately by the purchaser. Typically, different case rates are used for different diagnoses or eligibility categories; different rates might be used for enrollees categorized as having SPMI children in foster care, and women with dependent children. In Delaware, for example, the Medicaid program pays a case rate to the Department of Children and Families to provide services to children with moderate to severe emotional disorders.

In analyzing options and making decisions regarding the use of case rates, it may be easiest to develop baseline data around utilization of specific levels of care (e.g., mean cost-per-detoxification or intensive-outpatient episode). Case rates which cover a broad range of services for an individual over an extended period of time are probably the most difficult to determine accurately.

Determining the number of distinct rates. When choosing a risk-transfer payment system, purchasers of managed behavioral health services must determine how many distinct subpopulations, and thus distinct rates, to develop. Some purchasers have chosen a single rate blended for all enrollees, while others have used several different rate

categories. When more than one rate category is used, they can be based on many different types of variables. In many situations, the purchaser may also want to divide the total population of eligible persons and services into two or more different risk-sharing arrangements (e.g., adults with serious and persistent mental illness [SPMI], children with serious emotional disorder [SED], chronically addicted individuals). Indeed, using multiple categories of rates can result in more appropriate matching of payment to estimated costs of service provision, and, ideally, can be used to mitigate incentives for the MCO to undertreat those with highest needs.

The use of several categories, however, can also be cumbersome, and some States that initially used such an approach later simplified or abandoned it (e.g., Washington and Tennessee) because it was too difficult to be properly programmed or administered. Artificial boundaries drawn to divide responsibility for care based on anticipated costs or needs (i.e., stratifying enrollees by diagnoses, costs, or needs) can lead to problems with continuity of care and cause the system to lose focus on meeting the overall needs of the enrollee population. Multiple categories based on diagnosis or severity of illness also provide incentives for unethical MCOs on providers to claim that enrollees are more severely ill than they actually are or try to classify them in a different, more profitable rating category in order to receive higher payment rates.

d. Fee-for-Service Payment

Fee-for-service payment systems generally are not used to prospectively pay an MCO, but may be used by a prospectively paid MCO to pay its providers. This system shifts risk from the purchaser and providers to the MCO. Here fee-for-service payment systems provide an interesting legal issue. The fee-for-service payment to providers gives them economic incentives to provide access to the delivery system to enrollees because the provider is paid a fee each time the enrollee accesses the system. The issue that must be addressed is whether the purchaser or MCO can determine by a review of records whether a medically necessary treatment was paid for. The contract must allow for such a review and for the purchaser's or MCO's ability to recover funds spent for services other than those the purchaser or MCO determine were not medically necessary.

General Financial Requirements and Risk-Sharing Arrangements. Purchasers may wish to address the following in the RFPs and contracts:

Include all applicable Federal, State, and local accounting and actuarial requirements, including analysis of the financial stability of the vendor and its financial reserves.

Stipulate, where appropriate, that all payments are "subject to available funds" of the purchaser.

Indicate how often, when, and how the MCO will be paid, including any incentives.

Stipulate separation or integration of administrative and service costs and the basis for each.

If using an ASO arrangement, specify the frequency and method of fee payment and include performance guarantees.

For case rates and capitated payments, indicate the criteria an enrollee must meet to be considered for a certain rate category (e.g., by severity of illness, age, gender).

Clearly explain all parameters of a partial capitation arrangement, including risk-sharing ratios and risk-free corridors.

If using an individual stop-loss arrangement, indicate how and when the MCO would be paid for costs above the stop-loss, or what reinsurance arrangements the MCO must make.

If reinsurance is to be required, indicate the exact level of insurance the MCO is expected to have, what form of proof of insurance is necessary, and the renewal period of the reinsurance policy; include a requirement for providing proof of reinsurance.

Indicate what process is to be used for reconciling costs at the end of the contract year (e.g., calculation of claims incurred, but not reported and a method of accounting for any adjustments of errors).

Specify what is to be done with savings and their potential reinvestment in needed State, county, or local services (such as financing and development of housing for people with severe and persistent mental illness that may be outside of the scope of the contract) or expansion of the eligible population.

Stipulate the right of the purchaser to audit.

Establish whether--and if so, to what degree--financial and clinical risk may be transferred from the MCO to providers.

Require the MCO to be in compliance with the physician incentive plan prohibitions against financial incentives to reduce care, the provision of stop-loss coverage, and disclosure of the incentive plan and stop-loss arrangements.

Ensure that all legal, financial, and clinical responsibilities related to the risk agreement between the MCO and the subcapitated provider are precise, specific, and publicly available.

Specify insurance coverage requirements, if any, for providers assuming risk.

Establish what types of incentives and incentive structures for providers are allowed.

Require that, if the MCO places providers at risk, data must be submitted and reviewed that indicates the risk-bearing capabilities of those providers.

Require purchaser approval of financial arrangements between the MCO and providers, including rates, payment terms, risk arrangements, and other terms.

Require the MCO to seek approval from the purchaser for subcapitation or rate-setting policies.

Mandate that in capitated subcontract arrangements, MCOs must receive detailed reports from providers, which will enable the MCO to provide adequate information to the purchaser.

B. Applying Incentives and Sanctions to MCOs

Financial incentives and sanctions can be used by a purchaser to shape an MCO's behavior in desired directions, such as toward cost containment. Financial incentives and sanctions are common in commercial sector managed care contracts, but the use of incentives and sanctions to achieve a managed care initiative's goals in a publicly funded behavioral health system is in its infancy, though likely to grow rapidly. As of 1996, only a few States--Massachusetts, Arizona, and Hawaii--included incentives in their contracts with MCOs (Frank & McGuire, 1995; Huskamp, 1996; IOM, 1996). Pennsylvania permits its counties to include incentives in their contracts with MCOs.

Incentives and Sanctions in Contracts With MCOs

Incentives: Incentives are predetermined rewards, usually financial in nature, that are given to an MCO for successfully meeting targeted, contract-specified performance goals. They provide the purchaser with an effective means to motivate an MCO to achieve valued clinical, access, administrative, and/or financial goals. Incentives are especially useful when the behavior being rewarded is likely to result in significantly improved quality of care.

Sanctions: Sanctions are predetermined penalties, usually financial in nature, triggered when an MCO fails to meet specified performance standards or other conditions of the contract. They provide the purchaser with a powerful means to ensure that an MCO complies with key contractual provisions or standards crucial to quality care or operations. Sanctions should provide for a range of options of varying severity depending on the seriousness and nature of the contract violation. For extreme or repeated substandard performance, options include: suspension of new enrollees, suspension of payments, the appointment of temporary management to oversee operation of the plan, and suspension or even cancellation of the contract (Bazelon Center for Mental Health Law, 1995; Horvath and Kaye, 1995). Contracts should specify conditions that will result in early contract termination.

1. Specifying Standards and Associated Incentives or Sanctions

As discussed in Chapter IV and elsewhere, standards can be created to measure the performance and timeliness of various administrative, management, or clinical functions performed by an MCO (e.g., completion of financial reports, claims processing accuracy, or collections from third-party payers) and to measure quality of and access to care (e.g., hospital and admission rates, homelessness, criminal justice involvement, suicide-related behaviors, access to newer psychotropic medications, follow-up after inpatient discharge). Once the purchaser sets a standard, it can assign an incentive or sanction to that standard or to a group of standards. Standardized definitions and measurements should be used whenever feasible.

Incentives and sanctions usually take one of two forms:

- A flat dollar amount for failure to meet the standard (e.g., a $1,000 penalty if a report is not submitted by a specified deadline) or for exceeding the standard (e.g., a $1,000 penalty for too high a call abandonment rate); or
- A percentage of the MCO's fee (e.g., the MCO loses 2 percent of its fee for each percentage point the level of enrollee satisfaction falls below the standard of a selected percent).

A significant challenge for the purchaser will be determining the dollar amount of financial incentives and sanctions. Amounts should be large enough to influence behavior but not so large as to be unfeasible. Unfortunately, no solid guidelines exist at this time on determining the ideal amount of an incentive or sanction.

Some managed behavioral health contracts place limits on the level of penalties that can be incurred by the MCO. For example, a purchaser can specify various sanctions based on performance standards, but note that the total penalty incurred for all performance standards combined cannot exceed 20 percent of the MCO's ASO fee. In this scenario, regardless of how poor the MCO's performance is with respect to the standards, the MCO could never earn less than 80 percent of its administrative fee.

Performance standards, together with financial penalties or rewards, can help to align the MCO's goals for administrative performance, quality of care, and access to care with those of the purchaser. However, choosing appropriate standards and definitions can be difficult, particularly standards that accurately, validly, and reliably measure quality and access to care (see Chapter VI).

Another way of handling incentives and sanctions is "withholding"--which involves establishing a percentage of the MCO's fees, such as 10 to 15 percent, and withholding that amount and placing it in a reserve. The monies held are then paid out if and when the MCO has met a specified performance standard. However, the provisions of the contract must be negotiated carefully to ensure that the parties understand when an incentive payment is necessary or when a sanction is to be withheld. The contract must clearly define a measurable event that results in an incentive payment or sanction and must specify which party determines that the event has occurred.

2. Contract Termination

In the event that the MCO's poor performance becomes so persistent and serious that corrective action is no longer possible, purchasers should have the option of termination. There are two key issues in relation to contract language and termination:

- How and under what circumstances the contract can be terminated; and
- The effect of State or other laws and regulations on contract provisions about termination.

Virtually all purchasers provide for contract termination in the event of nonperformance (Rosenbaum et al., 1997). Included in some termination provisions are descriptions of events or circumstances that could trigger termination and the termination process, including timelines and notice provisions.

In some States, purchasers are confronted with the problem that a State law or constitution limits the operation of contract clauses. This situation sometimes arises when the law treats MCOs as providers and regards them as having due process property rights in the contract and in the enrollees. That treatment prevents purchasers from

terminating contracts with an MCO until the MCO has had an opportunity to exercise all of its pretermination hearing rights under State law.

Example of State Law Limitations on Contract Termination

The State of Illinois was enjoined from terminating the contract of an MCO that had presented substantial problems with payment of network providers, because enforcement of a termination provision amounted to State action to deprive the contractor of property and required observance of all due process requirements. The enrollees were considered the property of the MCO, and the State was prohibited even from informing the enrollees of their rights to change plans, since such conduct would interfere with the plan's property rights (*MedCare HMO v. Bradley*, 788 F. Supp. 1460 [N.D. Ill. 1992]) (Rosenbaum et al., 1997).

It is important to note that not all State purchasers face this external legal constraint. But States that do may experience the paradox of being treated as a private party (with none of the favorable presumptions that would be given to a government agency in the construction of the duties of the MCO) while at the same time bearing the legal burden of State action in attempting to terminate the contract. States that find themselves in this situation need to explore legal avenues for expediting pretermination review, as well as general limits due to emergency on the scope of State due process law. In fact, the court in the *MedCare HMO v. Bradley* case described above specifically noted the lack of any facts suggesting an emergency (Rosenbaum et al., 1997). States may also wish to revise State law on due process in the context of contracts with MCOs to ensure that contract terms enable termination (Rosenbaum et al., 1997).

Incentives and Sanctions. Purchasers may wish to address the following in RFPs and contracts:

Specify, where possible, the measures and standards for all requirements in the contract; sanctions and/or incentives should be attached as appropriate.

Specify the manner in which, and at what intervals, incentives and sanctions will be applied, and when and by whom performance will be measured.

Incorporate a set of incentives and sanctions that can be incrementally applied to exert increasing influence and that allow some flexibility in their application.

Specify actual measures, the means to determine compliance with these measures, and the triggers for incentive payments and sanctions.

Specify the amount, if any, to be withheld, reserved, or refunded from the MCO's fees.

Select a sufficient number of standards to motivate performance but not so many that interpretation or prioritization becomes prohibitive.

Specify who will be the auditor or evaluator.

Clarify the degree of the purchaser's flexibility (if any) regarding application of incentives/sanctions.

C. Dealing With Third-Party Payments

The management of third-party payments is an important financial issue for a purchaser contracting with an MCO. If sources of support (e.g., commercial insurance) must be exhausted before the purchaser must pay for services, the purchaser must clarify this in the contract. For instance, because Medicaid is generally a payer of last resort (an important exception being with respect to school-based services), all other sources of support must be exhausted before the purchaser can access Medicaid payments. In a Medicaid managed care initiative, the MCO will have to bill

Medicare or any commercial insurers before it can pay for services. Procedures for ensuring appropriate billing sequences must be in place prior to implementation of any managed care program.

The purchaser also should ensure that the MCO has an incentive to pursue third-party payment aggressively. In the case of Medicaid, the Health Care Financing Administration (HCFA) requires that certain documentation be submitted for dually eligible individuals (those eligible for both Medicaid and Medicare) prior to the payment of Federal claims, and that third-party payments be collected in order to offset the Federal Medicaid costs. Only then will the purchaser receive the Federal "match." To document exhaustion of these third-party sources, HCFA requires the purchaser (and the purchaser generally requires the MCO) to submit an "explanation of benefits" (EOB) with a denial of services, including the reasons for the denial by the third-party payer or Medicare.

The purchaser must consider the relative costs and benefits of holding the MCO responsible for collecting third-party payments. If the capitation payments to the MCO include an allowance for anticipated collection of third-party payments, then the MCO bears the risk for these payments.

Purchasers and MCOs should require providers to obtain documentation of denied claims and/or benefit limitations. When using these third-party payments to help finance the managed care system, a purchaser has two basic options:

The purchaser may subtract the anticipated amount of third-party recovery from the capitation payment, and then, to rid itself of this responsibility, contractually require the MCO or providers to collect these payments. This is sometimes referred to as a "net out" contract style. The anticipated amount must be reasonable, documented, and based on historical collection rates. It should be noted that the MCO and/or provider may or may not want to devote the necessary resources to collecting these monies, but it is important both that (1) there be a clear understanding about any role of these funds in the planned income stream of the MCO; and (2) responsibilities are clearly stated.

The purchaser can pay the MCO up front for the full cost of services, including anticipated or historical levels of third-party payments, and then either adjust future payments based on actual collections, or retain the responsibility for collecting these payments itself. This style of contract (sometimes called "pay and chase") provides less incentive for the MCO to ensure that providers will obtain the documentation needed to collect third-party revenue or to seek payment from third-party payers. Experience across the country with such contracts has shown that collection of third-party revenues is lower than those under other payment arrangements. The purchaser can provide financial incentives for recovery of third-party payments, including bonuses and penalties for certain performance targets.

Third-Party Payments. Purchasers may wish to address the following in RFPs and contracts:

Explain the responsibility and process for collecting third-party payments.

Require the MCO to pursue third-party payments, if applicable.

Mandate that the MCO require providers to secure documentation for payment denial (and of coverage, in general) based on third-party liability.

Indicate the process for reconciliation of third-party payments.

Require the MCO to document its third-party collection capability, subject to audit.

D. Making Decisions About Copayments and Deductibles

Many commercial managed care plans require that consumers contribute a copayment ("flat," scaled to income, or a percentage of charges) or be financially responsible for a certain deductible, both of which must usually be paid upon receipt of services. A primary purpose of copayments and deductibles (and sliding fees in the public sector) is to discourage the unnecessary use of services (e.g., inappropriate emergency room utilization). Public purchasers can sometimes adopt such requirements. However, copayments and deductibles should be designed and implemented carefully so they are high enough to limit unnecessary use of services but low enough so they do not inhibit access to services for low-income individuals.

Collecting copayments and deductibles from low-income individuals is often difficult or impossible. Indeed, it is important to note, regarding insurance copayments in general, that many providers of services, whether dentistry, chiropractic, or auto body repair, routinely waive the copayment, making the impact of having a copayment at all somewhat moot. In some States, however, waiving copayments is illegal. Generally, providers' only recourse if a low-income individual does not pay a copayment or deductible is to stop treatment. Stopping treatment may exacerbate the conditions of seriously ill individuals and is likely to be counter to the public policy intent of a public managed program. Providers are often reluctant (or prohibited by statute) to discontinue treatment for such individuals. Because providers often end up responsible for footing the bill for them, copayments and deductibles are sometimes categorized as a "provider tax" rather than a cost-sharing mechanism for consumers.

Copayments and Deductibles. Purchasers may wish to address the following in RFPs and contracts:

Indicate whether and how copayments, deductibles, and/or sliding fee scales will be used and for which services and settings.

Specify the dollar amount(s) of any copayments, deductibles, and/or sliding fee scales.

Specify the copayments, deductibles, and/or sliding fees that are permitted and indicate how and when consideration will be given to waiving any such requirements.

Stipulate the allowable limits of copayments and deductibles and the structure of sliding scales and the actions that may be taken if consumers do not pay.

Specify which entity has responsibility for collection of such payments.

Include information regarding any copayments and deductibles in consumer and provider handbooks with the rationale for copayments explained.

Specify whether the provider or the MCO is allowed to keep the copayment.

E. Managing Cash Flow

The timing of risk-transfer payments affects the purchaser's and MCO's cash flow management and is another financial issue that should be addressed in the managed care contract. In fee-for-service payment arrangements, purchasers usually pay vendors up to 30 days after services are invoiced, which occurs only after the actual delivery of services. In many public sector arrangements, payments are made in advance. Thus, advance payments to the MCO may have the effect of increasing cash requirements on the part of the purchaser in any fiscal year by 1 to 2 months' worth of total expenditures. In general, capitation payments are made one month in arrears, after the number of eligibles is known.

In addition, interest earned by an MCO from payments made to it by the purchaser, but not yet forwarded to providers, can be a substantial source of revenue for the MCO and can create a loss of revenue to the purchaser. In this case, the purchaser can require that the MCO use these funds to offset future premiums, to reinvest in community-based services (see section on reinvestment requirements below), or as refunds to the purchaser. If the MCO is allowed to retain the interest, that revenue should be considered in determining the reasonableness of the profits of the MCO. To minimize the interest received by the MCO, the purchaser can delay the payment of fees until providers are scheduled to be paid.

Fees paid by the purchaser can also be deposited into a special account maintained by the MCO as a resource or trust account. Depositing the fees permits easier reconciliation of payments, avoids many of the reserve accounting requirements associated with States' insurance regulations, and minimizes the risk of loss of funds in the event of MCO bankruptcy or termination of contract.

Managing Cash Flow. Purchasers may wish to address the following in RFPs and contracts:

Stipulate the timing of capitation payments to the MCO.

Indicate rules for the use of interest earned by the MCO from payments made to it by the purchaser.

Specify the use of a reserve account to simplify reconciliations and minimize the risk of the recovery of these funds by other creditors in the event of bankruptcy.

Stipulate the date by which the MCO must reimburse providers each month.

Specify banking and accounting standards, subject to audit.

F. Specifying Reinvestment Requirements for MCOs

The purchaser must make a decision early in the design stages of the managed care program concerning the MCO's reinvestment of money into the delivery systems. The RFP and contract must clearly specify whether the MCO is expected or required to place any portion of profits back into the delivery system. If the MCO is required to place profits back into the delivery system, the contract should address how the money is spent and what programs may be affected. Merely agreeing to agree is not sufficient. The purchaser will have to make a policy decision concerning how much input it desires in the process and whether it has final authority over the reinvestment.

One of the legal concerns a State Medicaid agency must consider is whether the use of such reinvestment violates Medicaid law in that it diverts money from the Medicaid program in violation of the waiver approved by the Federal Government. The Federal Government may assert that any savings attributable to Medicaid money belongs to it. The contractual terms between the purchaser and MCO should reflect the Government's authority in such situations, if applicable.

Finally, the purchaser must ensure that contractual provisions do not appear to violate the kickback provisions of the Federal Medicaid program. The reinvestment of Medicaid money cannot appear to be a kickback for withholding medically necessary care. Further, some are developing arguments to support the proposition that the use of managed care may violate the False Claims Act when underutilization is proven. The argument exists that the failure to make a claim for services that were medically necessary in order to achieve a profit under a capitated system amounts to a false claim in violation of the Federal False Claims Act. Purchasers should be aware of possible contractual provisions that appear to further incentives not to make a claim.

HCFA's reimbursement rules mandate that the Federal Government recover its share of cost savings due to savings related to managed care, unless the reimbursement procedures and the contract specify that savings are to be reinvested in other, specified services. (Under certain Medicaid waivers, HCFA has permitted alternative services, such as various types of self-help programs, to be funded from savings in the plan.) In a managed care initiative, purchasers may decide to expand old and/or develop new, alternative services, in lieu of the more medically oriented programs that are traditionally covered by Medicaid.

For example, in Iowa, the MCO that provided behavioral health services had $1 million in allowable profits in its first year and planned to forward the additional profits to the purchaser. But, rather than refunding the profits to the State and eventually to HCFA, the purchaser directed the MCO to reinvest the money in new services within the plan, i.e., to put the money back into the delivery system. The purchaser effectively made arrangements so that the State never took possession of this money. Such an arrangement can be used with or without capitation. The method Iowa used required a HCFA waiver.

Reinvestment Requirements. Purchasers may wish to address the following in RFPs and contracts:

Establish requirements for returning savings to the purchaser.

Set up parameters for reinvestment of savings in building the service array to ensure timely and effective startup of new programs.

Specify responsibilities for identifying, approving, and auditing the investment, the timing of actions to be taken, the methods of starting up programs (seed money, grants, etc.), and the amount of money (a percentage of savings) available for reinvestment.

Clearly explain any requirements for the use of savings on the part of the MCO (e.g., administration, salaries, services).

Solicit stakeholder input on how reinvestment funds will be used.

G. Requiring Financial Reports by MCOs

The ability of a managed care system to operate is grounded on the financial stability of the MCO as well as the delivery system used by that organization. The contract should provide for financial reporting based on both the provider's and the MCOs' needs. The purchaser's only means of ensuring the continued financial stability of the managed care program may be its ability to review current financial data. The contract should include specific provisions for reporting the financial condition of the entities involved in the plan at established intervals. This includes reports concerning utilization, denial of claims, denial of services, requests for payment, and requests for authorization--just to identify a few. The contract should clarify what information must be included and the timeframes for submission of different types of reports. Sanctions should be available to the purchaser in the event that the reports are not submitted in a timely fashion or do not include the information required. Depending on the circumstances of the particular public purchaser, the managed care contract may be subject to the financial reporting requirements included in the public purchaser's insurance regulations. Whenever feasible, accountability can be immeasurably enhanced by the linking of financial and clinical data.

Financial Reporting. Purchasers may wish to address the following in RFPs and contracts:

Indicate all Federal, State, and county insurance and other regulations related to financial reporting.

Clearly indicate deadlines and required format for all financial reports.

Clearly spell out the requirements for reporting financial expenditures for both administrative and service costs.

Require reporting of program administrative costs pursuant to OMB Circular A-87 and the principles for cost accounting in OMB Circular A-133, which require the reporting of costs by program and set standards for the allocation of overhead and shared administrative costs.

Specify different reporting requirements for each of the applicable funding sources (e.g., Medicaid, block grants, State funds).

Specify audit procedures and selection of auditor.

Determine which organization is responsible by statute for assuring fiscal solvency (in addition to the purchaser).

Specify an action plan if the MCO experiences financial problems with contract delivery.

Specify reporting requirements of expenditures for both substance abuse and mental health services as a percentage of premium spent for integrated health/behavioral health plans.

[1.] Maintaining a competitive position may provide incentive to the MCO to control service cost.

[2.] Economists would call this add-on to the payment a "risk premium."

CHAPTER VIII

Consumer Protections

Key issues in this chapter:

- Managed care consumers' rights
- MCOs' consumer complaint, grievance, and appeal procedures: intersection with the Medicaid fair hearing process

The need for consumer protections in the managed care contracting process has been emphasized in the preceding chapters. The most important consumer protections may be those that are not specifically labeled as such in the contract, including:

Clear requirements for coverage, network composition, and system capacity that create a duty on the part of the managed care organization (MCO) to make services accessible;

Financial arrangements that do not transfer excessive levels of risk or create other deterrents to medically necessary care; and

Quality assurance systems based on carefully developed practice guidelines and procedures for external review and review of complaints and grievances.

This chapter focuses on additional matters pertaining to the protection of the interests of consumers and their families in publicly funded managed behavioral health care plans:

Managed care consumers' rights with respect to managed care plan enrollment, confidentiality, involvement in treatment planning, and other areas; and

MCOs' procedures for handling consumers' complaints, grievances, and appeals.

In publicly funded programs, consumers with mental and addictive disorders and their families are typically low-income people who often lack resources such as reliable transportation, child care, and stable living arrangements. Consumers in publicly funded programs include individuals who are homeless, adults with severe mental illness, caregivers of children with serious emotional disturbances, and individuals with long-term substance use disorders. Some of them have severe impairments, so obtaining access to services and advocating on their own behalf is particularly difficult or virtually impossible. As many MCOs lack experience with consumers in publicly funded programs, it is up to the purchaser of managed care services to consider the interests of all of these consumers in drafting requests for proposals (RFPs) and contracts.

Report Card on For-Profit Managed Behavioral Health Care Companies

The National Alliance for the Mentally Ill (NAMI), a strong voice of advocacy for mental health consumers and their families, recently released a report based on a survey conducted with nine of the largest for-profit managed behavioral health care companies in the United States (NAMI, 1997). The report concluded that for-profit managed care companies contracting with States or counties to care for people disabled by severe mental illnesses have failed to provide basic clinical and support services.

The NAMI report assigned grades of pass, fail, or incomplete for nine components of care. It gave the overall industry a failing grade in each of the nine areas of care, although some companies received passing grades in several areas:

Presence of scientifically up-to-date guidelines for treatment;

Access to and adequacy of inpatient care;

Availability of intensive case management and of alternatives to hospital care;

Access to the most effective medications;

Response to suicide attempts;

Involvement of consumers and families in treatment planning and delivery;

Measurement of patient outcomes;

Access to rehabilitation services; and

Access to housing.

In light of its findings, NAMI recommended that States and the Federal Government implement quality standards for public sector managed care and develop consumer protection legislation for people with severe mental illness in managed care plans.

A. Managed Care Consumers' Rights

Past practices by MCOs that ignored or minimized consumers' rights sometimes resulted in inadequate or dangerous care. This led the President's Commission on Model State Drug Laws in 1993 to develop the Model Managed Care Consumer Protection Act, which sets a standard that "allows responsible managed care firms to continue to carry out their functions, but creates much-needed consumer protections [against] those firms whose policies or fiscal incentives can lead to less than adequate care" (CSAT, 1995c). In addition, many advocacy and professional organizations have established comprehensive "bills of rights" linked to the full spectrum of services to which the consumers of managed behavioral health care and their families may be entitled. Current Medicaid law provides Medicaid enrollees in managed care plans with "a wide variety of [rights], many of which are not enjoyed by most commercial enrollees" (Fried, 1996).

The discussion below focuses on several rights of consumers of managed substance abuse and mental health services that are often touched upon in consumers' bills of rights:

- The right to be given choices and protections in the managed care plans;
- The right to confidentiality;
- The right to be involved in treatment planning;
- The right to be protected from disenrollment by a health plan; and
- The right to representation.

The section closes with a discussion of involuntary commitment and court-ordered treatment.

Two examples of consumers' bills of rights—one developed by the Bazelon Center for Mental Health Law and one developed by the American Managed Behavioral Healthcare Association (AMBHA)—are shown in Exhibits VIII-1 and VIII-2 below. The general themes of these documents are that the basic rights of consumers (and, by implication, of consumers' families) are to be protected, that consumers and families have an easy way to file grievances with an MCO, and that a system of appeals ensures speedy resolution of problems (Bazelon Center for Mental Health Law, 1995).

Exhibit VIII-1.

Bazelon Center for Mental Health Law's Consumer "Bill of Rights"

No managed care entity may discriminate on the basis of disability, race, religion, national origin, income, gender, or sexual orientation.
Consumers have the right to be fully involved in all treatment decisions and to participate in the development of their service plan.
Consumers have the right to give or withhold consent to their service plan and to amend their consent as their plan is modified.
Children with a serious emotional disturbance should be in an interagency, interdisciplinary service plan developed with their family and approved by their parent or guardian.
Treatment plans must respect the individual consumer's choice of service and service setting.
Consumers have the right to refuse any treatment they do not feel is appropriate and may not be disenrolled because they have refused treatment.
Consumers may not be denied services that are appropriate to their needs because of their decision not to accept other services.
Managed care entities must ensure confidentiality of records, guarantee consumers full access to their own records, and protect individual privacy.
Consumers have the right to establish psychiatric advance directives or durable powers of attorney specifying how they wish to be treated in an emergency or if they are incapacitated. The managed care entity should be required to educate its providers on the use of advance directives.
Consumers have the right to appeal decisions about their treatment when they disagree. The managed care entity must have an effective, expeditious, accessible, fair, and uniform grievance procedure to allow consumers to appeal decisions about care they receive or services they are denied.
Consumers have the right not to be disenrolled from the plan without just cause.

SOURCE: Bazelon Center for Mental Health Law, 1995. Cited with permission from Bazelon Center for Mental Health Law.

Exhibit VIII-2.

AMBHA's Bill of Rights for Consumers* Accessing Behavioral Health Services

Parity: Benefit plans for the treatment of mental/psychiatric and addictive disorders, in both the public and private sectors, shall be comprehensive; i.e., they shall cover the entire continuum of clinically effective and appropriate services provided by all competent licensed professionals, and should provide identical coverage and funding to those benefits covering physical illness, with the same provisions, lifetime benefits, and catastrophic coverage.
Choice: Consumers shall have access to services and a choice of providers within a full continuum of network-based services, including recovery and peer support programs. Network providers are to be accountable to payers and consumers by documenting the positive clinical outcomes and consumer satisfaction that they deliver. It is recognized that consumers may be required to contribute to the cost of greater choice of providers under the terms of their insurance plan.

Confidentiality: Consumers shall be guaranteed the confidentiality of their relationship with their behavioral health professional except when the law dictates otherwise to assure their safety or the safety of others. Information exchanged between treating professionals and managed care organizations for third-party clinical review for clinical effectiveness, authorization of payment, and care coordination for the purpose of improving the quality and efficiency of health care delivery shall be held in the strictest confidence.

Determination of Treatment: Decisions regarding behavioral health treatment shall be made by duly certified and/or licensed behavioral health professionals in conjunction with the patient or his/her family as appropriate. Organizations providing care review/care authorization function as clinical consultants to the professional/patient relationship, and they authorize payment according to established criteria available to providers and consumers.

Review: Consumers shall be assured that any review for clinical appropriateness of their behavioral health treatment shall be done by a duly certified and/or licensed behavioral health professional.

Right To Know: Upon purchase of health coverage, consumers shall be informed in language they can comprehend of the extent of their behavioral health benefits and of the appeal and grievance processes available to them.

Benefit Usage: Consumers shall be entitled to use all the behavioral health benefits they have purchased if the health plan's processes, including the patient's decision, the duly certified and/or licensed treating behavioral professional's judgment, and the care authorization staff, determine that such services are clinically effective.

Compliance With State Statutes: Consumers shall not be denied treatment for services allowed under State law when those services are deemed to be clinically effective and appropriate by the health plan.

Disclosure: Consumers shall be informed by the licensed and/or certified behavioral health care professional providing their treatment of any arrangements, restrictions, and/or covenants established between the insurers and professionals that may influence treatment, at no jeopardy to the consumer.

Discrimination: Consumers who have undergone behavioral health treatment shall not be discriminated against by health, disability, life, or other insurance entities.

Appeals: Consumers will be given the opportunity for fair, reasonable, timely, and disclosed appeals and grievances.

Accountability: Providers and health plans shall be held accountable for the quality of services delivered. All parties treating patients or managing benefits for patients—providers, managed care entities, and health plans—shall be held accountable for any injury caused by negligence in their services. Providers and managed care entities are responsible for implementing a health plan's benefit structure.

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*The American Managed Behavioral Healthcare Association (AMBHA) uses the terms patients, consumers, and clients interchangeably.

SOURCE: American Managed Behavioral Healthcare Association (AMBHA), 1997. Cited with permission.

1. Consumer Choices and Protections in Managed Care Plans

Both the Bazelon Center's bill of rights and AMBHA's bill of rights assert that consumers and families have the right to choose health plans, as well as to choose the services, service settings, practitioners, and providers within a health plan. Disregarding consumer preferences in these matters can adversely affect consumers' adherence to a treatment plan, resulting in poorer outcomes.

MCOs routinely make decisions that have an impact on consumers' choices. MCOs that arbitrarily assign consumers and families to a practitioner or practitioners are denying consumers and families the right to have as much choice as possible within the system.

The size of an MCO's provider panels, including group practices, may affect the number of options for consumers and families from which to select (IOM, 1996). Some States have enacted "any willing provider" laws that require MCOs to contract with any provider willing to meet the terms and conditions of the MCO's contract (AMBHA, 1997), thus giving consumers a greater choice among providers and services. It should be noted, however, that requiring MCOs to subcontract with any willing provider does not necessarily mean that every provider the MCO contracts with will receive referrals from the MCO.

Consumer Choices and Protections in Managed Care Plans. Purchasers may wish to address the following in RFPs and contracts:

Reference existing State laws or regulations that address consumer protections.

Prohibit any limitations on practitioners concerning the discussion of clinically appropriate treatment options with patients and families or designated advocates (in accord with confidentiality laws [see below]).

Provide each enrollee in the plan with the option of choosing a specific primary care provider within the MCO network (with the provision that if one is not selected one will be assigned).

Ensure that each enrollee has the right to select an alternative provider if he or she so requests.

Allow the enrollee to disenroll and join another MCO if one is available.

Require consumer choice among network practitioners and facilities.

Offer clients a choice of providers within specific levels of care and if deemed clinically appropriate.

Reference State laws with respect to provider-consumer communication.

Require the MCO to give enrollees a choice of at least two case managers.

Require the MCO to give consumers and families a choice of at least two providers in each category of benefits (some exceptions may have to be made in the case of highly specialized benefits).

2. Confidentiality

Although the need for confidentiality is not an issue unique to managed care arrangements, consumers of substance abuse and mental health treatment services and their families are especially vulnerable to being stigmatized by information that may be disclosed when they seek authorization for treatment or are referred from one practitioner or provider to another. On the other hand, the use of multiple practitioners (and prescription drugs) by consumers without an integrated service plan may be dangerous to the consumer and not cost effective. The right of consumers and families to confidentiality often conflicts with the MCO's need to access information about the consumer, through utilization and case management activities designed to ensure appropriate and coordinated care.

Purchasers must be aware of all Federal and State laws and regulations affecting confidentiality. Federal substance abuse treatment regulations (42 C.F.R. Part 2) require that providers of substance abuse services maintain confidentiality of consumers and families, prohibit unauthorized disclosure of consumer-specific information, and limit ways in which disclosure can occur. These regulations protect the privacy of individuals entering treatment and help ensure that information about participation in treatment, even the fact of participation, cannot be disclosed without consent (IOM, 1996).

Whereas regulations governing substance abuse treatment are based on Federal law, mental health confidentiality regulations are based on State law, and they may be quite different from the laws governing substance abuse treatment. Furthermore, the degree of confidentiality of data from one jurisdiction to another may also be affected by a number of other relevant laws, such as HIV confidentiality statutes, Aduty to warn@ court decisions and statutes, abuse, and neglect reporting and decisions about the special status of provider-patient communications (privilege decisions).

Confidentiality in a managed care setting can be particularly problematic when MCOs ask for extensive disclosure of a consumer's records. Even though the Federal confidentiality regulations state that disclosures must be limited to only that information needed to accomplish the disclosure's purpose, MCOs sometimes ask for years' worth of records. Many MCOs will not approve care or reimburse for services delivered unless they obtain those records. Therefore, the purchaser may wish to stipulate in the contract the extent of information an MCO is allowed to ask a provider to disclose.

Confidentiality. Purchasers may wish to address the following in RFPs and contracts:

Require the MCO to establish strategies that maximize patient confidentiality.

Require the MCO to install confidentiality protections in the management information system (see Chapter V).

Ensure quality assurance mechanisms to safeguard consumer records.

Specify who is allowed to release and receive consumer information and how it will be used.

Reference 42 C.F.R. Part 2 of the Federal regulations pertaining to confidentiality regarding substance abuse treatment.

Reference all applicable State confidentiality and privacy laws.

Ensure that the confidentiality section of the RFP shall survive the termination of the contract and will apply as long as the MCO maintains any identifiable information relating to enrollees.

Ensure that the MCO instructs its employees to keep confidential any information concerning the business of the State's contract and the beneficiaries it represents.

Require informed consent from the consumer for the release of any consumer information.

Require the MCO to give consumers and families an opportunity to consent when their records will be shared outside the MCO network (i.e., do not permit the MCO to ask consumers to sign a blanket waiver of their privacy rights).

3. Consumer Involvement in Treatment Planning

A Arecovery-oriented@ philosophy views adult consumers and their caregiving families as partners with professionals in planning for treatment and service delivery, as long as the consumer consents to family involvement. Many believe that involving consumers and their families will generally facilitate consumer decisionmaking, help shape viable service plans, and lead to better consumer cooperation. As a partner in treatment, a consumer may face the difficult decision of refusing treatment if he or she feels that the recommended treatment is inappropriate.

In reviewing RFPs for managed behavioral health care, NAMI found that most RFPs did not specifically stipulate participation by either the consumer or the family in treatment planning or service delivery. Three States that did stipulate such participation included the following provisions (Huskamp, 1996):

The 1991 Massachusetts substance abuse and mental health RFP specified that the MCO must develop an Aintegrated aftercare plan upon discharge@ and that consumers and families, family members, providers, and other Aidentified supports@ should be involved in developing that plan.

The 1994 Oregon mental health RFP stipulated that the MCO Aexplain how input from service recipients and their family members (where involved) will be used to adjust service delivery.@

The 1993 Washington mental health RFP specified that both the consumer and Aappropriate others at the recipient's request@ be involved in treatment planning.

Consumer Involvement in Treatment Planning. Purchasers may wish to address the following in RFPs and contracts:

Ensure that the consumer will not be denied other potentially appropriate treatment if he/she has refused another service.

Require the MCO to involve enrollees in the development of their individualized service plan.

Allow consumers to sign off on their treatment plans in an unpressured environment.

Require that family caregivers of minors and legal guardians of adults also be fully involved in the development of the service plan and have the authority to sign off on it.

Stipulate that the MCO institutionalize a system whereby consumers and families may develop advance directives that provide instructions on treatment decisions and that network providers should be required to check such documents before making treatment decisions for individuals found to be incompetent.

Ensure that services are provided by individuals who speak the same language as the consumer and that there are no other cultural barriers to full participation by consumers and families from ethnic minorities.

Ensure compliance with State licensing rules concerning client involvement in treatment planning.

Require signed treatment plans to document consent and involvement.

Establish and monitor performance specifications for treatment plans with consumer involvement.

4. Disenrollment Protections for Consumers

Consumers of behavioral health services may be difficult to treat, and appropriate treatments may be very expensive, creating incentives for MCOs to disenroll them. Disenrollment from a managed care plan can cause problems for consumers if there is only one plan (that is, if re-enrollment in another plan is not an available choice) or if there is no default to fee-for-service reimbursement. Rosenbaum and her associates found numerous examples of State Medicaid managed care contracts in which disenrollment for noncompliance with the treatment plan was permitted (Rosenbaum, et al., 1997). This contract provision was particularly common for health plans that integrated general and behavioral health care.

If the purchaser of managed care services decides to allow the MCO to disenroll clients, the process should include multiple, well-monitored steps. Conversely, the process allowing consumers to voluntarily disenroll from a health plan should be simple and easy.

Disenrollment Protections for Consumers. Purchasers may wish to address the following in RFPs and contracts:

Specify the criteria that must be met by the MCO to proceed with disenrollment, or

Prohibit MCOs from disenrolling any individual from the plan; retain this authority for the purchaser, or

Allow some discretion for the MCO to disenroll individuals, but prohibit disenrollment due to all or some of the reasons listed above.

When disenrollment is permitted, require the following:

- Multiple and well-monitored steps established by the MCO or the provider; and

- A simple process for consumer-initiated disenrollment.

Require the MCO to report disenrollments and the reasons for them to the purchaser.

Specify that disenrollment is not allowed for some or all of the following reasons:

- Diagnosis or perceived diagnosis;

- Adverse changes in the enrollee's health or because of pre-existing conditions;

- High treatment costs or inability to pay deductibles, co-payments, or other fees;

- The consumer's refusal of treatment, rate of missed appointments, or other challenges to implementing the service plan;

- The consumer's not having completed necessary forms or paperwork;

- The consumer's difficult or unpleasant behavior, if such behavior is related to the individual's disability; and

- The consumer's attempt to exercise his or her rights under a grievance or appeal system.

5. Consumer Representation and Advocacy

Purchasers may want to ensure that consumers and families retain the right to representation, whether by an independent organization or a community advocate, to help them understand their rights and benefits. The Protection and Advocacy System, for example, is a federally funded, nationwide initiative to provide legal advocacy to persons with disabilities. Many public health agencies also provide community representation by trained individuals with a history of mental and/or addictive disorders. These individuals are often effective in working with consumers and families, who are likely to have more confidence in someone who has had similar experiences.

Consumer Representation and Advocacy. Purchasers may wish to address the following in RFPs and contracts:

Require that the MCO makes clients and their families aware of their rights to be represented by a consumer advocate.

Specify an arrangement with a formal external agent (i.e., not the MCO) or ombudsman to work with consumers, family members, and providers as a representative or advocate.

Designate the Protection and Advocacy System in the State to act as legal advocates for individuals in the managed care program.

Require dissemination of information about both internal and external advocacy mechanisms in several ways and ensure that information is accessible and easily understood by consumers.

6. Involuntary Commitment and Court-Ordered Addiction Treatment

A court may order treatment and hold entities in contempt if the court's orders are not met. The two types of court treatment orders are (1) orders of involuntary commitment; and (2) orders requiring offenders, especially drunk drivers, to get addiction treatment. Orders for addiction treatment of offenders are far more common than orders for involuntary commitment. In the case of addiction treatment orders, the legal requirement is on the offender/client, not the MCO or provider, but such orders pose a potentially significant demand for services.

Court-ordered treatment often evokes much discussion and strong sentiments among the parties involved. Some consumers and families contend that use of involuntary treatment signifies a breakdown in a care system and that a well-functioning system should not have many involuntary treatment episodes. It is essential that purchasers make thoughtful decisions consistent with State laws and regulations about this particular aspect of behavioral health care treatment.

A key issue related to court-ordered treatment is who, ultimately, will be financially responsible. If the State or county remains financially responsible for involuntary substance abuse and mental health commitments, the MCO may have an incentive to shift its costs to the State by seeking commitment in cases where the appropriate response is not clear cut. This situation may hinder consumers from getting appropriate voluntary treatment and act as an incentive to allow consumers' conditions to deteriorate to meet involuntary commitment criteria. In the case of court-ordered treatment, MCOs often object to being forced to pay for services they do not deem medically necessary and/or that the consumer may not want (IOM, 1996).

Purchasers, MCOs, and the criminal justice system must work together from the beginning of a managed care initiative to ensure clear lines of responsibility. The first step is to create a forum where courts can participate in discussions with the purchaser and the MCO. The MCO's responsibility in terms of assessment and treatment for responding to court-ordered referrals must be clarified. The courts must understand that the system provides medically necessary care and does not function as a secure alternative to incarceration. Each may need to adopt a new orientation to court-ordered treatment.

Court-Ordered Treatment. Purchasers may wish to address the following in RFPs and contracts:

Clarify the clinical, financial, and legal rights and responsibilities of the purchaser, the MCO, and providers with respect to court-ordered treatment. Delineate the relationship between these parties and the adult and juvenile criminal justice systems (i.e., who pays and who determines what services are provided and for how long).

Identify who is financially responsible for involuntary commitment. For example, the purchaser can hold the MCO financially responsible for any consumer committed to an inpatient or outpatient facility.

Define criteria that must be met to initiate an involuntary commitment, including reference to applicable State statutes.

Require MCOs to present plans for purchaser approval that are designed to minimize the use of involuntary commitment.

Ensure that regardless of who has responsibility for these decisions, court-ordered treatment decisions are made by counselors with credentials in substance abuse treatment and prevention, qualified health professionals, or approved licensed service providers.

Require the MCO to have defined written relationships with local law enforcement agencies to ensure smooth transfer of enrollees who are assessed to be a danger to themselves or others.

Stipulate whether the MCO will be responsible to pay for court-ordered treatment judged not medically necessary based on established placement, continued stay, and discharge criteria. Clarify whether any supplemental payment plans are available to fund services when the MCO determines that court-ordered treatment is not medically necessary.

Clarify whether enrollees on probation and parole are eligible for the plan.

B. MCOs' Consumer Complaint, Grievance, and Appeal Procedures: Intersection With the Medicaid Fair Hearing Process

When there are open avenues for managed care enrollees to express their questions, disputes, disagreements, and challenges, it is possible for consumers and families to challenge an MCO's decisions about eligibility, diagnoses, medical necessity determinations, types and levels of services, provider choice, and provider treatment procedures. If MCOs have procedures for resolving difficulties that are Aeffective, expeditious, accessible, fair, and uniform@ (Bazelon Center for Mental Health Law, 1995), consumers will gain reassurance that the MCO is responsive to their concerns. This reassurance may help encourage consumer participation and cooperation and lead to satisfactory settlement of disputes.

Protecting the rights of consumers and families to file grievances and appeals allows purchasers of managed care to have final control over issues that arise from the MCO's performance and its approach to problems related to quality of care. In addition, a well-functioning grievance and appeal process can also provide the purchaser with evidence of problems in the quality of care. Such information can be used to monitor the degree to which the MCO has addressed these problems.

Medicaid recipients are entitled to fair hearings in accordance with constitutional principles of due process and fundamental fairness whenever a State agency makes a fact-based decision to deny, reduce, or terminate Medicaid benefits. (Across-the-board reductions in Medicaid benefits resulting from changes in a State plan necessitate advance notice but not a fair hearing.) The denial, reduction, or termination of medical assistance that is considered medically necessary constitutes the type of State action that triggers the constitutional fair hearing requirements.

Extensive regulations governing fair hearings for Medicaid recipients are set forth in the Federal Regulations (42 C.F.R. '431.200). When a fair hearing is requested in a timely fashion (within 10 days of the notice of intended action), services must be continued until a decision following the fair hearing is reached. The initial notice of intended action must state the actions being taken and the reasons for them. The fair hearing itself must comport with due process standards.

Enrollment in an MCO does not annul Medicaid beneficiaries' fair hearing rights, because the MCO is acting as an agent of the State in making coverage determinations. Several court decisions have now held that managed care enrollment leaves Medicaid recipients' fair hearing rights untouched (*Wadley v. Daniels* [926 F. Supp. 1305 (M.D. Tenn., 1996)]; *J. K. v. Dillenberg* [836 F. Supp. 694 (D. Ariz., 1993)]. A rapid and fair managed care complaint and grievance process represents an important means for reducing the number of fair hearing requests and achieving more rapid resolution of enrollees' problems.

Federal regulations require MCOs to maintain internal grievance procedures that are approved in writing by the agency, provide for prompt resolution, and ensure participation by individuals with the authority to order corrective action (42 C.F.R. '424.53).

State Medicaid agencies should consider adopting for their Medicaid contracts the expedited review procedures required for Medicare+Choice plans, which procedures apply to Medicare beneficiaries enrolled in managed care arrangements. The expedited review procedures are designed to ensure rapid determinations and reconsiderations in situations where a health maintenance organization (HMO) determines that Athe application of the normal time frame [60 days] for making a determination (or a reconsideration following a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function@ (Social Security Act '1852(g)(3)). The provision gives the HMO 72 hours from the date of the request to make a determination or a reconsideration of the need for the expedited review, as well as a decision on the merits of the Medicare beneficiary's claim. Coverage denials are then reviewed by an independent organization.

MCO Consumer Complaint, Grievance, and Appeal Procedures. Purchasers may wish to address the following in RFPs and contracts:

Mandate that the MCO develop written policies and procedures that adequately address complaint, grievance, and appeal processes for the system of care.

Require the MCO to provide consumers and families with information at the time of enrollment that explains how to file a complaint, grievance, and appeal with the MCO or directly with the State. Ensure that this information is also supplied to advocacy organizations.

Require that the MCO monitor and log grievances and develop action plans based on recurring problems.

Require an expedited appeal for benefits if their denial could seriously jeopardize an enrollee's life or health or ability to regain maximum function.

Ensure that the consumer has representation rights in any complaint, grievance, or appeal procedure; this representative may be a community advocate, an ombudsman, an attorney, or any other individual chosen by the consumer.

Require that the MCO's written procedures list situations when consumers and families may want to file an oral or written complaint or grievance, such as the following:

- Delay or denial of service;

- Poor quality of care;

- Pressure to accept unwanted treatment;

- Not receiving services in the most appropriate and/or least restrictive setting;

- Lack of access to necessary specialty services;

- Cultural insensitivity; and

- Not having access to newer medications proven to be the most effective in treating an illness (e.g., receiving haloperidol rather than clozapine or olanzapine for schizophrenia).

Stipulate that the MCO has a formal process for review of all complaints and grievances concerning all administrative activities, such as information and referral activities, contracting procedures, claims payment, third-party revenue generation activities, and other aspects of the MCO's scope of administrative services.

Require the MCO to ensure that procedures for filing grievances and complaints are accessible and responsive.

Require the MCO to determine a means to provide immediate reconsideration of authorization decisions when necessary, which should take place within a specified time period (e.g., 1 day) so that clients in crisis do not experience a delay in treatment due to a disagreement between the provider and utilization managers.

Require the MCO to establish procedures for accepting and resolving consumer complaints, grievances, and appeals in a manner that is linguistically accessible and culturally appropriate.

Require the MCO to establish reasonable timeframes subject to purchaser approval for response to a consumer's complaint and resolution of a grievance or appeal.

Require the MCO to provide an expedited appeal process when a consumer's health is at risk.

Require the MCO and its provider network to systematically record and report to the purchaser complaints and their resolution.

Require second-level external, independent review of appeals, such as required in the U.S. Department of Defense's health care contracts.

Develop a monitoring plan for complaints, grievances, and appeals that may include incentives or sanctions based on the MCO's performance in this area.

Purchasers should be aware of the challenges that managed care procedures and requirements present to those in need of substance abuse and mental health services. These are the same consumers who challenge the system because of their extensive need for services. Consumers, their families, and advocates want to be, and should be, involved in designing plans of care for these individuals. Purchasers should make consumer protection a top priority and be vigilant in ensuring that systems are in place to guarantee that these vulnerable populations receive needed service in a timely, efficient, and competent manner.

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Abbreviations and Glossary

List of Abbreviations

ACMHA
: American College of Mental Health Administration

AHCPR
: Agency for Health Care Policy and Research

AIDS
: acquired immunodeficiency syndrome

AMBHA
: American Managed Behavioral Healthcare Association

APWA
: American Public Welfare Association

ASAM

American Society of Addiction Medicine ASAM PPC-2 ASAM's *Patient Placement Criteria for the Treatment of Substance-Related Disorders,* 2nd ed.

CARF

Commission on Accreditation of Rehabilitation (formerly the Commission on Accreditation of Rehabilitation Facilities)

CBO

community-based organization

CDC

Centers for Disease Control and Prevention

CMHC

community mental health center

CMHS

Community Mental Health Services (Block Grant)

COA

Council on Accreditation of Services for Families and Children

CSAP

Center for Substance Abuse Prevention

CSAT

Center for Substance Abuse Treatment

DEC

Digital Equipment Corporation

DSM-IV

Diagnostic and Statistical Manual, 4th ed. (American Psychiatric Association)

ECP

essential community provider

EPSDT

Early and Periodic Screening, Diagnosis, and Treatment (services)

FFCMH

Federation of Families for Children's Mental Health

FTA

Family Treatment Association

HCFA

Health Care Financing Administration

HEDIS

Health Plan Employer Data Information Set

HIV

human immunodeficiency virus

HMO

health maintenance organization

IDEA

Individuals with Disabilities Education Act

IEP

Individualized Education Plan

IHS

Indian Health Service

IMD

institution for mental disease

IOM

Institute of Medicine

JCAHO

Joint Commission on Accreditation of Health Care Organizations

LAAM

levo-alpha-acetyl-methadol

MBHO

managed behavioral healthcare organization

MCO

managed care organization

MHMA

Mental Health Management of America

MHSIP

Mental Health Statistics Improvement Program

MIS

Management Information System

NACBHD

National Association of County Behavioral Health Directors

NAMI

National Alliance for the Mentally Ill

NASADAD

National Association of State Alcohol and Drug Abuse Directors

NASDDDS

National Association of State Directors of Developmental Disabilities Services

NASMHPD

National Association of State Mental Health Program Directors

NCQA

National Committee for Quality Assurance

NIAAA

National Institute on Alcohol Abuse and Alcoholism

NIDA

National Institute on Drug Abuse

NMHA

National Mental Health Association

OMT

opioid maintenance therapy

PERMS

Performance-Based Measures for Managed Behavioral Health Care Programs

PSN

provider-sponsored network

QM

quality management

RFI

request for information

RFP

request for proposal

SAMHSA

Substance Abuse and Mental Health Services Administration

SAPT

Substance Abuse Prevention and Treatment (Block Grant)

SED

serious emotional disturbances

SMI

serious mental illness

SPMI

serious and persistent mental illness

SSI

Supplemental Security Income

STD

sexually transmitted disease

TAP

Technical Assistance Publication

TIP

Treatment Improvement Protocol

UM

utilization management

UR

utilization review

Glossary of Terms

Access: An individual's ability to obtain needed health care services. Barriers to access can be financial, geographic, organizational, and sociological.

Accreditation: A process whereby a recognized external organization determines that a hospital, health care plan, provider network, or other service delivery system complies with established standards.

Actuarial Study: Analyses of past health services utilization data and other statistical information to estimate future utilization and costs for specific groups and to establish insurance premiums and/or provider payments.

Acute Care: Services provided to protect the decompensating patient and/or resolve his/her urgent and severe problems so that he/she can return as quickly as possible to the previous level of function.

Adjusted Average Per Capita Cost (AAPCC): The basis of reimbursement to health maintenance organizations (HMOs) under Medicare risk contracts; the average monthly amount received per enrollee is currently calculated as 95 percent of the average costs to deliver medical care in the fee-for-service sector.

Administrative Capitation: Establishment of per member payments for services required to administer a health care delivery system, calculated by dividing the projected costs of administrative services by the projected number of enrollees, in order to tie an MCO's risk and payments to enrollment.

Administrative Services Only (ASO): A type of contract in which the contracted organization provides only administrative or management services (e.g., claims processing, utilization review) but not direct treatment services, which are provided by the purchaser or by another organization.

Adverse Selection: When a payer has a disproportionately large share of high-risk enrollees (i.e., those with high service use and high costs) due to offering relatively generous benefits for certain types of care; to avoid adverse selection, some plans limit coverage of certain services.

Agency for Health Care Policy and Research (AHCPR): A U.S. Public Health Service agency that is the Federal Government's focal point for reviewing health services research in order to enhance the quality, appropriateness, and effectiveness of health care services.

Aid to Families With Dependent Children (AFDC): A State-based Federal cash assistance program for low-income families that was abolished in 1997 by Congress and replaced by the Transitional Assistance for Needy Families Program.

Alcohol and Other Drug (AOD) Use Disorders: A term used to describe substance use disorders, which is designed to emphasize that alcohol is indeed a drug. Related terms include substance use disorders, addictive disorders, chemical dependency, and substance abuse.

All-Payer System: A health care delivery system in which prices for health services and payment methods are the same, regardless of who is paying, to minimize the shifting of costs from one payer to another.

Allowable Costs: Charges for care that are reimbursable as predetermined by the payer/purchaser.

Ambulatory Care: Health care services provided in an outpatient setting (e.g., a physician's office, clinic, or community mental health center) rather than an inpatient setting.

American Managed Behavioral Healthcare Association (AMBHA): A trade association, founded in 1994, of managed behavioral health care companies that manage care and that are not primarily engaged in delivering clinical services.

Americans With Disabilities Act: A federal law enacted in July 1990 that prohibits discrimination on the basis of disability in employment, programs, and services provided by State and local governments, goods and services provided by private companies, and in commercial facilities.

Ancillary Services: Supplemental hospital services other than room and board (e.g., laboratory tests and x-rays).

Any Willing Provider Law: A law that requires managed care organizations to contract with any interested health care provider in the geographic area who is able to meet contractual terms and conditions for service delivery.

Average Length of Stay (see also **Length of Stay**)**:** The mean length of an inpatient stay for a specific patient group, population, or time period; calculated by dividing the total number of treatment days by the number of patients discharged. The term also applies to outpatient services; it is calculated by summing the number of visits and dividing by number of patients discharged.

Behavioral Health, Behavioral Health Care>: Health in the areas of mental and emotional well-being and the use of alcohol and other drugs (as opposed to physical or somatic health), and the care provided for problems in these areas. Services provided for conditions related to mental health and/or AOD disorders.

Behavioral Health Care Firm: A specialized, managed care organization that manages mental health and/or substance abuse care rather than care for physical illnesses. Also referred to as managed behavioral healthcare organization (MBHO).

Benchmark (see also **Performance Goal, Performance Measure**)**:** A level of achievement of a performance goal that generally represents an industry-best standard.

Beneficiary (see also **Consumer, Enrollee, Member, Subscriber**)**:** An individual who receives benefits from or is covered by an insurance policy or other health care financing program.

Benefit Package: A set of health care services that a payer is legally obligated to pay for either by contract, law, or regulation. The package usually also specifies excluded services, limitations on covered services, and the means by which medical necessity is determined.

Beta Risk: A form of direct financial risk undertaken by a health care organization when it assumes that the cost of patients with catastrophic illnesses will be more than adequately made up for by fees received for the remaining covered population.

Bundled Services: Similar individual services that can be billed separately or in a "bundle"; bundled services may be billed at a greater or lesser rate than the total of the individual service charges.

Capitation, Capitation Fee, Capitation Payment (see also **Full Capitation, Partial Capitation, Per Capita**)**:** A method of prospective payment in which a fixed amount is paid to an MCO, a health plan, or a provider for each enrollee or each person served, without regard to the actual number or nature of services provided in a set period of time or defined episode. A capitation fee is usually expressed as a per member-per month rate. The terms "soft capitation" and "hard capitation" are sometimes used to describe partial- and full-risk situations, respectively.

Caps on Profits (see also **Risk Corridors**)**:** A contractual limitation on the amount of profit and/or loss that an MCO can realize in a risk-transfer system; designed either to minimize an MCO's financial incentives to excessively reduce service utilization or to limit their financial risk in high utilization situations. Risk corridors can be set up to limit profit and reduce risk (e.g., in a too high utilization situation, the purchaser or reinsurer might pay; in a too low utilization, the MCO might pay the purchaser back).

Carve-Out: An arrangement whereby a particular type of health care service, such as behavioral health care, is managed and/or provided separately from the total health care benefit package, generally so that the payer can maintain greater control of the costs. Services for certain populations or patient groups are also sometimes "carved out" of the overall package.

Case Management (see also **Intensive Case Management, Utilization Management**)**:** Coordination and monitoring of an individual patient's treatment by a third party, either by a single case manager or a case management team. The goals of case management are to ensure that a patient receives and makes the best use of needed services and adheres to the treatment plan, so that he or she maintains a stable life in the community and avoids costly care, such as inpatient treatment. Case management can occur at the provider level or the payer level.

Case Mix: The overall clinical profile of a particular group or subpopulation of consumers, determined by assessing such factors as diagnosis, severity of illness, and service utilization patterns; case mix is a key variable in establishing capitation rates and estimating costs.

Case Rate: A fixed, per-patient rate for delivery of specific procedures or services to specified types of consumers, such as persons with serious and persistent mental illness (SPMI), which are often time-limited (e.g., per episode, per year).

Catchment Area (see also **Service Area**)**:** A geographically defined service area for a health plan or provider delineated by such factors as population distribution, natural geographic boundaries, and transportation accessibility; all residents of the area are usually eligible for services, although additional eligibility criteria may be established.

"Cherry Picking": A practice employed by some managed care plans whereby they compete for the healthiest people and try to avoid enrolling people with the most expensive treatment needs.

Claim: A request by a provider to a payer for reimbursement for benefits/services delivered.

Closed Panel: A managed care plan that offers only a fixed group of providers to an enrollee from which he or she must select a primary care provider. In carve-out arrangements, the enrollee may only choose a provider from a predetermined list.

Coinsurance (see also **Copayment, Cost Sharing, Deductible**)**:** A cost-sharing feature that requires the insured party to assume a percentage of the costs of covered services, in addition to any deductible amounts.

Community Rating: A method of calculating a health plan premium or capitation rate for all enrollees within a specific geographic area, based on average actual or anticipated costs for the entire group; under this method the premium or capitation rate does not vary for different subgroups of subscribers based on their previous service utilization.

Community Rating by Class (Class Rating): An adjustment to a community rated premium or capitation rate whereby certain subscriber subgroups may have different rates based on factors such as age, sex, family size, marital status, and industry classification; such adjustments are permissible in federally qualified HMOs.

Concurrent Review: A kind of utilization review using predetermined patient placement criteria, conducted while the consumer is receiving services to determine whether the care being delivered is medically necessary or appropriate, and eligible for payment; performed either by an internal or external reviewer.

Consumer (see also **Beneficiary, Enrollee, Member, Subscriber**)**:** An individual who receives health care or health-care-related services.

Continued Stay Criteria: Predefined conditions or characteristics of consumers to be considered by providers and/or payers in deciding whether a consumer should continue to receive a certain type or intensity of care (e.g., inpatient services) or should be referred to what is deemed to be a more appropriate level, type, or intensity of care. For example, in decisions about substance abuse treatment, six categories of criteria are usually considered: acute intoxication and/or withdrawal potential, biomedical conditions and/or complications, emotional and behavioral conditions and/or complications, treatment resistance or acceptance, relapse potential, and the recovery environment.

Coordination of Benefits: Standard rules and procedures that help determine which of two or more payers is primary and which is supplementary; such procedures seek to avoid duplicate claims payments.

Copayment (see also **Coinsurance, Cost Sharing, Deductible**)**:** A cost-sharing arrangement whereby a beneficiary is responsible for paying a fixed fee per unit of treatment service (e.g., $5 per visit, $20 per inpatient day) that does not vary with the provider's charge. Copayments are designed to reduce the third-party payer's costs and decrease service utilization.

Cost-Based Reimbursement: A traditional, and sometimes required, reimbursement method between public funding agencies and not-for-profit organizations in which providers are paid for services based on the documented cost of providing them; it generally involves monthly negotiated payments reconciled to the actual costs of service periodically (e.g., quarterly or annually).

Cost-Plus Reimbursement: Similar to cost-based reimbursement with the addition of a profit, or earnings factor, to the reimbursement for profit-making organizations.

Cost Sharing (see also **Copayment, Coinsurance, Deductible**)**:** A feature of a benefit plan that requires enrollees to pay some portion of the costs for services in an attempt to control utilization and to lower premiums.

Covered Days: Maximum number of inhospital or residential days for which a payer will reimburse a provider for services to an individual; days may be limited based on an episode of illness, a year, a lifetime, or the length of time the beneficiary has been covered by the contract.

Credentialing: The process of validating the qualifications of a licensed independent practitioner to provide services in a health care network or its components; involves evaluating and verifying the individual's license, education, training, experience, and ability to perform the services requested.

Cultural Competence: A set of congruent behaviors, approaches, and policies in a system, agency, or among professionals that enable the system, agency, or professional group to work effectively in crosscultural situations; an ability to meet the needs of clients and patients from diverse cultural backgrounds.

Current Procedural Terminology (CPT): Five-digit codes assigned to services and procedures to standardize claims processing and data analysis.

Customary, Prevailing, and Reasonable (CPR): The current method of paying physicians under Medicare. Payment for a service is limited to the lowest among the following: (1) the physician's billed charge for the service, (2) the physician's customary charge for the service, and (3) the prevailing charge for that service in the community.

Deductible (see also **Coinsurance, Copayment, Cost Sharing**)**:** The expenses that must be incurred by a consumer before a payer will assume liability for all or part of the remaining cost of covered services; usually tied to a period of time (e.g., $100 per calendar year or $200 per episode of illness).

Deeming: The acceptance of another accreditation organization's competency standards and/or review process in place of one's own in some or all areas.

Default Enrollment: A process used by an MCO to assign an individual to a primary care provider if the individual has not selected one within a specified period of time.

Dependents: Generally, the spouse and children of a beneficiary, or other persons as defined by the contract.

Diagnosis-Related Group (DRG): Classification of patients by diagnosis or other criteria (such as treatment procedure) into groups for the purpose of determining a prospective payment for each group, based on the premise that treatment of similar diagnoses will generate similar costs.

Direct Contracting (see also **Physician-Hospital Organization**)**:** A direct, contractual relationship between a purchaser and a provider or provider system in which no intermediary manager of care is involved.

Direct Payment Subscribers: Persons enrolled in a plan who make individual premium payments directly to the payer rather than through a group. Rates of payment are generally higher, and benefits may not be as extensive.

Disallowance: A payer's denial of payment for all or a portion of claimed amount.

Discounted Fee-for-Service Payment: An agreed-upon reimbursement rate for a specific service that is usually less than the provider's full fee and based on an expectation of volume.

Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT): A Medicaid program mandated by Federal law for eligible children under age 21 covering any medically necessary service allowable under Medicaid regulations; the law requires all States (1) to have a system in place to provide active outreach, screening, and assistance in obtaining appropriate treatments for physical and emotional/behavioral disorders and (2) to provide health care treatments and other measures necessary to adequately address these disorders.

Employee Retirement Income Security Act (ERISA): A 1974 Federal law that established new standards and reporting and disclosure requirements for self-insured employers and their health benefit programs; self-funded health benefit plans operating under ERISA are exempt from State insurance laws and regulations.

Enrollee (see also **Beneficiary, Consumer, Member, Subscriber**)**:** An individual enrolled in a health plan or a dependent of an enrolled individual, who is also covered by the plan.

Episode of Care: All treatments provided for a specific condition over a period of time (e.g., an episode of substance abuse treatment is all services provided to a patient after a detoxification admission with a gap between services lasting longer than 90 days); used to analyze service costs, quality, and utilization patterns, and may be used to control the rate of payment.

Essential Community Providers (ECPs): Generally, not-for-profit public behavioral health care community-based agencies, which are required to be included in an MCO's provider network, usually with a defined transition period. This permits beneficiaries who had received grant-funded services to continue to receive services from the same provider in a managed care system.

Exclusive Provider Organization (EPO): A closed panel of providers that beneficiaries must use to receive covered benefits; some exceptions are usually included for emergency and out-of-area services.

Exclusivity Clause: A legal provision binding a provider to contract only with a single health plan.

Ex Parte Communication: By one party. Communication of one party, without an adversary's being notified or given an opportunity to be heard.

Experience Rating: A method of establishing payer premiums or capitation rates based on historical utilization data and characteristics of potential subscribers, such as age, gender, and health status, that are believed to affect utilization and costs.

Explanation of Benefits: A communication to a beneficiary explaining which claims submitted have been fully paid, partially paid, or not paid, along with an explanation for each action.

Federally Qualified Health Plans: Health maintenance organizations (HMOs) that have applied for qualification and have met a set of standards established by the HMO Act of 1973 and its many amendments.

Fee-for-Service Payment: A traditional reimbursement method that involves paying fees to providers for procedures or services for beneficiaries after those services have been delivered, often with a maximum based on what is a usual, customary, and reasonable fee. A plan based on this form of reimbursement is sometimes referred to as an indemnity health plan (compare **Capitation**).

First-Dollar Coverage: Coverage for services in which the beneficiary pays no deductible, although a copayment or coinsurance may be required.

Fixed Fee (see **Capitation, Prospective Payment System**)**:** A method of reimbursement to an MCO or a provider for administrative services, contract deliverables, or some other service unit, usually paid monthly; such fees are

often established through competitive bidding and through budget negotiations and remain fixed for a specified time, regardless of the actual costs.

Freedom of Choice (see also **Section 1915(b) Medicaid Waiver**)**:** A Medicaid term describing the requirement that a State must ensure that beneficiaries are generally free to obtain services from any qualified provider; based on section 1902(a)(23) of the Social Security Act.

Full Capitation (see also **Capitation** and **Partial Capitation**)**:** A payment method in which the health care entity is prepaid a fixed amount for each enrollee for providing all contractually defined administrative and covered clinical services; under this method the health care entity bears the financial risk for all services included in the benefit package.

Full Utilization Risk (see also **Risk-Bearing Entity, Risk Sharing**)**:** Risk-transfer arrangement in which the payer transfers to the service provider full responsibility for the potential rewards and costs of service utilization.

Gatekeeper (see also **Primary Care Case Management**)**:** An individual at the entry point of treatment, such as a utilization reviewer at an MCO or a primary care provider, who is responsible for initially assessing a consumer's needs, guiding the consumer to appropriate services, and restricting access to, or reimbursement for services, judged to be not medically necessary.

Global Budgets: A method of financing managed care based on a fixed, historically determined overall budget to serve the eligible population, often used when MCOs are unable to predict or reliably determine the number of eligible individuals or the likely number of enrollees; global budgets are often used to purchase a fixed amount of treatment capacity from providers to control the risk of overspending.

Group Model HMO (see **Health Maintenance Organization**)

Group Practice: An organized group of health care providers who generally share centralized administration and financial systems and who pool their income from the practice and redistribute it to group members according to prearranged terms; group practices vary widely in size, composition, and financial arrangements.

Health Benefit Plan: One of several methods of paying for health services by third-party payers, including HMOs, employers, insurance companies, various forms of pre-paid care, and government programs.

Health Care Financing Administration (HCFA): The agency within the U.S. Department of Health and Human Services that oversees the Medicaid and Medicare programs and conducts research to support those programs; HCFA maintains regional offices throughout the country, each responsible for working with a group of States.

Health Maintenance Organization (HMO): An entity with four essential attributes: (1) an organized health care system in a defined geographic area that accepts the responsibility to provide or otherwise ensure the delivery of (2) an agreed-upon set of basic and supplemental health maintenance, prevention, treatment, and rehabilitation services to (3) a voluntarily enrolled group of persons, and (4) for which services the entity is reimbursed through a predetermined fixed periodic prepayment made by, or on behalf of, each person or family unit enrolled. Six types of HMO models have been defined:

Staff model: The HMO delivers health services through a salaried group of physicians and other professionals who are employees of the HMO and provide services only to enrollees.

Group model: The HMO contracts with one independent group practice to provide health services.

Network model: The HMO contracts with two or more independent group practices, possibly including a staff group, to provide health services. Although a network may include a few solo practices, it is predominantly organized around groups.

Individual practice association model: The HMO contracts directly with physicians in independent practices, and/or contracts with one or more associations of physicians in independent practice, and/or contracts with one or more multi-specialty group practices; however, the plan is predominantly organized around solo/single specialty practices.

Mixed model: The HMO combines the model types listed above with no single predominant model.

Open-ended model: HMO enrollees can use out-of-plan providers or choose a provider at the point of service and receive partial or full coverage for the services.

Health Plan Employer Data and Information Set (HEDIS) (see also **Report Card on Health Care**)**:** A set of performance measures designed by the National Committee for Quality Assurance (NCQA) to enable health plans, employers, and others to compare the performance of different health plans.

Holdback (see also **Withhold**)**:** A form of reimbursement whereby an MCO withholds or sets aside payments to a provider until the end of a specified period, at which time the MCO distributes any surplus funds based on measures of providers' efficiency or performance; the measures reflect pre-established criteria for financial performance, productivity, utilization, and/or quality of care.

Hold Harmless Clause: A provision in a managed care contract that protects ("holds harmless") the MCO from all costs involved in defense, settlement, and judgment of patients' claims of injury, regardless of potential malpractice, negligence, or policies of the MCO. Also a clause that prohibits a provider from seeking payment from an enrollee if the health plan becomes bankrupt.

Horizontal Network (see also **Individual/Independent Practice Association (IPA), Physician-Hospital Organizations, Vertical Network**)**:** A network formed by similar types of providers to enhance efficiencies and improve service delivery, negotiate with a vertical network, and/or negotiate managed care contracts directly with payers.

Incentives: Economic or other rewards often included in a contract to encourage an MCO to achieve the purchaser's goals for care delivery and outcomes.

Incurred But Not Reported (IBNR) Claims: Claims associated with services already provided but not yet submitted to a payer.

Indemnity Insurance: An insurance contract that provides benefits in the form of cash payments for covered services already provided; rates and limits for different services are pre-established, and the beneficiary or provider must file a claim.

Indicator (see also **Outcome Measure, Performance Measure**)**:** A defined and measurable variable used to assess patient outcome or MCO and provider effectiveness and quality of care.

Indigent Care: Health services provided to those who cannot pay for them because of insufficient income or assets and/or lack of adequate health insurance.

Individual/Independent Practice Association (IPA) (see also **Horizontal Network, Provider-Sponsored Network, Vertical Network**)**:** A form of health care practice in which providers are organized into a group via a contract, an arrangement that facilitates their contracting with several health care plans; providers generally remain in their independent offices, seeing both enrollees of the IPA and private-pay patients.

Inpatient Care: Twenty-four hour in-residence health care in an acute care setting, such as a hospital, nursing home, or other medical or psychiatric institution.

Institution for Mental Disease (IMD): A hospital, nursing facility, or other institution with more than 16 beds engaging primarily in the diagnosis and treatment of persons with mental diseases.

Integrated Services Network: A network of organizations, usually including hospitals and physician groups, that provides or arranges to provide a coordinated continuum of services to a defined population and is clinically and fiscally accountable for outcomes. Also known as an organized delivery system.

Intensive Case Management: Comprehensive community services for patients with severe and persistent mental illness, including evaluation, outreach, and support services, usually provided on patients' own turf; the case manager

(or the team) generally advocates for the patient with community agencies and arranges services and supports; the case manager may teach community living and problem-solving skills, model productive behaviors, and help patients help themselves.

Joint Commission on Accreditation of Healthcare Organizations (JCAHO): A national, private, nonprofit organization whose purpose is to encourage the attainment of uniformly high standards of medical care via stringent accreditation; JCAHO establishes standards for the operation of hospitals and other health care facilities.

Lag Factor: Percentage of claims incurred in a given accounting period but received, processed, and paid in a subsequent period.

Last-Dollar Coverage: Coverage for services in which no arbitrary upper limits or maximums are imposed, such as a maximum or lifetime limit.

Lead Agency: A provider agency designated as the leader in a collaborative venture of several agencies and vested with full clinical responsibility, fiscal authority, and overall responsibility for contracting or otherwise arranging for needed services from external specialized agencies or other health and human service systems.

Length of Stay: The number of days a consumer spends in an inpatient facility, such as a hospital, usually reported as the number of days between admission and discharge; can also refer to number of visits in a nonresidential setting.

Loading (see also **Risk Load**)**:** A factor incorporated into a capitation rate to adjust for coverage of individuals and groups with certain characteristics used in conjunction with straightforward discounting.

Lock-In Feature: A requirement that enrollees in a health plan must obtain all nonemergency care from that plan.

Maintenance Interventions: Behavioral health services, which are generally supportive, educational, and/or pharmacological in nature, that are designed to avoid deterioration of a condition or illness and are provided on a long-term basis to individuals who have met *Diagnostic and Statistical Manual* (DSM) diagnostic criteria and whose underlying illness continues. The two components of maintenance interventions are (1) the provision of rehabilitative aftercare, and (2) support of patients' compliance with long-term treatment to prevent recurrence of acute incidents.

Managed Care: A system used by payers to control health care costs while ensuring accessible, effective, and efficient care for beneficiaries. The system uses gatekeepers, a preselected provider network, service preauthorization, case management, utilization review, and medical necessity review, as well as formal programs, such as provider credentialing and outcomes evaluation, to monitor quality; financial incentives are employed for beneficiaries to use the plan's providers and for providers to contain costs.

Managed Care Organization (MCO): An entity that employs the methods of managed care for the purpose of controlling health care utilization and costs and improving access and quality. Some MCOs provide only administrative, and not clinical, services (see **Administrative Services Only (ASO) Organization**).

Managed Fee-for-Service (Indemnity) Plan (see also **Fee-for-Service Payment, Indemnity Insurance**)**:** A health care benefit plan in which the cost of covered services is paid by the insurer after services have been used. Various managed care tools such as precertification, second surgical opinion, utilization review, and preselected provider panels are used to control inappropriate utilization.

Management Information System (MIS): Computer-based methods of information collection, storage, management, analysis, and reporting to support the operation and management of an organization or system.

Manual Rates: Standard rate tables included in an insurer's rate manual or an underwriter's manual that are used to determine premiums.

Maximum Dollar Limit: The maximum amount of money that a health plan or insurance company will pay for claims; limits may be based on types of illnesses, types of services, or annual or lifetime amounts. Annual or lifetime limits for treatment for mental illness are often less than the limits for other illnesses.

Medicaid: A Federal program enacted in 1965 (authorized by Title XIX of the Social Security Act) operated individually by participating State and Territorial governments that provides medical benefits for eligible aged, blind, disabled, and low-income persons. Subject to broad Federal guidelines, States determine who is eligible, benefits covered, rates of payment for providers, and methods of administering the program. Costs are shared by the Federal and State governments.

Medicaid Mandatory Services: Services that the Federal Government requires to be included in a State's Medicaid program, such as a hospital nursing facility, physicians' services, and laboratory and x-ray services. The State can limit mandatory services (e.g., number of days, visits).

Medicaid Optional Services: More than 30 different services that a State may elect to cover under Medicaid; mental health optional services include case management, clinic services, and psychosocial rehabilitation.

Medicaid State Plan: The document describing a State's Medicaid program. Each state is required to submit a plan to HCFA for approval. It can be amended annually, with HCFA approval, to delete or add optional services or alter limits on the amount, duration, and scope of services.

Medicaid Waiver (see also **Section 1115 Medicaid Waiver**)**:** A provision of Federal law that allows HCFA to approve a State's Medicaid plan even though it does not comply with all Federal requirements as long as certain safeguards and other criteria are met.

Medical Management Information System: A data system that allows payers and purchasers to track health care utilization and expenditures.

Medical Necessity: Services and supplies that are (1) appropriate and necessary for the symptoms, diagnosis, or treatment of sickness or injury; (2) provided for the diagnosis or direct care or treatment of sickness or injury; (3) within the standards of good practice; (4) not primarily for the convenience of the plan member or provider; and (5) the most appropriate level of care that can safely be provided. Medical necessity can be interpreted restrictively to deny clinically appropriate services to address psychosocial problems of persons with addictive and mental disorders.

Medicare: A Federal health insurance program (authorized by Title XVIII of the Social Security Act) for people aged 65 and over, for persons eligible for Social Security Disability Insurance (SSDI) payments for two years or longer (severely disabled individuals), and for certain workers and their dependents who need kidney transplantation or dialysis. Medicare consists of two separate but coordinated programs: hospital insurance/inpatient costs (Part A) and supplementary medical insurance/outpatient costs (Part B).

Member (see also **Beneficiary, Consumer, Enrollee, Subscriber**)**:** An individual or dependent who is enrolled in and covered by a health care plan.

Mental Health Statistical Improvement Program (MHSIP) Report Card (see also **Report Card on Health Care**)**:** A provider report card, developed by the Mental Health Statistics Improvement Program of the Center for Mental Health Services and published in April 1996, that focuses on data of particular relevance to consumers, such as quality of life outcomes.

Morbidity: Incidence and severity of illness, injury, or disability in a defined population, usually expressed in rates of incidence or prevalence (e.g., 150 cases per 100,000 population).

Morbidity Risk: A form of direct financial risk assumed by a health plan or insurer that results from the amount of psychopathology and psychiatric morbidity in the population.

Mortality: Death; the mortality rate expresses the number of deaths in a population within a given time and may be expressed as a crude death rate (e.g., total deaths in an entire population in a given year) or as rates for specific diseases or for groups based on age, sex, or other attributes (e.g., number of deaths from cancer in white males in a given year).

Multiple Option Plan: A health plan that offers the enrollee a choice of plan types, such as an indemnity plan, an indemnity plan with a preferred provider organization option, or a health maintenance organization.

National Committee for Quality Assurance (NCQA): An organization founded in 1979 and governed by a 14-member board of directors representing consumers, purchasers, and providers of managed health care that accredits programs in prepaid managed health care organizations and develops and coordinates standards and programs for quality assessment in the managed care industry.

Network (see also **Horizontal Network, Individual/Independent Practice Association, Physician-Hospital Organizations, Provider-Sponsored Network, Vertical Network**)**:** A system of provider groups and solo providers contracted by a managed care plan to deliver services. A structure of health care providers that allows for collaborations, affiliations, consolidations, joint ventures, and strategic alliances through formal and informal contracts and agreements.

Nonparticipating Provider: A provider who has not contracted with a given health plan.

Omnibus Budget Reconciliation Act of 1986 (OBRA '86): A comprehensive Federal law taking effect in 1991, one provision of which prohibits HMOs from making payments directly or indirectly to providers as an inducement to reduce or limit services to Medicare or Medicaid patients.

Open Enrollment Period: A specified time during which a health plan must accept all who apply, and members are allowed to change plans without restriction; it is a method to ensure that plans do not exclusively select enrollees who are good risks.

Open Panel: A feature of a health plan that offers a variety of types of treatment providers that subscribers can use for their health care without overly restrictive liability.

Outcome Measure: An indicator used to assess a consumer's change in health status after having received health care services.

Outcomes: The results of receiving health care services; outcomes are measured in a variety of ways, including decreased morbidity and mortality, symptom reduction, recovery from substance use disorders, physical and emotional functioning, quality of life, and consumer satisfaction. Both short- and long-term outcomes are measured.

Outcomes Management: Systematic efforts to improve the results of health care services, using established outcome measures.

Outcomes Research: Formal studies measuring changes in consumers' status resulting from specific interventions; such studies require careful methodologies to distinguish the effects of care from the effects of the many other factors that influence patients' health and satisfaction.

Outlier: Departure from an average, usually defined as at least two standard deviations from the mean; a hospital admission requiring either substantially more expense or a much longer length of stay than is typical for patients with a given condition or illness. Under Diagnosis-Related Group payment, patients who are outliers are given exceptional treatment subject to peer review and organization review.

Outpatient Care (see also **Ambulatory Care**)**:** Treatment delivered in a noninpatient (i.e., non-24-hour) setting; generally a less costly and less restrictive form of care.

Overutilization: Unnecessary or excessive use of services, often said to be a risk in fee-for-service reimbursement systems.

Partial Capitation (see also **Full Capitation, Per Capita**)**:** A method of payment in which some services are funded based on a risk-transfer contracting arrangement and some are funded through fee-for-service or other traditional forms of payment (e.g., inpatient services may be capitated while outpatient services are provided on a fee-for-service basis).

Payer: An employer, insurance company, prepaid health plan, or government agency that is legally obligated to pay for certain health-related services.

Peer Review: Evaluation by practicing physicians or other professionals of the effectiveness and efficiency of services ordered or performed by their peers; a form of utilization review. Also refers to the review of research by other researchers.

Peer Review Organization (PRO): A professionally sponsored and operated system, usually a physician-directed organization or program, for review of professional judgment about quality or appropriateness (medical necessity) of treatment; PROs arbitrate disagreements between physicians and other providers and third parties.

Penetration: A marketing concept that describes the proportion of a market or population that has contracted for services with an MCO; the percentage of possible enrollees accessing care.

Per Capita Payment (see also **Capitation, Full Capitation, Partial Capitation**)**:** A fixed per person amount paid by a purchaser to a provider for services during a specific time, usually expressed as a per member, per month rate; based on the number of enrollees or individuals covered, regardless of the number actually receiving services or the amount of services delivered.

Performance Goal: The desired level of achievement of standards of care or service; may be expressed as minimum performance levels (thresholds), industry-best performance (benchmarks), or the permitted variance from the standard. Performance goals usually are not static but change as performance improves and/or the standard of care is refined.

Performance Measure: An indicator used to assess a health plan's or provider's delivery of care as it conforms to practice guidelines, medical review criteria, or standards of quality; adherence to performance standards is expected to lead to desirable outcomes, but performance measures do not directly measure these outcomes.

Performance Payments: Incentive payments or bonuses to reward managed care organizations and providers for achievement of the purchaser's desired performance goals.

Personal Responsibility and Work Opportunity Act of 1996: A law that turns control of welfare over to the States; limits lifetime benefits to 5 years; requires adults to work after 2 years; and denies assistance to noncitizens.

Physician-Hospital Organization (PHO) (see also **Individual/Independent Practice Association, Provider-Sponsored Network, Vertical Network**)**:** A legal entity formed by combining a hospital and a group of physicians/providers into a collective negotiating and contracting unit for the purpose of obtaining contracts with health plans; typically owned and governed jointly by a hospital and shareholder physicians. Providers maintain ownership of their practices and accept managed care patients according to the contract terms.

Plan Administration (see also **Administrative Services Only**)**:** Management of a health benefit plan, including accounting, billing, personnel, marketing, legal services, claims paying, purchasing, and servicing of accounts.

Point-of-Service Plan: A health plan in which members can choose non-network providers who are reimbursed by a standard indemnity coverage, with members paying a larger portion of the fee. This plan is sometimes called an open-ended HMO.

Practice Guidelines: Systematically developed recommendations for the most appropriate diagnostic and treatment approaches for certain medical and mental illnesses, developed to standardize care and to facilitate decisions about appropriate care; generally, guidelines are based on scientific evidence and expert opinion. Also referred to as clinical criteria, practice parameters, protocols, algorithms, review criteria, preferred practice patterns, and guidelines.

Pre-Existing Condition: An illness or condition that is excluded from coverage by a purchaser because the condition existed before enrollment in the plan; coverage may be limited for a period of time, or indefinitely, creating significant obstacles to access to care.

Preferred Provider Organization (PPO): A formally organized entity of hospital and outpatient providers that agrees to accept discounted fees for treating enrollees of a managed care plan in return for prompt payment and an expectation of a larger volume of patients. Enrollees may choose non-PPO providers but usually pay a higher portion of the costs than for PPO providers.

Premium: Rate that a subscriber (either an employer or an individual) pays for a health benefit plan.

Prepaid Group Practice (PGP): A group model HMO or multispecialty association of physicians and other health professionals that accepts a fixed payment from a managed care plan to provide a wide range of preventive, diagnostic, and treatment services to a defined population; the fixed amount is determined in advance for each year.

Prepaid Health Plan (PHP): A health plan, such as an HMO, in which subscribers (or employers) pay the insurer in advance for access to a defined set of health care benefits.

Prepaid Individual Practice (see also **Independent/Individual Practice Association**)**:** Individual physicians or small physician groups who accept a fixed payment from a managed care plan for providing care in their offices to enrollees.

Preventive Care: Health care interventions that emphasize wellness, via prevention, early detection, and early treatment, including routine physical examination, immunization, well-person care, and patient education.

Preventive Interventions: Services designed to reduce the probability of development of clinically demonstrable substance abuse and mental health problems. They consist of (1) universal interventions targeted to a population group that has not been identified on the basis of individual risk (e.g., substance abuse prevention curricula required of all public school students); (2) selective interventions targeted to individuals or a subgroup of the population whose risk of developing clinical problems is significantly higher than average (e.g., bereavement support groups for low-income widows and widowers, life skills programs for chronically truant students); and (3) indicated interventions for individuals with minimal but detectable signs or symptoms foreshadowing mental or substance use disorders (e.g., parent-child interaction training for children identified as having persistent conduct problems).

Prevention Strategies: Prevention strategies include a broad array of activities including: (1) information, (2) education, (3) alternative activities, (4) problem identification and referral, (5) community-based processes, and (6) environmental approaches. (Reference 96.125 of the *Federal Register,* March 31, 1993, for definitions of these strategies.)

Primary Care Case Management (PCCM), Primary Care Gatekeeper Model: A utilization management strategy in which a primary care physician manages a patient's use of health services by acting as a gatekeeper who approves all referrals and monitors all covered services and who is paid for performing this role.

Primary Care, Primary Care Provider: Basic health care services that are generally administered by internists, family practitioners, pediatricians, or obstetricians/gynecologists in an ambulatory setting; usually regarded as general care received at the point at which the patient first seeks care from a medical system. Primary care is increasingly provided by nurse practitioners and physician assistants. Comprehensive primary care involves a primary provider who takes responsibility for a patient's overall health, whether problems are biological, behavioral, or social.

Primary Prevention: Programs directed at individuals and a subgroup of the population who do not require treatment for substance abuse. This includes educating and counseling on such abuse and providing for activities that reduce substance abuse and/or use.

Prior Authorization: A utilization management strategy that requires a provider to justify, in advance to a third-party utilization reviewer, the need for a particular treatment in order to be reimbursed for that treatment. Also called precertification, preauthorization, predetermination.

Proprietary: Owned and operated for the purpose of making a profit, whether or not one is actually made; often refers to materials developed and owned by the company that cannot be freely shared.

Prospective Payment System (PPS) (see also **Full Capitation, Partial Capitation, Per Capita Payment**)**:** Any payment system in which the amount to be paid to the provider is set before services are delivered, generally for the coming year. That amount is paid regardless of the number of enrollees served or the amount of services delivered.

Provider-Sponsored Network (PSN) (see also **Individual/Independent Practice Association, Physician-Hospital Organizations, Vertical Network**)**:** A formal alliance of providers formed into an integrated health care network for the purpose of contracting with payers to provide services to beneficiaries.

Purchaser (see also **Payer**)**:** A person, insurer, employer, health plan, or government agency that purchases health care for an individual.

Quality Assessment: Measurement of the structure of care, its processes, and its outcomes using predetermined performance and outcome indicators.

Quality Assurance: Objectively and systematically monitoring the process and outcomes of care to ensure and improve its quality by use of frequent performance and outcomes measurement.

Quality Assurance Reform Initiative (QARI): A process developed by the Health Care Financing Administration (HCFA), which created a health care quality improvement system for Medicaid managed care plans.

Quality Improvement: A set of techniques based on a feedback loop that focus on the ongoing improvement of treatment processes and outcomes by identifying problem areas, introducing improvements, and reassessing changes. Continuous Quality Improvement (CQI) and Total Quality Management (TQM) use consumer-oriented interdisciplinary teams to gather and assess data and to implement changes to better meet the needs and expectations of consumers.

Quality of Care: The degree to which health services meet established standards, are consistent with current professional knowledge, and maximize the probability of beneficial health outcomes while minimizing risk and other untoward outcomes. Quality is often described as having three dimensions: quality of resources (certification and training of providers), quality of the process of service delivery (the use of appropriate procedures), and quality of outcome of services (improvements in a patient's condition or reduction of harmful effects).

Reconciliations: Adjustments, usually retroactive, to capitation rates or other risk-transfer payments and an accounting reconciliation at the end of the agreed-upon period of performance.

Referral: The process of a health care provider or gatekeeper sending a patient to another provider for health care services; some health plans require primary care providers to authorize referral for specialty services.

Reimbursement: The process by which health care providers receive payment for their services. In health care, providers are often reimbursed by third parties who insure and represent patients.

Reinsurance: Separate insurance purchased by a health benefit plan from a third party to protect itself against losses that are not easily managed or are unpredictable; it limits the losses of the health benefit plan if expenses exceed the revenues from capitation payments.

Report Card on Health Care(see also **Health Plan Employer Data and Information Set [HEDIS]**)**:** A systematic presentation of data collected periodically from health plans that profiles their performance and outcomes; it can be used by policymakers and health care purchasers (employers, government bodies, employer coalitions, and consumers) to compare these plans. Data in major areas of accountability are provided, such as health care quality and utilization, delivery of appropriate services, patient outcomes, consumer satisfaction, administrative efficiencies and financial stability, and cost control.

Request for Information (RFI): A document used to solicit input from interested individuals on such issues as program design and network development and capacity, and to seek information on potential bidders.

Request for Proposal (RFP): A solicitation document issued to obtain offers from bidders that propose to provide products or services under a contract to be awarded using the process of negotiation.

Reserves: The practice of withholding a certain percentage of premiums to provide a fund for committed but undelivered health care, uncertainties, contingencies, overutilization of referrals, accidental catastrophes, and other situations; such accounts are sometimes used by public purchasers to safeguard public funds in the event of the managed care organization's financial weakness or failure.

Retrospective Reimbursement (see also **Fee-for-Service Payment**)**:** Payment made after services are delivered on the basis of the costs incurred to deliver them (compare **Prospective Payment System**).

Retrospective Review (see also **Concurrent Review**)**:** A form of utilization review conducted after services are provided to determine if the services met the requirements of the payer to justify reimbursement.

Rider: A legal addendum or provision that modifies a contract, usually in regard to expanding or decreasing coverage of certain conditions or expanding or limiting certain services.

Risk: The cost of health services. In managed care, the liability and chance of financial loss that a health plan or provider organization assumes when it agrees in a prospective payment system to provide a defined set of services to a specific population for a predetermined fee per enrollee, regardless of the amount of services eventually provided; loss occurs when the revenues of the purchaser are not sufficient to cover expenditures incurred in the delivery of services. Capitation financing has moved risk, as well as the potential reward, from the purchaser to the provider.

Risk Adjustment: A process that takes into account the health status and risk profile of enrollees in certain health plans (e.g., severity of illness, comorbidity, consumption of cigarettes and alcohol) and shifts premium dollars from a plan with relatively healthy enrollees to another with sicker members; this process minimizes financial incentives plans may have to select healthier than average enrollees. Those that attract higher risk enrollees are thus compensated for any differences in the proportion of their members that require high levels of care.

Risk-Bearing Entity: An organization that assumes financial responsibility for the provision of a defined set of benefits for some or all of the cost of care; the entity may be an insurer, a health plan or self-funded employer, a physician-hospital organization, a government agency, or another form of provider-sponsored network (PSN).

Risk Corridors, Risk Bands: The practice of limiting to a specified amount an MCO's exposure to losses and potential for profits; for example, losses and profits might be limited to 5 percent of premium or a predetermined dollar amount.

Risk Factor: An epidemiological term used in examining and quantifying the likelihood that morbidity or mortality will occur; a risk factor is analyzed along with many such factors and not regarded as a definitive predictor.

Risk Load (see also **Loading**)**:** A factor incorporated into a capitation rate to adjust for some adverse factor in the population or group in question.

Risk Pool: A defined account (e.g., defined by size, geographic location, claim dollars that exceed the level per individual, etc.) to which revenue and expenses are posted. A risk pool attempts to define expected claim liabilities and required funding to support the claim liability (combines risk for all or several groups of persons); an arrangement whereby part of a provider's payment is withheld and returned in proportion to the financial well-being of a health plan.

Risk Sharing: A variation of risk-transfer systems in which losses and profits are shared between two or more parties (e.g., between the purchaser and the managed care organization) in a contractually defined manner, rather than being assumed by one entity alone; this method spreads the risk of unplanned, unexpected financial loss resulting from underestimations of service needs.

Risk Transfer Systems: Methods of payment, including capitation, global budgets, and case-rate payment, that transfer the cost of services from the purchaser to an MCO or the provider.

Section 1115 Medicaid Waiver: A provision of the Social Security Act that waives, with the approval of the Health Care Financing Administration (HCFA), certain Medicaid requirements, allowing States to implement and evaluate the efficacy and cost-effectiveness of alternative delivery systems as long as the alternatives are likely to promote the objectives of Medicaid. The waivers allow States to radically change Medicaid program provisions, including eligibility requirements, the scope of services available, the freedom to choose a provider, a provider's choice to participate in a plan, the method of reimbursing providers, and the statewide application of the program.

Section 1915(b) Medicaid Waiver: A provision of the Social Security Act that allows States to require Medicaid recipients to enroll in HMOs or other managed care plans in an effort improve access to quality services and to control costs. The waivers allow States to implement a primary care case management system, require Medicaid recipients to choose from a number of competing health plans, provide additional benefits in exchange for savings

resulting from recipients' use of cost-effective providers, and limit the providers from whom beneficiaries can receive nonemergency treatment. The waivers are granted for 2 years, with 2-year renewals.

Self-Insurance, Self-Funding: A practice by which an organization (employer or group of employers) assumes complete financial responsibility for medical and/or behavioral health treatment costs for its members; insurance protection against excessive loss can be purchased. Benefits may be administered by the employer or handled through an administrative services only agreement with an insurance carrier or third-party administrator. Self-insured plans are exempt from State insurance laws and regulations.

Service Area (see also **Catchment Area**)**:** A geographic area served by a health plan or provider organization, such as a hospital or community mental health center, defined on the basis of such factors as population distribution, health resources, political boundaries, natural geographic boundaries, and/or transportation accessibility; facilitates effective planning, development, and delivery of health services.

Single-Stream Funding (Unified Funding Stream): The consolidation of multiple sources of funding into a single unified stream; a key approach used in progressive mental health systems to ensure that funds follow consumers and their service needs.

Skimming (see also **"Cherry Picking"**)**:** A practice, usually in a prospective payment system, by which a health plan attempts to enroll (by selection, policy, or other practices) only the most healthy subscribers and to systematically exclude less healthy individuals at higher risk for difficult or expensive treatment. A variation of skimming is the practice of providing only those services that are most favorably reimbursed by payers.

Social Health Maintenance Organization (S/HMO): A health maintenance organization that also provides a variety of social and preventive services to a special-needs population with unique long-term care requirements.

"Soft" Capitation: A capitation payment method in which the capitation rate can be modified by some form of risk sharing, allowing the rate to increase or decrease in certain circumstances.

<**Solo Practice:** Professional practice as a self-employed individual rather than in a group; also called private practice. It is not necessarily fee-for-service practice, as solo practitioners can be part of provider networks and accept capitated rates.

>**Staff Model HMO** (see **Health Maintenance Organization**)

Stop-Loss Insurance (see also **Reinsurance**)**:** Insurance coverage purchased by a payer to provide protection from losses that result when claims exceed prospective payments; used when risk is difficult to predict or manage. Such insurance often covers claims for any enrollee that exceed a predetermined deductible, such as $25,000 or $50,000, or situations in which total claims exceed a predetermined level, such as 125% of the amount expected in an average year.

Stop-Loss Provision: A provision in a risk-based contract that caps the amount of money for which an MCO is liable or establishes the maximum expense a provider can incur before the capitation rate structure changes. In a stop-loss agreement, the purchaser agrees to provide additional payment to the MCO in certain situations of loss. Also the maximum amount a beneficiary will have to pay out-of-pocket for deductible or coinsurance or copayments.

Subcapitation: A form of payment in which an MCO enters into prepaid agreements with providers, thus transferring some or all of the risk.

Subscriber (see also **Beneficiary, Consumer, Enrollee, Member**)**:** The individual (or employment group) who contracts for services with a prepaid health plan; the term does not include other individuals (e.g., family members) who may receive services as a result of this contract.

Substance Abuse and Mental Health Services Administration (SAMHSA): A U.S. Public Health Services agency whose mission is to provide a national focus for the Federal effort to promote effective strategies for prevention and treatment of addictive and mental disorders. It is primarily a grantmaking organization, promoting knowledge and scientific state-of-the-art practice. It strives to reduce barriers to high quality, effective programs and services for individuals who suffer from, or are at risk for, these disorders, as well as for their families and communities.

Supplemental Security Income (SSI): Title XVI of the Social Security Act established the Social Security Administration's program of direct payments to the aged, blind, and disabled poor. In most States, SSI recipients are categorically eligible for Medicaid.

Targeted Case Management: Medicaid term for case management services covered under Title XIX of the Social Security Act (as of November 1995). Federal law defines targeted case management as services that will assist individuals eligible under the State Medicaid plan in gaining access to needed medical, social, educational, and other services.

Third-Party Payer: The entity (e.g., insurer, State agency) responsible for paying for health care services delivered by a provider to a beneficiary; the first party is the person receiving the services and the second party is the provider.

Third-Party Payment: Payment for health care by a party other than the beneficiary.

Third-Party Revenue: Revenue for health services from commercial payers or from a State or government agency that offsets the costs of the program purchased by the county.

Transferability: An agreement between two or more health plans that they will accept the other's enrollees when an enrollee changes residency from one plan's service area to another's.

Treatment Interventions: Therapeutic services designed to reduce the length of time a disorder exists, halt its progression of severity, or if not possible, increase the length of time between acute episodes. An Institute of Medicine typology divides treatment into (1) case identification and (2) treatment for the identified disorder, to include interventions to reduce the likelihood of future co-occurring disorders.

Triage: The process of determining the degree of urgency of a client's needs and arranging for the appropriate level of care, either through referral or immediate treatment.

Underwriting: The process by which an insurer assumes liability for an insured party.

Usual, Customary, and Reasonable (UCR): The average fee charged by a type of health care practitioner for a specific service in a geographic area; the amount is often used by payers as the basis for reimbursing providers.

Utilization: The extent to which enrollees use a program or service; commonly examined in terms of patterns or rates of use of a single service or type of service (e.g., inpatient care, physician visits).

Utilization Management (see also **Case Management, Concurrent Review, Prior Authorization, Retrospective Review, Utilization Review**)**:** A set of techniques used by or on behalf of purchasers of health benefits to manage health care costs by influencing decisions about patient care made by providers, payers, and patients themselves.

Utilization Rates: Patterns of use of a single service or type of service, usually expressed in rates per enrollee, per 100,000 population, or for a period of time, such as a calendar year.

Utilization Review (see also **Utilization Management**)**:** A process used by a third party to assess whether a recommended treatment is medically necessary and appropriate based on standards of practice, practice guidelines, and other protocols.

Vertical Network (see also **Individual/Independent Practice Association, Provider-Sponsored Network**)**:** A network formed by different types of providers to offer comprehensive services (e.g., inpatient, residential, outpatient, specialized, and primary care) and to enhance efficiencies for the purpose of negotiating managed care contracts.

Withholds (see also **Holdback**)**:** A form of reimbursement whereby an MCO withholds or sets aside payments to a provider until the end of a specified period, at which time the MCO distributes any surplus funds based on measures of providers' efficiency or performance. Withholds often are 10 to 20 percent of fees and give providers an incentive to operate cost-effectively.

Resources

American Managed Behavioral Healthcare Association
700 13th Street, NW, Suite 950
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Tel: (202) 434-4565
Fax: (202) 434-4564
Website: *www.ambha.org*

American Methadone Treatment Association, Inc.
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Tel: (212) 566-5555
Fax: (212) 349-2944

American Psychiatric Association
1400 K Street, NW
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Tel: (202) 682-6000
Fax: (202) 682-6114
Website: *www.psych.org*

American Psychological Association
750 First Street, NE
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Fax: (202) 336-5501
Website: *www.apa.org*

American Public Health Association
1015 15th Street, NW, Suite 300
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Website: *www.apha.org*

American Public Welfare Association
810 1st Street, NE, Suite 500
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American Society of Addiction Medicine
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Website: *www.asam.org*

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Website: *www.bazelon.org*

Center for Health Policy Research
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Center for Mental Health Services
Substance Abuse and Mental Health
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Fax: (301) 443-1563
Website: *www.mentalhealth.org*

Center for Substance Abuse Prevention
Substance Abuse and Mental Health
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5600 Fishers Lane, Rockwall II
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Fax: (301) 443-5447
Website: *www.health.org*

Center for Substance Abuse Treatment Substance Abuse and Mental Health Services Administration 5515 Security Lane, 8th Floor Rockville, MD 20852 Tel: (301) 443-5052 Website: *www.treatment.org*

Centers for Disease Control and Prevention
1600 Clifton Road, NE
Atlanta, GA 30333
Tel: (404) 639-3311
Website: *www.cdc.gov*

CentraLink/Institute for Behavioral Healthcare
4370 Alpine Road, Suite 209
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Website: *www.ibh.com*

Commission on Accreditation of Rehabilitation
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Website: *www.carf.org*

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700 13th Street, NW, Suite 950
Washington, DC 20005
Tel: (202) 434-4525
Fax: (202) 434-4592 or 99
Website: *www.jcaho.org*

Legal Action Center
236 Massachusetts Avenue, NE, Suite 505
Washington, DC 20002
Tel: (202) 544-5478
Fax: (202) 544-5712

Mental Health Corporations of America, Inc.
2846-A Remington Green Circle
Tallahassee, FL 32308
Tel: (850) 385-5954
Fax: (850) 422-2012
Website: *www.mhea.com*

National Academy for State Health Policy
50 Monument Square, Suite 502
Portland, ME 04101
Tel: (207) 874-6524
Fax: (207) 874-6527
Website: *www.nashp.org*

National Alliance for the Mentally Ill
200 North Glebe Road, #1015
Arlington, VA 22203
Tel: (703) 524-7600
Fax: (703) 524-9094
Website: *www.nami.org*

National Association of Alcohol and Drug Abuse Counselors
1911 N. Fort Myer Drive, Suite 900
Arlington, VA 22209
Tel: (703) 741-7686
Fax: (703) 741-7698
Website: *www.naadac.org*

National Association of Case Management
37 Coconut Lane

Ocean Ridge, FL 33435
Tel: (561) 364-1349
Fax: (561) 735-4893

National Association of County and City Health Officials
440 1st Street, NW, Suite 450
Washington, DC 20001
Tel: (202) 783-5550
Fax: (202) 783-1583
Website: *www.naccho.org*

National Association of County Behavioral Health Directors
6000 Lamar Street, Suite 130
Mission, KS 66202
Tel: (913) 384-3535
Fax: (913) 791-5653
Website: *www.naco.org/affils/afflpres.htm#16*

National Association of Protection and Advocacy Systems
900 Second Street, NE, Suite 211
Washington, DC 20002
Tel: (202) 408-9514
Fax: (202) 408-9520
Website: *www.protectionandadvocacy.com*

National Association of State Alcohol and Drug Abuse Directors
808 17th Street, NW
Washington, DC 20006
Tel: (202) 293-0090
Fax: (202) 293-1250
Website: *www.nasadad.org*

National Association of State Medicaid Directors
810 First Street, NE, #500
Washington, DC 20002
Tel: (202) 682-0100
Fax: (202) 289-6555
Website: *www.medicaid.apwa.org*

National Association of State Mental Health Program Directors
66 Canal Center Plaza, Suite 302
Alexandria, VA 22314
Tel: (703) 739-9333
Fax: (703) 548-9517
Website: *www.nasmhpd.org*

National Clearinghouse for Alcohol and Drug Information
P. O. Box 2345
Rockville, MD 20847-2345
Tel: (800) 729-6686/(301) 468-2600
Fax: (301) 468-6433
Website: *www.health.org*

National Committee for Quality Assurance
2000 L Street, NW, Suite 500
Washington, DC 20036
Tel: (202) 955-3500
Fax: (202) 955-3599
Website: *www.ncqa.org*

National Council for Community Behavioral Healthcare
12300 Twinbrook Parkway, Suite 320
Rockville, MD 20852
Tel: (301) 984-6200
Fax: (301) 881-7159
Website: *www.nccbh.org*

National Council on Alcoholism and Drug Dependence
12 W. 21st Street, 7th Floor
New York, NY 10010
Tel: (212) 206-6770
Fax: (212) 645-1690
Website: *www.ncadd.org*

National Institute of Mental Health
National Institutes of Health
Parklawn Building, Room #7C02
5600 Fishers Lane
Rockville, MD 20857
Tel: (301) 443-4513
Fax: (301) 443-4279
Website: *www.nimh.nih.gov*

National Institute on Alcohol Abuse and Alcoholism
National Institutes of Health
Wilco Building, Suite 409
6000 Executive Blvd., MSC-7003
Bethesda, MD 20892
Tel: (301) 443-3860
Fax: (301) 480-1726
Website: *www.niaaa.nih.gov*

National Institute on Drug Abuse
National Institutes of Health
Parklawn Building, Room 10A-39
5600 Fishers Lane
Rockville, MD 20857
Tel: (301) 443-6245
Fax: (301) 443-7397
Website: *www.nida.nih.gov*

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314-2971
Tel: (703) 684-7722
Fax: (703) 684-5968
Website: *www.nmha.org*

National Technical Assistance Center
Georgetown University Child Development Center 3307 M Street, NW, Suite 401
Washington, DC 20007
Tel: (202) 687-5000
Fax: (202) 687-8899
Website: *www.dml.georgetown.edu/depts/pediatrics/gucdc/index.html*

Substance Abuse and Mental Health Services Administration
Parklawn Building, Room 12-105
5600 Fishers Lane
Rockville, MD 20857
Tel: (301) 443-8956
Fax: (301) 443-9050
Website: *www.samhsa.gov*

Utilization Review Accreditation Committee

1275 K Street, NW, Suite 1100
Washington, DC 20005
Tel: (202) 216-9010
Fax: (202) 216-9006
Website: *www.urac.org*

Appendix A--A Standard Request for Proposal (RFP)

Standard RFP specifications, characteristics, and components are listed below (Bazelon Center for Mental Health Law, 1995;Dougherty, 1996; Horvath and Kaye, 1995; IOM, 1996;Litwak, 1997; Rosenbaum et al., 1997).

Standard RFP Specifications

The role of the managed care organization (MCO) within the rest of the system;

The clinical, operational, and financial structures of the managed care arrangement;

The maximum time periods within which patients can access different types of care (adjusted for type of care, severity of need, and geographical factors);

The specific services to be provided by the MCO (and those not provided);

The purchaser's expectations about standards of care;

The mechanisms by which enrollees can access and use clinical services;

The methods by which access, quality, and outcomes will be measured;

The means by which the MCO's compliance with contract provisions will be measured, monitored, evaluated, and enforced;

Incentives and sanctions (penalties) associated with specified and obtainable performance standards and the conditions for applying them; and

Specific mechanisms to identify and resolve any differences of interpretation of contract language and to modify the contract as needed.

Standard Structural Characteristics of an RFP

Program Parameters:

The eligible population;

Clinical, social, and residential services covered;

Limitations of covered services;

Definition of medical necessity;

Geographic coverage; and

Funding sources.

Content Areas:

Clinical system design requirements or limitations;

Network design requirements or limitations (including permissible risk sharing with provider system);

Enrollment procedures;

Member services requirements;

Quality management;

Claims payment;

Reporting requirements;

Data exchange and management information system; and

Implementation schedule.

Major Sections of the RFP:

The statement of work;

The services description and requirements;

The roles and responsibilities of the parties; and

The implementation requirements.

Standard Business, Financial, and Legal Specifications:

Qualifications of bidders;

Bidding process:

- Bidding conference;

- Manner of submission of proposals (e.g., due date, copies, structure, any required separation of bidder's program and financial proposals);

- Process for review of proposals;

- Site visits policy; and

- Opportunity (if any) for clarification of amendment of bids.

Minimum financial requirements for bidders, financial arrangements between the State and the MCO;

Risk reserve requirements;

Limitations on profit or reinvestment of surplus;

Permissible financial arrangements between MCO and provider networks; and

Legal requirements:

- Right of the State or county to withdraw procurement and withhold award;
- Conflict of interest;

- Contact between purchaser and bidders;

- Conditions for final awards; and

- Contract to follow RFP award.

Standard Components of an RFP

Bidder's cover letter or transmittal letter noting key objectives and timetable for submission (see Appendix B of this guide);

Definition of terms;

Summary of overall objectives of the initiative;

Description of the specific eligibility categories of recipients;

Descriptions of all services to be delivered by the contractor, including covered direct services and any administrative and management services. Alternatively, the RFP could include a set of purchasing specifications that are incorporated into the RFP and the contract. The services of the contractor will include, but not be limited to:

- Enrollment and eligibility determination responsibilities;

- Member services support;

- Network development and management;

- Utilization management;

- Quality management;

- Management information systems;

- Claims payments;

- Federal and third-party revenue activities; and

- Procedures for the administration of complaints and appeals.

Procedures and requirements for all activities that are expected of the contractor, including meetings, reporting, and deliverables, among others;

Summary of the purchaser's responsibilities;

All requirements for the contract, such as dates of implementation and period of contract;

Description of the financing and reimbursement models of the service system, including administrative payments, service payments, and requirements for provider payment;

Requirements for the proposal. This section would include detailed requirements for submission of the proposal, including required sections of the proposal, issues to be addressed, page lengths, format, and submission instructions. Proposals should contain a business proposal, a technical proposal, and a cost proposal;

Description of the proposal evaluation process. Bidders should generally be rated on their experience and capabilities in the following areas: customer service; network development and management; utilization management; quality management; complaints, grievances, and appeals; information systems; benefit management; and general administration;
Information on procurement, including addresses and phone numbers of responsible parties in the agency, dates of key events (e.g., due date, award date), and rights of the purchaser to modify the RFP; and

Contract close-out procedures and requirements in the event of a cancellation of the contract.

Appendix B--Bidder's Transmittal Letter: Sample Specifications

In responding to a request for proposal (RFP), each bidder should submit along with its proposal to the agency that has issued the RFP a transmittal letter containing a number of affirmative statements and assurances. Each bidder's transmittal letter should include the following content:

The name and title of the chief executive officer or other individual authorized to legally bind the bidder;

The address of the bidder to be used for all notices sent by the purchasing agency;

A statement that the bidder is a corporation or other legal entity if it is the policy decision of the purchasing agency to solicit bids only from such organizations;

A statement identifying all addenda to the RFP issued by the purchasing agency that were received by the bidder. If no addenda have been received, the bidder should also so indicate;

A statement that no attempt has been or will be made by the bidder to induce any person or firm to submit or not to submit a proposal;

A statement of affirmative action that the bidder does not discriminate in its employment practices with regard to race, color, religion, sex, sexual orientation, marital status, political affiliation, national origin, or disability;

A statement that no cost or pricing information has been included in the technical proposal should the purchasing agency require to separate the two portions of the bidding procedure;

A statement that the bidder accepts the terms, conditions, criteria, and requirements set forth in the RFP;

A statement that the bidder accepts the purchasing agency's sole right to accept or reject any or all proposals submitted at any time;

A statement that the bidder accepts the purchasing agency's sole right to cancel the RFP at any time the agency desires;

A statement that the bidder accepts the purchasing agency's sole right to alter the timetables for procurement as set forth in the RFP;

A statement that the proposal submitted by the bidder has been arrived at independently without consultation, communication, or agreement for the purpose of restricting competition;

A statement that, unless otherwise required by law, the information in the proposal submitted by the bidder has not been knowingly disclosed by any bidder and that it shall not knowingly be disclosed by the bidder prior to the notice of intent to award;

A statement that no relationship exists, nor will exist, during the contract period should the bidder enter into a contract with the purchasing agency that interferes with fair competition or is a conflict of interest, and no relationship exists between the bidder and another person or organization that constitutes a conflict of interest with respect to an existing contract with the State;

A statement that no contact, direct or otherwise, has occurred with any purchasing agency employee or subcontractor of the agency as well as any entity providing consulting services in the development of the RFP;

A statement that no claim will be made for payment to cover costs incurred in the preparation of the submission of the proposal or any other associated costs; and

Each person signing the proposal should also certify that he or she is the person in the bidder's organization responsible for the decision as to prices being offered and that the organization and its agents have not participated, and shall not participate, in any action contrary to the RFP or contract conditions.

Appendix C--Definitions of Substance Abuse and Mental Health Services

Definitions of behavioral health services developed in the field that may be useful to purchasers of managed behavioral health care in developing requests for proposals (RFPs) and contracts are presented below.

The definitions of substance abuse treatment services presented here are adapted from the second edition of the American Society of Addiction Medicine's *Patient Placement Criteria for the Treatment of Substance-Related Disorders,* known as ASAM PPC-2 (ASAM, 1996). More complete definitions can be obtained from the original document.

The definitions of mental health services presented here were developed by the mental health community, under the leadership of the Bazelon Center for Mental Health Law, during the failed 1994 national health care reform effort. The hope was that this set of definitions (or something similar) could be used as a framework for the mental health services in the health benefit package. Although the wording of these definitions is probably not as precise as that needed by purchasers of managed mental health care services, the definitions do illustrate how mental health services were organized and defined by stakeholders in 1994.

Definitions of Substance Abuse Treatment Services

Level 0.5: Early Intervention

Early intervention is an organized service delivered in a wide variety of settings designed to explore and address problems or risk factors that appear to be related to substance use and to assist the individual in recognizing the harmful consequences of inappropriate substance use.

Level I: Outpatient Services

Organized nonresidential services delivered in a wide variety of settings that meet State licensing or certification criteria, such as office practices, behavioral health clinics, and primary care clinics. Appropriately credentialed clinicians (e.g., physicians, counselors, psychologists, social workers) and addiction credentialed clinicians provide professionally directed evaluation, treatment, and recovery services to persons with substance-related disorders under a defined set of policies and procedures and provided in regularly scheduled sessions of usually fewer than 9 contact hours a week.

Skilled treatment services may include individual and group counseling, family therapy, educational groups, occupational and recreational therapy, psychotherapy, or other therapies. Support systems may include medical, psychological, psychiatric, laboratory, and toxicology services that are available through consultation or referral. Medical and psychiatric consultation are available within 24 hours by telephone and, if face-to-face, within a time appropriate to the severity and urgency of the consultation requested. The program is directly affiliated with more and less intensive levels of care and emergency services are available by telephone 24 hours a day, 7 days a week.

Level II: Intensive Outpatient/partial Hospitalization Services

Outpatient treatment in Level II involves a structured day or evening treatment program that may be offered before or after work or school, in the evening, or on a weekend. For appropriately selected patients, such programs provide essential education and treatment components while allowing patients to apply their newly acquired skills within "real-world" environments. Programs have the capacity to arrange for medical and psychological consultation, psychopharmacological consultation, and 24-hour crisis services. In addition, they have active affiliations with other levels of care and can assist in accessing clinically necessary "wraparound" support services such as child care, transportation, and vocational training.

Beyond the essential services, many Level II programs provide psychopharmacological assessment and treatment, have the capacity to effectively treat patients with complex coexisting substance-related and mental health disorders,

and have the capacity to manage outpatient detoxification. Others have the capacity to provide supplementary services such as child care, transportation, meals, and unsupervised overnight lodging. The most common variations are Intensive Outpatient (Level II.1) and Partial Hospitalization (Level II.5).

Level II.1: Intensive Outpatient Treatment

Intensive outpatient treatment programs generally provide 9 or more hours of structured programming per week, consisting primarily of counseling and education around alcohol and other drug problems. The patient's needs for psychiatric and medical services are addressed through consultation or referral arrangements.

Level II.5: Partial Hospitalization

Partial hospitalization generally provides 20 or more hours of clinically intensive programming per week based on individual treatment plans. Programs have ready access to psychiatric, medical, and laboratory services, and thus have greater capacity than intensive outpatient treatment (Level II.5) to effectively treat individuals who have substantial medical and psychiatric problems.

Level III: Residential/Inpatient Services

An organized set of services staffed by designated addiction treatment personnel who provide a planned regimen of patient care in a 24-hour, live-in setting. Such services adhere to defined sets of policies and procedures, and are housed in, or affiliated with, permanent facilities where patients can reside safely, and which are staffed 24 hours a day. Mutual/self-help meetings generally are available onsite. The defining characteristic of all Level III programs is that they serve patients who need, and therefore are placed in, safe and stable living environments in order to develop sufficient recovery skills. These living environments may be in the same facility as the one in which the treatment services are provided or separate facilities affiliated with the treatment services provider. In this case, the relationship between living environment and treatment services must be sufficiently direct to allow specific aspects of the individual treatment plan to be addressed in both facilities.

Level III.1: Clinically Managed Low-Intensity Residential Services

A structured recovery environment offering low intensity professional addiction treatment services at least 5 hours a week (or as specified by State licensure requirements and staffed 24 hours a day. The services provided may include individual, group, and family therapy. Mutual/self-help meetings usually are available onsite. Interpersonal and group living skills generally are promoted in this level of care through the use of community or house meetings involving residents and staff. Treatment is directed toward applying recovery skills, preventing relapse, promoting personal responsibility, and reintegrating the resident into the worlds of work, education, and family life. The prime example of a Level III.1 program is a halfway house, and this level is not intended to describe or include sober houses, boarding houses, or group homes where professional addiction treatment services are not provided.

Level III.3: Clinically Managed Medium-Intensity Residential Services

Frequently referred to as extended or long-term care, Level III.3 programs provide a structured recovery environment in combination with medium-intensity professional clinical services to support and promote recovery. Services generally are considered to be of medium intensity and are presented at a slower pace than in more intensive residential services. Interpersonal and group living skills generally are promoted in this level of care through community meetings involving residents and staff. Treatment is directed toward overcoming denial of the presence and effects of addiction in patients' lives, as well as enhancing treatment acceptance and motivation, preventing continued use or relapse, and promoting eventual reintegration of the individual into the community. These programs require greater staff training and nursing supervision than Level III.1 and are thus able to address the needs of

residents with slightly more severe medical or emotional/behavioral problems. Reintegration of Level III.3 residents into the community involves case management activities directed toward networking the residents into community-based ancillary or "wraparound" services such as housing, vocational services, or transportation assistance to attend self-help meetings or vocational activities after discharge.

Level III.5: Clinically Managed High-Intensity Residential Services

High-intensity residential programs designed to address significant problems with living skills and providing a highly structured recovery environment in combination with moderate- to high-intensity professional clinical services to support and promote recovery. These programs are characterized by their reliance on the treatment community as a therapeutic agent that introduces and enforces appropriate social values and behaviors, and by a focus on reintegration of the resident into the greater community, with a particular emphasis on employment and education. Treatment is specific to maintaining abstinence and preventing relapse but also vigorously promotes personal responsibility and positive character change. Token economies and other behavioral therapies sometimes are incorporated into these intense therapeutic milieus. Programs vary on their capacity to meet the medical needs of those served. The prime example of Level III.5 care is the therapeutic community.

Level III.7: Medically Monitored Intensive Inpatient Treatment

Level III.7 programs offer an organized service, staffed by designated addiction treatment personnel or addiction-credentialed physicians, that provides a planned regimen of 24-hour, professionally directed evaluation, care, and treatment for addicted patients in an inpatient setting. Such a service functions under a defined set of policies and procedures and has permanent facilities, including inpatient beds. Level III.7 care is delivered by an interdisciplinary staff to patients whose subacute biomedical and emotional/behavioral problems are sufficiently severe to require inpatient care. Twenty-four hour observation, monitoring, and treatment are available. However, the full resources of an acute care general hospital or a medically managed inpatient treatment service system are not necessary. The treatment delivered at Level III.7 is specific to the substance-related disorder, but the interdisciplinary team and the availability of support services also accommodate detoxification and/or intensive inpatient treatment of addiction and/or conjoint treatment of coexisting subacute biomedical and/or emotional/behavioral conditions that could jeopardize recovery.

Level IV: Medically managed Intensive Inpatient Services

Level IV medically managed intensive inpatient treatment is an organized service that involves a planned regimen of 24-hour, medically directed evaluation, care, and treatment of substance-related disorders in an acute-care inpatient setting. It is designed for individuals whose acute biomedical, emotional, or behavioral problems are severe enough to require primary medical and nursing services. Three types of settings typically provide this level of care: (1) an acute care general hospital; (2) an acute psychiatric hospital or psychiatric unit within an acute care general hospital; and (3) an appropriately allowed conjoint treatment of any coexisting biomedical and emotional/ behavioral conditions that need to be addressed and that could jeopardize recovery. The service can provide life support care and treatment, as needed, either directly or through the transfer of the patient to another service within the facility or to another medical facility equipped to provide such care.

It is staffed by designated addiction physicians or addiction credentialed clinicians, including the following:

(a) An interdisciplinary team of appropriately credentialed clinicians (e.g., physicians, nurses, counselors, psychologists, social workers), who assess and treat adult patients with substance-related disorders or addicted patients with concomitant acute biomedical, emotional/behavioral disorders. Such clinicians must be knowledgeable about the biopsychosocial dimensions of addiction and biomedical and emotional/behavioral disorders.

(b) A team of appropriately trained professionals, daily medical management and physicians available 24 hours a day; primary nursing care and observation available 24 hours a day; and professional counseling services available 16 hours a day.

(c) Facility-approved addiction counselors or licensed, certified, or registered addiction clinicians to administer planned interventions according to the assessed needs of the patient.

Modalities of Substance Abuse Care Provided at Multiple Levels

Opioid Maintenance Therapy (OMT)

OMT is an organized, usually ambulatory, addiction treatment service for opiate-addicted patients. OMT is an umbrella term that encompasses a variety of pharmacologic and nonpharmacologic treatment modalities, including the therapeutic use of specialized opioid compounds such as methadone and LAAM (levo-alpha-acetyl-methadol) to psychopharmacologically occupy opiate receptors in the brain, extinguish drug craving and thus establish a maintenance state. It is delivered by designated addiction trained personnel or addiction credentialed clinicians, who provide individualized treatment, case management, and health education (including education about human immunodeficiency virus, tuberculosis, and sexually transmitted diseases).

The nature of the services provided (such as dose, level of care, length of service or frequency of visits) is determined by the patient's clinical needs, but such services should always include regularly scheduled psychosocial treatment sessions. OMT services function under a defined set of policies and procedures, including admission discharge and continued service criteria stipulated by State law and regulation and the Federal regulations at 21 C.F.R. Part 291. OMT is best conceptualized as a separate service that can be provided in any level of care, as determined by assessment of the patient's overall needs. Adjunctive nonpharmacologic interventions are essential and may be provided in the OMT clinic or through coordination with another addiction treatment provider.

Settings that typically provide OMT include permanent freestanding clinics, community mental health centers, community health centers, hospitals, medication units, satellite clinics, or mobile units attached to a permanent clinic site. Support systems include (a) linkage with or access to psychological, medical and psychiatric consultation; (b) linkage with or access to emergency medical and psychiatric affiliations with more intensive levels of care, as needed; (c) linkage with or access to evaluation and ongoing primary medical care; (d) ability to conduct or arrange for appropriate laboratory and toxicology tests; (e) availability of physicians to evaluate, prescribe, and monitor use of methadone or LAAM, and of nurses and pharmacists to dispense and administer methadone or LAAM; and (f) ability to provide or assist in arrangements for transportation services for patients who are unable to drive safely or who otherwise lack transportation.

Staff include the following:

(a) An interdisciplinary team of appropriately trained and credentialed addiction professionals, including a medical director, counselors, and the medical staff delineated in paragraph (b) below. The team will include social workers and licensed psychologists, as needed. They must be knowledgeable in the assessment, interpretation, and treatment of the biopsychosocial dimensions of alcohol/other drug dependence. Staff members receive supervision appropriate to their level of training and experience.

(b) Licensed medical, nursing, or pharmacy staff, who are available to administer medications in accordance with the physician's prescriptions or orders. The intensity of nursing care is appropriate to the services provided by an outpatient treatment program that uses methadone or LAAM.

(c) A physician, who is available during medication dispensing and clinic operating hours, either in person or by telephone.

Detoxification Services

Detoxification services are a modality of treatment that can be provided at any level of care, depending on the clinical severity of the individual and the resources of the program. Detoxification services should be designed to treat the patient's level of clinical severity and to achieve safe and comfortable withdrawal from mood-altering drugs (including alcohol) and to effectively facilitate the patient's transition into ongoing treatment and recovery.

Level I-D: Ambulatory Detoxification Without Extended Onsite Monitoring

Level I-D is an organized outpatient service, which may be delivered in an office setting, health care, or addiction treatment facility, or in a patient's home, by trained clinicians who provide medically supervised evaluation, detoxification, and referral services according to a predetermined schedule. Such services are provided in regularly scheduled sessions and should be delivered under a defined set of policies and procedures or medical protocols.

Level II-D: Ambulatory Detoxification With Extended Onsite Monitoring

Level II-D is similar to Level I-D with the exceptions that services are not offered in the home, not based on a predetermined schedule, and must include the availability of appropriately credentialed and licensed nurses (R.N., L.P.N.) for monitoring of patients over a period of several hours each day of service.

Level III-D: Residential/Inpatient Detoxification

Level III-D services are delivered in a variety of Level III settings with varying intensities of clinical services, particularly as demonstrated by the degree of involvement of medical and nursing professionals.

Level III.2-D: Clinically Managed Residential Detoxification

Sometimes referred to as "social detoxification," Level III.2-D is an organized service delivered by appropriately trained staff who provide 24-hour supervision, observation, and support for patients who are intoxicated and/or undergoing withdrawal. Some clinically managed residential detoxification programs are staffed to supervise self-administered medications for the management of withdrawal. Clinically managed residential detoxification is characterized by its emphasis on peer and social support and provides care for patients whose intoxication/withdrawal signs and symptoms are sufficiently severe to require 24-hour structure and support. However, the full resources of a Level III.7-D, medically monitored inpatient detoxification service, are not necessary. All programs at this level rely on established clinical protocols to identify patients who are in need of medical services beyond the capacity of the facility and to transfer such patients to more appropriate levels of care.

Level III.7-D: Medically Monitored Inpatient Detoxification

Level III.7-D is an organized service delivered by medical and nursing professionals, which provides for 24-hour, medically supervised evaluation and withdrawal management in a permanent facility with inpatient beds. Twenty-four hour observation, monitoring, and treatment are available. Services are delivered under a defined set of physician-approved policies and physician-monitored procedures or clinical protocols. The full resources of an acute care general hospital or a medically managed intensive inpatient treatment program are not necessary. It sometimes is provided by overlapping with Level IV-D services (as a step-down service) in a specialty unit of an acute care general or psychiatric hospital.

Level IV-D: Medically Managed Inpatient Detoxification

Level IV-D is an organized service delivered by medical and nursing professionals that provides for 24-hour, medically directed evaluation and withdrawal management in an acute care inpatient setting. Services are delivered under a defined set of physician-approved policies and physicianmanaged procedures or medical protocols. This level provides care to patients whose withdrawal signs and symptoms are sufficiently severe to require primary medical and nursing care services. Twenty-four hour observation, monitoring, and treatment are available. The treatment is specific to acute medical detoxification.

Definitions of Substance Abuse Prevention Services

For purposes of the Substance Abuse Prevention and Treatment (SAPT) Block Grant, primary prevention activities are those directed to individuals and a subgroup of the population who do not require treatment for substance abuse. These strategies and services are aimed at educating and counseling individuals and subgroups of the population on substance abuse and providing for activities that reduce the risk of abuse and/or use.

45 C.F.R. Part 96 requires States/Territories to develop and implement a comprehensive prevention program which includes a broad array of prevention strategies. These strategies include: (1) Information Dissemination, (2) Education, (3) Alternative Activities, (4) Problem Identification and Referral, (5) Community Based Processes, and (6) Environmental Approaches. For definitions of these strategies refer to 96.125 of the Federal Register for definitions of primary prevention strategies. All of these SAPT Block Grant prevention activities must be reported under at least one of the primary prevention strategies listed above.

Definitions of Mental Health Treatment Services

Prevention/Intervention Services

Prevention and early intervention services are a set of planned activities, services, or other measures intended to prevent or reduce the prevalence, severity, and/or consequences of mental and addictive disorders. They are intended to prevent or delay episodes of illness and disability in order to avoid more extensive and costly services later on. These services are generally aimed at the general population (primary prevention) or targeted to identified high-risk groups (secondary prevention), and are, from a public health perspective, seen as an essential component of any comprehensive health care system.

Screening Services

Periodic Screening for Children and Adolescents--Regular periodic screening of children and adolescents in accordance with guidelines established by the Early and Periodic Screening, Diagnosis, and Treatment (EPSTD) regulations and the American Academy of Pediatrics. These screenings should be performed on a regularly scheduled basis, with greater frequency at earlier ages. In addition to screening for physical health problems, such preventive screenings should include screening for developmental, mental, emotional, behavioral, and substance abuse disorders.

Brief Screening at Life Transitions--Brief sets of mental health and substance abuse screening questions added to health assessments at key transitions; these "life transitions" can be defined broadly or more narrowly as naturally occurring opportunities to identify mental and substance abuse disorders. The goal of such efforts is to provide prompt treatment for mental and substance disorders, thus preventing more severe disabilities and dependencies.

Outpatient Therapy

Psychotherapeutic counseling interventions provided at the most appropriate site including an office, clinic, home, school, or other location in the community as needed for the treatment of mental and substance abuse disorders. Includes:

> **Individual, Family, and Group Therapy**--Psychotherapeutic counseling services intended to treat mental and/or substance abuse disorders and delivered to an individual, family, or a group. Includes brief and extended treatment utilizing a variety of therapeutic approaches and may include such approaches as interactive therapy, behavioral therapy, cognitive therapy, and adjunctive therapies.

Family Education/Support--Therapeutic and educational interventions provided to families (and significant others) of individuals with mental and substance abuse disorders to provide education and consultation regarding the nature of the disorder, medication administration and monitoring, recognizing signs of relapse, risk reduction approaches, and specific skills which may assist in the care and management of a family member.

Medication Management--Brief visits to a physician and/or nurse for a variety of care and treatment purposes, usually including ongoing assessment and monitoring of psychiatric and substance abuse conditions, prescribing and monitoring medications and side effects, and assisting clients to manage symptoms.

Partial Hospitalization

An intensive, integrated treatment program provided within a structured therapeutic setting for a portion of a day designed to serve as an alternative to placement in a residential or inpatient treatment setting and/or to restore or maintain the functioning of individuals with serious mental and/or substance abuse disorders. Involves the provision of a multimodal therapeutic program which may include individual, group, and family therapy, pharmacotherapy, expressive and activity therapies, skill development, and psychoeducational services, and an educational component for children and adolescents. Includes full day, after school, evening, weekend, and summer day treatment programs offered in a variety of settings including schools, mental health centers, hospitals, or freestanding programs.

Psychiatric Rehabilitation

Sometimes called*psychosocial rehabilitation,* these services enable people to overcome functional deficits and social barriers resulting from mental or substance abuse disorders and restore their ability to live independently. In addition to the kinds of vocational and recreational rehabilitation services often used by people with physical disabilities, psychiatric rehabilitation includes socialization and training in such daily living skills as shopping, cooking, and money management, and in recognition and management of symptoms.

Behavioral Aide Services

Interventions which provide trained personnel who are deployed to provide one-to-one supervision and support to a child or adolescent with a serious emotional disturbance in order to avert the need for treatment in a residential or inpatient setting. Includes services provided in the home or school for a specified number of hours per day or round-the-clock for a specified period of time.

Psychosocial Rehabilitation

Interventions delivered to assist individuals to develop the skills and access the supports needed to achieve their maximum level of functioning within the community and to overcome the social and vocational handicaps associated with mental and substance abuse disorders. Includes services delivered in a variety of settings and interventions such as skill development, skill maintenance, and education related to activities of daily living (including instrumental activities of daily living), symptom management, preparation for attainment and maintenance of employment, socialization, and recreation.

Home-based services

Interventions provided on an outreach basis to work with individuals and their families, and delivered primarily in the home and community, for the purpose of averting the need for treatment in residential or inpatient settings or to facilitate the earlier return of individuals receiving inpatient or residential care. Interventions are multifaceted and include therapy, supportive counseling, skills training, and facilitation of access to other needed services and supports. Includes short-term, intensive approaches with the goal of stabilizing and connecting the individual with ongoing services and longer-term interventions with the intensity of services varying with clinical need.

Intensive Outpatient Services: Children and Adolescents

Three intensive outpatient services are especially important to children and adolescents with mental or emotional disorders:

Home-Based Services--Outreach to children, adolescents, and their family members (and significant others) at home, either to forestall the need for inpatient treatment or to facilitate the return of a family member from inpatient care. These multifaceted services include therapy, supportive counseling, skills training, and help in connecting the person to other needed supports and services in the community.

Day Treatment--A full range of services provided to children and adolescents in all-day, after school, evening, weekend, and summer programs, in a variety of settings including schools, mental health centers, hospitals, or freestanding programs.

Behavioral Aide Services--One-on-one supervision and support provided by behavioral aides to enable a child or adolescent to avoid inpatient treatment. Services may be provided at home or at school or both, and for just a few hours or around the clock.

Community Residential Treatment for Adults

Active treatment for adults provided within a range of residential environments which offer treatment, rehabilitation, and support and include halfway houses, three-quarter-way houses, and other residential program models designed to provide time-limited, structured rehabilitation and treatment services in therapeutic communities. Services often serve as alternatives to hospital care and stress normalization and maximum community involvement and integration.

Residential Treatment Centers

Treatment for children and adolescents with emotional disorders provided in structured and supervised residential treatment facilities. Therapeutic approaches include individual, group, and family therapy, behavior management, social skill development, and an educational component. Levels of structure, staffing, and supervision incorporated into the therapeutic environment can be varied to serve children and adolescents requiring different levels of care.

Therapeutic Group Homes

Treatment for children and adolescents with emotional disorders provided in the context of family-like, small group home environments. Therapeutic approaches include individual, group, and family therapy, behavior management, social skill development, and others. Levels of structure, staffing, and supervision incorporated into the therapeutic environment can be varied to serve children and adolescents requiring different levels of care.

Therapeutic Family Homes

Treatment for children and adolescents with emotional disorders provided in the homes of trained families within the community. Treatment parents are seen as the primary therapeutic agents and are specially trained, licensed, and clinically supervised. Clinical, supportive, and case management services are provided to each child and treatment family. Typically one child is served in each therapeutic family home.

Other Residential Treatment

Treatment, rehabilitation, and supportive services provided to individuals who are residing within a variety of other residential environments including board and care homes, supervised independent living, nursing homes, and others. Includes treatment and rehabilitative services, but not housing and nursing home costs which are financed through other funding streams. Interventions are intended to provide problem resolution, skill development, supervision, and support for the purpose of assisting individuals to make the transition to independent living. Includes clinical and rehabilitative services provided to older adolescents in preparation for independent living.

Inpatient Hospital Services

Active psychiatric and/or substance abuse treatment provided in general hospitals or specialized psychiatric hospitals for purposes of stabilizing and improving the condition of persons with mental and/or substance abuse disorders. Includes inpatient services to provide short-term, acute treatment and stabilization and long-term inpatient services for the extremely small percentage of persons who remain dangerous to themselves or others or whose illnesses result in extreme functional impairments. Includes medical detoxification in inpatient hospital settings only as required for the management of neuropsychiatric or medical complications associated with withdrawal from alcohol or drugs. Inpatient care for mental and/or substance abuse disorders is available only when less restrictive nonresidential or residential services are ineffective or inappropriate.

Crisis/Emergency Services

Telephone Crisis Services--Emergency telephone services available 24 hours a day to assess the nature and severity of mental health and substance abuse crises, to determine the need for face-to-face emergency services, and to provide crisis intervention and referral for appropriate treatment.

Walk-in Crisis Services--Emergency services available 24 hours a day at facilities including clinics, hospital emergency rooms, and others to provide prompt, face-to-face assessment of the nature and severity of mental health and substance abuse crises and to provide crisis intervention and referral for appropriate treatment.

Mobile Outreach Crisis Services--Emergency services available 24 hours a day to provide on-site intervention in the settings and locations in which the crisis is occurring. Includes assessment of the nature and severity of mental health and substance abuse crises, crisis intervention, and referral for appropriate treatment.

Crisis Residential Services--Crisis services provided in nonhospital, residential settings which provide short-term, acute treatment for purposes of crisis intervention and stabilization for persons experiencing crises related to mental and substance abuse disorders. Includes services provided in a variety of settings including family treatment homes, group crisis residences, crisis stabilization units, and others which provide structure, supervision, and a variety of therapeutic intervention.

Case Management

Assistance to an adult or the family of a child in obtaining needed services and resources from multiple agencies (e.g., Social Security, Medicaid, food stamps, housing assistance, health and mental health care, child welfare, special education, etc.), advocating for services, monitoring care, and so forth. Case management can vary substantially in intensity, duration, and focus.

Somatic Treatments

Treatments including pharmacotherapies, electroconvulsive therapy, dispensing of medications, maintenance on methadone and other narcotic agonists and antagonists and related oversight, and other somatic treatments deemed medically necessary and appropriate for the alleviation or management of mental and substance abuse disorders.

Assertive Community Treatment

Interventions provided to individuals with serious, disabling mental illness for purposes including increasing community tenure, elevating psychosocial functioning, minimizing psychiatric symptomatology, and ensuring a satisfactory quality of life. Involves the provision and coordination of treatments and services delivered by multidisciplinary teams using an active, assertive outreach approach and including comprehensive assessment and the development of a community support plan, ongoing monitoring and support, medication management, skill development, crisis resolution, and accessing needed community resources and supports.

Therapeutic Respite Services

Interventions delivered for the purpose of providing a planned or unplanned break for an individual with mental disorders and his/her caregivers in order to reduce stress and prevent disruption of primary caregiving. Includes therapeutic respite provided in the home or in out-of-home settings such as foster

homes or respite group homes for a period of several hours, overnight, or several days as determined to be clinically necessary and appropriate.

Appendix D--Excerpts From a State of Colorado Contract: Sample Substance Abuse Prevention and Treatment (SAPT) Block Grant Contract Language

The following language from a State of Colorado contract illustrates contract language for services purchased using Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant funds.

4. It is understood and agreed by the parties that the target populations to be served under this contract, in order of priority for State and Federal funds paid to the Contractor, are as follows:

a. Injecting drug users.

b. Pregnant women.

c. Women (parents) with dependent children.

d. Drug dependent persons with HIV (human immunodeficiency virus) or TB(tuberculosis).

e. Recipients of State Aid to the Needy Disabled who are disabled because of alcohol or drug addiction, and current and former SSI/SSDI benefit recipients who are similarly disabled, in accordance with CRS 26-2-106(6)(a).

f. Persons involuntarily committed to treatment under Sections 25-1-311 and 25-1-1107, CRS 1973, as amended. Such persons shall be placed in the type of service specified by the State, for the period of time specified in the court order.

g. Families and children referred by child welfare agencies who are class members of the Child Welfare Lawsuit Settlement Agreement ("*David Littman vs. State of Colorado*" Civil Action 94-M-1417), i.e., child welfare program areas 4, 5, and 6 who are abused and neglected and who meet the criteria for being at imminent risk of out of home placement.

h. Minors/adolescents adjudicated as delinquents, youth committed or detained by DYC and youth in pre-adjudicated programs such as diversion, programs established under CRS 19-2-Part 16 (Senate Bill 94) and Juvenile TASC.

i. Alcohol and drug abusing convicted felons.

j. Persons with both substance abuse and mental illness diagnoses.

k. Persons convicted of DUI (driving under the influence) offenses and sentenced to Level II education and treatment under CRS 42-4-1301(10) who are indigent under the most recent Income Eligibility Guidelines issued by the Colorado Supreme Court.

This listing is not intended to prevent the Contractor from assuring, or providing, service to other individuals and groups as may be proposed in Exhibit B, so long as the funds provided through this contract are used to serve the

above priority populations first, and in the order of priority for services given. In addition, services to handicapped persons, as defined in the Americans with Disabilities Act of 1990, including vision- and hearing-impaired individuals, must be provided either directly or through adequate referral and follow through procedures. . . .

14. In consideration of Federal Substance Abuse Prevention and Treatment Block Grant funds provided under this contract, the Contractor shall assure that the following activities and priorities are carried out within the substate area network:

a. Accept and give priority for admission to pregnant women, and provide a completed referral or interim services when admission within 24 hours is not possible. Referrals should be to accessible programs, preferably Special Connections or Specialized Women's Services providers. Interim services may include ad hoc counseling, case management, and support groups, and must include a referral for prenatal care and counseling on the effects of alcohol and drug use on the fetus. If these activities cannot be completed within 48 hours of the original request for treatment a contract provider must engage the Contractor, acting as MSO, to jointly develop and implement a service plan for the woman. If such plan cannot be implemented within the substate area, the Contractor shall contact the Alcohol and Drug Division for assistance.
b. Provide screening to clients to determine risk of HIV disease, together with such other early intervention services as may be required by regulation or specified by the State.
c. Provide counseling to all clients about tuberculosis, and make available such other tuberculosis services as may be required by regulation or specified by the State.
d. Provide continuing education in clinical care to the employees of the Contractor or any subcontractor who provide the services specified in paragraph 3 of this contract.
e. Develop and implement . . . specially designed services for pregnant women, post-partum women, and women with dependent children, including the following services:
    1. Primary medical care for women, referral for prenatal care, and while the women are receiving such services, child care.
    2. Primary pediatric care, and immunization, for their children.
    3. Gender-specific substance abuse treatment and other therapeutic interventions for women which may address issues of relationships, sexual and physical abuse and parenting and child care while the women are receiving these services.
    4. Therapeutic interventions for children in custody of women in treatment (may include meeting their developmental needs, dealing with issues of sexual and physical abuse and neglect).
    5. Case management and transportation to ensure that women and their children have access to the above services.
f. Accept and give priority for admission to injecting drug users, assure such admission no later than 14 days after treatment is requested or, if this is not possible due to lack of capacity, provide interim services within 48 hours of initial contact for persons awaiting admission. Notwithstanding the provision of interim services, the Contractor must assure that every such client seeking treatment is admitted within 120 days after treatment is requested. The Contractor must also provide State approved outreach activities to encourage injecting drug users in need of treatment to undergo treatment. . . .

Block Grant Prohibitions

30. In accordance with requirements of Public Law 102-321, the Contractor agrees that any Federal block funds provided under this contract may *not* be used:

a. To provide inpatient hospital services except as provided in applicable Federal law;
b. To make cash payments to intended recipients of health services;
c. To purchase or improve land; purchase, construct, or permanently improve (other than minor remodeling) any building or other facility; or purchase major medical equipment;
d. To satisfy any requirement for the expenditure of non-Federal funds as a condition for the receipt of Federal funds;
e. To provide financial assistance to any entity other than a public or non-profit private entity;
f. To provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs, unless a demonstration needle exchange program is approved by the Surgeon General of the Public Health Service; or
g. To make payment for any service to the extent that payment has been made, or can reasonably be expected to be made, under any Federal or State health benefits program including Medicare and Medicaid, Title IVA-EA, or under any insurance policy, prepaid health services plan, or State compensation plan.

Appendix E--Definitions of Adults With a Serious Mental Illness (SMI) and Children With a Serious Emotional Disturbance (SED) Under the Community Mental Health Services (CMHS) Block Grant

Definition of Adults With a Serious Mental Illness

Adults with a serious mental illness are defined pursuant to Section 1912(c) of the Public Health Service Act, as amended by Public Law 102-321, as follows:

> *"Adults with a serious mental illness are persons: age 18 and over, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R, that has resulted in functional impairment which substantially interferes with or limits one or more major life activities."*

The following is an analysis of this definition:

> SMIs include any mental disorders (including those of biological etiology) listed in DSM III (now DSM-IV) or their ICD-9-CM equivalent (and subsequent revisions), with the exception of DSM-IV "V" codes, substance use disorders, and developmental disorders, which are excluded unless they co-occur with another diagnosable serious mental illness.
> All SMIs have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects.
> Functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities including the following:

- Basic daily living skills (e.g., eating, bathing, dressing);

- Instrumental living skills (e.g., maintaining a household, managing money, getting around the community, taking prescribed medication); and

- Functioning in social, family, and vocational/educational contexts.

Adults who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are considered to have serious mental illnesses.

Definition of Children With a Serious Emotional Disturbance

Children with a serious emotional disturbance are defined pursuant to Section 1912(c) of the Public Health Service Act, as amended by Public Law 102-321, as follows:

> *"Children with a serious emotional disturbance are persons: from birth up to age 18, who currently or at any time during the past year, have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R, that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities."*

The following is an analysis of this definition:

> *"...from birth up to age 18"*

The definition is restricted to persons up to age 18. However, it is recognized that some States extend this age range to persons less than age 22. To accommodate this variability, States using an extended age range for children's services should provide separate estimates for persons below age 18 and for persons aged 18 to 22 within block grant applications.

> *"...who currently or at any time during the past year"*

The reference year in each of the definitions refers to a continuous 12-month period because this is a frequently used interval in epidemiological research and because it relates closely to commonly used planning cycles.

> *"...have had a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-III-R"*

DSM-IV is now the appropriate document to use. The 10th revision of the International Classification of Diseases (ICD-IO), developed by the World Health Organization, was published in 1992, but will probably not be officially adopted in the United States until late in the 1990's. These revised nomenclatures are likely to affect both the language of mental disorders and the types of disorders currently included or excluded from these definitions. As appropriate, the definitions will be updated by the Center for Mental Health Services (CMHS) accordingly.

> *"...that resulted in functional impairment which substantially interferes with or limits the child's role or functioning in family, school, or community activities."*

Functional impairment which "substantially" interferes will be operationally defined as part of the process of developing standardized methods for estimation.

SEDs include any mental disorder (including those of biological etiology) listed in DSM-IV or their ICD-9-CM equivalent (and subsequent revisions), with the exception of DSM-IV "V" codes, substance use, and developmental disorders, which are excluded unless they co-occur with another diagnosable serious emotional disturbance.

All SEDs have episodic, recurrent, or persistent features; however, they vary in terms of severity and disabling effects.

Functional impairment is defined as difficulties that substantially interfere with or limit a child or adolescent from achieving or maintaining one or more developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills.

Functional impairments of episodic, recurrent, and continuous duration are included unless they are temporary and expected responses to stressful events in the environment.

Children who would have met functional impairment criteria during the referenced year without the benefit of treatment or other support services are included in this definition.

Appendix F--Old and New Criteria for the Use of Community Mental Health Services Block Grant Funds

Proposed Consolidated Criteria (for 1999)	Criteria Under Current Law
Criterion 1: **Comprehensive Community-Based Mental Health Service Systems** Establishment and implementation of comprehensive community-based mental health service system Reduction of hospitalization Description of available services and resources in a comprehensive system of care, including case management	***Criterion 1*****:**Establishment and implementation of community-based system of care for adults with a serious mental illness (SMI) or children with a serious emotional disturbance (SED) ***Criterion 3:***Available services, treatment options, resources (including Federal, State, and local public services and resources, and to the extent practicable, private services and resources) ***Criterion 4:*** Health, mental health, rehabilitation, employment, housing, and educational services, medical and dental care and other support services to enable individuals with SMI or SED to function outside inpatient/residential institutions ***Criterion 6:*** Activities to reduce the rate of hospitalization of individuals with SMI or SED ***Criterion 7:*** Provision of case management services to each individual in the State with SMI or SED who receives substantial amounts of public funds or services
Criterion 2: **Mental Health Systems Data and Epidemiology** Quantitative targets for services	***Criterion 2:*** Quantitative targets to be achieved in the implementation of the mental health system, including the numbers of individuals with SMI and SED residing in the areas to be served under such system ***Criterion 11*****:** Estimate of incidence and prevalence in the State of SMI among adults and SED among children

Prevalence rates of serious mental illness (SMI) and serious emotional disturbance (SED)	
***Criterion 3:* Provision of Children's Services** Comprehensive community-based services for children with SED	***Criterion 9*:** Systems of integrated social, education, juvenile, substance abuse, and mental health services for children, that together with health and mental health services, are to be provided for such children to receive care appropriate for their multiple needs (including services provided under the Individuals with Disabilities Education Act)
***Criterion 4:* Targeted Services to Homeless and Rural Populations** Outreach and services to the homeless Provision of services to rural areas	***Criterion 8:*** Establishment and implementation of a program of outreach to, and services for, individuals with SMI or SED who are homeless ***Criterion 10:*** Description of the manner in which mental health services will be provided to individuals residing in rural areas
***Criterion 5:* Management Systems** Financial resources, staffing, and training Expenditure of block grant funds	***Criterion 5*:** Financial resources and staffing necessary to implement the plan, including programs to train individuals as providers of mental health services, with emphasis on training providers of emergency health services regarding mental health ***Criterion 12:*** Description of the manner in which the State intends to expend the grant for the fiscal year involved to carry out the provisions of the plan

Source: Proposed SAMHSA Reauthorization Package.

Appendix G--Examples of Outcome and Process Measures of Quality

In most cases, Medicaid carve-out contracts require the contractor to submit various reports as well as encounter data. The reports typically include basic utilization data such as admissions/1,000 enrollees, average length of stay, outpatient visits/1,000 enrollees, and bed days/1,000 enrollees. Many contracts also specify outcome and process measures that must be reported. Listed below is a sample of measures found in Medicaid and private-sector carve-out contracts (Huskamp, 1996):

Examples of Outcome Measures of Quality
Readmission rates (for substance abuse care, inpatient mental health affective disorder, inpatient other psychiatric disorder) Percent of diverted recipients (from inpatient to alternative care) and of nondiverted recipients who are rehospitalized within 30, 60, and 90 days after diversion or discharge, by rating category Client functioning (as measured by State's assessment tool) Measures of functional status at intervals appropriate to the service being delivered, by category of assistance, diagnosis, region, provider, and service type Progress toward treatment goals and appropriateness of the treatment plan (State currently uses measure for children)

Quality of life (e.g., improvement/stability with respect to school/employment status, housing, financial status, social network) (State currently uses a measure for adults)
Recidivism rates by service type and client population
Proportion of cases receiving a substance abuse detoxification service who had a substance abuse detoxification service within the past 90 days
Suicide attempts by patients in the system
Drug toxicity/severe adverse drug reaction
Patient satisfaction (based on survey results)

Examples of Process Measures of Quality

Utilization Measures

Percent of enrollees with a visit in the past 2 years
Proportion of patients in inpatient setting visited by psychiatrist daily
Reception of a mental health/substance abuse service of some sort by at least 10 percent of enrollees
Service penetration rates by age, diagnosis category, treatment setting, and clinician type
Determination of how dollars are spent for the population of people with severe mental illnesses: inpatient costs/total costs for people, outpatient costs/total costs, alternative care costs/total costs, and residential care costs/total costs for people with severe mental illnesses only
Proportion of adults receiving individual outpatient treatment for an adjustment disorder who have 10 or fewer visits

Utilization Review

Percent of service diversions that are appealed both to the contractor and the State
Reports of requests for care denied through utilization review
Utilization review report--percent of total requests for inpatient admissions that were approved, stratified by enrollee age and mental health vs. substance abuse; percent of total requests for inpatient admission that were diverted to alternative services, stratified by age and mental health vs. substance abuse; percent of total requests for inpatient admission and outpatient services that were denied, stratified by age and mental health vs. substance abuse

Case Management

Documentation of a treatment plan in place by the fourth outpatient visit
Documented coordination with primary care doctor in 75 percent of cases
Outpatient follow-up visit within 30 days of inpatient discharge for adults with a major depressive disorder
Proportion of patients who kept an initial outpatient appointment after discharge
Report on intensive clinical management (ICM) cases: total case cost by level of functioning, by region, and by demographics; percent of treatment goals attained within period of time prospectively allotted by the treatment plan; average duration of these cases; comparison of inpatient admission rates of ICM cases before and after admission to the ICM program
Linkages/coordination within the mental health care system and with physical health system (no measure specified in RFP)

Appropriate use of other social support services (no measure specified in RFP) Proportion of cases of children 12 years of age or younger who receive an ambulatory treatment activity of some sort (claim, authorization, or encounter) with documentation of an activity for a family visit Proportion of cases with a diagnosis of schizophrenia within a 12-month period who have treatment activities (claims, authorizations, or encounters) for at least four visits for medication management or brief visits with a psychiatrist
Contractor Capacity
Alternative care capacity--number of adult residential alternative beds divided by number of State hospital beds Annual report of number of bilingual providers and providers with specified types of expertise Proportion of providers in network who actually report that they are accepting new program enrollees (through independent phone audit) Initial routine appointments made within 4 to 7 business days Phone access to clinicians within five minutes for emergencies and three business days for non-emergencies Average speed of phone answer of 10-30 seconds and call abandonment rate of 3 percent or less. Phone response time (e.g., percent of callers to the 800 phone number reaching a human voice within 25 seconds; percent of calls abandoned before reaching a human voice)
Outreach
Community relationships and outreach--number of agencies making at least one referral to the program, number of self-referrals divided by number of new referrals, number of family or friend referrals divided by number of new referrals Documented attempts to contact patients after they fail to show up for an appointment
Grievances
Number of grievances and their resolutions, by region, provider, and service type Quarterly reports on complaints Number of resolutions and responses of written complaints taking place within 15 business days Number of appeals resolved within 30 business days
Plan Performance
Reports on enrollment/disenrollment Semiannual report on provider satisfaction Out-of-network admissions

Appendix H--List of Field Reviewers

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