



MEDICAID MENTAL HEALTH CARVE-OUTS:
IMPACT AND ISSUES IN RURAL AREAS



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**MEDICAID MENTAL HEALTH CARVE-OUTS:
IMPACT AND ISSUES IN RURAL AREAS**

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EXECUTIVE SUMMARY

Overview

Most states are currently enrolling some or all of their Medicaid population in managed care, and many are choosing to separate the financing and management of mental health from physical health benefits. These arrangements are often referred to as mental health carve-outs. Rural mental health service delivery systems are very different from urban systems. Because there are relatively few mental health providers (particularly psychiatrists) in rural areas, persons often must rely on primary care providers for their mental health care. Most mental health carve-outs are designed to work with panels of mental health providers and to reign in mental health utilization. How will carve-outs work in rural areas where there are few mental health providers and the challenge is often to enhance service delivery infrastructure, not to trim it?

Using a case study approach, we explore the experience and impact, to date, of Medicaid mental health managed care in rural areas of three states - Colorado, Oregon, and Washington (Figure 1). The study also draws upon the experience of several other rural states, including Iowa, Montana, and Tennessee (Figure 2).

Findings

1. Many states have expected managed behavioral health organizations (MBHOs) to solve long-standing problems, such as a lack of mental health providers in rural areas, while lowering mental health costs.
2. How an MBHO partners with providers is more important than the overall structure of a carve-out.
3. Although risk-sharing is a crucial component of a state's approach, rural mental health providers have only assumed a limited amount of risk.
4. Integrating mental health and general health remains a goal, not a reality. However, the linkage between primary care and mental health has not been weakened in rural areas.
5. In the states we studied, access to mental health care has generally not been restricted and in some states access has been improved. Some states experienced problems with access early in their implementation because they did not include Primary Care Practitioners on Managed Behavioral Health Organization panels. How states respond to such problems has varied.

6. Managed care has increased the administrative burden on mental health providers, but this doesn't appear to have adversely affected services.
7. Children's outpatient mental health services have increased.
8. Coordination between mental health and substance abuse has decreased under public sector managed care.
9. Some problems experienced by third generation carve-out states might have been avoided if states made more effort to learn from earlier experiences by other states.

Conclusions

Medicaid mental health managed care is still new and it is not known how well it may eventually work in rural areas. Our study provides evidence for cautious optimism. Several issues are raised by this study:

1. The major challenge in rural areas continues to be how to develop capacity, not how to reduce or trim it. Medicaid mental health managed care must be adequately funded.
2. How to evaluate adequate access to care in terms of available rural providers is crucial. This issue will be increasingly influenced by credentialing of providers.

**Overview of Medicaid Mental Health Carve-Outs:
Case Study States (Colorado, Oregon, Washington)**

	Colorado	Oregon	Washington
Waiver (Date Operational)	1915 B Medicaid Mental Health Capitation and Managed Care Program (8/95)	1115 Oregon Health Plan (2/94); Medicaid Mental Health Demonstration Program (5/95)	1915 B Coordinated Community Health Plan (1/93); 1915 B Integrated Community Health Program (12/96)
Geographic Coverage	Fifty-one of sixty-three counties	Twenty-five percent of state's population (includes majority of rural areas)	Statewide
Populations Covered	AFDC: All SSI: All	AFDC: All SSI: Adults at risk of hospitalized care, needing crisis services, or harm to self or others Children/adolescents at risk of hospitalization, removal from home due to serious emotional or mental disorder	AFDC: All SSI: All Non-Medicaid: Responsibility of regional support networks
Benefits	Full range of mental health inpatient and outpatient services. Substance abuse, alcoholism, mental retardation, and organic brain syndrome not included.	Traditional inpatient and outpatient mental health services plus educational and preventive services; substance abuse included under physical health benefit.	All medically necessary outpatient community rehabilitation services, 24-hour crisis services, face-to-face assessments of children. Inpatient services on FFS basis until Fall 97.
Service Delivery	Four CMHCS serving traditional catchment area. Three partnerships between CMHCS and Options, Inc. (MBHO).	Nine contracts to provide services to different regions of state; co-contractors include national MBHO, county community mental health programs, and consortia of 19 rural counties	Fourteen regional support networks; prepaid health plan within each RSN region administers managed care and risk, contracts with MCO.
Financing	State pays each contractor a monthly payment based on separate capitation rates for five sub-populations.	Prospective funding calculated across multiple capitation rates for different subpopulations. MCOs share risk with providers.	Complex funding streams; outpatients services capitated, inpatient services under FFS until Fall 97.
Local Areas Studied	Weld County (Northeast Colorado) Garfield County (Western Colorado)	Dalles Four County Program (Northwest Oregon) Josephine County (Southwest Oregon)	Grant County (middle of state)

Experience to Date

Colorado

State officials and participating MCOs and MBHOs are pleased so far. Access to children's services have increased.

Oregon

Program has been successful in urban and rural areas. Major problem to arise is adequacy and timeliness of payment to substance abuse providers.

Washington

Protracted and fragmented development of mental health managed care.

Overview of Medicaid Mental Health Carve-Outs:
Experience of Other Rural States (Iowa, Montana, Tennessee)

	Iowa	Montana	Tennessee
Waiver (Date Operational)	1915 B Medicaid Mental Health Access Plan (3/95, 9/95)	1915 B Montana Mental Health Access Program (4/97)	1115 TennCare (7/96)
Geographic Coverage	Statewide	Statewide	Statewide
Populations Covered	AFDC: All (Covered under Mental Health Services Plan or under participating HMO) SSI: All non-elderly disabled	AFDC: All SSI: All Non-Medicaid: Children and adults up to 200% federal poverty level with serious mental health problem.	AFDC: All SSI: Adults with serious and persistent mental illness and children with serious emotional disturbance receive enhanced benefit.
Benefits	Community based services and preventive and early intervention services inpatient.	In-and outpatient hospital care, residential treatment, individual and group therapy partial hospitalization, day treatment, case management; prescription drug benefit.	Psychiatric hospital, outpatient, pharmacy, lab, substance abuse.
Service Delivery	Merit administers a statewide program with network of providers. AFDC beneficiaries enrolled in HMO receive mental health service there.	Partnership between Montana Community Partners and CMG Health (National MBHO) Network of providers established in each county.	Two national MBHOs provide services to eligibles, state's physical health MCOs required to contract with MBHOs.
Financing	Capitated rates for groups of AFDC - children, AFDC Adults, SSI children, SSSI - adults, Medicare - Medicaid dually eligible.	All state and non-state Medicaid funds blended	Full capitation
Experience to Date	Some implementation problems which have been resolved.	Major access problem experienced in many rural counties because family physicians were not included in provider network.	Mental health carveout suspended over access concerns arising from delayed and insufficient payments by MBHO to providers.

INTRODUCTION

Rising health care costs and expanding eligibility of beneficiaries have severely strained state Medicaid budgets. Faced with the often conflicting demands to control Medicaid costs and maintain or expand access, many states have moved to managed care, either under a 1915B (“freedom of choice”) waiver, allowing them to enroll their Medicaid population in HMOs or other managed care models, or under a more comprehensive 1115 (“demonstration”) waiver. States have struggled with whether and how to include mental health benefits under these waivers.

Early experience with treating public mental health clients under managed care raised a number of concerns, particularly regarding under-service (Schlesinger, 1986; Durham, 1995). Consequently, most states moving forward with Medicaid managed care have been reluctant to include mental health benefits - particularly for persons with chronic mental health problems. For this reason, many states have separated the financial risk associated with the mental health benefit from the risk associated with the physical health benefit. Such arrangements have been loosely referred to as **mental health carve-outs**. In this paper we use this term broadly to describe any arrangement that either places the management of the general physical and mental health benefits with different entities or separates funding for these sets of benefits.

Mental health carve-outs take many forms. In the early years of Medicaid managed care, states typically separated the mental health benefit from the physical health benefit and maintained mental health benefits largely as they had been, usually under a fee-for-service arrangement. Since mental health services are optional under Medicaid, the scope of included mental health services varies among states. During the last decade, states have responded to the incentive to use federal matching funds by increasing the scope of mental health services covered under Medicaid, usually targeting new services to persons with the most severe mental health needs. Increased costs resulting from these services have, in turn, led many states to bring Medicaid mental health services and populations into managed care (Stone and Katz, 1996; Frank, McGuire, and Newhouse, 1995). The mental health benefit is still separated (carved out) from the general health benefit, but is now managed in some fashion, rather than simply reimbursed on a fee-for-service basis.

As of July 1997, thirty-seven states had implemented, or were designing, some form of mental health managed care (MHMC) under Medicaid (NASMHPD, 1997).ⁱ Some states have moved to implement MHMC over the entire state, some in part of the state, and some have sought to phase-in managed care in different regions over time. Regardless of timetable and approach, developing MHMC is a formidable task involving a complex set of political, organizational, and financial issues.

Rural mental health service delivery systems are very different from urban systems (Wagenfeld et al. 1994, Slifkin et al. 1997; Sawyer and Beeson, 1997). Because there are relatively few mental health providers (particularly psychiatrists) in rural areas, rural persons often must rely more on primary care providers for their mental health care. However, rural primary care providers are often constrained in providing this care because of large patient loads and limited options for consultation and referral. Stigma and transportation problems pose additional barriers to mental health care for rural persons. Most mental health carve-outs are designed to work with panels of mental health providers and to reign in mental health utilization. How will carve-outs work in rural areas where there are few mental health providers and the challenge is often to enhance service delivery infrastructure, not to trim it? This issue is exemplified by recent problems in access to mental health services experienced by Medicaid enrollees in twenty-four Montana counties without any mental health providers when the state's new MHMC program neglected to include primary care providers in their provider panel.

Using a case study approach, we explore the impact, to date, of Medicaid mental health managed care in rural areas of three states - Colorado, Oregon, and Washington. The study also draws upon the experience of several other rural states, including Iowa, Montana, and Tennessee. Major objectives are to:

- better understand **current approaches** to Medicaid mental health managed care (MHMC) in rural states;
- assess the impact of MHMC on **coordination** between primary and mental health care and **access** to mental health care in rural areas; and
- identify **key policy issues** for providing mental health services in rural areas under MHMC.

Current understanding of MHMC is based on two types of studies:

(1) inventories describing the status of different states' waiver applications to develop MHMC and (2) formal, longitudinal evaluations, required by HCFA, of the impact of MHMC in states receiving an 1115 demonstration waiver. Preliminary results are available from several of the waiver impact evaluations, but in most cases it will be several years before more longitudinal findings are available. By focusing on how MHMC has been put into practice and initial effects in rural areas, this study aims to fill the gap between studies which simply inventory the status and structure of waiver applications and longer term impact studies still underway.

This paper is divided into five sections. The next section describes different models of MHMC and discusses how the incentives contained in these models may work in rural areas. The third section describes the approach and methods used to conduct this study. Case studies of mental health managed care in Colorado, Oregon, and Washington are presented in the fourth section and information from three other states - Iowa, Montana, and Tennessee - are presented in this section as well. The last section discusses the major findings of the study.

BACKGROUND

Carve-In or Carve-Out?: The first choice a state faces in developing Medicaid MHMC is whether or not to include mental health in the basic list of benefits for which risk is transferred to a Managed Care Organization (MCO). If these benefits are not included in the general MCO contract, this is usually referred to as a mental-health carve-out. The vast majority of states implementing (or planning to implement) MHMC have opted to carve-out mental health. However, there are strong rationales for wanting to include mental health under general health care - including holistic care, enhanced clinical integration, and assumed economic efficiencies - which would result in a carve-in of mental health and physical health under managed care.

There are two general approaches to a mental health carve-out. Under the *general contractor model*, the purchaser enters into a single contract with an MCO, at which point we would call this a carve-in. However, if the MCO chooses to transfer the risk for a subset of benefits in a subcontract, it becomes a carve-out. For example, the MCO may pass one part of a premium on to a specialty insurer, who manages only prescription coverage. Similarly, the MCO may pay a managed behavioral health organization (MBHO) to manage the mental health benefits. Under the *multiple contractor model* the purchaser enters into multiple contracts with MCOs, MBHOs, or contracts directly with providers, such as community mental health centers.

The purchaser who has minimal technical knowledge, or who wants to be sure that the project doesn't exceed the budget, is likely to choose the general contractor approach. Purchasers may choose the multiple contractor approach if they feel they have the knowledge to select good subcontractors, or if they want to maintain closer control of the different subcontracts. States have tended to choose the multiple contractor approach for managing Medicaid mental health services because they want to oversee the MBHO directly and monitor utilization, access, and quality. Another reason is to assure that dollars saved from managing mental health are retained in the mental health sector, rather than being used to fund general health services.

Under either approach, there are a number of possibilities regarding who is awarded managed care contracts and how contracts are structured. An MBHO contract may be awarded to a single entity, which may be a large for-profit national MBHO who

agrees to cover the whole state, or to several entities, each of which serves a designated region of the state. Regional-based entities might include a not-for-profit firm, a coalition, or a community mental health center. Which local providers are included to partner with the MBHO, and the nature of this partnership will vary significantly. One of the most important components of the partnership is the degree of financial risk assumed by local partners.

Potential Effects on Rural Mental Health Service Delivery: No matter who receives the contract, carve-outs pose potential problems for rural mental health consumers and providers. Primary care providers are the major, and often the only, source of mental health care in rural areas (Wagenfeld et al. 1994). The assumptions and approaches of most mental health carve-outs often conflict with this reality.

Mental health carve-outs assume that an organization specializing in managing mental health utilization will do a better job reducing inappropriate utilization and assuring quality than a general service MCO (Christianson et al. 1995). This arrangement may direct mental health care away from the primary care setting toward the mental health setting, where their management practices presumably have the greatest effect. In rural areas in short supply of mental health providers, the carve-out may direct enrollees away from the primary care sector with no mental health providers available. The MBHO may use a panel of mental health providers requiring rural consumers to travel significantly further for mental health care than they would if they were treated in the primary care setting. Credentialing requirements which recognize only highly trained mental health providers are likely to accelerate this trend. The net effect of MBHO carve-outs may be reduced access to mental health services in rural areas.ⁱⁱ

Hospitalization accounts for a large portion of mental health costs (Freeman and Trabin, 1994). Managed mental health care has been able to reduce costs primarily by reducing inpatient use, particularly length of stay (Durham, 1995).ⁱⁱⁱ Inpatient facilities are often located some distance from rural communities which, by itself, does not imply low access since travel for inpatient psychiatric care is acceptable and often desirable. However, outpatient services are often needed following discharge, to prevent relapse and readmission. Earlier discharge may increase the need for outpatient services as part of aftercare. The continued downsizing of state mental health hospitals has increased the need for crisis services and short-term inpatient beds, exacerbating the

problem of under-supply in rural areas. Thus, MBHOs' efforts to reduce hospital length-of-stay may work out differently in rural areas.

METHODS

We conducted a series of semi-structured interviews in six states. States were selected that had substantial rural areas and had substantial experience under MHMC. We looked for states that had awarded a single statewide contract and for those that had awarded regional contracts. These states are shown in Figure 3, which also lists several other states not included in our study but which have implemented, or are soon to implement, Medicaid MHMC. States shown in Figure 3 are categorized in terms of three generations of MHMC carve-outs: first generation: (1991-1992); second generation (1995); third generation (1996-1997). We did not include first generation states (Massachusetts and Utah) in our study because they have been extensively studied (Callahan et al. 1995; Christianson et al. 1995).

We interviewed key people at the state offices of Medicaid and Mental Health, and other offices recommended to us by our initial contacts. We gathered information on the historical development of the carve-out, including the state's history with Medicaid waivers, structure of the state mental health system, political climate, and reasons for choosing a mental health carve-out. We then interviewed individuals providing services in at least one rural community including primary care providers, mental health providers, and, in some cases, welfare or social service workers. Interviews addressed changes in referral patterns, reimbursement, and communication between primary care and mental health providers. We also requested documents from each state, including the original RFPs and winning proposals, evaluation and monitoring reports, and other material chronicling the carve-out's development and implementation.

We selected and began to conduct full case studies in six states - Colorado, Iowa, Oregon, Tennessee, New York and Washington. We were unable to complete the case studies in three states: Iowa, New York, and Tennessee. Iowa's waiver was coming up for renewal and the state was in the process of issuing a new RFP for Medicaid mental health managed care. Mindful of the litigation following award of its first contract a few years ago, Iowa officials asked us not to interview local providers while the new RFP process was underway. Changes proposed in Tennessee's MHMC program

(TennCare), and the political turmoil which followed, made completing our full case study difficult. New York's waiver application was finally approved by HCFA on July 15, 1997, over two years after it was submitted. Programs had not yet been implemented when we began conducting our interviews.

We completed full case studies in Colorado, Oregon, and Washington which are presented in the fourth section of this report. While not as complete, the information gathered in Iowa and Tennessee was also very useful and we report on what we found in these states as well. As we were completing a draft of this paper, breaking developments from the Montana Mental Health Access Plan affirmed that directing patients away from primary care providers could have serious consequences for access in rural areas where there are no mental health providers. We include the experience in Montana (based on written material and interviews) in our discussion of these other rural states.

Figure 3

Generations of Medicaid Mental Health Carve-outs

Year Implemented	Contract	
	Centralized	Regionalized
1991-1992	Massachusetts	Utah
1995	Iowa Nebraska	Colorado Oregon Washington
1996-1997	Montana Tennessee	New York New Mexico*

 included in study

*Within the field, New Mexico is referred to as a “modified carve-in.”

COLORADO

OVERVIEW AND BACKGROUND

Colorado is a diverse state with frontier areas, small towns and cities, suburbs, and a very large urban center (Denver). There are rural areas of concentrated wealth as well as severe poverty and rural populations are culturally diverse. Ensuring access to mental health services in rural areas is a challenge because of geography (mountainous terrain), climate, low-density populations, and low supply of providers

Colorado began serving Medicaid beneficiaries under mental health managed care in August 1995 under a two-year demonstration program. Seven contracts were awarded. Four contractors were community mental health center programs and consortia serving eight counties in the Denver area and in northern Colorado. The other three contractors were partnerships between community mental health center consortia and Options, Inc. - a national MBHO - serving 43 counties in the southern and western parts of the state. These two groups of contractors provide an interesting contrast. Twelve counties, including the city of Denver, did not participate in the demonstration.

The groundwork for Colorado's entry into MHMC began in 1992 when the General Assembly passed legislation authorizing a pilot program to provide comprehensive mental health services to Medicaid beneficiaries through a capitated managed care system. The Colorado Departments of Human Services and Health Care Policy and Financing completed a feasibility study, obtained a 1915B Waiver from HCFA, and competitively bid proposals to operate the pilot. The decision to carve out mental health was never an issue. HMOs operating in Colorado had little interest in assuming the actuarial risk of providing mental health services. The state planned to reinvest any cost savings from MHMC back into the mental health system and assumed that this would be easier to do if mental health were carved out.

The demonstration was developed and implemented during a time when the state was shifting responsibility to the county level for a broad range of health and human services. Social services began operating under a managed care system, effective July 1, 1997.

We interviewed primary care, mental health and social service providers in two rural areas. In Weld County, the managed care contractor is a single community mental

health center. In Garfield County, the managed care contractor is a partnership between Options, Inc., and three community mental health centers. Weld County is located in the northeast section of the state; Garfield County is located in Colorado's Western Slope region.

DESCRIPTION OF CARVE-OUT

Procurement Process: A request for a proposal was issued in 1994. Entities eligible to bid included community mental health centers (CMHCs) under contract with the Colorado Division of Mental Health; organizations obtaining approval to become a CMHC; or organizations proposing specific strategies for coordinating Medicaid and non-Medicaid services to achieve the state's managed care goals.

The initial bidding process did not go smoothly and was challenged legally in March 1995 by mental health providers whose bids were not accepted. The Colorado Department of Human Services conducted a series of hearings with the contesting parties. The hearing officer recommended that the parties resolve the issues themselves by a certain date or the technical portion of the proposal would be reevaluated. Resolution was reached and contracts with the state signed. On August 1, 1995 three single community mental health centers and a consortium of community mental health centers began implementing MHMC. One month later the three partnerships between Options, Inc. and two consortia of community mental health centers and one free standing center began operating.

Populations Covered: All Medicaid beneficiaries (AFDC and SSI) within the 51 counties participating in the demonstration program are included (Figure 2). This represents 70 percent of all Medicaid beneficiaries in Colorado.

Benefits / covered services: A full range of inpatient services and outpatient services are covered. Outpatient services include psychosocial rehabilitation services, case management, medication management, 24-hour emergency services, respite care, pre-vocational and vocational services, family preservation services, family education and training services, and infants' and children's early intervention service. Under the contract, substance abuse, alcoholism, mental retardation and organic brain syndrome are not considered psychiatric services and the contractor is not responsible for treating

these conditions. All drugs currently covered under Medicaid remain Medicaid's responsibility. Contractors have the flexibility to offer new services.

Provider organizations / contractors: Four contracts were awarded to CMHCs serving their traditional catchment area: Weld Mental Health Center (Weld County), Mental Health Center of Boulder (Boulder County), Behavioral HealthCare, Inc. (Adams, Arapahoe, and Aurora counties), and Jefferson Center for Mental Health (Jefferson, Gilpin, and Douglas counties). Three contracts were awarded to partnerships between CMHCs and Options, Inc: SyCare Options (19 counties), PikesPeak Options (El Paso, Teller, and Park counties), and West Slope Options (21 counties).

Each of the three Options - CMHCs partnerships are structured as limited liability corporations. Community mental health centers had already formed a limited liability corporation in two of the three regions, which in turn, partnered with Options, Inc. to create a second limited liability corporation.

Financing / Capitation: The state pays each contractor a monthly payment based on current eligibility data. Payment is based on separate capitated rates for five sub-populations of Medicaid eligible persons.

IMPACT ON RURAL SERVICE DELIVERY

Weld County: The Weld County Mental Health Center (WCMHC) serves all of Weld County (4,000 square miles), which is among the most productive agricultural counties in the country. The most populated area is along the Snake River, running through the center of the county. The remainder of the county is sparsely populated grasslands. The WCMHC is located in Greeley (population 60,000) and operates three satellite mental health offices. The main office of the Weld County Division of Social Services and two health clinics, primarily serving Medicaid and other low-income citizens, are also located in Greeley. A third health clinic is located thirty miles south of Greeley.

WCMHC staff report that services for adults with severe, chronic mental illness have not changed appreciably under managed care. Colorado has targeted serving adults with chronic mental illness for a number of years and does not limit the number or length of services which these adults can receive. " We have had a good program for adults and have kept a broad panoply of services," observes the Center's clinical director.

Innovative mental health services maintained under managed care include a job clubhouse, a range of residential care options, and treatment of nursing home residents.

Since managed care began, an alternative inpatient unit has opened, which functions like a traditional inpatient unit, but can move people in and out more quickly. A continuum of treatment is provided to clients over 18 at risk of needing acute or long-term inpatient services. Following an interdisciplinary assessment, clients are placed in one of three service tracks: partial hospitalization, intensive inpatient, or outpatient.

Children's mental health services have been substantially increased since managed care began. 'Capitation has made it possible to do things we couldn't do before,' observes the Director of Children's Services of WCMHC. A Children's Acute Treatment Unit, a licensed eight-bed residential facility, opened in January 1996 and provides services to children age four to fourteen with a wide range of diagnoses and behavior problems. The eight beds are almost always full and there are plans to build a sixteen bed unit. The increase in community-based children's mental health services was spurred by Colorado's move to reduce inpatient children's beds, which occurred at roughly the same time that mental health providers were being placed at financial risk under capitation and when additional funds became available through the Family Preservation Act.

Weld Community Mental Health Center staff anticipated that primary care providers might be concerned that their patients would not receive appropriate mental health services under managed care. To allay such concerns, Center staff sent a letter to each local primary care physician to explain how services would work under managed care and to express their willingness to serve primary care patients.

Primary care providers' experience with mental health managed care has been favorable: they are pleased with their ability to refer patients for mental health care since the demonstration began.. The legislature mandated that all mental health referrals go to the designated mental health contractor. Some primary care providers wanted to maintain the option to refer patients to private mental health providers. However, they report that patients they refer for mental health care are being seen more quickly and easily and are receiving higher quality care since managed care began.

Providers are critical of the amount of paperwork required under the demonstration. The state is working on reducing the paperwork.

Western Slope (Garfield County): West Slope Casa, the Limited Liability Corporation (LLC) formed by the three CMHCs partnering with Options, Inc., serves a very large twenty-one county area (27,000 covered lives), stretching from the New Mexico to the Wyoming border. This area is very rural – Grand Junction, population 21,000, is the largest city. The major industries are agriculture, mining, and tourism related to skiing and hunting. There are pockets of extreme wealth (e.g., Aspen) and extreme poverty throughout the area, contributing to the tendency of rural persons to have strongly-held preferences about where they will and will not travel to receive care.

The goal of the CMHCs in partnering with each other and with Options was “to keep as many dollars as possible in direct services,” according to Western Slope’s executive director. Options brought to the partnership managed care infrastructure and knowledge (particularly with regard to financing and management information systems) and deep financial reserves.

Given the size of this service area, we focused our case study on Garfield County, which has a catchment area of 23,000 square miles, substantial service infrastructure, and high demand for mental health and social services. Garfield County is centered in Glenwood Springs (population 6,000). The Garfield County Mental Health Center for Outpatient and Acute Care Services (one of the three CMHCs in the West Slope Casa) provides outpatient and emergency mental health care (six beds). The Center employs thirty-six full time equivalent staff who provide family support, client access, community support, and emergency services at two clinic locations and seventeen sites throughout Garfield County, including nursing homes and club houses for persons with dual disorders (mental health and substance abuse). Most referrals to the Center come from schools, the Garfield Department of Human Services, physicians, and other parts of the mental health system.

Children’s mental health services have increased ten percent in Garfield County over the past year and now account for nearly half of all mental health services provided by the Center. The executive director of West Slope Casa attributes the increase in children’s services to the converging trends noted in our description of Weld County. Both mental health and social service directors add that it is difficult to disentangle the effects of managed care, decrease of children’s inpatient beds, and infusion of new

dollars for children's services on the increase in children's outpatient mental health services.

All three directors (CMHC satellite director, social service, and Western Slope-Casa) concur that, so far, managed care has worked well. As the CMHC director observed, "Right now, Options wants us to be doing what we are doing. We will see what happens over the next several years, as the focus shifts to outpatient care." The three directors agreed that the paperwork required by managed care is onerous and time-consuming.

Western Slope Casa – and Garfield County, in particular – are providing clients good access to services under managed care and are doing well financially under capitation. Implementation has gone smoothly. The partnership between Options and the mental health centers has gone smoothly. The relationship between primary care and mental health appears to be adequate, but somewhat limited, both before and after managed care began.

When asked to compare managed care in the Western Slope to more urban areas, respondents reported that there may be more cooperation in rural areas because of the need of rural providers to collaborate given limited resources. A good example is how the Western Slope counties have been willing to avoid fighting over "every last dollar" allocated through the Family Preservation Act and other funding streams. They collaborate as necessary, if they perceive the allocations to be basically fair and to foster capacity-building in their respective counties. Children's mental health providers in the higher supply, urban areas are reported to be more actively contesting allocation decisions.

Evaluation

Four external evaluations and reviews of Colorado's Medicaid mental health demonstration program are being, or have been conducted: (1) an NIMH funded evaluation by researchers at the University of California at Berkeley; (2) a state funded evaluation of children and families; (3) a state auditor's report; and (4) the Mental Health Services Report to the Colorado Legislature, by the Colorado Departments of Human Services and Health Care Policy and Financing. The UC -Berkeley study found no significant differences in utilization of mental health services in the 12-month periods before and after capitation. The Children's Study reported some concern during the first

two months under capitation with the ability of children to access inpatient care and with the adequacy of discharge arrangements. The State Auditor's Report recommended that current projects continue to be funded through the year 2000 and the Report to the Legislature recommended that Colorado proceed with statewide implementation of mental health managed care.

The amount of time to make and receive an outpatient visit did not increase under managed care. On average, clients were seen within a week for non-emergency situations. Among the Colorado Health Networks (Options - CMHC partnerships), the average time to obtain an outpatient appointment was reduced from 7.5 days before the demonstration began to 3.5 days after nine months and to 2 days after 18 months.

FUTURE PLANS AND ISSUES

Colorado state officials and participating MCOs and MBHOs are pleased with how MHMC has worked so far. The state, believing that the major structural components of managed care are solid, plans to extend it statewide. There are several areas where the state will be tightening requirements in the next round of contracts. These areas include better coordination with the Early Periodic Screening, Diagnosis And Treatment (EPSTD) program; ensuring that consumers have greater rights in deciding what services they need and establishing an appeal if they disagree with service choices; and better coordination between Medicaid and the public mental health system in treating members of the same family with different program eligibility. The state has reaffirmed its priority to continue to reinvest any savings from MHMC back into the public mental health system.

Staff from the Weld County Mental Health Center (WCMHC) remain somewhat cautious that managed care may result in their treating an increasingly more chronic care population over time. The WCMHC is exploring forming a coalition with providers in three counties in the northeastern corner of the state to extend managed care to this region. Colorado Health Networks plan to reinvest savings from managed care to strengthen emergency services; support client transportation; help develop tele-medicine; and support client scholarships for vocational training.

OREGON

OVERVIEW AND BACKGROUND

A major challenge rural states face as they move into Medicaid mental health managed care (MHMC) is how to develop sufficient infrastructure to deliver services. Oregon has extensive experience with managed care in the public and private sectors, providing a firm base upon which to develop the necessary infrastructure.^{iv} Oregon began a Medicaid mental health managed care demonstration program in May 1995 which includes 25 percent of the state's total population, but a majority of its rural counties. Nine contractors were selected to provide MHMC in different regions in the state and include national MBHOs, county community mental health programs, and the Greater Oregon Behavioral Health Inc. (GOBHI), a private, non-profit consortium of 19 rural counties.

The demonstration program was developed within the framework of the broader Oregon Health Program (OHP), begun in 1989 and implemented in 1994. The Oregon Health Plan (OHP) was one of the earliest and most ambitious state efforts to alter both the eligibility criteria and benefit package for Medicaid beneficiaries under an 1115 Medicaid waiver. The OHP consists of a series of reforms attempting to extend health care to all Oregon residents. The Medicaid component of these reforms sought to develop a prioritized list of services, emphasizing prevention and early intervention; expand eligibility to 100 percent of the federal poverty level; and organize the delivery of care through fully capitated health plans. A series of community meetings was held throughout the state to develop the list of services that residents felt were the most important to offer. This list, in which services were ordered from the highest priority to the lowest, became the best-known component of the much discussed Oregon Health Plan.

In 1993, the Oregon Legislative Assembly passed a bill to integrate mental health services into the prioritized list of services under the OHP. Fifty mental health conditions were added to the previous list of prioritized services. The Legislative Assembly eventually authorized funding for 38 of these conditions.

We interviewed primary care, mental health, and social service providers under MHMC in two rural areas – *The Dalles Four County Program*, in the northwest part of the state and the *Josephine County Mental Health Center in the southwest*. The first program is a member of GOBHI, the second is not.

DESCRIPTION OF CARVE-OUT

Procurement Process: The Oregon Mental Health and Developmental Disability Services Division (OMHDDSD) issued requests for proposals in July 1994. Applicants were restricted to fully capitated health plans contracting with the Office of Medical Assistance (the Medicaid Program) to provide physical health services and to organizations authorized by the local county mental health authority to provide mental health services. The second group includes community mental health centers and private mental health providers. Nine of sixteen proposals were accepted.

Populations covered: All persons covered under the Oregon Health Plan residing in twenty Oregon counties are eligible for services under Oregon's Medicaid Mental Health Managed Care Plan (Figure 1).

Benefits / covered services: The traditional Medicaid adult mental health benefit is based on a priority system serving persons who are at immediate risk of hospitalization, in need of services to avoid hospitalization, or pose a hazard to the health and safety of themselves or others. Services for children and adolescents were also prioritized to serve those at immediate risk of psychiatric hospitalization or removal from the home due to a mental or emotional disorder. Currently, an adult does not have to be an imminent danger to self or others to receive services. A broader scope of more preventive services are offered, including educational and support services for parents of children with disorders.

Provider organizations / contractors: Four of the nine Mental Health Organizations (MHOs) selected were county community mental health programs; three were fully capitated health plans and two had unique structures, including the Greater Oregon Behavioral Health Inc. (GOBHI). GOBHI is a private nonprofit public benefit corporation including community mental health program directors serving 19 rural Oregon counties. GOBHI grew out of the previously established Eastern Oregon Human Services Consortium and was created in May 1994 to enable small rural counties to participate in Oregon's mental health demonstration project.

Financing / Capitation: Prospective funding is calculated across multiple capitation rates set for different subgroups of the enrolled population. The MBHO bears full utilization risk for capitated services and can enter into at-risk contracts with its

service providers. The OMHDDSD bears the risk for community-based services for non-enrolled persons and for state hospital services.

IMPACT ON RURAL SERVICE DELIVERY

The Dalles Four County Program is a member of GOBHI, which provides much of the administrative infrastructure for providing managed care. The Mid-Columbia Center for Living (the CMHC) delivers most of the clinical services to the four counties served by the demonstration: Hood River, Wasco, Gillen, and Sherman. The Center has major offices in all counties but Sherman and employs two psychiatrists who prescribe medication, a primary care physician, a number of mid-level providers licensed to prescribe medication, and a psychiatric case manager.

Expanded eligibility under managed care has increased Mid-Columbia Center's overall caseload, the number of clients coming in for general assessments, and demand for mental health services by AFDC clients. The Center has been able to raise salaries for some positions under managed care, making it easier to hire staff to meet the increased demand. Most of the difficulty the Center has experienced under managed care has been administrative rather than clinical and involved learning to use the new MIS and computer systems. The major clinical issue was an increase in the severity of conditions of some clients being treated in outpatient settings, resulting from a decrease in inpatient care.

"A major advantage of managed care is the flexibility that capitation allows in tailoring services to the needs of clients," observes the Center's director. "A good example is community rehabilitation services which were not reimbursable under fee-for-service ." The director points out that GOBHI's low administrative costs allow much of the capitated dollar to be used for services. She cautions about not overlooking the importance of GOBHI in keeping their administrative costs low and the strong foundation upon which GOBHI could build.

Primary care and mental health delivery systems are reasonably well linked within the four county region, according to both mental health and primary care providers. The Dalles Health Clinic is located across the parking lot from the Mid-Columbia Center for Living, which facilitates referrals. "If someone really needs a mental health consultation, we can now escort them across the parking lot to the mental health center, rather than

setting an appointment and hoping that they show up,” observes a physician assistant at the health clinic. Coordination between primary care and mental health would be even better, she suggests, if the mental health center had more psychiatrists available and if the health clinic were routinely informed about the condition of patients they refer to the mental health center.

While most of the referrals go from the health clinic to the mental health center, the mental health center routinely refers patients to the health clinic for physicals and general health problems. The Center has made a concerted effort to engage primary care physicians by hosting pizza lunch meetings. Staff from the multi-specialty health clinic meet regularly (2-4 times a year) with mental health center staff to review procedures for referral and consultation and to stay informed about changes in each center.

Mental health providers report that coordinating mental health and substance abuse services is harder to do under managed care, primarily because substance abuse services remained under physical health care. Coordination between substance abuse and mental health providers is reported to be better, where they are co-located.

Josephine County Mental Health Center

The Josephine County Mental Health Center (JCMHC), in Grants Pass, serves a very rural area in southwestern Oregon. Under the demonstration, the JCMHC has major subcontracts for day treatment and for sexual abuse services. The JCMHC has been under partial capitation for just under two years. Under this arrangement, the Center is financially responsible for the first 31 days of inpatient hospitalization; the state is responsible for hospitalization beyond that. JCMHC shares a regional acute care mental hospital with several other counties. Center staff report that capitation has allowed them to be much more flexible in serving clients than under fee-for-service payment. “I have been in community mental health since 1978. This is the best situation I’ve ever seen,” observes the Crisis Supervisor. Services the Center now provides that it couldn’t before include family support and counseling, stress management, and anger support groups.

Some JCMHC staff are concerned that capitation is not set at a high enough rate to be able to provide all the services needed. There is a related concern that the Center’s 14,000 covered lives is too small a base to be actuarially sound. The Director of JCMHC

remains cautious about the financial viability of the current capitation level and worries that cost savings under mental health may be shifted to medical-surgical services.

Both mental health and primary care providers report that coordination between primary care and mental health in Josephine County is poor. The scarcity of mental health providers, particularly psychiatrists, was a problem before managed care and remains a problem today. The Siskowoc Community Health Center in Cove Junction provides approximately 17,000 annual visits to 4,500 patients. The Medical Director estimates that a fourth of these visits involve mental health problems, either directly or indirectly. She reports that it is difficult to get referrals into, or consultations from, the JCMHC, unless the patient is acutely suicidal. Physical distance doesn't appear to be the major barrier to coordinated care. Although the JCMHC operates a satellite clinic right next door to the Siskowoc Community Health Center, it is difficult for the Center to refer patients to this clinic, because it is open only two days a week, primarily to dispense medications.

JCMHC staff share the view that primary care and mental health are not well coordinated. The Center's director notes that "primary care providers have unrealistic expectations for what the mental health center can do ...they don't realize how busy psychiatrists are and that we have stricter liability laws than apply to primary care physicians." Independent physician assistants are the most common primary care provider in Josephine County and can dispense medication. There is a "gentleman's agreement" that primary care providers will leave prescribing anti-psychotic medication to the JCMHC.

Evaluation Findings

A comprehensive evaluation of the Oregon Health Plan, including mental health services, was mandated in the enabling legislation. Capitated mental health managed care services were to be compared with FFS health services with respect to: impact of integrated mental health services on utilization of physical health services; use and length of stay in private and public hospitals; use and length of stay in residential care facilities; treatment of specific conditions; treatment configurations; and effectiveness. Health Economics Research, Inc. was awarded the contract to evaluate the program under HCFA's 1115 waiver. The health plan unit within the OMHDDS Division is also collecting

data and conducting analyses on the impact of Oregon's Medicaid Mental Health Demonstration.

During the first year of the demonstration, use of mental health services was higher, but per capita cost lower, among persons served under managed care than those served under traditional fee-for-service (OMHDDSD, 1996). Nearly eleven percent of eligible persons served under managed care received mental health services, compared to eight and a half percent of persons eligible under fee-for-service. Persons served under managed care also were less likely to be hospitalized and had shorter lengths-of-stay for acute inpatient mental health care than persons served under fee-for-service (8.6 vs. 10.7 days). The annualized cost per mental health user served under managed care (\$1,829) was less than the comparable cost for persons served under fee for-service (\$1,908). The decrease in inpatient use is impressive, since Oregon had substantially reduced the number of persons served in institutional settings before the demonstration began.

Consumer satisfaction surveys of adult mental health users showed that persons served under managed care reported greater progress toward treatment goals and satisfaction with treatment than persons served under fee-for-service. Persons served under fee-for-service report that, on average, they waited eight weeks between when they sought and when they received services. This was four times greater than the average wait between seeking and receiving services (two weeks) reported by persons served under managed care.

FUTURE PLANS AND ISSUES

Oregon allowed a variety of different types of providers and contractors to participate in its MHMC demonstration program. By most accounts, the program has been successful, in rural and in urban areas, and most of the participating MCOs and MBHOs share credit for this success. The major problem to arise concerns the adequacy and timeliness of payment of substance abuse providers by general health care plans. While the contractual aspects of this dispute appear to have been resolved for the moment, the continued separation of substance abuse from mental health remains a concern.

The state appears committed to moving toward integration of physical and mental health in the future. The state's rationale is that fewer MCOs, serving larger geographic areas, are more efficient and effective. Rural county mental health authorities were concerned that the state would establish a minimum requirement for covered lives that would be sufficiently high to preclude many rural MCOs and MBHOs from participating in the latest bidding process for MHMC. While such a requirement was not included in the latest request for proposals, many rural providers and county mental health authorities wonder if they will be allowed to continue to manage mental health themselves, even though they have successfully done so.

WASHINGTON

OVERVIEW AND BACKGROUND

Washington's evolution toward Medicaid mental health managed care began in 1989 when the state legislature passed a mental health reform bill. Services for persons with mental illness had historically been fragmented and resources to provide these services were inequitably distributed across the state. Before the effort to reform Washington's mental health system, the Washington Division of Mental Health (WDMH) provided services at the county level. County governments were at risk for outpatient services but were not at risk for inpatient care, creating a strong incentive to hospitalize clients.

The 1989 reform bill strengthened the role of local mental health authorities and created Regional Support Networks (RSNs) in an effort to control state hospital utilization. Subsequent bills added Medicaid reforms and risk-contracting administered by Prepaid Health Plans (PHPs), located under the RSNs. Originally there were 17 RSNs, currently there are 14. In urban areas an RSN typically includes a single county, in rural areas an RSN includes multiple counties. The relative responsibility of RSNs and PHPs have remained complex and in flux, funded by a mixed capitation / case rate system. PHPs were not at risk for inpatient care, which remained under fee-for-service, until Spring 1997.

Washington's transition to Medicaid mental health managed care has been protracted and lacks the narrower focus and tighter time frame followed by other states. The geography of the state and its recent policy history provide important contexts for understanding this protracted transition. The Cascade Mountains separate much of the urban population from a very large rural population. Culturally, eastern and western Washington are very different. Interstate 5 runs along the western part of the state, connecting Seattle and its populous suburbs to a number of cities and towns to the north and south, whose populations are growing rapidly. In contrast, many of the counties in eastern Washington are frontier and the political culture is much closer to the rugged individualism found in Idaho than along the Pacific North-West.

While the Washington legislature authorized movement toward a regional-based mental health system in 1989, the WDMH has been slow to transfer authority to the regions. Tellingly, the 1989 Reform Bill has not been amended to reflect, or to create a

clear statutory basis for, the state's development of mental health managed care. Throughout much of this decade Washington has been among the leading states trying to reform its health system and expand health insurance to its citizens, primarily through the Washington Basic Health Plan. In the last few years, there has been a significant scaling down of this initiative, as funding and political support have weakened.

Washington's protracted effort to develop MHMC is more typical of many states' experience than states which have moved swiftly and surely. The uncertainty over managed care under which rural Washington providers have worked (e.g., when is it coming and how will capitation work) may illuminate the issues facing rural providers in other states not on the fast track to managed care. We interviewed providers in Grant County (2800 square miles, population 62,000), which is located in the middle of the state.

DESCRIPTION OF CARVE-OUT

Procurement Process: Regional Support Networks (RSNs) submitted applications over an 18-month period (January 1995 - June 1996) to manage capitated outpatient services, as they became ready to assume this responsibility. Most contracts started between January 1995 and February 1996; all ended on June 30, 1997. New contracts include responsibility for inpatient care, as well.

Populations Covered: Each RSN is, by statute, responsible for providing care for all persons in its region (Figure 1). However, RSNs are contractually obligated to serve the Medicaid eligible population, including children and adults. Medicaid beneficiaries meeting specific criteria are eligible for specially targeted services.

Benefits / covered services: The benefit package includes all medically necessary outpatient community rehabilitation services, as well as 24-hour crisis services and face-to-face assessments on enrolled children. Additional outpatient services are targeted to beneficiaries meeting eligibility criteria which reflect serious emotional problems and mental illness and high use of inpatient psychiatric care. These services are capitated. Inpatient psychiatric treatment services were reimbursed through June 30, 1997 on a fee-for-service basis.

Provider organizations / contractors: Fourteen Regional Support Networks have been awarded MHMC contracts. Prepaid Health Plans (PHPs) within the RSN's

region actually administer the provider network, funding, benefit design, and utilization review. They also bear the financial risk.

Financing / Capitation: Most dollars flow from the state general fund to the WDMH. The Federal Medicaid match is important because the contribution from block grants and other sources is negligible. Funding flows from the WDMH down five separate streams (McGuirk, Keller, and Croze, 1995). Two streams fund PHPs directly. A base capitation rate funds only most basic mental health services. A three-tier case rate supplements the cost of care for identified seriously mentally ill (SMI) adults and seriously emotionally disturbed (SED) children. The PHP contract specifies the funding mix, provides dollars prospectively, transfers full risk for the care of enrollees to the PHP and stipulates accountability requirements. PHPs are able to transfer risk to their sub-contracted providers if they choose.

The third funding stream runs from the WDMH to the RSN - site-based contract, funding services for unenrolled persons. Full risk for these services is held by the RSN. The fourth and fifth streams fund inpatient care through a mix of site-based grants to the state hospitals and Medicaid reimbursement by service units for inpatient care.

The state retains some risk for cost of these services and also contracts with the RSNs to share in that risk and manage inpatient utilization. If the RSN keeps inpatient utilization below a targeted amount, savings are available for reinvestment in community services. However, if the RSN exceeds its allocation, it is liable for the additional cost. This system corrects for what would otherwise be an incentive for local level providers to over-use inpatient services funded separately by the state.

IMPACT ON RURAL SERVICE DELIVERY

The Grant County Mental Health Center is located in Moses Lake in central Washington. Agriculture is the major industry of the region. The Center, responsible for providing comprehensive mental health services for the entire county, also operates sites at two other locations in Grand Coulee and Quincy. The Center provides a variety of services, including a substantial amount of care to children (in clinics and in schools) and residents of congregated housing facilities.

There are no practicing psychiatrists in Grant County and no inpatient psychiatric beds. To compensate for the absence of psychiatrists, the Center has expanded the

number of psychiatric nurse practitioners it employs and is trying to work more closely with primary care providers.

The Center serves a significant number of Hispanic and Russian immigrants, reflecting relatively large populations of these cultural groups in Grant County. Serving bilingual populations has presented challenges. The director reports that services to Hispanic clients improved significantly after the Center aggressively recruited bilingual staff. The Center was best able to do this by recruiting Hispanic staff and training them as mental health workers. Bilingual staff are paid at a slightly higher salary than other staff, in recognition of their special skill.

The Grant County Mental Health Center has, so far, fared reasonably well under managed care. According to the director, capitated rates for outpatient services have not posed a problem to the Center since it had not over-billed before managed care. In contrast, other mental health centers in Washington had billed at higher rates before managed care and the lower rates they must now live with have proved problematic. The Center is trying to expand its services to the non-Medicaid population.

Coordination with the Grant County Community Mental Health Center has always been a problem, but may have improved slightly since managed care began, reports the director of the County's Community Health Center (CHC).. Apparently, the CMHC doesn't like to take referrals from the CHC unless patients have very severe mental health problems and tends not to refer its own patients to the CHC unless they have major physical problems. A problem has arisen around differences in brand drugs prescribed by the CMHC and the CHC. The CMHC's pharmacy costs are capitated, while the CHC's pharmacy costs are reimbursed under fee-for-service. Consequently, these two centers usually prescribe different brands of the same drug, which sometimes impedes the continuity of medication for those patients that do get referred between the two centers.

FUTURE PLANS AND ISSUES

Washington's reform of its public mental health system has been underway for nearly a decade. The original problems reform sought to address - fragmentation of services and inequity of resources - have not been entirely solved yet. Washington's journey to mental health managed care has itself been fragmented and includes multiple

and complex funding streams and more levels of administrative responsibility than found in many other states moving forward with MHMC. Most significantly, inpatient care has just recently been capitated.

Rural providers have been waiting for MHMC for a long time. In some areas of the state, rural community mental health centers are reported to have reduced their staff in anticipation of capitation, only to discover that they had reduced their service capacity too severely. However, the pressure to reduce costs remains up and down the administrative ladder. Given the state's intention to reduce the number of Regional Support Networks (RSNs), individual rural counties are not likely to be able to maintain specialized services, such as emergency care. For example, there will be a single crisis system for a four-county RSN, rather than four systems. The more consolidation there is at the RSN level, the more consolidation there will be among rural county mental health systems.

EXPERIENCE OF OTHER RURAL STATES

IOWA

Iowa's entry into Medicaid mental health managed care received considerable attention on several counts. First, it sought to award a single contract to serve the entire state. This was newsworthy because Iowa is a relatively large rural state. Second, Iowa rescinded its original contract award to Value Behavioral Health Care after the bidder finishing second, MEDCO, filed a lawsuit alleging conflict of interest. Iowa then awarded the contract to MEDCO, which later changed its name to Merit Behavioral HealthCare of Iowa (MBCI). The lawsuit received considerable attention nationally and was closely noted by other states interesting in contracting for Medicaid mental health managed care.

Iowa has a population of 2.2 million, nearly 40 percent of whom live in rural areas. The total Medicaid enrollment in the state is 230,000. Iowa's rural mental health service delivery system has many of the shortcomings found in rural areas of other states. One fifth of all rural Iowa citizens are poor and even with the availability of Medicare and Medicaid, rural Iowans are less likely to have health insurance than their urban counterparts. Psychiatrists, psychologists, and other mental health providers are scarce in rural areas. Iowa's approximately 60 rural hospitals have an average daily

census of 5 to 10 patients; very few of these hospitals have psychiatric units. The front-line worker in Iowa's mental health system, particularly in rural areas, is a social worker.

Iowa's 37 community mental health centers are supported in part by county funding and receive no direct funding from the state office. The only relationship these centers have to the state Office of Mental Health is through the accreditation process. Counties are the major purchasers of mental health services, using federal block grant dollars, Medicaid dollars allocated by the state Medicaid office, and local tax dollars. Counties are also responsible for uninsured patients not covered by Medicaid. As a result, there is often little coordination in health services for poor persons, sometimes leading to disputes over whether the state or county is responsible for the non-Medicaid poor. Both the Division of Mental Health Services and the Medicaid program are housed in the Department of Human Services. Because a majority of funds flow directly from the counties, turf wars between the Medicaid and Mental Health divisions have not arisen.

State officials offered a number of reasons for deciding to carve out mental health:

- the high proportion of enrollees with serious mental health problems;
- previous difficulty in recruiting providers;
- need for sufficient expertise to develop new community-based services; and
- desire to assure that savings would be channeled back to mental health services rather than going into a general medical fund.

The decision to assign management of the mental health benefit to a single firm was not controversial and was made to promote statewide comparability. State officials firmly believed that a single managed behavioral health firm would be better equipped to accept risk for mental health services, and would have expertise in clinical information systems not previously available in Iowa.

Iowa's mental health managed care plan, known as the Mental Health Access Plan (MHAP), includes Medicaid beneficiaries who are AFDC-, SSI-, or dually (Medicare and Medicaid) eligible. Currently, MHAP has a monthly enrollment of about 165,000 and has contact with about seven percent of enrollees each month. Under fee-for-service, about five percent of enrollees per month had contact with mental health services. The remaining 70,000 Medicaid enrollees are served by HMOs in urban areas in Iowa and have their mental health benefits carved-in.

To assure that all Medicaid enrollees have similar benefits, a list of required services has been developed for Medicaid HMOs. This list requires HMOs to reimburse CMHCs and psychologists.. HMO enrollees are not covered by the MHAP and receive their mental health benefits and services through their HMOs. The MHAP panel is not uniform across Iowa, and has the same regional variations in availability of services as the mental health system as a whole.

The vision for MHAP includes a commitment to community-based services, with a goal of expanded access through new preventive and early intervention services. Seven services are now being funded that were not funded under FFS: 24-hour hot-line; mobile crisis; mobile counseling; sub-acute inpatient care; respite services; community support programs; and crisis stabilization beds. During the first year of the MHAP, 3.1 million dollars of savings from MHMC were spent on these newly covered services.

A consortium provides day-to-day oversight to the MHAP. The consortium includes consumers, staff from Department of Human Services, the Division of Mental Health, the Medicaid program, and line staff from child welfare and child and family services. The consortium monitors quarterly reports submitted by MBCI to assure access and quality. Indicators include the percent of requests approved, county-level utilization rates, and ratings from satisfaction surveys. The consortium has established several safeguards to assure that cost-saving strategies do not compromise access and quality:

- If a requested level of care is deemed not appropriate by MBCI, the appropriate level of care must be authorized, and a provider must be available close to the enrollee's home with an available bed/slot/appointment. Court ordered evaluations are automatically authorized for five days;
- Ten outpatient visits per year are allowed without authorization (originally three visits had been allowed); and
- UR guidelines used by MBCI have been modified to include psycho-social issues and environmental factors such as availability of appropriate aftercare and family support.

Once the lawsuit was settled, implementation proceeded quickly - staff were hired and services offered. Misunderstandings and confusion common in the implementation of a new system arose. Most were quickly resolved. The Alliance for the Mentally Ill of

Iowa received funding from the National Alliance for the Mentally Ill to monitor the implementation from the family and consumer viewpoint (Alliance for the Mentally Ill of Iowa, 1996). Problems reported during the first year include inadequate access to a psychiatrist for evaluation and assessment; lack of transportation and insufficient housing and supportive services.

Iowa's program has sought to look for, and react quickly to, implementation problems. A provider roundtable has been in place since the contract started to provide advice and oversight. Within a few days of implementation of MHAP, primary care practitioners found out that they could not get reimbursed for mental health services they were providing and voiced a protest through the roundtable. MBCI modified their policy and primary care practitioners are now allowed to bill for mental health services.

MONTANA

Montana's Mental Health Access Program began in April 1997. The program received close national attention during its development because Montana is one of the nation's most rural states and had very little previous experience with managed care. Since its inception the program has generated even more national attention because of the lack of access to mental health services experienced by residents of rural areas without any mental health providers. The program appears to have overlooked the role of primary care providers - who are not included as credentialed providers - in delivering mental health services in rural areas.

The Mental Health Access Program is operated as a partnership between a newly formed non-profit coalition of human service organizations, Montana Community Partners, and a national, for-profit, managed behavioral health care organization, CMG Health.^v Montana Community Partners includes the state's five community mental health centers and over fifteen other human service organizations. The Montana Department of Public Health and Human Services (DPHHS) administers the contract. The program's design is ambitious, blending all state and non-state Medicaid funds to serve Medicaid beneficiaries as well as the non-Medicaid adults (with a severe mental illness) and children (with a serious emotional disturbance) with incomes up to 200 percent of the federal poverty level. Covered mental health services include those previously covered

through Medicaid and other state programs, as well expansion of a prescription drug benefit to eligible non-Medicaid persons (Figure 3).

The first three months of the program (April 1 - June 30, 1997) were intended as an implementation period, with full operation scheduled to start July 1. In late June, the Montana Primary Care Association wrote to the Governor asking him to direct DPHHS staff to consider a number of changes in the statewide contract before moving to full implementation. The major concern was whether networks of approved providers, which do not include primary care providers, are sufficient to ensure access in a number of counties. There are no mental health providers in twenty-four Montana counties.

The Governor agreed to allow the Montana Primary Care Association to conduct an independent assessment of the adequacy of the Montana Community Partners Network, compared to the availability of providers reimbursable for mental health services under Medicaid in 1996, the year before the start of Montana's Mental Health Access Program. Their assessment found that as of July 1997, the Access program had not achieved a distribution of available providers comparable to that available in 1996 (Strange, 1997). Primary care providers and psychologists were the most conspicuously underrepresented in 1997 compared to 1996. The implementation period has been extended and efforts are ongoing to expand the list of approved providers to ensure access to care.

From one perspective, Montana's practice of first excluding primary care physicians as approved providers seems to confirm rural mental health policy makers and advocates worst fears of what can happen under managed care. Looked at another way, it may be that in the context of ongoing negotiations between MBHOs and MCOS and the state over balancing access with controlling costs, the negotiation moved too far, too fast, in one direction (control of costs).

The lasting lessons from Montana's early experience with mental health managed care may be the need to promote better partnerships among MBHOs, providers, consumers, and the state and the need to improve the contracting process. Montana's current difficulties with access to mental care in rural counties is very similar to problems experienced by Iowa several years before. Iowa moved quickly to resolve them and their difficulties, which were well publicized, should have been known to

Montana policy makers. It will be important to monitor where things proceed from here in Montana, which is still in its first year under mental health managed care.

TENNESSEE

When the TennCare program began in 1994, replacing Medicaid, state officials wanted managed care organizations (MCOs) to assume responsibility for basic mental health services and have the state Department of Mental Health retain responsibility for caring for persons with serious mental illness. The MCOs resisted providing even basic mental health services and the state abruptly changed course, submitting a waiver amendment to carve-out mental health dollars and direct them through the Partners Program. Starting in July 1996, the Partners Program funded two private managed behavioral health care organizations (MBHOs) to provide managed behavioral health care. The state's eleven MCOs were required to contract with one or the other of the MBHOs.

Initially, this arrangement seemed to be working well, with consumers apparently enjoying increased access. However, community mental health centers, which had signed contracts with the MBHOs, soon protested that their capitation rates were too low. A CMHC in Memphis closed and others reduced services. State officials requested, through their Congressional delegation, that HCFA investigate the problem. In February 1997, TennCare announced that the Partners Program would be replaced by the end of the year by a carve-in with the MCOs responsible for behavioral health care services.

When the state created a separate behavioral health carveout program, primary care providers practicing in TennCare managed care organizations (MCOs) were no longer directly reimbursed for mental health services. All mental health funds were capitated to separate behavioral health organizations (BHOs). This was troubling to many primary care practitioners who had been providing mental health services through their practices. The largest TennCare MCO, Volunteer State Health Plan, operated by Blue Cross and Blue Shield of Tennessee, responded by negotiating an agreement with its BHO partner, Green Spring Health Services. At issue were what, if any, mental health services would continue to be provided through the MCO's primary care practitioners, at what point referrals would be made to the BHO, and how the MCO would be reimbursed for any mental health services it did provide.

Working with a group of its physicians and other interested parties, Volunteer State Health Plan determined that primary care physicians had a particular interest in treating certain childhood disorders, which pediatricians considered integral to the overall treatment of their patients. These were attention deficit disorder (ADD), attention deficit hyperactive disorder (ADHD), and enuresis. Volunteer State Health Plan reached agreement with Green Spring that its MCO pediatricians would treat these conditions, and that the Volunteer State Health Plan would receive a subcapitation from Green Spring as payment for treating the conditions.

The agreement also makes clear that MCO practitioners will refer patients with other mental health diagnoses to the BHO for treatment. Conditions for which patients are referred include psychotic disorders, anxiety disorders, affective disorders, somatoform disorders, personality disorders, major depression when accompanied by certain conditions, and panic disorder when accompanied by certain conditions. Specific referral triggers, included for each major condition area, were developed.

The agreement between Volunteer State Health Plan and Green Spring also covers the dispensing of prescription drugs. In Tennessee, the MCO is responsible for drugs related to primary and acute care; the BHO is responsible for drugs related to mental health treatment. Two issues arise from this agreement. First, many drugs may be used to treat a variety of conditions, and the boundary between physical and mental health quickly becomes blurred. Second, the MCO and BHO each have their own drug formularies, which overlap but also include different drugs. The BHO is responsible for drugs when the condition treated is one included in the agreement, regardless of whether the treatment is delivered by the MCO or the BHO. The MCO agreed to provide information to its providers regarding the BHO's drug formulary, and MCO providers are required to adhere to the BHO formulary when prescribing for mental health conditions.

All of this has occurred as the Health Care Financing Administration has been scrutinizing the state's plan to eliminate the mental health carve-out in favor of integrating mental health services with primary and acute services through the MCOs. In the meantime, the agreement negotiated between Volunteer and Green Spring offers clarity at the provider level and appears to have allowed MCO and BHO practitioners to coordinate their services despite the raging debate about future changes to the mental health delivery system in Tennessee.

DISCUSSION

States have embraced Medicaid mental health managed care (MHMC) using a variety of approaches. This section discusses the findings of our study with respect to:

- different approaches to MHMC in rural states;
- impact of MHMC on rural mental health service delivery; and
- rural issues for states developing MHMC.

Approaches to Medicaid Mental Health Managed Care

How an MBHO partners with providers is more important than the overall structure of a carve-out. The original model and approach that a state starts with is far less important than what happens once managed care is implemented. The amount of funding available for mental health services, other health care system initiatives (e.g., managed care for physical health) and the condition and configuration of the existing physical and mental health care systems shape and often supersede a particular approach that a state takes. The approach a state takes in setting out to implement MHMC will inevitably be modified given the state's particular resources, service delivery systems, politics, and culture. Any particular approach may change since waivers are renewable and must be re-bid every two years.

Local mental health providers are keenly interested in whether a state awards an MHMC contract to a national MBHO or to a locally based MCO or MBHO. Local providers tend to feel more comfortable, at least initially, with locally-based organizations, feeling they may have more say in what happens and that services may be more responsive to local needs. Providers also recognize that national MBHOs may provide deep financial pockets, administrative infrastructure, and know-how to develop managed care. Our assumption at the start of this study was that, all things being equal, rural areas would fare better being served by regionally-based MCOs or MBHOs than by national MBHOs.

We found that it is not the location of the MBHO (regional or national) that matters, but how the MBHO partners with providers. An approach of “here’s what you do, here’s how you do it, “ is not likely to work well regardless of whether the contract is awarded in- or out-of state. The MCO or MBHO brings infrastructure and knowledge about managed care, but must work with many, if not all, providers in rural areas. While the MCO or

MBHO may exclude certain rural providers, more often their challenge is to build, rather than to reduce, capacity.

Although risk-sharing is a crucial component of a state's approach, rural mental health providers have only assumed a limited amount of risk. Central to capitated managed care is the assumption of financial risk at some level. Risk may be shared among MCOs, MBHOs, and providers. Whoever assumes the greatest risk needs to have sufficient financial reserves and market size to spread it. Individual providers, or even larger entities such as CMHCs and county mental health authorities, are usually unable to assume significant risk. A certain degree of provider risk-sharing is desirable to promote needed reductions in excess cost and utilization and to enable providers to share in cost savings. Rural areas pose particular problems because there are fewer clients over whom to spread risk, provider groups are not sufficiently large to assume risk, and the problem with mental health services is usually inadequate access and under-utilization, not over-utilization.

It is too early to tell how risk-sharing between MCOs, MBHOs, and providers will ultimately work. In general, rural mental health providers have assumed a very limited amount of risk. While this has protected them from the “downside” of risk-based contracting (losing money), it has also taken away the “upside” of increased revenue. The risk typically has been maintained at the MCO or MBHO level. In many states, providers are operating under what they derisively describe as “discounted fee-for-service.” Sometimes, as in Iowa, reduction of Medicaid fees occurred before managed care began. Often, MCOs / MBHOs have been required to bid at less than current Medicaid rates. Where bids are within 90 - 95 percent of current rates, providers have not been unduly harmed financially. Where Medicaid fees have been substantially reduced (e.g., Nebraska, which reduced fees over 20 percent) the results have been harmful to providers, consumers, and MCOs.

In Colorado, Iowa and Oregon, providers have been able to increase revenues by providing services reimbursed under managed care that were not previously reimbursed under Medicaid. Uncertainty over when capitated managed care would be implemented, and the rates that would be applied, led some rural community mental health centers in Washington to reduce their staff too severely, thereby restricting service capacity.

Integrating mental and physical health services remains a goal, not a reality. The vast majority of states have chosen to carve-out mental health services, particularly for individuals with chronic and severe problems. Carve-outs don't preclude coordination of mental and physical health services; good practice calls for protocols and incentives to be in place to foster referrals and consultation. However, when carve-outs are implemented long-standing barriers to integrating mental and physical health are often encountered. In some cases this leads to reducing or removing the barriers; in other cases it results in ignoring them. This issue is of particular concern to rural areas, where integration of primary and mental health services has long been prescribed as a solution to the shortage of mental health providers.

At the state level, Medicaid programs and Departments of Mental Health often differ in terms of mission and funding. At the service delivery level, mental health providers are concerned that primary care providers don't know how, or won't have sufficient incentive, to provide mental health care and that savings from mental health will be absorbed by the physical health side. Physical health providers wonder how to serve persons with severe and persistent mental illness, particularly in rural areas where there are few referral options. Many MCOs lack the expertise to manage care for persons with mental illness, especially those whose illness requires regular attention. Mental health carve-outs have yielded important lessons about how to better coordinate primary care and mental health and how to build effective "fire walls" protecting mental and physical health revenues in a capitated system. It is still the consensus of the field (Medicine and Health Perspectives, 1997a) and the respondents from this study that the road ahead to integrating physical and mental health care is a long one.

Policymakers in Oregon and Tennessee maintain the long-term goal of integrating primary and mental health care. In Oregon, this goal chiefly rests on the assumption that fewer MCOs, serving larger geographic populations, are more efficient and effective - clinically, administratively, and financially. Two of the nine MCOs chosen under the current Medicaid mental health demonstration were originally integrated models located in urban areas. Both MCOs transferred responsibility for mental health to an MBHO within the first six months of operation. By all accounts, organizational factors rather than problems in delivering mental health care drove this decision. Rural MCOs and MBHOs in Oregon were concerned before the state issued its latest RFP in late 1996 that

contractors would be required to serve a larger number of covered lives, thereby effectively eliminating the ability of most county mental health authorities in rural areas to bid successfully on the contract. While the number of required covered lives did not increase as substantially as first feared, many in the rural community believe that it may be increased in the future.

Coordination between primary care and mental health care providers has improved in some rural areas in Oregon, while mental health providers are cautiously observing consolidation among primary care providers and wondering if they will be their “new bosses” in several years. It is a testimony to MHMC in Oregon that implementation has succeeded and service delivery improved even as uncertainty continues.

Impact on Rural Mental Health Service Delivery

The linkage between primary care and mental health has not been weakened in rural areas. MHMC has tended to magnify the previous relationship between the primary care and mental health systems. This is illustrated by the two rural areas we studied in Oregon. Oregon has created explicit incentives within both managed general health and mental health care to increase referrals from primary care to mental health and from mental health to primary care. In Josephine County, relations between primary care and mental health were strained before managed care and they are still strained. In the Dalles region, relations between primary care and mental health were well established before and have improved under managed care, particularly with respect to referrals from mental health to primary care for physical exams and treatment of physical health problems.

In Iowa and Tennessee primary care and mental health providers are talking to each other more since managed care began. Issues involved in prescribing medications and use of formularies is fostering discussion between mental health and primary care providers and has led to local agreements in Oregon and creative solutions in Tennessee. It may be that whether or not a drug benefit is included under managed care, and who is granted the right to prescribe and be reimbursed will have longer term effects on coordination between providers.

Access to mental health care has generally not been restricted, so far, under MHMC. Most MHMC approaches assume that psychiatrists and other mental

health providers are available and accessible. Under a carveout, MCOs typically direct mental health care away from the primary care setting toward the mental health care setting. This may reduce access to mental health services in rural areas, where mental health providers are in short supply. Iowa experienced such access problems early on, but moved quickly to resolve them. It remains to be seen whether Montana's recent access problems will be similarly resolved.

Interviews with a variety of rural persons in Colorado and Oregon clearly suggest that access, at least on the outpatient side, has not been reduced and, in a number of instances, has increased. These accounts are consistent with data and results from more formal, longitudinal evaluations of MHMC in these states. Under managed care, one would expect utilization to be constrained, at least in the beginning, on the inpatient side. This has happened and, in some cases, increased the burden on outpatient care, which providers have generally been able to meet. Increased outpatient access may be a logical consequence of MCOs and MBHOs seeking to increase their market penetration and share. It is important to continue to monitor access in rural areas as MHMC matures. Once inpatient utilization has been reduced and market share obtained, MCOs and MBHOs may constrain outpatient care more than they have to date.

Managed care has increased the administrative burden on mental health providers, but this doesn't appear to have adversely affected services. More data and reporting are required of providers under MHMC and most providers interviewed would prefer if there were less. However, it appears that providers have been able to assume this responsibility without it affecting service delivery adversely. Primary care providers generally do not report being burdened by increased administrative requirements associated with MHMC.

Children's outpatient mental health services have increased. At the same time that MHMC has been developing, there has been a national trend to reduce children's mental health inpatient beds as well as an influx of funding for children's mental health services through the Family Preservation Act and other sources. The range and availability of children's mental health services have increased in our case study states. Apparently, the flexibility of reimbursing different types of services under managed care, the availability of diverse funding for these services, and the financial risk associated with not adequately serving children in the community have all contributed to this increase.

Coordination between mental health and substance abuse has decreased under public sector managed care. In most states, management of substance abuse and mental health care are developing separately. This is unfortunate since mental health and substance abuse problems often co-occur among persons with both moderate and very severe mental health problems (Drake et al. 1991). While private sector managed care has increasingly recognized and addressed this connection, the separation of mental health and substance abuse under public sector managed care represents a serious setback in the delivery of behavioral health services. In Oregon state officials had to intervene in a number of conflicts between substance abuse providers and health plans after an audit found both to be “at-fault” (Medicine and Health Perspectives, 1997b). An innovative dual-diagnosis club house program in rural Colorado has succeeded, in part, by local providers skirting around rules which require separate substance abuse and mental health records.

Rural Issues For States Developing Medicaid Mental Health Managed Care

Medicaid mental health managed care is still new and it is not known how well it may eventually work. Initial savings seem to be there, but it is not clear whether these savings can be maintained without hurting access to and quality of patient care in the longer-run. Snapshots of how well managed care is working need to be tempered by the volatility of state systems, service delivery networks, and the mental health managed care industry, in which mergers are a common occurrence (Croze, 1997). Given this environment, states should consider the following issues as they consider and develop mental health managed care.

One should understand a state’s motivation for undertaking mental health managed care – in the short- and long-run. States have multiple goals: to save money, ensure access, coordinate services, and assure quality. While a state will try to balance these goals, saving money is often the strongest one and it is easier to save money where there is more money being spent – usually in the urban areas. Even in states without a large urban area, this larger concern with saving money often dominates deliberations. This may explain why states often fail to learn from each other and sometimes repeat other states earlier mistakes (e.g., Montana not taking into account Iowa’s access problems).

The nature and interrelation of urban and rural markets are important.

Capitated managed care is easier to develop and sustain in larger markets with more covered lives. Not only is it easier to spread financial risk, there is a larger service delivery infrastructure and resources with which MCOs and MBHOs may work.

The major challenge in rural areas under Medicaid mental health managed care is how to develop capacity, not how to reduce or trim it. Consequently, Medicaid mental health managed care must be adequately funded. Rural areas tend to have too little, rather than too much, service capacity. Rural areas may be hindered by capitation rates based on historical fee-for-service costs which reflect low access to services. A major objective of MHMC is usually to contain costs and service utilization. It is important that MHMC be adequately funded and that price is not the only criteria upon which potential MCOs and MBHOs are judged. We found that states often expected MBHOs to solve long-standing undersupply problems in rural marea. MBHOs may not be able to meet this challenge if containing costs is the major criterion by which they are evaluated.

How to evaluate adequate access to care in terms of available rural providers is crucial. This issue will be increasingly influenced by credentialing of providers. As Medicaid mental health managed care matures, standards established by the National Committee on Quality Assurance (NCQA) become crucial for the viability of MCOs and MBHOs. NCQA's work in managed care has been more institutionally focused than on community-based providers and services and favors a uniform standard accreditation of providers in urban and in rural areas. MCOs and MBHOs must be able to reconcile "working within the box" of NCQA requirements with working "outside the box" to provide services in rural areas.

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ENDNOTES

ⁱ The vast majority still carve-out mental health from general health, but some states (New Mexico, Vermont) are beginning to include (carve-in) mental health services and individuals needing mental health care under the basic benefit package (Perez, 1997).

ⁱⁱ There is a long and ongoing debate about the ability of primary care providers to recognize and treat mental health problems. From the perspective of the managed care industry, increasing the travel distance of rural consumers to mental health care could be considered in the context of a tradeoff between access and quality.

ⁱⁱⁱ It was common practice for a number of years to keep patients hospitalized for a mental health problem for a fixed length of stay, although the length of this stay was not based on clinical evidence. Rather, common practice became prevailing practice and private and public insurers adopted inpatient benefits based on this practice. As mental health insurers became more cost conscious, hospital length-of stay emerged as a target for reduction.

^{iv} Oregon has one of the most extensive managed care markets in the country. More than 50 percent of the Portland Metropolitan Area health care market is under managed care and managed care is present in rural areas.

^v Within months of the programs start last Spring, CMG announced that it would be acquired by Merit, one of the unsuccessful bidders for the Montana's program. Even more recently, Magellan Health Services has proposed to acquire Merit.



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