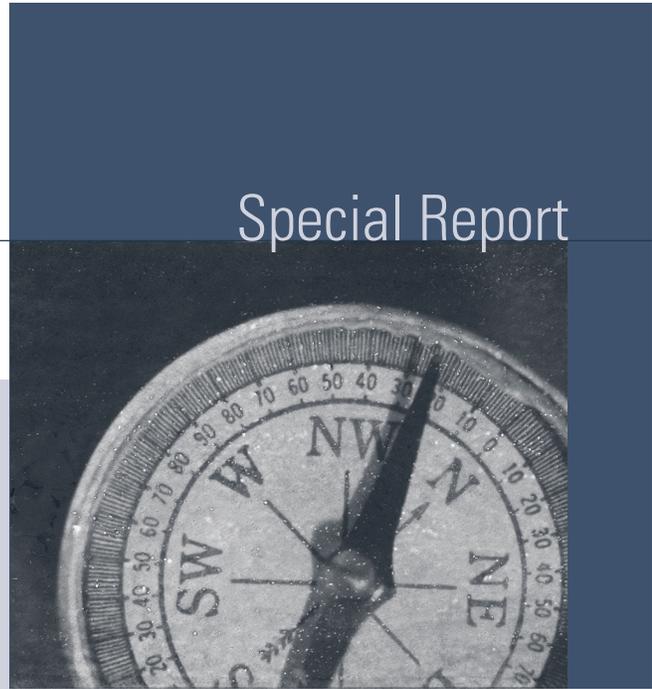


Special Report



CONTRACTING *for*
PUBLIC MENTAL HEALTH
SERVICES

*Opinions of Managed Behavioral
Health Care Organizations*



DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services



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*Opinions of Managed Behavioral
Health Care Organizations*

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Acknowledgments

This report was prepared for the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), by the Lewin Group under the project direction of Terry Savela and Gail K. Robinson, Vice Presidents. Research was provided by Sarah Crow. Leslie Scallet, Vice President, was Senior Advisor to the project. Government project officers were Jeff Buck, Tiffany Ho, and Shelagh Smith, CMHS, SAMHSA.

This report is a result of recommendations made by behavioral health managed care representatives, listed in the Appendix, who participated either in a full-day focus group meeting or in individual interviews. Special thanks also to Colette Croze for her contributions.

Disclaimer

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Originating Office

Office of Managed Care, Center for Mental Health Services
Substance Abuse and Mental Health Services Administration
5600 Fishers Lane, Room 15-87
Rockville, MD 20857
April 2000
DHHS Publication No. (SMA) 00-3438

Suggested Citation

Savela, T., Robinson, G., Crow, S. *Contracting for public mental health services: Opinions of managed care behavioral health care organizations.* (DHHS Publication No. [SMA] 00-3438). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2000.

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Executive Summary

This report synthesizes the collective experiences of four managed behavioral health care organizations (MBHOs) that hold public sector managed care carve-out contracts. Four representatives of these MBHOs participated in a daylong focus group meeting, and two others were interviewed by telephone. The views presented are solely those of the focus group participants.

The focus group participants represented the majority of the total managed behavioral health care market. In the public sector, over 70 percent of the 21 States with Medicaid carve-outs for behavioral health services contract with these MBHOs. The discussion and interviews examined practices used in public sector managed care contracting.

Today, fewer MBHOs are bidding on State and local public sector contracts. Preparing a responsive proposal has become extremely expensive because of an increasing number of program design specifications. Study participants predicted that States will see even less competition for those programs that require a large investment from MBHOs for marketing, start-up, and ongoing administration yet offer little potential for financial reward. The following are some of the specific problems that they cited:

- Public payers often fail to resolve design issues before the procurement process and do not provide necessary information and data to bidders. This can create confusion for both bidders and administrators.
- Excessive financial requirements may preclude generally desirable bidders from competition for managed care contracts. Limits on profits that do not recognize the potential risk involved also may significantly reduce the attractiveness of requests for proposals (RFPs) for some organizations.
- Benefits may be vague and/or reflect a “wish list” of the agency’s stakeholders.
- Contracts may identify specific providers as essential and exempt them from utilization management requirements imposed on other network providers. The role of State facilities and their relationship to the MBHO may be ambiguous.
- Performance measures may not be consistent with program goals or may be beyond the ability of the MBHO to measure.

-
- County-based programs may be too small to properly support a fully capitated program and may require excessive protections for county providers.

Focus group participants expressed the belief that the future of contracting in public sector managed behavioral health care will depend on public payers' willingness to design and administer programs that permit the contractors to succeed. Participants offered specific recommendations concerning managed care contracting, financial requirements and reimbursement, procurement processes, and implementation and ongoing administration of managed care programs. These include the following:

- RFPs should specify the requirements of the payer and ask offerors to describe how they will operationalize these requirements. Payers should avoid requirements that are overly prescriptive and that redefine an MBHO's management techniques and operational processes.
- The core benefit package should be specific and clear in the contract. Expectations for service coordination across health care and social support programs should be reasonable and should support additional service requirements appropriately.
- Clear and specific procurement specifications should be developed before the bidding process.
- Financial design should be compatible with the program design and should permit profit making. At-risk programs must include a sufficient scope of services and population size to be financially viable and actuarially sound. Reimbursement should accommodate start-up and ongoing administrative costs.
- Consumers should play an active role in advisory committees focusing on service-delivery issues and member services. Contracts should not require consumer representation on an MBHO's governing board.
- Performance measures should be tied to program objectives and should reflect those factors the MBHO can reasonably be expected to track.

The participants believed that, despite a variety of challenges, the MBHO industry will continue to be interested in public sector contracting. However, they indicated that their organizations are calling for more rigorous evaluation of public sector RFPs and more caution when entering such arrangements. Given the potential barriers to executing successful contracts, communication, cooperation, and coordination between States and MBHOs is essential. By establishing a cooperative program management style in relations with MBHO contractors, public behavioral health programs can better meet the objectives of the public payers and can continue to attract experienced, high-quality, reputable contractors.



Introduction

Public sector contracting for behavioral health services raises a number of issues between States and managed care organizations (MCOs). These issues reflect the background of the public agency staff involved in contracting, the agency's unique needs for the managed care contracts, an overall litigious environment, and multiple mergers among MCOs.

As States have moved from a traditional fee-for-service and grant-funded system to a managed care system based on negotiated rates and competition among bidders, they discovered that the procurement and contract processes were much more complicated and much less forgiving than under the traditional fee-for-service system. Developing an RFP and managing a competitive procurement demanded experience and skills not previously required for mental health and substance abuse authorities. Initially, these agencies were not adequately prepared for the intricacies involved in managed care contracts, a situation that has produced many challenges and lawsuits (Kaiser Family Foundation, 1997).

In the past few years, a number of public managed care contracts have expired, requiring renewals and new contracts. MCOs have noticed that these contracts are becoming more complex as States seek to ensure quality and breadth of services. States are also beginning to specify levels of treatment and prevention services for behavioral health care ("New Study Urges Close Scrutiny," 1998). In an attempt to hold MCOs to a higher

standard, some States have expanded their contracts by replicating requirements included in other States' RFPs. Unfortunately, some of these requirements have proven to be unduly costly, complicated, ineffective, and duplicative.

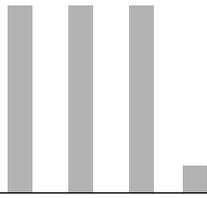
Lawsuits facing States and MCOs make the market seem risky. States, providers, and consumers have sued MCOs for what they allege to be unfair or dangerous practices. In turn, MCOs have sued States for unfair bidding processes and have withdrawn from programs they believe to be inadequately funded.

Rapid changes in the managed behavioral health care industry have further complicated contracting relationships. In recent years, the industry has experienced a flurry of merger and acquisition activity, reducing the number of MBHOs and increasing the size of those that remain. Consequently, in the past 2 years the number of national MBHOs active in public sector procurements has fallen from eight to three.

As a result of the above factors, fewer MBHOs are bidding on State and local public sector contracts. Preparing a responsive

proposal has become extremely expensive; complying with the increasing number of program design specifications introduces new and sometimes prohibitively high administrative costs. In some instances, only one bidder has come forward in response to an RFP. Given the potential

barriers to executing successful contracts, it is essential that States and MBHOs communicate, cooperate, and coordinate. The next sections contain the findings from focus group research on the critical issues faced by MBHOs currently providing managed behavioral health services to public sector clients.



Approach to the Study

This report synthesizes the collective experiences of four MBHOs¹ that hold contracts for public sector, managed care carve-outs. Together, the four MBHOs enroll over 106 million members and constitute more than 60 percent of the entire managed behavioral health care market (Findlay, 1999). Four experienced representatives from these MBHOs participated in a daylong focus group meeting. Two additional representatives were interviewed by telephone.

To ensure that the representatives would be able to draw on experience from different settings, the organizations invited to participate included those that have operated several public programs in different States. The four MBHOs (American Psych Systems, Magellan, United Behavioral Health, and ValueOptions) have significant experience providing managed behavioral health services for Medicaid and general assistance carve-out programs.² Over 70 percent of the 21 States with Medicaid carve-outs for behavioral health services contract with these four MBHOs, who manage the mental health benefits for almost 2.5 million Medicaid recipients (Croze, 1998; Lewin Group, 1999).

Participants were briefed on the purpose of the meeting and ideas for specific discussion topics were solicited in advance. The agenda for the discussion covered program

design (e.g., benefit package, financial requirements), procurement processes, and program administration and oversight. To promote a frank discussion of the issues, the meeting adhered to the following guidelines concerning the use of information and intent for any written report:

- Participants would be permitted to comment on this report before completion of the final draft.
- The names of specific participants would not be linked to their comments in the final report.
- Specific public programs discussed in the meetings as examples of problems would not be divulged.
- Specific programs put forth by participants as examples of successful design or implementation could be identified in the report.

The views presented in the following sections are solely those of the study participants. They do not necessarily represent the policies or opinions of the Center for Mental Health Services or the Substance Abuse and Mental Health Services Administration.

¹ See the Appendix for a complete list of focus group participants.

² One MBHO representative is currently with Menninger Care Systems, an MBHO that focuses on private sector clients. However, the representative participating had extensive public sector experience through her prior employment at United Behavioral Health.

IV. Program Design

When developing a managed care program, the State or county agency communicates the technical and financial design to potential offerors through a variety of documents and meetings. First and foremost, the agency describes program design in an RFP, which then becomes a part of the ultimate contract and is of primary importance to offerors. Public payers often provide an assortment of supporting materials that elaborate on the program requirements, the process for program specification development, and the rationale behind specific design features. States typically provide data pertaining to financial characteristics—the cost of services, utilization rates, and population size—in varying formats and degrees of detail. Throughout the procurement phase, program design features may continue to evolve through input provided by the contractors (during the procurement’s question-and-answer process) as well as a variety of other stakeholders. Technical and financial design features continue to evolve after contract award and program implementation. The study participants discussed those aspects of program design that they believe can be improved at any stage of this process.

In general, study participants observed that State and county RFPs reflect a trend toward micromanagement of MBHOs (“New Study Urges Close Scrutiny, 1998). They noted that payers seek experienced contractors for their expertise, clinical management capabilities, and operational efficiencies. However, the RFPs often circumvent much of an MBHO’s expertise by requiring specific structures, processes, and procedures that conflict with the MBHO’s operations. Consequently, the contractor must agree to retrofit its capabilities in order to bid. In some cases, the RFP’s detailed specifications have reflected a lack of understanding of

how managed care organizations function; how departments, providers, and information systems interact; and how functional needs and regulatory constraints have shaped existing MBHO organization.³ Furthermore, some requirements may be unnecessarily duplicative or even incompatible with each other, while others may simply be unclear.

Another issue noted by the study participants concerns the propensity for managed behavioral health RFPs to represent a wish

³ Such arguments reinforce the need for the State purchaser and the MBHO to develop contractual specifications together (see Croze, 1999).

list of the agency and its stakeholders. The RFP may include a compendium of changes to improve the existing system without fully considering whether the improvements are feasible or the anticipated funding is sufficient. The result, as witnessed in some markets by the study participants, is a lack of conceptual clarity in the purpose or objectives of the program; onerous data reporting requirements not addressed by administrative data sets; requirements for written agreements with a host of social service agencies and community-based organizations; and significant constraints on the composition of case management teams and internal utilization management. Some States release RFPs that appear to have combined all of the requirements set forth in other States' RFPs without assessing the need for them.

The representatives indicated that their MBHOs were calling for a more cautious approach to entering into public sector contracts. They believed there will be less competition for contracts that require MBHOs to make significant investments in marketing, start-up, and ongoing administration yet offer limited financial reward.

A. Benefit Package

The MBHO representatives spoke of difficulties in administering programs with vague yet expansive benefit packages. States often include this ambiguity to expand the scope of services beyond those traditionally covered without creating a sense of consumer entitlement to each specific service. Ironically, the MBHO representatives believe that such contracts actually promote that sense of entitlement. Vague contracts leave MBHOs vulnerable to legal and financial

complications. Likewise, a recent study suggests that State agencies face similar difficulties by failing to specify benefits.⁴ The participants prefer contracts that specify a well-defined core benefit package while permitting additional wraparound services based on the MBHO's determination of medical and psychosocial necessity and cost-effectiveness.

Focus group participants also believe that a contract should integrate substance abuse and mental health services.⁵ The existing separation of funding streams in public programs has created fragmentation and confusion, producing poor outcomes for dually diagnosed patients. MBHOs want public agencies to unify their funding streams and create coordinated programs that center on patients' needs. Under Iowa's plan for behavioral health, for example, the Medicaid agency and the Department of Public Health (including the State mental health and substance abuse authorities) integrated two separate carve-outs (one for mental health and one for substance abuse) into one statewide behavioral health program for Medicaid and non-Medicaid populations. A large component of this program focuses on individuals who are dually diagnosed.

⁴ Some experts suggest that States have failed to manage MBHOs closely enough and should increase contractual requirements. States that hold loosely defined contracts risk exposing themselves to legal and financial penalties if the MBHOs fail to meet Federal or State standards (see Rosenbaum et al., 1998).

⁵ Of 36 public-sector-managed care programs (in 21 States) that contract with behavioral health carve-outs, 19 offer both mental health and substance abuse services, 10 offer only mental health, and 7 offer only substance abuse services (see Lewin Group, 1999).

Some States require MBHOs to coordinate their traditional services with nonbehavioral health social services.⁶ In such cases, States should attempt to support the MBHO's efforts to make the services beneficial to enrollees. For example, Benefit Arkansas⁷ has been successful in combining funding streams from a variety of child-serving agencies, including family services, juvenile justice, and education, to provide nontraditional services to children. The MBHO defines medical necessity broadly and enables the inclusion of wraparound services, such as respite care for parents of children with serious emotional disturbance. Furthermore, agency leadership has fostered staff cooperation among the child-serving agencies and provided the contractor with necessary information and sufficient funding.

Service coordination does not work when public payers introduce requirements intended to address an historical lack of cooperation across agencies or a deficiency in services. Moreover, some coordination requirements do not clearly delineate between coordination and service delivery, leaving the MBHO potentially responsible for providing these services.

⁶ According to one study, States find that this collaboration ensures appropriate treatment of individuals with complex health needs who are under the care of several different agencies (see Rosenbaum, Silver, & Wehr, 1997).

⁷ Benefit Arkansas provides managed behavioral health and therapeutic foster care services to children eligible for Temporary Assistance to Needy Families (TANF), children in State custody and children covered by ARKids first. ARKids is Arkansas's Title XXI State Children's Health Insurance Program (SCHIP).

B. Performance Measures

Study participants strongly support the inclusion of performance measures in managed behavioral health contracts. However, public contracts sometimes include performance measures that divert attention from essential program objectives, seem difficult or impossible to measure, or are simply too numerous.

Participants spoke of difficulties with performance measures that could not be measured or had never been measured before the contract's inception. Requiring performance levels based on targets used by other States is unfair, because it does not account for variations in baseline measures.

The participants' other criticisms focused on the magnitude and range of expected improvement built into some RFPs. Participants believed that performance measures should include quality-of-life indicators. However, expectations must reflect the level of funding and the MBHO's ability to influence the particular measure under the terms of the contract. Meeting participants described situations in which payers continued low funding levels yet introduced aggressive expectations regarding improved outcomes and quality of life. In some cases, the measures were tied to information that the MBHOs could not capture or track. For example, although reducing the number of days in jail or days absent from school are laudable goals, the MBHO cannot track such information. Applying a financial penalty based on annual performance in these areas would defeat the purpose of performance measures, because the MBHO could not monitor and improve its own performance throughout the year.

Too many measures can distract the MBHO's administrators and divert attention from key determinants of the program's success. The expense of tracking a large number of measures is wasteful for both the MBHO and the payer.

Study participants identified several characteristics of effective performance measurement approaches. The most important involved focusing performance measures on essential operations during the first contract year to ensure stability of services. Such measures include timely provider claims payments (e.g., clean claims processed within 30 days) and responsiveness to enrollees and providers (e.g., acceptable telephone abandonment rates). The contract can include standards for service delivery to ensure that utilization levels and the proportion of the eligible population receiving services remain within a certain range of the previous year's level.

Focusing on these select measures does not diminish the importance of other program goals. Instead, it recognizes the many activities required of a new contractor during the transition to a new delivery system and management approach. The participants suggested that, in the early stages of the contract, MBHO staff must not be distracted from essential program elements. The first year of the contract should include the implementation of the data collection mechanism and methodology for measuring the performance level in order to establish baseline target levels for subsequent years.

Participants cautioned against using consumer complaints as an indication of a poorly operated program. The representatives indicated that a goal of the program should be to increase consumer feedback and establish mechanisms to encourage

complaints and questions. A better approach to using consumer complaints as an indication of program performance would be to track how the information is used and whether actions are taken to address the issues raised by consumers.

In particular, meeting participants cited the Massachusetts Behavioral Health Partnership (MBHP) as an example of a program in which the public payer implemented performance measures equitably and effectively. This program exemplified many of the characteristics of an effective performance measurement approach described by study participants, including

- explicitly tying performance measures to program objectives;
- introducing standards or increasing targets on an incremental basis while maintaining a core set of measures across contract years;
- developing a reasonable number of performance measures and maintaining that number by eliminating less important measures when new indicators are added (Massachusetts currently has 15 to 18 measures);
- involving all stakeholders in the identification of proposed measures;
- developing and documenting detailed methodologies for data collection and analysis; and
- finalizing performance measures each year through collaboration between the State agency and the contractor.

C. Grievance and Appeals Process

Meeting participants considered current requirements of the grievance and appeals processes in public programs to be misguided.

Instead of emphasizing formal processes, as they currently do, study participants indicated that the guidelines should encourage informal efforts to circumvent problems earlier and more effectively. Programs should emphasize an accessible and responsive mechanism for capturing consumer complaints and feedback. MBHOs should carefully analyze this information to identify potential changes in policy or education. For example, Vermont has established a proactive approach to deal with consumer concerns and complaints. In 1998, the legislature created an Office of Health Care Ombudsman. The ombudsman is an independent voice for consumers, tracking patterns and trends in consumer concerns and conveying information to plans and regulators about how they might better serve the public. Under Benefit Arkansas, an oversight committee of consumers and their families provides ongoing input. This feedback concerns how the project is going, what changes might be needed, and how each of the communities perceives the project.

An increase in the number of complaints received can indicate that consumers view the new program as accessible and receptive to such feedback. Many public programs, however, define consumer feedback as an official grievance and complaints as appeals. By catapulting these interactions into a formal grievance and appeals process, the payer may unnecessarily escalate the significance of the event and create an administrative burden.

D. Consumer Participation in Program Administration

Study participants felt that public payers are successfully including consumers in program design and ongoing administration and oversight. They found that this involvement is extremely beneficial to committees address-

ing the delivery system, quality of care, and other issues affecting consumers and their families. States and MBHOs have implemented a variety of efforts to elicit consumer involvement.

Colorado Health Networks provides a good example in its creation of many consumer drop-in and peer programs as part of its performance measurement system. Another private managed care company in Colorado has hired a consumer advocate as director of consumer affairs to further consumer rights and promote consumer issues. The State's RFP required the contractor to designate at least one staff member as the client representative, but the plan itself decided that this individual should be a consumer. This consumer affairs director reviews all complaints and grievances, sometimes handling the call personally. The director also sits on the quality improvement committee, reviews all trend analyses, and makes recommendations to the plan.

Moreover, the National Mental Health Association is advocating ombudsman programs. It has published a report detailing such programs in six States (California, Colorado, Indiana, Minnesota, Tennessee, and Washington) ("National Mental Health Association, 1999). The National Alliance for the Mentally Ill is strongly advocating third-party, independent consumer entities. Five States (Alabama, Georgia, Massachusetts, Ohio, and Pennsylvania) have established consumer satisfaction teams (CSTs). The programs in Philadelphia, Pennsylvania, and in Massachusetts are directly related to managed care. Philadelphia's CST is a unit of city government that manages the Medicaid managed care program. Massachusetts's MBHO finances the CST. Montana, Texas, and

Maine also received funding from their legislatures to implement such programs.

MBHO representatives pointed out that, while they support consumer participation, MBHOs sometimes encounter difficulties when they are required to include consumer representatives on the governing board of the organization. Consumers do not share the fiduciary responsibility of other governing board members; therefore, the participants believed that consumers should not have voting power on the governing board.

E. Requirements for Local Presence

To varying degrees, public payers seek some assurance of a local administrative presence by the MBHO. Meeting participants agreed that some requirements are reasonable and practical; however, others defeat the economies of scale that could otherwise be achieved by engaging an established MBHO. In many cases, an MBHO can offer a higher quality of service by using a centralized function than being required to recreate the function at the local level. Obvious examples of improved efficiency through a centralized resource are claims and data processing activities. Many other centralized functions can effectively serve the needs of the public agency and the enrollees and permit the MBHO to address those needs efficiently.

F. Protection of Existing Provider Infrastructure

Public agencies are typically concerned about the consequences of managed care programs for traditional providers. These providers may find their funding reduced or eliminated under the managed care program. If the MBHO decides to direct patients to other providers, these traditional providers may have little alternative but to close their

doors. This outcome runs counter to the historic goals of the public agencies, namely, building provider capacity for serving the population and finding the means to provide sufficient funding to support these providers. The meeting participants believe that the traditional delivery system has inefficiencies and other problems; nevertheless, they recognize payers' fears that managed care programs may harm the traditional delivery system.

To address that fear, many payers have included protections for these traditional providers in managed care contracts. Some States offer mild inducements in the contract for the MBHO to use these providers. Others, however, carve providers or services out of the managed care program and reimburse them on a fee-for-service basis. In some situations, payers may require significant use of traditional providers without granting MBHOs the authority to use the same utilization management requirements imposed on other network providers. Several States (e.g., California, Pennsylvania, and Michigan) have given county mental health agencies or local mental health programs first right of refusal in the RFP process. The participants said that MBHOs understand the public payer's need to ensure the maintenance of an adequate mental health infrastructure with the necessary service capacity. However, payers can improve some of their approaches.

The future roles of traditional providers serving the ambulatory needs of the population must also be considered. The most effective approach, the study participants indicated, is for the public agency to describe the desired characteristics of the future delivery system. MBHOs can then redistribute utilization of community-based services to improve

quality and cost-effectiveness of care without reducing the delivery system's capacity. These mechanisms can protect essential capacity rather than focusing on ensuring the continuation of each individual provider. By rewarding progressive providers, MBHOs can encourage the growth of the best providers and incrementally shift patients to sites that are more efficient.

In establishing managed care program objectives, the public payer should identify problems in the existing infrastructure that it intends to solve through the new program. The payer should then decide upon the intended role of the State hospital in the future delivery system. In particular, the public agency must determine its intentions for the State facilities and garner the political support for following through with these intentions. Given the potential for layoffs of public employees in the facilities, and the political backlash that can ensue, this groundwork must occur well before RFP development. By the time of the RFP release, the State should have a thoughtful transition plan for these facilities, with political consensus around the plan.

According to the participants, many RFPs are ambiguous regarding the current and expected future role of the State facility and its interaction with the MBHO under the proposed program. This ambiguity can lead to disputes and disruption in care, delaying the decisions necessary to move forward. The MBHO representatives requested that, in the RFP, State agencies describe the intended role of the State hospital in the delivery system in the short and longer term. The RFP should also discuss the responsibilities placed on the MBHO for use of the facility. The representatives recommended that the State hold the facility responsible

for complying with the MBHO's utilization management rules and for participating in discharge planning with MBHO staff. The participants reported that the State hospital offers the greatest challenge to the public payer and the MBHOs in terms of resolving competing pressures for introduction of cost-effective care coordination and utilization management and the protection of provider capacity.

G. County versus State Programs

In nearly half the States, county governments are primarily responsible for designing and administering public managed behavioral health programs. According to meeting participants, the resulting contractual relationships offer some complications over and above those found in State contracts. County mental health departments represent an important part of the traditional provider safety net. Publicly funded services not only account for a major source of revenue for these county providers but are viewed as supporting county jobs as well. Consequently, the desire to protect the capacity of safety net providers witnessed at the State level is even more pronounced at the county level, where county administrators find that the budgetary and employment implications of shifting to an at-risk MBHO are greater.

The representatives identified two potential problems with fully capitated programs at the county level. First, the desire to protect county jobs can lead to untenable restrictions in the MBHO contract. For example, these specifications may require the MBHO to use the county provider or to assume some responsibility for maintaining the facility and its workforce. Second, the size of the county may be insufficient to support a fully capitated program, so that the large fixed costs

associated with specialized administrative functions must be allocated over a smaller enrolled population. As a creative solution to this issue, Oregon's community mental health program directors came together in 1994 to organize Greater Oregon Behavioral Health, Inc. (GOBHI). This private, nonprofit, public benefit corporation allows the counties to partner with a managed care organization to share the risk of providing care to the State's most rural populations. Sixteen counties pool resources through GOBHI to provide mental health services across more than half of the State.

Participants suggested that in many instances counties recognize the contradictory incentives they face in protecting county providers while aiming to improve the efficacy of service delivery. As a result, they develop programs that require contractors to assume roles other than those of full-risk

managed care plans. Contractors may be required for contracts of administrative services only (ASO) in which they extend assistance in such areas as care coordination, financial management, medical economics, staff training, and information systems. Two counties in the State of Washington (Spokane and King) and one in California (San Diego) have ASO contracts with private managed care firms. In other instances, counties have set up their own MCOs to address some of the contradictory issues. For example, Oregon's Lane County established an MCO, known as LaneCare. LaneCare has been awarded a single contract under Oregon's managed care program and is at risk for mental health services provided to all Medicaid recipients. Other counties that have chartered their own MCOs include those around Philadelphia and Allegheny, Pennsylvania.

V. Financial Requirements and Reimbursement

Financial issues possibly represent the area of greatest concern among the MBHO representatives. The nature of public sector contracts, the contracting process, and the inherent financial risk associated with these contracts is quite different from the private sector contracting environment. In the public sector, the procurement process is much more onerous and the program design more complex. Furthermore, the requirements concerning benefit package, quality assurance, member services, provider contracting, and other components are much more detailed than in the commercial sector. From a financial perspective, State and local payers often set capitation rates rather than soliciting price bids. The study participants found that many payers provide insufficient information to evaluate the adequacy of the capitation rates. Furthermore, requirements designed to ensure fiscal soundness often go far beyond those required under State licensure specifications.

One of the most significant issues in the financial area identified by study participants is the need to recognize that financial risk for a program must be tied to control of the delivery system and the care management processes. The representatives reported that they often encounter an RFP that seeks a fully capitated contractor but applies provider guarantees, prohibitions on limitations for a range of services, requirements to expand the benefit package within existing funding levels, and detailed specifications on operational procedures. According to the MBHOs, financial risk must be combined with sufficient decision-making authority to manage financial outcomes.

Another major concern is the sufficiency of the funding levels for the service and administration requirements described in the contract. Focus group participants observed that public payers often overestimate the extent of managed care savings achievable through utilization management or have unrealistically low expectations of the costs of new services and administrative requirements. Participants suggested that, before procurement, payers should develop models to project the anticipated costs of the benefit package and the administrative functions. They must then compare these costs to the initial capitation rates developed for the program. Final capitation rates must be sufficient, based on

reasonable assumptions of utilization rates and administrative services.

The third major concern voiced by the MBHO representatives was the limits that public payers often place upon MBHO profits. Public payers consider acceptable levels of profit to be less than 5 percent, far less than MBHOs' expectations in commercial contracts. Compounding this problem, program designs can include much greater "upside" risk for the MBHO. MBHOs are often unable to get sufficient data from the payer to perform actuarial analyses, and the public payer will not divulge the methods used to establish the capitation rates. Consequently, the MCO may not realize that the capitation rates are insufficient to cover the cost of the program required in the RFP until significant losses have accrued.

As constraints on profit become more pervasive and upside risk remains high, study participants warned that the number of bidders will fall. Participants pointed to examples of recent procurements that generated little or no interest among experienced MBHOs. They indicated that their organizations are requiring thorough analyses of the business risk involved in pursuing each public sector contract. As new situations arise in which MBHOs lose money on public-managed behavioral health contracts, particularly for MBHOs that are otherwise performing well, the pressure increases to revisit the decision to pursue public sector business.

Participants suggested that public payers should more appropriately concentrate on applying performance measures to MBHOs rather than focusing on ways to constrain profitmaking. In some cases, however, the political environment requires limitations

on profit. Here, public payers must devise a measurement approach that recognizes the costs associated with providing those services required in the contract that are not necessarily clinical in nature. The application of minimum "medical loss ratios" (i.e., medical expenses divided by total revenues) to devise maximum profit thresholds fails to distinguish between administrative costs and profit.⁸

In programs that impose restrictions on the medical loss ratio, the definition of administrative activities becomes very important. Participants contend that many costs treated by public payers as administrative are actually costs associated with direct provider services. Although State mental health authorities often employ case management staff and consider them to be service providers, some public agencies treat the MBHO's case managers as administrative staff. Agencies are often unwilling to recognize case management as a legitimate service cost.

Participants identified several areas of activity required by public payers that involve supplemental efforts or retrofitting existing functions to meet those requirements. The resources needed to accommodate these requirements must be recognized as legitimate service costs in any profit measurement approach. Such areas include the following:

- Provider education and outreach.
- Access and triage.

⁸ Some public payers require that an MCO's medical loss ratio not fall below a specified level, perhaps 0.85 or even as high as 0.90. This requirement leaves only 15 or 10 percent of the capitation payments, respectively, to cover administrative expenses (which are often formidable in public programs) and profit.

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- Case management.
 - Quality improvement requirements.
 - Clinical appeals processes.
 - Information systems.

The issue of increasing requirements to ensure financial viability is related to the sufficiency of funding levels. These assurances may include requirements related to the maintenance of minimum reserve levels, acquisition of reinsurance coverage, required financial ratios, performance bonds, and hold-harmless clauses in provider contracts. Such assurances have become more numerous and sometimes, over time, duplicative. Some RFPs have combined specifications requiring significant investment in start-up activities with high restricted reserve levels (in some cases without allowing for a sufficient phase-in period to reach a fully funded reserve level) and strict limitations on profit. MBHOs with multiple public sector contracts may find themselves “investing” in multiple restricted reserve funds, thereby

losing access to these funds and becoming unable to achieve a reasonable profit.

In an environment in which public payers want to protect consumers’ choices and attract multiple qualified bidders to a program, such burdensome financial conditions will restrict competition to only the very largest MBHOs or to organizations of dubious qualifications. Although they may otherwise be qualified, start-up organizations formed by community-based providers may be unable to demonstrate the resources necessary to meet the conditions.

All aspects of the financial structure and reimbursement approach must “work” within the basic program design. The level of administrative investment in information services, provider and member services, and other areas of the administrative infrastructure must be warranted by the size and length of the contract. Without a sufficient number of covered lives and length of the contract term, the fixed administrative costs associated with start-up and operation of an at-risk program may be too great for an MBHO to absorb.

VI. Procurement Process

The procurement process in public-sector-managed behavioral health contracts has been a source of frustration and consternation to both MBHOs and public payers. Both sides have protested contract awards. These appeals delay program implementation, increase the administrative costs associated with implementation, and, in some cases, overturn award decisions. Questions of conflicts of interest, unfair bidding processes, and poorly executed evaluations have been raised and, in some cases, supported by the courts. In addition, the political environment is often highly charged. Advocates seek to protect the interests of the vulnerable seriously mentally ill population. Furthermore, county mental health agencies and other providers largely dependent upon State and local funds seek to secure sufficient resources to carry out their responsibilities.

The level of effort required to produce winning proposals diverts staff resources from other activities. Ambiguous procurement specifications can lead to misunderstood program requirements, ill-prepared proposals, and evaluations of questionable legal defensibility. In addition, vaguely conceived contracts can produce difficult contract negotiations as the winning offeror seeks clarification and modification to program requirements and reimbursement terms. These difficulties can delay the process and add to the MBHO's marketing and administrative costs.

Focus group participants cited the lack of resolution of design issues during the procurement as a common frustration. In many cases, public agencies change program specifications during the procurement and communicate these revisions late in the proposal

development process. Such changes can affect not only the offeror's descriptions of proposed approaches, but also the types of subcontractors needed for the program and the actuarial analysis of the program. In some cases, the revisions may influence an MBHO's decision to bid, causing an organization that has already invested substantially in proposal development to withdraw from the process. Alternatively, they may cause an organization to regret its decision not to bid. MBHOs must recover their marketing costs if they are to continue to do business in the public sector. Therefore, procurement problems that increase the cost of proposal preparation ultimately are costly to payers.

An MBHO's assessment of the reimbursement rates offered, or of the appropriateness of the rates bid in the proposal, depends on the quality of the information provided by

the public agency. Focus group participants cited many procurements in which the agency provides much data but little information. Payers need to include data that directly pertain to the population and benefits targeted by the program and provide the data in a format useful for actuarial evaluation.

According to meeting participants, evaluation processes adopted by public payers and execution of these processes are not always

effective. Organizations may submit proposals that stand up well under desk reviews but which describe capabilities, infrastructure, and outcomes that do not truly exist.

Separating the qualified from the unqualified offerors requires evaluators with operational expertise in managed behavioral health care, thorough on-site inspections and interviews, careful reference checks, and multiple question-and-answer sessions with offerors.

VII. Implementation and Ongoing Administration

Focus group participants reported that many public payers view the payer's role in administering managed behavioral health care programs as one of policing the MBHO. They endlessly search for contract requirement violations through constant data requests and surprise audits. In addition, agency staff may require significant amounts of time from the MBHO management team, distracting the MBHO staff from the work at hand.

Focus group participants believed that some payers see vigilant monitoring and punitive sanctions as the keys to a successful program. However, they pointed to payers who approach the contracted MBHO as a partner as the agencies most likely to be satisfied with contractor performance. Arkansas, Iowa, Colorado, Massachusetts, and Maryland all emphasize such a close collaborative approach. This philosophy produces a problem-solving atmosphere and an environment in which both payer and MBHO try to accommodate the needs of the other. In Massachusetts, the payer has daily face-to-face encounters with the MBHO staff, reflecting a close collaborative approach to program management rather than one characterized by authoritative supervision.

At the start of a new public sector program, MBHOs frequently confront a public payer that underestimates the time and management expertise needed by the State or

local staff to manage the program. Management tasks involve working with the MBHO to develop necessary administrative procedures and to ensure that implementation tasks are prioritized appropriately and completed effectively. Payers also must work with or respond to questions from other agencies, providers, and stakeholder representatives on issues relating to the program roll-out. The public payer should view start-up and implementation activities as a major project management challenge. They should ensure that the agency project director has sufficient management experience to take on the task. To better understand staffing needs during start-up and after implementation, the agency can interview other public payers with similar programs.

According to study participants, part of the skill of an effective project manager entails the ability to identify priorities. Contractor oversight during the initial stages of implementation should focus on

those areas most indicative of the program essentials: Can consumers access services? Are as many individuals receiving services now as before the program? Are providers being paid? Are phones being answered? The representatives suggested that public payers cannot expect 100 percent compli-

ance with every requirement beginning on the first day of the program. Agencies often fall into the pitfall of focusing attention on any requirement not being met immediately. Addressing that requirement at the start may distract MBHO staff from more fundamental activities.

VIII

Recommendations of Focus Group Participants

Recommendations on Program Design

- RFPs should specify contractor requirements and ask offerors to describe how they will operationalize these requirements. Avoid requiring descriptions of organizational structures, internal processes and procedures, and job positions unless a specific requirement is critical to the success of the program.
- During the planning stages of a new program and before the procurement “blackout” period, public agencies should engage MBHO representatives in discussions on program requirements and design components to understand operational and financial constraints, and barriers to successful implementation as perceived by the MBHO.
- If the issuing agency intends to use requirements from an existing program in another State, the agency should contact the other State’s program director to uncover any lessons learned or insights into the impact of the requirements.

A. Benefit Package

- Include a specific, clearly defined core benefit package in the contract; tie provision of services to medical and psychosocial necessity criteria. Also, adopt level-of-care standards with protocols that permit the MBHO to provide wraparound services on an as-needed basis.
- Include services for chemical dependency in the program and combine funding sources, but ensure that any requirements to coordinate services across agencies are fully supported by the affected agencies and by sufficient funding for the contractor.

B. Performance Measures

- Develop performance measures that relate clearly to the program’s objectives.
- Keep it simple—limit the number of measures and the complexity of data gathering and methodology. Avoid measures that MBHOs cannot track, for example, number of times a student has been seen by the school counselor, days in jail.
- First-year measures should reflect program essentials and focus on access to services and utilization, provider payment, and responsiveness to enrollees.
- For each performance indicator, outline the source of the data, the frequency of data collection, and the parties responsible for data collection.

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- Recognize that performance measures may require a significant investment in information systems, training, and personnel.
 - Apply uniform accreditation standards and performance measures across all contractors. For example, do not apply more rigorous behavioral health standards to the MBHOs, but do permit HMOs to provide the same services to the same population under less rigorous managed care standards.
- C. Grievance and Appeals Process
- Permit MBHOs to establish informal processes to receive and respond to enrollee feedback and complaints rather than require all such communications to flow through a formal grievance and appeals process.
- D. Consumer Participation in Program Administration
- Require consumer involvement in advisory committees focusing on service delivery issues (e.g., care coordination, quality improvement, provider network composition) and member services. Do not require consumer representation on the governing board, which should be limited to those with fiduciary responsibility for the organization.
- E. Requirements for Local Presence
- If the public agency prefers that certain administrative functions be performed locally, permit offerors to negotiate with the agency on the specific areas of activity that must be performed locally.
- F. Protection of Existing Infrastructure
- Before moving to the managed care model, while still under the traditional funding model, consider developing and implementing provider profiling tools to evaluate the relative productivity of safety net providers.
 - Develop a conceptual model of the desired delivery system before drafting the RFP requirements; design mechanisms for the managed care program that promote this model, while recognizing the flexibility and authority needed by the MBHO to manage services.
 - Phase out provider protection under the contract over a 3-to-5-year period. Permit the MBHO to screen safety net providers based on specific measures. Gradually increase these screening measures to the levels applied to other network providers.
 - Require safety net providers to comply with the MBHO's utilization management rules and to cooperate with discharge planning activities.
 - Clearly delineate in the RFP the State hospital's role in the managed care program and the financial effects on the MBHO.
- G. County versus State Programs
- Evaluate the need to protect county providers and the relative size of the enrolled population when designing a program to ensure the adequacy of the financial arrangements and the MBHO's authority to use and manage providers appropriately.

Focus Group Recommendations on Financial Requirements and Reimbursement

- Ensure that both reimbursement rates are developed based on both the specific benefit package and the population to be enrolled in the program. Communicate the methodology used to establish reimbursement rates to the offerors, along with any actuarial assumptions incorporated into that methodology.
- Ensure that financial prerequisites are sufficient to limit bids to responsible organizations but not too high to disqualify or dissuade otherwise desirable organizations from bidding.
- Make the level of financial risk commensurate with the degree of control permitted the MBHO to manage the program. Do not expect MBHOs to assume full financial risk while expecting them to accept severe restrictions on their ability to impose utilization management techniques, enforce provider performance requirements, negotiate provider payment and risk sharing terms, and impose provider selection criteria.
- Impose financial incentives based on quality indicators such as patient outcomes and consumer satisfaction rather than on profit limits. Requiring minimum levels of service spending extends the ill-advised incentives inherent in traditional fee-for-service and grant-funded systems.
- Fund the start-up phase separately under the contract. Develop a “bridge contract” or alternative mechanism to permit reimbursement for start-up activities in the event of a delay in the execution of the

main contract (without a corresponding delay in the required start date).

- Incorporate contract terms of 3 to 5 years (contingent upon future funding under State budgets). Consider the length of time needed to recover start-up costs (if start-up is not separately funded) in establishing the contract term.
- Avoid duplicative conditions relating to financial viability. Allow different approaches to demonstrate similar levels of fiscal soundness.
- If the political environment requires reinvestment requirements to be imposed to limit profit taking, analyze the economic and social return on the particular reinvestment target before making (or requiring the MBHO to make) the investment. Avoid funding programs simply for the sake of demonstrating a maintenance-of-funding level; instead, ensure adequate “returns” on the investment.

Focus Group Recommendations on the Procurement Process

- Before the procurement “blackout” period, invite industry representatives to meet individually with agency staff to discuss design issues and to give input. Finalize program design decisions, including reimbursement approach, before RFP release.
- Allot at least 8 to 12 weeks between RFP release and the proposal due date to ensure adequate time for bidders’ questions and responses and proposal preparation. All responses to bidders’ questions should be released no later than 4 weeks before the deadline for proposals.

- Provide data pertinent to the assessment of reimbursement rates, financial risk, and cost/benefit analyses with the release of the RFP (or set the proposal deadline based on the latest release date for procurement materials). Data should be specific to the services and population relevant to the program.⁹ Explain the source of the data, any assumptions used in its derivation, and any issues regarding its representation of the covered population and the articulated benefit package.
- Provide sufficient training to members of the evaluation team. Hire experienced consultants as needed. Use attorneys and Procurement Office staff before and during all phases of the procurement to ensure that procurement integrity standards are met. Include on the evaluation team an individual with expertise in behavioral health information systems.
- Require at least some of the evaluators to review proposals by reading them in their entirety, rather than assigning specific portions of proposals to the evaluators. In some cases, it may be essential to be familiar with one part of the proposal to evaluate another.
- Place less emphasis in the evaluation on the proposal submission itself, and more emphasis on evaluating the organization's capabilities through site visits and reference checks and on understanding each organization's proposed approach. The RFP should establish strict page limits for each section of the proposal, and should limit the number and size of attachments as well. Offerors who submit proposals that meet minimum standards should be required to deliver oral presentations, and the evaluation team should visit the sites. Before site visits, the evaluation team should submit questions to offerors based on the desk review of the proposal. The evaluation team should plan for follow-up questions after receipt of the first round of responses.
- Permit negotiation in the procurement process. The best-and-final-offer process can represent the negotiation as long as the payer clearly identifies the types of changes it is seeking to the original proposal.
- Foster evaluation teams that are free of political pressure and ensure permission to make fair and open decisions based on the team's review. In some situations, State evaluators have little expertise in the area of managed behavioral health care and receive no training to perform the evaluation.

⁹ Data should include the following: penetration rates (as defined by the Health Plan Employer Data and Information Set, a measurement tool developed by the nonprofit organization National Committee on Quality Assurance for use by consumers, corporations, and public purchasers to evaluate health plan performance in a standardized way); admissions per 1,000 full-time equivalent eligibles; visits per 1,000 full-time equivalent eligibles (with a clear definition of a visit; this measure may need to be broken down to multiple types of ambulatory services to avoid mingling disparate services with very different unit costs within a single measure); distributions of "per member per month" costs; units of utilization by quarterlies; unit costs; and payment rates.

Focus Group Recommendations on Implementation and Ongoing Administration

- Allot 6 to 8 months for the start-up phase, and provide funding for this phase. The time allotted for the start-up should be tied to the complexity of the program.

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- MBHOs should identify a staff member as the point of contact for the public agency during start-up. By acting as the conduit for questions and concerns, this staff member will help to protect the time of operational managers.
 - Execute a bridge contract covering—and reimbursing for—the start-up phase only if contract execution is delayed but implementation must remain on schedule.
 - Identify the appropriate priorities for each contract period and focus monitoring attention on those priorities. At the beginning of the start-up phase, the priorities are likely to include getting executed provider agreements, addressing the information system needs, and establishing the telephone lines. As start-up continues, the payer should focus on testing the eligibility system, data transfer systems, and MBHO provider payment system, and telephone systems.

IX. Summary

Focus group participants believed that the MBHO industry will continue to be interested in public sector contracting. However, they indicated that their organizations were calling for much more rigorous evaluations of public sector RFPs and a more cautious approach to entering into such arrangements. They believed less competition for those programs will require a large investment from MBHOs in terms of marketing, start-up, and ongoing administration yet offer little financial reward.

Furthermore, focus group participants noted the importance of policymakers' willingness to stand behind the program design and the agency administering, even under highly politicized circumstances. Study participants distinguished between ongoing improvements and modifications made during the course of a program on the one hand and broad-based changes driven by a political process on the other. Through various stakeholders' influence on State legislators, county administrators, and the governor's office, programs are sometimes changed without sufficient rationale for or planning behind the change.

Such changes impose administrative burdens on the MBHOs and can increase their costs significantly. Although it is difficult to formulate a simple recommendation to avoid this phenomenon (particularly as it can occur in environments that include an open and participatory process for program planning and design), study participants cautioned that MBHOs should consider the political environment when deciding to bid on a program. As their experience has grown over the past sev-

eral years, MBHO business planners are more cognizant of potential political pitfalls. Agency policymakers will face more pressure to manage the political process to ensure that qualified organizations continue to show interest in their business.

The future of public-sector-managed behavioral health contracting, as depicted by the MBHO study participants, will depend on public payers' ability and willingness to design and administer programs that permit contractors to succeed. Participants believe that payers should approach programs with an attitude of partnership and collaboration. Equally important, they should avoid actions or requirements that tend toward micromanagement.

These characteristics will help to maintain healthy competition among MBHOs for State and local-managed behavioral health care contracts. By further establishing a cooperative program management style toward the contractor, public behavioral health programs can better meet the objectives of the public payers and continue to attract experienced, high-quality, reputable contractors.

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XI.

Appendix: List of Focus Group Participants

T

he following individuals participated in the focus group meeting or telephone interviews:

American Psych Systems
Karen Hoehn
Vice President of Public Programs

Magellan
Ann McCabe
Senior Vice President of
Business Development

Menninger Care Systems
Sheila Baler
Vice President of Managed Care

United Behavioral Health
Keith Dixon
Vice President

ValueOptions
Cynthia Feiden Warsh
Senior Vice President,
Public Sector Development

Richard Sheola
Chief Executive Officer

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DHHS Publication Number SMA 00-3438

Printed 2000



Substance Abuse and Mental
Health Services Administration