HOW FIVE STATES ADDRESSED MENTAL HEALTH "BOUNDARIES" IN MEDICAID MANAGED CARE

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Author:

Cheri Vogel

Submitted to:

The Office of Strategic Planning
Health Care Financing Administration
Mail Stop C-3-19-07
7500 Security Blvd.
Baltimore, MD 21244-1850

Project Officer:
Penelope Pine

Submitted by:

Mathematica Policy Research, Inc.
P.O. Box 2393
Princeton, NJ 08543-2393
(609) 799-3535

Project Director:
Judith Wooldridge

ABSTRACT

This paper draws on evidence from site visits and record reviews in five states that have used Section 1115 waivers to shift to Medicaid managed care (Hawaii, Maryland, Oklahoma, Rhode Island, and Tennessee) to describe how the states structured systems to care for their chronically mentally ill populations. We describe how the new systems addressed existing "boundary" issues for populations with chronic mental illness, and whether they may have introduced new boundaries hindering access to care. Boundaries are points at which a person with mental illness and in need of services can either receive or fail to receive the services based on structures and policies in place in the system. Examples of boundaries are state screening methods to identify program participants, the states' methods to define who is eligible for special services, the ways that people who have been identified enter the programs, and the ways that services are delivered in the programs.

After reviewing the evidence from the five states, we draw the following conclusions:

- Each state attempted to structure special provisions for its beneficiaries who have chronic mental illness. Each one pursued highly different designs for the programs, and each experienced significant problems, particularly at start-up.

- Access problems were caused by policies related to identification and entry requirements. In particular, states that changed the criteria for entry into their special programs and those that required lengthy application forms and documentation may have created barriers to entry.

- Care coordination was a particular problem for such subgroups as children with serious emotional disturbance (SED) and those with dual mental health and substance abuse diagnoses. Compared with some groups, these groups tended to have poorer access to services, and to experience fragmented care. However, it seemed that some of these problems had been carried over from fee-for-service Medicaid and therefore were not specific to the new demonstration programs.

- Providers frequently cited network adequacy and credentialing requirements as complaints. Some providers complained about plan credentialing requirements even though this program feature may have improved the quality of care provided. Although others noted that some specialized services (especially residential treatment for children and child psychiatrists) were difficult to access, these services may have been in short supply before the demonstrations began.

- Beneficiaries with chronic mental illness who were in the new programs were highly satisfied overall. Conversely, providers in all five states had low levels of satisfaction. Beneficiaries who were able to enter the programs reported high satisfaction with the care they received, but providers complained about low payment rates, complex billing requirements that differed by plan, and long waits for receipt of payments.

Based on these conclusions, we draw the following lessons for other states interested in implementing similar programs:

1. *Solicit input during the design phase.* States that implemented their programs slowly and that sought the opinions of stakeholders seemed to benefit from more buy-in and greater stakeholder tolerance when problems arose.

2. *The specific design of the special program is less important than is inclusion of features that promote flexibility in accessing services.* Rhode Island and Maryland developed quite different approaches to serving their beneficiaries with severe mental illness (SMI) or SED, but both states received generally favorable marks from their various stakeholder groups.

3. *Recognize the complexity of treating populations with SMI/SED.* Populations with severe behavioral health problems are often difficult to serve. They require case management; many specialized services; and, often, concurrent substance abuse treatment. Most commercial managed care organizations and behavioral health organizations have limited experience in treating these groups and may not have developed adequate networks to serve them.

4. *Take steps to maximize care coordination.* Carving out specialty services can make it difficult to coordinate mental and physical care for those with SMI/SED, and to coordinate mental and substance abuse treatment for the dually diagnosed.

5. *Be aware of "turf" issues.* Separation of mental and physical health systems and of mental health and substance abuse providers in some of the states reviewed here was reportedly driven by each faction's desire to retain prominence. These turf issues can be destructive and work against coordination of care for individuals with SMI/SED.

As other states move toward applying for and implementing Medicaid demonstration programs, we are hopeful that the experiences of the five pioneering states will prove valuable in ensuring a smooth transition and adequate care for the most vulnerable of the vulnerable.

PREFACE

This report is part of a broader study to evaluate five Medicaid state health reform initiatives, which are being conducted as Section 1115 research and demonstration projects. States propose and administer these projects, while the federal government approves the demonstrations and monitors the projects. The five state projects being evaluated in this six-year research endeavor are Hawaii's QUEST, Maryland's HealthChoice, Oklahoma's SoonerCare, Rhode Island's RIte Care, and Tennessee's TennCare. These projects greatly increase the scope of managed care for Medicaid beneficiaries and, sometimes, expand eligibility for coverage.

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I. INTRODUCTION

Chronic mental illness is associated with a host of poor life outcomes, such as poor physical health, low educational attainment, and low income (McAlpine and Mechanic 2000). Those with chronic mental illness often experience stigma and other barriers to receiving necessary mental health treatment, which exacerbates these problems. For example, people suffering from mental illness are at high risk for homelessness (Unger et al. 1997) and are likely to be uninsured (McAlpine and Mechanic 2000); both conditions can have adverse impacts on a person's ability to access mental health treatment.

People with chronic mental illness have tended to rely on Medicaid to provide their physical and mental health care. States therefore play an essential role in providing care to this group, primarily through Medicaid (the largest single payer of mental health care in the United States (U.S. Surgeon General 1999) but also by funding hospitals that support long-term care, state mental health and substance abuse treatment programs, and community mental health centers. Since the mid-1990s, numerous states have used Section 1115 demonstrations to restructure their fee-for-service Medicaid programs, often to create some type of managed care arrangement. In the course of developing these Medicaid managed care demonstrations, some states also have developed special programs for Medicaid beneficiaries with chronic mental illness. However, the move to managed care has raised some concerns, mainly because many commercial managed care organizations (MCOs) lack experience in providing care to chronically mentally ill populations. In addition, the incentives of capitation may encourage cost shifting to other payers, thus minimizing treatment costs incurred by the MCOs. Therefore, this paper examines

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how the change to Medicaid managed care has affected beneficiaries with chronic mental illness.[1]

We explore the "boundaries" in state systems that may affect whether individuals in need can access care. Primary boundaries exist as a result of the way that states determine who is eligible for special programs, the way they define chronic mental illness (usually in terms of "severe mental illness" [SMI] or "serious emotional disturbance" [SED]),[2] and the way that the systems can respond to urgent needs for care.

Figure I.1 presents a schematic that illustrates the way we envision the boundaries might affect patient satisfaction outcomes for people with chronic mental illness. The first boundary exists at the point of assessment of the need for care. This boundary is especially important in systems that have entry requirements (often in terms of levels of functioning and diagnosis). Ideally, assessments of psychological status should be accessible, especially in states in which this assessment is a prerequisite for entry into the special program. A second potential boundary is the state's definition of SMI/SED. States can set their definitions of SMI/SED in ways that have profound impacts on the size of the eligible population. One study showed that, by changing the definition of SMI/SED, the proportion of a sample of children considered to have

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[1]We do not discuss beneficiaries with substance abuse problems exclusively because special Medicaid programs typically feature enhanced mental health benefits, rather than only substance abuse treatment benefits. In addition, eligibility for special programs usually differs across mental health and substance abuse diagnoses. For example, in the states discussed in this paper, a primary diagnosis of substance abuse is insufficient for entry into the special programs. We do include information on adults and children with chronic mental illness who have concurrent substance abuse treatment needs.

[2]States usually refer to people with chronic mental illness according to state-specific definitions. SMI and SED differ in that SMI refers to adults, and SED refers to children. We will refer to these groups jointly except in cases in which their experiences in the special programs differ.

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FIGURE I.1

CONCEPTUAL MODEL OF THE WAYS BOUNDARIES MIGHT AFFECT MEDICAID BENEFICIARIES WITH CHRONIC MENTAL ILLNESS
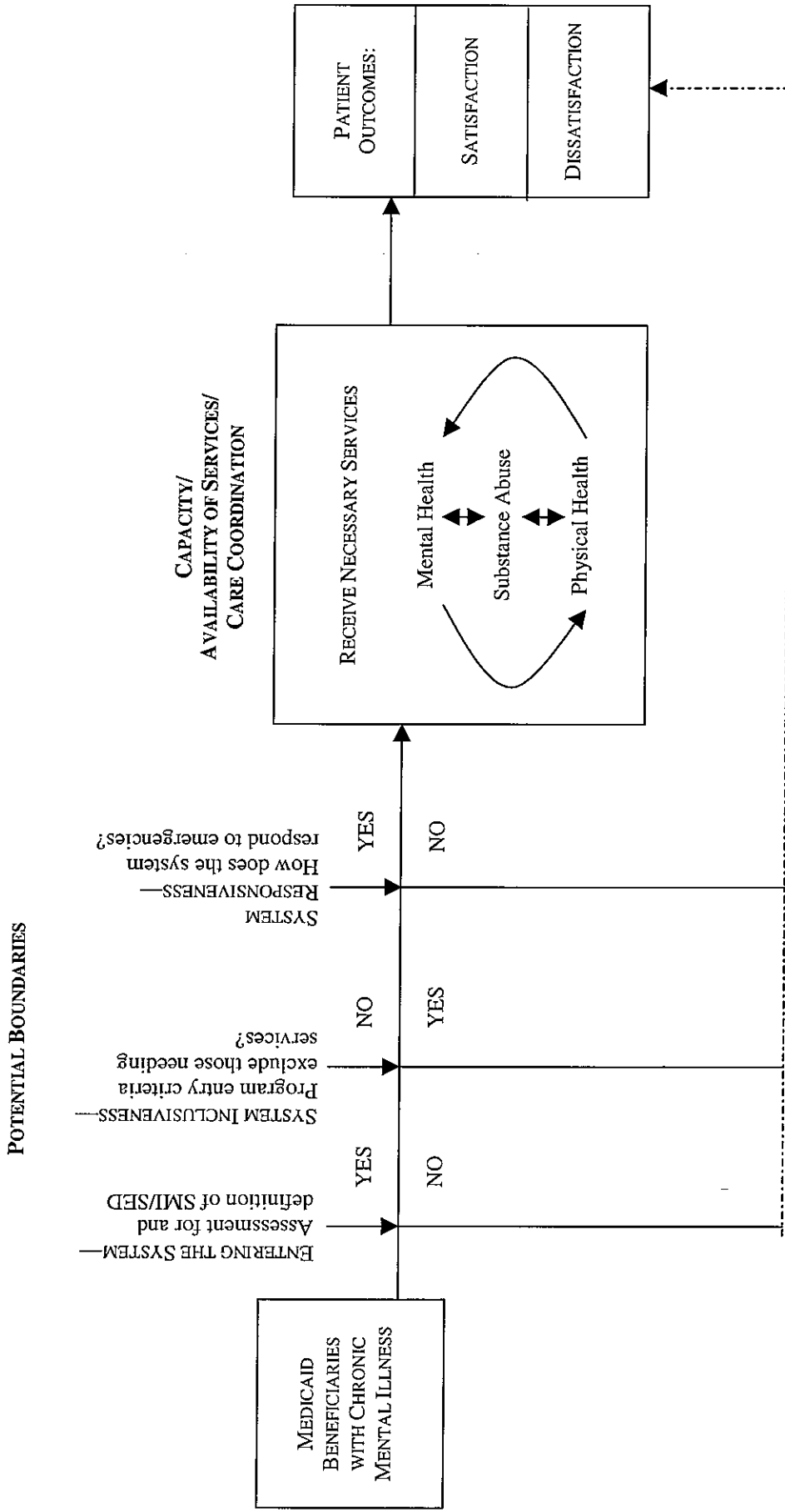
that the system responds to SMI or SED ranged from 3 to 23 percent (Narrow et al. 1998). The third boundary is the way that the system responds to emergency needs, as this point is a key one at which an otherwise well-functioning system could malfunction.

After an individual has entered the system successfully, such issues as the availability of care and coordination of care become important. Some coordination issues concern physical and mental health care, where the primary care provider may be unaware of mental health treatments or psychotropic drugs that other providers have prescribed. Others concern coordination between mental health and substance abuse treatment, conditions that frequently co-occur in those with chronic mental illness. If services are available and coordinated, individuals with chronic mental illness presumably will be more likely to experience positive outcomes. The outcomes we consider are necessarily subjective, because they address beneficiaries' levels of satisfaction with their plans and with the care they receive. Outcomes other than satisfaction with care, although important, are beyond the scope of this paper.

To assess the boundary issues presented here, we answer the following questions:

- Do special programs exist for people with SMI/SED? What is the design of these programs?

- How are those eligible for and in need of a special program identified?

- Once identified, how do people enter the program? How many enter?

- How responsive is the system to people with immediate treatment needs?

- What problems arise during the process? Are people satisfied?

This paper focuses on the experiences of populations with SMI/SED in five states that have implemented Medicaid managed care (Hawaii, Maryland, Oklahoma, Rhode Island, and Tennessee). It is part of a larger evaluation of Medicaid managed care in those states conducted by Mathematica Policy Research, Inc.

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A. BACKGROUND

The two principal service delivery models for mental health benefits within managed care are integrated and carve-out models, although subtypes within these broad categories also have been developed. Integrated models bundle behavioral health with physical (somatic) health benefits. In carve-out models, states carve out mental health benefits from physical health funds and administer the benefits separately or carve out special populations. In both cases, the carve-out can be to fee-for-service or to managed care.

Those in favor of integrated systems that combine physical and mental health services argue that systems of this type lead to closer coordination with primary physical health care, better patient outcomes, and reduced stigma (Institute of Medicine 1997; and Stelovich 1996). Supporters of carve-outs argue that carve-outs preserve dollars for mental health services, are more cost effective, do a better job of protecting patient confidentiality (because information is maintained in separate billing systems), and promote greater specialization of services (Institute of Medicine 1997). Stakeholder interests also often drive carve-out designs, particularly those that carve out services, because this service delivery model better supports existing local provider networks (Bachman et al. 1997).

Each of the states reviewed here adopted either an integrated or carve-out approach for delivering mental health services as part of its demonstration program. In describing rationales for the structure of special programs for people with SMI/SED, state policymakers cited concerns about access, adequacy, and equity of the care that SMI/SED populations received under the previous grant-funded and fee-for-service systems. In addition, however, states clearly were responding to concerns about retaining funding and other stakeholder interests.

Maryland and Tennessee carved out mental health services; Hawaii and Rhode Island carved out populations with SMI/SED. Oklahoma was the only state that did not carve out either services or populations, at least as its program operates in urban areas. Hawaii, Oklahoma, and

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Tennessee also provided additional services to those with SMI/SED. However, even within these broad program designs, there were large differences in specific state programs of each type. For example, Maryland provided some basic mental health services and all substance abuse services within capitated MCOs and carved out specialty mental health services to fee-for-service Medicaid. Conversely, Tennessee carved out services to managed care in fully capitated behavioral health organizations (BHOs) that also were capitated for substance abuse. Even the states that carved out populations could carve them out to fee-for-service Medicaid (Rhode Island), or to capitated BHOs (Hawaii). Table I.1 further illustrates how each of the five states provides mental health and substance abuse services. Note that Oklahoma and Tennessee made several substantial changes to their mental health delivery systems between the start of their demonstration programs and the present. We describe the structure as of May 2000.

TABLE I.1

SUMMARY OF MEDICAID BEHAVIORAL HEALTH CARE PROGRAMS IN EACH STATE

	Hawaii (QUEST)	Maryland (HealthChoice)	Oklahoma (SoonerCare)	Rhode Island (RIte Care)	Tennessee (TennCare-Partners)
Program Implementation Date	August 1994	July 1997	August 1995-April 1996	August 1994	July 1996
Program Rationale	Contain Medicaid costs, expand coverage, and improve the timeliness and quality of care for those with mental illness	Contain Medicaid costs, realize savings, and preserve Maryland's unique mental health system while improving care for those with mental illness	Control Medicaid costs and introduce greater efficiency to the treatment of beneficiaries' mental illnesses	Contain Medicaid costs and improve health care access for low-income beneficiaries	Preserve mental health dollars, collect federal matching funds, and build expertise serving the mentally ill
Managed Care?	Yes	Only for primary mental health and substance abuse services	Yes--urban enrollees only	Only for non-SMI/SED	Yes
Carve-Out of Population or Service?	Yes--population with SMI/SED carved out to a special program: adults have Community Care Services and children have a program in the CAMHD. Non-SMI beneficiaries receive behavioral health services through their MCOs.	Yes--service. All "specialty" mental health services carved out and provided fee-for-service by Specialty Mental Health Services, the public mental health system. Primary mental health services are available within the MCOs.	No--for urban employees, mental health benefits services are integrated with physical health.	Yes--population. Those with SMI/SED are carved out to fee-for-service Medicaid.	Yes--services. All mental health and substance abuse benefits carved out to a separate managed care system served by BHOs.
Benefit Package Different for Those with SMI/SED?	Yes--those with SMI/SED have access to an extensive benefit package. Non-SMI/SED groups have access to fewer services, many with limits.	No--services are provided only with a medical necessity criterion.	Yes--those with SMI/SED can access specialized services in addition to the basic benefit package available to enrollees without serious mental illness.	No	Yes--those with SMI/SED (the priority population) can access an enhanced benefits package without service limits that is not available to the general population.

SOURCE: Information obtained during on-site visits to each state between 1995 and 1999. MPR staff met with state Medicaid, state mental health department, and state substance abuse department employees; mental health association staff; representatives of MCOs and BHOs; Health Care Financing Administration representatives; and local Alliance of the Mentally Ill affiliates.

BHO = behavioral health organization; CAMHD = Child and Adolescent Mental Health Department; MCO = managed care organization; MPR = Mathematica Policy Research, Inc.; SED = serious emotional disturbance; SMI = severe mental illness.

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II. APPROACH

A. OVERVIEW

We identify elements of state Medicaid managed care systems that serve beneficiaries who have SMI/SED. This group of beneficiaries includes cash recipients, such as those receiving Supplemental Security Income (SSI) or Temporary Assistance for Needy Families (TANF), as well as beneficiaries eligible for Medicaid because they are medically needy. We describe how these programs work in practice and report what states, providers, and consumers believe are the effects of the program elements on both adults and children. Although of interest, data limitations prevent us from reporting on the distinctions between the current systems and the fee-for-service Medicaid systems they replaced.

B. DATA/METHODOLOGY

We use data collected as part of a larger evaluation of five states' experiences with Medicaid managed care. Most of the data we use are taken from additional research sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA).

We obtained the information used to compile this report during site visits to the states conducted between 1995 and 1999. During these site visits, MPR staff met with state Medicaid, state mental health department, and state substance abuse department employees; mental health association staff; plan representatives from MCOs and BHOs; and representatives of local affiliates of the Alliance of the Mentally Ill. We also conducted focus groups with providers serving mental health and substance abuse populations, as well as with mental health and substance abuse service recipients. We conducted supplementary telephone interviews with key informants in states to obtain updated information, as necessary, and we spoke with Health Care Financing Administration (HCFA) representatives.

We used the data to develop a comprehensive description of how those with mental health needs (and those with concurrent substance abuse treatment needs) are served in each state. We also used the data to determine how these services evolved over time.

III. FINDINGS

A. OVERVIEW OF THE FINDINGS

Several themes regarding the current state of affairs in the states emerged from our work. First, to some degree, access to mental health and substance abuse services is a problem in most of the five states. Access problems are related to the boundaries that we observed in many states. For example, in most states, people with SMI/SED require a diagnosis to enter the special program before they can access needed services. States can limit access to the special program by making assessments difficult to obtain, or by creating other barriers, such as lengthy application forms or documentation requirements. Indeed, some states made these boundaries more difficult to cross by changing entry requirements, which may have limited the size of the eligible population. In other states, people could enter the special programs but, because of network restrictions, still could not access specialized services. For example, availability of child psychiatrists, residential care, or substance abuse treatment was limited in several states.

A second theme was a lack of service coordination, especially for those with dual diagnoses (concurrent diagnoses of mental health and substance abuse). For example, several states required sequential treatment for concurrent mental health and substance abuse (that is, treatment of one problem, followed by treatment of the other), often in separate provider systems, rather than simultaneously. Children with SED frequently did not receive coordinated care. Nevertheless, fee-for-service Medicaid has long been criticized as providing fragmented care (Dickey 1997; and Talbott and Sharfstein 1986). In addition, it often requires consumers or their families to act as case managers. Therefore, the new programs probably did not *worsen* coordination of care; it is more likely that they simply failed to correct long-standing coordination problems.

Third, despite the problems we observed, focus groups revealed that consumers were generally happy with the services they received under the new systems. However, this satisfaction may have been at the expense of provider satisfaction. Across states, providers were unhappy about payment rates, timeliness of payments, the amount of paperwork, and preauthorization requirements. Providers may bear the brunt of the burden to obtain authorization for additional services for patients who need them or may provide these services without always getting paid. *It is also possible that our consumer focus groups overstated consumer satisfaction, as they included only those enrolled in the special programs, and not those who were unable to access these programs.*

B. DESIGN AND EVOLUTION OF STATE DEMONSTRATION PROGRAMS

There are a variety of ways to design special systems for providing care to individuals with SMI/SED. The selection of a strategy is often a highly politicized process subject to much pressure from various interest groups, with stakeholders' aims and values and the particular political environment contributing to the programs that emerge. Here, we describe the process by which states developed their programs, their rationale for doing so, and the stakeholders who contributed to the design.

Each of the five states cited interests in controlling or substantially reducing Medicaid costs as a rationale for their demonstrations overall. In developing their programs for chronically mentally ill populations, some states cited other aims, such as improving access to care and the quality of care. The states took into account varying amounts of outside input when developing their Section 1115 demonstrations generally, and their behavioral health programs specifically. We found that, overall, states with the most stakeholder involvement experienced less controversial implementation, and those that implemented more slowly had somewhat smoother transitions to Medicaid managed care

1. Hawaii

Hawaii's Medicaid managed care demonstration program, QUEST, is an acronym that describes some of the aims of the program: Quality, Universal access, Efficient utilization, Stabilizing costs, and Transforming the way care is provided. The impetus for the program was the desire to expand access to care while simultaneously containing rising Medicaid costs. Because of concerns about whether the regular system could provide quality care for the population with SMI/SED, Hawaii excluded that population from the regular QUEST program (according to Eric Rolseth, Director of Felix Implementation).[3]

QUEST was developed by consultants, rather quickly, over an 11-month period, with little public or provider input. It combined three existing state insurance programs and their funds (Medicaid, General Assistance medical assistance, and the State Health Insurance Program [SHIP] (Wooldridge et al. 1996).[4] Hawaii submitted the proposal for QUEST in April 1993 and implemented it in August 1994, after receiving HCFA's approval in July of that year. Under QUEST, Hawaii enrolled individuals with SMI or SED in a separate program with expanded mental health and support service benefits. Adults with SMI enrolled in Community Care Services, a program run by the Hawaii Medical Service Association, a network health maintenance organization (HMO). Initially, children with SED continued to be served by the Child and Adolescent Mental Health Department, a part of the state's Department of Human Services (DHS), as they had been under fee-for-service Medicaid. In 1997, the state cancelled

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[3]Felix is a consent decree (October 1994) that resulted from a lawsuit brought against Hawaii's Department of Health, Department of Education, and Governor charging that coordination of educational and health services for special needs children was inefficient. The state agreed that better coordination was necessary, and that an outside source was required to monitor implementation.

[4]General Assistance was the state-funded cash assistance program for low-income people not categorically eligible for Aid to Families with Dependent Children. SHIP was designed for people who were not covered by Medicaid or by Hawaii's employer mandate to provide health coverage to employees.

the contract with the Child and Adolescent Mental Health Department, citing poor record keeping, and transferred children with SED to Community Care Services. In 1999, however, responsibility for children with SED again reverted to the Child and Adolescent Mental Health Department, reportedly (according to the director of a family guidance center) because of concerns that the service array for children offered by Community Care Services was too limited.

Those included in the carve-out are eligible for a comprehensive service array, including social and recreational services, transportation, and community education, in addition to unlimited inpatient, outpatient, and detoxification services. Those without an SMI designation can access a much less expansive array of services through the MCOs, some of which have yearly service limits.

2. Maryland

Maryland implemented its Medicaid managed care demonstration program, HealthChoice, in July 1997, in response to rising Medicaid caseloads and expenditures. HealthChoice was designed to contain costs and realize 10 percent savings while improving access to care and coordination of care (Ormond and Goldenson 1999). Maryland differed from most of the states we reviewed in that it moved slowly through the design phase, soliciting substantial public involvement (Gold et al. 1999). According to these sources, the state initially planned to carve out groups with SMI/SED into a separate program. However, advocates objected on the grounds that this move would be stigmatizing. Integration proponents argued that it would enable beneficiaries to receive all their care from a single organization, thereby improving coordination and accountability. Others who opposed this plan were concerned that Maryland's unique mental health service system would suffer under integration. Consequently, Maryland created a separate mental health delivery system, the Specialty Mental Health System, under the aegis of the Department of Health and Mental Hygiene's Mental Hygiene Administration.

Maryland carves out all specialty mental health services, which are provided by the Specialty Mental Health System and paid fee-for-service by the state. It distinguishes specialty mental health services from "primary" mental health services on the basis of codes in the *International Classification of Diseases, 9th Revision* (ICD-9). Primary mental health services, such as treatment of mild depression, are available within plan from primary care physicians.[5] The new system replaced the public mental health system and combined all publicly funded mental health services under one program. Thus, anyone, whether with HealthChoice coverage or with no insurance, can access the system. This structure was designed to protect traditional public providers and to discourage providers from "dumping" Medicaid patients into the public mental health system. The Specialty Mental Health System also was meant to increase participation of private providers; however, few have responded, because they apparently do not view the Medicaid sector as a profitable one (Ormond and Goldenson 1999).

Substance abuse services are not carved out, because substance abuse advocates reportedly believed that mental health interests would dominate the carve-out to their detriment (Ormond and Goldenson 1999). Substance abuse services are included in the benefit package provided by the MCOs.

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[5]The state hired an administrative services organization, Maryland Health Partners, to pay mental health claims and preauthorize services.

3. Oklahoma

Oklahoma implemented its Medicaid managed care system, SoonerCare, between August 1995 and April 1996 (Ku and Wall 1997). The state was motivated to design this system by its desire to curb growing Medicaid costs.

SoonerCare's development included substantial public input (although some critics allege that suggestions were ignored), and the program has undergone significant structural changes since its inception. Unless otherwise noted, all references here are to SoonerCare Plus, the program that operates in urban areas of the state (Ku and Wall 1997).[6] At the start of the program, SoonerCare integrated mental health and physical health services. The integration of mental health services into Medicaid managed care was the result of perceptions in the state that mental health treatments were overused, did not result in measurable improvements, and tended to continue indefinitely. Oklahoma subsequently decided not to serve SMI/SED populations within SoonerCare, and plans began to refer beneficiaries to the program administrator (the Oklahoma Health Care Authority) for evaluation of SMI/SED status and for disenrollment into fee-for-service Medicaid. Later, the state allowed those with SMI who were receiving TANF to *voluntarily* enroll in Medicaid managed care.

By July 1998, the state had come full circle to an integrated design with mandatory enrollment in SoonerCare for Medicaid-eligible people who have SMI or SED. At the present, beneficiaries with SMI/SED receive mental health services under a medical necessity criterion, without the service limits that were in effect under fee-for-service Medicaid. The Oklahoma Health Care Authority determined a separate capitation rate for those with SMI/SED and a separate rate within SMI/SED groups, depending on whether a beneficiary is older or younger

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[6]A separate program, SoonerCare Choice, operates in rural areas. It is a primary care case management program that operates by partially capitating primary care providers, and by continuing to pay hospitals, specialists, and behavioral health providers fee-for-service.

than age 21. SoonerCare provides a basic package of mental health services, including inpatient, outpatient, and crisis treatment. People with SMI/SED can access these services from their MCOs, as well as receive intensive outpatient, rehabilitation, residential, mental health support, and (for children) therapeutic foster care.

4. Rhode Island

Rhode Island developed RIte Care as a response to rapidly increasing Medicaid expenditures. In addition, the state was concerned about some aspects of access in Medicaid. Specifically, Medicaid recipients tended to receive primary care in emergency rooms, had difficulty obtaining transportation to healthcare providers, and experienced difficulties caused by language barriers (Ellwood 1995). Program development in Rhode Island received substantial input to the Governor's Policy Office from DHS, the Department of Health, consultants, and the legislative committee but lacked consumer involvement. The RIte Care demonstration was approved in November 1993 and implemented the following August.

RIte Care carved out mental health services for individuals with SMI/SED to fee-for-service Medicaid, although physical health and substance abuse for these individuals remained in managed care. People without SMI/SED but who are in need of mental health services receive treatment within the MCOs. Plans cover outpatient group or individual therapy visits and substance abuse treatment visits up to a limit, but they are required to cover these visits only to the extent that they are medically necessary. Plans may differ on the number of outpatient visits they allow before requiring additional authorization. If treatments exceed the limits, plans can take advantage of a stop-loss provision and receive reimbursement on a fee-for-service basis.

5. Tennessee

Tennessee developed TennCare as an answer to rising Medicaid costs and an impending state budget crisis. Its swift implementation of TennCare, with limited involvement of the public or providers, has been documented extensively elsewhere (Gold and Aizer 2000; and Wooldridge et al. 1996). Initially, people with SMI/SED received their physical health care from MCOs and received mental health and substance abuse treatment outside the MCOs (on a fee-for-service basis). In July 1996, Tennessee implemented a managed behavioral health carve-out, TennCare Partners. TennCare Partners was developed with reported intentions to preserve mental health dollars, collect federal matching funds, and build expertise in serving the SMI/SED population (according to a TennCare Bureau official). Adoption and implementation were similarly swift (with the period from proposal submission to implementation spanning only about nine months) and, like TennCare itself, solicited little public input. In creating TennCare Partners, the state urged the partnering of five BHOs into two. Each MCO then contracted, or partnered, with one of the BHOs. As of May 2000, one company (Magellan) owns both BHOs, although they still operate under two separate TennCare Partners contracts.

Relative to people without serious mental health problems (the "basic population"), those with SMI/SED (the "priority population") are eligible for an enhanced benefits package, including unlimited inpatient days, outpatient treatment visits, residential treatment, and case management services. Those in the basic population have lifetime limits on inpatient and outpatient substance abuse treatment, detoxification, and inpatient mental health treatment. In 1999, Tennessee announced its intention to do away with the priority/nonpriority designation, and to integrate mental health benefits with physical health care in TennCare, using a medical necessity criterion. The rationale is that this integration will increase service coordination and will remove the entitlement inherent in creating a special service population, thus enabling

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everyone to access needed care (according to a TennCare Bureau official). As of September 2000, HCFA has not yet approved this proposal.

C. ELEMENTS OF BEHAVIORAL HEALTH SYSTEM DESIGNS

The variety of designs for providing mental health services to SMI populations presents an opportunity to analyze several important aspects of these systems. In particular, the designs permit analysis of the ways that different types of boundaries affect how persons with SMI/SED enter the system, how many enter, how they are served by programs, and how responsive the systems are to emergencies.

1. Entering the System

The first boundary is the way that the states provide for assessments of SMI/SED status. Closely related is the way that states define SMI/SED, and the staff responsible for determining and redetermining SMI/SED status. The states' criteria for what constitutes SMI/SED differ widely, as do their requirements for reevaluations for those in the special program. Some states reevaluate frequently, whereas others certify SMI/SED status for the duration of Medicaid enrollment. Table III.1 summarizes these definitions and distinctions.

a. Hawaii

The referral process in Hawaii is strict; only plans can make referrals to assess adult beneficiaries for SMI status, although referrals to assess children who may have SED can also originate in the Child and Adolescent Mental Health Department. Hawaii uses a Client Assessment Record (CAR) and diagnosis to determine SMI status. This instrument is the same one that both Oklahoma and Rhode Island also use. The CAR is an instrument that rates beneficiary functioning in a number of domains. The states vary in the number of subscales they consider. Hawaii uses six domains and four levels of impairment. Children are assessed with

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TABLE III.1

STATE DEFINITIONS AND DIFFERENCES IN DEFINITIONS OF SEVERE MENTAL ILLNESS
AND SERIOUS EMOTIONAL DISTURBANCE

	Hawaii	Maryland	Oklahoma	Rhode Island	Tennessee
Adults					
Referral for Assessment	By plans only	n.a. All specialty treatment by medical necessity; no referral necessary	Case managers	Plans or providers	Plans, providers, individuals, or family members
Assessment	By two state-employed psychiatrists		Case managers, with review by psychologists or licensed clinical social workers	Staff at the Division of Integrated Mental Health Services, Office of Special Programs unit at Mental Health & Mental Retardation Hospitals (a sister agency to DHS)	Staff at case management agencies, CMHCs, and regional mental health centers
Required Conditions for SMI Status	Diagnosis and CAR using six domains, with four possible levels of impairment		CAR using seven domains. Impairment: moderate in four, severe in two, or extreme in one. If illness present for one year, then moderate impairment in two or severe in one is sufficient.	Psychiatric, emotional, or behavioral disorder and CAR using five domains, with moderate impairment in two or severe in one, or evidence that either level would occur in the absence of treatment	CRG, a functional assessment with four levels (first three represent SMI)
Reevaluations	Determined by psychiatrist every 3, 6, or 12 months		Annually	None	Every six months
Children					
Referral for Assessment	Plans, parents, or CAMHD	n.a. All specialty treatment by medical necessity; no referral necessary	Case managers	Plans or providers	Plans, providers, or family members

TABLE III.1 *(continued)*

	Hawaii	Maryland	Oklahoma	Rhode Island	Tennessee
Assessment	Two state-employed psychiatrists		Case managers	Staff at the Department of Children Youth and Families (a sister agency to DHS)	Same as for adult
Required Conditions for SED Status	A mental health diagnosis; a score of 120+ on Child and Adolescent Functional Assessment Scale; illness present for six months; disorder will persist into foreseeable future		Same as adult but uses two additional domains	Eligible psychiatric diagnosis. CAR using nine domains, with severe impairment in two	TPG, a functional assessment based on diagnosis and GAF. GAF scores of<50 considered to represent SED
Reevaluations	Same as for adults		Annually	None	Every six months

CAMHD = Child and Adolescent Mental Health Department; CAR = Client Assessment Record; CMHC = community mental health center; CRG = Clinically Related Group; GAF = Global Assessment of Functioning; n.a. = not applicable; SED = serious emotional disturbance; SMI = severe mental illness; TPG = Target Population Group.

the Child and Adolescent Functional Assessment Scale. The state considers children to have SED if they score 120 or higher on this instrument. In making SMI/SED determinations, Hawaii considers severity of mental health diagnosis, severity of functional impairment, whether the illness has been present for at least six months, and evidence that the disorder will last into the foreseeable future.

The evaluation process in Hawaii has changed markedly over time. Initially, plans referred beneficiaries to researchers at the University of Hawaii, who conducted all the assessments. However, because the researchers also collected a great deal of ancillary data for their own research purposes, an evaluation might take four to five hours to complete. The result was a large backlog of cases waiting for assessment. In addition, plans reportedly were eager to refer beneficiaries for evaluation, as they were responsible only for services provided for 14 days after a referral. Because of the backlog, determinations often took much longer than 14 days, and the state was at risk for services provided after that time. Due to the delays and the expense of paying for services while waiting for an assessment, the state changed the way evaluations were conducted. Now, two state-employed psychiatrists complete all the assessments, and plans have responsibility for all treatment received until the physicians make a decision.

Despite this change, delays in determinations do not seem to have decreased under the new system. Providers reported that determinations might take as long as six months. The state-employed physicians conceded that determinations often were delayed but contended that submission of improperly completed paperwork by plans was the cause. Reevaluations for those who have been diagnosed with SMI/SED can occur at 3, 6, or 12 months after the initial determination. The interval is set at the discretion of the psychiatrist who completes the evaluation.

Hawaii has no independent process to review grievances. For example, the grievance procedure to protest a non-SMI/SED designation requires that the appeal be made to the

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physician who made the initial determination. Thus, it has not established any procedures for an outside review of the decision. Some sources have indicated that the process for referring candidates to the special program is unclear. Child and Adolescent Mental Health Department personnel noted that they sometimes had referred children they thought might be SED to DHS, alleging that DHS had not followed up on the referral by assessing the children.

b. Maryland

Maryland carves out services, not populations. People who providers determine to have a medical necessity for a service can receive that service. Patients can self refer or can be referred by a health plan or provider. Therefore, identification of SMI/SED status is not the issue that it is in the other states. Staff at Maryland Health Partners (the administrative services organization responsible for eligibility verification, claims processing, provider payments, and service authorization) report that they would much rather resolve problems than deny services--it is easier for them to follow the former approach because they are not at financial risk for services provided. According to Maryland Health Partners staff, only board-certified psychiatrists who have been in practice for at least five years can deny mental health services.

Maryland has several mechanisms to deal with consumer complaints. (The mechanisms cover the entire Medicaid managed care demonstration, rather than only the mental health services carve-out.) The state has an ombudsman, as well as a grievance and complaint process. It has established an action line for consumers who have questions on policies and procedures, and a similar line to answer providers' questions. Maryland reports that it has successfully resolved nearly all the consumer and provider complaints it has received. Until recently, however, the volume of consumer calls had been low, probably because the Maryland Health Partners telephone number was not printed on the MCO identification cards, so that many people did not know about the consumer line. Maryland Health Partners remedied the problem by

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publicizing the toll-free number and subsequently reported an increase in the number of consumer calls.

c. Oklahoma

In Oklahoma, only case managers can refer a beneficiary to be assessed for SMI/SED status. (Case managers also complete the assessments and make the determinations, although a psychologist or licensed clinical social worker reviews each one.) Case managers base their SMI/SED designations on an individual's functional level, diagnosis, and long-term needs. Reevaluations of those determined to be SMI or SED are completed annually.

Like Hawaii and Rhode Island, Oklahoma uses the CAR as its assessment instrument. It uses ratings of beneficiary functioning in seven domains. Those with a diagnosed mental, emotional, or behavioral disorder and moderate impairment in four areas, severe impairment in two, or extreme impairment in one are designated to have SMI. If the illness has been present for at least one year, then moderate impairment in two domains or severe impairment in one domain is sufficient for an SMI designation. The assessment for children with SED uses similar criteria, although two additional domains are rated. Based on this assessment, the state determines which of four levels of care, ranging from limited care to much care, is appropriate.

People deemed to be without SMI/SED have the option of appealing. A grievance process for SMI/SED decisions has been established, with review from a Program Review Panel. According to staff of the Oklahoma Alliance of the Mentally Ill and other respondents, however, people make only infrequent use of the state's grievance and appeals processes, in part because the information on how to file grievances is not routinely disseminated. People who do not meet the SMI/SED designation but need additional services can receive these services. However, they would require preauthorization by their MCO, because MCOs are not obligated to provide

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additional services beyond the basic benefit package to beneficiaries who do not meet the SMI/SED criterion.

d. Rhode Island

When plans or providers refer beneficiaries for assessment in Rhode Island, the instrument used to determine SMI status is the CAR. In Rhode Island, adults are deemed to have SMI if, in addition to having a psychiatric (psychotic, affective, or personality) disorder, they show sufficient functional impairment on the CAR. Rhode Island, which uses five CAR subscales, requires at least one scale to show severe impairment, two scales to show moderate impairment, or evidence that the individual would experience moderate or severe impairment if no treatment were provided. Adults also must have undergone intensive psychiatric treatment in the past (such as inpatient hospitalization). Children are evaluated on a child version of the CAR, using nine subscales. A child considered to have SED must have an eligible psychiatric diagnosis and severe impairment on at least two of the CAR subscales. The process to be designated as having SED has been described as highly complicated and cumbersome, requiring extensive documentation and corroborating evidence that necessitates the cooperation of several agencies.

Those who are identified as having SMI/SED retain that designation until they leave the system. There are no automatic reevaluations. Each health plan has instituted internal complaints, grievance, and appeals systems. Nevertheless, some advocates were of the opinion that a major problem with RIte Care was a lack of outreach, which excluded people from the RIte Care system completely, rather than excluded them only from the carve-out program.

e. Tennessee

In Tennessee, requests for assessments can be made by the BHO, MCO, primary care provider, the individual, or family members (TennCare Partners Contract 1996). Tennessee uses Clinically Related Groups (CRGs) to define SMI. The CRG is essentially a functional assessment with four levels. Those rated as a one, two, or three have SMI. Children with SED are determined according to Target Population Groups (TPGs). The TPG can be rated as a one (the child is in state custody), two (the child has SED), or three (the child is at risk for SED). CRG and TPG determinations are made by using mental health diagnoses and an assessment of the Global Assessment of Functioning (GAF). Scores on the GAF range from 0 to 100, with 100 signifying the most adaptive functioning. Children with GAF scores of less than 50 are considered to have SED. (This threshold has changed with the advent of TennCare Partners and will be addressed in the following section.)

The state trains staff at case management agencies, community mental health centers, and regional mental health institutes to conduct all evaluations for SMI/SED status. Reevaluations of people designated to have SMI/SED are made every six months. The BHOs have automatic mechanisms in effect to evaluate people who may have SMI/SED, based on mental health service use. However, staff at one community mental health center reported that they assessed anyone who used their services, rather than only those seeing private providers who had reached their service limits.

2. System Inclusiveness/Restrictiveness

The definitions of SMI/SED that states follow have implications for the size of the group eligible for services. In addition, attributes of the program can affect the ease with which people near the boundary can access additional services they may need, because any such boundary is somewhat arbitrary. In this section, we explore the number of people with SMI/SED who are

served in each state's special program, and what happens to those who are not identified as SMI/SED but who need treatment. Table III.2 summarizes the inclusiveness and restrictions of each state's program.

Some states may have increased the difficulty of accessing their programs by changing the criteria for SMI/SED status. For example, Hawaii and Tennessee substantially altered their scoring criteria, making it much more difficult to enter the special programs. However, Maryland, Oklahoma, and Tennessee also enroll those receiving SSI into their demonstrations. The inclusion of SSI recipients, who are more likely than those who do not receive SSI to have a serious mental illness, may greatly increase the numbers of people who are identified as program participants.

a. Hawaii

Multiple sources indicated that it is extremely difficult to enter the special program in Hawaii. In addition to the assessment backlog mentioned in Section III.C.1.a, paperwork requirements are formidable. Plan representatives informed us that assessments can take anywhere from six weeks to six months.

Hawaii serves approximately 30 children with SED, and 500 adults with SMI.[7] The original carve-out contractor for children with SED in 1994 was the Child and Adolescent Mental Health Department, which indicated that it had 125 children in the program at the time the contract ended. However, when Community Care Services took over in 1997, the program had only 40 children, 10 of whom were scheduled to age out of the system within six months (that is, would reach age 18). We have been unable to determine what happened to the rest of the children; however, a MED-QUEST official suggested that the then-recently decided Felix consent decree (which requires

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[7]Thus, assuming 450,000 enrollees, 0.12 percent of the enrollees in QUEST (non-SSI) are eligible for the program.

TABLE III.2

STATES' INCLUSIVENESS AND RESTRICTIONS TO ENTERING THE SPECIAL PROGRAM

Criteria	Hawaii	Maryland	Oklahoma	Rhode Island	Tennessee
Number of SMI/SED Identified	SMI: 500 SED: 30 (1998)	n.a.	500-600 (June 1997)	66-200 (August 1998)	65,000 (1998)
Proportion of Medicaid Population Who Are SMI/SED (Percent)	0.12%	n.a.	0.08%	0.05%	5.0%
Does Demonstration Include SSI Population?	No	No	Yes (phase in completed end of 1999)	No	Yes
External Criteria or Medical Necessity	External criterion	Medical necessity	External criterion	External criterion	External criterion
Did Scoring Criteria for SMI/SED Change with Demonstration?	Yes, became more stringent	n.a.	No	No	Yes, became more stringent

SOURCE: Interviews with stakeholders in each state.

n.a. = not applicable; SED = serious emotional disturbance; SMI = severe mental illness.

coordination of services for disabled children, including those with SED) had the effect of moving many children with SED to the mainland to receive care. Sources had different estimates of the number with SMI who receive treatment at any given time. The state asserts that only about half the identified population is in active treatment (because of the difficulty of locating these individuals), whereas Community Care Services reports that it actively treats approximately 98 percent of its SMI beneficiaries.

The standard used by the Child and Adolescent Mental Health Department to define SED before QUEST was much different than the definition currently used by the DHS physicians. Previously, those who scored below 60 were considered to have low-end needs. They might need family therapy, outpatient treatment, or medications. Those scoring 61 to 80 had moderate needs. They might need a therapeutic aide, partial-day hospitalization, or acute psychiatric care. Those who scored above 80 were considered to have high-end needs (that is, to have SED). They might require therapeutic foster homes, therapeutic group homes, or residential treatment. Under the new cut-off, children now must score 120, which is 40 points above what had been considered indicative of SED, to gain entry into the program.

Providers indicate that patients who have both mental health and substance abuse problems may have additional difficulties. Some suggested that Community Care Services has been inconsistent about whether a substance abuse diagnosis precludes participation in its program; according to documentation provided by Community Care Services, substance abuse can be present but cannot be the primary diagnosis. MCO representatives told us that it is unusual for beneficiaries who are not in the program to reach service limits, but that the MCOs try to enroll any who do reach these limits into Community Care Services. If they do not enter the program, the beneficiaries are limited to 24 outpatient visits, and providers usually "just work within the limits." QUEST officials reported that they had never investigated what happened to people who

reached their service limits. Community Care Services reports that it pays for care coordination for those it believes have SMI but who are unable to enter the program, although the state does not compensate it for doing so. Case management for those who are not in Community Care Services begins when the patient reaches 15 outpatient visits, but it can occur sooner, if the person is diagnosed as suicidal or violent.

b. Maryland

Maryland's system pays for all but primary mental health services (defined by ICD-9 codes) on a fee-for-service basis and therefore has little need to count the numbers of people who have SMI/SED. Anyone can refer himself or herself to the specialty mental health system and can receive any kind of medically necessary care.

c. Oklahoma

Oklahoma has identified and enrolled into its special program relatively few people with SMI/SED. It has been estimated that statewide, between 500 and 600 people fall into these categories.[8] According to providers with whom we spoke, people who have a mental illness that does not meet the state's criteria for SMI/SED can have difficulty accessing additional services, and they receive limited or inadequate case management services. Providers indicated that those designated as having SMI/SED could obtain additional mental health services easily, but had difficulty obtaining additional substance abuse services.

d. Rhode Island

It is difficult to determine with accuracy the number of people with SMI/SED who are served in RIte Care, because estimates of the number of people carved out differ, and we lack the

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[8]Oklahoma phased in enrollment of SSI recipients, but this process was not completed until the end of 1999. Therefore, the numbers of SMI/SED do not reflect the inclusion of SSI recipients.

data to reconcile these differences. However, relatively few people with SMI/SED have been identified and carved out. For example, DHS representatives reported that only 66 people had been carved out as of August 1998. (A state mental health/mental retardation representative disputed this number, stating that there must be approximately 150 to 200.) Regardless of which figure is correct, both are low given the size of Rhode Island's enrollment (100,000 people, or nearly 10 percent of the state's population as of early 2000). The size of the carve-out is something of a moot point, however, because Rhode Island's approach to service delivery is a flexible one, which differs from those of the other states. In Rhode Island, beneficiaries can access mental health services regardless of whether they have been carved out. This feature of the system encourages MCOs and providers to treat individuals with mental illness, thereby providing MCOs some protection from the costs.

At least seven reasons have been advanced to explain why so few people have been carved out. First, MCO representatives told us that plans do not want to appear to be "dumping" patients, so they generally do not initiate referrals for evaluation. The representatives stated that the MCOs encourage physicians to refer, but cannot compel them to do so. However, the MCOs are not overly concerned that there is little provider-initiated referral because they have stop-loss agreements with the state. Second, providers indicated that they are reluctant to refer patients to the carve-out because they feel it is stigmatizing. Third, providers also pointed out that they had no incentive to refer patients to the carve-out because they (the providers) would receive a higher payment from RIte Care MCOs than from fee-for-service Medicaid. Fourth, both providers and plans noted that they believed the fee-for-service system was uncoordinated relative to managed care. In other words, both believed patients were better off in the managed care system. Fifth, patients have access to state-funded specialty services from within RIte Care, so providers and MCOs see little harm in not referring. (Specialty services, such as Children's Intensive Services and a Community Support Program for adults, are available at community mental health centers

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and are paid by the state mental health agency.) Sixth, the carve-out process for children with SED has been described by clinical staff as a "nightmare," making the referral process itself a potential barrier. Seventh, the state does not enroll SSI recipients, many of whom also have chronic mental illness, which could also explain the small numbers of people carved out.

Rhode Island's system does not seem to provide routine screening for SMI/SED status or substance abuse, and it is not clear whether assessments can be triggered by a diagnosis or by service use. However, RIte Care enrollees have access to a comprehensive substance abuse benefit and can refer themselves to treatment if it is deemed medically necessary.

e. Tennessee

Although it is difficult to compare the current size of Tennessee's priority population with the numbers of people with SMI/SED prior to TennCare Partners, some evidence suggests that TennCare Partners is the more restrictive system. For example, according to advocates, before TennCare Partners, approximately 25,000 children were served in intensive settings that suggested the children should have been part of what later became the priority population. However, an advocate estimated that, in 1998, approximately 15,000 SED children were served in TennCare Partners. This drop probably was the result of changes to the score required to be classified as SED. Before TennCare Partners, a GAF score of 70 or lower was sufficient, whereas after TennCare Partners, scores below 50 were considered indicative of SED. Advocates asserted that a large proportion of children previously considered SED scored in the 50 to 70 GAF range and therefore no longer qualified under the new guidelines. We estimate that approximately 50,000 adults with SMI were included in the priority population in 1998. This large number is due in part to the fact that Tennessee had the largest demonstration of all the states, enrolling more than 1.2 million people into TennCare. The numbers of priority group members represent approximately five percent of the total.

3. System Responsiveness

The third boundary we consider is the way that a system responds to unexpected emergent cases. In this section, we explore whether each state's system is designed to respond quickly to someone with urgent treatment needs, and what program features make systems more or less responsive. Most states have at least some provision for emergency cases, although these mechanisms do not always work as well as they should. However, it is quite likely that many of the problems we noted are not related to managed care itself; rather, they may have been in existence under the previous fee-for-service system. Table III.3 describes each state's emergency response system.

a. Hawaii

Those interviewed in Hawaii say the system is not responsive to urgent needs; crisis services were cited as particularly problematic. The state's system provides a 24-hour hotline, staffed by Community Care Services care coordinators who transfer calls to a clinician for triage. Some providers in our focus groups alleged that crisis intervention personnel often call the police to intervene, rather than rely on less confrontational approaches. Community Care Services staff report that clinicians assess callers and direct care coordinators to see the caller. Although the primary aim is to divert a hospitalization, they also direct the care coordinators to arrange transportation to the hospital (either by ambulance or police car), if necessary.

TABLE III.3

MEDICAID DEMONSTRATION STATES' EMERGENCY RESPONSE SYSTEMS

Hawaii	Maryland	Oklahoma	Rhode Island	Tennessee
24-hour hotline (run by Community Care Services) ↓ Clinicians assess callers ↓ Dispatch care coordinators to visit patient/arrange transportation to the hospital, if necessary	Patient calls any provider to request emergency visit ↓ Provider calls the ASO to log visit and request additional emergency visit payment	All MCOs run 24-hour hotlines ↓ Dispatch crisis intervention staff. (Crisis intervention, police, or DHS staff can request psychological evaluation from any provider; parents can request one only from providers in their network.)	24-hour hotline/crisis intervention ↓ Clinician on call triages the caller. Can authorize ER visit, if necessary	BHOs have 24-hour hotlines ↓ Dispatch response team, if necessary. (ER staff, crisis teams, and individuals can make referrals for psychiatric evaluations.)

ASO = administrative services organization; BHO = behavioral health organization; DHS = Department of Human Services; ER = emergency room; MCO = managed care organization.

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b. Maryland

According to a representative from Maryland Health Partners, an individual in Maryland with urgent mental health care needs can contact a provider directly, and the provider will see that person within four hours. The provider then contacts the administrative services organization (Maryland Health Partners) to register the visit. Providers who see patients with urgent care needs receive a payment in addition to their normal payment.

c. Oklahoma

By most accounts, Oklahoma has a fairly responsive system that provides crisis intervention services. In emergencies, both the police and DHS staff can request a psychological evaluation from any provider, regardless of whether the provider is in the beneficiary's network. Parents can also request evaluations for their children, but they must use the provider network. Each MCO has a crisis line manned by master's level staff. However, some providers reported that coordinating emergency inpatient care for children with SED was quite difficult, because it could be challenging to find someone to locate an inpatient bed for a child, especially after hours.

d. Rhode Island

Rhode Island has a crisis intervention service and a 24-hour hotline to handle emergency situations. Nonclinical staff answer the telephone. If they determine that a caller believes the situation is an emergency, they can set up a three-way conference call with a clinician. The clinician can then triage the patient and authorize an emergency room visit. The state will pay emergency visits for psychiatric emergencies on a fee-for-service basis.

Until recently, the larger problem for those with SMI/SED was accessing RIte Care itself, rather than gaining admittance to the carve-out or accessing services. In recent years, the number of enrollees with SMI/SED has dropped. The state recognized the problem and made two changes to increase enrollment. First, it implemented an outreach program to enroll eligible

people. It encourages outreach workers to concentrate on non-English-speaking and low-literacy groups and pays them for each person enrolled. Second, it shortened the application form. Previously, the RIte Care application was 32 pages long and required both documentation of 13 elements and a face-to-face interview. The revised form requires documentation of only three items, and no interview.

e. Tennessee

In TennCare Partners, each BHO must have a 24-hour emergency hotline staffed by a qualified mental health staff person. These staff must be partnered with a response team that can be dispatched to intervene directly with the person experiencing the crisis, if necessary (TennCare Partners Contract 1996). In addition, emergency room personnel and crisis teams can make referrals for psychiatric evaluations, and individuals can self refer.

D. DID THE SPECIAL PROGRAM DESIGNS WORK?

Implementation of specialized behavioral health systems for people with SMI may not follow the intended designs; even if they do, they may not work satisfactorily. In practice, the SMI population may have to overcome new boundaries and difficulties. In this section, we summarize the way that respondents from each state viewed their state's design and implementation processes, as well as the design elements described in the preceding sections. We focus particularly on access, coordination of care, and consumers' and providers' levels of satisfaction.

A common theme emerging from all five states was that beneficiaries with SMI were generally satisfied with the care they received in their states' Medicaid managed care programs. However, this satisfaction may have come at the expense of providers, as providers routinely indicated that they were less satisfied under the new systems than under the former ones. In

particular, it appears that providers had substantial waits until they received payments from MCOs and BHOs, and that the payments themselves were inadequate.

Another common complaint was that the credentialing procedures many MCOs and BHOs followed made it difficult for providers to staff their offices. Previously, many providers could hire staff with relatively fewer credentials and at relatively low cost who would provide services under clinical supervision. The stricter credentialing requirements established by many MCOs and BHOs mean that these organizations do not reimburse for services provided by a staff member who lacks credentials. According to some providers, this policy has created a shortage of credentialed staff and may have had a disproportionate impact on small providers, who have difficulty offering competitive salaries. Others cite problems with uniformity of standards. They contend that some MCOs credential some individuals in an office but not others; furthermore, some providers find that they are credentialed by one MCO but not by another. Both substance abuse and mental health providers voiced these complaints. However, staff of substance abuse providers, who often have fewer formal credentials than do staff of mental health providers and, therefore, the most trouble under strict credentialing, were more vocal. Providers and MCOs/BHOs differed on whether stricter credentialing created constraints in the network. The positive side of strict credentialing is the potential to deliver higher-quality care. The negative side is that strict credentialing may limit the diversity of providers. To the extent that credentialing limits opportunities for supervised clinical experience, it may limit the pipeline of new providers.

a. Hawaii

The biggest reported problem is that it is extremely difficult to get new people into the Community Care Services program, because there are incentives to under-classify those with SMI/SED. The state has tightened access to the program by requiring that all assessments be

conducted by its own physicians, raising the SMI/SED cut-off score, restricting those who can refer people for assessment, and routing appeals of denials to the people who made the initial decision. Although people who can enter the special programs are eligible for an impressive and comprehensive array of services, those living on many of the more rural islands face some geographic barriers; Oahu provides the best access. A large MCO also complained that it paid for care coordination for enrollees whom it believed had SMI/SED but who had not been classified as such by the state.

In addition to access problems, the special programs in Hawaii have experienced operational difficulties. Providers often bill the Child and Adolescent Mental Health Department for QUEST services because family guidance centers cannot compel their clients to report their insurance status, and the Child and Adolescent Mental Health Department's rates are higher. This loophole results in the state paying twice for mental health coverage--once through QUEST capitation, and once through monies supplied to the Child and Adolescent Mental Health Department. It is not clear how the transfer of children with SED back to the Child and Adolescent Mental Health Department will affect this payment structure.

b. Maryland

Although respondents cited many positive aspects of Maryland's demonstration program, they also widely criticized the separation of mental health and substance abuse services. They asserted that this separation results in poor coordination of care for those with dual (mental health and substance abuse) diagnoses. With respect to specialty mental health services, Maryland Health Partners does not appear to have any incentive to delay treatment, as it receives a flat fee and is not at risk for services provided. In fact, according to the state, this feature is precisely why Maryland Health Partners is not at risk. Representatives from the state explained

that concerns about denial of care to this vulnerable group led it to remove any incentives to do so.

The separation of mental health and substance abuse services has resulted in cost shifting between programs. Under Maryland's system, specialty mental health services or substance abuse services are paid according to the primary diagnosis; originally, the system called for sequential treatment for the dually diagnosed. As envisioned, the entity responsible for treating the primary diagnosis (the MCO, for substance abuse; Managed Health Partners, for specialty mental health) is to treat that condition and then shift the patient to the other entity for the other treatment. According to Maryland Health Partners and the MCOs, however, in reality, the entity responsible for the primary diagnosis provides both types of care.[9] Although providing all services in one system probably leads to better coordination of care, it also leads to disputes between MCOs and Maryland Health Partners over which organization has responsibility to provide and pay for the services. In addition, mental health advocates are concerned that significant cost shifting is occurring, with Maryland Health Partners picking up the costs of substance abuse treatment. (The advocates believe that Maryland Health Partners pays for these costs more often than MCOs pick up the costs of mental health treatment, although MCOs may disagree.) The state recognizes that some cost shifting probably occurs, but its greatest interest is in ensuring that people receive the substance abuse treatment they need.

Many were seriously concerned that splitting responsibility for mental health and substance abuse services might create confidentiality breaches. Although the MCOs want Maryland Health Partners to update primary care providers on the mental health treatment their patients receive, the providers rarely are given this information. Part of the problem is that mental health

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[9]Providers did note that, even if mental health and substance abuse services were provided in the same center, patients often were treated sequentially, with the most pressing problem treated first. However, this split did not seem to be the result of HealthChoice.

providers are uncertain whether they must first obtain a signed release from the patient, or whether releasing information violates federal confidentiality law.

A more serious breach of confidentiality might occur if a patient's medical records were sent to the wrong primary care provider. Such an error could occur, as it is difficult to determine the correct provider; the state Medicaid office tracks MCO enrollment, but not patients' primary care providers, and, according to Maryland Health Partners, MCOs often lack this information as well. The fact that some large facilities, such as the University of Maryland, subcontract under a single HMO, which is unlikely to know the identity of a beneficiary's primary care provider, probably is a contributing factor. Instances of incorrectly routed transmittals of sensitive information have increased confidentiality concerns. In an effort to correct this problem, Maryland Health Partners reportedly is testing a pilot program to encourage patients in rehabilitation facilities to give their psychiatrist the name of their primary care provider. The goal is to foster communication among providers.

c. Oklahoma

Providers indicated that the system was not working to their satisfaction, although consumers seemed generally satisfied with it. Providers complained that credentialing requirements and the slow pace of becoming credentialed made it difficult for them to staff their offices. Mental health providers indicated that obtaining extra substance abuse services for patients was challenging; substance abuse providers complained that they were no longer receiving referrals. Providers also indicated that it was difficult to obtain coordinated services for the dually diagnosed. Advocates complained that the use of functional assessments (the CAR) made it difficult for people with SMI/SED to qualify as such, and to become eligible for the enhanced benefits package. An advocate for the Oklahoma Alliance of the Mentally Ill noted that people with SMI sometimes stabilized after receiving treatment, were reassessed and

determined to no longer have SMI, and thus lost the additional benefits that might have been necessary to maintain their stability.

It was reportedly difficult to access some services for children with SED, such as day treatment (many programs had closed) or child psychiatrists. (Sources in other states also have reported shortages of specialty providers for children and adolescents.) Because school staff are often the ones to identify children who may have SED, they often refer to the appropriate MCO to set up care. The system has a fail-safe component, as schools sometimes take on responsibility for providing (arranging) care for children in need if the MCOs do not act quickly enough. The schools have school-based contracts for early and periodic screening, detection, and treatment (EPSDT) services, enabling them to refer for screening or provide and bill for certain therapies. However, use of schools to provide services suggests that MCOs engage in some cost shifting to these institutions.

Transportation may be a problem for the population with SMI/SED. Some consumers reported that it is difficult to travel to an appointment even if it has been approved. One consumer noted that the rules for transportation were quite rigid. For example, a cab could pick her up only at home, not at work. If the transportation is for a child, the parent has to be present (that is, the cab cannot pick up the parent at work and pick up the child at school--both must be at home).

d. Rhode Island

Observers indicated that, despite some problems, RIte Care has broadened access to mental health services and had a "normalizing" effect by allowing Medicaid recipients to access private providers. Although SMI/SED may be under-classified, the problem does not seem to be a functional one, because beneficiaries can access specialty services regardless of whether they have been identified officially.

Consumers reported that they were generally satisfied with the program. According to a study commissioned by the state, beneficiaries generally have good access to care (Birch and Davis 1998). However, the study's authors identified some problem areas, including patient-provider language barriers and long waiting times. The population most at risk of not having its service needs met, according to providers, is the group with both mental health and substance abuse diagnoses, because its members often "fall through the cracks."

Providers voiced several complaints. First, they alleged that MCOs lack experience with the population with SMI/SED, and that they do not understand how to treat this group (for example, they claim that MCOs balk at allowing extra therapy sessions). Second, they described the preauthorization process as cumbersome. Several providers indicated that they were often put on hold, and that clients, who had to relay sensitive information over the telephone, found the experience intimidating. As a result, some providers considered it necessary to use treatment time to make calls for their patients. Third, providers, particularly substance abuse providers, complained that the credentialing process was too strict (plans require five years of postgraduate experience), cumbersome, and time-consuming.

The study by Birch and Davis (1998) noted that, in the period from 1997 through 1998, three of the four MCOs lacked formal policies or procedures for the care of children with SED (although children with SED should be carved out, plans still are responsible for coordinating their care). All but one MCO had formal policies for care of adults with SMI. However, most plans had seen few people officially diagnosed with SMI or SED, possibly the result of the previously discussed incentives to not carve these individuals out.

f. Tennessee

The evidence suggests that, at least as TennCare Partners was through 1999, changes in the definition of SED served to restrict the number of people in the priority population. Moreover,

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Tennessee's financing of TennCare may have provided an incentive to limit the number of priority group enrollees. Plans received the same blended capitated rate regardless of a patient's SMI/SED status. However, the state later "unblended" the rate, paying more for priority group members, and paying a variable rate subject to a monthly budget cap for nonpriority members (Hoag et al. 2000). This approach presents an incentive to classify and enroll more people into the priority group because it helps to maximize the amount paid for priority group members. Aizer and Gold (1999) note that, if one BHO has increasing priority group enrollment and another has unchanged priority group enrollment, the former will receive more money than the latter due to the spending cap.

Tennessee experienced (and is still experiencing) upheavals within TennCare Partners. The TennCare Bureau has had eight directors in five years and has undergone many other substantial organizational changes. For example, when TennCare Partners began in 1996, Tennessee's Department of Mental Health and Mental Retardation was the administrator. However, the department created such an extensive application form for TennCare Partners that multiple sources identified the form as a barrier to program entry. The state believed that the two programs would run more smoothly if both TennCare and TennCare Partners were administered by the same organization and, although many criticized the move, subsequently transferred administration to the TennCare Bureau.

The negative aspects of TennCare Partners seem to center around coordination of care. Several respondents noted that children with SED receive poor case management and poor coordination of care and have little access to specialty providers, such as child psychiatrists. Advocates stated that the mental health and physical health systems do not coordinate care. Some believed that the responsibility for treating these children was being shifted to the schools. Those with dual mental health and substance abuse diagnoses also face difficulties with coordination of care, because they are served by different systems. In a survey of urban SSI

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enrollees, about one-quarter of those who saw multiple providers reported that their physicians and therapists did not talk to each other about their care (Hill and Wooldridge 2000).

TennCare Partners may have affected the supply of providers. Community mental health centers reported that they had to lay off clinicians and hire extra clerical staff because each plan required separate forms and paperwork. In addition, providers stated that strict credentialing requirements make it difficult to hire someone who needs supervision, because plans will not reimburse for treatment provided by someone who has not yet been credentialed. In the past, providers were able to hire clinical staff who needed supervision to provide treatment at a lower cost. Now, only clinical staff with full credentials are hired. Providers claim that this change will affect the future supply of clinicians in Tennessee: new graduates will not be hired and trained because providers will not be able to afford to do so.

IV. DISCUSSION

A. IMPLICATIONS

This section revisits the research questions and frames the ensuing discussion based on the findings.

1. Have Special Programs Been Established for People with Severe Mental Illness?

Each state has made special provision for people with SMI/SED. Despite a diverse range of program designs among the states, we found that all five experienced similar problems. The overarching issue--access to care--presented a challenge to all five. Three access themes emerged. First, access was affected by the policies the states followed, and by the ways the states structured their Medicaid managed care programs. Second, people with SMI/SED and a concurrent substance abuse disorder faced additional barriers to care. Third, consumers and providers were nearly polar opposites in their feelings about their program--with consumers generally happy and providers generally unhappy.

2. Have Access Problems Arisen as a Result of the Methods of Identification and Entry?

Access problems can be caused by such policies as standards for entry to the special program, application requirements, and provider network adequacy. Two states made significant changes to the criteria used to judge whether a person had SMI or SED. In neither case were the changes from prior practice justified on empirical or clinical grounds. The changes made it more difficult for people to qualify for the special program and, therefore, to access additional services.

Several states instituted complex or burdensome application requirements to access either Medicaid itself or the special program in particular. Requirements like these can act as barriers to program entry and may be even more important, now that there no longer is an automatic

connection between welfare (cash assistance) and Medicaid. Moreover, people with SMI may be less able than others to persevere through complicated applications to access necessary services. After noticing that Medicaid enrollment was falling (in conjunction with the implementation of welfare reform), Rhode Island attempted to address the problem by instituting a simpler application process. Tennessee also simplified its initial application for benefits.

3. What Other Problems Have Arisen?

a. Coordination for the Dually Diagnosed

Care coordination for people with dual diagnoses probably did not worsen under Medicaid managed care. The fee-for-service Medicaid system often has been criticized for providing fragmented care, and managed care attempted to correct that shortcoming.

Policies for treating people with concurrent mental health and substance abuse disorders may limit access to services or the effectiveness of the services. In several states, the dually diagnosed had to obtain sequential rather than simultaneous treatment for their problems--at times within completely separate systems. Even in Maryland, where sequential treatment was provided within a single system, the physical and mental health systems conflicted over which one was responsible providing treatment. Concurrent mental health and substance abuse problems are common; one substance abuse treatment site in Maryland estimated that approximately 80 percent of its patients, many with SMI, had dual diagnoses. Others estimate that 40 to 60 percent of people with mental health conditions also abuse substances (Ross 1997). The presence of concurrent substance abuse problems can greatly exacerbate mental health problems. For example, expenditures can nearly double when a substance abuse disorder is also present (Dickey and Azeni 1996). Sequential treatment policies may have also undermined care coordination because of limited or nonexistent communication between mental health and other providers.

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b. Network Adequacy and Credentialing

Provider network adequacy is fundamentally related to access. Those who were able to enter special programs were not always able to access needed services. Children with SED seemed to have the most difficulty with network constraints (often facing shortages of child psychologists and residential treatment slots); people in rural settings also were likely to be affected by mental health provider shortages. However, these shortages may be carryovers from the fee-for-service Medicaid system, and not necessarily related to Medicaid managed care.

MCO credentialing requirements are potentially related to network adequacy. For the most part, substance abuse providers complained that these requirements focused too much on educational credentials, rather than on clinical experience. Mental health providers also complained about disallowing payments for providers operating under clinical supervision. They stated that the combination of strict credentialing and paperwork requirements made it difficult to hire qualified therapists and necessitated hiring additional clerical staff. These practices could restrict the pipeline of new providers and, potentially, the network of available providers, although there was no direct evidence that these changes have occurred. Despite these potential network problems, stricter credentialing standards may work to improve the quality of care provided.

4. Are People Satisfied?

Although each state experienced some problems with its Medicaid managed care programs, consumers generally expressed positive sentiments about the programs. Most consumers with whom we spoke were enthusiastic about the benefits available to them and expressed only relatively minor complaints (for example, about transportation difficulties). It is possible, however, that more highly satisfied users self-selected into our focus groups.

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These attitudes stand in stark contrast to the attitudes of most providers, who complained that Medicaid managed care payment rates were low, payments were received after long delays, and payment required substantial paperwork or other preauthorization activities. Some providers complained that the MCOs and BHOs expected them to perform case management activities but without receiving additional compensation. As a rule, the states have not adopted uniform paperwork requirements for their MCOs, which probably creates significant administrative problems for providers.

B. LESSONS LEARNED

Given these findings, what are the most effective ways for states to develop and implement special programs for those with SMI/SED? Examining the programs for people with SMI/SED in the five states shows that large systemic changes are difficult to develop and implement. All the programs experienced problems. Systemic changes, regardless of whether the program used carve-out or integrated designs, created some new problems, solved others, and left some former problems unchanged. Despite the problems, however, it seems likely that managed care is the future of Medicaid. Therefore, it is useful to draw lessons from which other states interested in Medicaid reform can benefit. We can draw the following lessons from the experiences of the five states we studied:

- *Solicit public input during the design phase.* Each of the programs reviewed here had varying levels of support when implemented. Those that were developed with the least input from stakeholder groups had the most contentious and controversial implementation periods. Moreover, although all the states experienced some disruptions when implementing their programs, those that moved slowly seemed to have fewer difficulties, and to have more public support despite their problems.

- *The general design is less important than are features promoting flexible access to services.* We found that states could provide good access to care regardless of the designs they developed to serve their SMI/SED populations. For example, although Rhode Island and Maryland developed quite different approaches to serving their SMI/SED Medicaid beneficiaries, both received mostly favorable marks from the various stakeholder groups. In Rhode Island, although the carve-out design did not

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seem to work as intended, the state allowed access to other state-funded programs without requiring beneficiaries to be carved out to fee-for-service Medicaid. In Maryland, the carve-out of services to a revamped public mental health system allowed anyone to self-refer for treatment, and to access care if medically necessary.

- ***Recognize the complexity of treating populations with SMI/SED.*** Populations with severe behavioral health problems are often difficult to serve. They require case management, many specialized services, and, often, concurrent substance abuse treatment. Most commercial MCOs and BHOs are not familiar with treating these groups and may not have adequate networks to serve them. Therefore, a state must ensure that, before implementation, networks are adequate to provide necessary services, including case management.

- ***Take steps to maximize care coordination.*** Carving out specialty services can create problems with coordination of mental and physical care for those with SMI/SED and of mental and substance abuse treatment for the dually diagnosed. Greater separation of treatment systems seems to increase the difficulty of communication between them. Although especially true in the case of separation of mental health and substance abuse services in Maryland, it was also true for states that treated mental and physical illness in separate systems. Because coordination of care is thought to be best for the well-being of the patient and is a cornerstone of managed care, structures that limit or impede it can interfere not only with patient health, but also with the efficiency of the system. This is not to say that carve-outs are necessarily a bad idea, but merely that states might be wise to consider ways to ensure coordination of care for particularly vulnerable groups within a carve-out design.

- ***Be aware of "turf" issues.*** Separation between mental and physical health systems and between mental health and substance abuse providers in some of the states reviewed here was reportedly driven by each faction's desire to retain prominence. This situation was explicitly cited as a problem in Maryland and Tennessee. These turf issues can be destructive and work against coordination of care for individuals with SMI/SED.

As states move toward applying for and implementing Medicaid demonstration programs, we are hopeful that the experiences of the five pioneering states will prove valuable to ensuring a smooth transition and adequate care for the most vulnerable of the vulnerable.

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