
Medicaid's Complex Goals: Challenges for Managed Care and Behavioral Health

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The Medicaid program has become increasingly complex as policymakers use it to address various policy objectives, leading to structural tensions that surface with Medicaid managed care. In this article, we illustrate this complexity by focusing on the experience of three States with behavioral health carveouts—Maryland, Oregon, and Tennessee. Converting to Medicaid managed care forces policymakers to confront Medicaid's competing policy objectives, multiplicity of stakeholders, and diverse patients, many with complex needs. Emerging Medicaid managed care systems typically represent compromises in which existing inequities and fragmentation are reconfigured rather than eliminated.

FOCUS

This article focuses on State experience with adopting Medicaid managed care, particularly for those needing behavioral health care. It builds on insights from indepth case studies of seven States' experiences with Medicaid managed care from late 1997-1999 to help identify better the issues policymakers need to consider. We studied seven States—California, Florida, Maryland, Minnesota, Oregon, Tennessee, and Texas (Kaiser Commission on Medicaid and the Uninsured, 1999; Gold and Mittler, 1999). All were implementing broad-based

Medicaid managed care initiatives that relied heavily on capitated risk-based managed care. They also include three of the five States nationwide—Tennessee, Oregon, and Maryland—that have 75 percent or more of their Supplemental Security Income (SSI) population in capitated managed care. Each of the three includes a behavioral health component and does so with a different model, which adds richness to our comparative analysis.

BACKGROUND AND OBJECTIVES

The Medicaid program is the major way health insurance is provided for those under age 65 who are not eligible for or cannot afford private insurance under our employment-based system (Altman, Reinhardt, and Shields, 1998). Over time, the Medicaid program has become increasingly complex as both Federal and State policymakers have turned to it to address particular gaps in insurance eligibility and coverage, to use Medicaid's financing (shared by the Federal Government and States) to stretch State funds by obtaining a Medicaid match for services previously covered solely with State dollars (like care for the chronically mentally ill), and to meet important other social objectives (Coughlin et al., 1999). This includes care for the uninsured who would not otherwise qualify for Medicaid, support for services for children with special needs, and funding for both safety net providers and those focused on services that typically are public responsibilities, like the care for the chronically mentally

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ill. Such funding strategies have been termed “Medicaid maximization,” in the sense that States have an incentive to maximize the amount of Federal Medicaid funds obtained and used them to limit State obligations. The use of these arrangements makes Medicaid relatively unique among insurance programs, though some cross-subsidies exist in all programs, especially public ones. In Medicaid, these financing arrangements lead to key constituencies, such specialized mental health, rehabilitation and safety net providers considering these funds as “theirs.” Further, as States bring more benefits and populations into managed care, it inevitably creates bureaucratic conflicts between Medicaid and other agencies and make coordination more difficult (Smith, 1999).

In this article, we examine State experience and use it to show how the complex structure of the Medicaid program creates relatively unique challenges and conflicts that often are not fully anticipated when States seek to move to Medicaid managed care. The “rules” policymakers develop for Medicaid managed care accommodate Medicaid’s complexity and aim to reconcile competing goals. Further, capitation by its very nature inherently has the potential to redistribute funds because it changes the locus of authority and risk for spending. This means policymakers need to anticipate the conflicts and issues that will arise and how their resolution will influence and shape the inevitable trade-offs and distribution of benefits and costs that accrue in introducing Medicaid managed care.

Anticipating such issues is more important now than ever, as States extend managed care programs beyond the traditional focus on low income families and children to other Medicaid program eligibles (Hurley and Draper, 1998a and 1998b.) These subgroups may include, for exam-

ple, individuals with physical disabilities, the severely and persistently mentally ill (SPMI), those who are mentally retarded or developmentally disabled, individuals with human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS), and others. Managed care programs that include one or more of these subgroups are increasingly prevalent. Recent data show, for example, that 27 percent of Medicaid individuals under age 65 with disabilities are in managed care, two-thirds in capitated programs (Regenstein and Schorer, 1998).

The policy challenges are particularly well illustrated by behavioral health services (mental health and chemical dependency) and thus it is used as an example for many of the points of this article. Medicaid does not cover inpatient care in mental health facilities for adults under age 65 and States historically have supported this system using a diverse set of State and Federal grant programs and increasingly fee-for-service (FFS) Medicaid payments (Grob, 1994). Behavioral health accounts for 10.3 percent of Medicaid spending and 21.6 percent of non-Medicaid State and local government spending for personal health care services (McKusick, et al., 1998).

STUDY METHODS

We selected the seven States we studied to provide a broad geographic mix from among States pursuing mandatory Medicaid managed care with an emphasis on capitated systems and broad-based implementation. Each State was studied in a week-long site visit that involved interviews with health plans, providers, and beneficiary groups in several communities, as well as State officials and other stakeholders statewide. (Only in Minnesota was the study more limited in that it was based

on telephone interviews with State officials.) The visits occurred between late 1997 and early 1999. Topics included the history and design of the Medicaid managed care initiative, the experience under it and the particular design and operational issues associated with covering those on SSI or with extensive need for care (like the chronically mentally ill). The latter are the focus of most of this article. In addition to the interviews, we also reviewed pertinent documents, administrative data, and reports. We also visited all the States but Maryland earlier (between 1994 and 1996).

FINDINGS

Medicaid Managed Care is Particularly Complex

When setting up mandatory Medicaid managed care programs like those we studied, States need to decide whom to include and how to integrate Medicaid's diverse health benefits under the managed care structure (Bachman and Burwell, 1998). Under a mandatory system, States specify operationally which populations must enroll; others are "carved-out," remaining either in traditional FFS or steered to a specialized managed care plan built around their needs. The State contract with managed care plans specifies which benefits managed care plans are responsible for providing; Medicaid beneficiaries remain eligible for other covered benefits but the State covers them under traditional FFS arrangements or through specialized managed care programs specific to that benefit.

Table 1 summarizes the main features of each program we studied including the statutory authority, geographic scope, the nature of basic (regular) managed care options, the Medicaid-eligible individuals excluded from these basic options, and the

way in which selected specific benefits and populations subgroups are handled. Medicaid managed care programs vary enormously but can be considered to fall into two classes: "traditional" programs that limit mandatory managed care enrollment for the most part to low-income families and children, excluding those with special needs; and "comprehensive" programs that include as broad a cross-section of the Medicaid population as possible in managed care. Among States we studied, California's two-plan model,¹ and the programs in Minnesota and Texas are traditional Medicaid managed care programs. Each excludes SSI eligible persons and has various other exclusions. Florida started as a traditional program that still has many exclusions but recently mandated managed care enrollment for the SSI population with a choice between health maintenance organization (HMO) and primary care case management. In contrast, California's county-organized health system,² and the programs in Maryland, Oregon, and Tennessee are more comprehensive programs that include at least non-Medicare-covered SSI eligible individuals. All but Orange County also aim to address specialized behavioral health care needs, including needs of those with SPMI.

The nature of benefits and needs under Medicaid means that even traditional Medicaid managed care programs are more complex than traditional commercial managed care. Medicaid's complex eligibility requirements make for complex rules mandating who must enroll. Children in various special circumstances

¹ This model is the dominant one in California. Under it, the State contracts with two managed care system in each locale—a local initiative which provide dedicated market share to public systems and safety net providers and a private managed care organization. (Draper, Gold, and Hudman, 1999).

² Under this option—in place in five demonstration sites—counties are at risk and organize care. Our study focused on Orange County in southern California. (Draper, Gold, and Hudman, 1999).

Table 1

Behavioral Health Benefits/SSI Populations in Mandatory Medicaid Managed Care, by State

Characteristics	California ¹									
	Los Angeles	Orange	Florida	Maryland	Minnesota	Oregon	Tennessee	Texas		
Federal Program Authority	1915b	1915b	1915b	1115	1115	1115	1115	1915b		
Geographic Scope	County ¹	County ¹	Statewide	Statewide	Mostly Urban/Statewide Phase-In	Statewide	Statewide	Mostly Urban/Statewide Phase-In		
Capitated Plans	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes		
PCCM	No	No	Yes	No	No	Limited	No	Most Counties		
SSI	No	Yes	PCCM Option	Yes	No	Yes	Yes	No		
Dually Eligible	No	No	No	No	No	Yes	Yes	No		
Institutionalized	No	Special Arrangements	No	No	No	No	No	No		

General Mandatory Managed Care Options

Populations Included

See footnotes at the end of table.

Table 1—Continued
Behavioral Health Benefits/SSI Populations in Mandatory Medicaid Managed Care, by State

Characteristics	California ¹		Florida	Maryland	Minnesota	Oregon	Tennessee	Texas
	Los Angeles	Orange						
Benefits Included in Mainstream Managed Care Capitation	No	No	Limited Mental Health/Five Counties Only	Chemical Dependence, Primary Mental Health	Behavioral Health	Chemical Dependence	No	Chemical Dependence and Limited Mental Health
Managed Benefit Carveouts	No	No	No	Specialized Mental Health System	No	Mental Health	Mental Health/Substance Abuse	
Specialized Managed Care for Excluded Populations	Specialized Mental Health (County FFS)	Specialized Mental Health (County FFS)	MH PCCM carveout (Tampa Pilot), CMS Transitioning from PCCM to Risk-Based Provider-Sponsored System	No	Pilots: Dually Eligible/SSI	No	No	Pilot: SSI
Benefit Exclusions (FFS Payment)	California Children's Service Benefits; LTC	California Children's Service Benefits	Behavioral Health; LTC	Self-Referral for Selected Preventive and Specialized Services (via HMO Capitation); LTC; selected HIV drugs	LTC	Psychotropic Drugs; LTC	Medicare Crossover Benefits; LTC	Specialized Behavioral Health; LTC

¹ California uses different managed care models in each county. We studied the largest county for two of the three main models. Los Angeles is 1 of 12 counties operating under the two-plan model and Orange County is one of five county-organized health system models.

NOTES: SSI is Supplemental Security Income. PCCM is primary care case management. CMS is children's medical service. FFS is fee for service. MH PCCM is a mental health carveout to PCCM. LTC is long-term care. HMO is health maintenance organization. HIV is human immunodeficiency virus. 1915b waivers allow States to implement managed care programs that require mandatory managed care enrollment, and to implement managed care in only part of the State or for certain categories of beneficiaries. 1115 waivers allow States to test new methods of administering Medicaid, and authorize States to undertake statewide managed care demonstration projects that do not meet Federal statutory requirements.

SOURCE: Authors' analysis of materials collected onsite from State, 1999.

often are excluded from managed care (e.g., foster children, medically fragile children, children in State custody). Adults may be excluded if they qualify for Medicaid for short periods of time (e.g., during pregnancy) or by virtue of a pre-existing medical need (e.g., spend down). And even if individuals are required to join a plan, often the benefit package may exclude certain services that continue to be provided under traditional arrangements—such as special children’s services, specialized mental health, and selected HIV pharmaceuticals. Often Medicaid policies on these issues are idiosyncratic to the way an individual State has chosen over time to provide and finance certain services. California excludes specialized mental health services and services for children with special needs from the capitation because these services historically have been provided by separate county and State programs respectively. While this situation may be unique to California, many States have similar “unique” programs that must be accommodated with the move to Medicaid managed care. Small pilots which differ from the general State program also may be underway. Both Minnesota and Texas, for example, are pilot testing on a small scale managed care approaches for various subgroups of SSI beneficiaries.

Managed care plans and providers more accustomed to commercial programs may be unaware of the dimensions of this complexity and how State policy influences both delivery and financial requirements. The fact that programs that are seemingly similar from the outside often differ in less visible ways also complicates cross-State comparisons. This means judgment and experience are important in deciding how best to interpret State experience both within a State and for other States.

Historical Cross-Subsidies and Funding are Threatened

Medicaid managed care that includes SSI eligible individuals raises a host of relatively unique issues that affect State-sponsored services for those with severe mental illness or chemical dependency. The public sector plays a more dominant role in financing the treatment of mental illness and chemical dependency than other health care, especially for those with the most severe needs (Mechanic, Schlesinger, and McAlpine, 1995). Many States make extensive use of the Federal match on State Medicaid funds to help pay for these services. Capitation has the potential to disrupt the flow of these Medicaid funds because capitation, by its nature, aggregates funds used by enrollees and authorizes a health plan to manage these dollars on an at-risk basis. To the extent that capitation includes funds for benefits and payments to providers, it, therefore, gives those providers less direct control over the funds than if the funds come directly to the provider from the State in either FFS or capitation payments. Further, State mental health systems historically have evolved separately from those of alcohol and drug services which means that, in moving to Medicaid managed care, States need to coordinate with at least two and often three or more separate State agencies, each with their own set of objectives and specialized constituent providers who often are heavily dependent on the flow of Medicaid and State-directed funding.

The fiscal implications of Medicaid managed care are particularly critical for mental health services. State services have historically taken the form of residentially based care for those with SPMI which means they often involve State-owned “bricks and mortar” staffed by State workers

(Grob, 1994). While Medicaid funds can be used only for children and for adults over age 65 in traditional mental institutions, Medicaid helps finance emergency and acute care for those with SPMI as well as an increasing array of less institutional settings. States also have become increasingly involved in community-based service delivery financed in part with Federal block grant funding that States may match with the State share of Medicaid funds. In many States, the dual focus on residential and community-based care means that two, and at times relatively independent, systems have evolved—one that consists of community care for the entire population and another that consists essentially of care, often in State mental institutions, for individuals with SPMI. These two systems may have their own, often conflicting, objectives and separate sets of providers and constituent concerns that complicate the design of mental health components of Medicaid managed care.

The State role in chemical dependency is less resource intensive and more outpatient based than with mental health care. Treatment often is more short term and community based. County systems may be complemented by a host of grant-contracted providers. Though Federal funds for these alcohol and drug abuse services (as well as mental health) have now been combined into a single block grant (Jacobsen and McGuire, 1996), many States continue to operate alcohol services separate from drug abuse services and the interests of these two constituencies may diverge.

Reconciling Objectives is Challenging

The complex funding streams and multiplicity of involved stakeholders just described factor heavily into the challenges of developing Medicaid managed care when it includes those with extensive

needs for behavioral services. Maryland, Oregon, and Tennessee all found that designing the “behavioral health components” of their comprehensive Medicaid managed care initiatives was challenging because of the wide range of service and providers involved in care for these individuals (Gold, Mittler, and Lyons, 1999; Mittler and Gold, 1999; and Aizer and Gold, 1999).

Table 2 highlights the scope and structure of Medicaid behavioral health in each of the three States, showing the parameters of organization that we summarize in narrative form. Each State employed a different strategy in seeking to reconcile Medicaid and other State objectives. Oregon kept its program narrow, aiming to reduce the impact on other State programs. Maryland took a middle course, with a specialty carveout program limited to mental health that involved only limited change for those who are institutionalized. In contrast, Tennessee’s program integrated funding on a risk model for all behavioral health care in the State, combining Medicaid with all other State funding for mental health services (including funds for State-run facilities) and developing a single capitated program for all behavioral health care. We briefly review each State’s structure and experience since it illustrates well the point about complexity and tradeoffs.

Oregon—In Oregon, chemical dependency benefits are included in the regular managed care benefit package. This structure is supported by the Office of Alcohol and Drug Abuse Programs whose leadership believes in integrated services and a medical model. But the State contracts separately with mental health organizations (MHOs) for Medicaid-covered benefits. (Extended care services, i.e. long-term residential care, are excluded and are maintained under the traditional FFS program.) The structures reflect a compromise between the Oregon

Table 2
Scope and Structure of Medicaid Behavioral Health Initiatives, by State

Characteristic	Maryland	Oregon	Tennessee
Benefits in Regular HMO	Primary Mental Health/All Chemical Dependency	Chemical Dependency	None
BHO Managed Care Carveout	Mental Health	Mental Health	Mental Health/Chemical Dependency
Medicaid FFS Benefits	—	Psychotropic Drugs	BHO Prescriptions (7/98) ¹
Relationship to State-Only Behavioral Health Programs	Integrated	Separate	Integrated
Administration	Mental Hygiene Administration Contract with a Private Mental Health Company Consortium Paid on an Administrative Services Only Basis	MHDDSD Contracts with Multiple Offerors per County ²	TennCare Contracts with Two Private BHOs Statewide
Beneficiary Access and Enrollment	Self and MCO Referral	Select Both MCO and MHO	BHOs Aligned with MCOs
Payment	MHA At Risk; Aggregate Payment for MHA; FFS for Providers	Contractor Capitated	BHOs Capitated; Two Benefit Levels (Basic and Advanced) Aggregate Limit on Spending an Issue

¹ Benefits were included under the BHO contract capitation before this.

² Mental Health and Developmental Disability Services Division.

NOTES: HMO is health maintenance organization. BHO is behavioral health organization. FFS is fee for service. MHDDSD is mental health and developmental disability services division. MCO is managed care organization. MHO is mental health organization. MHA is mental hygiene administration.

SOURCE: Authors' analysis of materials collected onsite from States, 1999.

Health Plan (OHP) staff (Oregon's 1115 waiver program for Medicaid), who wanted to integrate benefits through the Medicaid managed care program, and Oregon's mental health constituency that was concerned about the potentially adverse effects on the flow of patients and revenue to community mental health centers and county systems. The current system evolved through a legislatively mandated demonstration in 1993 that involved 25 percent of the population and reported positive results from a State-sponsored study that led to legislative approval in mid 1997.

Under Oregon's structure, each member of the OHP independently selects a regular HMO and a MHO.³ Capitation rates for each exclude costs of designated psychotropic drugs which the State pays for on a FFS basis when authorized by a qualified provider in either system. The State contracts with MHOs and defines service areas on a county basis. MHO selection aims to protect the safety net of county-based mental health providers. The stated goal is to have the traditional county network retain at least 50 percent of OHP eligible persons. (The 50 percent figure represents what State and provider advocates decided was required for viability; while MHO contracts have no provisions requiring this goal to be met, roughly 70 percent of OHP eligible persons were in such systems in early 1998.) MHO applicants were required to participate in a county-based planning process. Over time, some organizations have developed partnerships and new services, as HMOs aimed to treat the chronically mentally ill and county providers aimed to handle individuals with less severe or chronic conditions.

Maryland—In Maryland, the regular Medicaid HMO plans are responsible for chemical dependency and primary mental

health care, but all other mental health services are provided through a system directed by the Mental Hygiene Administration (MHA). This structure also reflects a compromise. State officials originally proposed to exclude individuals with SPMI from HealthChoice, Maryland's managed care program, and to cover the behavioral health care needs of others on an integrated basis through the managed care plan. We were told by staff of the MHA that the legislature ultimately decided to shift from a population exclusion to a service carveout in response to public hearings in which advocates for the mentally ill argued that a population exclusion would be stigmatizing. The benefit carveout was restricted to mental health because chemical dependency providers were concerned that they would suffer in a combined carveout. The legislature also authorized inclusion of "primary mental health" in mainstream managed care benefits. Primary mental health services are defined as services viewed by a primary care physician as being within the scope of his or her practice. For example, these services might include prescribing anti-depressants for post-partum depression or limited counseling in the course of a visit. However, in reality, the capitation rate to HMOs excludes costs for all visits with a mental health diagnosis, so the HMOs are paid only a limited amount (some pharmaceutical costs) to support the delivery of primary mental health care.

Maryland's managed mental health initiative—Maryland HealthPartners—covers Medicaid beneficiaries and others who are income or otherwise eligible for State-supported services. The system is funded by a mix of Medicaid funds, MHA grant funds, and selected other sources. Maryland HealthPartners operates as a joint venture by the Maryland's MHA, which is responsible for the program, and

³ Individuals also select a dental health organization.

two private behavioral health firms (GreenSpring Health Services and CMG Health) selected by competitive procurement to help operate the program. The State “owns” the provider network, and the firms are paid a fee for network administration, claims processing, and utilization management. The provider network includes local mental health centers and private vendors of both community-based and institutional services that can be accessed through a centralized intake process by self-referral or by referral from a regular Medicaid managed care provider. Core service agencies are responsible for planning and monitoring the program at the local level. Reportedly, provider capacity has increased five- or six-fold since the program began. MHA receives an aggregate payment that was originally calculated on the basis of estimated prior Medicaid costs for covered benefits (including administration but less the State’s 10 percent mandated savings). While the MHA is technically at risk, the system operates on a FFS model. This form of payment is new for many providers who were once grant funded.

Tennessee—TennCare—Tennessee’s Medicaid managed care program—initially integrated behavioral health into the benefit package for managed care. Care for adults and children with SPMI was excluded and continued to be paid for on a FFS basis. TennCare Partners (implemented in 1996) changed this, as the State pooled all Medicaid and State-only funded behavioral health care resources and contracted on a capitated basis with two statewide behavioral health firms that were forced mergers of the five organizations initially selected for the program. The State was motivated to push the mergers by a desire to limit administrative load. The two behavioral health organizations (BHOs) are assigned to individual managed care plans in

TennCare, with a deliberate 60/40 split of covered lives between them. When beneficiaries enroll in a TennCare managed care plan, they are automatically enrolled in the associated BHO.

Under TennCare Partners, two benefit levels are defined: one for adults and children with SPMI who had previously been served through the State system, and the other for all other TennCare beneficiaries. County mental health centers are charged with certifying eligibility for priority benefits. Separate capitation rates were set from the beginning for the two sets of individuals. In its second year of operation, TennCare Partners modified the rate method in order to impose an aggregate total limit on State spending by reducing capitation rates for those receiving basic benefits if the number of certified priority members exceeds projections. The program realigned funds and organizations very rapidly. Systems were not well developed. We heard of instances where they seemed to make it hard to get needed care (e.g., authorization for police to admit in emergencies, overnight stays for those at risk for suicide). All agree there are serious problems. Various modifications have been made (e.g., an FFS carveout of pharmacy benefit costs in the BHO package) or are under consideration (e.g., changes in assessment tools, a single benefit package and rating methods, new forms of administration and oversight).

Competing Objectives and Compromises Shape Programs

Political considerations strongly influenced program design in each State though the political dynamics and outcomes varied substantially from one State to the next. In all three States, mental health concerns drove the development and form of the “carveout” for specialized

managed care. Mental health and chemical dependency interests typically diverged, with chemical dependency providers seeming to prefer a role in shaping Medicaid managed care and its requirements to battling mental health constituencies for control over separate carveouts. The structure of each State's initiative represented a distinct political compromise between the two.

Oregon's final structure can be viewed as a Medicaid managed care model, adapted to offer some additional safety net protection for county providers. Thus, while the program includes a separately contracted and specialized mental health benefit carveout, the program is acute-care focused, built on the more traditional managed care model and limited to those covered under the OHP. While counties would have preferred a more separate and county-controlled system, politics seemed to favor the OHP philosophy, making the important concession to initially delay implementation pending a demonstration and, in contracting with plans, giving some preference to traditional providers in order to sustain the flow of revenue to them.

In contrast to Oregon, Maryland's evolution toward a mental health model was driven by concerns of mental health advocates and providers seeking control over Medicaid revenues. Their goal was to build a better and more integrated mental health system that would serve both Medicaid and State-funded individuals. With a well organized constituency and the leverage afforded by the threat of stigmatization, Maryland's mental health community gained support for a structure that gave it relative control over about twice as much revenue as before managed care: MHA continued its \$100 million in funding for State facilities and \$200 million in grant funding, and it gained control over \$300

million in Medicaid funds that previously had been paid to mental health providers directly by Medicaid on a FFS basis. Under the single State agency (the Maryland Department of Health and Mental Hygiene), MHA gained the flexibility to expand the network and potentially improve access to and coordination of mental health services both for the chronically ill, the initial focus of the MHA, and others with less severe or chronic mental health needs. Further, MHA reportedly will have a Medicaid revenue stream indexed to inflation in the Medicaid program, with aggregate payments increasing each year by Medicaid's rate of inflation.

Nevertheless, MHA's gains come with some risk if expenditures for Medicaid patients exceed budget projections and require cut-backs in services to non-Medicaid patients served in the MHA system. But the risk appears to be limited by the way in which aggregate payments are calculated and possibly by the strong legislative ties of mental health providers and advocates in Maryland. The converse may not be true for the core Medicaid program or for the State budget in general if MHA exceeds its budget or absorbs a disproportionate share of Medicaid's resources.

TennCare Partners is, in contrast, a strongly budget-driven model that aims to cap State obligations. Under the original structure of TennCare, behavioral health benefits were integrated into managed care, with plans developing various subcontracting arrangements with specialized providers to offer behavioral health care. But services that contributed substantially to State costs (State facilities and other services for the chronically mentally ill) were excluded. Tennessee policymakers modified the system in 1996 to establish TennCare Partners. In addition to concerns about better ways to coordinate care

across the variety of programs in the State, they hoped this would let them leverage Federal funds and gain more direct control over State facilities and their labor force.

Under TennCare Partners, BHOs are obligated to contract with all the community mental health facilities and the regional mental health facilities in the State. The contracts specify the amount of the per diem payment to the latter. The intent was to convert the open-ended program to a capped entitlement by the offsets built into the process of ratesetting using a two-level benefit package. In year 2, Tennessee structured payment by using a “floating capitation rate” for basic benefits. While the rate for SPMI was set in advance, the rate for those receiving basic benefits was adjusted retroactively so that total spending would not be exceeded if the number of SPMI members receiving priority benefits exceeded projections. This and other TennCare provisions were controversial for the BHOs. The BHOs set up under TennCare Partners also had operational weaknesses that resulted in substantial adverse publicity. However, while some changes have been made and others proposed, the basic structure of TennCare Partners remains intact.

Moving to a capitated managed care model can thus be expected to heighten the tension between competing interests in a State. Maryland’s HealthPartners program, for example, has the potential to considerably improve the delivery of mental health services in the State. But if this means that more Medicaid funds are devoted to mental health, it could also mean that fewer funds are available for other services or for expanding Medicaid eligibility, since State legislatures typically seek to control the rate of growth of Medicaid spending and make program cuts if costs exceed projections.

Complex Systems Generate Extensive Operational Demands

In moving to managed care models that include behavioral health services, States need to anticipate the expanded scope of often specialized providers as well as a diverse set of State agencies that oversee State programs for behavioral health, all of which make cross-agency communication and care coordination very important.

Medicaid policymakers that take coordination seriously will find that there are many more entities that have to be consulted when SSI beneficiaries are integrated into Medicaid managed care, and that the number grows particularly large when behavioral health is targeted. In Oregon, for example, the Office for Medical Assistance Programs is ultimately responsible for overseeing all Medicaid managed care. However, the Mental Health and Developmental Disabilities Services Division handles virtually all the oversight and coordination for mental health, including contract compliance, monitoring, and evaluation. Under this also falls the design of the initial pilot demonstration involving Medicaid managed care for mental health and the development of a quality management guide and standards for the mental health managed care program. Chemical dependency is included in the regular benefit package, but the Office of Alcohol and Drug Abuse Programs (OADAP) is active in educating plans about the system. OADAP also developed screening tools for physician use, established criteria for inpatient care, and developed specific contract standards. The Senior and Disabled Services Division also was actively consulted on policy for SSI eligible persons more generally.

Specialized providers often are not experienced in Medicaid or managed care. Maryland HealthPartners, for example, found that shifting from a grant to an FFS oriented system required extensive start-up efforts and training for providers who historically had little experience with billing or operating under this form of revenue stream, creating different incentives from those that exist with grants. Grants are front ended for fixed amounts, for example, whereas FFS payments vary with volume and require service documents. Under grants, providers may be accustomed to managing priorities or excess demands through capacity constraints on service volume. They may not have the infrastructure needed to manage care more comprehensively for defined populations of individuals (i.e. enrollees), as they are required to do under capitation contracts and Medicaid's entitlement. In Oregon, where some county mental health systems serve as MHOs, it is not clear whether county or State officials associated with the mental health program fully appreciate the conceptual differences between delivering care on a risk basis to a defined population and serving a target population with grant funds. Thus, while the shift in payment has potential to increase revenue flow it also is risky for providers unaccustomed to relying solely on such revenue alone and those without the systems to handle capitation well.

Compromises may not Align with Patient Needs

At least in theory, capitated Medicaid managed care has the potential to be a tool policymakers can use to improve access, better organize care, and increase accountability for performance. All the States we studied believe that they had fragmented services and limited capacity before man-

aged care was introduced, and that managed care could address these weaknesses. Risk-based managed care also more directly ties payment to a specific benefit package and individual. Strong State leadership can use the incentives of risk-based payment to move program managers beyond competing institutional concerns to a focus on encouraging more coordinated care for residents in the State. There are, however, serious challenges that States seeking to do so will confront.

Behavioral health carveouts are attractive compromises for conflicting State objectives. But many individuals have both medical and behavioral health needs, the latter including both mental health and chemical dependency. In all three States, coordination across separate systems for medical and behavioral health care created problems for people. In two (Maryland and Oregon), there was the further challenge of coordinated mental health (the carveout) with chemical dependency (not carved out). Maryland also had to coordinate "primary" and specialized mental health services.

But State policy, even within a carveout, will influence how easy it is to coordinate care for people. Designing financial incentives to encourage rather than discourage coordination is important. Tennessee's structure illustrates the problems that arise when incentives are poorly aligned. By capitating both managed care and behavioral health care, Tennessee created competing incentives since it is not always clear which system was at risk, and each had an incentive to argue that it was the other. This made coordination of care difficult, with difficulties particularly apparent in the area of pharmaceutical management of psychotropic drugs.

TennCare Partners also forced the merger into two BHOs of firms that competed with each other in other lines of business.

TennCare Partners also created HMO-BHO pairs, and similarly, some of the pairings had conflicting financial interests. All of these conflicts served as disincentives to share information on treatment and coordinate care.

The potential for conflict can be lessened by making incentives compatible with, rather than in opposition to, each other. For example, Oregon's decision to retain fiscal responsibility for psychotropic pharmaceutical payments and to allow providers in both systems to prescribe them lessened the strong conflict that would otherwise have existed because both HMOs and MHOs were capitated. (In 1998, Tennessee shifted to a similar policy for behavioral pharmaceuticals previously included in the BHO capitation rate.) Maryland's policy of including "primary mental health" benefits in the managed care capitation rate created an incentive for primary care physicians to refer patients needing costly long-term pharmaceutical management to specialists affiliated with Maryland HealthPartners, since this would mean the pharmaceutical costs would be paid for by Maryland HealthPartners. MHA officials said that they preferred this kind of incentive because it encouraged oversight over psychotropic drugs by psychiatrists. And the system appears to be financed well enough and to have sufficient provider capacity so that access has not, at least in the initial year, appeared to be an issue.

States also can encourage development of shared care protocols to facilitate coordination. Provider protocols for managing care that affects providers in both systems are one such tool. These protocols specify how care is to be delivered and responsibilities divided when both systems are affected. Both Oregon and Tennessee took this approach, though State leadership for the protocol-development process was much more extensive in Oregon than Tennessee.

In Oregon, the development of such protocols was guided by State officials who involved medical directors from both HMOs and MHOs. Tennessee required such protocols to be developed but left it to the BHOs to develop them. One of the BHOs had more success than the other at this, and in both cases, implementation was limited.

Other tools involve organizational mechanisms that encourage provider-to-provider coordination across systems for related care. Maryland HealthPartners has prepared a video and convened meetings with primary care physicians to orient them to its operations and to encourage appropriate referral. Maryland also plans a provider cross-walk that will identify providers from both systems who practice together. However, there are operational constraints that may limit their success. For example, while the State prepares a central directory of providers that includes data from all HMOs, it has found it difficult to get an accurate and current, consolidated listing, since contracts change and providers practice under different organizational names and in multiple sites, not all with the same affiliation. In Oregon, direct provider-to-provider coordination has been encouraged by partnerships that have developed between some of the medical and mental health organizations, as a result of a series of interlocking subcontracts. Such joint involvement of providers in each system appears to be valuable because it provides flexibility to tailor care to the diverse behavioral health care needs of Medicaid beneficiaries. It also erases the historical separation between providers with more expertise in caring for individuals with SPMI and those with expertise treating others with less chronic or severe needs.

Coordination Barriers: System Limitations and Privacy

State experience also highlights barriers to coordination. One major barrier is the need to maintain confidentiality and patient privacy, a particularly sensitive issue for those with behavioral health care needs. Coordination requires that information be shared among providers, but this sharing may not be possible across systems because of the rules each system uses to ensure confidentiality. Fragmented management systems are another barrier to coordination between systems: many States have different program-specific data systems that can't "talk to each other" as well as difficulties in generating encounter data which might allow them to surmount existing data constraints. Both privacy concerns and data constraints, for example, contribute to difficulties in monitoring adverse pharmaceutical interactions when individuals fill prescriptions in multiple systems.

The interest in managed care to promote better service to individuals leads to interest in performance data that can help assess change. But a big barrier is that there exist conflicting views on appropriate treatment and setting. In Maryland, for example, including treatment for chemical dependency under HMOs has sparked debate about whether access to these services has been eroded. Advocates perceive that HMOs are under-treating these conditions. But others speculate that part of the problem may be due to HMOs using providers not traditionally involved in the public system, and to care that is provided but not documented (or necessarily reimbursed). With each set of providers and managed care entities coming from a different base of experience, conflicts are more likely and mean that it can be harder to reach agreement on what care should be provided.

CONCLUSIONS

Our analysis shows that Medicaid is a highly complex program with objectives that extend far beyond its role as an insurance financing system for low-income individuals. Over time, Federal matching funds, together with the limitations in other funding streams, have encouraged States to use Medicaid to cover individuals and replace and expand what previously may have been 100 percent State-funded services for residents with complex and expensive needs that would not likely be met by private insurance (even if it were available). This expansion of Medicaid has, in many cases, prompted the development of specialized provider systems that depend upon Medicaid revenue and Medicaid patients. Medicaid managed care has the potential to increase the focus through capitation on the Medicaid patient as a whole, but it also threatens existing systems and providers that have depended on Medicaid revenue and may use it to cover the costs of other services. These issues become particularly visible when States mandate managed care for those covered by SSI, and they become even more visible when they affect care for the SPMI individuals, who account for a disproportionate share of both Medicaid spending and independent State spending on health care.

The systems that result are not necessarily optimally configured to meet the needs of Medicaid's diverse population, though neither is care under the traditional FFS model. The experience of the States in our study is that carveouts can allow specialization, but they also invariably make coordinating care a problem for people who have multiple service needs. Population exclusions are less affected by this problem but they may be less acceptable to advocates who fear stigma. States

choosing a service-carveout option can benefit by careful planning, developing shared protocols for providers in different systems, and creating systems that have compatible, rather than competing, incentives that encourage appropriate care and coordination. The study States provide good illustrations of both more and less effective ways of doing this.

A key shortcoming, no matter what the approach, is that systems that include carveouts typically retain some degree of fragmentation which conflicts with more integrated needs of people. Compared with FFS, risk-based managed care can create incentives to better organize services to maintain health and functioning for severely ill individuals, some of whom may now be served by fragmented and inadequate systems of care. But policymakers need to consciously reinforce this goal, since there are many reasons why coordination is hard to achieve. And policymakers also would be well advised to keep their expectations down since it is highly unlikely that managed care will be able to achieve a level of coordination and communication State governments themselves may never have been able to achieve.

In sum, our analysis indicates that State policymakers would be wise to assume that the push toward Medicaid managed care will make more prominent the competition between diverse State objectives that influence how Medicaid is viewed. These interested parties are substantially broader than under commercial managed care and even for Medicaid managed care when focused on low-income families. Policymakers clearly have a choice about the type of Medicaid managed care program to implement. Our analysis suggests that they are well-advised to be strategic about that choice and encourage systems that both anticipate the complex operational

challenges and seek to shape them in ways that take into account the ultimate impact on the people they are to serve.

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