Behavioral Health: Medicaid, Managed Care and Children
More Questions to Ask

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NHeLP has prepared a list of questions consumers should ask as their states begin working on developing or remodeling their Medicaid managed care programs (*Medicaid Managed Care: 20 Questions to Ask Your State*, National Health Law Program). Listed below are some additional questions to ask when behavioral health populations are being either included in the managed care programs or being enrolled in managed care through a separate "carved out" program.

1. **Does the structure of the system make sense for consumers?**

Is the state managing the program and acting as the provider? Or is the state contracting out management and/or provider functions? If so, to whom: counties, a private, for-profit entity to manage the system, regional behavioral health authorities? What is the experience and expertise of the entity that will manage the system or provide services? Are there protocols for where, how, and with whom these contracts will be let?

Where there is more than one entity (e.g. state, county, private provider) responsible for administering the program and/or for providing services, are the program plans, including managed care contracts, clear as to who has accountability for various tasks, including enrollment, case management, treatment authorization, provider contracting, data processing, quality monitoring, and claim payment?

What steps is the state taking to prevent the system from being "too diffuse, multi-layered, and cumbersome?" (Quotation from federal review of the Arizona Health Care Cost Containment System behavioral health managed care program)

How will managed care be coordinated with other state agencies and programs serving the behavioral health population, e.g. office of the courts, juvenile justice, youth treatment and rehabilitation, department of education? Will all entities receive training to understand the managed care system and the health needs of this population?

Will residents be able to apply for and receive mental health services in their communities?

Will children eligible for behavioral and mental health services be "carved out" of managed care completely (that is, receive no services from managed care entities and have their services paid for under a separate non-capitated system)? Or, will individuals be included under managed care just for primary care services (with the behavioral health services "carved out" of managed care)? Alternatively, will behavioral

health services be included in a managed care program, separate from primary care services? Or, will all services be provided under managed care?

If mental health is split off from physical health, will children's needs be met? In children's lives, pediatricians play a large role in addressing mental health needs, from screening for such problems as attention deficit disorder to providing counseling. Is the system designed to keep the physician in the loop? In addition if a child is sent to a mental health managed care system, will their physical needs still be taken care of?

Will the mental health managed care system be designed with an emphasis on case management? Even if there is a very good mental health managed care system available, who will screen for eligibility for those services? For example, will the managed care system dealing with physical health be responsible for detecting and referring out problems? Who will pay? Where will the incentives be?

2. Do the financial aspects of the system protect consumers?

Where for-profit entities are to receive managed care contracts, will the program address the tension between the health plan profit motive and the need for prompt, continuous health care? What is the reliance on for-profit psychiatric hospitals as contractors (that is will there be an over-reliance on an inpatient medical model)?

Will capitated rates be adjusted to account for the chronic needs of the population? If so, how? Has the state examined the insurance risks when populations of high risk individuals are clustered together? What sort of stop-loss protection is envisioned for providers serving high risk, high need individuals?

3. **Will the gatekeeping and referral aspects of managed care assure timely, appropriate behavioral health services?**

Who will be the gatekeeper - a health care provider, a state or local public child welfare agency, a network of child welfare service providers, individual child welfare service providers? As is often the case with low income groups, will the utilization review unit of the entity managing the state program, in fact, be the gatekeeper? What qualifications will the gatekeeper have in making referral or approval decisions?

What sort of training will the primary providers receive? Will they be trained on the differing diagnoses and treatment needs of the differing populations – people with mental illness or substance abuse problems, people with developmental or intellectual disabilities, injecting drug users, substance dependent pregnant women, etc.?

What screening/diagnosis instruments will gatekeepers use? Will these instruments be age appropriate and situation appropriate? Will gatekeepers be required to consider the social, educational, and developmental needs of a child when making a decision about institutionalization versus community-based care? Who will screen the child - a provider or a child protective services worker?

What sort of turn down/disenrollment practices will the state allow gatekeepers to use?

Will individualized treatment plans be developed? By whom? How often will they be reviewed? Will managed care plans be required to follow treatment plans developed for individuals by others? Will managed care plans be allowed to deny, terminate, or reduce services listed in individual treatment plans?

Are specialty panels and access to specialists sufficient, including for adolescent behavioral and mental health? Are there any rights to second opinions?

Is it clear that Medicaid medical necessity and Early and Periodic Screening Diagnosis and Treatment (EPSDT) rules will apply to coverage decisions for the Medicaid population (rather than the drugs and treatment rules traditionally covered by the health plan)?

How will the plan deal with patients with dual diagnoses?

4. **Will the scope of benefits recognize the range of behavioral health needs?**

Will all or some behavioral health services be "carved out" or included as part of the primary care managed care system? If some behavioral health services are excluded from the capitated system, what steps is the Medicaid agency taking to ensure that high need patients are not classified and dumped into these service categories? How will the state ensure that children not meeting the threshold eligibility criteria for the "carve-out" services, but who have behavioral health needs, get services under EPSDT standards?

Will the system ensure children's right to adequate case management?

Will benefits be limited to crisis care, with caps on psychotherapy (while caps are often set at twenty visits, the working caps are often set at 4 to 6 visits)?

Will outpatient services be limited (some states use working caps set at 2 visits per eligible per month)?

Will treatment of serious mental illness be limited to drug therapy without accompanying psychotherapy?

How will the program protect against premature hospital discharge to the community? How will the program protect against improper discharge (and then re-hospitalization) of adolescents?

Will the plan cover treatment for eating disorders? Will the plan cover treatment for conditions that will not improve? If so, how?

5. **How will the system be monitored?**

How will confidentiality of diagnosis and treatment be maintained? How often will medical records be reviewed and by whom?

Will providers collect and report encounter data? Will providers collect and report recidivism data?

How will quality be monitored for children with chronic conditions?

Will consumers (including parents of affected children) be included in any monitoring project? Will consumers (including parents, case workers, and school personnel) be surveyed to determine if children have been needlessly shuffled from one provider to another, if children have suffered needlessly from failing to receive necessary care, what kinds of barriers have been put in their way, and conversely, whether the system is working?

6. **What steps is the state taking to assure that the grievance and appeals mechanism will be usable?**

How will the state guarantee due process for individuals whose competence may be in question? How will the state protect beneficiaries' rights against forced treatment and/or institutionalization?

7. **What is the past experience with the state and managed care?**

There is little experience with behavioral health managed care, and therefore few studies on how people with disabilities, particularly those on Supplemental Security Income (SSI) fare in the capitated managed care setting.

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