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STATE OF COLORADO

DEPARTMENT OF INSTITUTIONS

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ROY ROMER
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October 1, 1992

The Honorable Ted Strickland
President of the Senate
State Capitol Building
200 E. Colfax Ave.
Denver, Colorado 80203-1716

The Honorable Chuck Berry
Speaker of the House
State Capitol Building
200 E. Colfax Ave.
Denver, Colorado 80203

Dear Senator Strickland and Representative Berry:

Enclosed is the feasibility study of a prepaid capitated single entry system for providing comprehensive mental health services to Colorado Medicaid recipients. The report assesses the costs, benefits, risks, alternatives, and impact upon recipients, providers and mental health services in the State.

Based upon the findings in the report, the Departments of Social Services and Institutions determine that a detailed design of the proposal should be developed and a federal waiver request should be submitted to the Health Care Financing Administration. As the report suggests, the proposed system holds great promise to provide a comprehensive array of services to Medicaid recipients. Furthermore, the system will place appropriate incentives for the provision of medically necessary cost-effective, yet most importantly, quality mental health services.

It is the intention of the Departments to further review the feasibility of the proposal after the detailed design is completed next summer. The Departments will further advise the General Assembly at that time.

If you or other members of the General Assembly or its staffs have questions or require additional information, please contact Garry Toerber at 762-4062.

Yours very truly,

Karen Beye
Acting Executive Director
Department of Social Services

Barbara McDonnell
Executive Director
Department of Institutions

cc: The Honorable Jeffrey M. Wells, Senate Majority Leader
The Honorable Larry E. Trujillo, Senate Minority Leader
The Honorable Scott McInnis, House Majority Leader
The Honorable Ruth Wright, House Minority Leader
Kenneth Conahan, JBC Staff Director
John Gomez, JBC Staff
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CAPITATING MEDICAID MENTAL HEALTH SERVICES IN COLORADO

A FEASIBILITY STUDY

I. Introduction

During the 1992 Legislative Session, the Colorado General Assembly passed H.B. 92-1306 which requested that the Department of Social Services and the Department of Institutions:

> jointly conduct a feasibility study concerning the management of mental health services under the "Colorado Medical Assistance Act," which study shall consider a prepaid capitated single entry point system for providing comprehensive mental health services.
>
> On or before October 1, 1992, the State Department and the Department of Institutions shall provide a written report to the General Assembly assessing the costs, benefits, risks, alternatives, and impact upon recipients, providers, and mental health services in this state, for each model or proposed program modification. Said report shall include recommendations for implementation of any model or proposed program modification.

The following report will provide the General Assembly with the results of the feasibility study of this issue. It will describe the current mental health system which is driving the changes described; it will describe the model that is anticipated; it will describe the benefits and risks of the plan, the impact on other related systems, the cost implications of the system, alternatives to the proposed system, and recommendations for the future.

II. Background on the Current Mental Health System

Mental health services represent the fastest growing service package in Colorado's Medicaid Program budget. There are numerous reasons for this rapid growth, including:

1. a growing awareness of the clinical value of mental health services;
2. a lack of consistently-applied criteria regarding the need for such services;
3. contradictory incentives in mental health service delivery;
4. the existence of a variety, and an increasing number, of non-integrated mental health providers; and
5. the lack of a clear locus of responsibility for providing these services to Medicaid clients.

At present, there are multiple systems offering mental health services to Medicaid clients in Colorado. Among these is the public mental health system, which is funded through the Division of Mental Health and which includes the community mental health centers and state mental health institutes (state psychiatric hospitals). In addition, there are a number of public and private organizations and individual providers, which may or may not be coordinated with other mental health systems or services. While many clients use more than one of these providers or provider systems, most, at least during an episode of illness, are primarily under the care of a single provider or system. The provider systems may be quite dissimilar in the service packages they offer, the types of clinicians used, their capacity to serve, and their utilization review systems. Multiple, non-integrated provider systems will not provide the most cost-effective system for serving Medicaid clients, and often lead to duplication and other inefficiencies.

In building a system for the future, the strengths in the current systems need to be emphasized, while weaknesses are addressed. Three basic issues must be addressed in order to improve the current Medicaid mental health system:

1. the development of a consistent, integrated organizational structure through which all Medicaid clients can be assured access to needed mental health services;
2. an effective quality assurance package which determines the mental health needs of Medicaid clients and assures these needs are being met; and
3. appropriate incentives to assure the operation of an effective and efficient system.

III. Goals of the Capitation and Managed Care System

The overall goals for a revised and improved system for the delivery of mental health services to Medicaid clients in this state are as follows:

1. assure appropriate access to mental health services for the Medicaid population;
2. assure the provision of the most appropriate mix of mental health services for the needs of each individual Medicaid client;
3. assure quality services are provided that meet the needs of consumers; and
4. assure the cost-effective delivery of those services provided.

Although this proposal addresses the mental health needs of Medicaid clients only, it is recognized that a system to meet the mental health needs of other populations also needs further development.

IV. Mental Health Model

The proposed Medicaid mental health system includes a number of key elements which are critical to its success and acceptance. In order to clarify the intent and direction of the proposed system, a description of the essential elements follows.

A. Managed Care System

The most critical element in this proposal is the requirement that all mental health services for a group of Medicaid clients must be accessed through a "single point of entry." This does not mean that all services would be provided at a particular geographic location. Rather, it means that a single organization, known as a coordinated assessment and services agency (CASA), would be responsible for assessing the need for services, coordinating services by directly providing services or referring the consumer to an appropriate provider, and monitoring the services received. In order to receive mental health services through the Medicaid Program, the consumer would be required to have the approval of the CASA.

This CASA is responsible for assuring that all mental health services offered to Medicaid clients are integrated and appropriate. In addition, this system facilitates access to services, because the CASA is clearly designated as the single agency responsible for managing the delivery of Medicaid mental health services for a group of Medicaid clients. Each contract agency will have to assure that its consumers have geographic access to all services. In addition, emergency services that do not require prior approval must be available 24 hours a day.

The managed care system provided through the CASA would perform a gatekeeping function, and advocate, organize, and manage the entire range of mental health services for the Medicaid client. Each CASA would be expected to develop and coordinate a comprehensive array of services as alternatives to hospitalization as well as provide hospital services when needed. Because inpatient treatment is the most expensive modality in any service array, all inpatient care would be prior authorized (authorized prior to payment) by the CASA. Moreover, any unauthorized services beyond those required to treat an emergency condition would be delivered at the financial risk of the provider.

Furthermore, since a single CASA is responsible for the entire range of mental health services to a particular consumer, the ability of an agency to refuse to provide for a necessary service and assume the service can be accessed elsewhere is reduced. Responsibility for assuring the availability of all services rests with a single agency rather than being diffused across a broad range of providers wherein no one agency has any overall responsibility. Assignment of responsibility to a single agency maximizes the probability that appropriate services will be available and provided to each individual consumer.

B. Eligible Populations

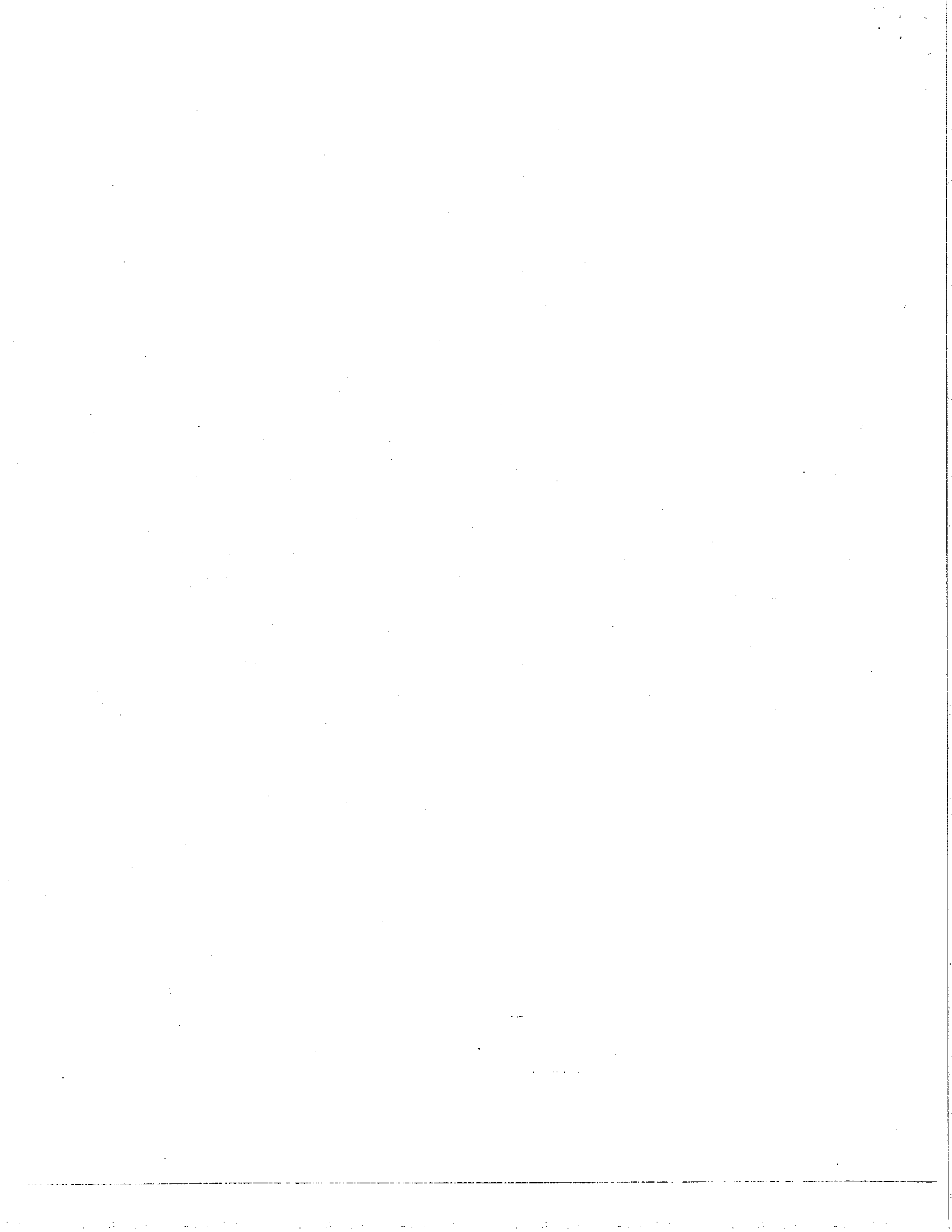
Persons who are eligible to receive Medicaid services constitute the target population for this proposal. In those geographic areas of the State in which this system is implemented, all Medicaid-eligible Colorado citizens would be included in the Program. (Persons who also have eligibility for the Medicare Program will be further studied to determine the most appropriate method of serving this population). Each Medicaid recipient would be required to receive necessary mental health services through this system, and would be enrolled with the CASA responsible for his/her geographic area/region of the State.

Enrollment in the program would begin with establishing the client's eligibility for the Medicaid Program. The establishment of Medicaid eligibility is and will remain the responsibility of the county departments of social services. Once eligibility is determined, assignment to the appropriate CASA occurs. An assignment mechanism, such as a Medicaid-eligibility card, would identify the recipient's CASA and serve as a control device to warn providers that any non-emergency services provided are not reimbursable unless delivered or authorized by the CASA.

C. Reimbursement System

Under the current reimbursement system, providers are paid on a fee-for-service basis. Payment occurs for "Medicaid reimbursable services" based on the number of services provided, and the authorized rate for each service. The greater the number of services delivered, the greater the amount of reimbursement generated. Under such a system, there are built-in incentives to deliver services that are reimbursable (but not necessarily cost effective), and to provide as many services as there are dollars to support (regardless of their appropriateness). This system produces contradictory incentives - to over-utilize those services that are reimbursable, but not necessarily those that may be the most clinically appropriate or cost effective in the long run.

The system being proposed is a capitated reimbursement system. Under this capitated system, reimbursement would be based on a certain dollar amount per Medicaid client per month. For each Medicaid-eligible client, a fixed payment per month would be calculated and paid. Assuming that all mental health services are covered under the



capitated arrangement, all Medicaid mental health services provided through the CASA would have to be funded by these capitated monthly payments.

Since this is a capitated system, the designated contract agency must be prepared to provide, or subcontract for, all "necessary mental health services." In addition, the services delivered under the capitated monthly payment do not otherwise have to be a benefit of the Medicaid Program. The significance of this feature will be addressed later in this document in section IV.E.

When calculated on a per-capita basis, total expenditures under the capitated model cannot exceed the amount that would have been paid for the same group of Medicaid clients under a fee-for-service model according to Federal rules and regulations. Capitated rates will vary according to a variety of factors, including geographic location and population group or category. At present, it is anticipated that future expenditures under capitation would be lower than the projected totals for fee-for-service expenditures. This is based on the assumption that a capitated system would lead to reduced rates of growth.

D. Level of Risk to be Assumed

Under the current system, the most desirable, least restrictive and cost-effective programs are likely to be the community programs. Conversely, the most expensive method of treating clients is in institutional settings. While institutional settings serve a very useful purpose, they should be used as a supportive service only when a consumer cannot be adequately cared for in a community setting.

Accordingly, the appropriate degree of risk that the CASA assumes should further the goal of maximizing the use of community services, and minimizing hospitalization. A capitated risk-based payment rate should certainly exist for hospital services. The CASA would be at risk for any over-expenditures for inpatient services (expenditures in excess of the dollars received from the hospital services capitation rate), and benefit from any savings achieved.

At least until some experience has been achieved, hospitalization costs at the two state mental health institutes will not be capitated. State hospital beds are considered to be resources of the public mental health system, and as such, access to these beds by the CASAs will need to be assured. In the future, the issue of capitating the appropriation of the state mental health institutes will need to be further considered.

Under a capitated system, additional community resources should be developed to reduce the need for high-cost institutional services. Savings from reduced hospitalizations could be used to develop an enhanced, more comprehensive array of community services. Thus, incentives that are developed should be designed to encourage the development of community resources. At least initially, the CASA should not be at total risk for the provision of community services. Rather some sharing of the risk between the agencies and the State should be built into the contract, in order to provide appropriate financial incentives to develop community alternatives to higher cost institutional services. The specific methodology of risk sharing will be developed during the detailed design portion of the study.

One goal of the capitated mental health model is the control of state general fund expenditures. As previously stated, the capitation method should offer incentives for the provision of more cost-effective care, and should also take into account the financial risk being placed with each CASA. For example, The State could pay a capitated rate for non-institutional services, subject to some degree of retroactive settlement at the

end of the year. To the extent that the model produces quantifiable savings, policymakers should consider using these savings for a variety of purposes, e.g., enhancing the community service system, providing mental health services to low-income individuals who are not medicaid eligible, or reducing future capitation payments in order to redirect the savings.

E. Benefit Package

Federal rules and regulations require that capitation contracts can only be signed with agencies that are Health Maintenance Organizations (HMOs) or meet the HMO qualifications if two or more Medicaid mandatory services are provided and the service package provided is comprehensive in nature. However, if the services provided are not "comprehensive" in nature (according to federal rules and regulations), or if only one mandatory service is provided (although as many optional services can be offered as desired), then the contract agency does not have to meet the HMO standards.

In this regard, if the services to be provided under the contract are limited to mental health services, the services are not considered comprehensive in nature and the CASA does not have to meet the multiplicity of HMO rules and regulations to be eligible for a capitation contract. However, the CASA would be limited to mental health services when provided in conjunction with a mandatory service. For example, necessary mental health services could be provided to consumers in a nursing home as long as the basic nursing home coverage is not a benefit covered through the capitation payment.

Under the Medicaid Program, there are mandatory and optional health services which constitute a relatively broad benefit package. However, within the mental health sector of the package, a potentially important set of services are not normally benefits of the Medicaid Program. Some examples of mental health-related services that are generally not reimbursable through Medicaid are pre-vocational and vocational services, respite care, and well as residential care.

In this regard, capitated dollars can be used to cover these heretofore non-reimbursable Medicaid services. The only federal limitation is that the dollars paid under the capitation arrangement cannot exceed what would have been paid for reimbursable Medicaid services. Hence, so-called non-traditional services can be provided as long as they are medically necessary. A more complete and flexible Medicaid service package can be provided, and those services necessary to keep consumers out of hospitals such as residential care can be provided by the CASAs. The service package needed will control the delivery of services, rather than the availability of reimbursement.

F. Utilization Review and Quality Assurance

Successful operation of a Medicaid capitation program requires that oversight be provided both to assure that all "necessary mental health services" are delivered, and that the amount and level of services are consistent with fiscal requirements. The contract agencies will have primary responsibility for maintaining programs within the fiscal constraints. The Division of Mental Health will have primary responsibility for oversight to ensure that all "necessary mental health services" are delivered in the most effective manner possible.

Since in many cases, Medicaid clients will effectively be restricted to a single mental health provider system, a strong quality assurance system is critical. The quality assurance program implemented will need to emphasize different factors under a capitated system than a quality assurance program would under a fee-for-service system. Under a capitated system, the quality assurance system must ensure that

adequate services are provided. Under a fee-for-service system, the quality assurance system must guard against over-utilization of services. Several methods will be combined in order to fulfill the necessary quality assurance oversight:

1. utilization of existing standards for Division of Mental Health contractors, which require the development and maintenance of an internal quality assurance system;
2. utilization of a monitoring system to ensure the availability and accessibility of appropriate services;
3. utilization of a consumer complaint system to record and monitor concerns identified by consumers and family members; and
4. utilization of a performance indicator system which monitors the performance of contract agencies using a set of objective measurements.

These four methods will be used to monitor contract performance, and to ensure that high-quality services are delivered to all individuals needing mental health services. This combination of quality assurance and monitoring systems should ensure that consumers of mental health services through Medicaid capitation are receiving the necessary mental health services.

G. Data System Requirements

Data systems will need substantial modification in order to meet the needs of the proposed capitation system. The collection and analysis of data will be critical to the operation of the new system. It is likely that, at least while capitation is under development, more data will need to be collected than presently collected. New systems will need to be designed and implemented to handle the data collected and special analyses will need to be completed to set final system specifications.

Data systems will have to meet needs that are both internal and external to the CASA. Internal data needs will include: listings of eligible consumers; tracking and payment of referral providers; claims processing; service utilization figures by type of service and individual; and dollar expenditures.

An external review (external to the CASA) of the success of the program will be conducted. Included in the external review of the program will be the need to assure that providers are delivering quality services, that consumers are receiving services that meet their needs and that outcomes are satisfactory for the individual clients, the CASAs and the mental health system. In addition, information will be needed for federal reporting purposes. Finally, claims data will be necessary to determine any retroactive settlements at the end of the year for services for which risk is not totally assumed by the contract agency.

H. Timetable for Implementation and Selection of CASA

The tentative timetable for the implementation of the mental health capitation proposal follows. (If possible, the timetable will be accelerated to implement the proposal more quickly). The feasibility study required by H.B. 1306 is herein submitted to the General Assembly. Based upon the feasibility study, the DMH, in consultation with the Department of Social Services as the Single State Medicaid Agency, will immediately begin to develop the required waiver application. The waiver application is scheduled to be submitted by February 28, 1993. The submission will seek a waiver of statewideness requirements and freedom of choice requirements. A statewideness waiver will allow the State to pilot the program in selected parts of the state. The freedom of choice waiver will allow the program to limit consumer choice to a single

CASA for the provision of necessary mental health services. It will allow for the denial of payment for those services provided by agencies not authorized by the CASA to provide those services.

At the same time that the waiver application is being prepared, the detailed design of the program will also proceed. This design will be completed by July 1, 1993. If the detailed design continues to suggest that the proposal is feasible, this timetable will allow 12 months for selection of the CASAs and for the CASAs selected to prepare for operation by July 1, 1994. If the detailed design phase indicates that the proposal should not be implemented by the State, a report will be submitted to the General Assembly indicating that, based upon further study, the proposal does not appear to be feasible.

The selection of the CASAs will occur through a competitive process by the release of a request for proposals (RFPs). The release of the RFPs will be on October 1, 1993. The selection of the CASAs will occur by February 28, 1994. The RFPs will specify the clients to be covered, the service package to be provided, other requirements, and statistics on previous utilization and expenditure data. Contracts will be awarded based upon the responses to the RFPs.

I. Phase-in of System

The phase-in process of the system will be two-fold. First, the system will be phased in according to the interest and ability of the contract agencies to operate under a capitation model. H.B. 1306 calls for the establishment of a pilot program in the state. A pilot program allows for the initial introduction of the capitation model in less than the entire state. As such, when the RFP is released, contracts will be awarded only to those agencies who meet contractual requirements and demonstrate the ability to implement the system. In addition, the DMH reserves the right to limit the number of contracts awarded based upon its capacity to monitor and operate a successful capitated and managed care system. RFPs will be let to implement programs in other areas of the state as administrative capacity expands and as additional agencies demonstrate their readiness to proceed.

The phase-in process will also be used to protect the financial viability of the system. H.B. 1306 states the "single entry point program shall, as much as possible, avoid exposing providers or community mental health centers and clinics to undue financial risk or reliance on supplemental revenues from state general funds, local revenues, or fee-for-service funds". As such, the system will phase-in risk, beginning with those services that can be most impacted by the built-in incentives, and increasing the risk by adding services consistent with meeting the risk levels intended by the section of H.B. 1306 herein quoted (see Section IV.D. above for more details).

J. Evaluation of the Program

An independent evaluator is already doing preliminary work with the State to analyze the success of program. The evaluator will analyze the cost-effectiveness of the program as required by H.B. 1306. In addition, the evaluation will include: quality of services provided; contract agency, consumer and provider satisfaction with the system; operational characteristics of the system; recommendations for changes; and overall recommendations regarding the future operation of the program. Finally, the evaluator will address any other issues required by the federal waiver award. The evaluation findings will be submitted to the DMH and the Department of Social Services for inclusion in a report due to the General Assembly on January 1, 1996.

IV. Impact of the Proposed System

The Colorado Mental Health Capitation and Managed Care Model described above will certainly impact Colorado Medicaid providers and consumers. The benefits and risks will be described. The anticipated impact is based upon numerous discussions with providers and consumers and an analysis of the impact of somewhat similar programs in other states.

A. Impact on Consumers

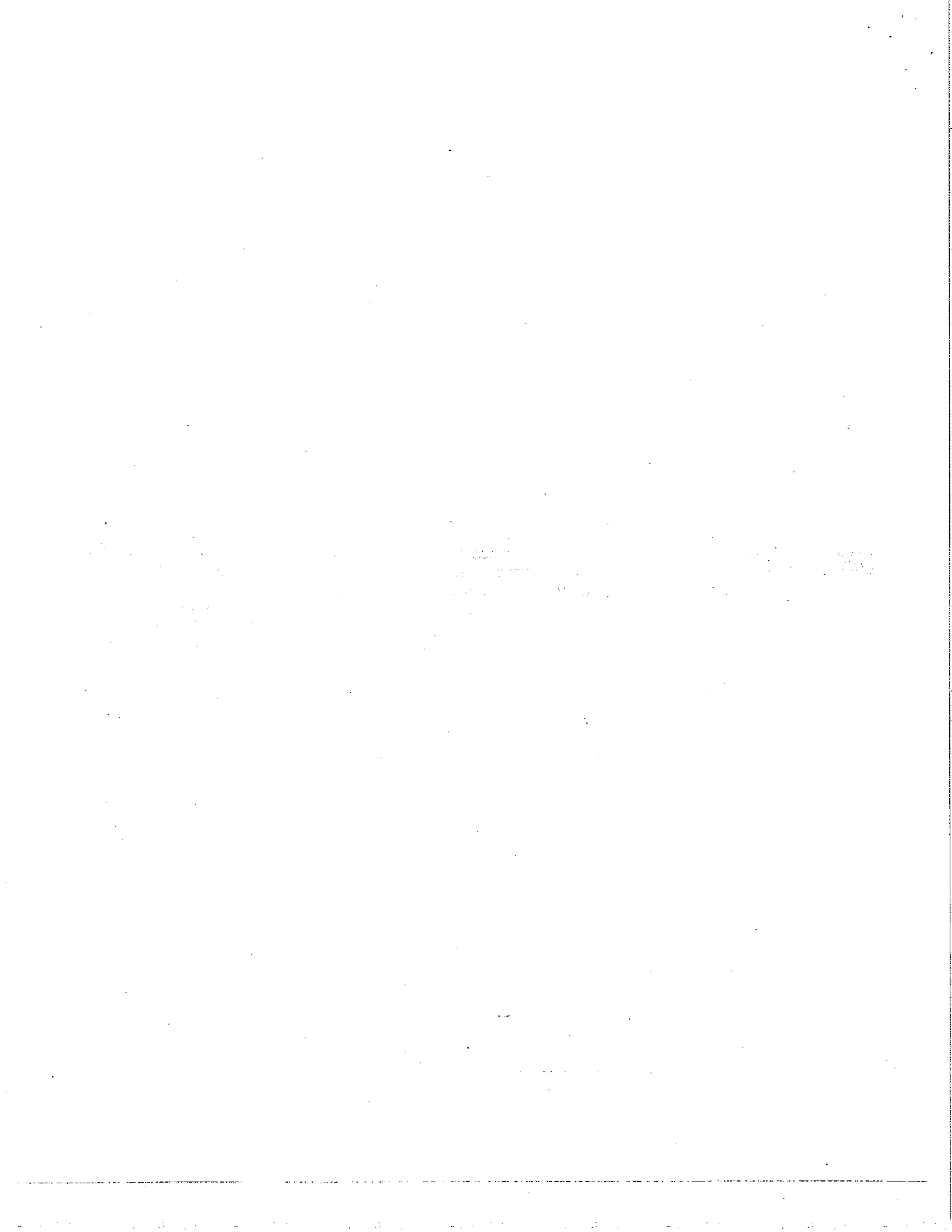
The model described above will impact consumers in several ways. First, the proposal will insure that each Medicaid recipient will have an agency responsible for all of his/her mental health needs identified at the time that Medicaid eligibility is established. Currently, it is often not until the onset of illness that most consumers seek a provider to serve their needs. Frequently, the delay can lead to the onset of a more serious and expensive mental illness that could have been at least partially avoided if services were provided on a more timely basis. Preventive and on-going services will be emphasized to control the use of more costly episodic services.

Second, case management will a required service provided to all Medicaid consumers. A case manager will act as the advocate, organizer, and manager of the entire range of services needed by the consumer. Case managers will also act as a gatekeeper to assure that unnecessary services are not provided.

Perhaps the most important element in the model will be the opportunity to offer Medicaid consumers an expanded benefit package. Currently, such services as residential care, respite care, prevocational and vocational services are not a Medicaid benefit. As such, when these services are needed, the client often ends up receiving alternative services if any services are received at all. If they receive alternative services, the services substituted are often institutional services and thus quite costly services. Under this proposal, residential care, respite care, prevocational and vocational services can and will be a benefit of the Medicaid Program. The service package needed by the consumer will control the delivery of services, rather than the availability of reimbursement. To the extent that third party payers other than Medicaid finance the care provided through the CASAs, the issue of variations in benefit packages among payers must be addressed during the detailed design phase. In many cases, Medicaid benefits are more comprehensive than those provided by other payers, although the service needs of the Medicaid population may be substantially different.

With a single point of entry, will come a restriction on consumer freedom of choice. All Medicaid clients will be required to utilize a contract provider. However, choice among contract agencies may occur in certain geographic areas. Furthermore, within a particular contract agency, the opportunity to choose the primary clinician will be encouraged. In addition, subcontracts with other providers in the area will be encouraged to provide client choice.

Reaction from consumers: The reaction of consumers has largely been twofold. First, consumers are pleased with the opportunity to receive an expanded benefit package. However, several consumers and advocates have expressed concern about the loss of freedom of choice of provider. This concern has been most notable among those consumers that utilize a private psychiatrist or psychologist, and among several consumers who utilize CHARG as their primary provider (CHARG is a consumer operated mental health provider). Procedures to maximize freedom of choice under the proposal described above will be important to these consumers.



B. Impact on Providers

One of the principal reasons for the development of this proposal is the dramatic increase in mental health expenditures in acute general hospitals, and, in general, the substantial increase in expenditures in the private mental health sector. Thus, the proposal is designed to directly reduce inappropriate hospital admissions and to also reduce the lengths-of-stay for those mental hospital admissions that still must occur. However, since Medicaid hospital expenditures represent less than ten percent of acute general hospital admissions, and less than twenty percent of these admissions have a primary diagnosis of mental illness, the impact of reducing mental health admissions should not significantly affect the financial health of the acute general hospital industry. Certainly, too, we do not expect to eliminate all mental health admissions to acute care general hospitals. Hence, the impact on hospital revenues should not exceed one percent, and will probably be substantially less than one percent.

Nonetheless, the impact upon an individual hospital could be significant. It is anticipated that CASAs will utilize certain hospitals more than others as they seek the best and most cost-effective facilities for necessary admissions. The impact upon an individual hospital can not be predicted at this time. It is safe to assume that those most negatively affected will be the hospitals that cannot effectively compete for Medicaid mental health care admissions. The proposal will have the potential to reward efficient hospitals and penalize inefficient hospitals.

Reaction of acute general hospital officials: The proposed capitation and case management model has been shared and discussed with acute general hospital officials that have historically provided the bulk of private mental hospital services. The industry spokesmen have not expressed concern about the proposal, nor have they expressed support for the proposal. Further discussions are expected with industry officials.

In addition to the private acute general hospital industry, the Medicaid program also contracts with private psychiatric hospitals. These facilities only receive Medicaid reimbursement for persons under 21 years of age. These facilities will have to compete with other inpatient facilities including acute general hospitals and the Colorado mental health institutes for Medicaid admissions. However, these facilities have quite competitive rates, and in a market where the contract agencies will gain financially from lower cost Medicaid rates, these facilities will be in an advantageous position to continue and perhaps even increase their market share. Again, until experience is gained under this system, the impact upon individual facilities cannot be judged with any degree of certainty.

Reaction of private psychiatric hospital-under-21 officials: The director of one of the two under-21-psychiatric hospitals has endorsed the concept in a letter to the Division. In his endorsement, he has urged that maximum competition be developed among providers of mental health services. Certainly competition will be emphasized by the Departments of Institutions and Social Services.

In summary, this proposal should reduce use of private hospitals. However, the impact will not be great in relationship to total hospital revenues. The impact will be expected to be the greatest upon those hospitals that are less competitive in the private hospital market. The incentives in this proposal should encourage competition for those necessary mental health admissions.

Private practitioners of mental health services will also see their services affected. Under this proposal, all Medicaid clients will be required to seek their care through the CASAs. It is not expected that all care will be provided by the CASAs, but care will be provided or approved through the CASAs.

As perhaps the best indicator of the impact upon private practitioners in Colorado, the experience of a similar program in Utah was sought. The experience in Utah would suggest that CASAs will, for a variety of reasons including capacity to serve and success in serving specific individual clients, seek to utilize subcontracts with private practitioners to serve specific Medicaid clients. This approach will be expected to also occur in Colorado. In fact, subcontracts will be encouraged in instances in which a long term relationship between a Medicaid client and a private practitioner exists.

It is, however, expected that any services provided by private practitioners will still be subject to utilization review by the CASAs. Services will also have to be case managed. It is expected that the use of private subcontracts will not undermine the basic tenants contained in this proposal.

Currently, psychiatrists and psychologists can directly bill the Medicaid program. Psychiatrists as medical doctors have always been direct care providers under the Medicaid program. Psychologists have only recently been given the opportunity to directly bill the Medicaid Program under special legislation passed by the General Assembly. All other mental health professionals must provide these services under the direction of either a psychiatrist or psychologist. Under this proposal, to the extent to which the CASAs grant authority to provide services, existing opportunities to serve the Medicaid population will remain.

Reaction of private practitioners: The proposal has also been shared with representatives of the psychiatrist and psychologist communities in Colorado. Both groups have generally given their support for the proposal. The psychiatrists who reviewed the proposal expressed only their interest in involvement in the development of utilization review protocols and potential employment in mental health provider agencies. A psychologist representing the association voiced his support for the proposal.

In summary, the proposal will provide for greater coordination of all mental health services. Private practitioners may still be used to provide services, but those services will be case managed and submitted to comprehensive utilization review procedures. It is expected that fewer direct services will be provided by private practitioners, but allowance will be provided for use of private practitioners where it is efficient and in the best interests of both client and the CASA.

All other providers like pharmacists, nursing homes, private laboratories, and home health agencies will continue to bill the Medicaid program as they have in the past. However, the need for these services will, in large part, be determined by the CASAs and other approved providers and agencies. Greater utilization review will be involved, but the method of payment will not be changed, at least during the pilot phase of the study.

C. Impact on the Mental Health System

The impact upon the public mental health system (defined here to mean those mental health services funded by the Division of Mental Health) will be substantial. First, dollars that heretofore have been spent in the private sector and billed directly to the Medicaid Program will be part of the capitation payment to the CASAs. As such the

Division will be responsible for all mental health payments on behalf of Medicaid clients. While in FY 1991 (the most recent year for which total mental expenditures are known), the Division allocated approximately about $43.5 million to the mental health institutes and the community mental health centers. This figure would grow to about $70 million if all Medicaid expenditures where allocated to the Division and paid under a capitation contract.

While it is impossible to predict who the successful bidders under this proposal will be at this time, it is certain that the CMHCs will be affected by this proposal. If a particular CMHC is a successful bidder, the Center will immediately take responsibility for an expanded list of eligible Medicaid recipients and a significantly larger budget to provide mental health services to this population. The Center would be required to provide or refer to other providers to provide for their mental health needs. Out of the budgeted dollars, the required services will have to be provided. The Center will accept considerable risk for the mental health services provided to Medicaid client.

Conversely, if the Center is not a successful bidder, the Center will relinquish care for the Medicaid client population (assuming that the Center does not subcontract with the CASA). The result will be a substantially smaller budget, with the attendant impact upon the financial requirements of the CMHCs, as well as upon the programmatic activities of the CMHCs.

Reaction of public mental health system provider officials: Community mental health center officials have expressed strong support for the proposal. Some officials have concern about the potential for increased demand for services among those Medicaid clients that have, in the past, utilized very little if any mental health services. An increased demand among these persons could create risk to the CASAs. This concern will create a need for comprehensive utilization review program, and ways of limiting risk to the CASAs.

The impact upon the private mental health system will also be noticeable. Where currently, Medicaid clients can access mental health services in virtually any setting including hospital outpatient room settings, hospital emergency rooms, and inpatient hospital settings, under this proposal episodic care should be curtailed dramatically. The use of the agencies or individuals outside of the CASAs will only occur under subcontract to the CASAs. Services provided will have to meet the utilization review criterion of the CASAs. The result will be a much more controlled environment with better control of the location of services and less episodic and duplicative services.

D. Impact on Social Services System

A mental health capitation and case management proposal holds great promise to improve the mental health services for the populations that are also served by the Department of Social Services. In particular, the proposal has the potential to better serve the mental health needs of families and children. Currently, no one agency has responsibility for providing the mental health services for the entire Medicaid population.

In fact, one of the current problems in serving this population is the lack of coordination among the service agencies. Community mental health agencies are often not involved or even knowledgeable of the mental health services provided to this population particularly for children and adolescents being admitted to hospitals for treatment of mental health problems. Under this proposal, the contract agency will be required to provide for the mental health needs and will have to determine the need for mental health services of a particular consumer. Coordination among the agencies

providing social and health care services will need to occur in order for mental health services to become available.

Efforts are currently underway to reduce the reliance upon hospitals for addressing the mental health needs of children and adolescents. A coordinated discharge planning system has been developed between the mental health system and the Medicaid and social service system. While the mechanisms have been developed to implement this system, limited success has been achieved because the financial incentives to develop alternative community service systems have not been developed. Furthermore, this system does not address admissions to hospitals, but rather it is directed to early discharge of the patient. Hence, it will not keep persons out of the hospitals, but only assist in more appropriately discharging persons from hospital settings. This capitation and case management model would not only place the CASA into the position of approving admissions to hospitals and additional days of hospital care, but also into the position of financially benefiting from the development of more appropriate and less costly community, non-institutional services to meet the needs of the children and adolescents.

Finally, it also recognized that the service needs of families and children are provided by many state and local agencies. In many cases, the coordination between agencies in the provision of services is inadequate. In part, this issue is being addressed in a state and local family and children restructuring effort that continues today. A mental health capitation and managed care proposal will need to be complementary and supportive of this effort.

Reaction of the Social Services agencies officials: Social service agencies officials have expressed great concern that the mental health needs of children are not being fully met today. Social service officials have observed that some mental health centers have not given priority to the mental health needs of children and adolescents and/or children in the child welfare system. Since the vast majority of these children are Medicaid eligible, this proposal to be successful must incorporate strategies to address the mental health needs of this population.

E. Impact on the Primary Care Physicians and Health Maintenance Programs

The Medicaid Program has a rather long history of use of health maintenance organizations and managed care practice protocols. Currently the Medicaid Program contracts with two health maintenance organizations (HMOs) and has developed a primary care physicians program (PCPP) to control the use of unnecessary medical care services.

However, in the case of the contracts with the HMOs, the benefit package included in the provision of mental health care services is limited, but some mental health services (not including those provided by a community mental health center) are still received from the HMO. Hence, the contracts with the HMOs allow consumers to seek care directly from the community mental health center in the region. Under the PCPP, mental health services are not controlled by the primary care physician. A referral from the primary care physician is not required for services to be provided by a private psychiatrist, a psychologist, or a community mental health center.

Under this proposal, since the provision of all mental health services will be the responsibility of the CASA, the HMO will have a reduced responsibility for this service and an adjustment in the rate will result. The savings under the HMO contracts will be included in capitation rates paid the CASAs. Alternatively, it would be possible to have the provision of all mental health services a responsibility of the HMO, if the HMO also

serves as the CASA. In this instance, the capitation rate would have to reflect this decision.

Under the primary care physician program, services provided by CMHCs or private practitioners are not under the control or authority of the primary care physician to authorize or approve. Mental health services have always been excluded from the authority of the primary care physician. Under this model, the primary care physician will have a single organizational unit to which to refer the consumer to receive mental health services. Coordination and cooperation should be improved to the benefit of the consumer.

F. Impact on the Physical Health of Medicaid Recipients

This proposal does not intend to replace the current protocols for the provision of medical care to the Medicaid client (defined here to refer to medical care excluding mental health services.) For example, if a chronically mentally ill consumer requires medical care services, those services would be provided and paid for under the existing mechanisms in the Medicaid Program.

As has been previously indicated, it is the intent of this proposal to improve access to mental health services, the package of mental health services available, and quality of mental health services provided to the Medicaid recipient. As such, it is anticipated that the evaluation of this proposal will measure the impact, if any, of adequate mental health services upon expenditures for medical care of the Medicaid population. In this instance, additional information should be gained about the impact of adequate mental health services upon the costs of medical care for the same population.

G. Cost Implications of the Medicaid Mental Health Capitated and Managed Care Model

One of the four goals of this proposal is to develop a less costly, more cost-effective mental health delivery system. Hence the measurement of the mental health expenditures under this proposal will be critical. Fortunately, with the use of Medicaid claims processing data, data are available on the cost of treating Medicaid patients under the current system. This information can then be compared with the cost of care under the proposed system.

In fiscal year 1990. Medicaid mental health expenditures totalled approximately $53.7 million. By 1991, (the most recent year for which complete Medicaid data are available), Medicaid mental health expenditures had increased to about $69.4 million, or an increase of 29.4 percent. (These data represent services provided and reimbursed during these timeframes rather than total payments made.) This represents a substantial increase in Medicaid mental health expenditures in a single year (data are not currently available for other years). A capitation system offers the opportunity to better control and reduce the rate of growth.

Moreover, in further analyzing the potential reasons for the rate of growth, the data show that mental health expenditures occurred in a number of different settings including the state mental health institutes, the CMHCs, private psychiatric hospitals, acute general hospitals, and private practitioner offices. More importantly, individual consumers utilized a number of different provider types over the period of a year. Coordination between these provider types is uncertain. Perhaps good coordination occurred in some instances for some patients. However, under the current system, there is no assurance that coordination occurred, or even that one provider knew of the use by a consumer of the other providers in the system. This proposal offers the opportunity to better control the rate of growth and to assure that coordination occurs.

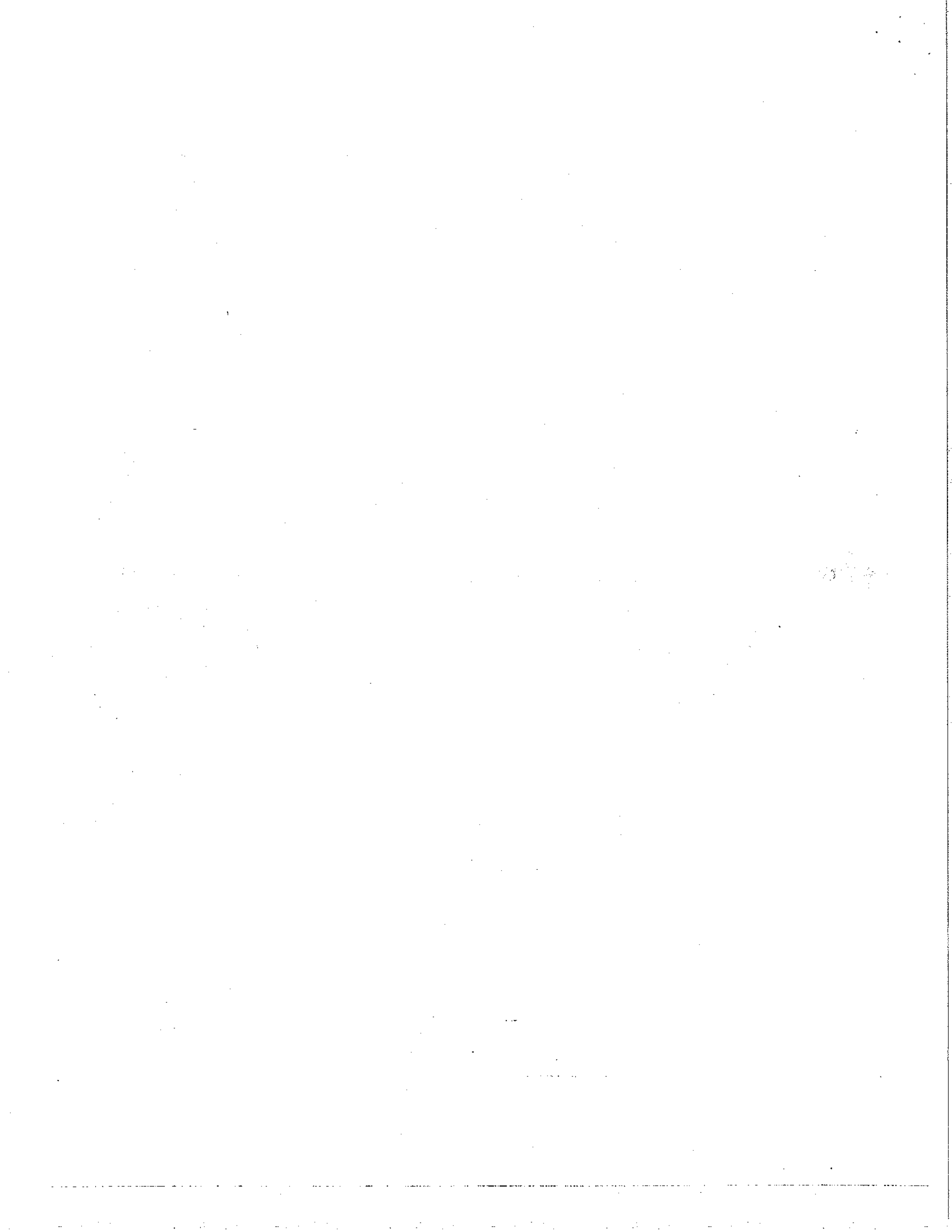


Table I provides data on the current level of expenditures in the Medicaid Program. It provides data on expenditure levels by provider type. Expenditures in the public sector including the state mental health institutes and the CMHCs totalled approximately $43.5 million. The other $25.5 million was spent in private psychiatric hospitals, acute general hospitals, and for the services of private practitioners. Of the money spent in the public sector, two-thirds was spent in community settings (CMHCs). Of the money spent in the private sector, four-fifths was spent in hospital settings. The opportunity to utilize lower cost community based services in place of hospital services does not seem to have been fully explored.

TABLE I

Medicaid Mental Health Expenditures
(Preliminary Expenditure Totals)*

Year	Inpatient State Hospitals	Inpatient Under 21 Psychiatric Centers	Community Mental Health	Private Hospitals-Inpatient	Private Hospitals-Outpatient	Psychiatrists and Psychologists	TOTAL	Percent Increase
1990	$11,858,726	$1,918,883	$23,173,419	$13,206,836	$1,308,482	$2,193,353	$53,659,699	
1991	$14,487,246	$2,074,570	$29,155,658	$19,015,955	$2,093,390	$2,564,323	$69,391,142	29.3%

*Expenditure totals for columns except inpatient state hospitals and community mental health centers come from the Medicaid Management Information System database and represent "date of service" rather than "date of payment" information. Expenditure totals for inpatient state hospitals and community mental health centers come from audited cost reports of the facilities. Only expenditure totals for inpatient state hospitals and for the community mental health centers include the individual costs of treating Medicare and Medicaid dually eligible persons. The method of treating Medicare and Medicaid dually eligible persons will be determined during the detailed design phase of program development.

However, even for public mental health center expenditure totals, substantial variation exists in the use and probably existence of community resources. The opportunity to utilize capitated dollars to develop alternative community resources remains one of the distinct advantages of the proposal.

Nonetheless, it must be remembered that H.B. 1306 stated that "Any prepaid capitated single entry point program shall, as much as possible, avoid exposing providers or community mental health centers and clinics to undue financial risk or reliance on supplemental revenues from state general funds, local revenues, or fee-for-service funds". Moreover, increased access to mental health services could result in increased demand. There are number of ways to protect the CASAs from undue risk. One method has already been discussed in this paper. This method is to initially share a portion of the risk for community non-institutional expenditures (the full risk for institutional services would rest with the CASA). The risk of expenditures in excess of the capitated amount in the community settings would be shared by the State and the CASA. Other methods of limiting risk include a stop-loss clause or use of re-insurance mechanisms. All of these techniques can be used without sacrificing the fiscal integrity of the Medicaid mental health program.

H. Total State Mental Health Expenditures

In addition to the Medicaid mental health expenditures, substantial general fund mental health dollars are spent annually in this state. For example, $21.7 million in general funds were appropriated in fiscal year 1991 for community mental health centers to spend to serve medically indigent non-Medicaid clients. To assure that these funds are utilized for those clients most in need, the Division defines as the target population for the use of these funds the chronically mentally ill in the state or persons with major mental illness. In addition, the mental health institutes were appropriated $52.3 million in general fund dollars to serve this population.

Even with the target population defined in the state, the Centers and the Institutes cannot serve all of the targeted population. The mental health needs of the chronically mentally ill and those with major mental illness remain seriously underfunded. Hence, the Division proposes that the state consider allowing the CASAs to utilize at least a portion of any "profits" from serving the Medicaid population to help develop community based services for all mentally ill persons.

From the perspective of the State of Colorado, certainly of major importance is the total general fund appropriation to serve the mental health needs of its citizens. Under the current public sector system, the general fund is protected while allowing an opportunity to secure additional federal funds to be captured by allowing CMHCs to utilize a portion of their general fund appropriation for non-Medicaid consumers as general fund match to serve additional Medicaid patients. In this manner, CMHCs can access additional federal Medicaid matching funds to better serve the mental health needs of consumers in their service area.

In the private sector, Medicaid expenditures, and the general fund necessary to match the Medicaid Program, have grown at an ever increasing rate. The advantage of the capitated system is to gain control over total Medicaid expenditures and to slow the rate of growth in these expenditures, and therefore control the rate of growth in general fund expenditures used as state match dollars in the Medicaid Program to the advantage of the State in its annual need for general fund dollars. It is anticipated that, over time, capitation payments will be lower than comparable fee-for-service payments as a result of ongoing efforts to control growth rates.

Furthermore, a sharing of the risk with the CASA for non-institutional expenditures, as described above, may be included without risking the fiscal integrity of the Medicaid mental health program. As the State is most interested in the bottom line of its general fund budget for mental health services, any State share of the risk for increases in the community services could come out of the total general fund appropriation for mental health services including a share of the projected increases in general fund expenditures that would have occurred in the absence of the capitated program. In this way, Medicaid could pay a larger portion of the mental health needs of all mental health expenditures while still reducing the rate of growth in the total mental health Medicaid budget. Consumers would be provided additional mental health services, while the general fund would be protected.

I. Administrative Expenditures

Administrative expenditures for the Division of Mental Health central office staff total only 1.1 percent of public mental health expenditures. As such, additional administrative resources will be needed to implement and operate the pilot program. During the first year of the planning phase of the proposal (FY 1992-93), the Division of Mental Health will undertake the additional developmental functions with current Division personnel. However, in year two of the planning phase, three additional staff will be needed. (See Table II below.) There are four major functions in the second year that will require additional administrative costs. First, a need exists to collect additional data from the year preceding the implementation of the proposal. This data will form a base year against which to measure the cost of the proposal as well as its impact upon the quality of care provided. Significantly, in this regard, a firm to evaluate the impact of the proposal has already been identified. Federal funding will be sought to undertake the evaluation of the proposal as well as collect the data in both the base year and during the pilot phase of the study.

Second, development of data systems will have to occur. Much of these data systems will have to be developed by the CASAs. However the State agencies will also be required to develop software systems to monitor the costs and quality of care provided under this system. The COIN and MMIS systems of the Department of Social Services will have to modified to track Medicaid eligibles, determine and pay capitation rates, measure the cost of care provided, and provide other administrative reports. (See Table II below).

Third, substantial utilization review and quality assurance procedures will have to be developed. Under a fee-for-service system, most systems measure the rate of inappropriate services provided. In contrast, under a capitated system, much of the utilization review and quality assurance efforts will be directed toward the danger of under-utilization. This switch in intent or goal of the quality assurance system will require the development of new monitoring systems.

Fourth, the RFP must be written, released, and the responses evaluated. This activity will be a very labor intensive effort. Division staff will be involved in this process along with Medicaid Program staff. All of these functions will culminate in the second year of the design, development and implementation phase of the proposal.

During the two years of the pilot phase of the project, a need will exist to continue the allocation of the three additional administrative staff. The major Division activity during the pilot phase will be to monitor the quality of care provided under this proposal. (See Table II below.) Technical assistance in systems development, cost accounting, payment of claims, and a host of other efforts will be necessary. From the

Division's perspective, it will be necessary to basically run two different systems: (a) the current fee-for-service system in some geographic areas of the state; as well as (b) a combined system in the pilot project areas of the state wherein a capitated program will be in operation along with a mental health system to serve public sector clients who are provided mental health services through a general fund appropriation. While it is anticipated that a portion of our current staff will be allocated to support the needs of the capitation proposal, additional resources will be needed. However, the additional resources will allow the development of a new system that offers great promise for the future.

In order to develop continuity in the project, a portion of the staff hired during the second year and design phase of the project will be retained. The program specialist will be retained to provide direction to the project and to undertake a substantial portion of the quality of care monitoring. Another important function will be to develop a grievance procedure. This activity will be particularly important during the initial start-up phase. Consumers who are for the first time required to utilize the CASAs will need a grievance procedure to assure that their concerns are fairly adjudicated. The administrative officer will fill this position. Data entry will be required primarily to support quality assurance activities. Finally, the 1/2 time secretary will be retained to provide maximum continuity during the design and implementation stages of the proposal.

TABLE II
Additional Resources Needs

Function	FY 1994	FYs 1995-96
Design, develop, and implement utilization review and quality assurance package	Prog. Spec.	
Program Administrator during FYs 1995-96		*Prog. Spec.
Develop software package to support	Systems Analyst	
Write RFP, evaluate, award contract	Admin. Off. (1/2)	
Grievance Officer during FYs 1995-96		**Admin. Off.
Administrative Support	Secretary (1/2)	Secretary (1/2)
Data Entry		Data Entry Off. (1/2)

COIN System changes:

a. Modify case records extract (2 weeks).
b. Modify recipient extract tape (6 weeks).
c. Modify sort and merge programs (1 week).
d. Modify message on recipient MAC cards (1 week):

10 weeks * 40 hours/week * $35/hour = $14,000

MMIS changes:

a. Generate capitation payment based on recipient demographics.
b. Create edit to deny services provided by anyone except the contractor(s).
c. Modify and recompile each program which reads the modified recipient extract tape.
   Total estimate of hours: 1,100.
   1,100 hours times $65./hour = $71,500

*Program Specialist will serve as Program Administrator in FYs 1995-96
**Administrative Officer becomes Grievance Officer in FYs 1995-96

V. Alternatives to the Proposed System

The most obvious alternative to a mental health capitation and managed mental health system is a continuation of the current system. However, as has been noted in this paper, the current system has seen a substantial growth in expenditures. It has seen fragmented care and an emphasis upon institutional care. The increases in mental health expenditures along with increases in other sectors of the Medicaid program have led to a state effort to develop alternatives to the current method of delivery of medical care and mental health services to Medicaid recipients.

Another alternative would be to develop a case managed single entry point system but continue the fee-for-service system. This approach would closely match the primary care physician model currently in use by the Medicaid Program. This proposal would encourage more coordinated care and perhaps some reduction in dependence upon institutional care. However, the ability to develop many of the community alternatives to institutional care such as residential care, respite care, prevocational and vocational services would be lost. Hence, probably the most powerful piece of the proposal which is to develop additional community programs to serve as alternative to the current reliance upon institutional care would be lost.

None of the other alternatives seems to hold as much promise as the capitated, single entry point, managed care model proposed in this paper.

VI. Recommendations and Future Actions

The Executive Directors of the Department of Social Services and the Department of Institutions recommend proceeding with detailed design of the proposal and with developing a Medicaid waiver for submission to the Health Care Financing Administration. This effort would occur over the next nine months. At the end of the detailed design phase, another decision would be made as to whether to proceed further with the proposal.

During the course of the detailed design, numerous committees would be formed. The committees would include consumers, county social service agency staff, staff of the CMHCs, private providers, and State officials. Some of these agencies and officials will be involved in actual design while others will be involved on reactor panels specifically designed to bring reality to the process.

If the decision is to proceed, starting July 1, 1993, efforts will be directed toward selection of coordinated assessment and services agencies. This will occur through an RFP process. It is anticipated that perhaps four geographic areas of the state will be covered during the pilot phase. It is anticipated that the areas of the state selected will represent geographic diversity,

along with diversity across other social indicators so that decisions can be made about the statewide feasibility of this proposal.

The results of the pilot will be reported to the General Assembly on January 1, 1996. Depending upon the success of the pilot, an effort will be expended to cover the entire state as soon as feasible.

This proposal holds great promise to provide the entire range of appropriate services under the Medicaid system. Those services provided will be those most clinically necessary, not those that in the past have been reimbursable. The system will place appropriate incentives for the provision of medically necessary cost effective, yet most importantly, quality services.

Appendix I
Summary of Agencies Contacted

Agency	Type of Contact
Community Mental Health Centers	Several meetings held with Community Mental Health Centers
Colorado Mental Health Planning Council	Mtg. held Sept. 1, 1992
Five-Party Advisory Council	Mtgs. on July 28, 1992 and August 11, 1992
Denver General Hospital	Mtg. held July 31, 1992
County Department of Social Services	Mtgs. held on Aug. 3, 1992, Aug. 26, 1992 and Sept. 22, 1992
Mental Health Advocates	Mtg. held Aug. 5, 1992
Public Forum for all Interested Parties	Mtg. held Aug. 14, 1992
Advisory Council of Public Sector Psychiatrists	Mtg. held Aug. 19, 1992
CHARG	Mtg. held Aug. 26, 1992
Children and Adolescent Continuity of Care Committee	Mtg. held Sept. 4, 1992
Colorado Psychiatric Hospital	Mtgs. held Aug. 21, 1992 and Sept. 10, 1992
Colorado Psychologist Society	Copy of Proposal sent and response received
Medicaid Psychiatric Hospital Advisory Committee	Copy of Proposal sent and response received from one hospital
Colorado Medical Society	Copy of Proposal sent
Colorado Association of Social Workers	Copy of Proposal sent

Appendix II
Summary of other Capitated Managed Care Mental Health Systems

WISCONSIN - 1971

In 1971, the state of Wisconsin instituted a new program for financing and provision of mental health services. Funding for these services would be provided by the state to each county on a formula basis, with the expectation that the county would contribute a minimum of 9 percent in matching funds. The formula was also adjusted for each county's population, historical utilization, urban/rural designation and inflation.

Given strong historical use of county mental health centers instead of state mental hospitals as well as strong powers vested in the counties, Wisconsin was largely able to decentralize its mental health care system from the state to the counties. By law, each county must have a Mental Health Board (or Unified Services Board which covers both mental health and developmental disabilities). The board consists of county supervisors and citizens appointed by the county executive. Reviewed yearly, services are either provided directly through the board, purchased through capitated contracts, or through a combination of both. To fund these services, the county uses per capita monies received from the state and adds its designated matching funds. Additionally, counties must bear the full cost of inpatient services, including those provided by the state hospitals.

MINNESOTA - 1981

In 1981 the Minnesota Department of Health Services was granted a waiver from HCFA and allocated funds to establish a demonstration project to enroll Medicaid beneficiaries into prepaid health plans. A unique aspect of this project was the explicit decision to enroll Medicaid beneficiaries with mental illness in mainstream Health Maintenance Organizations (HMO).[1]
Hennepin County, which contained 61,000 Medicaid beneficiaries, was chosen by the department as the urban county for the demonstration project. Thirty-five percent of all Medicaid eligibles were randomly selected to participate in the prepaid demonstration project. This included AFDC recipients, aged, blind and disabled clients, both institutionalized and non-institutionalized clients. Health plans under this program included standard HMOs as well as some new program-specific organizations operating under a capitated financing scheme.[2]
Several steps were taken to prevent disruption of treatment, and to assure client satisfaction and quality of care. Enrollees were given a choice of participating plans, and unless they requested a change within the first 60 days, they remained in the plan for one year, at which point they could again switch plans. An informal grievance procedure was established; if recipients felt that it failed, they could file a formal grievance with the state Medicaid program. County advisory groups developed quality

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1. Christianson, J.B., Lurie, N., Finch, M. and Moscovice, I. Mainstreaming the Mentally Ill in HMOs. *New Directions for Mental Health Services* 43:43-54, 1989.

2. Christianson, J.B., Lurie, N., Finch, M. and Moscovice, I. Mainstreaming the Mentally Ill in HMOs. *New Directions for Mental Health Services* 43:43-54, 1989.

assurance standards for health plans. Additionally, the contracts of participating plans were amended to allow enrollees to self-refer for mental health and chemical dependency treatment. During the first year, volunteer advocates were recruited to review client grievances.

Capitation rates were determined for 74 rate cells constructed by age, sex, Medicare participation, Medicaid eligibility category, and institutional/non-institutional residence. The state also offered re-insurance or stop-loss coverage for plans that participated in the demonstration. Health plans were mandated to provide all "medically necessary" services, but it is unclear whether this covered services like, for example, day treatment.[3]

An evaluation of the demonstration project was conducted to determine the effects of capitation on the severely mentally ill. However, one of the larger participating plans (Blue Cross/Blue Shield) withdrew from the project after seven months due to adverse selection. Because this plan served a large proportion of the disabled population, all the disabled enrollees were withdrawn from the demonstration after one year. Consequently, only short term outcomes (6-11 months) could be assessed. Evaluators found that seriously mentally ill beneficiaries enrolled in the capitated payment plan showed no short-term deleterious effects in treatment outcome. Also, use of community based services did not appear to decrease under the pre-paid plan.[4]

The purpose of implementing a prepaid capitation model is to provide incentives to improve the management and coordination of enrollees' utilization, to encourage enrollees to seek care early, and to improve the quality of care.[5] However, capitation also introduces incentives that could potentially harm enrollees. For example, participating plans might respond to capitation by underserving enrollees, by substituting less qualified professionals to provide care, or by shifting patients to publicly funded programs. Additionally, severely mentally ill may have difficulties in negotiating their way through the bureaucracy of an HMO.[6] The participating health plans therefore introduced several mechanisms to prevent problems in the provision of mental health services. A case management model was adopted, and treatment plans required review, approval, and monitoring. The data system was used identify and address, retrospectively, patterns of utilization that appeared excessive. These mechanisms appeared to work, and there was no evidence of worsened outcomes for the group enrolled in prepaid plans.[7]

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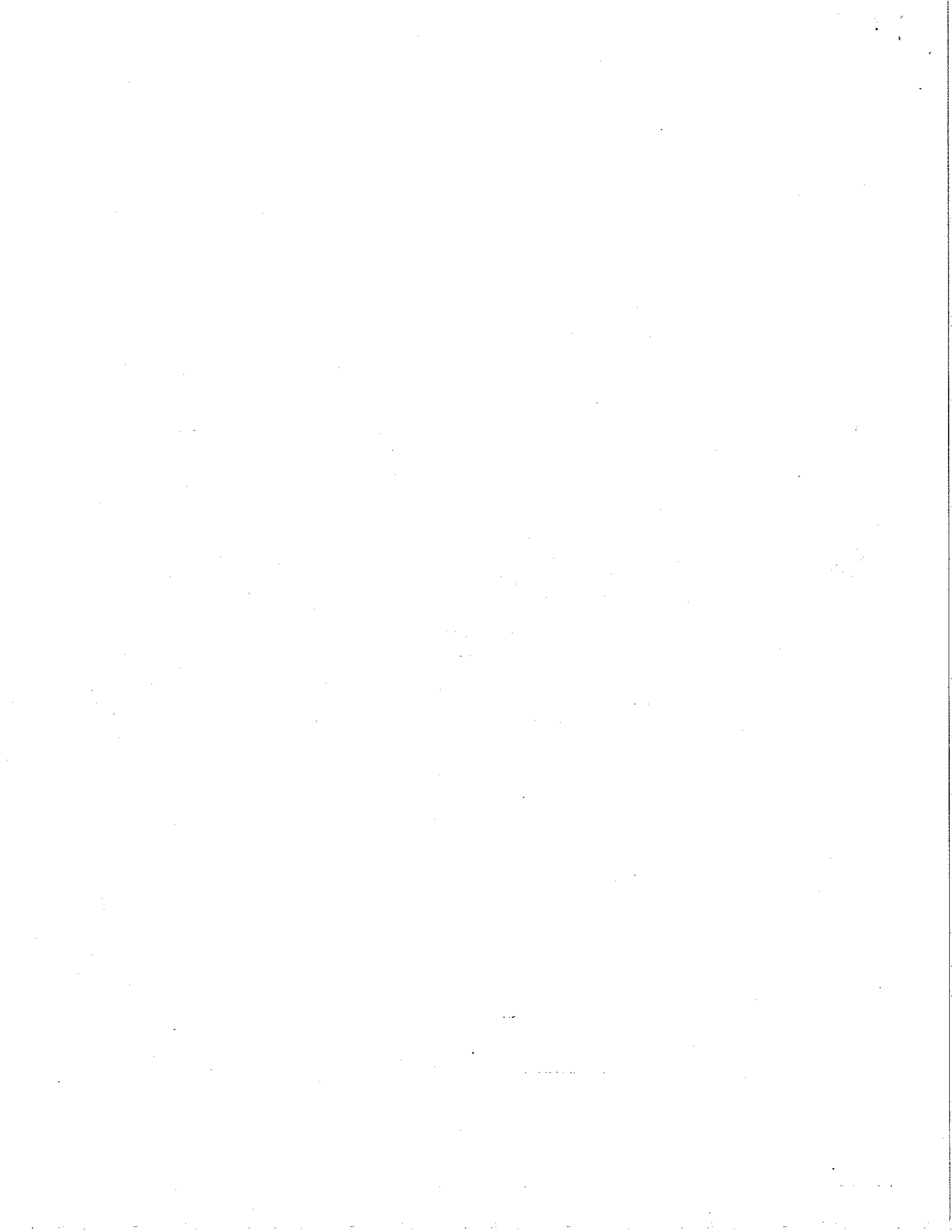
3. Lurie, N., Moscovice, I., Finch, M., Christianson, J.B., and Popkin, M. Does Capitation Affect the Health of the Chronically Mentally Ill? *JAMA* 267:3300-3304, 1992.

4. Christianson, J.B., Lurie, N., Finch, M., Moscovice, I., and Hartley, D. Use of Community-Based Mental Health Programs by HMOs: Evidence From a Medicaid Demonstration. *Am. J. Public Health* 82:796-798, 1992.

5. Lurie, N., Moscovice, I., Finch, M., Christianson, J.B., and Popkin, M. Does Capitation Affect the Health of the Chronically Mentally Ill? *JAMA* 267:3300-3304, 1992.

6. Christianson, J.B., Lurie, N., Finch, M., Moscovice, I., and Hartley, D. Use of Community-Based Mental Health Programs by HMOs: Evidence From a Medicaid Demonstration. *Am. J. Public Health* 82:796-798, 1992.

7. Lurie, N., Moscovice, I., Finch, M., Christianson, J.B., and Popkin, M. Does Capitation Affect the Health of the Chronically Mentally Ill? *JAMA* 267:3300-3304, 1992.



RHODE ISLAND - 182

The Rhode Island Division of Mental Health has utilized capitation as a method of financing community mental health services since 1982. The goal of this program was to deinstitutionalize long-stay patients from the state hospital and enroll them into alternative community programs. Additionally, it was intended to expand reallocation of funds from the state budget to community mental health program budgets. Funding is tied to specific patients who move from the state hospital to the community. The primary providers, community mental health centers, are not held at risk for the costs of inpatient care should these patients again require hospitalization. Given that providers are not at risk, Rhode Island's approach only partially fits under the definition of a capitated program.

Two capitation rates are employed which are based on different targeted client groups. Transfer I clients are lower risk, based on their having one year of uninterrupted residence in a state hospital, and are therefore assigned a lower capitation rate. Transfer II clients have two or more years of residence in a state hospital and are assigned a higher rate. Services covered for Transfer I clients include case management, medication maintenance, crisis counseling, vocational assessment, and community living skills. Services covered for Transfer II clients are residential programs, case management, counseling, psychosocial rehabilitation, and crisis intervention. Additional core services are provided by community mental health centers and are funded by separate contracts and grants. Inpatient services are not included in the capitation rate. Private insurers contribute to an outlier fund designed to prevent future cost-shifting.

To assure adequate care, clients are assigned a manager of care. Clients and services are tracked monthly, and clients are periodically assessed for functional level, to measure improvements, and to identify unmet needs. Annual quality and comprehensiveness reviews of program records are conducted.

No formal evaluations of the Rhode Island program have been conducted, and no comprehensive utilization and outcomes data are available. However, anecdotal evidence indicates that program development in the community did not expand as much as was expected. Rather than creating new programs, clients in the capitation program were put in vacant spots in existing programs. An additional weakness of the program is that the flexible service arrangements financed by capitation are not available to any other sets of clients. There is concern expressed by staff members of participating centers that the rates for both Transfer I and II clients are insufficient to provide adequate services.[8] Staff have also expressed concern that placement of Transfer II clients into existing group homes has shifted the mix of residents towards the more severely ill, while the staffing levels and training are geared towards less severely ill clients.

The capitation program implemented in Rhode Island has a number of features that distinguish it from the proposed Colorado model. First, it targets a group of severely mentally ill clients who have a history of long-term hospitalization. Additionally, Medicaid eligibility is not required for participation. Also, the primary purpose of this capitation program was to create incentives to move long-stay clients from the state

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8. Christianson, J.B., and Linehan, M.S. Capitated Payments for Mental Health Care: The Rhode Island Programs. *Community Mental Health Journal* 25:121-131, 1989.

hospital to the community mental health centers. However, it did not place the community providers at risk if clients required hospitalization.

ROCHESTER, NY - 1984

The Rochester, New York program is an experiment in managed mental health care services utilizing a comprehensive capitation model. The Integrated Mental Health (IMH) project is attempting to bring quality community care to chronically mentally ill patients whose primary source of care was public institutions. The experiment is designed to demonstrate that level of functioning for a majority of mental health care clients can be improved in a system in which limited resources are consolidated and responsibilities are clearly delineated by a case manager.

To be eligible for this program, clients must have a history of inpatient treatment at a state hospital or be currently enrolled in a community mental health center. There are three categories of eligibles: 1) continuous (270 days of inpatient treatment during the past 3 years); 2) intermittent (45 days or 30 continuous days of inpatient treatment during the past 3 years); 3) outpatient (25 outpatient services). For the continuous group, all mental and physical health care services, housing and personal expenses are covered by the capitation rate. For the intermittent group, only mental health and rehabilitation services are included under capitation, and for the outpatient group, only outpatient mental health services are capitated. There is a single rate for each of the three groups. Rates were developed based on cost estimates for the average treatment plan in the community setting. Inpatient services are not included for the intermittent or outpatient group.

Community Mental Health Centers are designated as lead agencies and receive capitated rates for each eligible that they enroll. They receive free IMH hardware and software to ensure accurate data collection and reporting. There is also a data base that is shared by all participating providers that shows client utilization across the entire mental health system, and which can be used to assess client outcomes, program costs, and service proficiency and acceptability. Lead agencies can be financially penalized if they fail to provide the agreed upon volume of services or if their use of the state hospital exceeds targeted levels. Funding is provided by the state of New York and United Way. Providers continue to bill third parties for services rendered, and return most of it to the state. The project did not require a HCFA waiver because Medicaid services were not capitated.

NIMH has funded a 5 year evaluation of the project. It is an experimental design that will examine the effect of capitation on client outcomes as measured by the following variables: 1) number of days in the hospital; 2) psychiatric symptomatology; 3) level of functioning; 4) financial and emotional burden to client's family; 5) life satisfaction, and; 6) costs. Findings from the evaluation will probably be available in the near future.

The program in Rochester is quite different from the model proposed by Colorado. First, it does not capitate Medicaid services. Additionally, it targets a specific group of mental health service users, chronically mentally ill clients whose primary source of care had been public institutions.

ARIZONA - 1987

As a result of a favorable court decision, the Arizona legislature established a pilot project to capitate mental health services in 1987. Ranked last in the country in terms of per capita expenditures for mental health, this state undertook a program to increase coordination between existing services given severe financial constraints. Both the state and the counties fund mental health services which are separate from the Arizona Health Care Cost Containment System (AHCCCS). A separate funding allocation was established by the legislature for the pilot project which would serve as the sole source of funding even though financial risk was shared by a number of parties. Approximately $15,000 per patient per year was set aside for limited numbers of patients at each county mental health care facility. Each patient was assigned a team of health care professionals with a case manager to coordinate care. The team had a choice of whether to deliver services or purchase them on behalf of their clients. This flexible system allowed for services to be delivered anywhere in the community and encouraged a client-driven and client-centered system of care rather than one that fits patients into pre-established services.[9]

PHILADELPHIA - 1988

Begun in 1988, the Philadelphia capitation program was a public-private partnership with contributions from the Robert Wood Johnson Foundation, state, and city funds as well as Medicaid funds. It was hoped that capitation would create incentives to provide better coordination and continuity of care and case management to high users. Additionally, capitation would increase the city's flexibility in deciding what services for Medicaid recipients should be paid for. Moreover, capitation would lead to a reduction in reliance on inpatient stays, allow community providers to develop alternative models of care, and bring Medicaid funding for acute and ambulatory psychiatric services into the overall city mental health system. A subgroup of chronically mentally ill clients who were considered high users of the system were enrolled in the capitated demonstration project.[10]

The capitation experiment consolidated funding from Medicaid and the city mental health budget and gave a central authority, which functioned like an health insurance company, a capitated payment for each enrolled client. Capitation rates were based on current costs and utilization levels.[11] To reduce the use of inpatient services, the central authority selected preferred providers, required pre-admission authorization for hospitalization, and developed performance contracts with community mental health centers with an incentive to reduce hospitalization. Additionally, 627 new residential beds for the severely mentally ill were created. Discretionary funding was also made available to community mental health centers that reduced hospital costs. No evaluation of the Philadelphia program has been conducted or is intended.

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9. Santiago, J.M., and Berren, M.R. Arizona: Struggles and Resistance in Implementing Capitation. *New Directions for Mental Health Services* 43:87-96, 1989.

10. Hadley, T. and Glover, R. "Philadelphia: Using Medicaid as a Basis for Capitation. *New Directions for Mental Health Services* 43:65-76, 1989.

11. Hadley, T. and Glover, R. "Philadelphia: Using Medicaid as a Basis for Capitation. *New Directions for Mental Health Services* 43:65-76, 1989.

While the capitation demonstration project in Philadelphia appears to be an interesting model, its effects on client outcomes, quality of care, access to services, and cost of care are unknown. It does, however, raise some important issues. While the central authority receives a capitated payment for each enrollee, it can reimburse providers either through capitation, fee-for-service, performance contracts, or through direct program funding.[12] Thus, the incentives that capitation introduces may not affect provider decisions about how much and what type of care to provide. Additionally, because the central authority selected specific providers to contract with for inpatient services, hospitals that previously served Medicaid clients will have to find other uses for these beds, which will likely be private pay clients. This may result in a two-tier system of care for public and private clients.

CALIFORNIA - 1988

California has implemented a capitation experiment in two counties (Long Beach and Stanislaus). The counties were selected through a competitive bidding process. Eligibility for participation is determined by selection panels made up of representatives from an integrated services agency (ISA), the local mental health department, and the State Department of Mental Health.

The state provides 100% of the funding for the ISAs. Capitation rates were limited by statute to $15,762 per person for 1989-90 fiscal year. The capitated rate covers all necessary services, including medication, and inpatient care in local or state hospitals. If involuntary care is deemed appropriate, the ISAs must assist clients in accessing the involuntary commitment system and must also pay for that care. However, agencies may receive an additional 10% of the total annual payment to establish new services or to meet unanticipated catastrophic costs. Additionally, ISAs assist clients in securing funds for other services, such as food stamps, SSI, etc. If no other funds are available, ISAs must pay for necessary medical and dental care for enrollees.

A formal evaluation of the California experiment is being funded by National Institutes of Health and is currently underway. The design of the evaluation involves a randomization of 400 enrollees at each site to capitation or cost-based reimbursement. The evaluation will look at the effect of capitation on cost-effectiveness, client outcomes, social costs, and family burden.

The California capitation experiment differs from the proposed Colorado project in that it is financed entirely by the state. Also, the project only targets people who are mentally disabled. Furthermore, the capitation rate is intended to cover all necessary services. The design of the ongoing evaluation in California is different from the proposed Colorado evaluation, as random selection of clients is being used in California rather than a matched control group design. However, the issues being evaluated in California are similar to those in the evaluation being planned for the state of Colorado.

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12. Schinnar, A.P., Rothbard, A.B., and Hadley, T.R. Opportunities and Risks in Philadelphia's Capitation Financing of Public Psychiatric Services. *Community Mental Health Journal* 25:255-266, 1989.

SOUTH CAROLINA - 1989

In operation since 1989, the South Carolina capitation program was designed to contain costs among Medicaid eligibles with long-term disabling mental illnesses who were living in the community and entitled to Department of Mental Health community support services. Administered on the county level, the program combines mental and physical health care under one capitation payment. Services under the capitated arrangement are limited however to inpatient, some outpatient counseling, and medications. The county mental health centers employ clinical services teams for mental health care. Each client is provided with a case manager as well as a professional treatment team. Physical health services are provided under contract to local community providers.

UTAH - 1991

The Utah capitation project has been in operation since July 1991 and is intended to accomplish several goals. The first is to contain the growth of expenditures on inpatient services and encourage a more cost-effective service delivery. The project is also intended to encourage the delivery of coordinated mental health care. Finally, it is hoped that client outcomes and access to mental health services will be improved as a result of capitation.[13] Three contractors were selected through an RFP process to deliver inpatient and outpatient mental health services to Medicaid recipients.

The Utah capitation program relies heavily on county mental health centers to administer the program and contract with other providers as needed. The community mental health centers have found that contracts with private practitioners have been beneficial. Financial risk is not entirely borne by the county, but rather by all three through an intricate method of providing extra funds for outlier cases. The capitated rate covers inpatient hospital psychiatric services and related physician services, an array of outpatient services, and targeted case management services. Although substance abuse treatment, emergency room care, medications, and x-ray and laboratory services are covered under Medicaid, they are not covered under capitation. For certain patients who exceed the capitation amount by 15%, an additional payment is provided to the mental health centers to care for those patients.

Risk to the contractors is phased in over the first two years of the plan. During the first two years, they are not at risk for outpatient services, while they are for inpatient services. Thus, fee-for-service data is being collected by participating agencies so that a comparison of costs could be made, and agencies reimbursed if necessary.

An evaluation of the effectiveness of capitation has been funded by HCFA. The evaluation will examine the impact of capitation on Medicaid expenditures, utilization, service mix, and client outcomes.

Anecdotal evidence about the preliminary effects of the capitation plan were published in April of 1992. First, contractors have reportedly stated that inpatient lengths of stay have declined, but that the number of readmissions of Medicaid recipients has increases somewhat. Contractors are also engaged in developing alternatives to

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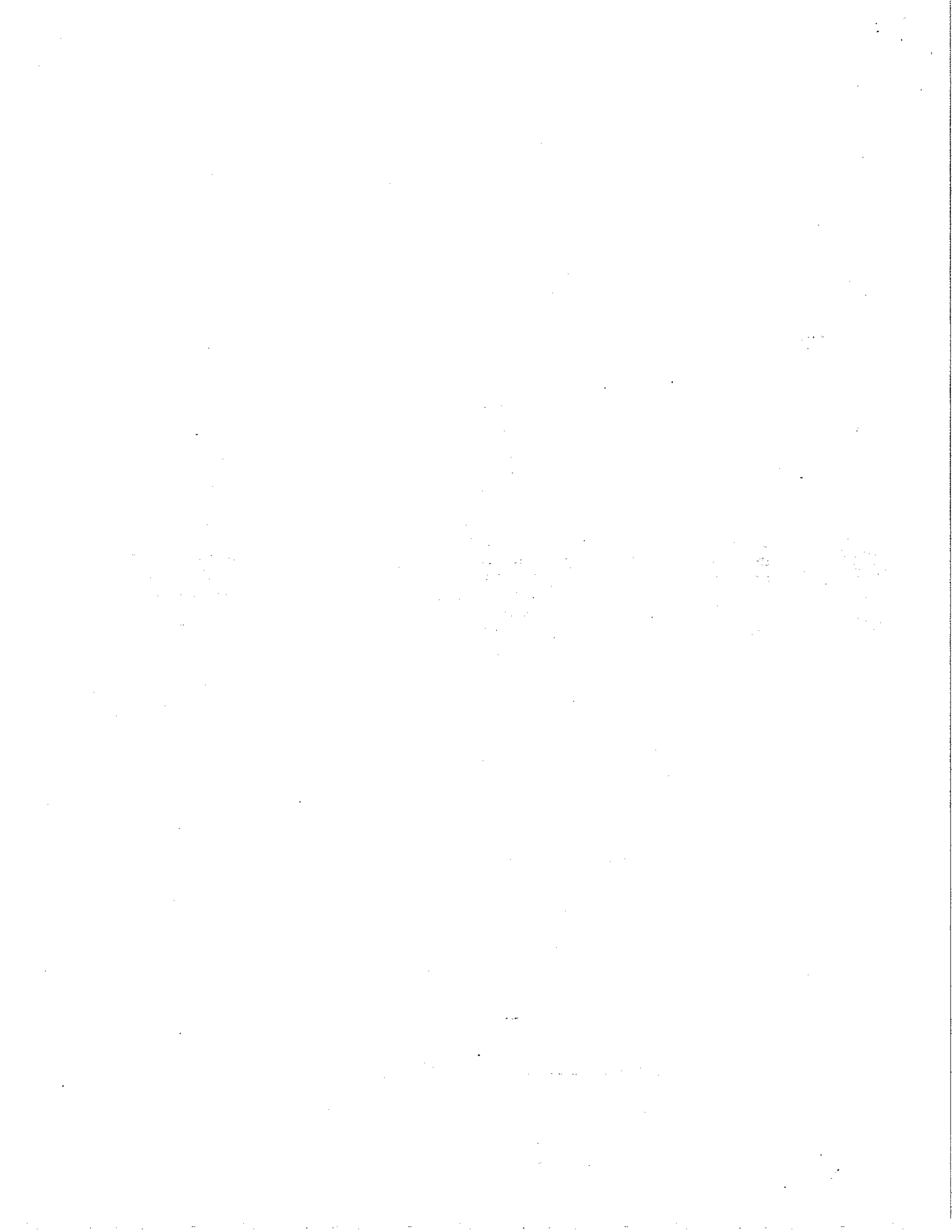
13. Utah Department of Health Division of Health Care Financing. The Medicaid Experiment: Utah's Prepaid Mental Health Plan, 1992.



inpatient treatment. The state also claims that cooperation between contractors, nursing home, hospitals, and the Division of Family Services has increased.[14]

14. Utah Department of Health Division of Health Care Financing. The Medicaid Experiment: Utah's Prepaid Mental Health Plan, 1992.