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## Reform Model Contract Lacks Certain Elements of an Accountable Behavioral Managed Care System

### 1) Lack of specificity regarding which mental health services must be covered

**Issue:** Since MCOs are only responsible for satisfying the requirements of their contract, it is essential that the contract provide clear, detailed requirements for the coverage not just of categories of services, but specific services.

Illustrative example: Crisis Services

**SAMHSA/GWU Model Specifications:** Defines five types of crisis services to be covered (telephone crisis services, walk-in crisis services, mobile outreach crisis services, residential crisis services, and crisis respite care services). [see § 103(b), page 19.]

**Reform Model Contract:** “Crisis intervention services include intervention activities of less than 24-hour duration (within a 24-hour period) designed to stabilize an individual in a psychiatric emergency.” [Section VI (B) (4)(i), page 97.] “The health plan shall operate, as part of its Crisis Support/Emergency Services, a crisis emergency hotline available to all Enrollees twenty-four (24) hours a day, seven days a week.” [Section VI (F), page 106.]

There are no provisions specifically requiring MCOs to cover any of these specific forms of crisis services defined in the model specifications.

### 2) Limited numerical standards to ensure MCO networks have adequate numbers of providers

**Issue:** Access to primary care and specialist providers is a concern when MCOs are permitted to limit access to specific providers within a network. MCOs also hold the potential to improve access if their networks expand the number and types of providers available to Medicaid beneficiaries.

**SAMHSA/GWU Model Specifications:** Defines requirements for provider networks with respect to: 1) composition of the network; 2) Measures for sufficient numbers of providers; 3) access to out-of-network providers if the MCO network is insufficient; 4) provider credentialing; and, 5) provider requirements and payment. [see § 205, page 68.]

**Reform Model Contract:** “The Health Plan shall have sufficient facilities, service locations, service sites and personnel to provide the...Behavioral Health Care described in Section VI.” [Section VII(A)(1), page 114.] “The Health Plan shall have at least one (1) certified adult psychiatrist and at least one (1) board certified child psychiatrist (or one (1) child psychiatrist who meets all education and training criteria for Board Certification) that are available within thirty (30) minutes average travel time for Urban areas and sixty (60) minutes average travel time for Rural areas of all Enrollees.” [Section VII(E)(1), page 118.]

The model contract addresses critical requirements for provider networks, but often in a minimalist manner. In particular, the requirement of only one certified adult psychiatrist and one child psychiatrist raises questions of adequacy in meeting the needs of Medicaid enrollees. For example, current enrollment in one reform plan exceeds 35,000 individuals.

### 3) No requirement for MCOs to provide services consistent with national mental health treatment guidelines

**Issue:** Given the focus on improving quality and ensuring all individuals have access to the highest standard of care, various efforts have been undertaken to articulate for treatment professionals guidelines for how to treat various conditions. Adherence to nationally-recognized standards can ensure consistency of treatment and can be a way to ensure that physicians and others incorporate the latest professional standards.

**SAMHSA/GWU Model Specifications:** Requires MCOs to furnish or arrange the covered services (defined elsewhere in the contract) to enrollees with behavioral health needs in a manner consistent with one or more of the following:

1. International Association of Psychosocial Rehabilitation Services (IAPRS), *Practice Guidelines for the Psychiatric Rehabilitation of Persons with Severe and Persistent Psychiatric Disability in a Managed Care Environment*
2. International Association of Psychosocial Rehabilitation Services (IAPRS), *Referral Guidelines for Psychiatric Rehabilitation*
3. Agency for Healthcare Research and Quality (AHRQ), *Depression in Primary Care Clinical Guide: Detection and Diagnosis/Treatment*
4. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*
5. American Psychiatric Association, *Practice Guidelines for the Treatment of Psychiatric Disorders: Compendium*
6. International Classification of Disease

(Separate guidelines are provided for substance abuse and co-occurring diagnoses.) [see § 107, page 39.]

**Reform Model Contract:** There is no reference to national or international treatment guidelines. The model contract requires MCOs to adopt practice guidelines that, “are based on valid and reliable clinical evidence or a consensus of Health Care Professionals in a particular field,” and meet other requirements. [Section VIII(B)(8), page 143.]

While MCOs could use the treatment guidelines referenced in the model specifications, MCOs could also choose to develop or adopt other guidelines that may not be consistent with other MCOs in the pilot project or with national treatment standards.

### 4) Incomplete enrollee safeguards for persons with mental health treatment needs

**Issue:** In addition to ensuring that MCOs meet their responsibilities to provide high-quality, medically necessary covered services, MCOs should also be required to take steps to protect enrollees from harm and protect their rights to secure all of the covered services they need. This issue is especially important for conditions such as mental illnesses which can be highly stigmatized and which raise unique concerns related to the health and welfare of enrollees.

**SAMHSA/GWU Model Specifications:** Describes safeguards with respect to: 1) confidentiality in disclosing data including safeguards related to alcohol and substance abuse treatment data; 2) unnecessary inquiries (related to inquiries into the existence of disabilities in violation of the Americans with Disabilities Act); 3) due process; 4) designation of enrollees as intended third party beneficiaries (to protect enrollee rights to enforce the terms of the contract under state and other law; and, 5) Other rights including requiring health care treatment facilities to comply with state law requirements related to restraints and seclusion and state consumer protection laws. [see § 210, page 88.]

**Reform Model Contract:** The model contract contains some of the requirements of the model specifications related to confidentiality safeguards. This includes requiring MCOs to comply with the privacy and security requirements of the federal Health Insurance Portability and Accountability Act (HIPAA) and some other confidentiality requirements in federal law (including 42 CFR 331 Subpart F). The model contract, however, does not appear to reference compliance with other federal law requirements related to alcohol and substance abuse treatment data (found at 42 CFR Part 2). [Section (X)(C)(z), page 159 and Section (X)(F)(1)(b), page 165]. The model contract also requires MCOs to comply with numerous due process standards related to grievances and appeals, and the Medicaid Fair Hearing process [Section IX, page 145]. The model contract does not appear to address the other recommended safeguards with respect to unnecessary inquiries, designation of enrollees as intended third party beneficiaries, and other rights.

The model contract does not appear to include heightened enrollee safeguards for persons with mental illnesses.

## 5) Incomplete protections to ensure continued access to medications in emergencies and on discharge from an institution

**Issue:** Prescription drugs have become central to the management of many disabilities and chronic conditions commonly experienced by Medicaid beneficiary. This is especially the case for people with mental illnesses for whom inadequate treatment and treatment interruptions can lead to relapse and negative health outcomes.

**SAMHSA/GWU Model Specifications:** Defines the duty of MCOs to cover drugs under the state plan or on the Medicaid formulary; contains a provision prohibiting the substitution of generic drugs when a behavioral health provider participates in the MCO's network and indicates that substitution is inappropriate; requires the MCO to ensure that a 72-hour supply of drugs is provided when there is an emergency medical condition; requires the MCO to dispense an adequate supply of prescription drugs until their next scheduled outpatient visit when an individual with behavioral health needs is discharged from an inpatient hospital or residential treatment center; and requires MCOs to dispense mental health drugs consistent with Medicaid law requirements designed to protect persons with mental illnesses . [see § 105, page 30.]

**Reform Model Contract:** The model contract has several positive pharmacy access provisions, including a requirement that protects against generic substitutions when the prescriber determines this is inappropriate. Consistent with the Henandez Settlement Agreement, the model contract also requires MCOs to prevent unreasonable delays or reductions in dispensing prescription drugs. The model contract does not, however, appear to contain requirements for a 72-hour supply of drugs in an emergency and does not require that a supply of drugs is dispensed on discharge from an inpatient facility. [Section (V)(F)(14), page 65.]

The contract's discharge planning requirements require, however, that a behavioral health program clinician provides medication management within 24 hours of discharge. This is not as protective as requiring that an individual is discharged with a short-term supply of drugs, but it should ensure that a problem accessing these drugs is flagged within a short period of time. [Section (VI)(I)(5), page 109.]

While the model contract has many positive prescription drug provisions, additional requirements may be needed to prevent treatment interruptions for persons with mental illnesses.

This document supplements the briefing paper on Florida's Experience with Medicaid Reform entitled, *Florida's Medicaid Reform Pilot Programs: Challenges with Mental Health Services*, which may be accessed at [hpi.georgetown.edu/floridamedicaid](http://hpi.georgetown.edu/floridamedicaid). For additional information, contact Jeffrey S. Crowley at [jsc26@georgetown.edu](mailto:jsc26@georgetown.edu).

*The Medicaid Reform Health Plan Model Contract, 2006-2009 (October 2007)* can be accessed at [www.fdhc.state.fl.us/Medicaid/medicaid\\_reform/provider/draftcontracts.shtml](http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/provider/draftcontracts.shtml).

*Optional Purchasing Specifications: Adults with Behavioral Health Needs*, George Washington University School of Public Health and Health Services, under contract with the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), 2001, is available at [www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/newsps/adultbhs/](http://www.gwumc.edu/sphhs/departments/healthpolicy/chsrp/newsps/adultbhs/).

Examples cited are illustrative examples only. They do not represent a comprehensive comparison of the model contract with the model purchasing specifications.