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**NAMI MAINE REPORT
MANAGED BEHAVIORAL HEALTH CARE IN MAINECARE:
A Plea for Caution**

MARCH, 2006

Maine's Voice on Mental Illness

Executive Summary

In 2005, the Maine State Legislature approved a \$10,400,000 reduction in spending on behavioral health services based on the implementation of managed MaineCare. The Department of Health and Human Services was charged with developing and implementing a plan to make these savings. Their preliminary plan was released in December of 2005. It was developed internally by the Behavioral Health Work Group (BHWG) without the input of families, consumers, or providers. That plan includes a timeline for quick implementation, including a sole source contract with Beacon Health Systems and implementation of managed behavioral health care by July 1, 2006.

Although 31 states operate managed care programs for the Medicaid population, just five exclusively enroll people with disabilities, and those five programs are voluntary. There is some evidence that managed behavioral health care does save money, but there is also evidence that it can create additional barriers for people with mental illness and their families in a system that is already fragmented and complex. The research about carving out public behavioral health care for management is consistent – it must be done carefully, with significant input from stakeholders, and, if not properly designed and monitored, can pose serious threats to the health and well being of people with disabilities. A study conducted for the health insurance industry in 2004 found that despite the millions spent on the MCO, overall cost savings in the Medicaid program result from managing the program.

The research also indicates that managed public behavioral health care will fail unless: (1) there is substantial consumer and family input into the development, design, oversight, and continued quality improvement activities of any effort to manage behavioral health; (2) a thoughtful, considered, and slow planning and implementation process; and (3) a full assessment of the existing behavioral health system, its strengths and weaknesses; and the development of a plan that addresses them.

In NAMI Maine's opinion, the state's current plan does not follow the approach suggested by research – it has been formulated without stakeholder input, has a precipitous timeline for implementation, and seeks immediate substantial cost savings.

NAMI Maine recommends the following:

- (1) The DHHS Behavioral Health Work Group immediately add at least two consumer and family representatives as full, voting members and issue no contract, RFP, or other documents that determine the future of managed MaineCare without enough non-advisory input from families and consumers.
- (2) The DHHS conduct an evaluation of the quality of and outcomes associated with Beacon Health Care's (the proposed sole source ASO or MCO) current work in Maine and its work managing Medicaid in other states and, based on this evaluation, consider a full RFP selection process, rather than a sole source contract.

- (3) The DHHS review the results of the state's earlier voluntary managed Medicaid initiative (carried out in the late 1990s) and determine what outcomes were obtained. That they use that information to design a plan to manage MaineCare, all of it, instead of carving out behavioral health.
- (4) The DHHS limit their first implementation of managed MaineCare to one region of the State, selecting a region where there is significant fragmentation and high cost, and use that regional pilot to understand the impact of, benefits of, and best ways to manage Medicaid. Get it right in one area first, before implementing on a state-wide basis.
- (5) The Government Oversight Committee of the Legislature or another external organization should evaluate the implementation of managed Medicaid from start to finish, assessing the impact of the pilot on consumers and families, costs, ease of access, quality of care, health outcomes. Use that information to inform the implementation of and expansion of managed MaineCare.
- (6) Include pharmacy, state hospitals, and other state provided services in the managed plan.
- (7) While the effort to obtain a federal waiver and develop a contract is underway, DHHS should (1) collect data about the financial impact of managed care in other states, the effect it has had on service provider budgets and service provision, particularly those states who have carved out behavioral health care and (2) assess the ability of the current provider system, in the pilot region, to absorb the proposed changes and the shifts in service utilization. Use this information to develop a realistic understanding of what, if any, savings will accrue, what if any assistance providers will need, and present that information to the Legislature with a realistic budget and a revised plan of action.
- (8) Delay the implementation of the project, creating an extended timeline.

Introduction

Under the strain of years of budget deficits and the need to control the cost of state spending, the Department of Health and Human Services (DHHS) proposed managing the provision of behavioral health services in Maine's Medicaid program – MaineCare. This concept was enacted by the State Legislature in 2005, along with a projected savings of \$10,400,000 in state dollars; an additional \$20,000,000 in federal dollars will be lost, and the cost of hiring a managed care company (as yet undefined) will also accrue. At the time the proposal was put forward, there had been four years of reductions to the community mental health care system. The proposed adoption of managed care was an effort to do the least harm by establishing a system that would promote quality and push cost reductions into the future. In December of 2005, DHHS issued a concept paper detailing their plans for managed care in Maine.

Statistics about people with disabilities are: 17% of Medicaid beneficiaries nation-wide are persons with disabilities; they account for nearly 40% of expenditures because of their intensive use of acute and long-term care services. Acute care accounts for 57% of spending; long term care for 43%.¹ Thirty-one states operate programs designed for the general Medicaid population.

Thirty-one states operate managed care programs designed for the general Medicaid population. The overwhelming majority have managed Medicaid for everyone – not just for behavioral health enrollees. Only five programs exclusively enroll people with disabilities and each of these programs is voluntary. Together the five programs represent less than one percent of total enrollment of persons with disabilities in Medicaid managed care programs.² Reports from consumers and families involved in behavioral health managed care arrangements point to serious impediments to care. *Their stories describe how they must now maneuver through a maze of cost-management rules and incentives to maintain what can sometimes amount to an army of health workers involved in varying degrees with their care. For them, managed care plans can thwart rather than facilitate access to care.*³ **Maine is entering a small, select, and unevaluated group.**

Although models are emerging for the management of behavioral health, there is little consensus about the best way of delivering and managing public behavioral health programs or coordinating them with physical health care. A 1996 report from the Institute of Medicine urged caution and additional research.⁴

¹ Kaiser Commission on Medicaid and the Uninsured: Medicaid Facts. March 2001.

² Ibid. pg. 11 NAMI recognizes that these numbers could have changed in the five years since this report was written, but maintains the view that most states managed all Medicaid, not just behavioral health.

³ Medicaid Managed Care for Individuals with Disabilities: A Closer Look. Kaiser Commission on Medicaid and the Uninsured. April 2000. pg. 2

⁴ Managing Managed Care: Quality Improvement in Behavioral Health. Institute of Medicine, Division of Neuroscience and Behavioral Health. National Academy Press. Washington D.C. 1996.

In March of 2006, NAMI national issued its landmark report: “Grading the States: A Report on America’s Health Care System for Serious Mental Illness.” That report gave Maine a B-, making it one of the top five states in the nation. (The average grade was a “D”, and many states received “Fs”.) Of note in that report is concern about how Maine implements managed care: “The state mental health and Medicaid agencies are working on a transition from a cost-based, fee-for-service model to a behavioral, managed care design. It remains to be seen whether the new system for managed care can lead to cost savings without compromising quality. **Significant concerns exist as to the quality of the planning and the timeline for implementation of this significant change.** Advocates fear an undue emphasis on cost containment in the state in response to a study by the Muskie Institute claiming that behavioral health costs are rising much more rapidly than other health care costs. Although the methodology has been criticized, the report has been used by some policymakers to support cutting funds.”⁵

Research on the Impact of Managed Care on People with Disabilities

1. Kaiser Commission on Medicaid and the Uninsured.

According to the Kaiser Commission on Medicaid and the Uninsured⁶, “Throughout the 1990s states have been turning to managed care in an effort to improve access to care and control costs for Medicaid beneficiaries...more recently, states have been attempting the more difficult task of finding managed care options for people with disabilities and chronic illnesses. Proponents assert that such programs have considerable potential to improve the health and functional status of people with disabilities by improving access to primary and preventive care, coordinating and integrating services and encouraging the use of home and community-based alternatives to institutional care.

Nevertheless, if not properly designed and monitored, managed care can pose serious threats to the health and well being of people with disabilities.” The report also suggests that managed care can create incentives to block access to services that are needed by people with disabilities and exacerbate the adverse risk selection in the health care insurance market. These difficulties may be part of the reason that few states manage public mental health care⁷.

Focus groups conducted as part of the Kaiser study were composed of people who had been Medicaid enrollees for many years and their families. These individuals complained that managed care presents a new level of challenges on an already difficult system. They described a system that is inflexible, wastes time and money, and delays their ability to get the services and treatment they need. If they battle the system, they eventually get approval for contested services. However, at times they need advocacy or

⁵ Grading the States – A Report on America’s health Care System for Serious Mental Illness. NAMI. March 2006. page 91.

⁶ Medicaid Managed Care for Persons with Disabilities: Case Studies of Programs in Florida, Kentucky, Michigan, and New Mexico. Regenstein, Schroer, and Meyer. April 2000. p. 1

⁷ Christine Koyanagi. Bazelon Center for Mental Health Law. 2-25-2006. Waterville, Maine.

pay out of pocket for covered services. They also describe less choice in selecting their provider, an enrollment process that is confusing, poor understanding of their options, little care coordination, and delays in service provision. All told of unfilled prescriptions, missed appointments and delayed services because of transportation problems. All told of too little time with their mental health professionals, feeling rushed during appointments, and frequent changes in providers making the development of an alliance difficult.

The key findings of the Kaiser review include:

- Very few studies have looked at utilization of services, outcomes, coordination of care, or overall satisfaction among persons with chronic conditions and disabilities in Medicaid managed care arrangements. Consequently, states wishing to include these populations in managed care programs have little to guide their efforts.
- Most managed care programs for people with disabilities are a one size fits all approach that fails to identify or address the unusual challenges facing people with disabilities in gaining timely access to a wide array of services.
- Health plans are paid through capitation rates that frequently do not reflect the widely varying risk profiles of different categories of enrollees or are not adequately increased over time to account for rising costs. Inadequate rates for people with chronic health needs have resulted in incentives for health plans to cream, skim, and avoid expensive patients as well as to freeze enrollment or withdraw.
- States have not generally held managed care plans strictly accountable for providing people with timely assessments or to use these assessments to determine the needs of enrollees with disabilities.
- Managed behavioral health care recipients experience numerous impediments to access to care which pose serious problems for them. **Virtually all state managed behavioral health programs are plagued by coordination problems within and across managed care plans.**

Based on these findings, the report recommends:

- **Moving slowly**, phasing in managed care requirements in stages, using a period of trial and adjustment. States that enrolled people with disabilities after an open planning process that involved consumers and advocates had smoother transitions, better designed programs, and less resistance over the long run.
- Consumers must be involved at all stages of program development. Ultimately, if the goal is to design a system that works well, saves money, and responds to client needs, consumer involvement is an absolute necessity. Moreover, **if family centered care is to be more than just a slogan, enrollees and their families must be involved in program design and midcourse corrections along the way.**
- Systems must be set up to **monitor the availability and utilization of prescriptions.** Though health plans must have flexibility in determining how to

use resources cost efficiently, there appears to be a bias against services designed to improve the physical and functional well-being of persons with disabilities. Steps should be taken to assure access to these important services.

- States must manage and oversee the plan, and develop standards that protect enrollees. Monitoring must include tracking people with chronic illness, early assessment, monitoring of progress, quality of care, and outcomes, and reporting on performance.
- States that are sensitive to provider needs and anxieties about managed care, historical turf issues, population diversity and other local concerns are more successful. Resolving these issues before adopting a plan will result in fewer problems with implementation and outcomes.

2. *Bazelon Center for Mental Health Law.*

In 1995, The Bazelon Center for Mental Health Law published “Managing Managed Care for Publicly Financed Mental Health Services”⁸ That report notes, **“Installing managed care for people with serious mental illness is a huge and risky endeavor, demanding extremely careful decision-making and sustained, informed advocacy. The real challenge is ensuring that managed care approaches do not result in inappropriate or insufficient services for people with serious mental illness and children with serious emotional disturbance who rely on the public sector for their care.”**

They recommend: (1) blending the advantages of managed care with the strengths of good public systems to create a flexible system of funding, (2) moving from a provider-driven system to one that is consumer driven, (3) shifting resources from politically popular line items like state hospitals to programmatically valuable services like psychiatric rehabilitation, (4) moving from fee for service and under funded grants to stable and predictable funding levels closely allied to real costs, and (5) overcoming the pervasive problems in public mental health systems such as difficulty finding and accessing services, lack of coordination and accountability, and disincentives for rehabilitative community based treatment.

“Managed care can be very good or very bad. Well run managed care appears capable of controlling health care costs without sacrificing quality. Poorly run managed care reduces benefits and results in denial of necessary treatment, while increasing costs in the long run.”⁹ The U.S. General Accounting office describes two factors that affect the success of state Medicaid managed care programs: planning and transition, how much time states allow for planning and execution and oversight, how much effort the state devotes to quality assurance, information gathering and financial review.

States have taken a variety of approaches:

⁸ Bazelon Center for Mental Health Law. *Managing Managed Care*. 1995. pg. iv

⁹ *Ibid.* page 1

- Fully integrated, where all services, physical and mental are included in a single health plan. This approach addresses the mental and physical health needs in a single plan, encouraging provision of mental health services in order to avoid medical costs (research documents that this approach can reduce primary medical care costs). However, it can mean that the MCO allocates inadequate resources to mental health and on primary care physicians, who have poor records of recognizing mental health problems.
- Carve out, where no mental health services are included within the basic managed plan and all mental health care is provided through a separate system. This can mean the creation of a specialized system designed to meet consumers' diverse needs. It can also result in low identification of and lack of appropriate treatment for mental health care needs. It has been known to result in less access to treatment for people with the most severe disorders, as providers respond to the demands of those with less intensive needs.
- Partial carve out, where some standard benefits, like inpatient care and limited outpatient services are covered in the general Medicaid population, but people with more serious disorders who need more intensive services are carved out into a separate managed care plan. This option can guard against the particular problems that managed care poses for these groups or result in two separate Medicaid programs, including separate providers and a lack of attention to recovery. Problems of flexibility, like recognizing that people move in and out of a need for high levels of care based relapse and recovery rates, may affect the transition between two systems or create additional risk – as all people who need intensive services are in one plan and benefits for mental health in the larger plan are generally too restrictive.
- Leaving out people with extensive mental health needs. This approach provides limited, basic mental health services in the general plan, and allows serious and persistent mental illness to continue to be treated fee-for-service and grant funded. In states where a managed care entity will be under funded, this may work. However, again, it places mental health into a separate and unequal system, perpetuating the second class status of people with mental illness and the second class system of care they receive.

Financing decisions must also be made as the planning takes place. For example, will the managed care entity administer the care themselves but shift service delivery responsibility to a community mental health center via a capitated contract? Will they manage information but have no responsibility for credentialing or service delivery? Though most states are hiring private, for-profit managed care companies with experience managing care in the privateer insurance market, some states have created their own public managed care agencies.

For states who are heavily invested in expensive hospital and residential programs (Maine spends 60% of its mental health dollar on these kinds of care), policy makers see a chance to save money, though there is no data or research that documents substantial savings. **Though the Kaiser report, (cited earlier) found 5-15% savings, they were found in programs for non-disabled adults and children, who generally have fewer**

service needs.¹⁰ In general, savings are likely to come from price discounts and reduced use of inpatient care, especially for addiction treatment and treatment for children and adolescents. Bazelon warns that pending federal budget cuts to Medicaid will most certainly have a dramatic impact on available resources. Without affirmative steps to ensure that mental health receives a reasonable allocation of funds, capitated managed care plans cannot succeed.¹¹ Failure to assure adequate funds will result in heavy alternative costs.

Based on their assessment, Bazelon recommends the following:

- Consumer and family involvement in the design, implementation and evaluation of the managed care plan.
- Protection of consumers rights.
- Provision of a comprehensive and appropriate array of services.
- Access to community services, implementation of strategies to limit involuntary treatment.
- Appropriate structuring of the managed care system, i.e., integration with physical health care delivery.
- Recognition of the changing role of public agencies.
- Resolution of financial issues that could undermine the system.
- Quality assurance and the use of outcome measures, and
- The establishment of standards for managed care organizations.

3. *Institute of Medicine*

Like the reports cited earlier, the Institute of Medicine¹² review of managed behavioral health identified possible benefits and possible problems, concluding that there is not enough evidence and research to tell us if managed behavioral health care works or how best to implement it. They noted: “The most unusual aspect of the care and financing system for behavioral health care services is the presence of a distinct and substantial publicly managed care system that serves as a safety net...as well as other factors which are not simultaneously present in any other substantial sector of the health care system.”¹³ Much of their findings and recommendations are similar to those of the studies cited earlier and recognize the need to protect against service denial and added barriers to access which can result in “undertreatment and neglect of some of the most vulnerable citizens.”¹⁴ In support of managed behavioral health care they indicate that there is “some evidence that supports the ability of HMOs to control the costs of behavioral

¹⁰ Ibid. pag. 10

¹¹ Ibid. page 11

¹² Managing Managed Care: Quality Improvement in Behavioral Health. Institute of Medicine. National Academy Press. Washington, D.C. 1996

¹³ Managing managed Care: Quality Improvement in Behavioral Health. Pg. @-3

¹⁴ Ibid. pg. 1-5

health care and that specialty behavioral health companies and other approaches to managed care lower costs compared with the costs of indemnity insurance plans.”¹⁵

They also found one study that showed people with serious and persistent mental illness in prepaid managed care plans developed new functional limitations over time, whereas those receiving care through a fee for service plan did not. Also, that “each subsequent layer of subcontracting draws an administrative fee, which reduces the funds ultimately available for direct services...and that insufficiently planned applications of private-sector managed care models in public-sector systems that serve men and women with serious mental illness and chronic substance abuse are unlikely to be successful.”¹⁶

4. *NAMI national*¹⁷

In 1996, NAMI national evaluated the impact of managed care on people with serious and persistent mental illness. Their report found that treatment dollars were being cut, hospital care reduced, and that the industry failed on nine measures: scientifically up-to-date treatment guidelines, adequate hospital care, availability of alternatives to hospital care, ready access to medication, suicide attempts recognized as medical emergencies, consumers and family members involvement in care, patient outcomes measures, access to rehabilitation services, and stable housing. NAMI called for congress to probe how managed behavioral healthcare handles people with serious and persistent mental illness and to consider legislation that would protect their needs. They also: recommended the development and implementation of quality standards, a study of the impact of managed Medicaid on people with serious and persistent mental illness, and the inclusion of core NAMI measures in managed care contracts.

5. *America’s Health Insurance Plans*

In July of 2004, The Lewin Group prepared a report, “Medicaid Managed Care Cost Savings – A synthesis of fourteen studies.” (None of the states or studies reviewed were behavioral health only programs and many were managing only recipients in urban areas not all Medicaid recipients). In addition to confirming information contained in the studies already cited (the need for consumer input into development, the fact that most states manage a broad Medicaid population) the report found that in most cases, states saved money and improved beneficiaries’ access to services. Most of the savings were attributable to decreases in inpatient utilization and pharmacy. Although they identified the fact that MCOs cannot collect pharmacy rebates like Medicaid can, they maintain that savings can be made – and recommend including pharmacy in any managed care effort. The report notes that rural managed care is more difficult because there are fewer providers and difficult economies of scale.¹⁸ This is an important message for Maine to consider. The report concludes that managing Medicaid generally results in a decrease in

¹⁵ Ibid. pg. 2-1

¹⁶ Ibid. 2-8.

¹⁷ Stand and Deliver: Action call to a failing industry. September 1997

¹⁸ Medicaid Manged Care Cost Savings: A Synthesis of Fourteen Studies. The Lewin Group. July 2004. p. 5

spending on inpatient services and increases in spending on rehabilitative, home based, and other outpatient services. In Texas, the MCO itself cost two million dollars, but also saved millions.¹⁹

Maine's Plan for Implementing Managed Care

In December of 2005, DHHS released a concept paper outlining how it intended to implement managed behavioral health care by July 1, 2006. This paper was developed by the Behavioral Health Work Group (BHWG), composed entirely of employees of the DHHS, without consumer representatives, provider representatives, or any stakeholder outside of the Department. The timeline included in that paper indicates that a draft contract with an MCO (managed care organization), will be started January 3, 2006 and a contract will be released in the winter of 2006, with vendor selection completed by spring. The plan describes a complete carve out – all behavioral health services in Maine's MaineCare program will be managed by a private for-profit managed care organization (MCO).

The goals of moving to managed care are stated as: (1) to make services individually centered and family focused, based on recovery and resiliency, (2) to allow each individual or family to direct his/her/their services, (3) to provide effective and individualized treatment services, (4) to deliver services in a culturally responsive and respectful manner in the least restrictive manner possible, (5) to base service planning and management on strengths and in consultation with family, caregivers, and others, (6) to assure services are accessible, accountable, of high quality, and well coordinated, (7) to provide an array of services including early intervention, treatment, community support, and activities that foster recovery, (8) to focus care on increasing consumers and families abilities to managed life challenges, and (9) to ensure continuous quality improvement.

The adoption of managed care is designed to: (1) improve access to care, (2) coordinate funding and make funding more flexible, including a single billing system and consistent data collection, management, and reporting, (3) provide a single assessment process and a single service plan in all settings, (4) establish uniform program standards, measurements, performance expectations, and family and consumer outcomes, (5) assure easy access to appropriately credentialed behavioral health providers, assure continuity of care and timely transitions, and (6) meet state, judicial, and federal mandates.

The plan calls for three phases. Phase One will begin July 1, 2006, at which time an MCO will be in place to manage mental health and substance abuse service provision to MaineCare recipients. All current services (residential, rehabilitative, crisis, and so on) will be included. In Phase Two, which will last between July 1, 2007 and June 30, 2009, behavioral health services in the Departments of Education and Corrections will be added to the managed care system. At that time, there will also be an attempt to include vocational, housing, TANF, sexual assault services, prevention, early intervention, transportation, and public health clinics into the managed care program. Phase Three,

¹⁹ Ibid. pg. 20

July 1, 2009 and onward, will be a time of maturation, adjustments, and a search for additional funding streams.

The 80,000 individuals who use behavioral health benefits under MaineCare will be involved in Phase One as well as those who receive behavioral health through grants, block grants, or other state funds. All current behavioral health providers will be able to provide care in Phase I, as long as they meet requirements. MaineCare psychiatric pharmacy will NOT be managed, nor will state provided services including Intensive Case Managers, Riverview Psychiatric Center, and Dorothea Dix Psychiatric Center.

The following roles are also described:

DHHS: will develop and maintain a statewide behavioral health plan, write and manage grants, develop a quality strategy which includes performance and outcome indicators, set capitation rates, develop and maintain service definitions, assure consumer and family input, provide medical and clinical leadership, assure the use of evidence-based practices, monitor fraud and abuse, and oversee licensing and certification.

MCO: will provide financial management, deliver training, contract for and monitor service delivery, be responsible for client and system outcomes, assure consumer and family input, enroll recipients of service, address legal issues, establish a database, provide utilization management and predictive criteria, provide interpreter services, handle grievances and appeals, handle claims management, billing, and payment, respond to fraud and abuse, meet regulatory requirements, and implement and maintain provider credentialing.

Consumers and Families: be involved in all aspects of contract development, oversight of the MCO and its providers, identify unique barriers and solutions, and advise the DHHS and the MCO about how to improve mechanisms for obtaining consumer involvement.

Additionally, information disseminated about the plan since the concept paper was published indicates that the current plan is to sole source contract, not issue an RFP. Beacon Health Care, which has been assisting the Department with their gatekeeper role, is the MCO that DHHS intends to hire.

NAMI Maine Conclusions and Recommendations.

NAMI Maine recognizes the potential positive impact of implementing managed care in MaineCare. The possibility that services could become less focused on high-cost restrictive care and more focused on recovery-oriented, community-based rehabilitative and preventive care makes a move to managed capitated care worth an attempt. The promise of ease of access, quality oversight, and cost effectiveness is also appealing. Nonetheless, **there is no evidence that any managed care effort in any other state, has achieved these promises**, though there are multiple versions of managed care operating in over 30 states. And, there is evidence that poorly done, managed Medicaid can be

harmful and result in increased costs. In addition, we have serious concern about the financing of this plan. In addition to the lost of an additional \$30,000,000 in programmatic funding, there is no way to estimate the additional administrative costs associated with hiring a for-profit management company. We believe this will remove substantial additional dollars from a system which has been significantly reduced over the last five years and which continues to have long waiting lists for care and a lack of community services that keeps Riverview Psychiatric Center from releasing or accepting citizens who need that level of care

What is clear from the limited existing research on managed Medicaid is that few states carve-out behavioral health care, and those who have experience difficulty, including, the family and consumer perspective that **managed care creates a system that is more difficult to navigate and has new layers of bureaucracy.**

NAMI Maine's conclusions and recommendations are:

- 1. The state has failed to involve family and consumers in the planning for or early design of the managed care effort.** The Behavioral Health Work Group (BHWG), which benefited from a review of other state's efforts about what works and what does not, and which drafted a preliminary plan had *no* family and consumer representation. In fact, the group had *no* external stakeholder involvement at all. Given that this preliminary plan was released in December, and called for a contact with a managed care organization to be drafted in January and implemented by early spring, implies that there is no real plan to involve families and consumers, despite national research that shows managed care is often unsuccessful without early, substantial, and ongoing involvement from families and consumers.
Recommendation: The BHWG immediately add at least two consumer and family representatives as full, voting members. No contract, RFP, or other documents that determine the future of managed MaineCare must be developed without enough non-advisory input from families and consumers.
- 2. The decision to go sole source lacks evidence to support it.** A decision to hire Beacon Health Services may be wise. But, without an evaluation of their experience managing Medicaid in other states and their work in Maine – including focus groups or surveys of families and consumers who have received services under their management – a sole source contract is unwarranted. There must be some evidence that they are doing a good job and that the customers they serve are satisfied, before a sole source contract should be considered. **Recommendation:** Conduct an evaluation of the quality of and outcomes associated with Beacon's current work in Maine and its work managing Medicaid in other states. Consider a full RFP selection process.
- 3. The decision to carve out behavioral health is potentially harmful.** The majority of states who manage Medicaid, manage all of Medicaid, not just behavioral health. We believe the decision to focus on controlling the cost of services for people with mental illness and substance abuse problems, rather than examine the delivery of and cost of all care in the Medicaid program is stigmatizing, short sighted, and potentially harmful. This separation is harmful both to the continued provision of adequate services for people with behavioral

health needs and to their holistic treatment. The historic separation of mental health and substance abuse from general health care has contributed to poor physical health outcomes for people with behavioral health diagnoses, lack of parity in insurance coverage, failure of the primary care system to recognize and treat behavioral health, resulting in delays in early identification and treatment. One reason stated for the merger of the former DBSA into the larger DHHS was the recognition that mental and physical health were one and should be holistically treated. This plan ignores that. Recommendation: Review the results of the state's earlier voluntary managed Medicaid initiative (carried out in the late 1990s) and determine what outcomes were obtained. Use that information to design a plan to manage health care. Manage MaineCare. Choose one region only, selecting a region where there is significant fragmentation and high cost, and use that regional pilot to understand the impact of, benefits of, and best ways to manage Medicaid. Get it right in one area first, before implementing on a state-wide basis.

- 4. It is unwise to implement managed care without establishing an external monitoring mechanism that can inform us about its impact and outcomes.** There is currently no external monitoring of this plan. DHHS will set it up and hire an MCO. The cost of hiring a firm to manage care as well as the need for real information about its impact calls for external evaluation. Recommendation: Have the Government Oversight Committee of the Legislature or another external organization evaluate the implementation of managed Medicaid from start to finish. Assess the impact of the pilot on consumers and families, costs, ease of access, quality of care, health outcomes. Use that information to inform the implementation of and expansion of managed MaineCare.
- 5. Leaving state provided services out of the plan could shift care provision to those services as a way for the managed care organization to save money and increase profits.** The current plan leaves state provided services out of the managed plan. Evidence suggests that managed care organizations shift care to those non-managed services in order to increase their profits. This could mean that the managed care company focuses on pharmacy, intensive case management, and state hospitals, as they will be the only services for which the MCO is not responsible, and which are not included in the capitated rate. This could produce the opposite result of what is desired - a shift away from more restrictive levels of care and pharmacy, to preventive, recovery oriented service categories. Recommendation: Include pharmacy, state hospitals, and other state provided services in the managed plan.
- 6. Expecting to save \$30,400,000 through managed care may doom the success of the effort.** Research about successful managed care indicates that is not premised on savings, but rather, it is guided by a commitment to quality, access, and improved outcomes. Starting Maine's program with a thirty million dollar reduction in cost is unwise. There are new costs – the cost of hiring the managed care organization that have not been assessed. Nor is there an understanding of how the existing service system will need to be expanded when fewer people are hospitalized. We believe this is a recipe for failure. Recommendation: While the effort to obtain a federal waiver and development of a contract is underway,

collect data about the financial impact of managed care has been in other states, the effect it has had on service provider budgets and service provision, particularly those states who have just managed behavioral health care. Assess the ability of the current provider system, in the pilot region, to absorb the proposed changes and the shifts in service utilization. Use this information to develop a realistic understanding of what, if any, savings will accrue, what if any assistance providers will need, and to present the Legislature with a realistic budget and a revised plan of action.

- 7. The Phase One start-up date of July 1, 2006 should be delayed.** There is compelling evidence from existing research on the implementation of managed Medicaid that careful planning and substantial input from affected stakeholders is crucial to a good outcome. There has been little involvement of those stakeholders and little time between December and March of 2006. There are gaps in the information we need to move forward. Recommendation: Delay the implementation of the project, creating an extended timeline. Plan to have an MCO within the next 18 months, in Maine's most populous region, with the largest number of providers and the greatest fragmentation. Plan to manage all of MaineCare in that region, not just behavioral health. Collect the data needed to get started, including what service gaps and overlaps are expected. Collect the process and outcome data needed to measure the impact of implementing managed care, including cost-benefit. Use that information to plan to expand to other areas or not.