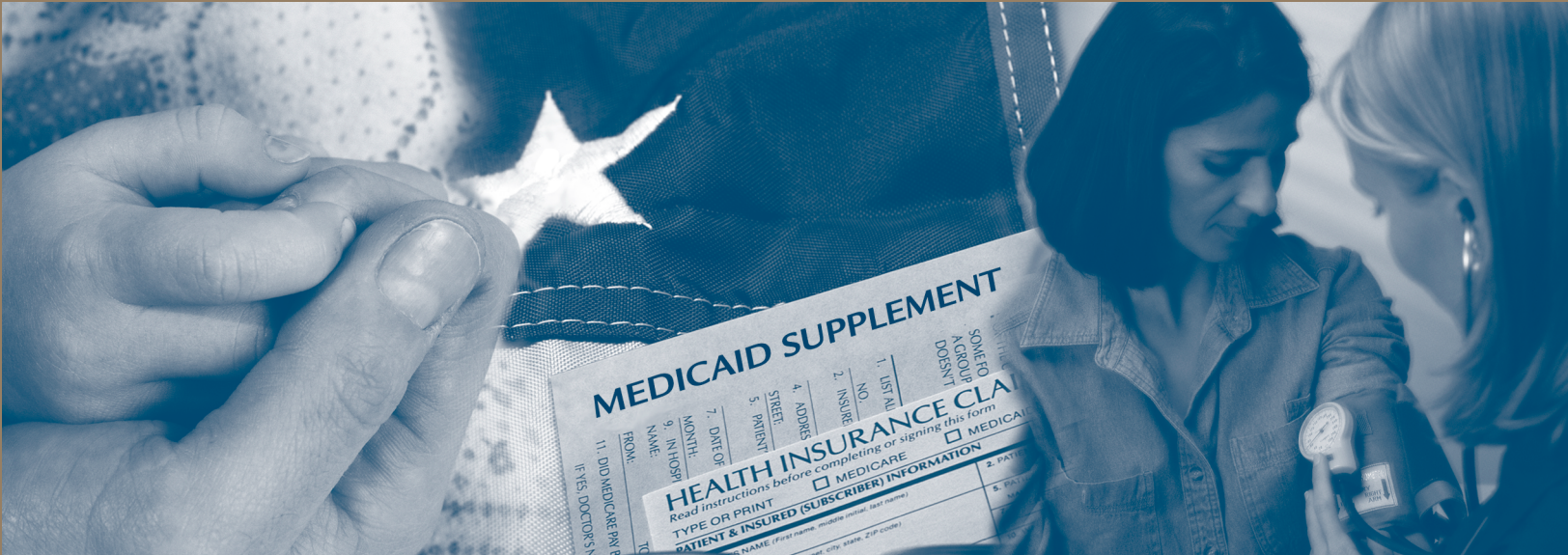


# Moving Medicaid to Managed Care in Georgia



Tenth Annual Rosalynn Carter Georgia Mental Health Forum  
May 19, 2005

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# Opening Remarks

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Rosalynn Carter

Chair, The Carter Center Mental Health Task Force

Managed care is coming to Georgia's Medicaid population. We all agree that this is a high-risk endeavor, and we are concerned about it. The important thing now is to make it as successful as possible. There is no doubt that something has to be done about the Medicaid program in our state. Its proportion of the state's budget is too large. And there is a possibility that managed care could be an improvement of the system we have now — there have been successes in other states — but there is also the possibility that it could be a failure. Today we will hear from national and local experts about lessons learned — successes and failures. We need to be open to the potential for improvement, but we also have to be vigilant. All of us have an interest in making sure that the transition is successful.

We have been told that managed care, if implemented effectively, not only can help contain costs but actually can improve mental health care. It is not, however, a panacea,

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***Managed care is coming to Georgia's Medicaid population, and this is a high-risk endeavor.***

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and we are going to have to monitor the situation closely to be sure that those who need care receive it. Are patients with mental illnesses receiving the services and supports they need to enable their recovery? Are appropriate treatments provided? Are they working? Are people working and staying in school? Do they have stable housing? Are

providers' formularies comparable across the state? We have come so far in knowing how to put people on the road to recovery. We must ensure that what we have learned is not lost.

Georgia is in the fortunate position to learn from the experiences of other states. We have been told that these lessons were considered in devising our state's new program. We have to be sure they are reflected in the implementation and in the evaluation of our program as it progresses. We need to develop effective outcome measures so we will know whether or not people's lives are better with this move. That means we have to monitor access and utilization rates. We are going to have to be sure a full array of services is offered. The mental health community here in our state has a big responsibility to be sure that the essential services needed for people who have mental illnesses will be firmly in place under this new system. The move to managed care actually does present us with a new opportunity to take advantage of and to form new relationships and new partnerships with all of the stakeholders working to improve mental health care for our poorest citizens.

*Rosalynn Carter*

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# Why Medicaid Managed Care in Georgia

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Abel Ortiz, M.S.W., J.D.

Policy Adviser, Office of the Governor, Georgia

**T**hank you for this invitation and opportunity to share some of Governor Perdue's vision for health care in Georgia and, specifically, Medicaid managed care.

When I considered coming to work in the state of Georgia, I had a meeting with Governor Perdue. At that meeting, he basically laid out two expectations for the job. These were in the form of a charge for the position and a challenge. The charge for the position was to guide him to do the right thing.

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***The governor challenged me to listen to the citizens of Georgia who are seeking health care.***

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He was very plainspoken about that. He said, "When I say do the right thing, I am talking about doing the right thing for health care for the people of Georgia." He said, "I do not want you to tell me to do the right thing politically, because I have other

people to do that. Your job is to guide me to do the right thing for health care and the people of Georgia." He also said, "One of the ways I want you to do this is look around the state and the country and find the best and the smartest people out there who know about health care, behavioral health, and juvenile justice." He also said, "Find out what the best practices are, find out what the research says is the best thing to do, and let's bring that thinking here to Georgia and get it working for the people of Georgia."

He also challenged me. He challenged me to listen. He said that many times government thinks all of the good ideas have to come from them, and that is a pretty narrow way of thinking. He challenged me to listen to the citizens

of Georgia who are seeking health care, to listen to their struggles, and to determine what needs to happen to make their stories have better outcomes. He challenged me to listen to providers, those who struggle to provide services to people who are low-income or completely uninsured, and he challenged me to listen to decision-makers who make hard



decisions about health care policy in Georgia. In doing this, I have found that Georgia's health care system is very complex and has both challenges and strengths. The challenges we face here in Georgia are our large rural areas where we have a scarcity of providers and we have people living in poverty who are completely dependent on state-funded and federally funded Medicaid or are completely uninsured.

We also have strengths. One is our citizens, who are willing to help each other and go the extra mile to help their neighbors no matter what the circumstances are. Our other strength is that we do have high-quality providers who are not so self-interested that all they think about is what is best for them. We also have very high-quality medical schools and institutions of higher learning that both train and are willing to provide services and willing to do the research we need to make sure that we make the best health care decisions for the citizens of Georgia.

Over the past seven months, I have had the opportunity to spend several hours talking to Governor Perdue about health care — to sit with him and explain what I have learned when I listened, what I have learned from best practices, and what I have learned from the research. I have watched him take that information and work with others to truly try to get to the bottom line of what is the right thing to do. These conversations have not always been easy, because health care problems in Georgia are very difficult. But the goal has always been a healthier Georgia. The decision to implement Medicaid managed care was one of those hard decisions based on the motive of doing the right thing for the people of Georgia. While I acknowledge that not everybody agrees with this decision and not everybody believes that this is the right thing to do, the decision was based on the experience of other states, getting information from citizens on what their needs were, getting information from providers around the state

on what their needs were, and truly evaluating how we needed to improve Georgia's Medicaid health care delivery system.

The decision was based on four goals for health care in Georgia.

The first goal was to improve the status of health care outcomes for Georgia citizens receiving Medicaid. What we know is that Georgians suffer from chronic illnesses that are



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treatable and preventable if people have consistent access to health care providers. What managed care has primarily come to establish is a medical home where Georgians can seek routine and regular care.

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Currently, many Georgians use the emergency room as their primary source of health care, whether it is mental health or physical health, and that is not the best way to ensure good health care outcomes for citizens.

Establishing these medical homes where the doctor and the patient know each other will help improve health care outcomes in general.

The second goal was to establish accountability for access to quality health care. As I listened to the citizens around the state, what I found particularly urgent was the access issue — especially in rural Georgia where there is a scarcity of health care providers and mental health providers in general — and even in urban areas where there, at times, is a scarcity of specialists, particularly in the trauma care area. What Medicaid managed care brings is a standard of access to care. Under our managed care plan, in the urban areas there must be two primary care providers within eight miles of a Medicaid recipient. In a rural area, there need to be two providers within 15 miles of a Medicaid recipient. When you look at the specialty services, there need to be one provider within 30 miles or 30 minutes in urban areas and one within 45 minutes or 45 miles in rural areas. For dental care, there needs to be one within 30 minutes or 30 miles in urban areas; one within 45 minutes or 45 miles in rural areas. As for mental health care providers, there need to be one within 30 minutes or 30 miles in urban areas and one within 45 minutes or 45 miles in rural areas. These standards are designed to ensure access; to create a

statewide provider network for all service delivery types. When this is accomplished, the entire state will have taken a big step forward for health care in Georgia. This is where managed care can really be a positive, particularly for behavioral health, in the state.

The third goal was to create a more efficient way to deliver health care through utilization management. Some might say, “Isn’t that just a fancy way of saying we are going to save money?” In fact, it is. But one of the points I try to make is that there is going to be no rationing of services; there is going to be no elimination of services. What we want is for the patient to work with his or her health care provider to get what he or she needs. As I mentioned, our first goal was to establish a medical home. A medical home applies to both physical and mental health. When patients work with their providers and focus on getting what they need for routine care and preventive care, we can avoid the serious illnesses, or diagnose serious illnesses early, to avoid hospitalizations and visits to the emergency room which are both expensive and very traumatic to patients and oftentimes lead to less likelihood of recovery. When a patient works directly with his or her health care provider on an ongoing basis, that provider knows the patient’s family history and his or her living situation. This will help improve the quality of health care for that patient and will also help reduce health care costs. This is the type of utilization management we want in Georgia’s managed care system.

Budget predictability is the last and final goal on which Medicaid managed care in Georgia was based. In 2005, Medicaid required 43 percent of Georgia’s new revenues. If nothing is done, this number will jump to 50 percent by 2008; by 2011, it will increase to 60 percent. The



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state just cannot sustain this type of growth. Nobody has the expectation that funding will decrease or that we will not have growth, because that simply would be a false expectation. But what we do want to happen is to begin to slow the trend. When you look at slowing the trend, you can look at states like New York and Texas that have both proven that you can slow the trend of Medicaid health care growth and still provide good outcomes.

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***Live Healthy Georgia is a prevention program that promotes smoking cessation, healthier eating, more exercise, regular health checkups, and better mental health.***

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How are we going to control this trend? This is where we look to managed care organizations to help work with patients to efficiently deliver services. They are at risk for doing that, and that is part of managed care. As the state, our job is to make sure that when they are at risk, they still provide the quality services that are needed. Managed care in the state of Georgia is going to be a task of monitoring and management for the state and for providers, consumers, and advocates.

Nobody thinks that managed care is the solution to all Georgia's Medicaid health care problems, particularly in the area of mental health and substance abuse. On the contrary, we expect that there will be bumps in the road. We are going to have to identify problems early and work together with providers and patients to fix these problems and to engage in a constant review and quality improvement with our managed care providers and in our health care system

in general. But because we know that managed care is not the complete solution to Georgia's health care problems, the state of Georgia and the governor's office have other initiatives that are high priorities to help do that. One of these priorities is the Live Healthy Georgia program, which is a prevention program that promotes smoking cessation, healthier eating, more exercise, regular health checkups, and better mental health. There is also an initiative to improve long-term care planning for our seniors. There is an initiative that was recently kicked off looking at reforming how community services are delivered for behavioral health and people with disabilities in Georgia and improving the state's trauma care system. These are the top priorities that the governor has asked me to work on this next year.

One of the things we also recognize in behavioral health, particularly when it deals with the area of mental health, is that many of our most chronic patients and people most in need of mental health services are not going to be involved in managed care because they are not Medicaid recipients and are just uninsured. This is an area where we need to make sure that we place particular emphasis. We know that managed care is not the solution for the chronically mentally ill because, unfortunately, they often fall through the cracks. So we need to maintain safety nets in our communities to make sure that we continue to provide quality care.

# Georgia's Plan

Mark Trail, M.Ed.

Chief, Medical Assistance Plans, Georgia Department of Community Health

I have the task of introducing two significant initiatives — the risk-based managed care initiative and also the disease management initiative — that are going on right now within the Georgia Department of Community Health and

***We seek improved health status, contractual accountability, lower cost through better utilization, and budget predictability.***

affect those who have mental illnesses and addictive diseases.

First of all, it is important to note that this year, had nothing changed in the Medicaid budget, we would have taken 43 percent of all new revenue that was coming into the state, and as Mr. Ortiz pointed out, that actually could go up to 60 percent within five years if nothing changes. If everything continues the way that it appears to be going today, that is the situation we would

face. And it is important to note that that is before the state invests in anything else — such as education, which also has some mandated funding formulas; such as corrections, which has its obvious drivers behind it; public safety; and a number of other things in which we invest in the state government's infrastructure. As Mr. Ortiz pointed out, that is just not sustainable. So what is driving the cost? We have two ways of depicting that, as shown in Figure 1.

If you look at projections for cost drivers in fiscal year 2006, you will see that we anticipated that costs are going to go up in 2006 and future years because we have more people using more services that cost more. On the right side of the figure, are some of the particular categories that are going to grow proportionately, including both the percent and the dollars associated with

that — hospitals being the biggest. Pharmacy is a tremendous cost driver for us as are physician services.

When we talk about price, some say there has not been an increase in our services for a number of years. But we do have some categories of service in Medicaid and PeachCare that do not have controlled prices. In pharmacy, for example, we pay based on a percentage discount off the average wholesale price. That literally does change monthly. So as those prices go up, our costs go up. It is the same way in hospital care. The way that we reimburse for outpatient hospital care, emergency rooms,

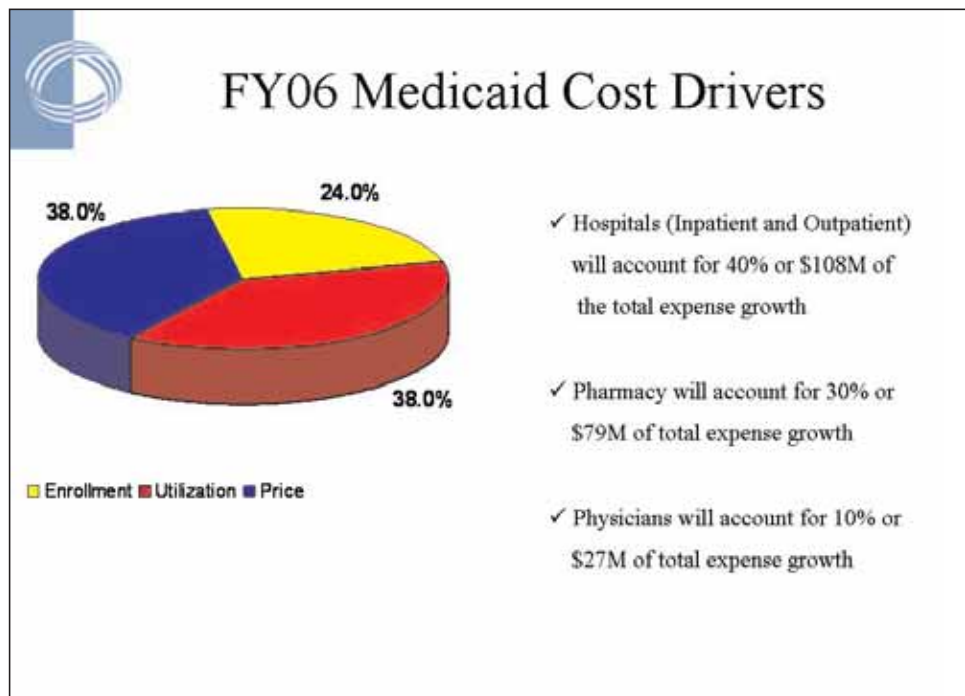


Figure 1. Projected Medicaid cost drivers for 2006.

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and other outpatient procedures is a percent of cost. So as cost goes up, so do our costs as well.

Based on the most recent 12 months of our expenditures in the mental health drug arena, we probably are going to spend a little over \$200 million a year on what would be considered the traditional behavioral health drugs.

Mr. Ortiz outlined several goals of the initiative as it relates particularly to the risk-based managed care, and he very aptly noted that we seek improved health status, contractual accountability, lower cost through better utilization, and budget predictability. Presently, in a fee-for-service world, there is no one that we can hold accountable for health care outcomes. We have very, very limited systems in place to

be able to turn to anyone and say, “You are responsible for making sure this happens; you are responsible for making sure that best practice is followed; you are responsible for making sure that if there are national treatment protocols available for disease states” — and there certainly are for many behavioral health disease states — “You are responsible for making sure that you follow those kinds of protocols.” With a risk-based managed care approach, we will be able to contractually hold someone accountable to work on achieving those kinds of outcomes.

I also will emphasize, though, that the state, to the extent that we have been practically able, has worked very hard to get broad input on the development of this plan. We had a number of conversations that began, actually, during the previous administration. Subsequent to that, we had about 16 meetings with different types of groups, including advocates and providers and other agencies, to get their input on what this should look like.

So what is our plan? It has been referred to as Georgia Cares. The state is divided into six regions (see Figure 2), and we anticipate that there will be two health plans within each of the five nonmetropolitan regions across the state, and then in the metro region, we anticipate that there will be as many as four health plans. A part of our design that may be different than in other states is that we do expect to cover the entire state with risk-based managed care plans. One of the leverages that we think will provide the stimulation to make that happen has to do with this notion of two health plans in the nonmetro areas and four in the metro area. Risk-based managed care for a metro area makes sense. It is easy to develop networks, and you have a concentration of members. In fact, almost half of all the members who will go into risk-based



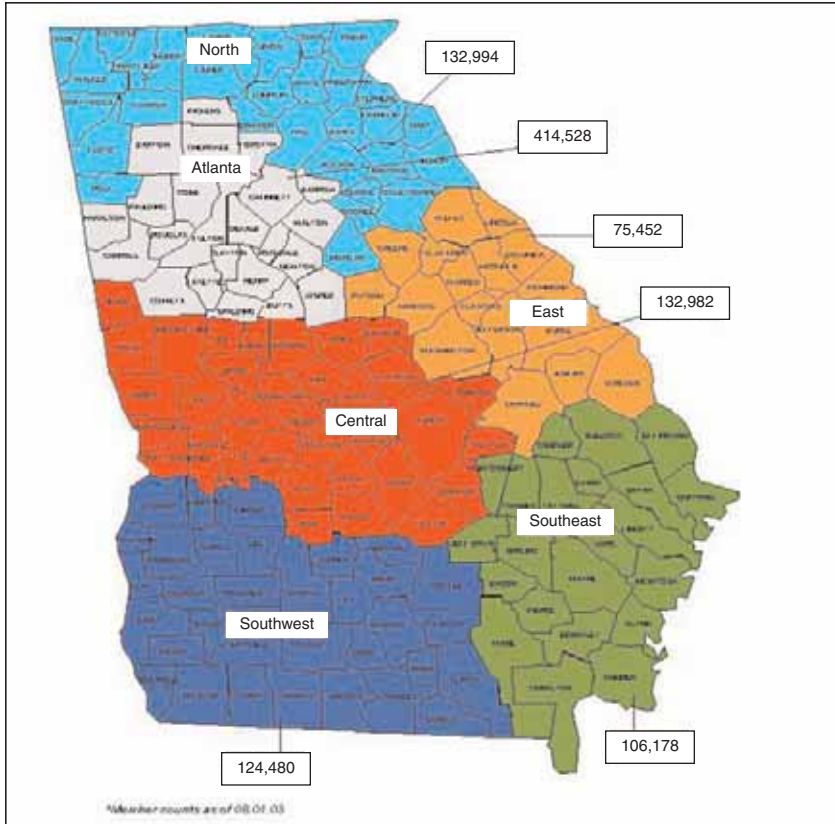


Figure 2. Proposed regions and eligible member counts.

managed care are in this metro region. It is much more difficult to do all those things out in the rural areas—build networks and engage members. In order for an offerer to get into the metro area, it must also have been successfully selected for one of the rural, or nonmetro, areas. So we believe that that will help us as we go forward to make this happen statewide.

We devised these six regions with a couple of things in mind. First of all, we looked at how we could create a sufficient pool of lives to make this program financially viable. Any actuaries that we talk to, as well as conventional wisdom and other research, say that you need at least 30,000 lives in a health plan to be viable, in order to spread risk across its members. So the regions were devised to be able to accomplish that at least. But in addition to that, then, counties were assigned with other considerations in mind: Where do folks go to get their health

care now? What are the health care use patterns? Certainly, as people go forward with this process, there will be problems. It is not a perfect design, but I can say that these regions were devised based on the majority of migration to various health care centers.

It is important to answer the question of “who is in?” We are not talking about people who are in what we would call the aged/blind/disabled groups. For example, people on Supplemental Security Income will not be in the risk-based managed care. So in actuality, the majority—certainly the majority of the adults who have chronic or persistent mental illness or addictive disease—will not be in the risk-based managed care effort. Many of them will be in the disease state management effort, but we will get to that later. Those who will be in are the low-income groups. These are the Temporary Assistance for Needy Families, or TANF, the more traditional low-income Medicaid folks, both women and children, and the RSM groups, or Right from the Start Medicaid groups as we refer to them here in Georgia. Basically, they are some of the expansion low-income groups, some pregnant women and their children primarily. The PeachCare for Kids population also will be in risk-based managed care. And finally, refugee groups also will be in the risk-based managed care organizations.

In regard to enrollment, it will be mandatory for those groups mentioned above. They will have a choice of plans, but being in a plan will be a requirement. That is one of the key differences between this effort and what we attempted back in the mid-1990s. Some have said, “We tried this and it failed in the mid-1990s.” Actually, we did try some risk-based managed care, but there were several factors that we have since

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learned were critical reasons that it did not work. One was that it was voluntary, so at its peak, we had three plans operating within the state, but taken together, all three plans did not have more than about 55,000–56,000 people enrolled. We now know that each plan had to have at least 30,000 lives in order to be viable. Also, the rates frankly were not actuarially sound, which is now a requirement for any health plan.

This new plan will be mandatory. Members will have an opportunity to select a plan. If they do not select a plan, then they will be auto-assigned to a plan. The logic behind that is that computers will look for where they have been getting health care before, who their primary care doctor was before, for example, and then will seek the plan or plans that have that doctor as one of the primary care doctors. That would be one of the first criteria. Other criteria would include where the rest of the family members are, if they are on Medicaid, and what plan they are in. So there is a different

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***We are concerned about how members take their medicine, whether they make their office visits in a timely way, or whatever it is that affects the outcome of the health care.***

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kind of algorithm that gets people into plans. Once they have made a choice, they will have 90 days to decide if they made the wrong choice — the doctor they want to use is not here or whatever the case might be — and to make a change without cause. In other words, they do not have to have a reason if they just want to change. After that, they will be locked into that plan until their one-year anniversary. They will have an opportunity for open choice again on an annual basis.

There are a number of contractual requirements within both the contract and the request for proposals. I wanted to point out just some of them that are most relevant. It is important to know that we will be initiating contracts. The first contract is for one year — that is the way the state works — with renewal options for up to six years after that. But every year of the contract, there is a conscious decision made to renew the contract. When they are making their proposals to us now, they are making the proposals for that full term. In other words, part of what they are bidding to us is not just the design and the quality measures and the assurances, but they are also bidding price to us, so they are going to be bidding that for the next several years. That is where that budget predictability begins to come in.

There are a number of requirements that the care management organizations must meet. They include standards of insurance, licensing, solvency, as well as a demonstrated ability to do the job. They also will have to demonstrate that they have the capacity to provide the services as well as the capacity to accomplish some of the quality measures. Those are requirements and desired attributes.

In other words, if a plan comes to us and describes that they do a certain thing really well, we ask that they give us examples of where they have done it and if they have documentation of how it has turned out. We will ask them, “Did you produce the savings, did you produce the quality measures?” So the offers are being evaluated not just on their saying they can do it but on their ability to demonstrate that they have done it.



who go to emergency rooms instead of their primary care doctors. That is a problem for us and a problem for hospitals because we do not pay the hospitals their full cost. We pay a percentage of cost, but right now it is 84.5 percent of cost. So when a member goes to the emergency room, the hospital is losing money. Some think, well,

There are a couple of points here that are very important about why we are doing all this. Our department has heard from many in the mental health community, as well as many other health care providers, about what is wrong with Medicaid. Some of the issues we have been able to address, some not. One of the things we have heard is that we do not pay enough. From time to time, when the economy is good, we are able to make improvements in rates. It has not happened in the past couple of years, but it has happened. In addition, there are concerns about administrative hassles. Certainly we have gone through a fair amount of that over the past two years with a change to a different fiscal agent, but we are close to getting that worked out and improved, and we actually do hear feedback from providers now that particularly the Web functionality for them is far beyond what most other payers offer.

One of the problems that we have not been able to do much about is member behavior. There is a lot of concern about members

hospitals want everybody to come in. No, they do not. Not our members. They would prefer to see members that at least pay 100 percent of the cost, I am sure. Hospitals would prefer that patients go to the primary care doctor.

Another thing that we hear about members is personal choice in the behavioral health field; we might call it compliance. We are concerned about how members take their medicine, whether they make their office visits in a timely way, or whatever it is that affects the outcome of the health care. We are looking for plans that explain how they are going to engage members, and we are assessing whether what they have proposed and what they have done in other states have been successful and accomplished the desired goals. In addition, we are looking for how the plans are going to motivate the member to use the health care system in what we would call the right way. The most used example is the patient going to the primary care doctor instead of the emergency room, but there are others as

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***We are looking for the use of advance directives in behavioral health.***

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well. For example, a patient who has diabetes should be checking his or her blood sugar regularly — are they doing that, the self-management of their own care? We expect these vendors to offer proposals for how they are going to accomplish those sorts of things.

Let's talk about behavioral health in particular. First of all, the plans are all required to present to us their overall design of how they are going to be providing behavioral health services. It is not part of the initial assessment, but it is part of the negotiation once the apparent winners are selected to provide us with their specific policies and procedures for behavioral health. One of the important features that we have asked for in this request for proposals is for the bidders to spell out how they will integrate behavioral health with primary care. It has been quite interesting to see what has been offered. But in particular, what drove us to include this in the request is that when we look at our claims data, for example, we see that almost half of the people who get selective serotonin reuptake inhibitors (SSRIs) do not go to a behavioral health care provider. They are getting it from either their primary care physician or some other specialist.

It is quite surprising when you look at people taking atypical antipsychotics. Forty percent of the people taking atypical antipsychotics in the Medicaid population do not go to a behavioral health provider. That is quite profound to us, and when we look at things like standards of care, you would expect that a person taking SSRIs would need to be on that medication for some period of time in order for it to take effect. What we see when we look at claims data is a lot of starts and stops. That is bad

care. That was a total waste of money to provide that medication if a patient is only going to take it for two weeks.

We know that this care is being provided in these settings but have not had any sort of organized way to make sure that it is happening correctly, either by consultations or by educating some of these primary care doctors to do some of this care. In rural Georgia, it is not likely that the primary care physician is going to have a behavioral health care provider at his or her disposal for consultation as he or she is seeing someone with a particular behavioral health disorder. So what is it that needs to be brought to the attention of that primary care doctor in rural Georgia to help him or her treat appropriately? We are looking for these care organizations to help us with that.

Another thing that may be cutting edge that we are looking for is the use of advance directives in behavioral health. This is a cutting-edge sort of technology, but when we think of advance directives in the traditional sense, we are thinking about end-of-life care, decisions that are very difficult for families to make. But you have the same kind of circumstance here. When individuals reach a point at which they cannot engage with the health care provider to make decisions about their own health care, they can provide for advance directives. We are looking for the plans to propose how to do this and how they will incorporate this in their care. We did include a requirement that any member can self-refer for the initial visit to a behavioral health provider. We think that is important and will encourage access to care.

Plans must attempt to include certain providers in behavioral health. This applies to several health care arenas, but in the behavioral health side of things in

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particular, they must attempt to contract with CSBs as well as the psychologists who provide care for us here in the state. We call these “significant traditional providers.” On the CSB side, they must attempt to contract with all of them. We did not say they must contract with them, because, hypothetically, a CSB could say, “We do not want a contract with you.” The providers have to make an attempt. They cannot say, “We will contract with you, and we will pay you a

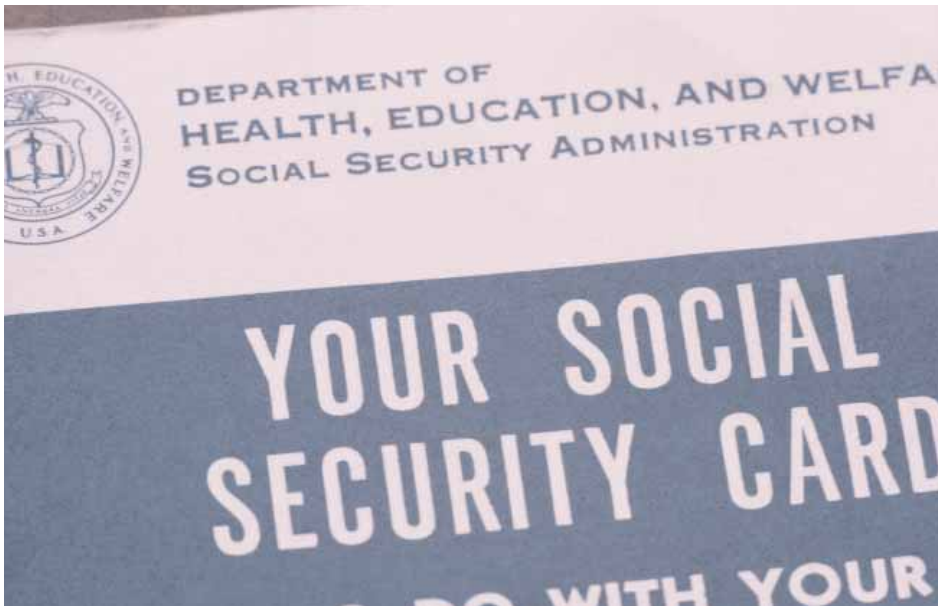
dollar a unit, a dollar per category of service, and everybody else is getting \$50.” They cannot play those kinds of games. It has to be the same deal that they would offer to the same kind of provider somewhere else. They must attempt to contract with the providers that provide up to 80 percent of the care in a category within the region.

With regard to access requirements, members in urban areas must have a provider within 30 minutes or 30 miles. In rural areas, a provider must be available within 45 minutes or 45 miles. In addition, there is an appointment time requirement of no more than 14 days. That is for non-emergency care. If that is accomplished, it will be an improvement from the current situation. I have heard of wait times as long as four to six weeks at some of our provider organizations. So indeed, this is an example of where we will contractually hold them responsible to achieve this. It is important to note that in all of these contracts, there are performance guarantees that have financial penalties in them. We also will hold providers financially accountable for things like appointment times and access.

We thought that it was important as we transition to this that any service authorizations that were granted in the fee-for-service world be honored by the risk-based organizations. For example, any triggers that are authorized for members just prior or sometime prior — perhaps 90 days — to the time they cross over into the risk-based managed care must be honored by the health plan that is taking over for an individual. Another important point is expedited review, another good example of where we will improve over the current system. The health plan must provide within 72 hours a review of any denied care.







We are looking for some other attributes in the plans as well. We have asked them to offer any of their ideas and experience in providing for innovative programs, in particular as it relates to pregnant women or parents who have substance abuse disorders, children and adolescents, as well as limited-English-speaking individuals and members of minority groups. They are to provide to us any sort of innovative programs they would propose here and relate successes they have had in other places.

You may not be familiar with the term “prudent layperson,” but in general health care, we are. Basically, this is a protection in the Balanced Budget Act that says if an individual believes that whatever is going on with their health at a particular point would cause great harm to them, either mentally or physically, then they can go to the emergency room and get care, and the health plan cannot deny the care. This requirement also will be in all of these contracts.

One of our expectations is improved coordination of care. We also are looking for member education. We have placed a lot of emphasis on self-management and a fair

amount of emphasis on evidence-based practices, or best practices. This deals with all disease states, not just behavioral health and not just the traditional ones you see in disease management like chronic heart failure, asthma, or diabetes. It is all potential disease states that might affect the members who are included. We are looking for improved health at a reduced cost. We expect to see case management of all co-morbid conditions. This is one of the rather significantly different features here in Georgia, more so than has been seen in some other states. Our disease

management effort is not going to be to seek out the patient who has diabetes and enroll him or her in a diabetes program or to seek out the patient who has chronic heart failure and enroll him or her there. Our expectation is that the provider will take the individual, regardless of what all his or her disease states are, and develop a care plan and a response for that individual to assist with all of those disease states. That is a salient feature that is different from what most states, or many states, have done in their disease management programs.

We hope to see some improvements come to the state, like an increased use of telemedicine or other in-home devices, through the disease management program. We are particularly interested in emphasizing self-management. Clinical outcomes will be monitored. Our expectation is that outcomes will improve. The performance requirements stated in contracts say that if you do not meet this or that or whatever the standard is, then there is a financial consequence.

Who are the people involved? The primary group involved is people on SSI over the age of 19. They will be auto-assigned. There

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are about 100,000 members on Medicaid today who are SSI-eligible. I am sure everyone thinks that will include a lot of people who have mental health disorders. I fully expect that will be the case. It will be a voluntary program. The question is: How do you get voluntary when you are

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***The provider will take the individual, regardless of what all his or her disease states are, and develop a care plan and a response for that individual.***

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auto-assigning? When the auto-assignment is made, then basically, individuals are enrolled in the program. They will have the opportunity to voluntarily opt out. Once they are contacted by the vendor, and the vendor offers its services, they may say, “Don’t want it; don’t need it; go away, don’t bother me,” and then they will be unenrolled from the program. Children on SSI — those under the age of 19 — can voluntarily opt in. They will not be auto-assigned, but they can opt in should they believe that the services would be helpful.

People who will be excluded — in other words, even if they want to opt in they cannot — are the dually eligible. Obviously, the people who are in care management organizations (CMOs) are receiving disease management. People in nursing homes or hospice care also are excluded and so are those who are a part of a targeted case management program such as SOURCE. There are some other exclusions, such as SSI foster kids and Georgia Pediatric Program. It may not be a program you are familiar with, but it used to be referred to as the “model waiver,” and it addressed children who were oxygen-dependent. We expanded that waiver to include medically fragile children. There are probably about 200 to 250 children on that waiver, but they will be excluded from the disease management program.

What are the services? One of the first things we expect is that the disease management organization (DMO) will stratify members. Once a plan is selected, we will give them the data, they will get all this claims data about the individuals who are enrolled, and then they will analyze that data. They will stratify the members based on acuity factors—things like diagnoses included, prescriptions used, other health care services used—and cost. It is our expectation that the people who are in highest risk levels will have a very direct, targeted kind of care plan. We expect to see a very direct touch to assist them in getting connected with their personal care provider. If they have contraindications on the drugs they are taking, whatever the issues might be, there is going to be a very direct touch in the care plan developed for them. Other people with lesser needs may get more generalized services, like education. This is where you might see some of the things seen in more traditional disease management programs like educational brochures, outbound calls to the member, those sorts of things.

Providers are going to benefit in a number of ways. We expect the DMOs are going to make some of these national standards and best practices easily accessible and a “quick read,” if you will, for the providers and also help them keep abreast of any changes that may occur in some of the best practices. In addition, they are going to be giving providers profiling information. Sometimes people may have negative thoughts about profiling in that it somehow is more controlling or used to be punitive. Our expectation in these contracts is that the plans will use profiling to help raise the bar. We have been told by a number of provider groups that profiling is helpful when you compare peers to peers, that maybe physicians are some of the most competitive

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among their peers, and simply showing them the picture helps to raise the bar. We are hopeful that is the case; we certainly have been told that. It also is important for the providers—particularly the primary care provider—to get a profile of the member. A lot of times, they do not know about all the other health care the member is receiving. They may not know all the other medications that the member may be taking. So the profiling of the member back to the personal care provider will be very helpful to them. Other services include things like case management, both direct face-to-face as well as telephonic. We expect that any successful offerer will provide a 24/7 nurse call line for advice. In addition, vendors are proposing other value-added services that they believe would make them the better candidate to be the provider here in this state.

We will have only two regions in this program rather than six. Remember, we are dealing with about 100,000 lives; I do not know if it falls exactly 50-50 on the north

and the south, but roughly, the state will be divided into north and south. The vendors must achieve certain quality standards as well as savings. Budget and legislative watchers will remember that it was around \$59 million. It was in the upper \$50 million range that the state Medicaid program must save as a result of this program in fiscal year 2006, so it is fairly aggressive savings. Vendors are bidding the savings that they believe they can actually accomplish, and we are hopeful it is as much as the budget requires, but we do not know that yet until we open the bids. The important thing for us to know here is that they also will be held contractually accountable for achieving those savings. If they do not achieve the savings that they bid to us, then their fees will be reduced proportionate to whatever amount of savings they do not make.

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## Questions and Answers

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**Q.** You are doing a lot of things all at once here. I was interested that you mandated the geographic access requirements for the managed care program but only asked for suggestions about how to make sure that there were culturally and linguistically appropriate services available to the Medicaid clients. Have you had any thoughts about tightening up that requirement or ensuring the availability of services, specifically mental health services, to individuals who are not English-speaking or from cultural groups that require special attention? You can imagine a Vietnamese client in Waycross being in some difficulty if there is not specific provision made for his or her needs.

**A.** There is that anticipation. I referred to innovative programs in behavioral health that would be culturally relevant. In another part of the RFP, they are required to submit to us their cultural competency plan, which, as I recall looking at the proposals, are all fairly substantial, so we have the opportunity to evaluate how well they will do that. We do require — and I apologize for not remembering the exact percent — that when there is a certain percentage of individuals who speak one non-English language, then the offerer absolutely must address that. To be able to address every language

when you may have a very small population, of course, as I am sure everyone would understand, is difficult to do. But they do have to provide for it. And each offerer has proposed different ways that it could do that, which will be qualitatively evaluated.

**Q.** Right now you run a very efficient system; your administrative overhead is probably in the single digits for administering the Medicaid payments to the TANF population. You are trying to bid with people whose medical loss ratios are probably in the low 80s, so there is a significant portion of funds now that will be shifted from payments for care to the administrative overhead and profits of the managed care organizations. Can you help us understand how that will save the state money over time without cutting services to clients?

**A.** There are probably several things to include in a response to that. First of all, the state will save based on what the vendor bids, as far as “the state” is concerned. I understand that you were asking the question in the context of “and still get the services that they need.” We do have the performance requirements that they must provide the services that are medically necessary. Do we believe there are a lot of services provided today that are not medically necessary? I think everybody in this room would say yes. The trick is getting to those and getting the right kind of utilization to happen.

To respond specifically to the profit margins and administrative costs, yes, I am actually very proud to say that the department’s administrative cost is in the mid-single-digit range and is very good. From all the reports that we get from the plans that are what you would call really the Medicaid managed care plans, this market has matured; there really are plans that know how to work with the Medicaid population and motivate the members to behave in ways that we would consider good, both in terms of healthy outcomes, self-management, and so forth. But what we understand is that if profits are actually 2 or 3 percent, they have had a great year.

What about the other administrative costs? We believe, have been told, and have seen in some of the studies done that administrative costs for a strong Medicaid type of plan actually can also be in the single digits—maybe an upper single digit. But keep in mind that they are bringing value-added services, as we refer to them, or enhanced services, to the state as a part of that bundle; these are some of the things that we are frustrated with not being able to do, like provide member education. The department has asked for money for member education for a number of years. I think three years ago we got about \$500,000. We have 1.5 million members; do the math. You cannot even buy a stamp. That is a real problem for us, and so we are looking in the proposals for those enhanced services that will be a part of that bundle. It is those kinds of costs that we think, quite frankly, would be better directed toward those kinds of activities that would be referred and captured in that sort of administrative pot. So until we



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open the cost proposals, we will not know exactly, but we believe that this market has matured enough that we are going to find that the things that they will spend money on will be the right kinds of things and maybe some of the very things that we have been frustrated about not being able to do.

**Q.** You talked very specifically about the 72-hour period that plans have to come back and say why someone was denied a service.

**A.** That is expedited review.

**Q.** What happens if someone receives a service and is dissatisfied? Is there a process for how individuals would complain or get satisfaction if they do not think they are receiving the services they need?

**A.** All offerers had to provide their complaints and grievances procedures and, at a minimum had to meet the state requirements. Obviously, we are looking for those that can go beyond that, do it more quickly, and have a reasonable and satisfactory approach to doing it that hopefully produces the outcomes that are needed. All the plans also will, over time, be doing things like customer satisfaction surveys, both for members and providers, and that is new, beyond what we have today. There will be both opportunities for the member to complain and then opportunities for the state and others to monitor how well that process is going.

**Q.** Will the complaints, though, be addressed only to inside members of the managed care identity, or is this a review panel that includes other people? I mean, it is kind of hard to complain to the people with whom you already are having a problem.

**A.** The initial complaints and grievances will take place at the plan. I will tell you that every plan proposes to do that in different way: some with a more public outside kind of involvement, and some with internal peer reviewers or something like that within their organization.

**Q.** Many people have worked really hard to have an open formulary for mental health medications. For the new companies that are coming in, it is my understanding that each one of them will have their own formulary. Do you not see this as a problem, and how will you address that?

**A.** We are requiring all of the plans to provide medically necessary services in the appropriate amount, duration, and scope. It is the same standard, by the way, that Medicaid is held to. For every class in which we cover drugs, they must also cover drugs. For example, they must have SSRI options available. They must have antipsychotic atypicals available. And they must have choices within that. They are not bound—I will just tell you quite frankly, because you all know it anyway—as the state Medicaid program is, to participate in rebates. They go negotiate their own rebate deals, and it is possible that they will have some drugs that are not covered. But keep in mind again that they must provide for medical necessity in amount, duration, and scope.

Let's talk specifically. I am not pretending I am a doctor, but I do understand, for example, in the atypical class, there are some medications that are more appropriate when there are allergies or maybe liver damage is a risk and so forth. But that plan then must provide for that, even though it may not be on their formulary, if it is appropriate for that member because of whatever the conditions are. It is key to know that they must provide products that are appropriate in amount, duration, and scope, and if there is some allergy or something else that they are concerned about that would lead them to a product that would not be covered, they will have to provide for that.

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**Q.** Then is it safe to assume that if somebody has already been on a medication that has not worked for them, they would not have to go on that medication again in the trial period before the company would let them be on the medication that has been successful?

**A.** I think it is very reasonable to assume that. I will tell you some things that we are doing to give them enough information so that they can make those decisions appropriately. They will get claims data back as far as five years—all claims data, both medical and pharmacy—so that they will know whether in fact that is the case. They have had to describe to us things like how they handle their pharmacy and therapeutics committees, how they will establish their preferred drug lists, and who is involved. The responses vary, some actually developing local groups and some using national groups, so obviously as we are weighing that, we will make decisions and score accordingly. But as far as them knowing whether someone has been prescribed a drug in the past, they will all have things like prior authorization processes available, and they will have to have medical criteria that are supportable behind that. It frankly is probably not a lot different from what we do today except the fact that they do not have to cover all drugs from manufacturers that provide rebates, like the Medicaid program does.

**Q.** I am somewhat concerned about this transition, and apparently you have received a lot of really good proposals. My concern about the proposals is this: Will the amount of savings that the managed care organizations plan to achieve be somehow transparent so that we can see what kinds of promises have been made? The second part of my question really has to do with your wonderful administrative staff, overworked as we both know, and their ability to hold the managed care companies' feet to the fire and make sure that they are complying with the requirements. What I am concerned about is this: Do you have enough people to ensure that they are providing the kinds of services that we are promising with this new system?

**A.** With regard to the last part of your question, there will be a changing of staff responsibilities, and in some cases, actually, some employees that do not have the skills that are needed to do the things that you are asking about are going to be let go. Most directly affected, I would say, is the program that we have referred to as Georgia Better Health Care—that kind of has been our managed care program up to this point—and I am not connecting GBHC to what I just said, that anybody in particular is going to be replaced. But the staffing requirements are very much on the forefront for this initiative as well as the disease state management initiative. We are working diligently to hire the staff that will have the skills required to do this and the things that you are talking about—hold people accountable, know what these reports mean when they get them, know how to respond when you are dealing with a contractor, and so forth.

As for transparency around cost savings, there actually is, contrary to myth, nothing that is not subject to open records, and with regard to the ongoing accomplishments of the plans, our board is very engaged. I am quite certain that we will have routine reports going to them, which is a very public forum. I cannot tell you that we have decided that we are going to publish this, that, or the other on the Web site on a routine basis, but I expect we will be doing something like that. There will be public information, over time, about the health plans and their performance, initially in terms of the algorithm I mentioned in assigning staff. If you cannot find any of those other things that I talked about — family members in the plan, whether you have ever used one of the health care providers, any of that sort of stuff — then the health plan that initially has the lower cost will get the auto-assignment as a preference. After we have had time to see the plans perform, there will be quality assessments — whether they are achieving the various measures, including the HEDIS measures, and other contract

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requirements — and that algorithm will change from cost to the quality initiatives. We cannot start that way because it is new here in the state. But those will also be published publicly, probably on the Web site and maybe other ways, for members to be able to look at and say this plan does a lot better than the other plan.

**Q. And this will occur within the year, do you think, or what is the time we are looking at?**

**A.** I think it will occur after a full year of implementation, which may mean that toward the end of calendar year 2007, that we will be prepared to actually start making that public.

**Q. So it will be implemented in 2006, and we will get information in 2007?**

**A.** As far as what I just described, the actual information available for members to select plans and so forth, yes. I do not know at this point exactly what information might be able to be made available as we are going along. I am sure it will be some. As I said, there will be other meetings and reports to boards and so forth that will be public.

**Q. When you spoke to enrollment, you grouped the addictive disease population with the SSI group in the disease management track. Could you speak a little further on how the overall health of those individuals with primary addictive disease or co-morbid addictive disease would be handled in this plan?**

**A.** In the disease management program in particular?

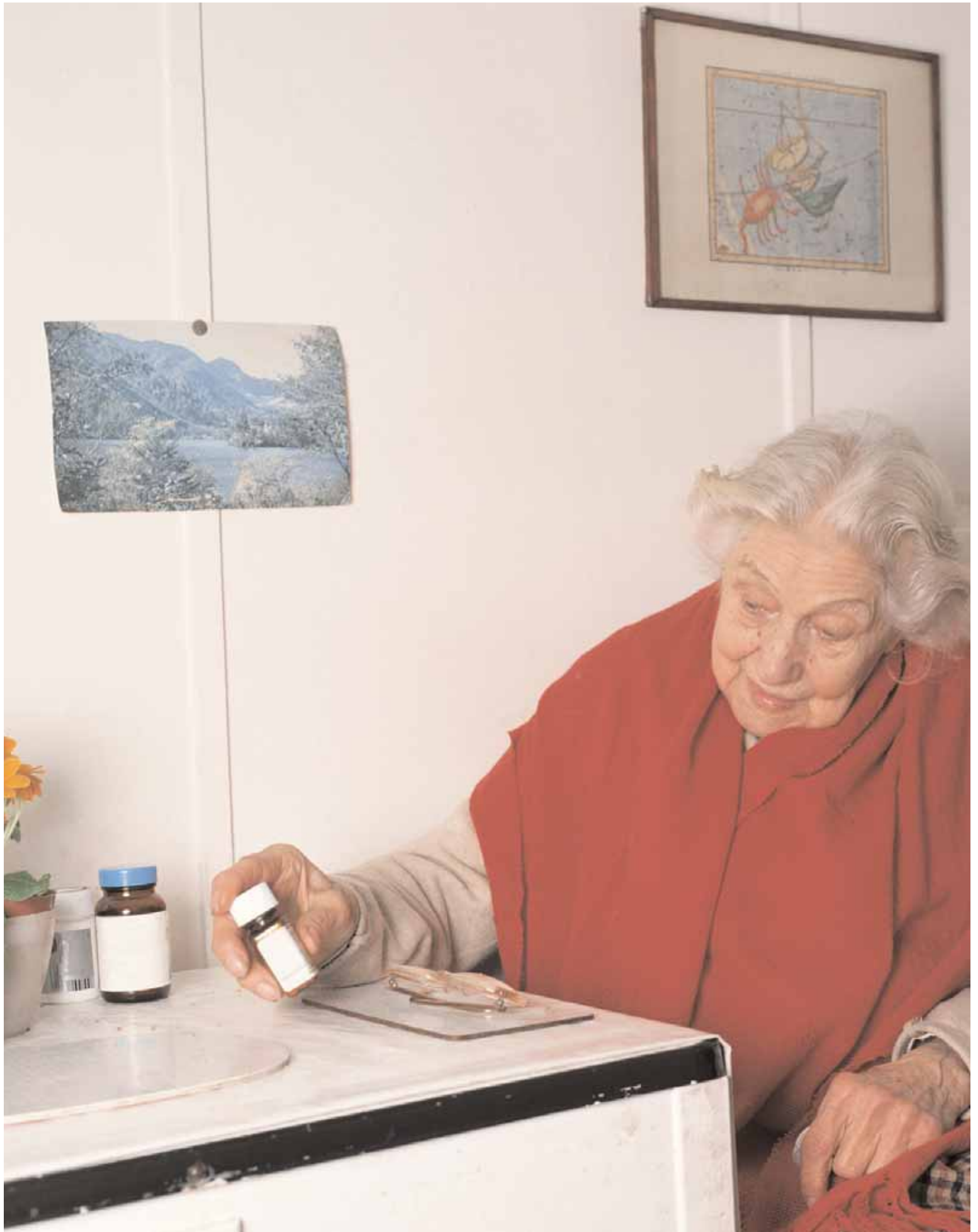
**Q. Is that where they are going to be grouped?**

**A.** Well, if they are on SSI, they will be in the disease state management program, and very clearly we are expecting them to deal with whatever co-morbid conditions exist — substance abuse and mental health and diabetes and whatever it is that is going on with that individual.

**Q. The issues that we currently have are that a lot of people who have addictive disease do not qualify for SSI and then there are reimbursement issues. So I am curious about why they are in that track, but in general, how will this product manage — and maybe they are not going to be in that track — addictive disease and reimburse providers for that?**

**A.** I am aware that a number of folks with addictive disease are not eligible for SSI and not eligible for Medicaid because that is the sole condition that would have brought them to that table, even though they may be quite debilitated by the disorder. I think we will find, unless they have other conditions, that some of those that I mentioned might be in the SSI group and that is what got them there. On the TANF or the risk-based managed care side, we very much believe that we will find folks that have substance abuse disorders. Probably it is going to be because there are more women in that group than men; it is probably going to be some of the moms, maybe pregnant moms, who also have substance abuse disorders. I can tell you that we have asked all of the managed care plans to propose innovative programs. Obviously some are better than others, but we fully expect that we will select plans that can address those kinds of co-morbid conditions as they pop up. Those folks will be on Medicaid not because they have substance abuse or a physical disability; it is because they are just simply low income or maybe pregnant and on for a short period of time.

**Q. So if I could just understand, those with a primary and sole diagnosis of addictive disease will remain uncovered?**





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**A.** I am not sure that I would qualify it that way. We are talking about substance abuse right at this moment, but if someone is in either of the programs and has a problem with addictive disease or substance abuse disorder of some sort, it is our expectation that the plan will address whatever that is, wherever the

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***They have to be concerned about the whole health care cost for the individual.***

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individual is. So it is not, from our perspective, a matter of choosing, well, you have this one we will ignore and that one we will address. The fact of the matter is, and this is a part of the reason why we put these plans at risk or at performance guarantee, that they have to be concerned about the whole health care cost for the individual. So you cannot ignore, in our opinion, something that is as serious as an addictive disease or a substance use disorder and expect that you are going to be able to manage the rest of the care. They are going to wind up in the emergency room over and over and it is going to cost money, or they are going to be complaining about all sorts of other things that they will be seeking care for—you know, it manifests itself in lots of ways. So we do not think they will be able to ignore it, and we will expect them to address it wherever it pops up.

**Q.** I have been having trouble with the way Medicaid says that once you get your prescription, a certain time has to go by before you can get your next prescription. I have been having problems with losing pills, like they fall down the sink. Sometimes I go to the pharmacist and I need a refill, but they say I cannot get my medicine because it is not time yet. I have to come back in a week or something or my insurance will not cover it.

**A.** There is a pharmacy point-of-sale system. In other words, when the pharmacist punches up your name and Medicaid on the computer, he or she will know when the prescription was filled last, and there are notifications built into the system to prevent so-called “early refill.” However, the pharmacist does have the option of requesting prior authorization, or a waiver; it is an administrative review and can be accomplished pretty simply with a phone call. So my suggestion would be a couple things: One is, of course, to know that and tell them, “Look, you know, I lost it and I would appreciate you asking for a prior authorization to get an early refill.” If they are not willing to do that, then my suggestion is to call the customer number on your card, and we will work with you to get it accomplished.

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# Keynote Introduction

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Gwendolyn Skinner, M.S.

*Director, Division of Mental Health, Developmental Disabilities and Addictive Diseases*

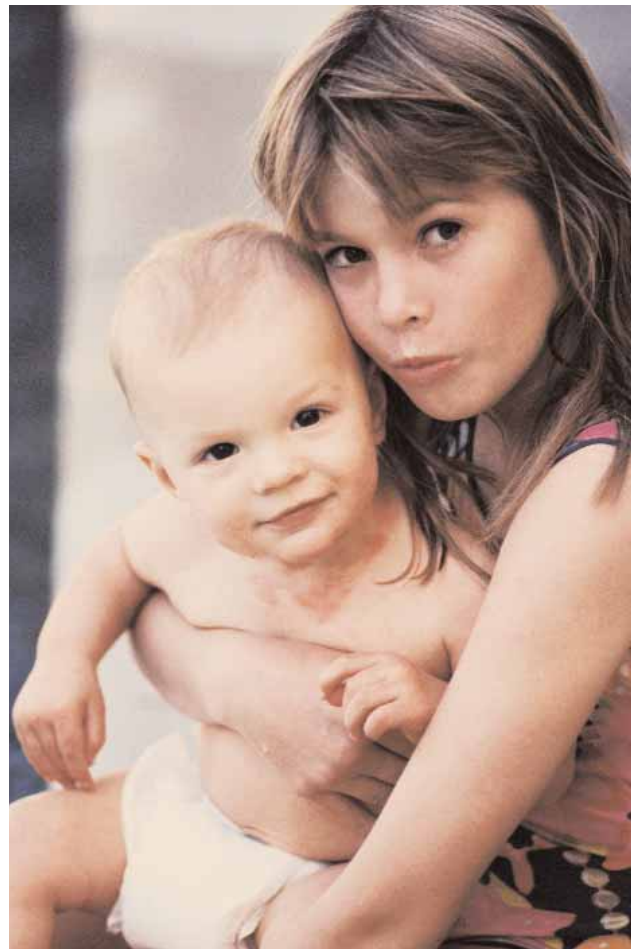
*Georgia Department of Human Resources*

I have had the opportunity and privilege of serving as the state director of the Division of Mental Health, Development Disabilities and Addictive Diseases for the past 10 months. And while it is without a doubt the most complex, tough, all-consuming, frustrating job I have ever had, it is always a privilege to be entrusted with a job that gives you the opportunity to impact others and improve a state system.

The Division of Mental Health, Development Disabilities and Addictive Diseases is changing. Moving Medicaid to managed care, although it is huge, is not our only challenge, and I want you to be aware of some of the things in which we are involved. We are involved in a very large child and adolescent infrastructure grant. We are very hopeful that we are about to secure a mental health system transformation grant. We operate seven hospitals across the state. Those hospitals currently operate as seven individual hospitals, and as our medical director pointed out to me, there is no reason for them to operate independently; we should be operating as a chain so that we can have some efficiencies.

We are changing our contracting process to be more outcomes driven. We are rewriting every policy that we have within the division. We are working on unlocking the waiting list for people with developmental disabilities to receive services and are

making substantial steps in that direction. We are working on developing forensics capacity because if you look at the trends, you know that we do not have adequate bed space. We have a 30-year-old data infrastructure system that we currently received the money to redo. We are working in the area of children and adults in institutions to ensure appropriate use of our most expensive resources. And then we are working on quality and ease of access because I think it is a very complex system that we have developed.



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# Keynote Address: A National Perspective

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Colette Croze, M.S.W.

Principal, Croze Consulting

I am going to talk about what I have seen and observed and what I think we have learned — maybe sometimes we have learned and maybe sometimes we have not — with public-managed behavioral health care. I used to call this my “See the USA in a Chevrolet” speech. I have not given it for a little while, but I have updated it to give you some more current information. One of the things about managed behavioral health care in the public sector is that we have a lot of experience now. We have 15 years of states and counties experimenting with and demonstrating the use of managed behavioral health care in the public sector.

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***We have 15 years of states and counties experimenting with and demonstrating the use of managed behavioral health care in the public sector.***

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We have large states and small states. The organizations those states have used have varied from for-profit managed behavioral health care organizations, not-for-profit organizations,

and hybrid arrangements where nonprofit and for-profit organizations have formed partnerships. So just as public behavioral health systems before managed care showed a great deal of variety, the same thing is true with managed behavioral health care.

The projects I am going to talk about are mostly carve-out projects, and when I say all notable projects have been carve-outs, it is notable because those are the projects from which we have received the most data and the most information. I think there are probably success stories within integrated health plan models, or carve-ins as folks call them. It is just that those have not seemed to rise to the surface, and I will discuss later

why that might be true. Carve-out models are usually chosen when enrollment is mandatory, which is true in Georgia’s plan, and also when SSI recipients are included, which is not true in Georgia’s plan. Your plan is going to focus with the care management organizations on TANF. It is not going to mandate enrollment for SSI. So it is not unusual to see a state choose an integrated health plan model.

We have had a few integrated models that have given us some data. For example, consider the amazing public policy experiment, the Oregon Health Plan. Amazing not because it used managed care but because there actually was a public process to rank and rate disease conditions and then to decide, through that process — plus medical expertise and clinical guidelines — what it was the state would cover in its health plan. That is an unprecedented way to design a benefit. Oregon does have some parts of the state covered with fully capitated health plans, which are health maintenance organizations — Kaiser Permanente, for example, is active in Oregon. But only 5 percent of the Medicaid beneficiaries are enrolled in those capitated plans. The other 95 percent are enrolled in what are called Community Mental Health Programs, which are county-sponsored managed care organizations.

There is New Mexico, which first integrated mental health and behavioral health benefits into a health plan model. That was SALUD. They probably were at this same point five years ago. There were significant difficulties with access and availability of services. The state then required that the



health maintenance organizations (HMOs) carve out services for children with serious emotional disturbance (SED) and for adults with serious mental illness, and they ran a sort of quasi-carve-out program for several years. Now New Mexico actually has just issued a request for proposals (RFP) and is in contract negotiations. They have picked a vendor, but they are going to a statewide behavioral health carve-out that I will talk about a little bit later.

We had some early attempts to use integrated models for plans that covered children with special needs in Connecticut and adults with serious mental illnesses in Rhode Island and Pennsylvania. It is important to note that these states were covering SSI recipients, unlike Georgia. Pennsylvania, as a state, knew that it was purchasing a health plan that included behavioral health and that the estimate of the price of the behavioral health benefit was about \$26 per member per month in capitation payment. That was the money going into the HMOs. Every HMO then in

Pennsylvania carved out the behavioral health benefit, and they carved it out for about \$6 per member per month. The state decided that was not a good return on its investment, and so Pennsylvania is another state that has now moved to a behavioral health carve-out.

We do have some research from the Florida Mental Health Institute, which reviewed 34 states' managed care plans and looked at the features of integrated models, single-benefit packages, and carve-outs. Again, this is for children with SED, so many of these children would be on SSI, although you will find children with serious emotional disturbance in your TANF population as well. So we will talk a little bit later about how you have to look closely at the needs of your beneficiaries and then design a benefit package that meets those needs, because these populations are not totally homogeneous. In other words, you do not just find children with serious emotional disturbance in the SSI population and never find them in the TANF group. But in the

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Florida Mental Health Institute’s review, the carve-outs offered an expanded array of services. They used the medical necessity criteria, which has more of a psychosocial thrust, rather than just a pure medical model. They were more likely to involve families in planning and implementation. They included specialized behavioral health services and gave much more attention to individualized and flexible care. There also was more attention to adequate rates, and they were more likely to include

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***The “true north” of health care is consumers and patients. We have to remember that.***

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performance bonuses or penalties, which thankfully Georgia has incorporated in its model. That is hopefully going to hold

you in good stead as you try to look at the effects of the care management organizations on the system of care.

One of our challenges in the commercial market as well as in the public market, if you think about integration, again, as not being one thing, as not being monolithic, is that there are dimensions of integrated models. While there are lots of other aspects of integration that you could take a look at (e.g., physical proximity), a lot of people try to collocate health and behavioral health benefits in the same clinic. You could look at temporal aspects of integration. I just want to look at four, which are organizational, benefit design, financial, and clinical. What I have seen in at least most, but not all, of the Medicaid managed care plans to date, and maybe Georgia will figure out how to cut to the chase on this, is an attention to organizational integration by having a single contractor who manages the benefit; an attention to benefit design where the behavioral health benefits are embedded in a larger health benefit; financial integration, with a single payment rate,

capitation or otherwise, to a vendor; but not near enough attention yet on how you actually integrate clinical care.

Integrating those first three will not necessarily get you collaborative integrated treatment at the client and practitioner level. So instead of looking at an integrated health plan administrator, integrated benefit package, and integrated financing, what you want to look for in your plan — because you have the potential since you have an integrated model — is benefit management, practices there that actually clinically integrate health and behavioral health treatment. It is really hard to do, as those who are either behavioral health or medical practitioners know.

The way a mental health practice works in contrast to the way a medical practice works is so different that trying to integrate and calibrate those types of treatments is a really big challenge. There is a very smart man over on the health care side who, even though I am in mental health, I try to read because I find him informative. Don Berwick, the founder of the Institute for Healthcare Improvement, is the person who told us that the “true north” of health care is consumers and patients. We have to remember that. He also said we have to stop integrating structures and start integrating experiences, the actual clinical experience, so watch for that issue and try to evaluate your own plan.

Although I talked about some of those comparisons of integrated plans and carve-outs, and for children with SED the carve-outs look better, I think it is possible to have potentially successful integrated plans if the expertise and input of folks who are knowledgeable in behavioral health are used in the design, if there are at least some

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customized design features for behavioral health, and if you keep your eye on the prize, which is integrated clinical care.

If we take a look at the typical practices in the carve-outs, we are going to see some clear similarities between behavioral health carve-outs and health plan models — risk is transferred or shared. So the state, the county, or the purchaser is trying to have someone else help them manage their financial liabilities. In almost all of these systems, Arizona being a small exception, providers are not at risk. It is some intermediary that the state has contracted with that takes risk on behalf of the state; it is not the providers themselves.

Performance measurement is sophisticated. Some of the states have just amazing amounts of data, and they are using it. We sometimes have public systems that have lots of data, but they do not quite figure out how to translate it into information and then into knowledge. Mrs. Carter talked about this as a high-risk endeavor, and I think that is one of the reasons why some of these public systems have gotten so much more serious about performance measurement, data, and quality management — because there are risks with a capitated model. The risk is that your vendor, whether it is a behavioral health care organization, a health plan, or a CMO, will receive a capitated payment just for a person enrolling. If there were no other safeguards, and there are in your plan as well as in other states' plans, the plan could receive the capitation payment and theoretically never provide a service, and they would have met their obligation of enrolling clients. Now, we are much smarter than this in public health, in behavioral health, and in Medicaid health, but that is an inherent risk in a capitated system.

As Mr. Trail told you about Georgia, most of the states that are really trying to use managed care see it is a tool. It can be done well or done poorly, but they use it as a tool to improve their system. They are very clear about tying performance expectations to rewards and penalties. It is a very important best practice within managed behavioral health care.

Someone earlier asked about administrative and profit caps. All of the public behavioral health carve-outs do have administration allowances, medical loss expectations, and profit caps. But as Mr. Trail said, it is very important to remember that what a public purchaser is buying through a care management organization, a managed behavioral health care organization, is something different, some products that they have never been able to deliver before. So you want to make sure not to decide that all administrative spending is bad but that the administrative spending level is equivalent to the expectations the purchaser has for that vendor in quality management, in care management, in member education, and so forth. Blessedly, almost every one of the managed behavioral health care carve-outs has been able to reinvest savings in the public behavioral health system. There were not extraordinary expectations for actually eliminating costs but rather to reinvest those savings into different services that the state had not previously supported.

Not all managed care is created equal, and this is the right time to update one of my old analogies that inherently it is neither Luke Skywalker nor Darth Vader; it is what it is in the eyes of not the beholder but the purchaser. But we have some examples in public behavioral health systems where the use of risk-based managed care arrangements has improved the system. We saw dramatic service expansion in several states, including Iowa and Massachusetts. The way a state

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has been able to expand services is to decrease the use of high-cost services, inpatient hospitalization most typically, and use those services in community-based alternatives. Many of the states actually were able to increase access to services as a result of managed care, which is known as penetration rates.

Even Massachusetts, which was pretty interesting, went into managed care having a 20 percent penetration rate; 20 percent of Medicaid recipients were receiving behavioral health services. But even with that penetration rate, they were able to increase it in the first several years of managed care—just by a couple of percentage points, but still an increase. In some systems, we have seen dramatic increases in self-help and peer support.

I would point out Colorado as a really outstanding example of a system that was able to make dramatic strides there.

In Pennsylvania, there was a significant community investment. What is good about the states that are trying to use money for reinvestment is they actually are trying to push the envelope, so they are moving to more recovery-oriented services; they are moving away from more traditional-based practices and really trying to provide at least better practice.

While we have not seen much real growth in the number of carve-outs or the coverage of the population, there has been some significant activity. The states that have embarked on managed behavioral health care have continued their programs, and you see examples of rebids. On the flip side of



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the coin, in TennCare, we have seen some significant retrenchment with loss of eligibility and loss of services to people with serious mental illnesses. Now I want to point your attention to New Mexico.

New Mexico had previously used an integrated model and then a carve-out, and now it is consolidating the purchasing of all behavioral health benefits. What is interesting, if you think about various

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***Colorado is an outstanding example of a system that was able to make dramatic strides in self-help and peer support.***

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dimensions of integration, is that New Mexico, in its mind, is integrated. What it is integrating is all behavioral health services. So the 14 different state agencies in New Mexico that purchase behavioral health services are now acting as a cooperative. They issued a single RFP. They are now preparing for implementation July 1, when there will be a single management entity that will assist the state in managing the variety of behavioral health benefits the state purchases, regardless of which state agency actually holds the money. This is going to be a fascinating experiment to watch.

What have we learned? The first point is that this all starts with an informed purchaser. In my travels in the 1990s, I would hear a lot of people complaining about this managed care organization or that one and why were they not doing this and why were they not doing that, and I said, well, if you would go look at the contract between the state and vendor, you would get some sense about why this was not happening or that was not happening. So the earlier question about the contracts with your CMOs is very important; you as stakeholders need to know what it is that that organization has committed to the state and what it is the state is expecting.

Price must be in synchrony with benefits and expectations. I call this honest pricing, and I have seen some examples of public behavioral health programs where the list of benefits that were expected, the details of expectations, and obligations that were being transferred to a managed behavioral health care organization were not in synchrony with the price that was set. So it is very important that you have honest pricing and that the care management organization in your case has a reasonable ability to meet the obligations that it has agreed to, based on the price that the state has paid.

Clinical and financial expectations must be aligned and clearly understood. Again, in public sector behavioral health, there should be return on investment, not excessive savings. It represents what it was the purchaser got for the price of the contract, not necessarily the amount of money that the vendor was able to extract from the system. Good programs went into capitation or risk arrangement, where the purchaser really understood the beneficiaries and what level of morbidity and mortality risk that group of beneficiaries carried so that the purchaser could be clear with its managed care organization on a capitation rate that would be sufficient to meet the needs of those beneficiaries.

I think what we have seen in public sector behavioral health, which is no different than what we saw in health care and even part of the reason we had managed care come on the scene, is that all clinical variance is not value-added, that there is inconsistency in the way services are delivered in public behavioral health. Yes, we value individualized treatment, but individualized treatment and supports within the context of evidence-based practice, or good practice.



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The other challenge I think that third- and fourth-generation public sector behavioral health programs have now is to try to “dig under the surface” of managed care, because what we have seen is managing care does not necessarily improve clinical practice. It may change utilization trends; it may mean that we are going to see more services in an outpatient arena than an inpatient arena.

But just managing care may not improve clinical practice. And just to make a big point about the honest pricing, there is no amount of goodwill or managed care technology that can overcome either bad benefit design or dishonest pricing. You just cannot come back from that. And I think in one of your neighboring states we have seen that.

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***The best programs are very clear about the behavioral health benefit.***

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The final point about lessons learned is that change of this magnitude has to be strategically managed by the purchaser, by the state. This is tough stuff. Just saying I am going to have an expert come in who knows about clinical guidelines and who knows how to try to motivate members for self-management is not enough. It really takes a lot of due diligence on the part of the state to make this happen.

What is best practice? I would say the highest performing systems I have seen, though not perfect, are Iowa, Massachusetts, and Pennsylvania. Those were highly collaborative ventures between Medicaid and mental health, drawing on the expertise, different though it may be, from each of those parts of government; folks having to negotiate and find common ground. It was not a slam dunk in Massachusetts that mental health was involved. It was not easy in Iowa to negotiate the Medicaid interests and the

mental health interests for the mental health access plan, which is what Iowa calls theirs.

But they did it, and I think they have a stronger product for it. The best programs are very clear about the behavioral health benefit. They are pretty smart about knowing enough about the beneficiaries, or enrollees, that they have a benefit that can be reasonably expected to produce some positive results. They are moving from traditional services to more evidence-based or best promising practices. I mentioned the expectations around how much of the capitation payment is spent on services rather than on administration or profit, again within reason.

Mr. Trail talked about your care management organizations being encouraged to include the community service boards (CSBs). What has been required in several public systems is that the care management organization (CMO) has had to develop organizational credentialing systems that are different from the kind of credentialing systems they use for private practitioners to accommodate public systems. When that has happened, the purchaser has been able to get a pretty good provider network, but it took some different approaches to credentialing than the norm.

For best practices, there must be adequate reimbursement rates and a sufficient provider network to deliver the benefits. You can write a good benefit in a contract. If rates are inadequate and there is no provider network, there is no benefit. The benefit is only real in the sense that consumers and families can access it and there are sufficient providers to deliver it.

As for best practices, states are now doing the very thing that Mr. Trail mentioned, being very specific about clinical guidelines, getting past the care management process

into the clinical process. What do we want to see happen in terms of clinically treating folks with trauma or co-occurring disorders? Best practice has specific access standards for behavioral health. He discussed what I call the geographic and temporal in terms of the first appointment, but being clear that, again, this relates to the fact that if there is not an adequate provider network, you will not be able to meet the access standards. It is very important that there is a process for the state to know that each of these CMOs has developed and contracted with an adequate network.

It is very important to watch penetration rates: what was it before managed care, what did it look like afterward, tracking denial rates by service. Are there differential practices around easily being able to access one service but not able to access another? Provider payment speed is very important. I have worked with a lot of the states that run the initial overhead, and I know we all want to be ambitious about this. But the first rule

for a managed behavioral health care program, or any managed care, is “do no harm.” And the two parts of “do no harm” are: Consumers can get services and providers can get payment. If that is done early, then you can move to some higher standards of quality and performance and outcomes. It is important to evaluate consumer and family satisfaction and then, in any plan, whether it is an integrated model or carve-out, to have some specific performance expectations with rewards and penalties around behavioral health services.

What has happened in many of the Medicaid integrated models is that when the behavioral health benefit was integrated with health, we lost track of it. We are seen as much more discretionary in the health care field than dialysis, and rightfully so. If you are a health plan trying to address the needs of people with some very serious chronic medical conditions, mental health/behavioral health may look a lot more discretionary. So you have to watch for that in integrated models.

So what are today’s challenges? This is regardless of the model you choose. In trying to figure out how to move again into the clinical process, could we move care management back to the place where care was delivered? That, of course, would be the most efficient approach. We extracted it in the 1970s and 1980s for lots of reasons. Some of it had to do with the variation of medical practice. But can we start looking to actually get back to the place where practitioners were delivering high-quality services, and they could be trusted, frankly, to manage the care in collaboration with the consumer and family as well as deliver it? I think



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it is a challenge, but we need to think about it. We have had a lot of emphasis in public behavioral health on case management. I think now it is time to marry it with clinical management.

Mr. Ortiz said one of the major objectives in the governor's interest in managed care is to have Medicaid recipients have a medical home. We need to think about this same challenge over on the behavioral health side and to make sure that our people have a clinical home that gives that kind of accountability that your state is looking for over on the medical side. We talk about integrating psychiatric and addictive disorders, but we have not really done it as much as we should. Shame on us if we do not figure this out in the next five years at least. We talk about adopting best practices, and I also talk to my clients about eliminating worst practice. We probably know a lot more about what is worst practice than we have consensus on what is best practice, but we need to work on both of those areas.

The challenge is decreasing client and family dependence and increasing self-management. Consumers and families need to be used as resources, not just as folks who are the beneficiaries of a service system. And then, of course, while we talk a lot about recovery and resiliency in public behavioral health, we still have a long way to go in actually operationalizing it and figuring out what kinds of services are best at supporting it and what kinds of services actually make it more difficult to accomplish.

So let me leave you with a few guideposts for Georgia's efforts, whether you are carving in or carving out or integrating or not. I think you can have some features that you are looking for in your health plan: consumers and families as managing partners, recovery and resiliency as goals, and services as a means to those ends. It is not just enough to have lots of services. Significant amounts of services that are delivered are not medically necessary and do not support recovery and resiliency. Those are the ones you have to weed out. The state needs to be a smart purchaser, taking advantage of its collective intelligence, wherever that should occur—Medicaid, mental health, and so forth. CMOs, as the purchaser's agent, are there to do the bidding of the state, and they will walk to the beat of the contract and the performance penalties, so it is important to know what is expected of them. Providers are partners with the care management organization and with consumers and families.

The last wish I would have for you is to use the move to managed care as an opportunity to improve services in the interest of the consumers and families who rely on them. That is why we are committed to this field, that is Medicaid's interest, mental health's interest, and that is the key objective of your move to managed care.

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## Questions and Answers

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- Q.** You said there have been significant decreases in inpatient hospitalization. Where that happened, was the managed care organization responsible fiscally for the state hospital beds, or is this just free-standing private hospital beds?
- A.** That is a good question. In Iowa, as is so often true in our public systems, it is not that clear. It is not even a case of whether it is the state hospital beds or the managed behavioral health care organization because Iowa has a county-driven system, and some portion of inpatient utilization is the responsibility of counties. But to keep it simple for the point of your question, state hospital beds were not included in the capitation rate. Those were managed separately from the mental health access plan, so it was private psychiatric units where the inpatient hospitalization was reduced.
- Q.** My question is along the same lines. Our seven hospitals, as freestanding psychiatric hospitals, are not able to bill for Medicaid services for mental health services, so we will not be able to participate in the provider networks within the managed care organizations. Could you speak to what we can anticipate in terms of utilization for the state public hospitals—negative or positive?
- A.** The rule of thumb is that when you operate a service that is not part of the benefit package, that is not part of the managed system, you run the risk of being the cost shift, just to be very direct about it. There were only two states—Tennessee and Montana—that tried to figure out how to include the state hospital beds. What every state has had to do is figure out what the rules of engagement are between the care management organization and those psychiatric resources that are available, like your state hospitals. But they are not part of the actual managed system of care. So best advice would be to have agreement on, or clarity from your own point of view on, the admission, the continued stay, and the discharge criteria for a state hospital. You should not discriminate against a person because he or she is enrolled with a care management organization, but you should make sure you are using consistent criteria so you are not at the mercy of someone else who wants to use you as a free resource because you are not in the network.
- Q.** Have you found around the country that hospital utilization has increased overall?
- A.** No, because in most of the states I talked about where it is carved out, it was Medicaid and mental health that did the design. They had an interest in using their state hospitals fairly so there were not excessive increases in state hospital utilization in those states. I have not looked at integrated plans, though.
- Q.** What has been the experience across different states that have implemented Medicaid managed care on the uninsured population? One anxiety that we had heard in some meetings with community health centers, which are the safety net providers for the uninsured, is that there would be a contraction in the Medicaid population or a slow growth of that. Has that been borne out in any other states, and are those important issues to build in as safeguards in terms of keeping the existing pool of Medicaid?
- A.** This relates to what Georgia is calling standard traditional providers, or STP. Yes, it has been really hard in most states, even with a lot of effort and attention. And with the federal government putting some constraints on states around federally qualified health centers, trying to keep them in the game has been hard. Those centers have not played a fee-for-service game typically. They were almost always cost-reimbursed centers, either through state Medicaid or the federal government. They have had a hard time shifting, and they also have had to operate differently in order to become a provider that was seen as

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important to the managed care organization's network. In their early days, there was lots of retraction because people had not figured out how to help those centers adjust to being in a provider network run by somebody other than the state or the federal government. I think it has evened out somewhat, but it is a challenge.

**Q.** What about the issue of the uninsured? Is there experience from different states as Medicaid managed care comes in on the overall pool of Medicaid recipients and whether there is any shifting, either from people off Medicaid losing the Medicaid insurance or an increased proportion overall?

**A.** I have not seen any data on folks losing Medicaid eligibility as a result of managed care. I have seen studies where states, especially Massachusetts, have tried to look and make sure there was not what they call "crowd out," that folks were not losing private insurance and having to come on Medicaid. But I am not really an expert on the health care financing side of this.

**Q.** You make a great case for a carve-out model, but you alluded to the possibility that in integrated models, there can be a drift of the percent of premium that is dedicated to mental health over time that some of those dollars might find their way to traditional medical care and away from mental health. Would you talk a little bit about that so people can understand what that means and how that plays out at the end?

**A.** I assume that right now Mr. Trail knows the money going into the CMO pool, the money that is available overall for all six regions, however many plans there will be, and Medicaid spending by various categories, one of which would be behavioral health. The first question is: Is it an expectation that at the end of the day roughly, that same percent of Medicaid expenditures will be spent on behavioral health? That is a question. I think some states have actually wanted to decrease the percentage of money spent on behavioral health and shift that money to health. So the first question is: Is that what the state wants or does not want? And then, is there a way to actually see that there was a reasonable percent of premium spent on behavioral health? I think there are two areas to watch. This is very hard — it is like tracking a block grant dollar; it is very hard to watch the money as it moves through every nook and cranny. But you need to look at access and penetration rates. What was the percentage of Medicaid recipients getting behavioral services, what is it today, and what is it a year and two and three from now in the CMOs? The second thing to watch is utilization patterns. What services were received by Medicaid recipients today, and how does that change or not change over the next three years? Those would be the two things I would look for.

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## Panel of Respondents

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Sharon Jenkins Tucker, M.A.

*Executive Director, Georgia Mental Health Consumer Network*

I will briefly discuss some of the perspectives that consumers of mental health services have regarding this issue of managed care. The Georgia Mental Health Consumer Network has some 3,000 members from across the state of Georgia. I would like to give you a brief history to lay the groundwork for my comments.

Take yourself back in time. It is the third week in August 2004. We are having our statewide conference on St. Simons Island with some 600 consumers from across the state of Georgia attending. Word gets to us that the governor is rolling out a plan to move Medicaid to managed care, and the people attending the conference spontaneously developed a petition that reads, "Governor Perdue: We, the undersigned, petition you not to change Georgia Medicaid to managed care. To do so would be detrimental to our care. Thank you." Hundreds of people signed that petition on that very day, and dozens, if not hundreds, of others who were not able to attend sent petitions in from their home communities.

I do not have to belabor the fact that the petition signed by hundreds of consumers of mental health care services did not derail the train moving Medicaid to managed care. We are very concerned that something so important to us, to our lives, and to our recovery would move forward without much input from us. I wear a button that says, "Nothing about us without us." It is a slogan that has been used by the mental health consumer/survivor movement for many years. You need to talk with us, you need to partner with us, and you need to hear us. We have much to offer you. We have concerns about choice and voice.

We do not feel well-educated regarding this movement of Medicaid to managed care and what our options are. We have concerns about where certified peer specialists, which is one of the really big recovery entities in our state, fit in. What about peer supports? What about other recovery-oriented services? Where do these fit in? We have concerns about what safety net exists for us, what type of consumer protections are in place for us. It is not something that can be a wait-and-see-how-it-goes thing. This is about real people and real lives. We are fearful about the drug formularies. We are not a one-size-fits-all group, and multiple entities with multiple formularies feels like a recipe for disaster. What happened to consumers as experts of ourselves? What happened with us developing meaningful relationships with our clinicians and working out treatment options and medications that work for us and help us to move on with our lives? We must be able to access care and treatments and medications to maintain our wellness and to move forward with our recovery.

Everyone is talking about saving money and managing risk, but we are not saving money if people's lives are negatively impacted and if we find ourselves in crisis, in emergency rooms, and in hospitals. It is not the collaborative recovery-oriented perspective that we deserve, that the system deserves, that everybody deserves. We are asking that you partner with us to ensure that consumers of mental health services get what they need to live the lives of their choosing.

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Anna McLaughlin  
*Co-Director, Georgia Parent Support Network*

I have admired Mrs. Carter's work for so many years and her force and voice for consumers and children and families who have mental health issues. Mrs. Carter said that our charge now is to make the move to Medicaid managed care successful, but I do not know how to make it successful if I do not address my real points of concern. The first one is the risk to state hospitals. Should a consumer be in managed care and be denied hospitalization in a private hospital, the safety net is the state hospital.

I work with children, so all my references are in terms of children. Johnny is taken to the hospital, and his mother asks that he be admitted because he is threatening suicide. He is denied access for some reason through managed care. Well, there is a 72-hour appeal process. In the meantime, Johnny is put back in the car and driven to the state hospital, where the state hospital admits him. Now he is in the state hospital three to five days. Those days add up, and there is a community that is charged with keeping those days below a certain number. Should all the Medicaid recipients who previously had access to private

hospitalization show up at the state hospital, those dollars will come out of community mental health services for people who do not have Medicaid and for people who do not have PeachCare. So the child who has no insurance has lost his safety net because those dollars have gone to pay for the state hospital due to over utilization. I have looked for studies on this in other states and cannot put my hands on any, but it is a real concern to me, and I would feel happier if somebody would address my concerns.

I also am concerned with drug formularies. I would be much happier with the process that we are in if I knew there was a grandfather clause, if I knew that my sister's Risperdal was not going to be taken from her, and if I knew that we were not going to have to have multiple fail rates to get the drugs that work if we already know they are the drugs that work.

Mr. Ortiz said we need to identify the problems early and have a safety net for the severely disabled population. One of my points of concern is that there is no process to open dialogue or communication between the community and the Georgia Department of Community Health (DCH). We do not have an open dialogue format right now, and the community has some concerns that we would like to address through an open communication process with the department. Another concern is about our safety network. Our Department of Human Resources (DHR) has acted as a safety network for the 15 years I have been here, so I am sure it is much longer than that. But DCH does not have open dialogue with the Department of Human Resources. It is a concern to me that the Department of Community Health is going to rely on



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the safety network to help identify problems early, yet there is no existing relationship of communication there.

I have a concern about the continuity of care at the consumer level, and this is probably the bottom line to all of it. What happens if there should be some cost shifting between the DCH and the DHR? How are we sure that the consumer does not get lost? How are we sure that when a consumer is moving from the DHR to the DCH funding pool that the consumer is not the person who gets harmed? Whoever is paying the bill should be irrelevant; what should be important is that the consumer gets continuity of care and consistent quality care.

There are a few things that I would like to applaud. I am very pleased that the Department of Community Health has added an advance directive. Advance directives are very important to consumers, and I would like to thank DCH for making advance directives a mandate for the care management organizations and the disease management companies. I would like to thank them for being sure that consumers could do self-referral. Frequently that step of

having to go through a primary care physician is the one step that keeps people from seeking the help that they need. I would like to thank them for adding performance bonuses and penalties; it is true we do what we are measured on, but we do not really worry about doing what we are not going to get in trouble for.

I would ask for some very specific information because that is what I do a lot. At the start, I would like to ask that we go ahead and form a collaborative that is inclusive of families and consumers that will work with DCH on oversight so that we can quickly catch any kind of potential cost shifting to the DHR. I would ask that we look at sufficient provider networks, especially in the more rural areas. And I would ask that the consumer and family satisfaction surveys be done by a third party, not the managed care organization. Because when the managed care organization is responsible for my care, I may not tell it the truth. And I would ask that the third party have consumer and family involvement. We are at a door that is going to open on us, and I would like to be more prepared than I feel right now when that happens.

Wendy Tiegreen, M.S.W.

*Program Director, Division of Mental Health, Developmental Disabilities and Addictive Diseases, Georgia Department of Human Resources*

This is such a monumental change for the state of Georgia, and with change comes anxiety but also opportunity. We want to talk a good bit about the latter here. I represent the Division of Mental Health, Developmental Disabilities and Addictive Diseases. Personally, because of my parents' jobs, I have been an advocate for mental health almost since birth. Since my professional career began, I have been something of a business manager for mental health services. So I come with both those hats—as an advocate and as somebody who

recognizes what the trends are, where the crunch is, and where the pressures are in the system in terms of the budgetary constraints that are beginning to show themselves on not just behavioral health care but in health care in general.

As a manager of the Medicaid Rehabilitation Option, and our system has been in that role since 1999, we have done a tremendous amount of studying and learning and have really progressed from the elementary understanding of Medicaid implementation to a more advanced understanding. I also



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have watched a lot of struggles with Medicaid managed care around the country and have seen some successes in innovation. I want us to look at this with fair and representative eyes, addressing some of the pitfalls and innovations as we go. I also want to recognize that there are opportunities here as well as challenges with implementation.

Specific to the Georgia mental health system and the state funds that our agency administers as well as the Medicaid Rehabilitation Option dollars that we, in partnership with the Department of Community Health, have administered over time, I think the most important thing that we bring to the table is the concept of recovery. We have become a national leader in the recovery movement, and we actually have a federal resource kit on peer supports that was authored by Georgians that will be released this summer. So we are very excited about having the opportunity to share our experience and our story about the evolution of recovery here in Georgia. We feel like there are still many things to be developed on our path to really mastering how we promote recovery for the people we support. The resource kit is going to have a chapter in it that highlights the partnership between the Medicaid authority and the mental health authority in Georgia.

As I have traveled around the country, people have asked, "How did you come to the place where you work so closely with Medicaid?" Part of it is our long-term relationship with Mr. Trail, who was an administrator in our system in years past. It is with amazement that I watch everybody around the country say, "We cannot even communicate with our Medicaid authority," because we have made such strides with that. And if we have used the kind of language developed on outcomes and accountability and cost-efficiency, all those

business words we use as purchasers, why can't we continue together to shock and amaze the behavioral health field? I think that we can have a groundbreaking partnership again, and while our division does not tout that we are Medicaid managed care experts, we have a tremendous amount of information that we have gleaned over the past few years in managing the Medicaid Rehabilitation Option.

It was during 1999 that we, along with the DCH, purchased the services of an external review organization, APS Health Care. If you are not familiar with external review, ERO is our acronym, and APS Health Care manages that for us right now for the Medicaid Rehabilitation Option. We and the DCH manage that contract jointly. While the implementation of the ERO created what was then felt to be a fair amount of trauma to our system, the ongoing initiative has offered us tremendous information, and as part of that, we have really worked toward some principles of managed care. So I also want to say that some of the principles of managed care are not necessarily ugly or restricting, but we need to understand where there are positive concepts and to work together with the DCH to watch that implementation. Because moving from concept to implementation is where my anxiety is with this initiative.

At the onset of the project, we had a very difficult time with our providers understanding where we were going with utilization and management (UM) and review. We have spent a tremendous amount of time with our provider network working with them on those concepts. Now, all of our core agencies have internal UM procedures. To begin with, our audit process was fairly unstable and performance was low. But at this point, we have achieved an average of 90 percent compliance scores on



audits. So again, we as managers internally in the Division of MHDDAD have really tried to drive the implementation of the philosophy into actual practice. We have spent the last five years reviewing Medicaid utilization and cost trends on a weekly basis, so day in and day out I am looking at data reports and sharing them with our regional system and our providers. We have not achieved

the level of sophistication we want but are at least evolving toward this practice.

We know what an average person in our system needs in terms of types of services based on diagnosis, so we have really begun to move toward being experts and would like to share that expertise. Annually, we evolve the services and supports that we provide to keep up with those trends. We look at utilization trends and discover we are not getting X, Y, and Z that we thought we would, which leads us to redefine things. Again, we have been doing that somewhat as an agent for the DCH and would like to continue to shape that process.

Another essential service, and this is something that advocates and consumers do not think a lot about, is that our office has been responsible for the Medicaid provider enrollment process for the Rehabilitation

Option. So not just for CSBs, which are kind of the traditional providers that Mr. Trail was talking about, but for a myriad of other providers, we look at all their credentials, their policies and procedures, to feel confident that these people are prepared to deliver the services that we want to have delivered. So again, I think that as the new entity begins to talk about provider enrollment and building provider networks, this is an area of expertise with which we can assist.

Throughout this process, we actually have controlled expenditures within the budgeted financial federal participation, so we have been proud of our efforts over the past few years. Again, we have lots of area for improvement in terms of sophistication but have mastered a lot and, in most cases, have what has appeared as a stable system on a day-to-day basis.

However, we have watched, along with DCH, the escalation of other cost centers, especially pharmaceutical costs, and we understand why this move is being made. With that said, there are a few things that I want to highlight in terms of our global concerns. Access is a tremendous concern for us. We love the access standards that are in the RFP—they look fabulous. What we know now, though, is that with the current type of specialty services that we are talking about for children with severe emotional disturbances and adults who live with a mental illness, we do not have really good access to those types of specialty services right now. And so given that, we look at community care support and psychosocial rehabilitation that are very intense and oriented toward adults with mental illnesses. For children, we are extremely interested in how we are going to promote access to that type of service or other types of services along that line that may get developed.

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We heard earlier from Ms. Croze that access is an issue and that, in some cases, the early perceptions are that it gets worse out of the gate, so we really want to be there to figure out how this impacts the people with mental illnesses around the state. Our two departments are probably the largest funders of community-based mental health services in the state, and I am hoping that we can learn from one another's challenges and successes. I also want to reiterate something that Ms. Skinner mentioned, that we are really trying to move forward with a transformative plan for our mental health system with the President's New Freedom Commission on Mental Health.

There are some specific guiding principles that we hope will be adopted. The individualized plan for supports and services that we have begun to implement is called the Recovery and Resiliency Plan. We are very hopeful that we might at least have some dialogue with the new vendors about these principles as a foundation for treatment planning. We agree that consumers and families must be fully involved in orienting the system toward recovery. Finally, the President's New Freedom Commission on Mental Health talks about advancing evidence-based practices. If we share the same provider pool with DCH, then hopefully we can work together toward the promotion of evidence-based practices; we can share providers throughout this process.

There are a couple of fallout issues that already have been addressed. We are concerned about access to the hospital system, and we do have new procurement that is live right now that talks about having admission and continued stay and discharge criteria on the hospital system to try and work with managing fair and appropriate access to intensive hospital services. Adults with mental illnesses continually tell us, and the network continually tells us, that employment is key to recovery. Medicaid does not reimburse for employment services and supports, so how do we work together to promote access to employment services for those Medicaid beneficiaries who may need this service? And for children, we are extremely concerned about the changing eligibility, particularly for the PeachCare consumers for whom one month there is eligibility, another month there is not, the third month there is, a fourth month there is not. We need to work together to ensure that this is a seamless process for the child and family.

But the other thing we are so interested in watching with you is how the disease management approach develops, particularly because diabetes and cardiovascular issues are so intertwined with behavioral health, so it is very significant that we are looking at physical health and behavioral health issues. In fact, we never should talk about them separately. We are really interested to see the information from that process.

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Gregg Graham, M.A., M.B.A.  
*President and CEO, Integrated Health Resources*

This is a tremendously important process that is beginning and will continue on in the Georgia mental health system as well as in the community, because it will impact the community.

Integrated Health Resources is a small, Georgia-based company, that over the years, has done a couple of things. I would like to give you a little history so you know where I am coming from and why I am saying the things that I am. At one point, among other things, we developed at-risk managed care programs for self-funded health plans and health maintenance organizations. Going through that process we learned about managed care and at-risk managed care contracting.



One of the things that seems to be recurrent in this is that managed care is both incredibly complicated but also fundamentally simple. It is simple because it is about managing risk; it is about managing the financial risk and the clinical risk. Having been a clinician, I began to understand that it was about risk management — are the rates adequate for the various kinds of risks, actuarial risks, and so forth — and it began to make a lot more sense.

In Georgia, all the advocates that I have been involved with railed about there not being enough money in mental health. And there probably has not been enough money in mental health services in Georgia over the years. But that is our foundation, and that is where we are starting from. So we are managing against some base, and we have certain goals that we are managing toward, and one of the goals that was outlined today is budget predictability. When we first started providing, or began to develop a managed care behavioral health carve-out for a health plan, essentially they took the premium dollar and identified how much they were willing to spend on mental health, and I can tell you it was not a lot of money. That was the baseline against which we managed the risk, which is an important point we all are concerned about, given where we are starting with the so-called premium dollar in Georgia.

But along the way, I also learned that managed care can offer a lot of benefits. It can help people utilize services appropriately. It can help practitioners or providers adopt better practices. It can collect data. We can interface with the people who are trying to manage the



pharmacy benefits to make sure that those dollars are spent wisely. It can interface with disease management. We previously did something around schizophrenia and also around depression, trying to match that up with how the pharmacy prescribing patterns were going. There were a lot of really innovative things that happened with managed care. We are dealing with managed care companies, hospitals and mental health centers, law enforcement, and the community at large. There are so many complexities in what the consumer, the consumer's family, and the people trying to help consumers get into services have to face. That is a real interesting challenge because we get to see the whole community and how the consumer or those trying to help the consumer navigate it.

The President's New Freedom Commission on Mental Health noted that the complexity of the mental health system overwhelms many consumers. Sometimes I think, "No kidding." It overwhelms all of us. And access is a huge part of that. Consumers have a hard time figuring out how to get to appropriate services. So again, the concern I have about managed care coming in is about access. I know that at this point, it is only for a certain population that is going to be covered, not the entire population of Georgia that is served by the public sector. Access is a tremendous issue because history has shown that as the system changes, access to care can actually get worse in the short run, which potentially will lead to more issues or problems or increased volumes for other systems in the community, like law enforcement and corrections.

Access is not just about what I would call the availability of practitioners. It is true that a system or network of providers must have enough qualified providers of various types, practitioners, and facilities. They need to be geographically accessible in the sense of how far they are from the consumers, and there needs to be an accessibility standard around how soon you can get in to see the practitioner.

I, too, worry about a standard of 14 business days. This is a great standard, actually pretty generous. But given the fact that today it is sometimes three or four weeks, in some cases several months, before we can get someone in to see an outpatient provider, getting from where we are now to there is a concern. I also worry about what I like to think of as the access transaction. In other words, that moment in time when the consumer or family members are trying to access services to enter the system and trying to figure out how to do that. These

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other things are important because that tells them who they can see, how soon they can see them, and how far they have to go, but it is that whole sort of transaction they have. Integrated Health Resources does single-point-of-entry work, so we work with a lot of people in the moment. Again, that is where a lot of people are sort of bumping into the mental health system.

What I worry about with managed care is the incentives that could bump people away from the system more than bring them into

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***We need to look at the process strictly in terms of the consumer having a need and then navigating the system to get a better outcome.***

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the system. For example, if a person is trying to get in to services and runs into a system that might say those services are not medically necessary or that he or she needs a different level of care, my

concern is whether that consumer gets lost to the mental health system and ends up in someone else's system.

Having that first self-referral visit is an excellent idea because it certainly will help that linkage. One of the reasons I advocate for external access, other than it being in my own self-interest, is that I really do think that independent access allows the mental health system to capture data and gain an understanding of what happens when consumers and families interface with the mental health system for the first time, not after they have been enrolled in the system.

Another issue that I have thought a lot about is this whole idea of the provider networks and how soon we will have networks of providers that can produce the array of services that the proponents for the behavioral health plans are outlining in their RFP responses. It will be a good thing

to have broader networks with more services available. But the development of those networks is going to be a challenge, and the development of networks that the consumers can access where the network provider actually understands managed care is going to be a challenge.

We do single point of entry in Fulton and Clayton counties, among other places. We work with law enforcement every day. They have their own mental health systems that are pretty large in some cases. Right now we estimate that there are 900 mental health clients in the Fulton County jail system alone. I do not know how many of those people were Medicaid clients or would have been under managed care if they were on the street, but there is a large body of folks who are being treated in these other systems, and that is going to be important for the managed care process to consider.

The final thing is to put the consumer at the center and look at the process strictly in terms of the consumer having a need and then navigating the system to get a better outcome. A better outcome might not be going to the local mental health center for the next 10 years. It hopefully would be some kind of recovery. So the financial issues and some of the other issues that go along with setting up a managed care system sort of almost push the consumer, or the enrollee, or the member, or the patient, or whatever term you want to use, to the side. But I think it is going to be real important that we figure out some way to keep the system looking at the system, throughout the development of this whole process, through the eyes of the consumers and what would meet their needs.

Joseph Bona, M.D., M.B.A.  
Medical and Clinical Director, DeKalb Community Service Board

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**The key for us is to put a structure together that makes a lot of sense.**

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This is a fabulous opportunity to open a dialogue on managed care and see if we can air some of the concerns and maybe come up with a process that works. I have chosen these four areas to speak about: access, integration, funding, and the potential for cost shifting in partnership. These themes have come up over and over again. It is important to acknowledge that a common thread of themes boils back down to these four issues.

Before beginning, I should declare some of my biases. I tend to be an optimistic guy. I actually believe that while it is raining, there are opportunities. I do believe that the state is on the verge of carving out an opportunity to maybe do things well or maybe to do things differently than have been done other places and learn from those experiences and do something well. That is bias number one. Bias number two: I tend to examine problems using a systems approach (see Figure 3). It is silly sometimes for us to

look at events that maybe happened at the top of the pyramid and say, "Well, why did that silliness happen?" or "How did you ever come to that decision?" without understanding that it is probably the end result of the way a system was put together. Why is that important? Because we are in the process right now of building a structure for what managed Medicaid is going to look like, and from the way we build that structure, we can start to predict how the patterns of behavior are going to affect that structure and how events are going to be handled at the end.

I also came over from the dark side. I used to be one of the behavioral health carve-out owners and managed the Tennessee project, TennCare, when it first came out of the chute. When I say "came over from the dark side," I am sort of doing my penance before I go up to the pearly gates and tell St. Pete I tried to do well with the rest of my career. We took a beating from 1993 through 1995 in the beginning of TennCare and its implementation. And people would say to us, "Well, why did you set up such a cockamamie system? That system makes no sense." The answer is that that is what the state asked us to do, that is what the state put in the RFP, that is what the state paid the HMO to do, and that is what the HMO pays us to do. At the end of the day, I was delivering what I was asked. So the point of the matter is that if we put a structure together that makes a lot of sense, managed care will deliver the end product that we contemplate. The key for us is to put together a structure that makes a lot of sense.

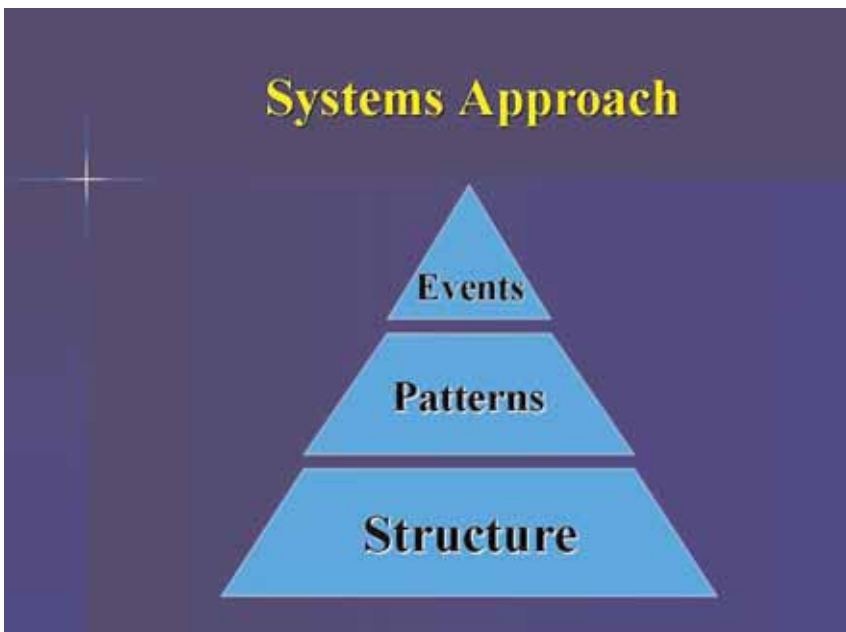


Figure 3. This pyramid shows the importance of structure in health care.

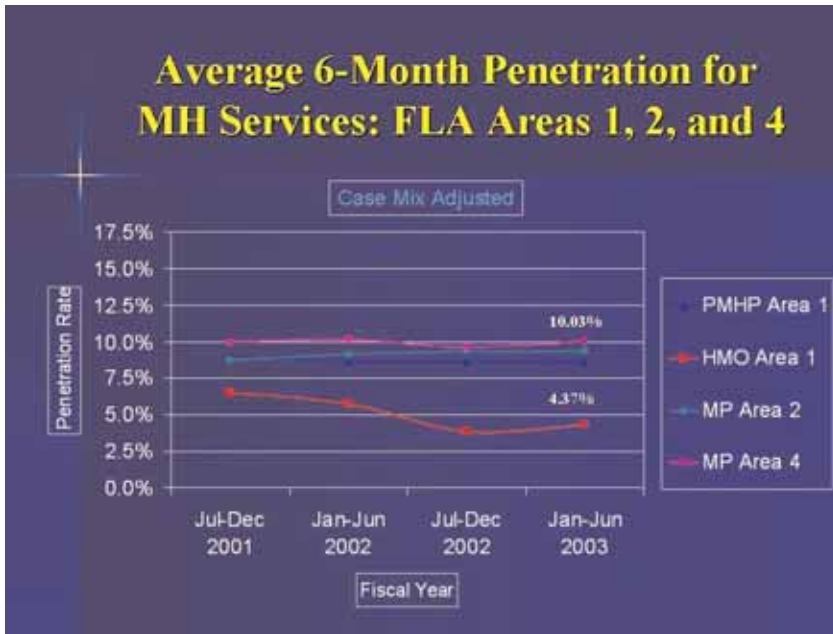


Figure 4. Penetration rates for select plans in Florida.

The third thing I will tell you is I tend to be an evidence-based, data-driven guy, so I am going to toss in some evidence from our neighbor states in Florida and Tennessee.

**Access.** Colette Croze already referred to a Florida Mental Health Institute study. The FMHI group was commissioned by the state of Florida to go back and study outcomes, and they were asked to study a number of important things, including access. Florida is in an interesting place because they have sort of a statewide experiment going on. Some parts of Florida are traditional Medicaid fee-for-services; some parts of Florida are prepaid mental health, which would be the carve-out model; and some are traditional integrated HMOs.

First, when it comes to access, implementation of managed care has not resulted in improved access to services (see Figure 4). So if we look at an average six-month penetration, or the managed care word for the number of members or the percent of members who access services in Florida, there are four different areas and four different concerns: prepaid mental health,

HMO, an unmanaged Medicaid plan in one area, and an unmanaged Medicaid plan in another area. What you will notice is that in the HMO model, penetration is significantly below all three other conditions. Why is that? HMO executives might say, “We squeezed out a lot of inefficiency; people did not really need these services right in here.” If you talk to a bunch of consumers and advocates, they are going to say, “The HMO has put up barriers to access.” I am not going to guess at the answer; I am just going to tell you that an integrated HMO model has been shown in other places to cut down access, in terms of penetration, to services. It is not just about penetration of services.

It turns out that the University of South Florida’s FMHI was able to show that enrollees are receiving fewer services and less intense services in the managed care condition and that HMO enrollees receive fewer services than people in the prepaid mental health plan (see Figure 5).

The important thing is that this is a case-adjusted mix. What that essentially means is that FMHI looked at cases that were adjusted, meaning that they looked at patients with schizophrenia in one plan, second plan, third plan, and fourth plan, adjusted by diagnosis and intensity of illness. So what that essentially does is allow you to compare apples to apples. You cannot say, oh, well maybe the HMO patients were healthier than the fee-for-service patients. It tells you, no, we are comparing apples to apples. The results show that in any HMO condition, less was spent per member per month in health care, or adjusted patient, as compared to the carve-out model and fee-for-service. If you then add in mental health services that are delivered in a primary care doctor’s office and then substance abuse services, the direct cost of mental health



**FLA PMPM Standard Costs by Category:**  
(Case Mix Adjusted)

| Expenditure Category                                 | HMO 1          | PMHP 1         | FFS            | FFS            |
|--|----------------|----------------|----------------|----------------|
| Carve Out Mental Health                              | \$16.64        | \$23.86        | \$29.36        | \$30.71        |
| Mental Health Services in the Health Sector          | .86            | 4.71           | 4.02           | 3.22           |
| Substance Abuse Services Paid by MCO                 | 1.08           |                |                |                |
| <b>Total Non-Pharmacy MH/SA Expenditures in Plan</b> | <b>\$18.57</b> | <b>\$28.57</b> | <b>\$33.38</b> | <b>\$33.93</b> |
| Pharmacy   | 13.47          | 21.01          | 23.94          | 20.09          |
| Fee for Service MH Services Outside of Carve Out     | 2.69           | 5.46           | 5.72           | 5.31           |
| Fee for Service SA                                   | .14            | 1.51           | 1.67           | 1.16           |
| <b>Total Mental Health</b>                           | <b>\$34.87</b> | <b>\$56.56</b> | <b>\$64.70</b> | <b>\$60.49</b> |

Figure 5. Expenditures for mental health care for select plans in Florida.

care to individuals, case adjusted, patient by patient, it turns out that integrated HMO models spend significantly less.

It also turns out that in HMO models, a percentage of premium gets contracted, and so consumers who need mental health care often get less care. Whether that is integrated or carved out, it often means they are going to get less care. If you add back in pharmacy, fees for mental health services outside the carve-out, and then total fee for services paid out of pocket for substance abuse services, you find that the bottom line is that in the HMO condition, less dollars are spent on mental health, and this is not because the patients are more healthy, because again, this is case adjusted.

Another example of problems when we talk about access to medications, in Florida, people with schizophrenia enrolled in HMOs are less likely to receive atypical antipsychotic medications. Access to atypical antipsychotics, again case adjusted, is only 60 percent for folks in HMO, where it is 76 and 73 percent for prepaid mental health and traditional Medicaid fee-for-

service comparatives. In the state of Georgia right now, in the Medicaid population and in the grant-in-aid population, access to atypical antipsychotics is about 70 percent, maybe a little bit higher. I know in DeKalb County, it is about 74 percent. So we already are above what might be a problem in terms of accessing atypical antipsychotics in the HMO condition, and we already heard some people talk about the formulary being at risk to the CMOs, which certainly would be one concern. Data suggest that in an unstructured sort of setting, HMOs tend to reduce the access to atypical antipsychotics.

As part of that study, then, you might ask the question, “Well, what about those consumers who have schizophrenia who are at low risk for being sick, and maybe have never been sick before, versus those at high risk for being sick?” And it turns out that you can stratify the data very clearly. Patients who are at high risk for schizophrenia have a 79 percent greater likelihood of missing more than 60 days of medication in a year. Clinicians know what that means; it translates into inpatient hospitalizations. On average, those patients, those consumers, are off their atypical antipsychotic medications about 14 days per month, which is half of the time. So that is a significant lack of adherence in that population. This is the group that is most likely, in the HMO condition, to be admitted to the state hospital, primarily because of poor adherence to medications.

**Integration and Fragmentation.** It turns out that HMO business arrangements in Florida have been accompanied by greater instability and complexity in organizational arrangements. The Agency for Health Care Administration subcontracted to eight CMOs. We know there probably will be four

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CMOs or so in the Atlanta region, but there are probably going to be more than that across the entire state, so this is not too unlike what you might expect in the state of Georgia. Those HMOs, then, subcontracted with a number of behavioral health carve-out organizations—Magellan, United Behavioral, Horizon, Well Care, APS. Some did direct fee-for-service arrangements with providers, which would be community mental health centers, our CSB equivalents, and other network providers. Other organizations did specialty arrangements. It is a very complicated deal, each organization having its own authorization process, its

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***A rule of thumb in managed care is that the managed care players make a fair amount of their profit margins in the first couple of years of managed care.***

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own reauthorization process, and its own billing functions. So you can imagine that the complexity of delivering health care for the end providers gets very, very high. Now, imagine the complexity for consumers trying to navigate their way through this system. For example,

I could belong to Stay Well, and Horizon is managing my benefit. Who do I call to get access, where do I go, what is in my network, which formulary do I belong to? It is a complicated deal. Some of the HMOs directly contract with mental health centers. There already has been some discussion with CMOs on whether they may want to do that in the Atlanta region.

Go forward two years and the complexity started to disappear. Some of the players went away. You have fewer players, fewer behavioral health carve-outs, and you have different sorts of payment arrangements going on. Some people are still doing fee-for-service, some people are doing capped inpatient-outpatient arrangements, and some are just capping outpatient arrangements, some are on risk sharing. Two things happened with community mental

health centers. The HMO players started to consolidate, and a number of the community providers started to disappear. While it looked very lucrative to community providers, private providers, in the first couple of years, they came to realize that the complexity was very high, and they chose not to play as much. So those other providers became less and less prominent, but the community mental health center system remained intact — suffering, but intact.

Fast forward another couple years and what happened? Even more consolidation. A rule of thumb in managed care is that the managed care players make a fair amount of their profit margins in the first couple of years of managed care. They are able to squeeze out some of the profit margin, they do real well, everybody seems to be happy financially and clinically, and then over time, when the profit margin starts disappearing, the managed care players start to disappear. And if they have not laid down some infrastructure in terms of reinvestment in the community, you leave big holes in the community. The community mental health centers are still there, only four players left, and now the state is contracting directly with providers to provide specialty services.

The point is that it is very complex in the beginning, it starts to consolidate over time, and at the end, you have a few providers still remaining. Usually it is the public sector providers, who have traditionally been in this business, who are still standing if they have not completely fragmented by that time, and a lot of the financial arrangements have changed over the course of time.

**Funding and Cost Shifting.** In Tennessee, the 1993 projected waiver cost for TennCare mental health through fiscal 2004

was expected to be \$638 million. In 1996 and 1997, they went to the TennCare Partners Program, which was the carve-out for mental health, and under that, the state expected to save a fair amount of money.

***We need to look at the process strictly in terms of the consumer having a need and then navigating the system to get a better outcome.***

The projection for 2004 was about \$476 million. But it is important to note what actually happened to the costs in Tennessee for TennCare. It exploded to more than a billion dollars. Now, fair

enough, pharmacy costs are embedded in those, and they eat up a fair percentage of the growth, but I think it is important that in the face of what Tennessee tried to do with TennCare and then TennCare Partners, they were not able to contain the cost of care as they had anticipated.

The shift to Medicaid managed care always raises concerns about cost shifting into DHR's world, to the state hospitals, people falling off the Medicaid rolls. What ended up happening in Tennessee, if you take out the pharmacy cost and just look at the cost

of health care, is that total funding exploded, but the rate of growth was on the DHR side, on the federal grant-in-aid side. It also grew for Medicaid, the DCH side, but not nearly as rapidly. The total cost continued to explode, even in the face of TennCare, and a fair amount of that growth fell over, or was cost-shifted, into the DHR equivalent of the grant-in-aid population.

Returning to the FMHI study, Florida wanted to look at the total costs of various plans, including the cost to payers and to society (see Figure 6). Direct cost to Medicaid in the HMO condition was a savings versus the carve-out and fee-for-service. But look what happened to public costs, and these include state hospitals, jails, emergency rooms — what would be the DHR-funded piece. These costs went up significantly versus fee-for-service. If you look at the total societal cost, which considers all the cost to the state and to the entire society, you will find that the HMO condition really did not save a lot of money, particularly versus the fee-for-service. The take-home message here is that while the HMO cost may be saving the plan dollars, overall society did not save that much money. And in fact, it probably cost about the same as in the fee-for-service.

**Conclusion.** It is interesting to look at data and ask what we can learn. What can we take from those experiences and apply to the state of Georgia? In terms of access, there is some value in setting access targets for services and actually to set them at pre-implementation levels. If DCH is able to figure out what the access standards and penetration rates are today, then it would be very easy to embed them in the HMO contract and say we expect access to be at least this much and maybe more than that. It is important that the HMO set up a network that is experienced in providing

|                    | HMO<br>(n=224) | PMHP<br>(n=234) | FFS<br>(n=171) | Total<br>(N=629) | p for Two Way Comparison* |              |             |
|--------------------|----------------|-----------------|----------------|------------------|---------------------------|--------------|-------------|
|                    |                |                 |                |                  | HMO vs. PMHP              | PMHP vs. FFS | HMO vs. FFS |
| Medicaid costs     | \$ 5,884       | \$ 9,022        | \$ 8,658       | \$ 7,725         | .00                       | .81          | .01         |
| Other public costs | \$ 8,245       | \$ 7,526        | \$ 6,789       | \$ 7,588         | .04                       | .05          | .00         |
| Private costs      | \$ 5,923       | \$ 5,550        | \$ 709         | \$ 4,404         | .47                       | .00          | .00         |
| Societal costs     | \$20,051       | \$22,099        | \$16,156       | \$19,719         | .20                       | .00          | .00         |

Figure 6. Real costs for mental health care for select plans in Florida.

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services to people with more severe illnesses, and I think Georgia has already done that by putting in the conditional providers. What ended up happening in some other states is that providers who were not experienced in doing public sector work or more experienced in commercial work got involved as network providers, and they were not capable of managing care for those who have significant persistent mental illnesses.

It also is very important to expect CMOs to invest or reinvest in the community. One of the states where this really works very well is Iowa. In Iowa, the profit margin for the CMO was capped, and above that profit margin, the CMOs are required to reinvest in the community. What they do then is invest in innovative community programs that can reduce costs in other places. It is a free market and free enterprise sort of deal, so that if in three, four, five, or six years the system implodes and the CMOs disappear, they will have left some infrastructure investment in the community. This is very important.

In terms of integration and fragmentation, keep the system simple. There is no value in complicated systems. You really do not get savings; you just layer on administrative costs. We are not going to direct carve-out here in the state of Georgia; we are talking about an integrated model, and if we are going to do an integrated model, we should make the CMOs keep that integrated model simple. If they subcap to a mental health or behavioral health group, the arrangement needs to be transparent and simple, and it needs to be moderated.

It is important to have consistent homogeneous systems. In the state of Florida in 2000, all of the different players in the field had noncontinuous or heterogeneous systems, so it was very difficult to compare

data from one program to the next and to make systemic changes or make systemic generalizations. It is important to have a consistent homogeneous system, and it is important to independently ensure the adequacy of the data and to have network readiness to provide this comprehensive benefit from the day we go. Whoever the end providers are, whoever the big providers are, they need to have the capacity to handle the information technology strain that is going to be coming. Information technology is a major issue here, and without it, we will be flying blind as a state and as end providers. It is important that the provider network be capable of handling the complexity of prior authorizations and payments. It is going to be very complex.

Finally, protect the percentage of mental health premium. In an integrated model, there is a drift in mental health percentage of premium, so while the state may expect that 4 or 5 percent or whatever that number is of the premium dollar to be passed to mental health services, inside an integrated HMO, it is very easy for those dollars to be redirected to other services. It is very important in terms of cost shifting to consider expanding the range of services, and there are a number of ways you can do that. You can independently fund specialized services, such as safety net services like crisis centers and so forth. Particularly if a crisis center can take some of the pressure off the state hospital, independently funding that might make a lot of sense. I know we are going to include the pharmacy benefit, but there are some data from Florida to suggest that maybe you ought to exclude the pharmacy benefit and find other ways to control pharmacy costs. I know we are working on disease management; I sit on the state's drug utilization review board, and we are looking at ways to refine the formulary in practice. I

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think those are probably the better approaches, rather than having a restricted formulary.

It is important to include substance abuse services. A question was raised about whether substance abuse services were included or not. I am not sure I understood the answer, but I think at the end of the day, it is going to be important for CMOs to provide substance abuse services, or they are going to end up paying for services in other, more expensive ways. And it will be important to ensure the viability of the provider network. Remember in the Florida experience, after four years, a lot of the end private providers headed for the gates. The providers who were still standing, trying to provide services, were the community mental health centers. They need infrastructure support; they need information technology capability. They are the ones that have been here all along. They really need to find a way to survive in this new system. It is going to be important, whether it is coming from DHR or DCH, that this provider network remain intact, because it is a safety net in the community.

It is very important that there be an independent advisory board to monitor the access, continuity, and utilization data for the state. Already people are talking about having an oversight committee — an independent advisory board that would not be state employees, would not be CMO employees, but would be made up of experts and advocates in the state who could

provide rational, unbiased feedback regarding what works and what does not. They would look at issues of access, continuity, and utilization, but I would recommend a separate quality council — again, independent from the CMOs and independent from the state — that would be skillful and expert in understanding what makes for good quality indicators and whether the CMOs, as aggregates or as individual CMOs, are hitting those predetermined quality outcome measures. We can all sit down together and decide on those outcome measures, but it is important for an independent board to be able to look at that and give feedback. In the states where this has been done, the system of communication works very well, and the feedback has been welcomed from both sides.

Finally, there are a lot of experienced stakeholders in this state, a lot of bright people who have worked on managed care, worked with managed care, who understand that policy design leads to end outcomes. It would be useful to somehow aggregate them on a state and regional level to help solve problems as they arise. Let's not wait until we are six months in to find out a CMO is not paying claims; let's see if we can work on this in real time and sit down with people who really understand this. If we are able to make some of the changes talked about here, we might have a product we can be real proud of and that will serve the people of Georgia.

Benjamin Druss, M.D., M.P.H.

*Rosalynn Carter Chair in Mental Health, Rollins School of Public Health, Emory University*

What has been striking is that many of the same goals articulated by the state for Medicaid managed care are actually the same as those presented by the panelists. They are the same kinds of things that we

all want. At the same time, there is some anxiety or wondering about which of those goals we will be able to meet with managed care and how we can help make sure that they are met as managed care is enacted.

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## Questions and Answers

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**Q.** I think it is striking that we all agree on the importance of mental health services and customer satisfaction to achieving those goals, but I think we also probably agree that funding is often a lot more limited than we would like for it to be in the real world. But lastly, and the issue that I think is most important to me, is the issue of quality. It is essential and should be monitored, not only in terms of determining best practices but for enhancing the treatment we provide our patients. I was struck by — it is simplistic in some ways — the pyramid depicting administrative organization and the idea that the structure leads to events or outcomes. I would like more specifics on how you get there. Implementation, and particularly utilization and monitoring, has been discussed, but how do you get to quality outcomes? What structures need to be in place? What works? What does not work? And how do we monitor the quality of quality monitoring?

**A.** **Joseph Bona** - There are a couple of ways. You actually have to start from the philosophical approach that quality does matter, and there are some places where managed care has just come in to control cost. But if we take the approach that quality matters and from it, if we do good quality work, costs will take care of themselves, then we need to sit down with an expert panel to decide those quality outcome measures. If we were just to harness the energy and the power and the brainpower in this room alone, we could sit down at the end of the day and come out with three or four disease-specific indicators of high quality. Then we need to force the CMOs to capture that data as part of a contractual relationship with DCH and have that funneled through some sort of quality committee, which is an independent group of people who then advise DCH as to whether those quality outcomes are being hit or not. Then use that feedback loop to get the CMOs to do better. I think that is ultimately the holy grail of what managed care was all about.

The problem is that a lot of payers really do not value the input of this independent advisory board, and they end up wasting or squandering the collective horsepower that is embedded already in their community. If the philosophical approach is that this is a good idea, we could put together a small committee to figure out what those quality outcomes are, together with DCH, and then have a system where you can start to track it. That would make some sense to me. It has been done; for example, Iowa has been one of those places where they have worked well with the behavioral health carve-out group and done a fairly good job. They have reduced utilization where needed but are continually investing in the community, trying to improve quality. It is a model for something that can work well.

**A.** **Wendy Tiegreen** - Partnering entities that have vested interests in mental health issues also are significant. DCH is participating with DHR right now on a system infrastructure grant for children and adolescent services for mental health in Georgia. All the key stakeholders for children's services come together at a table — now pretty aggressively — to talk about what each of the others is doing and to begin looking at those funding structures so that we do not end up with a system that looks like Florida before it evolved and corrected. In addition, DHR is moving toward making application for a system transformation grant for mental health in general, and as part of that process, the governor's office has already indicated some interest in how we begin partnering together on all of the pieces. Some of that structure has not always been well-established in Georgia, which is why many of us have been advocating for some partnership, some help, some assistance, whatever we need to do, so that we have that stable structure and then can move up the hierarchy.

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**Q.** There is a lot of support for an independent advisory committee to look at data and to help design outcome data but to be advisory to DCH. Is there a platform for that in DCH's contemplated structure?

**A.** **Mark Trail** - We have a number of advisory committees. Obviously, we are going to be doing business very differently than we have been, so those really need to be rethought. Do we have them all formulated at this point? No. But I have taken copious notes and will refer to this input. We hear you.

**Q.** I am the evidence that recovery works. It has not always been that way, though. I came from a world of despair, but now I am a CPS, certified peer specialist, and what I do is give hope and strength. By sharing my hope and strength, I am encouraging others to step out and take charge of their recovery. But a part of my recovery process was putting together a WRAP plan, and, of course, a portion of that is having supporters. I include my medical providers as a part of my support group. I am feeling the best I have in a very long time. Now, if I am having to be shifted in another direction, hopefully I can handle that. But I do not know whether the stress will set in and it will cause me to trigger. I do not know. But I am saying, because of the way I feel today, the advocacy I have done for myself, educating myself and being responsible for my recovery, I would hate to think that that might be disrupted at a time when it is most important and valuable to me. Part of what I do is share with others, educating them to take control of their own lives. And that means if I am going to a therapist or a doctor or whomever, and I do not think I am getting the services I need, I want to go to someone else who will provide me the services I want. Now that sounds different than this plan. But if I am wrong, please correct me.

**A.** **Mark Trail** - I would like to offer that the Peer Specialist Program here in Georgia has been a national model. It is absolutely terrific. I have received calls from my peers around the country, other Medicaid directors, who ask, "How did you do it? Why did you do it? What is it doing? Is it good?" I do not know of any reason why the managed care program would affect peer supports. For example, I do not know all the details of the study in Florida, but it sounded like it was dealing with folks who were more chronically and persistently mentally ill. I think they were talking about schizophrenia in particular. You occasionally might have somebody who is eligible for TANF, for example, who also has schizophrenia — I understand that that can happen, but it is not going to happen much — but those people are not going to be in risk-based managed care. I think that is important to understand. So the kinds of services, or people that would receive peer supports, might be people who have the more serious and chronic types of mental illnesses, will not be in the risk-based managed care.

Now, they will be affected by the disease state management program if they are on SSI. But remember also, and maybe I did not emphasize it enough, the disease state management program has nothing to do with gatekeeping, as we refer to it. They are not going to approve any medications, they are not going to say, "You get peer supports," or "You do not get peer supports." All of the authorization process actually will remain as it is today or change to the extent that we jointly agree that it ought to change as we go forward, and that contract is under re-procurement, I believe. So only to the extent that it changes as a result of that, will those kinds of authorizations change. It is important to understand that people with chronic and persistent mental illnesses who are more likely to be in the SSI eligibility group are not going to be in risk-based managed care.

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**Q.** But I want to clarify that that will not happen in Phase 1. Because Phase 2, as we understand it, would include that shift. And the timetable that we have been led to believe is that it would be one year later when Phase 2 might be implemented. Do I hear you saying that we ought not to worry about Phase 2?

**A.** **Mark Trail** - I have had no conversation with the DCH commissioner or with the governor that that is where we are going, to risk-based managed care for the aged/blind/disabled groups. That is the most honest and direct answer that I can give you. Does that mean that we will never have such a conversation? I obviously cannot tell you that. I can tell you, up to this point, that in our minds, there is no Phase 2 consideration to put everybody into risk-based managed care, like they have in Arizona, for example. Has the subject been brought up within the department? Sure. We researched Arizona. So we got the full presentation of possibilities.

At this point, the only thing that we have agreed to do is the disease state management brought to this Phase 2 that we are talking about. There have been conversations around using an administrative services organization for the whole balance of Phase 2. But again, that is very preliminary. The conversation that we got consensus on is for disease state management.

**A.** **Sherry Jenkins Tucker** - Disease management is still a relatively new science. Those of us who do it during the day and read articles and all that, we kind of know what that is about, so what this really points to for us is a real education process—not just for behavioral health consumers but probably for the Medicaid population in general. I would really like to see the Georgia Mental Health Consumer Network ultimately come in with a role of doing some training for people who have mental illnesses, for families with kids who may have a severe emotional disturbance serious enough that they may fall into the disease management program.

But I do not think people really understand that it is somebody kind of helping and coaxing and connecting and being sure that everything works together. Because of that, there will continue to be anxiety, and I think that that is where the consumer network can be a great help. We hopefully can come in and be a help. So I think that that is one more area that we can probably partner on, because people do not understand these terms that we all are talking about. The better job we can do in terms of education, then the more questions flow and the more dialogue flows, and anxiety goes down because they feel like they have access to that information.

**Q.** We have heard a lot about consumer and family participation, and there are a lot of us who are really interested in that concept and moving from token participation and input into real meaningful decision making. I want to ask two things. Ms. Croze, do you have any information about states that you think have really modeled this particular aspect of managed care well? For the panelists: Are these the kinds of things that we have in mind, and does this align with what we think we are working toward in Georgia?

**A.** **Colette Croze** - I would have to try to isolate some better practices. It has to go beyond token; it has to go beyond folks who are on advisory groups that do not really have an impact on policy or practice to places where they actually have consumer satisfaction teams and family satisfaction teams as a strong part of the quality improvement system where those folks do measure the member satisfaction with the services and the results of the services. I have seen a couple of examples where the results of those evaluation measures have actually been part of the performance penalty and incentive system. That is a really powerful connection between consumer and family measurement of satisfaction and putting the money where people say it ought to be.



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**Q.** And what is the panel's reaction?

**A.** **Sherry Jenkins Tucker** - I have lived and worked in states and reviewed state systems where, say, consumers and families are actually part of the system of creating RFPs, reviewing proposals, reviewing programs that come out of money being distributed, actually having consumers and families work and participate in what traditionally would probably be a function of a bureaucrat. I have lived and worked and reviewed in states where there are lots of consumer providers and peer services and programs, probably not unlike some of the peer programs that we have here in Georgia, and they exist in other places. That is where we find true consumer participation and involvement.

We need to move to a place where we actually have peers doing evaluations. We have expertise because of the knowledge and the experiences that we have through our lives as being people who experience mental health needs and addictive disease concerns, but there also are many of us who have other skills and training in addition to our mental health badge.

**A.** **Anna McLaughlin** - I do not think the state of Georgia has operationalized it at any level. I think that we actually are taking huge steps backward on the part of consumer participation in the government and in their own well-being in the systems that are going to be serving them. It is kind of across the board. I actually asked for a couple of things; I was very specific. I really want them and will just keep asking for them. I really want there to be—you can call it a utilization review board, I call it a collaborative effort—some sort of a community-based oversight with DCH for the managed care organizations. It should have full consumer and family participation, because this is the place where it will be seen first if it crashes, and the consumers and the family members need to be there to tell us that.

I do believe that we need to develop some sort of a satisfaction survey process that is done with full consumer and family involvement. Families will tell families things they will never tell professionals, and consumers will tell consumers things they would never tell a professional. Until we as a system acknowledge that that kind of expertise and that kind of information comes in when people who have a like interest meet, then we are never going to get all the information we need to do true quality assurance and true continuous improvement.

**A.** **Gregg Graham** - Part of consumers being empowered, families being empowered, is knowledge, so I really do hope we follow up on the idea of some consumer-to-consumer, family-to-family training in terms of there being some real understanding and ownership. When somebody is given a choice to opt out of disease management, they are not going to necessarily understand what that means, especially depending on how that is presented, where the fine print is, and how clear it is. It is going to make a huge difference in whether or not people are really making an informed choice about how they want their medical services and behavioral health services provided.

**A.** **Joseph Bona** - If the state decides that that is important, it embeds it in the structure of the benefit, and then the end providers and the managed care organizations are empowered to deliver it. So it is a question of do we, as a state, think it is important—it sounds like we do—and then if that is the case, let's embed it in the expectations, and then we will get results. We can talk a lot about how we want it to happen, but if we do not make it part of the structure, we are not going to get the effect we expect.

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# General Discussion

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Mark Trail, M.Ed.

Chief, Medical Assistance Plans, Georgia Department of Community Health

**I**t is difficult to get input from everybody and make sure that everybody is included. I am not making excuses, just stating our reality. But please know that we did exercise quite a bit of diligence to get as much input as was practically possible to bring us to where we are today. I already have emphasized that I know there has been some concern and, as was presented by Ms. Croze, that the carve-in models have not really been demonstrated to work very well for folks with serious and persistent mental illnesses. I would just emphasize that the risk-based managed care model that Georgia is pursuing does not include that group. Now, I know somebody will find someone — one person or two people — who happens to fit that characteristic, but as a group that will not be the case. Those who have serious and persistent mental illnesses are more likely to be in the SSI group and will not be in the risk-based managed care.

Another concern addressed the services and the service mix that the care management organizations might have and the possibility that it might be different or more restricted than the services currently available in the Medicaid Rehabilitation Option. To the extent that the members use those services in the rehabilitation option, the care management organizations must provide for them in the same amount, duration, and scope as we have currently in the fee-for-service system. It is going to be a contractual requirement that if a service is medically necessary, and they do have to have a care plan to receive those services, then those services must be provided. I do fully understand that, as a plan is exercising its judgment over what is medically

necessary, that is where the rubber hits the road. That is part of the reason we are requiring an expedited review process for folks in the care management organizations.

I heard a great deal of interest in having consumers involved with some of the different evaluation processes. I like those ideas and intend to take them back and discuss them with our commissioner and the chief of the Managed Care and Quality Section.

Zero percent of premium is a very interesting concept, and I do not say that lightly with this group. We are going to be putting just under 1 million people, out of the 1.5 million, into the risk-based managed care. Remember, this is the TANF groups, which include low-income moms and their kids, primarily the PeachCare kids, and the refugee group, which is fairly small. When you look at the behavioral health spending for that group, it is only around 2 percent. We spend about \$2.5 billion on those million members. Georgia Medicaid has passed \$6 billion in its total expenditures. Of that, \$2.5 billion is spent on these million folks. Of that spent, not including prescription drugs, only about 2 percent is spent on mental health services. That is not much, and that is in the fee-for-service world. Now, what it will be in the managed care world remains to be seen. I will tell you, to my knowledge, that we did not put a “no less spent than we currently spend” in the contract.

We are looking for integration with the primary care physician; we expect that actually there is a real opportunity for

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greater penetration rates this way. We will see what happens as we progress along, but I do not think that we put a minimum penetration in the contract. There were a couple of reasons why we did not do things like that. For example, on the price side, we did not stipulate that it can be no more than this or no less than that. We have had actuaries do studies on what the rate ranges ought to be, and if somebody says \$80 per member per month (PM/PM), we will know there is no way that is actuarially sound. But the reason that we did not say “bid it at this

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***Are these providers capable of interpreting, understanding, and then making a meaningful proposed bid to us?***

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price” or “in this range” is because we want their plans. They have received full disclosure of the claims data, so they should be able to project what the PM/PM costs

are going to be for the different cells. Quite frankly, it is a part of the test, if you will, of the plans—are they capable of interpreting, understanding, and then making a meaningful proposed bid to us? We will have enough knowledge of the actuaries’ work that has been done that we will know when they bid too high or too low and whether the plans can be done properly at all. It is going to be part of the evaluation process, which speaks to the administrative capacity of the plan.

Regarding cost shifting to the state hospitals, once the apparent winners are selected, the plans will have to negotiate with us on what their policies and procedures will be for behavioral health. During that time, we will have to lay out the parameters of when it is appropriate to refer to other state services or when it is appropriate for them to cover it themselves. This plan, while it did not have a behavioral health carve-out in general, does have some things that were carved out. For example, to the extent that our members

use the state hospital today and Medicaid does not pay, that part is still carved out of the rates. If it had been carved in, then what we would have done is go to the Department of Human Resources and ask them to give us the state portion for this group of Medicaid kids that are now going into risk-based managed care so that we can make it part of the rate. That probably would have been the cleanest thing to do, but we did not do that, for many reasons. That will present some administrative and clinical challenges for us as we go forward, but we will have to sit down at the table and figure that out.

Let me explain why, from Medicaid’s perspective, we think we are going to be better off. For a number of years, we have seen in our own claims data, as anyone familiar particularly with the child and adolescent (C&A) units knows, there have been progressively fewer and fewer beds available in the state. If you look at our claims data, you will see that there has been a progressive increase in the use of general acute care hospitals for psychiatric admissions for the kids who probably would have gone into some of those C&A beds. What that means is that we have been having a cost shift for a while. We are going to have to make sure that criteria are determined for what is appropriate. There could be an appropriate time and place when a child should be admitted to one of our psychiatric facilities for some stabilization period.

Another concern that was expressed was about keeping the health plans from just cost shifting and dumping the kids onto the state system. Again, I think those policies and procedures are going to have to address it, but also, I am not so certain that just dumping them is going to be a big problem. I am not going to tell you that could not happen in the short term, but to just dump

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them and leave them probably is not going to happen because the admission decision and the discharge decision remain in the hands of the department and the various state hospitals. If that member no longer qualifies, does not meet the criteria to stay in the hospital, then they can be discharged. And then the health plan is going to be responsible, still, for the mental health care and the other care that that member is going to need.

There are protections to keep the health plan from discharging a member from its plan. It cannot be done simply because the member costs a lot of money or is difficult to deal with. There are some very specific criteria that protect the member from getting dumped in that respect.

Changing eligibility was an interesting point, and it was raised particularly as it regarded PeachCare, with folks coming in and out of that program. Of course, that happens in Medicaid, too, particularly for families whose income is not like a regular salary. It might be hourly work or construction or something similar that goes up and down and brings folks in and out of eligibility. Managed care, disease state management is not going to change any of that. So if anybody had an expectation that that would be better as a result of this, please do not think that; that will not happen. Eligibility problems that have not otherwise been addressed will remain as they are today, and certainly they need to be addressed.

Complexity for members is an interesting concept. One of the value-added functions that we believe we are contracting for and are hopeful that has been expressed both in the RFP and in the contract, is that these plans are going to bring some coordination to the table. Today, for the regular family who is using fee-for-services Medicaid and

who has some kind of a behavioral health problem, who helps them now? To whom do they turn now in the fee-for-service world? If they call our fiscal intermediary, who pays claims and has some member support, I will be honest with you, these people do not have much knowledge of what services are available or of other providers in networks. Now, they do have on their Web site a place where you can specify a certain kind of a provider and they give you some access stuff, but you have to be a little more sophisticated to get into that.

Contracting with the plans as we anticipate is going to bring coordination to the table. There will be care coordinators who, with the nurse call system, are going to know everybody in the plan. Members will be talking to a nurse, not to a customer service representative who may or may not have a high school education. They are going to be talking to a nurse, and that nurse is going to know certain things. The nurses are going to have scripts and protocols that we will approve, and they are going to help members get to the right places, whether it is behavioral health or otherwise. So I really am expecting that the coordination that is not there today will be simpler tomorrow, when we engage these organizations.

In metro Atlanta, there will be complexity for providers. There will be potentially four plans, while in most parts of the state there will be two. When all decisions have been made there are going to be several things that will help make administration a little simpler. Will the plans have different forms? Very possibly. With regard to claims administration, everybody has to be HIPAA compliant now, which means that they all use the same claims transmission format, and they will have to use the same remittance advice format, so those will be simplified. Could they have different prior authorization criteria? That is quite possible.

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I would pose this. I understand that some CSBs do get into commercial insurance. When I directed a community health center, we were starting to get into some of the commercial insurance, and we dealt with it. As for Georgia Medicaid, a large provider organization, many of them

with more than \$20 million in business is probably doing a lot of the different kinds of functions already, and may in fact be working with the very same organizations that might be coming to the table. So it may well be more administrative work, but it may not be as much as one might fear.

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## Questions and Answers

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**Q.** I really appreciate your wanting to entertain the independent review board for the state. However, because this is a new initiative, I would like to ask if we could move that a little further and establish perhaps an independent review board in each of your six regions, especially initially because this is new and so that we will be able to identify early on some of the gaps and deficits that are sure to arise in this early process. The other thing I wanted to ask about is the need to create dialogue around establishing and moving forward in this plan. How do we, as advocates, as family members and consumers, create dialogue around some of the things we may be questioning about some of the plans?

Another thing that was mentioned was that managed care does not work for people who have chronic mental illnesses, many of whom are not enrolled in Medicaid, but some who are. Those who are not enrolled end up in our state hospitals. Are the state hospitals going to continue to be those safety nets? If so, is some of that \$59 million or so savings that the state is projected to realize within that first fiscal year going to be diverted to our much-needed mental health services that are already historically underfunded? Are some of those funds going to go to public mental health services, including the state hospitals?

Also, you did mention that dual eligibles would not be covered. Is this because of the Medicare Modernization Act, and are you waiting to see how it will impact this particular population? What are the plans for those people?

**A.** **Mark Trail** - What I said about the dually eligible is that they will not be a part of the disease state management program. They will still be covered by Medicaid if they continue to meet the eligibility criteria. Having a discussion about the dually eligible and the effect of the Medicare Modernization Act is probably another whole discussion. I do not know how many of you are aware that actually the dually eligible who currently have their drug benefit paid for by Medicaid will no longer have their drug benefit paid for by Medicaid come Jan. 1, 2006. It will be paid for by the Medicare Part D plans. But as far as their continued coverage in Medicaid otherwise, they will still be covered as they are today. It is just the disease management part that they would not be covered in.

As for the independent review for all six regions, I anticipate that when talking to the commissioner, that would be part of the conversation. It may not be practical to have just one review board, like a statewide level, but I have to have that conversation with him to know what he believes is feasible and what we can support and sustain.

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What happened to the \$59 million? That is total funds, and Medicaid, of course, is roughly 40 cents on a dollar of state funds. That money is already gone. That was part of the legislative process. When they go through the budget process, they make decisions about adding this, subtracting that. This was on the subtraction side. Basically, it was an attempt to balance the budget. Now, that does not mean that they took it and went and put it in schools or something else. It is important to remember that Georgia Medicaid projected an 8 percent increase for 2006 in the total spending over the previous year's spending. That was something in the neighborhood of \$800 million. We had to present budget cut proposals, and we did propose a budget cut for implementing disease state management. Our proposal was only about \$40 million, but when it went through the legislative process, it came out as \$59 million. But to prevent us from cutting something else at a greater rate, and I think this is the important point, they cut it on the disease management side so that we could afford this 8 percent cost increase.

We are concerned about the safety net, and we want to be supportive of the safety net, but outside of the people who are eligible for Medicaid, we are not the safety net. Those are the state-funded services — I presume we are talking about behavioral health in particular — that are supported by the Department of Human Resources. We certainly support the existence of a safety net. In fact, a statewide committee was started that is going to look at the whole system as a part of the New Georgia Commission. There was a very specific discussion in that committee meeting, on the need to be thoughtful about the safety net, what it should be, who it should cover, and how it should be supported.

**Q.** I would like to talk about the lost population. Obviously, the PeachCare population has been a problem for us for a number of years as children fall off the rolls. At the moment, I am much more concerned that approximately 22 percent of the children in Fulton County who are served by mental health are in the custody of the Department of Family and Children's Services, and they are now saying that all children will be returned to their families as soon as humanly possible. They will be under an exemption while they are in their foster home while the parent works to reunify them in their home, and then they will come home into a managed care situation. There may be a lack of continuity of care there. My concerns center around that population of children, which is our most vulnerable and most at-risk population in the state. We must allow for some sort of a reintegration period where children can stay in services so that we can have a smooth transition for those children.

**A.** **Mark Trail** - There are some things that we have consciously considered in making that transition smooth. The prior authorizations, for example, will be required as they transition. It is not just the initial transition going from no managed care to managed care, but also as they might move across different categories. If prior authorizations are approved, then as they are transferred over, that will be an ongoing requirement.

**A.** **Joseph Bona** - I do not want to let go of the idea that consumers will be faced with a more complex system. With choice comes complexity. My concern is that open enrollment will be an absolute nightmare. If consumers are in the Atlanta region and have two or three kids in what traditionally would have been PeachCare and maybe are not fully educated, with nobody there to help them, they have to choose among all these disparate plans. So complexity will be an issue, there is no question about it. I just want to make sure that whatever we put into place is at least easy enough for consumers to navigate through.

**A.** **Mark Trail** - I appreciate your pushing the question further. I have not talked at all about the enrollment broker who we will be contracting with, and that is a really important point to this concern. We will be engaging or hiring an enrollment broker who actually will be assisting the members in making the

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choices. We will not permit the plans to market directly to the members. They must go through an enrollment broker. All the marketing materials will be developed by the enrollment broker and approved by the department, so there is not going to be any of this “come join us, we will give you a toaster oven” or that kind of stuff. It will be controlled through a separate independent contractor who will not be a part of any of the plans, and they will assist members with choices. I will not tell you that if you have to choose between four plans, there will not be some effort to figure out what the advantages are for the different plans. I will say that probably it is a little less complex than some other plans because there are not judgments to make about who has the better co-pays and so forth. That is all mandated by the state. But participants will have to make decisions about providers: Is my primary care doctor, the one I like, in the plan or not? The level of complexity will be a little less than some employee plans, but it certainly will be there.

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## Closing Remarks

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Rosalynn Carter

*Chair, The Carter Center Mental Health Task Force*

This has been a wonderful Georgia Mental Health Forum with a lot of dialogue. It was an important meeting on a critical topic, and we have learned so much and definitely need the advisory boards that were talked about to oversee the transition to Medicaid managed care and its implementation. We must guarantee meaningful participation by consumer and family members as well as advocates.

Today we have discussed why the state has moved to managed care, what the plans are, and what other states are doing. We have had some really good recommendations from consumers and families. We have heard the hopes and expectations of the stakeholders of our state. It is a lot to absorb. It is a complicated and confusing matter, and I am glad so many of you know more about it than I do. I have a little more hope now that this might work—but we all are going to have questions, as well as some anxiety, as we move toward implementation. We now have a better understanding of what the transition will mean and what it will involve.

Today's presentations have helped address many of our concerns. We have been given the opportunity to meet the people who can answer our questions, and hopefully we have developed some partnerships that can help us in the coming months. Particularly important is the dialogue today between the state's representatives who are planning the move to managed care and those of us in the mental health community who want to be directly involved. I hope we can find a way to establish some dialogue between the community and the Department of Community Health, those who make the decisions. We face a tremendous challenge and have a huge responsibility to make this system work. Let us be determined; let us be vigilant; and let us do everything we can to make sure this new program succeeds. Georgia's most vulnerable citizens are counting on us.

*Rosalynn Carter*



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# Closing Thoughts

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Jerome Lawrence  
*Artist*

I am here today not because I am expert on managed care but because I am an expert on what it is like to be me. You see, I have been a consumer of mental health services since graduating college in 1984. Since early childhood, I have had a voice but rarely used it. I am not sure of the history, but I think that many consumers of the past had neither the right medicines nor the intense focus on recovery that we have today. This might have made it impossible for them to relay the depth and breadth of their experience with illness. I am fortunate to stand before you on new medication and adequate community supports to have worked my way off of Social Security Disability Insurance. I am sad to say, though, that while decisions were being made where my input would have been most valuable, I kept silent. Engrossed in illness and kept busy with the challenges of daily living, my excuses were many. "I was not asked." "I do not know how to speak or what to say." "I have never done it before." I did not know who to ask for help. I simply did not know what to do.

There are many reasons why we do not speak up, but they do not help our cause, and it actually hurts any decision-making process when there is not input from all sides. Now, we all like to think, or at least hope, that the people at the top know what they are doing. I myself claim to be the best artist ever, for those of you familiar with my e-mail address, [bestartistever@bellsouth.net](mailto:bestartistever@bellsouth.net), but soon after going into business creating and selling art, I learned that I was not the best bookkeeper ever nor the best publicist ever nor anything else that had to do with business except creating art. In 21 years of recovering from mental illness, I have learned that the best route to happiness and success is to balance that which is good for me with what is good for most everyone else. In my illness, I would have tried to guess at what people wanted, but in my newfound recovery, I decided to talk with people directly and ask questions. I was surprised at some of the answers. And now not only my artwork but my business is better.

As a person receiving services, I see many things. There is much happening directly to me that I could speak on, but I somehow feel that the people at the top are not accessible; that maybe it is not worth the effort; that of the many fires burning my coattails, this one can wait to be put out; and that the people at the top do not really care about me and what I have to say. I mean, why even bother when in the picture view of the decision-making hill, I am at the bottom? Today I will use my voice to say that the big picture is made up of lots of little pixels. No one wants to be at the bottom, and the hill narrows toward the top so there is room for fewer and fewer people. But the way a hill works is that the base supports the crown. Without a base, there is no hill. And so we uncover the true power of the people.

So why is the hill not turned on its head, with the larger portion being the decision-making body? Have you ever been in a car with your family and someone says, "Let's stop and get something to eat"? One wants to eat here, the other wants to eat there, you have changed your mind twice, and we all agree that we are never going to agree on one place. And so Mom and Dad, having the most power and, by the way, the most money, turn the hill

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back on its base by deciding to stop at the closest, most economical place. This upsets the children because they were not invited to the meeting where it was decided that Mom and Dad would decide. The kids threaten to revolt, but Mom and Dad, having control of the car and having consolidated their power, threaten to turn the car around, and then no one will get anything. The kids are hungry and ready to cave when you, being an advocate for the underdog, take out your cell phone and place a call to Grandpa and Grandma News Media.

Then something wonderful happens. There is discussion. And although not everyone gets their way, at least everyone's voice is heard, and no one goes to bed hungry. It is very important that members from all levels are represented at the decision-making table. The voice of our country's forefathers cried, "No taxation without representation!" This same kind of voice echoes today when we say, "Nothing about us without us."

Thank you.

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## About the Participants

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Joseph Bona, M.D., M.B.A.

Dr. Bona currently is medical and clinical director for the DeKalb Community Service Board. He also holds an academic appointment as associate clinical professor of psychiatry at Emory University's Department of Psychiatry and Behavioral Sciences. Previously, Dr. Bona served as medical director for the DeKalb Crisis Center at the DeKalb Community Service Board. Dr. Bona earned his medical degree at State University of New York at Buffalo and his Master of Business Administration at the University of South Florida.



Colette Croze, M.S.W.

Ms. Croze is a private consultant specializing in public resource management, focusing on purchasing and design options for managed systems of care. Her work has taken her across the country to numerous states and counties that are re-engineering public systems through the use of care management and risk arrangements with both public and private organizations. Ms. Croze has worked for county as well as state governments and has held senior management positions in both Missouri's and Illinois' mental health systems. Prior to beginning her private practice, she was senior consultant to the National Association of State Mental Health Program Directors, where she tracked state initiatives in managed behavioral health care and developed an extensive understanding of the operation of those initiatives.



Benjamin Druss, M.D., M.P.H.

As the first Rosalynn Carter Chair in Mental Health at Emory University, Dr. Druss is working to build linkages between mental health and broader public health and health policy communities. Prior to this position, he was on faculty in the departments of psychiatry and public health at Yale University, where he was the director of Mental Health Policy Studies. Dr. Druss has published more than 50 peer-reviewed articles in journals, focusing largely on the policy and systems issues on the interface between primary care and mental health. He has received several national awards for his work.



Gregg D. Graham, M.A., M.B.A.

Mr. Graham is president and CEO of Integrated Health Resources. He served as executive director from 1995 until he purchased the company from University Health Resources in June 2000. Integrated Health Resources provides screening and referral services and access management through its Behavioral Health Link program and employee assistance services through its CONCERN:EAP program. Additionally, the company has developed and managed at-risk behavioral health carve-out programs for managed care health plans in Georgia.



Jerome Lawrence

Mr. Lawrence, guest artist, discovered his artistic talent at an early age. He allows us to see differently, pleasantly, and creatively through his art—a perspective gained through a long and continuing bout with schizophrenia. He has studied at Georgia State University and privately with his friend Joseph Perrin, chairman emeritus at Georgia State University's College of Art and Design. He has exhibited in several shows and won two awards. Mr. Lawrence currently paints in his home studio in a home awarded him by Habitat for Humanity and teaches privately in southeast Atlanta.



Anna M. McLaughlin

Ms. McLaughlin is a degreed criminologist and the co-chief executive officer for Georgia Parent Support Network, a nonprofit family organization serving children and adolescents with severe emotional disturbances and behavioral challenges. Since 1996, she has been an essential partner in developing and monitoring the system of care in Fulton County, Georgia, that serves youth with severe emotional disturbances. Ms. McLaughlin represents GPSN programs at workshops all over the country and internationally. Agencies throughout the country have contracted with Ms. McLaughlin to help implement family-driven services, and she is considered an expert in the subject of wraparound. Ms. McLaughlin is also the family member of two young women with mental illnesses.



Abel Ortiz, M.S.W., J.D.

Mr. Ortiz serves as a policy adviser for Georgia Governor Sonny Perdue. In this position, he provides guidance in the areas of health care, human services, juvenile justice, and veterans affairs. Mr. Ortiz moved to Georgia in November 2004. Before joining the Perdue administrative staff, he gained extensive experience in health and human service administration in the state of Utah. His experience includes serving as general counsel and director of operational compliance for Davis Behavioral Health, deputy director for Utah's Division of Substance Abuse and Mental Health, director of projects for Utah's Division of Child and Family Services, health care compliance officer, and mental health therapist. In 2000, Mr. Ortiz was selected for the Annie E. Casey Foundation's Child and Family Fellowship, where he focused on systems transformation in human services and juvenile justice.



Gwendolyn Skinner, M.S.

Ms. Skinner was appointed by Georgia Department of Human Resources Commissioner B. J. Walker as director of the Division of Mental Health, Developmental Disabilities and Addictive Diseases in June 2004. Previously, she was employed by the Georgia Department of Juvenile Justice for more than 25 years, most recently as the deputy commissioner of operations with responsibility for all community-based services and programs for juvenile offenders as well as the department's secure facilities.

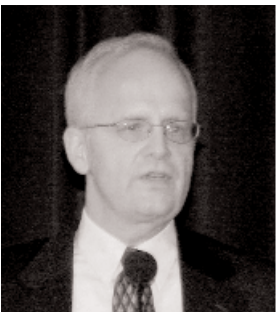
Ms. Skinner is a nationally certified school psychologist, a licensed marriage and family therapist, and a board-approved supervisor of marriage and family therapists in Georgia. In addition, she is a peace officer standards and training certified instructor. She and her husband have provided a home for more than 40 youth while serving as contract and foster home parents.



Wendy White Tiegreen, M.S.W.

Ms. Tiegreen is currently a program director for the Georgia Division of Mental Health, Developmental Disabilities and Addictive Diseases' Medicaid Systems Design Section. She coordinates the state's Medicaid Rehabilitation Option in partnership with the Department of Community Health's Division of Medical Assistance. In this role, she manages the contract for the state's external review organization. She was the primary mental health negotiator with what was then called the Health Care Financing Authority (now CMS) in the establishment of peer supports as a unique Medicaid-financed service and has been a recent presenter at national Medicaid and mental health management conferences.

Ms. Tiegreen has 12 years of experience working in services delivery and administration in the public mental health sector.



Mark Trail, M.S.

Mr. Trail is chief of the Division of Medical Assistance in the Georgia Department of Community Health. As chief of the state Medicaid agency, he is responsible for all Medicaid functions and services as well as the state SCHIP program, PeachCare for Kids. The combined programs provide health care coverage to more than 1.5 million Georgians, with expenditures approaching \$5 billion. He has worked for more than 27 years in a variety of health care fields, serving in both the public and private sectors. Mr. Trail has served as president of the Georgia Public Health Association, on the board of directors of the National

Association of County Behavioral Health Directors, as a member of the State Board of Nursing Home Administrators, and now serves on the executive committee of the National Association of State Medicaid Directors.



Sharon Jenkins Tucker, M.A.

Ms. Tucker is the executive director of the Georgia Mental Health Consumer Network. She previously worked for the West Virginia Mental Health Consumers' Association and directed the Mental Health Consumers Network and Office of Consumer Affairs. Prior to that, she worked as a behavioral health advocate for Legal Aid of West Virginia for nine years. Ms. Tucker is a self-identified consumer of mental health services and holds the credential of ITE, or I'm the Evidence — I'm the evidence that recovery works. She has extensive experience with the consumer/survivor movement and has expertise with WRAP facilitation, Leadership Academy training, peer workforce development, and advocacy.

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