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# TOLL GATE 5

# MENTAL HEALTH

# and

# SUBSTANCE ABUSE

PRELIMINARY STAFF WORKING PAPER FOR ILLUSTRATIVE PURPOSES ONLY

CONTENTS

# MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

## I. PRINCIPLES GUIDING BENEFIT STRUCTURE

Mental health and substance abuse services are an integral part of a national system of health care. The benefit structure for the treatment of individuals with mental and substance abuse disorders departs significantly from past approaches. This departure is appropriate as scientific evidence and societal attitudes have coalesced toward an understanding of these disorders as major health problems which, when untreated, generate considerable social and economic costs. It is increasingly recognized that treatment for mental illness and substance abuse problems yields important benefits such as improvement to overall health, reduced health care costs, increased productivity, potential savings in social welfare expenditures, and potential reductions in crime and criminal justice expenditures. In addition, scientific evidence and experience have led to the recognition that a comprehensive array of services, along with the flexibility to provide such services to individuals based upon medical and psychological necessity, produces better outcomes than experienced with traditional benefits. Thus, the development of the mental health and substance abuse benefit was guided by the following principles:

- The benefit structure should ensure that persons of all ages with mental and substance abuse disorders and their families participate fully in the health care system and that mental health and substance abuse services are available on the same terms and conditions as other medical and health services, eliminating current discrimination against mental health and substance abuse services in health care coverage.

- The benefit structure should ensure that persons with mental and substance abuse disorders have access to a comprehensive array of services for both acute and extended care, with the flexibility to provide the appropriate types, mix, level, and duration of services based upon medical and psychological necessity for each individual consumer.

- The benefit structure should encourage the development and use of alternatives to hospitalization, maximize the use of home and community-based treatment approaches, and ensure that services are delivered in the least restrictive environment appropriate to the needs of the individual.

- o The benefit structure should minimize the current two-class, two-tiered service delivery system, shifting of costs and responsibilities to the public sector, and fragmentation of service delivery, and should encourage integration of the public and private delivery systems.

- o The benefit structure should encourage early intervention, incorporate incentives to overcome reluctance to initiate mental health and substance abuse treatment, and remove financial barriers to early intervention.

- o The benefit structure should ensure the availability and provision of comprehensive and appropriate services within organized systems of care for individuals with serious and persistent mental and substance abuse disorders.

## II. ELIGIBILITY

Continuing concerns raised with respect to mental health and substance abuse benefits are related to ensuring appropriate utilization of resources. One such concern is that, without the imposition of special limits, services may potentially be overused or inappropriately used. In fact, there is evidence to support the countervailing view that individuals who should be receiving treatment often avoid it, costing themselves, their families, and society "unnecessary" expense in the long run.

Another concern is the potential for undertreatment of mental health and substance abuse disorders because that has largely been the history of managed care. In the new care system, financial incentives, along with appropriate standards and monitoring activities, are required to ensure that necessary and appropriate mental health and substance abuse treatment is provided.

To protect against inappropriate use of services and to better target resources, the following eligibility criteria are suggested:

All persons are eligible for screening and assessment and 24-hour crisis services. Persons are eligible for mental health and substance abuse services other than screening and assessment and crisis services if they have, or have had in the past year, a diagnosable mental or substance abuse disorder, which meets diagnostic criteria specified within DSM-III-R, and that resulted in or poses a serious risk for functional impairment in family, work, school, or community activities. These disorders include any mental disorder listed in DSM-III-R or their ICD-9-CM equivalents, or subsequent revisions, with the exception of DSM-III-R "V" codes (conditions not attributable to a mental disorder) unless they co-occur with another diagnosable disorder. Persons receiving treatment who without such treatment would

have met functional impairment criteria are considered to have a disorder. Further, family members of an eligible enrollee may receive necessary and appropriately related services (so-called collateral treatment).

## III. SCOPE OF SERVICES

### A. SETTINGS AND PROVIDERS

The services included in the mental health and substance abuse benefit can be provided in a wide range of settings and environments including offices, clinics, community mental health centers, homes, schools, hospitals, residential treatment facilities and other locations appropriate to the needs of consumers. Treatment facilities will be licensed and certified by states as meeting standards and criteria appropriate to the care to be provided. In addition, all services will be provided by qualified mental health and substance abuse professionals, certified paraprofessionals, and staff under the supervision of licensed or certified mental health and substance abuse providers. States will determine criteria for licensure and certification of professionals necessary to provide high quality services.

### B. ACCESS TO SERVICES AND SYSTEMS OF CARE

AHPs must ensure appropriate access to mental health and substance abuse services by having available multiple mental health and substance abuse specialty providers for screening, assessment, diagnosis, treatment, and rehabilitation services. In addition, AHPs will have multidisciplinary teams to review the needs of individuals with persistent and complex needs who require extensive services. Treatment planning will be conducted in partnership with consumers and consumer-designated representatives. The teams will authorize appropriate services including access to organized systems of care for adults and children and adolescents with serious and complex disorders.

Services for individuals with serious and persistent mental health or substance abuse disorders are provided most efficiently and effectively through organized systems of care. AHPs will have such organized systems of care that provide an array of services, multidisciplinary teams to develop and monitor individualized treatment plans, intensive case management, frequent case review, and close coordination with other agencies providing related services such as education and housing.

### C. RELATED AND SUPPORTIVE SERVICES

It is recognized that other related and supportive services are required by persons with mental and substance abuse disorders. AHPs must ensure that mental health and substance abuse providers establish linkages with agencies providing habilitation, social, and support services. At the client level, these services (e.g, education, child welfare, housing, vocational rehabilitation, transportation, legal, and others) will be accessed and coordinated by a case manager. It is recommended that a federal

"enabling pool" of dollars be established to facilitate linkages at the HIPC, AHP, and client levels with other systems and agencies providing related services.

## D. CLINICAL PREVENTION SERVICES

It is recommended that screening for mental health and substance abuse disorders be incorporated in the general health care benefit and service delivery system. Early identification of these disorders encourages consumers to secure services that may prevent or delay episodes of illness and disability and avoid more intensive and costly service provision. Thus, clinical prevention services including screening and early identification of mental and substance abuse disorders should be responsibilities of the AHPs. AHPs will fulfill this function through two primary approaches:

**Periodic Screening for Children and Adolescents** - AHPs will conduct regular periodic screening of children and adolescents in accordance with the guidelines established by the American Academy of Pediatrics. These screenings will be performed on a regularly scheduled basis, with greater frequency at earlier ages. In addition to screening for physical health problems, such preventive screenings will include screening for developmental, mental, emotional, behavioral, and substance abuse disorders.

**Brief Screening at Life Transitions** - AHPs will use "life transitions" as opportunities to screen for and identify mental and substance abuse disorders. The goal of such efforts is to provide prompt treatment for mental and substance disorders, thus preventing more severe disabilities and dependencies. Brief mental health and substance abuse screening questions will be added to health assessments at key transitions which may include the following:

- Women presenting for prenatal and well-baby care
- Adolescents entering high school
- Adolescents receiving school health check-ups
- Children and adolescents who are removed from their homes by the child welfare system and placed in shelter, foster care, or other settings
- All persons referred to the criminal justice or juvenile justice system for alcohol or drug-related offenses
- All persons receiving hospital services, including emergency room services, for whom the physician suspects possible substance abuse or mental disorder
- Family members of persons receiving treatment for substance abuse or mental disorders
- All persons presenting for periodic health assessments, ideally based upon the schedule recommended by the U.S. Preventive Services Task Force.

## E. MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The following list specifies the array of services to be provided or arranged for by AHPs. AHPs must provide these or substantially equivalent services, and may provide additional clinically indicated services at their discretion. The table on the following pages specifies which services are to be provided to children and adolescents and which are to be provided to an adult population.

SCREENING AND ASSESSMENT

- Mental Health/Substance Abuse Screening
- Mental Health/Substance Abuse Assessment

24 - HOUR CRISIS SERVICES

- Telephone Crisis Services
- Walk-in Crisis Services
- Mobile Outreach Crisis Services
- Crisis Residential Services

NONRESIDENTIAL TREATMENT SERVICES

- Medical Management
- Prescription Drugs
- Somatic Treatments
- Ambulatory Detoxification
- Outpatient Therapy
  - Individual, Family, and Group Therapy
  - Family Education/Support
  - Substance Abuse Counseling
  - Substance Abuse Relapse Prevention
- Home and Community Services
  - Assertive Community Treatment
  - Home-Based Services
  - Therapeutic Respite Services
  - Behavioral Aide Services
- Day Services
  - Partial Hospitalization
  - Day Treatment
  - Psychosocial Rehabilitation

RESIDENTIAL TREATMENT AND INPATIENT HOSPITAL SERVICES

Residential Treatment Services
- Therapeutic Family Homes
- Therapeutic Group Homes
- Residential Treatment Centers
- Community Residential Treatment - Adults
- Community Residential Treatment and Recovery - Substance Abuse
- Residential Detoxification Services
- Other Residential Treatment

Inpatient Hospital Services

CASE MANAGEMENT SERVICES

Service Coordination
Clinical Case Management Services

## F. COST SHARING

Cost sharing for mental health and substance abuse services is based upon the same principles as cost sharing requirements for other health services. No cost sharing is applied to services such as mental health/substance abuse screening, inpatient hospital services, or other services which serve as alternatives to hospitalization. Cost sharing provisions are displayed on the table.

| MENTAL HEALTH & SUBSTANCE ABUSE SERVICES | Children & Adolescents | Adults | Cost Sharing |
|---|---|---|---|
| **SCREENING & ASSESSMENT** | | | |
| Mental Health/Substance Abuse Screening | X | X | None |
| Mental Health/Substance Abuse Assessment | X | X | Same as Diagnosis |
| **24-HOUR CRISIS SERVICES** | | | |
| Telephone Crisis Services | X | X | None |
| Walk-In Crisis Services | X | X | Same as Emergency |
| Mobile Outreach Crisis Services | X | X | Same as Emergency |
| Crisis Residential Services | X | X | None |
| **NONRESIDENTIAL TREATMENT SERVICES** | | | |
| Medical Management | X | X | Same as Visit |
| Prescription Drugs | X | X | Same as Drugs |
| Somatic Treatments | X | X | Same as Procedures |
| Ambulatory Detoxification | X | X | Same as Visit |
| Outpatient Therapy | | | |
| Individual, Family, Group Therapy | X | X | Same as Visit |
| Family Education/Support | X | X | Same as Visit |

| MENTAL HEALTH & SUBSTANCE ABUSE SERVICES | Children & Adolescents | Adults | Cost Sharing |
|---|---|---|---|
| Substance Abuse Counseling | X | X | Same as Visit |
| Substance Abuse Relapse Prevention | X | X | Same as Visit |
| Home & Community Services | | | |
| Assertive Community Treatment | | X | Same Home Health |
| Home-Based Services | X | X | Same Home Health |
| Therapeutic Respite Services | X | X | Same Home Health |
| Behavioral Aide Services | X | | Same Home Health |
| Day Services | | | |
| Partial Hospitalization | X | X | None |
| Day Treatment | X | X | None |
| Psychosocial Rehabilitation | X | X | None |
| **RESIDENTIAL & INPATIENT HOSPITAL SERVICES** | | | |
| Residential Treatment Services | | | |
| Therapeutic Family Homes | X | | None |
| Therapeutic Group Homes | X | | None |
| Residential Treatment Centers | X | | None |

| MENTAL HEALTH & SUBSTANCE ABUSE SERVICES | Children & Adolescents | Adults | Cost Sharing |
|---|---|---|---|
| Community Residential Treatment - Adults | | X | None |
| Community Residential Treatment & Recovery - Substance Abuse | X | X | None |
| Residential Detoxification Services | X | X | None |
| Other Residential Treatment Services | X | X | None |
| Inpatient Hospital Services | X | X | None |
| **CASE MANAGEMENT SERVICES** | | | |
| Service Coordination | X | X | None |
| Clinical Case Management Services | X | X | None |
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## G. DEFINITIONS

### ASSESSMENT AND DIAGNOSIS

**Mental Health/Substance Abuse Screening** - Initial screening to assess identified problems and make an initial determination of the presence of a mental or substance abuse disorder, the need for further evaluation and/or a comprehensive assessment, the clinical necessity for intervention at a specified level of care, and an appropriate referral for further services, if indicated.

**Mental Health/Substance Abuse Assessment** - Comprehensive assessment/evaluation of symptomatology and psychosocial functioning including the administration of such diagnostic testing deemed necessary and appropriate in specific instances. Results in the development of recommendations for the clinical necessity for intervention at a specified level of care.

### 24 - HOUR CRISIS SERVICES

**Telephone Crisis Services** - Emergency telephone services available 24 hours a day to assess the nature and severity of mental health and substance abuse crises, to determine the need for face-to-face emergency services, and to provide crisis intervention and referral for appropriate treatment.

**Walk-in Crisis Services** - Emergency services available 24 hours a day at facilities including clinics, hospital emergency rooms, and others to provide prompt, face-to-face assessment of the nature and severity of mental health and substance abuse crises and to provide crisis intervention and referral for appropriate treatment.

**Mobile Outreach Crisis Services** - Emergency services available 24 hours a day to provide on-site intervention in the settings and locations in which the crisis is occurring. Includes assessment of the nature and severity of mental health and substance abuse crises, crisis intervention, and referral for appropriate treatment.

**Crisis Residential Services** - Crisis services provided in nonhospital, residential settings which provide short-term, acute treatment for purposes of crisis intervention and stabilization for persons experiencing crises related to mental and substance abuse disorders. Includes services provided in a variety of settings including family treatment homes, group crisis residences, crisis stabilization units, and others which provide structure, supervision, and a variety of therapeutic interventions.

NONRESIDENTIAL TREATMENT SERVICES

**Medical Management** - Brief visits for a variety of care and treatment purposes including ongoing assessment and monitoring of psychiatric and substance abuse conditions, prescribing and monitoring medications and side effects, and assisting clients to manage symptoms.

**Prescription Drugs** - Prescribed medications necessary for the treatment of mental and substance abuse disorders.

**Somatic Treatments** - Treatments including pharmacotherapies, electroconvulsive therapy, dispensing of medications, maintenance on methadone and other narcotic agonists and antagonists and related oversight, and other somatic treatments deemed medically necessary and appropriate for the alleviation or management of mental and substance abuse disorders.

**Ambulatory Detoxification** - Treatment and clinical oversight services for the purposes of medical and/or social, and psychological management of an individual who is in the process of withdrawal from alcohol and/or drugs.

**Outpatient Therapy** - Psychotherapeutic counseling interventions provided at the most appropriate site including an office, clinic, home, school, or other location in the community as needed for the treatment of mental and substance abuse disorders. Includes:

> **Individual, Family, and Group Therapy** - Psychotherapeutic counseling services intended to treat mental and substance abuse disorders and delivered to an individual, family, or a group. Includes brief and extended treatment utilizing a variety of therapeutic approaches and may include such approaches as interactive therapy, behavior therapy, cognitive therapy, and adjunctive therapies.
>
> **Family Education/Support** - Therapeutic and educational interventions provided to families (and significant others) of individuals with mental and substance abuse disorders to provide education and consultation regarding the nature of the disorder, medication administration and monitoring, recognizing signs of relapse, risk reduction approaches, and specific skills which may assist in the care and management of a family member.

## RESIDENTIAL TREATMENT AND INPATIENT HOSPITAL SERVICES

### Residential Treatment Services

**Therapeutic Family Homes** - Treatment for children and adolescents with emotional disorders provided in the homes of trained families within the community. Treatment parents are seen as the primary therapeutic agents and are specially trained, licensed, and clinically supervised. Clinical, supportive, and case management services are provided to each child and treatment family. Typically one child is served in each therapeutic family home.

**Therapeutic Group Homes** - Treatment for children and adolescents with emotional disorders provided in the context of family-like, small group home environments. Therapeutic approaches include individual, group, and family therapy, behavior management, social skill development, and others. Levels of structure, staffing, and supervision incorporated into the therapeutic environment can be varied to serve children and adolescents requiring different levels of care.

**Residential Treatment Centers** - Treatment for children and adolescents with emotional disorders provided in structured and supervised residential treatment facilities. Therapeutic approaches include individual, group, and family therapy, behavior management, social skill development, and an educational component. Levels of structure, staffing, and supervision incorporated into the therapeutic environment can be varied to serve children and adolescents requiring different levels of care.

**Community Residential Treatment - Adults** - Active treatment for adults provided within a range of residential environments which offer treatment, rehabilitation, and support and include halfway houses, three-quarter-way houses, and other residential program models designed to provide time-limited, structured rehabilitation and treatment services in therapeutic communities. Services often serve as alternatives to hospital care and stress normalization and maximum community involvement and integration.

**Community Residential Treatment and Recovery - Substance Abuse** - Treatment and recovery services for individuals with substance abuse disorders provided in the context of a variety of residential environments. May include: 1) residential substance abuse treatment provided in chemical dependency programs, therapeutic communities, modified therapeutic communities (i,e.,

**Behavioral Aide Services** - Interventions which provide trained personnel who are deployed to provide one-to-one supervision and support to a child or adolescent with a serious emotional disorder in order to avert the need for treatment in a residential or inpatient setting. Includes services provided in the home or ~~school~~ for a specified number of hours per day or round-the-clock for a specified period of time.

**Day Services**

**Partial Hospitalization** - An intensive, integrated treatment program provided within a structured therapeutic setting for a portion of a day, but not extending overnight, and designed to serve as an alternative to acute hospital care and/or to restore or maintain the functioning of individuals with serious mental or substance abuse disorders. Involves the provision of a multimodal therapeutic program which may include individual, group, and family therapy, pharmacotherapy, expressive and activity therapies, skill development, psychoeducational services, and educational component for children and adolescents.

**Day Treatment** - An integrated treatment program provided within a structured therapeutic setting for a portion of a day designed to serve as an alternative to placement in a residential or inpatient treatment setting and/or to restore or maintain the functioning of individuals with serious mental or substance abuse disorders. Involves the provision of a multimodal therapeutic program which may include individual, group, and family therapy, pharmacotherapy, expressive and activity therapies, skill development, and psychoeducational services, and an educational component for children and adolescents. Includes full day, after school, evening, weekend, and summer day treatment programs offered in a variety of settings including schools, mental health centers, hospitals, or free-standing programs.

**Psychosocial Rehabilitation** - Interventions delivered to assist individuals to develop the skills and access the supports needed to achieve their maximum level of functioning within the community and to overcome the social and vocational handicaps associated with mental and substance abuse disorders. Includes services delivered in a variety of settings and interventions such as skill development, skill maintenance, and education related to activities of daily living (including instrumental activities of daily living), symptom management, preparation for attainment and maintenance of employment, socialization and recreation.

**Substance Abuse Counseling** - Psychotherapeutic counseling and educational interventions intended to treat substance abuse disorders delivered to an individual, family, or a group.

**Substance Abuse Relapse Prevention** - Counseling interventions for persons who are in remission or recovery from substance abuse disorders for the purpose of preventing relapse which are delivered to individuals, families, or groups.

**Home and Community Services**

**Home-Based Services** - Interventions provided on an outreach basis to work with individuals and their families, and delivered primarily in the home and community, for the purpose of averting the need for treatment in residential or inpatient settings or to facilitate the earlier return of individuals receiving inpatient or residential care. Interventions are multifaceted and include therapy, supportive counseling, skills training, and facilitation of access to other needed services and supports. Includes short-term, intensive approaches with the goal of stabilizing and connecting the individual with ongoing services and longer-term interventions with the intensity of services varying with clinical need.

**Assertive Community Treatment** - Interventions provided to individuals with serious, disabling mental illness for purposes including increasing community tenure, elevating psychosocial functioning, minimizing psychiatric symptomatology, and ensuring a satisfactory quality of life. Involves the provision and coordination of treatments and services delivered by multidisciplinary teams using an active, assertive outreach approach and including comprehensive assessment and the development of a community support plan, ongoing monitoring and support, medication management, skill development, crisis resolution, and accessing needed community resources and supports.

**Therapeutic Respite Services** - Interventions delivered for the purpose of providing a planned or unplanned break for an individual with mental disorders and his/her caregivers in order to reduce stress and prevent disruption of primary caregiving. Includes therapeutic respite provided in the home or in out-of-home settings such as foster homes or respite group homes for a period of several hours, overnight, or several days as determined to be clinically necessary and appropriate.

those with psychiatric and/or medical capability), or other community residential programs licensed to provide residential substance abuse treatment and 2) residential recovery programs such as halfway houses, quarterway houses, social model programs, and other community residential programs licensed to provide residential substance abuse recovery and support services.

**Residential Detoxification Services** - Treatment services provided within a residential environment for the purposes of medical and/or social, and psychological management of an individual who is in the process of withdrawal from alcohol and/or drugs.

**Other Residential Treatment** - Treatment, rehabilitation, and supportive services provided to individuals who are residing within a variety of other residential environments including board and care homes, supervised independent living, nursing homes, and others. Includes treatment and rehabilitative services, but not housing and nursing home costs which are financed through other funding streams. Interventions are intended to provide problem resolution, skill development, supervision, and support for the purpose of assisting individuals to make the transition to independent living. Includes clinical and rehabilitative services provided to older adolescents in preparation for independent living.

**Inpatient Hospital Services** - Active psychiatric and substance abuse treatment provided in general hospitals or specialized psychiatric hospitals for purposes of stabilizing and improving the condition of persons with mental and substance abuse disorders. Includes inpatient services to provide short-term, acute treatment and stabilization and long-term inpatient services for the extremely small percentage of persons who remain dangerous to themselves or others or whose illnesses result in extreme functional impairments. Includes medical detoxification in inpatient hospital settings only as required for the management of neuropsychiatric or medical complications associated with withdrawal from alcohol or drugs. Inpatient care for mental and substance abuse disorders is available only when less restrictive nonresidential or residential services are ineffective or inappropriate.

CASE MANAGEMENT SERVICES

**Service Coordination** - Case management services provided to children, adolescents, and adults with mental or substance abuse disorders for the purpose of planning and monitoring service delivery and assisting individuals to gain access to necessary medical, housing, social, educational, vocational, legal, and other related services,

resources, and supports deemed necessary for them to achieve their maximum level of functioning, particularly services not provided within the AHP.

**Clinical Case Management** - Case management services which combine clinical and coordinating functions and are provided to children, adolescents, and adults with serious and complex mental or substance abuse disorders. Includes taking a lead role in assessing needs, coordinating the development of a comprehensive service plan, ensuring that all needed treatment and support services are provided, adapting services to changing needs, providing necessary services, and monitoring the adequacy and appropriateness of services on a continuous basis. Typically involves smaller caseloads to allow for intensive involvement with each consumer and family.

## Risk Adjustment

The simulation results (see Cost Simulation section) for the Comprehensive Mental Health Benefit show that the Accountable Health Plans (AHPs) will receive substantial premiums for providing coverage for the treatment of mental disorders and substance abuse ($275 in 1994 dollars). As indicated by the simulation results roughly 36% of the premium is accounted for by the costs of treating the 2.2% of the population that is severely ill. The severely ill segment of the population are generally identifiable by the AHP and are typically not effective consumers in terms of advocating for care on their own behalf. Thus, the AHP stands to earn significant profits by collecting the "full premium" and either avoiding this population entirely or undertreating them.

The existing research on capitated mental health care provides empirical support for these concerns. Demonstration research on capitation of mental health benefits have revealed a tendency on the part of HMOs to shift patients to the public sector and to encourage disenrollment by people who are severely mentally ill. Risk adjustment of AHP premiums in conjunction with a carefully designed set of standards for monitoring and service use (see section on Standards and Quality Measurement) can constrain the propensity to undertreat and target services to the less impaired ("cream-skimming").

Techniques for risk rating of mentally ill persons are not well developed. The development of a patient classification system for psychiatric inpatients under Medicare's Prospective Payment System (PPS) demonstrated the weak explanatory power of available methods of classifying psychiatric patients for the purposes of payment. Risk rating a population is considerably more difficult than creating a hospital classification system. For this reason we believe a significant research effort is needed to develop a patient classification system for mental health and substance abuse.

In the interim, until a satisfactory classification system can be developed, we recommend a so-called mixed capitation system. Under a mixed capitation system a portion of the capitated premium is paid prospectively (e.g. 60%) with the remainder paid retrospectively on the basis of costs actually incurred. The payment would be based on aggregate mental health expenditures. Thus the average AHP with the average population mix in the nation would receive the average premium for their enrollees.

This approach to reimbursement reduces the incentives to "cream-skim" and undertreat the severely ill enrollees because the potential profits and losses from undertaking such actions are reduced. Thus even if the classification system used is flawed the incentive effects of

prospective capitated premiums have been attenuated. The cost of taking this mixed capitation approach is that some of the cost containment incentives have been reduced. Yet the evidence on the responsiveness of mental health providers to capitated payments suggest that even under a mixed system there will be significant reductions in utilization of hospital care in particular. The threat of overuse by paying a portion of the premium based on incurred costs we believe is small. This solution is similar in spirit to the solution to prospective hospital payment for psychiatric care under Medicare (TEFRA). The TEFRA payment system is in effect a mix of prospective and cost based reimbursement (with a cap on the level of risk sharing).

Staff from the Mental Health Working Group consulted with staff from Working Group 5 on insurance reform in developing this approach to risk adjustment for mental health and substance abuse. This approach fits within any of the options developed by Working Group 5 on Insurance Reform.

## Baseline Assumptions that Require Confirmation

The comprehensive model for ADM services is premised on a few assumptions that fundamentally affect the strategy for implementing the model. If any one of these assumptions is incorrect, adjustments would be required in the model and/or the implementation strategy:

- With the exception of persons in custody as a result of criminal proceedings, persons with ADM disorders will receive **all their healthcare** through an AHP.
- **All funding** streams for healthcare services will flow to and be consolidated in the HIPCs which will then fund AHPs on a capitated basis.
- The **costs** of care for the most severely disabled should be **borne equitably** throughout the healthcare system rather than in isolated programs.
- The current level of **state and local funding for ADM services will be retained** in the new system.
- Concrete, quantifiable **standards** and routine **monitoring** activities **will be imposed** to insure appropriate care for persons with ADM disorders. While large numbers of standards are unnecessary, those that are adopted will be enforced vigorously for this historically underserved and undemanding population.
- The **transition** to the new system of care will occur **simultaneously** for all populations and funding sources, at least on a state-by-state basis.[1]
- Federal funds will be available in adequate amounts to **support enabling services, service system development and training, and population based prevention activities.**[2] Federal funding will be integrated in formula grants that earmark amounts for the three components but do not separate each component for categorical treatment.

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[1] This is the current preferred option offered by the Transition Cluster #18. Other options under consideration involve phasing of populations over time, with Medicaid covered adults phased-in last.

[2] For descriptions of these system components, see Part 5, Section III.

- **"Preferred" or "essential" provider** designations are important methods for integrating current public providers into the new system during transition. States will be given the **flexibility** to assign this status consistent with their long-term strategy for creating a single service delivery system. These designations will be **limited to the transition period**, after which all providers must be successful competitors to remain in the system.

## Standards and Quality Measurement

The comprehensive benefit plan presents an unprecedented opportunity to fully integrate mental health services for all people with ADM disorders and eliminate costly service duplication and substandard systems of care. However, there is the possibility that without standards, quality measures and ways to monitor these, those most in need of ADM services will not receive adequate care in a system where the incentive may be to minimize service utilization. For those with severe ADM disorders standards and quality measures are especially critical because the public sector system will no longer be available to serve as a safety net. In addition, this group of people with severe disorders often requires a variety of coordinated services to ensure adequate treatment, so there is a further need to establish standards for organizing and linking ADM services with other service systems.

### A. General Standards

We support the general standards for the federal and state governments and the HIPCs and AHPs developed by the group that is addressing access and quality of care for low income, vulnerable, and underserved populations in the new system:

(1) We endorse the proposed federal responsibility to establish standards for universal access and non-discrimination, portability of coverage, proximity and accessibility of services.

(2) We agree it is imperative that a uniform data reporting system be developed so that plans can be assessed adequately for their delivery of care to all people.

(3) We also concur that HIPCs should conduct outreach adequate to notify all eligible people of their right to enroll in plans but they should also actively facilitate their enrollment in those plans.

(4) Further, we agree that AHPs should have demonstrable ability to provide services outlined in the benefit plan, that they should ensure services are accessible to all members of the plan and that they demonstrate the ability to provide services for underserved and high risk populations.

### B. ADM Specific Standards

In this section we propose standards for the States, HIPCs and AHPs that are essential to ensure adequate identification and treatment of people with ADM disorders. These standards

address the specific concerns regarding ADM disorders and are intended to supplement those developed for the overall health plan. At the time this document was prepared there was no clear direction from the overall group regarding the separation of responsibilities for the states and HIPCs. Thus, a revision may be needed to conform with the general standards.

National Board

-Shall have a representative from the ADM area

State

-Shall be responsible for forensic care involving people with ADM disorders

-Shall ensure that permanent institutional ADM care is available

-Shall be responsible for licensing, credentialling and monitoring of ADM facilities, programs and practitioners

-Shall establish a mechanism for ensuring coordination of health and other relevant service systems in the state (including but not limited to education, housing and social services)

-Shall ensure appropriate use of ADM funds

-Shall ensure that ADM utilization management standards are publicly available and evaluated

-Shall require the use of established practice guidelines for ADM disorders by all AHPs and ensure compliance (as they become available)

-Shall evaluate and implement ADM outcome measures (as they become available)

HIPC

-Shall have an ADM consumer or family member of an ADM consumer on the board

-Shall have a representative from the state ADM system

-Shall have representative from other service systems (e.g., social services, criminal justice system)

-Shall develop outreach programs to notify all eligible persons (including those with severe ADM disorders) of their right to enroll in AHPs and shall seek out and ensure the enrollment of underserved ADM populations

-Shall have an established and timely grievance and appeal procedure for complaints regarding AHPs and shall provide an ombudsperson to assist in filing of complaints regarding plans

-Shall be responsible for monitoring access of people with ADM disorders to AHPs

-Shall ensure that plans provide reasonable access to the array of ADM services outlined in the comprehensive benefit design or a substantially equivalent package of services

-Shall conduct studies of quality of care for ADM disorders using specific tracer ADM conditions and/or ADM services

-Shall collect consumer and provider data

AHP

-Shall provide ADM services in the least restrictive environment consistent with clinically appropriate care

-Shall have multiple ADM specialty providers available for screening, assessment, diagnosis and treatment

-Shall be capable of coordinating/linking health and ADM services with other social services (including but not limited to housing, juvenile justice system and education services)

-Shall ensure that treatment is planned in conjunction with ADM consumer or consumer designated representative

-Shall have available multidisciplinary teams to manage ADM cases

-Shall for complex cases involving those with ADM disorders have a capacity for developing individualized treatment plans and for ensuring interagency coordination and case management

-Shall have specific guidelines for ensuring confidentiality and informed consent among its ADM enrollees

-Shall be responsible for ensuring that it can provide the full list of ADM services specified under the list of benefits or substantially equivalent services

-Shall have grievance and appeal procedure for handling complaints about the plan in a timely manner with ombudsperson to help those (esp. those with severe ADM disorders) who may have trouble negotiating the system

-Shall provide court ordered services including involuntary treatment

## Quality Measures

In addition to those standards outlined for HIPCs and AHPs it is essential that there are measures of access and the quality of care that a given plan delivers. These measures will allow consumers to compare plans and will ensure that those in need of services are receiving appropriate care. People with severe ADM disorders are especially at high risk for receiving inadequate services. Traditionally quality of care measures are divided into three categories: structure, process and outcome. However, in this section we present our proposed measures in categories that conform to those used by the overall group: access, appropriateness of care and outcomes. Most of the measures will be collected by the AHP (except as noted otherwise) and monitored by the HIPC.

Access

1) Access to plan enrollment and services -- this can be assessed by:

a) determining the % of enrollees with ADM disorders seen for treatment in the plan and/or there might be a screen for ADM disorders given to all enrollees as part of a general screening assessment -- these data would be compared to findings from epidemiologic studies that indicate the expected number of people with ADM disorders (to ensure that underserved populations are represented it will be necessary to stratify the data by demographic variables known to be related to need such as income and ethnic/racial status).

b) The % of people with enrollment in specific AHPs should be assessed in jails, shelters, emergency rooms, schools, child welfare systems, juvenile justice systems and EAPs to determine not only if there is high % of people without enrollment but

also to determine if any particular plan is avoiding treatment of people with ADM disorders (data collected by the HIPC).

c) Another measure of access is the % of people with ADM disorders that disenroll from the plan in one year.

2) Access to specialty services -- this can be assessed by:

a) determining the % of people with ADM disorders seen by an ADM specialist during 1 year (there may need to be some adjustment for rural areas).

b) determining the length of time from identification of need until treatment by ADM provider

Appropriateness of Care

Appropriateness of care refers to the process aspect of quality of care measurement. There are a variety of general process criteria that could be used for measurement as outlined below. However, we would propose that the best way to be sure of adequate process (and clinically appropriate outcomes) is to have the HIPC monitor such aspects through yearly studies using tracer conditions and/or tracer services.

1) Continuity of care -- determined by tracer study

2) We would propose that there is a need for more specific quality measures (e.g., measuring the % of people with major depression who receive medication and/or psychotherapy; measuring the % of children with severe disorders who receive integrated multidisciplinary treatment plans). If the overall plan will implement these more specific measures then such measures could be proposed for the ADM area. This may be crucial to ensure that those people with ADM disorders at greatest risk for undertreatment (esp. those with severe disorders) receive appropriate care. Another way of addressing this is to use specific tracer conditions/services as noted above.

Outcomes

1) Consumer data -- A specific survey should be developed that would collect data from consumers with ADM disorders. Such a survey should be given to a sample of both those who received care during the preceding year and those who did not. In the ADM area it is important that both the consumer and a family member be given such surveys. It is also crucial that typically underserved populations be targeted to receive the survey. These

surveys might include such items as functional status measures, satisfaction scales and brief screeners of symptoms.

2) Provider data -- A specific survey for those delivering ADM services should be developed and administered to all providers of ADM services (this could include primary care physicians). Providers in other systems (e.g., social services, criminal justice system) should also receive this survey (data to be collected by the HIPC).

3) Mortality rates by plan -- would specifically want to follow suicide rates.

4) Readmission rates to any inpatient, residential or nursing home facility -- this is a potential proxy for lack of adequate outpatient services.

5) Like other disabling disorders, those with ADM disorders are at risk for poor outcomes especially if there is limited choice of treatment. Therefore, it may be necessary to develop outcome measures for certain high risk clinical problems. If such measures are used in the overall plan then such measures should be incorporated for ADM disorders.

Structural Variables

We think it is crucial to also monitor structural variables in the ADM area to ensure that plans have multidisciplinary teams to ensure adequate care. Such structural variables could include:

1) number of specialty ADM providers

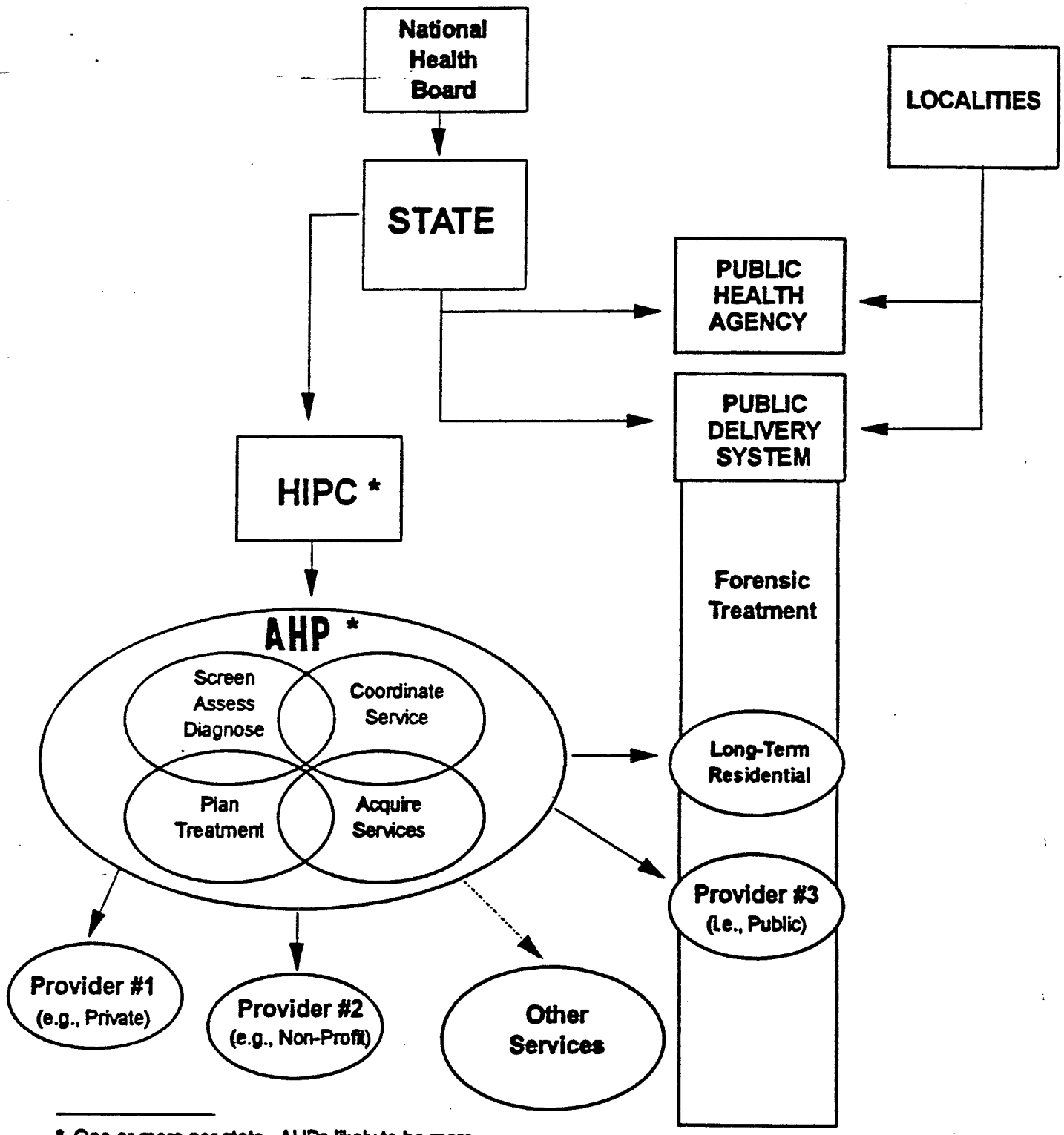
2) ADM provider/enrollee ratio

# COMPREHENSIVE PLAN: SYSTEM AND FINANCING MODEL

## I. Overall Description

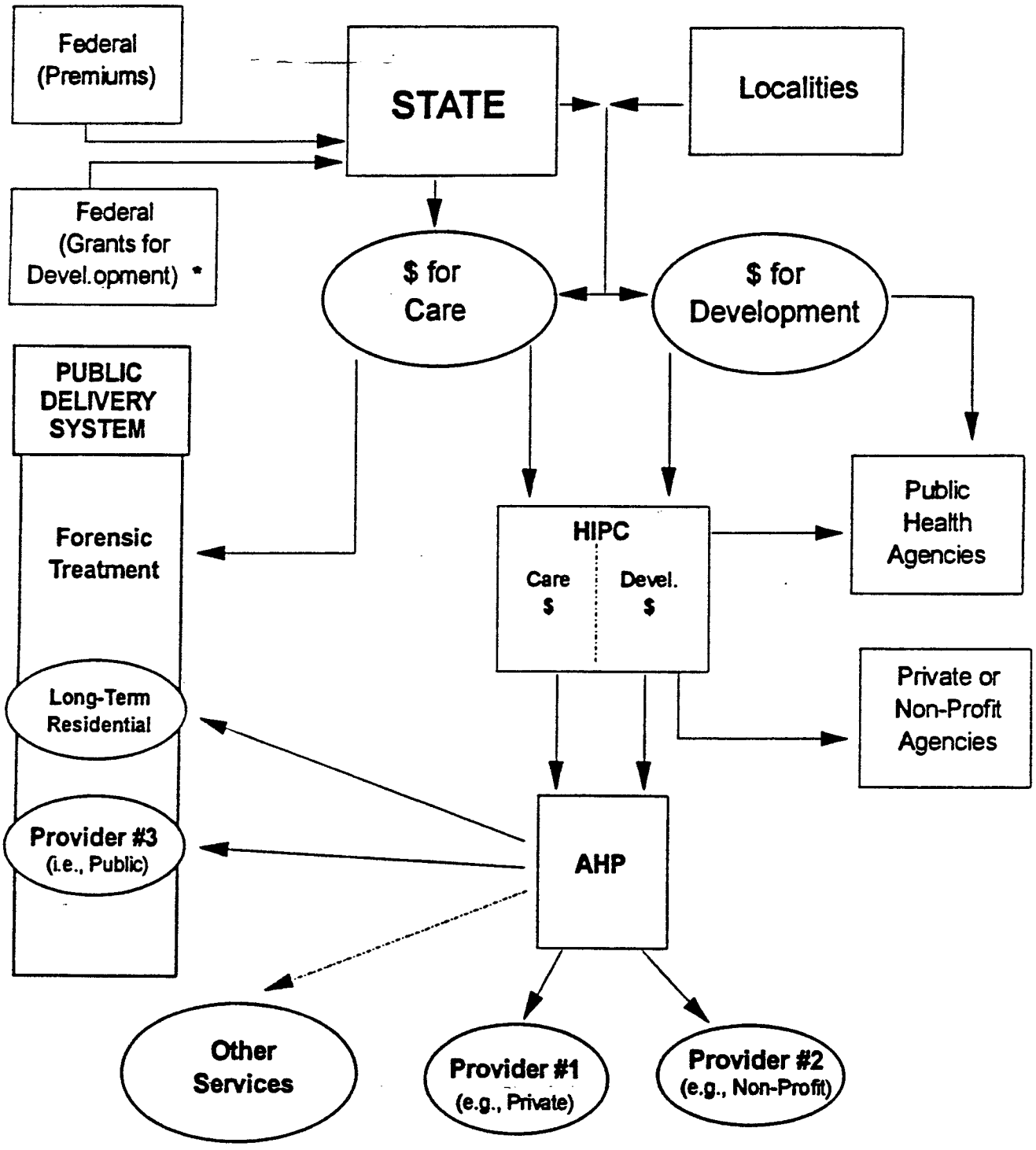
The comprehensive ADM system is outlined in the charts on the following two pages.

A. Service Delivery Model




* One or more per state. AHPs likely to be more.

B. Funding Stream Model




* Development = Capacity Development, Infrastructure, and Prevention

## II. Functional Responsibilities

### A. Government

1. Federal

- Finances a percentage of the cost of services to the poor and/or uninsured.[3]

- Operates the National Health Care Board to set national priorities and health goals.

- Supports the development and maturation of an effective service delivery system for ADM disorders, including activity in:

  1. Research, evaluation and dissemination: including development and testing of new theories and models of ADM services and service delivery systems, testing new theories and models on a pilot or demonstration basis, development and promulgation of guidelines for prevention and treatment services, technical assistance and knowledge dissemination.

  2. Infrastructure development: including funding programs at state and local levels, including seed funds for targeted capacity expansion, workforce development and training for ADM providers in such areas as prevention, diagnosis and treatment of ADM disorders, funding and technical assistance for development of new service technologies and organized systems of care and service coordination functions, and funding and technical assistance for development of organized systems of care.

  3. Planning and goal setting: including establishing goals and objectives, setting national priorities, defining problem areas, and assessing progress toward attaining goals.

  4. Health epidemiology and surveillance: including collection, analysis, and dissemination of information on the incidence and

[3] See Section V below. Replaces Medicaid. But a similar matching formula could be used.

prevalence of ADM disorders, service capacity and utilization, costs and outcomes of services, and evaluation.

5. Public health activities: including examination of national trends in need and service utilization among the various states, identifying market forces causing variation in service delivery patterns and identification of groups excluded from adequate care: for example migrants, illegal aliens, homeless adults and families, substance abusing pregnant women and persons with HIV or at risk for HIV infection.

6. Direct service activities: providing direct services to populations that remain direct Federal health care responsibilities, currently:

   - Prisoners incarcerated through the Federal prison system.
   - Active duty personnel in the armed forces.
   - Native Americans on reservations.
   - Refugee populations.

o Beyond the obligations incurred in the health care package, shares financial responsibility with the States in three major areas:

   - Prevention Services
   - Enabling Services
   - Infrastructure/Capacity Development[4]

Appropriate financial mechanisms, such as formula grants, will be used to distribute these funds at a level consistent with the need to create a recognized system of care for beneficiaries, especially seriously emotionally disturbed children, seriously and persistently mentally ill adults, and co-morbid substance abusers.

o Shares with the States the responsibility for major public health activities, such as surveillance of national problems, population-based prevention activities, and intervention in disaster situations.

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[4] See descriptions of these service components in Section III.

2. State

- Contributes a percentage of the costs of care for indigent and state residents with severe and persistent mental illness (SPMI) and children with serious emotional disturbance (SED).
- Maintains the current level of effort for ADM research, training, infrastructure and capacity development, prevention, and outreach.
- Determines HIPC service areas and creates/selects HIPCs.
- Regulates HIPCs and perform necessary oversight, monitoring and quality assurance functions.
- Ensures appropriate service delivery system linkages among state and local agencies necessary to enable AHPs to implement organized systems of care.
- Sponsors, through public health mechanisms, outreach activities that are designed to assist currently disenfranchised persons to gain access to the healthcare delivery system.
- Establishes treatment "groundrules" for AHPs, including other system linkages, breadth of acceptable services, outcome expectations.
- Delivers forensic mental health services[5] and safety net extended care inpatient services purchased by AHPs.[6]
- Provides population-based prevention services for state residents

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[5] Includes delivery of mental health services in prisons and other correctional facilities. Note that AHPs will be responsible for these persons immediately before and immediately after incarceration. Linkages between the healthcare system and corrections system are needed to ensure continuity of care and reduce excessive costs due to the failure to achieve early intervention. See Issues List.

[6] It is assumed that some number of state hospital extended care beds could be needed to supplement AHP provided hospitalization, especially for individuals with serious behavioral problems. While provided through a residual state system, these beds would be purchased by AHPs at a "penalty" rate which is greater than the cost of community based care and used per the AHP treatment plan.

3. Local

- o Contributes funds for indigent care and existing programmatic and physical plant assets to the healthcare delivery system.[7]
- o Ensures appropriate service delivery system linkages between AHPs and other local agencies providing related services.
- o Provides direct care under certain circumstances.[8]
- o Works with state and HIPC on community outreach and prevention activities with federal and state support.
- o Promotes citizen input to the development of healthcare delivery mechanisms which meet the unique requirements of the locality.

B. Service Delivery System

1. National Health Board

- o Establishes basic principles governing the healthcare delivery system.
- o Establishes national healthcare goals and a strategic plan to achieve them.
- o Sets basic practice standards, including preferences for least restrictive alternatives and mainstreaming of the mentally ill.
- o Sets oversight requirements for States, HIPCs and AHPs.
- o Sets guidelines that provide a framework for healthcare practice in the system.

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[7] Financial contributions would track current contributions, with some localities making a large contribution and others none at all.

[8] See Section VII. A. The Role of the Public Sector.

2. HIPCs

- Pools financial resources and manages the annual global budget.
- Solicits bids, negotiate and award contracts to AHPs.
- Monitors AHP performance.
- Prospectively and retrospectively risk adjust for high intensity service user outliers.
- Advocate on behalf of the needs of persons with ADM disorders.

3. AHPs

- Provide all health, mental health and substance abuse services and ensure linkages to supportive services and coordination with other systems.
- Provide comprehensive screening, assessment, diagnostic, treatment and rehabilitative services based on individual need.
- For persons with severe ADM disorders, develop organized systems of care that address treatment needs comprehensively and across multiple service systems and providers, using multi-disciplinary treatment teams, intensive case management and frequent case reviews and interagency coordination.
- Regulate access to services by ensuring that service frequency and/or intensity is commensurate with the severity of illness and medical and psychological necessity.[9] Provide access to ADM services through an ADM screener as needed and access to organized systems of care through multi-disciplinary ADM teams.
- Provide advocacy/brokering/case management services at a level of intensity necessary to execute the treatment plan.

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[9] Service provision is viewed as a function of medical or psychological necessity rather than desirability for all customers of the AHP. Desirable but unnecessary services are purchased outside the HCR system at full cost to the customer.

4. Providers

- o Deliver and document mental health and substance abuse interventions to enrollees of the AHP.
- o Can be AHP employees, individual providers and/or private, private non-profit and public system agencies under contract to the AHP.
- o Include multiple ADM specialists appropriate for the range of services specified in the comprehensive ADM benefit.
- o Deliver services that are responsive to the cultural characteristics of the communities they serve.
- o States have flexibility to define qualifications of providers within broad guidelines established by the National Health Board.

## III. Special Funds

There is a need for special funding to cover activities which are not included in the ADM benefit but which are critical to effective functioning of the new health care system for persons with ADM disorders. Three types of special funding are recommended.

### A. Description of Special Funds

"Enabling Funds"

Purpose: a) to provide outreach to populations who are typically underserved

b) to provide or arrange for facilitating services, such as transportation, translation, and child care, that enable typically low income and other underserved individuals to make use of ADM services

c) to develop and maintain interagency arrangements at HIPC and AHP levels to facilitate access to services and supports that are not included in the ADM benefit (e.g. housing, vocational rehabilitation, education and social services).

Why Needed: Many individuals with ADM disorders, especially those with serious disorders and those who are poor, have been underserved traditionally and tend not to be effective advocates on their own behalf.

Many individuals with ADM disorders, especially those with serious disorders and those who are poor, require additional help to make use of services, such as transportation or translation assistance.

Many individuals with ADM disorders, especially those with serious disorders and those who are poor, require services and supports that are not included in the ADM benefit, such as housing. Linkages with the agencies that provide these related services are critical to ensure that AHP clients receive necessary support services. These linkages need to occur at all levels of the health care delivery system (i.e. at HIPC, AHP and client levels).

Service Capacity Development and Human Resource Development Funds

Purpose:

a) to provide seed or start-up funds for development and expansion of community-based service capacity, targeted to services now in short supply (e.g. assertive community treatment, home-based services, family treatment homes, etc.)

b) to provide seed or start-up funds for development and expansion of organized systems of care for persons with serious ADM disorders, which include an array of services, interagency coordination and case review mechanisms, multi-disciplinary case planning and review, intensive case management and family and consumer involvement

c) to provide ADM workforce development and training to increase the supply of ADM providers and to ensure appropriate skills, particularly those related to newer community-based service technologies,, such as home-based services, and those needed for organized systems of care.

Why Needed: A major rationale for a comprehensive ADM benefit is that an array of services will allow for more appropriate care and alternatives to costly hospitalization. However, community-based services, especially the newer service technologies, are in short supply in most areas of the country. Development of the newer community-based service approaches needs to be stimulated.

Research demonstrates that services for individuals with serious ADM disorders are provided most effectively and efficiently through organized systems of care. However, experience in both the public and private sectors with creating and managing these systems of care is limited. Facilitating development of organized systems of care is needed.

There is a serious shortage of trained mental health and substance abuse professionals in many areas of the country. Shortages are especially severe of staff trained in the newer service technologies and in system of care principles and management. In addition to the shortcomings in the numbers and skills of the ADM workforce, minimal attention is paid currently by either the public or private sectors to assessing workforce requirements for delivering ADM services.

A major goal of a comprehensive benefit is to promote early detection and intervention. However, primary care providers often lack training in mental health and substance abuse. This is an important issue in all areas of the country, but it is especially critical in areas where there are severe shortages of ADM professionals, such as rural areas, where consumers will be relying on primary care providers for "front-line" ADM services.

Prevention Funds

Purpose: a) to reduce the incidence and prevalence of alcohol, tobacco, and other drug use and mental health problems by targeting individuals who do not yet require treatment for their substance use or mental condition. Population based prevention includes education and attitude change programs and policies for entire populations, and activities targeting sub-populations at particularly high risk of developing ADM disorders.

Why Needed: Research demonstrates that population-based prevention is effective in reducing the incidence and prevalence of ADM disorders. Core programs are those which have proven effective across a wide array of populations among diverse communities. Examples of such prevention activities include:

Community-wide -- public attitude and awareness campaigns; comprehensive community-wide prevention coalitions, public policy changes

Prenatal and infant -- prenatal and postnatal parenting training and outreach to families; targeted alcohol, tobacco, and other drug awareness campaigns

Child and adolescent -- comprehensive school-based health promotion programs and policies; non-school and after school substance abuse and violence prevention programs and policies

Adult -- work site wellness and health promotion/prevention programs and policies

Elderly -- medications, alcohol, and mental health awareness programs

**B. Funding Mechanism**

These funds could take the form of formula grants, trust funds or some other mechanism. They would be distributed by the federal government to the states (i.e. Governor). States would have the flexibility to distribute these funds to HPICs, AHPs, public or mental health authorities, local governments, private non profits, etc., based on the priority needs in the state.

This special funding does not necessarily need to be three separate grants or funds. Funding could take the form of one grant to the states, with certain percentages earmarked for "enabling" activities, service capacity and human resource development activities and prevention activities. Current ADM block grant funding could finance this special grant.

This special funding for ADM activities also could be part of a larger "pooled fund", comprised of all current federal categorical health funding. If that were the case, funds would need to be earmarked for ADM service capacity and human resource development activities and for ADM prevention; however, ADM "enabling" funds could be combined with other enabling funds since ADM and other health consumers have similar requirements with respect to outreach, facilitating services and interagency linkages.

## IV. Relationships/Linkages with Other Service Systems

Effective and efficient service delivery for persons with ADM disorders, particularly those with persistent and complex disorders, requires coordination of planning, program development, service provision and, possibly, financing, across service systems.

For children and adolescents, linkages are critical between the health care delivery system and the education, child welfare and juvenile justice systems. For adults,

linkages are critical with the housing, social services, long term care, criminal justice and vocational rehabilitation systems. Linkages obviously also are critical between the health care delivery system and the state mental authority for both populations.

Linkages are essential at the following levels:

- o systems level, that is, between HIPCs and other state agencies.
- o services or program level, that is, between AHPs and other agencies and systems providing related services.
- o client level, that is, between ADM providers and other service providers to ensure access to and coordination of services.

A. System Level Linkages - HIPCs need to develop memoranda of understanding with related state agencies that address system-level coordination issues, including:

- o the resources to be provided by the related state agency (for example, the HIPC might negotiate with housing to designate a certain number of Section 8 certificates for persons with ADM disorders);
- o the resources to be provided by the HIPC;
- o joint planning, needs assessment, research or prevention activities; and,
- o monitoring and evaluation issues (for example, monitoring of any cost-shifting from AHPs to other systems, such as child welfare or education).

B. Program Level Linkages - AHPs need to have protocols in place for ensuring linkages with other agencies providing related services. These may include agreements, memoranda of understanding, formal liaison arrangements or others which ensure that ADM providers work collaboratively with providers from other human services systems. Plans must ensure that participating providers have protocols in place for linkages and that providers are trained in interagency competencies.

C. Client Level Linkages - Coordination of services and linkages at the client's level will occur through case management mechanisms, including more intensive case management for individuals with persistent and complex ADM disorders.

Linkages typically do not occur, particularly at the program and client levels, unless the time involved in establishing and maintaining them is funded. At the HIPC and AHP levels, funds for linkage development would be available from the enabling fund described earlier. At the client level, case management is included in the comprehensive benefit premium.

D. Legislative Implications - In addition to HIPC/AHP standards, quality controls, monitoring and risk adjustment mechanisms, another route to minimizing underserving and cost-shifting is to provide as many incentives as possible to bring resources together across system boundaries when they are needed to adequately meet service delivery needs under the new system. The following are examples of actions that can improve access to enabling services for both children and adults:

- o amending the Individuals with Disabilities Education Act to require the AHPs to provide health/mental health and substance abuse services that are specified in a child's IEP (individualized education plan) or IFSP (individualized family services plan);
- o amending the child welfare statute to require the AHPs to provide health/mental health and substance abuse services specified in a child and family's case plan;
- o amending the Comprehensive Mental Health Community Services for Children Act to provide resources for service capacity development that are consistent with the ADM benefits package.
- o modifying eligibility criteria for other public benefits and services to provide that AHP clients with documented need receive priority consideration;
- o Condition Federal grants for social services, e.g. Section 8, welfare, etc., on formal linkage to the healthcare delivery system for functionally impaired persons who need such services to avoid hospitalization; and,
- o Encourage states, through targeted grant mechanisms, to supplement services in order to decrease health costs.

# V. Special Issues

## A. Role of the Public Service Delivery System

The comprehensive service delivery model assumes that current public providers of ADM services constitute an important resource that must be accommodated in the new system. It also recognizes that the current two-tiered service delivery system is inequitable and that services are often delivered inappropriately and/or inefficiently under the current system. The model copes with two realities by providing a clear methodology for incorporating current public providers into the system with certain constraints. The principal provisions for public providers in the new system are:

- Public providers from any public system that has ADM services capacity, e.g., public mental health, child welfare, education, juvenile justice can stay in business as "preferred" providers or as successful competitors.

- States are given the flexibility to designate preferred providers in their jurisdiction without mandating such a designation for any provider category or group at the national level.

- By the end of the transition period, assumed to be at least 5 years, all providers, including public providers must be successful competitors to remain in the new system.

- From the beginning, public providers deliver services through the AHP which perform basic treatment planning, gatekeeping and utilization review functions.

- From the beginning, public providers are reimbursed for services by the AHP under whatever contractual arrangement is made between the provider and AHP. Public providers can be guaranteed specified level of reimbursed service volume at fixed rates, but public provider budgets would no longer be derived through direct appropriations.

- Some number of state psychiatric beds remain available. If used, must come through AHP which purchases bed days on basis of customary costs (high cost = $ disincentive)

- o States continue forensic beds (full population carve-out).[10]

B. Housing

The comprehensive system model assumes that the increased costs of expanded coverage are offset, in part, by significant reductions in very expensive inpatient hospitalization utilization. Some of this inpatient care is for acute episodic services and some for longer term institutionalization of seriously and persistently mentally ill persons. Shifting of the costs for institutional care to community-based care depends heavily on the availability of alternative housing arrangements to achieve the required decrease in inpatient bed days. Finally, as inpatient hospitalization becomes increasingly unavailable because of the constraints of capitation, provision for alternative housing arrangement becomes an increasingly important protection against creating more mentally disabled homeless.

For these reasons, the linkages to other systems described in Section VI., D., are a crucial part of the service system design. But, effective linkage with other service delivery systems may not be enough. While it is clear that the political and economic risks of including housing entitlements in a healthcare package are likely prohibitive, some form of supplementation for housing costs for severely disabled persons who would otherwise remain hospitalized is necessary to make the comprehensive system successful.

Research demonstrates that adequate housing in non-healthcare settings accompanied by aggressive community-based mental health services delivery is both effective therapeutically and less costly than hospitalization. For this reason, substantive investment of both state and federal dollars in the "Enabling" fund described in Section V. is critical. Further, federal priority should be given to establishing a clear mandate at HUD to directly support, with the fewest possible bureaucratic barriers, funding for housing supports for the severely disabled mentally ill who need housing to avoid extended inpatient hospitalization and to accommodate presently homeless ADM persons who will be covered by the new system.

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[10] Doesn't include "civil" commitments, which are handled through AHPs under the comprehensive system. Civil commitments can be on an inpatient or outpatient basis. State contracting for involuntary hospitalizations in private hospitals now occurs in a number of jurisdictions.

C. Outreach

A disproportionate number of people unserved or underserved by the healthcare system suffer from ADM disorders, especially the homeless. Therefore, special attention to outreach activities is a crucial aspect of the healthcare "system" for ADM sufferers.

The comprehensive system model envisions outreach as a state/local public health function which targets high risk populations. However, AHPs should be expected to participate in outreach activities where services to enrolled clients place providers in contact with unserved populations.

A HIPC also has a broad outreach responsibility associated with overall management of its geographically defined service population.

States must ensure that outreach services are actually provided but that they are appropriately coordinated.

D. "Essential" or "Preferred" Providers

In order to take advantage of already developed service capacities, particularly for underserved populations or areas, "Preferred" or "Essential" providers should be permitted but only within the new system and only for a 5 year transition period.

The best assurance of the delivery of quality care to unserved or underserved populations is to include these populations and commensurate financial resources within the HIPCs, with appropriate standards and monitoring of AHP care delivery and a percentage of dollars targeted to infrastructure, outreach and development of linkages with related agencies. It is recognized, however, that during a five year transition period, it may be necessary for the HIPC to recognize preferred providers with whom AHPs would contract on a less than fully competitive basis, but that would be funded through HIPC resources rather than a separate Federal funding stream. Such preferred providers may be the only source of a particular type of care, etc. The recognition of preferred providers would ease the transition to the new system as well as take advantage of existing capacities.

However, at the end of a five year transition period, provider bidding to offer care for an AHP needs to be done competitively with two or more bidders

whenever possible. If competition is not possible, then HIPCs would need to control price from single source providers, subject to Federal monitoring. Careful monitoring would be essential to assure quality service delivery.

Creation of federally mandated groups of "essential providers" outside the HPIC structure and with no time limits on this protected status poses serious risks, among them: (1) political pressure by various special interests to be designated essential providers; (2) perpetuation of inefficient service delivery in some instances; (3) further reduction in incentives for the market to develop service capacity for poor or "unattractive" populations; and, (4) perpetuation of two-tiered, two-class delivery systems.

E. Unresolved Issues

There are several important issues that remain unresolved under the comprehensive model, mostly due to known inconsistencies in approach within other Cluster groups. These issues include:

- For persons insured under Medicare, will there be any opportunity to opt in to the comprehensive system, for example by paying an additional premium? If no, can these persons receive some form of service comparable to the comprehensive package through revision of Medicare coverage or development of a Medicare with residual Medicaid wrap around services?

- How do covered persons access nursing care and other LTC services?

- Should incarcerated persons be excluded from coverage as currently proposed? Many would argue that coverage should be extended to this population in order to avoid use of the criminal justice system as the last dumping options for those with intensive care needs. Also, improved ADM care for inmates of corrections programs has been shown to reduce recidivism and overall costs of care.

- Should cost-sharing for certain substance abuse services be eliminated so that there are not financial disincentives to treatment

- Should the residual Federal role, beyond that set out under Section II, Federal Functions, be spelled out in greater detail? There are other technical assistance, oversight, evaluation and supportive functions that

could enhance the contribution made by the Federal government to healthcare reform.

- o Should links to other services system be forged within the healthcare reform legislation? For example, treatment services required under Individual Education Plans required under the Education for the Handicapped Act, child welfare statutes, housing subsidies under a variety of federal statutes could enhance the potential for comprehensive, integrated services for persons with ADM disorders.

## VI. Financing/Payment Mechanisms

Capture of state and local dollars now spent for ADM services is a crucial component of the Comprehensive Service Plan because approximately twice the proportion of state and local funds is invested in ADM services as in other healthcare services. In addition, there is significant differential in the type, quantity, and quality of services delivered to persons suffering from ADM disorders among the states, making equitable adjustments in funding necessary if a standard benefit package will be offered to all Americans. The following paragraphs address important considerations regarding this issue.

### A. Important Principles

- o The current state and local investment in ADM services must be retained in the new system to make it financially viable without major infusion of new federal funds.

- o Localities (counties, municipalities) spend money on ADM services. Capture of those funds should be a state obligation if the state determines it is necessary to meet its financial obligations under the health care system.

- o AHPs must serve all enrolled persons to assure universal coverage and to spread risk across the broadest population group. There can be no population carve-out.

- o HIPCs must be the focal point for all financial resources in the plan to assure a single point of financial accountability and to simplify accounting procedures and administrative overhead. There can be no financial carve-out.

- The fundamental state obligations met through its contributions to the healthcare system are:

  a. supporting state residents who cannot afford to pay for their health insurance, and

  b. meeting historical obligations to deliver ADM services to state residents.

- Federal contribution for healthcare are primarily directed at achieving uniformity in the availability of good quality healthcare services among the states.

- Insurance premiums are assumed to be community-rated.

- The new system should not result in a decline in the current level of appropriate care to any population.

- Payment for services actually delivered should be on a **capitated** basis, with provision for risk adjustment.

The specific details of both the financing strategy and the payment mechanisms necessary to accomplish funding of the comprehensive ADM benefit will depend on the financing mechanisms established for the overall healthcare system. Specific decisions are required in the following areas:

1. whether insurance premiums will be calculated to include part or all of the projected costs of healthcare for the currently uninsured or severely disabled persons now served by the public system;

2. whether premiums will be paid through federal state or HIPC administrative channels, thus affecting flexibility to redirect revenues to more needy states;

3. the extent to which states will be able to bear the costs of the difference between revenues from premiums and the costs of healthcare, i.e. how much leveling will be required system-wide; and,

4. What mechanism will be used to capture state and local dollars that are now invested in other healthcare activates that will be covered in the new system.[11] In general, a uniform mechanism for capturing all state healthcare funds is preferable although not necessary.

## VII. Opt-Out Scenario

- o For basic services, including mental health for non-SPMI/SED populations, federal government certifies and deals directly with HIPC(s) in opt-out state, by-passing state involvement and ensuring coverage for state citizens within HCR system. This is same as the whole system scenario established by Cluster 1.

- o For persons with severe ADM disorders, 100% State responsibility for service delivery (a full SPMI/SED populations carve-out), OR inclusion in LTC Package.

## VIII. Transition

It is preferred if all populations should enter the system at the same time, with full population coverage through the HIPCs and appropriate financial resources made available to the HIPCs for needed care. Full integration of all populations into the new system is preferred because: (1) it would help assure that the HIPCs could use actuarial and insurance practices to spread risk to the broadest population group, while assuring quality care at a reasonable price, and (2) it would allow all persons to take advantage of the comprehensive ADM benefit rather than staying in the current fragmented and generally ineffective system.

The comprehensive model depends on multiple funding streams to finance care to a mix of populations -- without a direct correspondence between populations and current resources. As a result, it would be preferred to develop an implementation plan that covers all populations and pools all of the funding at one time. Service

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[11] As discussed in Mental Health Working Group documents, there are five basic mechanisms that could be used to capture state dollars: (1) contractual arrangements based on state plans approved by the federal government, (2) federal matching of funds as a persuasive incentive to contribute state funds, (3) formula grants based on level of state contribution, (4) compliance with a legislated formula for state contributions that is a condition of participation in the overall healthcare system, and (4) a reinsurance mechanism for states to purchase coverage for extended mental health and substance abuse care for all state residents from the federal government as a replacement for the public sector system.

capacity would need to develop in phases, and certain "preferred" providers might need time to enter a competitive market, but the comprehensive model would best be served by a full implementation strategy with a short timetable. Although a phased implementation in which employed populations enter first, followed by the uninsured (employed and unemployed) along with state categoric resources, followed by Medicaid is feasible, it is associated with several serious problems. First, this phasing strategy could compromise the care of the Medicaid population by delaying its entry into the new, comprehensive system. Second, it could lead to escalating costs on two fronts (coverage of the uninsured and Medicaid). Third, the creation of parallel ADM healthcare financing systems could lead to duplication of burdensome administrative costs and system-to-system fragmentation.

Timetable

Transition will likely be multi-staged, involving at least three levels of implementation:

Level 1: At 18 months - the service delivery system is in place for all citizens. Many services continue to be delivered by current public and private providers under varied arrangements with AHPs.

Level 2: At 5 Years - all AHPs and providers are playing under essentially the same ground rules and the playing field has been leveled.

Level 3: At 10 years - system integration is achieved, with permanent functional responsibilities between the public and private sector resolved. Implementation is complete.

It is assumed that more public providers will be "preferred providers" early in transition and more "competitive" later in transition, if they remain in business at all.

As a general rule, direct care delivery by public providers declines as transition progresses. The public focus is increasingly on coordination with other public systems, regulation and outcome measurement analysis, and public health functions.