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BEHAVIORAL HEALTH ISSUE BRIEF SERIES

Double Issue Brief #11 & 12

Care Coordination and Physical and Behavioral Service Integration in Managed Care Contracts: Analysis and Sample Purchasing Specifications

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Introduction

This double Issue Brief on the issue of managed care contracts and care coordination has been prepared for the Substance Abuse and Mental Health Services Administration as part of a series that examines legal issues in managed care for persons with mental illness and addiction disorders. This Issue Brief is presented in two parts. Part 1 presents an analysis, based on managed care contract data bases developed by CHSRP, of the extent to which public and private group purchasers maintain agreements that specify care coordination as part of the standard of care for persons with co-occurring physical and/or behavioral illnesses and conditions. Part 2 sets forth sample purchasing specifications that are designed to establish care coordination as part of the standard of care.

Part 1

Background and Overview

In recent years, as data regarding the co-occurrence of physical and behavioral illnesses and conditions have mounted, health professionals, professional societies, managed care organizations, managed care purchasers, and public policy makers have begun to pay increased attention to the issue of physical and behavioral health service integration. The growing attention to the issue of integrated care is not based merely on financial and

administration considerations, although the role of integration in reducing “inefficiencies” and cost is a matter of concern.¹

More fundamentally, the movement to integrate physical and behavioral health care appears to be embedded in the basic belief that integration is fundamental to the professional standard of care itself. This evolving concept of the standard of primary health care reflects a growing body of research that finds a strong correlation between certain physical health symptoms and the presence of one or more forms of commonly experienced “behavioral” illnesses and conditions.²

The professional standard of care is a dynamic concept that sets the legal standard of performance for medical and health professionals. The professional standard has its roots in 18th century English jurisprudence and continues to be the standard by which the quality of care is measured today.³ As advances in medicine, science, and the understanding of health care quality evolve, so does the professional standard of care.

It is most typically in the context of professional liability litigation that one sees discussions of the professional standard of care. However, modern legal scholars have evolved broader goals for the concept, having identified the professional standard of care as a matter that should be the subject of prospective and deliberate, contractual negotiations between health care providers and consumers of health services.⁴

It is therefore not surprising that matters related to the standard of care arise within the legal framework in which managed care operates. Managed care constitutes health care merged with risk-based financing⁵ and has as one of its primary goals improving the quality of care through the organization and rationalization of health care delivery. As a result, it is logical to expect that the legal framework that governs managed care should focus on issues related to the standard of care, in this case service integration and care coordination. Furthermore, in the relatively deregulated legal environment in which American health care providers operate,⁶ it is logical to expect that contracts between buyers and sellers constitute the primary source of law in which prospective negotiations over the standard of care will be conducted.

¹ See, e.g., Stephen P. Melek, “Research Report: Financial Risk and Structural Issues Related to the Integration of Behavioral Health Care in Primary Care Settings under Managed Care” (Milliman and Robertson, Seattle, WA) (undated). This monograph cites as its first basis of justification for an integration focus the fact that “healthcare costs are back on the rise!” (p.2).

² *Id.* See also Surgeon General’s Report on Mental Health (HHS, 2000).

³ Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, NY, NY 1997; 2000-01 supplement)

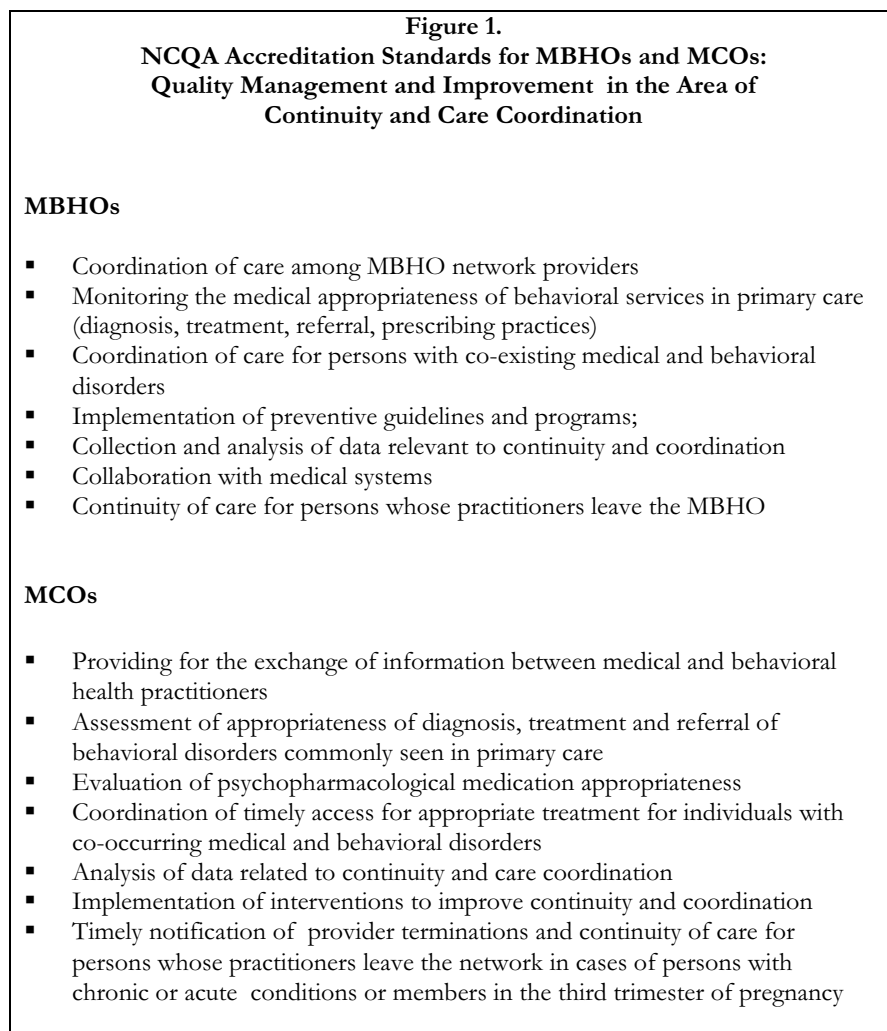
⁴ Clark C. Havighurst “Altering the Applicable Standard of Care,” 49 *Law and Contemporary Problems* 2655 (Spring, 1986).

⁵ *Pegram v. Herdrich*, 530 U.S. 211 (2000).

⁶ This is not to suggest that there is no regulation of managed care. In recent years both federal and state policy makers have become increasingly willing to consider regulation of the industry. Anecdotal evidence in the form of interviews with purchasers and industry leaders suggest that most of the regulatory standards adopted, whether by statute or rule, tend to reflect measures of performance that are already encompassed in the majority of contractual arrangements and thus have gained at least the tacit acceptance of the managed care industry.

At least in theory, were the industry to set its own self-imposed and clearly articulated standards for service integration and care coordination, contracts would not have to articulate the standard of care; instead, they would merely reference the industry's own standards. In the context of managed care, the industry standard can be found in the accreditation standards that govern managed care. Coordination of care is a matter addressed in at least one of the major managed care accreditation systems, with separate standards for behavioral and general service health plans.⁷

An examination of the accreditation standards set forth in the accreditation materials maintained by the National Committee on Quality Assurance indicates that continuity and coordination of care are essentially part of the anticipated standard of care for both managed behavioral health organizations and general service managed care organizations. The NCQA standards address the topics depicted in Figure 1.



⁷ National Committee on Quality Assurance, Accreditation Standards for Managed Care Organizations and Managed Behavioral Health Care (Washington D.C., 2001).

However, not all managed care organizations are accredited; alternatively, some managed care purchasers may believe that the standards set forth in accreditation guidelines are sufficient to address their needs. The desire on the part of a buyer for a *more customized standard of care* may be particularly strong in the case of certain purchasers, such as Medicaid agencies, whose patients are sicker and higher risk, disproportionately members of racial and ethnic minority groups and disproportionately in need of health service delivery in a culturally competent fashion. In addition, the typical Medicaid service benefit plan is broader than that available to privately insured persons (especially in the case of children), and Medicaid patients may be more likely to intersect with multiple “systems of care” (e.g., child welfare agencies, school-based health services, the judicial system; public agencies furnishing mental illness and addiction disorder services, agencies with oversight of care for persons with developmental disabilities or mental illness, and other entities responsible for health care).⁸

For example, the NCQA standards are designed to set the standard of care for a privately insured population whose coverage is driven by conventional insurance principles and classic concepts of insurance contractual benefit design. Under these classic concepts, coverage (and thus service) duties are driven by the “four walls” of the insurance contract. As a result, the NCQA standards (understandably) do not address the issue of an entity’s ability to coordinate its services with *extra-contractual* benefits and out-of-plan sources of care. This issue is important to Medicaid agencies, as illustrated by previous studies of Medicaid/MCO contracts,⁹ both because of the needs of the patients and the broader nature of Medicaid coverage. Similarly, the NCQA care coordination standards, beyond describing the generic competencies of the professionals conducting coordination activities, do not specify standards for the accessibility of services or the specific competencies of care coordinators, a matter not uncommon in Medicaid contracts.

Because Medicaid agencies may be somewhat less likely to contract with NCQA-accredited MCOs and MBHOs and have service and coverage “customization” expectations that extend beyond those embodied in NCQA accreditation standards, we assumed that most, if not all, Medicaid contracts would address care coordination and service integration. Medicaid contracts are extremely complex, reflecting the different standards and expectations by which they are governed. Even though managed care entities that specialize in serving the Medicaid population can be expected to develop their own “customized” standard of practice in light of the higher risk nature of the populations they serve (and studies of Medicaid-only MCO performance tend to confirm this),¹⁰ the public procurement nature of Medicaid managed care spurs the use of lengthy and detailed contracts regardless of the industry standard, in order to ensure direct accountability to the purchaser.

We also assumed that managed care contracts governed by private insurance principles (i.e., contracts applicable to employer-sponsored plans) would be less likely to

⁸ Sara Rosenbaum, et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (George Washington University, Washington D.C., 1997; 1998 and 1999 editions)

⁹ *Id.*

¹⁰ Bruce E. Landon and Arnold Epstein, “Quality Management Practices in Medicaid Managed Care: A National Survey of Medicaid and Commercial health Plans Participating in the Medicaid Program,” 282 JAMA (18) (Nov. 10, 1999); Suzanne Felt Lisk, *The Characteristics and Roles of Medicaid-Dominated Managed Care Plans* (Kaiser Commission on Medicaid and the Uninsured, Washington D.C., 2000).

address the matter of care coordination in depth. Our assumption was based in part on the existence of coordination as an accreditation matter, and in part on our belief that private group purchasers would (quite possibly incorrectly) not perceive their members as having the types of heightened health risks and problems that merit in-depth attention to the twin issues of service integration and care coordination.

Methodology

For this study we conducted two separate legal analyses that were designed to determine the extent to which physical/behavioral service integration and care coordination are specified as part of the formal standard of care within managed care contracts and purchasing documents.

In the case of service integration, we studied the extent to which public and private purchasers define primary health care to include the concept of “primary behavioral” health care, since such a definition would be clear evidence of an expectation on the parties’ part of a formal behavioral health care component as part of the primary care standard of care. In our earlier studies for SAMHSA of Medicaid managed behavioral health care, we noted that some contracts appeared to specify the inclusion of behavioral health services, not only as a specialty service (either within a general service agreement or a separate behavioral health contract), but as primary care itself.¹¹

In order to conduct these analyses, we conducted two separate reviews. The first involved a review of all contracts between Medicaid agencies and managed care organizations (both general service entities and specialty behavioral health organizations). The data base used to conduct this review is the product of a point-in-time, annual assessment of Medicaid managed care contracts, which has been in continuous operation since 1994 and which has been designed and maintained in a special data base by CHSRP. The data base is searchable electronically and permits detailed analysis of very large legal documents to examine issues of contract design. The contracts used for this analysis were in effect in 1999.¹² Some of the contracts included in the data base are agreements prepared by states that either never “went live” with their managed care arrangements or else have subsequently terminated their contracts. However, the contracts continue to reflect a means of measuring how states conceive of managed care and their expectations of managed care as a matter of general policy.

A total of 52 contracts are included in the 1999 data base; 39 are general and 13 are “behavioral.”¹³ However, most general services agreements do in fact contain at least some level of coverage for “behavioral” services as distinct services. Separate behavioral contracts most commonly are used to provide services for persons whose mental illnesses and addiction disorders fall into a higher level of severity than that which can be addressed under the standard of coverage found in conventional insurance agreements.

¹¹ Sara Rosenbaum, et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (Special Ed., 1997)

¹² The 2000-01 data base is in its final stages of construction.

¹³ Iowa is the only state that maintains separate behavioral contracts for mental health and substance abuse.

The second review involved a data base consisting of nine employer-sponsored agreements involving state employee benefit plans. These agreements were collected during the 1999-2000 time period. The states from whom the contracts were collected were California, Colorado, Rhode Island, New York, Ohio, Wisconsin, New Jersey and Maryland.

Four sets of tables were prepared and can be found in Appendices A-D. Appendices A and B contain all entries relevant to care coordination from both the Medicaid contracts and the employer sponsored agreements, respectively. Appendices C and D contain all entries for the Medicaid contracts and employee benefit contracts, respectively, related to the definition of primary care.

From Appendices A and B, we prepared a typology that synthesizes the contents of the care coordination provisions of the contracts and analyzes their provisions. The results of this synthesis and typology are found in Table 2. From Appendices C and D we prepared Table 1, which sets forth definitions of primary care found in those public and private contracts that specify a definition of primary care that includes behavioral health care.

For purposes of this study we also adopted a definition of “care coordination” based on that developed by researchers at Mathematica Health Policy who have studied care coordination extensively for the Center for Health Care Strategies. Under this definition, care coordination consists of the activities shown in Figure 2. From this definition we developed the typology presented in Table 1. To this typology we added the concept of performance measurement.

Figure 2. Care Coordination Defined

- Activities designed to increase access to care and the quality of care
- Access assistance extends to community services and beyond contract services
- Operates as an independent, identifiable function in managed care
- Supported by an information system dedicated to care coordination and linked to other managed care information systems
- Contains policies and procedures describing the relationships between care coordinators and health care providers
- Contains a specification for written plans of care
- Includes ongoing monitoring and modification of care plans when needed
- Is readily accessible
- Is furnished by individuals with appropriate training, in accordance with formal standards

Source: Center for Health Care Strategies (2001)

Findings

Contractual integration of behavioral health care into the primary care standard of care

Tables 1 and 1A show the integration of primary care into behavioral health care. Among the Medicaid contracts, two agreements (California and Oklahoma) contain language that specifically references the link between primary care and behavioral health. The remaining agreements, while referencing primary care, are silent on what is meant by the term; other than identifying acceptable categories of primary care practitioners, the agreements do not discuss the function of primary care itself.

The California contract (Table 1) is the only agreement that explicitly assumes that some level of behavioral health treatment and management will occur within the scope of primary care. Oklahoma’s agreement is diametrically opposed; the language of the contract implies that any level of behavioral health care furnished by a primary care physician would be viewed by the state as an impediment to appropriate care. For all relevant language, see Appendix D.

Table 1.
Medicaid Contracts that Include Behavioral Health as Part of the Primary Care Standard of Care

State	Definition
California	<p>The following mental health services are excluded from the Contract: all of SD/MD mental services (inpatient and outpatient); FFS/MC outpatient mental health services provided by psychiatrists and psychologists; FFS/MC inpatient mental health services; and all psychotherapeutic drugs prescribed by psychiatrists.</p> <p>The Contractor will provide outpatient mental health services within the Primary Care Physician's scope of practice. The Contractor will refer Members who need specialty mental health services to the appropriate FFS/MC mental health provider or to the appropriate SD/MC provider. The Contractor will case manage the physical health of the Member and coordinate services with the mental health provider of the Member. The Contractor will provide all psychotherapeutic drugs prescribed by its Primary Care Providers.</p>
Oklahoma	<p>Primary care physicians will not act as gatekeepers or case managers for behavioral health services. Contractor must establish an internal utilization management process specifically to oversee the furnishing of behavioral health benefits. The purpose for this utilization management function is to ensure that all members are able to obtain medically necessary behavioral health services as readily as possible, and in the most clinically appropriate and cost-effective setting.</p>

Among the nine employee benefit contracts reviewed, only Wisconsin’s definition suggests an ability to identify and at least primarily manage any condition, whether physical or behavioral. Wisconsin’s definition is shown in Table 1A. See Appendix C for all relevant language.

Table 1A.
Employer Plans that Include Behavioral Health as Part of the Primary Care Standard of Care

State	Definition
Wisconsin	<p>Definitions: Primary Care Provider: Means a Plan Provider who is a physician named as a Participant’s primary health care contract. He/She provides entry into the Plan’s health care system. He/She also (a) evaluates the Participant’s total health needs; and (b) provides personal medical care in one or more medical fields. When medically</p>

needed, he/she then preserves continuity of care. He/She is also in charge of coordinating other provider health services and refers the Participant to other Providers of Health Care. You must name your Primary Care Provider on your enrollment application or in a later written notice of change. Each family member may have a different primary physician

Care Coordination

Medicaid contracts

Table 2 in the Appendix presents a typology and synthesis of the Medicaid care coordination entries found in Table A in the Appendix.

Care coordination as a contractual service. Among the 52 contracts reviewed, 38 address care coordination. Table 1B shows language from two of the 38 contracts that address care coordination.

Table 1B. -- Examples of Care Coordination as a Contractual Service

State	Contract Language
New Mexico (General)	<p>"2.A.5 Referral and Coordination: The CONTRACTOR shall have and comply with written policies and procedures for the coordination of care and the arrangement, tracking, and documentation of all referrals including referrals to the following providers: behavioral health providers...</p> <p>2.A.5.a Coordination of Physical and Behavioral Service Benefits: Physical health and behavioral health services must be provided through an integrated, clinically coordinated managed care system. Both behavioral and physical health care providers need access to relevant medical records of mutually served members to insure maximization of the benefit of services to the member.</p> <p>"2.D.30.h Case Management Services for The Medically at Risk: Case management services for individuals who are under twenty-one (21) who are medically at risk as set forth in Medical Assistance Division Program Manual Section MAD-744, EPSDT CASE MANAGEMENT." New Mexico Contract, page 44.</p> <p>"2.D.31.b Case Management Services or the Chronically Mentally Ill : The benefit package includes case management services as set forth in the Medical Assistance Division Program Manual Section MAD 773, CASE MANAGEMENT SERVICES FOR THE CHRONICALLY MENTALLY ILL." New Mexico Contract, page 45.</p>
Ohio (General)	<p>"2. Mental Health Services... HMOs will work with ODMH and ODHS to develop care coordination protocols necessary for the successful management of mental health and physical health conditions for enrollees. Core elements of care coordination protocols include, but are not limited to: a) Assisting primary care providers in determining when an enrollee should be referred to local mental health providers for specialized mental health treatment, and in developing appropriate linkages and coordination. b) Assisting mental health providers in determining when an enrollee should be referred back to primary care providers, and in determining appropriate linkages and coordination. c) Specifying the arrangements for the timely sharing of all pertinent clinical information between mental health and primary health providers in accordance with applicable federal and state regulations." Ohio RFP, pages 15-16.</p>

State	Contract Language
	<p>"3. Substance Abuse Services... HMOs will work with ODADAS and ODHS to develop policies and procedures which address all issues necessary to establish effective referral and linkage, including confidentiality procedures, scope and frequency of mutual reporting assessment and treatment information, procedures necessary for accessing treatment services and management of care, and problem resolution procedures, i.e., care coordination protocols necessary for the successful management of alcohol and other drug addiction treatment services and physical health conditions for enrollees. Core elements of care coordination protocols include, but are not limited to: a) Assisting primary care providers in determining when an enrollee should be referred to local alcohol and drug addiction treatment service providers for specialized alcohol and drug addiction treatment, and in developing appropriate linkages and coordination. b) Assisting alcohol and drug addiction treatment service providers in determining when an enrollee should be referred to primary care providers, and in developing appropriate linkage and coordination. c) Specifying the arrangements for the timely sharing of all pertinent clinical information between alcohol and drug addiction treatment service and primary care providers, in accordance with applicable federal laws and state statutes. d) Assisting primary care providers and alcohol and other drug treatment service providers in complying with requirements of Substitute House Bill 167 as described in Section V.B.5. of this RFP document." Ohio RFP, pages 16-17.</p> <p>"Core elements of care coordination protocols include, but not limited to: ... a) Assisting Primary care providers in determining when an enrollee should be referred to local mental health providers for specialized mental health treatment, and in developing appropriate linkages and coordination. b) Assisting alcohol and drug addiction treatment service providers in determining when an enrollee should be referred to primary care providers, and in developing appropriate linkage and coordination. c) Specifying the arrangements for the timely sharing of all pertinent clinical information between alcohol and drug addiction treatment service and primary care providers, in accordance with applicable federal laws and state statutes. d) Assisting primary care providers and alcohol and other drug treatment service providers in complying with requirements of Substitute House Bill 167 as described in Section V.B.5. of this RFP document." Ohio Contract, page 17.</p>

Twenty-five of the agreements containing care coordination language are general service (two-thirds of the 39 general service agreements), while 13 are behavioral (all of the behavioral agreements). Among the 38 states that address care coordination, two (Maine and North Dakota) exclude it as a service, while several others partially exclude coverage for certain populations. Fourteen contracts are silent on the issue of care coordination.¹⁴

The contracts vary significantly in how they define the functions of care coordination. Furthermore, few agreements specify as an explicit contractual performance standard the structure and operational elements specified by the Mathematica study, *supra*.

Care coordination as a subject of performance measurement. Contracts can not only set forth standards to which the parties have agreed but also, in complex contractual cases such as managed care, identify how performance will be measured. Among the 38 contracts that include some level of care coordination as a contractual obligation, five agreements appear as

¹⁴ Under normal rules of contract interpretation, silence would probably be interpreted as non-coverage. See Corbin on Contracts (7th ed.) (West Publishing, St. Paul., MN, 1998)

a contractual matter to make care coordination the subject of performance measurement. Table 1C shows language from two of these five agreements.

Table 1C. -- Examples of Care Coordination as a Subject of Performance Measurement

State	Contract Language
Kentucky	<p>"Coordination of Benefits Between Partnership and MBHO Contractors</p> <p>Coordination and continuity of care for physical and behavioral health care services are required.</p> <p>Contractors for Medicaid managed physical and behavioral health care services must be able to coordinate assessment, treatment, and follow-up for members as they utilize multiple providers, services sites, and levels of care, both within and outside the respective plans. Through enrollment phases and continuing educational programs for members and providers, Contractors must assure that each provider understands which services are contained within the respective physical and behavioral health plans. Appropriate information sharing and careful monitoring of diagnosis, treatment, follow-up and medication usage are especially important when members use Partnership and MBHO services simultaneously.</p> <p>[...]</p> <p>The monitoring and evaluation of the above standards must be a part of the Quality Improvement Plan of both the Partnership and MBHO Contractors." Kentucky Contract, Attachment XI, page 103-104.</p>
Massachusetts (Behavioral)	<p>"5.1.1C.5: PERFORMANCE INCENTIVES AND PENALTIES; INITIATIVES...</p> <p>c. Incentives Only... 4) Intensive Case Management/Consumers who are Dually-Diagnosed</p> <p>The Contractor shall target an increase in enrollment in the Intensive Case Management (ICM) program of at least 100 individuals, at least 75 of whom must be members with a dual-diagnosis (substance abuse and psychiatric) and include both disabled adults and adolescents. All dually diagnosed individuals must be newly enrolled in the ICM subsequent to June 30, 1997..." Massachusetts MH/SAP Contract 1997 Amendment, pages 14, 16-17.</p>

Care coordination obligation described. The contracts reveal a substantial variation in the terminology used to describe care coordination. Some contracts refer to the activities related to care coordination as case management, while others use the term care coordination to distinguish it from conventional managed care case management, which generally is understood to involve utilization management of contract services.¹⁵ Some contracts codify the service as a “consumer protection” activity, others, as an administrative service, and still others, as a component of clinical care. Some of the contracts contain minimal provisions, while others contain extensive specifications regarding the structure and content of the care coordination activity they expect to be furnished.

Scope of the care coordination responsibility. Among the 38 agreements that cover care coordination as a contractual benefit, 17 (nearly half) contain language that appears to extend the scope of the obligation beyond the limits of services covered in the Medicaid contracts. Table 1D shows language from two of these 17 contracts.

¹⁵ See, e.g., the utilization management provisions of S. 1344 and H.R. 2954 (managed care legislation enacted by the Senate and House in the 106th Congress).

Table 1D. -- Examples of Scope of Care Coordination Responsibility

State	Contract Language
Washington (Behavioral)	The Contractor shall: a) coordinate services to meet the service recipient's mental health care needs. Referrals to other providers shall be documented in the service recipient's records, whether or not services are provided; b) coordinate with non-participating health and social programs including, but not limited to physical health (e.g. Healthy Option Medicaid medical plans, Basic Health Care Plus), Area Agency on Aging, Aging and Adult Services, Alcohol and Substance Abuse Treatment providers, Children and Family Services, vocational rehabilitation services, Developmental Disabilities, school, corrections, juvenile detention and juvenile justice, etc.; c) ensure appropriate referrals for community health and social programs; d) ensure the existence of an advisory committee(s) for children, older persons, ethnic minorities which meets quarterly. For children and adolescents include: parents of children/adolescents currently receiving services, early intervention providers, health providers, juvenile court, child welfare, local tribes, and substance abuse treatment providers to meet EPSDT requirements." Washington State Mental Health Contract, pages 22-25.
Oregon (Behavioral)	3. Integration and Coordination : a. Mental Health Services Which Are Not Covered Services : Contractor shall coordinate services for each OMAP Member who requires services from agencies providing mental health services which are not Covered Services... b. Local Mental Health Authority (LMHA)/Community Mental Health Program (CMHP)... c. Community Emergency Service Agencies... d. Local and/or Regional Allied Agencies... e. Psychological Health Care Providers... f. Chemical Dependency Providers... g. Medicare Payors and Providers... h. OMAP Members in Extended Care Settings . Contractor shall coordinate with ECMU of Division and extended care service providers to integrate services for OMAP Members in Extended Care Programs. ECMU shall determine, after consulting with Contractor and the Extended Care Program, when an OMAP Member is ready to discharge from the Extended Care Program. Contractor shall ensure that such OMAP Member receives Covered Services following discharge to ensure timely discharge.

The remaining agreements limit the service reach of the obligation to contractual benefits (either within one or both contracts in the case of states with both general and behavioral agreements).

Several states use particularly broad language to describe a care coordination scope that reaches both extra-contractual Medicaid benefits (i.e., benefits covered under the state plan but not contained in either a general service or behavioral health agreement), as well as services and benefits that are health or health related but lie outside of Medicaid (e.g., child welfare services, special education services, housing, employment, social services). Massachusetts, Washington State, and Kentucky all offer expansive specifications regarding the scope of the care coordination obligation, with performance standards that reach both extra-contractual benefits and non-Medicaid health and health support services.

The contract language in Appendix A illustrates that states have different population-based expectations of care coordination. In some states, a care coordination obligation is conceived of generally; that is, all populations with special needs that necessitate the use of a broader array of health and medical services would be covered under the terms of the agreement. In most states, however, the care coordination obligation is limited to specific sub-populations (e.g., pregnant women with addiction disorders, children with serious emotional disturbance, adults with severe mental illness).

With one exception, all states with more than one agreement (i.e., states with both general and behavioral agreements) include care coordination language in both agreements. That is, where one contractor is expected to coordinate with another contractor, reciprocal language is contained in both agreements. For example, see the Massachusetts, Oregon, and Nebraska contract language in Appendix A. Hawaii appears to be the only state that includes care coordination responsibilities in its behavioral agreement, but does not specify a reciprocal activity in its general contract.

Access standards and provider capabilities. Nine contracts address the issue of access standards and provider capabilities. In general these specifications are broadly stated and do not set specific time frames for performance. Capabilities are typically expressed in terms of the ability to furnish services in a “team” approach. Table 1E shows language from Ohio and Washington State.

Table 1E. -- Examples of Access Standards and Provider Capabilities

State	Contract Language
Ohio (General)	<p>"3. Substance Abuse Services... HMOs will work with ODADAS and ODHS to develop policies and procedures which address all issues necessary to establish effective referral and linkage, including confidentiality procedures, scope and frequency of mutual reporting assessment and treatment information, procedures necessary for accessing treatment services and management of care, and problem resolution procedures, i.e., care coordination protocols necessary for the successful management of alcohol and other drug addiction treatment services and physical health conditions for enrollees. Core elements of care coordination protocols include, but are not limited to: a) Assisting primary care providers in determining when an enrollee should be referred to local alcohol and drug addiction treatment service providers for specialized alcohol and drug addiction treatment, and in developing appropriate linkages and coordination. b) Assisting alcohol and drug addiction treatment service providers in determining when an enrollee should be referred to primary care providers, and in developing appropriate linkage and coordination. c) Specifying the arrangements for the timely sharing of all pertinent clinical information between alcohol and drug addiction treatment service and primary care providers, in accordance with applicable federal laws and state statutes. d) Assisting primary care providers and alcohol and other drug treatment service providers in complying with requirements of Substitute House Bill 167 as described in Section V.B.5. of this RFP document." Ohio RFP, pages 16-17.</p> <p>"Core elements of care coordination protocols include, but not limited to: ... a) Assisting Primary care providers in determining when an enrollee should be referred to local mental health providers for specialized mental health treatment, and in developing appropriate linkages and coordination. b) Assisting alcohol and drug addiction treatment service providers in determining when an enrollee should be referred to primary care providers, and in developing appropriate linkage and coordination. c) Specifying the arrangements for the timely sharing of all pertinent clinical information between alcohol and drug addiction treatment service and primary care providers, in accordance with applicable federal laws and state statutes. d) Assisting primary care providers and alcohol and other drug treatment service providers in complying with requirements of Substitute House Bill 167 as described in Section V.B.5. of this RFP document." Ohio Contract, page 17.</p>
Washington (Behavioral)	<p>“Individualized Tailored Care : Following are key elements of Individualized Tailored Care (ITC)...</p> <p>3. The Individual Support Team shall collaboratively and collectively develop a care plan focusing on strengths of the person to create supports and services to enable the</p>

State	Contract Language
	person to live, work, and participate more fully in his or her culture in the community. The voice of the service recipient shall be the driving force... 4. Services/supports are comprehensive, addressing needs in several life domain areas such as family, housing, educational/vocational, social/recreational, psychological, emotional, legal and safety. Services shall be informed by and coordinated with other formal service system and/or informal support systems, in which the service recipient is involved. In addition there must be a crisis plan in place which is reviewed to meet changing needs every 180 days. 5. Services/supports are developed creatively and flexibility to meet the unique needs of the individual service recipient, and not hindered by categorically defined services or programs. Services are sought from other formal systems as appropriate and feasible, as well as supports from informal or voluntary sources/natural supports (e.g., churches, family, friends, neighbors)." Washington State Mental Health Contract, page G-1.

Written plan of care and continuous monitoring. Twelve agreements appear to specify some level of written plan and continuous monitoring of persons receiving care coordination in order to adjust the plan as needed. Table 1F shows representative language from Minnesota and Pennsylvania.

Table 1F. -- Examples of Written Plans of Care and Continuous Monitoring

State	Contract Language
Minnesota (General)	(Appendix) b. MH/CD Treatment Planning and Referral The HEALTH PLAN must provide the following treatment planning and referral services for its enrollees who are assessed as needing MH/CD services: i. A written treatment plan must be developed for each client. The individual treatment plan must contain measurable goals, specified treatment strategy or services, person(s) responsible for providing services and an identified case manager. ii. A multi-disciplinary team of mental health and/or CD professionals must be available for case review and consultation for each client." Minnesota Contract, Appendix I, page 4.
Pennsylvania (Behavioral)	"a. The MCO will provide timely access to diagnostic, assessment, referral, and treatment services for members for the following benefits: ... 13) effective July 1, 1997, the following will be in-plan services: ... c) targeted mental health case management (intensive case management and resource coordination)..." Pennsylvania Behavioral Health RFP, pages 51, 52. "d. The MCO must provide comprehensive service management, with clear access and lines of authority. Each member's plan of care, including the commencement, course, and continuity of treatment and support services, must be documented in such a way as to permit effective review of care and demonstrate care coordination within services covered by the MCO. e. Evidence of a coordinated approach for those persons with mental health and drug and alcohol conditions as well as for older adults with psychiatric and substance use disorders, particularly those with coexisting physical impairments, and other special needs populations who experience mental health and/or drug and alcohol disorders (e.g., persons with mental retardation, homeless persons, pregnant drug abusers, persons with HIV/ADS and physical disabilities) is demonstrated." Pennsylvania Behavioral Health RFP, page 52.

Information systems. Three states, as shown in Table 1G below, make some mention of the information that contractors are expected to be able to maintain. At the same time, none specifies the information system capabilities that contractors are expected to maintain in the area of care coordination.

Table 1G. -- Examples of Information Systems Requirements

State	Contract Language
Ohio (General)	<p>"2. Mental Health Services... HMOs will work with ODMH and ODHS to develop care coordination protocols necessary for the successful management of mental health and physical health conditions for enrollees. Core elements of care coordination protocols include, but are not limited to: [...] c) Specifying the arrangements for the timely sharing of all pertinent clinical information between mental health and primary health providers in accordance with applicable federal and state regulations." Ohio RFP, pages 15-16.</p> <p>"3. Substance Abuse Services... [...] Core elements of care coordination protocols include, but are not limited to: [...] c) Specifying the arrangements for the timely sharing of all pertinent clinical information between alcohol and drug addiction treatment service and primary care providers, in accordance with applicable federal laws and state statutes. Ohio RFP, pages 16-17.</p>
Massachusetts (General)	<p>3.13 MH and SA Case Management Programming: The HMO shall maintain a structured Case Management program with a process for identifying complex MH and SA cases at all levels of care. Case management shall pro-actively coordinate and follow member progress through the continuum of care until stability in life functions is achieved." Massachusetts Contract, Appendix B, pages 25-26.</p> <p>"2.11 Case Management Services: ...</p> <p>B. Case Management Services shall include, but not be limited to: 1. an effective mechanism to initiate and discontinue Case Management services in both inpatient and outpatient settings, in addition to catastrophic incidents; 2. an effective mechanism to coordinate services required by Enrollees, including, but not limited to, MH/SA transportation, community support services, and all primary and specialty care; settings that may benefit from active Case Management. When appropriate, such activities shall be coordinated with those of Department of Social Services (DSS), Division of Youth Services (DYS), Department of Mental Health (DMH) and community agencies; 3. care plans specifically developed for each case managed Enrollee which ensure continuity and coordination of care among the various clinical and non-clinical disciplines and services based on individual need of an Enrollee; 4. a process to provide for reasonable benefit coverage flexibility on a case-by-case basis, based on clinical and psychosocial needs; and 5. a process to evaluate and improve individual Case Management services as well as the effectiveness of Case Management as a whole." Massachusetts Contract, Appendix B, page 16.</p>
Massachusetts (Behavioral)	<p>"2.06.07 Agreements with State Agencies</p> <p>The Contractor shall: ... b. Develop and submit to the Division for prior review and approval within the first six months of the Contract, a plan to ensure that its Network Management staff communicate on an ongoing basis, and no less than monthly, with DSS designated staff, DPH/BSAS designated staff, DMH area directors and other appropriate state agencies' designated staff to address Enrollees' service planning, admissions, discharge plans, utilization, and coordination of DMH Continuing Care Services." Massachusetts MH/SAP Contract, Appendix B, page 22.</p>

Privacy: Four agreements make mention of privacy and confidentiality, typically in broad language indicating the need to maintain confidentiality. Specifically not described are privacy standards for the exchange between contractors, or between a contractor and other systems of care (e.g., child welfare agencies, mental health agencies, court systems) that

maintain information on patients.¹⁶ Relevant contract language from Kentucky and Pennsylvania appears in Table 1H.

Table 1H. -- Examples of Privacy and Confidentiality Requirements

State	Contract Language
Kentucky (General)	Memorandum of Agreement When a Partnership and a MBHO both serve a member population, Contractors are required to execute a Memorandum of Agreement regarding standards for the coordination of physical and behavioral health care services. The Memorandum of Agreement shall: [...] Facilitate the exchange of non-confidential member information in an effective and timely manner throughout its delivery system [...] Of priority are: [...] With member approval, exchange appropriate clinical information between the Partnership primary care provider and the MBHO or designated behavioral health care provider on the diagnosis, treatment, and referral of a member; Provide members with information needed to understand how to obtain necessary care; Identify a method to evaluate the continuity and coordination of care, including member-approved communications between behavioral health care providers and primary care providers; and Protect the confidentiality of member information and records.
Pennsylvania (Behavioral)	a. The MCO and the HealthChoices HMOs are required to develop and maintain written agreements regarding the interaction and coordination of services provided to recipients enrolled in the HealthChoices program... The written agreements should include, but not be limited to: 1) Procedures which govern referral, collaboration, and coordination of diagnostic assessment and treatment, prescribing practices, the provision of emergency room services, and other treatment issues necessary for optimal health and prevention of disease... 3) Exchange of relevant enrollment and health-related information among the MCO, the HMO, and primary care practitioner (PCP) in accordance with federal and state confidentiality laws and regulations; (e.g., periodic treatment updates with identified primary and relevant specialty providers); 4) Obtaining releases to share clinical information and provide health records to each other as requested consistent with state and federal confidentiality requirements; 5) Training and consultation to each other to facilitate continuity of care and cost-effective use of resources... 8) Development of adequate provider networks to serve special needs populations and coordination of specialized service plans for members with special health needs (e.g. behavioral health services for children and adolescents in medical foster care). 9) The MCO is expected to provide crisis and other behavioral health emergency services. The HMO and MCO must establish clear procedures for coordinating the transport and treatment of persons with behavioral health emergencies who initially present themselves at general hospital emergency rooms to appropriate behavioral health facilities.

Employee benefit contracts

Table 3 presents a similar typology for employee benefit contracts, whose care coordination excerpts can be found in Appendix B. As Table 3 illustrates, while several contracts allude to something akin to care coordination, no specifications are provided. The

¹⁶ A recent presentation at a Center for Health Care Strategies meeting attended by Ms. Rosenbaum focused on a special child welfare initiative between L.A. Care (a safety net health plan) and the Los Angeles Child Welfare system. The initiative provides an example of the complexities surrounding privacy. Because the child welfare agency and the Medicaid agency had never established interagency agreements or standards regarding the exchange of information, L.A. Care was required (with the cooperation of the child welfare agency) to obtain a court order allowing it to identify children in the child welfare system who were patients of the plan so that it could carry out basic care coordination functions that involved preventive interventions to the families. Because good care coordination inevitably requires access to information as well as the exchange of data, the identification and resolution of privacy matters assume a central importance in any care coordination initiative.

language from the Ohio contract illustrates coordination of referrals for care and matters relating to coverage disputes and appeals processes:

Benefits: 4. All mental health and substance abuse (MHSA) services are provided under a separate contract between the Department of Administrative Services and United Behavioral Health (UBH). The HMO agrees to coordinate the provision of mental health and substance abuse services with the state as follows: Employees obtaining such services through the HMO will be covered by the HMO in the event a Primary Care Physician is providing the treatment until the HMO elects to make a referral for MHSA treatment through UBH. The HMO agrees to cooperate with the state's MHSA contractor including, but not limited to: Timely referral of patients in need of MHSA services; Education of providers about the program; Resolution of coverage disputes; Arranging for internal or contracted prescription drug vendors to fill prescriptions for psychotherapeutic drugs prescribed by UBH physicians; Coordination of the appeals process when appropriate; Coordination/provision of the delivery of health promotion programs with the state and UBH, Abiding by the United Behavioral Health Interface Document, a summary of which is provided in the Appendix to this RFP (Exhibit 3); Abiding by administrative protocols which may be developed in clarification of medical interface issues delineated in the Interface Document. [Ohio Contract, pp. 26-27]

Implications

The findings from this analysis support several conclusions:

First, the NCQA accreditation standards suggest that purchasers that contract with NCQA-accredited MCOs and MBHOs can expect some level of care coordination as a basic element of performance. While the level of care coordination received will be limited to contractual services, the ability to coordinate among network providers and services and across managed care contractors is a recognized core competency within the NCQA accreditation system.

Second, there are two types of purchasers that might wish to consider the use of express contractual terms related to care coordination. The first is purchasers that do not limit their contracts to managed care entities that hold NCQA accreditation. It is possible that as an informal matter the concept of care coordination has made it sufficiently into the managed care dynamic to be basic to the enterprise. We would assume that this is not the case, as evidenced by a desire on the part of NCQA to move the industry to this point through the use of accreditation standards. While traditional case management activities tied to cost containment are standard to managed care design,¹⁷ the types of activities identified in the Mathematica study probably extend well beyond the limits of many managed care plans. A purchaser might be willing to rely on a company's informal representations of its standard of care, but such representations would be neither enforceable nor measurable in the absence of an express contractual specification.

The second type of purchaser who would want to consider the inclusion of contractual expectations would be the purchaser who wants a standard of care that transcends the standard of performance contained in the NCQA accreditation. This type of purchaser would want a care coordination system that can address the coordination of extra-contractual benefits and capabilities and that possesses information and data capabilities that are necessary to support cross-system care coordination. This expectation would appear to be particularly true for Medicaid agencies, which appear with great frequency to expect a "customized" standard of care coordination that reaches both Medicaid and non-Medicaid health and support services. This expectation is of course consistent with the nature of the Medicaid managed care membership, which faces higher health risks and has greater health needs.

A third major conclusion concerns purchasing standards. While public and private purchasers anticipate care coordination as a contractual standard of performance, the findings from this study suggest that few address the range of issues identified through health services research as basic elements of the care coordination standard of care. Particularly rare is the use of performance measurement or the development of benchmark measures against which to measure the quality of care coordination. Even among states that seek enriched care coordination that extends beyond contractual services, there is little consensus on the essential elements of the model. Furthermore, even where issues are addressed, the level of drafting varies significantly.

¹⁷ Pegram v. Herdrich, *supra*.

The findings from this study support further research and policy development efforts aimed at addressing what is meant by this type of care coordination and the development of coordinated strategies for addressing some of the fundamental policy issues that require resolution, particularly issues of information systems, performance measurements and privacy of information. These findings warrant research that focuses on the specific expectations of Medicaid agencies and the development of sample purchasing specifications tied to Medicaid coverage and financing options.

The final conclusion concerns is the definition of primary care itself. There is ample evidence of missed opportunities in the area of behavioral health and primary care. The lack of a primary care definition that includes a clear expectation of behavioral health competency is a matter that needs closer attention given this evidence.

To the extent that such a behavioral competency already is in fact a basic element of the modern primary care standard of care, there may be no need to establish this competency as a contractual expectation. But the data on missed diagnoses, inappropriate treatment, and under-treatment of persons with mental illness and addiction disorders whose conditions should have or could have been detected and managed in primary care suggest otherwise. It is difficult to contract for a standard of care that an industry is simply unequipped to deliver; expectations cannot outstrip reality so thoroughly that a seller is simply unable to deliver the product. However, there may be clear expectations that do not fall so far outside existing standards that they should become part of contractual standards. Indeed, the NCQA accreditation standards themselves suggest that it is not unreasonable to expect network primary care professionals to be able to possess and display measurable competencies in the area of behavioral health.

Part 2

SAMPLE PURCHASING SPECIFICATIONS FOR CARE COORDINATION AND PHYSICAL AND BEHAVIORAL SERVICE INTEGRATION IN MANAGED CARE CONTRACTS

Introduction

This document sets forth illustrative language for the purchase of physical and behavioral care coordination and integration services from managed care organizations (MCOs) and managed behavioral health organizations (MBHOs) by state agencies administering Medicaid and other managed care purchasers. The specifications include two components. The first component concerns how the basic primary care duty is defined in managed care agreements and presents sample specification language designed to ensure that the fundamental concept of primary care encompasses the provision of services (within the capabilities of primary care professionals) related to the prevention, treatment and management of mental illness and addiction disorders.

The second component relates to the coordination of physical and behavioral care. These specifications are intended to provide purchasers and other interested persons with sample language that would create performance standards to promote higher integration of services both between and within managed care organizations, as well as between managed care and the broader health and social services system for persons with mental illness and addiction disorders, of which managed care is a part.

These sample specifications were prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA) by Professors Sara Rosenbaum and Brian Kamoie of the George Washington University School of Public Health and Health Services. These specifications are part of a broader project whose purpose is to examine the design of primary care and care coordination services as they relate to the treatment and prevention of mental illness and addiction disorders.

The specifications should be viewed as tools to help managed care purchasers identify key physical and behavioral care coordination and integration issues as they negotiate and draft their purchasing agreements with MCOs and MBHOs.

This document is not designed to stand alone. Instead, it is designed to be incorporated, in whole or in part, into more comprehensive purchasing agreements. Thus, this document contains language related to the definition of primary care and coordination of physical and behavioral health care services.

These specifications can be obtained in electronic format from the Center for Health Services Research and Policy at the George Washington University School of Public Health and Health Services (www.gwhealthpolicy.org)

**Sample Purchasing Specifications - Care Coordination and Physical and Behavioral
Service Integration
Managed Care Contracts
May, 2001**

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Part 1 – Physical and Behavioral Service Integration

§101. Definition of Primary Care

- (a) Primary care defined -- the term Primary Care shall mean the following care and services
 - (i) [drafter insert any other provisions related to the definition of primary care];
 - (ii) such preventive, assessment, diagnostic, treatment and referral services for mental illness and/or addiction disorders that fall within the scope of primary care practice as described in written practice guidelines developed or adopted by the Contractor in consultation with experts in primary care and the treatment and management of persons with mental illness or addiction disorders, and disseminated to Contractor's primary care network members following approval by the purchaser.
- (b) Periodic review – Contractor shall periodically review (no less than annually) and update as recommended the guidelines described in (a)(ii).
- (c) Performance measure – Contractor shall

(i) submit its practice guidelines and updates, accompanied by an explanation of the evidentiary basis for the guidelines¹⁸

(ii) submit documentation regarding the quality assurance procedures it uses to assure that network primary care providers are furnishing services in accordance with the guidelines; and

(iii) document in claims data the provision of services related to the prevention, treatment and management of mental illness and addiction disorders in primary care settings.

Part 2 - Care Coordination and Physical and Behavioral Health Services

§201. Coverage of Care Coordination

(a) The following items and services are covered under this agreement –

(i) Care coordination, as described in §202.

§202. Care Coordination Defined¹⁹

(a) The term care coordination consists of the following services and activities when furnished to plan members who are receiving both physical health care and specialty diagnostic, treatment, and management of mental illness or addiction disorders, regardless of whether the Contractor furnishes both physical and specialty services related to mental illness and addiction disorders treatment under the terms of this Agreement --

(1) Procedures for identifying plan members who are receiving both physical health care and specialty services for the treatment of a mental illness or addiction disorder;²⁰

(2) Assessment of the health, educational, social services, employment, and other support and community service needs of such members, without regard to whether the needed services are enumerated in this Agreement;

¹⁸ Commentary – by evidentiary basis we mean any of the following: (a) results of studies that have appeared in peer reviewed journals and similar publications; (b) the results of professional consensus meetings to develop standards; (c) government practice guidelines; and (d) other sources of information that are both relevant and reliable.

¹⁹ This definition of care coordination is based on Mathematica Health Policy's research for the Center for Health Care Strategies (2001)

²⁰ **Query to Eric: We assume that this coordination activity should focus on persons who are getting both physical care as well as MI/AD services from specialists (i.e. whose health problems are significant enough to require a specialist and who are not merely getting both physical and behavioral care from their own primary care provider. If you want care coordination to reach the latter group as well, we can redraft).**

(3) Development of a written care coordination plan that (I) describes all services that are necessary to enhance the physical and mental well-being of enrollees to maintain or restore their ability to function independently at the highest level that their condition permits, including necessary transportation to obtain such treatment and services, regardless of whether such services are covered under this Agreement; (II) is updated periodically as the member's condition or relevant circumstances change; and (III) that provides for involvement in plan development and modification as needed by the member (or the member's family or guardian where relevant), and any health care provider or agency involved in the provision of care to the member regardless of the provider's membership in the Contractor's network;

(4) Assistance in obtaining all services identified in the written care coordination plan, included necessary care that is covered under an Agreement that covers a separate health plan in which the member is simultaneously enrolled;

(5) A written explanation regarding (i) how agencies and providers can request services on the Member's behalf, regardless of their status as network providers; and (ii) the dispute resolution system available to agencies and providers with respect to denials, terminations, or reduction in services requested on a Member's behalf.

(6) Written educational materials for network providers regarding the physical, behavioral, care coordination, and other support services that are covered under this agreement and available to members;²¹

(7) Maintenance of appropriate information systems that are capable of reporting on an individual basis on the care coordination activities set forth in this section that are provided to members;

(8) Written policies and procedures regarding the duties of network providers to furnish information necessary to proper care coordination;

(9) written standards related to the privacy of members receiving care coordination services that are disseminated to all network providers;

²¹ Commentary: In the case of Medicaid purchasers that do not include all state plan services in their managed care contracts, this provision should be expanded to include an explanation by the contractor of all physical and behavioral health services (including both additional classes and additional levels of coverage) that are available directly from the Medicaid agency.

(10) written standards for the education, training, and capabilities of individuals who are authorized by the contractor to furnish care coordination services.

§203. Quality Performance Measurement and Improvement

- (a) Written protocols -- Contractor shall submit the protocols it uses to measure the quality of its care coordination activities
- (b) Minimum elements – at a minimum, quality improvement protocols shall include the following:
 - (1) performance benchmarks in the following areas
 - (i) identification of members who need care coordination;
 - (ii) timelines for the provision of assessment and care coordination plan development and provision of care coordination assistance;
 - (iii) handling of requests for services from providers and agencies; and
 - (iv) resolution of disputes regarding treatment under this Agreement,
 - (2) procedures used to evaluate care coordination performance by care coordinators and network providers; and
 - (3) the use of incentives to achieve care coordination improvement.