

Managed Care

Behavioral Health Carved in or Carved out?



Maine is one of 27 other states with a federally funded statewide consumer network organization. Maine's Advocacy Initiative Network surveyed our counterparts in these

states to find out how managed care was working for them. 80% of the respondents have managed care and 75% of those have a behavioral health carve out. Arizona's experience provided the most compelling argument for a carved out behavioral health plan.

"With a carve out our voices are not lost in the sea of medical need in the larger population."

Whole health is of extreme importance so a well defined plan for how the behavioral health carve out MCO will work

with the medical MCO is critical. Most echo what Deb Delman, Executive Director of the Massachusetts statewide network says "The carve out has helped tremendously because we have fewer places to go to advocate and bring quality issues. We had a demonstration shortly after " the company won the contract where we went to the Medicaid authority office because we had not been listened to. The MCO and MassHealth have put performance incentives into each contract year which have resulted in shifts such as Peer Specialists in Emergency Services Programs across the state, Recovery Learning Communities, provider training on recovery, peer bridging pilot, examination of statewide warmline services, funding of 1 leadership academy event each year, funding of Consumer Quality Initiatives to evaluate on-the-ground quality issues, and implementing Pat Deegan's CommonGround in 2 clinics over the past 2 years.

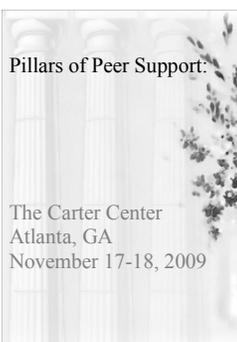


Medicaid, peer support

Robert Glover, Ph.D. executive director of the National Association of State Mental Health Program Directors (NASMHPD) said "Opportunities for the new year include a new Medicaid option 1915(i). The option provides states an opportunity to offer services and supports before individuals need institutional care, and also provides a mechanism to provide state plan home- and community-based state plan home- and community-based services (HCBS) to individuals with mental

and substance use disorders. The revised provisions of 1915(i) became effective Oct. 1, 2010. Under the Affordable Care Act, states may continue to specify needs-based eligibility criteria but they are no longer permitted to limit the number of eligible individuals who can receive 1915(i) state plan HCBS or establish a waiting list for those services. According to the Centers for Medicare and Medicaid Services (CMS), the changes to 1915(i) under the ACA enhance an important tool for states in their efforts to serve individuals in the most integrated setting and to meet their obligations under the Americans with Disabilities

Act (ADA) and the U.S. Supreme Court's *Olmstead* decision. The inclusion of peer support services is also important for states, Glover said. "We know that Medicaid has been approved for reimbursement of peer support services and that's important," he said. Glover cited two *Pillars of Peer Support Services Summits* held in 2009 and 2010 at the Carter Center in Atlanta that brought together state representatives interested in developing peer services. A report is now available at www.pillarsofpeersupport.org.



Pillars of Peer Support:

The Carter Center
Atlanta, GA
November 17-18, 2009

As we Consider the Grievance Process in our Managed Care System

It is important to consumers to have various methods available for trouble shooting prior to filing grievances. They depicted the process and time it takes for grievance resolution as too often burdensome, confusing and intimidating. By the time their service problems reach the mark for grievance, they described facing fear of retribution, diminished relationships with their providers, and bearing additional undue stress. They described an imbalance of power as they are left to struggle alone for remedy, while agencies have an infrastructure to support staff and administration in their decisions. Some of their ideas for early response to problems include a toll free telephone help-line, e-mail and web based options. They also cited training as important for both customers and providers in order to be better able to communicate and mutually develop solutions. Other ideas included:

Process:

- Grievance process must be Accessible, publicized and easy to understand.
- Include process for going to the source (MCO, state, providers) to find out what the problem is.

Consumer:

- Consumer review & decision panels – not provider driven.
- A toll free number for access to all advocacy programs.
- Peer support or case managers be paid to provide support in process.
- Peer advocates supporting and guiding us through the process of grievance and resolution.

- When I have a problem I want *them* to come see me – “just like the Sear’s repairman” – not expect me to meet all the challenges of finding day care, etc. to find them.
- 24 hour response to receipt of grievance – 7 business days for a solution.
- When filing an appeal the customer must have access to an independent advocate with relevant expertise at no cost to the customer.
- Consumer with grievance has opportunity to attend all discussion and decision-making meetings .
- Build in protections from retribution.
- Disability Rights Center must be available to talk with consumers and document the problems for any grievance not just those with the potential for litigation.
- We need legal advocacy available for the completion of advance directives.

Outcomes:

- Our grievances and complaints must be accompanied by the opportunity to CHANGE things – (not just go through a process with no lasting outcomes).
- Customer involvement in all aspects of the grievance process – at the table when and where decisions about us are made.
- Data must be collected and used to justify crafting incentives, instituting financial rewards and penalties, and terminating contracts

Data:

- Monitor all data regarding grievances to identify early warning system and create interventions for problems
- A designated consumer organization should get the grievance data – possibly consumer councils.

Education, Education, Education...

On Access from another state

I feel having managed care is beneficial to some and detrimental to others in regards to accessing services. I feel informed consumers of mental health services have a higher chance of getting the right services they need within their community. In my experience consumers who do not know the ins and outs of exactly what their Medicaid insurance provides and how managed care operated have a more difficult time receiving the right services for their needs, understanding the full benefits of their insurance, and have a more difficult time transitioning in their community and recovering from a mental health disability.

Managed Care Event – Waterville, ME (2/25/06)

Participants agreed that a managed care system cannot be successful without clear commitment to the role of its customers to design and carry out training and share crucial information.

They talked of needing written materials, posters and hand books that are written by them, for their care providers. Materials must be developed and reviewed by consumers before publication.

PROVIDE TRAINING

- Training and mentoring for ASO-MCO, providers (including case managers), consumers and peer facilitators in proven recovery models
- Make sure the people who do utilization review are trained in proven recovery models
- Training for consumers to be care managers
- Peer training regarding grievance process
- Train peers to support others through grievance process
- Consumers and parents given updated training concerning grievance opportunities
- Disease education geared towards consumer understanding

CREATE WRITTEN MATERIALS

- A manual for guiding providers in decision-making regarding our managed care will be available to us and written in language we understand (Understanding the limitations of covered care, number of visits, reimbursement, etc. allows us to share responsibility for care decisions.)
- Consumer/family/youth manual
- HANDBOOK regarding grievance containing language for and reflective of diverse cultures
- Publicly funded materials and contractors must use person-first language (i.e. we are not “the mentally ill”, “mentally ill offenders”, or “bi-polars and schizophrenics”, etc.)

CREATE PUBLIC AWARENESS

- In order to establish a greater level of public trust, successes and challenges must be openly shared with Maine citizens, our Legislature and other policy makers. A public relations campaign focused on garnering additional resources and greater community buy-in must use current events to promote behavioral HEALTH. Publicly funded PR messages must reflect and endorse our vision and values. Resiliency and recovery deserve greater public attention. Public information about catastrophic life experiences must be balanced by responses that eliminate bias and unfriendliness toward us, and value us as members of our communities. Ideas for greater public awareness also included:
 - Public forums for ongoing feedback
 - Media campaign that show faces of success (pictures of mental HEALTH include children in school, adults working, empty jails, etc.)
 - Posters, brochures, and other materials that represent resiliency & recovery E
 - Events that include our talents

All information must be available in multiple formats ie. Audio, visual, brail, language and culturally