Health Management Associates

Four State Medicaid Managed Care Approaches to the Delivery of Behavioral Health Benefits

Implications for the Ohio Medicaid Managed Care Program

Prepared for the Ohio Association of Child Caring Agencies
1-6-2015
Introduction

There is ample policy discussion across the country regarding the intersection between behavioral health care and state Medicaid managed care programs, and for good reason. The World Health Organization has estimated that by 2020, mental health and substance use disorders will surpass all physical diseases as a major cause of disability worldwide. As Medicaid continues to be the single largest payer for mental health services and is seeing an increasing role with care associated with substance use disorders, state programs are looking for ways to meet the need with positive outcomes and manageable costs. Data demonstrating the poor health outcomes for adults with serious mental illness have furthered the intensity and interest around specific initiatives. As integration efforts continue to unfold, states have begun to address the separation of general health and behavioral health within the managed care structures in many states. According to Kaiser’s 50-State Medicaid Budget Survey for State Fiscal years 2013 and 2014:

- In FY 2013, in 12 states new eligibility groups were added into managed care. Most often the new eligibility groups were seniors and persons with disabilities and children in foster care.
- For FY 2014, a total of 23 states indicated new eligibility groups were being enrolled in managed care. States most frequently reported the addition of the new Medicaid expansion population and other previously excluded groups, e.g. those receiving limited benefits, foster children, and some aged and disabled groups.
- In FY 2013, seven states reported other changes, largely related to carving-in behavioral health services or expanding behavioral health services covered under existing managed care arrangements. Nineteen states reported planned changes in FY 2014, largely concerning the incorporation of enhanced management of behavioral health services.

The focus on children and youth is likely in response to the last three years, where CMS began to address the documented lack of access to quality of care (CBHSQ, 2013; SAMHSA, 2014) and to needed services for children and young adults with serious emotional disturbance (SED). This focus and increased guidance has come through both a Center for Medicaid and CHIP Services (CMCS) and Substance Abuse and Mental Health Services Administration (SAMHSA) joint informational bulletin (IB), and a series of other IBs and Medicaid Director letters (SMD November 2011, IB August 2012, IB March 2013, IB May 2013). Within this guidance, CMCS have identified effective benefit design for mental health services for children, youth, and their families, and substance use disorder services as a priority for the next several years. Amid the focus on the health disparities of adults and youth with behavioral health disorders, state and federal policy makers have paid particular attention to quality and coordination of care.

While some states maintain or are implementing new Behavioral Health Organizations (BHOs) and programs separate from existing acute care contracts, many are incorporating coordination of care requirements across programs and in some cases with shared incentives. In October 2011, CMS issued a technical assistance brief acknowledging the various managed care options utilized by states and highlighted ways within various structures that states were successfully integrating physical and behavioral health care with positive results. The Brief summarized key elements for integration that could be enforced in purchasing contracts:
- Aligned financial incentives across physical and behavioral health systems
- Real-time information sharing across systems to support the availability of relevant information to all members of a care team
- Multidisciplinary care teams accountable for coordinating the full range of medical, behavioral, and long-term supports and services, as needed
- Competent provider networks
- Mechanisms for assessing and rewarding high-quality care.

The brief discussed the pros and cons of the different models, highlighting issues for states utilizing traditional MCOs, PCCM programs, BHOs as integrated care entities, and separate MCO/PCCM and BHO contracts. One can assume Ohio will give consideration to these various managed care structures when considering their model. Below are summaries of four states with differing managed care models for the delivery of Medicaid behavioral health services. Summaries include publically available information regarding current vendors, i.e. national MCO/BHO and/or local managing entities, MCO/provider program goals or successes, outcome data when available, notable RFP requirements specific to OACCA populations, and implementation challenges.

State Summaries

Arizona
Arizona has a long history of using managed care for the administration of their Medicaid programs. The state currently administers the behavioral health benefits under a carve-out structure, i.e. managed care services are administered under managed care but in contracts separate from administration of physical health benefits. This behavioral health (BH) carve-out has evolved over the past several years utilizing lessons learned in the earlier stages of their managed care program. The Division contracts with Regional Behavioral Health Authorities (RBHAs), and Tribal Regional Behavioral Health Authorities (TRBHAs), to administer integrated managed care delivery services in six (6) distinct geographic service areas (GSAs) throughout the State.

The Arizona Medicaid managed care programs are administered under an 1115 waiver which allows the state to also combine state funds and other federal funding for behavioral health services within the BH managed care contracts. Additional federal funds include the Substance and Mental Health Services Administration’s (SAMHSA) block grant funding for mental health and substance use disorder prevention and treatment. The Arizona Division of Behavioral Health Services (DBHS) operates under the Arizona Department of Health Services (DHS) and is responsible for administering a comprehensive, regionalized, behavioral health system of community-based prevention, intervention, treatment and rehabilitative services for individuals and families. The Arizona Health Care Cost Containment System (AHCCCS), i.e. AZ Medicaid, is a separate cabinet level agency. ADHS/DBHS and AHCCCS have an Intergovernmental Agreement (IGA) which combines administration of both the Medicaid and non-Medicaid benefits to beneficiaries under the RBHA contracts. This program has evolved over multiple cycles of managed care contracts. Most recently the state prioritized integrated physical and behavioral health services to Medicaid eligible adults with Serious Mental Illness (SMI), with plans to expand to other populations. What makes the Arizona integration effort unique is that rather than carving BH
services into the acute care (physical health) managed care contracts, the state chose to carve physical health benefits into the existing BH managed care contracting structure.

Drivers behind 2012 RBHA scope of work and procurement structure included a recognition of the health disparities of SMI population which was driven by data collected in previous contract cycles as well as nationally recognized studies. In addition consumer, provider, and other stakeholder feedback was garnered through state sponsored focus groups. The State also sponsored a conference allowing providers to share successful programing changes focusing on integration. Lastly there was interest and input from the highest levels of the administration, with the Governor notably concerned with issues affecting persons with mental illness due to her own son’s diagnosis of schizophrenia.

RBHA and TRBHAs are paid through a capitation payment structure. Contracts include management of Medicaid and non-Medicaid public behavioral health benefits including prevention, crisis, treatment, and rehabilitative services to a variety of populations, including:

- Children and Adolescents
- Adults with a Serious Mental Illness (SMI)
- Adults with General Mental Health Disorders (GMH)
- Adults with Substance Use Disorders (SUD/SA)

The following populations are excluded from receiving services through a RBHA:

- Individuals enrolled in the Children’s Rehabilitative Services (CRS) Integrated AHCCCS Health Plan which serves children with complex and chronic health care needs who require specialized services.
- Individuals enrolled in the Arizona Long Term Care System (Elderly and Physically Disabled)

Notable Contract Requirements

The contracts require that the RBHA provider network includes Provider Network Organizations (PNO) which are comparable to community mental health centers, supportive housing providers, crisis providers, and hospitals. Other notable contract requirements include compliance with and monitoring activities required under a settlement agreement for the longstanding Arnold v. Sarn lawsuit. These
requirements are focused on access to community based services for adults with SMI. The Maricopa RBHA RFP also had the following specific requirements associated with behavioral health service delivery to children and in conformance with the Arizona’s Clinical Guidance Documents (The Child and Family Team) and The Arizona Vision-Twelve (12) Principles for Children Service Delivery:

- Comply with established caseload ratios for case managers assigned to serve children identified as having high/complex needs.
- Utilize a network of generalist support and rehabilitation providers.
- Utilize Home Care Training to the Home Care Client (HCTC) as an alternative to more restrictive levels of care when clinically indicated.
- Implement the ADHS/DBHS method for in-depth review of Child and Family Team practice.
- Utilize acuity measure instruments as directed by ADHS/DBHS.
- Implement service delivery models as directed by ADHS/DBHS.

The contract further requires collaboration with a variety of stakeholders including to meet, agree upon and reduce to writing collaborative protocols with each County, District, or Regional Office of:

- Arizona Department of Economic Security/Child Protective Services;
- Arizona Department of Economic Security/Division of Developmental Disabilities;
- Arizona Department of Economic Security/Rehabilitative Services Administration;
- Arizona Department of Corrections and Arizona Department of Juvenile Corrections; and
- AHCCCS’ Children’s Medical Dental Plan.

The contract also requires regular meetings with a broad spectrum of behavioral health providers to gather input; discuss issues; identify challenges and barriers; problem-solve; share information and strategize ways to improve or strengthen the behavioral health service delivery. The (T)RBHAs must also meet with a broad spectrum of peers, family members, peer and family run organizations, advocacy organizations or any other persons that have an interest in participating in improving the system.

_Outcomes_

RBHAs are required to report specific measures associated with:

- Outcomes-Impact on Quality of Life
- Access to Services
- Service Delivery
- Coordination/Collaboration

The following child and youth outcomes and performance measures by geographic service area (GSA)/RBHA region was provided on the Arizona State website at [http://www.azdhs.gov/bhs/dashboard/](http://www.azdhs.gov/bhs/dashboard/) and provide a summary of the measures the state is capturing through its managed care program.

**OUTCOMES: Has quality of life improved for individuals served by the behavioral health system?**

<table>
<thead>
<tr>
<th>Individuals....</th>
<th>GSA 1 NARBHA</th>
<th>GSA 2 Cenpatico</th>
<th>GSA 3 Cenpatico</th>
<th>GSA 4 Cenpatico</th>
<th>GSA 5 CPSA</th>
<th>GSA 6 Magellan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drug/alcohol use history, now reduced or no use</td>
<td>62.2%</td>
<td>63.6%</td>
<td>58.0%</td>
<td>57.6%</td>
<td>54.8%</td>
<td>55.5%</td>
</tr>
<tr>
<td>Are not homeless</td>
<td>99.9%</td>
<td>99.6%</td>
<td>99.8%</td>
<td>99.8%</td>
<td>99.9%</td>
<td>99.7%</td>
</tr>
<tr>
<td>Are employed</td>
<td>11.7%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>66.7%</td>
<td>14.1%</td>
</tr>
<tr>
<td>Attend school</td>
<td>84.5%</td>
<td>86.7%</td>
<td>85.5%</td>
<td>85.5%</td>
<td>81.4%</td>
<td>88.1%</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td>Have no recent criminal justice system involvement</td>
<td>94.9%</td>
<td>98.0%</td>
<td>98.0%</td>
<td>98.7%</td>
<td>95.6%</td>
<td>98.2%</td>
</tr>
<tr>
<td>Participate in self-help groups</td>
<td>22.5%</td>
<td>2.7%</td>
<td>7.0%</td>
<td>1.4%</td>
<td>1.4%</td>
<td>3.0%</td>
</tr>
</tbody>
</table>

**ACCESS TO SERVICES:** Do individuals and families have access to recovery and resiliency oriented services?

<table>
<thead>
<tr>
<th>Individuals....</th>
<th>GSA 1 NARBHA</th>
<th>GSA 2 Cenpatico</th>
<th>GSA 3 Cenpatico</th>
<th>GSA 4 Cenpatico</th>
<th>GSA 5 CPSA</th>
<th>GSA 6 Magellan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are satisfied with their access to services</td>
<td>93.0%</td>
<td>90.7%</td>
<td>92.0%</td>
<td>90.9%</td>
<td>83.1%</td>
<td>80.7%</td>
</tr>
<tr>
<td>Receive timely services</td>
<td>83.0%</td>
<td>95.0%</td>
<td>96.9%</td>
<td>96.0%</td>
<td>92.8%</td>
<td>89.7%</td>
</tr>
<tr>
<td>Live within 15 miles of an outpatient clinic (within 10 miles for GSA 6)</td>
<td>82.2%</td>
<td>98.6%</td>
<td>93.0%</td>
<td>91.3%</td>
<td>98.0%</td>
<td>99.2%</td>
</tr>
</tbody>
</table>

**SERVICE DELIVERY:** Are services provided based on the needs of individuals and families?

<table>
<thead>
<tr>
<th>Individuals....</th>
<th>GSA 1 NARBHA</th>
<th>GSA 2 Cenpatico</th>
<th>GSA 3 Cenpatico</th>
<th>GSA 4 Cenpatico</th>
<th>GSA 5 CPSA</th>
<th>GSA 6 Magellan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participate in their treatment plans</td>
<td>96.0%</td>
<td>93.1%</td>
<td>92.5%</td>
<td>93.2%</td>
<td>93.6%</td>
<td>91.9%</td>
</tr>
<tr>
<td>Have a current and complete service plans</td>
<td>88.2%</td>
<td>87.5%</td>
<td>87.5%</td>
<td>82.4%</td>
<td>70.6%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Receive services identified on their service plan</td>
<td>78.6%</td>
<td>93.3%</td>
<td>85.7%</td>
<td>82.4%</td>
<td>71.4%</td>
<td>100%</td>
</tr>
</tbody>
</table>

**COORDINATION AND COLLABORATION:** Do individuals and families get seamless behavioral and medical care coordination?

<table>
<thead>
<tr>
<th>Individuals....</th>
<th>GSA 1 NARBHA</th>
<th>GSA 2 Cenpatico</th>
<th>GSA 3 Cenpatico</th>
<th>GSA 4 Cenpatico</th>
<th>GSA 5 CPSA</th>
<th>GSA 6 Magellan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Have their care coordinated with their medical doctor</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>88.2%</td>
<td>64.7%</td>
<td>88.2%</td>
</tr>
<tr>
<td>Return to a psychiatric hospital</td>
<td>2.2%</td>
<td>11.1%</td>
<td>0.0%</td>
<td>14.3%</td>
<td>3.0%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Stay in a psychiatric hospital an average of…days</td>
<td>14.0</td>
<td>8.7</td>
<td>10.6</td>
<td>9.4</td>
<td>12.9</td>
<td>9.1</td>
</tr>
</tbody>
</table>

The most recent reporting of these measures can be found through the following link:

**Implementation Challenges**

Arizona managed care programs have been in place for a significant period of time and many of the implementation challenges were addressed during the initial start-up. However, it is well documented that the initial roll out of the RBHAs allowed for these entities to be providers of services. The state experienced many difficulties with the initial vendor and therefore with subsequent procurements modified the contracts to prohibit the RBHAs from also being a provider of services. The second iteration of the program included challenges for providers including clearly defined roles for case and care management, creating infrastructure for RBHA reporting requirements and other changes associates with a new vendor such as adopting new claims and prior authorization policies and procedures.
Georgia

In 2003, the Georgia Department of Community Health (DCH) identified unsustainable Medicaid growth and projected that without a change to the system, Medicaid would require 50 percent of all new State revenue by 2008. In addition, Medicaid utilization was driving more than 35 percent of total growth each year. For that reason, DCH decided to employ a management of care approach to organize its fragmented system of care, enhance access, achieve budget predictability, explore possible cost containment opportunities and focus on system-wide performance improvements. Furthermore, DCH believed that managed care could continuously and incrementally improve the quality of healthcare and services provided to patients and improve efficiency by utilizing both human and material resources more effectively and more efficiently. The DCH Division of Managed Care and Quality submitted a State Plan Amendment in 2004 to implement a full-risk mandatory Medicaid Managed Care program called Georgia Families (GF). Behavioral health is carved in to Georgia Families and DCH provides behavioral health services through its fee-for-service (FFS) delivery system for individuals who are not enrolled in GF.

Children enrolled in PeachCare and children, pregnant women and women with breast or cervical cancer on Medicaid are eligible to participate in Georgia Families. Excluded populations include Duals, children receiving IV-E benefits and those in skilled nursing facilities, to name a few.

Covered services under GF includes medically necessary medical and behavioral health services, including services provided by Tier 2 Core Medicaid Providers of mental health and substance abuse services.

Contracted Health Plans
Care Management Organizations (CMOs) under contract with the state are Amerigroup Community Care is a wholly-owned subsidiary of Amerigroup Corporation; WellCare of Georgia, Inc.; and Peach State Health Plan (Peach State) is a physician-driven, Georgia-based Medicaid managed care plan and subsidiary of the Centene Corporation. Fact sheets detailing service areas by CMOs are available at https://dch.georgia.gov/sites/dch.georgia.gov/files/GeorgiaFamilies_FY14_Final%20%282%29.pdf.

Notable Contract Requirements

- The Contractor is responsible for care coordination – a set of member-centered, goal-oriented, culturally relevant and logical steps to assure that a member receives needed services in a supportive, effective, efficient, timely and cost effective manner. Care Coordination includes Case Management, Disease Management, Transition of Care and Discharge Planning.
- The Contractor shall develop and implement a Care Coordination system to ensure and promote: timely access and delivery of Health Care and services required by members; continuity of members’ care; and coordination and integration of members’ care.
- The Contractor shall develop disease management programs for individuals with Chronic Conditions. These programs must target the prevalent chronic diseases within the Contractor’s population.
- The Contractor must notify DCH of the disease management programs it initiates and terminates and provide evidence, on an annual basis of the effectiveness of such programs for its enrolled members.
• The Contractor must submit Quarterly status reports to DCH which include specified Disease Management Program data in addition to the annual report.

Outcomes for the Georgia Families Program
The state’s November 2013 performance improvement project report showed the following outcomes for the three CMOs:

Figure 1 - PIP Validation Scores for Amerigroup Community Plan, Peach State Health Plan and WellCare

<table>
<thead>
<tr>
<th>PIP</th>
<th>Amerigroup Community Plan</th>
<th>Peach State Health Plan</th>
<th>WellCare of Georgia, Inc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>% Evaluation Elements Score Met</td>
<td>% of Critical Elements Scored Met</td>
<td>Validation Status</td>
<td>% Evaluation Elements Score Met</td>
</tr>
<tr>
<td>Adolescent Well-Care Visits</td>
<td>88%</td>
<td>86%</td>
<td>Not Met</td>
</tr>
<tr>
<td>Annual Dental Visits</td>
<td>97%</td>
<td>92%</td>
<td>Partially Met</td>
</tr>
<tr>
<td>Appropriate Use of ADHS Medication</td>
<td>78%</td>
<td>82%</td>
<td>Not Met</td>
</tr>
<tr>
<td>Avoidable Emergency Room Visits – Collaborative</td>
<td>62%</td>
<td>50%</td>
<td>Not Met</td>
</tr>
<tr>
<td>Childhood Immunizations – Combo 10</td>
<td>96%</td>
<td>100%</td>
<td>Met</td>
</tr>
<tr>
<td>Childhood Obesity</td>
<td>82%</td>
<td>87%</td>
<td>Partially Met</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care</td>
<td>88%</td>
<td>93%</td>
<td>Not Met</td>
</tr>
<tr>
<td>Member Satisfaction</td>
<td>91%</td>
<td>100%</td>
<td>Met</td>
</tr>
<tr>
<td>Provider Satisfaction</td>
<td>91%</td>
<td>100%</td>
<td>Met</td>
</tr>
</tbody>
</table>

Foster Care
In addition to Georgia Families, the state implemented a Medicaid managed care program for children involved in foster care and the juvenile justice system called Georgia Families 360°. Georgia Families 360° launched in March of 2014 and is expected to enroll approximately 27,000 children and young adults. Enrollment is mandatory for eligible children in foster care and juvenile justice systems but optional for the adoption assistance population. Only one managed care plan, Amerigroup Community Care, serves the foster care, adoption assistance, and juvenile justice populations for the state. Amerigroup is also one of the 3 Care Management Organizations that participates in Georgia Families.

The goals of Georgia Families 360° are to:

• Improve access to health care services, particularly for physical and behavioral health services covered by the Medicaid program
- Increase continuity of care, including when members transition in and out of foster care
- Enhance health outcomes, provide additional care coordination and improved physical and behavioral health oversight

Covered Populations are:

- Children up to age 26 who are receiving foster care
  - Note: the Affordable Care Act extended Medicaid coverage up to age 26 for youth who age out of foster care - ACA section 2004
- Children up to 21 who are receiving adoption assistance, or up to 26 if enrolled in certain waiver programs
- Young adults less than 26 who were in foster care at age 18 if in Medicaid at 18 or the higher age at which the state’s foster care assistance ends
- Certain youth in the Juvenile Justice System
  - Children less than 19 eligible for Right from the Start Medicaid and placed in community residential care
- Children eligible pursuant to the Interstate Compact for the Placement of Children or the Interstate Compact for Adoption and Medical Assistance

Included Services are medically necessary services and benefits pursuant to Georgia’s Medicaid state plan and the Georgia Medicaid Policies and Procedures Manual, including individuals with Disabilities Education Act (IDEA) Part C services. Enhanced Services: place strong emphasis on programs to enhance the general health and well-being of members, make health promotion materials available to members, participate in community-sponsored health fairs and provide education to members, families and providers about early intervention and management strategies for various illnesses.

Covered services under Georgia Families 360\(^0\) are as follows:

- Acute care services
- Post-stabilization services
- Family planning services
- Pharmacy
- Perinatal services
- Emergency transportation
- Foster care forensic exam
- EPSDT services up to age 21
- Vision and dental care
- Emergency services
- Urgent care services
- Sterilization, hysterectomies and abortions (according to restrictions)
- Immunizations up to age 21
- Parenting education
- Mental health and substance abuse services
- Lab services
- Required screenings and follow-up care

Value added-services provided by Amerigroup are:
• Free Boys and Girls Club memberships (ages 6-18)
• Free Girl Scout memberships

• Free round-trip rides to doctor appointments (up to 15 round trips per year)
• SafeLink cell phone if qualified and free reminder text messages
• Free flu shots

• Neonatal intensive care graduate program (case management)
• Free over-the-counter medicines
• Disease management
• Vision exam and glasses – one per year, 21 and older
• Free flu shots
• Dental care (21 and over)
• Entertainment coupon book
• Taking Care of Baby and Me program
• Weight Watchers meetings – at least 10 years of age
• Case management

• Nurse Helpline
• Case management
• Entertainment coupon book
• Taking Care of Baby and Me program
• Weight Watchers meetings – at least 10 years of age

Members may self-refer for behavioral health and substance abuse treatment. Behavioral health specialists can offer covered BH and/or substance abuse services when:

- Services are within scope of license
- BH specialist is a credentialed Medicaid provider and registered in the Amerigroup network
- Services are within scope of the benefit plan
- PCPs and BH providers are required to send each other initial and quarterly summary reports of members’ physical and BH statuses
- The Care Coordination team functions as a liaison between the physical and BH providers and facilitates the coordination of the discussions when indicated

**Outcomes for the Georgia Families 360°**
Outcomes data is not yet available for the benefit.

**Implementation Challenges**
The state’s FY 2011 Annual Report is available at [https://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/56/61/186983219DCH_FY2011_Annual_Report.pdf](https://dch.georgia.gov/sites/dch.georgia.gov/files/imported/vgn/images/portal/cit_1210/56/61/186983219DCH_FY2011_Annual_Report.pdf) and describes a number of DCH accomplishments. However, an undated evaluation of the Georgia Families program by the Georgia Hospital Association states in part that “Georgia’s current program has failed to achieve promised savings and has cost far too much.”

**Tennessee**
TennCare is the state of Tennessee’s Medicaid program that provides health care for approximately 1.3 million Tennesseans and operates with an annual budget of approximately $10 billion. TennCare members are primarily low-income pregnant women, children and individuals who are elderly or have a disability. TennCare covers approximately 20 percent of the state’s population, 50 percent of the state’s births, and 50 percent of the state’s children.

TennCare is one of the oldest Medicaid managed care programs in the country, having begun on January 1, 1984. It is the only program in the nation to enroll the entire state’s Medicaid population in managed care. The TennCare program operates under a Section 1115 waiver from the Centers for Medicare and
Medicaid Services (CMS) in the United States Department of Health and Human Services. Unlike traditional fee-for-service Medicaid, TennCare is an integrated, full-risk, managed care program.

TennCare services are offered through managed care entities. Medical, behavioral and Long-Term Services and Supports are covered by “at-risk” Managed Care Organizations (MCOs). Each participating MCO creates their own contracts with providers, maintains their own fee schedules, and has their own in-network specialists and providers. Four MCOs provide services across three regions of the state: West, East and Middle Tennessee.

In addition to the MCOs, there is a Pharmacy Benefits Manager for coverage of prescription drugs and a Dental Benefits Manager for coverage of services to children under age 21.

Contracted Health Plans
MCOs include: Amerigroup, Blue Care, United Healthcare Community Plan and TennCare Select.

Notable Contract Requirements
- MCOs must adhere to minimal requirements for the integration of physical and behavioral health care
- MCOs must ensure that all members receiving behavioral health services from providers whose primary focus is to render behavioral health services have individualized treatment plans. Affected providers include: Community mental health agencies; case management agencies; Psychiatric rehabilitation agencies; psychiatric and substance abuse residential treatment facilities; and psychiatric and substance abuse inpatient facilities.
- MCOs must provide a Care Coordination Program designed to help members who may or may not have a chronic disease but have acute health needs or risks that need immediate attention. The goal of the Care coordination program is to assure members get the services they need to prevent or reduce an adverse health outcome. Services provided are short-term and time limited in nature and may include assistance in making and keeping needed medical and or behavioral health appointments, hospital discharge instructions, health coaching and referrals related to the members’ immediate needs, PCP reconnection and offering other resources or materials related to wellness, lifestyle, and prevention.
- For all eligible members MCOs must provide a Chronic Care Management Program. The goal of the program is to improve the quality of life, health status and utilization of services, of members with multiple chronic conditions, by providing intense self-management education and support.

In addition, the state’s service guidelines clearly define and provide criteria for the determination of serious emotional disturbance (SED) in children and severely and/or persistently mentally ill (SPMI) adults.

Covered Behavioral Health Services
Behavioral health services covered by TennCare plans include:

- Behavioral health crisis services (mental health, alcohol and drug abuse services)
- Outpatient behavioral health services
- Mental health case management
• Inpatient and outpatient substance abuse benefits

**Behavioral Health Providers**

Behavioral health providers under contract with MCOs to deliver mental health and alcohol and drug abuse services include an array of community behavioral health organizations and licensed clinicians such as Clinical nurse specialists, psychologists, and clinical social workers.

**Outcomes**

The Comparative Analysis of Audited Results from TennCare MCOs, available at [http://www.tn.gov/tenncare/forms/hedis13.pdf](http://www.tn.gov/tenncare/forms/hedis13.pdf), identifies a number of 2013 HEDIS and CAHPS outcomes. Selected behavioral health-related performance measures indicate the following:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Weighted State Rate</th>
<th>HEDIS 2012 National Medicaid Avg.</th>
<th>Changes 2012 to 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012</td>
<td>2013</td>
<td></td>
</tr>
<tr>
<td><strong>Behavioral Health</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antidepressant Medication Management (AMN):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Effective Acute Phase Treatment</td>
<td>47.12%</td>
<td>49.10%</td>
<td>51.11%</td>
</tr>
<tr>
<td>Effective Continuation Phase Treatment</td>
<td>28.50%</td>
<td>30.78%</td>
<td>34.43%</td>
</tr>
<tr>
<td>Follow-Up Care for Children Prescribed ADHD Medication (ADD):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Initiation Phase</td>
<td>38.28%</td>
<td>46.02%</td>
<td>38.83%</td>
</tr>
<tr>
<td>Continuation and maintenance Phase</td>
<td>47.21%</td>
<td>57.54%</td>
<td>45.87%</td>
</tr>
<tr>
<td>Follow-Up After Hospitalization for Mental Illness (FUH):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7-day follow-up</td>
<td>45.73%</td>
<td>48.03%</td>
<td>46.50%</td>
</tr>
<tr>
<td>30-day follow-up</td>
<td>66.83%</td>
<td>68.80%</td>
<td>64.99%</td>
</tr>
</tbody>
</table>

**Implementation Challenges**

Tennessee has a long history with Medicaid MCOs and carved-in behavioral health services. However, a July 2014 statement issued by Darin Gordon, Director of the Bureau of TennCare, described the state’s challenges with the Medicaid Expansion process, stating that in order to accommodate the “no wrong door” requirement for eligibility processing the state had to develop an entirely new system. While the system experienced implementation delays, the state did not experience a backlog preventing Tennesseans from enrolling in TennCare.

**Texas**

Currently, there are three population focused Medicaid managed care programs in Texas: STAR, STAR+PLUS, and STAR Health, in addition to managed care contracts to serve the CHIP population and provide dental coverage for eligible beneficiaries. The State reimburses each managed care organization (MCO) a capitated rate for each member enrolled in their respective program. Reimbursement rates for services are then negotiated between the provider and the MCO. Processes such as prior authorization requirements and claims processing are determined and therefore may be different between MCOs. However the 2013 Texas Legislature approved several expansions of Medicaid managed care and directed the Texas Health and Human Services Commission (HHSC) to develop a performance-based payment system that rewards outcomes and enhances efficiencies. The State’s goals for the managed care programs are to:
• Emphasize preventive care
• Improve access to care
• Ensure appropriate utilization of services
• Improve client and provider satisfaction
• Establish a medical home for Medicaid clients through a primary care provider (PCP)
• Improve health outcomes, quality of care, and cost-effectiveness

Texas has recently begun to expand managed care, including carving in mental health rehabilitative services and targeted case management previously carved-out of managed care and reimbursed fee-for-service (FFS) by the state. As part of the carve-in, MCOs are initially being required to utilize the State Mental Health Authority’s utilization management guidelines, and providers certified by the state, to determine eligibility for these services. These requirements are consistent across all managed care programs as they are added to the MCOs responsibility. It is important to note that utilization management guidelines for substance use disorder treatment are defined in statute and therefore the MCOs are statutorily bound to those parameters beyond the initial implementation and expansion requirements.

**STAR Health**

Texas has a risk-based contract with a single Managed Care Organization (MCO) to manage a statewide program for foster care children and transitional youth, known as the STAR Health Program. Specifically STAR Health is intended to be a comprehensive managed care program designed to better coordinate and improve access to health care for:

• Children in DFPS conservatorship (under age 18).
• Youth in CPS extended foster care (ages 18 to 22).
• Youth who were previously under DFPS conservatorship and have returned to foster care (ages 18 to 22) through voluntary foster care agreements.
• Youth ages 18-21 who were previously in foster care and are living independently and receive Medicaid for Transitioning Youth (MTFCY).
• Former foster care youth (ages 21 to 23) enrolled in an institution of higher education located in Texas enrolled in the Former Foster Care in Higher Education (FFCHE) program.

Texas is currently reforming its Child Protective Services and Foster Care System, as required by legislation enacted in 2011. As part of the “redesign,” DFPS is contracting with Single Source Continuum Contractors (SSCCs) that are responsible for providing the full continuum of paid foster care placement and services for children and youth in DFPS conservatorship in designated geographic catchment areas. The MCO will need to have working relationships with these entities for coordination purposes.

STAR Health began on April 1st, 2008. The Texas Health and Human Services Commissioner chose Superior HealthPlan Network (Superior), a subsidiary of Centene, through a competitive procurement process to run the STAR Health program. They continue as the vendor today. The program provides a full-range of Medicaid covered medical and behavioral health services for children in DFPS conservatorship and young adults in DFPS paid placements. As of November 2013, there were 31,000 youth enrolled in STAR Health.
Beginning January 1, 2014, Texas will provide Medicaid benefits to adults under age 26 who were in foster care and receiving Medicaid when they aged out. This program is called the Former Foster Care Children Program (FFCC). FFCC Members will receive health care benefits in one of two programs. These are based on their age:

- Members who are 18-20 years old will continue to get their benefits in the STAR Health program, unless they want to change to a STAR plan.
- Members 21-25 years old will get their Medicaid benefits through a STAR plan of their choice.

Medicaid for Transitioning Foster Care Youth (MTFCY) is still available, but only for those that were not receiving Medicaid when they aged out of foster care.

Former Foster Care in Higher Education Members (FFCHE) will change to the FFCC program beginning January 1, 2014. If members do not meet the requirements for the FFCC program, they will continue to get benefits until their 23rd birthday, or until they no longer meet eligibility requirements, whichever happens first.

The State’s goal for STAR Health is to ensure that children in state care receive timely and coordinated medical and behavioral health care services. STAR Health benefits and services include:

- Preventive health care services which includes regular checkups and immunizations, office visits, visits to the dentist and visits for eye checkups
- Dental services
- Vision services
- Service coordination
- Clinical service management and disease management
- Physical, occupational, speech, and other health-related services
- Behavioral health care services
- Hospital coverage including inpatient services
- Prescriptions and medical supplies
- Teledermicine including consultations and assessments done by a provider using teleconference capability
- Access to the Health Passport which collects key Member health information and stores it in a secure website. Medical Consenters, health care providers, DFPS caseworkers and some people who work for STAR Health may have access to the information.
- Nursing and Behavioral Health help-lines for caregivers and caseworkers - 24 hours a day, 7 days a week,
- Medical advisory committees to monitor healthcare provider performance
- Recruitment of providers with a history of treating children who have been abused or neglected

The most recent STAR Health procurement required potential MCOs to include foster care specific questions that address a network provider’s experience with conditions that are prevalent in the foster care population within their provider credentialing profile sheet, e.g., treatment of physical or sexual abuse, developmental disabilities, and post-traumatic stress disorder, as well as experience with
evidence-based modalities or promising practices, such as Trauma Focused Cognitive Behavioral Therapy and Child Parent Psychotherapy. The RFP further required the provider network to include providers who are trained in and knowledgeable about:

- Screening and treating co-occurring BH and substance use disorders
- Treating physical and sexual abuse and in providing sex offender treatment, such as registered sex offender treatment providers
- Lesbian, gay, bi-sexual, transgender related issues
- Eating disorders
- TF-CBT screening, treatment, and assessment
- Diagnosis and treatment of I/DD
- Treating children with autism
- Screening and treating children with Fetal Alcohol Syndrome or related disorders

In addition, the MCO must permit members, DFPS staff, or medical consenters to participate in the selection of appropriate BH providers and to self-refer to any network BH provider. Other requirements include provider trainings on trauma-informed care (and specifically Trauma-Focused CBT) and proper use of psychotropic medications in the foster care population. These requirements demonstrate the state’s recognition of the special needs of the target population and specifically the need for culturally and clinically competent providers.

**Texas STAR Program**

Texas STAR is the Medicaid managed care program for children, newborns, pregnant women and otherwise eligible families and children. In the Texas STAR program, members receive behavioral health services from the managed care organization within their service area. In most service areas, behavioral health services are either part of a managed care organization’s integrated benefits package or delivered through a sub-contracted behavioral health organization. In the Dallas service area, STAR and STAR+PLUS members receive behavioral health care through the NorthSTAR program, a behavioral health carve-out which contracts with ValueOptions, a behavioral health organization. However the state has stopped referrals to this program and is requiring MCOs to manage the behavioral health needs of any new enrollees. This signals a plan to discontinue rather than expand the BH carve-out program.

The state is monitoring specific outcomes and satisfaction of integrating behavioral health and physical health benefits. The *Texas Medicaid Managed Care: STAR Child and STAR+PLUS Adult Behavioral Health Survey Report for Contract Year 2013* can be accessed through the link below:


**Significant Traditional Providers**

As Texas Medicaid has evolved into a managed care system, the state has taken special measures to minimize the disruption of the relationship between Medicaid clients and their historical providers. The Legislature directed HHSC to ensure that significant traditional providers (STPs) of Medicaid services be included in MCO networks during the implementation of managed care. Before each implementation of managed care in a new area of the state, HHSC produces a list of STPs, based on historical service patterns, for MCOs to use in establishing their provider networks.
MCOs must give STPs the opportunity to participate in their networks for a period of at least three years from the date an MCO model is implemented in an area. Providers must: (1) accept the MCO’s financial terms; (2) meet any credentialing requirements of the MCO; and (3) comply with the terms and conditions of the MCO’s standard subcontractor agreement.¹

Texas Foster Care Pharmacy Initiative

Recent studies have raised concern over the use of psychotropic medications and polypharmacy within the foster care population and have emerged as a growing issue of concern. In 2011, CMS released a State Medicaid Director letter (SMD-11-23-11.pdf) providing background on a then recent study regarding the prevalence of psychotropic medication prescribing for youth in foster care. Both Texas and Washington have successfully responded to this issue with prescribing monitoring programs that have begun to address this disproportionate practice, with applicability to all youth served within the Medicaid program. In addition to targeting pharmacy edits to youth in foster care, some states such as Indiana have also targeted polypharmacy specific to psychotropic prescribing in adults. These efforts have been utilized to address both the widespread increased incidence of prescription drug abuse among the general population and the negative health outcomes associated with poor prescribing and monitoring practices, including a lack of medication reconciliation across providers, for adults with serious mental illness.

In 2005, the Texas best practice guidelines Psychotropic Medication Utilization Parameters for Foster Children were released. The second edition was released in 2007, and the third edition in 2010. These Parameters include general principles for optimal practice, reference material, and a listing of commonly used psychotropic medications with dosage ranges and indications for use in children (both FDA approved and literature based). The guidelines have been incorporated in the managed care programs and impacted outcomes in the following ways:

- Annual analysis of how Medicaid prescribing practices align with these guidelines has revealed that psychotropic prescribing to children in foster care has steadily decreased since the release of the guidelines in early 2005, both in terms of the percentage of children in foster care and in the overall number of children receiving medication regimens outside of the recommended criteria.
- The STAR Health MCO conducts ongoing Psychotropic Medication Utilization Reviews on children in foster care whose medication regimens fall outside of the expectations of the guidelines.
- Effective March 2012, with the carve-in of prescription drug coverage into managed care, all antipsychotic medication prescribed for children under the age of three years require a prior authorization. Expansion of this requirement beyond the foster care population to the Medicaid population statewide has further minimized antipsychotic medication usage in very young children. This carve-in has also provided the STAR Health MCO with opportunities to enhance its psychotropic medication monitoring.

¹ Texas Medicaid and CHIP in Perspective: Ninth Edition - January 2013; (The "Pink Book") Chapter 7: Medicaid Managed Care
Representatives from DFPS, HHSC, DSHS, and the STAR Health MCO hold bi-monthly meetings of a Psychotropic Medication Monitoring Group. This group reviews the monitoring conducted by the STAR Health MCO and its behavioral health subcontractor. It also oversees an annual report on psychotropic utilization and the biennial review of the parameters.

The grant project entitled “Accelerating Utilization of Comparative Effectiveness Findings in Medicaid Mental Health” was developed to support evidence-based use of psychotropic medication in Medicaid, and includes six other state Medicaid programs (California, Maine, Missouri, New York, Oklahoma, and Washington) that collectively account for 33 percent of Medicaid enrollment nationally. Under the grant, Rutgers University will work with an existing network partnership, the Network for Evidence Based Treatment (NET), to create a consortium focused on increasing the utilization of evidence-based clinical and delivery system practices in the provision of mental health treatment for beneficiaries of state Medicaid programs previously mentioned. Texas participates in the current network of states that will collaborate as sub-recipients of the grant. This project is a coordinated effort with DFPS, DSHS, and HHSC.


In a report released in 2013, Texas demonstrated that psychotropic prescribing of all types has significantly decreased since the release of the Parameters in early 2005 both in terms of the percentage of foster care children receiving them and in the overall percentage of children receiving medication regimens outside of the recommended criteria of the best practice Parameters. Specifically, the rate of foster children prescribed psychotropic drugs dropped from 42 percent in 2004 to 32 percent in 2012. During that time the population of foster children grew from 27,400 to 47,900, and the overall number prescribed psychotropic medications went from 10,850 to 15,250.

Health Passport

Health Passport is a patient-centered, internet based health record required for use by the STAR Health MCO and encouraged for use by their provider network. This tool makes a foster child’s information available to authorized Providers and medical stake holders such as medical consenters and caseworkers. The data in Health Passport does not provide complete medical record, but it does contain information on patient demographics, claimed visits, allergies, lab test results, immunizations, and filled medications. In order to use Health Passport, providers must have access to a computer with internet connectivity. The STAR Health MCO must contractually require BH providers to provide the following information in Health Passport:

- Primary and secondary (if present) diagnosis
- Assessment information, including results of a mental status exam
- Brief narrative summary of clinical visits/progress
- Scores on each outcome rating form(s)
- Referrals to other providers or community resources

---

2 Texas Medicaid and CHIP in Perspective: Ninth Edition - January 2013; (The "Pink Book") Chapter 7: Medicaid Managed Care
• Health Care Service Plans
• Evaluations of each member’s progress at intake, monthly, and at termination of the HCSP or as significant changes are made in the HCSP
• Initial and at least monthly narrative summary reports of the member’s BH status
• Any other relevant information

Implementation Challenges
Inclusion of the full range (MRO and targeted case management) of behavioral health benefits is new with the recently procured contract. It is assumed the state will be closely monitoring the MCO for any implementation issues as among the goals for the program was a focus on access to and delivery of behavioral health services, and specifically to ensure access to medically necessary BH Services. The provider network had to include providers experienced in treating victims of child abuse and neglect and providers who specialize in trauma-focused cognitive behavioral therapy (TF-CBT) and other evidence-based treatments.

Summary
The state of Ohio has several options in the design of a managed care program that incorporates behavioral health benefits. Variation seen among programs primarily focus on populations covered, benefits included, vendors considered, provider network requirements, and outcomes measured. The table at the end of this section provides a summary to highlight the different approaches of the states reviewed. While most states reviewed have a significant history with managed care, it is noteworthy that each has modified programs over time and in most cases gradually included behavioral health into these programs where a behavioral health carve-out program was not the initial program design.

Program Structure
States have great flexibility when designing Medicaid managed care programs. Programs can be designed to serve specific populations such as Texas Star Health (children in DFPS conservatorship) or may be focused on a specific set of benefits across multiple populations, such as the Regional Behavioral Health Authority model in Arizona. Lastly some states have gradually incorporated all populations and benefits into comprehensive programs and contracts such as the TennCare program in Tennessee.

Covered Benefits
States have the option of including all covered benefits within its managed care contracts or “carving out” a portion of the benefits from the contract or into separate management contracts. While the states reviewed have carved in the majority of behavioral health services and populations, there are states who have chosen to exclude certain services from their managed care contracts. This is especially common during early adoption of managed care. Indiana for example initially only included traditional clinic-based services when implementing managed care for the CHIP and TANF populations. Mental health rehabilitation (MRO) services, primarily community-based, remained in a fee-for service (FFS) structure and reimbursed by the state. However, Indiana has since announced plans to carve currently excluded populations and services into managed care over a multi-year process as seen recently with Texas. The initial phase in Indiana included a recent procurement for the aged, blind, and disabled (ABD) populations. Within these initial ABD contracts foster care children and MRO services remain a carve-out.
Vendors
Another area of flexibility for states is type and amount of vendors awarded managed care contracts. Some states choose to award statewide (Tennessee, Georgia) contracts to single or multiple vendors. Other states (Arizona) have developed regions for managed care programs and do not require vendors to serve the entire state. Texas chose to have a single, statewide vendor for serving the foster care population but utilizes a regional, multi-vendor approach for other programs. Some states (Illinois, Oregon) have chosen to work with providers to create new management entities apart from or in addition to the well-known national companies such as Anthem, WellCare, and Magellan. These new managed care vendors were born out of efforts to encourage improved care coordination by providers, often through patient centered medical home (PCMH) and health home models of care. The four states reviewed demonstrate the use of both national (Georgia, Tennessee) and state grown (Arizona) MCO entities. Lastly, while not evident with those reviewed, some states have begun to prohibit the use of subcontractors, i.e. MCO use of BHO subcontractor, to administer their programs and for those that do, have added notable requirements to ensure true integration of administrative functions (claims payment, system reporting, etc.).

Provider Network Requirements
The MCO must ensure that its provider network includes all provider types in sufficient numbers and with sufficient capacity to provide timely access to all covered services. Typically the MCO must also ensure the waiting times for appointments do not exceed specified standards. These requirements are passed on to participating providers. An example would be providing an intake within 14 days of request or follow-up after a discharge from inpatient services within 72 hours.

It is not uncommon for states to contractually require the MCO to include specific groups of providers within their provider networks, especially during initial implementation of a Medicaid managed care program. States may require vendors to utilize providers with longstanding relationships with the state, such as community mental health centers. In cases where the state allows the vendor flexibility to choose, and possibly limit its network, they will continue to be required to demonstrate network adequacy described above. However network adequacy is measured differently across states and programs. Measures of adequacy can also include practitioner to member ratios or distance travelled to access services. In summary, “any willing provider” participation is not guaranteed in a managed care environment therefore lobbying efforts may want to be focused on ensuring MCO/BHO utilization of OACCA Member organizations.

Outcomes
States are not only measuring the outcomes of their managed care arrangements, many are incorporating pay for performance within their contracts with vendors. While outcomes can vary across programs, more states are looking to National Committee for Quality Assurance (NCQA) and HEDIS measures to provide established and standardized measures of system performance.

In conclusion, there is flexibility in the design of state Medicaid managed care programs and Ohio will have the benefit of lessons learned from previous states. OACCA may want to consider recommendations to the state associated with provider network requirements, outcome reporting (administrative burden considerations), and populations and benefits carved-in to the initial program(s).
<table>
<thead>
<tr>
<th>State</th>
<th>Program Structure</th>
<th>Populations Included/Excluded</th>
<th>Current Vendors</th>
<th>Benefits</th>
<th>Provider Network Requirements</th>
<th>Outcomes Measured</th>
</tr>
</thead>
</table>
| Arizona | Behavioral health services carved out into separate regional contracts; physical health benefits recently carved-in for adults with SMI | Adults and Youth; Medicaid and non-Medicaid covered individuals | One RBHA per Region. Combination of locally created (Mercy Maricopa, Health Choice Integrated Care (HCIC), Community Partnership of Southern Arizona) and national (Centene) management entities | 1. Prevention  
2. Crisis  
3. Treatment, and rehabilitative behavioral health services for all populations; Medicaid covered physical health benefits for eligible adults with serious mental illness  
4. Provider Network Organizations (PNO) which are comparable to community mental health centers, supportive housing providers, crisis providers, and hospitals. | Specifically for Youth:  
1. Educational Status  
2. Primary Residence  
3. Number of Arrests  
4. Substance Abuse  
5. Reduction of Substance Abuse  
6. Emotional Regulation  
7. Becoming Ready to Learn  
8. Environmental Exploration and Adaptation  
9. Parent-Child Interaction  
10. Improved Family Support (Improved Family Stress Level) (0-4)  
11. Lives with Family (0-4)  
12. Improved Family Support (Improved Family Stress Level) (5-17)  
13. Lives with Family (5-17)  
14. Success in School  
15. Progression of Developmental Milestones (Stable/Productive Adult)  
16. Improved Youth Support (Increased Stability)  
17. Decrease in Safety Risk |
| Georgia | Single program, Georgia Families, contracts with four vendors to provide management across three regions of state. One | Children enrolled in PeachCare and children, pregnant women and women with breast or cervical cancer on Medicaid are eligible to participate in | Georgia Families vendors: Amerigroup Community Care, WellCare of Georgia, Inc.; and Peach State Health Plan (Centene). Amerigroup is the sole plan responsible for Covered services under GF includes medically necessary medical and behavioral health services, including services provided by Tier 2 Core Medicaid Providers of mental health and substance abuse services. | Tier 2 Community Medicaid (CMP) Providers. Must offer choice for consumers with Medicaid. CMPs are required to:  
1. Well-child visits  
2. ADHD Medication follow up  
3. Immunization rates  
4. Dental-children  
5. Obesity-children  
6. Comprehensive Diabetes Care;  
7. Avoidable Emergency room utilization;  
8. Member satisfaction  
9. Provider satisfaction | Tier 2 Community Medicaid (CMP) Providers. Must offer choice for consumers with Medicaid. CMPs are required to:  
1. Well-child visits  
2. ADHD Medication follow up  
3. Immunization rates  
4. Dental-children  
5. Obesity-children  
6. Comprehensive Diabetes Care;  
7. Avoidable Emergency room utilization;  
8. Member satisfaction  
9. Provider satisfaction |
<table>
<thead>
<tr>
<th>State</th>
<th>Program Structure</th>
<th>Populations Included/ Excluded</th>
<th>Current Vendors</th>
<th>Benefits</th>
<th>Provider Network Requirements</th>
<th>Outcomes Measured</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>statewide plan operates Georgia Families 360 (the plan for children in foster care and juvenile justice systems)</td>
<td>Georgia Families. Excluded populations include but are not limited to: Duals, children receiving IV-E benefits and those in skilled nursing facilities. Children in Foster Care and Juvenile Justice are eligible for Georgia Families 360.</td>
<td>operation of Georgia Families 360.</td>
<td>Offer the essential core benefit package of services, serve Medicaid-covered individuals and Serve Both MH &amp; alcohol and drug Individuals</td>
<td>1. Antidepressant Medication Management (AMM) 2. Follow-Up Care for Children Prescribed ADHD Medication (ADD) 3. Follow-Up After Hospitalization for Mental Illness (FUH) 4. Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication (SSD) 5. Diabetes Monitoring for People With Diabetes and Schizophrenia (SMD) 6. Cardiovascular Monitoring for People With Cardiovascular Disease and Schizophrenia (SMC)</td>
<td></td>
</tr>
<tr>
<td>Tennessee</td>
<td>Single program, TennCare, contracts with four vendors to provide management across three regions of state</td>
<td>All Medicaid eligible populations are included in the TennCare Program</td>
<td>AmeriGroup, BlueCare Tennessee (a licensee of BlueCross BlueShield) and UnitedHealthcare, effective Jan. 1, 2015</td>
<td>All Medicaid covered services for which the individual is eligible</td>
<td>Behavioral health providers under contract with MCOs to deliver mental health and alcohol and drug abuse services include an array of community behavioral health</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Program Structure</td>
<td>Populations Included/ Excluded</td>
<td>Current Vendors</td>
<td>Benefits</td>
<td>Provider Network Requirements</td>
<td>Outcomes Measured</td>
</tr>
<tr>
<td>-------</td>
<td>------------------</td>
<td>--------------------------------</td>
<td>----------------</td>
<td>----------</td>
<td>------------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Texas</td>
<td>Multiple managed care programs based on population; behavioral health services carved in with physical health benefits</td>
<td>Population based managed care programs; STAR Health serves Children in DFPS conservatorship (under age 18), including youth in CPS extended foster care (ages 18 to 22), youth ages 18-21 who were previously in foster care and are living independently</td>
<td>Single MCO vendor (Centene dba Superior) for STAR Health; Multiple regional contracts for Texas Star there are regional contracts with multiple national and local plans</td>
<td>1. Preventive health care services which includes regular checkups and immunizations, office visits, visits to the dentist and visits for eye checkups 2. Dental services 3. Vision services 4. Service coordination 5. Clinical service management and disease management 6. Physical, occupational, Significant Traditional Providers based on historical service patterns; and providers experienced in treating victims of child abuse and neglect and providers who specialize in trauma-focused cognitive</td>
<td>STAR Health performance measurement, according to the Contract boilerplate, will be measured by: (a) Adherence to this Contract, including all representations and warranties; (b) Delivery of the Services and Deliverables described in the RFP; (c) Results of audits performed by HHSC or its representatives in accordance with Article 9 (Audit and Financial Compliance); (d) Timeliness, completeness, and accuracy of required reports; and (e) Achievement of performance measures developed by MCO and HHSC and as modified from time to time by written agreement during the term of this Contract. RFP responses for this contract are currently under review so performance measures not available.</td>
<td></td>
</tr>
</tbody>
</table>

7. Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA) 8. Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment (IET) 9. Mental Health Utilization (MPT) which includes the number and percentage of members receiving the following mental health services during the measurement year:  
- Any services  
- IP  
- Intensive outpatient or partial hospitalization  
- Outpatient or ED
and receive Medicaid for Transitioning Youth (MTFCY) and former foster care youth (ages 21 to 23) enrolled in an institution of higher education located in Texas enrolled in the Former Foster Care in Higher Education (FFCHE) program.

Superior Health offers the following value added services:

1. Extra Transportation: bus tokens for medical and non-medical visits
2. Start Smart for Your baby: classes, care management and Baby Showers
3. Home visits to new mothers

speech, and other health-related services
7. Behavioral health care services
8. Hospital coverage including inpatient services
9. Prescriptions and medical supplies
10. Telemedicine including consultations and assessments done by a provider using teleconference capability

behavioral therapy (TF-CBT) and other evidence-based treatments.
<table>
<thead>
<tr>
<th>State</th>
<th>Program Structure</th>
<th>Populations Included/ Excluded</th>
<th>Current Vendors</th>
<th>Benefits</th>
<th>Provider Network Requirements</th>
<th>Outcomes Measured</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4. Pre-programmed cell phone for pregnant members and members in Care Management</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
References


3. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (May 6, 2014). The CBHSQ Report: Serious Mental Health Challenges among Older Adolescents and Young Adults. Rockville, MD.


