

North Carolina Department of Health and Human Services

2001 Mail Service Center • Raleigh, North Carolina 27699-2001

Tel 919-733-4534 • Fax 919-715-4645

Beverly Eaves Perdue, Governor

July 10, 2009

Lanier M. Cansler, Secretary

The Honorable Beverly M. Earle, Chairman
Appropriations Subcommittee on Health and Human Services
North Carolina General Assembly
Room 634, Legislative Office Building
Raleigh, NC 27603

Dear Representative Earle:

Section 10.15(y) of Session Law 2008-107 (House Bill 2436), requires the Department of Health and Human Services to study Medicaid waivers for all Local Management Entities (LME). Additionally, the legislation requests the Department to identify and recommend strategies to increase flexibility for LME's management of mental health services and delivery in situations where waivers are not appropriate for an LME. The legislation requires the Department to submit a report on the development of this plan. It is my pleasure to submit the report at this time.

Please direct all questions you may have regarding this report to Tara Larson, Chief Clinical Operating Officer for the Division of Medical Assistance at (919) 855-4100.

Sincerely,

A handwritten signature in black ink that reads "Lanier".

Lanier M. Cansler

LMC:trl

Attachment

cc: Allen Feezor
Dan Stewart
Tara Larson
Leza Wainwright
Sharnese Ransome
Jennifer Hoffmann
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Beverly Eaves Perdue, Governor

July 10, 2009

Lanier M. Cansler, Secretary

The Honorable Bob England, M.D., Chairman
Appropriations Subcommittee on Health and Human Services
North Carolina General Assembly
Room 303, Legislative Office Building
Raleigh, NC 27601

Dear Representative England:

Section 10.15(y) of Session Law 2008-107 (House Bill 2436), requires the Department of Health and Human Services to study Medicaid waivers for all Local Management Entities (LME). Additionally, the legislation requests the Department to identify and recommend strategies to increase flexibility for LME's management of mental health services and delivery in situations where waivers are not appropriate for an LME. The legislation requires the Department to submit a report on the development of this plan. It is my pleasure to submit the report at this time.

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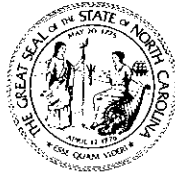
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July 10, 2009

Lanier M. Cansler, Secretary

The Honorable Verla Insko, Chairman
Appropriations Subcommittee on Health and Human Services
North Carolina General Assembly
Room 307-B1, Legislative Office Building
Raleigh, NC 27603

Dear Representative Insko:

Section 10.15(y) of Session Law 2008-107 (House Bill 2436), requires the Department of Health and Human Services to study Medicaid waivers for all Local Management Entities (LME). Additionally, the legislation requests the Department to identify and recommend strategies to increase flexibility for LME's management of mental health services and delivery in situations where waivers are not appropriate for an LME. The legislation requires the Department to submit a report on the development of this plan. It is my pleasure to submit the report at this time.

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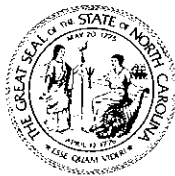
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Beverly Eaves Perdue, Governor

July 10, 2009

Lanier M. Cansler, Secretary

The Honorable William Purcell, Co-Chair
Appropriations on Health and Human Services
North Carolina General Assembly
Room 625, Legislative Office Building
Raleigh, NC 27603

Dear Senator Purcell:

Section 10.15(y) of Session Law 2008-107 (House Bill 2436), requires the Department of Health and Human Services to study Medicaid waivers for all Local Management Entities (LME). Additionally, the legislation requests the Department to identify and recommend strategies to increase flexibility for LME's management of mental health services and delivery in situations where waivers are not appropriate for an LME. The legislation requires the Department to submit a report on the development of this plan. It is my pleasure to submit the report at this time.

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July 10, 2009

Lanier M. Cansler, Secretary

The Honorable Doug Berger, Co-Chair
Appropriations on Health and Human Services
North Carolina General Assembly
Room 526, Legislative Office Building
Raleigh, NC 27603

Dear Senator Berger:

Section 10.15(y) of Session Law 2008-107 (House Bill 2436), requires the Department of Health and Human Services to study Medicaid waivers for all Local Management Entities (LME). Additionally, the legislation requests the Department to identify and recommend strategies to increase flexibility for LME's management of mental health services and delivery in situations where waivers are not appropriate for an LME. The legislation requires the Department to submit a report on the development of this plan. It is my pleasure to submit the report at this time.

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Beverly Eaves Perdue, Governor

July 10, 2009

Lanier M. Cansler, Secretary

The Honorable Martin Nesbitt, Co-Chair
Joint Legislative Oversight Committee on MHDDSAS
North Carolina General Assembly
Room 300B, Legislative Office Building
Raleigh, NC 27603

Dear Senator Nesbitt:

Section 10.15(y) of Session Law 2008-107 (House Bill 2436), requires the Department of Health and Human Services to study Medicaid waivers for all Local Management Entities (LME). Additionally, the legislation requests the Department to identify and recommend strategies to increase flexibility for LME's management of mental health services and delivery in situations where waivers are not appropriate for an LME. The legislation requires the Department to submit a report on the development of this plan. It is my pleasure to submit the report at this time.

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Beverly Eaves Perdue, Governor

July 10, 2009

Lanier M. Cansler, Secretary

The Honorable Verla Insko, Co-Chair
Joint Legislative Oversight Committee on MHDDSAS
North Carolina General Assembly
Room 307-B1, Legislative Office Building
Raleigh, NC 27603

Dear Representative Insko:

Section 10.15(y) of Session Law 2008-107 (House Bill 2436), requires the Department of Health and Human Services to study Medicaid waivers for all Local Management Entities (LME). Additionally, the legislation requests the Department to identify and recommend strategies to increase flexibility for LME's management of mental health services and delivery in situations where waivers are not appropriate for an LME. The legislation requires the Department to submit a report on the development of this plan. It is my pleasure to submit the report at this time.

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Beverly Eaves Perdue, Governor

July 10, 2009

Lanier M. Cansler, Secretary

Marilyn Chism, Director
Fiscal Research Division
Room 619, Legislative Office Building
Raleigh, NC 27601

Dear Ms. Chism:

Section 10.15(y) of Session Law 2008-107 (House Bill 2436), requires the Department of Health and Human Services to study Medicaid waivers for all Local Management Entities (LME). Additionally, the legislation requests the Department to identify and recommend strategies to increase flexibility for LME's management of mental health services and delivery in situations where waivers are not appropriate for an LME. The legislation requires the Department to submit a report on the development of this plan. It is my pleasure to submit the report at this time.

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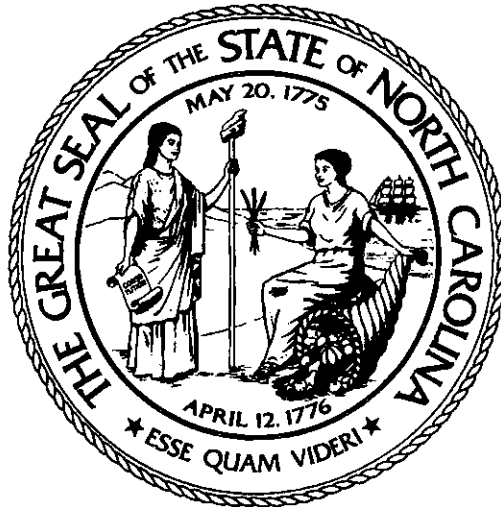
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Legislative Report
Medicaid Waivers for LMEs
S.L. 2008-0107 Section 10.15(y)



State of North Carolina
Department of Health and Human Services
Division of Medical Assistance



April 2009

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Executive Summary

The Department of Health and Human Services (DHHS) Division of Medical Assistance (DMA) and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) reviewed waiver options under Section 1915 of the Social Security Act. Per **Session Law 2008-0107, Section 10.15.(y)**, the objective of this project is to study Medicaid waiver options for North Carolina and, where waivers are not appropriate for an LME, recommend other strategies for LMEs.

Medicaid State Waiver Options

The Social Security Act allows states flexibility in operating the Medicaid program under waiver and demonstration authorities. Under Section 1115 of the Social Security Act (SSA), the Secretary of Health and Human Services may waive certain Medicaid requirements for states seeking to provide services under experimental, pilot, or demonstration projects. Under Section 1915 (b) of the SSA, the Secretary may grant waivers that allow states to implement managed care delivery systems, or otherwise limit individual's choice of provider under Medicaid. Under Section 1915 (c) of the SSA, the Secretary may waive Medicaid provision in order to allow long-term care services to be delivered in community settings. States may opt to simultaneously use section 1915(b) and 1915(c) waivers to provide a continuum of services to disabled and/or elderly populations. In essence, states use the 1915(b) waiver to limit freedom of choice, and 1915(c) waiver to target eligibility for the program and provide home and community-based services (Centers for Medicaid and Medicare Service [CMS], 2008).

Managed Behavioral Healthcare Organizations (MBHO)

Over 34 states have opted to use 1915 (b) and 1115 waivers to implement Medicaid managed behavioral healthcare (MBH) plans. The American Medical Association defines managed care as "those processes or techniques used by any entity that delivers, administers and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization or costs and prices or outcomes of such services provided to a defined enrollee population."

Under North Carolina mental health reform, LME functions reflect managed care principles. LMEs are directed to develop provider networks, organize local resources, and connect consumers to appropriate resources (Judge David L. Bazelon Center for Mental Health Law [Bazelon], 2000).

Some of the positive effects of managed behavioral healthcare (MBH) reported by states include

- increased access to services
- decreased use of inappropriate inpatient care
- an expanded array of services and providers
- emphasis on recovery, rehabilitation, and work
- increased innovation and reliance on best practices (Judge David L. Bazelon Center for Mental Health Law [Bazelon], 2000).

Problems that may arise as a result of using managed care include:

- an incentive to undertreat or underserve people with serious disorders
- frequent billing and payment difficulties during start-up
- difficulty in ensuring quality and outcomes consistently across regions (Bazelon, 2000).

If a managed behavioral healthcare system is to be successful, the state leadership needs to know what outcomes it wants to achieve and must have the structures in place to procure and manage them effectively. With a managed care contract, the state has a strong mechanism to require accountability and demand improved performance through sanctions and rewards. As the contract progresses, problems can be addressed in a planned and careful manner (Bazelon, 2000).

As the public demands responsiveness and returns on its tax dollars, managed care holds the promise of improving service delivery and demonstrating whether chosen outcomes have been delivered. State officials report that if properly planned and administrated, managed care is a good tool to:

- provide financial discipline
- demand accountability
- generate innovation (Bazelon, 2000).

Accountability

The comprehensive data systems used by managed behavioral healthcare organizations enable states to require reporting of key outcome data. To ensure accountability, some of the questions states should consider include:

Is the MBHO meeting contract requirements? Contract data would include measures of:

- Access to care including penetration rates and encounter data
- Consumer satisfaction including grievance and appeals data

How well is the plan performing? Performance data would include measures of:

- Readmission rates; reduced use of inpatient or residential services
- Time to first appointments and follow-up services

How effective, overall is the plan? Outcomes data would include measures of:

- Improved functioning or quality of life
- Increased work activities

Appropriate measures and the data they produce can help states to solve problems in their mental health system. Accountability also involves sharing information with the consumer and the public, which helps to keep the system accountable. Finally, all managed care contracts must include specific outcome measures in order to be approved by the Centers for Medicaid and Medicare Service (CMS).

Cost Containment

Managed care can be a useful tool for achieving cost efficiency in a dynamic system while off-setting risk and protecting consumers. Typically, an MBHO agrees to provide an array of services to recipients for a flat fee or capitation rate paid on a per member per month basis. The incentive is for MBHOs to control their costs by steering clients into the most appropriate, often less costly, services.

Under a *risk-based* financial model, an MBHO is paid a monthly capitation rate and assume some or all of the financial risk for the delivery of services. The MBHO incurs loss if the cost of furnishing the services exceeds the payments under the contract. Under an *Administrative Services Only (ASO)* financial model, the MBHO is paid a defined amount for administrative services and takes no financial risk for the cost of services.

Models of MBH

Basic models of Medicaid managed care include **carve in**, **carve out**, and **managed fee for service (FFS)**. In a **carve in** model, the state contracts with a general health managed care organization (MCOs), which either covers behavioral health services or directly subcontracts to a specialty MBHO which manages behavioral health services for the MCO. In a **carve out** model, MBHOs are typically placed at financial risk for the provision of behavioral health services, either on a capitated or a risk-sharing basis. In states utilizing a **carve out** model, physical health services are provided to Medicaid enrollees under separate managed care plans or on a fee-for-service basis. In a **managed FFS** system, the state implements a number a managed care tools through a MBHO and pays providers on a traditional fee-for-service basis.

Once a basic model of MBH is chosen, states must determine if administrative and care management functions will happen at the state-wide or regional level. In a **centralized organizational model**, a specialty MBHO provides a statewide infrastructure for access, utilization review, provider management, and financial and information systems. Local functions are carried out by the staff of the MBHO or local agency partners placed in the community. Iowa and Massachusetts use this delivery model. In a **regional model**, each region contracts with a MBHO. The regional model provides flexibility in customizing a service delivery system for different areas of a state. Pennsylvania, Colorado, Washington, and Arizona use this model. Other states contract with a state-wide MBHO for **administrative services only (ASO)**. The ASO does not assume any financial risk, which falls to the state (Bazelon, 2000). Maryland and New Jersey use this model.

Mercer Report Recommendations

In 2008, under contract from the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, Mercer Government Human Services Consulting (Mercer) completed a study of the 25 Local Management Entities (LMEs) in North Carolina to evaluate optimal mechanisms to consolidate LMEs and to determine the readiness of the LMEs to assume utilization review functions for Medicaid recipients.

To reduce administrative cost and duplication of functions and to increase efficiency, Mercer recommends administrative and care management functions provided at the regional or state-wide (centralized) level. Using these **regional** or **centralized** models, LMEs could become MBHOs and assume risk similar to Piedmont Behavioral Healthcare, return to direct provision of services, or develop into **Core Service Agencies** which could provide a comprehensive array of services and perform local planning, stakeholder and community collaboration functions. Under these options, an LME or consortium of LMEs could bid on becoming the Regional Managed Entities (RMEs) or Centralized Management Entity (CME).

Conclusions

Using a Medicaid waiver to shift to managed behavioral healthcare represents a significant shift in thinking for all stakeholders in North Carolina. Such a change takes multiple years to research, implement, and refine. Most states who used waivers to implement MBH plans recommend extensive research of the current system and proposed options and planning involving all stakeholders.

Recommendations

- I. Based upon preliminary research, DHHS tentatively recommends that DMA, in coordination with DMH/DD/SAS, continue research and planning towards applying for a 1915 (b) waiver for a regionally-based, at-risk, MBH plan for the state of North Carolina.
- II. DHHS recommends that all stakeholders, including LMEs, consumers and their families, providers, advocacy groups, and other relevant entities, be included in the planning process. The Community Care of North Carolina (CCNC) networks must be integrally involved in helping define carve in and carve out risks and benefits to the entire system.
- III. Given the review of “lessons-learned” from other states, DHHS recommends that funds be allocated for comprehensive evaluations by industry experts of the current public behavioral healthcare system and cost analyses of regional and centralized managed care models to ascertain which model would be best for North Carolina—a model that is both cost-effective and sensitive to the needs of consumers. The analysis should build upon the experience of Piedmont Behavioral Healthcare and the CCNC networks.

Legislative Mandate

Session Law 2008-0107 Section 10.15 (y) directed the Department of Health and Human Services as follows:

“The Department of Health and Human Services, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, shall study Medicaid waivers, including 1915(b) and (c) waivers, for all LMEs. In cases where Medicaid waivers are not appropriate for an LME, the Department shall identify and recommend strategies to increase LME flexibility to provide case management, assessment, limit provider networks, or other innovative approach for managing care. Not later than March 1, 2009, the Department shall report its findings and recommendations to the House of Representatives Appropriations Subcommittee on Health and Human Services, the Senate Appropriations Committee on Health and Human Services, the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, and the Fiscal Research Division.”

Introduction

The Department of Health and Human Services (DHHS) Division of Medical Assistance (DMA) and Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) reviewed waiver options under Section 1915 of the Social Security Act. The objective of this project is to study Medicaid waiver options for North Carolina and, where waivers are not appropriate for an LME, recommend other strategies for LMEs.

Information for this project was gathered from:

- Research and review of publications from behavioral health policy and consulting firms,
- Research on programs and innovations in selected states,
- A review of managed behavioral healthcare organization and accreditation websites,
- A review of recently published academic literature on behavioral health trends,
- Interviews with experts internal and external to DHHS,
- A meeting with Local Management Entity (LME) directors and the NC Council of Community Programs.

States are increasingly using 1915 (b), 1915 (c), and 1115 waivers to develop innovative methods of managing public behavioral healthcare, substance abuse and developmental disability services through managed care systems. Managed care tools are used by many states as a way to contain costs and improve efficiency and quality of services. In the past, some states privatized their behavioral healthcare systems through contracts with private managed care vendors; now many states are using managed care tools within their existing behavioral healthcare systems. This paper reviews Medicaid waiver options, managed care principles and models, and select state managed care plans against the backdrop of North Carolina’s current behavioral healthcare structure. The overall goal of this project is to consider how best to use the strengths of North Carolina’s existing LME structure while improving the behavioral healthcare system state-wide.

Findings from the project research are organized and discussed in the following sections:

- Medicaid State Waiver Options
- Managed Behavioral Healthcare Organizations (MBHO)
- Trends in the Organization of Managed Behavioral Healthcare (MBH)
- Representative State Models of Managed Behavioral Healthcare
- Mercer Report Recommendations
- Conclusions
- Recommendations

Medicaid State Waiver Options

The Social Security Act allows states flexibility in operating the Medicaid program under waiver and demonstration authorities. These options include: 1115 Research and Demonstration Projects, 1915(b) Managed Care/Freedom of Choice Waivers, and 1915 (c) Home and Community-Based Services Waivers. Each waiver number represents sections of the Social Security Act (SSA). Each authority has a distinct purpose and distinct requirements (Centers for Medicaid and Medicare Service [CMS], 2008).

Section 1115 Research and Demonstration Projects

Under Section 1115 of the Social Security Act (SSA), the Secretary of Health and Human Services may waive certain Medicaid requirements for states seeking to provide services under experimental, pilot, or demonstration projects. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems. Projects are generally approved to operate for a five-year period. Demonstrations must be "budget neutral" over the life of the project; the project must not exceed the cost of providing State Plan services in the absence of a waiver (CMS, 2008).

Section 1915(b) Managed Care/Freedom of Choice Waivers

Under Section 1915 (b) of the SSA, the Secretary may grant waivers that allow states to implement managed care delivery systems, or otherwise limit individual's choice of provider under Medicaid. A 1915 (b) waiver must be cost effective; it cannot cost more than what the Medicaid program would have cost without the waiver (CMS, 2008).

Under a 1915 (b) waiver, states may waive provisions of Section 1902 of the Social Security Act which describes requirements for a State Medicaid Plan.

Under a 1915 (b) waiver, the most frequently waived provisions of Section 1902 are:

- Freedom Of Choice: This allows freedom of choice of providers to be restricted.
- Statewideness: This allows services to be offered in some areas of the state but not in others.

- Comparability of Services: Additional services can be delivered to certain enrollees that would not be available to all Medicaid beneficiaries.
- Participation: The state can mandate enrollees into a single health plan.

Section 1915(b) waivers can be granted for one or more of the following purposes only:

- Section 1915(b)(1) -- Primary Care Case Management Systems (PCCM) or Specialty Physician Services Arrangements

States can restrict the provider from whom a recipient can obtain services or mandate Medicaid enrollment into managed care.

- Section 1915(b)(2) -- Locality as a Central Broker

A locality (jurisdiction or agency) may assist eligible individuals in choosing among competing health plans by providing more information about the range of health care options available to them.

- Section 1915(b)(3) -- Sharing of Cost Savings

Cost savings resulting from the use of more cost efficient medical care may be used to provide additional services to recipients.

- Section 1915(b)(4) -- Restriction of Recipients to Specified Providers

Beneficiaries may only obtain services from specified providers (CMS, 2008).

Section 1915 (c) Home and Community-Based Services (HCBS) Waivers

Under Section 1915 (c) of the SSA, the Secretary may waive Medicaid provision in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings. States have the discretion to limit the number of consumers that may be served under a HCBS waiver program. 1915 (c) waivers must demonstrate "cost neutrality;" services provided under the waiver must not exceed the cost of providing State Plan services in the absence of a waiver (CMS, 2008).

Under a 1915 (c) waiver, the most frequently waived provisions of Section 1902 are:

- Statewideness: This allows states to target waivers to particular areas of the state where need is greatest, or where certain types of providers are available.
- Comparability of Services: This allows states to make waiver services available to people at risk of institutionalization, without being required to make waiver services available to all Medicaid recipients.

- Income and Resource Rules in the Community: This allows states to provide Medicaid to persons who would otherwise be eligible only in an institutional setting, often due to the income and resources of a spouse or parent.

Combined 1915 (b)/(c) Waivers

States may opt to simultaneously use section 1915(b) and 1915(c) waivers to provide a continuum of services to disabled and/or elderly populations. In essence, states use the 1915(b) waiver to limit freedom of choice, and 1915(c) waiver to target eligibility for the program and provide home and community-based services. By doing so, states may provide long-term care services in a managed care environment or use a limited pool of providers (CMS, 2008).

States may implement 1915(b) and 1915(c) concurrent waivers as long as all federal requirements for both programs are met. States must demonstrate cost neutrality in the 1915(c) waiver and cost effectiveness in the 1915(b) waiver (CMS, 2008).

Currently in North Carolina, DMA contracts with Piedmont Behavioral Healthcare (PBH) to provide behavioral health services as a prepaid health plan. The program operates under concurrent 1915(b)/(c) waivers which are administered by DMA. Session Law 2008-107, (House Bill 2436) SECTION 10.15.(z) recognizes PBH as a demonstration model for the State. See *Representative State Models of Managed Behavioral Healthcare* for additional information on PBH.

Managed Behavioral Healthcare Organizations

Over 34 states have opted to use 1915 (b) and 1115 waivers to implement Medicaid MBH plans. The American Medical Association defines managed care as “those processes or techniques used by any entity that delivers, administers and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization or costs and prices or outcomes of such services provided to a defined enrollee population.” Increasingly, states are extending a managed care approach to individuals with serious mental and emotional disorders—effectively utilizing managed behavioral healthcare.

Under North Carolina mental health reform, LME functions reflect managed care principles. The North Carolina General Assembly, in Session Law 2001-437, designated the LMEs as delivery system managers for the provision of all publicly funded MH/DD/SA services. LMEs are directed to develop provider networks, organize local resources, and connect consumers to appropriate resources. These administrative efforts are expected to achieve greater system efficiency, improve access, develop a comprehensive provider network, and reduce instances of ineffective, wasteful use of limited public resources.

Some of the positive effects of MBH reported by states that have implemented managed care include:

- increased access to services
- decreased use of inappropriate inpatient care

- an expanded array of services and providers
- more flexibility in service delivery
- more consistency in clinical decision-making
- emphasis on recovery, rehabilitation, and work
- more focused and goal-oriented treatment
- cultural-competent services
- increased innovation and reliance on best practices (Judge David L. Bazelon Center for Mental Health Law [Bazelon], 2000).

On the other hand, the expansion of managed care into the public mental health system has been controversial. Problems that may arise as a result of using managed care include:

- an incentive to undertreat or underserve people with serious disorders
- an undue focus on acute care and neglect of rehabilitation services
- frequent billing and payment difficulties during start-up
- difficulty in ensuring quality and outcomes consistently across regions (Bazelon, 2000).

If a managed behavioral healthcare system is to be successful, the state leadership needs to know what outcomes it wants to achieve and must have the structures in place to procure and manage them effectively. Using managed care appropriately, the state is in a position to demand far greater accountability from mental health providers than it has ever been able to in the past. With a managed care contract, the state has a strong mechanism to require accountability and demand improved performance through sanctions and rewards. As the contract progresses, problems can be addressed in a planned and careful manner (Bazelon, 2000).

As the public demands responsiveness and returns on its tax dollars, managed care holds the promise of improving service delivery and demonstrating whether chosen outcomes have been delivered. State officials report that, if properly planned and administrated, managed care is a good tool to:

- provide financial discipline and contain costs
- demand accountability
- force service integration
- generate innovation (Bazelon, 2000).

Accountability Standards

The comprehensive data systems used by MBHOs enable states to require reporting of key outcome data. Federally mandated waiver rules also require states to conduct independent evaluations of the managed care system. To ensure accountability, some of the questions states should consider include:

Is the MBHO meeting contract requirements? Contract data would include measures of:

- Access to care including penetration rates and encounter data
- Consumer satisfaction including grievance and appeals data

- Encounter data to determine the existence of a qualified provider network and to ascertain patterns of care delivery

How well is the plan performing? Performance data would include measures of:

- Readmission rates; reduced used of inpatient or residential services
- Time to first appointments and follow-up services
- Provision of sufficient information to consumers

How effective is the plan overall? Outcomes data would include measures of:

- Improved functioning or quality of life
- Increased work activities
- Increased time spent out of hospitals

Appropriate measures and the data they produce can help states to solve problems in their mental health system. For example, providers can be compared in terms of outcomes and any problem situations can be addressed. Data can be used to create incentives and impose sanctions for a variety of specific consumer outcomes. Data enables policymakers to adjust the risk to plans of serving significant numbers of people with high levels of needs. Funds can be directed to areas where they may be needed most. Performance and outcome data can be used to track how the most vulnerable populations are faring (Bazelon, 2000). Accountability also involves sharing information with the consumer and the public, which helps to keep the system accountable. Finally, all managed care contracts must include specific outcome measures in order to be approved by the Centers for Medicaid and Medicare Service (CMS).

Cost Containment

Managed care can be a useful tool for achieving cost efficiency in a dynamic system while off-setting risk and protecting consumers. For example, Piedmont Behavioral Healthcare (PBH) managed to lower costs for Community Support between 2006-2008 while the statewide fee-for-service program experienced millions of dollars of increase. During that same time period, PBH per member per month cost of inpatient and residential services was 30% lower than the rest of the state (Mercer, 2008). Other states have shown similar results and, under waiver regulations, states can reinvest those savings into additional services for Medicaid recipients.

Typically, an MBHO agrees to provide an array of services to recipients for a flat fee or capitation rate negotiated in advance. A capitation payment is made on a per member per month basis; the rate is determined by actuary data. The incentive is for MBHOs to control their costs by steering clients into the most appropriate, often less costly, services in a timely manner so that problems do not escalate and require more acute, expensive services. Depending on contract arrangements, the MBHO is able to keep any excess funds or reinvest them in other services for recipients. Managed care controls are balanced with protections and legal rights under the Medicaid State Plan and waiver regulations so that recipients are not denied choices and appropriate services in an effort to save costs.

Payment Strategies

Under a risk-based financial model, an MBHO is paid a monthly capitation rate and assumes some or all of the financial risk for the delivery of services. Under a ***Comprehensive Risk Contract***, the MBHO assumes the financial risk for all covered services, including inpatient services. Under a ***Risk Contract***, the MBHO assumes risk for the cost of specific services outlined in the contract. Under either contract, the MBHO incurs loss if the cost of furnishing the services exceeds the payments under the contract.

On an ***Administrative Services Only*** basis, the organization is paid a defined amount for administrative services and takes no financial risk for the cost of services.

Basic Models of Medicaid Managed Care

Basic models of Medicaid managed care include:

Carve in: In a **carve in** model, the state contracts with a general MCO, which either covers behavioral health services or directly subcontracts to a specialty MBHO which manages behavioral health services for the MCO. This approach is less prevalent among states (Trout, 2008).

Carve out: In a **carve out** model, MBHOs are typically placed at financial risk for the provision of behavioral health services, either on a capitated or a risk-sharing basis. In states using a carve out model, physical health services may be provided to Medicaid enrollees under separate managed care plans or on a fee-for-service basis. This carve out model is used in over 83% of states (Bazelon, 2000). Carve outs have the benefit of specialized professional expertise to a certain degree, and often expand benefits and service options. Other benefits include better accountability of funding for behavioral health expenses and more likely coordination with other non-health systems such as social service and juvenile justice (Trout, 2008).

Managed Fee-For-Service (FFS): In a **managed FFS** model, the state implements a number of managed care tools through a MBHO and pays providers on a traditional fee-for-service basis. In North Carolina, a state-wide vendor provides utilization management for Medicaid behavioral health services reimbursed on a fee for service basis. Four LMEs have also been selected to begin utilization management by July 1, 2009.

Trends in the Organization of Managed Behavioral Healthcare

Centralized Managed Behavioral Healthcare Organization

Once a basic model of MBH is chosen, states must determine if administrative and care management functions will happen at the state-wide or regional level. In a centralized model, a specialty MBHO provides a statewide infrastructure for access, utilization review, provider management, and financial and information systems. Typically, specialty MBH vendors or partnerships of MBHOs and coalitions of local agencies are selected because they have established infrastructures and financial resources to ensure coverage for the entire state for all

services needed. Local functions are carried out by the staff of the MBHO or local agency partners placed in the community. Local structures are needed to ensure responsiveness to local needs (Mercer Government Human Services Consulting [Mercer], 2008).

Some states have chosen to contract with large, nationally known MBHOs because these states did not have the financial and data systems that would enable them to administer or run managed care themselves (Bazelon, 2000). In this centralized model, the State oversight agency has the responsibility to procure, manage and monitor the contract. The burden of State oversight is significantly reduced due to working with only one centralized administrator (Mercer, 2008).

Regional MBHO

A regional model provides flexibility in customizing a service delivery system for different areas of a state. Regions are usually structured around single or multiple counties based on population size and patterns of use. In order for an MBHO to be cost-effective, an optimal enrollment size must also be considered when determining regions. Some states establish MBHOs within the existing public mental health system, using state, county, or local mental health networks to run—or bid on contracts to run—the mental health system under a managed care model (Mercer, 2008). Generally speaking, existing mental health networks often need to demonstrate that they have the necessary financial resources to assume risk and the data systems to manage for outcomes (Bazelon, 2008). In this regional model, the state defines the standards for the operations of the regional entities, holds separate contracts with each managing entity, and monitors compliance across all contracts.

Administrative Services Organization (ASO)

Other states contract with MBHOs for administrative services only. Those services may include a broad array of administrative and medical management services such as utilization management, claims administration, data reporting, and marketing. The ASO does not assume any financial risk, which falls to the state (Bazelon, 2000).

Representative State Models of Managed Behavioral Healthcare

The following descriptions of state managed care plans are copied from original documents. Each author or source is cited under the entry with the full citation listed in the “References” section of this paper.

Centralized MBH Models

Iowa

Iowa’s centralized MBH program, the *Iowa Behavioral Health Plan (IBHP)* serves all Medicaid members from 99 counties. *IBHP* assumes all financial risk for all behavioral health and substance abuse services through a capitated arrangement. Two state agencies have oversight roles: the Department of Human Services (DHS) for mental health services and the Department of Public Health (DPH) for the state funded substance abuse services. *IBHP* uses teams to work

with local communities in the development and expansion of services. It is important to note that Iowa has a smaller population than North Carolina (3 million compared to 9 million respectively) and less geographic diversity than North Carolina (Mercer, 2008, p. 46).

Massachusetts

The Department of Medicaid Assistance (DMA), contracts with the *Massachusetts Behavioral Health Partnership* (MBHP), its single managed care organization, to supply behavioral health services for 22,000 Medicaid recipients. Under this agreement, the DMA is responsible to the Division of Mental Health (DMH) while MBHP is responsible to the DMA. DMH is organized into six geographic regions, each of which is managed by an Area Director. Each Area is divided into Local Service Sites. Each Site provides case management and oversees an integrated system of state and vendor-operated adult and child/adolescent mental health services. Citizen advisory boards at every level of the organization participate in agency planning and oversight. Some DMH clients receive behavioral health services paid for by *MassHealth* (the State's physical health program) through its four Managed Care Organizations (MCOs). In addition, some DMH clients with Medicare or commercial insurance access Medicaid behavioral health care on a fee for service basis ("About the Department of Mental Health," 2008).

Regional MBH Models

Pennsylvania

Under the *HealthChoices* program, Pennsylvania uses a 1915 (b) waiver to contract with counties that coordinate behavioral health services. Counties had the first opportunity to contract with the State Office of Mental Health and Substance Abuse Services (OMHSAS) to act as their own managed care entity. The design feature of giving counties the first option to act as their own MCO builds on the historical structure and experience in the State, which has given the counties the authority for behavioral health care delivery since 1960. Counties then directly contract for service delivery or contract with a MBHO to manage and coordinate service delivery. Counties may also choose to opt out of directly managing services. For these counties, OMHSAS manages a contract with a MBHO. Pennsylvania established a minimum population guideline of 10,000 *HealthChoices* enrollees in order for a county, a group of counties, or a BHMO to qualify for a contract. State contracts with counties are risk-based, and counties, in turn, may enter into risk-based arrangements with a MBHO. There is only one MBHO per county (or cluster of counties in case of sparsely populated areas). Each of the counties or clusters contracts with one of the same five MBHOs in the state. *HealthChoices* is funded with a blend of medical, mental health, and substance abuse dollars. *HealthChoices* also provides for reinvestment of saving generated by the system back into the county of origin (Pires, 2002, p. 19-21).

Colorado

The current Colorado Medicaid *Community Mental Health Services Program* (CMHSP) provides mental health care under a 1915 (b) waiver. Five nonprofit Behavioral Health organizations (BHOs) are capitated for the managed mental healthcare and delivery of services in their

geographic areas based on enrollee patterns. Each BHO operates the *Program* in a specific geographic area, and only one contractor operates in any given area. The community mental health centers (CMHCs) that comprise the primary provider networks for each of the BHOs have varying degrees of controlling interest in the BHOs and are subcapitated for services. The BHOs contract with other community providers in order to maintain adequate network access and expertise. The overall administrative oversight of the program is provided by the Managed Care/Behavioral Health Section of the Benefits Division, in the Colorado Department of Health Care Policy and Financing. The day to day program administration is performed by the BHOs. The direct service delivery is provided by the community mental health centers (CMHCs) and other providers. The BHOs are capitated on a full risk basis for mental health services only. The waiver allows CMHSP to offer a variety of alternative mental health services such as intensive case management, vocational services, recovery services, clubhouses and drop-in centers (Trout, 2008, p. 16). Colorado has a separate 1915 (b) waiver for the *Special Connections Substance Abuse Treatment Program*.

Washington

In 1989, Washington's Mental Health Division (MHD) created 13 county-based Regional Support Networks (RSNs) to design and administer a managed care mental health delivery system under a 1915 (b) waiver. The RSNs administer the Medicaid mental health care system directly, or subcontract with qualified community mental health agencies (CMHA). The first opportunity to demonstrate qualifications and enter into capitated managed mental health care contracts was provided to county-based Regional Support Networks. This opportunity was contingent upon the RSN's agreement to enter into a full-risk capitation contract. RSNs were required to demonstrate capacity to meet the program and fiscal requirements. If an RSN choose not to participate, or was unable to meet required qualifications, the MHD would choose a managed care contractor ("Washington State Integrated Community Mental Health Program," 2008).

Arizona

The Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) contracts with community based organizations, known as Regional Behavioral Health Authorities (RBHAs), to administer behavioral health services throughout the State. RBHAs function in a fashion similar to a health maintenance organization. The RBHAs manage State and Medicaid funds for a single county or multiple counties depending on the size of the population and geographic area and manage the financial risk associated with these funds through a capitation arrangement. In this model, there is a strong local stakeholder involvement ("About Behavioral Health Services," 2008).

Piedmont Behavioral Healthcare (PBH)—North Carolina

Piedmont Behavioral Healthcare, a public MBHO, manages the *Piedmont Cardinal Health Plan* (PCHP) serving a five-county region in North Carolina under concurrent 1915 (b)/(c) waivers. PBH oversees a comprehensive MH/DD/SAS provider network and is responsible for authorizing payments for services, processing and paying claims, and conducting utilization and

quality management functions. PBH manages both Medicaid State Plan services and services contained in the new Home and Community Based Services *Innovations* waiver [1915 (c)]. PBH uses comprehensive community providers (CCP) as enrollment and eligibility determination sites. These CCPs provide a variety of mental health services and serve as the clinical home for Target populations. PBH has four CCPs, two in each county.

Piedmont is at financial risk for a discrete set of mental health, developmental disabilities and substance abuse services, including both Medicaid State Plan services and services contained in the Home and Community Based Services 1915 (c) waiver “Innovations” for persons with mental retardation and developmental disabilities. PBH is paid per member per month capitated payments. The Division of Medical Assistance (DMA) approves all policies and requirements concerning the waiver.

PCHP has generated savings through care and utilization management strategies, and has received approval from CMS to invest the savings in 1915(b)(3) services for PCHP Medicaid recipients. The (b)(3) service package contains cost-effective, supplemental services and supports aimed at decreasing hospitalizations and helping individuals remain in their homes and communities when preferred and appropriate (“State of North Carolina Piedmont Cardinal Health Plan,” 2007, pp. 5, 7).

Administrative Services Organization (ASO) Models

Maryland

As part of the 1115 *HealthChoice* waiver process, specialty mental health services, were carved out into a separate managed fee-for-service system. This system, the Specialty Mental Health System (SMHS), is administered by the Mental Hygiene Administration (MHA), local Core Service Agencies (CSA's), and an administrative services organization (ASO), which is currently APS Healthcare (APS). APS Healthcare (APS) authorizes services and pays claims for the SMHS. Any claims for non-emergency specialty mental health services for both *HealthChoice* and non-*HealthChoice* recipients must be authorized and paid by APS Healthcare (“Specialty Mental Health Services,” 2008).

New Jersey

The Division of Child Behavioral Health Services (DCBHS) utilizes a statewide ASO-type entity to coordinate, authorize, and track care for all children entering the system and to assist the NJ department of Human Services to manage the system of care and improve quality. A non risk-based contract was awarded to Value Options (VO), to coordinate 24-hour access to care, operate a toll-free Access to Care line, and support utilization management, quality management, and information management functions. VO also facilitates a single method for paying providers of behavioral healthcare and maintains one electronic record of behavioral healthcare across child-serving systems (Pires, 2002, p. 14).

Mercer Report Recommendations

In 2008, under contract from the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MD/DD/SAS), Mercer Government Human Services Consulting (Mercer) completed a study of the 25 Local Management Entities (LMEs) in North Carolina to evaluate optimal mechanisms to consolidate LMEs and to determine the readiness of the LMEs to assume utilization review functions for Medicaid recipients.

According to the Mercer report, the two organizational models that are most representative of carve out managed behavioral health plans for North Carolina are **regional** and **centralized** (Mercer, 2008).

Consolidation & Core Service Agencies

To reduce administrative cost and duplication of functions and to increase efficiency, Mercer recommends administrative and care management functions provided at the regional or state-wide (centralized) level. Using these **Regional** or **Centralized** models, LMEs could become MBHOs and assume risk similar to Piedmont Behavioral Healthcare, return to direct provision of services, or develop into **Core Service Agencies**. Many states, including Colorado and Washington, utilize a system of **Core Service Agencies** to provide a comprehensive array of services and perform local planning, stakeholder and community collaboration functions. The Core Service Agency model preserves local influence, authority and the knowledge of local resources (Mercer, 2008).

Regional Management Entities (RMEs)

Under a **Regional** model, LMEs would consolidate into three to five Regional Management Entities (RMEs). It would be expected that voluntary associations among the LMEs in adjoining catchment areas would occur as part of a bidding process for the managed care contract. This option would allow some of the LMEs to become RMEs and others to become direct service providers or Core Service Agencies with local functions that preserve local input. Under this consolidation strategy, an RME would be responsible for a larger number of consumers and families, thus obtaining economies of scale in administrative activities. This option would capitalize on the resources invested in the LMEs to date, while moving the system forward to achieve better access to services, improve performance, and contain costs (Mercer, 2008).

Centralized Management Entity (CME)

A **Centralized** model provides the most efficiency and could be consistent with the State's goals of having local authority, especially if this model includes the use of former LMEs as Core Service Agencies. Under this option, an LME or consortium of LMEs could bid on becoming the Centralized Management Entity (CME). Furthermore, the LMEs could subcontract with a specialty BH managed care vendor to provide service management functions (Mercer, 2008).

A competitive procurement process will allow DMA and DMH/DD/SAS to select the CME or RME from the best proposals. The procurement would be open to LMEs, specialty BH managed care vendors and a combination of both (Mercer, 2008). The Centers for Medicaid and Medicare

Service (CMS) also has specific requirements for procurement of managed care contracts under a 1915 or 1115 waiver.

Conclusions

Using a Medicaid waiver to shift to managed behavioral healthcare represents a significant shift in thinking for all stakeholders in North Carolina. Such a shift requires major changes in both service delivery and financing and requires the balancing of competing interests. Such a change takes multiple years to research, implement, and refine. In 2000, Bazelon published a collective study that detailed the “lessons learned” from senior officials of multiple state and local governments who transformed their public mental health systems using managed care principles.

Most states in the study recommended extensive planning before introducing managed care into the public system. State officials suggested an in-depth review of the current system and recommended involving all stakeholders including legislators, LMEs, providers, consumers and their families, professional associations, and advocacy groups in the planning process. The involvement of these various interests in other states led to greater consensus about the state’s goals (Bazelon, 2000).

These states have also found that several factors have been especially important to the success of a shift to managed care. Some of these factors are listed below.

- Cost estimates must be developed for different groups to determine risk adjustment and capitation rates.
- State and provider data and information systems must be improved.
- State and local administration must develop skills to regulate a managed care contract.
- The state must decide which populations to cover.
- The state must determine how the behavioral healthcare system will interact with other involved public agencies and local governments.
- The state must address how to meet needs in rural areas (Bazelon, 2000).

Recommendations

- I. Based upon preliminary research, DHHS tentatively recommends that the Division of Medical Assistance (DMA) in coordination with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS) continue research and planning towards applying for a 1915 (b) waiver for a regionally-based, at-risk, Managed Behavioral Healthcare (MBH) plan for the State of North Carolina. A 1915(b) waiver will allow a statewide reform, while a regionally-based model will capitalize on the current resources and the LME system in the State. An at-risk managed care contract(s) will allow for cost containment and improved quality and efficiency in service delivery.
- II. DHHS recommends that all stakeholders including LMEs, consumers and their families, providers, advocacy groups, and other relevant entities be included in the planning process. The Community Care of North Carolina (CCNC) networks must be integrally involved in helping define carve in and carve out risk and benefits to the entire system.
- III. Given the review of “lessons-learned” from other states, DHHS recommends that funds be allocated for comprehensive evaluations by industry experts of the current public behavioral healthcare system and cost analyses of regional and centralized managed care models to ascertain which model would be best for North Carolina—a model that is both cost-effective and sensitive to the needs of consumers. The analysis should build upon the experience of Piedmont Behavioral Healthcare and the CCNC networks.

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