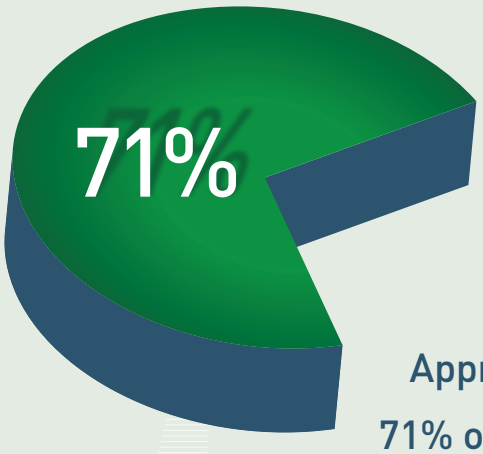
FACT SHEET

Medicaid in Transition:

Moving From a Fee-for-Service to Managed Care Model

MEDICAID AND MENTAL HEALTH

- Medicaid provides services and support for 58 million adults and children.[1]
- Medicaid is the single largest payer for mental health services in the United States.[1]
- Non-Medicaid mental health services funding has been cut by $1.6 billion between 2009 and 2011, making Medicaid increasingly important for low-income individuals living with mental illness.[2]



Approximately 71% of Medicaid beneficiaries nationally (49 million people) are enrolled in some form of managed care program.[3]

SCOPE OF MANAGED CARE IN MEDICAID

- All states, except Alaska, New Hampshire, and Wyoming, have some percentage of their Medicaid populations enrolled in managed care*—17 states use managed care organizations (MCOs), 12 use primary care case management (PCCM), and 19 states use both models, with combined enrollment rates ranging from 9.3% in Mississippi to 100% in Hawaii and Tennessee.[4]
- A 2010 survey found that 20 states anticipated some expansion in Medicaid managed care programs in fiscal year 2011.[3]

MEDICAID MANAGED CARE AND MENTAL HEALTH

- Medicaid managed care programs can provide cost-effective, high quality, coordinated care for people living with chronic mental health conditions if designed and implemented appropriately.
- **In changing from traditional fee-for-service Medicaid to a managed care model, a clear, enforceable managed care contract is critical. Federal law mandates many Medicaid managed care contract requirements,[5] but states may add others.**

*Managed care is defined as all Medicaid plans that supplement or replace traditional fee-for-service models, including comprehensive risk-based plans, primary care case management, prepaid ambulatory health plans, prepaid inpatient health plans, etc.

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MEDICAID MANAGED CARE CONTRACT REQUIREMENTS

Provisions needed for Medicaid managed care to adequately meet needs of beneficiaries living with mental health conditions
Protect access to comprehensive mental healthcare, services, and medications;
Ensure adequate numbers of **qualified mental health providers** within managed care networks;
Specify standards for **reasonable waiting times** and travel distances to see a provider, as well as language-access accommodations for members who are not proficient in English;
Encourage coordination of care, particularly for people with complex medical conditions;
Define the information required to be provided to members (eg, member handbooks, confidentiality policies);
Set out straightforward, **user-friendly grievance and appeals processes** for members;
Define how quality assurance, data collection, and reporting will be accomplished, and provide for member assessment of plan performance;
Identify the **payment rate per member** ("capitation") and how long the plan has to pay claims;
Define—and limit—**member cost-sharing obligations** (eg, copyaments);
Specify how the contract will be enforced and **sanctions for noncompliance** that are significant enough to incentivize compliance.

1. Centers for Medicare and Medicaid Services, *Overview: Mental Health Services*. April 2011. www.cms.gov/MHS/. 2. National Alliance on Mental Illness. *State Mental Health Cuts: A National Crisis*. March 2011. www.nami.org/Template.cfm?Section=state_budget_cuts_report. 3. Medicaid and CHIP [Children's Health Insurance Program] Payment and Access Commission. *Report to the Congress: The Evolution of Managed Care in Medicaid*. June 2011. http://docs.google.com/viewer?a=v&pid=sites&srcid=bWFjcGFjLmdvdnxtYWNwYWN8Z3g6NTM4OGNmMTJlNjdkMDZiYw.
4. The Kaiser Commission on Medicaid and the Uninsured. *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey*. Washington DC: Kaiser Family Foundation; 2011.
5. Managed care. *Fed Regist*. 2011;76(108):32816-32838. To be codified at 42 CFR §438. ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&tpl=/ecfrbrowse/Title42/42cfr438_main_02.tpl.

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