

Montana's History with Managed Mental Health Care

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Background

Montana moved into and out of a managed care mental health system in the 1990s, starting in 1993 with planning and legislative efforts that laid the groundwork for managed care and ending in mid-1999 with cancellation of a problem-plagued managed care contract.

The 1999 Legislature essentially forced cancellation of the contract with Magellan Behavioral Health, which had failed to make payments to providers as scheduled, sought to cut provider rates, and -- based on an agreement with the state -- changed service offerings and premiums.

Magellan, for its part, said it lost \$15.7 million in its first year of operation in Montana and was losing \$1 million a month on the contract.¹ The Atlanta-based Magellan inherited the \$400 million, 5-year managed care contract when it bought Merit Behavioral. Merit had acquired the original contractor, CMG Health, just months after CMG started operating the managed care program in April 1997.

The Vision for Managed Care

Before the state moved to the managed care model, it provided mental health services to Medicaid recipients on a "fee-for-service" basis, meaning providers billed the state for any eligible service provided to a patient. It also used state general funds and federal block grants to contract with a limited group of providers, primarily community mental health centers, to serve low-income consumers who did not meet Medicaid eligibility requirements.

As Medicaid expenses rose, the state looked for ways to control the costs. In April 1993, the state began talking with consumers, advocates, and providers about the managed care option. During a budget-cutting special session in November and December 1993, lawmakers approved House Bill 33. The bill allowed for capitated health care, or health care provided by an entity that receives a fixed payment to design and provide services to a target population. HB 33 also gave the state the ability to contract for management of mental health services and created an advisory group to work on a managed care plan.

The 1995 Legislature enacted further provisions, through Senate Bill 223, to allow managed care to go into effect for mental health services,

Meanwhile, DPHHS sought and received a Medicaid waiver that allowed it to put a managed care program in place. A Medicaid waiver allows a state more flexibility in how it provides services to a targeted group of people, as long as the costs of the services offered under the waiver costs are the same as they would have been for services provided under the traditional Medicaid rules.

¹Kathleen McLaughlin, "Magellan, Care Coalition Compromise," *Missoulian*, Sept. 17, 1998 [online]; available at <http://www.missoulian.com/articles/1998/09/17/export57401.txt>; accessed Oct. 6, 2008.

The department then issued a Request for Proposals (RFP) in October 1996 that laid out its vision for a managed care mental health program -- a vision that sounded much like the goals voiced by advocates and administrators today: to provide services to eligible individuals "in a manner which will increase access to a flexible, consumer-centered array of high-quality, cost-effective mental health services."²

However, the services were to be provided "through an integrated, risk-based system of managed care".³

The RFP said the move to managed care was prompted by a growth in Medicaid mental health expenditures and a perception among legislators, consumers, state agencies, and providers that the existing system was not meeting needs or expectations.

Under the managed care model, the successful bidder would be paid a fixed amount and would assume all financial risks for providing or arranging for the necessary services. In return, the company could keep up to 7.5% of the profits it made, depending on which targets it met for paying providers of services in a timely manner. Profits above the various targets for performance would be returned to the state. The RFP emphasized that the company receiving the contract "**should endeavor to avoid the possibility of profits in excess of established maximums by reinvesting revenues in service development and improved quality of services.**" (Emphasis original to the RFP.)

The contract was awarded to CMG Health, which began operating the managed care program in April 1997. Within months, Merit Behavioral acquired CMG and shortly thereafter, was itself acquired by Magellan.

The Promise Fades

While managed care for the mental health system was ushered in with the hopes it would improve services, spur creativity in service development, and better manage the state's costs, problems with the system surfaced within months. And barely a year after managed care went into effect, a financial audit of Magellan raised red flags about the firm's continued operations in Montana.

The audit said the company lost \$15.7 million in its first year of operations and faced numerous complaints from health care providers and patients. Shortly after that news came out, Magellan proposed to cut provider rates in order to reduce its costs, threatened to cancel the contract, and eventually negotiated with the state for changes designed to control costs. The changes required some clients to pay premiums and eliminated some services.⁴

Despite the changes, provider and consumer complaints mounted, and Magellan was unable to consistently meet the contractually set targets for paying providers on time.

In February 1999, the Joint Appropriations Subcommittee on Human Services eliminated funding for a managed care contract. As a result, the state and Magellan agreed to terminate the contract effective June 30, 1999.

²State of Montana Request for Proposal, Managed Mental Health Care, Oct. 8, 1996, P. 100-1.

³Ibid.

⁴Kathleen McLaughlin, "Montana, Magellan Make Peace," *Missoulian*, Oct. 24, 1998 [online]; available at <http://www.missoulian.com/articles/1998/10/24/export58091.txt>; accessed Oct. 6, 2008.