Introduction

As Medicaid healthcare services across the country are increasingly delivered by managed care organizations (MCOs), their potential role in coordinating and delivering associated non-medical services is growing. These additional services can be funded by enhanced capitation payments, non-health care funding sources or other strategies. Because these services are not commonly covered under Medicaid managed care, purchasing them may require special contracting provisions and monitoring practices.

The Stay Well, Stay Working (SWSW) intervention, which created a coordinated benefit set of health, behavioral health, and employment supports, provides an important example of how Medicaid managed care...
programs can coordinate with non-medical supportive services to better address the needs of vulnerable populations, such as those at risk of becoming disabled.

About this Brief

This research brief discusses the contracting arrangements used in SWSW, modifications that were needed as the program was implemented, and lessons learned. Implications for implementing these types of practices in other managed care programs and alternative reimbursement strategies are also presented.

Building a Provider Network to Support Work and Wellness

The SWSW program was implemented through a public-private partnership between the Minnesota Department of Human Services (DHS) and a provider network administered by Medica Health Plans, a non-profit managed care organization.

Contracting a Coordinated Network of Health, Behavioral Health, and Employment Support Providers

Minnesota’s goal for SWSW was to create a comprehensive and coordinated set of health care, behavioral health, and employment supports for employed individuals with serious mental illness. Using a competitive request for proposals (RFP) process, Medica was selected as the prime contractor for the program for a variety of reasons including Medica’s ability to address the mental health needs of clients and willingness to use non-traditional rehabilitation and support services for clients with more serious problems. In addition to its management role, Medica was responsible for delivering medical services and subcontracting for the rest of the services in the SWSW program.

Medica’s scope of services was covered under two separate contracts. One contract covered the provision of medical, behavioral health, and dental services for SWSW participants through an amendment to Medica’s existing contract for Medicaid services to income-eligible children and families. Because SWSW was a new program with no prior cost history, the per member per month (PMPM) rate was negotiated based on analysis of claims for similar individuals in General Assistance Medical Care (GAMC), MinnesotaCare adults without children, and Medical Assistance for Employed People with Disabilities. No special service requirements or performance provisions for the small, time-limited SWSW population were added.

A second contract (through the Minnesota Department of Human Services Disability Services Division (DSD)) covered the management and implementation functions of the SWSW program, as well as services outside of the standard Medicaid benefit, which Medica subcontracted to different provider organizations serving the Twin Cities and Northeast County regions. These services included: Wellness and Employment Navigators, Employment Assistance and Support Entity (EASE) services, Employee Assistance Program (EAP), and Wellness Recovery Action Plan (WRAP) Services (Table 1).

The DSD contract covered the position of a SWSW Liaison at Medica who oversaw program implementation, communicated with the state, managed subcontractors, and facilitated the coordination of medical and mental health services. Because of the concern that a few individuals needing high cost medical care could far exceed the capitation revenues for this very small group, Medica negotiated protection through reinsurance coverage, the cost of which was included in the DSD contract.

The contract also included specific requirements related to program implementation. Medica provided a significant amount of training on the DMIE program to subcontractors and network mental health providers during program startup. Medica developed and provided a week long training for SWSW Navigators on the full-benefit set available to participants, and how to access services provided by the network of medical and mental health services.
improve engagement between Navigators and participants, Medica also provided Navigators training on motivational interviewing techniques. In addition, Medica was required to develop an informational brochure and a Wellness and Employment Planner, a comprehensive resource document that provided participants with information about available benefits and services, and aided them in developing and implementing their individual Wellness and Employment Success Plans.

**Roles and Responsibilities of the SWSW Provider Network**

**Minnesota Resource Center (MRC).** MRC was subcontracted by Medica to provide the Navigation and EASE service components (intensive employment supports) of the SWSW model. Medica selected MRC because of their community-based orientation to service provision, geographic presence in the Twin Cities and Duluth, and their experience providing employment services to people with disabilities. As a division of RESOURCE, Inc., MRC is a non-profit provider that offers services including vocational evaluation, placement skills and training, and employment retention.

MRC was responsible for providing Navigation services for all participants and in-person services for SWSW participants needing more intensive employment supports, such as a more extensive needs assessment, career counseling, Americans with Disabilities Act (ADA) disclosure training, job placement, and computer training.

**Medica Behavioral Health and Optum.** Prior to implementing SWSW, Medica had existing subcontracts with United Behavioral Health (now known as Medica Behavioral Health) and Optum, both of which are subsidiaries of UnitedHealth Group. Medica added SWSW enrollees to these existing subcontracts. Medica Behavioral Health used its existing provider and clinic network in Minnesota to serve SWSW participants. Several clinics in this network also participated in the pre-enrollment eligibility determination process by conducting diagnostic screenings.

Employee Assistance Program (EAP) services provided by Optum were delivered primarily by telephone, although participants were eligible to access three face-to-face visits with EAP counselors, many of whom were also in the Medica network of outpatient mental health providers.

**Consumer Survivor Network.** The Consumer Survivor Network is a peer operated organization that delivers peer support services using the Wellness Recovery Action Plan (WRAP). WRAP is an 8-week wellness and peer support program that teaches strategies for identifying and managing symptoms to enhance wellness and recovery, and to create positive changes. The Network also provided individual follow-up by peer workers.

**Managing Work and Wellness for Participants: Managing and Fine Tuning the Program**

DHS and Medica collaborated on the administration of the SWSW program, including implementation, making needed modifications, and performing oversight and management functions.

**Facilitating Communication and Collaboration Across the Provider Network.** Medica and DHS invested considerable time in developing a structure to facilitate communication across the various stakeholders regarding implementation decisions and program adjustments, and to monitor progress, including: 1) Monthly leadership meetings at Medica that included the SWSW provider network leads, DHS and the evaluation team; 2) Medica liaison meetings with SWSW network providers and MRC to address care coordination and service access issues; 3) Monthly calls among the management coordination group, which included Medica, DHS, MRC, evaluators and representatives from the Adult Mental Health Division of DHS; and 4) Regular meetings with Navigators for case consultation.

**Contractual Changes.** There were changes required in the Medicaid Managed Care contract over the course of the SWSW.
Demonstration. The payment rate proved adequate and Medica’s expenditures for the health, behavioral health, and dental services used by DMIE enrollees were approximately 92 percent of the contracted PMPM.

- **DSD Administrative Contract:**
  Several adjustments and modifications were needed in the DSD contract and provider network contracts to maximize enrollment and improve overall program implementation. Initial enrollment into SWSW was much slower than anticipated. Consequently, the initial arrangement to pay Navigation costs through a PMPM rate therefore did not generate adequate funding to cover start up costs. Medica negotiated a cost reimbursement budget for Navigator services. There was no need to adjust the contract for EASE services since they were reimbursed on a fee-for-service basis similar to rates used for Medicaid Adult Mental Health Rehabilitative Services.

- **Increased Reimbursement Rate for Diagnostic Assessment:**
  Another contractual change was made to increase the reimbursement rate for clinics conducting the initial diagnostic assessments required for eligibility determination. The standard Medicaid rate used initially to reimburse this service was $53 per half hour. However, to ensure the timeliness of the assessments and adequate provider availability to meet the demand as the volume of applicants increased, Medica requested state permission to raise rates to $80.50 per half hour. That, together with face-to-face meetings to recruit and educate providers to conduct the assessments, generated timely assessments that kept enrollment on track.

- **Tailoring EAP Services to the Needs of the SWSW Population:**
  EAP services were proposed by Medica and offered by Optum as an enhancement to the SWSW model to offer a traditionally private sector brief intervention service to a public sector population. At the rate of $1 PMPM, Medica and DHS were hopeful that this addition to the provider network would be a cost-effective resource for the SWSW population. Because Optum primarily served a private sector clientele, Optum phone counselors needed additional training on how to meet the needs of the SWSW population through low or no-cost service referrals. Although participants were frequently referred to this service, utilization rates were low. As a result Optum collaborated with MRC to develop and deliver in-person educational workshops on topics of interest to SWSW participants.

- **Adjusting the WRAP Program Schedule to Accommodate Workers:**
  Wellness Recovery Action Project (WRAP) courses were paid at a standard fee for each SWSW participant. While many SWSW participants were interested in the concept of peer support for recovery, the class requirements often conflicted with their work schedules. Several adaptations to the program were made to better meet the needs of SWSW participants. Participants were allowed to participate in classes at a pace that fit their individual schedules rather than enrolling in the standard eight weeks of classes. Classes were offered in the evenings so they would not conflict with participants’ work schedules.

### Lessons Learned from Managing the SWSW Provider Network

#### Contracting Medical Services

Under the terms of the CMS Demonstration grant, Minnesota provided services similar to those in the Medicaid state plan to SWSW participants and received the federal share for this coverage. This allowed the state to add this group to its contract with an existing Medicaid Managed Care Organization, which was administratively efficient. The negotiated rate was adequate in covering the cost of medical care for the SWSW Demonstration.

As Medicaid expands under health reform to cover low income adults without dependents, claims experience data will accumulate,
expanding the understanding of how employed individuals with mental health conditions who are at risk of disability compare to other group members in terms of utilization and cost of services. Better information about population costs can refine the rate calculations, and offering services to larger target groups can lessen the need for risk sharing arrangements or reinsurance.

**Contracting Program Management and Navigation**

As the evidence increases that employment is a stabilizing force for maintaining health, interest among states and employers to enhance health care benefits with services such as navigation and employment supports is growing. Similarly, there is accumulating evidence that providing social supports to stabilize the living situations of Medicaid eligible individuals with significant health problems is necessary for them to make better use of health care services and attain desirable health outcomes. As a result, states may begin calling on their MCOs to coordinate with a broader array of health and human services providers, work with states and employers to define and set standards for new services, and develop appropriate payment methods.

**Collaborating with Community-Based Organizations (CBO).** In contrast to traditional managed care services which focused on health care utilization, improving health outcomes for vulnerable populations (e.g., persons at risk for disability) increasingly requires MCOs to engage in partnerships with CBOs to deliver non-health services. To foster strong partnerships, MCOs need to recognize that many CBOs have fewer administrative resources and tighter operating margins than many providers in managed care networks and may have limited experience participating in the health care system. They may therefore have different reporting capacities, billing systems, terminology, expectations and standard practices. Finally, they may include peer organizations, which are often young and have constrained financial, organizational and staffing resources. These factors may limit their ability to change how they offer services.

**Defining and Setting Standards for New Services.** MCOs entering into the development of programs like SWSW should be prepared to spend considerable time developing relationships, discussing and reaching consensus on program design and policies, measuring and monitoring program roll-out and operations, and developing solutions for problems that arise. To ensure resources for these activities, at least one full time program manager or liaison should be responsible for the program during its start-up period. That person should have Senior Management support to ensure responsiveness from other parts of the organization, since this program is likely to be a very small part of the company’s overall business.

**Balancing Standard Protocols and Program Flexibility to Deliver Person-Centered Services.** Both state purchasers and MCOs will face the challenge of agreeing upon appropriate standards for the delivery of person-centered services that balance the flexibility needed to respond to individual needs, while ensuring desirable levels of accountability, productivity and performance. Expectations for SWSW Navigation services were simple. They included meeting in-person to: 1) conduct a comprehensive intake and assessment; 2) establish wellness and employment goals and 3) develop an individually tailored success plan. Every 30-45 days, Navigators were also expected to attempt to contact their caseload to maintain engagement. Thus Navigators had considerable flexibility to develop individual relationships with clients and to do what was required to meet their needs.

Evaluation data provided information about the most critical aspects of delivering Navigation services. There was considerable variation in the time to first contact between Navigators and participants, and the number of contacts per participant. Those participants who had their first visit closer to the time of enrollment, and those who had a least 10 additional
contacts during the year and participated in an annual review achieved greater benefits. Given these findings, performance standards related to timely initiation of service and frequency of contact could increase focus on important aspects of the Navigation service without significantly increasing administrative burden or limiting Navigator flexibility.

**Financing Strategies for Cross System Service Coordination**

The change to a cost reimbursement approach for navigation was a good choice to limit Medica’s risk during program start-up, given that they did not have control over the recruitment and enrollment pace, which DHS performed. It also allowed for the payment of one-time start up costs that were spread across the initial contract period. However, because of the slow enrollment, per unit costs during this start up period were high.

**Alternative Reimbursement Models for Consideration.** Other reimbursement models may be appropriate when a program is more stable and has a consistent caseload. At that point, purchasers and providers can more accurately predict program costs and productivity to calculate the cost of the service. Purchasers can choose from various payment methods, each with different administrative requirements and incentives. Table 2 presents the definitions of different reimbursement models, including the advantages and disadvantages of each. MCOs can modify or balance these approaches by setting standards for minimum outreach, service provision, or outcomes. Methods requiring providers to carry more risk are less appropriate for small and unsophisticated providers.

One promising innovation for financing is Pay-for-Performance. Pay-for-Performance provisions can be combined with other payment methods to incentivize outcomes or service quality. Although not yet frequently used in mental health service reimbursement, Vocational Rehabilitation often bases some or all payments on employment outcomes. Minnesota initiated this type of payment in 2007 for job placement services, paying: 1) when an employment plan is completed; 2) when a client begins a job; and 3) after a specified period of maintaining the job. With this type of payment, it is important to ensure that payment rates and timing are sufficient to support the provision of services prior to payment. It is also important to have clearly defined payment milestones. However, this could be difficult for an already employed population like SWSW with goals to attain different and better jobs, achieve a better quality of work life, or increase earnings in their existing jobs. Improvements in wellness could also be considered, measured by indicators such as improvements in care for chronic conditions or reductions in emergency room and hospital use.

Pay-for-Performance could be challenging to price, and might begin with a relatively small percentage of reimbursements tied to outcomes until providers and purchasers have more experience in measuring and implementing these efforts. In addition to paying for the performance of navigation services, states and MCOs can consider establishing incentive payments tied to outcomes such as improvements in functioning measured by self-ratings on activities and instrumental activities of daily living, and decreased dependency on public programs such as Food Stamps, General Relief and Temporary Assistance for Needy Families. It may also be useful to measure changes in income, but in the current economic climate, it may not be fair to hold a contractor responsible for economic outcomes.

With this wide range of potential payment methods, purchasers will need to carefully weigh the relative advantages and disadvantages of each, and determine their suitability for the potential provider network, especially in relation to the ability to accept and manage risk.
Conclusion

Contracting Terms and Monitoring Practices.

As a demonstration program, DMIE service contracts included reporting requirements related to an external evaluation that were more extensive than the reporting typically necessary for monitoring and managing a program of this type. Purchasers need to carefully plan reporting requirements to document services provided, program process, client utilization and outcomes and program costs and to ensure balanced monitoring and management. As discussed above, program and reporting requirements should permit monitoring of potentially undesirable patterns of service provision and counter them through management oversight.

Purchasers also need to find an effective balance between high levels of specificity about program standards and requirements, and allowing the provider to respond flexibly to client needs and preferences. Standards written directly into contracts can be harder to modify than policy documents developed with provider and client feedback as programs develop.

SWSW standards will be helpful for MCOs establishing a similar service, but may need to be modified to suit the local service network, employment environment and mix of clients. Industry standards can also provide a foundation for initial specifications. For example, the Association of Information Referral Specialists sets standards applicable to a wide range of information and referral services (See http://www.airs.org/files/public/AIRS_Standards_6_0Final.pdf). State standards covering mental health case management or rehabilitation counseling services may also be relevant.

Payment Methods

Capitation payments for health, behavioral health, and dental services under the SWSW program were feasible to implement, at least for small groups where financial risk was limited. As experience covering the population grows, this method can become more accurate and actuarially sound.

There are a number of approaches to contracting for Navigation and related DMIE services. A cost reimbursement contract is well suited for start-up, especially if enrollment processes have not been implemented or proven effective and predictable. Once the enrollment and service delivery process is established, it is easy to set rates for and implement fee-for-service billing based on time spent with an individual client and it provides a predictable payment and revenue stream. Pay-for-Performance involving a small percentage of reimbursement could help offset some of the disincentives that result from fee-for-service methods. With a large enough enrollment group and the right information, larger providers could take on more risk through capitation or a Pay–for-Performance system.

Reporting requirements and monitoring should be based upon the reimbursement method chosen, and should include outcome information that helps focus purchaser and provider attention on service results rather than process.

Author Information

This research brief was a joint collaboration of The Lewin Group and DMA Health Strategies. Author collaborators included Karen W. Linkins, PhD, Jennifer J. Brya, MA, MPP, Wendy Holt, MA, and Richard Dougherty, PhD.

### Table 1: Stay Well, Stay Working Provider Network Contracts

<table>
<thead>
<tr>
<th>Contractor</th>
<th>Service</th>
<th>Contract Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medica</td>
<td>Health Care Services</td>
<td>PMPM capitation based on claims of similar individuals in other Minnesota Health Plans ($836.09 throughout the Demonstration period)</td>
</tr>
<tr>
<td>Medica</td>
<td>SWSW Program Management</td>
<td>Cost reimbursement</td>
</tr>
<tr>
<td>Minnesota Resource Center</td>
<td>Wellness and Employment Navigation</td>
<td>Originally covered by capitation rate of $77 PMPM which also covered Navigation services. Changed into a cost reimbursement contract</td>
</tr>
<tr>
<td>Minnesota Resource Center</td>
<td>Employment Assistance &amp; Support Entity</td>
<td>Specified unit rates depending on type of service</td>
</tr>
<tr>
<td>Medica Behavioral Health</td>
<td>Mental Health and Chemical Dependency Services</td>
<td>Subcontracted out of same total capitation as for medical services</td>
</tr>
<tr>
<td>Optum Health</td>
<td>Employment Assistance Provider</td>
<td>$1 PMPM</td>
</tr>
<tr>
<td>Consumer Survivor Network</td>
<td>Peer Support Services (Wellness Recovery Action Plan Services (WRAP))</td>
<td>Specified rates for standard WRAP course and for individual follow-up</td>
</tr>
</tbody>
</table>

Source: MN Department of Human Services DMIE Contracts and Amendments
<table>
<thead>
<tr>
<th>Reimbursement Method</th>
<th>Definition</th>
<th>Administrative Requirements</th>
<th>Advantages</th>
<th>Disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Grant or Cost Reimbursement</td>
<td>Annual budget with 1/12th payment, reimbursement of costs incurred or other methods</td>
<td>• Considerable detail on costs may be necessary&lt;br&gt;• Separate reporting on service provision</td>
<td>• Covers costs when enrollment and service provision can’t be predicted&lt;br&gt;• Levels of staffing can be negotiated as program develops&lt;br&gt;• Can cover 1-time start up costs</td>
<td>• No incentives for productivity and attainment of desired outcomes</td>
</tr>
<tr>
<td>Fee For Service</td>
<td>Payment for specific unit of time spent providing service, or for specific service components to eligible individuals; Navigation payments should cover cost of time for telephone and consultation services</td>
<td>• Provider administration increases with the number of different service units defined&lt;br&gt;• Fees should be based upon staff productivity levels that are desirable and achievable</td>
<td>• Familiar to both MCOs and most human service providers&lt;br&gt;• Can price different services at different levels, if warranted&lt;br&gt;• Incentivises staff productivity and delivery of billable services</td>
<td>• Single rate for navigator services might discourage face-to-face meetings since they are relatively expensive&lt;br&gt;• Can incentivize providing more service than needed</td>
</tr>
<tr>
<td>Case Rates</td>
<td>Negotiated or fixed monthly amount paid per client served; should require some minimum level of service (measured in contacts, hours, or minutes)</td>
<td>• Administratively simple to document and bill</td>
<td>• Providers have considerable flexibility to serve clients as needed within a predictable revenue stream&lt;br&gt;• Can price initial month of service higher to reflect more intensive service provision</td>
<td>• Incentivizes minimum level of services to each client</td>
</tr>
<tr>
<td>Subcapitation</td>
<td>An overall monthly premium for each person enrolled</td>
<td>• Administratively simple</td>
<td>• Providers have considerable flexibility to manage within a predictable revenue stream</td>
<td>• Incentivizes minimum level of services to each client&lt;br&gt;• Puts provider at risk for enrollment into program, which it may not control&lt;br&gt;• Financial/risk provisions may exceed capacity of small providers</td>
</tr>
<tr>
<td>Pay for Performance</td>
<td>Incentive payments made when provider reaches specified levels of performance or outcomes; if these levels are not reached, the provider forfeits the payments</td>
<td>• Requires ability to objectively measure targeted performance&lt;br&gt;• Requires providers to manage to performance and outcomes&lt;br&gt;• Payment amount and timing must be sufficient to support provision of services prior to achieving outcomes</td>
<td>• Can incentivize outcomes at the specified level in the most cost-effective manner&lt;br&gt;• Percentage of payment at risk for performance can be varied</td>
<td>• Smaller non-profits may have difficulty managing the variable and delayed revenue flow and level of performance required by this method if a high percentage of revenues are paid in this way&lt;br&gt;• Can be challenging to price outcomes or performance levels</td>
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