

## BEHAVIORAL HEALTH ISSUE BRIEF SERIES

### Selected Key Issues in the Development and Drafting of Public Managed Behavioral Health Care Carve-Out Contracts

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December, 1998

### Executive Summary

The development of managed behavioral health care carve-out contracts covering a discrete subset of benefits available for use by persons with mental health and/or substance abuse disorders poses major challenges for public purchasers. This Issue Brief explores several key issues that arise when drafting such agreements. Many of the issues that arise in the drafting of carve-out agreements will require the public purchaser to resolve basic policy questions well before the drafting of requests for proposals or contracts can proceed.

Analyses of public sector managed behavioral health care contracts by attorneys at the Center for Health Policy Research suggest that there are four essential areas that must be addressed if mental health and substance abuse services are carved-out (either by the purchaser or by a comprehensive managed health care entity): (1) what population is eligible for enrollment; (2) what services is the contractor expected to furnish; (3) what triggers a duty on the part of the mental health or substance abuse carve-out contractor to provide services; and (4) how are services furnished by the managed behavioral health care contractor integrated with or coordinated with services furnished by a beneficiary's primary health care provider, with pharmaceutical benefits, and with other services that may be available to a beneficiary through a fee-for-service or other mechanism.<sup>3</sup> However a purchaser chooses to resolve these four issues, it is essential that parallel clarifying clauses are also built into the contracts of primary health care providers and other entities providing needed services for persons whose mental health and substance abuse service needs are

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<sup>3</sup> Note that these four contracting areas are not specific to mental health and substance abuse carve-out contracts, but are applicable to efforts to carve-out services in other areas and are important to consider when drafting both partial-risk and administrative services-only contracts.

covered by the carve-out. Underlying all of these issues is the fact that ambiguity, vagueness, or failure to define terms and responsibilities can create unexpected and unwelcome clinical and financial liabilities to purchasers.

## **Introduction: An Overview of Public Managed Behavioral Health Care Carve-Out Contracting**

As of January, 1997 eleven states purchased some or all mental health and/or substance abuse (MH/SA) disorder treatment and prevention services through separate managed care contracts with companies that specialize in the delivery of care to persons with these conditions.<sup>4</sup> Since then, the number of states and local governments using carve-out contracts has increased considerably. Growth in the use of carve-out agreements can be attributed to the special concerns that arise in the care and management of persons with mental health and substance abuse disorders, the financial and governmental underpinnings of publicly funded mental health and substance abuse disorder treatment and prevention services,<sup>5</sup> and the lack of experience with this population on the part of managed care companies that sell standard product lines to public agencies and employers.

It is hard to generalize as to whether the advantages of carving out certain benefits from a general managed care contract outweigh the disadvantages. The formal research concerning the relative strengths of separately contracting for managed behavioral health care and for primary health care or contracting for comprehensive health and behavioral care with a single vendor is just emerging, and there appears to be no consensus.<sup>6</sup> Some research suggests that managed behavioral health care carve-out contracts have the potential to reduce overall costs, even as they increase administrative costs.<sup>7</sup> For example, specialized behavioral health care companies create economies

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<sup>4</sup> S. Rosenbaum et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts (2d Ed.)*, *Special Report: Mental Illness and Addiction Disorder Treatment and Prevention*, p. 3 (The George Washington University Medical Center, Washington, DC, 1998). Note that in this Issue Brief we do not distinguish between a carve-out provider (or contract) and an administrative services organization (ASO) (or contract). For whether an ASO is administering a public managed health care program on a no- or partial-risk basis or a carve-out plan is providing services on a full-risk basis, the duties for which the contractor is responsible do not vary. In other words, both the no-risk ASO and the full-risk carve-out contractor—and everyone in between—must provide the full range of services specified, for example, in a state's Medicaid plan, irrespective of who eventually ends up paying for those services.

<sup>5</sup> Historically, the care and treatment of persons with these conditions was the responsibility of state and county governments and special state institutions and programs. With the enactment of Medicaid in 1965, much of the funding for the program came from other units of government which operated systems of care and which attributed a portion of their expenditures to the Medicaid program via intergovernmental transfer arrangements. Managed care arrangements may affect the flow of funds away from publicly operated or managed programs toward private corporations that tend to contract with private health care providers. In order to avoid this result, a number of states have elected to maintain carve-out systems that permit them greater flexibility in the selection of network providers and the design of their care than would be the case if they were to buy standard products from private companies. States may view this arrangement as particularly attractive in cases in which they desire to combine Medicaid with other sources of public funding (e.g., child welfare funds and state and local substance abuse and mental health revenues) that commonly are used to support public delivery systems. This permits the development of a broader range of service delivery systems than might otherwise develop through a private company acting alone.

<sup>6</sup> For a more detailed discussion of the studies performed, see Ching-to Albert Ma and Thomas G. McGuire, "Costs and Incentives in a Behavioral Health Carve-Out," *Health Affairs* 17:2, pp. 55-6 (March/April 1998).

<sup>7</sup> New administrative costs have been estimated to range from 8 to 15 percent of MH/SA benefit costs. Richard G.

of scale and can negotiate for volume discounts. Managed behavioral health care carve-out contracts may also help ensure that funds intended by the public purchaser to be spent on mental health and substance abuse disorder-related care are actually expended for that purpose. By carving out behavioral health care services, separate financing is established for behavioral health care, and carve-out contracts may help prevent health plans from allocating the behavioral health care component of their premiums to other service areas. Conversely, the segregation of funds also can mean that savings from reduced health care utilization associated with provision of behavioral health care services (cost offsets) are not available for mental health and substance abuse disorder services.

Carve-out contracts also have the potential to improve the quality of care, in that behavioral health care companies can develop specialized clinical practice protocols to guide care delivery, employ mental health and substance abuse professionals as care managers, and manage a comprehensive network of behavioral health service programs and practitioners. General health plans, on the other hand, are less likely to invest in state-of-the-art behavioral health practice guidelines, employ specialists as case managers, and maintain comprehensive behavioral health service networks. General health plans also are less likely to identify members with mental health or substance abuse problems, and to provide intensive and up-to-date treatments for members who are diagnosed with a behavioral disorder.<sup>8</sup>

A carve-out approach may also have certain shortcomings. Carve-out contracts may further fragment the health care delivery system by increasing the likelihood that care will be poorly coordinated between primary health and behavioral health services for multi-problem members. In addition, individuals with behavioral health care needs often will not seek care on their own due to stigma, lack of access, or lack of knowledge.<sup>9</sup> The extra layer of administration potentially necessitated by a carve-out contract may further reduce their willingness to actively seek help.

Whatever the benefits, there is little question that the decision to develop separate contracts for managed behavioral health care services raises a series of important policy and drafting challenges. Public beneficiaries who receive care through dual contractors effectively have three distinct sources of coverage: coverage through their primary health care plan (e.g., MH/SA benefits covered by the primary health care plan); coverage from their behavioral health plan (i.e., a behavioral health care carve-out plan); and direct coverage from other public sources for services not included in either contract (e.g., residual services provided on a fee-for-service basis, separate carve-outs for medications, or additional state or county grants). Drafting carve-out contracts under these circumstances

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Frank, et al., "Solutions for Adverse Selection in Behavioral Health Care," *Health Care Financing Review*, p. 119 (March 22, 1996).

<sup>8</sup> See Cyril F. Chang, et al., "Tennessee's Failed Managed Care Program for Mental Health and Substance Abuse," *JAMA*, p. 868 (March 18, 1998); and Stroul, B.A., et al., "Health Care Reform Tracking Project: Tracking State Managed Care Reforms as they Affect Children and Adolescents with Behavioral Health Disorders and Their Families," 1997 Impact Analysis, University of South Florida (1998).

<sup>9</sup> See Barbara Starr and Steven Findlay, "Mental Health: Solving the Quality Problem," Medical Economics Publishing Company (November, 1994) (citing the statistic that 50 percent of individuals with mental health problems will not seek care due to stigma, lack of access, and lack of knowledge).

requires skill in order to ensure that each responsible entity--the primary contractor, the behavioral health care contractor, and the public agency (in the case of services that remain covered directly under the public entity's plan)--have a clear sense of their respective duties. Moreover, the contracts must be drafted in such a way that service, coverage, and payment duties relating to persons with co-occurring conditions (e.g., mental health and substance abuse disorders or mental health and physical health problems) are clear. Indeed, even in cases involving individuals with only a single significant behavioral health problem, coordination is important, since the member will be receiving care from two separately financed and managed health systems.

## Issues to Consider When Drafting Carve-out Agreements

All of the issues that are relevant in general contract drafting (e.g., eligibility, enrollment, coverage, provider selection and network composition, access, quality performance, and data and information) apply equally to specialty drafting.<sup>10</sup> As with general contract drafting, a purchaser can elect to specifically address many policy and practice issues in detail or can instead choose to remain silent on any particular topic. Where the drafter of the agreement elects to remain silent, the document will be construed as leaving the matter to the discretion of the other party. Thus, in the absence of an overarching statute or regulation, silence on the question of how severe and persistent mental health needs, for example, are to be measured for eligibility purposes under a behavioral health care agreement could be construed as leaving to the discretion of the seller the authority to define the term and apply the measure to individuals seeking assistance.

While all issues relevant to general contract drafting apply to specialty contracts, four areas merit particular scrutiny because they have implications for the interaction between the primary health care contractor and the managed behavioral health care contractor.

### *1. The population eligible for enrollment*

The first issue is defining the population eligible for enrollment under the agreement and establishing an eligibility determination process. Certain public health entities use their carve-out agreements to deliver all behavioral health care services needed by any member of the primary health care plan. In this situation, the eligibility issue is quite simple: all managed care enrollees are eligible for medically necessary carve-out services simply by virtue of their membership in the primary health care plan. For example, Utah's Behavioral Health Care Contract states:

'Enrollee' or 'Medicaid Enrollee' means any Medicaid eligible person whose eligibility has been established within the geographic boundaries of the enrollment

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<sup>10</sup> For general guidance in drafting contracts for public managed substance abuse and mental health services, see "Partners in Planning: Consumers' Role in Contracting for Public-Sector Managed Mental Health and Addiction Services," prepared by the Judge David L. Bazelon Center for Mental Health Law and the Legal Action Center for the Substance Abuse and Mental Health Services Administration (Managed Care Technical Assistance Series, April, 1998); Stephen Moss, "Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers" (Center for Substance Abuse Treatment, July, 1998).

area served by the CONTRACTOR, excluding residents of the Utah State Hospital and Utah State Developmental Center . . .

B. Covered Groups—The Contractor must be able to provide covered services to the following groups of Medicaid eligibles:

- 1) categorically needy groups (aged, blind, disabled, AFDC children and adults, and poverty level pregnant women and children);
- 2) medically needy groups (blind, disabled, AFDC children and adults); and
- 3) children and youth under the statutory responsibility of the Utah Department of Human Services. Outpatient mental health services for this group will be prepaid, but contractor will not be at risk for the outpatient mental health services.<sup>11</sup>

A more complex issue arises, however, in cases in which public health entities use their carve-out plans to furnish care only to certain categories of members who need MH/SA services. Numerous states maintain carve-out agreements that cover only certain members, with eligibility tied to diagnosis, the extent of care required, or some other factor (e.g., persons with severe and persistent mental illness or intensive health needs). For example, New York’s Mental Health Contract states:

Enrollment in the OMH plan will be voluntary, and will be limited to individuals who are:  
1) Eligible for medical assistance under Title XIX, specifically SSI cash, SSI MA only, and AFDC MA only; and 2) Are currently receiving inpatient, outpatient or Community support Services at an OMH-operated adult psychiatric center; and 3) Are not currently receiving licensed outpatient services at non-state operated programs; and 4) Are either aged 18-21/22 or 65 or over if residing in an inpatient psychiatric center, or aged 18 or over if admitted to an outpatient psychiatric center program.<sup>12</sup>

In cases in which fewer than all general enrollees have access to the carve-out plan, public health entities need to both consider a number of policy issues and ensure that the policies they want instituted are properly drafted in the contract itself. The importance of addressing the issue of who has access to the carve-out services is particularly great in those counties and states in which the primary health care contractor maintains at least some obligation to cover mental health and/or substance abuse disorder services, either as a primary care physician (PCP) service<sup>13</sup> or as a limited specialty service. Without clarity regarding who is eligible for the carve-out plan, disputes could arise between the two contractors regarding both payment and service duties.<sup>14</sup>

The following eligibility issues should be addressed in developing and drafting carve-out

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<sup>11</sup> Utah Behavioral Health Contract [S. Rosenbaum et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts (2d Ed.)* (The George Washington University Medical Center, Washington, DC, 1998).

<sup>12</sup> New York Mental Health Contract [*Id.*].

<sup>13</sup> California’s managed care contract, for example, specifies that general contractors are responsible for those behavioral health services customarily furnished by primary care physicians.

<sup>14</sup> Note that since primary health care contracts (the basis for *Negotiating the New Health System*, *supra* note 11) do not normally include provisions regarding who is eligible for services under a carve-out or what triggers a carve-out contractor’s duty to provide care, we do not offer an example of either type of provision here.

agreements (particularly those that are limited to only certain members):

- Which entity--the carve-out contractor, the primary health care contractor, or a third party (e.g., an independent evaluator under contract to the agency)--makes the determination regarding whether the conditions of eligibility are met?
- What evidence must be considered by the decision-maker in reaching this decision?
- What grievance and appeal rights apply in the case of individuals who are determined to be ineligible, and who must provide for the appeals process?<sup>15</sup>
- In the case of Medicaid, how will individuals who are denied services be apprised of their fair hearing rights?<sup>16</sup>
- Where the determination is that eligibility conditions are no longer satisfied (i.e., that an individual receiving treatment is no longer eligible to do so under the terms of the contract), which entity--the public health entity or the behavioral health plan--is obligated to continue paying for care in the event that the aggrieved person requests a fair hearing in a timely fashion?
- Where an individual who applies for special carve-out services is denied care or care is terminated, what duties, if any, attach to the primary health care contractor?
- What duty to communicate its decisions regarding eligibility for treatment does the carve-out contractor (or other deciding entity) have with respect to the individual's PCP under the general contract?<sup>17</sup>
- What dispute resolution process will be used in cases in which there is disagreement between the contractors regarding an individual's eligibility for services?
- What exchange of records/other information between the contractors will be required so that each contractor is aware of the other's treatment decisions and course of care?<sup>18</sup>

## 2. *Services covered*

A second critical question concerns the range of services to be offered by or through the managed behavioral health care contractor. As noted, contractors may offer some or all mental health and/or substance abuse disorder-related services covered under the state or local government plan, as well as other services (e.g., physical health care) for populations receiving managed care services.

Drafting coverage provisions in contracts necessitates several distinct sets of policy decisions:<sup>19</sup>

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<sup>15</sup> For examples of contract provisions addressing beneficiary grievance procedures, see *Negotiating the New Health System*, *supra* note 11, Table 6.2.

<sup>16</sup> For a discussion of Medicaid fair hearings, see *An Overview of Medicaid Managed Care Litigation* (Issue Brief No. 2), Managed Behavioral Health Care Issue Brief Series, Center for Health Policy Research (Washington, DC, November, 1998).

<sup>17</sup> For examples of contract provisions addressing network provider and plan relationships, see *Negotiating the New Health System*, *supra* note 11, Table 6.3.

<sup>18</sup> For examples of contract provisions addressing exchange of information between contractors, see *id.*, Table 2.8.

<sup>19</sup> For a full discussion of coverage and medical necessity, see *Coverage Decision-Making in Medicaid Managed Care: Key Issues in Developing Managed Care Contracts* (Issue Brief No.1), Managed Behavioral Health Care Issue Brief Series, Center for Health Policy Research (Washington, DC, May, 1998); and *Defining "Medically Necessary" Services to Protect Plan Members*

- Which classes of services will be covered?<sup>20</sup>
- Within any covered class of service, what, if any, amount, duration, and scope limitations will be permissible?<sup>21</sup>
- What, if any, exclusions and limitations may the contractor impose on otherwise covered services, such as exclusions for court-ordered treatment, services offered as part of special education or child welfare initiated plans of care, or services furnished in certain community settings?<sup>22</sup>
- In deciding when otherwise covered services are medically necessary for an individual, what standard of review will the contractor use?<sup>23</sup>
- What evidence will be permissible in making a medical necessity determination?
- What procedures, if any, will contractors be instructed to use in making coverage determinations (e.g., qualification of reviewing personnel, determination time lines for routine and urgent services, and limitations on the use of prior authorization for certain types of services)?

Contracts should also address appeal and grievance procedures, fair hearing notice requirements, and requirements related to continuation of assistance when a fair hearing is requested in a timely fashion by an individual facing a termination or reduction of benefits. Finally, as in the case of eligibility determinations, public entities should consider including in their contracts procedures for resolving disputes between plans as well as for the exchange of records and information pertaining to coverage and treatment in the case of persons receiving care from both plans, assuming that confidentiality requirements are met and that the individual consents to the disclosure.

### 3. *Initiation of carve-out services*

An issue closely aligned to eligibility decision-making is the question of treatment initiation. In the world of managed care, behavioral health diagnosis, treatment, and management services are considered specialty care, even if they are furnished as part of the basic health care regimen of a person with serious mental health issues. As such, before managed behavioral health care firms initiate diagnosis and treatment services, there must be some triggering event (e.g., a self-referral, a

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and *Defining “Medically Necessary” Services to Protect Children* (Issue Paper Nos. 1 & 5, respectively), Protecting Consumer Rights in Public Systems’ Managed Mental Health Care Policy, the Judge David L. Bazelon Center for Mental Health Law (Washington, DC, March, 1997 & April, 1998).

<sup>20</sup> For a list of mental health and substance abuse services offered in states’ managed care carve-out contracts, see *Special Report: Mental Illness and Addiction Disorder Treatment and Prevention*, *supra* note 4, Figure 4. For examples of contract provisions addressing mental health and substance abuse services offered, see *Negotiating the New Health System*, *supra* note 11, Table 2.2.

<sup>21</sup> Issue Brief Nos. 1 and 2, *supra* notes 19 & 16 respectively, explore the extent to which states may remain liable for services that are required under federal Medicaid amount, duration, and scope regulations but that are excluded by contractors. For example, federal regulations prohibit arbitrary limitations on the amount of mental health coverage for children and would prohibit the application of arbitrary diagnosis-based distinctions in coverage decision-making.

<sup>22</sup> See Issue Brief No. 1, *supra* note 19, for a complete discussion of coverage decision-making.

<sup>23</sup> For examples of contract provisions addressing medical necessity, see *Negotiating the New Health System*, *supra* note 11, Table 2.7.

referral from the individual's PCP, a referral from a school system or another outside agency, and so forth). Therefore, in developing and drafting a contract, it is important to know who can initiate care and, equally important, the obligation of the contractor to respond to the initiator. State contracts vary widely in the degree to which they address this matter and are often vague on this point. Silence or ambiguity on this issue could create situations in which specialty contractors refuse to honor certain types of referrals, even for diagnostic services, which the purchaser contemplated would be covered. In some cases a refusal to furnish diagnostic, evaluation, or treatment services because of the type of referral path used could leave a public agency liable for direct payment for a benefit, especially in the case of diagnostic and treatment services that are sought for children receiving early intervention and special education services.<sup>24</sup> In addition to liability issues, refusal to furnish services because of the type of referral path can lead to poor patient care and adverse outcomes for patients and their families.

Arizona's carve-out contract comes closest to the imposition of a blanket duty to initiate care, as illustrated by the following provision:

AADHS shall ensure that all members who are referred for behavioral health services receive a screening and evaluation, including an assessment for case management needs, within one week of referral.<sup>25</sup>

Even in this instance, however, the term "referral" is unclear and contains ambiguities regarding what would constitute a "referral".

The following policy questions are important to consider when deciding what is meant by "referral" and how it triggers a duty to treat:

- What is meant by a "referral"?
- Which entities may initiate a referral?
- Will self-referrals be permitted, and under what circumstances?
- What duties are triggered on the part of the contractor upon receiving an appropriate referral?
- To whom must the contractor disclose the results of the referral, assuming that confidentiality requirements are met, and the individual consents to the disclosure?

#### 4. *Coordination with other portions of health care system*

A fourth issue involves the manner in which the behavioral health care contractor is

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<sup>24</sup> Federal law requires state Medicaid agencies to cover medically necessary services that are included in individualized education plans and individual family services plans under the Individuals with Disabilities Education Act. 42 U.S.C. 1396b(c).

<sup>25</sup> Arizona Behavioral Health Contract [*Special Report: Mental Illness and Addiction Disorder Treatment and Prevention*, *supra* note 4, at 66].



required to relate to other parts of the health care system.<sup>26</sup> Some of these relational matters have already been explored, but there are a host of issues that can arise in this context, from the development of joint practice guidelines and performance measures in the case of individuals with co-occurring conditions to the exchange of specific treatment information for clinical management purposes. For example, contracts are frequently unclear with respect to the obligations of contractors to coordinate services and payment for care with primary health care contractors, other programs and agencies, and the public agency itself, and many of the general service agreements in states with carve-out behavioral health care plans also lack clearly articulated standards for coordination of coverage.

Gauging the relationships between managed behavioral health care organizations and the rest of the health care system is particularly important in the case of individuals with dual, or multiple, diagnoses. Coordination is also extremely important where prescribed drugs are covered under the primary health care plan but prescribed by practitioners participating in the specialty plan. Clearly specified duties and responsibilities should be detailed in the complementary service agreements with the behavioral health care carve out contractor, the primary health care contractor, and any other entities responsible for providing service for which a beneficiary may be eligible.

Iowa is unique in its approach of maintaining separate managed care contracts for mental health and substance abuse disorder services. Each contract contains a provision regarding coordination of care for persons with dual MH/SA diagnoses, as illustrated by the following excerpt:<sup>27</sup>

Some individuals who would otherwise be eligible persons may be diagnosed as mentally ill as well as substance abusers. If the primary diagnosis is mental health, the individual will not be an eligible person for covered services under [this contract]. If the primary diagnosis is a substance abuser, the individual will be an eligible person under [this contract] and the contractor shall arrange and pay for any necessary mental health treatment. The primary diagnosis shall not be determined merely by the provider's designation but shall be determined based upon clinical criteria to be developed jointly by the contractor, the Departments and the [mental health contractor]. If a definitive primary diagnosis cannot be made for any reason, the primary diagnosis will be deemed to be mental illness.<sup>28</sup>

Most common, however, is the use of blanket phrases in both general and specialized service agreements, such as the following provision from a California contract that creates a broadly-worded expectation, compliance with which may be impossible to measure:

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<sup>26</sup> For contract provisions addressing how plans are required to coordinate services, see *Negotiating the New Health System*, *supra* note 11, Tables 2.8 and 4.1.

<sup>27</sup> Note that while this provision may be a good example, Iowa has requested modification of its 1915b waiver to allow it to negotiate a single behavioral health care contract for mental health and substance abuse services.

<sup>28</sup> Iowa Substance Abuse Contract [*Negotiating the New Health System*, *supra* note 11, at 67].

The Contractor will case manage the physical health of the member and coordinate services with the mental health provider of the member.<sup>29</sup>

In drafting the coordination provisions of both general and carve-out contracts, purchasers may wish to address the following matters:

- The development of joint practice guidelines for individuals with co-occurring physical and mental conditions;
- The development of procedures to facilitate communications between the primary treating provider in each plan, assuming that confidentiality and consent considerations are addressed;
- The development of mechanisms for monitoring and reporting coordination efforts;
- The development of incentives and sanctions for coordination;
- The development of procedures for notification of both plans in the case of critical incidents or events that have overall health care implications;
- The development of common case identifiers across primary health, behavioral health, and pharmacy contractors;
- The development of information systems within each contractor that facilitates integrated case tracking;
- The development of joint training programs for health care providers managing persons with dual diagnoses and co-occurring conditions; and
- A mechanism for periodic cross-contractor conferences to discuss issues that arise in the management of persons with mental health and/or substance abuse disorders.

## Conclusion

Generally speaking, managed care contracting by public agencies requires clear policy decisions and careful drafting because of the potential coverage and financial implications of error or ambiguity. However, the development of managed behavioral health care carve-out contracts may pose even greater challenges for public purchasers, because these specialized contracts create multiple sources of coverage and multiple points of accountability. The major issues that arise when drafting such agreements--the conditions under which a managed behavioral health care contractor assumes a duty to serve eligible populations, the events that trigger this duty to provide services, the range of services that the contractor is expected to furnish, and the manner in which services furnished by the contractor are to be integrated with services furnished by other contractors or public agencies--necessitate on the part of public purchasers an attention to detail when drafting contract language and the deliberate use of a monitoring system that utilizes performance measures specifically tailored to evaluate performance integration. Otherwise, public entities risk the danger of creating major gaps in coverage and access due to the legal and operational voids that exist between and among the various contracts at issue.

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<sup>29</sup> California Contract [*Id.* at 67-8].