Managed Public Mental Healthcare: Issues, Trends, and Prospects

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Abstract

Objective: **To describe the structure and status of public mental healthcare and the impact of managed behavioral healthcare on this system.**

Study Design and Methods: **The structure and financing of public mental health systems were reviewed. Because there are no controlled multisite studies of managed public sector behavioral healthcare, case examples were used to illustrate trends and issues.**

Discussion: **The methods, results, and impact of public managed behavioral healthcare are incomplete and uncertain. The complexity of the public sector system, the patients served in it, and the services provided are daunting. The variability of patient needs, the role of Medicaid versus state funding, and the variable governance structures of local systems in different states make managed care methods more complex than in private markets.**

Conclusions: **The organization, structure, and financing of public mental health systems have developed rapidly in the past generation as care has been moved from hospital to community. Early efforts to apply managed behavioral healthcare methods used in the private, commercially paid sector have not been very successful, and most public sector managed care efforts have been limited to Medicaid-paid care. The trend in public mental health systems is to "unpack" managed care and use its tools selectively.**

(Am J Managed Care 1999;5:SP71-SP77)

Managed care has been the dominant trend and theme in healthcare in the 1990s—certainly the biggest story since the attempted Clinton healthcare reform in the first part of the decade. Managed care has changed the organizational structure of the healthcare system, temporarily brought cost increases under control, and stimulated wide criticism for its impact on patients and providers. In fact, the biggest legislative healthcare issue near the end of the decade may be how to regulate and prevent managed care "abuses."

Looking closer, it is apparent that the managed care revolution has been both uneven and incomplete. The revolution is incomplete because to date managed care has been implemented largely as managed cost. As one Washington health newsletter put it, "managed care has now deployed its greatest ready assets—discounting and utilization control—throughout the area where they have their maximum value, among working families and the relatively healthy mothers and children who account for most Medicaid managed care enrollees."[1] The side of managed care that involves careful coordination of care is certainly less well developed. Managed care's impact has been incomplete because its penetration and impact vary widely among regions and among commercially paid insurance, Medicaid, and Medicare.

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As illustrated in Mechanic's introduction to this Special Issue, the impact of managed care in mental health is even more mixed and complex.[2] Managed care's market share has grown more rapidly in behavioral healthcare than in healthcare in general. Managed care successes and failures also have been more spectacular in behavioral healthcare.

A fundamental reason why managed care has affected mental healthcare differently is that such a high proportion of mental healthcare—especially for individuals with more serious mental illness—is financed and managed by government. According to the Institute of Medicine, "the most unusual aspect of the care and financing system for mental health and substance abuse treatment is the presence of a distinct and substantial publicly managed care system that serves as a safety net."[3] Furthermore, unlike the dominant governmental health financing programs (Medicare, Medicaid) the public mental health system is predominantly financed and managed by states (and in many states, county governments). This means that the public mental health system is highly decentralized, with a great heterogeneity of organizational models and financing strategies. These distinctive qualities of mental healthcare are often ignored or underestimated, perhaps because commentators oriented to healthcare in general are not aware of them, and those inside the mental health field take these patterns for granted.

··· MISSON, STRUCTURE, AND PROCESSES OF THE PUBLIC MENTAL HEALTH SYSTEM ···

The public mental health "system" is a collection of mostly state-financed, local service systems that provide safety net, specialty care for individuals with mental disorders. This safety net role—which compliments the role of commercial plans that often care for healthier patients—means that a primary focus is caring for people with serious and often long-term disorders. A necessary consequence of this mission is that the services offered or coordinated by the public mental health system must be diverse in order to meet the needs of people with complex disorders. Services such as low-income housing, supports for employment, and coordination of benefits are as integral as healthcare or psychiatric care.

Second, the public mental health system is primarily financed and managed by state governments (a situation unique in American healthcare), although care is usually coordinated at the local level by counties or not-for-profit community mental health centers under contract with the state. This means that there is great variability in the details of financing and also that the locus for operational control of the public mental health system is not in Washington, DC, but in state capitals and local communities.

It has been just a generation from the beginning of the community mental health era, marked by enactment of President Kennedy's Community Mental Health Centers legislation, to the end of the 20th century. During this time, the public mental health system has been completely transformed. The locus of care has been shifted from large, predominantly long-term state hospitals to communities. The magnitude of this shift can be illustrated with an example from the state of Ohio. In the early 1960s there were almost 30,000 patients in Ohio state hospitals, and only 20,000 individuals received any publicly funded community care annually. By 1997, the census of state hospitals was reduced to fewer than 1500 patients, with about 250,000 individuals receiving publicly funded community care during the year. The locus for managing the system also was largely shifted—in today's jargon, "devolved"—from state government to counties or local agencies. In about half the states, with about 75% of the nation's population, public mental health services are coordinated in whole or part by local governmental entities—mostly counties.

The focus of community mental health services also has changed dramatically in the past generation. As Morrissey and Goldman pointed out, reform during this period was based on a fundamentally different understanding of the nature of serious mental illness and thus of mental healthcare.[4] Every major prior mental health reform effort had involved a different approach to short-term treatment of mental illness. Each had failed, in part, because of the long-term, episodic, and disabling nature of illnesses such as schizophrenia. Such conditions were not amenable to cure, and short-term treatment—whether in hospitals or community clinics—was only successful as long as it was sustained. As Morrissey and Goldman note, the Community Support Program approach[5] reframed the work of mental health from an acute treatment model toward the provision of flexible, long-term community assistance. This model was a much more realistic fit with the demands imposed by adjustment to community life with a disabling condition. In the Community Support Program model, providing supports such as housing—previously taken for granted

for patients in hospitals but largely ignored in communities—was legitimized as a crucial mental health activity. This model made the work of community care more effective, but also more complex, requiring coordination of support as well as treatment services.

The second major set of changes in the public mental health system has involved financing. Dollars formerly spent on institutional care have been reallocated to pay for community services. In Ohio, state hospitals consumed about two thirds of state mental health spending in 1989. A decade later, two thirds of the state mental health budget is dedicated to community services. Just as significantly, Medicaid has emerged as a major revenue source for community metal healthcare. This is particularly significant because virtually every managed behavioral health initiative in the public sector has been driven by Medicaid.

Medicaid's Complex Role in Public Mental Healthcare

As originally enacted, Medicaid did not pay for specialty mental health services and covered mental health treatment only in the general categories of hospital and physician care. However, after the critique of limited federal assistance in deinstitutionalization by the General Accounting Office[6] and the recommendations of President Carter's Commission on Mental Health, coverage for relevant mental health services such as case management and rehabilitation was made available on an optional basis.[7] These resources have proven to be critically important. Medicaid has become an important source of financing for public mental health services; its total contribution of $14 billion in 1996 was exceeded only by the combined resources of the state mental health agencies.[8]

Medicaid's role in funding public mental health services is complex and poorly understood. Most mental health benefits in Medicaid are optional and are provided only as a state choice. Furthermore, aside from hospitalization, Medicaid reimbursements for mental healthcare generally are made to providers who are under contract with state or county mental health agencies. Most state mental health funding is disbursed via grants, intergovernmental transfers, or contracts to pay for specific mental health services that are delivered based on clinical need. These resources always have been limited. Thus informal, de facto managed care practices were commonplace in community mental health systems.

Medicaid is an entitlement program that reimburses qualified providers for units of services to eligible individuals. However, only some community mental health clients are Medicaid eligible, eligibility status may change every month, and some mental health services (eg, physician services, counseling, medications) are Medicaid reimbursable whereas others (eg, housing, job training) are not. As a practical matter, this means that community mental health agencies bill Medicaid for some services for some clients some of the time and use state funding to cover the rest of their costs. Obviously, changes in Medicaid (eg, the introduction of managed care) have complex ripple effects throughout the rest of the public mental health system.

··· DEVELOPMENT OF MANAGED CARE IN PUBLIC MENTAL HEALTH SYSTEMS ···

Mechanic described the development of the managed behavioral healthcare industry and some of its successes in controlling costs in commercial plans.[2] However, employer-paid plans and public mental health systems vary on almost every dimension. The Table illustrates some of these differences.

As shown in the Table, the logic and "wiring" of employer-paid plans and public systems vary fundamentally. Although managed care may theoretically be useful in either, as a way to ensure that consumers receive the right services at an affordable cost, the fundamental financial and clinical dynamics of the systems are so different that generalization of managed care successes from the private to the public sector inevitably proves challenging. Reviewing some of the more notable experiences in the public sector illustrates these challenges and reveals how the field has gradually become more sophisticated about these problems.

An Early Success: Massachusetts's Statewide Medicaid Carve-Out Contract

Setting aside the substantial de facto use of some managed care techniques in many public mental health systems, the first significant contract to explicitly manage public behavioral health services was Massachusetts's 1992 effort. Massachusetts's Medicaid program contracted for management of all Medicaid-paid inpatient and ambulatory behavioral health services; the non-Medicaid community care programs financed by the state mental health agency were not directly affected. This project was modeled on, and in many ways was quite similar to,

the successful commercial managed care projects that controlled costs by simply cutting payment rates and length of stay in expensive inpatient settings.

Massachusetts's effort was widely regarded as successful; the rapid previous growth in inpatient spending was curtailed and the program avoided major problems and controversy.[9] The success of this effort may have been due in part to several wise choices. First, the contract and program focused on a limited array of mostly acute behavioral healthcare services and did not attempt rationing of rehabilitation or support services. Second, the contract's financial design wisely avoided incentives to reduce utilization too much. Finally, and importantly given the complexity and novelty of the effort, good working relationships were maintained among the parties (the state Medicaid and mental health agencies, the contractor, and providers). Adequate provisions also were made to keep constituents informed of progress and issues.

Massachusetts's success in contracting for private administration of a Medicaid managed behavioral health program came at a critical time. After the failure of President Clinton's proposed Health Security Act, the use of managed care grew dramatically in the commercial behavioral health marketplace. Several interrelated developments led to a surge in efforts to manage Medicaid behavioral health benefits.

First, controversy over the federal budget and the ballooning federal deficit focused attention on the high increases in federal health expenditures, especially in Medicaid. Conversion of Medicaid from a federal-state entitlement to a block grant even was considered, a change supported by Republican governors. However, President Clinton promised that his administration would encourage and support state efforts to curtail Medicaid spending by accelerating the approval of waivers from normal Medicaid requirements. States were acutely aware of the need to control Medicaid spending, and some of the obstacles to achieving this control thus were lifted.

Second, the market for large managed behavioral healthcare contracts in the commercial insurance marketplace rapidly became much more competitive. The marketplace was becoming somewhat saturated, with a high proportion of commercial behavioral healthcare subject to managed care controls. Additionally, given a decade of competition for private contracts, private-sector price competition was intense, and profit margins in the commercial marketplace were tightened. Therefore, firms offering these services were looking to public contracts. A network of marketing and lobbyists experts—many hired out of state mental health agencies—traveled the country looking to expand public-sector use of managed care contracts. The combination of double-digit increases in Medicaid costs, a relaxed environment for federal waivers, Massachusetts's success, and pressure from the industry led to an almost frantic environment regarding public managed care contracting in mental health in the mid 1990s.

Table. Differences Between Private and Public Mental Health Systems

Variable	Private Systems	Public Systems
Goal	Control costs while maintaining adequate access and quality	Maximize access within a fixed budget, especially for most needy consumers
Consumers	Employed individuals and families in generally good health	Indigent persons in generally poor health
Benefits	Narrow, well-defined array of treatment services	Broad, often imprecisely defined mix of treatment and support services
Financing	Health insurance plan Goal: expenditure control	Multiple funding sources Goal: revenue maximization

Success in Public-Sector Behavioral Managed Care Hard to Achieve

Unfortunately, during the 1990s few states were able to replicate the relative success of Massachusetts's Medicaid carve-out behavioral managed care contract. Iowa experienced a measure of success, initiating a statewide Medicaid carve out that bundled all Medicaid mental health services under private management while leaving non-Medicaid services at the county level. This effort suffered some early operational problems in areas including claims payment and was criticized by local mental health

officials and providers. But the program survived these growing pains and achieved its objectives of cost control and better coordination of Medicaid-paid mental health services. The relatively manageable size of the state, as well as the relatively clear boundaries between state and county responsibilities, were factors in Iowa's success.

In several states, state officials believed that making use of managed care technology and private-sector experience might be a way to reform healthcare and mental healthcare generally, as well as a way to gain better control of Medicaid costs. This endeavor required efforts on a much broader scale than what Massachusetts or Iowa had attempted, and it introduced new complexities as well. The most notorious experiment on this broader scale was Tennessee's TennCare program, which coupled expanded eligibility for Medicaid benefits with broad introduction of privately administered managed care techniques. This effort was designed by state Medicaid officials, with little initial involvement of state mental health officials.

TennCare attempted to include virtually all state-funded mental health services in the program. This effort ran into great difficulties, perhaps in part because mainstream managed care entities were unable to handle the additional complexities of behavioral health constituencies, benefits, and providers. In revising the program, Tennessee also experimented with an alternative approach of carving out mental health benefits under separate management (including non-Medicaid mental health resources). This approach was also problematic. However, it is difficult, even in hindsight, to determine the root cause of Tennessee's problems. Certainly one fundamental challenge was the complexity of contracting for the management of essentially all public mental health services. An alternative explanation for TennCare's problems is simply that too much was attempted too soon, and that subsequent efforts to fix the program were thwarted by the instability that by then characterized the entire system and by the resistance and fears of stakeholders. In Tennessee's approach, as with Montana's subsequent effort to contract for private managed care administration of essentially all public mental health resources, it appears likely that state officials underestimated the complexity of both the existing system and the process of change.

Procurement Challenges

A further set of obstacles to private managed behavioral health contracts in the public sector emerged in the form of court challenges to public bidding for contracts. These challenges were virtually unknown in the bidding and award of contracts to manage employer-sponsored insurance, but the combination of detailed federal procurement rules and the market pressures of an industry undergoing rapid corporate consolidations proved problematic. Litigation emerged in several contract awards, creating an additional risk for state officials considering a managed care approach.

Litigation regarding a contract award in Ohio illustrated the potential legal risks associated with public procurement. After a lengthy procurement process designed by a national benefits consulting firm in 1996, Ohio officials announced award of a $170 million contract to manage inpatient and office-based behavioral health services to Ohio Behavioral Health Partnership. The award was contested in federal court by Value Behavioral Health, an unsuccessful bidder that was simultaneously engaged in high-stakes merger talks with another firm. The award was promptly halted by the federal court, which found myriad problems in the process.

Setting aside the legal arguments in this case, the result was the entire project being tabled after at least a year of work. Ohio officials found it necessary to move quickly to restore some of the benefits that would have been centrally managed into health maintenance organization (HMO) contracts that were being negotiated on a parallel track. Given the complexities of this process, constituent concerns about any large managed care effort, and the court's unprecedented appointment of a special master to oversee subsequent procurement, state officials simply abandoned the program in favor of a more incremental effort.

This incremental work, still under way in Ohio, involves gradually installing several tools of managed care (eg, utilization review, selective contracting) into Ohio's existing public system. Such an approach—rather than contracting for the full clinical management and financial risk of public responsibilities—is emerging as the new benchmark for public-sector managed behavioral healthcare.

Ohio's difficulties illustrate a danger of large "all as nothing" managed care procurements, where bidding companies cannot afford to care "no" for an answer. Federal procurement laws are so complex and arcane that litigation is almost certain to short circuit the process. This case may have masked a shift toward smaller and more manageable, incremental approaches.

··· TRENDS IN MANAGED PUBLIC BEHAVIORAL HEALTHCARE ···

In the most recent comprehensive survey of public-sector managed care activities conducted by the federal Substance Abuse and Mental Health Services Administration, several patterns emerge.[10] First, the most common single arrangement is enrollment of Medicaid-eligible individuals in HMOs. This pattern recapitulates the trend in commercial healthcare. Little is known about the patterns of behavioral healthcare available in Medicaid HMOs, but it is likely that most of the enrollees are not seriously disabled and that patterns of care are somewhat comparable to those in HMOs in general.

With respect to specialty public mental healthcare, which is usually coordinated and largely financed by the state mental health agencies (with the participation and assistance of Medicaid), trends are more complex. However, the Substance Abuse and Mental Health Services Administration survey revealed that a slight majority of specialty or carve-out behavioral managed care programs are now contracted to public-sector entities. These include counties (as in California and Pennsylvania), county-based boards (as in Michigan), regional authorities (as in Arizona), and community mental health centers (as in Colorado and Rhode Island). In several states (eg, New Hampshire, Vermont), managed care responsibilities are being assumed by the state agency.[10]

The emerging pattern is to deconstruct managed care and selectively install managed care tools or practices into the existing organizational structure for public behavioral health services. The view at the beginning of the decade—that private managed care firms would take over public responsibilities for managing mental healthcare—has been tempered by experience and perhaps by the management and political realities of public mental healthcare.

In retrospect, these patterns should not be surprising. The "dynamic complexity" of public mental health systems that have evolved for over a century has tended to resist the blunt instrument of private managed care.[11] At the same time, this system has continued to change and adapt, and there can be little doubt that managed care—as a set of values and technologies—is the latest powerful force to affect its evolution. Although few states have turned public responsibilities over to the private sector, the Substance Abuse and Mental Health Services Administration survey finds that only 10 states "report no longer having mental health or substance abuse services under a fee-for-service system . . . or they have very limited services remaining fee-for-service."[10(p1)]

In a provocative analysis, political scientists Marmor and Gill concluded that the American political system—with its balance of powers between branches of government and between federal, state, and local authorities—was poorly suited to the kinds of integrated care and systemic reform required for effective mental healthcare.[12] They believed that good mental healthcare must be strongly integrated across sectors and levels of government. However, because the American political system resists deep structural change, needed reforms were unlikely.

The history of public mental health reform in the past generation and especially in the 1990s—the decade of managed care—makes it unclear whether Marmor and Gill were correct. Certainly, this nation's unusual division of labor for mental health, involving commercial insurance versus governmental responsibility and a continued mix of specialty care for mental health disorders versus care in the mainstream of healthcare, is likely to continue for some time. On the other hand, the pace of public-sector mental health reform in the last generation has been substantial. The movement from asylums to community support and from state administration to local service systems has been broad and deep. Managed care has introduced new forces and dynamics into this dispersed system. The results are not yet clear. It remains to be seen whether the new discipline of managed care will help the public mental health system function more rationally or compromise the progress that has been made in a generation of reform.

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