STATES’ EMBRACE OF MANAGED MENTAL HEALTH CARE

by Susan M. Essock and Howard H. Goldman

Prologue: Much of the mental health services provided in this country have come from the states, whose historical responsibility has been to care for the most disabled persons with the greatest need. In a sense, the state mental health authorities (SMHAs) have been an island around which swirled the turbulent waters of a managed care-driven marketplace. More states have been led by economic necessity and legislative mandate to embrace managed care to meet the needs of the vulnerable populations that depend on them. Now SMHAs find themselves needing the tools that private vendors of managed mental health services have perfected over the past decade, such as management information systems, incentive contracts, and fee negotiation. States have valuable experience working in an environment of limited resources and rigid bureaucracies, but they lack these tools of managed care. This has prevented them from moving to a higher level of cost containment and efficiency building. Because they entered the managed care market “late,” they must buy the expertise they need. In this paper Susan Essock and Howard Goldman discuss the extent to which states have embraced managed mental health care and outline some of the dilemmas states face in doing so. The authors express concern that the needs of the most severely disabled do not get trampled on or overlooked, as SMHAs deal with private-sector companies that are driven by a profit motive, and as they attempt to contain their own costs. Essock is director of psychological services for the Connecticut Department of Mental Health, a position she has held since 1987. She received a doctorate in psychology from Brown University. Goldman is director of the Mental Health Policy Studies Program at the University of Maryland School of Medicine in Baltimore. He holds a joint medical degree/master of public health degree from Harvard and a doctorate in social welfare research from Brandeis University.
Abstract: Historically, state mental health authorities have dominated public mental health services, operating with fixed resources and responsible for a large population. A good public mental health system has many of the attributes of a well-managed private mental health system. Unfortunately, public systems are not flexible enough to contract creatively with multiple providers; they lack many of the tools of modern managed care. As a consequence, state mental health authorities have begun to contract with private managed care firms to assist them in managing their health care reform efforts, particularly reform of Medicaid. This paper examines the forces shaping managed behavioral health care in the public sector and describes strategies for managing care, such as contracting, utilization review, and monitoring.

States play a central role in providing mental health care, far exceeding their role in the delivery of general health care services. For more than 150 years state mental health authorities (SMHAs) have been responsible for the prudent use of public funds to assure that people with serious mental illness have access to appropriate treatment. Historically, SMHAs have operated with categorical program budgets: Each year they receive an appropriation of public funds to operate services directly for citizens who are qualified categorically on the basis of mental illness. Hospitals have dominated the state mental health care system, although ambulatory services continue to increase. Beginning in the 1960s with the advent of Medicare and Medicaid, states began to deliver public mental health services using a mix of categorical dollars and federal third-party payments. By the late 1970s it had become common for states to contract for services that they did not already provide, typically using community mental health centers (CMHCs) and other emerging not-for-profit service agencies. The SMHA, once almost exclusively a provider of categorically funded hospital services, had become the manager of a complex array of services funded by categorically financed facility budgets, contracts, grants, and third-party payments.

How State Systems Work

Hallmarks of a good public mental health system include an appropriate, flexible array of services provided by a qualified network of professionals; gateways/gatekeepers to ensure appropriate access to care for eligible persons; and appropriate use of funds as indicated by systematic monitoring and evaluation. These same characteristics are central to the prudent managing of private health care expenditures. In confronting the problems and opportunities of health care (particularly Medicaid) reform and the responsibility to provide care to persons who are uninsured or underinsured, SMHAs have become interested in the potential cost-saving benefits associated with managed care techniques and with managed mental health care vendors. While some managed care techniques have been pioneered in the public sector, others are relatively untried (for example, concurrent review
of care and fluid contracting with panels of providers to whom business can be directed or redirected with ease). Market forces have prompted the emergence of private managed mental health care vendors, which promise to help purchasers of mental health care to receive good value for their health care dollar.

Managed mental health care firms routinely use most of the techniques that fall under the rubric of managed care (for example, prior authorization, concurrent review, networked providers, and negotiated rates), and they are an assertive force in the current move for states to contract for mental health services. This paper emphasizes what states stand to gain and lose from dealing with managed mental health care vendors, be they vendors of the new school of large, national managed care firms or the more familiar hospitals, outpatient clinics, and nonprofit providers that also are responding to the market and offering to participate in new contracting arrangements with state agencies.

In the 1980s, when managed mental health care firms were growing rapidly in size and number, their primary market was employers paying for health care. Company benefit managers were seeing mental health care costs rise even more rapidly than general health care costs. For example, mental health care costs for IBM’s roughly 600,000 covered lives rose from $80.8 million in 1987 to $105.7 million in 1989—an increase of more than 30 percent in just two years. Viewing these increases with concern, benefit managers at most major U.S. corporations concluded that they needed specialized health care management expertise that was unavailable to them “in house.” They chose to “carve out” mental health benefits, separating them for management by a specialized vendor. Managed mental health care vendors proliferated in response to this eager market. Savings to employers could be realized relatively easily, primarily because of the reduced fees the vendors negotiated with providers and secondarily because of the various utilization controls imposed. In IBM’s case, the 1990 carve-out of mental health benefits to a managed mental health care vendor was followed by a drop in expenditures to $97.9 million in 1992 and to $59.2 million in 1993.

Whether the initial savings typically realized via reduced fees when a corporation carves out mental health care to a managed mental health care vendor will be achievable in the public sector will depend in part on whether the providers to be used already are providing services for rock-bottom prices and the extent to which managed care techniques are already being applied in the public sector.

As their responsibility for financing and managing care increases in scope and complexity, SMHAs find themselves key players in state health care reform. While SMHAs typically have much more expertise than private-

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sector managed care vendors have in meeting the diverse treatment needs of persons with serious mental illness, they typically are relatively uninformed about the subset of managed care techniques associated primarily with the private-sector managed care business. Furthermore, SMHAs’ abilities to use such techniques are often severely constrained by the nature of the state bureaucracies within which they must operate. Enter the specialized managed mental health care vendor.

Because the private-sector carve-out of mental health benefits is now the rule rather than the exception, there is little new business for managed mental health care vendors in that market. Furthermore, the initial savings associated with reductions in utilization and in fees have already been realized for clients in that market. Therefore, these managed care firms are now looking to public-sector mental health services as their next sales frontier, because the industry’s growth now allows them to enter markets for which they would have been ill prepared ten years ago (the start-up costs associated with a contract the size of a state Medicaid contract would have been daunting). At the same time, states are looking to such companies to assist them with cost containment and service delivery issues (such as coordinating care among categorical providers; contract agencies; and independent, fee-for-service, third-party providers).

This paper examines some of the forces causing states to embrace such new contracting arrangements with managed mental health care vendors and makes recommendations about how to create incentives for better-managed care.

Management Goals Of SMHAs And Their Fit With Managed Care

SMHAs are charged with providing appropriate services within a fixed budget to a targeted population. SMHAs must accomplish this as large entities within state bureaucracies. They are more like ocean liners than motorboats, in that they work best when not required to turn quickly. Hence, in addition to service delivery and budgetary goals, SMHAs’ goals also include finding ways to function within state bureaucracies: sensing and finding ways to capitalize on changing political winds, finding ways to change without getting stuck in the bureaucratic swamp, and surviving (having the governor and legislators value what they do and staying out of the newspapers). SMHAs must rise to the challenge of finding their own paths for providing cost-effective services for persons disabled by psychiatric illness, or they run the risk of disappearing as states move to obtain health care from outside sources.

Increasingly, states are looking to contract out public health care services, mental health care included, as a means of controlling costs and
gaining flexibility. Ohio, for instance, has been a pioneer in shifting fiscal and clinical responsibility from its SMHA to local mental health authorities, creating incentives to reduce the use of hospital services and provide more cost-effective care, and retaining an active monitoring role for the SMHA. States may opt to perform managed mental health care activities without contracting out for these services or contract out for all or part of these services. The paths that states follow in this arena are determined by the horrendously and inherently complex forces that influence the functioning of state governments.

These forces commonly include the relationship between the SMHA and the state Medicaid agency, state/county dynamics, the state/federal Medicaid relationship (for example, the willingness of the federal government to grant Medicaid waivers), the willingness of state legislators to alter the revenue flows of current service providers, and the extent to which labor unions will tolerate a decrease in the number of unionized jobs. Arriving at an educated guess about the best route to cost-effective care calls for an understanding of the political environment in which care is to be delivered, including the feasibility of obtaining permission to contract for care and of negotiating, implementing, and monitoring contracts for care. The forces to be negotiated along the way represent a formidable list of challenges. Yet, increasingly, state policymakers are investing the time, effort, and development costs to contract with managed mental health care vendors. Clearly, great benefits are expected. The potential gains vary by location but include fiscal savings, expanding Medicaid eligibility via Medicaid waivers, and circumventing state hiring constraints (such as unions and hiring caps). The move to contract with managed mental health care vendors and providers is too new and can play out in too many ways to make global pronouncements about whether such carve-outs are “good” or not. But policy proceeds in the absence of data, and fiscal and political pressures are such that many states are actively involved in this process. Unless a string of unequivocal disasters ensues, more managed care contracts are likely to follow.

### Contractual And Monitoring Issues

When contemplating “make-versus-buy” decisions, some states may not have enough services to make the development of managed care technologies cost-effective compared with contracting out to a managed mental health care vendor, with its economies of scale. Whether the SMHA’s role is to make (perform the managed mental health care functions, including contracting for services, itself) or to buy (contract with a vendor), public systems will work better if SMHAs take active roles in contracting and
monitoring mental health services. Having the SMHA (rather than, for example, a state’s contracting authority or Medicaid agency) monitor vendors’ performance ensures that this crucial function will be carried out by an entity that is familiar with the service needs of persons with serious mental illness. Several states, such as Massachusetts, Minnesota, Utah, Hawaii, and Iowa, are in various stages of contracting with managed care vendors for Medicaid mental health services. The challenge that remains is how to structure the organization and financing of mental health services to foster high-quality, cost-effective care.

Whereas SMHAs have always been faced with the challenge of stretching the mental health dollar by figuring out what is effective for whom, they increasingly must also figure out prudent ways to structure and monitor the purchasing of effective services. What is new is the public sector’s expanded access to managed mental health care vendors and the providers and management practices they represent. Vendors offer SMHAs assistance in providing cost-effective treatment and shifting risks. By using such vendors, SMHAs can “outsource” what they typically are not designed to do well (such as contracting quickly or billing for services).

Health care providers serve the beneficiaries of the entities that contract with them. Increasingly, these entities are managed care firms with a mixture of public- and private-sector clients, all being funneled to the firms’ networks of providers. Depending on the routes by which the funneling is accomplished, public- and private-sector patients may, on the one hand, have access to the same providers with only need for care determining access. On the other hand, more needy (hence, more expensive) patients may be underserved under such contractual arrangements.

The structure of the contract between the payer and the managed care entity along with the monitoring and enforcement of that contract-exerts a crucial influence on who receives what quality of care. The behavior of managed mental health care vendors, and the providers under them, will be influenced by the performance incentives and disincentives established by the contract terms and a payer’s ability to enforce those terms. For example, if an SMHA is concerned that a vendor will “dump” difficult-to-treat patients by having them admitted to state hospitals, then the SMHA should include in the managed mental health care contract that the firm will be charged at a substantial daily rate when persons covered under the contract are admitted to state hospitals. Contracts can be used to create incentives to provide good care as well as to avoid poor care. For example, if an SMHA wants to promote continuity in treatment, the contract can reward meeting continuity benchmarks (for example, at least X percent of patients receiving medication management sessions see the same psychiatrist at least once every Y weeks for at least 2 months). The important point
here is that, in contrast with SMHAs, which typically are legislatively mandated to serve a nebulously defined public good, managed mental health care vendors can be expected to provide only what they have contracted to provide, and then only if there are negative consequences for nonperformance. Hence, a crucial role for the SMHA is crafting and monitoring managed mental health care contracts—be they with vendors or directly with service providers—to ensure that appropriate services are available to the people whom SMHAs are legislatively charged to serve.

Managed Care Techniques In The Public Sector

Many managed care techniques are not new to the public sector. Delivering services within a fixed, annual program budget set by appropriation creates some of the same incentives for efficiency that are inherent in capitation. Indeed, managed care cost containment strategies such as “benefits flexing,” which permits coverage of needed care in settings not usually allowed under the benefit plan (for example, treatment in a residential treatment center as an alternative to hospitalization), are hallmarks of public-sector case management programs, which stress mobile delivery of what the client needs when the client needs it, to help keep people out of the hospital. In many instances, the categorically funded SMHA can create innovative service packages tuned to the needs of individual clients without regard to rigid reimbursement rules, because SMHAs often do not receive payment from third parties for many of these services. Similarly, the “gateway/gatekeeper” functions provided by managed care organizations have many parallels in public-sector programs, such as requiring that clients be certified as eligible prior to receiving any services, limiting spaces on assertive community treatment teams to persons meeting additional criteria that demonstrate their need for more intensive services, and limiting access to openings in group homes to persons who cannot live safely in less structured settings. (One indicator of the success with which public mental health systems have long functioned as managed care systems is the number of former public-sector employees who now fill senior management positions in managed mental health care firms.) Nevertheless, some managed care techniques are much more easily practiced in the private sector than in the public sector. For example, because contracting is typically a protracted process in most state bureaucracies, public mental health systems have been at a comparative disadvantage when using managed care techniques that involve shifting contracts (and referrals) among various providers, modifying contracts in a timely fashion to alter incentives for providing particular types of care, and the like.

Some managed care techniques are relatively foreign to the public sector.
Utilization review performed by a managed mental health care firm is typically much more thorough, in percentage of cases reviewed and intrusiveness into discharge planning, than is review of state or general hospital care paid for by Medicaid. Traditional utilization review activities are a labor-intensive means of monitoring practice patterns to identify problems in the appropriateness of treatment and to encourage use of less expensive settings for care whenever feasible. The public sector has typically substituted, with mixed results, less labor-intensive practices to decrease inappropriate use (such as placing tight restrictions on admissions to a state hospital or setting Medicaid payment rates for psychiatric care so low that there are few willing providers). Unlike many hospitals hoping to keep their beds fully occupied while operating in a fee-for-service environment, SMHAs typically seek to keep the hospital census low, especially for patients for whom there is no private or federal payment. The SMHA’s fixed program budget has an effect similar to that of an annual capitated payment, in that it creates an incentive to decrease care and to shift care to less costly settings.

SMHAs and managed mental health care vendors are beginning to use computerized service records to examine practice patterns and client outcomes. Properly structured and maintained, such databases can allow management to identify and intervene with patients who are readmitted unusually quickly and their providers; providers who lose contact with clients; patients and providers with an unusual number of missed appointments; providers paid to deliver services in the community but who are staying office-bound, and so on. The Mental Health Statistics Improvement Program (MHSIP) of the Center for Mental Health Services (CMHS), formerly sponsored by the National Institute of Mental Health (NIMH), has provided modest but very useful fiscal incentives for states to leverage development of management information systems that allow such tabulations of data. However, few state systems can generate easily even the items just mentioned. The information systems of managed mental health care vendors also are evolving to meet the demands of performance-based contracting. Because public systems have not excelled in the past at developing information systems, a public-sector agency would gladly include their development when contracting out for services. SMHAs have rarely had to prove by numbers that they were providing a competent network of providers, managing access well, and providing cost-effective care. Yet contracts with managed mental health care vendors routinely include these elements. It is no wonder that managed mental health care vendors’ information systems appear to be evolving more rapidly than those in SMHAs, and vendors are better positioned than SMHAs are to provide electronic summaries of practice patterns.
Shifting From Doing To Monitoring

Managed care is more than managing costs. Costs can be managed simply by paying less and saying “no” a lot, but managing care requires controls that attend to the availability and quality of care in addition to the cost of that care. A lengthening string of court cases speaks to the unacceptability of controlling costs without attention to the care involved. Instead of focusing solely on the costs of care, purchasers of services (be they individuals, employers, SMHAs, or states) increasingly are questioning the value of the care received and asking for outcome studies to support claims. Payers and planners are asking what treatments work, for whom, by whom, and in what settings.

As public entities shift from providing to purchasing care, and from purchasing individual hours or days of care to purchasing as-needed use of a system of care, the importance of objective monitoring of the system’s functioning increases. The question, “Who will manage the vendor?” looms large. Opportunities for efficiency in the public and private sectors differ; hence, techniques developed in the private sector may not translate well to the public sector. The existence of incentives to underrecognize, underdiagnose, and undertreat persons with serious mental disorders has been argued. Thus, public-sector contracts with managed mental health care vendors should include incentives to identify such persons and treat them appropriately via fiscal rewards and/or penalties.

To protect persons with serious mental illness, it is critical that parties who are knowledgeable about their needs and vulnerabilities are at the table during contract negotiations and renewal and take part in monitoring a vendor’s performance. The success of such managed care ventures hinges on the ability of SMHAs to participate in the structuring of appropriate contracts with enforceable clauses in key domains. While the SMHA’s primary data collection requirements decrease dramatically when services are contracted out, new oversight functions involving auditing and monitoring should emerge to ensure that contract stipulations are being met.

Introducing managed care techniques into a system creates a new interface to monitor. For example, when care requires prior authorization, the authorizer’s decisions should be monitored via sampling to ensure that decisions are appropriately documented and that they adhere to standards for access by patients. Although introducing a managed mental health care vendor may decrease an SMHA’s information-processing requirements in areas such as client tracking and billing, the new monitoring requirements do require the ability to track the vendor’s performance in key domains and to audit the vendor’s internal processes that are accomplishing these tasks.
Creating Incentives For Better-Managed Care

As mentioned above, the terms of the contract between a payer and a managed care vendor/provider create incentives and disincentives to provide good care. As the market of new clients for managed mental health care vendors shrinks, pressure is increasing for competition among companies based on outcomes in addition to price. In this buyer’s market, SMHA contracts should stipulate the timely provision of accurate data on practice patterns and outcomes. These data are useful in monitoring the vendor’s performance, whether or not the findings influence payments to the vendor. To increase pressure on vendors to provide such information, purchasers should form user groups to lobby for their priorities (for example, expanded performance reports, upgrading of clinical review staff to include more specialists and more clinical supervision, and arranging for more consultations for difficult cases). Without such pressure, vendors may choose to invest their development efforts in other product lines or simply to realize greater profits.

Data reports from the vendor should be augmented by clinical and fiscal audits of the vendor by representatives of the state agency holding the contract and by surveys of key stakeholders regarding their satisfaction with the vendor’s services and practices. The agreement with the vendor should require that corrective action plans be initiated to deal with any adverse findings from these audits and surveys. The contract should set a base rate of monitoring, with an increase in monitoring if problems are found, and the vendor should be responsible for expenses associated with any such for-cause increase in monitoring. The vendor also should be required to have an appeals process with an independent component during which decisions about the ways in which care is being authorized can be challenged and open to independent review. Contracts also should be structured so that the results of surveys of key stakeholders (clients, families, and providers) influence payments to the vendor. Performance-based contracting with recontracting at the option of the SMHA helps to assure the vendor’s attention to the problems with a contract rather than to a squeaky wheel elsewhere. Caps on risks and rewards help to assure the vendor’s attention without allowing exploitation by either party.

Concluding Remarks

In an effort to control costs, minimize risks, and contract out what they do poorly themselves, many states are opting to contract for a wide variety of managed mental health care services. The impact of these contracts on the quality of the care received by persons with serious mental illness will
be heavily influenced by the structure of the contracts, the sophistication of the managed care vendor with respect to services for persons with serious mental illness, and whether knowledgeable agents such as state departments of mental health participate effectively in both developing and monitoring the contracts.

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NOTES

3. Ibid. The number of covered lives decreased by about 6 percent during this period.
9. See, for example, Schlesinger and Mechanic, “Challenges for Managed Competition from Chronic Illness.”
0. Callahan et al., “Mental Health/Substance Abuse Treatment in Managed Care.”