Competing Interests: Public-Sector Managed Behavioral Health Care

As states pursue contracts with managed behavioral health organizations, they need to be aware of market and political influences.

by Michael H. Bailit and Laurie L. Burgess

The development of public-sector managed behavioral health care programs in the 1990s to serve Medicaid and other publicly financed populations represented a dramatic change in economic control and power within the behavioral health care system. Some have cogently argued that states make decisions regarding how to contract out (“carve out”) the management of such programs and which carve-out model to use based upon a complex consideration of strategic objectives within a political context. This paper argues that, on the contrary, it is changes in market power and political influence that drive states’ purchasing choices and subsequent decisions.

A case in point, we observe, is the managed behavioral health care market. Providers that lost control and power in the first public-sector managed behavioral health care programs reacted aggressively. Their behavior, in turn, shaped the market that now offers program models in which providers play a dramatically different role from the one they assumed in the original carve-out models.

State purchasers must be cognizant of this power shift, of how the market has influenced (and influences) their managed behavioral health care choices, and of what the implications are for a state that chooses to implement a carved-out managed behavioral health care program today.

Development And Impact Of Carve-Outs

Before the development of managed behavioral health care carve-outs, providers of mental health services and, sometimes, chemical dependency services worked in collaboration with state mental health authorities (SMHAs) to meet the needs of public beneficiaries. Many providers were created and had existed primarily to serve these populations. Separate delivery systems served the generally healthier privately insured population.

Providers tended to have stable long-term relationships with the SMHAs. There was little competition to serve the publicly funded populations. Financing for behavioral health services was largely provided in many states through a separate state Medicaid agency.

A cost containment tool. This delivery approach began to change in the early 1990s. State Medicaid budgets were experiencing dramatic increases, particularly in the area of behavioral health services. As the increases in state Medicaid budgets created fiscal crises for many state legislatures, as we experienced in Massachusetts, states looked for new tools to use to manage their unrestrained behavioral health care costs. It was at this time that a few states, including Massachusetts and Iowa, decided to contract with private man-

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aged care organizations that specialized in behavioral health care, to rein in their Medicaid behavioral health spending. Private employers had begun to report some success in cost containment through the use of such contractors, particularly by reducing psychiatric hospitalizations and lengths-of-stay. There was every reason to believe that these approaches might work for Medicaid programs.

- **A threat to providers.** The step taken by Medicaid agencies to use managed care to assume control of their behavioral health spending also resulted in a shift of power and control away from behavioral health care providers and to Medicaid. Medicaid agencies explicitly, or implicitly, were forcing providers to contend with a "new master." Traditional providers of behavioral health services suddenly found that they no longer held contracts with the sympathetic SMHA, but held them instead with aggressive managed care organizations that were bent on reducing the volume of services providers delivered and the rates they were paid. This was especially true for providers of inpatient services. In addition, the new managed care contractors were introducing competition among providers where it had not existed before. Private hospitals were suddenly vying with traditional providers for contracts with the managed behavioral health organizations (MBHOs) for the delivery of inpatient services. The aggressive challenge posed to traditional vendors by the entrance of these hospitals into the publicly funded market was compounded by MBHOs' efforts to ensure reductions in total inpatient use.

These changes had a momentous impact on the public behavioral health care delivery system, creating shock waves in the states. Providers began to work hard, politically, to regain their position of influence, using legislative lobbying, merger-and-acquisition activity, and negotiations for new risk-based reimbursement arrangements to better position themselves.

In the early and mid-1990s, in states that had not yet implemented but were beginning to anticipate a shift to managed behavioral health care, providers were closely observing the effects of implementation in the first few states with managed behavioral health care programs. Traditional providers of behavioral health services in these states were wary of experiencing the same loss of power and control that they had witnessed in other states. In anticipation, they began to position themselves to retain their current positions of influence even after transition to managed care. The political and market arenas were primed in these states for a high-stakes power struggle for financial and political control.

- **External forces.** Two separate events occurred in the mid-1990s that strengthened the position of traditional behavioral health care providers nationally. First, the national health care inflation rate and the Medicaid budgetary inflation rates experienced sudden and unexpected declines. While state policy had some influence on these trends, much of it occurred because of factors beyond states' direct control. These decreases removed the extreme pressure for cost containment that had caused state Medicaid agencies, such as those in Massachusetts and Iowa, to move quickly and aggressively. With the atmosphere of fiscal crisis abated, providers could negotiate positions and protections that would not have been attainable in the previous crisis environment.

The second event was the escalation of national anti–managed care sentiment. Extending far beyond the arena of public managed behavioral health care programs, this phenomenon was, and continues to be, fueled by providers’ advocacy efforts, although not
without some consumer support. This anti–managed care fervor has heightened concerns about the impact of MBHOs among legislators and SMHAs. Some have become more sensitive to the fate of behavioral health care providers under managed care. MBHOs, well aware of the threat of these sentiments, began to consider how they could garner important political support from providers so that they could continue to win state contracts.

**New arrangements.** The net effect of these events and trends has been a dramatic shift of power and control back to the same entities that experienced their sudden loss in the early 1990s. New models of managed behavioral health care that are more accommodating to providers are becoming common. In addition, increasingly, legal partnerships have been created between provider organizations or coalitions and MBHOs. In other recent models, provider organizations function as the lead contractor to the state, and they in turn subcontract with the managed care organizations to provide the administrative services that the provider organization cannot deliver effectively or efficiently. These arrangements allow providers to retain policy influence relative to the managed care organizations’ operations and also to reap some of the financial gains that otherwise would accrue solely to the managed care contractor and the state.

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**Implications For States**

■ **Benefits of the new model.** The relative benefits to be realized from the new publicly managed behavioral health program models are unclear. A model in which providers have an ownership stake in the state-level MBHO might have the following results for states: (1) greater provider input to policy development; (2) greater provider support for the policies and procedures adopted by the MBHO; (3) the ability for provider organizations to realize some of the savings generated by the program and to be able to reinvest them in services; and (4) greater acceptance of managed behavioral health care by consumers and advocates.

■ **Trade-offs.** There are some potential trade-offs, however, related to this model. Elevating providers’ influence can result in lost accountability on the part of the MBHO to the state, for the following reasons: (1) Providers may be less willing to make programmatic decisions that could have harmful economic influences on some or all of them; (2) MBHOs may be less likely to use competitive market pressures (such as dropping poorly performing providers from their networks) to drive improved performance and accountability; and (3) providers may use their new economic influence to harm competitors’ standing rather than to further the interests of the state and the consumers it serves. Generally speaking, such a model has the potential to result in less-aggressive management.

■ **Factoring in market and politics.** Given the options now available to state purchasers and how those options evolved, we draw several conclusions. First, state purchasers clearly have, and must be aware of, a very different choice of managed behavioral health care models today than they had in previous years. Second, state purchasers must make their purchasing decisions cognizant of the types of compromises that may be required, what those compromises will mean for the state’s ability to attain its desired objectives,
and whether the anticipated compromises are worthwhile. Third, state purchasers must watch changing market and political dynamics closely to be prepared for future changes in the managed behavioral health care model that will have bearing on the approach they are able to pursue. The effects of the changing market may create new opportunities that are not available today. They also may result in pressures for future compromises that are unacceptable. The earlier these can be foreseen, the better. The state of New Jersey, for example, had decided to use a single managed behavioral health care vendor for its Medicaid population. When the state learned that this approach would not be politically feasible, it ceased its procurement-development effort to pursue an alternative, non-provider-based, approach.

Ideally, understanding the influence providers now have politically and in the marketplace, bidding scenarios can be anticipated by states, so that decisions can be carefully made whether to continue (or pursue) a particular managed behavioral health care approach before significant resources have been invested. With keen foresight and an understanding of the market’s control over purchasing options, prepared public purchasers will be able to read market dynamics, understand the ramifications, and recognize either when they must abandon an approach early on or when new opportunities appear for adapting existing practices advantageously.

NOTES

5. This resumption of political and economic control by behavioral health care providers is somewhat similar to what has happened in the physical health sector. There, provider organizations are increasingly assuming partial and full risk for most or all services delivered to enrolled populations. In addition, the physical health provider organizations are assuming delegated responsibility for many traditional health plan functions. In many markets the role of the managed care organization is becoming increasingly limited as large provider organizations consolidate their market power and demand newly defined relationships that apportion lost power and influence back to the provider entities.