Effective Public Management of Mental Health Care:

Views from States on Medicaid Reforms That Enhance Service Integration and Accountability

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Foreword

This report distills the experience of senior officials of state and local government in adapting the techniques of managed care to the needs of persons with mental illnesses, especially severe and chronic illnesses. The theme of the report is that public managers can use many of these techniques to improve the quality and cost effectiveness of behavioral health services. However, the techniques of managed care must be modified to take into account the challenges of integrating services for persons with mental illnesses, the characteristics of patients and providers in each jurisdiction, and the requirements of public accountability.

The report is the collective work of a group of state and local officials convened by the Bazelon Center and the Fund. The Center, founded in 1972, is a nonprofit national legal advocacy organization for people with mental disabilities, working to protect their rights and promote their access to the services they need for full participation in community life. The Fund is an endowed national foundation, established in 1905, that works with decision makers in the public and private sectors to carry out nonpartisan analysis, study, research, and communication on significant issues in health policy.

Each of the officials we convened had firsthand experience with managed behavioral health care. The officials spoke frankly about their experiences and achieved consensus about the themes of the report and its structure. They also decided that the report should not call attention to the specific experience of any one state. Hence particular states are not identified within the report.

The persons who created this report as well as those who reviewed it in draft are identified in the Acknowledgments. We are particularly grateful to Charles Palmer, who served with distinction as Director of the Iowa Department of Human Services, for leading this project from its inception in 1996.

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Acknowledgments

This report is the collective work of a group of state and local officials that met twice under the chairmanship

of Charles Palmer, then Director of the Iowa Department of Human Services; staff of the Bazelon Center and the Milbank Memorial Fund also helped to produce the report. Colleagues in government, managed care, business, and the health professions reviewed various drafts of this report. All persons named below are listed in the positions they held at the time of their participation.

The officials who crafted the report are: Marilyn Eckley, Director, Bureau of Operations and Quality Management, Pennsylvania Department of Mental Health and Substance Abuse Services; Brian Hepburn, Clinical Director, Mental Hygiene Administration, Maryland Department of Health and Mental Hygiene; Thomas A. Kirk, Deputy Commissioner, Connecticut Department of Mental Health and Addiction Services; Michael McCracken, Executive Director, Association of Oregon Community Mental Health Programs; Dennis Mohatt, Deputy Director, Nebraska Department of Health and Human Services; Oscar Morgan, Director, Mental Hygiene Administration, Maryland Department of Health and Mental Hygiene; Candy Nardini, Project Director, Mental Health Access Plan, Iowa Department of Human Services; Karen Snyder, Chief Operating Officer, Connecticut Department of Mental Health and Addiction Services; Barney Speight, Administrator, Oregon Health Plan Policy and Research; Don Thomas, Director, Hamilton County Department of Human Services, Cincinnati, Ohio; and Martin Wasserman, Secretary, Maryland Department of Health and Mental Hygiene. Damian Kirwan, President, National Association for Rural Mental Health, Mesa, Ariz.; and Richard E. Ramsay, Senior Associate, Proskauer Rose LLP, Washington, D.C., joined these officials, each for one meeting.

The following persons reviewed the report in draft: Kevin Concannon, Commissioner, Maine Department of Human Services; Mary Jane England, President, Washington Business Group on Health; Donald P. Galamaga, Executive Director, Integrated Mental Health Services, Rhode Island Department of Mental Health; Laura Lee Hall, Research Director, National Alliance for the Mentally Ill; Peter F. Hayes, Senior Consultant, J & H Marsh & McLennan, Inc., Portland, Me.; Billy Jones, Senior Vice President and Medical Director, Magellan Public Solutions, New York, N.Y.; Danna Mauch, Chief Executive Officer, Public Solutions Group, Magellan Behavioral Health, Burlington, Mass.; Neil Meisler, Assistant Professor, Department of Psychiatry, Medical University of South Carolina; Cynthia O'Neil, Executive Director, Rhode Island Mental Health Association; Christopher Queram, Chief Executive Officer, The Alliance, Madison, Wisc.; James E. Sabin, Associate Clinical Professor of Psychiatry, Harvard Medical School; James Stone, Commissioner, New York State Office of Mental Health; Marylou Sudders, Commissioner, Massachusetts Department of Mental Health; Richard C. Surles, Executive Director, Center for State Health Policy, Rutgers University.

William Goldman, Senior Vice President, Behavioral Health Sciences, United Behavioral Health; and John M. Ludden, Associate Clinical Professor, Department of Ambulatory Care and Prevention, Harvard Medical School, reviewed the final draft of the report.

The project began with a meeting convened by the Milbank Memorial Fund in March 1996 that was planned and led by Charles Palmer and Richard C. Surles, then Executive Vice President of the Merit Behavioral Care Corporation, on the subject of "Managed Care Contracting for Behavioral Health Services." Participants in that meeting were: Rachel Block, Acting Director, Medicaid Managed Care Team, Health Care Financing Administration, Department of Health and Human Services; Sherral Crown, Director, Medicaid Mental Health Substance Abuse Program, Massachusetts Division of Medical Assistance; Susan Dore, Chair, Taxation Committee, Maine House of Representatives; Mark Gibson, Senior Health Policy Advisor, Office of the Governor of Oregon; Robert Glover, Executive Director, National Association of State Mental Health Program Directors; Henry Harbin, President and Chief Executive Officer, Green Spring Services, Columbia, Md.; E. Clarke Ross, Executive Director, American Managed Behavioral Health Care Association.

Staff of the Bazelon Center for Mental Health Law who worked on this project were: Robert Bernstein, Executive Director; Joseph Bevilacqua, Consultant; and Chris Koyanagi, Director, Government Relations, State Initiatives Project. Thomas D. Romeo, formerly Rhode Island Commissioner of Mental Health and Mental Retardation, now Executive in Residence, College of Human Sciences and Services, University of Rhode Island, assisted the Fund in managing this project.

Executive Summary

The use of managed care in public mental health systems is spreading, but few clear patterns have emerged. While a number of states continue to privatize their mental health systems through contracts with outside corporations, others are adopting the techniques of managed care by using designs tailored to the existing organization of their systems.

Although there is no one correct approach, the greatest successes to date have come when policymakers start with a vision of what goals they want the service system to achieve and then, engaging in comprehensive planning with stakeholder groups, use managed care to reach those goals. Managed care appears to be a useful and cutting-edge tool for achieving cost efficiency in a dynamic system while offsetting risks and protecting consumers.

This report addresses the need for accountability and effective management of public mental health systems and reviews policy issues that arise in adapting Medicaid managed care to adults and children who have serious mental disorders that need treatment.

The expansion of managed care to people on Medicaid who have a significant disability due to serious mental illness has been controversial—both reviled as a system of unreasonable rationing that hurts those most in need, and held up as the solution to a series of long-standing and difficult problems in public mental health systems. According to state officials with several years' experience, neither of these assessments of managed care in this field is accurate. Many states that have already adopted managed care approaches in their public mental health systems report considerable success, but they also warn of limits on the extent to which reform can be accomplished by changing organizational structures and financing. Positive effects are:

- increased access;
- decreased use of inappropriate inpatient care;
- an expanded array of services;
- more flexibility in service delivery; more consistency in clinical decision making; more focused, goal-directed treatment; and
- an increased emphasis on accountability and outcomes.

However, problems that may arise as a result of using managed care include:

- an incentive in a risk-based contract to undertreat—particularly to underserve—people with serious disorders;
- an undue focus on acute care and neglect of rehabilitation and other services with significant long-term payoff in improved functioning;
- potential difficulties created by Medicaid managed care contracts in serving the non-Medicaid population;
- frequent billing and payment difficulties during start-up; and
- difficulties in ensuring quality and outcomes consistently across regions.

Managed care for people with serious mental illnesses is most often carved out into a contract separate from other managed care services. A number of states initially sought such contracts from nationally known managed behavioral health care entities. Today there is more diversity, and various trends have emerged in the organization of managed mental health care:

- replacement of the full-risk contracts with private, out-of-state, for-profit companies with arrangements that are for administrative services only (ASO) or that are otherwise limited;
- increasing reliance on traditional safety-net providers;
- assumption by states of their own managed care, shifting their systems to performance-based contracts but providing the management;
- reduction in statewide system reforms—especially in larger states—in favor of the development of county-based systems or systems organized through existing community mental health boards.

While cost management is a legitimate and ethically necessary target for health care policy, and while rationing is inevitable in underfunded systems, public systems are ultimately responsible for the care of people with serious mental illnesses. Accordingly, while cost issues are states' primary motivator, an important secondary concern is access. Another major concern—an overriding one for many consumers, advocates, and providers—is quality of care.

A serious problem in the management of public mental health arises from the fragmentation caused by the existence of multiple funding streams and service-delivery systems; such fragmentation is exacerbated by

differences between various programs' eligibility criteria. The costs of a fragmented, inefficient system are significant, and contribute to the administrative problem of cost-shifting. Savings said to have been realized through cost-shifting are not real. The traditional fuzziness of the boundaries of mental health care must therefore be addressed anew in the shift to managed care.

The lack of accountability in public mental health and health systems has created a policy dilemma. Better data from the more comprehensive information systems used in managed care can be used to improve this situation. Policymakers will find different challenges of accountability, depending on whether they have contracted with a for-profit company or used the existing network of nonprofit providers. Generally speaking, commercial companies need to be monitored to ensure that people with serious disorders are served adequately, while nonprofit networks need to demonstrate that they have the necessary data and financial management systems to manage for outcomes. Alternatively, policymakers can try to combine these forces, but this is no small task and has always taken longer than anticipated.

Introduction

This report addresses the need for accountability and effective management of public mental health systems and reviews policy issues that arise in adapting Medicaid managed care to adults and children who have serious mental disorders that need treatment.

The use of managed care in public mental health systems is spreading, but few clear patterns of how it has been implemented and whether it has been successful have emerged. While a number of states continue to privatize their mental health systems through contracts with outside corporations, others are adopting the techniques of managed care through designs that are specific to their existing systems.

Today, governments face ever greater demand for accountability in public spending. However, the ensuing overhaul of public systems has raised other public concerns. State policymakers believe they have used managed care to focus on cost management in responsible manners. They also believe managed care is improving efficiency and, thereby, quality.

Although there is no one correct approach, the greatest successes to date have come when policymakers start with a vision of what goals they want the service system to achieve and then, engaging in comprehensive planning with stakeholder groups, use managed care to reach those goals. Managed care appears to be a useful and cutting-edge technology for achieving cost efficiency in a dynamic system while offsetting risks and protecting consumers.

Medicaid provides health and mental health care coverage to 41 million low-income individuals. It is also a very important source of revenue for public mental health systems. Medicaid funds nearly half of all expenditures for public-sector community mental health care; in 1998, Medicaid spending for publicly controlled mental health services reached $14 billion (roughly 8 percent of all Medicaid spending)[1]. Individuals with mental illnesses—both those on Medicaid and those with private coverage—tend to be frequent users of both health services and disability benefits[2]. This makes it all the more important to address their mental health needs effectively.

Defining Managed Care

The term "managed care" has different meanings to different audiences. The American Medical Association defines managed care as "those processes or techniques used by any entity that delivers, administers and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization or costs and prices or outcomes of such services provided to a defined enrollee population."

The Health Insurance Association of America defines managed care as "systems that integrate the financing and delivery of appropriate health care services to covered individuals through the use of four elements: arrangements with selected providers to furnish a defined set of health care services to

members; explicit standards for choosing those providers; formal programs for ongoing quality assurance and utilization review; and significant financial incentives for members to use the plan's providers and procedures." However, the HIAA's qualification of "incentives . . . to use the plan's providers and procedures" often does not apply in a public-sector program, in which enrollees in managed care plans may have no option to seek care from providers other than the ones contracted by the plans.

With that caveat, these two definitions capture the essential elements of managed care as used in public-sector mental health care delivery systems. Both emphasize the integration of financing and delivery, and both highlight managed care's focus on quality and outcomes. These definitions reflect the working understanding of managed care used by state and local officials engaged in public-sector planning and oversight of managed mental health care who contributed their ideas and concerns for this report.

Status of Medicaid Managed Mental Health Care

As of 1997, more than half of all Medicaid beneficiaries were in managed health care plans. Yet states have been more cautious about using managed care for Medicaid beneficiaries who are elderly or who have significant disabilities; 75 percent of these individuals are still in fee-for-service plans[3]. Although most Medicaid managed care plans provide limited mental health services for low-income women and children, a smaller number of specialized mental health managed care entities provide more comprehensive services to individuals who have significant disabilities and receive services through the public mental health system. However, states are increasingly seeking to extend the managed care approach to people who have serious mental or emotional disorders, and 31 now have Medicaid managed care plans for at least some individuals in the public mental health system[4].

This expansion of managed care to a population with significant disabilities has been controversial. The use of managed care in public mental health systems has been, on the one hand, reviled as unreasonable rationing that hurts those most in need and, on the other hand, lauded as the answer to a series of long-standing and difficult problems in public mental health systems. According to state officials with several years' experience with managed care, neither description is accurate. State policymakers will likely find that the use of managed care:

- may worsen some existing problems, particularly cost-shifting across systems;
- may solve some long-standing and intractable problems—for example, it is likely to significantly decrease unnecessary use of expensive services, especially 24-hour institutional care; and
- may create or expose new problems, often reflecting the state's own particular situation and mental health system, which must then be addressed.

Of the 31 states with Medicaid managed care arrangements for individuals in the public mental health system, 21 have specialized statewide carve-out models for mental health care contracts; five have county or regional specialized managed mental health care; and three have smaller pilot projects. Only two states provide coverage through significant areas of the state (one statewide) using integrated plans that provide both health care and acute and extended mental health managed care[5]. Although the plans vary in such details as eligibility groups enrolled, benefits covered, age range of participants and organizational arrangement of the managed care entity, they all integrate financing and delivery (most use risk-based contracts) and include some form of utilization control.

The remaining states continue to use fee-for-service Medicaid for individuals with serious mental or emotional disorders—the traditional public-sector mental health clients. Most also include a limited acute care mental health benefit in their managed care plans for low-income women and children[6].

"Privatizing" Public Mental Health Systems

Generally speaking, state officials, when considering how to contract out management of their public mental health system, are in positions similar to those of private corporations that seek good coverage for their employees. Despite some important differences in populations served, both types of payers are concerned with accountability, predictability of costs, and good consumer outcomes. Public systems can therefore learn from the experiences of private purchasers.

However, unlike private providers, public systems must serve primarily individuals with severe and complex disorders. The public sector is the safety net. As a result, the number of patients with ongoing needs for significant levels of service in the population that uses public-sector services is significantly greater than that in the population served by private plans. Accordingly, while public and private purchasers have some common concerns, there must still be significant differences between a Medicaid contract for managed mental health care and a private plan. These differences are the reasons stakeholders in mental health care often express concern about the experience and skills of managed care companies whose previous contracts have been primarily in the private sector.

Initially, a number of states sought contracts with these large, nationally known managed behavioral health care entities. Today, there is more diversity, as some states have established managed care entities within the public mental health system. In these states, public agencies (counties or state mental health authorities) or local mental health and substance-abuse providers are organized to run—or bid on contracts to run—the mental health system, using managed care techniques. However, it is important to recognize that many public systems do not have any option for adopting managed care other than contracting with a private entity through a capitation agreement. Many states have neither the capacity to pay claims nor the data systems that would enable them, for example, to contract for administrative services only or run managed care themselves.

The different choices that states have made have clearly arisen from different objectives and possibly different problems. States that have sought to move quickly away from public bureaucracies and to reorganize cumbersome or out-of-date systems have favored using for-profit out-of-state vendors, hoping to inject corporate business practices directly into public mental health care. In some states, officials say, switching to an external managed care entity—such as a private, for-profit vendor—created an opportunity for reforms that would have been politically impossible for the public agency itself to achieve. States with these contracts report success both in holding down costs and in expanding access while securing consumer satisfaction.

States that have chosen instead to rely on the nonprofit sector or to operate their own managed care programs, on the other hand, have been responding in part to concerns that the for-profit vendors do not have the skills to run complex public mental health systems, which cater to those with the most severe mental illnesses. Under these arrangements, established specialized public-sector contractees serving high-risk, low-incidence populations continue in place, though with greater oversight. These states have sought to protect their existing investments in public-sector systems and may have been seeking less radical reforms of their systems. Moreover, by itself, contracting with traditional providers is no guarantee of good outcomes[7].

Trends

Various trends have emerged from states' experiences with managed mental health care:

- States are carving out separate contracts for services for people who have severe disabilities (including but not always limited to those who are eligible for SSI disability benefits).
- Full-risk contracts with private, out-of-state, for-profit companies are giving way to arrangements that are for administrative services only (ASO) or that are otherwise limited.
- There is increasing reliance on traditional safety-net providers.
- States are becoming their own managed care entities, shifting their systems to performance-based contracts but providing their own management.
- Statewide system reforms are giving way—especially in larger states—to county-based systems or to systems organized through existing community mental health boards.

Many states have had considerable success in adopting managed care approaches in their public mental health systems. A significant number now have several years' experience, including more than one round of contracts. Whether typical or not, these state experiences are instructive for policymakers in other states.

Among the positive effects of managed care reported by many states are:

- increased access;
- decreased use of inappropriate inpatient care;
- an expanded array of services;
- more flexibility in service delivery, more consistency in clinical decision making, and more focused, goal-directed treatment; and
- an increased emphasis on accountability and outcomes.

On the negative side, states have found that various problems may arise as a result of using managed care:

- There is an incentive in a risk-based contract to undertreat—particularly to underserve—people with serious disorders.
- Managed care may focus too much on acute care and neglect rehabilitation and other services that could have significant long-term payoffs in improved functioning.
- Medicaid managed care contracts may have difficulties in serving the non-Medicaid population, who then have no means of access to public-sector mental health services.
- Billing and payment difficulties are frequent during start-up.
- Because quality and outcomes can be hard to measure, it is difficult to ensure consistency across regions.

States have also discovered limits to the extent of reform that can be accomplished by changing organizational structures and financing. Altering provider practice, for example, to ensure high-quality care and the use of state-of-the-art approaches is extremely difficult. It is important not to overestimate the ability of managed care to address such problems.

Managed care, then, represents only the latest tool that states can use to manage their systems, though it can improve focus on consumer outcomes and improvements in the quality of care, along with better accountability. The managed care principle of purchasing outcomes has particular appeal. This report is therefore organized to specifically illustrate the outcome-driven nature of managed care reforms: the setting of system goals, the integration of public mental health with other systems of support, and the incorporation of mechanisms for evaluating and ensuring accountability.

Motivations

The use of managed care in Medicaid for physical health care has led to a more organized system of care, resulting both in improved access and continuity of care and in control of the costs for low-income women and children in the program. The broad public-policy objectives for using managed care techniques in mental health are the same: to ensure a cost-effective delivery system and workable financing mechanisms while also improving access. Additionally, many states are interested in stimulating innovation and improving effectiveness.

Different stakeholders have different concerns about the adoption of managed care. An overriding concern for many consumers, advocates, and providers is the quality of care. Providing high-quality care is not necessarily at odds with the ambitions of prudent fiscal managers, since in the absence of quality services a system can be neither effective nor cost efficient. Quite simply, quality services are the vehicle through which a system purchases its intended outcomes. Recovery, now a potential outcome that consumer groups endorse strongly for even the most severely impaired, is a long-term process that can alleviate disabilities and reduce public expenditures. As a number of states have demonstrated, managed care can meet consumer and family expectations in part because of the improved access to a wider range of effective services.

In the present climate of public scrutiny, managed care is often criticized for inappropriately rationing care. Yet cost management is a legitimate and ethically necessary target for health care policy—a fact often overlooked in heated debates about the use of managed care in public mental health systems. State officials point out that both public policymakers and prudent private purchasers must be concerned about costs. No matter how state and local public mental health systems are organized—whether as managed care, fee-for-

service, grant-in-aid, or some combination—they are chronically short of resources and have always had to limit care, albeit not always explicitly.

Cost concerns arise in different contexts, such as the cost of the Medicaid program, the rate of cost increases in Medicaid, the cost of uncompensated care, and the predictability of future costs—this last possibly as important as the extent of any actual savings.

Discussion of how to control costs immediately leads state officials to consider two other critical aspects of the system: access and efficiency. An inefficient system will be needlessly costly for the outcomes it produces. And if expenses are controlled merely by limiting access, the population in need may then be cost-shifted to other parts of state government.

To improve efficiency will require addressing the current fragmentation of service, which can be remedied by better integrating programs for acute-care treatment and longer-term rehabilitation. Efficiency can also be improved through greater collaboration between mental health, health care, substance-abuse, and various other support and social service systems. Integration of local and state systems, as well as of funding streams, can also improve efficiency.

States have been motivated to shift to managed care partly in order to exert more control over both the providers of care and the new vendors or managers of care. Once there is a contract, officials report, a state has a strong mechanism to require accountability, demand or improve performance, and distribute agreed-upon sanctions and rewards when problems arise. This was more difficult in traditional mental health bureaucracies, which had to negotiate between various grant-in-aid agencies and fee-for-service (both private nonprofit and civil service) providers. With managed care, the state can require data and performance reports not generated previously. In contrast to grant programs, which some state officials said led local providers to act as if they were entitled to continued state funding (almost a franchise), managed mental health care emphasizes a *consumer's* entitlement to covered services and meaningful outcomes. Consumers have much stronger voices when they have the ability to seek alternative providers.

While there can be several motivations for shifting to managed care, if a mental health system is to be successful, the state leadership needs to know what outcomes it wants to achieve and must have the structures in place to purchase them. In such cases, state officials report, managed care is a very good tool to:

- provide financial discipline,
- demand accountability,
- force service integration, and
- generate innovation.

Thus, as the public demands responsiveness and returns on its tax dollars, managed care holds the promise of improving service delivery and demonstrating whether chosen outcomes have been delivered.

Goals

Although short-term goals should not be ignored, a shift to managed care provides an opportunity to address some long-term problems in and long-range ambitions for the mental health system. State mental health officials who have made the shift recommend that other states consider the following goals:

- creating a seamless, integrated health/mental health system;
- saving resources and getting a handle on costs;
- improving access and creating a single health care home;
- emphasizing recovery, rehabilitation, and work rather than only abatement of mental health symptoms;
- creating (or reorganizing) and supporting a well-developed community service system and reducing reliance on inpatient care;
- reinvesting savings from reduction in use of inappropriate services back into development of new services;

- ensuring high-quality care that produces good outcomes for consumers;
- addressing the special needs of rural/frontier areas;
- focusing particularly on children's unique needs;
- addressing the needs of ethnic and racially diverse populations of consumers; and
- ensuring a true state/community partnership.

In addition to the achievement of specific goals, states report some unanticipated advantages of shifting to managed care. For example, provider networks are often broader under managed care and, in important ways, function very differently than they do under traditional models. In one state, there has been a significant expansion of culturally diverse providers (from 200 to 1,100), a boon to consumers. (Some states require linguistically appropriate services and participation by specific types of providers, such as Native American healers.) In addition, because capitation arrangements encourage plans to utilize less costly professionals and paraprofessionals whenever appropriate, states have found that provider networks shift toward more efficient use of highly credentialed providers, such as physicians and psychologists with doctorates. At the same time, managed care may also address the opposite concern, that some public programs rely too heavily on nonprofessional staff, who can fail to identify clinical issues.

Managed care can also increase competition, bringing in private providers who may not previously have taken Medicaid clients. Another unexpected consequence for some states has been that, since new provider networks serve both public and private clients, the lines that had defined the traditional two-tiered public/private mental health system became blurred. Managed care thus expanded consumers' choice of providers and services and moved states to mainstream services for people with serious mental illnesses.

States have found that one of the most significant advantages of shifting to a managed care approach is greater flexibility in service delivery. However, the state officials who felt most successful in achieving this outcome set important parameters first. They began by ensuring that their Medicaid programs were comprehensive, adding new service options where necessary[8]. To ensure the delivery of new but effective approaches, validated models of care were encouraged by these states. In this regard, one goal should be to minimize the time between the discovery of an intervention or system that works and its implementation in the field. This is especially important when such models have good long-term effects, though improved outcomes may not be apparent during the fairly short life of a managed care contract. While managed care is a strategy that emphasizes the importance of outcomes and leaves decisions on how to achieve those outcomes to the contractor, some constraints on that flexibility have proved necessary to ensure the adoption of state-of-the-art approaches. In particular, accountability and measurement have proven hardest to change in outpatient, private office practices.

Making the Shift

Managed care represents a significant shift in thinking for state administrators, providers, consumer and family organizations, and other stakeholders. It calls for major changes in both service delivery and financing and requires balancing competing objectives. In most states making this shift, stakeholder opposition has focused particularly on the use of for-profit private plans to manage the public mental health system. Also common is provider opposition to changes in the status quo. To allay such concerns, most states recommend extensive planning before introducing managed care into the public system. A review of the current system's strengths and weaknesses followed by engagement of stakeholders, particularly consumers and families, can ease the process considerably. Some states have thus been able to build broad stakeholder support and maintain it.

Officials in states that have changed to a managed care system therefore feel strongly that the goals of reform must be subject to wide and thorough debate. Managed care forces a top-to-bottom review of the complexities of public mental health care policy and can introduce a strong consumer voice to system design. Greater consumer participation in service-system planning, officials believe, contributed to the dramatic reductions in consumer complaints some have experienced following their adoption of managed care.

To begin such planning, state officials suggest an in-depth review of the current system by various

stakeholders: legislators, relevant agencies (Medicaid, community mental health, substance-abuse, health, child welfare, education, criminal and juvenile justice, and social service agencies), providers, consumers and their families, professional associations, and advocacy groups. The involvement of these various interests can lead to greater consensus about a state's goals.

Managed care focuses the debate on the important concerns of cost, efficiency, and quality. It confronts the ossification of public systems, which have often become removed from review. As a result, for example, managed care may help introduce new and effective service approaches that will encourage recovery, facilitate innovation, and bring positive change to a system. Several states report that managed care has moved their systems from an illness model to a philosophy of rehabilitation and recovery involving a wide array of providers. This outcome is endorsed strongly by many consumer groups.

During this debate, state officials must deal with arguments by providers and other consumer-advocacy groups for retaining the status quo. This view often stems from the current backlash to managed care with respect to private insurance. In private insurance, the growth of for-profit managed care emphasizing efficiency and a price-sensitive consumer has generated a strong negative reaction and calls for more government protections. The public mental health system, however, already has strong consumer protections. Medicaid requires the availability of appeals to the state and to an independent entity, and consumer rights and responsibilities are generally spelled out in state mental health law. Issues in the public sector relate more to concerns over resources. Here, too, private-sector managed care, which has contributed to a significant recent reduction in the percentage of the health care dollar spent on mental health services, exacerbates the backlash against managed mental health care in the public sector.

Many traditional public-sector providers are also concerned about losing power. Managed care, one official reported, changes the central question from "How many slots are there?" to "What are the outcomes?" Many providers view this as threatening, in part because they don't have the necessary data-reporting systems and are not experienced in managing from data. They have concerns that a new entity will make precipitous decisions about how to streamline the system and eliminate seemingly unnecessary care. State officials report that providers associated with public mental health, heretofore relatively shielded from such scrutiny, regard such monitoring as a threat. However, providers may also gain under managed care. In some states, rates for ambulatory care increased even as costs came under control.

Based on experience, public officials who propose introducing a managed care system can anticipate the most heated debate to occur over the question of who should run the system: a private, for-profit contractor, a county, a local provider consortium, or another traditional mental health system entity. To determine whether or not to use private, for-profit managed behavioral health care entities (national or local), it is necessary to assess their strengths and deficiencies. Generally speaking, private companies have little experience with public-sector contracts. Their experience in the private mental health sector has given them expertise in hospital- and office-based care for populations with acute mental health care needs. However, agencies in the public mental health sector lead those in the private sector in care management for individuals with serious and disabling mental illnesses, in advances in community-based alternatives, in encouraging recovery, and in defining consumer rights and responsibilities. The public sector must also deal with involuntary treatment, court-ordered services, and the involvement of various public agencies in important decisions about an individual's care.

To make the shift, private plans need appropriate utilization standards and protocols for the nontraditional services. They must also have trained staff who know how to coordinate care across complex networks, not just how to manage a single clinical event. Since public-sector agencies have more experience with this disease-management approach in mental health care, they and private plans that come into this field should share their different expertises. Private plans should also allow time for meaningful standards of care to evolve.

The debate over the use of private for-profit companies has been compounded by rhetoric that has exaggerated the potential of managed care to solve problems. To enter this market, many plans oversold their abilities. They appeared to claim that problems with which public mental health authorities had struggled for years could be resolved in months through the use of good data systems and by "managing for outcomes." While some early experiments with private managed care companies went relatively smoothly, dramatic improvements did not occur. A few such contracts have led to very bad results, and more than one jurisdiction has ended its contract with a private corporation.

Many stakeholders are also concerned about the role of profit in a private system. They argue that public systems have historically been underfunded and now require investment in a range of effective community

services. Demands for high levels of profit will weaken such systems even further. Even though significant resources may be conserved by controlling inappropriate use of hospital and institutional care, some public officials recommend that states maintain current spending levels in order to permit reinvestment and expansion of community-based services. This approach will flatten escalating spending trends, though it will not reduce direct spending.

Where the use of private companies has been successful, the companies have overcome their inexperience in the public-sector (sometimes by putting former public-sector officials in charge) and have invested effort and resources in appropriate technologies for billing, payment, and data collection. Some states have also found success by limiting the role of the company to administrative services or by adopting other hybrid arrangements, instead of choosing either an entirely privatized system or an entirely public-sector one.

Several states' recent rejections of privatization may well reflect consolidation within the private sector, which has left only a handful of companies in the business of public-sector managed behavioral health care. These states may also be responding to pressure from traditional nonprofit providers of care that organized into consortia in order to compete with for-profit companies.

Smooth Transition

The adoption by a state of a managed care approach is a dramatic shift in organization and financing. Implementation problems are inevitable, even with very careful planning, and should be expected and dealt with promptly. As the contract progresses, increased sophistication can be introduced, and problems can be addressed in a planned and careful manner. For these reasons, contracts work better when they are not too short—three to five years seems to be a good time frame. Problems can then be addressed as opportunities to improve or as positive challenges. Many states have forged ongoing, collaborative, problem-solving partnerships with managed care providers and various stakeholder groups; they believe this has greatly improved operations of their systems.

Several factors have been found especially important to the success of a shift to managed care. Finding the appropriate capitation rate and level of expenditure is a challenge, so information-system issues need to be addressed in a meaningful way early in the process, and new administrative skills may be needed within a given agency. It is necessary to determine which populations to cover and which ways the managed mental health care system will interact with other involved public agencies. Relationships with local governments must be determined, and certain special problems, such as how to meet needs in rural and frontier areas, must be addressed. All of these are complex issues, and state officials urge strongly that they be addressed through a comprehensive, careful planning process and that states take the time to resolve them.

Resource Issues

Problems will arise if there is not an appropriate balance between contractual expectations, the needs of the enrolled populations, and the capitation rates paid to the managed care provider. Failure to ensure this correlation has been a major factor in the problems that have faced some managed care programs. States that have tried to reduce their actual, historical spending levels while at the same time adding new populations and services to their systems have had very negative experiences with managed mental health care. In areas where managed care has been used with success, the capitation rate has been based on the population covered, the benefits stipulated, and other contractual requirements. Resources have often been sufficient to permit reinvestment, and ongoing collaborative relationships have been built with the companies to allow careful and gradual improvements over time.

State officials caution about setting rates and designing budgets in the absence of reliable data. Before overall resource levels can be finalized, cost estimates must be developed for different groups so that some form of risk adjustment can be made. These groups include people with serious and persistent mental illness (Medicaid and non-Medicaid), families receiving Temporary Aid to Needy Families (TANF), low-income children, and wards of the child welfare system[9]. As discussed below, the information necessary to understand the financing for all these populations may not be available. This can lead to a significantly under-resourced system. Once implemented, however, managed care can begin to generate the necessary data and, ultimately, improve understanding of the system, leading to more accurate capitation rates.

Data Systems

Moving a large public mental health system to a managed care approach is often a technical nightmare. To

be prudent managers of limited resources, states must know where their dollars are going, who is being served, and how well. Yet data and billing systems in the public sector are, as a rule, poorly integrated and woefully out of date. They were never designed to deliver the kind of data necessary for managed care. For example, in a system that manages both services and costs, it is basic and fundamental to be able to assess the true size of all populations to be covered. Yet many state officials report that an accurate count of users of the public mental health system cannot be made using their existing data systems. Further, although states have been concerned with such measures as recidivism rates, they have not traditionally compiled data on costs and clinical outcomes for the populations they serve.

Without underwriting data, it is virtually impossible to change to a capitated model. While a few states have strong data systems, others have reasonable data only for their Medicaid populations, not for the uninsured or other users of the public mental health system, and even that is not necessarily comprehensive, complete, or current. To take advantage of new technology, a state's data systems must be improved, and when entering into managed care contracts states must include resources for implementing sophisticated information systems. This requires new funds, up front, and it is not cheap.

Part of the problem is the fragmentation that has long prevailed among functions of state and local government, whereby registration processes, consumer identifiers, and service/benefit codings may vary widely among state mental health authorities, county-based community mental health systems, private providers, Medicaid programs, and other pieces of the overall system. State officials emphasize that consolidation or coordination of these data sources is no small task, given that the various information systems were not designed to be compatible.

Provider data systems, too, need to upgrade their capacities in such circumstances. They must be able to supply up-to-date information about the delivery and costs of specific services. Many community providers need a great deal of assistance in adopting the technology necessary for appropriate reporting. Such problems have seriously impaired early progress for many managed care systems, contributing to delays in provider payments and other problems.

Finally, the managed care provider itself must have a good data system so that it can provide performance and outcome analyses. While private managed care contractors have more refined data systems, their levels of efficiency are not nearly as high as some states had expected.

In retrospect, many states report that they failed to recognize early in their planning just how inadequate these systems were. All states have experienced a certain amount of difficulty with start-up data and billing systems; a few have had catastrophic, widely publicized meltdowns.

State Administration

As the state becomes a purchaser of service outcomes rather than a payer, the need for new skills in state administration, different from those needed to regulate fee-for-service or grant-in-aid programs, becomes a significant concern. Some states, finding their staff inexperienced in managing a contract of this magnitude, have responded by adding specialized technical and legal expertise to their mental health staffing. Retraining can overcome job-security concerns among the staff and ensure adequately trained manpower.

Population Covered

Each state makes its own decision about which populations to cover in a Medicaid managed care arrangement. There is great variation from one state to another. Populations to consider covering include adults with disabilities resulting from serious mental illnesses, children with serious emotional disturbance, low-income children, low-income adults, children in child welfare custody, other Medicaid-eligible groups, and the uninsured.

The allocation of resources among the various target populations has sometimes proved challenging. Furnishing a comprehensive system of care for people with serious disorders is expensive. In a climate oriented toward purchasing outcomes, some legislators have asked why significant sums are expended on a population that, because of the severity and duration of its members' disability, is not likely to show immediate, dramatic improvement, while those with less severe disorders that can be treated less expensively are sometimes denied any services at all. However, public systems are responsible for those who have no other options, and states must ensure that people with serious disorders are not affected adversely by the concerns, however appropriate, over cost control.

Some states have chosen to cover only the Medicaid population under managed care, but this has also raised concern, since it leaves unanswered the question of how to ensure services to people who have similar levels of need but are not Medicaid eligible. Failure to ensure access to services for those who are uninsured results only in higher costs due to higher need when such people ultimately access the public mental health system.

Another serious coverage issue arises from the fact that many individuals are on Medicaid for only a short time and thus move frequently into and out of the program. The opportunity and motivation for early intervention often hinges on consistency of enrollment in the managed care plan. State policies that allow individuals to remain on Medicaid for 12 continuous months even if they cease to be financially eligible improve the likelihood that managed care arrangements will focus on prevention and early intervention.

Another challenge, not anticipated by most states, arises after access is improved and care is then sought by people who were not in the targeted population under fee-for-service Medicaid but who nonetheless need some level of mental health services. It is therefore important both to define the covered population clearly and to decide what response to have when previously ineligible individuals seek services from the public system. Some states have been under pressure to expand their systems to include various groups, such as those in need of early intervention and prevention services; children who are moving from children's services to the adult service system who have significant mental health needs but no serious mental illness; sex offenders; and juvenile offenders with mental health needs. During the process of planning a transition to managed care, states need to clarify the definition of the eligible population, and they must ensure that the resources available match the needs of the population to be served.

Structure

Reorganizing the mental health system has led to broader thinking on mental health policy in many states. Legislators and executive-branch policymakers raise questions that have never been adequately resolved, such as whether it is best to make the mental health system primarily a part of the health system or of the disability/social service system. Public mental health systems tend to straddle the line between the two systems. Most of them include some obvious health care components (hospitals, therapeutic mental health services, pharmacy services), along with components that have been associated with social welfare (housing, financial subsidies, vocational services). Some states have attempted to resolve this dilemma by consolidating mental health, social service, and public health agencies. Often, however, these decisions are pragmatic, rather than conceptual, and fragmentation still occurs in these states.

In their Medicaid managed care reforms, states have adopted varying approaches. Greater integration with the health system has been emphasized in some, and greater integration with social service systems in others. Generally speaking, integration with health systems facilitates care for those with less serious disorders, while closer alignment with various other social and rehabilitative services best serves people with more serious disorders. The latter approach has been achieved by opting for a carve-out model for individuals with the most serious disorders. In order to meet the needs of such significantly impaired populations, these contracts include a broader array of services, more home- and community-based services, and greater flexibility than do the integrated designs[10]. For other low-income individuals on Medicaid, integrated plans are favored, allowing greater alignment of mental health and health services.

Other Challenges

Once a managed care system is in operation, new challenges arise, and unexpected consequences occur. Legislators commonly ask whether the system provides value for the resources expended. New arrangements give rise to great expectations, which the managed care arrangement might not be able to meet. During the early years of a managed care contract, states have found that cost containment may be fairly simple to achieve, but costs may rise in later years, leading to discussions about narrowing the target population or cutting back on services.

When a state shifts into managed care, local officials are likely to react, sometimes in unexpected ways. For example, once managed care revenue enters the system, some counties have assumed that they can withdraw local resources. This leaves the system underfunded and has led, in some states, to provider closures and other significant cuts in services. Requiring maintenance of effort in the allocation of public funds can keep this from happening.

Local problems have also arisen when Medicaid revenue under fee-for-service had varied greatly around the

state. A statewide plan pays uniform rates, but some large counties and urban centers may receive lower rates under managed care than they received under fee-for-service. They may also lose revenue if they have had a history of billing more than the rural counties. This readjustment in resources has forced providers to close in parts of some states.

All states have significant issues concerning rural populations, and frontier regions pose particular challenges. Even states in which the population is principally urban or suburban have to address their rural infrastructure. Rural areas may have no psychiatrists and no crisis teams with 24-hour response; rather, the frontline workers are usually primary-care physicians, nurses, and police officers. State planners have found it necessary to allow more flexibility for plans operating in rural and frontier areas, to ensure that residents have access to services.

Another unexpected consequence in at least one state has been the sudden loss at university medical centers of the income they had received under a prior fee-for-service system. In response some states have created ways to subsidize them. Similarly, the costs of clinical trials and experimental procedures are not reimbursed under managed care[11].

Some states have found it possible to create what are effectively block grants to counties. Unlike a traditional block grant, however, which provides a finite level of funding, a managed care program's funding base grows with increased enrollment. The results of pilot efforts also suggest that giving this high degree of latitude to local decision makers works well but requires the state to invest in information systems to assure accountability.

The War at the Borders

A serious problem in public mental health lies in the fragmentation of multiple funding streams and service-delivery systems, combined with differences in eligibility criteria between programs. While managed care can rectify certain inefficiencies in a system and thereby save costs, in some states it has compounded the problem of cost-shifting. This is because capitated systems provide an incentive to do less and to avoid paying costs that can be met through some other system. If various agencies and managed care contractors battle to avoid costs, the state is left with the inefficiencies this creates. Since every agency and contractor is spending the public's money, savings from cost-shifting are not real, and the increased expense of a fragmented, inefficient system is significant.

Cost-shifting has occurred in both directions. On the one hand, a managed care plan may deny services that it considers the responsibility of another public agency. On the other, a strong managed mental health care system can encourage other agencies to assume, unrealistically, that the consumer's every need can be met through the capitated mental health system. Either situation can leave consumers without access.

When writing a contract for a capitated system that details specific service responsibilities for a specified population, it is necessary to address the fuzzy boundaries found traditionally in mental health care. A capitated model can work no other way. Unless boundaries between systems are defined clearly, states will find that they have created gaps or allowed the duplication or waste of resources. They also fail to create continuity of effective care for consumers.

Defining precisely who pays for a specific service is therefore an overriding concern. States that have dealt with these problems report that the expertise of mental health authorities (state or local) is valuable, particularly when trying to integrate various payers and providers in an effective program. Solutions differ significantly from state to state, but the mandate for clarity about roles and responsibilities has enabled some states to create collaborative policies.

However, some states have found even less integration and more cost-shifting under managed care. For example, in some states managed care has exacerbated the problem of families' giving up custody to child welfare agencies in order to secure services for children with serious emotional disturbance. In more than one state, plans have denied care to many families on the grounds that the parents could receive services for their emotionally disturbed children by giving up custody to child welfare agencies. This is an example of

a revenue-driven reaction by a capitated entity, rather than a more efficient (for the state) provision of good patient care.

Perhaps because of the complexity of integration policy, the issue is not often considered early in the development of a managed care approach. Integration decisions will drive the way the system behaves, so many policymakers have focused first on the direction they wanted for their system and then used that decision as a basis for how to integrate various services, agencies, and financing streams. Usually, states have adopted an incremental approach, putting the pieces of their managed care system together first and dealing with integration issues more gradually, after fiscal discipline has been achieved and better measurement tools are available.

There is also no consensus on how far integration can go, on which systems should be integrated, or on how this can best be done. Different constituencies may have different values and concerns regarding efficiency. States have tried various approaches. Some have focused on the integration of mental health and social services as a first critical step, while others have tried to align health and the mental health systems more closely. Some have seen integration as needing to occur at the local level and have facilitated it through state policies.

Dimensions of integration considered by states have included:

- integration of populations (SSI, TANF, Medicaid, and non-Medicaid);
- services integration—acute care with rehabilitative care, health with mental health;
- agency integration and collaboration;
- integration of financing streams; and
- state-local integration.

Integrating Populations

A critical first step in dealing with the integration puzzle is to define the population to be covered. States have flexibility on this point, and existing arrangements vary considerably. But choices about which populations to cover then lead to a further set of choices about how best to integrate the services these populations need and about which financing streams will underwrite those services. States vary in whether they integrate care-delivery systems for the TANF population, the members of which generally have acute but less serious illnesses, with care for those disabled by serious mental disorders, some of whom are recipients of SSI. Some states also include children in the child welfare system, many of whom have significant need of mental health services.

Services Integration

Mental health services are often thought of as the medical and clinical services provided by physicians and other licensed health professionals, particularly psychologists, psychiatric social workers, and psychiatric nurses. But they are also rehabilitative, focused on promoting higher levels of functioning for individuals who have long-lasting, serious disorders and on retaining current functioning and preventing regression or relapse. In this respect, the mental health system has been dealing for years with "disease management" for meeting the needs of individuals whose disorders are chronic and long-term. Additional support services beyond those covered by Medicaid are also needed, in order to compensate for the deficits that result from an individual's illness and the consequent disability. These services include housing, income support (severe mental illness impoverishes), job training and supported employment, and education, particularly for children.

Coordinating and facilitating integration of all these services has never been easy, but states have found that providing mental health services in isolation is not efficient; under Medicaid fee-for-service programs, states have traditionally integrated mental health clinical care and rehabilitation services. The degree of integration differs from state to state, but a review of responsibilities for the affected groups is an important early step in planning for managed care. For example, contracts must stipulate which services a contractor is responsible for, and states have learned that the effectiveness of those services is compromised if the state fails to make explicit how services not included in the contract will be delivered. Making the contractor responsible for the Medicaid service of targeted case management can facilitate connections between non-Medicaid services, such as housing and employment, and the contractor's treatment and rehabilitation services.

One of the more problematic areas for collaboration, and perhaps the most important, is the integration

between physical health care and mental health services. Although the broad public-policy goals of health and mental health care are similar, mental health services have traditionally been viewed more skeptically, financed separately from and organized differently than other health care. As a result, people with serious mental disorders have relied on the poorly funded public system, which does not coordinate with other systems providing needed services and supports. Indeed, many individuals with serious mental illnesses have significant health problems that are often untreated in the current fragmented system.

Increasing the coordination between the physical health care and mental health systems has long been a concern, even under fee-for-service programs, and lessening the distinction between physical health and mental health care is a goal in a number of the states engaged in managed care reform. Within health care systems, there is also increased appreciation of the cost of paying too little attention to the role of mental health in health care, where it can affect recovery, cause offsetting problems and costs, or be a precursor of later problems. While the movement to integrate health and mental health care is progressing slowly in both public and private sectors, state policymakers often grapple with how to stimulate greater connection between primary health care providers and the managed care of mental health treatment.

Integration of physical and mental health services may be easier now that advances in knowledge about the brain and behavior have led to much better understanding of the etiology of mental illnesses and to more specific and more effective treatments. And because public mental health services are now funded predominantly through Medicaid (except for long-term institutional care for a shrinking population of forensic and civil admissions), the mental health system now uses the same financing approach as other health care programs intended for low-income individuals. The commonalities between health and mental health are therefore much greater than they have been.

Notwithstanding this goal of integration, however, at this time the organization of managed mental health care under carve-out plans appears essential in order to meet the needs of individuals with serious mental illnesses. State officials are concerned that well-designed, integrated plans for this group have not been demonstrated successfully. Another reason for using the carve-out model arises from concern over the small percentage of resources typically allocated to mental health care under integrated managed health care plans[12].

State and county carve-outs that are based on the severity of consumers' illnesses and on their level of functioning have been quite successful, but only when patients are able to move as necessary between the carve-out and the integrated system, based on their clinical status or the degree to which mental illness is the predominant issue in their lives. To accomplish this, there must be a clear set of protocols to clarify responsibilities across both the carve-out plan and the health plan. Other carve-outs cover all mental health services, both acute and extended care, but in any case the carved-out services and other health care must be coordinated.

Agency Integration

As they have shifted to managed care, some states have attempted to integrate the mental health services funded through other state agencies with those of the mental health authority. One state reported finding, prior to the implementation of managed care, as many as eight caseworkers for a single individual and clients who had three or four different treatment plans.

Services that fall under the authority of the following agencies will likely be needed for some clients of the managed care plan: substance abuse (if different from services provided through the mental health authority), child welfare, social services, vocational rehabilitation, housing, education (including special education and adult education), juvenile justice, and criminal justice. Clarity of responsibilities among these agencies and information sharing must be spelled out. Many states require formal coordination (through memoranda of understanding) between the managed care entity and critical state agencies.

Some of the most significant problems have involved care of children. Various systems—such as schools, child welfare, and juvenile justice, in addition to mental health—are responsible for meeting children's needs. School-based services often are not reimbursed by managed care entities, potentially leading to uncoordinated care, duplication of services, or gaps in service. Responsibility for court-ordered treatment often is not clarified in contracts, and this creates tensions between the managed care entity and the child welfare and juvenile justice systems.

Collaboration across service agencies is an ongoing issue, but the shift to managed care offers states an

opportunity to address it directly. Some states' actions include:

- mandating joint treatment planning, in which the consumer, all relevant agencies, and the managed care plan decide who pays for what and when. The contractor can be penalized for failure to provide joint treatment planning;
- clarifying whether the managed care entity or an existing state agency is responsible for specific services, such as court-ordered treatment or school-based services;
- ensuring that intersystem confidentiality issues are dealt with at the state level;
- developing compatible technology systems to ensure efficiency across systems.

Integrating Funding Streams

Public mental health policy has promoted the integration of funding streams in order to create comprehensive systems of care for both adults and children with serious disorders. This approach takes service/agency integration to a higher level by merging funds from two or more funding streams. Which agencies' resources are best blended will vary, depending on which populations are to be included in managed care. While difficult to implement, such arrangements, which create greater flexibility for care providers, can cut through red tape, eliminate overlap and duplication, and fill gaps in the service system.

If a state fails to include non-Medicaid resources that were previously available to serve the covered population, the managed care provider may well compensate for the resulting insufficiency of resources by tightening its decisions regarding medical necessity. Maintenance of effort by all involved agencies becomes a crucial factor in ensuring that resources remain available to consumers under managed care.

The resources that some states have blended into a managed care plan include Medicaid, federal mental health block grant and substance abuse funds, state mental health appropriations, federal and state child welfare funds, education and special education resources, and juvenile justice prevention funds.

State-Local Integration

Pooling of resources also requires consideration of which levels of government will contribute resources and of what their corresponding roles in management will be. States vary in the degree to which state or local governments bear responsibility for mental health services, and this can significantly affect the design of a managed care plan. In 22 states, mental health services are controlled at the county level, and in several of those the counties (or groups of counties) have been given the authority to contract for managed mental health care. Had only state resources been included, it would have been extraordinarily difficult to coordinate care for clients between the managed care entity and the counties.

Some states have decategorized the money that flows from the state level, and some have provided incentives and resources to local governments that try new approaches. Greater local authority to manage public systems has, in some instances, also improved accountability within the public sector.

Integration in Rural and Frontier Areas

The stigma surrounding mental illness complicates service delivery in rural areas, where typically everyone knows everyone else. In-home services, for example, cannot be furnished anonymously because neighbors will notice. The same is true when a client visits the local community mental health program. Integration of mental health into the health care delivery system holds significant potential to overcome access problems that result from this stigma; it can also lead to early identification and treatment.

Rural and frontier-area issues have been addressed in some states by requiring the managed care entity to contract with primary care physicians for the provision of mental health services. Otherwise, a rural area might have no one to provide mental health services, as has occurred in some states. The use of technology—video conferencing or Internet communication, for example—can also significantly improve access in rural and frontier areas. MCO quality standards must also take account of rural realities: a scarcity of providers, distance from treatment, and other factors will affect response times, quality, cost, and outcomes.

Authorizing Services

The contractual definition of what is "medically necessary" will fundamentally affect all attempts by the state

to integrate its services and systems. Private-sector plans often have more limited definitions of medical necessity than does Medicaid[13]. These plans' definitions were developed to meet the needs of individuals with acute mental illnesses while avoiding demands by consumers or their providers for unnecessary services or unnecessarily lengthy care. As such, they are not well suited to a public-sector population with severe illnesses, many of whom may be reluctant to seek care or remain in treatment. Individuals whose needs are complex and whose illnesses have a significant impact on all aspects of their lives are better served in a health plan that more fully addresses long-term treatment and rehabilitation needs.

States have had major problems with health plans that apply a narrow definition of medical necessity to a public-sector contract. Under such definitions, public clients have been found to need more support services, children have had safety issues that were not addressed, and many people have been discharged with no place to go. While this situation may change as the plans develop approaches to disease management, there is still a considerable knowledge gap between public and private delivery systems about how serious mental illness is managed.

To avoid denial of payment for services that are generally reimbursed under Medicaid fee-for-service and commonly provided by public mental health systems, some states have adopted different terminology in their contracts, such as "social necessity" or "psychosocial necessity." Other states have continued to use the term "medical necessity" but have created a definition more in line with Medicaid policy and the population that the Medicaid managed care plan is to serve. Another technique to deal with narrow definitions of medical necessity is to require plans to have a "keep-people-safe policy." In one state, seriously disabled individuals cannot be denied care; they must be served at some level, in some setting, somewhere.

Many states require plans to delay application of their medical-necessity standard so as to encourage early intervention. Easy initial access—up to five contacts, for example—is permitted[14]. Inappropriate utilization can then be controlled, using the medical-necessity definition and managed care techniques (utilization review) for individuals who seek additional levels of service. In this way, people who do not need more services will not use them, but those who will benefit from early identification and treatment can self-select and receive some level of care.

Ensuring Accountability

Having shifted their systems to managed care, policymakers will quickly be challenged to prove that goals are being achieved, costs are under control, consumers have real access and choice of quality services, and the performance-based contract is providing the best practice and leading to good outcomes. Legislators, governors, and the public expect an adequate level of quality at a reasonable cost. In addressing this issue, policymakers must decide the appropriate role for government oversight and regulation, balancing opposition to government regulation against public-accountability needs.

Managed care, with improved performance and outcome measures, provides one means by which to demonstrate accountability. The more comprehensive information systems used by managed care providers enable states to require reporting of key data and to demand outcomes, thereby holding plans accountable for what they do. This can provide greater understanding of what is actually occurring in the system and can enable a state to know whether its goals are being reached. At the same time, managed care gives plans great flexibility about how to achieve those outcomes, thus still permitting innovation.

Policymakers find that the challenges of accountability depend on whether the state has contracted with a for-profit company or used the existing network of nonprofit providers. Generally speaking, commercial companies need to be monitored to ensure that the population with serious disorders is being served adequately, while the nonprofit networks need to demonstrate that they have the necessary data and financial-management systems to be able to manage for outcomes.

To demonstrate reasonable expenditure for positive outcomes, state managed care systems must show:

- that expenditures are within budget, something that was rarely true before;
- positive trends: the full impact of change takes time, but comparisons with historic trends (when the state has baseline data) should enable assessments of costs per client/per service between the new system and the old and (where appropriate) between the new system and the private sector;
- savings for other systems;
- significantly reduced use of intensive hospital/residential services;
- timely consumer access to needed services;
- improved capacity for home- and community-based services; and
- improved consumer outcomes.

A wealth of data can be produced, but the value of that data depends greatly upon whether the most appropriate reporting requirements have been selected and whether the purchaser (or some other independent contract agent) has the capacity to analyze and interpret it. State mental health systems have been criticized in the past for collecting data passively, without clear purposes and without the ability to retrieve it in useful ways.

In addition to reporting by the plans themselves, some states have found it helpful to have independent evaluations of their managed care systems. Program audits, fiscal audits, assessments of grievance and appeals data, and analyses of performance and outcome data can all assist in ensuring real accountability. State officials believe the plans, in addition to having a strong vested interest, are not as capable of doing this themselves.

However, the highly sophisticated indicators offered by new data systems may not provide all of the hoped-for insight about what is happening in a system. The field's ability to measure and understand outcomes is in its infancy. As a result, several states use performance measures to assess processes, as a proxy for measuring client outcomes. For example, the performance measure of how soon outpatient services are provided after an inpatient stay is used as a proxy for improved community tenure. But states need to be clear about their longer-term plans for data systems and indicators that can lead to effective assessment of outcomes. A blueprint for data management should ensure that proxy measures will not become institutionalized.

Some of the early indicators will be very ad hoc and quite crude; it may not be possible initially to add everything up and net everything out. States report that system savings (or reinvestments) may not show up immediately; indeed, some expenditures, such as for medications, have increased dramatically when states have shifted to managed care.

An important part of accountability involves sharing information with the consumer and the public, which hold systems accountable. Making data public can influence the system in very direct ways. In one state, a hospital closed after people no longer used it because of its poor performance data. Stakeholders have often been invited to participate in the selection of performance indicators to ensure that their questions are addressed by the data.

Areas to Measure

To ensure accountability for their managed care contract, states consider several factors:

- Is the contractor following the specifications in the contract and, if not, what can be done about it? (This will depend on the contract language, but options include negotiation, application of intermediate sanctions, or cancellation of the entire contract.)
- How well is the plan performing? The degree to which the plan is providing the level of appropriate services (such as time to first appointment, timely follow-up services after discharge, etc.) should be reported.
- What are the outcomes of the services delivered? How effective, overall, is the managed care plan? It is important to measure specific outcomes for clients (e.g., improved functioning or quality of life; increases in employment rates) and for the achievement of policy objectives (e.g., reduced cost-shifting to other systems by avoidance of criminal justice contacts).

Each of these factors is discussed below.

Meeting Contract Requirements

These measures will vary, depending on the contract, but could include measures of:

- access;
- consumer satisfaction; and
- quality, as measured by both performance and outcomes.

To measure access, a review of penetration rates and encounter data is important. This gives an indication of how the plan is conducting outreach or accepting people into care. It also enables the state to examine services by type of client, program, provider, diagnosis, or region so as to detect over- or underutilization[15]. Standards should ensure reduced waiting lists and shorter delays for treatment, increased numbers of people with access, and expansion of home- and community-based services.

To measure consumer satisfaction accurately, policymakers have found that it is insufficient to rely on consumer-satisfaction surveys alone. According to a report from the Office of the Inspector General of the Department of Health and Human Services, Medicaid agencies have found that these surveys provide little useful information about plan performance but instead largely confirm what was known from other sources[16]. State mental health officials also reported that these surveys can be unreliable and not related to quality care. Other effective measures used by states to gauge and ensure consumer satisfaction are: grievance and appeals data, including the level of denials (and for which services) and the complaints coming to the state agency; focus groups with consumers, families, and representatives of social service agencies and communities; and engagement of consumers and families in consumer satisfaction teams and consumer monitoring groups[17].

Through various means, state officials suggest, recipients need to be asked (1) whether the services they were provided helped them feel more in control of their lives; (2) whether they feel they are getting better; and (3) whether they feel they have a person that they can go to when they need help with the effects of their mental disorder.

Another way to guarantee quality is to ensure the existence of an accessible and qualified community network of providers. Quality of care can also be measured to some degree by examining encounter data to ascertain patterns of care delivery. For example, managed care has enabled one state (which had virtually no data before) to cross-reference multiple systems and identify the providers who were discharging patients without follow-up and the hospitals that had the worst readmission rates.

Performance Data

Several states have very detailed requirements for performance measures. One state has gradually increased the number of its required performance measures from 20 to 60. Performance data capture information that can be used as a proxy for measuring quality. For example, information about symptom remission can be inferred from data on how long people are retained in care and on readmission rates. Critical-incident reports are also a good overall indicator, which can flag potential weaknesses in service delivery.

Continuity of care, a major problem in the public mental health system, can be assessed in ways not previously possible. For example, one state found that the majority of hospital admissions were of people who had not previously been in care, raising questions about prior lack of access to community services. This led the state to develop policies for reaching people earlier, before their illnesses became critical. Continuity of care can also be measured through clinical standards—for example, after a patient is diagnosed with major depression, continuation of antidepressant medication should be assured.

Some states have also included measures related to interagency service planning and coordination. Interagency performance measures can identify cost-shifting and other adverse outcomes.

Outcomes Data

Because the science of outcomes measurement is in its infancy, states are careful about relying on outcomes reporting to ensure accountability. It is particularly important not to view outcomes measurements in isolation. The health status of the population in the plan and various outside factors can significantly affect consumer progress. The lack of any baseline is also a problem. Suicide rates, for example, are important data, but if the rates prior to managed care were poorly documented, comparisons may be inaccurate and can lead to false conclusions.

It may also take time for good outcomes to become apparent. The typical managed care contract is for three years, which is too short a period to assess the impact of services on outcomes and quality of life. This is

particularly true for people with serious mental illnesses who have endured years of poor service and for whom good benchmarks do not yet exist. For this reason, it is important to track consumer outcomes over a substantial period of time, even over the life of more than one contract, for an overall assessment of the system.

Nonetheless, the measurement of outcomes can enrich the data used to assess managed care. In particular, simple measures that track trends can be very helpful. Examples of this include work activity, increased time spent by adults out of the hospital, more children staying with their families, improved school attendance, and upward trends in grades for children.

One state has created a five-point scale for several simple, easily understood, and hard-to-refute outcome measures for adults and children. These data provided important information to the state about the new system's performance with respect to:

- living situation, scoring from (1) for living at home up to (5) for living in an institution;
- children's education placement, ranging from mainstream to residential;
- interactions with the justice system, ranging from no trouble with law to incarceration;
- work, ranging from competitive employment to not laboring.

Assessing Cost Savings

A central aspect of accountability is cost control. In assessing costs, it is relevant to look beyond the mental health system. Assessments of the degree of cost-shifting to various other state and local systems or to federal sources will, necessarily, have to be based on gross measures, but they can indicate trends. It is also important to assess overall costs in the system. Too narrow a focus, such as looking only at the rising costs of prescription medications, may not capture the overall impact of the use of more effective treatments.

States have documented cost savings in many ways, as a result of:

- a drop in the growth of Medicaid mental health spending;
- a decrease in the percentage of funds allocated for the most expensive services (inpatient and residential);
- a comparison of spending under managed care with spending under a fee-for-service plan, such as through shadow billing, based on actuarially sound rates (remembering that all rates may be escalating);
- an external evaluation of both costs and quality by a neutral group to determine cost effectiveness;
- the impact on other service systems, evidenced by greater or less use of those systems' services;
- a cost shift *into* the mental health system, indicating that it is meeting broader needs;
- an impact on service needs of the un- and underinsured.

Other Areas of Accountability

In addition to the data that plans are required to report under their contracts, various other mechanisms have been used by policymakers to ensure accountability. Some states have sent teams of consumers and families to visit service sites. Others have applied the accountability requirements found in private-sector plans to the public sector. For example, recent state regulations of managed care have required:

- grievance and appeal mechanisms, including external appeals, for all consumers;
- provision of sufficient information to consumers, so they can understand their options;
- internal systems of quality assurance;
- representation of enrollees on governing boards; and
- independent ombudsman programs to help inform and protect consumers.

Using the Data

Appropriate measures and the data they produce help states to solve problems in their mental health systems. For example:

- Counties can be compared with one another—and providers can be similarly compared—in terms of outcomes.
- Problem situations can be followed up. Were consumer complaints resolved? Is there truly access to the system, and do consumers have real choices? Can case examples be cited?

Data can also be used to create effective incentives. While counties have often been given financial incentives to pursue deinstitutionalization policies, managed care can offer incentives for a variety of specific client outcomes. For example, counties that excel can receive more resources from the state; those that perform poorly can be required to pay half of a federal sanction.

Better data enable policymakers to adjust the risk to plans of serving significant numbers of people with high levels of need. Although risk adjustment in mental health is another area where the science remains inadequate, with specific data it is possible to increase the flow of funds to areas where they may be needed. For instance, performance and outcome data can be used to track how the medical-necessity criteria are being applied and how the most vulnerable populations are faring.

Conclusion

The use of concepts and methods derived from managed care in public mental health systems is spreading, but few clear patterns of how it has been deployed and how it has performed have emerged. Several states are now reconsidering the privatization of their mental health systems through contracts with outside corporations. Instead, they are adopting the techniques of managed care through designs that are specific to their existing systems. County-based systems are proliferating, as are internal managed care arrangements and traditional safety-net consortia. Nonetheless, a significant number of states still use private, for-profit managed care entities, and others may follow suit. One state may shortly switch from a publicly managed system to a competitive system, which could result in a private-sector contract. In other states, public and private responsibilities are shared, such as when a state contracts with a private plan only for administrative services. The various organizational arrangements notwithstanding, many states use carve-out plans for mental health care, at least for individuals with significant disabilities.

States clearly consider managed care a potentially useful tool for addressing many systemic issues. But they are also aware that it can create other problems and that it requires careful administration. However, states report that managed care can improve accountability significantly. While there is no single solution, and while it is impossible to say in advance what approach will work best in any one state, the greatest successes have come when policymakers start with a vision for what they want the service system to achieve and then use managed care as a strategy or toolbox to realize it.

Careful planning allows time to deal with the significant challenges states have encountered. Policymakers have found they must approach reform through a process that permits consensus building, even though in the end some may still oppose the plan. Nevertheless, the planning process itself provides an invaluable review of the system.

Managed care contracting offers obstacles, pitfalls, and difficulties. Policymakers have found they must wrestle with various problems, including some that were previously unaddressed, such as integration of mental health care with other health or social service systems. Putting consumer needs at the center of any change has proved to be effective in planning for a system of managed care.

Innovation is fundamentally a local matter of adapting ambitious hopes to existing constraints and opportunities. There are limits to how fully the experience of one state can be translated to another. Nonetheless, the general principles discussed here seem to be reasonably applicable across states and localities.

Public-sector approaches to managed mental health care are relatively new but already evolving rapidly. Lessons from states involved in these shifts emphasize that the complexities of the issue require states to set clear goals, in collaboration with key stakeholders, so that the managed care strategy can further improvement in a state mental health system. States ignore these complexities at their peril. Managed care has the potential to exacerbate the problems of cost shifting, and this makes it all the more imperative to deal with the integration of services, systems, and funding streams. Managed care can, eventually, help blur the boundary between public and private for-profit mental health care and facilitate movement toward a single system of care for all.

In sum, states have found managed care a useful technology for achieving cost efficiency and responding to the demands of a dynamic system in a way that balances risks and protects consumers, while encouraging more independence and mainstreaming for them. Using managed care appropriately, states are in a position to demand far greater accountability from mental health providers than they have ever been able to in the past.

Notes

1. Lutterman et al. 1999. In addition to publicly controlled Medicaid spending, private providers bill Medicaid directly, so that total Medicaid spending on mental health care is higher, although the amount is unknown.

2. Lopez 1999; Burgess et al. 1999.

3. Kaiser Commission 1999.

4. Lewin Group 1999.

5. Bazelon Center for Mental Health Law 1999; Lewin Group 1999.

6. Lewin Group 1999.

7. General Accounting Office 1999.

8. Ibid.

9. Frank et al. 1995.

10. Stroul et al. 1996; Bazelon Center for Mental Health Law 1996; and Bazelon Center for Mental Health Law 1997b.

11. An initiative in North Carolina, where three university medical centers have banded together to pursue their own statewide carve-out contract, is an alternative way to address this problem.

12. Christianson and Osher 1994; Cole et al. 1990; and Bazelon Center for Mental Health Law 1997a.

13. General Accounting Office 1999.

14. Ibid.

15. General Accounting Office 1999.

16. Office of Inspector General 1997.

17. Ibid.

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