Managed Care:
Understanding and Navigating the System
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Course Introduction

There is no doubting the impact of managed care on today’s system of health care. Counselors, as well as their clients, have made numerous adjustments in their practice and treatment seeking behaviors since managed care’s growth in the early 1990s. One definition of managed care is “negotiated quality for a negotiated price.” Another is “any health insuring arrangement in which the corporate entity, whether directly or through sub-contracts, enters into a formal contractual arrangement with one or more purchasers to both insure a defined group or members and provide members with the care and services that it insures through a network of providers who have been selected by the entity and who are subject to its controls.”

This article, supplied by the U. S. Center for Mental Health Services discusses the current reality of managed care and how it actually works. Counselors will find this information invaluable for daily practice management as well as for the welfare of their clients. The information in this course will reflect that all parties involved in health care must make a greater effort to educate potential clientele about their rights as health plan enrollees.

Learning Objectives

Upon completion of this course, you will learn

- Basic, fundamental information regarding managed mental health care
- About systems of care and cost containment
- Medical necessity and accountability
- Delivery of managed mental health services
- Major issues regarding managed mental health care in the United States

Course Content

Article: The Promise and Reality of Managed Behavioral Health Care, pages 3-36.

The Promise and Reality of Managed Behavioral Health Care

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Introduction

Managed care has been characterized as “one of the most significant changes to our nation’s health care financing and delivery system in recent years” (Davis, Collins, & Morris, 1994, p. 178). One of the Nation’s most senior State mental health commissioners has observed that managed care “is probably one of the most complicated topics of the day. It’s a profound change—a shift in the whole way of organizing health and mental health care” (Surles, 1991, p. 4).

For the purposes of this paper, two definitions of managed care will provide context. One definition is that managed care is negotiated quality for a negotiated price: “Capitated prospective payment to preferred providers based on a performance contracting system; whereby the provider assumes financial risk for the treatment of illness, preferred whereby providers must demonstrate quality and accessibility, and performance whereby the provider must earn the reimbursement” (Dyer, 1992, relying on Boland, 1991).

The second definition, by Rosenbaum and Teitelbaum (2000), is “any health insuring arrangement in which the corporate entity, whether directly or through subcontracts, enters into a formal contractual arrangement with one or more purchasers to both insure a defined group of members and provide members with the care and services that it insures through a network of providers who have been selected by the entity and who are subject to its controls. Managed care companies can take many forms, ranging from non-profit companies to investor-owned insurance companies. A single company may offer many different types of managed care products, ranging from products that are loosely configured to those that are tightly managed, with greater or lesser discretion given to members and providers alike to make decisions regarding the consumption of health care resources. Regardless of the type of product, however, the merger of coverage and care into a single corporate structure is what distinguishes managed care from earlier indemnity or service benefit plans that gave physicians and health professionals full discretion over participation and treatment decisions. In managed care, a single entity empowers itself through its control over providers’ access to patients to effectively make treatment decisions by virtue of its coverage decisions.”

From a management and policy perspective, managed care’s “idea is to make sure the right people are getting the right services at the right time” (Surles, 1991, p. 5). What has been the promise of managed behavioral health care? And has practice been consistent with promise?

On November 20, 1996, the Institute of Medicine (IOM), National Academy of Science (NAS), concluded:

With great speed and a considerable amount of controversy, managed care has produced dramatic changes in American health care. At the end of 1995, 161 million Americans—more than 60% of the population—
belonged to some form of managed health plan... At the end of 1995, the behavioral health benefits of nearly 142 million people were managed, with 124 million in specialty managed behavioral health programs and 16.9 million in an HMO (p. 1-1).

The Surgeon General of the United States (U.S. Surgeon General, 1999, pp. 420–421) has observed: “Managed Care represents a confluence of several forces shaping the organization and financing of health care. These include the drive to deliver more highly individualized, cost effective care; a more health-promoting and preventive orientation; and a concern with cost containment to address the problem of moral hazard.”

While 18.8 million Americans have their behavioral health benefits internally managed through HMO (health maintenance organization) enrollment, 176.8 million Americans now have their behavioral health benefits managed by managed behavioral health care organizations (MBHOs) (Open Minds, 1999, p. 5). Three MBHOs—Magellan Behavioral Health (with 36.56 percent market share), ValueOptions, and United Behavioral Health—dominate 57 percent of the market. Over 85 percent of the market is controlled by 11 MBHOs (Open Minds, 1999, p.5).

Estimated 1995 MBHO revenues were $2.6 billion based on these assumptions (Oss & Moghul, 1996):

- $193.9 million: employee assistance programs (20.2 million enrollees @ $9.60 per year);
- $190 million: integrated programs (9.9 million enrollees @ $19.20 per year);
- $1.6 billion: risk-based network programs (26.6 million enrollees @ $60 per year);
- $404.6 million: non-risk-based network programs (28.1 million enrollees @ $14.40 per year); and
- $187.7 million: behavioral health utilization review programs (39.1 million enrollees @ $4.80 per year).

**Major Issues**

Among major issues facing managed behavioral health care are the following:

1. Ability to control cost;
2. Substitution of types of mental health services;
3. Adequate services;
4. Seamless systems of care;
5. Medical necessity versus clinical necessity versus human necessity;
6. Public accountability using performance measures of positive clinical outcomes and consumer satisfaction;
7. Consumer, family, enrollee participation; and
8. Forms of delivery.

Two important issues not addressed in this text are the distress, distrust, and conflict among professionals, providers, payers, and consumers caused by managed care (Dorwart, 1990; Hall, Edgar, and Flynn, 1997; Schreter, Sharfstein, and Schreter, 1994) and the conflict over access to and confidentiality of medical records.
1. Ability to Control Cost

The U.S. Surgeon General (1999, p.182) concludes:

Managed care provision of mental health services emerged partially in response to the overutilization of costly inpatient hospitalization by adolescents in the 1980s (Lourie et al., 1996). The purpose of managed care has been to control spiraling mental health service costs, mostly by limiting hospital stays and rigorously managing outpatient service usage (Stroul et al., 1998). Managed care can offer advantages in terms of cost effective services to meet the needs of children with flexible benefits. It may also lead to denial of needed treatment. While its potential negative effect on the efficacy of mental health care delivered under its aegis is a hotly debated issue, for the most part managed care furnishes the same traditional services available under fee-for-service insurance. The drive for efficiency, however, had led to the introduction of intermediate services designed to divert children from hospitalization. Managed care has shortened hospital stays and increased the use of short-term therapy models (Eisen et al., 1995; Merrick, 1998). Managed care also has lowered reimbursements for services provided by both individual professionals and institutions. This has been accompanied by the construction of provider networks, under which professionals and institutions agree to accept lower than customary fees as a tradeoff for access to patients in the network.

Since 1992, managed care has begun to penetrate the public sector (Essock & Goldman, 1995). The prime impetus for this has been an attempt to control the costs of Medicaid, in both the general health and mental health arenas. Since Medicaid appears, on the surface, to be similar to a private health insurance plan, administrators of state Medicaid programs have recently implemented managed care approaches and structures to reduce health care costs. However, Medicaid populations tend to have a higher prevalence of children with serious emotional disturbance than that seen in privately insured populations. Those children generally need longer-term care (Friedman et al., 1996b; Broskowski & Harshbarger, 1998). Managed care strategies, which developed in the private sector, are geared toward a relatively low utilization of mental health services by a population whose mental health needs tend to be short term and acute in nature. As a result, the kinds of cost-cutting measures used by managed care organizations, such as reduction of hospital days and encouragement of short-term outpatient therapies, have not worked as well in the public sector with seriously emotionally disturbed children as they have in the private sector (Stroul et al., 1998) (p. 185).

The Surgeon General expands this discussion of cost control and cost shifting:

Advocates express concern that the restrictions of public managed care on mental health services shift costs of diagnosis and treatment to other agencies, a process known as cost-shifting. Under public managed care, hospitalization for mental disorder is being substantially cut, with youths being discharged from the hospital before adequate personal and/or community safety plans can be instituted. Child welfare and juvenile justice agencies have been compelled to create and pay for services to support those children who are no longer kept in the hospitals. Thus, while Medicaid’s mental health costs may be decreasing in such cases, there may be a substantial cost increase to the other agencies involved, resulting in little if any overall cost saving (Stroul et al., 1998). Similarly, management of only the Medicaid portion of a complex funding system that includes Medicaid, mental health, special education, child welfare, and juvenile justice funds not only creates the cost-shifting described above, but also underestimates the need to manage the funds spent by all agencies (p. 185).

The IOM, NAS, has concluded that “managed care methods are growing at a faster rate in the behavioral health
care sector than in the rest of the health care system because of their demonstrated ability to control costs in private health plans and because states are turning to managed care as a strategy to control Medicaid costs” (p. 8-1).

The foremost success of managed behavioral health care is the ability to control cost. Examples include the following:

“Major corporations such as Dupont, Dow, Federal Express, and Xerox have reported cost reductions of 30–50 percent over one or two years and have increased the flexibility of their mental health benefits by eliminating certain coverage limits” (Frank, McGuire, & Newhouse, 1995).

“Some large employers, such as Xerox, Sterling-Winthrop, Alcan Aluminum, and Conoco, have reported overall savings in plan costs for mental health/ substance abuse care of about 40% over 2 years after the introduction of managed care” (Frank & McGuire, 1995).

“The experience of the Bell South Corporation illustrates her point. Mental health services, which once accounted for 17% of employee health costs, were cut to 8% of the total after the company adopted a managed care program emphasizing alternatives to hospitalization” (Pear, 1996).

Initial results from the Massachusetts Medicaid Mental Health project: (1) persons using services increased 5 percent; (2) expenditures were reduced by 22 percent; (3) hospital readmissions were reduced; and (4) a more comprehensive array of community-based services were provided (Callahan, Shepard, & Beinecke, 1994).

The U.S. Department of Health and Human Services Office of the Inspector General (HHS-OIG) (2000) documented that four of seven Medicaid managed mental health programs saved from $4 million to $12 million the first year, compared with the previous year’s fee-for-service (FFS) expenditures. The other three States limited expenditures to the previous year’s expenditures. Four of these States returned “off the top” savings to the State’s general fund. The other States used the savings to expand Medicaid to non-Medicaid-eligible persons or to pay for managed care administration.

The debating point is at what price have costs been controlled?

2. Substitution of Types of Mental Health Services

The IOM (1996) concluded that “in the late 1980s, the majority (70 percent) of mental health funds spent by Medicaid and private insurance went for inpatient care, leading many researchers, clinicians, and advocates to question the imbalance and to search for policy changes. Only the introduction of managed care arrangements has led to a significant shift away from costly and often unnecessary inpatient stays to a more appropriate range of outpatient and community-based care (p. 1-1).

Study after study, some previously cited (Frank & McGuire, 1995; Frank, McGuire, & Newhouse, 1999) and others cited below, document that when managed behavioral health care is introduced, inpatient care declines, psychotherapy declines, and alternative services such as residential treatment, day treatment, psychiatric rehabilitation, and case management increase. Examples include the following:

Value Behavioral Health New York State Employees 1993 experience: (1) mental health and substance abuse services delivered increased 20 percent from the previous year; (2) acute inpatient hospital admissions per 1,000
persons declined from 6 to 3.8 from the previous year; (3) New York State saved $25 million from the previous year; (4) use of outpatient chemical dependency treatment visits rose from 20 per 1,000 persons to 71.6; and (5) admissions for alternative levels of care increased from 0 to 1.5 per 1,000 (Shaffer, 1995).

FHC Options CHAMPUS 1986–1994 experience in the Virginia–North Carolina region: (1) persons enrolled increased from 219,764 to 256,839; (2) persons receiving services increased from 7,600 to 19,180; (3) average length of hospital stay declined from 58.11 days to 7.2 days; (4) average cost per inpatient admission declined from $18,539 to $2,013; and (5) partial hospitalization and related day admissions per 1,000 persons increased from 0 to 3.2 (Krupnick, 1995).

Such substitution had resulted in significant tensions between mental health professionals and providers and great hostility toward managed care organizations (MCOs). As Figure 1 documents, provider referrals and reimbursements have changed dramatically as a result of these shifts (Oss & Moghul, 1996; chart created by Clarke Ross).

An HHS-OIG report (2000, #00340) documented that seven State Medicaid managed mental health programs had “dramatic declines” in inpatient costs. One State reduced inpatient costs from 51 percent of mental health costs to 17 percent in one year. In two States, there was a reduction of 40 to 50 percent in available psychiatric hospital beds. In one State, average length of stay dropped from 30 to 20 days.

Four of these seven States documented increased utilization of services from 1 percent to 2 percent after conversion to a managed care system. The seven States developed new services that previously did not exist—residential services, vocational services, respite care services, in-home programs, clubhouses, day services, and personal services.

In six States, psychiatric hospital readmission rates were higher under managed care, with increases ranging from 4 percent to 9 percent. Only one State did not see any “noticeable increase.” The HHS-OIG concluded that “lower average length of stays and increased readmission rates may indicate that persons with serious mental illnesses are being released from inpatient care too quickly.”

In a separate report (2000), the HHS-OIG concluded that “reductions of inpatient care for children was greater than that for adults.” One State reported that children using inpatient care was down 40 percent, compared with a decrease of 2 percent by adults for the same period. Another State reported a 30 percent decrease in psychiatric hospital admissions for children, compared with a decrease of about 6 percent by adults during the same period.

While outpatient programs expanded in all seven States, “the number of children that access services are still generally below the level of access for adults.” In one State, the rate of adults accessing outpatient mental health services was 123.7 per 1,000, while the child rate was 54.8 per 1,000. In another State, while 6 percent of adults accessed out-patient services, only 3 percent of children accessed such services.

3. Adequate Services to Persons With Severe Mental Illnesses: “Appropriate Payment Is a Critical Safeguard”

“Appropriate payment is a critical safeguard” is a recommendation and conclusion from the July 1999 draft Health Care Financing Administration (HCFA)-National Academy of State Health Policy (NASHP) report on special needs populations enrolled in Medicaid managed care. Managed care capitation payment rates are
often arbitrary and are set in such a way that total funding is lower than the previous Medicaid FFS base. Most public mental health systems in the Nation have historically been underfunded, so capitation rates determined on discounts from past funding are usually inadequate to fund quality care. National Institute of Mental Health researcher Dr. Roland Sturm (1999) recently observed, “Financial viability of managed behavioral health ventures in the public system has been difficult to achieve.”

Montana, perhaps the worst public managed mental health program in the Nation (terminated by the State legislature after 23 months) (Croze, 1999a, 1999b; Sturm, 1999), is an example. The five-year managed care contract of $380 million was $6 million less in the first year than the previous year’s FFS spending. In addition, Montana added a pharmacy benefit to the capitation contract, and the MCO then absorbed $4 million in pharmacy outlays, $2.8 million over the previous year’s FFS pharmacy outlays. The MCO, by contract, was obligated to continue current funding to the State hospital in Warm Springs, limiting community-based services (Faulkner & Gray, 1999; Kanapaux, 1998a, 1998b, 1999a, 1999b, 1999c, 1999d, 1999e, 1999f, 1999g; Rudd, 1998a).

Montana added uninsured persons to the Medicaid managed care program. This group had never been served before, so another $11 million in expenditures were incurred by the MCO. Thus, the MCO received $6 million less than the previous year’s spending and incurred $13.8 million in extra and unbudgeted (and thus deficit) expenses in 23 months. Provider payments were substantially squeezed, and consumers were denied services. The MCO was not entirely blameless. From the outset, the original vendor (subsequently sold to another company) had difficulties paying claims in the first place (a capability the State inadequately evaluated during the bidding), a problem that alienated providers and fostered hostility to the program. In one instance, the claims payment issue bankrupted a community mental health center highly regarded by local consumers and their families (Kanapaux, 1998a, 1998b, 1999a, 1999b, 1999c, 1999d, 1999e, 1999f, 1999g; Rudd, 1998a).

Kapur, Young, Murata, Sullivan, and Koegel (1999) conclude, “Previous research has not yielded a fail-safe formula for implementing a publicly funded capitation program.” Inadequate resources will lead to program failures. Kapur and colleagues describe the 1993 Los Angeles County Department of Mental Health capitated care program for persons with the most serious mental illnesses. Six not-for-profit community providers were given between $14,000 and $21,000 per client per year to serve persons whose previous-year expenditures averaged $30,000 and were in the top 15 percent of mental health services expenditure users. Providers could disenroll clients and return them to the FFS system. The result was that 1,188 of 1,563 assigned clients were disenrolled. Those disenrolled had average previous-year expenditures of $24,500, while those retained in capitation had previous-year average expenditures of $17,510.

Proper targeting— matching targeted clients to targeted services— can be effective. Magellan’s Iowa managed mental health care program targeted an extra and special payment of $900 per member per month (PMPM) for programs of assertive community treatment (PACTs) for the population with the most severe illnesses. This targeting has resulted in marked improvement in consumer functioning and a reduction in average annual treatment costs from $18,000 to $11,000 (Zwillich, 1999).

Determining adequate payment levels for public mental health services is difficult, particularly when comparing State-to-State. But some State-specific information has to be used to make an initial judgment of adequacy. Massachusetts capitation rates are $100 PMPM for persons with mental illness on Supplemental Security Income (SSI) and $70 PMPM for non-SSI-eligible persons with mental illness enrolled in Medicaid and also served by the State mental health department (GAO, 1999a; Open Minds, 1999; Sheola & Lane, 1999). Compare this to Arizona’s Maricopa County rate of $44.49 PMPM for persons with serious mental illness.
(Davis, 2000; Open Minds, 1999; Rudd, 2000c). Are the costs of living between Arizona and Massachusetts really that much different? What accounts for these dramatic differences? In a Federal class action lawsuit against Arizona, the parties, including the State, agreed that at least $316 million was required by Maricopa County to adequately finance its public mental health system (Snyder, 1999). Currently, $112 million is spent.

In Massachusetts, 100 percent of the capitation goes to direct clinical care. Pharmacy is not part of the capitation. A separately funded administration budget is separately negotiated. Massachusetts uses for-profit vendors, but profit is exclusively tied to the achievement of performance goals. In year one, the vendor receives a bonus for achieving performance targets. In year two, the previous bonus target becomes a contractual obligation with financial penalties. New performance targets are introduced each year, so the program continually improves. And Massachusetts uses risk corridors, so profit and loss are limited. Massachusetts’s capitation financing is unique in the Nation (GAO, 1999a; Sheola & Lane, 1999).

Capitation rates can be designed as incentives or disincentives in serving the most disabled of the population with mental illness. Tennessee is an example. In 1996–1997, the State used a blended behavioral capitation rate of $22.93 PMPM. The result was that persons with serious mental illness were largely unserved. In 1997, the capitation rate was adjusted. Persons with serious mental illness who were served received a PMPM rate of $319.41. The result: by the end of 1999, the proportion of the population with severe and persistent mental illness and serious mental illness actually served was identical to Center for Mental Health Services (CMHS) estimated prevalence (2.6 percent and 5.4 percent of the enrolled population). But in an inadequately financed system operating under a global budget, the amount left over for persons without serious mental illness was $8.83 to $10.35 PMPM. Community mental health providers entered the year 2000 demanding an end to the “two-tiered” capitation system so they could serve more persons with less serious mental illness. The problem, if the change is enacted, would be again underserving persons with serious mental illness (Kanapaux, 1999d; Open Minds, 1999; Wooldridge & Mitchell, 2000; Yennie, 1998; Yennie & Birch, 1999).

The Dallas, Texas, North Star managed behavioral health care program has come under recent criticism for underserving the population. The capitation rates used in North Star are $3.06 PMPM for an SSI aged recipient, $10.24 PMPM for an SSI child, $45.61 PMPM for an SSI adult, $23.99 PMPM for a Temporary Assistance for Needy Families (TANF) adult, and $9.25 PMPM for a TANF child (Bagwell, 2000; Kanapaux, 2000; Rudd, 2000a, 2000b, 2000c). After a bumpy first two years, the Iowa managed behavioral health care program is generally viewed by national experts as a positive program (Croze, 1999a, 1999b; Sturm, 1999). The SSI child capitation rate varies geographically from $78.84 PMPM to $117.72 PMPM, while the SSI adult PMPM capitation rate varies geographically from $70.85 PMPM to $103.98 PMPM (Faulkner & Gray, 1999; Open Minds, 1999; GAO, 1999a).

A 1993 study of expenditures in three States (Larson et al., 1998) demonstrates that serving persons with mental illness is more expensive than serving the rest of the Medicaid population. In Michigan, the average Medicaid expenditure was $1,726 for persons with mental illness and $583 for other Medicaid persons. In New Jersey, the differential was $3,143 for Medicaid-eligible persons with mental illness compared with $1,301 for others. In Washington, the differential was $1,119 and $570. Are the capitation rates paid to serve persons with mental illness reflective of such differential expenditure histories? In the National Alliance for the Mentally Ill’s (NAMI) 1997 Managed Care Report (Hall, Edgar, & Flynn, 1997), managed care programs failed to provide persons with serious mental illness with adequate hospital length of stay, programs of assertive community treatment, access to the newest classifications of medications, psychiatric rehabilitation, and supported housing (Hall, Edgar, & Flynn, 1997). To what degree is inadequate funding a root cause of this failure? CMHS
supported researchers (Wooldridge & Mitchell, 2000) have concluded that “few, if any, States have succeeded in setting capitation rates correctly.” The reason is that States lack good encounter data.

Adequate payment is a complex and difficult subject. Several strategies can be advanced to address this issue:

1. The HHS-OIG (2000; #00343) recommended that drug formularies be excluded from managed care. The HHS-OIG studied seven Medicaid managed mental health programs. None included pharmacy “primarily because States were unsure of how to accurately determine the cost for this benefit… States believed that if they did not set the capitation rate for prescription drugs at a correct level, managed care organizations would have an incentive to restrict access” (p. 8; see also Wooldridge & Mitchell, 2000). 2. Another strategy is to document actual per-person utilization. Unfortunately, only 27 State mental health systems in the Nation can do this. States should develop and use an unduplicated count of persons served in public systems (SAMHSA, 2000).

3. As tempting as the goal of universal coverage is, don’t add the uninsured into capitated managed care until a historic utilization pattern is known. That means financing the uninsured through FFS or special risk arrangements until actual experiences are known. Montana and Tennessee added to their financial pressures by adding the uninsured to their managed care program without a real utilization history (Kanapaux, 1998a, 1998b, 1999a, 1999b, 1999c, 1999d, 1999e, 1999f, 1999g; Tennessee, 1999; Rudd, 2000c; Wooldridge & Mitchell, 2000; Yennie, 1998; Yennie & Birch, 1999).

4. Implement managed care and, if there are savings, make a judgment after the savings have occurred about whether to invest in additional services or return the savings to the State treasury. Reinvestment is always a possibility, as in Colorado and Iowa (Croze, 1998). Iowa required that, for three consecutive years, profits of $1 million each year be invested in mobile counseling and therapeutic socialization programs. Colorado required that $1.3 million in year one profits and $1.9 million in year two profits be invested in telemedicine, 24-hour intensive care, and respite care (Croze, 1998; GAO, 1999a; Nardini, 1999).

5. Compare different States’ capitation rates. Yes, local costs and composition of professional services differ but not to the degree reflected in current State capitation funding levels for these types of programs.

6. When historic utilization is not known, use a risk corridor. Risk corridors set limits on the amount of profits and losses that are realized by MCOs. Risk corridors apply whether the MCO is a for-profit or a nonprofit. Eight States (California, Hawaii, Massachusetts, Nevada, Ohio, Oklahoma, Utah, Wisconsin) currently use risk corridors (HCFA-NASHP, 1999) and one (Massachusetts) uses risk corridors in its mental health program.

Even following these strategies, capitation rates remain problematic. Studies by the New York and Ohio Departments of Mental Health (NASMHPD, 1993; Roth, Snapp, Lauber, & Clark, 1998) document significant client movement in and out of Medicaid and out of community mental health programs. This movement makes questionable the use of risk-adjusted capitation plans based primarily on past service utilization. On the other hand, the New York data show that even though a third of the 212,000 Medicaid-eligible persons with severe mental illness annually leave the program rolls, both the aggregate number of eligible persons and utilization of similar patterns of care remained generally constant, affirming capitation rates based on prior utilization. As
Roth and associates conclude, “clearly there is a critical need for more systematic, longitudinal information about people with severe mental disabilities and their service utilization.”

Inflexible reliance on prior utilization also presents problems. As New York unveils its special-needs plans for adults with serious mental illness, counties with better reform track records are being financially penalized. New York City, which has a recent history of moving persons out of hospitals and into community treatment, will receive a per member per year capitation of $8,479. But Westchester County, which has historically relied much more on inpatient care, will receive a per member per year capitation of $12,087 (Kanapaux, 1999i).

4. Seamless Systems of Care That Include Integrated and Coordinated Delivery: Linkage Between Medicaid and Public Mental Health Has Failed

Managed care for persons with mental illness in the government sector has been initiated through the Medicaid program. Medicaid is the single most significant payer of public mental health services, and yet, there has been little linkage between the State Medicaid and State mental health agencies. Without such linkage, failure in providing appropriate treatment and support services will and does occur. This is a fundamental systemic and structural flaw that is pervasive throughout the United States.

This linkage problem occurs even in the State-managed mental health programs considered by national experts to be the most positive. Some experts (Croze, 1999a, 1999b; Sturm, 1999) consider Massachusetts one of the more positive experiences, but here linkage fails. The Medicaid managed mental health program is responsible for “acute” care while the Department of Mental Health is responsible for “continuing” care. But where is the linkage between the two? There are no clear linkages. For example, consumers and families wait for services and providers refuse to serve until complex billing procedures between the two agencies are clear. Colorado Health Networks is considered by some observers (Croze, 1999a, 1999b; Sturm, 1999) to be a positive program. But the Medicaid managed mental health program is not responsible for persons requiring State psychiatric hospital care. The consequences: numerous Medicaid enrolled persons are transported to State hospitals (suggesting that financial incentives are, perhaps, as alive and well in the public sector as they are in the private). Because Fort Logan, near Denver, is a smaller hospital with typically 100 percent occupancy, many persons in north and central Colorado are transported, at a cost of $450 a ride in an ambulance or in shackles by police, to the southern hospital in Pueblo (Ross, April 1999).

Any public managed care program for persons with severe mental illness must have precise boundaries established between the Medicaid managed care entity and the State mental health agency— or no boundaries at all (i.e., consolidation). Minimally, all consumers, families, and providers must know which agency is responsible for which services under which conditions. If boundaries and responsibilities are not clear, or if agencies remain fragmented structurally or functionally, persons will wait for treatment, and this could be extremely dangerous, particularly for those with the most severe illnesses.

Frank and Morlock (1997) have observed, “When multiple parties exert partial authority, act according to different rules, and respond to incentives from a variety of financing sources, the result is unlikely to be coordination among complementary community institutions.” They conclude that “simple strategies that just manipulate either the organizational or the financial arrangements do not enhance systemic coordination.” Frank and Morlock (1997) propose “mixed strategies” of “blending centralized organizational structure” and “aggressive management in the form of monitoring, feedback, and education at the provider agency level.” Irrespective of the particular expertise of a managed care vendor, and even in the face of an overwhelming
social commitment from these private organizations, service will continue to be abysmal if public fiscal and administrative agencies are unable to collaborate on a plan of action.

The HHS-OIG (2000, #00344) observed that in seven Medicaid managed mental health programs, “responsibility for care is fragmented with possible cost shifting,” and the OIG recommended the development of interagency agreements to promote coordination.

5. Medical Necessity

Managed care makes cost-effectiveness treatment decisions with the construct of “medical necessity” protocols (Bennett, 1996; Astrachan, Levinson, & Adler, 1975; Ross, December 1996). At first blush, the application of medical necessity criteria seems relatively straightforward. Care is medically necessary where there is a diagnosable mental illness or addiction disorder, the patient has impaired function or is clinically unstable, and treatment is authorized to restore normalcy or reduce disability. However, uniformity of professional judgment regarding each of these three criteria is lacking. Professional disagreements over these three criteria and the complex, unique, and sometimes persistent need of persons with serious illness have resulted in criticism of managed care’s reliance on medical necessity protocols (Hall, Edgar, & Flynn, 1997).

Shaffer and Lieberman (2000) discuss the justification and evolution of medical necessity within the managed behavioral health care field. Medical necessity was a concept used to govern access of care using a standardized methodology of criteria for certifying care through managed care arrangements.

Viewed as proprietary managed care protocols not sharable with the provider community, the use of medical necessity “resulted in a significant amount of confusion and animosity in the provider community toward managed care” (Shaffer & Lieberman, 2000).

Today, the use of medical necessity in the private insurance world generally includes six elements (Shaffer & Leiberman, 2000). The first and most significant element is the following: intended to prevent, diagnose, correct, cure, alleviate, or preclude deterioration of a diagnosable condition contained in ICD–9 or DSM–IV that threatens life, causes pain or suffering, or results in illness or infirmity.

The other four elements include an expectation to improve the individual’s level of functioning; individualized services to treat the person’s symptoms and diagnosis not in excess of the patient’s need; based on nationally accepted clinical standards; and no more intensive or restrictive than necessary to balance safety, effectiveness, and efficiency. Controversy has revolved around “not in excess of need,” who determines clinical standards, and the balance with efficiency.

Professional disagreements abound over the medical nature of many emotional situations such as marital stress, bereavement, and life-adjustment situations; over which profession working in which treatment setting is most effective; and over the medical nature of “humanistic tasks,” such as growth and development activities to assist persons dissatisfied with themselves or with their interpersonal relations. For persons with serious mental illness, rehabilitation and habilitation are required in order to reduce disability and foster self-sufficiency. Historically, only the more progressive and affluent public mental health systems, greatly aided by the rehabilitation option of Medicaid, have paid for psychiatric rehabilitation.

Sabin and Daniels (2000) provide an instructive lesson on modifying medical necessity protocols in public managed mental health care programs. They use Iowa as a case example. Sabin and Daniels observe that
medical necessity “is the vehicle for specifying how broad or narrow insurance coverage will be.”

Relying on the work of Hollingsworth and Sweeney (1997), Sabin and Daniels (2000) contrast the typical private insurance definition of medical necessity with the typical public sector definition of medical necessity. Hollingsworth and Sweeney (1997) documented that, in Wisconsin, private insurance definitions of medical necessity would cover only 60 percent of current public sector treatment of persons with serious and persistent mental illness.

Sabin and Daniels (2000) say that all stakeholders agree that “the central source of turmoil” in Iowa’s Medicaid managed mental health care initial implementation in 1995–1996 “was the clash between private-sector medical necessity criteria and public-sector safety-net functions” (p. 446; also see Hall, Edgar, & Flynn, 1997). The State and its managed care vendor, with the involvement of consumers, families, and providers, negotiated three changes to the vendor’s typical private insurance model of medical necessity:

(1) Up to five days of mental health inpatient and one day of substance abuse inpatient court-ordered evaluation are covered under the Iowa Medicaid plan.

(2) Children may not be discharged from inpatient settings until “a safe living arrangement and a plan for the necessary follow-up for mental health treatment has been arranged.” As a result, 194 children were retained in inpatient care for an average of 17.6 days each, and for the first time a wide array of alternatives became available.

(3) “Psychosocial necessity” was added to the operational definition of medical necessity. Psychosocial necessity is defined as an expansion of medical necessity “that examines environmental factors that inhibit or hamper the effectiveness of treatment when they are addressed” and explicitly includes rehabilitative and supportive services. “Managed care case managers are instructed to specifically consider the potential for services/ supports to allow the enrollee to maintain functioning improvement attained through previous treatment.”

Rosenbaum, Shin, Zakheim, Shaw, and Teitelbaum (1998) document the tremendous variety in State Medicaid managed behavioral health care structure and specificity of contractual obligations in defining and implementing medical necessity. They cite the Iowa contract as a model for the Nation. The Iowa contract provides specific guidance on the protocols that are applied in determining the medical necessity of care at various levels and stages of treatment. The contract also establishes an accepted practice standard of coverage that is specific to mental illness and specific to addiction treatment, as contrasted with general health standards of treatment.

6. Public Accountability

_In God we trust; everyone else must supply outcome data._

—U.S. Health Care (Ross, 1997)

_Cost is the driver—delivery is the key._

—American Managed Behavioral Healthcare Association
(Ross, 1997)
Three concepts and approaches underlie managed behavioral health care: (1) documented performance by managed care companies and providers as the basis of continued business; (2) positive clinical outcomes and consumer satisfaction as a basis for such documented performance; and (3) the management of innovative and comprehensive service delivery networks in order to deliver individualized, appropriate, and flexible service arrangements (Ross, 1997).

In 1996, the IOM concluded that much additional work is required: “The committee members chose to take an evidence-based approach to their task, but they found that the research bases and the development of quality assurance and accreditation standards are far less advanced in behavioral health care than in other areas of health care… Further, development of analytical tasks is necessary and this evidence base needs to be expanded before detailed recommendations can be made… In their current forms, performance indicators are not specific for particular treatment characteristics (organizational and clinical), and there is a lack of consensus of clinical judgment with regard to the relationship to outcome.”

The HHS-OIG concluded the “the overall effect on the health of persons with serious mental illnesses” in seven Medicaid managed mental health programs “was not quantified” (2000). Further, “none of the states included in our study had working outcome measures in place before or after they connected to managed care. Even basic utilization data, such as lengths of hospital stays and number of visits, was inconsistently reported by states” (p. 13). The HHS-OIG recommended that the HCFA and the Substance Abuse and Mental Health Services Administration (SAMHSA) collaborate to develop outcome measurement systems.

Managed care is a paradigm shift. The role of the management agent, or managed care vendor, is at the core of both decision making and accountability. Figure 2 is an attempt to demonstrate this paradigm shift.

The collection of data on managed behavioral health care organizations is challenging for two primary reasons:

1. The desire, and the legal requirements of Federal antitrust mandates, for individual organizations to maintain strict ownership and confidentiality related to such data (i.e., the competitive advantage issue), and

2. The degree of resources (time, money, human resources) needed to develop the data and report results in the requested form of a data collection instrument.

A handful of States and their MCO vendors have developed, use, and make publicly available documented performance measurements. Colorado Health Networks has done an outstanding job at documenting its performance in developing self-help groups and drop-in centers, and in publicly documenting average time for first appointments, penetration rates, hospital readmission rates, average hospital length of stay, waiting list elimination, mental health and physical health follow-up services within 30 days from inpatient discharge for both adults and children, 1 and involvement of family and guardians in discharge planning (Forquer, 1999). Iowa State officials have published in numerous journals and newsletters about the performance data they require of their MCO vendor; yet the public’s access to actual data has been difficult (Nardini, 1999; Rudd, 1998b). Massachusetts has structured its entire profit scheme to the attainment of performance data (GAO,
These are the more positive States, the “beacons of success.”

Only 27 State mental health agencies in the Nation are able to provide an unduplicated count of persons served and the services that they use (SAMHSA, 2000). How can meaningful performance information be collected if a State cannot even provide an unduplicated count of persons served?

Consumers want plan-by-plan comparisons using performance data. But where does this exist in the Nation? The National Committee on Quality Assurance (NCQA) has developed the HEDIS (Health Plan Employer Data and Information Set). Work groups of the Mental Health Liaison Group, a coalition of national mental health associations working together in Washington, DC, believe that the HEDIS data set is grossly inadequate in terms of meaningful measures for serving the most seriously mentally ill population. It derives, as it name suggests, from the needs of employers and employed persons—not the indigent or those whose disabilities preclude employment. Yet, HEDIS has value to consumers because it is a nationwide standard performance system, data are posted on the NCQA website (www.ncqa.org), and it does contain two measures of importance: antidepressant medication management experiences and follow-up of care after hospitalization within seven days. But HEDIS is a voluntary process and few MCOs and MBHOs in the Nation make public their HEDIS reporting. Maryland, New Jersey, and Utah publish consumer guides that contain plan-by-plan comparisons using HEDIS data. Several States, such as New York, require MCOs to provide the State with HEDIS data but then refuse to release such data to the public.

The behavioral health care field—through the National Government’s Center for Mental Health Services (1996); the managed care industry’s trade group, the American Managed Behavioral Healthcare Association (AMBHA, 1995, 1998); the Nation’s largest family and consumer membership association, the National Alliance for the Mentally Ill (Hall, Edgar, & Flynn, 1997; NAMI, 1999; Steinwachs, Flynn, Norquist, & Skinner, 1996); and the field’s administrative leadership (American College of Mental Health Administrators [ACMHA], 1997; Ganju & Lutterman, 1998; National Association of State Mental Health Program Directors [NASMHPD], 1998) has demonstrated leadership and innovation in the development of performance measurement. None of these initiatives currently allow health plan enrollees and their families to actually compare plan-specific performance, but each has moved forward the concept and state-of-practice in managed behavioral health care.

The National Government’s CMHS developed the Mental Health Statistics Improvement Program (MHSIP) Consumer-Oriented Mental Health Report Card (CMHS, 1996). CMHS relied extensively on focus groups of persons with mental illness. CMHS MHSIP is a comprehensive array of performance indicators including clinically based outcomes (symptom distress reduction, independent functioning increase) mixed with consumer life expectations (hope, personal freedom, autonomy in personal decision making).

The managed behavioral health care industry trade association, AMBHA, has developed two versions of performance measures, known as PERMS (Performance Measures for Managed Behavioral Healthcare Programs) (AMBHA, 1995, 1998). PERMS is a modest set of measures resting on three principles: meaningfulness, measurableness, and manageability. Unlike the other behavioral health care performance measures, actual national aggregate performance data have been collected and published (AMBHA, 1996). However, AMBHA has refused to release MBHO-specific performance data. So an actual benchmark has been established, but no comparative data are publicly available.

In 1995, NAMI and Johns Hopkins University established the Outcomes Roundtable. Involving a variety of stakeholders, the Roundtable “set in motion a process to develop science-based approaches to outcomes
assessment that should strengthen the delivery of cost-efficient, high quality mental health care and substance abuse treatment in real-life settings” (Steinwachs, et al., 1996). The Roundtable has assessed the state of science in outcomes measurement and its application, and individual members of the Roundtable are testing the feasibility of various outcomes assessment.

In 1997 (Hall, Edgar, & Flynn, 1997), NAMI issued a report card on the managed behavioral health care industry. NAMI’s report compared MBHO written responses with NAMI member expectations in nine areas. In 1999, NAMI developed its Accountability Template— What Consumers and Families Expect from Treatment Systems for Persons with Severe Mental Illness (NAMI, 1999).

In its 16-State Project, the National Association of State Mental Health Program Directors (Ganju & Lutterman, 1998; NASMHPD, 1998) gathered potential performance measures that State mental health agencies were considering for use and merged this with the CMHS MHSIP measures. Some of these measures were then field-tested in five State mental health agencies. A range of performance data was reported from the five States on the 46 percent of indicators that these five States claimed they were able to report. While important benchmarks were created, no comparable State-specific performance data are available.

In an effort to merge existing performance measurement systems and to develop “consensus” first within the mental health field, followed by outreach with the substance abuse field, the American College of Mental Health Administration (ACMHA, 1997) developed a summary foundation document. ACMHA is still refining the domains of consensus, and no data collection has occurred.

Another major performance measurement effort currently taking place is an initiative of the MacArthur Foundation and CMHS to adapt a generic consumer-focused assessment instrument specifically focused on behavioral health care (R.O.W. Sciences, 1999). In 1997 the National Government’s Agency for Health Care Research and Quality supported research by Harvard Medical School, RAND, and the Research Triangle Institute that led to the development of the Consumer Assessment of Health Plans (CAHPs). Both NCQA HEDIS and AMBHA PERMS use some CAHPS measures. Beginning in June 2000, a sample of Medicare recipients enrolled in managed care plans will be administered the CAHPS (HCFA, 2000). In current development by MHSIP, in collaboration with Harvard University, is a Consumer Assessment of Behavioral Health Survey (MHSIP CABHS) (R.O.W. Sciences, 1999).

Much creative intellectual development work has occurred in behavioral health care. Only AMBHA PERMS has collected and published aggregate performance data. Only NCQA HEDIS has collected and published comparative health-plan-specific performance data.

Four States (Colorado, Iowa, Massachusetts, Washington) studied by the U.S. General Accounting Office (1999a) require their managed care vendors to collect encounter data, but none of the four systematically use the data other than to cite penetration rates, the proportion of an enrolled population actually receiving mental health services. The range of penetration rates between four State managed mental health programs were Massachusetts, 25.1 percent; Iowa, 12.8 percent; Colorado, 11.9 percent; and Washington, 7.0 percent. GAO concluded that data from MBHOS “were untimely, incomplete, or inaccurate.” Sturm (1999) has concluded: “While all companies claim to measure outcome, none are systematically examining key outcomes for people with serious mental health problems.”

In the NAMI 1997 Managed Care Report Card (Hall, Edgar, & Flynn, 1997), NAMI failed the leading MBHOS for not maintaining scientifically up-to-date and comprehensive treatment guidelines and for failing to use
measurable patient outcomes used to determine coverage policy. Most MCOs publish consumer satisfaction surveys which consistently show that roughly 80% percent or more of enrollees are satisfied. The surveys are usually done by internal MCO marketing departments and occasionally by contracted public opinion firms or universities. These studies often do not reveal levels and areas of dissatisfaction. Even this generalized satisfaction is changing. In a June 1999 survey by Hewitt Associates (Bureau of National Affairs, 1999), 22 percent of consumers in managed care plans reported they were dissatisfied, an increase from 17 percent in 1997.

The use of independent, third-party, and consumer-and family-staffed organizations is basic to NAMI’s evolving agenda to ensure accountability by all participants in the health care arena—payers, purchasers, health plans, management agents, delivery systems, and providers (Ross, December-January, 1998–1999; Ross, March 1999). Several public mental health systems have launched and are using consumer-and family-staffed independent consumer interview teams who focus on consumer dissatisfaction and mechanisms for resolving such dissatisfaction. Alabama, Georgia, Massachusetts, Ohio, and Pennsylvania operate such CSTs (consumer satisfaction teams). None are ideal in their independence. All have had to accommodate purchaser and political realities. Some involve providers. One uses focus groups rather than individual consumer interviews. One is financed by the MCO, calling into question its independence. Yet all offer more independence and a greater consumer/family focus than normal MCO operations (Ross, December-January, 1998–1999; Ross, March 1999).

Few public purchasers have contracted with external evaluators at the beginning of a managed care contract and made a commitment to continually using such external evaluators to assist them in judging vendor performance. Massachusetts (Beinecke, Keane, Symanzick, & Casey, 1999; Callahan, Shepard, & Beinecke, 1994; Beinecke & Lockhart, 1998) started such an external evaluation, but did not sustain it. Florida (Shern & Robinson, 1999) has such an evaluation agreement in its Tampa Bay and Jacksonville demonstration projects.

The use of third-party independent entities to promote accountability continues to grow. In 2000, NCQA will require independent validation of all HEDIS data provided by health plans. Twenty-nine States now mandate independent external clinical appeals (NCSL, 1999). A centerpiece of all major legislative proposals before Congress is mandatory, independent, third-party clinical review. Four States—Delaware, New Hampshire, Oklahoma, and Pennsylvania—currently use third-party, independent consumer and family monitoring teams in their State psychiatric hospitals (GAO, 1999b; Ross, December-January, 1999–2000). Two State Medicaid managed mental health care programs (Colorado and Washington) use independent ombudsman programs (GAO, 1999a).

The HHS-OIG (2000) has recommended that Medicaid managed mental health programs “established independent, third party mental health systems for conducting beneficiary satisfaction survey.”

Clearly, much more needs to be done in the area of public accountability, but the trend is clearly toward more accountability. Johnston and Romzek (1999) have concluded, “There is a tendency in privatization efforts, and especially in contracting relationships, to assume that contract management and accountability will take care of themselves or that they can be relatively easily achieved through contract monitoring. The reality is that contract management and accountability do not take care of themselves.”
7. Meaningful and Authentic Consumer, Family, and Enrollee Participation Is Rare in All Aspects of Services Planning, Implementation, and Evaluation

Many public purchasers and their management agents fail to meaningfully involve consumers, families, and enrollees in their operations. Consumers lack necessary information. In an October 1998 NAMI survey of its members’ experiences with managed care, 55 percent of respondents did not know how to file an appeal with their MCO. Respondents to the survey were those members who took the initiative to send in a survey response, so one would assume that they are the more involved and knowledgeable citizens. This survey demonstrates that all parties involved in health care must make a greater effort to educate citizens about their rights as health plan enrollees. CSTs, previously discussed, are vehicles for education, as are consumer and family organizations, such as NAMI, and ombudsman programs.

NAMI’s 1997 Managed Care Report Card (Hall, Edgar, & Flynn, 1997) failed the leading MBHOs regarding consumers and their family members being effectively engaged in their care. Not only can consumer and family organizations, ombudsmen, and purchasers help, but health plans themselves can actively involve consumers and families. In a representative democracy, citizens expect representation, which includes the important principle of meaningful and substantial involvement in the design, delivery, and monitoring of the system. Authentic public participation includes not only this representation, but also the citizens’ confidence that their input has an impact. Impact determines whether the involvement was authentic. Since 1986 and the P. L. 99–660 Federal Mental Health Block Grant requirement, every State has had to operate a citizens’ mental health planning and advisory council. Some of these have been forums for meaningful and authentic involvement. Health plans will have to learn from their State council counterparts.

Pires, Armstrong, and Stroul (1999) have studied how MCOs and MBHOs have involved families in their operations. By and large, MBHOs significantly involve families more than MCOs. Regarding initial planning and implementation activities, families were significantly involved in 36 percent of MBHOs compared with 13 percent of MCOs. Involvement in current refinements were even more striking: 47 percent of MBHOs significantly involved families, while only 13 percent of MCOs involved families. While 77 percent of MBHOs provided a training and orientation program to families, only 23 percent of MCOs provided such training.

Some States have attempted more meaningful family and consumer participation (HCFA-NASHP, 1999):

Oregon’s Medicaid staff held weekly meetings with health plan representatives, beneficiary representatives, and State social services agencies for more than a year before bringing beneficiaries with disabilities into managed care. These meetings covered topics such as building a common understanding of case management and case workers. After implementation, Medicaid staff met regularly with MCO management, medical directors, and advocacy and social service agency representatives to discuss payment rates, data reporting, and other matters relating to health care.

In Colorado, the Medicaid Managed Care Contracting Disability Working Group, composed of individuals who are disabled and their family members, MCO administrators, and State personnel, formulated recommendations to assess risk-adjusted rates and choice of a home health agency.

In Vermont, a Quality Improvement Advisory Committee composed of consumers, advocates, MCO representatives, providers, and State staff was established to assist the State with ongoing and comprehensive improvements of its managed care program.

In California, a 13-member committee is composed of community advocates (one seat is reserved for a
representative of persons with disabilities), MediCal beneficiaries, and representatives of the county social services agency and health care agency.

The Massachusetts Medicaid managed mental health program has a consumer advisory council and a family advisory council that meet monthly with both State officials and the managed care vendor (Sabin & Daniels, 1999). “When asked about the councils’ most important accomplishment, council members cited their work to influence the annual performance standards for the carve-out company” (p. 884).

Sabin and Daniels (1999), advocates of meaningful consumer and family involvement, conclude, “Consumers, families, and the public cannot be expected to trust health care systems that do not hold themselves accountable for demonstrating that their limit-setting policies are reasonable and fair” (p. 883).

The HHS-OIG (2000) has recommended that Medicaid managed mental health programs involve beneficiaries and families in the conversion process from FFS and in treatment planning.

8. Forms of Delivery

There are many different forms of managed behavioral health care delivery. As cited previously (Open Minds, 1999), MBHOs dominate the market. MBHOs deliver management of care in two forms: direct contracts with payers (known as “carve-outs” because behavioral health care is carved-out from other health care) and subcontracts with MCOs, in which the MCO contracts directly with the payer and then the MCO subcontracts with the MBHOs.

Three other management forms are important in today’s market: the full-service HMO, the preferred provider organization (PPO), and point of service (POS).

A full-service HMO is an organization that provides comprehensive medical care for a fixed annual fee. Behavioral health care is delivered as any other form of health care. There are four of these types of HMOs: group model, individual practice association, network model, and staff model.

A PPO is a variation of the traditional FFS care arrangement in which health plan enrollees receive services through a “preferred” network of providers. When the enrollee goes outside the network, which is allowed, the enrollee is frequently required to pay a higher copayment.

A POS plan is a form of PPO. Primary care physicians are usually the first provider of intervention and, as in PPOs, enrollees are charged significant additional copayments when they go out-of-net-work.

While these are the predominant forms of delivery, there are additional delivery forms based on function, including the following:

- Administrative services organizations or administrative service only organizations (ASOs), in which the management agent assumes no financial risk and is contracted to perform administrative services only, such as claims processing;
- Employee assistance programs (EAPs), in which services are designed to assist employees, their family members, and employers in finding solutions to workplace and personal problems;
- Integrated EAPs, in which an employee is enrolled in an MCO or MBHO for health benefit services, and that MCO/MBHO also provides EAP services; and
- Stand-alone utilization review (UR)/case management: These organizations provide clinical review of
inpatient or outpatient services.

- They may also have case management responsibilities for certain individuals with substantial health challenges. These organizations are usually paid a set fee for each UR or each case managed.

Only one published study exists that compares the delivery of managed behavioral health care services to the same enrolled population in the same geographic areas by two different delivery systems (HMOs vs. MBHOs). An evaluation of Tampa Bay and Jacksonville managed behavioral health care delivery (Shern & Robinson, 1999) compared HMOs that either contracted with MBHOs or internally managed benefits. The University of South Florida evaluation documented that MBHOs far outperformed HMOs in the areas of penetration rates, proportion of adults with serious mental illness who reported receiving mental health services, persons with schizophrenia who received atypical antipsychotic medications, and individuals who are discharged from inpatient settings and are seen within 30 days. HMOs and MBHOs performed about equally in terms of persons with major depression who received selective serotonin reuptake inhibitors (SSRIs). MBHOs performed somewhat better than HMOs in providing day treatment and targeted case management.

**Conclusion: Promise and Reality Don’t Connect**

The Nation stands at a critical juncture. Homelessness, the criminalization of mental illness, and public acts of violence have increased during the past decade. The Nation’s work to reduce stigma, reflected in a plethora of parity legislation across the country, combined with our concerns about homelessness, criminalization, and violence, draw unprecedented attention to mental health care delivery in public programs. Evidence-based best practices exist in pockets of excellence around the country. How do we replicate these best practices to further the public interest? That is the challenge.

Managed care has overpromised what it is capable of delivering. Seamless systems of integrated and coordinated delivery have not happened. The linkage between Medicaid and public mental health has not occurred. Adequate services to persons with serious mental illness do not exist in many parts of the country and are more an exception than the norm. Appropriate funding doesn’t happen. Payers and MCOs rarely make public their documented performance. Little meaningful and authentic consumer, family, and enrollee participation occurs. But there are beacons of success.

In 1998, one of the managed behavioral health care industry’s founders (Cummings, 1998) published an article on the “Spectacular Accomplishments and Disappointing Mistakes” of the industry. Cummings cited cost containment, industry growth, saving the mental health benefit, accountability, continuum of care, and self-regulation as the accomplishments. He identified the disappointments as loss of clinical focus, price merger mania, the public relations disaster, competitive paranoia, and integration with primary care.

In 1999, one of the Nation’s leading mental health services researchers (Mechanic & McAlpine, 1999) concluded that the “mission” was “unfulfilled” and littered with “potholes.” While there has been “an increased democratization of care,” with more persons with mental illness receiving more care, through a similar uniform level of treatment, this standardization has further undermined care for persons with the most serious forms of mental illness. While some managed care plans have reduced hospitalization and increased alternative services, many other plans have merely reduced hospitalization and increased profit.
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