

## **Managed Mental Health Care**

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## Executive Summary

Mental illness is a prominent issue in the U.S. According to the Substance Abuse and Mental Health Services Administration, approximately 18.5% of adults in the U.S. currently experience any mental illness and 4.2% experience serious mental illness. Despite the prevalence of this condition, many individuals do not have access to quality mental health services. This high level of unmet need notwithstanding, federal, state, and local governments have been under pressure for several years to control spending. Thus, the health care system has been continuously evolving to maximize the efficiency of health care services and to establish/maintain a high quality of care. One major development is the utilization of managed health care. Accordingly, mental health care, and behavioral health care at large, has progressively become more managed.

This report examines many aspects of managed mental health care, with specific focus on managed mental health care outcomes in general and the managed mental health system in Florida. Some of the major findings in this report include:

- States are increasingly relying on Medicaid managed care plans to contain costs, especially for individuals with complex needs such as those with serious mental illness.
- There is much variation among managed mental health care plans (e.g., structure or for-profit/nonprofit status, contractual and oversight requirements, and fiscal incentives).
- Several years ago, the health care system was dominated by the fee-for-service structure. Under this type of system, health care costs rose increasingly and uncontrollably. The utilization of managed health care expanded with the Health Maintenance Organization Act of 1973. Major transitions from fee-for-service care to managed mental health care began to occur rapidly during the 1990s and have continued since.
- Managed mental health care has been associated with several positive outcomes, including: reduction and/or control of costs; reduction of inappropriate, ineffective, and/or unnecessary care (e.g., expensive inpatient care and extensive outpatient care); improved access to care in outpatient settings; implementation of embedded quality improvement processes; emphasis on prevention; and integration of health services.
- However, some of the positive outcomes associated with managed mental health care have been extensively questioned. Opponents of managed mental health care argue that the cost reductions are linked to lack of access to care, decreases in quality of care, and shifting to other sources/sectors. Managed mental health care has been associated with several other negative outcomes, including: reduction in fees/reimbursement and increased administrative demands for providers, which can affect provider satisfaction; increased inappropriate care that results from placing too much focus on acute services and neglecting long-term care; bad public perceptions, especially in regard to for-profit structures; restriction of access to higher-intensity services that are needed by individuals with severe disorders; and discontinuity of care.
- No specific or single managed health care plan is clearly the best in meeting the needs of individuals with mental illness; integrating physical and mental health services can be complex regardless of carve-out or carve-in design; benefit packages should provide accountability but still allow flexibility to encourage plans to develop individualized care approaches; the setting of clear goals during development of a state's managed mental health care program is critical for success and consumer involvement is also important; several outcome and quality process measures are available for these programs (e.g., length

of time the consumer is in the community and caseload ratios); fragmentation caused by multiple funding streams and service delivery systems can be problematic; and monitoring systems to identify and correct potential problems in the programs are beneficial. When considering the applicability of any specific state managed mental health programs to other states' systems, it is important to analyze variables such as the demographic compatibility (e.g., rural and urban areas, geography, population, and network of service providers), structure of provider participation, and data collection arrangements.

- Florida has very recently begun to make major changes in its Medicaid managed care programs, including the behavioral health program. In 2013, the federal Centers for Medicare and Medicaid Services approved Florida's request to move almost its entire Medicaid program for acute care services into managed care; and in 2014, in an effort to reduce service fragmentation and allow for better coordination, Florida became the first state to offer a Medicaid health plan designed exclusively for individuals with serious mental illness, through a for-profit company.
- Close monitoring of the efficacy of the recent changes in state Medicaid managed mental health care programs is needed. Subsequent evaluations, and especially comparisons, can help to guide future policy. The systematic collection of quantitative data, especially on cost reductions, access to care, utilization rates, and quality of care, will be essential.

## Section 1. Introduction

Mental illness is a prominent issue in the U.S., where a large population of individuals are currently living with mental illness. According to a recent report by the Substance Abuse and Mental Health Services Administration (SAMHSA), in 2013, approximately 43.8 million adults aged 18 or older in the U.S., 18.5% of all adults in this country, had any mental illness (AMI) in the past year.<sup>1</sup> The report also reveals that in this same year, approximately 10.0 million adults aged 18 or older in the U.S., 4.2% of all adults in this country, had serious mental illness (SMI).<sup>2</sup> Despite the prevalence of mental illness, many individuals do not have access to quality mental health services. According to the SAMHSA (2014)<sup>3</sup> report, only 19.6 million, 44.7%, of the individuals with AMI and 6.9 million, 68.5%, of the individuals with SMI, in 2013, received mental health services in the past year. Furthermore, there were 11.0 million adults aged 18 or older, 4.6% of all adults, who perceived an unmet need for mental health care.<sup>4</sup>

Among the 5.1 million adults aged 18 or older in 2013 who had a perceived unmet need for mental health care and did not receive mental health services in the past year, several reasons were reported for not receiving mental health services. These included an inability to afford the cost of care (48.3 percent), believing at the time that the problem could be handled without treatment (26.5 percent), not knowing where to go for services (24.6 percent), and not having the time to go for care (15.8 percent)... (Substance Abuse and Mental Health Services Administration, 2014, p. 24)<sup>5</sup>

Access to mental health services does not necessarily guarantee the quality of these services. According to another SAMHSA (2013)<sup>6</sup> report, less than one-third of adults receive minimally adequate mental health or substance use disorder care, as defined by guidelines specified by various national organizations. This high level of unmet need notwithstanding, federal, state, and local governments have been under pressure for several years to control spending. Mental health funding has remained far from adequate to meet the increased need for care.

Although mental health expenditures have increased in the past two decades (from \$75 billion in 1990 to \$155 billion in 2009), they have fallen as a share of all health expenditures. (Substance Abuse and Mental Health Services Administration, 2013, p. xxiv)<sup>7</sup>

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<sup>1</sup> Substance Abuse and Mental Health Services Administration. (2014). *Results from the 2013 National Survey on Drug Use and Health: Mental health findings*, NSDUH Series H-49, HHS Publication No. (SMA) 14-4887. Rockville, MD: Substance Abuse and Mental Health Services Administration.

<sup>2</sup> Ibid.

<sup>3</sup> Ibid.

<sup>4</sup> Ibid.

<sup>5</sup> Ibid.

<sup>6</sup> Substance Abuse and Mental Health Services Administration. (2013). *Behavioral health, United States, 2012*. HHS Publication No. (SMA) 13-4797. Rockville, MD: Substance Abuse and Mental Health Services Administration.

<sup>7</sup> Ibid.

States such as California, Illinois, Nevada and South Carolina, which made devastating cuts to mental health services previously, have made further cuts for fiscal year (FY) 2012, putting tens of thousands of citizens at great risk. States have cut more than \$1.6 billion in general funds from their state mental health agency budgets for mental health services since FY2009, a period during which demand for such services increased significantly. These cuts translate into loss of vital services such as housing, Assertive Community Treatment, access to psychiatric medications and crisis services. In contrast, some states increased their state general fund appropriations for mental health in FY2012. However, these increases do not mitigate the damage that has been done by cuts to the infrastructure of services for people living with the most serious mental illnesses. (Honberg et al., 2011, p. 1)<sup>8</sup>

The conservative nature of mental health spending makes cost-effectiveness in terms of available mental health interventions/treatments even more critically important. Thus, health care systems have been continuously evolving to maximize the efficiency of health care services and to establish/maintain a high quality of care. One such development is the utilization of managed health care.

Managed care is an approach to financing and delivering health care that seeks to control costs and ensure or improve quality of care through a variety of methods, including provider management and quality assurance. (National Alliance on Mental Illness, 2011, p. 1)<sup>9</sup>

Managed health care programs exist in both the public and private health care sectors; examples include certain state Medicaid plans and health maintenance organizations (HMOs)/preferred provider organizations (PPOs), respectively. Mental health care, and behavioral health care at large, has progressively become more managed. States are increasingly relying on Medicaid managed care plans to contain costs for individuals with complex needs, such as those with SMI.<sup>10</sup> There is much variation among the models of managed mental health care. According to the National Alliance on Mental Illness (NAMI), whether managed health care plans are beneficial depends on a variety of factors.<sup>11</sup>

Rather than the specific managed care model, structure or for-profit/nonprofit status, it is often contractual requirements, fiscal incentives, oversight and leadership that have the most significant impact on how a managed care plan will meet the needs of children and adults living with mental illness and co-occurring substance use or primary care disorders. (National Alliance on Mental Illness, 2011, p. 2)<sup>12</sup>

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<sup>8</sup> Honberg, R., Kimball, A., Diehl, S., Usher, L., & Fitzpatrick, M. (2011). *State mental health cuts: The continuing crisis*. Arlington, VA: National Alliance on Mental Illness.

<sup>9</sup> National Alliance on Mental Illness. (2011). *Managed care, Medicaid, and mental health: Resource guide*. Arlington, VA: National Alliance on Mental Illness.

<sup>10</sup> Ibid.

<sup>11</sup> Ibid.

<sup>12</sup> Ibid.

Some of the most recent changes to managed mental health care have centered on expanding managed health care to populations with significant health issues (e.g., those with serious and persistent mental illness) and designing systems to integrate and coordinate care they receive.

## **Section 2. Historical Analysis of Managed Mental Health Care**

Several years ago, the health care system was dominated by the fee-for-service system, in which providers typically receive a fee for each delivered health service. This type of care, however, created financial problems mainly by allowing some providers to employ unnecessary services to make monetary gains. Under this type of system, health care costs rose increasingly and uncontrollably. Policy makers became alarmed with these exponential health care costs and sought mechanisms for restriction. Managed health care became one possible solution. The utilization of managed health care expanded with the Health Maintenance Organization Act of 1973. This act helped support the development of HMOs and set standards throughout the health care industry.

Major transitions from fee-for-service care to managed mental health care in particular began to occur rapidly a couple of decades ago, especially during the 1990s.

The entry of managed care into behavioral health lagged behind its entry into primary care by about a decade... Part of this lag was associated with the difficulty of developing a capitation rate for a population of individuals with hard-to-predict needs... However, due to high costs of treating persons with serious mental illness (SMI), states and private insurers alike have turned increasingly to managed care as a solution... and behavioral health became a major growth area for managed care through the 1990s... (Isett et al., 2009, p. 210)<sup>13</sup>

However, this transformation has not been without controversy. For example:

When I (Cantor) was president of the American Psychological Association (APA) in 1996 –1997, the furor of the psychological profession and the public with managed care was at a boiling point. I was able, as president, to convene a summit meeting of the presidents of nine national organizations of mental health professionals, including psychiatrists and social workers, to develop a unified response to the crisis. One of the things that made the collaboration so remarkable was that for this project, we were able to put aside the issues that divided our professions for the mutual benefit of all of our patients and those who were treating them. From our joint perspective, the obsession of the health care system with controlling costs was compromising the rights of individuals to competent and quality care. In March 1997 we issued *Your Mental Health Rights*, a bill of rights that focused on the right to full information about insurance coverage, confidentiality, choice, parity, and accountability... We shared the document with every member of Congress, and we believed that we had an influence on the

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<sup>13</sup> Isett, K. R., Ellis, A. R., Topping, S., & Morrissey, J. P. (2009). Managed care and provider satisfaction in mental health settings. *Community mental health journal*, 45(3), 209-221.

Patients' Bill of Rights that Congress passed soon after. (Cantor and Fuentes, 2008, p. 638)<sup>14</sup>

Health care standards were developed in the mid-1990s to help ensure the quality of health care; the initial lack of such standards was a major concern among those opposed to managed health care.

The transition to managed mental health care has continued steadily throughout the past decade.

Unlike European countries where the government both funds and dominates most mental health care services... in the USA almost all mental health care in both the private and the public sector (Medicaid and Medicare) is managed by large, private, and for-profit organizations. (Acker and Lawrence, 2009, p. 270)<sup>15</sup>

Several states are currently making a wide range of changes to their public health care programs, especially Medicaid. Many states have applied a managed health care delivery system to these programs. It is important to note that when designing and implementing a managed health care delivery system, states must comply with federal regulations. According to Medicaid.gov, these regulations include requirements for a managed health care plan to have a quality program and provide appeal and grievance rights, reasonable access to providers, and the right to change managed health care plans, among others. Approval must be given by the Centers for Medicare and Medicaid Services (CMS).

### **Section 3. Positive Outcomes Associated with Managed Mental Health Care**

As previously mentioned, one of the driving forces behind the shift to managed mental health care has been the pressure to reduce and control mental health costs. Managed mental health care has been shown to typically result in cost reductions.

The aims of managed care include ensuring accountability for health care resources and reducing costs by implementing utilization controls and payment mechanisms intended to reduce inappropriate, ineffective, or unnecessary care. These cost reductions are also designed to be achieved by promoting the use of safely delivered, lower intensity services that achieve desirable health outcomes. (Mauery et al., 2006, p. 7)<sup>16</sup>

Many analyses of large databases of mental health insurance claims have shown that managed mental health care saves money, as measured in reductions in absolute costs for employer and state agency purchasers. Although there appears to

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<sup>14</sup> Cantor, D. W., & Fuentes, M. A. (2008). Psychology's response to managed care. *Professional Psychology: Research and Practice*, 39(6), 638-645.

<sup>15</sup> Acker, G. M., & Lawrence, D. (2009). Social work and managed care measuring competence, burnout, and role stress of workers providing mental health services in a managed care era. *Journal of Social Work*, 9(3), 269-283.

<sup>16</sup> Mauery, D. R., Vaquerano, L., Sethi, R., Jee, J., & Chimento, L. (2006). *Managed mental health care: Findings from the literature, 1990-2005* (DHHS Pub. No. SMA-06-4178). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

be no consensus in the literature on the best way to measure savings, they have most often been documented in the form of reduced expenditures for persons with mild to moderate mental conditions such as dysthymia or unipolar depression by maximizing the use of outpatient and psychopharmaceutical treatments. (Mauery et al., 2006, p. 1)<sup>17</sup>

These cost reductions are evident not only in public managed mental health care systems, but also in private sector settings that have introduced managed mental health care policies. For example, Goldman et al. (1998)<sup>18</sup> found that over nine years, a large private employer that introduced managed behavioral health care was able to reduce mental health care costs by greater than 40%; this cost reduction was not attributed to decreased access to services, but rather fewer inpatient sessions per user, reduced probability of an inpatient admission, reduced length-of-stay for an inpatient episode, and substantially lower costs per unit of service.

Managed mental health care has also been shown to typically improve access to care, although more empirical research on this topic is needed.

Although much of the literature is anecdotal and large quantitative studies are lacking, it appears that managed mental health care improves access to care overall, primarily for persons whose mental health conditions are typically treated in ambulatory outpatient settings (e.g., mild to moderate depression or anxiety). (Mauery et al., 2006, p. 1)<sup>19</sup>

Managed mental health care has also been shown to decrease the utilization of inappropriate services (e.g., costly inpatient care and extensive outpatient care). Managed care has thus allowed for the steadying of expenditures on hospitalization and outpatient care. According to Frank et al. (2009),<sup>20</sup> spending within these two sectors has been virtually flat or declining for all payers during a time when expenditures on overall health care have grown.

Managed mental health care has been anticipated to result in better quality mental health services. There are embedded quality improvement processes in many managed mental health care programs, which cause an increased emphasis on accountability and outcomes. Managed mental health care also promotes the shift from inpatient care to outpatient and community-based services. Such services are not only generally more cost-effective than inpatient services, but they are also highly preferred by consumers. These services can result in better quality of life and recovery-oriented trajectories.

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<sup>17</sup> Ibid.

<sup>18</sup> Goldman, W., McCulloch, J., & Sturm, R. (1998). Costs and use of mental health services before and after managed care. *Health Affairs*, 17(2), 40-52.

<sup>19</sup> Mauery et al., supra, note 16.

<sup>20</sup> Frank, R. G., Goldman, H. H., & McGuire, T. G. (2009). Trends in mental health cost growth: An expanded role for management?. *Health Affairs*, 28(3), 649-659.



Relatedly, managed care organizations (MCOs) have been shown to employ more utilization/treatment management strategies for outpatient mental health care.<sup>21</sup> Such strategies have numerous health care benefits.

Utilization management may be defined broadly to include prior authorization, concurrent review, case management, medical necessity criteria, and practice guidelines...

... Utilization management can serve to triage patients into appropriate care, facilitate access to services, and eliminate unnecessary or inappropriate care, enabling limited resources to be used efficiently while containing costs. Furthermore, there are related treatment management mechanism such as standards for timely access to care that clearly aim to facilitate service delivery. (Merrick et al., 2006, p. 105)<sup>22</sup>

Managed mental health care plans tend to emphasize preventative care/interventions (e.g., screening and psychoeducation services). Preventative options can reduce potential suffering and the costs of treatment.

Many managed mental health care programs are evolving to better integrate physical and mental health services and to better organize and coordinate the fragmented mental health care delivery system.

Although numerous mental health providers have negative reactions to managed mental health care, some research indicates that such care may not actually negatively impact the satisfaction of these providers. A study by Isett et al. (2009)<sup>23</sup> reveals that:

Interestingly, and contrary to empirical findings in the general healthcare literature, managed behavioral health care was not uniformly associated with lowered job satisfaction compared to fee-for-service settings. Administrative burden was the only dimension with which managed care had a significant association; managed care did not influence ratings of satisfaction with worker autonomy, the quality of patient care relationships, or compensation for behavioral health care employees. (Isett et al., 2009, p. 217)<sup>24</sup>

Overall, more empirical, quantitative data and analysis is needed to help clarify and assess the magnitude of the impact of managed mental health care on costs and outcomes.

#### **Section 4. Negative Outcomes Associated with Managed Mental Health Care**

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<sup>21</sup> Merrick, E. L., Horgan, C. M., Garnick, D. W., & Hodgkin, D. (2006). Managed care organizations' use of treatment management strategies for outpatient mental health care. *Administration and Policy in Mental Health and Mental Health Services Research*, 33(1), 104-114.

<sup>22</sup> Ibid.

<sup>23</sup> Isett et al., supra, note 13.

<sup>24</sup> Ibid.

Some of the positive outcomes associated with managed mental health care have been extensively questioned. Opponents of managed mental health care, for example, argue that the cost reductions are linked to lack of access to care, decreases in quality of care, and shifting to other sources/sectors.

Managed mental health care has been accompanied by the perception, and often times, reality, that providers in managed care arrangements receive drastically reduced fees. Reduced reimbursement rates and increased administrative demands for providers often accompany managed mental health care. Since there is already a shortage of mental health providers in many areas, additional provider disincentives can further limit access to mental health care.

Presumably, since reimbursement rates under managed health care tend to be low, it is difficult to find mental health providers, especially psychiatrists, who will accept consumers. A recent study by Bishop et al. (2014)<sup>25</sup> reveals that many psychiatrists do not accept any type of insurance, especially Medicaid.

The percentage of psychiatrists who accepted private noncapitated insurance in 2009-2010 was significantly lower than the percentage of physicians in other specialties (55.3% [95% CI, 46.7%-63.8%] vs 88.7% [86.4%-90.7%];  $P < .001$ ) and had declined by 17.0% since 2005-2006. Similarly, the percentage of psychiatrists who accepted Medicare in 2009-2010 was significantly lower than that for other physicians (54.8% [95% CI, 46.6%-62.7%] vs 86.1% [84.4%-87.7%];  $P < .001$ ) and had declined by 19.5% since 2005-2006. Psychiatrists' Medicaid acceptance rates in 2009-2010 were also lower than those for other physicians (43.1% [95% CI, 34.9%-51.7%] vs 73.0% [70.3%-75.5%];  $P < .001$ ) but had not declined significantly from 2005-2006. (Bishop et al., 2014, p. 176)<sup>26</sup>

Additionally, complaints from other mental health providers, such as psychologists, include managed mental health care negatively impacting the ability to make a living.<sup>27</sup>

As previously mentioned, managed health care results in increased administrative demands that can be taxing and affect provider satisfaction. In the study by Isett et al. (2009)<sup>28</sup>, administrative burden within managed mental health care arrangements had a significant association with mental health provider satisfaction. Another study, by Rupert and Baird (2004),<sup>29</sup> compiled the results from two national surveys on the impact of managed mental health care on the independent practice of psychology and found that:

Both surveys indicated that managed care was a source of stress, with external constraints, paperwork, and managed care reimbursement being the mostly highly rated stresses. These stresses had not increased in the 5 years between surveys, and

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<sup>25</sup> Bishop, T. F., Press, M. J., Keyhani, S., & Pincus, H. A. (2014). Acceptance of insurance by psychiatrists and the implications for access to mental health care. *JAMA psychiatry*, 71(2), 176-181.

<sup>26</sup> Ibid.

<sup>27</sup> Cantor & Fuentes, supra, note 14.

<sup>28</sup> Isett et al., supra, note 13.

<sup>29</sup> Rupert, P. A., & Baird, K. A. (2004). Managed care and the independent practice of psychology. *Professional Psychology: Research and Practice*, 35(2), 185-193.

the most recent survey suggested that, overall, psychologists did not report high levels of burnout. However, in contrast to respondents with low managed care involvement, respondents with high managed care caseloads worked longer hours, had more client contact, received less supervision, reported more negative client behaviors, experienced more stress, were less satisfied with their incomes, and scored higher on emotional exhaustion. (Rupert and Baird, 2004, p. 185)<sup>30</sup>

Similarly a study by Cohen et al. (2006)<sup>31</sup> reveals, through in-depth, semistructured interviews conducted with therapists regarding therapy changes under managed mental health care plans, that:

A central theme in the interviews was a culture clash between managed care companies and these therapists. Working for managed care organizations demanded several practices that violated the therapists' standard of care and professional ethics. Also, participants reported that managed care personnel misrepresented the nature of psychotherapy to clients, thereby undermining the therapeutic work and the therapist-client relationship. (Cohen et al., 2006, p. 251)<sup>32</sup>

Some research has indicated that the initial cost savings that result from managed mental health care are merely transformed into additional costs in other care-related sectors. For example, a study by Shern et al. (2008)<sup>33</sup> found that:

Managed care was associated with a tendency toward reduced overall costs to Medicaid. However, private expenditures for managed care enrollees offset decreased Medicaid expenditures, resulting in no net difference in societal costs associated with managed care... For adults with mental illnesses, efforts to manage Medicaid expenditures may result in substituting individual and family resources for Medicaid services. Government must focus on the distribution of societal costs since risk-based financing strategies may redistribute costs across the fragmented human services sector and result in unintended system inefficiencies. (Shern et al., 2008, p. 254)<sup>34</sup>

Managed mental health care-related shifts have not only been noted in terms of societal costs, but also in the costs of specific types of treatment. Frank et al. (2009)<sup>35</sup> states that certain managed health care programs have incentives that promote a shift of treatment costs from inpatient and outpatient services to medication/drugs. This has implications for the quality of care received under managed mental health care plans.

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<sup>30</sup> Ibid.

<sup>31</sup> Cohen, J., Marecek, J., & Gillham, J. (2006). Is three a crowd? Clients, clinicians, and managed care. *American journal of orthopsychiatry*, 76(2), 251-259.

<sup>32</sup> Ibid.

<sup>33</sup> Shern, D., Jones, K., Chen, H., Jordan, N., Ramoni-Perazzi, J., & Boothroyd, R. (2008). Medicaid managed care and the distribution of societal costs for persons with severe mental illness. *American Journal of Psychiatry*, 165(2), 254-260.

<sup>34</sup> Ibid.

<sup>35</sup> Frank et al., supra, note 20.

Another facet related to quality of care under managed mental health care programs that has been questioned is inappropriate type of care. Care received through managed mental health care plans can place too much focus on acute services and neglect long-term care.<sup>36</sup>

Designing and implementing managed mental health care programs can be especially complex because of the subjective nature of mental illness and the associated treatment options. It is of the utmost importance that management does not result in restriction (e.g., an unreasonable limit on covered therapy sessions) that impedes recovery.

Public perceptions, especially in regard to for-profit companies, are typically negative surrounding managed health care plans.<sup>37</sup> Many individuals believe that the managing companies are more interested in saving money than providing proper health care. These negative perceptions not only impact the reception of managed mental health care programs, but also the confidence in the health care system as a whole.

Certain costly populations, such as individuals with serious and persistent mental illness, have historically been disadvantaged by managed mental health care plans. Components of managed mental health care programs including utilization management techniques and reimbursement policies might restrict access to the higher-intensity services (e.g., inpatient options) that are needed by individuals with serious disorders.<sup>38;39</sup> Fortunately, some managed mental health care programs are evolving to better serve these individuals.

Quality assurance outcomes and structures in managed mental health care programs need to be more extensively and carefully evaluated than they have been so far.

## **Section 5. Examples of (State) Managed Mental Health Care Programs**

State managed mental health care programs typically exist within the state Medicaid programs. Generally:

State expectations of managed care vary but may include cost control, enhanced effectiveness, improved quality of care, and more integrated substance abuse and mental health treatment services. Adoption of managed care principles and practices, however, occurred relatively rapidly and, for the most part, without benefit of empirical evaluations to guide system design and implementation. (McCarty et al., 2003, p. 7)<sup>40</sup>

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<sup>36</sup> Bazelon Center for Mental Health Law & Milbank Memorial Fund. (2000). *Effective public management of mental health care: Views from states on Medicaid reforms that enhance service integration and accountability*. Milbank Memorial Fund.

<sup>37</sup> Schur, C. L., Berk, M. L., & Yegian, J. M. (2004). Public perceptions of cost containment strategies: Mixed signals for managed care. *Health Affairs*, W4-516-525.

<sup>38</sup> Mauery et al., *supra*, note 16.

<sup>39</sup> Bazelon Center for Mental Health Law & Milbank Memorial Fund, *supra*, note 36.

<sup>40</sup> McCarty, D., Dilonardo, J., & Argeriou, M. (2003). State substance abuse and mental health managed care evaluation program. *The journal of behavioral health services & research*, 30(1), 7-17.

As previously mentioned, managed mental health care plans began to expand in the 1990s. Over the past couple of decades, some of these plans have been evaluated.

A 1997 report by Riley et al. (1997)<sup>41</sup> discusses the nine states participating in the “Transitioning to Managed Care: Medicaid Managed Care in Mental Health” symposium. These nine states, all with diverse approaches to Medicaid managed mental health care, include: Colorado, Connecticut, Delaware, Iowa, Massachusetts, Oregon, Tennessee, Washington, and Wisconsin. It was determined that no specific or single managed health care model was clearly best in meeting the needs of individuals with mental illness. Among the states included in this symposium, a variety of models of care were used, including those which integrate mental health services into traditional HMOs, those which offer mental health services completely separate from physical health services, and those which use partial carve-out structures. It was found that integrating physical and mental health services was complex regardless of carve-out or carve-in design. In regard to integrating care, the report recommends that:

Benefit packages need to be designed to provide sufficient accountability but still allow enough flexibility to encourage plans to develop individualized, consumer-sensitive care approaches and to overcome the institutional bias of fee-for-service Medicaid. Several states have attempted to encourage more flexible benefits by pooling Medicaid and mental health dollars in the capitation rate paid to plans. (Riley et al., 1997, p. iii)<sup>42</sup>

The authors concluded that evaluation of each state’s available network of plans and providers and then the subsequent setting of clear goals for the state’s managed mental health care program according to these evaluations was critical for program success.<sup>43</sup> This type of explicit goal setting was also critical for the oversight and monitoring quality of the program. Some of the outcome and quality process measures used by states to stress accountability include: length of time the consumer is in the community, consumer improvements on pre/post-treatment symptoms and community functioning, access, caseload ratios, and HEDIS-type quality indicators. Consumer involvement was another important area of focus identified in this symposium.

Mechanisms must be in place to assure that consumer input is used in planning or modifying the program. Feedback loops create ways to make sure input is used. Using peer leaders to educate consumers on their rights and responsibilities as managed care enrollees was stressed. Some states also use special care coordinators who teach persons with mental illness how to enroll and use the system with no disruption of care. (Riley et al., 1997, p. iv-v)<sup>44</sup>

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<sup>41</sup> Riley, T., Rawlings-Sekunda, J., Pernice, C., & National Academy for State Health Policy. (1997). *Transitioning to managed care: Medicaid managed care in mental health*. Portland, ME: National Academy for State Health Policy.

<sup>42</sup> Ibid.

<sup>43</sup> Ibid.

<sup>44</sup> Ibid.

Finally, the discussion in this report concluded that administrative issues, such as acquiring and synthesizing the data needed to set rates and determine risk sharing arrangements, can be difficult.<sup>45</sup>

States need staff and data resources to contract for, evaluate, and monitor managed mental health care and to develop needed relationships with stakeholders. (Riley et al., 1997, p. v)<sup>46</sup>

A review on the use of managed care in public mental health systems by the Bazelon Center for Mental Health Law and Milbank Memorial Fund (2000)<sup>47</sup> similarly found that the use of such systems was spreading, but that no single approach emerged as the most successful. Also similarly, this review determined that public managed mental health care programs were most useful and efficient, especially in terms of cost-effectiveness, offsetting risks, and protecting consumers, when state leaders engaged in collaborative efforts with stakeholder groups and providers to outline explicit goals for the program and to comprehensively plan and evaluate the system. This review addresses the circumstances surrounding managed mental health care for people with serious mental illness, a population that is heavily reliant on public sector services.

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 the larger states-in favor of county-based systems or systems organized through existing community mental health boards. (Bazelon Center for Mental Health Law and Milbank Memorial Fund, 2000)<sup>48</sup>

Some of the major problems with public managed mental health care programs included fragmentation caused by multiple funding streams and service delivery systems, the lack of accountability in public mental health systems, and difficulty developing comprehensive information systems in these programs.<sup>49</sup> Suggested solutions to some of these problems included: integrating programs for acute-care treatment and longer-term rehabilitation, establishing collaboration between mental health and physical health service systems, integrating local and state funding systems and funding streams, creating contracts that facilitate the addressing of inevitable problems and program improvement, basing capitation rates on reliable data (e.g., confirmed population information and benefit stipulations), and launching adequate data systems.

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<sup>45</sup> Ibid.

<sup>46</sup> Ibid.

<sup>47</sup> Bazelon Center for Mental Health Law & Milbank Memorial Fund, *supra*, note 36.

<sup>48</sup> Ibid.

<sup>49</sup> Ibid.

A common theme throughout these reports has been the importance of a monitoring system to identify and correct potential problems in public managed mental health care programs. A 2002 report by Kaye (2002)<sup>50</sup> discusses perspectives on the use of rapid monitoring systems from a summit on effective managed behavioral health care program monitoring.

The Substance Abuse and Mental Health Services Administration (SAMHSA) and the Centers for Medicare & Medicaid Services (CMS) have worked with program administrators and other stakeholders in Pennsylvania, Vermont, and Oklahoma to pilot Early Warning Systems (EWS). These systems use a limited set of measures and administrative processes to oversee the managed care behavioral health system and provide real-time, performance-based information to state, federal, and local governments; consumers; families; providers; advocates; and other key stakeholders. The EWS is designed to rapidly identify weaknesses in clinical care and to facilitate quality improvement efforts, leading to enhanced patient health outcomes. The program combines the use of current performance measures with a system of public accountability that increases stakeholder involvement in performance monitoring. (Kaye, 2002)<sup>51</sup>

Despite the variability among each of these state's EWSs, the eight unanimous and key findings identified at this summit include:<sup>52</sup>

1. It is important that monitoring efforts can both (a) rapidly identify and address potential problems and (b) assess achievement of long term health and societal outcomes, outcomes that may not be measurable for several years.
2. Most of the tools needed to develop a system to rapidly identify and address potential problems already exist.
3. Stakeholders are likely to identify three issues as being particularly important for early warning systems to focus on: (1) enrollee access to care, (2) the timeliness of provider payments, and (3) the cost of providing care. The relative importance of these three issues will change as a program is implemented and becomes established.
4. A need exists for standard reporting among states to provide comparative data, but states will also always need the flexibility to address local concerns.
5. An effective system to identify potential concerns must be able to identify unanticipated problems.
6. States have to balance the need to rapidly identify problems with the need to ensure that the data they use to make decisions accurately reflect contractor and program performance.
7. States must also balance the need for consistent reporting with the need to keep up with an evolving program and focus on issues that are currently important.

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<sup>50</sup> Kaye, N. (2002). *Perspectives on using a rapid monitoring system: A report from the effective managed behavioral healthcare program monitoring summit*. National Academy for State Health Policy.

<sup>51</sup> Ibid.

<sup>52</sup> Ibid.

8. Routinely sharing performance data creates a starting point for working with consumers and advocates. (Kaye, 2002)<sup>53</sup>

Rapid monitoring systems embedded in state managed mental care health programs have the potential to increase the efficiency and success of such programs.

In 2003, a study by McCarty et al. (2003)<sup>54</sup>, which evaluated publicly funded state managed care initiatives for substance abuse and mental health treatment, was released. Initiatives in Arizona, Iowa, Maryland, and Nebraska were analyzed.

States were chosen, in part, because their plans for publicly funded managed care for mental health and substance abuse services varied. Programs in Arizona and Iowa coordinated funding sources (Medicaid, block grant, and state appropriations) but varied in the use of regional (Arizona) versus statewide (Iowa) managed behavioral health care organizations. Nebraska, in contrast, did not include substance abuse services as a Medicaid benefit for adults and used two distinct managed behavioral health care models to control Medicaid (a full-risk contract) and non-Medicaid funds (an administrative services only contract) for behavioral health care. Finally, Maryland required qualified health plans to assume responsibility for the delivery and management of services for abuse and dependence on alcohol and other drugs. Substance abuse treatment is managed as a subset of community mental health services in Arizona and Nebraska. Maryland and Iowa, conversely, have relatively distinct service systems and management plans for mental health versus substance abuse treatment. (McCarty et al., 2003, p. 8)<sup>55</sup>

The findings indicate that public managed mental health care can be effective for mental illness and substance abuse treatment.<sup>56</sup> Certain programs were able to limit or reduce Medicaid expenditures for mental health treatments and shift utilization emphasis from inpatient care to outpatient and community-based treatments. However, the findings also suggest that data systems need to be improved so that the effects of these systems can be appropriately measured and accountability can be maintained.

The evaluations used administrative data and suggest a continuing challenge to structure plans so that undesired deleterious effects associated with adverse selection are minimized. Successful plans balanced risk with limited revenues so that they permitted greater access to less intensive services. (McCarty et al., 2003, p. 7)<sup>57</sup>

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<sup>53</sup> Ibid.

<sup>54</sup> McCarty et al., *supra*, note 40.

<sup>55</sup> Ibid.

<sup>56</sup> Ibid.

<sup>57</sup> Ibid.



Once again, there was consensus that no single approach was the best in regard to introducing and developing a public managed mental health care program.<sup>58</sup>

A study by Frank and Garfield (2007)<sup>59</sup> reviewed the literature on managed behavioral health care, carve-outs in particular.

As the managed behavioral health care market has matured, behavioral health carve-outs have solved many problems facing the delivery of behavioral health services; at the same time, they have exacerbated existing difficulties or created new problems. (Frank and Garfield, 2007, p. 303)<sup>60</sup>

Behavioral health care carve-outs have been shown to successfully reduce costs and to improve access to care.<sup>61</sup> However, some criticisms of such systems include increasing fragmentation in mental health care delivery, compromising professional autonomy, placing constraints on care giving, increasing administrative burdens, and negatively financially impacting providers. Recommended continued carve-out changes include coordinating mental and physical health services, addressing fragmented public financing systems, and implementing quality improvement.

Overall, there has been much variation in state managed mental health care program structure; some states have experienced negative outcomes with these programs, while others have experienced positive ones. Examples of a couple of states that have been associated with these negative outcomes include Tennessee and New Mexico.

Tennessee launched a managed mental health and substance abuse program, which had a publicly funded, carve-out approach, called TennCare Partners in 1996. A report by Chang et al. (1998)<sup>62</sup> found that this initial program struggled a great deal.

Many patients did not receive care or lost continuity of care, and the traditional “safety net” mental health system nearly disintegrated. (Chang et al., 1998, p. 864)<sup>63</sup>

This report suggests that the negative outcomes associated with TennCare Partners resulted from a flawed design, especially since funds that were earmarked for individuals with SMI were spread across the entire Medicaid population.<sup>64</sup> The recommendations from this case study include:<sup>65</sup>

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<sup>58</sup> Ibid.

<sup>59</sup> Frank, R. G., & Garfield, R. L. (2007). Managed behavioral health care carve-outs: Past performance and future prospects. *Annu. Rev. Public Health, 28*, 303-320.

<sup>60</sup> Ibid.

<sup>61</sup> Ibid.

<sup>62</sup> Chang, C. F., Kiser, L. J., Bailey, J. E., Martins, M., Gibson, W. C., Schaberg, K. A., ... & Applegate, W. B. (1998). Tennessee's failed managed care program for mental health and substance abuse services. *Jama, 279*(11), 864-869.

<sup>63</sup> Ibid.

<sup>64</sup> Ibid.

<sup>65</sup> Ibid.

States contemplating similar reforms should strive to protect vulnerable patients by risk-adjusting capitation payments and by focusing resources on care for severely mentally ill persons. States should also minimize program complexity and ensure the accountability of managed care networks for their patients' behavioral health care needs. (Chang et al., 1998, p. 864)<sup>66</sup>

New Mexico launched a major reform of publicly funded behavioral health care in 2005. This reform sought to consolidate state funding and integrate behavioral health services by initiating a for-profit managed care program with the company, ValueOptions New Mexico. A report by Willging et al. (2014)<sup>67</sup> on the impact of this reform on service agencies that care for low-income adults, including those on Medicaid reveals that:

Information technology problems and cumbersome processes to enroll patients, procure authorizations, and submit claims led to payment delays that affected the financial status of the agencies, their ability to deliver care, and employee morale. Rural employees experienced lower levels of job satisfaction and organizational commitment and higher levels of turnover intentions under the reform when compared to their urban counterparts. (Willging et al., 2014, p. 276)<sup>68</sup>

The recommendations in this review include:<sup>69</sup>

The challenges faced by SNIs in our study may be averted through greater attention to IT issues, local contextual conditions, workforce, infrastructure, and escalating administrative costs under managed care. The effects of large-scale system change on these struggling agencies and their employees deserve careful monitoring, preferably through mixed-method analytic research. (Willging et al., 2014, p. 289)<sup>70</sup>

Alternatively, some states that have been associated with positive outcomes in regard to implementing managed mental health care programs include Massachusetts, Colorado, and Nebraska.

Massachusetts initiated a statewide specialty mental health managed care program in Medicaid in 1992. In this program, mental health and substance abuse care was managed as a benefit carve-out by the company, First Mental Health, Inc. Massachusetts was thus the first state to introduce a Medicaid managed care program with capitated mental health care.<sup>71</sup> A study by Callahan et al. (1995)<sup>72</sup> of this program reveals that:

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<sup>66</sup> Ibid.

<sup>67</sup> Willging, C. E., Sommerfeld, D. H., Aarons, G. A., & Waitzkin, H. (2014). The effects of behavioral health reform on safety-net institutions: A mixed-method assessment in a rural state. *Administration and Policy in Mental Health and Mental Health Services Research*, 41(2), 276-291.

<sup>68</sup> Ibid.

<sup>69</sup> Ibid.

<sup>70</sup> Ibid.

<sup>71</sup> Callahan, J. J., Shepard, D. S., Beinecke, R. H., Larson, M. J., & Cavanaugh, D. (1995). Mental health/substance abuse treatment in managed care: The Massachusetts Medicaid experience. *Health Affairs*, 14(3), 173-184.

<sup>72</sup> Ibid.

Over a one-year period, expenditures were reduced by 22 percent below predicted levels without managed care, without any overall reduction in access or relative quality. Reduced lengths-of-stay, lower prices, and fewer inpatient admissions were the major factors. However, for one population segment-children and adolescents-readmission rates increased slightly, and providers for this group were less satisfied than they were before managed care was adopted. Less costly types of twenty-four-hour care were substituted for inpatient hospital care. (Callahan et al., 1995, p. 173)<sup>73</sup>

Thus, the authors in this review conclude that Massachusetts offers a good example of the usefulness of public managed mental health care programs, especially for at-risk populations.<sup>74</sup>

Colorado experienced similar outcomes following the implementation of the Colorado Medicaid Capitation Pilot Program in 1995. Under this Medicaid mental health capitation payment program, contracts were made with community mental health centers that manage mental health services and joint ventures between these centers and a for-profit managed care company.<sup>75</sup> Bloom et al. (2002)<sup>76</sup> examined the outcomes for individuals with SMI under this program. The Medicaid mental health capitation resulted in cost reducing service changes, especially in comparison to fee for service plans, for individuals with SMI. The authors recommend further analysis to identify the main sources of program cost-effectiveness.

Nebraska implemented a Medicaid managed care carve-out program for behavioral health services in 1995. A study by Bouchery and Harwood (2003)<sup>77</sup> evaluated the impact of this program on not only expenditures and mental health service utilization, but also quality of care. This study found that:<sup>78</sup>

Implementation of the program is correlated with progressive reductions in both total (about 13% over 3 years) and per eligible per month (20%) expenditures and a rapid, extensive decline in inpatient utilization and admissions. The percentage of enrollees receiving any type of treatment for a mental disorder actually increased modestly. Most important, several indicators of quality of care (eg, timely receipt of ambulatory care following discharge from inpatient care and readmission to inpatient care shortly following discharge) suggest that quality of care did not materially change under the carve-out. (Bouchery and Harwood, 2003, p. 93)<sup>79</sup>

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<sup>73</sup> Ibid.

<sup>74</sup> Ibid.

<sup>75</sup> Bloom, J. R., Hu, T. W., Wallace, N., Cuffel, B., Hausman, J. W., Sheu, M. L., & Scheffler, R. (2002). Mental health costs and access under alternative capitation systems in Colorado. *Health Services Research, 37*(2), 315-340.

<sup>76</sup> Ibid.

<sup>77</sup> Bouchery, E., & Harwood, H. (2003). The Nebraska Medicaid managed behavioral health care initiative: Impacts on utilization, expenditures, and quality of care for mental health. *The journal of behavioral health services & research, 30*(1), 93-108.

<sup>78</sup> Ibid.

<sup>79</sup> Ibid.

This finding is thus especially critical because it suggests that public managed care programs can allow states to contain Medicaid expenditures without negatively affecting quality of care.<sup>80</sup> It is important to note, however, that the authors recommend further, more thorough assessment of quality of care impacts.

A 2010 survey on Medicaid managed care programs in the U.S. found that nearly all states, the exceptions being Alaska, New Hampshire, and Wyoming, operate comprehensive Medicaid managed care programs.<sup>81</sup> This survey also found that dental care and inpatient and outpatient behavioral health care are the Medicaid services that are most often carved out of MCO contracts; 21 states with Medicaid MCOs carve-out some or all outpatient and inpatient behavioral health services.

Currently, many state mental health programs, including the Medicaid systems, are in flux. For example, Idaho has recently transitioned and New York is attempting to transition their state Medicaid programs to managed care for mental health and substance abuse services.<sup>82;83</sup> Arizona, California, and Texas have recently worked to strengthen the coordination and integration of mental health services with other relevant services in their Medicaid managed care programs.<sup>84;85</sup> Nebraska Medicaid has shifted to full-risk managed care for all mental health and substance use disorder services. New Mexico has also recently launched a variation of behavioral health care reform. According to a report by Willging and Semansky (2014):<sup>86</sup>

Gubernatorial administrations in New Mexico have initiated four overhauls of the publicly funded behavioral health care system over the past two decades. The most recent effort, Centennial Care, was implemented under a Section 1115 Medicaid waiver in January 2014. The authors describe Centennial Care, which closely resembles the now defunct restructuring of the public system that introduced Medicaid managed behavioral health care to the state in 1997. They also note disruptions in services to clients and hardships for providers, described locally as a “behavioral health crisis,” that resulted from actions taken in 2013 by the current gubernatorial administration to force the takeover of 15 nonprofit service delivery agencies by five Arizona companies. These actions led to an onsite investigation by the Centers for Medicare and Medicaid Services. (Willging and Semansky, 2014, p. 970)<sup>87</sup>

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<sup>80</sup> Ibid.

<sup>81</sup> Gifford, K., Smith, V. K., Snipes, D., & Paradise, J. (2011). A profile of Medicaid managed care programs in 2010: Findings from a 50-state survey. Washington, DC: Kaiser Commission on Medicaid and the Uninsured.

<sup>82</sup> Idaho Department of Health and Welfare. *Idaho behavioral health plan (IBHP)*. Retrieved from: <http://healthandwelfare.idaho.gov/Medical/Medicaid/MedicaidBehavioralHealthManagedCare/tabid/1861/Default.aspx>

<sup>83</sup> New York Department of Health. *Behavioral health transition to managed care*. Retrieved from: [https://www.health.ny.gov/health\\_care/medicaid/redesign/behavioral\\_health\\_transition.htm](https://www.health.ny.gov/health_care/medicaid/redesign/behavioral_health_transition.htm)

<sup>84</sup> Gifford et al., *supra*, note 81.

<sup>85</sup> National Association of Medicaid Directors. (2013). Appendix A of *Policy recommendations to support Medicaid behavioral health services*. Washington, DC: National Association of Medicaid Directors.

<sup>86</sup> Willging, C. E., & Semansky, R. (2014). State mental health policy: Back to the future: New Mexico returns to the early days of Medicaid managed care. *Psychiatric Services*, 65(8), 970-972.

<sup>87</sup> Ibid.

Given New Mexico's previous issues with Medicaid managed care, the authors state that the success of this most recent reform remain uncertain and they recommend that New Mexico invest capital in workforce development and focus on system changes designed to benefit vulnerable individuals who are at a heightened risk of hospitalization due to prolonged gaps in care.<sup>88</sup> The report further concludes that:<sup>89</sup>

Unlike other states, however, New Mexico is returning to an old system that adds bureaucracy, isolates the management of Medicaid dollars from other public funds, and has the potential to intensify service access problems. (Willing and Semansky, 2014, p. 972)<sup>90</sup>

When considering the applicability of any of these specific state programs to other states' systems, it is important to analyze variables such as the demographic compatibility (e.g., rural and urban areas, geography, population, and network of service providers), structure of provider participation, data collection arrangements, etc.

Close monitoring of the efficacy of the recent changes in state Medicaid managed mental health care programs is needed. Subsequent evaluations, and especially comparisons, can help to guide future policy. The systematic collection of quantitative data will be critical. Furthermore, since several states are currently in the process of changing their programs, it is important to observe the interactions among policy makers, stakeholders, providers, hospitals, and the public during the planning and development process.

## **Section 6. Managed Mental Health Care in Florida**

Managed care for general health services under Florida's Medicaid program began in 1984, and prepaid mental health programs for community mental health care began in 1996.<sup>91</sup> This Medicaid mental health carve-out demonstration began in the Tampa Bay area under a 1915(b) waiver.<sup>92</sup> Initial evaluations on this arrangement state that:

Findings suggest that the carve-out demonstration has succeeded in creating a fully integrated mental health delivery system with financial and administrative mechanisms that support a shared clinical model. However, other findings raise concerns about the HMO model in terms of stability, access to care, efficiency, and more generally about the shifting of risk and public responsibility "downstream" to private organizations without sufficient governmental oversight. (Ridgely et al., 1999, p. 400)<sup>93</sup>

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<sup>88</sup> Ibid.

<sup>89</sup> Ibid.

<sup>90</sup> Ibid.

<sup>91</sup> Shern, D., Robinson, P., Sasser, A., Vargo, A., Boothroyd, R., Constantine, B., ... & Dohnt, K. (2006). *Evaluation of Florida's Medicaid managed mental health plans: Year 9 report*. Tampa, FL: Louis de la Parte Florida Mental Health Institute, University of South Florida.

<sup>92</sup> Ridgely, M. S., Giard, J., & Shern, D. (1999). Florida's Medicaid mental health carve-out: Lessons from the first years of implementation. *The journal of behavioral health services & research*, 26(4), 400-415.

<sup>93</sup> Ibid.

Florida's managed mental health care program seems to have also experienced difficulties related to distribution of costs. A study by Shern et al. (2008)<sup>94</sup> evaluated the effects of Florida's Medicaid managed mental health care versus fee-for-service care on expenditures. This study found that Medicaid managed care was associated with an overall reduction in costs to Medicaid, but that these reductions were offset by increased private expenditures, especially in relation to informal caregiving, for managed care enrollees. This may mean that the true cost savings of Florida's Medicaid managed mental health plans have been overestimated.

In the past decade, two different approaches to the public managed mental health care system have been employed in Florida. One approach has been a behavioral health care carve-out plan, the Prepaid Mental Health Plan (PMHP); the other approach has been to have HMOs receive an integrated risk-adjusted premium that includes general health, pharmacy, and the community mental health services that are identical to those in the pre-paid plan, thus characterizing this approach as a carve-in purchasing arrangement.<sup>95</sup> However:

Both the PMHPs and HMOs are at financial risk for the mental health service utilization of their enrollees for the services that are specified in their contractual arrangements, which we refer to as the carve-out services. (Shern et al., 2006, p. 9)<sup>96</sup>

The Florida Mental Health Institute has analyzed the implementation of varied managed mental health care programs in Florida. These analyses identified several issues, including: the initiation of such programs is associated with disruptions in care, confusion and disruptions in service payments related to the new relationships between HMOs and traditional providers, the lack of integration of service networks (despite the integration of the mental health and general health premium of the HMOs), and increased administrative costs.<sup>97</sup>

Other findings raised concerns about the quality of care for individuals with SMI and children with serious emotional disturbances (SED), the diminished involvement of community mental health centers in the provision of services for MCO members, and the failure to reduce inpatient care in most of the areas of the state included in the evaluation.<sup>98</sup>

Additional studies from the Louis de la Parte Florida Mental Health Institute have revealed that following the statewide implementation of mental health managed care for Medicaid enrollees, consumer perceptions of care (e.g., on service quality, improvement in functioning and symptoms, and ability to obtain treatment and information from MCOs) were moderately positive and in

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<sup>94</sup> Shern et al., *supra*, note 33.

<sup>95</sup> Shern et al., *supra*, note 91.

<sup>96</sup> *Ibid.*

<sup>97</sup> *Ibid.*

<sup>98</sup> Murrin, M. & Constantine, R. (2008). *The administrative data component of the pre-paid managed care evaluation: Year III*. Tampa, FL: Louis de la Parte Florida Mental Health Institute, University of South Florida.

almost every service type, overall penetration rates within PMHP plans were higher than in HMO plans.<sup>99:100</sup> It is important to note that:

In the Inpatient follow-up analyses, penetration rates for all service categories are significantly higher in PMHP plans than in HMO plans. In this service group, PMHP plans also have significantly lower rates of Baker Act initiation and Florida Department of Law Enforcement (FDLE) arrest rates compared to the HMO plans. In all adult diagnosis groups, PMHP plans have significantly lower rates of arrest compared to HMO plans. (Teague et al., 2012, p. 1-2)<sup>101</sup>

Florida has very recently begun to make major changes in its Medicaid managed care programs, including the behavioral health program.

On June 14, 2013, the federal Centers for Medicare & Medicaid Services (CMS) approved Florida's request to move almost its entire Medicaid program for acute care services into managed care... The agreement was the culmination of many years of negotiations between the state and federal government. (Alker and Hoadley, 2013, p. 1)<sup>102</sup>

Significantly:

In addition to the plans that will serve the general Medicaid population, five other companies were selected to offer specialty plans intended to serve individuals with specific conditions (e.g., HIV/AIDS or severe mental illness) or select eligibility groups (e.g., children in the welfare system)... (Alker and Hoadley, 2013, p. 3)<sup>103</sup>

In the summer of 2014, Florida became the first state in the U.S. to offer a Medicaid health plan designed exclusively for individuals with SMI.<sup>104</sup> Florida's previous Medicaid plan contracted with separate companies to provide coverage for mental health services. In an effort to reduce service fragmentation and to allow for better coordination, Florida now plans to contract with:

Magellan (Complete Care), a for-profit company that oversees the behavioral health of 34 million enrollees, was the only company that bid on the mental health plan contract, which could be worth as much as \$1.5 billion over five years.

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<sup>99</sup> Boothroyd, R. A., Rynearson-Moody, S., Ort, R., & White, R. (2011). *Florida Medicaid enrollee perceptions of care with mental health services* (Agency for Health Care Administration (AHCA) series 220-141). Tampa, FL: Louis de la Parte Florida Mental Health Institute, University of South Florida.

<sup>100</sup> Teague, G., Murrin, M.R., Wang, S., & Green, J. (2012). *Florida mental health managed care evaluation: Administrative data analysis: FY 2011-2012* (Agency for Health Care Administration (AHCA) series 220-151). Tampa, FL: Louis de la Parte Florida Mental Health Institute, University of South Florida.

<sup>101</sup> Ibid.

<sup>102</sup> Alker, J., & Hoadley, J. (2013). *Medicaid managed care in Florida: Federal waiver approval and implementation*. Jessie Ball DuPont Fund & Winter Park Health Foundation.

<sup>103</sup> Ibid.

<sup>104</sup> Galewitz, P. (2014). Florida shifts Medicaid mental health strategy. *Kaiser Health News*. Retrieved from: <http://www.kaiserhealthnews.org/stories/2014/july/07/florida-program-for-mental-health-coverage.aspx>

Magellan’s model centers on a care coordination team made up of nurses, doctors and other specialists who will work with members and their families to achieve health goals. Magellan will also provide each member with a personal health guide who will help schedule appointments, arrange transportation to providers and help them follow treatment plans. (Galewitz, 2014)<sup>105</sup>

Florida’s managed behavioral health care program has immense implications for the behavioral health care system in the country at large. Arizona, Minnesota, and Tennessee have also recently made changes to increase the coordination of mental health care in their respective systems.<sup>106</sup> These state examples can serve to inform other states on methods to improve public mental health care dissemination.

## **Section 7. The Future of Managed Mental Health Care**

Large-scale quantitative studies are needed to better understand the effect of managed mental health care programs on important outcomes such as cost reductions, access to care, utilization rates, and quality of care.

... The growth of managed care in behavioral health has continued unabated, and virtually all serious behavioral treatment is now managed. Managed mental health care is now taken for granted, and there has been little serious research in the last decade on the continuing effects of management on access and quality. (Mechanic, 2011, p. 529)<sup>107</sup>

The use of formal program evaluation methods is needed to supplement qualitative evaluations based on key stakeholder expert opinion and would serve to further inform programmatic issues, such as pooling funding streams, intended to enhance financing and service delivery flexibility. (Mauery et al., 2006, p. 5)<sup>108</sup>

Modification, and hopefully improvement, of managed mental health systems will continue. Examples of some potentially positive changes include: increasing funding for mental health services to allow for the expansion of quality mental health services; maximizing utilization of cost-effective services, while taking into consideration the importance of the social and ethical implications of such transitions; moving the focus of care to long-term, recovery-oriented outcomes for individuals with SMI; ongoing integration of services and coordination among providers; and providing incentives for mental health providers to enter and remain in this underserved field and to engage in managed mental health care plans.

Key issues identified in previous studies of managed mental health care, including provider resistance and administrative burden, should be addressed. There is some evidence to indicate that incorporating incentive programs for providers in managed behavioral health care plans is feasible

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<sup>105</sup> Ibid.

<sup>106</sup> Ibid.

<sup>107</sup> Mechanic, D. (2011). Behavioral health and health care reform. *Journal of Health Politics, Policy and Law*, 36(3): 527–31.

<sup>108</sup> Mauery et al., supra, note 16.



and potentially beneficial.<sup>109</sup> More research and clinical data on different types of such programs is necessary. Interventions to reduce workforce dissatisfaction, such as reducing large caseloads, allowing for better compensation/reimbursement, and stressing continuity of care, should be pursued.

Development of new outcome measures, especially patient-centered measures, are needed to provide better feedback on quality of care outcomes.

In regard to designing/modifying and executing managed mental health care programs, there is considerable evidence that behavioral health care carve-outs can lead to costs reductions in both private and public sector plans.<sup>110</sup> Furthermore:

Numerous sources in the literature indicate that carve-outs are preferred by purchasers, with certain safeguards regarding care coordination. Managed mental health carve-outs are preferable to carve-ins for persons with milder mental health conditions, when care coordination requirements between physical and mental health care are less crucial, than for adults with SPMI or children with SED... The main advantages of carving out include better accountability of mental health expenditures, expanded treatment services, and ability to control claim costs. The main disadvantages include higher administrative costs, potential for fragmentation of physical and mental health services, and potential consumer confusion regarding how to access services. (Mauery et al., 2006, p. 25)<sup>111</sup>

Additionally, according to Mauery et al. (2006)<sup>112</sup> several evaluations indicate that combining multiple funding streams across service sectors is an effective method to overcome the fragmentation of mental health systems. Braiding funds might allow for better financial accountability than blending funds.<sup>113</sup> For reference, blended funding combines funds from multiple sources into a single pool used to pay providers; braided funding uses funds from multiple sources by authorizing payment to providers based on the relative distribution of the levels of each source/agency's responsibility for treatment service delivery.

The National Alliance on Mental Illness (NAMI) provides the following public policy guidelines for implementing/administering managed care:<sup>114</sup>

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<sup>109</sup> Meredith, L. S., Branstrom, R. B., Azocar, F., Fikes, R., & Ettner, S. L. (2011). A collaborative approach to identifying effective incentives for mental health clinicians to improve depression care in a large managed behavioral healthcare organization. *Administration and Policy in Mental Health and Mental Health Services Research*, 38(3), 193-202.

<sup>110</sup> Green, C. A., Estroff S. E., Yarborough B. H., Spofford M., Kitson R. S., & Perrin N. A. (2014). Directions for future patient-centered and comparative effectiveness research for people with serious mental illness in a learning mental health care system. *Schizophrenia Bulletin*, 40(Suppl 1), S1-S94.

<sup>111</sup> Mauery et al., supra, note 16.

<sup>112</sup> Ibid.

<sup>113</sup> Ibid.

<sup>114</sup> National Alliance on Mental Illness. (2014). *Public policy platform* (10<sup>th</sup> ed.). Arlington, VA: National Alliance on Mental Illness.

1. (6.5.1) Governments at all levels must continue to have authority over and be accountable for the delivery of treatment and services for persons with serious mental illnesses when contracting out treatment and services to private managed care organizations (MCOs).
2. (6.5.2) NAMI believes that even when treatment and services are contracted out to MCOs, persons with serious mental illnesses who are employed but cannot obtain employer-provided health care coverage should continue to be eligible for public health care benefits and government at all levels must maintain the availability of a comprehensive community-based system of treatment and services for persons with serious mental illnesses.
3. (6.5.3) There must be meaningful participation by consumers and families in the design, implementation, monitoring and evaluation of managed care system as well as cultural sensitivity to ethnically diverse populations and communities.
4. (6.5.4) Whenever government at any level contracts with MCOs or other entities to solely manage or deliver Medicaid-funded services for persons with serious mental illnesses, there must be no resulting division within the overall mental health system that causes persons who are most severely disabled by serious mental illnesses and require the greatest use of more costly treatment and services to be carved out into less funded or less effective public mental health care systems.
5. (6.5.5) When contracting out to MCOs results in reduced public expenditures, the savings must be reinvested in expanding services to persons with serious mental illnesses.
6. (6.5.6) MCO administrators and treatment staff must be trained and expected to understand serious mental illnesses, work with persons with serious mental illnesses including awareness of the consumer and family perspective and accept accountability for the quality of services provided.
7. (6.5.7) All MCO treatment staff must be rigorously and appropriately credentialed by appropriate state agencies.
8. (6.5.8) MCOs must provide comprehensive community-support services available for persons with serious mental illness regardless of ability to pay and these services must include the availability of the most individually effective medications, talk therapy, inpatient treatment, residential support services, intensive case management, psychosocial rehabilitation, consumer-run services, around-the-clock crisis services seven days a week and outpatient services that are mobile and accessible.
9. (6.5.9) MCOs must be accountable for appropriate and effective linkages to housing as well as supportive services and employment services.
10. (6.5.10) MCOs must be required to adhere to appeal and grievance procedures that are user-friendly and timely, given the life-threatening nature of psychotic episodes.
11. (6.5.11) MCOs must provide sufficient information and government at all levels must report at least annually on the number of persons with serious mental illnesses and other mental illnesses who 1) are identified but fail to present for services; 2) are in jail, prison or juvenile detention; 3) have been placed in a

hospital, nursing home, or long term care facility; and 4) have died. (National Alliance on Mental Illness, 2014, p. 46-48)<sup>115</sup>

These guidelines are designed to help achieve the kind of transparency regarding coverage policy and benefit design that is needed to foster trust and positive relations between policy makers, stakeholders, providers, and the public.

The recent impact of the enactment of several major policy initiatives, such as the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act, on the mental health care system and managed mental health care programs should be evaluated. These acts expand health care coverage, especially through the extension of Medicaid eligibility. So far:

The literature on parity suggests that it (1) creates incentives for insurance plans to use managed behavioral health care contracts to control costs and utilization; (2) generally does not increase overall costs to plans and may result in decreased expenditures, particularly if carve-outs are initiated and both medical and behavioral health services are managed similarly; (3) reduces out-of-pocket costs for consumers; and (4) does not threaten access to mental health services. (Green et al., 2014, p. S29)<sup>116</sup>

Far more research on evidence-based mental health services in general and the comparative cost-effectiveness of such services (e.g., screening, assessment, outreach, prevention, and treatment) is needed. For example, limiting treatment expansion for certain mental disorders such as bipolar disorder and schizophrenia to primarily pharmaceutical options is not consistent with the evidence-based treatment of these conditions.<sup>117</sup> The incentives in managed mental health care programs should reflect, and be compatible, with scientific findings in regard to treatment.

The mental health system at large would benefit greatly from quality assurance research/measures. A recent review suggests that:

Although there has been much activity in recent years in the development of (mental and/or substance use) M/SU indicators, efforts have lacked coordination, have focused on limited areas of clinical activity, and have not been clearly linked to quality improvement activity. The study recommends that the United States government forms an entity to better coordinate efforts and address these concerns. Clinicians and provider organizations should also increase the use of already developed M/SU indicators to improve quality of care delivered. (Herbstman and Pincus, 2009, p. 623)<sup>118</sup>

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<sup>115</sup> Ibid.

<sup>116</sup> Green et al., *supra*, note 110.

<sup>117</sup> Mechanic, *supra*, note 107.

<sup>118</sup> Herbstman, B. J., & Pincus, H. A. (2009). Measuring mental healthcare quality in the United States: A review of initiatives. *Current Opinion in Psychiatry*, 22(6), 623-630.

Overall, one of the most important future endeavors in the realm of managed mental health care is to conduct updated and comparative empirical research on different managed mental health programs.

Much of the literature on care financing is policy focused or descriptive, rather than comparative. Policy changes in the 1990s, however—as well as the development of capitated models, carve-outs, managed care for behavioral health, and implementation of parity for mental health benefits—offer interesting opportunities for natural experiments in both the public and private sectors. That said, we could not identify any systematic reviews or meta-analyses addressing financing strategies. Most comparative studies are observational, relying on analyses of Medicaid claims or administrative data, or data from large employers and integrated health systems. Additionally, much of the literature dates from more than 5 years ago, and more recent publications often use or cite data from older studies. The most recent literature addresses recent health care reform initiatives and are thus largely editorial. (Green et al., 2014, p. S26)<sup>119</sup>

Close monitoring of the efficacy of recent state Medicaid managed care program changes, especially in Florida, will be critical.

## **Section 8. Conclusion**

As the mental health system continues to evolve, the implementation of managed mental health care programs is a potentially promising option, especially for containing, or reducing, costs and improving access to care. However, regulations must be in place to ensure that such programs balance containing expenditures with adequately addressing and assessing the mental health needs of the beneficiaries. Specific recommendations for the advancement of managed mental health programs include:

- Exploring the most effective methods to expand managed mental health care coverage to individuals with SMI
- Continuing efforts to integrate services and coordinate care, delivery, and funding
- Gathering empirical, quantitative data to critically analyze the effect of such programs on access to care
- Carefully evaluating, and ensuring, the quality of care received under such programs
- Analyzing the nature of relevant cost savings to confirm that distribution of costs to other sectors is not occurring
- Lessening administrative burden associated with implementing such programs
- Protecting providers (e.g., through raising reimbursement rates and providing incentives)

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<sup>119</sup> Green et al., *supra*, note 110.

- Communicating more effectively with the public to reduce negative perceptions and guarantee that individuals are able to navigate managed mental health care systems
- Involving both providers and consumers (e.g., through feedback loops) in the planning or modifying of such programs
- Acknowledging the research supporting the efficacy of carve-out designs, while understanding the need to increase coordination under such designs
- Collaborating and setting explicit goals when creating public managed mental health care models
- Establishing monitoring and accountability measures (e.g., rapid monitoring systems), and utilizing the data collected from such measures
- Modifying/updating data collection systems to maximize efficiency
- Considering specific state demographics before generalizing models/policies
- Collecting reliable data on which to base capitation rates/contact arrangements when designing such programs
- Updating and conducting more comparative evaluation research on the emerging managed health care programs, especially on the Florida model, in order to inform stakeholders, providers, policy makers, and the public

Appropriately designed managed mental health care programs can have great implications for both states and individuals. The recent changes within managed mental health care models, such as expanding managed health care to populations with significant health issues and designing systems to integrate and coordinate care, can continue to improve the efficacy of these programs. It is of critical importance, however, that before more program developments/modifications are made, adequate empirical evaluations are conducted to assess the continuing effects of managed mental health care, especially on access to and quality of care.