Administration and Policy in Mental Health, Vol. 32, No. 4, March 2005 (© 2005)
DOI: 10.1007/s10488-004-1662-3

OVERVIEW OF PUBLICLY FUNDED MANAGED BEHAVIORAL HEALTH CARE

Mardi Coleman, William Schnapp, Debra Hurwitz, Sabine Hedberg, Linda Cabral, Aniko Laszlo, and Jay Himmelstein

ABSTRACT: Using MEDLINE and other Internet sources, the authors perform a systematic review of published literature. A total of 109 articles and reports are identified and reviewed that address the development, implementation, outcomes, and trends related to Managed behavioral health care (MBHC). MBHC remains a work in progress. States have implemented their MBHC programs in a number of ways, making interstate comparisons challenging. While managed behavioral health care can lower costs and increase access, ongoing concerns about MBHC include potential incentives to under-treat those with more severe conditions due to the nature of risk-based contracting, the tendency to focus on acute care, difficulties assuring quality and outcomes consistently across regions, and a potential cost-shift to other public agencies or systems. Success factors for MBHC programs appear to include stakeholder involvement in program and policy development, effective contract development and management, and rate adequacy.

KEY WORDS: managed behavioral health care; managed behavioral health care organizations; Medicaid.

Managed Behavioral Health Care

Managed behavioral health care (MBHC) is a fairly recent innovation that emerged in 1990 in response to states' needs to control rising health

Mardi Coleman, B.A., is a Research Associate at the UMass Center for Health Policy and Research. William Schnapp, Ph.D., is a Professor at the University of Texas Medical School at Houston. Debra Hurwitz, M.B.A., B.S.N., R.N., is the Director, Sabine Hedberg, M.A., M.P.A., is a Project Director, Linda Cabral, M.M., is a Project Director, and Aniko Laszlo, M.A., M.B.A., is a Research Associate, all at the UMass Center for Health Policy and Research. Jay Himmelstein, M.D., M.P.H., is a Professor of Family Medicine and Community Health.

Material for this article was developed in part to support a comprehensive evaluation of the MassHealth Primary Care Clinician Plan behavioral health carve-out, conducted by the University of Massachusetts Center for Health Policy and Research at the request of Phyllis Peters, M.B.A., Deputy Assistant Secretary for the MassHealth Office of Acute and Ambulatory Care.

Address for correspondence: Mardi Coleman, B.A., UMass Center for Health Policy and Research, 222 Maple Avenue, Shrewsbury, MA 01545. E-mail: mardia.coleman@umassmed.edu.

care costs and their ability to access the federal 1915(b) demonstration waivers. In 1915(b) waivers, the federal government grants states flexibility in establishing and operating their Medicaid programs in exchange for their extending coverage beyond mandated populations and meeting major program objectives in a cost-efficient manner. This is achieved by allowing states to require its Medicaid beneficiaries to enroll in a managed care plan, thus limiting their choice of available providers.

In 2004, states again need to control rising health care costs, driven in part by spiraling pharmacy costs. Again, a new federal waiver, the Health Insurance Flexibility and Accountability Initiative, HIFA, is available for states to reconfigure how, to whom, and how much health care they will deliver. The President's New Freedom Commission report, *Achieving the Promise: Transforming Mental Health Care in America*, has issued a largely unfunded call to action and a national agenda to support care integration and a focus on recovery that many believe is at odds with the Medicaid's limited funding mandate to provide only medically necessary care (Center for Mental Health Services, 2003). In order to appreciate the current challenges facing managed behavioral health care, it is important to understand the context of its emergence, as well as the lessons learned from its implementation.

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While there are many milestones in treatment of behavioral health problems, the three most frequently cited as having profoundly changed the landscape of care delivery are: the pharmacological advances that began in 1950s, the creation of Medicaid in 1965, and the deinstitutionalization movement of the 1970s (Geller, 2000; Mechanic, 1998; Mowbray, Grazier, & Holter, 2002; Office of the Surgeon General, 1999). These three milestones directly or indirectly led to the establishment of managed behavioral health care, which may be considered a fourth milestone.

Advances in pharmacological approaches permitted many people with previously intractable mental health disabilities to receive more effective treatment. These advances in treatment, coupled with the creation of Medicaid and Medicare, as well as growing concerns about abuse and neglect in state hospitals and state institutions serving the mentally ill spurred and supported the deinstitutionalization movement that began in the 50s and reached full force in the 60s and 70s.

Deinstitutionalization was originally conceived as a means to treat people with long-term disabilities, particularly developmental disability and mental illness, in smaller residential facilities with community-based services. This was financially possible with the new Medicaid funds for those states choosing to access the funds. However, over time the Medicaid 1915(c) waiver led to a deinstitutionalization process that was fundamentally different for those with mental illness.

The introduction of Medicaid funding and public mental health care meant that Medicaid recipients would be treated in the community, and no longer limited in their choice of provider or service setting. This led to ''a proliferation of providers seeking to supply services to people with mental health problems'' (CMHS, 2003). The availability of funds also encouraged conversion of unused surgical/medical beds in general hospitals to inpatient beds for psychiatric and substance abuse services to accommodate treatment for those who would have been otherwise treated in a state institution. Because providers are typically reimbursed for service provision rather than serve as the individual's ''medical home'' (i.e., provide case management or care coordination), there was no financial incentive to limit service provision or refer patients to other types of providers. Hospitals were likely to provide patients with 30-day treatment stays. In an environment that provided no oversight for in- or out-patient utilization, Medicaid expenditures for substance abuse and mental health services increased rapidly (Beinecke, 1999).

The Omnibus Budget Reconciliation Act of 1981 established block grant funding for states and repealed the 1980 Mental Health Systems Act. This repeal erased efforts to establish a national and systematic approach to care by enabling states to administer their own funds and develop their own independent programs. This led states to turn to Medicaid as an increasingly dominant mechanism for shifting the locus of control for community mental health systems from federal to state and/or local authorities. However, this also allowed states to leverage state general fund revenues with Medicaid funds, known as Federal Financial Participation (FFP), serving to create opportunities for states to effectively double mental health care resources for eligible populations.

Medicaid regulation specifically bans the usage of funds for care of the mentally ill in long-term care facilities that are classified as institutions for mental diseases. However, through its 1915(c) waiver programs initiated in 1981, Medicaid allowed states to fund community alternatives to long-term institutional care for the elderly and individuals' developmental disabilities, with the belief that community alternatives would be more cost-effective than institutional care. This led to distinct differences in the types of community services available to these two populations. Under the waiver, those with developmental disabilities became eligible to

receive an array of Medicaid-funded services considered diversionary to institutional placement and thus cost-effective. These Medicaid-funded services include residential services, day habilitation, vocational training, transportation, and case management. Because people with severe mental illness (SMI) are not eligible to receive Medicaid-funded long-term institutional placement, Medicaid has not been available to fund a similar array of diversionary services for this population.

States can define eligibility and implement waiver programs for their overall Medicaid programs in very different ways, resulting in varying service packages.

Over time, advances in pharmacology, Medicaid and the Medicaid waiver programs, and deinstitutionalization effectively: (1) reduced the census of state mental health hospitals and state institutions for the developmentally disabled; (2) led to unequal service systems, supports, and treatment options for those with serious mental disorders; and (3) led to increased financial burden for states as care shifted to community care within a context of an unmanaged fee-for-service delivery system.

1915(b) Waivers and Managed Behavioral Health Care

In an effort to help states manage and control health care costs, the federal government introduced the 1915(b) waiver program that allowed states to launch managed care programs. States turned to managed behavioral healthcare in the hopes it would:

- Control the escalating costs of behavioral health care that frequently centered on 30-day inpatient hospitalizations
- Improve access through a reinvestment of savings in programs, required by the waiver
- Achieve greater predictability, accountability, and efficiency (value) for states' health care dollars through capitation (Office of the Surgeon General, 1999)

In addition, as states realized the possibilities of managed care, other goals emerged, such as (1) improving the integration of physical and behavioral health and between mental health and substance abuse services; (2) improving the quality of care through such means as evidence-based practice guidelines, and the development of data systems to monitor outcomes; and (3) supporting innovation and development of new programs.

The Delivery of Managed Behavioral Health Care

MBHC differs markedly from the fee-for-service system of reimbursement, and care can be ''managed'' in a number of ways. Services are said to be ''carved-in'' when the cost to provide behavioral health services is a part of the global health capitation rate paid to a managed care entity. This model is typically associated with Health Maintenance Organizations (HMOs). An HMO may establish its own provider network or subcontract some or all if its behavioral health care services to a separate entity. This later economic relationship is called a ''partial carve-out.''

In a carve-out, behavioral health services are contracted separately, or ''carved-out,'' from physical health services. States may choose to carve-out some or all behavioral health services, such as substance abuse, mental health, or administrative service (ASO) functions. Because states contract for specific services, a carve-out model assures that financial resources will be directed towards contracted behavioral health care, and allows for the creation and monitoring of behavioral health outcomes.

In a carve-in model, the primary care provider serves as the service gatekeeper, and is more likely to support the coordination and integration of behavioral and physical health. The President's New Freedom Commission's report indicates that this integration is critical for recovery of those with mental health disorders.

States Implement Highly Individualized Approaches

It is important to keep in mind that states have implemented managed behavioral health care in a variety of ways. While all states must provide a core set of mandatory services to covered members in order to receive Medicaid FFP, states can define eligibility and implement waiver programs for their overall Medicaid programs in very different ways, resulting in varying service packages (Mann, 2002). States may focus on a traditional service population, or provide expanded services to special populations. Thus, a person who is eligible for Medicaid in one state may not be eligible in another.

The services provided by one state may differ considerably in amount, duration, or scope from services provided in demographically or geographically similar states (Bergman & Bush, 1999). States may contract with a single or multiple providers, and may implement managed behavioral health care across all counties or regions of a state, or in a single county or region while retaining fee-for-service in other areas or for specific populations. Further, they frequently use multiple-service models to deliver behavioral heath care, and may choose to have some populations or services remain fee-for-service. For instance, Massachusetts currently utilizes a variety of programs to provide its managed behavioral health

care. About one-third of its Medicaid population, almost exclusively the elderly and disabled, continues to utilize Medicaid fee-for-service for its behavioral health care (SAMHSA, 2000). The remaining Massachusetts Medicaid members utilize managed behavioral health care, and are about evenly split between four traditional commercial MCO programs, which utilize both carve-in and partial carve-out models, and the state-run managed care plan (the PCC plan) which utilizes a statewide carve-out to serve its members.

States may choose to contract with the managed care entity to ''carve-out'' any or all of the following services: mental health, substance abuse, and administrative services. States may further carve-out mental health and substance abuse services within state children's welfare, juvenile justice, and criminal justice agencies. Specific services may also be carved out. For instance, New York and Hawaii use partial carve-out contracts for more intensive treatment, and the conventional plan to cover basic Medicaid benefits. Rhode Island has a capitated plan for patients with at least a year in the state mental hospital. By comparison, Wisconsin allows members with severe mental illness to stay in the fee-for-service system (National Council of State Legislatures, 1998).

Service needs and goals...may be different for rural states and counties who typically face ongoing service delivery infrastructure and access challenges.

In county or regional systems, services and eligibility can vary from county to county and region to region depending on the types of funding streams and the autonomy available to develop those systems. Further, service needs and goals for a state or regional managed behavioral health program may be different for rural states and counties who typically face ongoing service delivery infrastructure and access challenges (Lambert, Gale, Bird, & Hartley, 2003).

A number of state agencies may administer the state's managed care plan, either singly or in combination. How state agencies are organized is likely to impact how behavioral health care is coordinated and how policy is formulated. How states organize their mental health, substance abuse, criminal justice, elder, youth, and family-serving agencies and departments varies from state to state. It is important to note that in most states, the mental health authority has oversight responsibility for all mental health issues. However, the state Medicaid agency, because it is the primary funder and contractor for public mental health services, can also have a significant impact on state mental health issues and policy formation (Buck, 2003; Gold & Mittler, 2000).

The 2001 SAMHSA Tracking Report indicated that state Medicaid agencies tended to set policies and rates, and manage the contracts with managed care entities. In nearly 90% of programs purchased by Medicaid, the Medicaid agency enrolled individuals or determined eligibility. In comparison, state mental health and substance abuse authorities were typically involved in activities regarding specialty sector certification, accreditation and licensing, clinical management, and network development (The Lewin Group, 2001).

The GAO report, *Four States' Experience with Mental Health Carveout Programs* (GAO, 1999), provides a snapshot of the variation that can occur in state agency oversight of the managed behavioral health care program(s):

- *Colorado*. Responsibility of the state Medicaid division, but managed by Mental Health Services within the Department of Human Services, through an interdepartmental memorandum of understanding with the Department of Health Care Policy and Financing.
- *Iowa*. Joint Medicaid and substance abuse divisions, with the Division of Medical Services and the Division of Substance Abuse and Health Promotion each in a different department. The Division of Mental Health and Developmental Disabilities and the Division of Medical Services are both within the Department of Human Services.
- *Massachusetts*. Responsibility of the state Medicaid division. Division has interagency service agreements with the Department of Mental Health and the Department of Social Services. This arrangement changed in 2003, when the Massachusetts Executive Office of Health and Human Services reorganized and restructured its agencies. Contract management now resides within both the Department of Mental Health and the Office of MassHealth.
- *Washington*. Mental Health Division within the Department of Social and Health Services was the state carve-out manager and also the contract administrator (US GAO, 1999).

Further, states at different points in time may be seen as success stories and then struggling with their delivery of MBHC, as is the case with Tennessee and Arizona. Conversely, some states may be seen to be struggling and later recognized for their innovation, as with Iowa (Randel, Pearson, Sabin, Hyams, & Emanuel, 2001; Rohland, 1998). Political will and financial necessity may also cause states to change their programs, as with Texas. Comparing outcomes of states' experience with managed behavioral health care is further complicated by the fact that states do not have one entity that gathers data on all associated public mental health care service delivery costs. Thus, the old saying, ''If you've seen

one Medicaid-funded behavioral health program, you've seen one Medicaid behavioral health program,'' helps put into focus the problems that are inherent in understanding and comparing states' experiences.

The Expansion of Behavioral Health Care

Much has happened in the field of publicly funded managed behavioral health care since it first began in the early to mid 1990s when seven states—Utah (1991), Arizona (1992), Massachusetts (1992), Washington (1993), North Carolina (1994), Colorado (1995), and Iowa (1995)—began to use the 1115 Research and the 1915(b) Managed Care Demonstration Waivers to determine if managed behavioral health care could help their states better serve their members and simultaneously lower the cost to provide services. These seven early adopter states served as catalysts for change that affected how most of the nation came to deliver its publicly funded behavioral health care (Kotler, 2002; U.S. GAO, 1999).

By June 30, 1999, the SAMHSA (2000) Tracking Report found that 42 states had implemented some form of managed behavioral health care, with over 17 million people enrolled in public sector behavioral health care programs, and as described earlier, with states implementing their programs in a number of ways (The Lewin Group, 2001). Ten states—California, Michigan, Tennessee, Massachusetts, Pennsylvania, Maryland, Washington, New York, Texas, and Oregon—accounted for 80% of the 17.2 million members enrolled in a managed behavioral health care program, and of those, California, Tennessee, and Michigan accounted for half of the national enrollment (The Lewin Group, 2001). In an effort to build upon existing infrastructure that was responsive to local needs, states were more likely to carve-out services using community mental health centers as the managed behavioral health care organization and implement programs on a county or regional basis (Bergman & Bush, 1999).

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Managed Care is Still a Work In Progress

From 1999 to 2000, six states—Alabama, Arkansas, Kentucky, New Mexico, Montana, and North Carolina—terminated their managed behavioral health care programs. In some cases this occurred because the program was not working, and in some it was due to a need to take time

to reevaluate and reconfigure the state program to better match needs. For instance, Kentucky withdrew from the behavioral health carve-out primarily because of the slow pace of implementation of its other managed care program, Health Care Partnerships, on which the 1915(b) waiver depended. Montana reverted to FFS in large part because providers were unwilling to accept the new Medicaid reimbursement rate that led to inadequate access to providers. New Mexico withdrew from managed behavioral health care when HCFA (now CMS) warned that the entire New Mexico managed care program would be terminated if behavioral health services were not carved out. North Carolina allowed its waiver to expire in order to develop a new statewide delivery system (The Lewin Group, 2001).

As noted above, the initial goals of managed behavioral health care were to control escalating costs, increase access, and increase value and efficiency, with other goals emerging over time. This section examines outcomes in each of these areas.

Cost Savings Have Been Documented

The early adopter states realized almost immediate and positive results through decreased inpatient stays, the reduction of costs and increased utilization of behavioral health services. The cost savings in publicly managed behavioral healthcare has been documented in a variety of public and for-profit settings (Bloom et al., 1998; Callahan et al., 1995; Christianson, Parente, & Taylor, 1995; Ma & McGuire, 1998; Mechanic & Bilder, 2004; Shepard, Daley, Ritter, Hodgkin, & Beinecke, 2001).

Yet over time, initial cost savings have been difficult to sustain. The 2003 CHCS Reprocurement Resource Paper notes that the ''current business environment makes it difficult to achieve the kinds of returns to which MBHOs and their investors have become accustomed. The 'easy' savings from provider discounts and gate-keeping have generally been realized, and now the opportunities for savings come from the more difficult task of improved service quality, care coordination, and reductions in unnecessary practice variation'' (Dougherty, 2003). Other studies, such as the Fort Bragg demonstration site study, have documented reduced costs but at the expense of access, cost-shifting to other public agencies, and high member dissatisfaction (Heflinger & Northrup, 2000).

Access to services can be increased through the open credentialing process, an expansion of the number of hospitals with psychiatric units that become available to members, and through the reinvestment of savings (Callahan et al., 1995). Access in rural and frontier states can be difficult with or without managed care, but it is possible to increase access in rural states through managed behavioral health care (Lambert, 2001).

However, while inpatient hospitalization stays have been reduced, some types of patients who experience shorter stays may be at risk for more frequent rehospitalization (Geller, 2000). MBHC has the potential to decrease access if the following occur: providers choose not to enroll as vendors due to a number of factors such as low reimbursement rates, added layers of paper work and bureaucracy, and frequent utilization denials; or there is increased burden on members to enroll or receive services (e.g., utilization requests are quickly denied, copayments are required or increased, or services are reduced; Chang & Kiser, 1998; Heflinger & Northrup, 2000; The Lewin Group, 2001).

Increased value and efficiency have been described in a number of studies. Value can be increased through an expanded array of services; more flexibility in service delivery; more consistency in clinical decision-making; more focused, goal-directed treatment; and an increased emphasis on accountability and outcomes (Millbank Memorial Fund, 2000; Office of the Surgeon General, 1999). Managed behavioral health care organizations (MBHOs) can provide economies of scale and technology expertise to streamline administrative functions as well as data collection and performance monitoring (Forquer & Sabin, 2002). In order to better monitor the quality of their managed behavioral health care services, some states are adopting behavioral health standards such as those provided by the National Committee for Quality Assurance (NCQA), or outcome measures including the use of report cards and creating standards for and monitoring rehospitalization rates. However, for a number of reasons, but particularly as a result of inadequate data systems infrastructure, states can have difficulty monitoring outcomes (The Lewin Group, 2001).

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It is important to note that a number of studies have reported on the essential role that contracts play in ensuring accountability for access, quality of services, and consumer and provider satisfaction, as well as putting in place arrangements that allow the MBHC organization to function as a profit-making entity (Chang & Kiser, 1998; Rohland, 1998; SAMHSA, 2000; Savela, Robinson, & Crow, 2000; Teitelbaum Rosenbaum, Burgess, & De Courcy, 1998; U.S. DHHS OIG, 2000; U.S. GAO, 1999).

An expanded array of services, new program development, and the support of innovation can be maximized through the contracting process. Many states have used contracting to develop new and innovative programs, or to assure that the needs of specific populations are

addressed and support the use of evidence-based practices (The Lewin Group, 2001; SAMHSA, 2000).

However, concerns remain about managed behavioral health care. Social justice and equity issues have been raised that those most in need of services are not able to access them because the funding once dedicated to the public safety net has been shifted to managed care (Appelbaum, 2003; Schnapp, Bayles, Raffoul, & Schnee, 1999). There continue to be concerns that those with mental illness and the dually-diagnosed are reinstitutionalized into other systems such as prisons, homeless shelters, or smaller community institutional settings (Geller, 2003). The Millbank Memorial Fund reports that unless care is taken in the contracting process, managed behavioral health care can provide an incentive in a risk-based contract to under-treat—particularly to under-serve—people with serious disorders, and provide an undue focus on acute care and neglect of rehabilitation and other services that have long-term payoff in improved functioning (Milbank Memorial Fund, 2000). This can be particularly true in the provision of services to children and youth where an ''ecological approach'' (which focuses on prevention, early intervention, and diversion through programs delivered across the various communities where they interact) is recommended for services, and children have higher rates of emotional disorders than adults (Chang & Kiser, 1998).

Managed care can exacerbate an already fragmented service delivery system. For instance, child and adolescent services frequently suffer because of the lack of continuity and integration of services and/or funding streams across the multiple systems and providers that serve them (U.S. Public Health Service, 2000). This is also frequently true for mental health and substance abuse services, especially when block grant funds specifically mandate that funding streams cannot be blended. While carve-in models should support integration of services, there is little evidence to support that integration occurs on a systematic basis, except in small-scale models where considerable planning, leadership, oversight, and in some cases, dedicated funding are in place to support its ongoing occurrence (Blount, 2003). Further, managed care can impact the formation of behavioral health policy, leading to the creation of systems of care for specific eligible populations rather than effective systems of care for all state citizens (Kotler, 2002).

Lessons Learned

The following lessons learned have been drawn from major review studies. Generally speaking, public sector managed behavioral health care is an improvement on the previous fee-for-service model from a cost-

and-access perspective, but implementation has varied widely (Dougherty, 2003; Forquer & Sabin, 2002; The Lewin Group, 2001; SAMHSA, 2000).

No model can take the place of good planning, or can make up for inadequate funding. Good planning relies on good data collection and analysis; the ability to articulate a vision for who, how, and why care should be delivered; and meaningful and broad stakeholder input (Millbank Memorial Fund, 2000). A state's success requires full participation from five key stakeholders: (1) state leadership (including all state agencies involved in behavioral health care delivery), (2) managed behavioral health organizations, (3) providers, (4) consumers, and (5) families (Dougherty, 2003). The 2001 report, *Medicaid Managed Behavioral Health in Rural Areas,* comments about the decisions of Montana, Arkansas, Kentucky, Arizona, and North Carolina to revert to fee-for-service care, ''In the final analysis, they were undone not by their failure to manage care but by their inability to address problems that threatened the stability of their key stakeholders'' (Lambert et al., 2001).

Once planning has taken place and the goals of the program have been agreed upon by stakeholders, the contract serves as the primary means to assure that the communal vision is implemented. Generally speaking, providers are unlikely to do more than what is specified in their contract. While performance incentives can lead to the development of new programs and support innovation, the contract must contain realistic and attainable goals (Savela et al., 2000; U.S. GAO, 1999).

Key external or political issues associated with a need to retool proposed or current systems (Tennessee, New York, Texas) or return to FFS (New Mexico, Montana) include opposition from providers, consumers and advocacy groups, poor plan design, contracting that did not adequately address risk, concerns about government effectiveness, provider survival, job security for unionized workers, feared loss of services, and social justice issues (Chang & Kiser, 1998; The Lewin Group, 2001).

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Litigation against managed care companies and public and private purchasers has grown, leading case law to evolve rapidly. Many of the leading cases regarding managed care involve some aspect of behavioral healthcare. The Americans with Disabilities Act and the Olmstead Decision are likely to serve as continued sources of litigation against states (Rosenbaum & Mauery, 2001).

Future contracts should emphasize shared-risk arrangements, a stronger role for safety net providers, and selective purchase of administrative

services. The ''pooling of agency funding and creating coordinated financing pathways'' is seen as a ''rational developmental pathway'' (Dougherty, 2003; Forquer & Sabin, 2002).

While integration of physical care, mental health care, and substance abuse treatment may be desirable, there are very few successful models (CMHS, 2003; Dougherty, 2003; Forquer & Sabin, 2002). In part, this is due to a lack of clarity as to what specifically defines an integrated model and failure to define and reward concrete roles for primary care and mental health providers (Blount, 2003; Lambert et al., 2001).

Children and adolescents are viewed as the population most at risk over the next few years for a number of reasons, including lack of specialty providers in general, lack of specialty providers due to low reimbursement rates, a fragmented service system, lack of integration and coordination between the providers of services (e.g., physicians, mental health providers, schools, other social service agencies, community service providers, and the family), lack of appropriate step-down programs for children and youth ready for hospital discharge, and lack of dedicated adolescent substance abuse services (Dougherty, 2003; Forquer & Sabin, 2002; Office of the Surgeon General, 1999, 2000).

SAMHSA has recommended that states adopt six evidence-based practices, but their adoption has not been widespread. While evidence-based practices can be used to improve accountability and quality of care, there are many structural and cultural barriers to their dissemination and use. These range from state and federal law to stakeholder resistance to state's lack of expertise in adequately contracting and incentivizing their use. The use of a multi-pronged approach to address these barriers is recommended (Carpinello & Rosenberg, 2002; Corrigan, Steiner, McCracken, Blaser, & Barr, 2001; Goldman et al., 2001).

New Directions in Behavioral Health Care

The following are current innovations in MBHC that are being tested or implemented. Many of these innovations may be seen as addressing some of the gaps in managed behavioral health care, such as rising costs, lack of adequate wraparound service, lack of service coordination and care management, and lack of integration between physical and behavioral health providers. Others resonate with the frustration that is felt when people with serious mental health disorders do not get ''better'' and there is perception that the failure to improve is due to treatment non-compliance.

It is important to point out that one innovation, consumer-directed health care, has not yet been adapted to MBHC, but holds promise to considerably change the landscape of care. Others, such as primary care

case management or integrated case management, are currently being piloted in Massachusetts and/or other states. These innovations are offered because they reflect the national landscape, and should not necessarily be considered best practices.

Consume-Directed Health Care (CDHC)

This innovation is based on consumer-directed choice as a means to provide a more effective and efficient use of services by giving consumers a more direct financial incentive to purchase more cost-effective health care. In this model, informed consumers assess their own need for care, choose how and by whom their needs will be met, and then monitor the quality of services received. By shifting the focus of health insurance from an entitlement to an asset to be managed, it is felt that consumers will be more likely to receive the services that will be meaningful to them, better choose quality providers, use resources wisely, and be more empowered in their care. It is expected that use of the Internet will be a primary source for consumers to gather information. For those with serious mental disorders or for those who lack stable housing, access to the Internet may be a challenge. Currently, this model is in place and being tested for managed physical health care in the private sector, but not as yet for behavioral health. (Dougherty, 2003; Christianson et al., 2002).

Health Insurance Flexibility and Accountability Demonstration Initiative (HIFA)

Recently, a new section 1115(b) waiver demonstration initiative, HIFA, was introduced at the behest of the Bush administration to increase the number of low-income Americans with health insurance and promote employer-sponsored insurance as a means of coverage (Rosenbaum & Mauery, 2001). An initiative that requires budget neutrality, HIFA has been designed to allow states to reduce services for some Medicaid recipients and extend a more modest benefit to the uninsured. However, the initiative also allows states to simply reduce Medicaid expenses without expanding coverage (NMHA, 2002). The National Association of Counties in their 2002 *Resolution on HIFA Waiver and Services to Low-Income Individuals* noted their concern that ''without adequate oversight, HIFA waivers could easily be used to reduce benefits, increase cost-sharing, and set limits to the most vulnerable low-income population, those receiving Medicaid and State Children's Health Insurance Program (SCHIP). To the extent the core beneficiaries of Medicaid and SCHIP do have covered services decreased and/or cost-sharing increased, the burden will fall on counties to provide additional services.'' As of 2002, nine states had applied or implemented this demonstration waiver program. While most of those states have chosen to exempt behavioral health benefits from

reductions, others (Utah, New Mexico, and Oregon) have proposed using HIFA to decrease access and/or increase copayments for mental health services, including inpatient hospitalization and drug copays, or to limit services to those with biologically-based mental illness (NMHA, 2002).

Mental Health Courts

A fairly recent innovation, mental health courts are appearing in a number of states. Mental health courts have been developed to address the needs of those people with mental illness who become involved with the criminal justice system. Advocates of mental health courts believe these courts divert persons from incarceration. Their emergence seems to reflect a desire to ensure that state agencies provide that array of wrap-around services that are required not only for jail diversion, but also for recovery; require some level of case management; and expect treatment compliance. Mental health courts are defined as courts that:

- Are adult criminal courts
- Have a separate docket dedicated to persons with mental illnesses
- Divert criminal defendants from jail into treatment programs
- Monitor the defendants during the treatment and have the ability to impose criminal sanctions on failure to comply (NAMI, 2003b)

Mental health courts are funded by the Mental Health Courts Grant Program. Mental health courts can help make available a wide array of intervention and support services. However, the Bazelon Center for Mental Health Law notes ''that their staff perceive adjudication by a mental health court to be unduly coercive, stigmatizing and discriminatory, and to reflect mental health systems' shameful tendency to shift the responsibility for people they see as hard to serve to other service systems,'' (Bazelon Center for Mental Health Law, 2003). Mental Health Courts are currently being utilized by the following states: Alabama, Alaska, Arizona, California, Florida, Georgia, Idaho, Indiana, Iowa, Kentucky, Maryland, Missouri, Montana, Nevada, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oklahoma, Oregon, Pennsylvania, South Carolina, Tennessee, Utah, Vermont, Washington, and West Virginia. Note that Alabama, Kentucky, New Mexico, and North Carolina no longer utilize managed care, and have returned to FFS to deliver public behavioral health care. To date, there have been no evaluations conducted on the efficacy of the mental health courts.

Mandated Treatment

Currently, many states have some form of civil commitment that compels those with mental illness to comply with treatment. As of 2003, 40

U.S. jurisdictions had statutes authorizing outpatient commitment, but states have only recently begun to consider making use of these laws. Generally, civil commitment requires that the individual be found to be dangerous to himself or others by reason of mental illness and then ordered to comply with prescribed community outpatient treatment. This approach was deemed constitutional in 1975 in the landmark Supreme Court case O'Connor v. Donaldson (Brown, 2000). A recently completed study by RAND Health, commissioned at the request of the State of California, came to the following conclusions about mandated treatment:

- There is no evidence that a court order is necessary to achieve compliance and good outcomes, or that a court order, in and of itself, has any independent effect on outcomes.
- The attorneys, behavioral health officials, and psychiatrists who were interviewed support involuntary outpatient treatment as a way to make sure people get needed services, but many felt the services offered in their communities were inadequate for making involuntary outpatient treatment work.
- The data suggest that a significant percentage of people with mental illness who need services are not getting them, and those who do get very few (Ridgley, Borum, & Petrila, 2001).

Open Access to Medications

In response to budgetary constraints, many states are addressing the main source of rapidly rising expenditures, pharmacy costs, through the creation of preferred medication pharmacy lists, fail-first provisions, and/or prior authorization programs to control pharmacy costs and utilization. As noted earlier, HIFA waivers may also be used to limit access to medications or increase member medication costs, either of which may impact the number of people who will be able to receive care. Many advocates strongly oppose these measures (NAMI, 2003a).

Primary Care Integration Initiatives

Effective care integration between physical and behavioral health providers has been difficult to achieve regardless of how it is funded. Eight states, including Massachusetts, are piloting programs that apply the chronic disease management model of care to behavioral health care management. This model, supported by SAMHSA and the Robert Wood Johnson Foundation, has been developed over the last 10 years and promotes a biopsychosocial model of health care by teaming mental health and medical practitioners and making them available at the same site.

Other primary care integration initiatives include: placing a mental health/substance abuse provider on site within a health center, integrating mental health/substance abuse services into primary care by locating mental health providers within primary care clinics, and integrating mental health providers into primary care (Kotler, 2002).

Single Point of Entry/No Wrong Door

People with behavioral health problems frequently require a variety of services, such as mental health, substance abuse, housing, and vocational training services. With or without managed care, service coordination among the various services and agencies providing behavioral health care is lacking. Some states are working to improve access and coordination to needed services by developing a single point of entry into care systems, or through the establishment of a ''no wrong door'' service system. In a single point of entry system, a single agency is designated as gatekeeper into the system. A ''no wrong door'' approach recognizes there may be multiple agencies serving a person, and serves to designate one agency with the responsibility of linking each client to those services appropriate to their need. Both approaches can serve to increase access to and integration of the array of needed services, and increase efficiency in the delivery of services (NAMI, 2003b).

Swing Away from Full-Risk or Capitated Plans

The CHCS Behavioral Health Reprocurement Resource Paper reports that states are beginning to move away from full-risk or capitated plans toward a hybrid of public and private sector functions for overall administration of the program. Faced with budget constraints, some public officials are considering having state agencies assume some administrative functions not traditionally undertaken by the government, such as utilization management, call centers for customer service functions, credentialing and network management activities, and implementing new information systems for claims payment. (Dougherty, 2003).

CONCLUSION

While there is consensus that managed care has irrevocably changed the landscape of how behavioral health services are delivered, there is also consensus that it is a model in transition. States are facing rising health care costs within a climate of reduced or static budgets. In some ways, MBHC has come full circle back to the original problems that

brought it into existence. Currently, pharmacological advances continue to allow many to reach the goals of recovery and successful community life while states are faced with staggering costs for these medications. Deinstitutionalization has, for some, evolved into reinstitutionalization (in jails and homeless shelters). Medicaid continues to undergo substantial changes at both federal and state levels.

As this article has shown, MBHC initiatives exist in varying degrees in most states. When viewed collectively, they represent a continuing work in progress. This work is directed at the often seemingly irreconcilable goals of cost containment and effective service delivery to a difficult-to-treat, largely indigent population. These two goals will most likely remain the defining imperatives of America's future efforts to provide services to persons with mental illness. As explained by other papers in this issue, the Massachusetts behavioral health program incorporates a number of promising innovations. Rather than full risk-sharing, the Massachusetts program illustrates effective contract development with shared risk and incentives for quality improvement. While the state program has not implemented consumer-directed health care, consumers and other stakeholders are involved in program development and monitoring. Thus, the Massachusetts experience can inform national policy about the applicability of many innovations in managed behavioral health care.

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