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Observations & Recommendations Managed Care and Community Mental Health Systems of Care

Kelly Gunning, Operations Director - NAMI Lexington

[2011]

Observations/ Recommendations

Managed Care and Community Mental Health Systems of Care

For decades, the philosophy of community-based systems of care has guided the delivery of mental health services for individuals served by publicly funded agencies. This philosophy supports system attributes that include a broad array of services; interagency collaboration; treatment in the least-restrictive setting; individualized services; family and consumer involvement; and services responsive to the needs of diverse ethnic and racial populations. The notion of systems of care emerged in an era when managed health care also was gaining popularity. However, the effect of managed care on the delivery of community mental health and substance-abuse services—also known as behavioral health services—has not been widely studied.

Preliminary results from the nationwide **Health Care Reform Tracking Project (HCRTP)** and other emerging studies can inform current discussions about the impact of managed behavioral health care on services for individuals enrolled in state Medicaid programs. Most states have used some type of “carve-out design” to finance the delivery of behavioral health services, and there is a trend toward contracting with private-sector, for-profit companies to administer these benefits. In general, managed care has resulted in greater access to **basic** behavioral health and community-based services, *though access to inpatient hospital care has been reduced. Under managed care, it also has been more difficult for individuals diagnosed with serious mental illness (SMI), as well as the uninsured, to obtain needed services.* With managed care has come a trend toward briefer, more problem-oriented treatment approaches for behavioral health disorders. A number of problems related to the implementation of managed behavioral health care were illuminated by the HCRTP and other surveys of states. First, there is concern that ongoing efforts to develop systems of care for the seriously mentally ill are not being linked with managed care initiatives. *The lack of investment in service-capacity development, the lack of coordination with other agencies serving populations in the behavioral health realm and cumbersome preauthorization requirements which may restrict access to appropriate service delivery were other concerns raised by respondents about managed care.* As the adoption of managed behavioral health care arrangements for Medicaid beneficiaries expands rapidly, the HCRTP , emerging studies and surveys will continue to analyze how this trend has affected individuals with behavioral health problems and their families.

With the escalating enrollment in managed care plans that has occurred during the past decade, individuals with behavioral health diagnoses and their families are increasingly being served in mental health care systems that have adopted managed health care approaches directed at controlling service utilization and containing costs. *The behavioral health spectrum poses the greatest challenge for managed care systems, because these individuals often require a broad range of services at varying levels of intensity for extended periods of time.* In addition, managing the care of these illnesses often requires coordination across multiple systems, including mental health, substance abuse, social services and criminal justice. As a context for understanding the effects of managed care on behavioral health, it is important to be aware of significant recent developments in the organization, financing, and delivery of mental health services. These developments include the creation of community-based systems of care for delivering mental health services, as well as the significant role of Medicaid in financing such systems of care. This overview of existing information briefly describes these trends, outlines the risks and opportunities posed by the introduction of managed care to the delivery of mental health and substance-abuse services and presents findings from the first major research projects designed to track the effects of managed mental health care on the delivery of community based delivery system.

Development of Systems of Care for Mental Health Services

In 1969, the Joint Commission on Mental Health found that individuals with SMI were typically underserved, or were served inappropriately in excessively restrictive settings such as residential facilities and psychiatric hospitals. Numerous subsequent reports have substantiated these findings. All of the most recent reports concurred that to serve these populations effectively coordinated systems providing a wide range of services were needed. Since then, the notion of community-based systems of care—also referred to simply as systems of care—has become the prevailing ideology for mental health service systems. This system-of-care philosophy emphasizes a broad array of services, which includes a range of intensive non residential and residential options; such as outpatient therapy, inpatient hospitalization, home-based services, day treatment, crisis services, case management, and other services; also interagency collaboration among the systems that share responsibility for intervening with this population, criminal justice, public health, substance abuse; Treatment in the least-restrictive, appropriate setting; Individualized and flexible treatment and services; Family and consumer involvement in all aspects of the planning and delivery of services; and Culturally competent services that are responsive to the needs and characteristics of diverse ethnic and racial populations. During the past decade, there has been a great deal of progress throughout the country in the implementation and financing of such systems of care, primarily in the public sector, for those with the most serious needs. State Medicaid programs increasingly have been used to fund these more coherent service-delivery systems.

For individuals whose mental health services are funded by private health plans, the vast majority of mental health services are still provided in a more traditional, nonsystematic, fragmented manner. Reports have identified several obstacles that have impeded the development of a system-of-care approach to mental health service delivery within the private sector. Perhaps most important, private mental health services traditionally have been delivered using a medical model, which focuses narrowly on the pathology of mental health problems and fails to integrate treatment with supportive aspects of care, such as recovery services and family support services. In addition, the model adopted by the private mental health delivery system primarily attends to acute care needs, often relegating care for long-term, disabling conditions—such as serious mental illness—to public service systems, including special education, social welfare, and criminal justice, as well as to the public mental health system.

Managed Care and Mental Health Services

During the same decade in which the system-of-care philosophy was embraced, managed health care arrangements were widely adopted. Initially, the use of managed care to finance and deliver mental health and substance-abuse services—also referred to as behavioral health services—occurred primarily within private, employer sponsored health plans. In recent years, however, managed care arrangements for behavioral health services have been implemented more widely in the public sector, particularly in state Medicaid programs. With the advent of managed care, many questions have been raised about the implications for delivering mental health services. Of particular concern is whether progress in building systems of care is in jeopardy, whether the system-of-care philosophy will be abandoned, whether the use of Medicaid to support system-of-care components will be curtailed, and whether access to appropriate, comprehensive, high-quality behavioral health services will be compromised.

Although these questions focus mostly on apprehensions about managed care, both opportunities and risks related to the application of managed care approaches have been identified. In terms of potential positive effects, managed care is clearly intended to result in improvements in the efficiency and cost-effectiveness of services, in part by reducing the use of high-cost services, such as hospital care, when other service options might be equally effective. The shift to managed care also provides an opportunity to redesign the service system and expand the array of services covered by Medicaid, adding a range of intermediate services and supports such as home-based services (peer support?), day treatment, and crisis services. Increased

accountability and a greater focus on outcome and quality measurement are seen as opportunities related to managed care. Although there could be clear benefits associated with well planned managed behavioral healthcare, potential risks are of concern to policymakers, mental health providers, and advocates. ***In effect, the reality of poorly designed managed care systems is that they seem focused on cutting costs and making profits. Rather than expanding the array of covered services, the advent of managed care could result in a regression to the traditional insurance model of covering a limited number of services for a limited amount of time (typically 30 psychiatric inpatient hospital days and 20 outpatient mental health visits).*** Some variation of this approach has usually been offered as part of basic managed care plans through health maintenance organizations (HMOs). If adopted as part of managed care reforms, both the range and level of services covered by Medicaid would be restricted. Another hazard is that individuals with the more chronic, severe illnesses could well be underserved.

Without effective risk-adjustment strategies to protect the financial interests of managed care organizations(MCOs) and providers, there is little incentive in a managed care system to serve the “high utilizers” of services—those who are the most expensive to serve. For individuals with the most serious and complex problems, under service within the managed behavioral health care system, there would be a likely result of shifting the responsibility for providing and funding their care to other systems such as those we are currently seeing in criminal justice and incarceration of the mentally ill. The loss of an interagency focus is another concern. Interagency planning at the systemic level and interagency service planning are both integral aspects of systems of care. Both of these elements could be lost if they are not directly incorporated into managed care plans, requests for proposals, and contract requirements for MCOs. Many of the private, for-profit MCOs that are increasingly managing Medicaid behavioral health services have limited experience with interagency systems of care. Concerns about providers have been raised; particularly that smaller programs and nontraditional programs and providers might be eliminated from provider networks and no longer be available. ***Another serious concern is that consumers and families will have less input in the decisions about services and less input in the planning and operation of the systems.*** Further, it is feared that the needs of culturally diverse populations will receive less attention under the new managed care systems, with fewer nontraditional providers, less outreach, and fewer services such as transportation and translation, which often enable individuals to use needed health care services. The potential risks and opportunities identified above may influence the effect that managed care has on the delivery of behavioral health services. However, the impact managed care has had in this area is largely still unknown.

States selected for site visits in the HCRTTP were required to be far enough along in the implementation of managed care for behavioral health services for effects to be discerned. The design of managed care systems and geographic diversity were considered in the site selection process. Both components of the HCRTTP (a state survey and site visits to a cohort of states) will be repeated during upcoming years of the study to update information, track reforms, and further assess the impact of managed care for behavioral health services.

Contextual Issues for Managed Medicaid Behavioral Health Services

Several broad observations provided insight and understanding of the more specific findings about the impact of managed care on the delivery of behavioral health services. First, many systemic problems related to serving the seriously mentally ill existed prior to the advent of managed care. The absence of a broad array of mental health services, a lack of interagency coordination, a lack of family involvement at the system and service delivery levels, a lack of cultural competence, and poor data systems are among the problems with which states and communities have struggled for many years. ***The introduction of managed care is not a panacea for these long-standing problems, but may offer an opportunity to address some of them. However, many of these problems persist, largely unaffected by managed care.***

A second observation is that the introduction of managed care arrangements into state Medicaid programs forces marriages between two very different cultures: (1) the human-service philosophy that has guided publicly funded behavioral health care on the one hand, and the business philosophy of private-sector managed care on the other; the public-sector movement toward decentralization on the one hand, and the centralized control favored in managed care on the other; and (3) the public sector's emphasis on collaboration on the one hand, and the business world's emphasis on competition on the other. These differences create dynamic tensions at all levels of the behavioral health system, and highlight the need to foster a balance between the two opposing cultures. **Another issue complicating the mental health reform process in many states is the speed with which managed care has been implemented. In some states, the result has been damage to relationships with stakeholders, as managed behavioral health reforms have been planned and implemented at breakneck speed, without the benefit of a participatory planning process.** Some managed care systems for behavioral health have been designed without input from mental health experts or consumers and family members of individuals with SMI. The fast-paced process has resulted in misinformation and unrealistic expectations about the managed care system. One result has been the need for added mechanisms, one to two years into some managed care initiatives, that adjust the system and make it more responsive to the needs and concerns of all stakeholders.

Finally, the Medicaid population has some characteristics that create unique challenges for managed care systems. MCOs, particularly those that have dealt exclusively with the commercial sector, often do not understand the needs of Medicaid enrollees, including the importance of a strong link between treatment and the home and community environment. For example, some families may not have telephones, transportation, childcare, or other supports that are essential to accessing services. Transportation was identified as a top problem in the state surveys, both in rural and inner city areas. Also, some families may not have the educational level needed to read and process complicated materials.

Impact of Managed Care on Medicaid Behavioral Health Services

The context outlined above frames the more specific effects of Medicaid managed care on the delivery of behavioral health services. The effect of the design of managed care systems will be considered, as well as Medicaid managed care's effect on financing and costs of behavioral health services, access to services, service delivery, systems of care, behavioral health providers, accountability, families of individuals with emotional disorders, and cultural competence.

Impact of Design and Administrative Arrangements

To consider whether different types of system designs for managed behavioral health care have different effects, study samples have included states with the three different designs typically used to finance and deliver behavioral health services under managed care. These include the carve-out design, integrated design, and divided benefit design. The states surveyed revealed that in the majority of states implementing managed care reforms (72%) were using some type of carve-out arrangement—either full or partial—to administer and finance the delivery of behavioral health services. Findings from these state studies indicate that states with carve-out arrangements include a broader array of services, more home- and community-based services, and more nontraditional services than states with integrated designs. **When physical health and behavioral health benefits are integrated, physical health needs often take precedence, and the percentage of available dollars allocated to behavioral health services may be insufficient, resulting in constrained behavioral health services.** Although an integrated design expands access to a basic level of mental health services—primarily acute care—there is indication that access to extended care and supportive services has become more difficult for those with more serious and complex disorders.

Further, although it is often hypothesized that an integrated design may strengthen the connection between physical and behavioral health services, this has not proven to be the case. Coordination of these services

appears to be challenging regardless of the health system design, and hence requires concerted efforts. States are using a variety of arrangements to administer managed behavioral health benefits for Medicaid recipients. In some cases, state agencies or regional authorities serve as MCOs and directly operate the managed care systems. Other states contract with community mental health centers, regional boards, other nonprofit organizations, for-profit managed care companies, or some combination of these types of entities to serve as MCOs. State surveys found that nearly one-third of states contracted directly with for-profit managed health care companies, which in turn sometimes contracted with specialized behavioral health care companies to manage the behavioral health benefit. Another one-third of the states contracted directly with for-profit, specialized managed behavioral health care entities to operate their systems. These arrangements indicate an important trend toward the use of private-sector, for-profit companies to manage public-sector behavioral health care services. Although conclusions about the optimal administrative arrangements for managed behavioral health services cannot be drawn presently, the HCRTTP has elucidated pros and cons of various approaches. The proprietary managed care companies have greater expertise in implementing managed care, as well as the necessary infrastructure in the areas of data systems and financing. These companies also have more capital, and can withstand fluctuations in revenues more easily. **However, they are perceived by key respondents as putting their shareholders and profits first, and as being driven primarily by the profit motive, even though profits are capped by states in many systems. In addition, the for-profit entities tend to have the least experience with, and understanding of, Medicaid recipients, potentially compromising the quality of care for this population.**

Nonprofit MCOs are seen as having a greater stake in the community, as evidenced by boards made up of community members, and in many instances, a history of service delivery in the public sector. These organizations, however, tend to have less access to capital, and therefore less ability to assume risk. Finally, both nonprofit organizations and public mental health entities—such as regional or local mental health authorities—typically have less experience in implementing managed care, and require a great deal of start-up technical assistance.

Impact on the Financing and Cost of Care

Ideally, managed care is intended to streamline service-delivery systems, making them more efficient and less costly. In part, this may be accomplished by reducing the use of high cost hospital care when lower-cost alternative services may be equally effective, and by reducing administrative costs. It is uncertain, however, whether managed care has indeed helped to contain Medicaid costs for behavioral health services, either by cutting costs or by slowing the rate of growth. **In many states, the tremendous administrative burden and costs have reportedly increased following the implementation of managed behavioral health care. This is particularly true at the provider level, where additional paperwork is now required. Vigilance by states and MCOs is needed in this area, because increasing the bureaucracy and administrative burden has adverse implications for both cost and service delivery.** A few states report cost savings simply because the behavioral health budget was cut before implementing managed care. Respondents in many states studied reported cost savings associated with reductions in inpatient hospital use. However, it is also reported that, increased accesses to services and greater utilization of outpatient and community-based services have offset any savings that might have been associated with reductions in inpatient care.

The effect of managed care on behavioral health costs in other systems, such as criminal justice, special education, and social welfare, must be determined as well. For example, interviewees from the criminal/juvenile justice and social service systems in many states suggested that their costs were going up as a result of managed behavioral health care reforms. Most states, however, are not systematically tracking the **cost shifting** that may be occurring across the systems of care and these reports remain anecdotal and impressionistic reports.

A major area of concern is that the capitation and case rates paid to MCOs are based on data of poor quality. Respondents to state surveys report that the lack of good historical data on the utilization of behavioral health services led to establishing unrealistically low rates. Low capitation or case rates create incentives for MCOs and providers to limit services to enrollees, making it likely that those with behavioral health treatment needs will be underserved. The risk of under service is greatest for individuals with serious and complex disorders, since these individuals are the most expensive to serve. The challenge of rate setting is compounded for this population because in many instances, the broader service array envisioned for the managed care system has not yet been fully developed. Also, behavioral health services are currently spread across multiple systems. Some states studied have compensated by building in “floating” capitation rates, which are expected to change at specified intervals based upon new utilization or encounter data that is more reflective of the reformed system. ***A related issue with which states are struggling is how to structure risk to ensure that providers are protected and that incentives to under serve recipients are minimized, particularly for persons with serious disorders.*** There are no or few proven methodologies or formulas available for behavioral health risk structuring to guide states in this area, particularly with respect to seriously mentally ill/high utilize individuals. States are experimenting with different approaches, including stop-loss provisions, risk pools created by states to protect MCOs against losses, capitalization requirements for MCOs, and others.

Impact on Access and Service Delivery

It appears that managed care reforms are resulting in greater access to mental health and behavioral health services in several respects:

Penetration rates have increased—more people are receiving mental health and substance abuse services than before. It appears to be easier to obtain a **basic** level of mental health and substance abuse care. Waiting lists and delays for services have been minimized because of system standards that prohibit them.

Despite these improvements in access, findings suggest that ***it is more difficult for individuals with serious degrees of illness to obtain necessary services under managed care.*** These individuals tend to be high service utilizers, and are often involved with multiple agencies; they pose a particular challenge to managed care systems because they tend to require services at varying levels of intensity for extended periods of time.

Managed care systems that limit behavioral health benefits must determine how extended care needs for these individuals will be met. There are indications that this group fares better in carve-out situations, in which there are better prospects for a planning process focused on their needs. Several states, realizing that their managed care systems are not meeting the needs of this group, are engaged in planning processes to design managed care strategies that will address the needs of this most vulnerable population more effectively. ***A pressing issue brought up by some states was the dwindling resources available to serve individuals with behavioral health diagnoses who are not eligible for Medicaid.*** For these individuals—the near-poor or those who have exhausted their insurance benefits—services have been harder to obtain since the implementation of managed behavioral health care. As increasing portions of state mental health budgets are used to fund Medicaid services, as well as those services not included in managed care contracts for Medicaid recipients, the behavioral health needs of this non-Medicaid group may be increasingly neglected. Many states indicate that managed behavioral health care has made it easier to obtain home and community-based services, but more difficult to access to inpatient hospital care. Managed care reforms have made it easier, in states that have used behavioral health carve-out designs, to provide flexible, individualized services. However, the use of managed care to finance the delivery of publicly funded behavioral health care ***has not solved preexisting problems with service capacity, nor has it diminished the need for states to invest in service-capacity development.***

Many interviewees reported that MCOs expected providers to develop services on their own initiative, but that providers were not willing to take such risks without knowing which services would ultimately be

purchased by MCOs. To promote the availability of behavioral health services, states ***are structuring their managed care systems to require or encourage the investment of any profits beyond a specified level in creating new services.*** The development of service capacity is particularly important in behavioral health, where, historically, there have been enormous gaps in the range and availability of mental health and behavioral health services. One of the major effects of managed care on direct service delivery is a discernible trend noted in all states, ***toward briefer, more problem-focused treatment approaches for behavioral health problems.*** Many respondents welcomed this shift, because in the past, people often were kept in treatment for unnecessarily long periods of time. However, ***respondents also complained about time-limited treatment being inappropriately applied when individuals needed more long-term services for serious or complex problems.*** In some states, the implementation of managed care for Medicaid-covered behavioral health services has improved the availability of case management services.

To improve the effectiveness of case management services, some have implemented two levels of case management: one level focuses on service coordination with other agencies, and the second level involves intensive case management interventions. The HC RTP and other surveys also explored interagency treatment and service planning whereby representatives of all involved agencies come together, in partnership with the individual to jointly develop and implement a coordinated, individualized service plan for the individual. ***In many states requirements for interagency service planning were included in managed care systems, but stakeholders indicated that this is not actually occurring to any great degree.***

Impact on Family Involvement and Cultural Competence

Individuals with behavioral health diagnoses and their families typically were not involved in planning, designing, or implementing managed care systems. Findings from the HC RTP show that this was the case even in states with strong family-advocacy organizations, indicating that the system-of-care philosophy of involving families at all levels of the system typically is not adopted by managed care systems. In some states, efforts to create avenues for family input and involvement are occurring only ***after*** the initial design and implementation of managed care. States are slowly beginning to create and include consumer and family advisory groups, on established planning and advisory bodies, focus groups and are consulting with family organizations regularly, and some are beginning to hire family advocates to fulfill various roles within managed care systems.

Overall, stakeholders indicated that managed care reforms have not affected the level of cultural competence in the system and most report that little to no attention was given to cultural issues in the initial planning and implementation of the reforms. In most states, managed care has not resulted in significant changes in the availability of culturally diverse providers or in culturally appropriate service delivery for individuals with SMI and for minorities. ***This is not an endorsement but rather a reflection of the fact that there has never been appropriate consideration given to culturally competent services in behavioral health.*** Some states are making efforts to incorporate cultural competence goals into managed care. A few states have some requirements related to cultural competence, for example, that culturally and linguistically diverse providers be included in provider networks. Other states, including Washington and Arizona, have ensured that services such as interpreters and indigenous providers—for instance, Native American healers—are incorporated into managed care networks. Despite these efforts, the need to improve the cultural competence of service-delivery systems is a long-standing problem that remains a challenge regardless of managed care reforms.

Impact on Systems of Care and Interagency Relationships

Major concerns emanating from the studies of managed care in behavioral health are that, ongoing initiatives to develop community-based systems of care for populations with behavioral health disorders and their families are proceeding separately from, and without much connection to, the managed care initiatives. In these areas, little thought was given to how the system-of-care philosophy could shape and guide managed

care arrangements for behavioral health. In other systems, the introduction of managed care was reported to be supportive, to some degree, of the development and ongoing functioning of systems of care, with substantial local variation in interpretation of various aspects of managed care, depending upon local “buy-in” to the system of care concept. The sense seems to be that when the system- of- care philosophy is not incorporated into managed behavioral health contracts, along with compliance monitoring, it is not likely to be implemented by MCOs. ***Requirements for a broad array of community-based services, family involvement, interagency coordination, and cultural competence are unlikely to be implemented without strong mandates that they be a part of the Medicaid managed care system for behavioral health.***

The lack of interagency coordination among agencies caring for SMI populations continues to be a problem under managed care. The HCRTF found that other systems— including social services and criminal justice— usually were not consulted or involved in planning for managed behavioral health care. The lack of interagency involvement has created new problems, or has exacerbated preexisting problems, in some states. To address this issue, some states have convened “process improvement teams” of mental health representatives to develop strategies addressing intersystem problems that have arisen. Similarly, “roundtables” to obtain input from other agencies and stakeholders have been formed. Respondents in several states indicated that managed care reforms may actually improve interagency collaboration by *default*, forcing systems to come together to resolve problems and issues created by the initial implementation of managed care systems. In many areas, however, managed care reforms have reportedly aggravated the problems of determining which system is responsible for delivering and paying for behavioral health related services.

Cost shifting from the managed care system to other systems (especially social welfare and criminal justice) was alleged by stakeholders in many states, although many states are not systematically tracking this. Individuals who are involved in social welfare agencies because of a history of abuse or neglect comprise a population that is seemingly especially challenging to managed care systems. A range of problems is associated with providing behavioral health services to this group, including a lack of coverage for sexual abuse treatment; MCOs discharging individuals from hospitals without regard to the availability of safe placements; disagreement between courts and MCOs regarding treatment needs; individuals relocating and requiring shifts in MCOs or providers; and individuals moving in and out of the Medicaid managed care system based upon changing involvement with social welfare agencies or the criminal justice system, which determines their eligibility. Although states are working through these problems, minimal integration between these types of agencies and Medicaid managed care exists in most states.

Impact on Mental Health Providers

Managed behavioral health care may influence several aspects of provider practice, including clinical decision making and practice patterns; credentialing and licensing requirements; and the inclusion of small or nontraditional agencies in provider networks. Identifying the flow of clinical decision making is critical for managed care systems. This identification encompasses a determination of how, by whom, and on what basis decisions will be made about the type, amount, and duration of services for consumer or family. The medical necessity criteria that guide these decisions are open to interpretation, and many individual respondents reported that such criteria are inconsistently applied across different MCOs, geographic areas, and individual cases. Some complained that the medical necessity criteria are too narrow, particularly for behavioral health services targeting individuals and adolescents. Iowa has responded by developing “psychosocial necessity criteria” appropriate for this population. Further complicating the decision-making process is the lack of well-developed, standardized guidelines for the delivery of mental health services. Although this problem extends well beyond the boundaries of managed care systems, the lack of well developed, standardized guidelines for

clinical decision making for behavioral health populations forces each state and/or MCO to develop its own practice guidelines.

Of all of the managed care techniques used to influence practice patterns and control service delivery, the one that has generated the most concern in the area of mental health services is *prior authorization*, which requires that recipients receive authorization from their MCOs for behavioral health services. MCOs often are perceived as *micromanaging care by requiring authorization for every service provided*.

From the perspective of MCOs, however, this requirement is a tool to prevent the overutilization or unnecessary utilization of services. Concerns about this requirement seem to be alleviated in situations in which providers have the flexibility to provide a specified number of outpatient visits without obtaining prior authorization, or in which only more intensive services—such as day treatment, residential care, or inpatient services—require prior authorization. Complaints about prior authorization are largely eliminated when providers are involved in sub-capitation payment arrangements with MCOs (through which they are at financial risk), offering them more flexibility and control in making clinical decisions.

The HCRTF and surveys also found that credentialing and licensing requirements for providers have changed in some states with the implementation of managed behavioral health care. In some instances, managed care has made the requirements for staff more rigorous, and has excluded certain providers, such as paraprofessionals, substance-abuse counselors, and bachelor's- or even master's level staff. To ensure that the availability of mental health providers is not reduced, a few states have adopted provisions to allow these providers to offer services as long as they are under the supervision of credentialed staff within an agency. Respondents in some states, however, reported that managed care reforms have resulted in an expanded array of providers in the system. Results from the HCRTF and other managed care surveys show that smaller agencies and nontraditional agencies and providers often have a more difficult time surviving under managed care. They may not meet credentialing standards or have the *requisite administrative and financial capacity* needed to participate in managed care networks unless they affiliate or merge with larger agencies. It is important to note that the agencies that have served culturally diverse populations tend to be smaller and less traditional, and thus are likely to experience some of these problems.

Impact on Accountability

Greater accountability for the delivery of behavioral health services, and an increased focus on outcome and quality indicators, are potential benefits associated with managed care. However, early results from states suggest that the development of quality measurements and the use of outcome data for evaluating behavioral health services are rare. Some recent studies have revealed that states were monitoring managed care plans with respect to *cost, access to services, and utilization patterns; less attention was being given to the measurement of clinical and functional outcomes. However, clinical and functional outcomes were more likely to be tracked in states with carve-out designs for behavioral health services than in states that used integrated systems for the delivery of physical and behavioral health services.* Only a few states (Utah and North Carolina, for example) had defined measurable outcomes for behavioral health disorders, and were monitoring the managed care system for these. Stakeholders in some states reported some efforts to assess the quality of services, with the major focus on the *process* of service delivery. The measurement of clinical and functional outcomes is at an early stage of development, with many states reporting that the development of outcome measurement systems is in process. With respect to utilization patterns, reports point to hospital admissions and/or lengths of stay for psychiatric disorders being reduced as a result of managed behavioral health care reforms. There seems to be a correlated increase in recidivism rates. There are many states reporting increases in the use of residential treatment, often outside the managed care system—a change attributed by many respondents to the tighter controls on inpatient use. The use of home- and community-based services was reported to have increased also; often outpacing the savings from inpatient services.

Conclusion and Recommendations

The adoption of managed care arrangements to finance and deliver Medicaid behavioral health services is occurring rapidly. The future evaluation and data from reports such as the HC RTP will continue to describe and analyze how this shift to managed care affects individuals with SMI and other behavioral health problems and their families. Current findings from this project provide some important lessons to direct future policy and planning efforts. The following recommendations, which emanate from stakeholder interviews, are of relevant importance for system planners and administrators as well as for providers, families, and advocates as they continually strive to refine both the design and the operation of proposed managed care systems. The following are important recommendations which should be implemented as the decision making process related to MCO's in Kentucky are considered. We must take our time and learn from shortcomings and failures in other states, particularly as it focuses on Profit VS. Non-profit based providers, as well as, maintaining and building an integrated system of care which involves stakeholder input and evaluation. Following are high priority features which must be considered in any move toward managed care for behavioral health as well as some important ethical concerns:

System Planning

Use the system/communities-of-care philosophy to shape the design and implementation of managed behavioral health care systems. Include requirements in requests for proposals (RFPs) and managed care contracts for such features as; a broad array of behavioral health services for individuals and adolescents, interagency service planning, flexible and individualized care, consumer and family involvement, and cultural competence.

Stakeholder Involvement

Include consumers of SMI services and families in the planning, implementation, and refinement of managed care systems. Create opportunities for agencies that serve behavioral health needs to offer input, participate in designing managed care systems, and participate in ongoing problem solving and system refinement to ensure that systems are more responsive to the needs of individuals with SMI and their families.

Access and Service Delivery

Ensure that states and managed care organizations invest resources in building needed service capacity for individuals with serious mental illness. Ensure that a dedicated process is adapted to plan and manage service delivery for individuals with serious mental illness. Develop strategies to provide services to individuals with SMI who are not Medicaid eligible, but who are dependent upon the public sector for behavioral health services.

Data and Evaluation

Improve data and methodologies for establishing appropriate capitation and case rates, as well as adequate risk-adjustment strategies to *minimize incentives for under serving* individuals with SMI and to protect providers from undue financial risk. There must be evident systems to conduct or support ongoing research and evaluation on the effects of managed care on individuals with serious mental illness and their families.

Advocacy and Oversight

Ensure strong participatory leadership, advocacy, and oversight at the state and local levels so that the needs of individuals with serious mental illness and their families will be well informed and met within managed care.

Ethical Concerns Around Managed Care

Disregarding personal and medical privacy.

Privacy is especially important in mental health because of the sensitive and personal nature of topics such as; sexual abuse/orientation, drug and alcohol use and intimate family problems. Decision making in MCO's require info be shared by a myriad of individuals such as gatekeepers and utilization reviewers, stored in files accessible to hundreds of employees.

False Advertising

Many for-profit managed care companies claim to offer a wide array of mental health services when they actually only provide ultra brief therapy and short term treatment that must go through a prior authorization process.

Using Deceptive Language

Professional ethics demand giving patients accurate and straight forward information which is easy to read and/or understand. MCO's which intentionally restrict choice call themselves use names like "Choice Health" or "Options Health." Companies who are hired to restrict access to treatment call themselves a name like "Access Health." Cost cutting programs are called "quality improvement programs." Gatekeepers, hired to divert patients from treatment, are called "patient advocates." Such misleading language does not belong in health care.

Practicing Outside a Professional's Area of Competence/Expertise

All ethical codes forbid professionals from practicing outside of their area of competence. In managed care, on the other hand, professionals are encouraged and, at times, even required to practice outside of their competence. Because managed care limits referrals to specialists, it forces many professionals to treat special problems for which they do not have the training or experience. Utilization reviewers commonly do not have the credentials or training necessary to confirm that they are competent to overrule and change the decisions of the treating professional. For example, in managed mental health, utilization reviewers often have merely a bachelor's degree or a master's degree with limited experience. These reviewers routinely overrule and change the treatment decisions of greatly experienced specialists with a master's or doctorate degree. A utilization reviewer's decisions may overrule the decision of the professional who is conducting the treatment. However, the reviewer's decision often is based upon the limited information contained in a two page form and discussing a case for a few minutes with the treating therapist. When evaluating the treatment of a patient with a condition as complex as a mental health problem, it is outside of all professionals' areas of competence to overrule the treating professional based on such meager information. Unless a professional conducts an in depth evaluation, the most appropriate action is to defer judgment to the person who is treating the patient.

Creating and Intensifying Conflicts of Interest

Medical ethical codes require that health professionals avoid and minimize conflicts of interest regarding their primary obligation to the patient's welfare. Managed care, on the other hand, does just the opposite. It seeks out and develops conflicts of interest in which professionals profit the most when the patient receives the least treatment. The conflict is most serious with case rates and capitation in which the professional is paid a set fee regardless of how much treatment the patient is given. While sometimes the conflict of interest is obvious as it is with case rates, other times it is more subtle but just as harmful to the patient. For example, professionals may avoid dealing with important long-term issues or cut therapy short because managed care prefers to refer new patients to therapists with a record of short-term treatment. The therapist has a conflict

here between treating current patients for the necessary length of time, or cutting treatment short to assure future referrals.

Violating Informed Consent Procedure

The rights patients have to control the treatment of their own minds and bodies are protected through a procedure called informed consent. In this procedure, patients are given the important information about treatment and the major treatment options, and after being informed, they can decide if they will consent to treatment and choose which treatment. Managed care, on the other hand, often fails to inform patients of any treatment alternatives outside of the plan. This failure to inform serves the purposes of the managed care company because patients who do not know other treatment is possible are more likely to report satisfaction with the managed care treatment. Unfortunately, this failure to inform also undermines the patients' control, because the patient loses the choice to self-pay for the preferred treatment. Medication is frequently presented as if it is complete treatment. In truth, psychotherapy for many problems, either in place of medication or along with medication, is better treatment than medications alone, and psychotherapy is a treatment that many patients will pay for out-of-pocket if they believe it will help. Patients who are sent to psychotherapy are usually told that ultra-brief therapy is the treatment of choice, and if they don't improve, they are told that there are no realistic alternatives. The reality is that longer-term psychotherapy is a more effective treatment, and many patients find it so helpful that they will self-pay for longer psychotherapy. Patients, particularly individuals, are rushed through treatment, either therapy or medication, without being informed of the benefits of psychological and educational testing to evaluate and diagnose problems. Again, some patients or parents choose to self-pay for this testing when they know it is available.

Squandering Money Entrusted to Their Care

Let us learn the lessons of Oakwood & PassPort. Oakwood-proven disaster... PassPort – No one seems to know whether any money was saved by the PassPort program; we do know, however, that there were exorbitant spending on executive salaries and perks.

In Closing

In view of the fact that there are few long term studies available and devoted to MCO's and Community Mental Health Delivery Systems; these recommendations are broad and primarily focus on the development and refinement of managed behavioral health systems for individuals with serious mental illness and their families. The design of any system created to improve behavioral health outcomes for the vulnerable population of individuals with serious mental illness must focus on quality and systems/communities of care and not just exclusively on financial incentives and cost savings. This must be paramount in any adaptation of care delivery systems as they relate to individuals with serious mental illness and their families who depend on public systems for their survival and care.