

**The ‘Business Models’ for the Delivery of
Public Managed Behavioral Health Care**
An Assessment

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Background:

Over the last six years, the behavioral healthcare industry, in general, and public sector delivery systems have undergone enormous change. Slowed in the growth of their commercial and HMO product lines, managed behavioral healthcare organizations (MBHOs) have merged, consolidated and actively pursued public sector business opportunities with a sense of urgency that could not have been foreseen a decade ago. The public sector market has presented challenges to these MBHOs, however, because each managed care project has involved quite different organizational structures and designs.

In the early 1990’s, Medicaid and public sector mental health services were poorly understood by most managed care organizations. The public sector was seen as too high a risk due to the severity of the illness of the chronically mentally ill, the uncontrollable impact of poverty on those receiving publicly funded mental health services, and the unpredictability and perceived risk of public politics and funding. At the same time, there were some leaders in the field, generally those who had been trained in the public mental health system, who sought out the existing opportunities hoping for many states to follow. The field has developed slower than some would have liked but as of 1997 there were more than 9 Section 1115 Medicaid behavioral health related waivers and more than 16 1915(b) waiver initiatives¹ across the country serving as many as 5,000,000² covered lives.

Early efforts to implement managed behavioral healthcare programs for Medicaid were generally extensions of HMO procurements for physical health services. They were usually voluntary enrollment programs under Medicaid, generally resulting in low numbers of the seriously mentally ill and sometimes restricted to the AFDC population, a population that has utilization characteristics more like those of the employed population than the disabled. HealthPass in Philadelphia, a specialty Medicaid HMO, was one of the early pioneer programs that included a specialized mental health program for beneficiaries.

In 1990, Utah filed the first waiver for a specialized behavioral healthcare carve-out initiative for Medicaid funded services. The Utah effort was built upon the county/regional

¹ Perez, Sarah. “Medicaid Managed Care and Behavioral Health: An Overview of 1915(b) and Statewide 1115 Waivers.” 1998 Medicaid Managed Behavioral Care Sourcebook, Faulkner and Gray, Inc.: New York: 1997.

² Bloom, Stewart. “Public Sector Managed Behavioral Care: Early Results and Likely Trends.” 1998 Medicaid Managed Behavioral Care Sourcebook, Faulkner and Gray, Inc.: New York: 1997.

community mental health centers in Utah. Over the last decade the effort has grown from the more concentrated urban areas in Utah to more remote rural regions. This was followed shortly thereafter with the landmark Massachusetts waiver application for the first statewide carve-out of mental health and substance abuse services for AFDC and the disabled. In 1994 and 1995, after the failure of national healthcare reform, state and federal policymakers were actively encouraged by the administration to expand managed care services under Medicaid research and demonstration (1115) waivers and “freedom of choice” waivers (1915b) for state level reforms. The result has been a new series of waiver applications with a number of different designs and organization but all with the shared goal of controlling cost growth and creating more flexibility in the administration of benefits funded by Medicaid.

Introduction:

This article summarizes and discusses the strengths and weaknesses of the different “business models” used by states and county governments over the last several years in their managed behavioral healthcare efforts. The term “business model” refers to the financial and contractual relationship between the government purchaser, MBHOs and providers in the implementation of managed behavioral healthcare services. With greater understanding of the various business models used by states, policy makers and public sector managers should be better able to design a system of care the best fits the unique local requirements. These models should not be viewed as static. As with business in general, the models for care and delivery systems are changing in order to address inherent problems in each model and to address the changing healthcare business environment.

The models that have been developed to date have varied widely. In addition to the business models used by states, other factors that have added to the variability of the plans include the:

- Degree of risk states have delegated to the MBHOs;
- Extent of control over key design decisions exercised by the managed behavioral healthcare organizations;
- Degree of centralization v. regionalization of system management;
- Numbers of entities under contract with the purchaser;
- Extent to which the effort has also involved the privatization of services that were previously publicly delivered.

In addition, several initiatives have included different models for different populations and over time, within the same effort. For instance Massachusetts has included behavioral health services in its HMO benefits, but has carved-out the benefit for those enrollees selecting the Primary Care Clinician benefit plan. San Diego County, on the other hand, is implementing a county-wide Administrative Service Organization (ASO) with a plan to develop regional networks of providers over the first two years of the contract with the ASO.

It would be wrong to confuse the success or difficulty of certain state initiatives with the business model that they have used. Each model has certain built-in characteristics that can lead to unintended consequences of the plan. The difficulties experienced with the TennCare initiative, as an example, are not necessarily a result of the business model chosen, but largely a result of the insufficient financing of the program and the broad scope of benefits, including state hospital services, that were included. Similarly, the general success of the Massachusetts program is not necessarily related to the use of a statewide carve-out approach but more likely the result of the quality of staff hired by both contractors, the transitional implementation plan, the level of competition that existed in the Massachusetts market, and the relatively high level of base funding in the system.

In the sections that follow, each of the different business models are presented, with variations and examples of each approach, with their strengths and weaknesses.

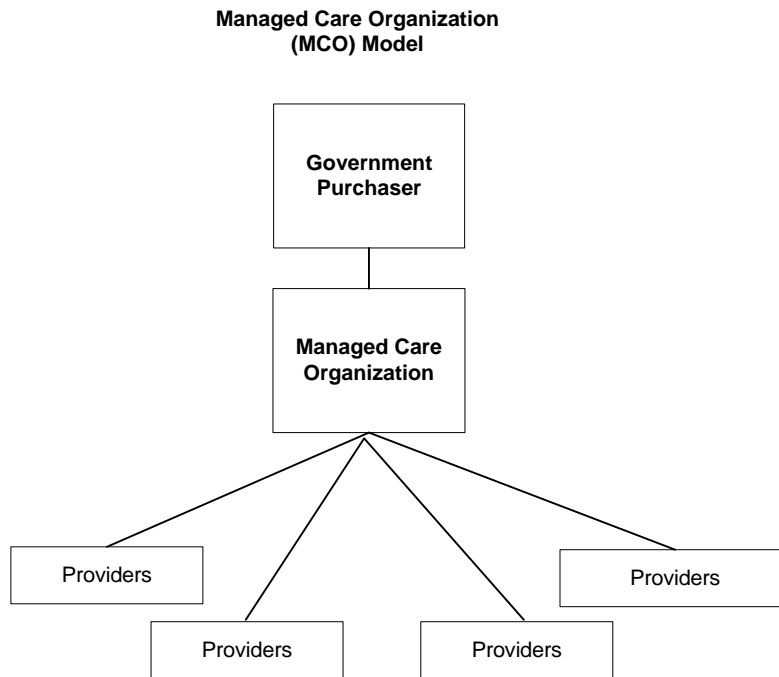
Managed Care Organization (MCO) Model

One of the more common approaches for the procurement of managed care services has been for the government agency to contract with a managed care organization for the administration of the Medicaid or other benefit plan (see next page). In this business model, the government agency is responsible for the procurement and oversight of the services delivered by the MCO. The MCO, in turn, contracts with providers for direct services. Usually, the MCO is not a provider organization in the network nor related to one, with the exception of being a provider of utilization and often certain intensive case management services. This is a result of the concerns over the conflict of interest that might result from self-referral and the consequent fears of “restraint of trade” by other providers.

In the MCO model, a share of the risk for utilization and cost is transferred to the MCO by the government. In fact, one of the principal distinguishing factors for this model from the Administrative Service Organization model (ASO) discussed further below, is the fact that risk is assumed by the MCO. In programs, such as Massachusetts and Iowa, that just involve Medicaid funding, the MCO is usually reimbursed on a capitated basis. Most Medicaid carve-out initiatives have involved some degree of risk-sharing, meaning that the losses and profits for the MCO are limited and savings in the plan are shared with the government purchaser.

The MCO model has advantages for states planning the implementation of Medicaid managed care. It is relatively easy to implement, can result in significant cost savings and in Iowa and Massachusetts, generates competition among the national MBHOs, and can simplify the contract administration and monitoring requirements for state purchasers. On the other hand, the MCO model is often resisted by consumers and advocates because of their fear of MBHOs generating unwarranted profits as a result of the risk they assume. During the planning and procurement process, many providers voice concerns about the loss of public control over and accountability for the services, however based upon the experience in Massachusetts and Iowa, a number of those same providers support the effort after implementation. Finally, the MCO

model can create barriers that may not have existed previously between programs supported by state general funds for the uninsured and between health plans (HMOs) and the MCO for those behavioral health issues that also have physical health symptoms or that can often be readily



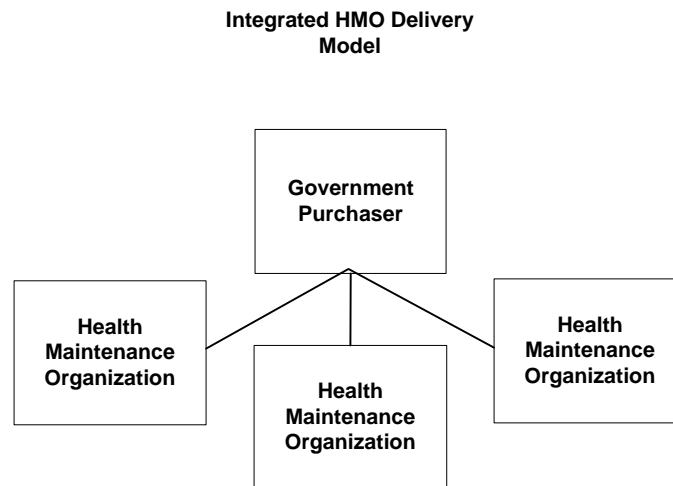
managed by primary care physicians. Major examples of this include depression and substance abuse.

Integrated HMO Delivery System Model

Another option for government agencies involves the procurement of behavioral health services as a part of a physical health procurement with HMOs. HCFA requires that the implementation of mandatory HMO enrollment permits consumer choice of HMOs, i.e. at least two HMOs must be included in the waiver implementation. For mental health consumers and advocates, the HMO model has generally not been a popular approach. This is a result of the perception that the needs of consumers for mental health and substance abuse services have generally not been met in commercial HMOs. HMOs have generally resisted providing the level of reporting on utilization and costs that have been required in many other behavioral health waivers. Some would also argue that HMOs lack the experience in working with seriously and persistently mentally ill individuals, though this is changing. Many purchasers, however, have

chosen this option because it is simpler, it is generally cost effective, and it promises the benefits of integration with physical health services³.

Over the last number of years, with some exceptions such as Massachusetts, many of the HMO delivery system models that have included behavioral health benefits have been restricted to the AFDC population because of concerns on the part of states that services to the disabled will be “compromised”. This is changing increasingly, however. One example of this is the Medicaid waiver program in New Mexico, that has included behavioral health in the HMO benefit, but required a carve-out of these benefits by each HMO to an approved behavioral health specialty organization. Texas has implemented a similar approach in a number of counties, including Houston. This allows for the separate standard setting, monitoring and oversight of behavioral health services. Another approach has been instituted in Massachusetts, where the



Medicaid agency allows choice by consumers of either HMOs, with behavioral health benefits included, or the PCC program which includes the managed behavioral health carve-out. This effectively gives mental health consumers the choice between integrated services or a carve-out approach. Data from the effort shows a tendency for SSI eligibles to enroll at slightly higher rates in the PCC plan, though it is unclear what the enrollment patterns are for those with mental illness as a disabling condition.⁴

³ In the last several years, integration of mental and physical health care services has been actively promoted by HMOs and others partly because of the benefits that more active mental health treatment can provide for reducing medical costs (medical cost offset) and perhaps also to capture greater market share.

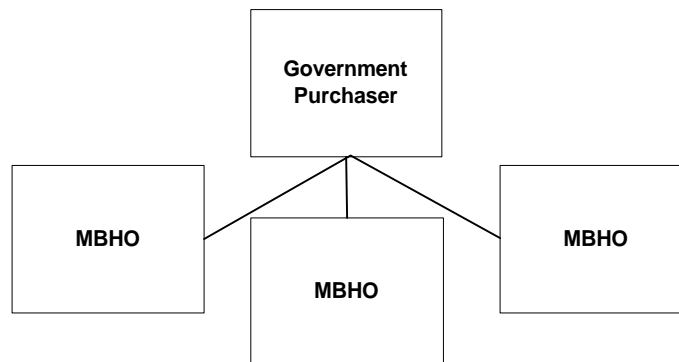
⁴ Massachusetts has also recently put forth standards for quality and reporting for HMOs that are equivalent to those of the behavioral health carve-out in the PCC program. HMOs that choose to subcontract with the carve-out vendor will be deemed to automatically meet these standards.

Competitive MCO Carve-outs

One of the frequently voiced complaints about most managed behavioral health carve-outs is the lack of consumer choice in plans. In fact, recent HCFA standards for managed care initiatives that will not require waivers in the future are that the state effort include the choice of at least two competing plans. A key characteristic of this model is that the MBHOs compete and each offer statewide or region wide coverage. The model has the a clear advantage of offering consumer choice and may lead to some competition on rates and quality by the MBHOs. However, some of the drawbacks of this approach include the following:

- Competitive plans require states to implement some mechanism for an objective enrollment process for each of the plans. Competition among plans requires separate rate setting and contract negotiation, monitoring and quality assurance procedures.
- If the state and/or region does not have many eligibles for enrollment, the enrollment in multiple plans may lead to a reduced economy of scale in each of the plans. This is more of a factor in behavioral health plans than in HMOs due to the lower premium levels.
- Despite the fair enrollment procedures required by HCFA and the states, plans will have to incur and recover marketing costs to attract enrollees.

MCO Carve-out Model

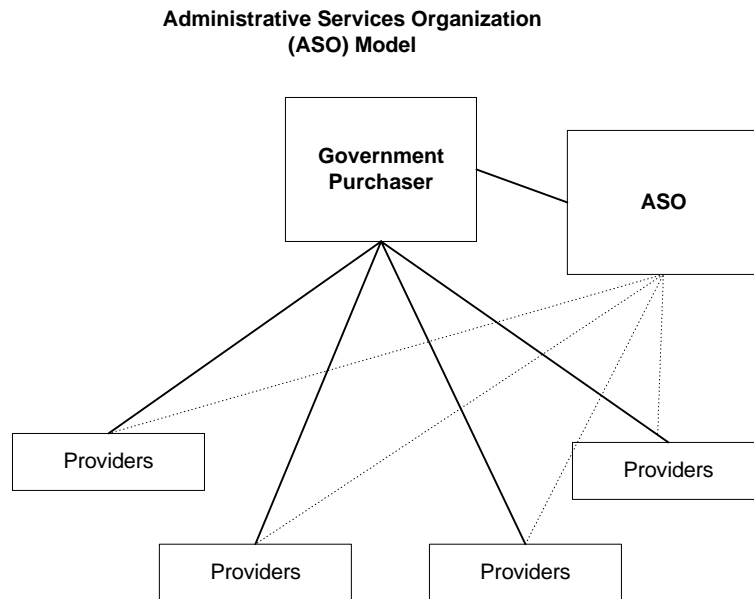


- Finally, there is a risk, as in HMO enrollments, that without risk adjustment of the rates there is likely to be some selection bias in the enrollment of each of the plans. This would occur in situations where those likely to have higher costs may enroll in a certain plan because of a perception that this plan offers better services for those with more serious needs.

Until recently there were few good examples of the Competitive MCO model. Tennessee had a variation of this in its early TennCare implementation, however, rather than having consumers select MCOs, as well as HMOs, and since state officials were concerned about health and behavioral health integration, TennCare paired the MCOs with an HMO and recipients were enrolled in them as a package. A new carve-out initiative in Dallas, just announced by Texas, will feature two MCOs in competition to serve the Dallas metropolitan area. Together they will serve more than 200,000 TANF and SSI eligible beneficiaries. Texas Medicaid officials have interpreted new HCFA managed care policies as mandating this approach, despite mental health officials' objections. New York's Special Needs Plan (SNP) initiative will also offer the choice of different SNPs, especially in the more populated areas. It is likely that other examples of this type of model are implemented over the next several years.

Administrative Services Organization (ASO) Model

Consumers and advocates have long been concerned about the “loss” of savings to the system in risk based healthcare plans. In a full risk plan, savings, or a portion of the savings, that may be experienced by the plans in the first several years of operation may be retained by the MBHO as “profit”. Risk sharing strategies can help to moderate this, reducing the incentive



of risk based MBHOs to artificially seek to reduce care in order to generate excess profits. Another approach taken by many government purchasers recently, has been to contract with a managed care organization for administrative services only, without transferring the underwriting risk to the MBHO. In this model, the state can retain contracts with providers,

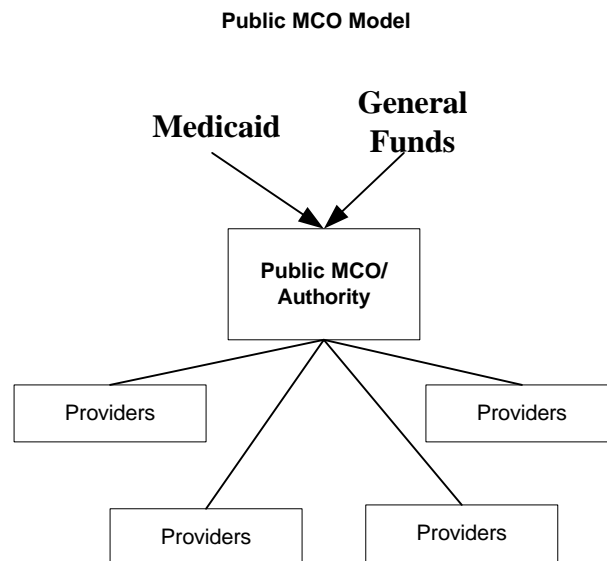
while claims, utilization, quality and information systems management may be performed by the ASO, on behalf of the government agency.

Another approach involves the ASO negotiating and entering into contracts with the providers in the system, without assuming any of the risk, i.e. there is a pass through of government funds. Schematically, this would look more like the MCO model discussed above, without the assumption of risk by the managed care company. Sometimes government agencies prefer this approach, because it removes them from contract decision making and government procurement regulations and procedures, while they can still retain a great deal of control over the system of care. Advocates also usually prefer this approach because of the belief that excess profits will remain in the system. Often, however, future appropriations may be reduced by the government as a way to capture the savings.

Recent examples of the ASO approach include Maryland, San Diego County, King and Clark County in Washington, and initiatives undertaken by certain of the Pennsylvania counties.

Public MCO

Many public managers have argued that they have been managing care all along. They feel that they have always been at risk for rates and service utilization. They have had to live within global budgets for years. In some administrations, the implementation of managed care is not synonymous with privatization! Many Counties, and at least one state, have elected to implement what we refer to here as a publicly managed system of care (Public MCO). The terms of each of these efforts varies by state and county, but the general rule is that the Public MCO (state or county) enters into some form of risk based contract with Medicaid or the applicable



state agency. This helps the Medicaid agency and the federal government avoid cost shifting and unplanned revenue maximization efforts by providers and the state. The Public MCO, in turn, negotiates contracts, manages utilization and benefits of the plan and oversees quality for the Medicaid population. Usually, the Public MCO is also the administrator for mental health services to the uninsured, thus integrating the care for both populations.

The public agency may elect to contract for certain select administrative services, generally claims and/or MIS services. The key differences in this model from the ASO contracting model and the business model prior to managed care are that generally, the Public MCO has consolidated Medicaid and general funds, previously separate funding streams, and it has entered into a risk based capitated contract with the Medicaid agency and by extension HCFA for the Medicaid behavioral health benefits. In addition, the Public MCO will generally need to reorganize to implement utilization management, quality assurance and network management activities. Some variations on the approach have also involved the development of a separate, quasi-public entity (either a public authority or non-profit agency) that assumes the responsibility for program administration. A recent example of this approach has been implemented in Philadelphia.

Examples of the Public MCO approach, in addition to Philadelphia, include certain California counties, and Vermont. In at least one California county, for instance, the County has also applied for and received Knox-Keene (HMO) licensure, in order to assume risk bearing contracts. Critics of this approach argue that it may do little to force efficiencies and reorganization on the government agency. They also believe that the administration of the effort by a public agency is likely to minimize the changes in the provider system that will result from the implementation of managed care due to the continued political influence of providers. Advocates of the approach point to the value of continuity of experienced public sector employees and the continued public accountability and decision-making.

Provider Networks

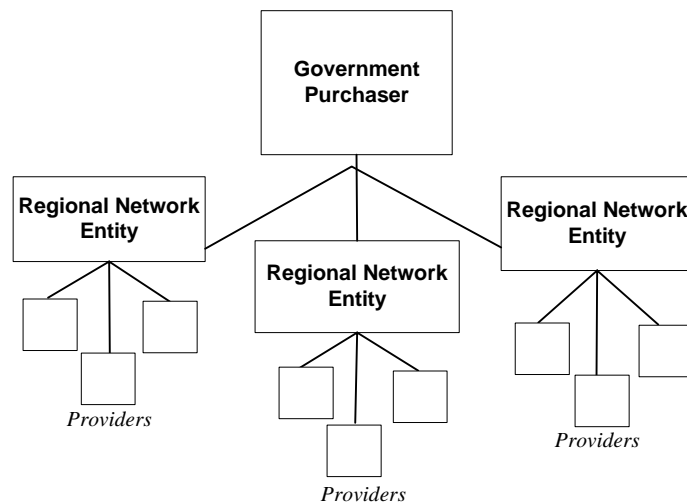
Recently, government purchasers have expressed an increased interest in the procurement of risk based, regional networks or local integrated delivery systems. The concept of developing fully integrated delivery systems, managing risk in the region or local community and making utilization and case management decisions as close to the client as possible, has always had strong appeal to public and private managers since the development of community mental health centers in the 1960's. This is a model that tends to have strong support of advocates, as long as the benefits and standards are consistent across all networks.

Unlike many of the statewide provider networks, referred to as horizontal networks, that have formed in many states prior to the implementation of managed care, regional networks are generally provider sponsored and are organized "vertically", i.e. they have a full continuum of care. This trend is similar to developments in physical health delivery systems, where hospitals have begun to acquire, merge, or partner with physician practices and specialists to create a full

range of services to sell to insurers. From the government purchaser’s perspective, the presence of multiple provider networks with regional coverage maintains a desirable level of competition among networks and can provide backup services in the event of failure of one of the networks. Furthermore, the use of “provider-sponsored” networks allows for the development in providers of the internal infrastructure for managed care, holds the promise of lower levels of administrative cost, and provides an additional financial margin for these agencies.

Advantages of the regional network approach are that the management and decision making for the system of care are decentralized to a more local level. Most feel that there is an efficiency that results from having provider sponsored networks, minimizing the multiple layer of administration between providers and plan administrators. Local systems of care are perceived as being able to be more responsive to specific community and consumer needs. Obviously provider sponsored networks are also appealing to local providers, providing that there are no restrictions or other barriers to these providers, such as requirements for HMO licensure.

Provider Network Model



On the other hand, there is a need for a certain economy of scale in administering regional networks. Most would say that from 30,000 to 50,000 Medicaid lives must be covered for a regional system to be feasible. State administrators, responsible for overseeing the regional systems, may also have to have a higher level of staffing in order to coordinate the multiple regional plans. Without some level of central coordination and standards setting, there is a likelihood of differential levels of quality in the regional plans and it may become more difficult to aggregate utilization, cost and quality data across the plans. Finally, few local providers have the infrastructure needed to manage services under a risk based reimbursement method. The government purchaser is likely to need to allow more time for the development of these networks, including technical assistance and systems support. In San Diego County, the

Countywide ASO has the responsibility of procuring regional network services and providing the assistance needed by the successful regional lead entities. To ensure a smooth start-up of the networks, the County has allowed for almost a full year to plan for and develop the regional networks. Some might say that this is more time than is necessary

Conclusion

So, what is the best business model for states to consider in the implementation of managed care? Specific procurement requirements and the characteristics of the behavioral health market in a state or county will have an influence on the choice of a business model. For instance, in Maine, the reimbursement to community-based mental health providers have not allowed them to accumulate much equity, influencing how much they might have available to build a provider sponsored network. In Massachusetts, with a very well developed community system, the state had significant concerns about conflict of interest for a statewide plan covering almost \$200M in benefits. This helped lead to the MCO model with a requirement for the MCO to be independent of any providers in the system. In Montana, being a more rural state, the concerns over conflict of interest of the MCO were somewhat overshadowed by the need to build upon and provide resources to providers in the system. As a result, the state chose not to include conflict provisions in the RFP.

The principal objectives of the plan and the time available for full implementation will also have a significant influence on the choice of a business model. Statewide MCO or ASO models are generally the fastest to implement, though an implementation period of at least four to six months should be allowed. The MCO or HMO models are likely to be the cheapest options for the state if there is a sufficient level of competition and historical state per capita spending was above average. Unless there is a high level of competition in the market, the development of regional provider networks may need to take as much as a year post-implementation to fully develop data systems and the capacity to manage risk. However, the public MCO models may be able to start relatively quickly because they generally have the needed staffing in place and some preliminary data systems. However, operations will probably have to be redesigned during the first year of operation for optimum efficiency of operations.

Other issues that have obvious, but sometimes overlooked, influence on the choices made by states are the politics of the individual state and the level of delegation of decision making to appointed officials. Strong pro-business states tend to want to privatize the system of care and may elect to pursue the MCO or HMO options. Governments with strong labor backing may favor the public MCO or the ASO model if they are pushed to implement “managed care” at all. At the same time, even in very pro-business environments, the more that state or county elected officials seek to maintain control over the decision making of their appointed officials, the more likely it is that there will be modification of the plans and the slower they will be implemented.

Government agencies, advocates and others should study the various procurement options carefully. Many variations are possible for each model, including reimbursement, public-

private integration and other options. The goals of the state and the urgency for change are the factors that will have the greatest influence on the model chosen. A comprehensive public planning process can help to ensure that the final approach optimizes the outcomes of the effort for public agencies, providers and consumers alike.