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Partners or Antagonists: Medicaid and the Public Mental Health Agency in the Era of Managed Care

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The failure in the early 1990s to reach consensus between the Administration and Congress regarding the shape of national health care reform has fueled the continuing efforts of individual states to address an array of lingering problems, principally through Medicaid managed care initiatives. These programs are intended to control spiraling costs, expand coverage and access to services, and improve quality of care. The recent relaxation of waiver requirements in the Omnibus Budget Reconciliation Act is likely to continue this trend. Within this environment, mental health has perhaps been the most prominent specialty service to command the attention of Medicaid directors across the nation. Although payments for mental health and substance abuse treatment services represent only about a quarter of total Medicaid expenditures, inflation rates for these services have typically been higher than the already steep rate of medical cost increases. While public mental health directors have been busy completing a process of downsizing large public institutions, attempting to develop and consolidate community-based systems of care, and supporting a burgeoning consumer movement, they have had to cope with a rapidly changing business landscape reflected through changes in the Medicaid program.

The goal of this paper is to examine the manner in which structural, procedural, and political aspects of the relationship between Medicaid and the public Mental Health Agency (MHA) impact the design and implementation of managed care initiatives. Of particular interest are the variables impacting the manner in which Medicaid and the public MHA work together, or at cross purposes, in setting the course of public mental health policy. Acknowledging the unique fashion in which individual states organize and finance their public mental health systems, the current paper will:

- discuss the manner in which Medicaid and the public MHA typically take either similar or divergent approaches to eligible populations, benefit design, purchasing strategies, provider networks, quality management, financial management and other administrative functions;
- identify areas of both collaboration and conflict, using examples of existing managed care initiatives; and

- suggest possible strategies to enhance cooperation.

Payer, Purchaser, Provider

It is helpful to conceptualize the management of the public mental health system in terms of three broad functional categories: governance, systems administration, and service provision. Central to the *governance* function are the key political/public policy decisions regarding who will be served and how much public money shall be allocated. Governance is the true province of public policy makers, including the executive and legislative branches of government, plus the direct stakeholders, especially consumers and advocates. *Systems administration* refers to the set of operational activities required to implement policy, i.e., network development and management, financial management, information management, and quality management. Operating the public mental health system has long been the (fairly exclusive) province of the MHA, but one of the major questions today is whether some or all of the systems management tasks can be more efficiently and effectively handled by for-profit or not-for-profit private sector managed care organizations including managed mental health care organizations. In the public mental health system, a mix of public and private, mainly nonprofit, inpatient and community-based organizations have traditionally been responsible for *service provision.* The manner in which service provider networks are selected and managed is another area of debate regarding efficiency and effectiveness.

As a 'mere' payer for a discrete set of mental health services, Medicaid has not historically taken a great interest in the overall systems management function of the public mental health system. Indeed many would describe Medicaid's pre-managed care participation in the governance function as fairly passive: in most states Medicaid allowed itself to be a financing source for the deinstitutionalization/community development policy which was shaped by the MHA. Two factors have significantly altered this state of affairs: first, Medicaid's financial stake in mental health services has increased significantly (to the point where it is the dominant payer for certain services), and second, Medicaid has begun to enroll increasingly larger percentages of its recipients into managed care plans.

During the 1980s, Medicaid came to represent a major source of funding for mental health and substance abuse treatment services. As MHA directors began to pursue mainstreaming campaigns, clients under their care who required inpatient services increasingly were hospitalized in community general hospitals using Medicaid financing. At the same time, many MHA directors began to collaborate with their Medicaid counterparts to implement optional clinic and rehabilitation services. By 1994, total Medicaid reimbursement for mental health was $22.9 billion, accounting for almost half the funding for public services (Oss, 1995). Other public funding of mental health included state and local government ($21.7 billion), Medicare ($3.1 billion), and other Federal government ($2.8 billion).

At the same time that Medicaid has increased its investment in the public mental health system, its embrace of HMOs and other managed care plans has necessitated an internal transformation from an indemnity *payer* organization to a *purchaser* of managed benefit packages. Like employers and commercial insurers, Medicaid has been attracted to the promise of more predictable costs and greater accountability offered by the plans. Posing the central question, "Are we receiving value for our dollar?," Medicaid directors have begun to work with organizations like the National Committee for Quality Assurance (NCQA) to develop meaningful and appropriate measures of plan performance. Although their main focus remains general medical care, this new approach combined with the greater investment in mental health have resulted in Medicaid directors becoming active participants in systems *governance* — formulating public mental health policy. Moreover, by contracting with private for-profit or not-for-profit managed mental health care organizations, Medicaid has also become a significant force in the *systems administration* function.

MHA directors have historically been active in all three functional areas. In most states, the long standing tradition of setting public mental health policy (governance) is the most common component of the MHA's role. MHA systems operations show greater variation from state to state, with centralized *systems administration* at one end of the continuum, and regional/local (including county-based) at the other. There is also significant variation in the extent to which the MHA assumes a direct *service provision* role. Although an ideological embrace of mainstreaming has led to a greater reliance on private (mostly non-profit) providers, some state delivery systems remain largely within the public sector, and virtually all state MHAs continue to operate a (reduced) number of public hospitals. The issue here is whether the MHA, with a history in governance, systems administration, and service provision should continue in all three roles, and if so, in what manner, with which emphases. Is this history a qualification for future continuation, or does it merely result in a resistance to necessary and worthwhile change? Furthermore, if the activities of the MHA change — or even if they do not — what is the proper role of the Medicaid agency? How ought Medicaid and the MHA work together in the future?

Organizational Mission

Mission statements are intended to help organizations think clearly about who they serve — who their customers are — and how they serve them. Public mental health directors describe their mission in terms of providing systems of care for people suffering from serious mental illnesses. With respect to their customers, there has been a change of focus over the past decade: although persons with serious mental illness were the priority, before the mid-1980s MHAs tended to assume responsibility for matters affecting the mental health of all citizens in their states, regardless of their level of disability. The narrowing of mission can, in part, be understood in the context of a changing political environment that has sought to limit the role of government. Confronted with dimin-

ishing resources and the fact that many citizens have access to some insurance coverage, at least for episodic care, the MHA came to focus its resources on adults with serious mental illness and children and adolescents with serious emotional disturbance. Most mental health directors see this as a positive shift that affirms a long standing commitment to the most vulnerable groups of citizens. It simultaneously releases them from an inherently frustrating charge to "be all things to all people." During this period, many states developed specific legislative mandates which in effect determined (limited) eligibility for services funded by the MHA.

While the 'who we serve' aspect of the MHA's mission has narrowed, thinking about 'how we serve' has been expanding. With the downsizing of state operated institutions, the locus of care is shifting to community-based systems of care. The ability to understand the continuing care needs of vulnerable populations and to plan, design, and monitor innovative and responsive services is considered an area of MHA competence. Mental Health directors note that they developed many of the creative elements of a fully developed continuum of care, including intensive case management, rehabilitation services, mobile crisis teams, and diversionary services. As part of their development of community-based systems, MHAs have increasingly looked to the private sector for provision of care. While there is significant variability from state to state, all MHAs now have a mix of public and private providers in their service networks.

Medicaid directors describe their mission differently, as providing comprehensive health insurance benefits for poor and disabled citizens. Following an era of runaway growth, there is also a clear mandate for Medicaid directors to contain costs. They have increasingly turned to managed care, with its promise of cost savings and improved quality, as the most viable solution. In 1993, 8% of the Medicaid population was enrolled in a managed care plan; by 1996 that figure had grown to roughly 40%. In contrast to MHAs, the trend with Medicaid programs has been toward expanded coverage. Although Medicaid has not, as the "insurer for the poor," provided coverage to all citizens at or below the Federal poverty level, several state Medicaid Agencies have taken a leading role in attempting to address the national problem of more than 40 million uninsured individuals. These states have sought to use savings from their managed care initiatives to fund new eligibility criteria that now include persons meeting ever higher percentages of the Federal poverty level guidelines.

The move toward managed care has also had profound implications for the manner in which Medicaid agencies operate. As an indemnity insurance entity, they previously focused on claims administration and regulations regarding provider clinical and administrative qualifications and practices. In a fee-for-service environment, financial management was accomplished principally through pricing mechanisms that more often than not set provider reimbursement at below-market rates. Under a managed care approach, Medicaid agencies now strive to redefine themselves as value purchasers of benefit plans for their enrolled populations. The emphasis now is on contracting with managed care

plans, including HMOs, often on a pre-paid basis. Medicaid staff have been at the forefront in developing contract management skills and using vendor management as a primary vehicle for program implementation.

While both the MHA and the Medicaid agency are units of government, and thus ultimately share a common purpose to improve the welfare of the greater society, different missions, multiple agendas, and differing priorities can contribute to different visions of what constitutes the best public mental health policy. The mandate for Medicaid to control costs is an area of tension in many states. In situations where interagency relationships are less than optimal, MHA directors are skeptical about the stated purpose of managed care initiatives, believing that 'expanded access' and 'improved quality' are secondary to saving money. Carrying the concerns of primary consumers and advocates, they worry that the cuts in spending are too deep. For their part, Medicaid directors question the MHA's commitment to sound management, particularly when it comes to spending Medicaid funds for which the MHA is not held directly accountable.

Eligible Populations

MHAs primarily use diagnostic and functional criteria to determine eligibility for services. Because the MHA has statutory responsibility to assure emergency services for all citizens, eligibility determination has ordinarily come to mean eligibility for an array of continuing care services, such as case management or residential rehabilitation. Many adults with a serious mental illness and children/adolescents with a serious emotional disturbance who are identified as priority clients by the MHA also meet disability criteria used by the Social Security Administration for determining eligibility for Supplemental Security Income (SSI). The Federal government has defined standards for SSI that are used by the states. In addition to functional status, financial criteria, which vary significantly from state to state, are also used to determine Medicaid (and SSI) eligibility. For those clients who meet MHA criteria for service eligibility but are not Medicaid eligible, i.e., whose income and assets exceed the limits set by their particular state, the MHA is the payer of last resort, providing the safety net for this population.

While from the MHA perspective there is almost complete overlap between MHA priority clients and persons eligible for Medicaid, adults with serious mental illness and children with serious emotional disturbance are only a small percentage of the total Medicaid population. Medicaid provides coverage for two broad categories of assistance: those classified as Aged, Blind, and Disabled (ABD), and those qualifying for Aid to Families with Dependent Children (AFDC). Roughly 27% of the total Medicaid population fall into the ABD category, and less than half this group suffer from a psychiatric disability. Within these categories, Medicaid is responsible for several high risk populations that tend to be significant users of mental health services, including persons with developmental disabilities, persons with addictive disorders, and children suffering from

neglect and abuse. The majority of Medicaid-reimbursed mental health services are consumed by recipients in the AFDC categories. However, penetration rates (i.e., the percentage of eligibles who actually use services) and per capita expenditures are much higher for ABD recipients. Under a managed care approach, this sub-group is an obvious target for cost savings, potentially providing the greatest return on a per-case basis.

The fact that there are significant populations eligible for services from both Medicaid and the MHA, but also important groups that are not shared, creates opportunities for both interagency conflict and collaboration. From the MHA perspective, Medicaid funding has become a critical financing element for the *entire* public system. Decisions by Medicaid directors to award contracts to HMOs or managed behavioral health care organizations are seen by the MHA as a potential threat to the very existence of the public delivery system that must serve as the safety net for the uninsured consumer. However, to the extent that Medicaid is able to expand coverage to the working poor and uninsured (i.e. the safety net populations), additional Federal revenues may become available to allay MHA financial concerns.

The volatility of Medicaid coverage is a complicating factor for interagency collaboration. To remain eligible, Medicaid recipients must follow through with regular redetermination procedures; failure to do so results in termination of coverage. While coverage may be reinstated, even retroactively, if it is terminated for a period of time, the MHA must act as the safety net and assume responsibility for services. Changing numbers of eligible users of services makes planning difficult for the MHA, and can result in unexpected demands on scarce resources.

The perceived inability of MHA directors to specify exactly how many people they serve and how much service they receive also makes joint Medicaid-MHA planning a challenge. Because it is part of a national insurance program and must meet relatively rigorous Federal information requirements, the single state Medicaid agency has years of experience maintaining an accurate, standardized eligibility database — a prerequisite for developing risk-based managed care programs. Most MHAs have no such experience. As their mission requires them to make services available to all persons in need, they have not traditionally thought of eligibility in terms of insurance coverage. Furthermore, MHAs have not had an oversight agency such as the Health Care Finance Administration (HCFA) driving (and funding) the development of their information systems, which largely remain inadequate. Finally, although criteria may be well defined, in practice eligibility based upon diagnosis and functioning can raise serious questions regarding inter-rater reliability. The 'messiness' associated with MHA eligibility can thwart interagency efforts to integrate services through a blended funds approach. MHA directors, unlike their Medicaid counterparts, do not ordinarily think in terms of per capita spending, because they are never certain either about the size of the beneficiary pool, or what percent of eligibles actually utilize services — but these are precisely the types of analyses necessary for developing actuarially sound rates.

Covered Services

In a public sector managed care initiative, the issue of which services are to be included in the benefit is obviously a critical design decision, one which presents opportunities for interagency collaboration or conflict. If in their respective approaches to covered populations, Medicaid's mission has been relatively expansionary and the MHA's more restrictive, the opposite seems to have been true regarding mental health benefits. MHA directors have led efforts to expand the scope of services and the continuum of care for persons with serious mental illness. Unlike their Medicaid colleagues, MHA directors have not historically thought in terms of limiting benefits. Rather, they have been actively involved in creating new service models and expanding the community-based continuum. The concept of 'wraparound' services perhaps best exemplifies the MHA approach: providers are encouraged to work directly with consumers, to be creative and flexible — to use services not traditionally considered mental health if necessary. The emphasis is on doing whatever it takes to meet the needs of the client.

As a national insurance program, Medicaid is required to take a more conservative approach to covered services, and is based largely upon a medical model. Indeed, one of the chief and explicitly stated goals of Medicaid managed mental health care initiatives to date has been to bring greater flexibility to the use of Medicaid funds by expanding the range of covered services. Title XIX mandates a standard benefit, after which states have considerable leeway over final benefit design. Mandatory Medicaid mental health benefits include standard inpatient[1] and outpatient services for adults, and a somewhat broader range of EPSDT (Early Periodic Screening, Detection and Treatment) services for children. States vary in their use of optional benefits, which may include targeted case management, clinic, and rehabilitation services. In states with a broad Medicaid mental health benefit, the optional services have been added to the state Medicaid Plan in the last decade, typically as part of an interagency revenue maximization initiative.

One of the main challenges regarding managed care design facing both MHA and Medicaid managers lies in clarifying responsibility for managing and financing a comprehensive benefit package. Medicaid is more likely than the MHA to express concerns about the inappropriate use of its funds to pay for services that do not fit strict definitions of medical necessity. In one state, an explicit objective of the managed care initiative is to curb the excessive use of residential treatment for adolescents for social (i.e., protective) rather than for clinical reasons. Medicaid, the state purchaser, wants managed care organizations to develop step-down alternatives to residential care. Besides 'inappropriate' use of the Medicaid benefit, there are other related and non-medical services needed to complete the continuum. In designing comprehensive services for

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[1] Mandatory Medicaid inpatient benefits do not include services rendered in so-called Institutions for Mental Diseases (IMD), i.e., hospitals in which over 50% of the residents are mental health consumers. IMD services are an optional benefit for children and adolescents under the age of 21.

persons with serious mental illness, MHA directors have recognized the necessity of providing housing supports, employment training, and other non-clinical services. While there may be consensus between the MHA and Medicaid as to the value and necessity of these non-medical services, there often are questions about service definition as well as funding responsibility.

The different properties of the Medicaid covered services can also be a complicating factor for interagency relations regarding managed care design. Medicaid has two types of covered services: the basic or mandatory services which cover acute needs, and the additional, more comprehensive optional services, which generally target continuing or long term care. The former are funded completely out of the Medicaid budget; the latter, however, are not and states often use the MHA budget to supply the state matching funds, while the single state Medicaid agency draws down the Federal financial participation (FFP). In states where Medicaid has taken the lead in developing a statewide carve out program, the basic benefit has included only the mandatory Medicaid services; management of the continuing care benefit has remained the province of the state or county MHA. The challenge for both agencies in this design thus becomes one of coordinating benefits to make the system as seamless as possible. One state placed all Medicaid and MHA services (including the state hospital) under the benefit to be administered by a single, statewide managed care organization, thereby hoping to avoid the potential vicissitudes involved with benefit coordination across agencies — the managed care organization is the single, accountable entity responsible for both acute and continuing care benefits.

Network Providers

Except in those states where the provider network is predominantly state- or county-operated, both Medicaid and the MHA tend to have separate contracts or agreements with many of the same community-based direct services providers. The nature of their provider relationships are quite different, however. Where the MHA tends to buy whole programs, often on a cost reimbursement basis, Medicaid pays for services as needed, exclusively on a fee-for-service basis. The MHA approach is generally to make estimates of needed service capacity and to then purchase accordingly, while Medicaid typically allows the participation of any and all interested providers, as long as they demonstrate the ability to meet regulatory requirements and/or credentialing standards. Thus the MHA may, for example, cover the fixed costs associated with maintaining 24-hour emergency response services (and thereby purchase "excess" capacity), while Medicaid will act as a marginal payer, reimbursing only for services rendered.

Perhaps the most important difference between these co-financers of the public mental health system lies in their attitude toward providers. The MHA tends to view community-based provider organizations as extensions of themselves; their missions are congruent, and the MHA is usually the dominant customer. Senior MHA managers often

have been providers themselves, adding to the affinity between these entities. While MHA directors may feel that they have developed and nurtured the provider system in their own image, Medicaid's provider relationships, including those with its mental health providers, have been more formal, business-like, at arms length. Medicaid directors are less concerned about the consequences of using a free market approach when they control the managed care design, perhaps, in part, because they do not view the provider system as their own.

The issue of free market versus protectionism relative to the 'traditional provider' is undoubtedly one of the more contentious areas of debate in the era of managed care. Political fault lines are readily observable when a for-profit managed care company is thrown into the mix. In its extreme forms, the rhetoric is characterized as pitting greedy corporate executives lacking experience with adults with serious mental illness or children with serious emotional disturbance versus committed, altruistic, clinically superior providers (the provider/advocate perspective) — or as pitting efficient, quality-oriented data-driven managers versus well meaning but inefficient, technologically-challenged, politically entrenched monopolists (the for-profit managed care organization perspective). Conflict is not inevitable; there are many creative compromises available in terms of network development. In some states, for example, equity partnerships between traditional providers and a private, for-profit managed behavioral health care organization are seen as a vehicle for improving network efficiency while maintaining continuity of mission. The point is that the MHA tends to experience a strong pull to advocate for partnership with the community-based provider industry, while the Medicaid agency usually does not. To the extent that providers are well organized politically and are perceived to be competent and to hold the high ground as consumer advocates, they can become a significant ally for the MHA. Policy makers in one state credit the support of the providers, as well as consumers and advocates, for swaying the administration away from the original Medicaid-sponsored carve-in design toward the MHA-proposed carve-out.

Quality Management and Approach to Customer Service

In theory, quality management represents an area of systems administration that may afford Medicaid and the MHA some of the best opportunities for collaboration: all parties can agree that improving quality is an important and worthwhile goal. The two agencies have somewhat complimentary strengths in their approaches to quality. As with network providers, it is safe to say that the MHA has historically been closer to the ultimate customer of the public mental health system, the consumer of services. As a provider and a systems manager, the MHA has had more direct experience meeting the needs of its clients than has Medicaid, the insurance organization. The nascent consumer empowerment movement has been consistently supported by MHA directors across the country, many of whom have established offices of consumer affairs within the office of the director.

In recent years, the concept of involving consumers, not only in their own treatment planning and delivery, but also in systems design and governance, has gained wider acceptance. Even where Medicaid and MHA relations have been strained, Medicaid has accepted the wisdom of emphasizing consumer rights, grievance and appeals processes, and consumer participation in policy development as part of its procurement specifications.

Medicaid's approach to quality management, consistent with trends in the managed care industry, has been to establish systems for measuring and monitoring plan performance. Medicaid directors have displayed leadership at the national level through their work with NCQA to adapt HEDIS (Health Plan Employer Data and Information Set) for their covered populations. MHA directors have also been eager to support the emphasis on creating meaningful, manageable, data-driven performance indicators, working with the Federal government in the creation of the Mental Health Statistics Improvement Program's (MHSIP) Consumer-Oriented Report Card. Both agencies share a common desire to institute provider profiling on a regular basis, although neither has yet demonstrated the technical capacity to implement such systems. Medicaid was the first to point out the advantages of procuring private sector technological capabilities in the service of quality management; the MHAs, although at times skeptical as to the merit of marketing claims by managed care organizations regarding their capabilities, have largely agreed.

Other Considerations: Structure and 'Turf'

There are several other factors unrelated to history, mission or operating style that appear to have an impact on interagency relations. These include the place of each agency within the governmental structure; the history of working relationships between agencies; and the ambitions, credibility, and public management skills of the agency head. Surprisingly, it is difficult to discern any trends with respect to where each agency is housed in the administration. For example, in some states, the two agencies have historically been in different cabinet level Departments. Such separation may create a distance that makes interagency dialogue more difficult, and interferes with coordinated policy making. By the same token, considerable tension can occur in managed mental health care initiatives, even when both organizations are housed within the same Secretariat. Yet, a history of solid interagency working relationships does not, as one might suppose, automatically lead to collaboration on specific managed care initiatives. In some states, good long-term relations coupled with the intimacy of a small state government, have facilitated that state's blended funds approach; in others, however, good working relationships at the staff level ultimately proved powerless against strong differences in vision and style between agency heads.

The permutations associated with locally-based MHAs, specifically the balance of power and responsibility between the state and local- and county-level MHAs, is yet another complicating factor in terms of designing and implementing a managed care

quality management processes; management information systems and reporting capabilities; and system financing. Such a review should be comprehensive and should incorporate the activities of both agencies.

Identify strengths, weaknesses, and areas of competence, for each agency. In addition to identifying the highest priority goals for systems-level reform and improvement, the interagency review should also explore the core competencies of each agency. The goal is to work as a team, building upon current capacity and taking advantage of complimentary strengths.

Develop an interagency action plan. The end product of interagency review activities should be a jointly published vision for system reform, including priority goals and the steps necessary to achieve them. It is important to clarify the roles and responsibilities to be assumed by each agency, particularly the manner in which they are to manage and facilitate the participation of key stakeholders.

Develop meaningful, manageable measures of systems-level performance. Any plan of action that results from an in-depth interagency systems review must include systems-level (as opposed to individual client- or provider-level) performance indicators. A major challenge for the agencies will be to come to agreement on how to measure success.

The use of public funds to purchase managed care programs for consumers of mental health services is a relatively new phenomenon. Responding to varying histories and arrangements regarding Medicaid and MHA funding and functioning, different states have launched a series of unique experiments. A number of important issues are still being actively debated: which populations can or should be managed under the same plan; whether use of a specialty mental health benefits management (carve-out) organization is preferable to an integrated approach; what is the legitimate role of the profit motive in the management and delivery of services. In an environment that has heightened expectations for accountability and cost control, state policy makers are particularly challenged to coordinate and optimize the use of limited resources. Although we currently lack empirical evidence, we suspect that interagency antagonism results in less than optimal service system quality and efficiency and that interagency collaboration is critical to successful system reform.

References

Oss, M. (1995). Trends in mental health financing. *Open Minds - April 1995.* Gettysburg PA: Behavioral Health Industry News, Inc.