



**MENTAL HEALTH POLICY
IN A MANAGED CARE ENVIRONMENT:
IMPLICATIONS FOR ACCESS, QUALITY AND COST**

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MENTAL HEALTH POLICY IN A MANAGED CARE ENVIRONMENT: IMPLICATIONS FOR ACCESS, QUALITY AND COST

ISSUE: As the growth of managed care results in changes in the delivery and financing of our health care services in both the commercial marketplace and the public sectors, there are unique features in the area of mental health requiring consideration. All players in the mental health field -- including policymakers, regulators, purchasers, providers and consumers – through budgeting and appropriations, contracting, regulations and purchasing decisions are shaping the types of products that are available. What is the role of state government with respect to public and private sector actions and strategies such as carve-outs, integrated plans and parity considerations in a climate where programs are competing for scarce dollars and funding has typically been categorical?

INTRODUCTION

Concerns about the high costs of mental health and substance abuse services have catalyzed the development of managed mental health care strategies in both the public and private sectors. The same forces driving the move to managed care for physical health services are also in operation in the mental health specialty sector.¹ And as with the general health care arena, there are advocates and critics debating the effectiveness and efficiency of managed mental health care in providing accessible services at reasonable costs without reducing quality of care.

This issue brief focuses on the complex mental health policy issues emerging in the managed care environment, as they are evolving against the backdrop of mental health parity on both federal and state levels. Although current trends in managed care are to provide "behavioral health" care, which encompasses a full range of mental health and addictions programs and services, in this brief we will limit discussion to mental health policy. In this Forum, we will focus on mental health services, rather than on the full spectrum of behavioral health (which includes substance abuse and addiction treatment), allowing focused discussion on the complex problems of mental health policy. A separate Forum will be presented in

¹ Currently, approximately 70 percent of the population under 65 years of age now receive some form of managed care (Mechanic, 1997).

the near future on the equally complex issues surrounding substance abuse and addictions.²

TRENDS IN THE DEVELOPMENT OF MANAGED MENTAL HEALTH CARE

During the early 1990s, managed mental health care swiftly advanced in pace and scope: an estimated 75 percent of employees (and their dependents) were enrolled in managed mental health systems in 1992; while, in the same year, only 50 percent of the workers and their dependents were in managed care programs for their medical and surgical care (England, 1995).

In the private sector, the shift to managed mental health care began in the 1980s. In an essay entitled "From Fee-for-Service to Accountable Health Plans," Dr. Mary Jane England provides a brief sketch of the evolutionary "phases" of managed mental health care in this sector. Beginning in the mid-1980s, utilization review alone was used and mental health care had to be pre-authorized by medical reviewers (Ibid). While pre-

²In a recent General Accounting Office study evaluating substance abuse and addictions treatment programs, it was reported that Federal, state and local governments, along with the private sector, report contributing several billion dollars annually to substance abuse treatment and prevention programs. The report noted that actual expenditures are most likely much higher, owing to under-reporting by the groups involved. An estimated 10 million Americans have at least one mental disorder co-occurring with one alcohol or drug-related disorder (National Health Policy Forum, Issue Brief No. 709, "Mental Health Parity" November 13, 1997).

authorization was decreasing inappropriate use of in-hospital care, benefits remained capped and many patients were left without access to preventive and ambulatory care.

The next phase, starting around 1990, England views as "utilization review with selected providers." Managed care companies developed networks of providers -- including psychiatrists, psychologists and clinical social workers -- to provide mental health services. Although outpatient services were expanded during this period to provide a continuum of care, benefits continued to be capped and once individuals reached their limits, they were without mental health insurance coverage.

Trends: The Behavioral Health Care Plans

In response to ongoing cost and access issues, employers looked to carved-out behavioral managed care as a way to improve patient access and treatment quality, while keeping costs under control. During the past five years, the trend emerged in which employers began to separate ("carve-out") mental health and substance abuse care from major medical benefits. As a result, enrollment in managed behavioral health care plans has increased dramatically: an estimated 149 million Americans are now covered under managed behavioral health care plans (National Health Policy Forum, *Issue Brief*, November 1997).

In most carve-out scenarios, employers make contracts with independent managed behavioral health care companies that act as vendors providing mental health and substance abuse services. In the carve-out system, rather than limiting benefits per person, employers pool the risks for their employee group (England, 1995). Employers then pay a fixed per-capita rate for all covered workers and their dependents. The managed behavioral health care firms provide a range of services available -- which may include outpatient therapy, in-home services, group homes and short and long term hospitalization. Proponents of managed behavioral health care assert that because plans provide a wide range of mental health services, access to services is improved.

Concerns about separate carve-out arrangements for the provision of mental health services include:

- Absence of integration between physical health care and mental health care services; and the potential loss of interaction between the primary care physician and the mental health provider;
- Use of such determinations as "medical necessity" to limit access to appropriate services and to limit length of time for service utilization; and,
- Limitation of certain providers (such as psychologists) from participation in their provider networks and/or restricting certain types of medications for which they will reimburse.

As with much of the activity in the managed care field, the jury is still out regarding the positive and negative impact that entities such as carve-out managed behavioral health companies are having on access, quality and cost of services. At present, supporters on each side of the issue offer conflicting research studies proving either cost-savings related to managed behavioral health care, or limited access to services as a result of the imposing of utilization controls by such companies. Reliable and consistent data reporting and research studies are critical in determining the pros and cons of managed mental health care services and costs.

In a piece entitled, "Characteristics and Growth of Managed Behavioral Health Care (MBHC) Firms," the author points out that much of the information about these firms is proprietary, and many are not traded publicly (Kihlstrom, 1997). In pointing to "turbulence" in the field of MBHC firms, such as consolidation and merger activities, the researcher emphasizes that it "may be difficult to understand the nature of MBHC firms and their effectiveness in providing appropriate care and generating cost-savings" (Ibid).³ As a result of her

³ The Chairman of the American Managed Behavioral Health Association (AMBNA) recently pointed out that for a managed behavioral health care company to survive in the present environment, it must "have a foothold" in three areas: direct relationships with employers, contracts with HMOs and Medicaid contracts (www.njamha.org.1097).

research analyzing MBHC firms, Kihlstrom raised issues about their performance, including:

- The need for MBHC firms to evaluate treatment outcomes by developing formal programs of outcomes research;
- Ongoing analysis to determine whether or not carve-out arrangements are becoming more expensive to administer and require more coordination among health care providers.

The second issue is most significant because the lack of integration between the specialized providers, such as the BMHC firms, and the general medical providers can cause inappropriate care and fragmented services. Statistically, many mental health and substance abuse problems also include medical issues; therefore, coordination between the mental health provider and general medical providers is critical. As with other dimensions of managed care, there is a critical need to develop intensive outcomes research to design appropriate measures of clinical and functional status, life satisfaction, safety and welfare.

Trends: Mental Health Policies and Programs for Severe Mental Illness – From the Private Sector to the Public Sector and Vice-Versa

In the National Institute of Mental Health (NIMH) survey conducted in the mid-1980s (the most recent period for which data is available), about 22 percent of the adult population is affected by mental disorders over a one-year period. Most episodes of mental illness are of short duration. Those who experience serious mental illness over the course of a year comprise 2.8 percent of the overall adult population. In the age group of children, aged 9 to 17, about 3.2 percent experience serious mental illness over a six-month period (Hegner, 1997).

Over the past 50 years, treatment and care of Americans with severe mental illness has been largely provided by individual families and through services provided by Federal, state and local government. In a 1991 Johns Hopkins Study of families involved in the National Alliance for the Mentally Ill (NAMI), 60 percent of those with severe mental illness were diagnosed with schizophrenia and 38 percent had severe and

persistent depression and bipolar disorder (Stretcher, 1995). Costs for providing mental health services for this population are consistently high because of the need for intensive services, especially hospitalization. Between 35 to 50 percent of the severely mentally ill are re-hospitalized within six months after discharge and two-thirds of the readmissions occur within three months of initial discharge (Ibid).

Those afflicted with severe and chronic mental illness have felt societal stigmatization, and access to appropriate mental health services has been a long-standing problem. Employers and insurers "have tended to limit their mental health benefits because of concerns about the efficacy and cost-efficiency of existing diagnostic and treatment modalities" (National Health Policy Forum, *Issue Brief* No. 709, 1997). The reality of such limitations on benefits has resulted in public programs' providing the safety net for those individuals and their families with severe and persistent mental illness whose private insurance for mental health care has "run out."

In the aggregate, private insurance and out-of-pocket payments account for about 40 percent of all expenditures for mental health and substance abuse services (Iglehart, 1996). The Federal government, through Medicare, Medicaid and the Department of Veterans Affairs currently accounts for 22 percent of total expenditures, and spending by state and local governments accounts for the remaining 38 percent (Ibid).

Initially, hospitalization was the treatment setting for the severely mentally ill. By the early 1950s, as a result of new drug therapies and mental health advocates calling for a need for more humane and effective treatment of the severe and chronically mentally ill, efforts were mobilized to deinstitutionalize patients from the hospitals that had become the major center of care for those with mental illness. The Federal Community Mental Health Centers Act of 1963 heralded a dramatic shift from institutional to outpatient care: from 559,000 institutionalized mentally ill in 1955, to 138,000 in 1980 - a 75 percent decrease.

The policies and politics of the deinstitutionalization movement have been both applauded and deeply criticized. The most

pragmatic of allies and adversaries acknowledge that the community mental health system of care is still affected by the problems confronting it from the outset: there was not an integrated infrastructure in place when the deinstitutionalization process began. The provision of mental health care has been compromised by fragmentation of services and service providers and by insufficient outreach to clients in the communities. Ironically, the component of treatment that has made living in the community possible -- the development of effective and relatively safe psychotropic medications for the treatment of mental illness -- is one of the weakest links in the treatment plan because often times patients are non-compliant with taking their medication and relapse, once again requiring hospitalization and more intensive services. Case management and medication monitoring are two critical pieces of a continuum of care in mental health service delivery. (See, below, regarding New Jersey's comprehensive, community-based services plan.)

Throughout the 1980s and 1990s, there has been continued attention to the large numbers of deinstitutionalized and never institutionalized seriously mentally ill. The role of state and local government in providing "safety net" services for those with serious and persistent mental illness is one of critical significance: the "vast majority" of these individuals are not covered by employer-based insurance as most are unemployed as a result of their illness (Mechanic, 1997). Of greater importance to public policymakers, is the fact that when insurance is available, it is too limited to provide the scope and continuity of services required for appropriate treatment. Consequently, there is great dependence on the Medicaid, Supplemental Security Income (SSI), Medicare programs, and Social Security Disability Insurance (SSDI) for those who have worked at some point during their lifetime. (See, below, discussion on parity and its implication for public sector responsibilities for mental health care.)

FEDERAL GOVERNMENT'S ROLE IN MENTAL HEALTH SERVICES

In a report to Congress on "Issues in the Transition to Managed Behavioral Health Care," the Federal Substance Abuse and Mental Health

Services Administration (SAMHSA)⁴ and its Office of Managed Care pointed out that the public sector, through the Medicaid program, has looked to managed care to improve access to a comprehensive range of services while also reducing costs (1997). SAMHSA's report acknowledges that managed care has the potential to improve access to a comprehensive range of benefits for a population with multiple and chronic mental health and behavioral health needs, "yet it also has risks, given financial incentives to limit costs and the health care system's limited experience in setting capitation rates for services needed by this population" (Ibid).

At present, the Department of Health and Human Services is beginning work on developing a *Surgeon General's Report on Mental Health*. The report, which will focus attention on promoting mental health, aims to raise awareness about the stigma associated with mental illness, to encourage early recognition and intervention for mental health problems and to promote innovative service delivery systems that support mental health in communities (*Center for Mental Health Services Report*, September 1997).

MEDICAID MANAGED MENTAL HEALTH CARE - A WORK IN PROGRESS

During the early 1990s, as states have enrolled increasing numbers of Medicaid beneficiaries in managed care plans, they have been confronted with making choices about payment and care arrangements for mental health services. Both states and counties in their movements towards creating managed mental health care programs have found that the knowledge base for estimating capitation rates and risk adjusting is very weak, especially for vulnerable populations (SAMHSA Managed Care Initiative Report, 1997).

⁴Before 1992, the major federal substance abuse and mental health delivery services and research activities were combined under one agency, the Alcohol, Drug Abuse and Mental Health Administration. Under P.L. 102-321, SAMHSA was established to administer services activities, and research activities were coordinated under the National Institutes of Health (NIH). Since 1992, SAMHSA's budget has been stable at \$2 billion each year, most of it in the form of block grants to the states. In Fiscal Year 1996, these grants totaled \$1.2 billion for substance abuse prevention and treatment services and \$275 million for mental health services.

In the current atmosphere of devolved authority to the state and local levels for program administration, in particular in health, mental health and social services, change is being handled piecemeal and differing types of programs are being introduced. At present, states are exploring ways to efficiently and effectively create Medicaid managed care mental health programs, yet no single model has been identified as exemplary.

Initially, enrollment in Medicaid managed care targeted relatively healthy populations -- such as low-income families who received financial assistance under Aid to Families with Dependent Children (AFDC; now TANF) and pregnant women and children who qualified for Medicaid. Current strategies are targeted to vulnerable populations with more complex and chronic health and mental health problems, such as those with severe and persistent mental illness. The mental health and health problems of these vulnerable populations are complex; their specialized needs are complex and require aggressive case management and monitoring services, in addition to skilled professionals who are trained to manage their care in the most appropriate way. Different models have emerged for managed mental health care, as states are gaining more sophisticated skills in purchasing and contracting out such services.

In a 1997 National Academy for State Health Policy Report, researchers noted that within three years all states are expected to have some form of Medicaid managed mental health care (Riley et al, 1997). Approaches to managing mental health care for Medicaid beneficiaries can be characterized by three models:

- Integrated Model - mental health services are included in the general physical health managed care program;
- Partial Carve-out Model - some mental health services are integrated, but other mental health services and/or populations operate under a separate managed care program;
- Full Carve-out Model - mental health services and/or populations are completely separated from the physical health program into their own managed care program.

The National Academy's comparative report points out that states' approaches to Medicaid managed mental health care are evolving: for example, Tennessee will be shifting from its current carved-out program to one which will be integrated with its general managed care plans by the beginning of 1999 (Ibid). The report offered various reasons for states' choice of one model over another. Those which chose an integrated model believed it better integrates physical and mental health care, is more likely to eliminate cost-shifting, reduces the stigma for clients with mental health problems and will create cost-savings. Those states that have chosen separate carve-out plans reported that they believe such plans improve the capacity to meet enrollee mental health needs, improve access, create a system of expertise in providing specific services and allow for reinvestment of savings. States that use the partial carve-out model are exploring the "best of both worlds" in using some facets of carve-outs, along with some facets of integrated programs (Ibid).

Significant issues confronting states in the ongoing development of Medicaid managed mental health care include:

- The capacity of appropriate plan and provider networks;
- Service integration among the newly contracted mental health service providers and those long-standing safety net providers of mental health care to their communities;
- Decisions regarding risk adjustment and the development and selection of the "right" risk-sharing arrangements with the managed care organization;⁵
- Oversight of the effectiveness of these programs and the ongoing monitoring of quality and accountability of outcomes;
- The development of reliable data sources in order to evaluate and monitor managed mental health care;

⁵A Lewin Group report examining current types of risk-sharing arrangements in Medicaid managed mental health care found a full-range of full risk, shared risk and no risk contracts (1997).

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- The importance of ongoing consumer and family involvement in program design and fine-tuning.

AND WHAT ABOUT MENTAL HEALTH PARITY?

Historically, health insurance coverage for mental illness has been administered under tight parameters:

- Ceilings limiting the amount of inpatient days and outpatient visits;
- Higher copayments and deductibles;
- Exclusions placed on certain providers;
- Cost-sharing is more pronounced than for other health benefits, particularly for out-patient care;
- Limited lifetime caps.

[EBRI Issue Brief, 1997]

At present, insurance policies generally have lifetime caps of \$50,000 for mental health, compared with a cap of \$1 million or more for other general health care. Purchasers of insurance for mental illness and insurers alike based such limiting actions on their express beliefs regarding the "ill-defined" nature of mental illness, concerns about the effectiveness of diagnostic and treatment practices and concerns about overuse of mental health services (Hegner, 1997). During the past five years, the application of managed care strategies in the provision of mental health services has addressed some of these concerns through utilization control.

On September 26, 1996, the Domenici-Wellstone amendment (attached to an appropriations bill) was signed into law as the Mental Health Parity Act of 1996 (P.L. 104-204). The law's provision calling for the elimination of certain limits on coverage for mental health care under private insurance, is viewed as an advancement towards "parity" in mental health services. In plain language, parity in this context means equal coverage for mental and physical conditions. While the original amendment was much broader in scope, the Act includes significant limitations regarding parity. However, advocates regard the Act's passage -- challenged by strong oppositional lobbying via the business community -- as a significant step to regulate discriminatory insurance practices that limit mental health coverage (Koyanagi, 1997).

The parity law goes into effect on January 1, 1998 and sunsets on September 30, 2001. Currently, over 15 states have introduced parity laws following the Federal lead, and others are introducing resolutions to explore the viability of parity statutes in their states. The parity law:

- Prohibits employers from imposing annual or lifetime dollar "caps" on coverage for mental health benefits that are more restrictive than those applied to medical benefits;
- Does not apply to plans of employers with 50 or fewer employees;
- Only affects plans that include mental health benefits; nothing prevents a plan from providing no mental health coverage at all.
- Will not apply to any plan if its implementation increases the health plan's costs, resulting in premium increases of one percent or more;
- Permits health plans to limit mental health services to those deemed "medically necessary" and to use managed care to control costs.

[Koyanagi 1997]

The National Advisory Mental Health Council, in strong support of parity laws, reported that their passage would work towards ending discrimination against the mentally ill, reduce disability by creating access to appropriate services, decrease costly out-of-pocket expenses and increase "the productivity of people with mental illness to maintain positions as productive members of society" (NAMHC Report, 1993).

An October 21, 1997 analysis in *The New York Times* focused on the "one percent" aspect of the law, which allows an exemption if the new mental health benefits increase the cost of a group health plan or coverage by one percent or more. However, the law does not define cost, nor does it specify how the exemption process works. As the Administration drafts its parity regulations, mental health advocates continue to voice their concerns that if the new rules are not strong about defining the terms of the exemption, employers would report that they would qualify for the exemption rather than provide parity in mental health coverage. As

the proposed regulations currently stand, employers may be allowed to exempt themselves from the parity law based on projections of health plan cost increases, rather than on actual data. Private employers and health plans support exemptions based on projected cost increases; in contrast, mental health advocates and managed behavioral health care companies want exemptions based on a full year of actual 1998 data.

As with other components of the dynamic health care system evolving in a managed care environment, there are many unknowns about how parity will affect mental health services in the dimensions of access, cost and quality. Not surprisingly, critics and advocates are in disagreement regarding such outcomes.

Advocates argue that:

- The Mental Health Parity Act of 1996 actually has much more limited scope than was envisioned in the original Domenici-Wellstone bill;
- In a managed care environment, competitive forces will discourage plans from enrolling high-risk individuals, such as those with serious and persistent mental illness.

Insurers and purchasers argue that:

- Parity is so expensive it may force employers to cut back on offering employee health insurance benefits;
- Under parity, decreased out-of-pocket costs for mental health services would drive up demand and utilization of mental health services.
- Health plans that offer more generous mental health benefits will attract those enrollees with the highest demand for mental health care (adverse selection).

[Hegner, 1997].

In a recent *Health Affairs* analysis, Harvard health economist Richard Frank pointed out that "regulating the structure of coverage in the benefit plan (i.e., through parity laws) is now only one factor among several determining the actual availability and use of covered services" (1997).

Frank and his colleagues debate the expected benefits of parity, when a managed care plan may be limiting access to mental health services by applying various "utilization" controls, such as determining that a requested service – e.g., outpatient psychotherapy for depression – is not found to be "medically necessary" by a claims reviewer.

As regulators of health care, how can government most effectively monitor and regulate the activities of managed care entities to ensure that consumers are protected from "inappropriate" practices that may compromise access to mental health care?⁶ A July 1997 analysis of state trends in promulgating managed care regulations pointed out that while some industry observers believe that "government's role should not be to increase regulation", others assert that "unless government regulates, there is a competitive push to degrade benefit standards" (*State Initiatives in Health Care Reform*, July 1997). Clearly, the debate will continue as the industry continues to evolve.

PARITY AND PUBLIC SECTOR EXPENDITURES FOR MENTAL HEALTH CARE

Historically, public programs have held the burden of covering mental health care expenditures for the most severely mentally ill, and there has been long-standing debate as to how the cost of mental health services should be divided among private employers, government programs and individual families. How will parity laws, if implemented appropriately, influence the share of private responsibility for the payment of mental health services for those with severe mental illness? Does their implementation have the potential to shift responsibility from public sector payers? Mechanic points out that the "safety net" of mental health providers -- state and county mental hospitals, community mental health programs, and substance abuse and rehabilitation programs -- provide services for those who do not have access to private insurance coverage because in the past private coverage has been so limited (1997).

⁶ The National Institute of Mental Health's estimates indicate that as few as 20 percent of the estimated 30 million Americans suffering from mental illnesses are actually seeking services for them (Shore & Beigel, 1997).

According to the National Advisory Council on Mental Health Care, in 1993 while state, local and other (non-Medicaid and non-Medicare) government sources accounted for 14 percent of overall health spending, these payers funded 28 percent of all mental health care (Hegner, 1997). Further, for people with serious and persistent mental illness, state and local government programs are responsible for 31 percent of the expenditures.

Currently, the states of Arkansas, Arizona, Colorado, Connecticut, Indiana, Maine, Maryland, Minnesota, Missouri, New Hampshire, North Carolina, Rhode Island, South Carolina, Texas and Vermont have parity laws; however, there is wide variation in scope and parameters in the laws. For example, four of the states exempt small employers from their laws, and under Federal law, all states are restricted in their ability to regulate ERISA plans, the Medicare and Medicaid programs and federal employee health benefit plans.⁷

PRELIMINARY RESEARCH ON THE IMPACT OF PARITY LAWS

A May 1996 report study looked at the effects of parity laws in Minnesota and Maryland (the only two states with the same requirement as the new Federal law of equal coverage for mental health care). General findings indicated that parity laws resulted in cost-effectiveness and fairness in mental health programs.

- In Minnesota, in the year after the state parity law took effect, one large managed care plan increased its fee by only 26 cents per member per month. A major insurer announced a 5-6 percent premium reduction in the plans it writes for small businesses.
- In Maryland, data on the first year showed a continuing decline in the length of inpatient stays, which is the most costly mental health service.

[Bazelon Center for Mental Health Law; National Mental Health Association, 1997]

⁷Hegner (1997) points out that while the state of Maryland has one of the most comprehensive parity laws in the country, it is estimated that the law applies to insurance policies that cover only about 30 percent of state residents.

A recently released Rand Corporation study examining data from 24 public-employer health plans with more than 140,000 enrollees each found that allowing equal coverage for mental health would involve only minimal costs for employers. All the plans in the study used managed behavioral health care carve-out programs. While study findings applied only to carve-out plans, it was found that removing the typical \$25,000 yearly limit on mental health benefits would raise employers' group insurance costs by only about \$1.00 per enrollee a year (*The New York Times*, November, 5, 1997). Further, costs for mental health coverage were lower based on reduced hospitalization rates and a shift to outpatient care.

NEW JERSEY'S MENTAL HEALTH SYSTEM: A Snapshot

New Jersey's Division of Mental Health and Hospitals, as part of the Department of Human Services, supports a comprehensive system of inpatient and community-based mental health care. Mental health services advisory and planning organizations in New Jersey include the State Community Mental Health Advisory Board and the New Jersey Mental Health Planning Council, which monitors the status of the state mental health plan. The Division directly operates seven psychiatric hospitals. The facilities offer acute, intermediate and long-term inpatient care, with additional acute services provided through a network of affiliated general acute care hospitals. Fiscal Year 1997 total operating costs for the state hospitals is \$213,921,000. According to 1997 data, approximately 6,300 clients were served annually in the hospitals; an average of 2,141 clients are served on a daily basis (See, below, regarding plans for the closure of Marlboro Psychiatric Hospital in Monmouth County).

The Division's State Aid program funds approximately 90 percent of the costs of indigent inpatient care in six county psychiatric hospitals in Bergen, Hudson, Union, Essex, Burlington and Camden. The county hospitals are operated under the direction of the County Boards of Chosen Freeholders. The 1997 State Aid appropriation was \$76.0 million for the county facilities. Annually, approximately 6,000 clients are served in the system. On a daily basis, 851 clients are served.

The Division also administers specialized services for children and youth at the Brisbane Child Treatment Center; for the elderly at Hagedorn Gero-Psychiatric Hospital; and at the Forensic Psychiatric Hospital for those found not guilty by reason of insanity.

Through contracts with 120 not-for-profit providers and two mental health centers associated with the University of Medicine and Dentistry of New Jersey, the Division purchases community mental health services. Mental health programs include:

- outpatient services
- partial care services (intensive day treatment and psycho-social rehabilitation services)
- residential services in group homes and residential health care facilities;
- case management services;
- other services, such as systems advocacy, supported employment and intensive family support services.

In 1996, community-based services covered 253,805 clients at an annual state funds expenditure of \$148.8 million (plus client fees, third party insurance and local/government funding) (New Jersey Division of Mental Health Services, 1997).

Overall, the New Jersey Division of Mental Health Services has been moving forward with its ambitious "redirection" plan to "expand and strengthen community mental health services and consolidate state hospital resources." First initiated in July 1995, the three-year plan aims to expand community services; when completed in mid-1998, it aims to redirect \$68 million in state hospital resources toward a full range of community services, including Programs in Assertive Community Treatment (PACT) Teams, community residence development, Intensive Family Support Services, Supported Employment, consumer-managed Self-Help Centers and Integrated Cases Management Services.

The implementation and ongoing activities of these programs involve strong linkages with providers, consumer advocates, consumers themselves and family members. For example, the Intensive Family Support movement in New Jersey is actively engaged in developing psychological,

vocational and social support networks in local neighborhoods for individuals with mental illness and their families.

P.L. 1997, Chapter 28 (approved September 23, 1997) -- the Community Mental Health and Developmental Disability Services Investment Act - - addresses the activities of investing in community-based services as expenditures for state inpatient resources are reduced under the state's plan.

The plan also includes the closure of Marlboro Psychiatric Hospital; the current census is just under 400 patients, decreased from 776 when the plan was first initiated. Personnel and physical plant changes continue to take place at the remaining state psychiatric hospitals, as Marlboro's closing moves toward completion.

At present, the Division of Mental Health Services is involved in a joint initiative with Medicaid and the Division of Addiction Services (Department of Health and Senior Services) to implement, for New Jersey's Medicaid beneficiaries, a managed care program for mental health and substance abuse. A Request for Proposals (RFP) for the Managed Care for Mental Health and Substance Abuse program is pending. The state plans a carve-out model for the program, which may involve the selection of a managed care organization or administrative service organization. The New Jersey Association of Mental Health Agencies, Inc., reported that the administration of the Medicaid managed care plan may be operated "regionally" (NJAMHA Cybertext, September, 1997).

State-level activities in New Jersey are also focusing on the design of an appropriate system of charity care managed care for mental health and substance abuse services. Research on charity care utilization indicated that approximately 10.5 percent of charity care dollars were provided for treatment of alcohol and drug abuse, and another 7.0 percent for mental health services (Fishman, 1997).

Currently, the state of New Jersey has not yet determined the level of mental health services to be included under the recently developed New Jersey KidCare program, in part supported by Federal block grant money. Under the federal Balanced Budget Act of 1997, which allocated \$24 billion in block grant money to states to design health

insurance coverage programs for uninsured children, there is a mandate for mental health coverage. It falls to state-level policy makers to decide on the scope of the mental health coverage to be offered through their program.

NEW JERSEY: Legislation

At present, several bills remain in Committee about mental health coverage and treatment of mental illness in New Jersey. Introduced in June 1997, S2167 (Bassano & Codey) would mandate that hospital service corporations, medical service corporations, commercial, individual and group health insurers, HMOs and health benefits plans issued pursuant to the New Jersey Individual Health Coverage and Small Employer Health Benefits Programs are required to provide health benefits coverage for the treatment of mental illness "under the same terms" as provided for any other sickness. Senator Codey's S1621 requires hospitals, medical and health service corporations, commercial insurers and HMOs to offer in all contracts and policies benefits for the treatment of mental illness and nervous disorders. The bill would also establish minimum levels for these benefits.

Assembly Bill A349 (Quigley & Imprevuduto) changes the maximum amount that will be paid for treatment of mental illness or functional nervous disorders under the State Health Benefits Program. Current annual caps for such illnesses stand at \$10,000, with a lifetime maximum payment of \$20,000. The bill would allow for charges for these illnesses to fall under the existing major medical lifetime maximum of \$1 million.

A supplemental appropriation of \$4 million to the Department of Human Services, Division of Mental Health Services for the purpose of providing grants for case management and related mental health service for chronically mentally ill residing in community placements would be designated under A821 (Arnone & Farragher).

NEW JERSEY: A Case Study - Policy Implications

In Winter 1997, the *New Jersey Reporter* focused on the state's on-going Shore-Easy program, implemented in 1995 to relocate more than 400 boarding home residents, the majority of whom are mentally ill, who had clustered in Asbury Park, Ocean Grove, Long Branch and Lakewood. The

Shore-Easy program was announced just six months after the state unveiled plans to close down Marlboro Psychiatric Hospital, an 800-bed hospital in Monmouth County. Shore communities were concerned about even greater numbers of deinstitutionalized mentally ill re-locating to their communities, which they believed were already over-stressed. In 1994, Asbury Park and Ocean Grove had 45 percent of Monmouth County's 3,092 boarding home beds. The municipalities reported that this population was burdening the local social services, such as fire, police, first aid and local social services (Irvine, 1997).

At present, more than 160 residents have been relocated. The census of patients in Marlboro has decreased from 790 in 1995 to fewer than 400 as patients are transferred to state hospitals in Trenton and Ancora, and patients are no longer being assigned there. Four state agencies are coordinating the program: the Department of Community Affairs (which licenses rooming and boarding homes); the Department of Health and Senior Services (which licenses and inspects residential health care facilities); the Department of Human Services and its Division of Mental Health and Hospitals; and the New Jersey Housing and Mortgage Finance Agency, which provides affordable housing. While many advocates are pleased with the process and feel that appropriate placements are being made, critics are concerned about the continued availability of beds and the provision of adequate oversight for residents, who are at risk for noncompliance with their medication.

While it is still too soon to tell whether or not the Shore-Easy program has been successful, it represents a microcosm of the issues surrounding New Jersey's low-income population with severe and persistent mental illness. Public policy issues include:

- The commitment to create a safe "least restrictive environment" for those with mental illness;
- The costs associated with hospitalization and hospital closures;
- The development of appropriate community-based services, including outreach, case management and continuity of critical services

such as medication monitoring and rehabilitation;

- The coordination across state and local health, social services and housing agencies;
- Community education in order to achieve community acceptance and support;
- Coordinating planning to prevent future clustering of this population in communities and to monitor their whereabouts.

A 1997 National Academy for State Health Policy Report on mental health care for vulnerable populations indicates that service coordination and integration of medical, mental health and supportive services is complex regardless of carve-out or carve-in designs. Focusing on the reality that persons with mental illness need a range of services and supports, how will New Jersey's Medicaid program effectively coordinate with other government funders and agencies who provide services to this population, including veteran's affairs and the criminal justice system? What is our position on

the coordination and provision of "wrap-around" social support services, rather than relying on a single-service model of medical care only?

CONCLUSION

The evolution of managed mental health care in both public and private sectors is an ongoing, dynamic enterprise. The inclusion of mental health parity laws raises the stakes in the interplay of responsibility for these two sectors regarding coverage for mental health services. Implications for access, cost and quality of care are significant. Lessons learned from the past five years of evaluating the managed care "work in progress" underscore the importance of ongoing evaluation and monitoring of the delivery of health and mental health services and the role of state government in this challenging task.

GLOSSARY

AFDC	Aid to Families with Dependent Children, a cash assistance program for low-income families. This Federal program – whose participants were automatically Medicaid-eligible – has been replaced with Temporary Assistance for Needy Families, or TANF – which makes no automatic connection to Medicaid. However, former AFDC recipients (even those who will not receive assistance under TANF) continue to be Medicaid-eligible.
BHO	Behavioral health organization: a managed care organization that provides mental health (and frequently substance abuse treatment) services.
Capitation	A form of payment for health care services in which providers are paid a set amount per enrollee per month (referred to as the capitation payment for providing all covered health care services for that enrollee.
Capitation organization Rate	The per-person per-month rate paid (in this case, by the state) to a managed care organization to provide care to enrollees. This rate is set independently of the actual number and costs of treatment an individual enrollee uses.
Carve-out	A population or service not included in the managed care plan.
CMHC	Community Mental Health Center
Contractors	Can be a variety of organizations. The following are frequently mentioned: <ul style="list-style-type: none">• MCOs or HMOs are managed care organizations/health maintenance organizations that provide physical health care services. They may or may not provide mental health services.• BHOs (behavioral health organizations) are managed care organizations that provide mental health (and frequently substance abuse treatment) services.
Fee-for-service	A form of payment for health care services in which the payer (here, the state) pays providers for each service rendered to an eligible individual. Payment does not exceed the provider's billed charge for that service.
Full Carve-Out Model	A management approach in which mental health services and/or populations are completely separated from the physical health care program into their own managed care program.
HCFA	Health Care Financing Administration (part of the U.S. Department of Health and Human Services): (among other things) grants Medicaid waivers to states which allow them to pursue managed care.
HMO	Health Maintenance Organization: a managed care organization that provides physical health care services. HMOs may or may not provide mental health services.
Integrated physical Model	A management approach in which mental health services are included in the general managed care program.
Managed Care	A system for delivering health care services where the provision of an agreed upon set of health care services is coordinated by an entity or person (a health plan or primary care case manager) obligated by contract or other agreement to be responsible for the care provided

(or not provided) to an individual. Medicaid managed care can be either risk-based or non-risk in the form of primary care case management programs (PCCMs – see below).

Mandatory State managed care programs which require beneficiaries to enroll into managed care without **Enrollment** an option to remain on fee-for-service.

Medicaid A state-administered federal/state program which pays for certain medical expenses for eligible low-income people. Mandatory services, which may be particularly relevant to mental health care, include:

- Inpatient hospital services
- Outpatient hospital services
- Physician services
- Rural health clinic (including Federally Qualified Health Center) services
- Early and periodic screening, diagnosis, and treatment (EPSDT) service for children below age 21.

Optional services which may be particularly relevant to mental health care include:

- Services provided by other licensed practitioner (including psychologists and medical social workers)
- Clinic services
- Prescriptions drugs
- Psychiatric inpatient hospital services and nursing facility services for individuals aged 65 and older in an institution for mental diseases
- Inpatient psychiatric services for individuals under age 21
- Case management.

MCO Managed Care Organization.

Network The group of physicians, hospitals and other service providers contracted by a managed care organization to serve its enrollees.

Partial Carve-mental Out Model A management approach in which some mental health services are integrated, but other health services and/or populations operate under a separate managed care program.

PCCM Primary Care Case Management: a system of assigning responsibility for the care of a particular Medicaid beneficiary to a specific primary care provider who receives payment on a fee-for-service basis and who (typically) receives a small additional fee per enrollee per month to compensate for case management functions.

Risk-based or Medicaid Managed Care used A health care delivery system in which the state Medicaid agency contracts with an entity individual (the contractor) to provide or arrange for the provision of an agreed upon set of services in exchange for a set fee where the prepaid fee does not vary based on services used

by the individual enrollee. In other words, in risk-based managed care the contractor assumes some level of financial risk for providing care to enrollees.

Risk Limitation A strategy employed by the state to minimize the greater financial risk faced by managed care plans in meeting the complicated care needs of certain high-cost populations. It also lessens the possibility of risk selection occurring.

Spend Downs	Individuals whose incomes/assets fall above the state medically needy standard, but who would fall below if their medical expenses were factored in.
SSI	Supplemental Security Income, a Federal program that provides cash assistance to persons who: (1) are elderly, blind or disabled and (2) whose income falls below 75% of the Federal poverty line. SSI recipients are automatically eligible for Medicaid in most states.
Voluntary services Enrollment	Managed care programs in which the Medicaid beneficiary can choose to obtain health services through the state's risk based managed care program, PCCM program, or traditional fee-for-service system.
Waiver	Granted by the Health Care Financing Administration (HCFA), it exempts the state from certain federal Medicaid requirements.

Source: Riley, T., J. Rawlings-Sekunda and C. Pernice. The Kaiser-HFCA State Symposia Series. "Transitioning to Managed Care: Medicaid Managed Care in Mental Health." National Academy for State Health Policy. June 1997.

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