

**The Introduction of Managed Care into Public Mental Health:  
The Massachusetts Experience**

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## INTRODUCTION

The introduction of managed care in the public mental health system in Massachusetts has to date replicated the experience of earlier waves of policy innovation. Initial enthusiasm on the part of implementers has given way to the imperatives of political and economic accommodation, solving some problems, yet creating further fragmentation. This is not unexpected. Managed care is a broad term encompassing such diverse goals as cost containment and quality improvement which, its proponents believe, can be achieved through an active managerial approach using techniques such as case management, preauthorization, utilization review, creation of provider circles, capitation, and performance contracting.

The story of managed care in Massachusetts is an unfinished one. In 1996 the state began implementing a second generation, carved-out program for all Medicaid-funded services through a state-wide, behavioral health corporation. The first generation implementation of managed care occurred between 1992 and 1996, and involved the establishment of a privately operated, statewide mental health carve-out program. The current rendition of the program not only preserves this design but also dramatically expands its scope. It is intended to improve the coordination between service systems by clearly differentiating the state mental health authority's continuing care program from the Medicaid funded program for acute care. Before examining the specific experience since the 1992 introduction of behavioral health carve-out programs in the Commonwealth, this chapter will first review the major institutions and trends in the state which have combined

to drive the efforts to contain costs, privatize, and manage service delivery during the late 1980s and early 1990s.

## **BACKGROUND**

This section will discuss trends that predate and contribute to the managed care initiatives in the Commonwealth. It will then consider the role of managed care in the mental health policy development efforts of both the Dukakis (D) and Weld (R) administrations which preceded and accompanied the introduction of the current, carve-out programs in the Commonwealth.

### **Key Trends**

The dramatic expansion of health care costs in the last twenty years has created considerable pressures for cost containment. Earlier efforts to contain costs, such as through the use of Diagnostic Related Groups which were introduced into Medicare in 1982, focused on physical health, but exempted psychiatric services. For this reason, private psychiatric services had been one of the few growth areas in health care during the 1970s and early 1980s. It was an expansion which in part reflected efforts of providers to capitalize on the lack of controls and traditional fee-for-service plans where were dominant in the mental health field (Dorwart, 1993). It was not until the middle and late 1980s that health care purchasers began to control private psychiatric hospitalization levels, mainly through the shortening of lengths of stay.

The growth of private psychiatric inpatient services has contributed to the myth that the deinstitutionalization of mental hospitals had subsided by 1980. This view also arose

out of an official policy of many State Mental Health Authorities (SMHA) to place a moratorium on the reduction of state hospital census as well as in official NIMH statistics which showed only a slight reduction in hospitalization levels between 1980 and 1990. These statistics were largely a result of the inclusion of residential services into the same category as inpatient hospital services in NIMH statistical monographs, and largely camouflaged the dramatic reductions in overall hospitalization levels during this period. According to 1980 and 1990 U.S. Census, the total count of persons in all types of mental health inpatient units dropped by about one half (52.7%) during the decade of the 1980s (see Hudson, et al., 1995, p. 11). Much of this drop is due to the decline in private psychiatric hospitalization in the later part of the 1980's which occurred mainly through shortened lengths of stay. For example, the Xerox Corporation has reported that the average length of stay of its employees in mental health facilities dropped from 33.7 days in 1987 to 9.9 in 1994 (Iglehart, 1996, p. 133).

Probably the most important effect of this was the doubling of vacancy rates in private psychiatric hospitals in Massachusetts from 10.5% in 1983 to 20.9% in 1988 (Manderschied, 1992, p. 88). The growing vacancy rates contributed to a new found interest on the part of private hospitals in negotiating arrangements with state officials to assume the care of those patients which formerly were seen as public wards. Thus, without the newest, but least visible, wave of deinstitutionalization, state administrators would have had little success in efforts to privatize and shift the costs of the seriously mentally ill to non-state sources.

By the late 1980s, managed care and behavioral health companies had largely exhausted the corporate market and were looking to the public sector, in particular Medicare and Medicaid, as the next frontier (Essock and Goldman, 1995). The mental health components of these two federal programs had been, until the 1980s, dominated by institutional care (Mental Health, United States, 1995, p. 225). The Reagan administration, however, had introduced the possibility of state waivers of selected sections of Titles XIII and XIX of the Social Security Act for the purpose of increasing state experimentation and permitting broader community services.

A relaxation of federal waiver requirements under the Clinton administration also made it possible for states to shift some of the costs of inpatient services to the federal government. Medicaid can not be collected by certain institutions classified by the Health Care Financing Authority (HCFA) as Institutes of Mental Disorder (IMDs), including private and state mental hospitals, which have more than 50% of their clientele with a primary diagnosis of mental illness for patients 18 to 65. General hospitals with psychiatric units, as well as public health facilities with a minority of psychiatric patients, however, are not effected by this regulation. State officials have become increasingly sophisticated with circumventing the IMD limitation, such as through wrap-around arrangements in which a general hospital manages and thereby wraps its license(s) around a state psychiatric unit. Such strategies directly serve local interests of cost containment, in particular cost shifting, as they transfer 50% or more of the costs of psychiatric care to the federal government through increased access to Medicaid payments.

Deinstitutionalization as well as the imperatives of cost containment and cost shifting have fueled the emergence of managed care companies in the public sector. At the same time as deinstitutionalization and privatization have developed in tandem (Hudson, Salloway, & Vissing, 1992), managed care has been the most recent facet of this megatrend to emerge. The introduction of behavioral health companies in public mental health privatizes not so much service delivery as the oversight of the service system. The impact of this shift is yet to be determined.

An examination of accompanying trends that are reflected in the Massachusetts experience provides only limited basis for optimism. These include not only the accelerated shift from institutional to community care, but also a shift from tertiary to secondary and preventive services. Agency and group-based practices are favored over private practice, short-term over long-term treatment, just as group and family modalities are being promoted over individual. At the same time, a possible loss of autonomy and fragmentation of clinical decision-making may offset whatever benefits that could emerge out of the other trends cited, especially if fiscal incentives are permitted to dominate professional decision-making.

**Dukakis Administration.** During the 1980s state mental health was largely driven by the pressing need to redress the consequences of deinstitutionalization. These included the neglect of the seriously mentally ill and the fragmentation of the public mental health system in each state. In Massachusetts, as in many states, this meant narrowing of the focus of the state department of mental health to this population through not only provision

of case management, but through supported housing, clubhouses, and psychosocial rehabilitation. Massachusetts state officials carefully balanced their responses to a powerful mental patients rights movement, led by Empower, and allied themselves with the burgeoning family movement, led by the Alliance for the Mentally Ill (AMI), which advocated for both biological and rehabilitative services. In 1985 Governor Dukakis released his Special Message which committed the state to a dramatic expansion of community mental health services, while maintaining a moratorium on reductions of its nine state hospitals with approximately 2,200 patients (DMH, Comprehensive Plan, 1985).

The 1980s also included a period of protracted struggle between SMHA and the former, federally funded community mental health centers. As the SMHAs became stronger through the Reagan era federal block grants, as well as through their alliance with patient and family groups, they sought to more actively manage their contracts with local mental health centers. This was typically achieved through instituting some version of performance contracting or through a state case management system.

Despite the many ways through which the state department of mental health under the Dukakis Administration sought to actively assume control for its system of vendors, the rhetoric of managed care was not yet part of the program. Brotman (1992) points out that Massachusetts already had a *de facto* managed care system as its payments to its vendors were effectively capitated through the budgeting and purchase-of-service (POS) systems. In addition, it officially instituted in 1987 its 'expanded brokerage' model of case management, in part to fulfill the requirements of the newly enacted federal Mental Health

Planning Act of 1987. By 1992 the state was providing case management services to 7,265 adults and 745 children (Leadholm and Kerzner, 1995, p. 549). However, it was only three years after the Dukakis 1985 Special Message that the recession made its effects felt. By 1988 staff freezes effectively aborted the ambitious five year program outlined by that message.

The Dukakis administration set the stage for managed care through its attempts to take control and manage its extensive and fairly autonomous system vendors. Its rhetoric was one of public-private partnership rather than the 'managed competition' and aggressive privatization of both services and administrative oversight functions that characterized the succeeding administration of Governor Weld. The Dukakis Administration's targeting of the seriously mentally ill, thus, set the stage of a later policy shift back toward less intensive, short-term services for those less disabled. This shift has been embodied mostly by the transition in Medicaid mental health services from institutional to community services under the managed care programs of the Weld Administrations.

### **Weld's 'Reinventing government'**

At the time William Weld was elected Governor in 1991 the Commonwealth was in the midst of its worst, most unusually protracted, recession in a decade. The state was in fiscal crisis. Taxpayers saw state government as bloated, inefficient, and expansive. The private sector was continuing to lose jobs (Leadholm & Kerzner, 1995, p. 543). The dramatic expansions in the Medicaid budget also contributed to this crisis.

As a moderate Republican, Governor Weld had vowed to streamline and cut waste

in Government, to maintain and improve services, while cutting costs through both reorganization and privatization. Reorganization in the mental health field was initially pursued through the appointment of a Special Commission on Hospital Consolidation. Its mandate was to streamline the state hospital system and to extend the principals of the Brewster consent decree. This decree, which had earlier established a model community mental health services in the Western part of the state, was to be extended throughout the remainder of the state (Wisor, 1993). Privatization was also pursued through the successful application to HCFA for a waiver of 1915b regulations of the Social Security Act. This involved securing permission to establish the MassHealth Medicaid program, part of which involved subcontracting the management of all mental health and substance benefits under Medicaid to a private behavioral health corporation.

The interlocking trends of cost containment, deinstitutionalization, and privatization have driven the introduction of managed care in the public mental health arena in Massachusetts. Similarly, the rhetoric of private-public partnership under the Dukakis Administration set the stage for a reluctant shift to the concept of managed competition under the succeeding Weld Administration, a topic to which we will now turn.

## **DEPARTMENT OF MENTAL HEALTH INITIATIVES**

Shortly after his election in 1991, Governor William Weld appointed Eileen Elias, a veteran DMH employee, as the Department of Mental Health Commissioner. By this time budget cuts had crippled the community mental health initiatives of the former administration. The challenge for the new DMH administration was to find some way to "join its mission" with that of the new Governor's, to design a cost efficient system, and at the same time, continue its previous program development efforts (Leadholm & Kerzner, 1995). The new commissioner's strategy relied on a "Comprehensive Community Service System / Public Managed Care" (CCSS) initiative. This program had several components which included the closure or consolidation of several state hospitals as recommended by the Special Commission; reinvestment of saved resources in community care initiatives; reduction of area and site offices; introduction of an extensive participatory planning process; and cooperation with the Department of Public Welfare in its 1915b Waiver program involving the establishment of the Medicaid-funded Massachusetts Mental Health / Substance Abuse Program.

Beginning with the above changes, the Department began embracing the rhetoric of public managed care:

As a first step towards the development of public managed care, the Department has undertaken three major initiatives--the privatization of acute psychiatric inpatient services; the closure/consolidation of our of its state hospitals; and the movement of state hospitals funds to expand the community-based service system. These are three basic tenets of the development of public managed care. The term public managed care refers to a network of integrated comprehensive, accessible, quality, and flexible community based services. (DMH, Jan. 1993, p. 5).

Another department official attempted to define the Department's public managed care policy as consisting of the implementation of a dozen key tenets, including: (1) the centrality of privatization of service delivery; (2) the CCSS participatory planning process; (3) flexibility services characterized by continuity of care; (4) a case management system; (5) clinical services provided in the least restrictive environment; (6) quality management; (7) accountability, and defined expectations for DMH; and (8) targeted services for homeless and multicultural and linguistic minorities (Leadholm & Kerzner, 1995, p. 546). Although these tenets, as well as the preceding definition, define several of the generic principals of mental health programming, only a few of which are commonly associated with managed care, most notably quality management. None specifically defines a managed care strategy as it is commonly recognized. By embracing some of the rhetoric of managed care, yet stopping short on implementing its most essential features, such as capitation, the Department found itself in the position of having to follow the lead of the state Medicaid program in the development of a full-fledged mental health managed care program.

At the heart of the Department's change efforts were the closure of state hospitals. Several of the hospitals were archaic, very costly structures built in the 19th century, and were only being partially used, often for patients who were awaiting community placement, or who had complicated dual diagnoses involving medical conditions, substance abuse, or development disabilities, in addition to their mental illnesses.

On Feb. 26, 1991, Governor Weld signed Executive Order 301 that established the Governor's Special Commission on Consolidation of Health and Human Services

Institutional Facilities. After a rushed study of the feasibility of closures, the Commission made recommendations on specific institutions.

On June 19, 1991, the Commission submitted its recommendations to the Governor for approval, and were implemented shortly thereafter (DMH, Jan. 1993, p. 2). DMH staff immediately pursued an extensive planning process for the closures that were to be accomplished under tight time schedules and budgets. Metropolitan State Hospital was the first to be closed (January 1992) and was followed by Danvers State (June 1992) and Gaebler's Children Center (September 1992). In May 1993 the process was complete with the closure of Northampton State Hospital. These closures represented a reduction in patient census from 1,852 to 1,084, or 41.5%, over a two-year period. During this same time, 1,706 staff positions were eliminated. Between FY1990 and FY1994, \$62 million were saved (DMH, Jan. 1993).

Most of the savings in the hospital system were achieved through privatization and cost shifting. The 'closure' of Danvers State Hospital was somewhat of a misnomer. The majority of the hospital's intermediate and long-term units were immediately reopened, with many of the same staff, at Tewksbury Hospital, a state public health facility which served mostly indigent older adults with long-term medical problems and which had considerable unused space. Despite the extensive costs for remodeling, this initiative saved DMH money by effectively transferring approximately one half the Danvers State Hospital costs to the federal government. Tewksbury Hospital was not classified by HCFA as an Institute of

Mental Disorders, and thus is eligible for Medicaid reimbursement for mental health services to adults between 18 and 65.

The admissions and short-term units from Danvers, and other hospitals, were relocated in private general hospitals with a psychiatric program. This was accomplished through a contracting process in which the Department agreed to be payer of last resort, after all possible payments were collected from third-party insurance sources, such as Medicaid. In total, a dozen such short-term units were established through out the state. This strategy would not have been possible if vacancy rates in such hospitals had not been particularly low. Furthermore, the Department had recently been exempted from Public Health's Determination of Need standards which tended to restrict the establishment of new medical units (Leadholm & Kerzner. 1995). Nonetheless, considerable planning and expenditures were required to assure that the new facilities would be reimburseable since Medicaid reimbursement requires that the facilities be HCFA-certified and accredited by the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO),.

A key point of controversy between advocates and Department officials was whether the costs of the new units would be greater or lesser than the envisioned savings. Most advocates eventually accepted the Department's accounting which showed that of \$133.7 million in gross savings which consisted of \$62 million closures, \$17.9 million, from revenue enhancement; \$11.1 million, from staff insurance savings; and \$42.7 million, saved renovation costs. In contrast, costs totaled \$65.8 million of which \$26.7 million were expended for inpatient replacement beds; \$34.1 million for residential expansion and \$5.0

million for the placement of mentally retarded individuals. In total, a net savings of \$67.9 million could be claimed (DMH, Jan. 1993, p.4).

The other development that contributed to the entry of privatization and managed care into inpatient care was the expansion of the community care system. At the center of this expansion was an extensive participatory planning process conducted in 1991 in each of the Department's catchment areas. In the NorthEast area (north east suburbs of Boston and Merrimack Valley areas), for instance, fifty to one hundred consumers, family members, and agency personnel took part in a half dozen committees over a six month period to assess needs and recommend new services. Although this was designed to be a "consumer-driven" system, the CCSS committees were frequently dominated by professionals who represented agency interests. Despite minimal systematic planning, these groups produced recommendations that highlighted particular areas of need, such as respite beds and programs for the dually diagnosed. The efforts of these groups were supplemented by a state-wide needs assessment contracted to the Human Services Research Institute which relied on focus groups of consumers and professionals.

At the same time the CCSS committees were generating their recommendations, Department personnel were busy planning for a major expansion of the residential care system using monies saved from the hospital consolidations. This plan involved the addition of low-intensity residential beds which permitted additional patients in moderate and high-intensity homes to be transferred, thereby opening bed space for the more seriously disabled patients who were awaiting placement out of the state hospitals. A total

of 625 new community residential beds were created between 1991-1992, and overall 1,400 beds were added between 1990 -1995. These new beds effectively transferred several hundred patients to the care of private vendor corporations, thereby creating a *de facto* managed care system operated through the Department's Purchase of Service (POS) and case management systems.

At the same time the community care system saw some expansion, such as emergency services, respite beds, and clubhouses, the traditional community mental health centers had to increasingly restrict psychotherapeutic services to those with third-party coverage. Those centers most dramatically affected included the 'Partnership' clinics in which assigned state employees worked, often at higher salaries, alongside agency employees. All 825 of these state employees were laid off. Eighty percent (80%) of the saved salaries were reinvested without fringe benefits into agency contracts. Those who were fortunate enough to transfer to regular employment with the Partnership agencies, typically had to accept pay cuts in the 20% to 40% range (Brotman, 1992). Many others were forced to accept work on a fee-for-service basis under considerably less favorable terms than their former agency or state contracts. Supporters of this move argued that these agencies were able to 'double-dip' as they would bill the state for services performed by the assigned state employees. However, others characterized the lay-off as 'union busting', pointing out that privatization has typically meant circumventing gains unions had made for state employees.

Two themes pervaded the Department's rationales for changes in the hospital and community care systems during this period: (1) The system was to be made consumer-driven; and, (2) public managed care was to be a central organizing principal. These mandates required state administrators to accommodate a Republican Governor, generate new revenues and wrest greater control of the community care system from the unions. The solution consisted of cost-shifting, increasing control through privatization using the purchase of service (POS) system, and adopting the rhetoric of managed competition and managed care. Had it not been for the Medicaid program simultaneously developing its own mental health system, by using a mainstream managed care strategy, the Department may have been able to better adapt managed care to the needs of mentally ill individuals.

## **THE MEDICAID CARVE-OUT PROGRAM: THE FIRST GENERATION**

The focus of this chapter will now shift to the development of the Commonwealth's Medicaid program for the mentally ill -The Massachusetts Mental Health / Substance Abuse Program - during the 1992 to 1996 period in which the Department of Public Welfare, and later, the Division of Medical Assistance, contracted with Mental Health Management of America, Inc. (MHMA), to operate the state-wide program under a 1915b HCFA Waiver. At the same time that the new MHMA program was implemented to provide for the mental health and substance abuse needs of Medicaid recipients, the state Department of Mental Health operated a parallel system of services directed at the seriously mentally ill, many of whom were also Medicaid recipients. After an overview of the new Medicaid program, this section will examine its initial implementation, its fine-tuning, and the data available on its impact.

### **Program Overview**

In May 1991 the Massachusetts Department of Public Welfare applied to HCFA for a waiver of selected conditions of Title XIX of the Social Security Act which assure comparability of services and the right of recipients to select their own providers. After a request for additional information, in particular for information to establish that the program would be cost-neutral, HCFA granted the waiver for a two-year period, beginning in January 1992. The waiver allowed Massachusetts to contract with primary care clinicians to act as gatekeepers and referral sources for each recipient's primary care needs, and to contract with a prepaid health plan to serve as the state's agent for the delivery of mental

health and substance abuse services to eligible Medicaid clients (Approval letter, Jan. 30, 1992). Exempt for the program are specialty services such as family planning, AIDS, dental and optical, nursing home, transportation, abortion, and inpatient rehabilitation hospital, and inpatient psychiatric services to persons over 65 (Waiver application, 1991, p. 7).

The approval of the 1915 b waiver effectively established the MassHealth Managed Care Program. Under this program, all Medicaid recipients must select either one of 13 HMOs, or a doctor (or nurse practitioner) from the Primary Care Clinician Program (PCCP). Under the PCCP, most of the 5,770 physicians who formerly accepted Medicaid clients were signed up. The PCCP physician acts as gatekeeper for all the recipient's medical services, exclusive of the exempted services, i.e. abortion, family planning, etc., as well as the mental health and substance abuse services. The HMOs are required to provide the same level of mental health and substance abuse services as the PCCP, unlike previously when the HMOs were required to provide only the standard commercial benefit, and the state paid for additional services on a wrap-around basis (Bullen, 1995). In contrast, the PCCP recipients receive their mental health services from the Mental Health / Substance Abuse Program (MH/SA Program) as implemented by a private vendor. Because this vendor is a distinct entity vis-à-vis' the provider of medical services, the program is regarded as a carved-out program, unlike an integrated program in which the same vendor provides both medical and mental health services.

The MH/SA Program represented the first such statewide, specialty managed care plan in the nation. Initially its planners envisioned contracting with separate providers in

each region of the state. After the waiver was initially submitted it was decided as part of the RFP process to select a state wide provider. After review of applications from several of the major behavioral health companies, state officials selected Mental Health Management of America, Inc. (MHMA), a Tennessee corporation that is a subsidiary of First Health Services Corporation, which in turn, is a subsidiary of First Financial Management Corporation (Fendell, Fall 1994). Of the state's 656,000 Medicaid recipients, 252,000 were initially enrolled in the PCC and MH/SA Programs, whereas 93,000 were enrolled in the HMOs. The remainder were older adults or persons otherwise exempt because they had other forms of insurance (Bullen, 1995, p. 7).

Unlike the fee-for-service PCCP, the MH/SA Program, operated by MHMA, was supported by a type of "soft-capitation" contract in which the state and vendor would share risks (Frank, McGuire, Newhouse, 1995). Under this plan the vendor would receive an advanced capitated payment for each recipient covered, and a somewhat higher one for each disabled (SSI) recipient. However, the managed care organization (MCO) – MHMA - paid its providers on a fee for service basis. It ended the practice of permitting hospitals to bill separately for room and board, ancillaries, and physician's fees. Comprehensive rates were negotiated instead (Dickey, et al. 1995, p. 102). Under this arrangement, MHMA was held at risk. However, the contract also contained important incentives. Any unspent revenue was shared with DMA/Medicaid, with Medicaid retaining 92 percent and MHMA 8 percent (Dickey, et. al., 1995, p. 102). Under the contract, MHMA could earn \$50,000 for each percentage point reduction in hospitalizations beyond an agreed upon goal, up to a

maximum of \$300,000. Later, bonuses for savings to the state were increased to \$2 million (Fendell, March 1993, p. 13).

The contract between the MHMA and the state was comprehensive. MHMA was required to arrange all acute inpatient, crisis stabilization, outpatient evaluation and treatment, psychiatric day treatment, residential detoxification, and methadone treatment needed by its Medicaid recipients. MHMA was permitted to use diversionary services, such as residential treatment programs, family stabilization, and partial hospitalization. Furthermore, the contract specifies that MHMA was also responsible for utilization review, claims processing, systems support, provider relations, and in general, for a decentralized regionally-based care management and network management (Dickey, et al., 1995, p. 102).

The plan under MHMA was to establish circles of inpatient and outpatient service providers. Recipients were free to see outpatient therapists for up to 8 sessions, and after that special approval was needed for extensions. Group therapy was actively promoted as two 90 minute sessions were treated as the equivalent of one session of psychotherapy. Responsibility rested on the provider to secure the necessary authorizations, and unless they were turned down outright, the recipient would usually not hear about it (Fendell, Fall 93, p. 14). All 24-hour services required prior authorization which were usually valid for only a few days (Callahan, et al., 1995, p. 174). Patients who are considered extraordinarily violent or who required unusually high levels of services were by policy excluded and referred to a DMH facility until their condition improved (Fendell, Fall 93, p. 17). Latter

MHMA contracted with the same crisis intervention/hospital screening teams which DMH contracted with to handle decisions concerning hospital admissions.

### **Initial Implementation**

MHMA commenced its statewide operations in early 1992 through a brief, phase-in process. In April it began screening requests for inpatient hospitalizations, and by July it had assumed the role of gatekeeper for outpatient, mental health services. Also in July, the partially capitated reimbursement contract between MHMA and the Department of Public Welfare commenced (Fendell, March 1993). At this time the state enrolled 375,000 persons in the MassHealth Program (Callahan, et al., 1995, p.174). A key decision made during this period would later be the basis for an unexpectedly high level of goodwill in the provider community. This was the hiring of almost all their staff locally, from among this community. Other tasks accomplished during this period included the development of a provider manual, initial set-up of their information systems, and establishment of regional offices.

A major problem in implementing the larger MassHealth Program, of which mental health was part, involved securing decisions from each of the recipients as to which HMO or primary care provider they wished to use. The Department of Public Welfare (DPW) employed 80 Health Benefit Managers to answer questions over an 800 number, or actually meeting with recipients, as well as providing packets of information. Language barrier was one part of the problem. This was ameliorated through assuring a dozen languages were spoken by the various Health Benefit Managers. Despite the mailings and calls, fewer than half of the recipients made an initial choice of provider. Eventually, the

Department was forced to use a system of computerized assignment, which took into account age, gender, address, language, disability, health, and previous providers. Even so, individual determinations were often required (Bullen, 1995, p. 8). Key issues involved the weighting of geographic proximity vis-a-vis continuity of care, how providers should be paid, what risks should they have to assume, and who should be responsible for orienting recipients about the new system.

In late 1992 and early 1993, implementation efforts shifted to the formation of a MHMA provider network. According to one DMH official, this was perhaps the most politically difficult task in the implementation process. Steps included a formal application process, several surveys, and extensive visits to various facilities. In October, MHMA awarded contracts to 45 inpatient providers who would be the only facilities eligible for Medicaid reimbursement, in other than emergency situations (Fendell, March 1993; Dickey, et al., 1995, p. 102). Then, in January 1993, contracts were awarded to outpatient providers. Only a small proportion of applicants was accepted. For example, 465 physicians were selected out of 2,209 applications; 135 clinics out of 263, and 57 hospital outpatient clinics out of 239 (Fendell, March 1993, p. 13). The formation of such provider circles enables the managed care company to purchase services 'in bulk' at low rates, and to gain some control over the provider system in exchange for a reduced range of choice on the part of recipients. By contracting with a reduced number of providers, each provider becomes more dependent on the insurer as a larger percentage of their budget originates from the insurer than in a fee-for-service environment.

Another task involved the development of the pre-authorization and appeals processes. Although these were later improved, providers consistently reported major problems with receiving authorization for services. In addition, there were many problems with the billing and reimbursement systems, as MHMA's MIS department appeared overwhelmed, payments were often inaccurate, and the prior approval process was a "nightmare" (Beinecke, et al., 1995, p. 45). Despite these problems, the number of appeals to MHMA was extremely small, no appeals were filed, and no hearings had to be held before the Department of Public Welfare (Fendell, Fall 93, p. 14). Between July and December 1992, there were 528 service denials or diversions. None, however, involved outpatient services. One half of the informal requests for reconsideration of service denials were reversed. A Department of Public Welfare survey found that two-thirds of the providers expressed some hesitation over appealing MHMA decisions due to concern for their contracts as providers (Fendell, Fall 93, p. 14).

Much of the impact of the MHMA program was achieved during the initial year of implementation. During this period, total expenditures were reduced by 22 percent supposedly without any reduction in quality or access (Callahan, et. al., 1995, p. 173). This inflation-adjusted 22 percent figure is taken off of a projection of expected increases under the previous fee-for-service program, and thus, assumes a constant rate of increase. It has been suggested that state officials would have adjusted the rates paid to providers had the new program not been implemented (Fendell, 1993). Costs declined by about 19% for mental health services, and by 48% for substance abuse services. In both cases, this was

attributed to inpatient utilization.

In addition to the decline in inpatient utilization, there were slight declines in readmission rates, from 19.9% to 18.9%. One study found that the percentage of recipients with one or more hospitalizations decreased from 25.8% in FY92 to 14.2% in FY93, and those with 5 or more hospitalizations, from 2.0% to .4% in the same period (Dickey, et al., 1995, p. 109). At the same time, average length of stay in general hospitals dropped from 15.2 to 11.6 days. However, children's readmission rates increased slightly (Callahan, et al., 1995, p. 173), at the same time that reports from the field indicate that children were being discharged earlier from hospitals than prior to the implementation of managed care (Fendell, March 1993). Selected key outpatient services such as outpatient detoxification, clinic treatment, medication, day treatment, clinic evaluation, methadone counseling were actively promoted (Callahan, et. al., 1995, p. 179), although, in aggregate, they were diminished slightly during the first year (Dickey, et al., 1995, p. 114).

Despite the decline in inpatient utilization, the socioeconomic and diagnostic profile of the recipient population remained essentially unchanged during the first year. Specifically, the disabled were not diminished either in number or percentage (Dickey, et. al., 1995, p. 107). The one unambiguous change was a dramatic increase in substance abuse comorbidity, from 35.6% of the recipients to 59.8%. Whether this is a reliable indication of increased substance abuse, or of MHMA's encouragement of outpatient substance abuse services remains unclear. Finally, it was also reported that 3 of 4 indicators of continuity of care were improved (Dickey, et al., 1995, p. 107).

## **Fine-Tuning the Program**

Despite the initial successes in reducing costs, administrative problems persisted throughout the remaining three years of the program. These were somewhat ameliorated through redesigned paperwork which was applauded by direct service practitioners. In general, outpatient providers viewed MHMA's program positively because it was less rigid and required less paperwork than several of the other managed care corporations. Some of the progress in streamlining administrative procedures was attributable to the July 1993 transfer of the state Medicaid program from the Department of Public Welfare to the Division of Medical Assistance. Because the Division's overriding responsibility is the administration of Medicare and Medicaid, it was better positioned to manage its contract with MHMA.

During the remaining years of the program, MHMA pursued several initiatives designed to build on the gains made during the first year. In order to minimize problems of coordination with the parallel DMH service system, MHMA contracted with the same system of emergency services providers and inpatient crisis units used by DMH. In order to enhance the continuity of care in April 1993 a Primary Inpatient Psychiatric Facility was designated for each recipient. This policy innovation followed complaints about constant changes of hospitals on the part of those recipients who needed frequent hospitalizations.

This same year a Family Stabilization Team was initiated to assist families of the seriously mentally ill. Unfortunately, this program never reached more than a token number of recipients and their families. A somewhat better used program was the Intensive Case

Management (ICM) Program which was established in November 1994 to work with 236 adult and 70 child high users. These ICMs did not replace DMH case managers, even though both systems use a brokerage approach as that "tracks and coordinates service delivery and outcomes " (Fendell, Spring 1995, p. 9). Despite objections from DMH officials concerned with duplication, MHMA proceeded to implement this service (Schaeffler, 1995).

Throughout the implementation and subsequent fine-tuning of the MHMA program, problems of coordination with the state mental health program were sidetracked. Each system had developed its own system of hospitals, case managers, and other providers. Frequently these systems were duplicative. The two systems, however, used different service categories; for example, MHMA was able to provide a type of partial hospitalization and adolescent residential treatment which DMH was not set up to support (Schaeffler, 1995). The two organizations also lacked a shared database for joint planning and monitoring. DMH's role in coordinating the acute care MHMA system with its own long term care system was unclear, especially which institution would function as the state mental health authority (Elias & Navon, 1995, p. 49). The limited progress made on these problems was accomplished on an informal basis, often between regional and area administrators of the two agencies. It was not until just before to the termination of the contract with MHMA that these issues were addressed in any systematic manner (see Expansion and Integration of Medicaid Program).

Mid-way through the MHMA contract, the first external evaluation of the programs' impact was released in January 1994 by Brandeis University (Callahan, et al., 1994).

Because DPW had contracted for this evaluation under the constraints of an extremely limited budget, it was not possible for these researchers to conduct either a client satisfaction or outcome component. It relied on the analysis of existing databases, as well as on a survey of administrators of provider agencies. As a result, the project produced a favorable report but one which amplified on a few of MHMA's administrative problems. The report received only lukewarm reviews from the advocacy community. Its failure to survey consumers exemplified to many the general lack of consumer involvement in the program (Fendell, Spring 1994). Some pointed out that the positive report from providers may actually represent a measurement problem: "Off the record, medical professionals at hospitals and clinics report fear of retaliation for direct or indirect criticism of MHMA." (Fendell, Spring 1994). Later, DMA conducted their own survey of 2,000 consumers, which reportedly revealed a high level of satisfaction (DMA Newsletter, 1995). One of the few changes to come out of the Brandeis evaluation was a push on the part of DMA to have MHMA develop a quality assurance program, which it subsequently did (Schaeffler, 1995).

### **Overall Impact of Program.**

Two external evaluations have been conducted on the MHMA program, and neither was able to assess its impact on recipients (Callahan, et. al., 1995; Beinecke, et. al., 1995). However, one internal DMA survey did find an overall level of consumer satisfaction (DMA Newsletter, 1995). However, there is considerably more information available from these evaluations on the programs' impact on service delivery patterns and costs.

During the first year, the MHMA program lead to a 2.4% reduction in hospitalization

levels from the previous year, from 16.5 to 16.1 users per 1000 enrollees. (See Table 1). This level remained fairly constant in the following years, at 16.2 for 1994, and reportedly at similar levels in FY95 and FY96 (Fendell). Some observers complained about a scarcity of diversionary beds, though there were more than previously (Psychiatric News, 1995). In substance abuse there were particularly dramatic shifts, as inpatient care dropped from 9.1 to 3.5 in the first year, and then to .9 by the second year (Callahan, et al., 1995; Beinecke, et al., 1995).

### **INSERT TABLE 1 ABOUT HERE**

More dramatic shifts in services took place in community programs, specifically those dispensing medications. Although MHMA and DMA staff had promised to increase outpatient care, in light of their plan to reduce inpatient services, utilization of outpatient services were actually reduced, from 59.7 to 48.7 in the first year, to 44.5 in the second year. One report had it that there was a 6 percent increase in the number of enrollees receiving only outpatient treatment. However, this is no doubt due to the even greater reductions in hospital and other services (Psychiatric News, 1995). By 1994, the decline in outpatient utilization was reported to have stabilized (Fendell, 1994). In contrast, an initial population of 4,000 persons in July 1992 who took psychiatric medications ballooned to 7,500 by September of 1995 (Fendell, Fall 1995), an 87.5% increase. Similarly, the

Callahan report found a 29.1% increase in medication utilization during the first year, from 24.7 to 31.9, while the Beinecke study found a subsequent 32.6% increase in the second year, from 31.9 to 42.3 (Callahan, et al., 1995; Beinecke, et al., 1995).

The increase in psychiatric medications was paralleled by dramatic increases in methadone dosing and counseling in the substance abuse arena. While methadone dosing increased from 5.2 to 6.3 in the first year, and to 7.6 in the second, or 46.2% in the first two years of the program, methadone counseling increased almost as much in these two years, from 5.4 to 7.5, or 38.9%. Similarly, freestanding detoxification also grew dramatically, from 5.5 to 9.2 in these two years, or by 67.3%. Psychotherapeutically oriented practitioners may have historically been extra cautious regarding the use of psychiatric or other mind-altering drugs. However, cost conscious MHMA managers no doubt saw major gains to be made through the promotion of these therapies. Whether the optimum level of medication usage is closer to the baseline or the latter levels is a question that only a consumer outcome study can answer.

A key component of community care is crisis intervention. During the first two years of the program the levels clearly decreased, from 18.3 to 15.9, or 13.5% in the first year, back up to 17.3 in the second year, or a 8.8% correction (Callahan, et al., 1995; Beinecke, et al., 1995). One report indicated that the growth in the second year continued at a "dramatic" pace in the program's third year (Fendell, Fall 1995).

After an initial growth of day program utilization in the first year, from 3.7 to 4.7, or 27%, in the second year these levels returned almost to their original one, i.e. 3.9.

According to more recent data, utilization levels fell 20% between July 1992 and October 1994 (Fendell, Spring 1995).

Officials have pointed out dramatic increases in some of the other areas of community programming, but by 1996 each of these areas could claim only a minimal enrollment of Medicaid recipients. When actual enrollment levels are examined, these changes consisted of increases from very to extremely low levels of utilization. For instance, out of 373,000 enrollees in Spring 1996, only 19 were receiving community support; 1, flex benefits; 17, partial hospitalization; and 203, crisis stabilization (Fendell, 1996, p. 9). With the exception of medication, virtually every area of community care saw decreases in service utilization. Because of the dramatic increases in the prescription of psychiatric medications during the first year of the program, over all levels of service utilization remained fairly constant by only increasing slightly, from 212.7 to 222.6, or 4.6%. Unfortunately, no data is reported on the average length of stay or number of units of service used, except for inpatient care where average length of stay leveled off. None of the evaluations have attempted to assess the reliability of the data, or the statistical significance of the shifts in service utilization.

Limited data is available on the impact of the foregoing service patterns on subpopulations such as children and the disabled. MHMA did significantly decrease length of stay in 24 hour facilities for children and adolescents, by 29.8% between FY92 and FY93, and for adults, by 10.3%. At the same time, the re-admission rate was increasing among children. Shepard, one of the Brandeis investigators, suggested that this was mainly

the result of the Massachusetts child welfare agency (Department of Social Services) "parking kids in hospitals " (Psychiatric News, 1995). However, the Brandeis study reported that for the first year the non-disabled were more seriously affected than the disabled.

Fendell who reviewed data on the remaining years of the program concluded that disabled recipients experienced larger cuts in mental health clinic and hospital outpatient therapy. Between June 1992 and May 1995, the number of disabled recipients seen by clinics declined by 13%, and by hospitals clinics, 15%. Similarly, units of treatment rendered to disabled recipients by hospital clinics dropped by 25% (Fendell, Fall 1995, p. 13). This took place at the same time that 79% of providers noted in one survey that their clients were more severely disturbed than the year before [FY 1993] (Beinecke, et al., 1995, p. 29). Overall, the preponderance of evidence suggests that the disabled – those on SSI – were disproportionately affected by the reductions in services.

Some of the evaluations have examined the program's impact on the quality of administrative decision-making. In one study, one tenth of the providers (10%) rated the review process as excellent, while slightly over half (53%) rated it as very good; 28%, as good; 6%, as fair; and, 3%, as poor (Beinecke, et al., 1995, p. 37). In general, compared with other managed care corporations, MHMA was considered to be about the same or slightly better with respect to the characteristics of quality of utilization review decisions, access for clients, flexibility, and promptness in making decisions (Callahan, et al., 1995, p. 181). One provider noted that,

The Medicaid carve-out has been fairly cooperative and collegial versus adversarial and oppositional. My feeling is that the people who have been

hired to do this were reasonably knowledgeable regarding the state and sensitive in terms of access to treatment by a more disabled population and not restricting the provider network. (Psychiatric News, 1995).

The managed care program has also had some impact on service organization and administration on the provider level, although much of this impact is no doubt a response to the general infusion of managed care and increased competition into the service community. The Beinecke study found that almost half the providers reported that they had recently merged, acquired, or otherwise affiliated with one or more other organizations (p.181). This represents an effort to reduce overhead costs and enhance their attractiveness to managed care companies. Virtually all of them (94%) said they had increased the measurement of services and outcomes; over two-thirds of them (71%), expanded or improved their management information systems; and most (84%), added or strengthened internal gatekeeper and utilization review functions (p. 51). Some of these developments have been specifically linked with the state's use of detailed contracting specifications and reporting requirements on access, service expenditures, and consumer compliance (Psychiatric News, 1995).

Since a key rationale for the Medicaid managed care program was that it would save money, or at least be cost neutral, each of the evaluations have examined costs. Both concluded that substantial savings were achieved, but mostly during the start-up period (Beinecke, et. al., 1995, p.25; Callahan, et al., 1995). The greatest savings were achieved by diverting hospital admissions from inpatient services to outpatient care, particularly in substance abuse, and by negotiating substantial price reductions with hospitals (Frank,

McGuire, Newhouse, 1995, p. 53). It is reported that between June 1992 and May 1995 per recipient expenditures fell by 44%, and for children, by 53% (Fendell, Fall 1995, p. 14). Nonetheless, outpatient expenditures also declined, in part due to reimbursement rates not rising as fast as inflation (Psychiatric News, 1995, p. 4). However, in specific areas there were substantial cost increases, as would be expected from the earlier review of service trends. These include crisis care (Fendell, Spring 1995) and medication prescription (Fendell, Spring 1996). It should be pointed out that both the Callahan and Beinecke evaluations were premised on the assumption that had the previous program continued, costs would have continued to rise in a straight-line fashion, and thus, this predicted level was used as the baseline from which cost-savings of the new program were calculated.

Overall, the formal evaluations found that the program saved money, maintained access, and quality of services. These studies only focused on the first two years of the program, and many of the trends identified did not hold up in the third and fourth years. The only consistent increase in community services throughout the period appears to have been in medication utilization. While initially there were increases in crisis care, even this subsided by the end of the program. Unfortunately neither of these studies provided data which was directly relevant to the quality of services, as the study relied on service providers rating their quality in a time of diminishing resources and competitiveness for managed care contracts, a hardly convincing or reassuring methodology. In addition, no data have been collected on any consumer outcomes, other than recidivism rates. Thus, while there is some data to suggest cost savings, the data on service trends suggests the

reduced utilization of most types of services, except medication prescription. Despite overall provider approval of MHMA, one of the most frequent complaints of the advocacy community has been its failure to share information. This perhaps illustrates one of the central limitations of the privatization of the oversight of services, that policy decisions and resulting trends become increasingly inaccessible, thereby crippling the ability of advocates to monitor the system.

### **EXPANSION AND INTEGRATION OF MEDICAID PROGRAM**

During 1995 and 1996, the Medicaid program was being expanded on two fronts. The first involved recontracting with the Mental Health / Substance Abuse Program, managed by MHMA, Inc. until June 30, 1996. In its recontracting, the program was expanded to include acute care services previously contracted by DMH. The second involved an 1115 HCFA waiver that consolidates several programs and in general expands Medicaid coverage to almost all low-income persons without medical insurance.

#### **Expansion in the MH/SA Carve-out Program**

Throughout the four years of the MHMA program, DMH and DPW/DMA had no formal, written agreement about their respective areas of oversight responsibility. In September 1995, DMH and DMA signed a Statement of Understanding that committed these agencies to develop an Interagency Agreement resolving the various problems inherent in the state operating two public mental health systems.

After several drafts and numerous public hearings, the Interagency Agreement was signed in the Spring of 1996. The agreement preserved the notion of two separate

systems, but attempted to reduce areas of overlap by defining the DMH system as one of continuing care, and the DMA-Medicaid system as one involving acute care. This distinction was defined by the transfer of DMH funds to DMA for contracted services for short-term inpatient crisis units with private general hospitals, and with agencies for crisis intervention and other diversionary services. In turn, DMA agreed to use these funds to contract with the managed care organization (MHMA) for these same services. In exchange, about 30,000 DMH eligible consumers, whether Medicaid recipients or not, would receive acute care services through the DMA managed care system. Long-term and intermediate care hospital and community-based services would continue to be directly managed by DMH (DMA Newsletter, Fall 1995). The Interagency Agreement also formalized a role for DMH in establishing and monitoring the contract with the MCO as well as a role for DMA in overseeing certain DMH responsibilities.

Many in the advocacy community, as well as many providers and some state officials, have questioned the logic of dichotomizing the system into acute and continuing care, or the practicality of implementing the labyrinthine agreement intended to coordinate them. To many, it provides too many opportunities for state officials to 'pass the buck' or in general, too many convoluted administrative procedures to be effective. However, the DMH Commissioner at that time, Eileen Elias, argued that, "This agreement will end the two-tier system of mental health service delivery that has existed for too long. More importantly, it will fulfill the vision and promise of the community mental health movement." (DMA Newsletter, Fall 1995).

Massachusetts was the first state to pursue a joint purchasing agreement on such a scale between its SMHA and Medicaid agencies (DMA Newsletter, Fall 1995). The initial idea for this second generation program was reported to have originated from Commissioner Elias after she learned of Medicaid take-overs of SMHA services in other states. Concerned about this possibility, she initiated the discussions with the DMA Commissioner about a formal agreement in which DMH would turn over designated services, but retain some control. The central means for the implementation of the agreement involved a Request for Proposals (RFP) for the renewal of the contract between DMA and its MCO, until this time, MHMA, dated September 22, 1995. Most observers had assumed that MHMA would have its contract renewed. Despite vocal consumer concerns about MHMA, an interagency review committee was reported to have supported contract renewal for MHMA. However, the state did not accept this recommendation. Instead it negotiated a contract for the third ranked alternative, a joint application by Options Mental Health and Value Mental Health. Together, they formed the Massachusetts Behavioral Health Partnership (MBHP or "The Partnership"). Unsuccessful appeals from other applicants slowed the signing of the new contract until only two days prior to its start date of July 1, 1996. The reasons for the state not selecting MHMA have not been divulged. One further development, however, may represent a possible reason. In the final months of the MHMA contract, there were reportedly major cost overruns, which resulted in a lawsuit filed by Mental Health Corporations of Massachusetts on behalf of MHMA providers. This lawsuit resulted in a settlement in which MHMA agree to pay its vendors 70 percent of

outstanding balances (Schaeffler, 1995).

An even more complicated system of incentives and disincentives have reportedly been built into the contract with the new MCO. It attempts to put more of the responsibility for the costs of mental health services on federal and other non-state funded programs (Fendell, Fall 1995, p. 13). It also relaxes human rights requirements in contracts for short-term hospital units and allows hospitals to develop their own human rights protocols "consistent" with DMH human rights policy (Fendell, Fall 1995: p. 12). In addition, it includes sanctions designed to improve discharge planning, reduce untimely inpatient admissions, inappropriate referrals to DMH continuing care services, delayed prior approvals and payments to providers, as well as late submission of reports to the state (Fendell, Fall 1995). Unlike in the former contract, the new contract specifically allows the use of capitation funding from the MCO to its providers in the third year of the contract. MBHP's new provider manual suggests these cost pressures were being passed through this system to clients. For instance, among the criteria for eligible clients are the stipulations that, "individuals must demonstrate response/improvement to treatment as a condition to its continuation" and that "Individuals must demonstrate compliance (medication and program) or they shall not receive services" (Flory, 1996, p. 5-6). In light of the incentive structures developed, Brotman's comment - that "the criteria for choosing a successor is being driven increasingly by downward pricing pressure, which could have a negative impact on the chronically disabled" - is particularly insightful (Psychiatric News, 1995).

### **Overall Expansion - The 1115 Waiver Program**

From 1994 to 1995, Commissioner Bruce Bullen of DMA had a team developing an application for a second, extended federal waiver program. Laurie Burgess, the Director of this group, reported that the largest barrier involved the need to demonstrate that extensions of the program would ultimately be budget neutral (DMA Newsletter, Dec. 1994). The final waiver application developed and submitted called for the extension of Medicaid to 75% of the currently uninsured persons with incomes below 200% of the poverty level, and to virtually everyone with incomes below 133% of the federal poverty line (DMA Newsletter, Dec. 1994). This would include most DMH non-Medicaid consumers as well as virtually all the homeless. In addition, it calls for the consolidation of several health care programs, such as the Medical Security Plan for the short-term unemployed and CommonHealth Plan for the disabled, to be folded into the MassHealth Program. It consisted of the option of either an HMO or the PPCP and MH/SAP. There would be a single application form for all state medical assistance programs. Besides the program consolidations, other funding would arise from savings gained through the increased use of managed care and of small state assistance programs (Hospital & Health Networks, 1995).

The federal government approved the 1115 waiver application on April 24, 1995 (DMA Newsletter , July 1995). Almost immediately (April 28, 1995) Governor Weld filed the state legislation required to make the waiver program part of a more comprehensive health care reform package, which was sent to a "Special Commission on Health Care". After being approved by this group in September 1995, the legislation was forwarded to the Massachusetts House Ways and Means Committee. After being consolidated with other

health reform legislation, the reform package was passed by the legislature and signed by the Governor in July 1996. The act was contingent upon on further study to assure the program in total would be cost neutral. This study was completed in Fall 1996 and demonstrated either cost neutrality or savings for all but one implementation scenario. As a result, it was planned that the implementation of the waiver would begin by July 1997. Although Governor Weld supported the program, he subsequently backed off supporting the component that would insure all children in families with incomes between 133% and 200% of the poverty line (Boston Globe, January 12, 1996). Despite the uncertainty about the implementation of the children's component, it has survived as the only part to be implemented as of February 1998.

## **CONCLUSION**

In its inception, managed care embodied a range of ideals involving the integration of service delivery. However, due to the pressures for cost containment, managed care in mental health has come to be regarded primarily as a tool of cost savings. A primary means for such savings has been cost-shifting, the transfer of service costs to other sources, most recently to the federal government through the Medicaid waiver process and the further privatization of service delivery, and especially of service oversight.

In Massachusetts, the management of mental health care has had a long history. It has only been since the early 1990s that the rhetoric of managed care in DMH efforts has been supplanted with its actuality under Medicaid leadership. Because of this rhetoric, as well as DMH's most recent privatization efforts, the stage was set for Medicaid to assume

control of important mental health services in the current second generation carve-out program. Beyond the transfer of control of the acute DMH services, the most important change has been the extension of the privatization of DMH oversight functions, under Medicaid auspices. In the first generation program these changes have meant a medicalization of mental health services, and a retreat from a comprehensive continuum of care, including psychiatric rehabilitative programs, to increasing reliance on medication. It has also meant the fragmentation of professional decision-making. While costs were reduced, partly through cost shifting, the initial ideals of managed care involving services integration have been side-tracked through political and economic accommodations.

This author is yet to hear a serious argument from any of the constituents of the current dichotomized system of acute and continuing mental health care in Massachusetts that such a split will improve the integration of service delivery. Given that managed care is being implemented, the critical question is whether a separate, carved-out system for disabled populations, such as the long-term mentally ill, will better protect their interests than an attempt to merge them into mainstream managed care organizations, such as HMOs. This question has only served to detract from the equally important question of the role of the state mental health authority in managing the service system. However, both problems become particularly urgent now that most of the long-term mentally ill, who formerly did not have Medicaid, become enrolled in the Medicaid system under the 1115 waiver program in Massachusetts, and no doubt soon, in other states.

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