Financing of Community Behavioral Health Services

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Introduction

It is essential for community psychiatrists and other professionals and stakeholders in our community behavioral health system to understand the fundamentals of financing of Community Behavioral Health Organizations (CBHO). Healthcare financing in the United States is complex and operates at many levels: from the capture of a simple single fee for service (FFS) to much more complex payment structures and cost management mechanisms that apply to payer system interactions. Government sources play a much more prominent role in the financing of behavioral health services than for general healthcare (National Healthcare Expenditures 2003). Medicare, local government grants, and Medicaid are the predominant payers of behavioral health services delivered in the United States. In order to develop a framework from which to understand financing of community mental health care, this chapter begins with describing a rationale for understanding financing, then discusses the essential structural components of CBHO financing, and proceeds to examining the historical development of public funding mechanisms, particularly considering the developmental roles of local, state, and federal governments. From this examination and detailed description of the current state of CBHO funding, speculation is provided into possible future developments, particularly with regards to health policy in the first several decades of the twenty-first century.

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Why Understand Behavioral Health Financing?

Understanding the components of system financing is a first step in developing the capacity to influence services development at local, state, and national level. Financing is often not included as a component of professional, and particularly psychiatric, training and when it is, often it is included as a secondary "necessary evil" rather than a core element. Only recently have elements of understanding systems of healthcare been included among the core competencies of postgraduate medical education (ACGME 2000–2011). These core competencies have been developed to assure that all physicians are appropriately equipped to function effectively in

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clinical and administrative leadership roles in the complex US healthcare system.

Community psychiatrists may have a designated leadership role as medical directors or chiefs of service or they may be in direct care provision in staff psychiatrist roles. Often in CBHO staffing patterns, a psychiatrist interacts daily with multiple clinical staff on a variety of levels. Primarily because of the relative expense of psychiatric time, there is often pressure to limit professional and psychiatric services to the provision of direct care. Psychiatrists who are able to effectively engage with executive leadership often find their jobs to be stimulating (Ranz et al. 2001) and this leads to limiting the professional burnout that can be quite frequent in CBHOs for psychiatrists and all professional staff. Moreover, this engagement can create a healthy synergy between individual psychiatrists and CBHO management.

Understanding the evolution of the societal role and financial context of community behavioral health services development provides a necessary foundation to effective leadership within a CBHO. Additionally, participation as an effective advocate for positive changes in the CBHO services system requires a good working knowledge of the context and financing of services. The advantage in having state government so integrally involved in Medicaid mental health benefit design, for example, is that state government officials are generally accessible and are formally accountable to citizens who are their constituents. This provides an important opportunity to understand that advocacy is possible in service development.

In considering the development of mental health services, we have seen movement from a community service system marked by basic humanitarian and public safety elements to one requiring complex financing and sophisticated business management just to hire staff and provide services. Moreover, the cost of care has risen alarmingly in the past few decades, causing increasing emphasis on how to control it (Marks 2003). At the same time, attention to the quality of services has grown and service providers have greater accountability. The challenge for the service system is how to create a balance among these forces, using financing creatively to achieve good outcomes at a reasonable cost. The challenge becomes greater as resources dwindle. Whatever other controls are put in place, who gets paid, how they get paid, and who holds financial risk, largely determine the type and quality of services provided (The American College of Mental Health Administration 2003). The financing mechanisms we invent create incentives supporting certain behaviors and if we do not recognize those incentives, we will often be left with unintended consequences. Understanding incentives will enable service design to achieve desired results. The trend to consciously consider and promote incentives in services system design is relatively new. Earlier mental health system designs were more simply related to public service and public safety. Incentivization is associated with a move into the modern fiscal and business world.

How Are CBHO's Funded?

CBHOs are typically funded through multiple sources, predominantly governmental. Only a small portion of funds are from private insurance, self-pay, or philanthropy. In general, local, state and federal governments are involved in funding CBHO services in different ways and a useful way to categorize government funding is to consider these three. Local government includes county and city government. An example of county funding might be a grant that would support school-based mental health services in a school system. State funding for CBHO services is predominantly through Medicaid; however, states may also fund CBHO services through general funds under the direction of state mental health authorities. The kinds of programs that Medicaid funds are broad and they are defined by a state Medicaid plan. Examples of CBHO services that are commonly funded by Medicaid include supported employment, targeted case management and therapy. Federal funds that come to CBHOs are predominantly through the federal portion of Medicaid and Medicare and

some funding may be available to CBHOs through the Federal Mental Health Block Grant (MHBG) or other demonstration project grants. This chapter centers on funding related to professional services provided within CBHOs, though many consumers of CBHO services are also involved with other government programs such as social security, prescription medication coverage, social services, housing programs, and/or food stamps (Frank and Glied 2006).

Rules and Regulations Govern Access to Funding

The types of rules or regulations that CBHOs are subject to as a prerequisite for funding range from local government laws such as building and fire codes, to state mental health agency licensing regulations, to state human rights laws. It is common for CBHOs to be licensed by state governments and the requirements for such licensure varies by state. Requirements range from the very rudimentary to extremely complex clinical, human rights, and operational standards. Licensure is typically defined in a state legal code and may be required for the State's Medicaid plan in order to qualify for federal approval of Medicaid reimbursed services.

CBHOs often are accredited by The Joint Commission or an organization called CARF (Commission on Accreditation of Rehabilitation Facilities). Joint Commission or CARF accreditation may be a requirement of state licensure and may be a requirement to participate in Medicaid funding. Another set of standards that may be required by payers are the professional credentials of staff. CBHOs are typically staffed with a wide range of professional and paraprofessional staff. It is not uncommon for payers to require a certain level or type of staffing. An example of this might be an assertive community treatment team that must have a registered nurse and psychiatrist accessible 24 h a day. Some behavioral health billing codes can only be billed by professionals with specific credentials or teams with a specific minimal combination of professional and paraprofessional staff. Historically, many CBHOs were allowed special status to bill for professional services provided by staff who were not fully licensed as independent mental health professionals. This special circumstance allowed CBHOs to hire new graduates who had finished coursework but not all of the necessary clinical supervision to sit for a licensing examination, or had taken and not yet passed a licensing examination or were grandfathered in as professionals due to tenure at an agency or degree of supervision in lieu of completion of a professional graduate degree and a licensing examination. Increasingly consumer participation is encouraged or required as a component of the CBHO workforce. Consumers often serve as members of a governing board which is often required by state licensure and they may also work as direct care providers as peer support specialists.

The following section presents the development of the public mental health system in terms of financial resources. While chronological, it is not intended to be a history lesson as much as a description of the relative roles of various funding sources and of stakeholders so that trends in financing and their impact are clear. Understanding the development of mental health services in terms of what citizens, through their government, are interested and willing to finance is essential in understanding the current financing trends.

Community Mental Health Financing Through Time

Communities have long had a role in addressing the mental health of the people who live within them. Communities with high social capital and high engagement of members thrive and produce more successful individuals than do communities with low engagement (Putnam 2000). By its basic nature, a community supports the common good and well-being of its members. In broad terms, this serves as a kind of prevention activity.

In thinking about how communities address mental illness, a concept of "loud" and "quiet" mental illnesses is useful. Quiet mental illnesses are those associated with internalizing illnesses, such as depression and anxiety. Quiet and

internalizing mental illnesses generally do not represent a public safety risk and affect a community through loss of social roles. For example, a father with depression might not be able to maintain the family farm, attend work regularly, or advance to community leadership roles. Loud or externalizing illnesses are characterized by obvious, disinhibited, or positive symptoms that might pose a threat to the person or material objects of others. As such, a young woman who has a paranoid delusion that electrical substations are sending electricity to children's brains to brainwash them and then destroys the substation with an axe so that electricity is shut down to an entire community would be a challenge for communities to tolerate. Communities have primary interest in containment of those with loud conditions that pose a literal threat to the safety of its members. The spectrum of mental health services over time has moved from basic containment of externalizing, loud conditions to a more comprehensive capacity to, and interest in, also addressing quiet internalizing illnesses that are likely to adversely impact productivity and well-being. Public debate continues regarding the degree to which public funds should be limited to the containment of individuals with externalizing threatening illnesses vs. support for a wider array of services to individual with quiet internalizing illnesses through the provision of prevention, early intervention, and treatment.

In American society, communities have financed structures since early colonial times. The aims and relative roles of various funding sources have changed over time. For the purposes of organization, this chapter is divided into four eras: a Dark Ages Era, the Institutional Era, the Community Tools Development Era, and the Recovery Era.

Dark Ages Era (Before 1800)

The term *Dark Ages* connotes a period in post-Roman Europe when civilization was inconsistently organized and did not operate from a predictably fair framework. Just as the Dark Ages in European history describes a period of inconsistent ideology and uneven justice, so too does the term "dark ages" describe the situation of the approach in the United States to persons with mental illnesses before about 1800. As the ideology of humanism among thought leaders of the Renaissance brought an end to the Dark Ages, so too does the ideology of moral treatment and humanism bring the end of a "Dark Ages Era" of mental health services in US history.

The colonial approach to managing mental conditions often centered on providing protection through containment of individuals with loud, externalizing mental illness who represented a threat to others and the community. Containment occurred in jails and sometimes with shackles or cages and these places of confinement were supported by local community funds that were generated through taxation. In the Dark Ages Era of mental health services in the United States, individuals with internalizing conditions, and their families, had no common community resources available. Social services needs were typically provided informally by extended family, neighbors, or faith-based groups. Later, many communities developed the fiscal capacity to provide alternatives to incarceration for some through the development of alms houses which were designated for "social dependents" or persons who were unable to work to provide for themselves. Almshouses and similar institutions were most often funded by city or county local government sources.

The dark ages era was gradually replaced by moral treatment ideology which has roots in the humanism of the european renaissance. Dorothea Dix is widely credited with being a major force in catalyzing the development of the state mental hospital system which promoted the humane treatment of mentally ill individuals. Dix, the daughter of a colonial minister, centered her advocacy on the provision of more humane treatment of individuals with mental illnesses. Humanism is the foundation for universal human rights, and at its very core, human rights asserts a right for every human to pursue an autonomous function that is not unfairly impeded by others. Dix conducted tours and inspections of prisons

and almshouses where individuals with mental illnesses were contained and recorded her observations in a series of reports called memorials. These memorials exposed the inhumane and deplorable conditions within these places. Limited and inconsistent funding primarily from local government sources was often cited as a reason for these wretched conditions. She aggressively promoted the idea that state governments were much more likely to have the larger and more stable financial resources necessary to consistently support proper treatment institutions.

Through her repeated, passionate, and consistent advocacy, she and others promoted a more humanistic, fair, and just approach to individuals with mental illnesses. Advocates of this era were very clear that moral, humane treatment was a financial and social responsibility of a civilized government. The construction of regional- and state-funded asylums was the way to bring the inconsistency and often inhumane conditions of the Dark Ages Era to an end. This was at a time in American history wherein the federal government was very young, having just recovered from financing the War of 1812 and still working out issues related to the role of the federal government in levying taxes. A significant political event of this era articulating the federal government's decision to opt out of mental health (and social welfare) financing was Franklin Pierce's 1854 presidential veto of Congressional legislation championed by Dix that would have set aside revenue from the sale of several million acres of federal land for the indigent insane. Pierce reasoned that it was not the role of the federal government to provide for the social welfare of citizens.

The role of state vs. federal governments was actively debated and it was widely accepted that social concerns would be the primary financial responsibility of state governments. The federal government, in comparison, would be responsible primarily for a common defense, international diplomacy, and the establishment of a common justice framework or judicial system. The debate regarding the appropriate relative roles of federal, state, and local governments in the provision of social and healthcare services is ongoing today.

The Institutional Era (1800–1950)

In the early 1800s, asylums first began to be built in the United States and, as noted, these were mostly financed with state capital funds. The asylum buildings were often designed by leading architects and held as a symbol of a state government's civility and humanitarianism. Whereas earlier alms houses and poor farms were built for social dependents by local governments, asylums were built more specifically for the indigent insane and were predominantly funded by state governments. Some private and faith-based institutions did exist, but the predominant model was state-funded institutions. Patients with families of means were expected to provide financial support for their institutionalized family members in varying degrees including inheritance and trust funds. In general, state asylums were expected to be as self-sustaining as possible and only what could not be produced or grown within a facility was obtained through direct state fund allocation. Many of the routine needs of these growing asylum communities were met with uncompensated patient labor which was also considered to be part of the treatment. Patients were involved in maintaining asylum farms for produce and livestock that would be used to feed patients and staff. Other facility jobs that helped to sustain the operation of facilities included clothes making, food preparation, and building and grounds maintenance. Some facilities had surplus crops that were sold for profits that were used to support the institution. Hospital budgets were commonly a part of the state general budget. As the proportion of state funds necessary to operate these institutions grew, states began to form state departments of mental health. As the number of asylums grew within a state, a state typically would create geographic catchment areas such that asylums were responsible for the needs of the subpopulation of people with mental illnesses within that area. Though not in its contemporary sense, one might

use "capitation" for this arrangement of the asylum being allocated a fixed sum of money to provide treatment to a given population. From the perspective of the consumer, this system resulted in a kind of soft "entitlement" in that individuals with mental illness within an area had an asylum that served that area. Many asylums had very limited ability to restrict admissions, particularly of individuals legally committed to their facility for treatment. This typically resulted in admissions occurring at a higher rate than discharges. Throughout much of this era, there were virtually no community providers to refer individuals to. The role of the state mental health department was to advocate and broker the needs of the asylums with a governor and/or elected state government officials. New buildings and institutional growth was supported through increased allocation in state government budgets. Within a state asylum, progressively called state hospitals, the superintendent generally had a great degree of autonomy regarding level of staffing, quality of treatment, and program development.

It has become common to think about incentives in contemporary healthcare financing. In the Dark Ages Era of mental health services, the development of fledgling mental health containment services was associated with protection of the public and of individuals. Elected officials were accountable (incentivized) to their community to protect society by the removal or isolation of individuals who were perceived to be dangerous. Similarly, the concept of incentive in the Institutional Era is tied to the social mission of public safety as well as the fulfillment of the humanitarian ideal to provide asylum and potential cure for disturbed individuals. Facilities were incentivized to advocate for and obtain increasing funding levels from the state to resource an asylum.

By 1940, the census of US facilities had reached 450,000 (Grob 1983). These state institutions had become large, expensive, crowded, and challenging to manage. Very little in the way of outpatient and community-based treatment existed. As the Institutional Era drew to a close, the majority of mental health services were provided through large facilities that were primarily state financed, albeit with several private asylums and hospitals funded through private contributions and fees.

The Community Services Development Era (1950–2000)

At the outset of the Community Services Development Era, attention and emphasis shifted from state government-funded long-term institutional care to the development of community supports. Conceptually, community services would be able to provide continuity and treatment services to individuals that could be discharged from institutions. As a part of the New Frontier policy initiative of the Kennedy administration, the Mental Retardation Facilities and Community Mental Health Centers Construction Act was enacted in 1963 (Cutler et al. 1992). This Act is significant as it represented the first significant foray into funding of community mental health by the federal government. Aligned with the concept "New Frontiers" was the idea that individuals within institutions could experience new opportunities and new frontiers in community settings. In contemporary parlance, we might use the term "federal stimulus" in that the funding for mental health was not to be used to support operations or services so much as the necessary infrastructure development to develop and build mental health services in a community. Under these grants, federal funds diminished to zero over a 5–8-year period, after which other sustainable funds for ongoing services were to be established by the community and from local county/city government or the state's department of mental health funding. Federal grants developed under this law were made available to communities and included the designation of 3,000 catchment areas, each containing between 75,000 and 200,000 persons wherein five essential services would be provided. These services included: inpatient, outpatient, day treatment, emergency services, and consultation and education services.

Medicare and Medicaid were both enacted in 1965 during the Johnson Administration.

These two programs were complimentary in providing a national framework for a humane healthcare safety net for the nation's most at-risk individuals, the aging and the extremely poor. In 1964, State of the Union Address President Johnson announced his declaration of the War on Poverty as a major initiative of his challenge for America to become a truly Great Society. Medicare and Medicaid were important components of this ideology.

As services evolved, matured and diversified within the Community Services Development era, so did the funding that enables services to be provided. At the outset of the Community Services Era, the costs for any of the rare community services that did exist were generally paid from state general funds that may or may not have been carved out from state hospital budgets. Local county and/or city governments often supplemented state funding for the special needs of their community. By the end of the community Services Development Era, funding for community-based services has evolved into a very diverse and complex amalgam of resources. In order to understand the context and perspective of current funding streams, it is necessary to examine the component revenue elements. An understanding of the origin and role of the CBHO revenue elements will help with an overall understanding as to how they fit together to create the patched, braided, or mishmash of revenue sources that support contemporary CBHOs.

As Medicaid developed, states began to transition from grant or program funding supported by state or county funds to current FFS financing. FFS denotes reimbursement for discrete episodes of services. For example, to provide an after school adolescent program for adolescents with serious emotional disturbance, fees to the program are not paid until the patient receives the service and the fees are only paid for days the person actually attends. This FFS transition or "Medicaidization" of community services resulted in some dramatic shifts in incentives. With grant funding, governmental entities would contract with providers to offer services to a defined population, or to catchment areas (Buck 2003). This approach has certain advantages that include few restrictions on the types of services provided, and providers can be flexible and creative in designing service plans. Since the served population was fixed, providers could potentially focus on long-term outcomes and prevention. At the same time, this arrangement created some problems that eventually led to its demise. Providers held no financial risk, and often, overspending was rewarded with supplemental allocations at taxpayer expense. Outcomes were not uniformly defined, and providers had little accountability for results or serving all persons within their catchment, including those with the most severe mental illnesses. Catchment area organization did not give consumers a choice of their provider, so there was no competition between providers to attract "customers" by providing a better product. In the end, neither quality nor economy was served well.

FFS creates very different incentives. Without catchment areas, providers compete for customers and presumably attempt to provide a superior product. They must be efficient in the way they use their resources in order to cover expenses or they will incur uncompensated losses. While this arrangement does allow a greater degree of uniformity and accountability, with a defined set of established "billable" services, it limits creativity and nonbillable activities such as consultation, integration, prevention, and team interaction. It rewards entities that produce more billable hours or procedures. There is disincentive to provide services to persons requiring intensive support beyond a billable service, and the process of billing itself creates administrative costs. Competition can provide an incentive to improve quality, but only when the supply of services is greater than demand for them, which is seldom the case in the public sector.

Medicare

Medicare provides a foundation to understand government health financing mechanisms and it is presented here first because it is more straightforward in design and administration. Medicare was developed from federal programs that provided medical care for the aging widows of United States veterans who would otherwise not

have access to health insurance through veterans benefits or employee-based insurance (because husbands were deceased and therefore not employed). Currently, about 84% of Medicare beneficiaries are persons over the age of 64 and, about 16% of all Medicare beneficiaries are Medicare recipients because they are disabled (Kaiser Family Foundation 2009 data). There is not an income test for Medicare eligibility. Since 1973, individuals who have been determined to be disabled by the Social Security Administration are eligible for Medicare.

The federal government funds 100% of every Medicare dollar and the program is managed by regional carriers that, in turn, define specific regional policies. As of 2001, Medicare provided about 15% of the total funding for inpatient, outpatient, and pharmaceutical mental health services spent in the United States and at that time there were just fewer than 40 million Medicare beneficiaries (National Healthcare Expenditures Report 2003). Most Medicare mental health payment is for inpatient treatment, and in 2001, mental health expenses comprised only 2.4% of the total Medicare health expenditures (National Healthcare Expenditures Report 2003). Medicare may pay for partial psychiatric hospitalization and home health and general outpatient psychiatric treatment, but the program does not pay for many of the rehabilitative services that CBHOs often provide, such as case management, rehabilitation programs, or assertive community treatment. When persons have Medicare and Medicaid (also known as being a "dual eligible"), Medicaid is the payer of last resort and is used only if Medicare or any other benefit a person might have does not pay for a service.

Medicaid

From its inception in 1965, the impact of Medicaid on mental health services has evolved tremendously. Originally, Medicaid was developed to replace a combination of federal grants and payments to physicians and hospitals for the treatment of needy individuals. In 1965, Medicaid was created by federal legislation as a state-operated and dually financed (state and federal government) healthcare insurance program for the poor. State governments finance 50% or less of the total payment for healthcare services, with the federal government paying the remaining portion. The part that the federal government pays is also referred to as the Federal Medical Assistance Percentage or FMAP. About one quarter of states, those with highest income per capita, have a 50/50 FMAP. The FMAP for the remaining states is generally between 51 and 75% and states with the lowest per capita income have the highest FMAP.

Eligibility for Medicaid is based on means. This includes annual income to a household as well as consideration of the assets an individual possesses such as bank accounts and real estate. The income eligibility requirement for Medicaid is determined by each state and is codified in each state's Medicaid plan. Eligibility was originally associated with receipt of other federal welfare programs such as Aid to Families with Dependent Children (AFDC or ADC) and most recently has been shifted to an annual household income test that is keyed to federal poverty guidelines. Federal poverty guidelines are established by the Department of Health and Human Services (HHS) as an eligibility criteria reference for several federal programs including Medicaid. For example, if a state determines that the Medicaid eligibility level is 200% of HHS federal poverty guidelines, individuals or families earning up to 200% of this figure are eligible for that state's Medicaid program. Likewise, a state Medicaid plan that has 90% federal poverty guideline eligibility means that only individuals or families who earn less than 90% of the poverty guideline are eligible. This provides a mechanism through which regional cost of living, state taxation rates and revenues, and other factors can be taken into consideration. Eligibility can also be determined by special population needs. Some states limit Medicaid eligibility to poor children and women of child-bearing age, whereas others include persons who are poor and disabled, blind, and/or aged. Traditionally, and in keeping with general American social policy ideology that able bodied men should not be encouraged to become dependent on government programs, men are traditionally the least likely to be eligible for Medicaid.

In order to participate in the Medicaid program, a state must create and propose a state plan to the federal Center for Medicare and Medicaid Services (CMS). Once approved, the plan serves as a kind of contract between the state and federal governments. Any state-initiated amendments, waivers, or other changes to the state plan must be reviewed against federal regulations and laws and approved by CMS. Initially, the services that CMS allowed Medicaid to pay for were traditional healthcare services such as hospitalization, outpatient physician visits, and nursing homes. In general, *amendments* are used to make proposed changes to the existing approved state plan and *waivers* have been used to propose specific alternatives to expensive long-term care or institutional costs for a particular population. Waiver applications from a state Medicaid office typically must demonstrate that they are no more expensive to operate than long-term institutional care. Waivers in many states are well developed for individuals with intellectual or developmental disabilities who otherwise would be housed in facilities such as a specialized state-operated care facilities called intermediate care facilities, or ICFs. Medicaid waivers are also used to fund alternative services to nursing home care. The ideology of using waivers as mechanisms that enable the redirection of funding from long-term institutional care to community-based treatment has been important in the financing of certain services in the CBHO.

Community Services Development Era

Medicaid funding of community mental health services has increased dramatically over the last several decades such that Medicaid is now the largest payer for community mental health services in the United States (Buck 2003). The increased ability of states to access matching federal dollars greatly facilitated service development in this era. There was great appeal for every million dollars a state spent to provide outpatient services to have federal matching funds, creating two million dollars in services. Medicaid pays for inpatient psychiatric treatment in non-IMD facilities such as psychiatric units in general hospitals. However, because of a special condition in the original federal Medicaid legislation, Medicaid cannot be used to fund any services within a freestanding institution of mental diseases, or "IMD." By definition, an IMD is a freestanding psychiatric hospital with more than 16 beds. This provision, the IMD exclusion, was created so that states would not be able to shift the responsibility state government has long held for provision of long-term care and treatment of indigent individuals with mental illnesses to the federal government. This policy has had the longer term effect of enabling the development of community services and the closure of many expensive state psychiatric hospitals.

A crucial element in considering Medicaid and its role in services development is recognition that Medicaid's FFS structure. FFS does not permit a community agency to receive a bundle of funds to operate a set of services for a population. In contrast, grant or *capitation* of funding sources might finance a certain dollar amount to provide a certain intensity in all aspects of programming for a specific target number of service recipients (or single individual in the case of capitation). Therefore, under traditional "unbundled" Medicaid FFS funding, there is limited capacity to support planning, start up, and general services administration costs.

Another important concept to understand in the financing of CBHO services is that Medicaid services are an entitlement. While states have a great degree of latitude regarding establishing the rules for eligibility levels and the range of services that are offered, once a person is determined to be eligible for Medicaid, he or she is entitled to all the services that are available and medically necessary for a given condition.

In consideration of incentives under a simple FFS structure, health organizations that provide more services to more individuals receive greater revenue. Understanding the possibility of financial incentives that might impact CBHOs and delivery of Medicaid behavioral health services is more complex than a simple FFS arrangement. Medicaid typically has low reimbursement rates particularly for physicians and professionals

compared to Medicare and other health insurance plans (Zuckerman et al. 2009). CBHOs typically address this financial gap through close management of physician and expensive professional staff productivity and through cost sharing from the direct care and administrative revenue of other incorporated programs that have a greater difference or margin between expenditures and revenue collection. In general, the larger an organization is, the larger the wiggle room or margin there is to pay for a range of professional and paraprofessional staff. Some CBHOs have grown specifically in order to have a larger or more stable source of revenue from a diversity of programs; others have not been able to maintain sufficient revenue to provide services or continuously operate at the margin.

Federal Mental Health Block Grants

This source of federal funding for mental health services and administration began in 1981 under the Reagan administration. The establishment of the Mental Health block grant (MHBG) was a compromise that followed the repeal of several significant mental health provisions that had been passed in 1979 during the Carter Administration in response to the report of a presidential Mental Health Commission (Sharfstein 1982). These funds are issued to state mental health authorities and require that states create a comprehensive state mental health plan that must be developed by a statewide planning council. For many state mental health budgets, the MHBG funding is a very small proportion of the whole mental health budget. However, this funding is not tied to individual patients and can be used much more flexibly in that it resides outside federal Medicaid regulatory purview and can provide for planning and program administration in ways that FFS designs, like Medicaid, cannot provide. For many states, the MHBG is 1% or less of the total expenditures on mental health services.

Local Government Grants

Grants provided to entities for particular services are an important component of overall funding for community mental health services. These funding mechanisms take several different forms. They can range from support for broad administrative services as a recurring expense in a county or city government budget to very specific specialized programs funded through time-limited grant instruments. Examples of these types of grants include: in-school or after-school professional services, summer camps for kids with serious emotional disturbances, employment programs, mental health services in shelters, and community-wide mental health first aid programs. In 2003, the federal Substance Abuse Mental Health Services Administration (SAMHSA) determined that local government entities contributed 24% of all the expenditures for mental health services to Americans (Mark et al. 2007).

Managed Behavioral Healthcare

Managed care emerged in the early 1980s as a mechanism to reduce costs, particularly the costs of psychiatric inpatient admissions that were paid for by private insurance. As state governments reduced the numbers of long-term state psychiatric hospital beds, community inpatient units, private freestanding psychiatric hospitals, and outpatient resources grew. The IMD exclusion provision in Medicaid law provided a strong incentive for state governments to move individuals in state hospitals (which are IMDs) into treatment in acute units in general hospitals. Individuals in need of psychiatric services and with some form of insurance were usually admitted to freestanding private psychiatric facilities or general hospital psychiatric units. Because of rising costs and high variability in utilization elements, particularly length of stay, managed behavioral healthcare was developed and supported by the insurance industry as a way to address costs and adopt more standardized clinical practice. Several new cost containment techniques were developed by the managed behavioral healthcare industry. These techniques include attention to standardizing admission criteria, length of stay, and price of the service. Admission criteria became more standardized through the development of the concept of *medical necessity*. A medical necessity criterion is a standard and written set of conditions that must be met in order

to access a service. Examples of the types of medical necessity utilized by managed behavioral health companies include: the presence of certain diagnoses, level of acuity of the condition, presence of particular symptoms, failure of prior lower levels of treatment to stabilize a condition, and level of impairment or dysfunction. Length of stay in inpatient settings has been intensely managed such that a length of stay may be 5 days or less, whereas in the premanaged care era a length of stay may have been as long as 30–45 days on an acute psychiatric unit and as long as years in a state institution. In general, prior to managed behavioral care, there was greater ability for physicians, professionals, and patients to direct the care they believed was best for a given clinical situation. With managed care, a much sharper focus was placed on costs and standardized treatments; patients and physicians were put in the position of having to *prove* the need for a particular level of service to justify the insurance claim for payment.

In the mid-1990s, Massachusetts was the first state to contract with a behavioral health-managed care company to manage the costs of public funded mental health benefits for Medicaid recipients. Within a decade, over 45 state Medicaid programs contracted with behavioral healthcare entities to manage the costs of state Medicaid expenditures (Sturm 1999). Managed behavioral healthcare techniques generally have been successful in standardizing services and in reducing cost increases. State Medicaid programs that contract with behavioral health-managed care entities may have one of several different types of arrangements. Behavioral health benefits may be managed in the same way that general health is managed or behavioral health may be carved out to a specialized behavioral health management company. Within the behavioral health set of benefits, services can be managed in one of three broad types of arrangements. The first of these is a full-risk arrangement such that the managed care entity assumes the entire management of and financial risk for mental health services to a population. In this arrangement, the managed care company has potential gain or loss depending on the number and cost of services delivered. Inherent in this arrangement is a financial incentive for the managed care entity to limit the number and intensity of services provided. A part of the public concern about the managed care model being so integrally involved in the management and allocation of public funds for services is that the presence of a managed care entity creates a layer in the relationship between government and the citizens—constituents to which government officials are accountable.

A second arrangement structure that a state might employ to manage Medicaid mental health benefits is a partial risk structure wherein the behavioral health-managed care company has a range of potential risks and losses with the state bearing the full potential risk or gain in the management of services. This type of arrangement puts caps on the potential profit or loss that private managed care companies can earn when administering or managing the public Medicaid dollars. A third style of arrangement is a no-risk arrangement wherein the state Medicaid program contracts with a managed care company for a set fee to support the utilization management of services. In this third type of arrangement, also referred to as an administrative services only, or ASO, arrangement, the managed care company does not have financial risk for profit or loss, rather it is hired and paid to perform a specified set of management services.

Overall, the rules and rates created by the managed behavioral healthcare industry have been strongly shaped by the technology of powerful data systems that provide accurate and timely information on claims. Many state government information technology bureaucracies, particularly state offices of mental health that are not directly linked to state Medicaid claims information, do not have the capacity to effectively manage large population utilization data without outsourcing to managed behavioral health entities. The modern information technology capacity of managed care companies has increasingly become more sophisticated over the last several decades and has resulted in managed care entities influencing policy development from the perspective of trends in cost and claims-based data as opposed to a more traditional public health

model of assessment of population health needs and the development and funding of treatments that meet those needs. A central policy question is: has the insertion of the business of managed care resulted in a change in focus from the use of public dollars to provide behavioral health services that meet a humanitarian and safety need to a more narrow focus on fiscal viability? (Minkoff 1997).

The Recovery Era (Since 2000)

Since the beginning of the twenty-first century, we have been in the Recovery Era and it is distinct from the Community Development Era in several ways. As discussed in detail in Chap. 7, recovery itself is an important organizing theme or big idea that challenges individual consumers, professionals, and stakeholders to think beyond mental illness symptom resolution to living a hopeful, purposeful, and meaningful life. The beginning of the millennium also is associated with several prominent health and mental health policy developments particularly at the federal level. Parity and the healthcare reform strategies of the 111th US Congress and of President Obama's Administration that were put forward in the Patient Protection and Accountable Care Act (ACA) (HealthCare.gov 2012) in 2010 capture and codify ambitious ideas that are likely to influence American health policy in the foreseeable future. The full impact of the ideas and policy direction of the Recovery Era is not known, but the stage is set for a new era in community behavioral health services. This era will likely be characterized not so much as one of expansion and new frontiers so much as consolidation and focusing of services so that effective treatment that promotes recovery is coordinated, individualized, and aligned with a person's needs at a point in time.

President George W. Bush Administration's report of the New Freedom Commission clearly supported goals of recovery for all Americans with mental illness (New Freedom Commission Report 2003). A central aspect of the Recovery Era is the existence of engaged and empowered consumers who are challenged to assume responsibility for the management of their illnesses and lives. This paradigm shift imparts on professionals and services the expectation that they support and challenge each patient to be the best that they can be.

In the current phase of the Recovery Era, through Medicare, Medicaid, and the Medicaid-expanded service for children (Children's Health Insurance Plan or CHIP), CMS will finance services to over one third of the US population or about 105 million Americans and will have beneficiary expenditures of over 800 billion dollars (CMS Budget Report to Congress, FY 2012). Ongoing awareness of the cost to maintain these two large government-financed healthcare programs has resulted in intense debate about the role of these government programs nationally. Current policy terminology includes the hope that mechanisms can be introduced that will decrease the rate of rise in healthcare costs, particularly in Medicare and Medicaid.

Parity is an important foundation for mental health services financing in the Recovery Era. Parity for mental health services was enacted in Congress originally in 1996 as the Mental Health Parity Act (MHPA) and was refined and reinforced with the Mental Health Parity and Addictions Equity Act (MHPEA) in October of 2008. Parity has been refined and carried forward as a cornerstone of the Obama Administration's health reform policy. The original federal MHPA parity law eliminated lifetime limits on mental health dollars and inpatient number of days and services. The MHPEA of 2008 states that health insurance benefits and the management of those benefits for persons with mental illness and substance abuse can be *no more restrictive than* the benefits provided for general health. An important refinement is the clarification that substance abuse treatment is included as a benefit to be covered at parity with mental and general health. The federal parity act was supported by principles associated with the Americans with Disabilities Act (ADA) that was enacted in 1990 (ada.gov 2012). The ADA provides protection from discrimination based on a disability to individuals in public settings, public programs, and in employment. Furthermore, until the Olmstead decision of the Supreme Court in 1999, there was not a

clear precedent that mental conditions were included as a disability condition under ADA. Olmstead clearly established the precedent that individuals with mental disabilities are included as a disabled group and have ADA protection from discrimination on a par with all disability groups in public programs, public settings, and in the workplace. Although most states had previously passed parity laws that applied to the operation of state insurance programs before the 2008 MHPEA, these were based on the earlier 1996 parity laws and had not been uniformly enforced and regulated. Parity is an important milestone in the financing of behavioral health services and sets the stage for a number of mental healthcare reform initiatives.

The subsequent Patient Protection and Affordable Care Act (ACA) included several features that will influence behavioral healthcare financing. A significant component of the ACA decreases the number of uninsured Americans through the broadening of Medicaid eligibility, federal subsidy of premiums, and increased availability of affordable insurance. Persons with mental illness are overrepresented in uninsured populations and this is likely to increase demand for behavioral health services. A foundation of the ACA includes demonstration projects that encourage experiments with bundled funding for a range of services that are to be better coordinated and more specifically tracked and actively case-managed. This is intended to increase experience with a move away from individual-oriented FFSs reimbursement and toward more of a capitated style of funding to a provider entity such as a primary care practice or hospital system that is accountable for providing and managing a range of services to the individual patients served by that entity. Incentives in this type of financial model would encourage healthcare provider organizations to promote increased access to lower cost services that are preventive in nature and conceptually would prevent or limit a downstream need for higher cost services.

Earlier in this chapter's discussion regarding state Medicaid arrangements with managed behavioral health companies, three types of relationships were presented: full risk wherein the managed care company assumes full financial risk for a population and also stands to profit if costs are kept low; limited risk wherein potential loss and profit are restricted for the behavioral health-managed care company; and no-risk, in which the managed care company provides administrative services only. This general style of payment is also present in several initiatives within the ACA to finance bundled care payments to health entities for the total management of an episode of care. An example of an episode of treatment might include an acute myocardial infarction (AMI) with all related hospital and professional fees including intensive care, diagnostic procedures, and outpatient rehabilitation being bundled together into a single payment. In this example, if the cardiology service fails to identify depression as a complication of the AMI and the person requires readmission for treatment of depression or has an unnecessarily protracted course the hospital might lose funding, on the other hand, early identification and treatment of depression could shorten the course, reduce total cost, and result in better overall outcome or the patient. In a general sense, the concept of *bundling* a payment is designed to promote efficiency and coordination of resources and expenses within a provider organization or hospital so that incentives for multiple individual fees are diminished. Bundling is a kind of limited risk relationship which provides incentives for cost management within an episode of care. Bundling of payments to provider entities is one of the big ideas in current Recovery Era healthcare reform that may shape financing for the immediate future.

A second and related financing model being undertaken in association with the ACA is financing for accountable care entities. The concept of an accountable care entity, also known as a healthcare "integrator," is seen with several demonstration projects, particularly in Medicare. *Accountable Care Organizations* are hospitals or groups of providers who assume responsibility for medical care for a population. *Health Homes* are primary care-oriented entities that provide coordinated care to a group of patients. Payment structures for this service are varied, but typically are based on three elements: a *case rate* for all or

qualifying high-risk members of the population of patients, FFS, and opportunities for performance-based incentives. A case rate is a form of capitation, with a set periodic payment that is typically gauged on the basis of risk for utilization of services, particularly unplanned high cost services. As of this writing, the full potential of these models for CBHO financing is not known, although many organizations have had experience with the administration of some of these models. An example would include the ways case management is funded, which typically includes a case rate for a given minimal number of encounters per month.

Medicaid and Medicare in the Recovery Era

Medicaid is currently the predominant funding source for mental health services. For many reasons, including healthcare reform provisions that enable a broader income range to be eligible for Medicaid, the state of the general economy so that more people are unemployed or underemployed and are Medicaid-eligible, and diminishing capacity of some local governments to fund local government grants for CBHO services, the proportional role of Medicaid is likely to continue to increase. Most of the provisions that expand Medicaid are financed by the federal government. Additionally, the ACA proposes to increase the FMAP for Medicaid in many states, particularly those with high unemployment rates so that the federal share is greater than it had been.

Medicare is a program with a growing number of aging baby-boomer beneficiaries. There are two significant initiatives within Medicare in the Recovery Era that impact CBHO financing. Medicare Part D, the prescription drug benefit, was initiated in 2003 in the Bush Administration's Medicare Modernization Act. This benefit was added in order to provide financial relief for Medicare recipients who had high costs for medication. Medicare beneficiaries that choose to participate select a plan from among a variety of prescription benefit plans that compete for enrollees. The programs establish competitive premiums and a competitive formulary to attract beneficiaries. Because of the provision that Medicaid must be the payer of last resort, all adults who are dually eligible must obtain medication through a Medicare D plan and not Medicaid. With the Medicare D plan, the pharmaceutical cost incurred by dually eligible individuals has shifted from Medicaid to Medicare. Some CBHOs provide psychiatric medications to patients and are at risk for the costs. The increased complexity in using the Medicare D benefit for psychiatric medications is difficult for many and often requires CBHO staff time to facilitate access to medications.

The second major initiative within Medicare in the recovery era that impacts CBHO financing is the range of demonstration financing models, as discussed earlier in association with the ACA. There is a general trend toward bundled payment plans and away from simple independent FFS payments.

Although the Mental Health Block Grant overall is currently not a large funding component for CBHO services, the Substance Abuse Prevention and Treatment Block Grant or SAPTBG does provide substantial dollars to substance use disorder treatment providers. CBHOs may or may not provide Mental health and substance abuse services. In 2011, the federal Substance Abuse and Mental Health Services Administration, the agency that administers these two block grants, announced its intention to merge these grants into one. Highly expanded block granting continues to be debated in policy and political circles. As recently as with the George W. Bush administration's Fiscal Year 2005 budget (Finegold 2004), and again in the congressional budget hearings for the FY 2011 federal budget, the proposal to allow states to convert their entire current Medicaid program into a block grant program was proposed. The advantage to a state would be increased flexibility of states to manage all funds because a state would no longer have to meet federal Medicaid requirements. However, the block grant design would effectively eliminate the legal entitlement that eligible individuals have with Medicaid services. With conversion of the entire Medicaid system as it is known now to a block grant

mechanism, governments, including federal and state, would have increased ability to control and predict costs. Given the predominance of Medicaid in financing CBHO services, any changes to Medicaid would have tremendous impact on CBHOs.

Another distinct method of financing services that has been used is service user *self management* or *self-directed care* (Alakeson 2008). In these arrangements, service users may be given an allowance to purchase their healthcare needs, choosing the provider who offers the best services or the types of services desired. In some arrangements, a person may choose alternatives to traditional services such as the payment of fees to participate in a community weight management program in lieu of an ongoing support group at a CBHO. This arrangement often offers consumers choices that they otherwise could not afford.

Conclusion and Summary

The funding of contemporary community mental health services is complex. It is comprised of multiple sources with different rules that render the funding mechanisms difficult to sort out at the clinical level in a CBHO. Mental health services have played a significant medical, humanitarian, and public safety role in American communities for well over 200 years in American history. Over time, funding sources for services have shifted from predominantly local government to state government and now more to our federal government. Too often, funding is seen as a barrier to the provision of ideal services to individuals with serious mental illnesses. It is critical for community psychiatrists to have a basic understanding of the major categories of funding and the general rules that govern access to these funds. Whether in CBHOs leadership positions or as line clinicians, having this understanding is a requirement to effectively advocate within systems for patients—both on individual and population-based scales. The basic information on funding sources in this chapter is intended to provide a background and orientation to help develop further understanding and utility of funding at the service level.

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