MENTAL HEALTH POLICY IN THE UNITED STATES

BEHAVIORAL HEALTH FINANCE IN THE UNITED STATES

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Abstract: This lecture provides an overview of behavioral health finance in the United States including behavioral health spending and sources of funding. Spending patterns, I note, have changed considerably as fundamental policy has shifted from institution to community-based. Funding sources have also changed. There is still a mix of public and private sources, but the public share has grown considerably. Within the public share, the federal share has grown to exceed state and local shares. This reflects very substantial growth of Medicaid spending on behavioral health, as well as some growth of Medicare spending.

This lecture also provides an overview of the issue of “parity”, which was arguably the major advocacy issue regarding finance over the past quarter century.

The lecture also provides an overview of “cost containment”, i.e., of efforts to limit the rapid growth of health and behavioral health expenditures. These efforts include “certification of need”, the development of rate-setting methodologies, the use of payment mechanisms that create incentives to provide medically necessary care while holding down expenditures, preferred drug programs, and managed care.

During my discussion of financing, I note some thorny policy issues. At the end of the lecture, I note what I think are the major policy issues regarding behavioral health finance today.

Let me begin with the obvious, without money there would be no behavioral health services.

There are two corollaries:

1. To know what behavioral health—or any policy—is in reality rather than just in rhetoric, you have to know what is funded and how much funding is provided. Crudely stated, policy makers—especially politicians—often do not put their money where their mouths are. Follow the money to know the real policy.

2. When developing policy, you must figure out how to fund it. This includes determining:

    - How much funding is needed

    - Where the funding should come from

        - Private or public sectors or both
        - Federal, state, or local governments
        - If Federal--Medicaid, Medicare, Block Grant, etc.
        - If State—direct funding of services by the state or transfer of state funds to localities
        - Operating or capital budgets

- What revenues, taxes, or rearrangement of current funds (often called "**reinvestment**") will support it

- How the money will be distributed

- What payment mechanisms will be used

- And much, much more.

This is all incredibly complex. And, in what follows, I will only be able to provide some fundamental facts and give a sense of how behavioral health financing works (or fails to work). I will touch on behavioral health spending and sources of funding. I will also provide an overview of "cost containment", i.e., of efforts to limit, the rapid growth of health and behavioral health expenditures. And I will comment here and there about some of the many, many, thorny financing policy issues that behavioral health policy makers and advocates have to deal with constantly.

BEHAVIORAL HEALTH SPENDING

How Much Is Spent On Behavioral Health Services?

Although most behavioral health advocates believe that funding for mental and substance abuse services in the United States falls far short of the need, the fact of the matter is that a lot of money is spent on behavioral health. One estimate puts it at $225 billion for 2020.[1] Another projection puts it at about $280 billion.[2] For purposes of this lecture, I'll split the difference and say it was about $250 billion in 2020 and more now.

Obviously, that's a lot of money, but actually it's only 6% of all spending on health care, which is in the vicinity of $4 trillion per year.[3]

Policy Issue: Is it necessary to increase spending for behavioral health services in order to meet the need, as most behavioral health advocates maintain, or would it be possible to meet the need by re-arranging what is currently spent on people with behavioral health conditions including spending in the physical health care and criminal justice systems?

Because estimates of behavioral health spending are based only on the data included in the National Health Expenditure Accounts, it is certainly an underestimate of total spending on behavioral health services.* Very importantly, it does not include spending for direct mental health or substance use services in the human services sector outside the health system—in child welfare, homeless housing, aging services, criminal justice, etc. It also does not include funding for workplace services such as employee assistance, disability management, and wellness programs. And estimates generally do not include several conditions that arguably should be regarded as mental conditions, such as dementia and developmental disabilities.**

In addition, official estimates of spending on behavioral health conditions do not include the costs of the treatment of the medical conditions that people with mental or substance use disorders have. This population has higher risks of health conditions such as obesity, diabetes, heart disease, sexually transmitted diseases, AIDS, injuries due to violence and living in dangerous environments, etc. And their conditions are generally more severe by the time they get treatment because they are likely not to seek or get access to treatment early on. It is the costs of treating these physical health conditions, not the costs of the treatment of their behavioral health conditions, that make this population a major driver of America's very high health care costs.[4]

One further note. To know the total costs of mental and substance use disorders to the American society, we would also need to include the cost of lost productivity, which has been estimated to be at least $200 billion per year[5]—a significant underestimate in my view.

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* Reliance on the National Health Expenditure Accounts to determine how much is spent, I think, buys into the erroneous view that behavioral health policy is a subset of health policy rather than an amalgam of social welfare, criminal justice, and health policy. It also reflects acceptance of conceptual divisions between behavioral and physical health that are used now but have been different in the past and, I hope, will be different in the future.

** There are studies that include dementia as a mental condition. For example, Roerig, C. (2016). "Mental Disorders Top The List Of The Most Costly Conditions in the United States" in *Health Affairs*, June 2016.

Components of Behavioral Health Spending (See Appendix One)

By definition, behavioral health funding is used for both mental health and substance use disorders. It pays for direct service, pharmaceuticals, administration, research, training, public health/preventive interventions, equipment, and facilities. Some is for inpatient services, some for outpatient or for community services. Some is for hospitals, some for community organizations, and some for "physicians".*

In 2015, hospitals and pharmaceuticals each got about 25% of total funding for behavioral health services. Community organizations and professionals each got roughly 15%.

The cost of insurance administration was only about 8% in 2015. That's surprising, given that insurance companies get 15% or more for administration and profits. The reason that it's so low overall is that the cost of administering government insurance is exceedingly low, (2-3%).

Policy Issue: Should there be for-profit insurance companies? If so, should their profits and management costs be capped at a reasonable level? What is a reasonable profit margin for health insurance?

Changes in Behavioral Health Spending

Over the years, the use of funds for behavioral health has varied with changes in policy and practice. For example, the proportion of spending that goes for inpatient services has decreased dramatically over the past half century, and more is now spent on outpatient services than inpatient. When I began working as an advocate about 45 years ago, inpatient services, we said, consumed 75% of mental health funding.** Now it is under 20%.

Policy Issue: Some mental health advocates argue that too little is now spent on inpatient services. Others argue that inpatient spending could be almost totally eliminated if funds "wasted" in hospitals were reinvested in the expansion of community services.

* In Medicare, the term "physicians" includes nurse practitioners and psychologists as well as MDs but does not include social workers or counselors unless they are under the supervision of a "physician".

** 75% is arguable. My personal estimate at the time was closer to 50-50. But advocates often use numbers that make their case whether they are accurate or not. That's one reason why most public officials do not trust numbers developed by advocates.

In addition, there has been increased spending for mental health services provided by primary care physicians, who increasingly are the resource of first resort for people with behavioral health problems.

Spending on pharmaceuticals[*], which is now more than 25% of all mental health spending, has also grown considerably.

In 2015,[6] spending on mental health services was far larger than spending on substance use services—roughly 75% vs. 25%. But spending on substance use disorders has probably been growing faster than spending on mental health, because of increasing alarm about the opioid epidemic and drug overdose deaths and because substance misuse is increasingly regarded as a disease, for which treatment is the appropriate response.

Of course, these numbers are from 2015. As I am writing this, more recent numbers are not available that I know of. So, our knowledge of how much is spent and on what is really quite limited.

The Behavioral Health "Industry"

What we do know is that a lot of money is spent on behavioral health services. From an economic—and political—point of view, behavioral health care is a huge industry.

To say that it is an "industry" is not to disparage it, but simply to acknowledge that there's a lot of money involved in the benevolent effort to provide care for people. As a result, **the usual human motivations that arise when money is at stake play a very significant part in the decisions that are made about what services to provide, who should provide them, etc.**

And it is important for **behavioral health advocates to understand that politicians regard them as lobbyists for their industry.** Yes, there is some respect for us as having some motivation that is not self-interested. But in the end, we are just more people asking the government to give us more money. The case we make that may seem to us to be morally compelling is generally not seen that way by elected officials.

Sources of Behavioral Health Funding: Public and Private

As I noted in the lecture on the roles of government, the financial responsibility of government for behavioral health services is a matter of debate. Currently, behavioral health funding in the United States is a mix of public and private funds—roughly 55/45 as of 2015—and projected to have

[*] Recently, the proportion of spending on pharmaceuticals declined from about 33% to 27% because of the expiration of patents for major drugs.

been 65/35 in 2020.[7]

Policy Issue: Advocates for "Medicare for all" and similar government-based universal health insurance maintain that all private spending for health and behavioral health services should be replaced with public funding. Others argue that this is not affordable and that eliminating the private sector of health care would (1) close off rightful access to some medical services that some people prefer and are willing to pay for and (2) limit innovation.

Governmental Funding

Recently, government funding has increased as a proportion of behavioral health spending, and federal spending has increased as a proportion of governmental funding, outstripping state and local spending just a few years ago. This largely reflects the gradual growth of Medicaid and Medicare spending on behavioral health. Currently Medicaid is about 25% of all behavioral health spending; Medicare covers about 15%.

Over the past 15 years or so, the growth of federal funding reflects changes in Medicaid and Medicare, of course. But to some extent it also reflects the increase in governmental funding to make up for losses of employer-based health insurance during the Great Recession of 2008.[8, 9] And it reflects the growth of emergency federal funding during the pandemic.[10]

Policy Issue: Does the growth of federal funding for behavioral health vis a vis state and local funding reflect progress regarding acceptance of a national responsibility for behavioral health or does it reflect a dangerous drift away (1) from the tradition of separating federal and state responsibilities and (2) from funding priorities that reflect state and local circumstances?

The dominance of federal spending is a very important development because of the shifting locus of control (1) from state to federal government and (2) from state mental health agencies to the state agencies that are responsible for Medicaid. In NYS, that is the Department of Health. This shift in power often results in tension between the state department responsible for Medicaid and the state department(s) responsible for mental health and substance abuse services. It has also resulted in great frustration on the part of directors/commissioners of state mental health and substance abuse agencies, who have much less control than they did when most funding for behavioral health came from the states.[11]

In addition to Medicaid and Medicare, there are other sources of federal funds for behavioral health, much of it targeted to specific populations and programs. The Mental Health and Substance Abuse Block Grants, which allow states to set their own funding priorities, are often noted as if they are major sources of funding. But in truth they are a relatively small portion of overall spending on behavioral health in the United States. The Mental Health Block grant request for 2023 is $1.7 billion—about 1% of all mental health funding. The Substance Abuse Block grant is about $3.0 billion, less than 5% of all substance abuse funding.[12]

> Policy Issue: Should the mental health and substance use block grants grow and replace more and more of the federal targeted funding so as to give more autonomy and control to state governments?

Medicaid [13]

As noted above, Medicaid is the largest source of funding for behavioral health services. It is health insurance primarily for people who are poor.

The Medicaid law provides for the federal government to pay a share of the health and behavioral health costs of the covered population in states that **choose** to provide Medicaid benefits. Currently all states provide Medicaid but not all states provide all of the options available for federal cost sharing, known as "federal financial participation" (FFP). Historically, for example, some have not used the "rehabilitation option". [14]

> Policy Issue: Should states be required to provide Medicaid? The Affordable Care Act did this, but the Supreme Court ruled that that violated the essence of the federal Medicaid law, which created options, not mandates, for the states.

Medicaid is administered by federal, state, and local governments; and it is funded by federal and state governments for the most part. In some states, **such as New York, there is a local share for some parts of Medicaid.** The federal share of Medicaid expenses varies from state to state and in other ways, but it is at least 50%.

> Policy Issue: What should the state and federal shares of Medicaid be? Should it be the same for every state or vary depending on the relative affluence of the state? Should there be different shares for different populations? For example, should there be a larger federal share for treatment of people with serious and persistent mental illness?

Currently, Medicaid is an **entitlement**, which means that it is "open-ended" funding. Open-ended funding requires payment to an authorized provider for medically necessary services for a person eligible for Medicaid even if it exceeds the federal, state, or local budget for annual Medicaid costs.

Policy Issue: Do open-ended entitlements result in excessive spending? Should there be an annual limit on Medicaid and Medicare spending? Should they become block grants rather than entitlements?

Medicaid does not cover all types of services for people with behavioral health disorders. For example, it limits coverage of services outside of established offices, in homes or community settings. It also limited coverage of tele-mental health services prior to the pandemic and may again after the official pandemic emergency is over.

Policy Issue: Should Medicaid expand coverage to include outreach, offsite, and tele-mental health services? Should there be any restrictions?

One of the most controversial restrictions of Medicaid is known as the "IMD exclusion", according to which the federal government will not share the costs of care for adults 22-64 in "institutions for the mentally diseased". This provision was included in Medicaid so as to maintain the American tradition that the states and not the federal government are responsible for care of people with severe psychiatric disabilities. It also holds down the federal cost for Medicaid. And, very importantly, it is a powerful incentive for states to get patients out of state hospitals/asylums.

Policy Issue: Should the IMD exclusion be loosened or even eliminated? Those who believe that deinstitutionalization has gone too far tend to favor modifying the exclusion so as to provide federal support for long-term psychiatric treatment in institutions. Those who support growth of community services instead of expanding inpatient care tend to argue for retaining the IMD.

As previously noted, both Medicare and Medicaid have increased over the years, in part because the Affordable Care Act (ACA)[15] significantly increased eligibility for Medicaid. The ACA is often referred to as "Obamacare", and Republicans have opposed it from the beginning. During the Trump administration, they attempted to repeal the ACA and to convert Medicaid from an entitlement to a block grant*. Had they succeeded, there would

* Republicans have argued that Medicaid should become a federal block grant to the states, which would give the states greater flexibility to devise their own programs and would cap

have been a loss of health coverage for about 30 million people and a loss of mental health coverage for as many as 60 million people.[16] As it is, the Supreme Court ruling that the mandates included in the Affordable Care Act (ACA) for states to expand Medicaid coverage and for individuals to have coverage are unconstitutional resulted in loss of coverage for more than 10 million people.

In addition to recent efforts to repeal the ACA and to end Medicaid as an entitlement, many efforts have been made over the years by both political parties to control Medicaid costs. Some of these proposals have failed politically, but quite a number of controls have been introduced. They have probably slowed the growth of Medicaid spending, but they certainly have not stopped it. As a result, there has been a strong sense among elected officials that Medicaid spending is out of control. And each year further efforts are made to limit Medicaid spending on behavioral health. I discuss these later in the section on cost containment.

Even though most funding for Medicaid is federal and there are a great many federal regulatory requirements, Medicaid spending plans are developed by the states drawing from various options open to the states under federal law and regulation. State plans are subject to federal approval.

States develop laws, regulations, and plans that determine the specifics about:

- Eligibility for Medicaid
- Types of services reimbursable by Medicaid
- Licensing and authorization of providers to receive Medicaid
- New program development
- Amounts to be paid
- Methods of payment
- And more.

States can apply for waivers of Federal law on the grounds that waiving certain federal requirements can improve care and coverage without increasing cost.

All this means that states play a huge role in Medicaid spending.

Policy Issue: Is the balance of state and federal authority regarding Medicaid appropriate or should there be substantially greater state or federal control?

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federal financial participation. President Reagan tried, and failed, to do this, largely because of very aggressive advocacy to retain Medicaid as an entitlement.

Medicare [17]

Medicare is health insurance for people (1) who are 65 or older (2) who are disabled but have a work history and are eligible for Social Security Disability Insurance (SSDI), (3) who are adults who developed a disability prior to becoming adults and whose parent(s) have a qualifying work history, **or** (4) who have end-stage renal disease.[*] Unlike Medicaid—which is means tested—Medicare eligibility does not depend on income or wealth.

Policy Issue: Should eligibility for Medicare be expanded to include some middle-aged people? 55? 50? Should it replace all other forms of health insurance? I.e., should there be "Medicare-for-all"?

Medicare is administered and funded by the federal government with some funding from those who are covered via premiums and co-pays.

Policy Issue: Should Medicare beneficiaries by required to pay premiums and co-pays or should Medicare be free to everyone? Free to those who are poor? Free for people with some conditions but not others?

Like Medicaid, Medicare is an entitlement.

Medicare is divided into four parts—A, B, C, and D. Roughly speaking, Part A covers the cost of hospitalization including psychiatric hospitalization up to a lifetime limit. It also covers a very limited amount of nursing home care. Beneficiaries do not pay a premium for Part A.

Policy Issue: Should Medicare cover long-term care in nursing homes, in assisted living facilities, and in the home?

Part B, roughly speaking, covers physicians' services including some mental health services. Beneficiaries pay a premium for the coverage, and there is a co-pay of 20% of a maximum fee set by Medicare. Until a few years ago, the co-pay for mental health services was 50%. This led to an advocacy campaign for "**parity**", i.e., for equal co-pays for mental and physical health services.

[*] These are somewhat imprecise statements of eligibility for Medicaid and Medicare. See Original Medicare (Part A and B) Eligibility and Enrollment | CMS

Part C is an "HMO" option generally known as "Medicare Advantage". This option can be used instead of Parts A, B, and D and considerably lowers consumer costs. Consumers can choose from a variety of plans that comply with very complex federal standards. Because Medicare Advantage plans also require use of network providers, a major concern to many people on Medicare, most of them opt for the more expensive alternatives. (There has been growth of the use of Medicare Advantage since the pandemic.)

Policy Issue: Should Medicare Advantage replace the original Medicare provisions so as to achieve substantial cost savings?

Part D of Medicare, which was added during the George W. Bush administration roughly 40 years after the creation of Medicare, covers prescription medications. It is administered and partially funded by the federal government. It is largely funded by premiums paid by consumers who can choose among many different plans operated mostly by for-profit insurance companies. As far as I know, all Part D drug plans use some form of preferred drug program to control costs. Originally, some psychiatric medications were not covered; now most are, though at varying prices depending on the plan.

Policy Issue: Should Medicare Part D plans all use "preferred drug programs"? For all drugs? For psychiatric drugs? Should some or all Part D plans be operated by the government instead of private, for-profit insurance companies? Should there be one and only one Part D plan?

People who use traditional Medicare, i.e., Parts A and B but not C, can purchase supplemental insurance ("Medigap") to cover co-pays.

Unlike Medicaid, which has become more flexible over the years, Medicare has stuck more rigidly with the medical model, making it less useful for people with serious and persistent mental illness and for those with substance use disorders.

Policy Issue: Should Medicare cover only medical services, including psychiatric services, or should it also cover services such as care management, rehabilitation, housing, and long-term care that are often essential for people with serious behavioral health conditions?

Because of Medicare restrictions, many people eligible for Medicare due to psychiatric disabilities also need Medicaid coverage. Perhaps 50% of this population are known as "**dual-eligibles**" because they have both Medicare and Medicaid. This has been an obstacle to developing Medicaid managed

care for people with serious and persistent mental illness because so many of them receive SSDI and therefore are covered by Medicare.

Medicare rules are federal with some regional variations. Unlike Medicaid, the states play no role in making rules for Medicare.

Although there has been no effort yet to end Medicare as an entitlement, the Center for Medicaid and Medicare Services of HHS works to control Medicare costs via tight rate setting, the use of "value-based" payment methodologies, and other means. Some very conservative Republicans mutter about the possibility of privatizing Medicare. Ominous talk. Fortunately, so far it is politically fatal.

The Private Sector

35-40% of all behavioral health funding is private. This includes employer-based insurance, personally purchased insurance, personal payment for behavioral health services, and philanthropy.

Private Health Insurance:

Much of the behavioral health funding from the private sector comes from commercial insurance, mostly employer-based; in 2015 it was nearly 30% of all behavioral health funding.

> Policy Issue: Should employers be required to provide health insurance including coverage of behavioral health conditions? If so, how extensive should the required coverage be?

Over the years, there have been major battles regarding coverage of behavioral health services in private insurance plans. Professional providers and many consumer organizations have advocated for full coverage of behavioral health conditions. But insurance companies and the businesses that purchase insurance from them have been reluctant to open the spigot fully and have imposed a variety of controls including only covering medically diagnosable conditions, placing a limit on the number of outpatient visits or days of inpatient care that they will cover annually and over the lifetime of the covered person ("caps"), limiting the fee that will be paid, using utilization review to determine whether care is medically necessary, establishing hefty co-pays to discourage people with coverage from using it, and more.

Workplace

In addition to paying for employer-based health insurance, most large

employers and some small employers provide employee assistance programs, disability management, and wellness programs. I do not know the cost of these programs nationally; but it is substantial, and it is growing.[18]

Self-Pay ("out of pocket")

Because some people have no or inadequate health insurance or no or inadequate behavioral health coverage, people pay a substantial amount personally for behavioral health services. Some of it is for deductibles, some for co-pays, some for uncovered portions of charges, and some of it to cover total charges. Self-pay amounts to about 10% of behavioral health spending.

Other Sources, Especially Philanthropy

4% ($8.5 billion) of all behavioral health spending in 2015 came from "other" sources. Most of this is probably philanthropic funding. This is not a very significant portion of spending on behavioral health, but it has considerable impact because it can be used for innovation, quality, and survival at the margins not to mention good publicity.

Parity

Funders in both the public and the private sectors have funded physical and behavioral health services differently. Many employer-based and commercial health insurance plans initially did not cover behavioral health at all or only covered inpatient and not outpatient care. Over time plans emerged that covered both inpatient and outpatient treatment but set greater restrictions on behavioral health than on physical health coverage. Typically, this included higher deductibles and co-pays (typically 50% vs. 20%) for behavioral health as well as low maximum fees, caps on numbers of outpatient visits per year, and low annual and lifetime caps on spending.

Behavioral health advocates perceived the differences between coverage for physical and behavioral health as **unjust disparities** and **as barriers to treatment**. And the goal of **parity** became arguably the major behavioral health advocacy issue of the past quarter century. The concept applied primarily to public and private health insurance, but it extended as well to complaints about the overall underfunding of behavioral health service and research.

There have been 3 basic approaches to gaining parity—federal mandates, state mandates, and voluntary behavioral health coverage by employers and

insurance companies.[*] All have been successful to some extent. Most states have parity laws. The federal government adopted the principle of parity for its own employee benefit health plans during the Clinton Administration. And several federal laws were passed that gradually applied the principle of parity to Medicare, to the plans sold through the Affordable Care Act, and more. Remarkably, some of the largest and most progressive corporate employers also adopted the principle of parity as more and more of them realized that mental illness and substance use disorders had a terrible impact on productivity and also drove up recruitment, training, and physical health insurance costs.

Currently the most commonly noted live issue about parity is the alleged failure to enforce parity requirements.

Although parity remains a top priority for behavioral health advocates from the provider community, it is not clear that parity provisions have resulted in increased access to treatment. For example, a study of the outcome of mandating parity for coverage of federal employees that compared changes in utilization of behavioral health services with and without parity showed virtually no difference[19]. It appears that, because parity always comes with managed behavioral health care, increased use of services due to lower out-of-pocket costs via parity is tempered by more limited access due to managed care. In addition, it may be that parity is of greater benefit to providers than to the people they serve. It does result in higher fees and more income for providers, but whether it results in more people getting services is open to question.

Policy Issue: Parity remains high on the behavioral health advocacy agenda after several decades of legislative progress. Should it continue to be a major priority for advocacy?

Cost Containment [**]

The advent of Medicare and Medicaid and the growth of behavioral health coverage in commercial health insurance plans fueled considerable growth in health spending. Some of it was due to providing more services for more people. Some has been due to increased labor costs.[***] Some of it has

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[*] David Mechanic's chapter on mental health finance includes good information about federal and state laws. NAMI-NYC's web site has good information about the effort to win voluntary coverage.

[**] Cost containment does not mean reducing healthcare costs; it means holding down their rate of growth.

[***] The effort to hold down labor costs is a two-edged sword. On the one hand it helps to contain overall health care costs. On the other hand, the health care industry has been a

been due to increased use of costly, high tech equipment, some to renovation and construction of new health facilities. And some of it has been due to the increasing prices that health care providers and drug companies charged.

Not surprisingly, governments, insurance companies, and employers, which pay for physical and behavioral health care, have sought ways to control their costs and to get what they pay for.

These efforts are referred to as "cost containment". They include:

- **Control of program and facility expansion and modernization** ("certification of need")
- **Rate-setting** by the payers rather than allowing providers to set their own prices
- Using **payment methods** that create incentives not to provide unnecessary care
- **Preferred drug programs** to induce drug companies to lower the costs of some drugs and to provide incentives to patients to use less expensive drugs
- **Managed care, including behavioral managed care,** to control utilization and assure that people get only services that are medically necessary.

Certification of Need [20]

Roughly ten years after the advent of Medicare and Medicaid, federal and state governments became alarmed about the growing cost of health care in the United States. Organizations often established new and expanded services, bought new expensive high tech equipment, and renovated or built new facilities. The cost of expansion was increasingly borne by Medicaid and Medicare. To limit expansion, reginal and state Health Systems Agencies were established that made determinations about the need for expansion. And a process known as "certification of need" was put in place to avert spending that was not needed such as hospitals that wanted to install high tech equipment that was available and under-used in other facilities. Organizations that want to start new programs, to expand, renovate, etc. generally need to get permission to do so. They are required to file an application with the state in which the program will be located. Applicants must make a convincing case that the new or expanded services are needed, that the program will be financially viable, that it will be operated by competent people, that it will comply with state licensing regulations, and

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very large source of new jobs in the American economy, contributing considerably to the recovery from the last recession and to the growth in jobs as the economy has rebounded from the pandemic.

that the "owners" or members of the boards of directors are honest, trustworthy, and competent.

During the Reagan years and as Republicans became governors, a preference for market-based planning emerged, resulting in less rigorous certification of need programs in some states.

Policy Issue: Should government have substantial control of changes in service programs and facilities, or should providers be relatively free to make changes at their own risk as most businesses are?

Rate Setting

Beginning in the 1970s, governments and insurance companies moved to place limits on the prices health care providers could charge. The basic approach was to set rates that would be covered by Medicaid, Medicare, or commercial insurance.

Governmental rates are required by law to be reasonably related to cost. One way to set cost-related rates is with "prospective" rate methodologies that use past ("historical") costs to project future costs and to set limits on payments based on the operating costs of similar facilities in similar regions. This is extremely complicated and was pursued in different states in different ways. For example, in most states different payers pay different rates, while in some states—Maryland, for example—there are "all-payer" rates for hospitals.

Policy Issue: Should governments and insurance companies control what providers can charge? Is price control legitimate in health care?

Preferred Drug Programs (PDPs)

Because in the United States drug costs are extremely high, federal and state governments and insurance companies sought ways to control drug. The primary method has been "preferred drug programs". In Medicaid the states will only pay for the use of certain, preferred, drugs, for which drug companies have set reasonable prices. All Medicaid PDPs provide for exceptions on the basis of medical need. There are huge debates about what the exceptions should be. For Medicare and commercial plans, preferred drug programs usually have "tiered" co-payments, which are lower for generic and preferred drugs and much higher for brand name and other drugs chosen by patients and their doctors despite the costs. Recently (in June 2022), a big step has been taken to control drug prices. A law was

passed that will allow Medicare to negotiate prices with drug companies.

> Policy Issue: Should governments and insurance companies be allowed to require the use of certain drugs if doctors and their patients prefer to use different drugs? I.e., do PDPs violate important principles of professional autonomy, patient choice, and the privacy of the doctor-patient relationship? Drug companies and many consumer advocates argue that the selection of drugs should be left to doctors and their patients and that treatment decisions should not be made by bureaucrats. Payers argue that this would give carte blanche to the drug companies to set outrageous prices.

Payment Methods

One of the major efforts to contain costs has focused on payment methods and the incentives they create.[*]

Fee-for Service is the most fundamental and common form of payment. A payment is made for a specific service such as an office visit, a psychotherapy session, an evaluation, a medication management visit, a day in the hospital, etc.

A fee-for-service system creates an economic incentive to provide more services because the more services you provide, the more you get paid. This can be achieved by increasing the number of people you provide services for or by increasing the number of services you provide for each service recipient. Higher income can also be achieved by providing services that have higher fees.

The expectation that providers will seek to maximize their income has led to a perception among health economists that the fee-for-service system is largely responsible for the high cost of health care in America and that it leads to too much testing and treatment and to pricing that is excessive but benefits providers economically.[*]

To counter this, payers have set limits on rates, established standards of "medical necessity", and pay only for services that are medically necessary. Payers have also set up various auditing procedures, called "utilization

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[*] A fundamental assumption of health economics is that people act to maximize their own economic benefits, and that those who get paid for providing services will alter their behavior to make more money.

[*] There is reason to believe that the primary reason for higher medical spending in the US is not how much service is provided but the price of services. Anderson G. et al (2003)

review", to make sure that providers are charging only for services that are medically necessary. And they have also established behavioral managed care to pre-certify services and shift incentives in the hopes of holding down utilization, especially of inpatient treatment.

But fee-for-service is not the only form of payment. Case payment and capitation have been used for many years as forms of payment that may hold down costs.

Capitation is payment for taking responsibility for a person's health and/or behavioral health for a specified period of time. The amount that is paid to the provider or to the organization that provides care does not vary with the amount of service that is provided. If, for example, I am covered by a plan or provider getting a capitated rate and I use no service, payment is made anyway. And if I have psychotherapy 4 times a week rather than once, no additional payment is made.

Obviously, this creates **a financial incentive not to provide more treatment than I need**. In fact, some argue that it provides an incentive not to provide treatment that I do need. The counter-argument is that if I am not given treatment that I need, I may get sicker and the costs of caring for me will go up. So, **capitation presumably provides an incentive to keep covered people well**.[**]

Capitation, with a number of alternative names, is the basic funding mechanism for the new Medicaid managed care initiatives.

Case payment creates similar incentives. This is payment for an episode of illness or for a period of treatment. Medicare, for example, pays for inpatient treatment for physical conditions using diagnostic related groups (DRGs). A rate is set for treatment of the episode of illness which does not vary with the length of stay in the hospital. This creates an **incentive to get patients out of the hospital quickly, perhaps too quickly**. Adjustments have been made to this system to counter this incentive. For example, readmissions within 30 days generally will not generate additional payment.

Another example is the funding of community residences in NYS. A monthly rate is paid, but to avoid the incentive to discharge people prematurely, a minimum stay is required. Similarly, payment for case management is generally a monthly rate, but to avoid the possibility that case managers will not see their clients frequently enough, a minimum number of contacts per

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[**] This is based on the assumption that the organization getting a capitated rate will continue to have responsibility for the health care of a covered person well into the future. In fact, however, there is tremendous movement in and out of plans ("churning").

month is required.

Policy Issue: How to balance structural incentives to overserve or to underserve is one of the great constant challenges of behavioral health finance.

Contracts and Grants

Historically, behavioral health organizations that get public funding have had a mix of fee-for-service payments and contracts and grants. A contract (or a grant) specifies services to be provided, populations to be served, the amount of service to be provided over the course of the contract, and how much will be paid. Reports are always required, and audits are common.

Critics of the use of contracts complain that they often do not set or enforce reasonable expectations regarding the amount of service to be delivered, the population to be served, and the beneficial outcomes expected for the population served.[*]

As a result, the concept of "performance-based" contracts emerged some years ago and has been revived in various forms in recent years as "pay for performance", "value-based payments", etc. The central idea is simple. Contracts should specify required outcomes and providers should only be paid if they achieve the required outcomes.

Easier said than done, however. The most important outcomes are clinical, but these are exceedingly hard to track objectively. The easiest outcomes to track are process-outcomes, such as number of people served, number of sessions, and so forth. Quantity rather than quality.

Policy Issue: There is widespread agreement that contracts and grants should have well-defined outcome requirements. How to set and measure reasonable goals is an ongoing challenge.

[*] One form of contract is called a "deficit contract", which got criticized years ago for creating an incentive to run up a deficit. This criticism reflected vast misunderstanding of how deficit contracts actually worked and ruined a system that actually created an incentive to expand outpatient mental health services at a point in history when that was desperately needed. A story for another time.

Behavioral Managed Care

Behavioral managed care emerged in the early 1980s to get control of increased health insurance costs due to growing coverage and use of behavioral health services—especially inpatient services.* Progressive employers understood the importance of addressing mental and substance use disorders and therefore provided coverage for inpatient and often for outpatient treatment. But as claims and costs increased, employers became skeptical about the need for some of the services that they were paying for.

- Did people who were getting treatment have mental and/or substance use disorders or were they merely experiencing normal emotional vicissitudes of human life, often referred to as "problems of living"?
- If a provider said that the patient had a diagnosable disorder, were they correct? Were they being truthful or providing a diagnosis in order to qualify for payment?
- And if there was a disorder, did it disrupt functioning at work and/or at home?
- If treatment was being provided, was it treatment that was likely to be effective or treatment that would go on and on without significant clinical or functional improvement?
- If inpatient treatment was being provided, was it necessary or would outpatient treatment be equally or perhaps more effective?
- Was the price reasonable?

To get answers to these questions, employers and health insurance companies decided that it would be useful to have professional 3rd parties between the payers and the providers. They would determine whether care was **medically necessary**, whether it was the best possible treatment in the least restrictive setting, and whether the price was reasonable. Various utilization review measures emerged. They were the origins of behavioral

* Several accounts of managed care trace it back to the passage of the Health Maintenance Organization Act of 1973. Arguable but perhaps reasonable—for physical health. Managed care specifically for mental health and substance abuse began later and initially used utilization management rather than capitation as the primary mechanism to control costs. Capitation came to behavioral managed care later in its history.

managed care.

Policy Issues: Should health insurance for behavioral health conditions cover only people with diagnosable disorders or should it also cover people with emotional distress that does not meet criteria for mental or substance use disorders? Should behavioral health insurance only cover medically necessary services, or should it also cover socially necessary services such as housing? Should utilization review in which professional judgments are second-guessed by people who may or may not have professional training be used to limit access to treatment? Etc.

In the beginning, managed care functioned as an alternative to arbitrary caps that were built into behavioral health insurance plans. 20 outpatient sessions per year, 50% coverage instead of 80% for physical health services up to a maximum session fee that was well below ordinary charges, 30 days inpatient per year, lifetime as well as annual caps—these were all common features of behavioral health insurance coverage prior to managed care.

The problem, of course, was that arbitrary limits resulted in denying people care that they actually needed. In contrast, **the goal of managed care is twofold—to assure that people get the care they need and do not get care that is not medically necessary.**

For example, in the early 1980s I helped to establish a behavioral managed care company as a for-profit subsidiary of a not-for-profit mental health agency. The arrangement we made with an employer and its insurance company suspended all caps with the understanding that we would only use mental health providers who specialized in short-term treatment and who would do everything possible to avert hospitalization. **In our first year, there were no hospitalizations**.

We were not alone. Virtually all behavioral managed care organizations had great success in reducing inpatient utilization. This spurred expansion of managed care, and it is now used by virtually all health plans.

Unfortunately, as competition between managed care organizations became fierce, they began to promise to hold costs below the old caps. Many critics characterize this as a shift from managed care to "managed costs" and attack the managed care companies for greedily placing profit above quality care.

Perhaps this is a fair criticism, but managed care companies did far more than providers did to track the outcomes of treatment. Their findings suggest that managed care was certainly no worse than unmanaged care—no more suicides, for example. And it may be that managed care had better outcomes because managed care organizations developed a variety of ways to improve standard treatment via clinical guidelines and the monitoring of outcomes.

Providers have continued to attack managed care as venal, low quality, and dangerous. But to the best of my knowledge, there is little if any evidence to support their angry claims.

During the 1990s, a major shift took place in how behavioral managed care companies were paid—**from an administrative fee to risk sharing**. That is, insurance companies/employers entered into contracts with managed care organizations that included funds to pay for services as well as for care management. This vastly reduced financial risk for employers and their insurance companies, and it created a very powerful incentive for managed care companies to hold down costs.

Policy Issue: Does risk sharing by payers and care managers create an excessive incentive to hold down costs without adequate concern about quality of care and outcomes? What performance standards should be set for behavioral managed care organizations in risk sharing arrangements?

Medicaid Managed Care

By the late 1980s, state governments frustrated with their unsuccessful efforts to visibly slow the growth of Medicaid became infatuated with the apparent success of commercial managed care in holding down both physical and behavioral health care costs. They, therefore, created Medicaid managed care.

For example, New York State created Prepaid Health Systems Plans (PHSP).[*] These plans were paid a capitated rate to manage and pay for physical and behavioral health care for people eligible for Medicaid who enrolled in their plans. After debate about whether behavioral health services should be "carved in" or "carved out" of the basic health coverage plan, coverage of

[*] PHSPs are a form of HMO, which were increasingly seen at the time as the solution for an American Health system characterized by high cost and poor health status.

behavioral health in basic plans was limited to people who were **not** seriously and persistently mentally ill or addicted. Populations with severe, long-term behavioral health disorders were to be covered by "special needs plans" because the services they needed were vastly more complex than office-based outpatient treatment or short-term inpatient care.

The Special Needs Plan for SPMI never got off the ground in NYS. There were very interesting reasons why. Most notably, a great many people with serious and persistent mental illness turned out to be on both Medicaid and Medicare ("dual-eligibles"), a complication that federal and state bureaucracies could not handle. In addition, the technicians who devised the plan came up with capitation rates that made absolutely no sense on their face because they were lower than costs five years earlier. And these plans did not address the common co-occurrence of mental and substance use disorders or the physical health needs of the population.

Elsewhere in the United States, complex plans were also devised to cover people with serious and persistent mental illness and/or addiction. Some succeeded, but many did not.

> Policy Issue: Should behavioral managed care be a component of overall health plans so as to encourage integration of physical and behavioral health care and to be able to interchange funds available for both physical and behavioral health care? Or should there be separate managed behavioral health plans for people with long-term mental and/or substance use disorders so as to devise and fund non-traditional services for this population?

Managed Care for High Cost Cases

Research about the causes of the high costs of serving people with serious mental illness revealed that very roughly speaking 20% of the people on Medicaid incurred 80% of the cost. The high-cost patients were almost all people with chronic, co-occurring mental, substance use, and physical disorders. [21] And much of the very high costs were for the treatment and care of chronic physical conditions that were neglected until they became acute and critical.

Ordinary managed behavioral health care is not adequate for this population because it is so heavily focused on controlling utilization and price. For the

people who are at high risk of needing extensive and expensive care what is needed is identification of, and connection with them before that care is necessary. That is, to control costs it is necessary to reach out and find people at high risk, such as homeless people, who are not easy to find before they turn up in emergency rooms. It is also necessary to integrate treatment of mental, substance use, and physical disorders and to provide treatment **before** health deteriorates and results in heavy use of emergency rooms and of inpatient treatment for behavioral and/or physical health conditions.

Current Medicaid managed care plans for people with serious mental illness are all built on that fundamental insight. They vary from state to state, but all are (1) extremely complex risk sharing plans in which people enroll (or are enrolled by mandate) and all (2) provide care managers for outreach, to arrange services, and authorize payment for behavioral and sometimes physical health services.

These systems are known by various names such as Accountable Care Organizations, Health Homes, Person-Centered Medical Homes, Health and Recovery Plans, etc.

Policy Issue: Should behavioral managed care focus on the high risk, high cost populations rather than those people minor and/or short-lived conditions, whose cost of care varies little from the general population? How do service systems need to be changed to reach and serve high risk populations?

Behavioral Health Finance Today

Confused? You should be. Behavioral health financing in the United States is an unholy stew of public and private and of federal, state, and local funds that are used to pay for a very broad array of services—inpatient, outpatient, crisis, rehabilitation, housing, community supports, case/care management, etc.—that are provided through a vast variety of structures. All in all, financing for behavioral health is a chaotic cacophony of conflicting goals, complex payment systems, and desperate measures to gain some control of costs while assuring that people with behavioral health disorders get the services they need.

In addition, despite spending over $250 billion per year on behavioral health services in the United States, 40% or more of people with mental or substance use disorders do not get treatment. This suggests, of course, that a major—I would say **the** major—issue regarding behavioral health finance today is the need for more funding.

Not so long ago, during the Trump administration, the major issue was the threat to cut behavioral health funding.[22] At that time Republicans were making efforts repeal the Affordable Care Act (ACA) and to end Medicaid as entitlement. For the moment, these threats do not exist. But if Republicans regain control of the federal government, they will undoubtedly return.

In the meantime, major financing issues include:

- Increased funding for behavioral health services via

  - Expansion of the number of people covered by Medicaid
  - Expansion of the services covered by Medicare
  - Enforcement of parity requirements
  - Increased federal, state, and local appropriations for behavioral health services
  - Increased employer-based funding for employee assistance services and disability management

- Increased targeted funding for high priority programs and populations

  - Improved psychiatric crisis services including 988, the new emergency call number
  - People at risk of addiction to opioids
  - People at risk of overdose deaths
  - People at risk of suicide
  - People struggling with the psychological fallout of the pandemic, especially adolescents and young adults
  - People who are homeless or incarcerated
  - Increased quantity and improved quality of the workforce
  - Criminal justice reform

- Continued regulatory provisions to require payment for tele-mental health services

- Continued efforts to devise managed financing structures that contribute to increased use and integration of services for the high risk, high cost populations, i.e., those with co-occurring chronic physical, mental, and substance use disorders.

- Enhanced efforts to address social "determinants" (I prefer "drivers") of poor behavioral health such as poverty, racism, and violence

Daunting!!! And it simply isn't possible to achieve everything in one fell swoop. Behavioral health policy, and the funding needed to make it real, proceed incrementally with occasional broad conceptual changes. When it comes to behavioral health, I'm afraid, we are not at a time of revolution.

There are too many other social priorities. But there is much that can be accomplished by plugging away at reconstructing behavior health finance in ways that are more rational and effective than is now the case.

Appendix One

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES SPENDING 2009

SECTOR

	Billions	%
Mental Health	**$147.4**	85.8%
Substance Abuse	**$24.3**	14.2%
Total	**$171.7**	**100.0%**

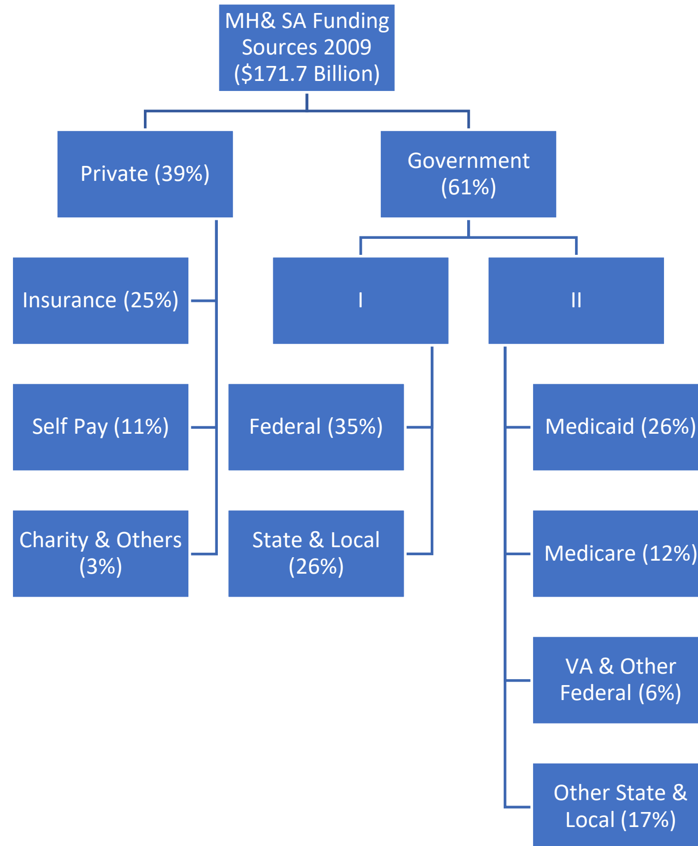
PROVIDER TYPE

	Billions	%
Hospitals	**$45.3**	26.4%
MH and SA Centers	**$32.0**	18.6%
Professionals	**$27.5**	16.0%
Medications	**$42.9**	25.0%
Long-Term Care	**$12.2**	7.1%
Insurance Admin	**$11.8**	6.9%
TOTAL SPENDING	**$171.7**	**100.0%**

SERVICE TYPE

Outpatient	$57.0	33.2%
Inpatient	$30.7	17.9%
Residential	$29.3	17.1%
Pharmacy	$42.3	24.6%
Ins. Admin	$11.8	6.9%
TOTAL SPENDING	**$171.1**	**100%**

Appendix Two



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