Section II: Supporting Good Decision-Making

Chapter 4

Toward a Typology of Behavioral Health Care: Featuring Purchasing, Partitioning, and Risk-Transfer

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Background

Mental health concerns, like general health concerns, are coextensive with life. They therefore are reflected in every significant sector of society: family, workplace, schools, neighborhoods, primary care settings, hospitals, nursing homes, armed services, jails, prisons, and more.

As the U.S. society and its economy evolve, the modes, technology, and mechanisms for delivering behavioral health services adapt and mutate, sometimes slowly, unevenly, and at the margins. Engines of change, both internal and external, include advances in research and treatment, professional and bureaucratic politics, and emerging patterns of new service demand. Over the decades, new delivery models have been invented; sources of financing have broadened; and the roles of government, private markets, and the nonprofit sector have diversified, shifted, and realigned.

In the dynamic interaction of these forces, new demands are placed on public and private policymaking. Decisionmakers must grapple with novel service technologies, new and largely untested models of care, and growing demands for cost control, effective treatment outcomes, better use management, and greater accountability.

Behavioral health care has become more sprawling, variegated, and complex and ever more a part of what the venerable scientist, psychologist, and philosopher William James aptly called "one great blooming, buzzing confusion" (James, 1890).

Behavioral health care is more difficult to monitor, measure, and understand than ever before. Emerging policy interests place new demands on data collection, field surveys, information systems, services research, policy analysis, and other sources of intelligence and advice needed to support timely, informed, and responsible decisionmaking.

Major Trends

Major trends that have contributed to the bewildering complexity include fragmentation, integration, managed care, privatization, and changes in financial management.

Fragmentation. Forty years ago, the Federal government officially set a national goal "to bring the care and treatment of the mentally ill into the mainstream of American medicine." The Surgeon General reiterated this ambition in his 1999 *Mental Health: A Report of the Surgeon General—Executive Summary* (U.S. Department of Health and Human Services, 1999). Despite this bold and salutary goal, however, mental health care has not yet become a full partner in the general health care system, nor has it become more fully integrated internally. Instead, over the intervening four decades, a number of significant service elements were successively factored out of the broader field (Kimmel, 2000):

- In the 1940s, 1950s, and early 1960s, care and treatment was substantially provided in large, isolated, and mainly custodial public State mental hospitals.

- In the mid-1960s, especially with the advent of the Federal Community Mental Health Centers (CMHCs) program, mental health care began to shift to a wide array of intermediate community-based treatment centers and clinics based in both the public and private sectors.

- At the same time, mental retardation service programs were transferred out of the mental health field to specialized community programs. In due time, these programs embraced a broader set of developmental disabilities.

- In the mid-1970s, many alcohol treatment services were moved outside the traditional mental health system. Drug treatment programs soon followed.

- Paralleling these trends, children's services became more specialized in separate programs and settings, many within or linked to the school system.

- Specialized programs for delinquent and violent youth were developed within the juvenile justice system, while those for adult offenders were established in many jails and prisons.

- More recently, care and treatment of dementia, Alzheimer's disease, and related brain and neurological disorders also have evolved in settings outside the usual behavioral health system.

- Finally, growing dissatisfaction with mainstream medical and behavioral health care has stimulated the growth of a multibillion-dollar industry of "alternative" and "complementary" approaches to general and mental health care.

Together, these divergent trends have generated many unconnected bits, pieces, and subsystems of care and have led to the splintering of the overall service system.

Integration. In reaction to, and sometimes intertwined with, these centrifugal forces are a set of opposing and countervailing—centripetal—forces to cope with the constraining, disabling, and costly effects of fragmentation:

- There is growing recognition that the differentiation and separation of treatment for mental disorders, alcohol disorders, and drug disorders has complicated and inhibited adequate and appropriate diagnosis and treatment of very common multiple, or co-occurring, disorders.

- More broadly, research and clinical experience highlight the complex interplay of a range of somatic disorders, such as heart disease, cancer, stroke, and diabetes, with emotional, psychiatric, and behavioral symptoms and disorders. A growing appreciation exists of the need for, and efficacy of, integrated and holistic therapeutic approaches. Many illnesses and disorders are not just psychosomatic but somapsychological as well.

- The stronger, more articulate, and better organized voices of mental health consumers have demanded services that are better integrated, more therapeutically effective, family focused, and logistically manageable within coordinated settings that result in higher levels of customer satisfaction.

- Scientific breakthroughs increasingly stress the role of the brain and central nervous system with their potent neurochemicals, along with the endocrine system, in behavioral disorders. And all this within sight of breathtak-

> ing prospects for better understanding and treatment of diseases and illnesses of all kinds through genome mapping, biochips, gene therapy, and genetic medicine.

Together these convergent developments militate for more integrated, coordinated, and collaborative forms and models of behavioral health care (Kimmel, 2000).

Managed Care. Successive decades of spiraling, out-of-control, double-digit cost escalation spawned the rapid evolution of managed care, designed to curb costs, increase efficiency, manage use, and ensure more effective treatment. This movement led, in turn, to new corporate aggregations of treatment services, new financial management practices, and a change in incentives for sponsors, professionals, providers, and purchasers of care.

The spread of health maintenance organizations (HMOs) and managed care organizations (MCOs) in the general health sector was followed quickly by the spread of behavioral HMOs and behavioral MCOs.

Managed care also amplified the role of primary care providers in behavioral health, placing the primary care physician in the role of "gatekeeper" and agent of cost control. By the mid-1990s, the volume of mental health services provided in offices of primary care had grown to about 50 percent (Regier et al., 1993). Psychological factors appeared in some way in up to 75 to 80 percent of all primary care cases (Blount, 1998).

Managed behavioral care also has stimulated widespread use of new contractual arrangements for the purchase and delivery of both specialized and integrated services. For example, general health plans often purchase specialized mental health services through a "carve-out" from their general health service plan, or they ensure specialized behavioral services within their general plan through a behavioral "carve-in."

Privatization. Privatization of public responsibilities has accelerated as managed care has pervaded both public and private sectors (Donohue and Frank, 2000). Many jurisdictions that previously provided behavioral health care services directly now manage contracts with providers or contract with competing commercial managed care companies to do so. In 1997, 75 percent of the privately insured population received benefits through a managed behavioral health care organization (MBHO) (*Psychiatric Services*, 1997). As of 1999, 41 States and the District of Columbia provided behavioral health care services under managed care arrangements, 29 of which involved a carve-out to a private MBHO (Substance Abuse and Mental Health Services Administration, 2000).

These changes have profoundly affected patient care and altered the delivery system itself. For example, there has been both vertical and horizontal consolidation of providers. The share of psychiatrists practicing in groups has more than doubled since 1990, and practice management companies have arisen to create and manage networks of providers for managed care contracting (Rosenthal, et al., 1999).

Financing. Like lunch, there is no free behavioral health care; costs must be covered by income and revenue. To plumb the question of who is at financial risk for care, it is useful to pursue the dictum "follow the money."

Forty years ago, the overwhelming bulk of services were provided by State mental hospitals publicly financed by tax revenue. Because of narrow benefits in most private health insurance, other mental health services were generally limited to people who could afford traditional fee-for-service care.

With the advent of Medicare and Medicaid in the mid-1960s, the financial base for services for the aged and poor expanded significantly. And government agencies became not only direct providers of service but also common sponsors and major purchasers of contract services from an array of for-profit and not-for-profit providers as well.

The CMHC program precipitated a large number of new, intermediate care providers financed from multiple public and private sources. These providers were joined a decade later by the growth of specialized forms of substance abuse programs also financed from multiple sources.

After decades of discussion, Congress proposed, but has not yet mandated, that coverage of behavioral health in private insurance plans should be brought finally into some parity with coverage of general health.

Powerfully transformed by managed care, these interacting developments created more active concern for ways to identify, monitor, and control the degree of financial risk associated with incurring the costs of service. These new ideas included the use of methodologies to estimate the size of those risks and contractual incentives to control cost and share or transfer financial risk or otherwise stop losses (Ettner and Frank, 1998).

Impact on the Service System. In their total effects, these trends and developments have created a

bewildering array of provider models, service sponsors, contractual arrangements, patterns of fragmentation and integration, and mechanisms for the transfer of financial risk, as well as a long and mixed agenda of current and latent policy issues for the attention of policymakers.

What can be done to organize, rationalize, and focus attention on key variables in this variegated, dynamic, and complex system? How can a laundry list of pressing policy issues be sorted into a meaningful and prioritized agenda for the attention of legislators, mental health officials, managed care executives, researchers, policy analysts, and other stakeholders?

One key approach is to fashion a classification system, or typology, that defines important types, or models, of service for closer examination and analysis and that helps map the overall terrain of the service system.

Toward a Typology of Behavioral Health Care

The goal of a typology is to classify diverse phenomena into meaningful and distinct subgroups. In health services research, "meaningful" subgroups should be predictive of processes and, particularly, outcomes of care. To be useful in a policy context, a typology must be built on consciously selected dimensions of acknowledged concern and significant policy interest. Together, the dimensions define a mutually exclusive set of conceptual types (categories) that exist in the real world.

A typology must define classes broadly enough to generate a manageable number of major types while highlighting the key differences that affect relevant outcomes.

This chapter outlines a major typology of the behavioral health care system. To enhance its utility, drafts of the typology were circulated to a panel of behavioral health experts in both public and private sectors and to a series of focus groups to test the salience and consistency of the constructs employed. Focus group participants represented the views and interests of consumers and families, providers, MCOs, public sponsors, and researchers (Noonan, et al., 2001).

The typology attempts to strike a balance between simplicity and comprehensiveness. It was developed as part of a larger initiative of the Survey and Analysis Branch (SAB) of the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), Department of Health and Human Services (DHHS), to design and implement an integrated information framework for behavioral health care, known as *Decision Support 2000+,* or DS2000+.

DS2000+ incorporates standards for epidemiologic, administrative, clinical, performance, and outcome data in a Web-based information system that will enhance collection, reporting, and use of behavioral health data and thereby contribute to improving the quality of care for people with behavioral health problems (Dewan and Lorenzi, 2000; Henderson, et al., 2001; Minden et al., 2000).

Data requirements and capabilities depend, in part, on the network of organizational and contractual relationships that connect consumers, providers, MCOs, government agencies and programs, and private-sector actors that sponsor behavioral health care benefits. Properly understanding and classifying these arrangements is imperative so the decision support system can interface with them appropriately.

The Proposed Typology. The basic typology that emerged from this work is presented in figure 1.

This typology is based on three underlying principles. First, classification is made according to *function* as distinct from *structure*. Most recent typologies that deal with health care organization and financing focus on the structure of MCOs, insurance products, or programs (Hurley and Freund, 1998; Weiner and de Lissovoy, 1993; Welch, et al., 1990). The proposed typology does not describe discrete organizations or programs, such as a prepaid group practice or the Medicaid program in Los Angeles County, but rather depicts three key functions embodied in these programs.

Second, like the approach of Bazzoli and colleagues (1999) and Brach et al. (2000), the emphasis is on relationships among functions within a system rather than on either the functions themselves or the entities that perform them.

Third, as far as is known, the typology focuses for the first time specifically on the organization and financing of behavioral health care as distinct from health care in general.

Three Key Functions. The three key functions in the typology that connect consumers to services are *sponsoring, purchasing,* and *providing*. These are judged the most important functions in the behavioral health care system today.

First is the sponsoring function. Following usage in the managed competition literature (Enthoven, 1993), this function involves designating

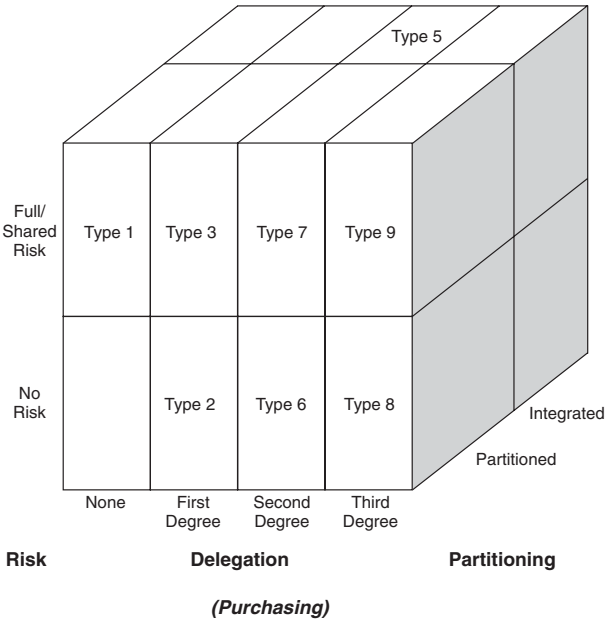

Figure 1. Proposed Typology.

the set of individuals eligible for the benefit, defining the scope of the benefit, and being ultimately accountable for ensuring that consumers receive the intended coverage in terms of access and quality. To a large degree, sponsoring means setting the rules by which the rest of the relationships operate; deciding, for example, how decentralized the other functions will be.

The second key function is purchasing behavioral health services (hereafter "purchasing"), which includes designation of eligible providers to serve the enrolled population, definition of payment arrangements, and the payment function itself.

The third key function is actually providing services to the consumer. Other possible functions, such as use and quality management, are not included because they are of lesser importance.

Delegation of Authority. Delegation of authority refers to the contractual transfer of certain functions by the sponsoring entity (sponsor) to a third-party agent. Whereas the sponsor typically retains oversight and ultimate accountability for the behavioral health benefit, delegated functions are performed by the agent and are beyond the direct control of the sponsor. In this typology, the two functions that may be delegated are purchasing and actually providing services.

The most visible example of delegation is privatization. When public mental health systems privatize, they are, essentially, delegating one or more functions to a private entity. For example, in Massachusetts, the first wave of privatization involved delegation of the provision of inpatient services and the maintenance of inpatient capacity to private hospitals. This permitted the sponsoring State agency to close or consolidate State-owned facilities.

Delegation may also involve the transfer of authority from one public entity to another. To illustrate, in Ohio, the State mental health agency contracts with local mental health authorities to manage State hospital funds for their catchment areas.

Finally, delegation takes place in the private sector when an employer contracts with an HMO to manage a health benefit for its employees and again when that HMO subcontracts with an MBHO to manage the behavioral health component of the benefit. Delegation thus captures a wide range of arrangements, all of which involve one or more "principal-agent" relationships.

For a number of reasons, the concept of delegation is important for examining how well a set of behavioral health arrangements perform in terms of access, cost, and quality. First, principal-agent relationships in health care are inherently imperfect because of asymmetric access to information. Because it is difficult to observe both health care needs and the effort expended to match appropriate treatments to consumers, the principal in a delegated relationship cannot simply direct the behavior of the agent to fulfill the principal's objectives (e.g., provide all services whose marginal benefit exceeds marginal cost). As in all hierarchical systems, every level of delegation brings with it some opportunism and dilution of the pursuit of the sponsoring entity's goals.

Although multiple levels of contracting involve additional layers of administration that can be costly and obscure accountability, a second important reason for delegation is that it may be associated with a number of benefits. Contractual mechanisms, for example, are inherently more flexible than direct control (ownership). This is most obviously the case for hospital facilities where a State cannot easily reduce its bed capacity in owned facilities in the short run. In a delegated arrangement, however, the State may have substantially greater ability to reduce or expand the number of contracted beds from year to year. In some cases, delegation also allows the sponsor to take advantage of the potential cost-reducing and quality-enhancing effects of competition. By contrast, publicly owned agencies and facilities that are not subject to competition

have little incentive to reduce costs or improve quality.

Finally, delegation may allow the sponsor to take advantage of economies of scale and specialization. This argument is often made for delegating the management of behavioral health services to MBHOs.

Because delegation can occur at a number of different levels, with different implications for accountability, access, cost, and quality, the typology distinguishes the *degree* of delegation. The baseline case is no delegation at all. Instead, the sponsor provides services directly. The most prominent examples in the public sector are State mental hospitals that are publicly owned facilities staffed by State employees.

Next is first-degree delegation, in which the sponsor contracts directly with another entity that provides the services. Thus, a set of contracts separates the sponsor from the provider of services.

Second-degree delegation adds another layer of arm's-length relationships. In this case, the sponsor contracts with a third party that does not provide services itself, but purchases services from providers.

Finally, in the case of third-degree delegation, the sponsor contracts with a purchasing entity (e.g., an HMO) that subcontracts to another purchasing entity that contracts, in turn, with providers. To distinguish the latter two cases, the terms "primary purchasing" and "secondary purchasing" are employed.

Partitioning the Purchase of Behavioral Health Care From That of Somatic Health Care. Carve-outs and carve-ins are among the most important developments in the financing of behavioral health services over the past decade. A growing body of literature has shown differences in cost, access, and quality of care for consumers served by these arrangements (Goldman, et al., 1998; Ma and McGuire, 1998; Stein and Orlando, 2001; Sturm, 1999). The typology, therefore, distinguishes between arrangements in which behavioral health services are purchased separately (partitioned) from somatic health care and those in which the purchasing function is performed by a separate specialty organization (e.g., an MBHO or a county mental health system).

Such partitioning (separation), on the one hand, permits sponsors to minimize client selection problems, set aside a fixed budget for behavioral health care, and improve the management of both costs and quality of care (Frank, Huskamp, and Newhouse, 1996). Integrated purchasing, on the other hand, may allow sponsors more efficient tradeoffs between behavioral health and other services.

The concept of partitioning between purchasing of behavioral and somatic health care could also be extended to the other two basic functions of sponsoring or providing. But to maintain focus and simplicity, that is not done here. However, please note that if the sponsor (e.g., a State mental health agency) oversees only a behavioral health benefit, the arrangements it makes to ensure access for its enrollees is not regarded as partitioned. Similarly, if an HMO contracts with a different set of facilities and provider organizations for both somatic and behavioral health care under an integrated health benefit, that is not considered partitioned (separate) purchasing.

Transfer of Financial Risk by the Sponsor. The final dimension of the typology is related to the financial arrangements between a sponsor and a contractor. The transfer of financial risk for service costs alters the incentives for the contractor as well as the sponsor. Financial risk-sharing in behavioral health care has been shown to affect use and other important outcomes (Sturm, 1999).

Clearly, this concept is not relevant to sponsors that do not delegate any functions to a third party. However, it applies both to the arrangements in which the sponsor contracts directly with service providers (first-degree delegation) and to those in which it contracts with purchasing entities (second- and third-degree delegation).

For simplicity, only two categories are designated: no risk-sharing at all and shared or full risk. If there is no risk-sharing, then the sponsor retains financial risk for all claims and pays the purchaser on the basis of whatever administrative services it provides, such as claims processing and network management. With shared or full risk, the sponsor makes some or all of the purchaser's (net) fee contingent on realized costs. Risk-sharing could be accomplished through a variety of mechanisms, including a bonus based on claims, risk corridors, or capitation (full risk).

The Resulting Typology. The three dimensions just described (delegation, partitioning, and risk-transfer) define the matrix of 16 (4 x 2 x 2) separate types presented earlier.

Nine of the 16 types (classes) that are actually observed in the real world also can be seen as an end point of a particular branch along a decision tree as displayed in figure 2 (they are listed in concrete examples in table 1).

In figure 2, the primary decisionmaker may be thought of as the sponsor who sets in motion the

cascade of arrangements that enable consumers to access services. Choices of contractual arrangements are likely, of course, to be the result of negotiations rather than merely the sponsor's decisions. And some decisions will be delegated to other entities. For simplicity, however, the typology assumes that the sponsor ultimately determines the branches that make up the actual arrangement.

The first decision the sponsor makes is whether to delegate the provision or purchasing functions. Four basic possibilities are shown in figure 2: no delegation, first-degree delegation, second-degree delegation, and third-degree delegation.

The first option, no delegation, cannot be broken down further with respect to risk-sharing or partitioning of the behavioral health purchasing function from somatic health because there are no third-party contracts (see figure 1). In this arrangement, the sponsor has the license to provide services and does so by employing clinicians. The major example of this basic type is the traditional State mental health authority that owns the State hospital and pays staff clinicians to provide care. It thereby functions simultaneously as the sponsor, purchaser, and provider of care. The sponsor is also the service provider in the case of an employee health unit in a general hospital that uses its own employees (physicians, nurses) as clinicians to provide care to the rest of its employees. This branch defines Type 1 in the figure, Direct Provision of services.

Moving along the tree, the next possibility is first-degree delegation. Here the sponsor also performs the purchasing function and then delegates the service provision to third parties (e.g., hospitals, integrated delivery systems, clinicians). The sponsor may do this with or without putting the service provider at financial risk for the cost of services. Partitioning is not possible in this case because the purchasing function is performed directly by the sponsor.

There are two types of direct purchasing of services. Type 2 involves no risk-sharing, as when the Medicare or Medicaid programs give people access to professional behavioral health services. Type 3, Direct Purchase with risk-sharing, involves shared or full risk for the provider. This type characterizes Medicare's facility arrangements for behavioral health services provided in general hospitals, which are reimbursed through the Diagnosis-Related Group (DRG) system.

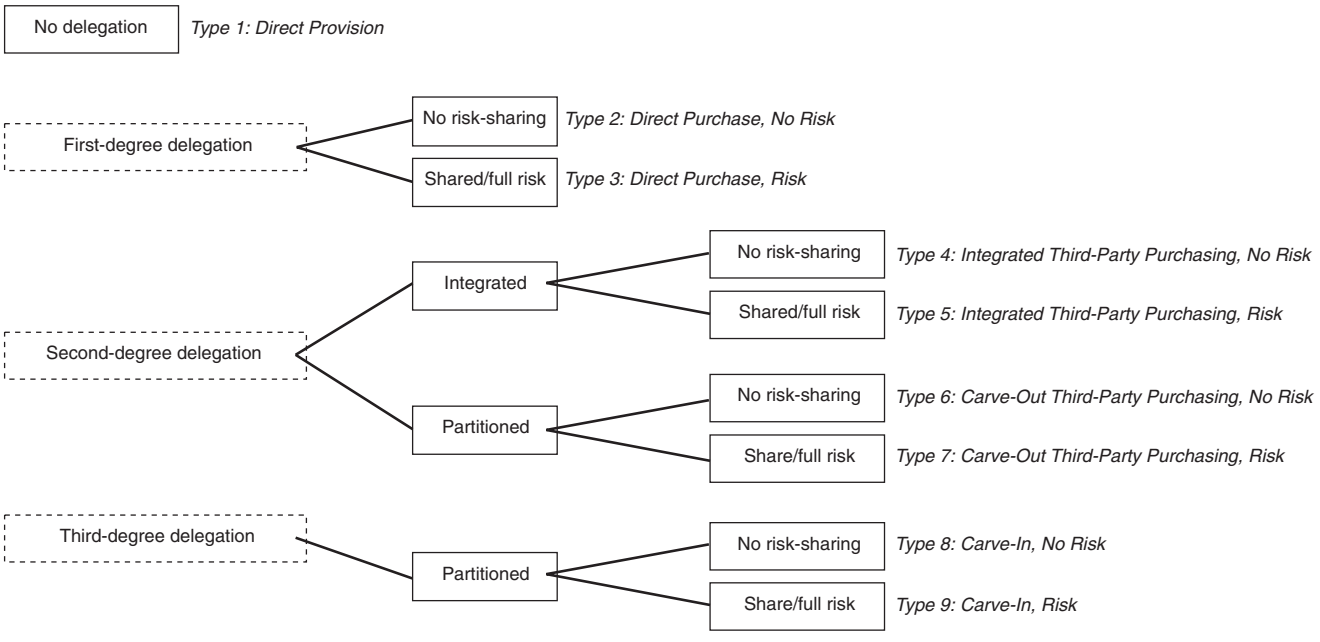

Figure 2. Decision Tree: Nine Observed Types.

Along the third major branch of the tree are both integrated and partitioned arrangements with or without risk-sharing by the sponsor. This major branch leads to four types. Types 4 and 5 closely resemble the state of private insurance prior to 1990, when employers typically contracted with health plans for both somatic and behavioral health benefits. Whereas integrated purchasing arrangements

today often involve risk transfer from employers to purchasers through capitation contracts (Type 5), self-insured employers typically retain all claims risk even when they contract with HMOs (Type 4).

The next two types (6 and 7) in this part of the tree are generally referred to as carve-out arrangements. Here the sponsor contracts with a specialty organization, such as an MBHO, which then purchases behavioral health services. Arrangements that do not involve the transfer of financial risk for claims costs (Type 6) are also referred to as Administrative Services Only (ASO) contracts and appear to be prevalent in privately sponsored insurance (Goldman, McCulloch, and Sturm, 1998). Shared-risk arrangements, predominantly using "risk corridors" or limited risk-sharing, are also found in both private and public sector Type 7 carve-outs (Ma and McGuire, 1998).

The last two types (8 and 9) in figure 2 are based on third-degree delegation, in which the ultimate purchaser of behavioral health services is once removed from oversight by the sponsor. There is a subcontract between a primary purchaser, with whom the sponsor has contracted, and a secondary purchaser, with whom the primary purchasing entity contracts. Because there do not appear to be more than one or two anomalous examples of integrated subcontract arrangements that cover behavioral health, separate categories have not been defined, although these arrangements could evolve in the future. Thus, the last branch consists of only partitioned arrangements.

In the behavioral health literature, Types 8 and 9 are sometimes labeled as carve-ins. From the consumer or provider perspective, they are indistinguishable from carve-outs, but important differences exist from the point of view of the sponsor. Carve-ins, for example, do not ameliorate adverse selection problems, because each competing health plan will make its own arrangements for behavioral health and does not provide an opportunity for the sponsor to designate a separate budget for behavioral health services. Like carve-outs, carve-ins may be set up without financial risk for claims as Type 8 (ASO) or with risk-sharing as Type 9.

Figure 2 shows clearly that moving from Type 1 (direct provision of services) to Type 9 (carve-in with risk) entails increasing decentralization. Sponsors of behavioral health benefits choose increasingly to "buy" rather than "make" (carry out) both service-purchasing and service-provision functions, thus removing themselves from any direct operational responsibilities.

This trend, and the partitioning (separation) of behavioral health care purchasing, is justified by the advantages and gains of specialization and economies of scale. But this approach may lead to administrative duplication and the attenuation of accountability.

Limitations

Like all new constructs, this typology has some limitations. First, it inevitably abstracts from a number of real-world issues. The typology is based on sponsored care only and does not explicitly account for branches along which care is accessed by uninsured consumers and by those who, for other reasons, self-pay. Care arrangements that are not sponsored, however, can be fitted into the typology with some minor modifications. For example, the provider can act as the sponsor when services are provided without charge; the consumer who self-pays also acts as the sponsor. Similarly, in defined contribution arrangements the sponsor essentially delegates the sponsoring function to the consumer.

Second, the typology does not address variation in the way third-party purchasers contract with providers or otherwise organize the provision of care. Purchasers, including some HMOs and MBHOs, may employ individual providers or may set up networks of independent providers with or without sharing financial risk. In some cases, use management may be performed by purchasing entities or delegated to service-providing organizations (typically with risk-sharing).

Third, the typology greatly simplifies the financial aspects of contracts between sponsors and purchasers by dichotomizing them as "no risk transfer" and "some or all risk transferred." In reality, there is a continuum of possible financial arrangements, many of which involve nonlinear risk-sharing of claims costs and incentives (e.g., use of risk corridors with stop loss provisions). Although all these features are important, they vary less than the dimensions identified in the proposed typology.

Finally, there are other frameworks through which a typology could have been constructed. For example, one could be designed on the basis of organizational structures, such as those of traditional providers. Another might focus on dimensions of clinical practice, such as treatment setting, treatment modality, therapeutic practice methods, and severity of treated disorders. Or one could focus on use management practices and methodologies, or on the management of quality, and so on. The proposed

typology, however, rests on dimensions judged the most important to behavioral health care today.

Illustrative Policy Issues Suggested by the Typology

Despite its limitations, the typology immediately suggests a rich agenda of illustrative policy questions and issues.

Basic Models Compared. Consider the following policy questions and issues dealing with basic models:

(1) How do the nine observed service types or models compare in terms of client outcome, unit cost of service, demographic profile of the client population, accountability, and unintended consequences?

(2) What characteristics of the models produce the most effective client outcomes? For what mix of disorders?

(3) Which models serve significant numbers of severe or difficult-to-treat cases, such as co-occurring disorders? Which show the best overall level of performance?

(4) Which models produce programs that are the most culturally and linguistically appropriate for their client populations? What is the level of customer satisfaction for these models?

(5) Which models are better at controlling costs and stopping financial loss?

(6) What is the frequency of each of the basic models within the overall service system? Which basic models are more common in the public sector? Which in the for-profit sector? Which in the not-for-profit sector?

(7) What effect does the overall pattern of alternative models have on equitable access to services? What effect does it have for the poor and disadvantaged? For racial minorities? For the aged? What effect does the pattern have on revolving doors? On gaps in care?

(8) Which models tend to be most prevalent among Medicaid programs provided directly? Which among Medicaid programs provided through contract? Which among programs sponsored by Medicare?

(9) Which models give public agencies the best leverage for reaching the unserved and underserved? Which for achieving efficiency and effectiveness? Which for ensuring accountability?

Effects of Delegation. Consider the following policy questions and issues dealing with the effects of delegation:

(1) What are the differences, if any, in the unit cost of service, client outcome, and customer satisfaction among models that provide services (a) directly, (b) through a prime (first-degree) contract, or (c) through a subcontract (of second or third degree)?

(2) Is accountability reduced as the degree of delegation increases? Which of the alternative models provide government agencies with adequate oversight and monitoring opportunities?

(3) Are there differences among the four basic delegated types in the extent to which severely disordered or difficult-to-treat cases are excluded or extruded from the delivery system?

Impact on Financial Risk. Consider the following policy questions and issues dealing with the impact on financial risk:

(1) How do costs behave as the assessment and management of risk shifts from the case of direct provision of service to delegated contract arrangements? Consider first-degree, second-degree, and third-degree delegation.

(2) What, if any, key features of service contracting (of whatever degree of delegation) appear to reduce financial risk to sponsors? To purchasers? To providers? In what ways? By how much?

(3) As the financial risk to providers increases, to what extent do they "cream" clients with easy-to-treat disorders or "dump" those with hard-to-treat disorders? Are there thresholds for creaming and dumping?

Effects of Integration. Consider the following policy questions and issues dealing with the effects of integration:

(1) Are specialized behavioral carve-outs more costly than integrated carve-ins? How do they compare in overall performance? Are there differences in unintended consequences or side effects?

(2) Do comparable integrated (carve-in) and carve-out behavioral services have the same overall patient profiles? Are specialized behavioral health services provided as readily in an integrated setting as they are in a carve-out setting?

Next Steps and Summary

The proposed typology can be applied usefully to both public and private sector arrangements. It captures new and important key developments in behavioral health care organization and financing, including privatization (a form of delegation) and carve-outs/carve-ins. Table 1 provides a summary of some real-world examples of each type drawn from both the public and private sectors.

The behavioral health care system is far from full development or evolutionary closure. Nor is it optimal in organization, financing, operation, or performance. The system is a work in progress that raises for decisionmakers and other key stakeholders a broad array of policy issues and questions.

The full policy usefulness of the proposed typology will become clear as the three main dimensions (purchasing, partitioning, and risk-transfer) are tested for future policy relevance and importance; as the types (models) are more adequately researched, analyzed, and compared; and as the typology is vigorously exercised in field research, policy issue paper development, and rigorous policy analysis.

Next Steps. A useful program of research and analysis to exercise and test the proposed typology might well include the following next steps:

(1) Perform a set of empirical case studies to flesh out the main types (models) and to test and refine the key dimensions of the typology.

(2) If the results of empirical case studies are promising, conduct a pilot survey to test the feasibility and value of a stratified sample of service sponsors, purchasers, and providers. A follow-on would inventory the frequency with which the alternative types (models) appear in the overall universe of the service system and estimate the sizes and distributions of their service populations.

(3) Follow the preliminary development of detailed profiles and standards for each of the major types (models), drawing on the results of steps 1 and 2.

Brief Summary. The organization and financing of behavioral health care is evolving rapidly, with implications for both the public and private sectors and for the consumers of service. To help make sense of new organizational and contractual arrangements and to facilitate the creation of new decision support systems, a typology has been proposed based on the relationships among three key functions that ultimately connect consumers with services: sponsoring, purchasing, and providing care.

These functions were examined along three dimensions: the degree of delegation (in purchasing) involved, whether the purchase of behavioral care is partitioned (separated) from the purchase of somatic health care, and whether financial risk is shared and transferred.

The analysis generated 16 distinct alternative types (models), of which 9 are observed in the real world. They were arrayed from a centralized direct provision of services model to the highly decentralized carve-in model. Because these alternative models have major implications for efficiency, effectiveness, and accountability, different branches of the typology generate a variety of basic policy issues and questions and suggest a variety of hypotheses regarding cost and quality-of-care outcomes for future applied research.

Finally, because information flows are highly contingent on the nature of contractual or organizational relationships among service entities, the typology should aid in the design of an appropriate interface for *Decision Support 2000+,* sponsored by the Federal Government.

Table 1. Examples within the typology

Type	Setting	Description
1. Direct Provision	New Hampshire public mental health system, New Hampshire Hospital	State owns psychiatric inpatient facility
2. Direct Purchase, No Risk	Medicare arrangements for professional services	Centers for Medicare and Medicaid Services (CMS) pays unrelated (i.e., not federally employed) providers according to fee schedule
3. Direct Purchase, Risk	Medicare arrangements for inpatient services in general hospitals	Centers for Medicare and Medicaid Services pay hospitals a prospectively set rate per discharge (Diagnosis-Related Group [DRG] payment)
4. Integrated Third-Party Purchasing, No Risk	Self-insured employer	Employer contracts on an Administrative Services Only (ASO) basis for integrated health care benefit (managed or unmanaged); health plan purchases both somatic health services and behavioral health services
5. Integrated Third-Party Purchasing, Risk	Lubbock County Service Area, Texas Medicaid program	Texas Department of Health contracts with competing Health Maintenance Organizations (HMOs) for integrated benefit provided under capitation arrangement
6. Carve-Out Third-Party Purchasing, No Risk	West Virginia Medicaid program	State Medicaid Agency carves out benefit to managed behavioral health care organization (MBHO); pays MBHO fee-for-service
7. Carve-Out Third-Party Purchasing, Risk	Massachusetts Group Insurance Commission	Employer group carves out benefit to MBHO, pays MBHO administrative fee, and shares cost risk inside a fixed region (risk corridor)
8. Carve-In, No Risk	Self-insured employer	Employer contracts with health plan on ASO basis; health plan subcontracts with MBHO for behavioral health services on ASO basis
9. Carve-In, Risk	Federal Employees Benefit program	Federal employees may choose, for example, an HMO, which carves in to its own behavioral health subsidiary with a subcapitation arrangement for behavioral health

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