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Public-Private Turf War Consumes Mental Health Reform

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The intent of the 2003 law seemed clear: The state's 39 Mental Health and Mental Retardation authorities would, wherever possible, stop offering direct medical services and start recruiting and managing networks of private providers.

The goals seemed simple: to cut costs, increase choice and serve more patients in a historically under-financed and overwhelmed sector of Texas health care. The MHMRs would become "providers of last resort," only stepping in to offer care when their attempts to create a competitive marketplace failed, according to the law. But the slow-motion political scrum that followed the law's passage has become a textbook case of legislative intent crashing on the rocks of bureaucratic maneuvering and logistical realities. Seven years later, MHMRs have done little to privatize mental health services.

The question of why gets complicated quickly. The dispute centers on services for about 235,000 Texans — the vast majority with three specific diagnoses: schizophrenia, bipolar disorder and major depression — and pits the regional authorities against private providers looking to break into the business. The infighting has erupted against a backdrop of severe shortages in mental health care across Texas; indeed, the state's real "providers of last resort" are currently jails and prisons.

Private providers, gathered in a new lobbying organization called Behavioral Health Advocates of Texas, allege a pattern of obstructionism and foot-dragging by the MHMRs, aided by their chief legislative advocate, state Rep. Vicki Truitt, R-Keller, and the Department of State Health Services. The delays, they say, come despite the coming expansion of Medicaid under national health care reform, which will make it all the more urgent to increase choice and grow a marketplace of top-notch providers. But the MHMRs have clutched tightly to their roles as providers, keeping money, jobs and control inside regional bureaucracies, private providers say. The latest example: DSHS has sought a federal waiver that would give the MHMRs sole control over rehabilitation, shutting out private companies from direct contracts with the state, as would normally be the case.

"Honestly, I don't think they want to give up being both the authority and the provider. They don't want to make the choice," says David Pan, regional director of Telecare Mental Health Services of Texas. "They get the money, and they pay themselves."

Truitt, along with officials from DSHS and the MHMRs, counter that many of the private providers have misinterpreted the law and only want to cherry-pick the most profitable Medicaid-financed services, including rehabilitation. The MHMRs, created as part of Great Society legislation in the 1960s, still play a key role in shepherding patients through a system laboring with scarce money and medical staff. They can only serve as "providers of last resort" if there are "available and appropriate" private providers to take their place, says Mike Maples, DSHS's assistant commissioner for mental health and substance abuse services. But in most regions, the MHMRs can't find enough quality providers to take on the full menu of services that — carefully knitted together — provide at least a minimum safety net at the meager rates the state can afford to pay.

"In mental health care, there's a need for comprehensive services" delivered or at least managed by the same provider, Maples says. "We don't want a system of fragmented services because we know it doesn't work. … It's the whole package of services that keeps people out of jail."

In fact, whatever Texas does currently isn't keeping the mentally ill out of jail. One recent study estimated that the state's prisons housed eight times as many mentally ill people as the it psychiatric hospitals and that 16 percent of all prisoners need mental health care. In the rare point of agreement, private and government mental health providers say Texas does not finance mental health care at anywhere near the demand. Maples estimates that the local authorities serve only about 25 percent of the need. At any given time, about 6,000 people are on waiting lists for mental health care, and even that doesn't fully reflect the demand. "They are just the ones who come to our system, get seen and get turned away," Maples says. "That doesn't count the ones who show up in emergency rooms, jails or just become homeless on the street."

In a draft copy of a federal block grant application that was recently circulated for comment, state officials laid out the plight of mentally ill Texans in blunt terms: "Texas consistently ranks near the bottom of all states in per-capita funding for mental health services," the application reads. "According to the Texas Medical Association, for 2009, Texas ranked 49 out of 50 in per-capita mental health funding." Further, visits to mental health authorities have increased sharply with the recession and population growth in Texas, according to the application.

Lost legislative intent

The 2003 law that pushed privatization of the mental health authorities — or tried to — didn't pretend to solve every problem, particularly the glaring lack of funding. And it came as part of a larger state reorganization of social services. But the intent was clear, says the bill's author in the Texas House, former state Rep. Arlene Wohlgemuth, R-Burleson.

The law, she says, aimed to break the MHMRs' stranglehold on mental retardation and mental health services and to eliminate a basic conflict of interest: They controlled the money, assessed the patients and provided the services. "The nature of competition is that they are going to assign themselves as many clients as they can. They made sure their facilities were full so they were maximizing income ... providing services in competition with the private providers," says Wohlgemuth, who is now the executive director of the Texas Public Policy Foundation. (A spokeswoman for the Department of Aging and Disability Services said many services for the mentally retarded have in large part been contracted out, though she could not immediately provide statistics on the trend.)

Private mental health providers contend that the MHMRs and their advocates have successfully obstructed the law through a series of political and bureaucratic maneuvers. In 2005, Truitt passed a bill repealing the "provider of last resort" provision, but it was vetoed by Gov. Rick Perry, who wrote: "This current law ... provides greater participation by private providers. A true market-oriented approach is ultimately better for Texans dependent on these services." In 2006, the state Health and Human Services Commission sought an attorney general's opinion asking if the law really applied to mental health services; yes, it did, the AG opined. In 2007, Truitt passed another bill seeking to clarify the "provider of last resort" language, but it has had little effect either in promoting or limiting privatization, advocates for the private providers say.

Last year — after finally being forced to do so — the MHMRs put contracts out to bid but made them so cheap and restrictive that no private provider could bid on them with any hope of making a profit, two executives at interested companies say. Meanwhile, officials of DSHS, which oversees the

MHMRs, asked federal Medicaid officials last fall for a waiver that would give the mental health authorities sole control over rehabilitation services — preventing private providers from contracting directly with the state, as is normally allowed.

“It’s a closed loop, and it doesn’t work that way in any other state where we do business,” says Pan, of Telecare. “We’re just looking for implementation of the law and for not instituting a waiver that grants sole hegemony over rehab to the authorities. Basically, we’d like a level playing field.”

The MHMRs also have thwarted private competition by issuing requests for proposals that private providers could not possibly accept, says Richard Wallace, state executive director for Providence Services of Texas. When the first group of 13 MHMRs recently issued contract terms, they offered to pay between only between 85 and 95 percent of the standard Medicaid rate per service, Wallace says, skimming off the rest for “overhead” in managing the contract. Wallace contends that Medicaid already pays agencies for overhead and that other states generally do not take such a deduction; advocates for the authorities say the management costs are necessary and appropriate.

“We do it all over the country for the [full] Medicaid rate,” Wallace says, describing the bid specifications in Texas as “hardly worth our time. Many of the contracts … don’t guarantee any certain number of clients. So you could go all the way through the process and still never get one referral.”

Wallace believes the MHMRs simply do not have the capacity or the desire to convert themselves to managers rather than providers of care. “They really need to look at how their administrative services can be consolidated [statewide] so they don’t duplicate HR departments, credentialing departments, claims payment departments 39 times” for each regional authority, he says. “Those services are completely invisible to the consumer and have nothing to do with local control or preference.”

Protecting the safety net

Advocates for the current regime, with careful expansion into privatization, contend that private providers have misconstrued “provider of last resort” to mandate free-wheeling privatization at all costs. But the care of the mental ill doesn’t fit neatly into the familiar political divide on privatization, they insist. Truitt, the biggest legislative champion of the MHMRs, is a Republican who calls herself a champion of the free market, but she finds herself, in this case, defending local governmental control of a safety-net system that she believes the free market cannot adequately replace.

“Competition is a wonderful thing,” she says. “But there are some outfits that don’t want to go to each [MHMR], each community and serve their needs. They want the state to hand them a big fat contract, and [they] say, ‘We’ll save you money. Don’t worry about it.’”

Danette Castle, the CEO of the Texas Council of Community MHMR Centers, the lobbying group for local authorities, says she ordinarily has a similar free-market bent. “I have a tendency to believe that where the free market can step in, it should,” she says. “But it doesn't work here ... Why doesn’t it work in health care? The whole country is struggling with this. The profit motive presents a whole different set of expectations for the provider. It doesn’t mean private providers can’t play an important role.”

In Tarrant County, the MHMR has done some limited contracting, says its deputy CEO, Susan Garnett, and hopes to expand services in the future — but it's a challenge to make the deals work. "When you talk to private providers, they say there are too many regulations ... They say, 'We don't need all that training.' Well, okay, they are state requirements, and we have to pass them on," she says. "The rates are another issue, but the state of Texas probably isn't going to raise rates. If I were a for-profit business whose shareholders insist on certain returns, I wouldn't look at Texas as a place to make a profit."

The question of money, or the lack of it, may underlie almost all of the dysfunction between public and private providers, advocates for the MHMRs believe. Private mental health providers want to take on some services — the ones from which they can eke out a profit — but not others. State officials say that's an awkward fit, with a delivery model that demands continuity of care managed tightly by one entity.

“A business is going to try to deliver as much of their service to as many people as possible” to maximize profit, Castle says. “But when you have scarce resources and a broad population that needs them, [the authorities] have to make tough choices about who gets care and who doesn’t.”

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