MANAGED BEHAVIORAL HEALTH SERVICES

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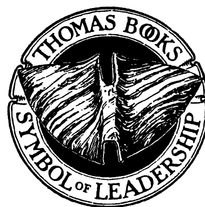
Perspectives and Practice

Edited by

SAUL FELDMAN



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"The art of progress is to preserve order amid change and to preserve change amid order."

–Alfred North Whitehead

PREFACE

A decade ago, when the predecessor to this book was published, managed behavioral health organizations (MBHOs) were well into their adolescence–growing rapidly, unclear about their future, unsure about their identity, uneasy about their relationships, and, at least in their view, under-appreciated. Still growing, albeit much more slowly than in the past, MBHOs now dominate how behavioral health services are provided and paid for. They also have influenced behavioral health policy. Parity benefits, for example, would not likely have happened were it not for the well-documented, empirically based evidence that parity is affordable, but only under managed care.

The future of managed behavioral health is still unclear. To what extent, for example, is it likely to be a transitional object, less needed than in the past? Has it had an enduring and significant enough effect on the provider behavior that brought it about? Lest we forget, before the era of managed care, behavioral health services were too often characterized by long, expensive, and inappropriate, if not fraudulent, hospitalizations–particularly of children and adolescents. As a result of a lengthy investigation, "psychiatric hospitals and addiction centers paid over $500 million in Federal fines to settle charges of profiteering and diagnostic fraud in recruiting patients with generous mental health insurance" (Sharkey, 1999, p. 5). It was commonplace to use up limited substance abuse benefits on 28-day inpatient stays despite demonstrably less costly and more effective alternatives. As a result of all this and more, costs were escalating at a rate 20 to 30% higher than in general medical care, with no evidence of added value. If managed behavioral health were to disappear, would we return to what some would consider those "good old days?"

A decade ago, the cost of general health and behavioral health services was a major public concern, particularly its growing percentage

of the gross national product. There were fearsome predictions of a linear progression that would, if nothing was done, severely damage the country's economy. The conventional wisdom was that health care costs were out of control, increasing much more rapidly then general inflation. Newspapers across the country spoke of behavioral health costs surging–even faster than other health care costs–and payers were especially troubled by the rise in hospitalization for adolescents with behavior problems and the like.

But there was something else going on, related to rising costs, but more subtle and at least as important. Whether it be in human services, foreign policy, the environment, or other major societal concerns, in order for change to occur, there must be real or fictional villains to blame, victims to pity, and potential saviors to root for. So it was with behavioral health (though *mental* health was the term more frequently used then). The designated villains were the private, for-profit psychiatric hospitals and the inpatient substance abuse facilities–blamed for profiteering, coerced admissions, bad or nonexistent care, and unnecessarily extended lengths of stay, terminated only when the benefits ran out. The victims were the patients, particularly but not exclusively children and adolescents; as reported by the media, they did not need to be hospitalized and were confined against their will, kept in the hospital too long, and psychologically damaged by the experience. To what extent these allegations were true–and to what extent they were hyperbole or a reflection of the media's hunger for tragic human interest stories–has never been clear, but it is likely that they are not entirely without foundation.

Clinicians were also vilified (albeit to a lesser extent) and were accused of seeing patients for too long, of not being able to demonstrate that the therapy was doing anybody any good, and of being indifferent to the societal consequences of the costs of their services. *Wave therapy*–an unkind but, unfortunately, not entirely inaccurate term–was used to describe the behavior of those psychiatrists who would walk through the hallway of a psychiatric hospital, wave to the patients in the rooms, and bill the insurer for each wave.

Managed care was then perceived as the savior, as the solution to the escalating cost problems, to the poor quality of care, to the absence of data, and to the lack of accountability by hospitals and clinicians. Like the HMOs before them, MBHOs, it was believed, would curtail unnecessary care and save money by providing the right services, at

the right time, in the right place, at the right price.

Thus it was–a decade ago–that the villains, victims, and saviors were clearly identified and portrayed so convincingly that their images became fixed and part of the conventional wisdom. By the end of the 1990s, however, the first full decade of managed behavioral health, a profound change had taken place. At least in the perceptions of the public, the villains had traded places. Managed behavioral health was increasingly portrayed as the villain, whereas the providers, who a decade earlier had been portrayed as villains, came to be seen as victims. As before, patients remained the victims, but were now seen as being victimized by too little care rather than too much.

Who by now has not read or heard about needed services being denied? About clinicians not being allowed to care for their patients properly, being dictated to, if not exploited, by the MBHO? About so-called hard-hearted bureaucrats and insurance administrators making clinical decisions? And the list goes on. As with a decade ago, fiction and reality are interwoven, indistinguishable, but nonetheless persuasive.

The public's image of hospitals and clinicians was bad a decade ago; it is better now. The image of managed care was good then; it is worse now. Managed behavioral health–seen as the solution to the problems of a decade ago–is now, more frequently than in the past, portrayed as the problem. Fostered by the media, politicians, and special interest groups, simplistic generalizations abound as they did then. Then and now, the question should not be whether managed care, psychiatric hospitals, or clinicians, for that matter, are good *or* bad; they are, of course, good *and* bad, depending on what they do and how they do it. Differentiation is the key to understanding.

I leave it to those wiser and more courageous than I to predict who the next savior and what the next "solution" will be, how enduring, and how long it will be before the solution metamorphoses into the problem, at least in the mind of the public.

With time, MBHOs have become more sure about who they are, what they do, and why they do it. This heightened sense of security is, in good measure, engendered by their customers, who continue to see MBHOs as an important and permanent part of the behavioral health landscape. Employers, health plans, and other payers do not stop using MBHOs, although they may from time to time switch from one to another. Identity issues remain, although less so than in the past, as

MBHOs have added a number of services–disability, employee assistance, and others–and have broadened their scope, far beyond their traditional role.

Relationships with clinicians and facilities, however, remain far more problematic than those with customers. Managed health care therefore continues to be a leading topic of discussion in the professional media and wherever behavioral health practitioners gather. And the rhetoric, often negative and sometimes vitriolic, is only slightly less passionate now than a decade ago. Candidates for the presidency of the two major professional membership organizations (American Psychological and Psychiatric Associations), for example, apparently believe that they cannot possibly be elected without a strong and widely communicated position against managed behavioral health. It is ironic that those practitioners who are most critical of managed behavioral health did the most to bring it about in the first place. Had their behavior been different, so would the conditions under which they are now practicing; managed care would not have been needed.

Money, something that was in the past not discussed or argued about openly, remains an issue. Behavioral health practitioners tended to deny or at least not acknowledge their self-interest while actively pursuing it; they gave the impression that they viewed money "much like the Victorians viewed sex. It was seen as vulgar, as a sign of character defect, as something an upstanding professional would not be interested in" (Levinson & Klerman, 1972). Times have certainly changed. Whether or not related to the advent of managed behavioral health, financial self-interest is more overt than in the past. How much practitioners are paid and how promptly is not infrequently (or inappropriately) an important issue in their relations with MBHOs.

Provider concerns about managed behavioral health include the erosion of the professional prerogatives so highly valued by behavioral health professionals. These concerns are real and go to the heart of the major changes that MBHOs have brought about in the way that practitioners and hospitals do their work. The changes challenge what many behavioral health practitioners hold most dear and most zealously try to protect: their professional autonomy. The ability (or divine right) to be free of all controls over their behavior, to work in splendid isolation, is highly cherished by behavioral health professionals–par-

ticularly, but certainly not exclusively, by physicians. I have used the term "M.Deity" as a perhaps uncharitable description of this attitude in physicians; "Ph.Deity" is not far behind. This dimension–that is, the involvement (some would say intrusion) of MBHOs in clinical decisions that have historically been the almost exclusive domain of practitioners–has engendered the most opposition to, and most heated opinions about, managed behavioral health.

Other negative criticisms–not necessarily unrelated to money and power, but stated differently and in a more socially acceptable way–are about "quality of care" and "patient needs." To be sure, any time that a change of consequence to patient care takes place, its effects on quality must be addressed and closely examined. But not surprisingly, those who believe that their financial and power needs are threatened by change somehow seem always to see change as bad for the quality of care and the status quo as good, or at least better.

The effects of managed behavioral health are more clear now then they ever were. Access to outpatient care is up, inpatient care is down, costs are contained, utilization patterns have changed, community alternatives to hospitalization are more prominent, parity benefits have arrived, and employee assistance/work/life programs are now commonly part of the services that MBHOs provide. Nevertheless, still too "little is known about managed behavioral health's effect on treatment outcomes" (Feldman, Cuffel, & Hausman, 1999, p. 6). In an annotated bibliography listing 111 empirically based studies published between 1994 and 1998, only seven had to do with treatment outcomes. Moreover, those seven were all studies of the public sector even though over the past ten years, the amount of research done on managed behavioral health services has grown exponentially (Feldman et al., 1999). Most of the studies have focused on issues of cost and utilization, benefit design, and managed care in the public sector. So despite all the new research, conclusions about the effects of managed behavioral health on quality and outcomes are still indeterminate and very much in the eye of the beholder. Impassioned judgments on all sides continue to rely more heavily on anecdotal "evidence" than anything else.

It is clear that some of the processes used by some MBHOs do not reflect a sufficient understanding of the differences between control and accountability in their relationships with care providers. Control is undesirable; accountability is not. Accountability should be the

essence of what good managed behavioral health is about–the accountability of providers and managers of care to each other, to the people they serve, to those who pay them, and to the public interest. Such accountability is not possible without data collection and analysis, and without appropriate processes to evaluate such factors as access, cost, and quality. None of this was possible in the days prior to the advent of managed behavioral health. It is much more possible now.

Accountability is also not possible without checks and balances, the constructive tension between care manager and practitioner when they interact around such issues as treatment planning and locus of care. This exchange between well-qualified professionals with somewhat different perspectives leads, in my judgment, to the best clinical decisions. But checks and balances work well only when the parties to the process are independent, neither being overly dominant. MBHOs must resist the temptation toward excessive control over practitioner behavior, however tempting with regard to efficiency and ease of operations that prospect may be. Failure to do so is to the detriment of patient care and practitioner autonomy.

MBHOs must also recognize that while they influence the nature of the interactions between practitioner and patient, quality of care is determined as it has always been, by what goes on in the consultation room between clinician and patient, in the hospital, and wherever else people who need help with behavioral problems are seen. Even with the best of intentions, practitioners who feel alienated from, and dictated to, by MBHOs are likely, unconsciously or not, to allow those feelings to affect their work with patients.

Care providers are not any less or more virtuous than care managers; opportunities for excessive self-interest are abundant and are available to both. Since the nature of behavioral health services allows care providers and managers a wide range of discretion, the opportunity to transform the public's needs into their own interests and the patient's problems into their own solutions is omnipresent for both. In such an environment, self-interest and sanctimony are not easily distinguished from altruism and devotion.

At its best, managed behavioral health can improve quality, reduce inappropriate utilization, control costs, and protect behavioral health benefits from being wasted on unnecessary care. But at its worst, it can deprive people of services they really need, truncate the role of behav-

ioral health care providers, and damage the quality of the clinician-patient relationship that is so central to the success of the therapeutic process.

We have seen managed behavioral health at its best and at its worst. We have unfortunately not yet witnessed an appreciable enough increase in the ability of practitioners, payers, and society at large to tell the difference. Managed behavioral health continues to be a fact of life and may well be so for some time. There is no clear alternative, at least not yet, nor anytime soon. Done well, it can and does do good. It has the potential to do better still.

Saul Feldman
San Francisco, California
March 2002

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INTRODUCTION

Much of what was published about managed behavioral health in its first decade is best described as opinion—often well expressed, but less well informed. This is not surprising, given the strong feelings that managed behavioral health evoked and the inevitable delay between the time that so profound a change begins, and informed analyses, published. In managed behavioral health's second decade, empirically based research has contributed greatly to what is known about its effects on such questions as access, utilization patterns, patient satisfaction, and economics. Strong opinions still abound, though tempered somewhat by data and also better founded than in the past.

This book is not free of opinion. But we have attempted (readers will judge how successfully) to keep the opinions as informed as possible. The chapters are based on the authors' personal experiences with managed behavioral health, what they know from the experiences of others, and the published literature. Where studies and data do exist, strong efforts have been made to incorporate them.

All the authors are experts in the particular areas of managed behavioral health about which they have written. Where the authors' proximity to, and personal experience with, managed behavioral health care might skew them one way or another, they and the editor have tried to be aware of it and mute the bias wherever possible.

The subjects included in the book are, in the editor's opinion, among the most important to its potential audiences: those involved in, or connected to, the managed behavioral health enterprise as payers, managers, providers, and health-benefit consultants; those who have a research or teaching interest in the subject; and decision makers in government and the private sector.

The choice of subjects in a multi-authored book is never easy, con-

strained by a number of factors, including the editor's judgment and the availability of willing and knowledgeable authors. The latter constraint was, in fact, not much of one at all. The subjects I had in mind and the people best able to write about them matched very well. If readers feel that either was not well chosen, it is clear where the fault lies.

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It would not have been possible to convey the breadth and complexity of managed behavioral health without the participation of contributors who, despite heavy commitments, were willing to lend their time and expertise to this project. I particularly appreciate their tolerance for so finicky an editor.

The editorial assistance of Stephen Scher and the persistence of my assistant Katie Egen made a book of what might otherwise have remained a work in process.

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MANAGED BEHAVIORAL HEALTH SERVICES

Chapter 1

CHOICES AND CHALLENGES

Saul Feldman

By any measure, managed behavioral health organizations (MBHOs) grew rapidly during the last two decades of the twentieth century, and the so-called carve-out now determines how over 100 million people in this country use their behavioral health benefits. The term *carve-out* came into common usage with the advent of MBHOs as a way to differentiate them from medical health organizations. The term is relatively new; the ideology, policy, and practice are not.

The opening of the first psychiatric hospital in America (Virginia Eastern Lunatic Asylum, 1773) was, in effect, the first behavioral health carve-out. It established a framework for the relationship between behavioral health and medical services that has endured for over two centuries. Since then, behavioral health services have for the most part remained organizationally separate from medical care. The reasons for this include: the discomfort, if not antipathy, with which "difficult and or unpleasant" patients with behavioral disorders were and are often viewed by physicians; powerful advocacy groups that value independence as a means of obtaining greater visibility and resources for behavioral health services; and the general perception by behavioral "healthers" that when their services are simply a unit within, and financially dependent on, a general health care organization, the services are more likely than not to be undervalued and underfunded. As Michael Bennett (1992, p. 79) has written,

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Note: Portions of the discussion above previously appeared in the June 1998 Special Issue of the *American Journal of Managed Care* (pp. 5P59–5P67).

> Forced to compete with the priorities of the general health care setting, and to operate within the value systems and models of care common to the medical setting, mental health often does not fare well. There is a tendency to underfund and to "medicalize": to rely excessively on active interventions and on techniques of diagnosis and treatment that emphasize the biological, sometimes at the expense of human service elements of care.

So the behavioral health carve-out involves new terminology but not a new practice–it is consistent with tradition and time-honored practice. What is new (about 20 years old) is the particular form that the carve-outs have taken–that is, as free-standing, predominately private, for-profit MBHOs that work with the already large, but still growing, number of employers, HMOs, insurers, and public sector agencies that have chosen to administer their behavioral health benefits differently from their medical.

CHARACTERISTICS

A typical MBHO contract with a customer is the outcome of a process that includes: a comprehensive response by the MBHO to a request for proposal; a presentation by the MBHO to the prospective purchaser (and frequently its health benefits consultant); and a negotiation process about rates, performance standards, reports, and implementation matters. A common part of the contract addresses performance standards–a major departure from unmanaged behavioral health services–that the MBHO is required to satisfy. The standards generally cover such things as telephone-response time, accuracy and timeliness of payments to providers, utilization targets, member satisfaction, access to services, and the like. Failure to meet any of these challenging standards requires the MBHO to return a portion of the fee it is paid.

MBHOs are generally paid in one of two ways: a flat fee per employee or per member for its services (generally referred to as "ASO," administrative services only); or a monthly per capita payment for each member or employee (under which the MBHO, like an HMO, is at financial risk for the cost of all the administrative and clinical services that it is required to provide). In general, MBHO contracts with HMOs include this capitated, "fully insured" type of payment; in effect, the HMO transfers to the MBHO its risk for the cost

of behavioral health services received by its members. Most MBHO contracts with self-insured employers, however, are ASO; the employer retains the financial responsibility for the cost of the services, and benefits from whatever savings may come about from the management of the care.

It is not clear whether the way in which MBHOs are paid affects the process through which care is managed, the quality and the cost of care, or utilization patterns. In their study of the Massachusetts Medicaid MBHO, Frank and McGuire (1997) found, “In light of the contract’s weak cost-savings incentives [for the MBHO], it may be surprising that so much was saved.” In his study of an MBHO with both ASO and fully insured contracts, Sturm (1997) found no significant utilization differences when the care was managed by the same staff under the same clinical standards. These early findings suggest the need for further research on the relationship between how the MBHO is paid and how it performs.

Clinicians and facilities provide, under contract, the services for which the MBHO is responsible. These providers are “credentialed” and then, generally every two years, “recredentialed” in order to be certain that they continue to meet MBHO requirements such as licensure, ethical practice, and patient satisfaction. Most clinicians are paid in one of two ways–fee for service (the most common method) or capitated (typically a flat fee per member per month without regard to the amount of services they provide). This latter model puts clinicians at risk for the cost of the services that they provide to all those for whose care they are responsible. In effect, the less care they provide, the better off they are financially.

The fee-for-service model is dominant, but some clinicians and MBHOs prefer capitation. To the clinicians, capitation sounds attractive because it means payment in advance, greater autonomy, less accountability, and less interaction with the MBHO with regard to treatment plans, authorizations, and claims payments. But it may well raise difficult ethical and practice-management issues, particularly for clinicians who have had little experience with it and who are not skilled in time-limited, goal-focused treatment. For the MBHO, capitation saves time and money–less interaction with clinicians, less care management around patient needs, and fewer operational issues. But it also detracts from the “constructive tension” between the clinician and the MBHO.