

## The State of Behavioral Health in Managed Care

David Mechanic, PhD

Most Americans, whether in public or private insurance programs, now have their mental health and substance abuse benefits managed. The notion of managing mental healthcare has been more familiar in mental health than in other areas of medicine because, traditionally, care for the most seriously mentally ill was a public responsibility and many providers of care, particularly non-medical mental health professionals, worked within budgeted agencies that had to make continuing tough resource allocation decisions. Indemnity mental health and substance abuse coverage, although not directly managed, was subject to strict benefit design limitations that contained private mental health and substance abuse expenditures. A further constraint was the stigma of mental illness and substance abuse and their treatment, which functioned to ration services beyond what might be reasonably sought and provided.

The most dramatic change in recent years has been the very rapid growth of large, private behavioral healthcare organizations that have contracted with private employers, healthcare plans, and government agencies to manage mental health and substance abuse services on administrative and risk bases.<sup>1</sup> Although precise, unduplicated data are difficult to obtain, *Open Minds* (<http://www.openminds.com>) reports that by August 1997 nine behavioral healthcare companies had approximately four-fifths of the market and were managing the care of almost 120 million people. With Magellan's acquisition of Green Spring Health Services and Merit, it

alone was managing the behavioral health benefits of more than 50 million people.

The emergence of the behavioral healthcare industry followed several other trends that changed insurance patterns for behavioral health. As new psychoactive drugs and other behavioral treatment technologies improved, and as large employers became more aware of the role of behavioral health problems in work disability, absenteeism, and low productivity, they responded to the call for improved mental health and substance abuse benefits. With improved treatments, increased respectability of mental health services, and better educated and more sophisticated consumers, the stigma of recognizing behavioral health problems and seeking treatment was reduced. The increased availability of insurance also allowed mental health professionals and mental health facilities to provide more extensive behavioral health services, often to the limits of their clients' insurance coverage. An obvious result was an increase in behavioral healthcare costs and, in many instances, a substantial increase in these costs as a proportion of total medical outlays.

Some large, self-insured employers with more extensive behavioral health coverage became alarmed at the rapid rise in behavioral care expenditures and turned to newly developing companies to manage utilization for them. Introducing utilization management substantially reduced expenditures, particularly in the first year or two.<sup>2</sup> Most of these reductions were achieved not by closing access to services, or even making inpatient admissions more difficult, but rather by substantially reducing the length of inpatient stays that were relatively long. For example, the Xerox Corporation was averaging 276 to 327 days of inpatient care for mental health and substance abuse per 1000 employees in the period from 1987 to 1990. After the introduction of utilization management, inpatient days fell to 77 and then 61 in the period from 1993 to 1994. These gains

---

From the Institute for Health, Health Care Policy, and Aging Research, Rutgers University, New Brunswick, NJ.

Address correspondence to: David Mechanic, PhD, Rutgers University, 30 College Ave, New Brunswick, NJ 08901.

were achieved largely by reducing the average length of stay from about 33.7 days to about 10 days.

As managed behavioral healthcare has penetrated the insurance sector, it has reinforced the already strong ideologic and administrative trend toward deinstitutionalization in a range of inpatient facilities.<sup>3</sup> In the private nonprofit hospital, where the vast majority of insured persons with mental health or substance abuse problems are treated, the average length of stay fell from 12.6 days in 1988 to 9.4 days in 1994, despite the fact that admitted patients were more seriously ill.<sup>4</sup> The fall in average length of stay occurred for all major diagnostic groups, and it was during this period that utilization management was routinely introduced. Data from a variety of studies of employed populations indicate that most of the reductions have come through aggressive concurrent review of inpatient stays.<sup>5</sup>

The behavioral healthcare industry and its management approaches are dynamic and adaptive. Management of care is a customized product developed for individual purchasers and can be combined in innumerable ways. Such customized services may be joined with employee assistance programs, preferred providers, point-of-service options, and other organizational innovations and may give different emphasis to utilization management strategies such as the use of gatekeepers, pre-review of service plan, concurrent review of care, and high-cost case management.<sup>6</sup> The services provided may be on an administrative contractual basis, or the behavioral healthcare companies may assume some or all of the risk. Although the adaptiveness of the industry is an advantage, it makes the effectiveness of its various strategies difficult to assess because management strategies may vary a great deal. These programs also can vary a great deal in the network of care providers and services, the qualifications and experience of reviewers and managers, and the systems in place to monitor performance and assess quality. They also can vary significantly in the philosophical commitments of the managers and how they balance their private interests against commitments to respond to needs and improve quality.

Although the academic discussion of behavioral healthcare is focused on the relative merits of integration of services versus carve outs, the latter has become the prominent pattern, more so than in any other area of medical care. Over time, there has been a strong shift toward carve out risk contracts with behavioral healthcare companies, but risk is less likely to be transferred to providers than in many other areas of medical activity. For the most

part, behavioral healthcare companies manage risk through utilization management and by negotiating advantageous rates of payment with mental health professionals and facilities.

Behavioral healthcare, like managed care more generally, is a work in progress, but it is clearly transforming every aspect of mental health practice. The rapid changes have been difficult for professionals to accept as they see their remuneration and autonomy at risk. Many feel their bargaining power is being diminished and fear being excluded from networks if they fail to conform to company norms and expectations. Provider groups report that the large companies tend not to negotiate; they simply dictate the rates. Consumer groups worry about reduced access to specialty care, denial of necessary care, and disruption of established therapeutic relationships.<sup>7</sup> Facing embarrassing and stigmatizing problems, many resent having to go through a gatekeeper and worry about confidentiality.

As managed behavioral healthcare has demonstrated initial success in reducing utilization and cost, it is being adopted by state Medicaid programs generally and is being extended to disabled populations as well. Although available data are very uncertain, some conclusions seem reasonable. Traditional mental health practice in both the private and public sectors was highly undisciplined. Thus, the introduction of utilization management could produce rapid short-term savings by reducing length of stay and long-term unfocused therapies. The available data show large initial reductions in cost in the first year but much smaller reductions after that time.<sup>2</sup> The challenge of reducing utilization without impairing quality is likely to become much tougher for the industry in the future, and its profits are likely to be smaller. For the general population there has been little indication thus far that managed behavioral healthcare has diminished quality or adversely affected patient outcomes. Major companies that have carried out surveys of their employees report acceptance of managed behavioral healthcare. Clients seem to be more likely to receive at least some mental health and substance abuse services under managed behavioral healthcare than under traditional insurance practices, but the intensity of care has been significantly reduced.

Managed behavioral healthcare has been primarily a private sector enterprise, focusing on the employed population and their families. These companies have had relatively little experience in managing care for clients with severe and persistent mental illness and complex comorbidities. Their

definitions of mental healthcare and medical necessity are quite narrow compared with the approaches and services now demonstrated to be most effective in treating persons with severe and persistent illness, including assertive case management, housing assistance, psychosocial rehabilitation, and family psychoeducation.<sup>8</sup> Public mental health authorities have spent several decades building the support systems and developing the expertise needed to provide appropriate community care to more disabled clients. As they move into this area, managed behavioral healthcare organizations will have to learn a great deal quickly and work cooperatively with various public programs and consumer groups. The styles of management and care will be very different than typical experiences in the private employment sector.

We have much less experience with managed behavioral healthcare in the public sector, but the available research suggests the need for caution and careful monitoring. There is evidence that managed behavioral healthcare reduces the cost of public sector care, but it is less clear that it can reduce cost for those patients who are most severely and persistently ill. Moreover, several studies of capitated services suggest that persons with the most serious problems fare less well in capitated practice over time,<sup>1</sup> although the reasons for these different outcomes are not understood. In the Medical Outcomes Study, patients with depression did more poorly in health maintenance organizations when treated by psychiatrists, particularly within networks, and this appeared to be related to the failure to maintain medication within these organizations as compared with fee-for-service practice.<sup>9</sup> The outcome studies also show that differences do not immediately appear and, thereby, require monitoring over some significant time period. Most studies, in contrast, have quite limited follow-up periods.<sup>8</sup>

The character of managed behavioral healthcare depends on what purchasers are willing to pay. The industry developed largely around the idea of reducing costs. But standards of care are sufficiently uncertain so that in eliminating unnecessary care, useful and efficacious care is also reduced. Consequently, as costs are ratcheted down, a point is reached where quality suffers. In mental healthcare, where new efficacious, though expensive, drugs have recently been developed, the drive to constrain cost can readily reduce access. In this sense, we face a new paradox. One of the potentials of managed behavioral mental healthcare was that it might allow parity in healthcare. The assumption

***Complaint and grievance procedures are typically characterized as patient protections, but they also provide important intelligence to delivery systems and organizations about problematic areas in their service programs.***

was that once adequate controls were in place, there would be no need to limit access through restrictive benefit design. The resource base already available was seen as adequate to provide appropriate managed care without strict limitations of benefits. It is not clear, however, that the resource base is keeping pace with psychiatric advances or with medical care more generally.

If we are to believe the evidence from numerous clinical and epidemiologic studies, then mental illness and substance abuse are vastly undertreated and many persons who could benefit either do not seek or receive appropriate care.<sup>8</sup> Clinical studies of schizophrenia and depression show vast failures in providing or maintaining evidence-based treatments.<sup>10-12</sup> Although there is no indication that managed behavioral healthcare has reduced access to initial mental health services, there are complaints from professionals, patients, and consumer organizations that managed care has inappropriately reduced the intensity of care. These complaints are very difficult to evaluate without much better data. However, there are increasing anecdotal indications from individual employers and plans that mental health and substance abuse services account for a decreasing proportion of all medical care expenditures. Given the degree of unmet need in the area, this would be disconcerting if more generally true.

There is evidence from individual health plans that mental health and substance abuse services are reduced more sharply by managed care strategies than other medical and surgical interventions.<sup>5</sup> It remains unclear whether this is because the historic high levels of inpatient utilization and long-term therapeutic interventions made lowering the intensity possible, or because the historical stigma of such services and the uncertainty about standards of care make these services easier to cut without wide-

spread complaints. The need, therefore, for evidence-based standards, quality assurance processes, and outcome evaluations should be evident.

One of the major advantages of managing care within a more flexible benefit design is the ability of the case manager to substitute equally efficacious but less expensive alternatives for inpatient care and other very expensive modalities. One would therefore anticipate that significant reductions in inpatient care should be concurrent with increases in outpatient mental healthcare and other related services. Once again, we have little appropriate data that allow adequate assessment. It does appear, however, that a common pattern is significant reduction in both inpatient and outpatient services. Conceivably, overuse and waste existed across all sectors of care. Such patterns, however, need to be scrutinized very carefully to assess whether appropriate care is being provided. Consistent drops across sectors of care should serve as a red flag for a more intensive audit.

Much of this special issue deals with appropriate outcome criteria and how to use effectiveness research to improve the quality of care. Given the diversity of managers and management strategies, the complexity of managed care products, and the rapidity of change, we will never have sufficient effectiveness research in place to answer all the critical issues we face. Therefore, we have to maximize opportunities to identify problems, obtain feedback, and audit questionable performances. In addition to practice effectiveness research and other services research endeavors, there is a need to maintain open lines of communication among purchasers, consumers, professionals, health plans and their trade organizations, and regulatory agencies. The managed care industry insists that media anecdotes have been misleading and misrepresent the positive roles of care management. But anecdotes are often a reasonable point from which to make further assessments and to correct possibly faulty practices early.<sup>13</sup> Complaint and grievance procedures are typically characterized as patient protections, but they also provide important intelligence to delivery systems and organizations about problematic areas in their service programs. Thus, such systems need to be easily accessible and user-friendly and to provide for any needed review by experts who have no financial interests at stake.

Managed behavioral healthcare is at an important turning point in its history, and its future is somewhat clouded. The explicit nature of some of the rationing strategies such as utilization management has attracted significant criticisms of the media, leg-

islators, regulators, and consumer groups. Purchasers, both private and public, have come to expect the decreased expenditures that managed behavioral healthcare brings and have become sophisticated bargainers in gaining attractive rates. The industry has already made the easy economies in care and is now functioning at capitation rates and rates for providers that challenge the ability to provide high-quality services. Facing increasingly difficult financial challenges, the industry must now fine-tune its practices to administer care at marginally adequate rates consistent with the need to ensure quality outcomes. Only time will tell how the industry adapts to these new conditions and the extent to which it maintains appropriate networks of care, particularly those affecting the most seriously and persistently mentally ill.

Clearly, the challenges are not only for managed care providers but also for purchasers, regulators, consumers, and the mental health research community. As in other areas of medical care, new technology brings advanced treatment but also increased costs. It is not clear that the shrinking mental health rates paid by purchasers or paid to providers can support the new opportunities for treatment and community management. This challenge will require serious cooperation on many fronts, including increased agreement on standards of practice and criteria for evaluation and quality assurance. It also will require greater openness of proprietary organizations to public concerns and requests for information and the willingness of these organizations to work cooperatively with purchasers, consumers, and the government in establishing a fair and workable framework for the future.

---

... REFERENCES ...

1. Mechanic D. *Managed Behavioral Healthcare: Current Realities and Future Potential*. San Francisco, CA: Jossey-Bass Publishers; 1998. New Directions for Mental Health Services; No. 78.
2. Hodgkin D. The impact of private utilization management on psychiatric care: A review of the literature. *J Ment Health Adm* 1992;19:143-157.
3. Mechanic D. Emerging trends in mental health policy and practice. *Health Aff* 1998;17(6):82-98.
4. Mechanic D, McAlpine DD, Olfson M. Changing patterns of psychiatric inpatient care in the United States, 1988-1994. *Arch Gen Psychiatry* 1998;55:785-791.
5. Wickizer TM, Lessler D. Effects of utilization management on patterns of hospital care among privately insured adult patients. *Med Care* 1998;36:1545-1554.
6. Mechanic D, Schlesinger M, McAlpine DD. Management

of mental health and substance abuse services: State of the art and early results. *Milbank Q* 1995;73:19-55.

7. Hall LL, Beinecke R. Consumer and family views of managed care. In: Mechanic D, ed. *Managed Behavioral Healthcare: Current Realities and Future Potential*. San Francisco, CA: Jossey-Bass Publishers; 1998:77-85. *New Directions for Mental Health Services*; No. 78.

8. Mechanic D. *Mental Health and Social Policy: The Emergence of Managed Care*. Boston, MA: Allyn and Bacon; 1999.

9. Rogers WH, Wells KB, Meredith LS, et al. Outcomes for adult outpatients with depression under prepaid or fee-for-service financing. *Arch Gen Psychiatry* 1993;50:517-525.

10. Lehman AF, Steinwachs DM. Patterns of usual care for schizophrenia: Initial results from the Schizophrenia Patient Outcomes Research Team (PORT) Client Survey. *Schizophr Bull* 1998;24:11-20.

11. Young AS, Sullivan G, Burnam A, et al. Measuring the quality of outpatient treatment for schizophrenia. *Arch Gen Psychiatry* 1998;55:611-617.

12. Wells KB, Sturm R, Sherbourne CD, et al. *Caring For Depression*. Cambridge, MA: Harvard University Press; 1996.

13. Rochefort DA. The roles of anecdotes in regulating managed care. *Health Aff* 1998;17(6):142-149.