

# Research Highlights

## Tracking Changes in Behavioral Health Services

### How Has Managed Care Changed Care?

#### Introduction

The system for providing treatment for mental health and substance abuse has changed so quickly and dramatically that research about its effects has not been able to keep up. There are few empirical studies about how managed care affects access, quality, outcomes, and costs of mental health and substance abuse services. Reliable data are essential for sound policy decisionmaking. For example, in the mid-1990s, many were concerned that the costs of parity legislation (mandates requiring employers to cover mental health care at the same level as medical care) would be prohibitive. But RAND studies of managed care plans that had already implemented full parity showed that under comprehensively managed care—today's dominant arrangement—unlimited mental health benefits cost not much more than capped benefits, and substance abuse benefits were also not very costly.

Parity legislation addresses *nominal benefits*, i.e., coverage limits, deductibles, and copayments. However, managed care can affect health care coverage in many other ways. Several new RAND studies investigate how the most common form of managed care for mental health, managed behavioral health organizations (MBHOs), has changed care, and how incentives embedded in contract design or in administrative procedures affect delivery of care in the private sector. MBHOs, which specialize in administering behavioral health benefits that have been *carved out* of a comprehensive health care plan, were unheard of 15 years ago. Now, MBHOs cover the majority of privately insured individuals and an increasing number of Medicaid recipients.

#### For more information:

Gresenz, C. R., and R. Sturm. Who Leaves Managed Behavioral Health Care? *The Journal of Behavioral Health Services and Research*, Vol. 26, No. 4, 1999, pp. 390–399.

Liu, X., R. Sturm, and B. Cuffel. The Impact of Pre-authorization on Outpatient Utilization in Managed Behavioral Health Plans. *Medical Care Research and Review*, 2000.

Stein, B., M. Orlando, and R. Sturm. The Effect of Copayments on Drug and Alcohol Treatment Following Inpatient Detoxification Under Managed Care. *Psychiatric Services*, Vol. 51, No. 2, February 2000, pp. 195–198.

Stein, B., E. Reardon, and R. Sturm. Substance Abuse Service Utilization Under Managed Care: HMOs Versus Carve-Out Plans. *Journal of Behavioral Health Services and Research*, Vol. 26, No. 4, 1999, pp. 451–456.

Sturm, R. Cost and Quality Trends Under Managed Care: Is There a Learning Curve in Behavioral Health Carve-Out Plans? *Journal of Health Economics*, Vol. 18, 1999, pp. 593–604.

Sturm, R. How Does Risk Sharing Between Employers and Managed Behavioral Health Organizations Affect Mental Health Care? *Health Services Research*, 2000.

Sturm, R. Managed Care Risk Contracts and Substance Abuse Treatment. *Inquiry*, 2000.

Sturm, R. Tracking Changes in Behavioral Health Care: How Have Carve-Outs Changed Care? *Journal of Behavioral Health Services and Research*, Vol. 26, No. 4, 1999, pp. 360–371.

Among the key findings from these studies:

- Small changes in contractual design can affect utilization as strongly as can the benefit changes mandated by parity legislation, suggesting that this traditional tool of health care policy may have lost much of its leverage under managed care.
- Managed care plans experience a learning curve, with improved performance over time.
- Some private-sector behavioral health carve-out plans perform better on some dimensions of quality—e.g., lower disenrollment rates, higher follow-up rates after detoxification treatment—than do fee-for-service plans or the managed care plans of the 1980s.

## How Can Contracting and Procedures Affect Delivery of Care?

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Two of the most powerful features of managed behavioral health that can shape an individual's effective benefits are the *nature of risk-sharing* and *procedures* such as utilization review, which affect the kind and amount of care provided.

### Nature of Risk-Sharing: Contracting

In a pair of studies, Roland Sturm examined the *effects of contract design* between 49 employers representing a wide range of industries in all 50 states and United Behavioral Health (UBH), a very large managed behavioral health organization. Sturm analyzed whether there were any differences between those plans in which the MBHO only managed the benefit and passed costs of care through to the employer and those plans in which the MBHO was at risk because it also acted as the insurer.

Sturm found that the type of risk-sharing had no significant effect on either access to care or hospitalization rates. This is a positive finding, since economists have suspected that contract designs would have large effects on access to care. However, in contracts in which the MBHO was at risk, inpatient costs for mental health care were significantly lower, as were both inpatient and outpatients costs for substance abuse care (see Figure 1).

### MBHO Procedures

*Pre-authorization* is an example of a procedure that can shape an individual's benefits. In pre-authorization, MBHO staff assess a patient's problems and refer the patient to a specific

provider for a fixed number of sessions. When the initial authorization is exhausted, providers must apply to obtain reauthorization for additional visits. Intended to reduce unnecessary, inefficient, and inappropriate care, this process is standard in managed care plans.

Xiaofeng Liu and colleagues examined how pre-authorization affected outpatient use of care in managed behavioral health organizations. He examined claims and authorization data from UBH for plans that had similar benefits but authorized visits in different increments—5 visits or 10 visits. He found that pre-authorization creates an artificial boundary in the length of a treatment episode. Patients authorized in 5-visit increments were nearly three times more likely to terminate treatment at exactly the fifth visit than if they were authorized in 10-visit increments.

These data suggest that the smaller increments in which care is authorized may increase the number of patients who terminate treatment prematurely. For a variety of reasons, mental health providers may not apply for reauthorization when the assigned sessions are exhausted: They may (1) not want to spend the time required to fill out the reauthorization request, (2) fear they will lose future referrals if they make "too many" requests for reauthorization, (3) misunderstand the authorization process, or (4) recall a negative experience with another managed care organization in seeking reauthorization. Thus, procedures that call for authorization of visits in small numbers of increments could create a barrier to effective courses of treatment.

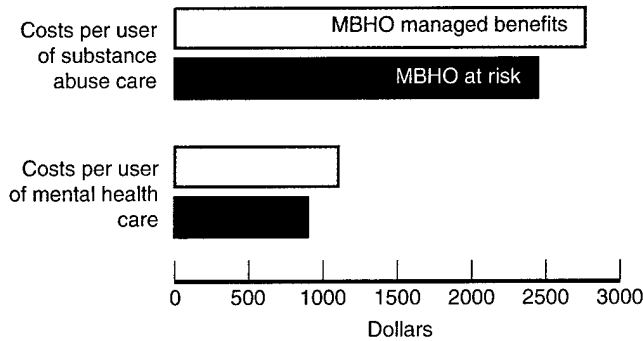
## How Do Carve-Outs Affect Quality?

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Cost declines associated with using MBHOs raise concerns that costs are falling because access has been reduced or quality of care is poorer. Because there are fewer scientifically based treatment standards of care for mental health and substance abuse than for common medical conditions, it is more difficult to hold MBHOs accountable and to define or detect inappropriate care. Valid measures of quality and outcomes in behavioral health are urgently needed.

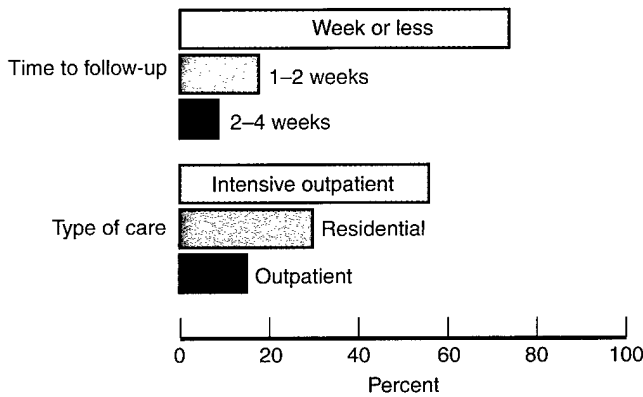
One crude indicator of quality is follow-up care. Bradley Stein et al. found that 80 percent of patients received formal substance abuse treatment following detoxification, and most received it within one week (Figure 2). This follow-up rate and the interval between discharge and follow-up care compare

Figure 1



The type of risk-sharing in managed behavioral health organizations does not affect access to care or hospitalization rates. But when the organization also acts as the insurer, costs per user are lower.

Figure 2



Follow-up care is a critical part of treatment for substance abuse. Most of the patients in these managed behavioral health organizations received follow-up care quite promptly after detoxification.

favorably with those found in non-privately insured populations. For most patients, initial treatment was at an intermediate level of care, such as residential treatment or intensive outpatient care, a treatment pattern consistent with the philosophy of the American Society of Addiction Medicine Patient Placement Criteria, which envisions patients moving along a continuum of care to the least-restrictive setting that meets their needs.

Some experts have suggested that the rate at which members leave MBHO plans could indicate unsatisfactory care—that is, members voting with their feet. But Carole Gresenz’s analysis of data from 250,000 MBHO members showed lower disenrollment rates among patients with depression than among members in managed care 10 years ago. Users and nonusers of mental health services appear to leave plans at about the same rate.

Even in plans that experience substantial declines in costs over time, indicators of access to care and follow-up care after hospitalizations remain constant. Sturm examined data from a large employer that had moved from an indemnity to a carve-out plan for mental health at the same time that it expanded mental health benefits. Costs dropped by more than 40 percent in the first year that the carve-out was introduced, and they continued to fall slowly over the next six years. The organization appeared to have benefited from a *learning curve*: Costs declined 10–15 percent whenever the organization’s amount of managed care experience doubled.

### Implications for Behavioral Health Services

The essence of managed behavioral health care is far more complex than putting providers at risk. Indeed, most of the case studies in the private sector show that managed care is primarily about information systems and managed-care tools such as utilization review, not about financial incentives to providers, who are usually paid on a fee-for-service basis.

The picture for managed behavioral health care in the private sector is cautiously positive: Costs have been contained while access to specialty care has tended to remain constant or even increase. But despite claims to the contrary by all MBHOs, monitoring quality of care or outcomes remains rudimentary. Both policymakers and researchers urgently need collaborations between managed care organizations, purchasers, and researchers to fill this information void.

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