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Trends in Behavioral Healthcare—Benefits Versus Costs

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Summary: This session presents recent trends in benefit design, cost, pricing, risk management, and delivery of behavioral healthcare.

Mr. Stephen P. Melek: I have expanded my presentation to also cover trends in the delivery of services and managed Medicaid, as well as some outcome-related comments. These are trends from my perspective. They are not absolutes, but trends I have seen in my consulting experiences. I am sure that you have your own trends from your personal experiences. It would be welcomed if you could contribute as much as possible. I have five main categories to cover: behavioral healthcare benefits, costs, healthcare delivery, Medicaid, and outcomes.

I am with Milliman & Robertson in Denver. I have been with them for six years, although I was in the Chicago office for four of those years. I have been in the actuarial profession for about 20 years, and have worked with behavioral healthcare organizations—mostly over the last three years. A lot of it had to do with a big political push, back when Hillary Clinton and the Health Security Act were viable, and with it the potential for nondiscriminatory parity benefits for behavioral healthcare. I have worked with many national behavioral healthcare organizations, as well as provider groups, different carve-out companies, etc.

What can actuaries do in this whole area? One of the things that has struck me and got me started in this three or so years ago is, from my perspective, the lack of many actuaries within the industry doing a great deal in this area—or at least a lack of writing, publishing, and researching. One of the issues that comes up is that it is hard to focus a lot on $4 or $5 or less per member per month out of the whole

healthcare pie. Most people are focusing on the other $95, $100, or more, and that is very understandable. A couple of years ago I volunteered on an SOA task force whose objective was to research activities related to behavioral healthcare. It was very difficult to get much done because of a low prioritization generally given to this field by actuaries, which is understandable. If there is anything I can do to encourage people to focus some of their interests and activities in behavioral healthcare to do more research, to get more published, to obtain more intercompany interest, whatever it happens to be—I think the industry will be better.

I have been working recently with the American Managed Behavioral Healthcare Association (AMBHA), an association that was formed back when the Health Security Act was around. Its emphasis, at that time, was to make public its own objectives, interests, thoughts, pricing issues, etc., related to behavioral healthcare, since national reform was so heavy. What has grown out of that is an association of very large organizations covering approximately 80 million lives. Think about how many people have their behavioral healthcare benefits with one of those organizations.

We are working on some research efforts that we will start this fall and will be able to publish next year related to benefit designs, types of delivery systems, utilization and cost levels, regional variations, and many different actuarial items. This is a research effort by AMBHA. Milliman & Robertson is going to be working with it and another organization called Open Minds. The more of this sort of thing that can happen within insurance companies, health maintenance organizations (HMOs), etc., I think the better overall for this subindustry, or whatever we call them.

As I mentioned, I'm going to be talking about benefit designs, costs and pricing, delivery of services, and managed Medicaid. I am not going to say much about managed Medicare. We are talking about 4% or 5% of the healthcare dollars on the commercial side. Maybe it is bigger on the Medicaid side, but it is definitely smaller on the Medicare side.

First, I will talk about benefit design, specifically types of benefits. In the 1980s, what kind of benefits did you see? A quick history here. If you go back far enough, there was parity of benefits for mental health and alcoholism, until costs went through the roof and you had 15%, 25%, and 35% annual cost increases in these benefits.

In employer organizations, the employers said, we cannot live with 15% or 20% healthcare increases overall, and if we have 30% increases in behavioral benefits, something has to happen.

What was the quick solution? Change the behavioral benefit structure; put inside limits on it. That is what we have done, and that is what still exists today in a number of places. You get limits on the number of inpatient days—30 or 60 days per calendar year or per episode, or whatever it happens to be.

Psychotherapy visits and outpatient visits were the second component in many of the old benefit designs. There were two components. Either this or that—inpatient acute or outpatient therapy sessions—and that was it.

That is hardly what you see delivered today, although in practice, or in the context of the actual benefit description, you might still read it that way. Given the liberty of providing a full continuum of services, many behavioral healthcare organizations are doing just that. You seldom see in practice just acute inpatient days and outpatient therapy sessions.

Under the old benefit structure and style of delivery, if you were a behavioral healthcare provider, what would you do? If you knew that your patients had only two types of benefits to receive, what were you going to provide? The benefits were covered if they had 30 days of inpatient care. It is funny: 30-day programs started popping up in facilities and you had treatments just that long for adolescents, for adults, and for different diagnoses. Therapy sessions had a tendency towards the programs being designed around the benefits, and that is what happened even with the inside limits. You really did not see utilization levels and the cost levels going down a lot, because the programs were structured to use the benefits up and then treatment was over, which is unfortunate if it was not successful.

Certainly I think we have come a long way from the behavioral healthcare standpoint. There is a great deal of increased use of treatment alternatives. You may be familiar with many of these different alternative programs, even though your benefits might not quite read this way. You have residential treatment facilities, partial hospital programs, day treatment programs of various designs for adolescents and adults, ambulatory detox, and other intensive outpatient services. It is no longer just an acute inpatient day and an outpatient therapy visit or medical management visit.

Successful behavioral healthcare programs have a full continuum of services. You see a lot of use of step-down-type techniques—where you want to get patients in the least restrictive, most cost-effective setting, yet have a successful outcome within this full continuum of services. They might start with an acute inpatient stabilization period, but they want to step patients down as often and as quickly as possible and get successful treatment and a successful outcome as a result. If you have a

capitated scenario, and providers have more alternative treatment liberty to obtain successful outcomes, you are going to see a lot more use of that.

We still see a lot of inside benefit limits, but from my experiences, there is an upward creep in many of these things. Slowly organizations and employers are saying, "I can take the lid off of some of these things. It is really not biting me as I thought it might five years ago, because of the way this behavioral system and the care is being managed nowadays."

You have upward creep on inside limits on inpatient days, outpatient visits, and the whole benefit package. Some employers and some benefit designs are lifting calendar year dollar limits. They might not be lifting lifetime maximum limits, but they might be lifting other benefit limitations.

There is still a lot of difference between medical/surgical coinsurance and behavioral coinsurance. Some plans might have 80%, 90%, or even 100% coverage on the medical side, and maybe 20–30% lower coverage on the behavioral side. You are starting to see that gap shrink in many cases. If you take it far enough, you talk about full parity.

You can argue about some of these inside limits. It is funny, it is almost like some of the designs are prepared too cautiously. You have a limit for everything and, in some cases, even overlapping limits. You have calendar-year limits on total dollars spent and inpatient limits on total days. You are going to run into one before you hit the other one, so do you really need all these inside limits in some of the benefit designs? Then you get the information systems and the claims-payment systems people squawking about how they are going to program and administer all these limit triggers. Maybe you do not need all of those.

Then you go all the way to full parity where there is no benefit difference. Behavioral benefits are treated like any other medical condition. You get state mandates which are involved in a lot of these things. For example, in Texas, alcoholism is treated like any other sickness. More states are moving in that direction, or at least exploring the prospects of removing some of the discriminatory benefit design features in minimum benefit plans.

If you go back to federal reform activities, one of the things that AMBHA was promoting back during the Health Security Act discussions was a nondiscriminatory behavioral benefit design. With the more recent federal design, we had the Coalition for Fairness in Mental Illness Coverage, which included NAMI, the A+PA (psychiatrists), AMBHA, and a couple of other organizations as a part of this coalition. Again, they wanted to further the cause of nondiscriminatory behavioral

benefit design. From their perspective, and taking an objective point of view, you can understand why they would want to promote that kind of thing. That is what they deliver, and they would like to be able to deliver more of those services. That is what they do.

If the belief is that you can do more behavioral healthcare delivery for less than a lot of people think, then you promote that cause. You get into parity being pushed, and you have employers and organizations like the Association of Private Pensions and Welfare Plans and a Watson Wyatt Worldwide report which might say that if you raise the minimum benefit design for behavioral benefits up to a full parity benefit via federal reform mandates, you are going to increase the average cost to an employer in their health plan by 8–10%. By just taking the benefit lid off this small healthcare slice, some say it is going to blow costs way up such that the total employer's cost is going to go up by 10%. Employers would then start dropping healthcare coverage, people are going to be unemployed, and there will be all kinds of potential consequences. That is an argument from one perspective.

Then you have the other perspective, which is the managed care perspective from managed behavioral healthcare organizations. Their perspective is that they have been doing this for a long time, they have a history of proving they can manage this on a parity basis for a lot lower cost than what others are saying, and that it's not going to cost nearly that much, so what is the big concern? You have this clash from the two different sides. The answer is probably somewhere between the two extremes. Until parity really happens, and perhaps even afterward, it will be debated.

There are case studies where you have First Chicago and other organizations that have actual proven experience where they have lifted outpatient therapy visit limits entirely from their plans, or gotten a lot closer to full parity, or gone all the way to full parity. If you want to learn more about that, you can approach those organizations to find out what they have.

There are good studies out there, which I am not going to comment on today, that say it is not going to cost very much in some cases if it is well managed and done properly—certainly not as much as some of the fee-for-service cost environment would suggest.

In a fee-for-service delivery scenario, where there may be little or no incentive to manage costs, you take the lid off benefits and you have people going to their therapists a couple times a week with no management, or incurring long-term inpatient stays for whatever behavioral condition they have. You have to manage it

and that is part of the clash between the fee-for-service, blank-check environment and the capitated, managed-delivery-system scenario.

If you think managed care and managed behavioral healthcare are here to stay (we have 80 million covered lives within that industry already), then I think you can see some of the cause and the reasons for the argument that it might not cost quite as much as some of the studies have stated.

Table 1 refers to costs and pricing. Here are some numbers we have seen. These are national commercial population levels. These acute inpatient days really are a basket which include all of the acute inpatient alternatives that are adjusted on an equivalency basis. For example, if you had a partial hospital program and you said one unit of that treatment alternative is about one-third of an acute inpatient day, you took all of your partial days divided by three and added them back into the acute inpatient days. You did that for all your alternatives, whatever they are, and you have boiled down your composite acute inpatient days. You can see some of the huge savings which have been available from old loosely managed fee-for-service delivery styles to well-managed programs.

TABLE 1
COSTS AND PRICING
UTILIZATION LEVELS - NATIONAL COMMERCIAL POPULATION

	Unmanaged	Moderately Managed	Aggressively Managed
I/P Admits	6.8	4.7	2.5
ALOS	14.4	12.6	6.1
Days/1,000	98	59	15
O/P Visits/1,000	340+	275	225(–)

If your system still uses loosely managed fee-for-service-style behavioral healthcare, I should not be the first person to tell you that you can obtain a lot of savings getting into some sort of managed behavioral healthcare program. You have annual inpatient days that are up around 100 days per 1,000 covered lives—very loosely managed fee-for-service with long lengths of stay, lots of admits, etc., which can be reduced all the way down to 15 days or lower. Some might call it aggressively managed care delivery, some people call it best-observed practice. That is how low some of the inpatient-day utilization rates have gotten.

Annual outpatient visits can be between 300 and 400 per 1,000 covered lives and a lot higher than that under loosely managed scenarios. With outpatient services, you

have a variety of things going on. You have acute inpatient days being managed down through alternative delivery modalities, which results in more use of outpatient visits. On the other hand, if you are loosely managed, you probably have an overutilization of outpatient visits. You manage that down some, too. But you are using them more as an alternative, so you do not see the same sort of total savings there as on the inpatient side. Then you have things such as access issues that might get into play here. Setting that aside, we still see some annual outpatient visits per 1,000 in the low 200s or even lower.

For those who are familiar with your own utilization rates, what kind of inpatient days per 1,000 are you achieving these days?

From the Floor: We have achieved 20.7.

Mr. Melek: How long have you been at it?

From the Floor: Six years.

Mr. Melek: Any idea what it would have been six years ago?

From the Floor: High.

Mr. Melek: Anybody else?

From the Floor: High 20s.

Mr. Melek: Another good result. Is that through a lot of managed-care activities?

From the Floor: Yes.

Mr. Melek: Nothing is as black and white as it sounds. One of the gray areas is determining how much self-selection you have. Many of the managed behavioral healthcare organizations may be a carve-out from an HMO, or a carve-in from their own parent, or an integrated delivery system, but they cover a lot of lives. That does not mean that they are all in managed, capitated environments. A lot of times an indemnity plan might hire them just to do utilization management or maybe large case management. I am sure there is some self-selection of healthier people going into some of these lower numbers. From unmanaged scenarios with high utilization, well-managed behavioral healthcare can achieve significantly higher saving rates than you would ever get in a medical/surgical scenario. It is two times or even three times the amounts of proportional savings than what you would get in a managed-care scenario on the medical/surgical side.

Let's talk about trends in unit costs. You start managing costs down and people start having to get competitive in the whole environment. Years ago we saw fee-for-service inpatient costs of about $1,000 a day for a combination of all the different kinds of behavioral diagnoses. Outpatient costs per visit for medical management, therapy, diagnosis, testing, etc., were about $125. That cost comes down when you get into these negotiated contracts and aggressively priced plans. You get savings of about 50% in these cases, where their visit rates are about $60 and inpatient costs per day are about $500 or less.

Anybody want to volunteer their latest negotiated inpatient behavioral per diem or outpatient visit rates? Are they close to these $60–$500 rates, or lower or higher than that?

From the Floor: Very close.

Mr. Melek: I do not think you see too many plans still paying $1,000 a day or $100 plus per visit. If you are still paying these rates, you might want to revisit that and see if you can do better through negotiation.

With the impact of all this, as actuaries you all know your net result per member per month is just a combination of utilization rates and average unit costs and what you are using along the continuum of services. The combined impact of the reduced utilization, discounted fees, stepdowns, intense competition, etc., has reduced the $10–$12 per member per month or more behavioral cost in a fee-for-service-environment in some cases to an eye-popping low level: $2–$4 is reasonably common today, sometimes higher. It depends on the benefits. There is still a lot of variation in benefits, but I have heard of some cases with rich benefit designs where the competition has gotten so intense that the per member per month (PMPM) is about $1.25. I shudder to think how you manage to profit on that without getting into some ethical, access, and other challenges, if you are trying to deliver quality care at that kind of a rate. You wonder how much quality you achieve and what you are delivering at a rate like that, unless it is only a limited outpatient benefit. But a full comprehensive set of benefits—how do you do it?

Let's discuss delivery of services. The traditional style of behavioral specialty care is that you have particular psychiatrists doing the diagnosing, testing, prescribing, and the ongoing medication management, and you have psychologists, clinical social workers, and other trained professionals doing some of the trudging, testing, and providing of different therapies and group programs, etc. Then you have various specific subspecialties, whenever the general psychiatrists and psychologists are not skilled to treat someone who comes in—for example, someone who is anorexic or who suffers from bulimia—so they will go to an eating disorder recovery center and

pay them on a case rate or fee-for-service basis. You have specialists on ADHT and things like that. There are subspecialties in specific disorders that the average behavioral provider might not be able to attend to. That is the way it has traditionally been partitioned.

Traditionally, you have primary care, medical, and surgical specialties on one side and the behavioral organization on the other side. In a managed care environment, how do your organizations work? How do your own health plans and delivery systems work? You probably go to your primary care physician (PCP) first. There are a lot of referrals that go through the PCPs in the traditional style. It is a multistep process in a lot of cases, or maybe, worse yet, primary care providers try to treat some of the things they are really not trained to treat. They try to treat patients who then return, and many PCP visits can go by before the PCP may finally try to treat through the behavioral organization. There are many reasons for that. The trend that I am seeing is PCP and behavioral health specialists talking about collaboration and efforts in integration.

There is more of an interest in integrating primary and behavioral care. There is collaboration with not having such a distinction between the delivery of medical and surgical services in a primary care specialty referral mode and the behavioral community. You can understand why a lot of times it was set up distinctly. I do not want to say a lot about this, but you wanted to be able to isolate the behavioral costs. The specialists, the behavioral guys, knew how to treat it. Their costs, maybe, were too high. So you tried to isolate it, have it stand alone, capitate it, get it off to the side, get that $4, $6 maybe less, over there. Then attend to the big piece of the pie in the medical/surgical area, and work with all those guys and set up all their systems over here. The behavioral group was off on the side. I think there is more of a trend that this may not be the most effective way to treat people with behavioral healthcare conditions.

There is comorbidity at stake between psychological illness and some of the chronic physical diseases. Have you looked into how much patient compliance you have when primary care doctors are trying to treat people with behavioral health conditions? If the PCPs are really not trained in behavioral healthcare and do not know what to look for, and are just either prescribing antidepressants, or maybe they are referring patients to a specialist—have you ever tried to track how many referrals were written by the PCP and how many actually were acted upon by the patient? What are your patient compliance rates for behavioral referral visits from PCPs?

I think you would find that these compliance levels are low. Maybe patients are hesitant to talk about their behavioral condition in the first place. Then, if they have

to go through this other step—maybe going across town or down the street, wherever it happens to be, but it is another step that they have to take for this specialty referral—it is just easier to take the primary care doctor's Prozac prescription home and go back to the primary care doctor when they are not feeling so well again. That is the way the gatekeeper mechanism was set up. They may not comply even after they are referred, for whatever reason.

Why is primary care integration important? If you believe that there is a trend in that direction, and I do, here are some statistics that you may find startling. I do not have all the references for these statistics, so I will say that right up front. These are statistics that I have from many different sources. I know one of our colleagues has stated that at least 30% and up to 60% of all medical visits have no confirmable medical or biological diagnosis. That is 60% of all medical visits—primary care and specialty. Some are saying that they have quantified 88% of their primary care patient visits as having no real diagnosis. You have fatigue, you have headaches, you have back pain—you have symptoms—but no real diagnosis as to what they are really treating. Could it be behavioral related?

How many of these office visits—if you can get to the real cause and treat it—how many primary care visits can you reduce? How many specialty visits can you reduce? How many can you eliminate if you start integrating medical and behavioral care and get to the root cause quicker or get to it at all? Of patients seeking primary health, 15–20% have anxiety and depressive disorders—whether they know it or not. HMO mental-health settings see only 5–6% of their covered members in a given year. How many people may suffer from some sort of minor depression, major depression, anxiety disorders, or behavioral disorder? If only 5–6% of these sufferers are going to their HMOs, how many untreated behavioral conditions are out there, especially if the HMO is serving as a gatekeeper? Another statistic is that 50% of all behavioral healthcare delivered is being done in a primary care setting in some way, shape, or form. These are big numbers.

Two-thirds of all psychotropic medications are written by nonpsychiatrist physicians. That includes stimulants, tranquilizers, sedatives, etc. Two-thirds are written and prescribed by nonpsychiatrists. I wonder if all of that utilization is necessary or if it is always as effective as it can be. Are you taking a look at your detailed prescription drug utilization and figuring out where the behavioral medications fall? I bet they are high, maybe even at the top of the list.

Primary care patients are noncompliant, as I have already mentioned, when it comes to behavioral healthcare referrals. Different statistics mentioned by different organizations are that they are noncompliant from 30 to 75% of the time.

Undiagnosed and untreated anxiety and depressive disorders result in significantly greater medical costs—up to double the costs—and greater social and vocational disabilities. We are not going to get into medical-cost offsets, but there are studies that have to do with the effects of treatment of some of these behavioral disorders versus undiagnosed and untreated behavioral disorders and the related effects on medical costs.

Along those lines, I'd like to discuss comorbidity prevalence. Here are some different chronic conditions on the medical side and rates of comorbidity from some epidemiologic studies that some organizations have done on the relationship between psychological illness and chronic physical diseases. These figures are age/sex adjusted. Arthritis has a 25% prevalence of a psychological illness. Other prevalence rates are 30% of all cancerous conditions, 23% of diabetes, 35% of heart disease conditions. Hypertension is at 22%, chronic lung disease at 31%, neurological disorders at 38%, and even well patients are at 18%. In other words, 18% of medically well patients have some sort of undiagnosed or diagnosed psychological illness.

Now that we have talked about why primary care integration is important, here are some of the trends in the integration of medical and behavioral systems. There is an ongoing trend towards the coordination of separate but related mental health and medical agendas and care. There are interdepartmental and interclinic care planning for patients, case management for patients, and program development. They are getting together departmentally and within their clinics to plan to manage care on a concurrent basis, to develop programs, and to try and get a smooth transition between the medical and mental health portions of care for people with chronic conditions, or people who are presenting themselves with a medical condition that has a related behavioral diagnosis.

If you get these professionals together working interactively, how much improvement can be made in the system? Mental health professionals are then being treated just like one of the doctors. You have cardiologists, orthopedists, and psychiatrists all in the same room talking together on a friendly basis.

There are on-site behavioral members in the medical teams, medical planning, etc. You see more of them in the same halls working interactively together. They are getting involved together with case-finding programs. It is a process where they are seeking out problem cases ahead of time with early intervention instead of waiting for things to pile up and happen. They are trying to prevent more costly care later. This could include inpatient medical/surgical problems. For example, while patients are in a facility for different sorts of diagnoses and reasons, the behavioral team working with the medical/surgical team would go patient by patient through

the facility trying to explore potential causes of medical problems, even if they are not on the surface, including behavioral, alcohol, or drug abuse conditions, that need to be addressed while the patient is in the facility. The behavioral team and the medical/surgical team are also working together in the emergency rooms (ERs).

There is one study that has been done that says the average panic disorder patient goes to an emergency room nine times before they start getting treatment for their panic disorder condition. That is because the ER medical/surgical clinicians often do not identify the true underlying disorder. If someone is suffering from panic disorders, their condition is being expressed in all kinds of different ways. If you do not have the behavioral professional there to help identify that, unnecessary medical treatments and observation can just go on and on. How would you like to cut your outpatient ER visits for these types of patients from nine down to two or three? How much will that save, and how much earlier do you get to the root cause? Do you get to the root cause where you never did before? There are ways to do that with behavioral professional interventions.

I have a client who is trying to identify patients who overutilize ER services—heart monitoring, electrocardiogram (EKGs), observations, etc.—within short periods of time, without ever getting admitted. This is because they presented themselves as if they had various different kinds of heart conditions, which they really do not suffer from on a serious basis, but instead suffer from the panic disorder effect. If you can identify those people, and actively go after them with some sort of behavioral treatment intervention, how much can you save on the medical side? How much can you save from worsened behavioral conditions down the road? This is the integration of medical and behavioral systems at play.

Other types of integration efforts include therapy groups run in primary care settings. If you do not have a lot of experience with behavioral healthcare, there is some resistance from people. There is the stigma that you have to identify up front, and there is also the resistance to being classified. You are one of "those," you suffer from depression, or you have a drug abuse problem. There is the stigma that you have to go "over there" to get treated, whereas if you can get treated in a primary care type setting or in the regular medical clinic with all the other specialists, there is something favorable to be said about that—especially for adolescents. There are groups that are running psychotherapy sessions right in the pediatric clinics, so that kids feel more comfortable with what is going on instead of having to go to a separate behavioral clinic. It is normalizing the treatment and the conditions a bit more.

You have examples like the Early Start Program, which is a type of early behavioral intervention for substance-abusing pregnant mothers, to try to get these mothers, at

least temporarily if not permanently, away from their substance abuse. They are not doing that in a fancy behavioral clinic in most cases—they do it right there in the medical clinics. You have the moms there on normal visits for their pregnancies. But if you identify them as a high substance-abuse risk, you can intervene and try some behavioral-related interventions to get them off their substance of choice and, hopefully, reduce premature deliveries, complicated deliveries, postpartum problems, etc. These are some of the things that are going on.

You have multidepartmental treatment of chronic pain and attention deficit hyperactivity disorders—all the different professionals working together to allow the patients, and the providers themselves, to experience more of a global approach. It is not like a segmented, specialized approach. It is a teamed approach to healthcare delivery that is interested in the total wellness of the patient. You have the team approach including, for example, cardiology, psychiatry, and psychology. The primary care doctors and specialists are involved in a team approach, decreasing some of the possibility of certain treatments being overlooked, using more of a woven approach to healthcare and wellness from the patient, provider, and employer perspective as well.

We are all familiar with how much employers can shop their healthcare. My personal belief is if you have a delivery system that is well-run, well-managed, has good access and good quality care, where your employees are happy—there is not going to be a lot of reason to switch carriers other than pure price wars, which I think more large employers are getting away from. They are increasingly concerned with the overall wellness of their employee base. Employer desires include getting and keeping their employees and dependents well, reducing disability days, nonproductive days, and sick days, achieving higher productivity within the work environment, etc. I think employers are getting more focused on total wellness, integrated healthcare, and having happy employees.

How are providers responding to some of these integrated efforts? You have video conferencing going on. If the primary care doctors do not know how to treat behavioral conditions, what do they do? They can set up these big video conferences and get the primary care doctors in a room and set up a big screen, and have the behavioral guys on the other end teaching them how to identify these things. If they cannot interact with them on a day-to-day basis right on site, a video conference is one thing they are doing. They have joint staff meetings instead of separate staff meetings. It includes use of online systems and technology. In a primary care setting, they can get help on some of the behavioral healthcare issues—even if they do not have the behavioral professionals right on site to treat them.

I will talk a little bit about medical costs offsets. Here are some of the medical cost reductions achieved. These are medical reductions achieved in different service categories through behavioral medicine interventions. Ambulatory care visits were reduced by 17%. Visits for minor illness (primary care visits) reduced by 35%. Remember how I talked about how many primary care visits really have no specified diagnosis related to them? Pediatric acute illness visits were down 25%. Office visits for acute asthma were down by 49%. Office visits for arthritic patients were down by 40%. Average length of stay for surgical inpatient admissions was down by a day and a half. This has to do a lot more with the stress levels and the anxiety levels of the patients who are going in for major surgeries. It has to do with the way they are coping with the surgery overall. The behavioral intervention is with major surgery patients and addresses how much can be saved through some of those efforts and activities. C-section rates went down by 56%. Epidural anesthesia during labor and delivery was down as much as 85% in some of the studies.

Now I want to branch over to Medicaid and managed Medicaid programs. If you do not have much experience on this, there has been a lot of effort—increasingly so on a state-by-state basis—to manage Medicaid healthcare costs. Many times states have actually started by managing their Medicaid behavioral costs.

First of all, you have the differences in Medicaid costs based on enrollment. It is mandatory in over 30 states, or at least in some part of their states, that the Medicaid recipients must choose a managed care plan to receive services in their area. The other alternative is a voluntary basis. This is the way it is run in Colorado. They also have a Medicaid pilot program for behavioral healthcare. In voluntary areas, you have managed care organizations marketing directly to the Medicaid eligibles to try to secure their enrollment. They have a choice, but you have the Medicaid HMO plan going to the eligible people and trying to get them to sign up.

I do know that there are conflicting findings about which type of program is more likely to produce cost savings. Some of the mandatory programs say they save more, and some of the voluntary programs say they save more. I would suggest you investigate and make your own choice.

Within managed Medicaid you have risk versus nonrisk programs. The most common model is a primary care case-management program in which the primary doctors are serving as gatekeepers for approving the various primary care and specialty services. This role, in a specialty plan, might be held by a behavioral healthcare organization that undertakes the utilization management.

You have primary care case-management programs typically paying on a fee-for-service basis, rather than any sort of a shared-risk basis, in a lot of cases. I think the

trend in Medicaid and managed Medicaid programs is toward a full-risk program, where an HMO or an insurance company is accepting a fixed capitation from the state to provide for all primary care and specialty care services. Often they will either carve in or subcontract out all the behavioral services using a subcapitation.

An example of that would be within Colorado. We had a five-area pilot program that kicked off a while ago that the state presented where the fee-for-service style Medicaid delivery costs had been for behavioral healthcare. They measured it by eligibility category—social security income versus aid to families with dependent children versus foster care, etc. They trended that forward and identified their upper payment limits. All interested bidders knew the highest bid the state would accept. They also identified the minimum set of benefits that must be provided. So you have the maximum rate and the minimum benefits to design a proposal. You could go up to the maximum rate by eligibility category, and you could provide anything above and beyond the minimum services. Your chance of winning was related to how many additional new services you were going to provide beyond the minimum benefits that the state established, and how competitive your bid prices were while going up to but not above the maximum cap rates.

The state was also concerned about all the community mental health centers that had been providing a lot of this care to the Medicaid and the uninsured populations. They were concerned about big behavioral healthcare organizations coming in and taking over. The state required that there would be some sort of partnering or teaming between any managed behavioral healthcare organization and the community mental health centers. Our client was chosen with one of the five pilot programs awarded.

Interestingly, as a footnote, our client got a bit concerned with the very favorable financial results that came in the first year. It got its award a bit under the maximum cap rates, while offering a variety of new services. It started managing the care—very effectively during the first year. Without stating numbers, it saved the state a fair amount of money. It also made a fair amount of money from the state's capitated payments versus its total behavioral healthcare costs.

One of the requirements in some of these capitated Medicaid programs is not just the capitation, but also the experience reporting as you go along. The state may be concerned that if you do really well financially, maybe it set the cap a little bit high. The concern of the client was that if it was so financially successful the first year, would the state start pushing the cap rates down on them? We discussed issues related to year-to-year statistical fluctuation, risk-based capital requirements for healthcare delivery, other risk reserves that it had not set up, incurred but not

reported reserves, etc. If you have been involved with some of these state Medicaid programs, I would be interested in hearing your comments on this issue.

There have been different approaches with the state Medicaid programs—carve-ins and carve-outs. One of the reasons why organizations are going after Medicaid business is that other markets are getting saturated. If you have behavioral healthcare organizations covering so many lives already, where is the new business to be found? The new business is to be found under Medicare risk contracting, which has far more risk on the medical/surgical side, but also with managed Medicaid business.

I think carve-outs are more common among the state Medicaid programs. I have talked about the Colorado pilot already, which is a carve-out. That has an advantage from the behavioral network position because it puts them closer to the state policymakers. It allows them to treat the seriously and persistently mentally ill, if that is a part of their covered population, with more direct access than traditional providers. The problem here is the potential gap between primary medical and behavioral services.

In a carve-in program, you have the financial integration with primary medical care. The HMO takes the carve-out from the state and then, within it own organization, carves in the behavioral healthcare. It encourages a closer integration of services. From the behavioral perspective, however, it is farther removed from what is going on. It does not have access directly as it would on a carve-out basis through the state decision-makers. There could be concern about the behavioral treatment dollars getting squashed a little bit. If the HMO was having trouble on the medical/surgical cost side, it could choose to reduce the behavioral carve-in cap rates. What can the carve-in behavioral organization do if it is downstream from those decisions? So that is the potential problem. It could be a problem. It could be a solution. It depends on what your perspective is.

What about some early results of some of these programs? Massachusetts has claimed—and I do not have the most recent results—that it saved over 28% on the behavioral cost side. During a three-year period, Massachusetts saved over $70 million through its own managed Medicaid program. Hawaii is claiming it lowered medical costs through managed mental health programs. This is not cause and effect, but Hawaii is claiming that when it compared fee-for-service Medicaid behavioral programs to managed Medicaid behavioral programs, coincidentally its medical service utilization and costs were 20–40% lower as compared to their control groups.

TennCare has even reduced its costs. Everyone is probably familiar with the problems of TennCare. It reduced its cost increases. Instead of having 20% or more increases per year in its Medicaid services, TennCare has it down to almost a flat level now where it is seeing very small increases. It wants to see decreases in the near future. TennCare has gone from a carve-in approach to a carve-out approach. It is a fluid environment right now.

Generally speaking, these Medicaid programs have reduced inpatient admissions and average lengths of stay. They have increased the use of outpatient treatment plans, and they have stated that there has been no change in the treatment completion rates. Some of the concern is that with fee-for-service programs, everybody finishes the programs because the providers want to get those fees. In a managed environment, there may be people dropping out of programs early and, therefore, they are unsuccessful in their outcomes. However, there are a lot of claims that so far this is not happening even in a managed environment—patients are still staying with the programs.

Let's discuss quality and access pertaining to Medicaid. First of all, it is certainly difficult to measure quality in a lot of these things. There have been few clear results. There are efforts in that regard, but there is not a lot being said as far as measurable Medicaid results yet. They are saying that they are seeing slightly lower recidivism rates and overall improvements in quality scores from providers, except for some concern about inadequacies on the child and adolescent side in these managed Medicaid programs. There is concern about whether they are all being properly cared for there.

Patients enrolled in HMOs were less likely to have their depression treated or detected. They were less likely to receive care by psychiatrists or maintain a medication regimen for two years of followup. Massachusetts reported a 5% increase in their number of Medicaid patients gaining access, and that is including greater access to inpatient alternatives. Some patient advocacy groups are concerned and are closely monitoring the access issue. Some of the managed Medicaid programs are also involved with the uninsureds in their particular states. They are trumpeting the fact—and I think rightfully so—that they have improved access to some of the previously uninsured residents in their areas.

I want to say a few things about measuring outcomes and trends in that area. It has to do with retrospective versus concurrent measurement. Historically, people have talked about outcomes on a very retrospective basis. Purchasers are now asking that outcomes make the transition "from the bench to the trench"—meaning concurrent outcomes be conducted regularly rather than retrospectively at the end of one or two years. Data systems must be accessible and user friendly to make

concurrent outcomes even plausible. Setup and ongoing operational costs must be manageable.

Ideally, a continual approach using real-time data is the goal of a lot of these outcome systems that occurs when you collect and analyze information about the patients and the different treatment modalities while the patients are getting treatment, which is easier said than done.

What about the effects of our outcome measurement on providers? You have clinical feedback groups to refine the treatment and medication programs while patients are in treatment. You have concurrent review constantly, with ongoing clinical evaluation and feedback loops. You can set corrective actions, especially with some of the more serious conditions that are going to need more case management, more ongoing review, and constant correction, if mid-course corrections are necessary.

Some of the concerns relate to using these concurrent reviews and these outcome measurements to do provider profiling. The system may identify providers that are really good in a particular area and then may send all of certain types of patients to them. This may create specialists out of generalists. The providers may not care for that. Worse yet, from the providers' perspective, are you going to use concurrent review and provider profiling to tell them that they are not measuring up to a particular standard and then kick them out of your network?

From a treatment perspective, concurrent outcomes make a lot of sense—especially if you have a teamed approach where you have chronic medical and behavioral conditions. If you have chronic behavioral conditions and concurrent reviewing going on, it makes a lot of sense to funnel back results into the delivery system. It can help with a more precise definition of medical necessity. It can also help to identify program dropouts, patients at high risk for rehospitalization, and patients with symptom clusters needing earlier use of psychopharmacology.

Regarding future trends and outcomes, I think there is a movement toward disease management, instead of delivering care on an episode-by-episode basis. Another future trend is there is more activity in managed disability and managed workers' compensation. If you believe that behavioral healthcare and behavioral conditions affect the cost of medical benefits, they are also going to affect disability benefits and workers' compensation benefits. It is not about managing specific episodes. It is about managing for wellness.

Mr. Jeffrey L. Smith: I have a couple of comments, some concerns and cautions, and maybe some hopeful thinking going forward on Medicaid products. I want to

talk specifically about a situation in Ohio. Ohio has a combination of some mandatory and some voluntary counties for Medicaid enrollment. Mental health currently is a carve-in program. There was some attempt in fiscal year (FY) 1997 to carve that program out. Capitation rates in Ohio actually have gone down the last two years. They went down in FY 1996 and are going down again in FY 1997 in aggregate. This is fairly typical based on a reduction from the existing fee-for-service equivalent cost in the state's own program, or in mandatory counties based on some artificial fee-for-service kind of estimated equivalency.

The real issue is, as in many other states, that Ohio is assuming that managed care is going to provide some savings, and it is building that into the capitation rate-setting methodology. Specifically, where 95% of the fee-for-service equivalency was used in the past, Ohio is now saying that is one benchmark. Ohio is going to cut an additional six points, and expects overall managed care to be six points better. Additionally, it is going to carve out mental health as a fee-for-service equivalency. It's ignoring the fact that managed care is operating already better than that. Ohio is going to carve it out at a bigger rate, and expects it to be 6% better in total. Ohio is also considering treating some pharmacy programs differently. Managed care must use Ohio's wide-open formulary and still keep that 6% cost reduction.

If we want to do more integration, whether it's risk-sharing or data-sharing integration in order to have the different medical disciplines work together, many of these approaches, such as what Ohio is trying to do, are actually going the wrong way. They are going to get some short-term savings, but in the long term either networks are going to fall apart, or the quality is going to go down. In the long term, the benefits and the cost for the Medicaid recipients are certainly going to deteriorate.

I would just comment and, hopefully, encourage a little bit of an awareness from the regulators. I think we're all in this to save money over the long term, but let's not damage things by taking incorrect approaches in the near term.

Mr. Melek: I think that you would probably get a fair amount of agreement if you talked to carve-out, free-standing behavioral healthcare organizations on where the trend is going to go. Ultimately, I think the trend is towards integration. I think that self-contained, carve-out type companies realize that. It is only a matter of time, probably, before the number of carve-out companies dwindles farther through mergers or acquisitions. Integration may become very important to everybody. The industry is probably going to change, and I think in a positive direction. It makes sense to have that kind of integration and not have all this, as you described, segmentation and fragmentation of delivery of care.

From the Floor: I offer no experience at all. From a delayed perspective, it seems to me that within the medical community, the procedures, the protocols, and the range of difference in those is not terribly wide. In a behavioral approach, however, I have seen all sorts of different procedures and techniques and things that would be used to compare programs.

How do you know the statistics from the studies are astounding in terms of how much savings there can be in the costs, particularly when you do the integration? How can you know that you have a behavioral program that is going to have that kind of effect on the overall costs, and not be something that really will not provide anything or will end up costing more?

Mr. Melek: That has been part of the debate from day one—that of defining medical necessity. For a cardiologist, for example—although within any specialty—there are always gray areas about what is medically necessary and what is not. Medical necessity definitions in a lot of medical and surgical specialties are a whole lot narrower than the medical necessity criteria, or lack of criteria, in behavioral healthcare. That has been part of the knock related to the subjective nature of behavioral healthcare delivery.

With potential behavioral interventions and medical cost offsets, however, suppose you leave it to the behavioral healthcare specialists—the psychologists, psychiatrists, etc.—to be able to, using their clinical expertise, design new programs that work and that are cost effective. If it is a fee-for-service system, you may think about whether they should do all those things if treatment decisions are so gray. Should they start up a new program if it is just going to drive behavioral healthcare costs up? You may be concerned about the loss of control of the way they deliver behavioral healthcare services. That is part of the old style. If they are all at risk, then they have got to run their business and design their programs so that they work, both clinically and financially. If they do not, they are the ones that are at risk for losses.

When they start interacting these programs with the medical/surgical staff, and if a primary care doctor asks the psychiatrist how does he or she know that this new program is going to work, that is now a different discussion. If both of their dollars are jointly at risk, then they have got to prove that their case works. That is where you need case studies and proven examples.

If you are an organization that always wants to look through the back window and see where you have been and let somebody else take the risk and prove new programs work, you can run a shop that way and be very effective. If there are significant paradigm shifts in the industry, you may be a little late in the game and

lose a fair share of your business, whatever that happens to be, if you do not have that innovative side to you. I am not saying jump on every behavioral bandwagon that is coming along. There is a fair amount of risk-taking they have to do with their own programs to make this work, proving their cases with the medical/surgical side and taking it piece by piece as they go along.

Mr. Robert H. Plumb: With regard to the last question, I am aware from anecdotal studies of the psychiatric profession that, first, there is this tremendous problem of repeated primary care visits by nonproperly treated depressive patients of various types. Second, I'm aware that there is a tremendous number of variations within the behavioral health context, protocols, etc., that are advocated and used. There seem to be many of them, and the various branches don't talk to one another. They say we're the greatest, you're no good. There are some very sharp divides. It is not like the rest of the medical profession where there may be some differences in the way the protocols are put together, but at least there is a set of protocols. With behavioral health, there seem to be sets of them and more invented every day, and it seems to be widening more than contracting at the moment.

Pilot studies in the U.K. into this sort of idea of managed care in behavioral health are working. Some of the figures are being seen, but they are by no means as advanced or as targeted as the ones that you have.

Mr. Melek: For behavioral healthcare, that is one other hot subject if anybody wanted to offer their comments. Let's take an informal poll. How many of those present think that we will eventually see parity of behavioral healthcare benefits compared with medical/surgical benefits—that it will happen some day? Most everybody. How many people think that it should happen? Still most hands. I am surprised. I thought there would be more anti-parity people than pro-parity people here.

Mr. Thomas P. Edwalds: I want to get a clarification from you on quality and access. You mentioned there are inadequacies found for children and adolescents. Was that strictly for Medicaid managed care?

Mr. Melek: Yes.

Mr. Edwalds: What were those inadequacies? Exactly what problems were discovered?

Mr. Melek: This is a bit anecdotal, but my understanding of some of the concerns on that side gets to prioritization of patients within a managed behavioral healthcare organization that has to treat a wide variety of conditions within the Medicaid

population. There may be more drug abuse, alcoholism, or many other things. There may be a lot of problem kids, seriously emotionally disturbed kids, etc.

The anecdotal concerns I have heard are that it has been more common for the dollars and the attention to be paid on the adults than on the adolescents and the kids. For whatever reason, that is what the concern is. The concern is increased when you get into these managed programs and you have only so much you can do. The concern is more about the kids with the problems, and more kids having the problems, and is the care really being spent more on the adults.