



*The Provision of*  
**MENTAL HEALTH  
SERVICES** *in*  
**MANAGED CARE  
ORGANIZATIONS**



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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# Acknowledgments

The preparation of this report on mental health was supported by a contract (#98M-0028601) by the Substance Abuse and Mental Health Services Administration (SAMHSA), U.S. Department of Health and Human Services (DHHS) with the Schneider Institute for Health Policy, Heller School for Social Policy and Management, Brandeis University. Primary support for the overall project was provided by the National Institute on Drug Abuse (NIDA) (Grant #RO1 DA10915) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) (Grant #RO1 AA10869). We thank our project officers, especially Jeffrey Buck at SAMHSA, who provided the initial concept for this report; as well as William Cartwright at NIDA and Michael Hilton at NIAAA, who each provided guidance and support throughout this project. William L. Wallace assisted in the preparation of this report.

The authors acknowledge the contributions of our Brandeis colleagues, Della Faulkner, David Goldin, Michele King, Grant Ritter, Kate Skwara, Terri White, and Galina Zolotusky. We appreciate the interest and support provided by the executive directors, the medical directors, and their colleagues in the managed care organizations included in our study. We also thank individuals in the managed behavioral health care organizations that helped with this study.

We thank the members of our expert advisory panel: Laura Altman, John Bartlett, Kenneth Cohen, Bruce Davidson, Thomas Dial, Richard Frank, Suzanne Gelber, Thomas McLellan, Claire Sharda, and Kenneth Wells. Numerous other advisors and colleagues also provided useful input at various stages of the project, including Steve Adelman, Stuart Altman, Paula Breslin, Audrey Burnam, James Callahan, Mady Chalk, Thomas D'Aunno, Spencer Falcon, Judy Feldman, Robert Fusco, Eric Goplerud, Dennis McCarty, Margaret O'Kane, David Osser, James Sabin, Rebecca Smart, and William Zwick.

Staff members from Mathematica Policy Research, Inc.—especially Charles Denk, Todd Ensor, Marcia Giletto, Marsha Gold, Patricia Nemeth, Joanne Pascale, Frank Potter, Julie Rothbard, Richard Strouse, Sally Waltman—and the interviewers provided invaluable expertise in helping to design the survey instrument and sample, and in collecting the data.

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*Recommended Citation*

Horgan, C. M., Merrick, E. L., Garnick, D. W., Hodgkin, D., Cenczyk, R. E., Lusenhop, R. W., & Bhalotra, S. (2003). *The provision of mental health services in managed care organizations*. DHHS Pub. No. (SMA) 03-3797. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

*Originating Office*

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Center for Mental Health Services  
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5600 Fishers Lane, Room 15-87  
Rockville, MD 20857

Printed 2003

DHHS Publication No. (SMA) 03-3797.



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# Executive Summary

**T**his study reports on a nationally representative survey of managed care organizations (MCOs) regarding how mental health services were provided in 1999, and how the provision varies by product type and contracting arrangement.

“Product type” refers to how the MCO organizes or packages the health services it sells. This paper refers to three types of products:

- health maintenance organizations (HMOs)
- point-of-service (POS) plans
- preferred provider organizations (PPOs)

“Contracting arrangement” refers to whether mental health services are delivered internally by the MCO (through salaried providers or a network managed by the MCO) or delegated to another organization through contractual arrangements. A specialty contract indicates that mental health services are contracted to a vendor such as a managed behavioral health care organization (MBHO) that specializes in the delivery and management of behavioral health services. A comprehensive contract includes both mental health services and general medical services from a single vendor or network. Key findings are reported below.

## **Products and Contracting**

- HMOs are most likely to report using specialty contracts with MBHOs.

- Products with specialty contracts are more likely than those with comprehensive contracts to delegate functions such as formation of provider networks, claims processing, utilization management, and operation of quality improvement programs.
- About half of products with specialty contracts place the MBHO at some risk if claims costs exceed targeted amounts.
- HMOs are more likely than PPOs to include performance standards in their contracts with MBHOs.
- PPOs are the only product type that makes extensive use of comprehensive contracts.

## **Benefits**

- A majority of products have annual limits on outpatient mental health visits (most often 20 or 30 visits) and on inpatient days (most often 30 days). Outpatient visits are subject to substantial cost sharing.
- Cost sharing for outpatient visits is notably higher for mental health than for general medical care.

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## Screening and Treatment in Primary Care

- Fewer than 10 percent of products require screening in primary care settings for mental health disorders using standard screening instruments.
- About half of products distribute practice guidelines for selected mental health disorders to primary care providers.

## Entry Into Treatment

- The vast majority of products feature either direct self-referral or phone center referral for specialty mental health care.
- Even among HMOs, few require approval of primary care gatekeepers to access specialty mental health care.
- Prior authorization generally is required for inpatient care. HMOs and specialty contract products are much more likely to require preauthorization for outpatient care.

## Treatment Process

- Most products have standards for how long one must wait for a first appointment.
- HMO and specialty contract products are more likely to have specialized programs

for patients with co-occurring mental health and substance abuse disorders.

- Products with specialty contracts usually delegate initial utilization review to the MBHO.

## Quality Management

- About three-quarters of products conduct patient satisfaction surveys, track performance indicators, and have practice guidelines regarding behavioral health.
- Half of all products conduct clinical outcomes assessment.
- These activities are more common among HMO and specialty contract products.

This study shows that MCOs provide mental health services in diverse ways. Elements of this diversity include whether to contract out mental health services to a specialty vendor, which utilization review responsibilities to delegate, whether to require primary care providers to screen patients for mental health problems, and which quality-of-care activities to conduct. Understanding issues related to access, cost, and quality of mental health treatment services requires knowledge about the service variation that is related to product type and contractual arrangements.



# Background and Study Methods

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**D**espite the fact that most privately insured individuals in the United States receive their health care under managed care, little is known about how individuals receive mental health services under these arrangements. This study reports on a national survey of managed care organizations (MCOs) regarding mental health services—the first such survey conducted since 1989 (Interstudy, 1992). Tremendous growth and tumultuous change occurred during the 1990s. This report provides an in-depth update about mental health service provision under managed care. The goal of this report is to provide an understanding of MCOs’ provision of mental health services for privately insured enrollees.

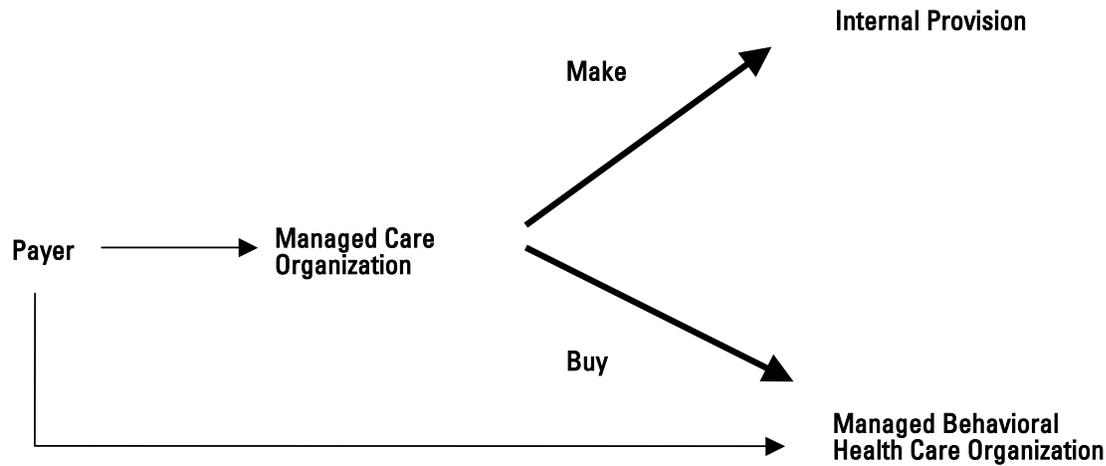
## Background

The organization and financing of mental health services have changed dramatically in recent years. MCOs are now the predominant form of private health plan coverage in the United States, enrolling almost 90% of those with employment-based health insurance (Gabel et al., 2000). Simultaneously, the managed behavioral health care industry—managed behavioral health care organizations (MBHOs) specializing in mental health and substance abuse services—has experienced huge growth. Two-thirds of Americans with health insurance now are enrolled in some type of managed behavioral health care program, with enrollment increasing 86% since 1995 (Oss, Jardine, & Pesare, 2002).

The growth in the managed behavioral health industry has occurred because some employers, government purchasers, and health plans have looked to MBHOs as a way to control costs and/or to improve the quality of care. Employers and government

purchasers can choose to separate (“carve out”) mental health and substance abuse services from the rest of the medical care package and contract directly with MBHOs for behavioral health services (Figure II.1). Alternatively, they can follow the traditional approach and purchase behavioral health coverage along with general medical benefits from the MCO. The MCO can choose to manage and provide (make) behavioral health services within its own organization or to contract out (buy) these services from a specialty MBHO. This report is based on a survey of MCOs focusing on how the MCO provides behavioral health services—that is, the right-hand portion of Figure II.1. We do not report on direct employer or government purchaser contracts with MBHOs, which require different data sources such as employer surveys (including Buck et al., 1999; Horgan et al., 2000; Salkever & Shinogle, 2000) or studies of state Medicaid programs (including Callahan et al., 1995;

Figure II.1: Pathways to MBHOs



Source: Adapted from Hodgkin, Horgan, & Garnick, 1997.

McGuire, Hodgkin, & Shumway, 1995; Rosenbaum, Shin, & Smith, 1997).

The ways that MCOs structure and deliver mental health care, including decisions to contract out these services, can affect the experience of enrollees seeking and receiving treatment. Given the fact that most people with mental health problems do not receive care despite the availability of effective treatments, it is crucial to facilitate access to and continuation of necessary and appropriate services (Regier et al., 1993; DHHS, 1999). Gatekeeping requirements to access specialty mental health care, utilization review procedures, provider practice guidelines, and screening for mental health problems in primary care settings are all examples of delivery system features that can influence the care that people receive.

The growth of managed care in general, as well as managed behavioral health care in particular, has raised both hope and concern. Some observers note that MBHOs may improve the quality of behavioral health care

through the development of comprehensive services, coordination of care, improved networks of care, and increased use of “best practices” (Jeffrey & Riley, 2000). Because they are specialized, MBHOs may have a greater level of expertise, which would make achievement of these goals more likely. Others are concerned that financial arrangements with MBHOs may lead to limited access or undertreatment, and that the administrative separation of behavioral health from general medical services may lead to fragmentation of care (Strosahl & Quirk, 1994; Sederer & Bennett, 1996).

A substantial body of research has been published on employer or government purchaser carve-outs (Grazier & Eselius, 1999; Sturm, 1999; Horgan et al., 2000). However, little recent information was available regarding MCOs’ provision of behavioral health services in relation to contracting choice until the current study, which was designed to help address this gap in the literature (Garnick et al., 2001; Garnick et al.,

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2002; Hodgkin et al., 2002; Hodgkin et al., 2002; Merrick et al., 2002). For an overview of the full study, see Horgan et al. (2000).

The overarching purpose of this report is to present key findings about how MCOs provide mental health services and how this varies both by type of MCO and by whether the MCO carves out service provision to a specialty vendor. The study concentrates on MCOs' commercial products, since Medicare and Medicaid managed care has various special characteristics, discussed elsewhere (Buck, 2001; Hanson & Huskamp, 2001). The current study focuses particularly on aspects of MCOs' mental health care arrangements that can clearly affect enrollees' experience of accessing and receiving mental health services. MCOs face a myriad of decisions with respect to these issues. The outcomes of these decisions have the potential to support or hinder the use and quality of behavioral health services for large numbers of people. While the study is organizational in nature and therefore cannot provide information about utilization patterns or quality of care in MCOs, the results provide a comprehensive picture of how MCOs (and their vendors, when applicable) currently finance and organize their delivery systems for mental health services. The results will help to inform policy-makers, consumers, advocacy organizations, and other stakeholders (including MCOs and MBHOs themselves) in the ongoing debate over the promises and pitfalls of managed mental health care in its various forms.

## **Methods**

### *Data Sources and Sample*

The primary data source for this report is Brandeis University's *Survey on Alcohol,*

*Drug Abuse, and Mental Health Services in Managed Care Organizations* (hereafter referred to as the "Brandeis survey"). The Brandeis survey was funded by the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) for primary data collection and analysis, and was supplemented by the Substance Abuse and Mental Health Services Administration (SAMHSA) for additional data analysis and case studies on mental health services. This nationally representative survey collected information from 434 MCOs in 60 market areas regarding behavioral health services during 1999, achieving a 92% response rate. Each MCO was asked about its top three commercial managed care products. The Brandeis survey included an administrative module addressing contracting arrangements, benefits, and provider payment; and a clinical module addressing utilization management, treatment entry mechanisms, prescription drug formularies, quality improvement, and other clinically oriented topics. This report presents the Brandeis survey data on the provision of mental health services only; information regarding alcohol and drug service provision is reported elsewhere (Garnick et al., 2002; Hodgkin et al., 2003).

The Brandeis survey is linked methodologically to the *Community Tracking Study* (CTS), a longitudinal study of health system change funded by the Robert Wood Johnson Foundation and described more fully elsewhere (Kemper et al., 1996). The CTS sample design contained strata for large metropolitan, small metropolitan, and nonmetropolitan market areas. Within strata, nearly all sites were randomly selected, with probability proportional to size. The primary sampling units for the survey were the 60 market areas

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selected for the CTS to be nationally representative. The second sampling stage consisted of selecting MCOs within market areas. MCOs serving multiple markets were defined as separate MCOs for the survey, and data were collected with reference to the specific market area.

Within each market area, the sample frame of the Brandeis survey was based on the CTS follow-back survey, which used information from household survey respondents to question insurers and health plans regarding health plan characteristics. The follow-back survey yielded approximately 1,000 entities categorized as managed care plans across all sites. Based on information from Web searches and industry directories, the Brandeis survey excluded entities that were only indemnity plans as well as MCOs that were no longer present within market areas. This left 944 MCOs as the sample frame. The sampling allocation of MCOs within market area was stratified by two categories: preferred provider organization (PPO) only and health maintenance organization (HMO)/other (including HMO only and multiproduct).

Responses were sought from a sample of 720 market-specific MCOs, but 247 were categorized as ineligible because they had low enrollment (less than 300 subscribers) in the market area, did not offer comprehensive health care products, served only Medicaid and Medicare, or offered only indemnity products in the market area. This left 473 eligible MCOs, of which 434 (92%) responded. They reported on 787 eligible products for the administrative portion of the Brandeis survey. For the clinical module, 417 MCOs completed those items regarding 752 products. When an MCO had multiple products that were similar in terms of out-of-

network coverage, referrals, and role of primary care physicians, they were collapsed into a single product for the purposes of the survey. Collapsed eligible products were categorized as HMO, PPO, or point-of-service (POS) products.

### *Data Collection*

The telephone survey was conducted by Mathematica Policy Research on behalf of Brandeis University. Typically, two respondents (executive director and medical director, or their designees) were questioned at each MCO. For some national or regional MCOs, respondents were interviewed at the corporate headquarters level regarding multiple sites. In some cases, the MCO referred interviewers to the MBHO for more detailed information. All survey questions applied to individual products within each market area-specific MCO.

### *Scope of Survey Content*

The Brandeis survey covered a wide range of administrative and clinical topics. The administrative module gathered data on the following:

- *Plan characteristics*, which included products offered, enrollment, ownership, and affiliation with a national chain.
- *Contracting with vendors*, which included contracting arrangements with both specialty behavioral health vendors and comprehensive networks (general medical and specialty providers alike), which vendors were used, functions included in the contract, and performance standards.
- *Benefit design*, which included mental health and alcohol and drug abuse benefits, in the most commonly purchased package for each product. This section

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included extent of covered services, lifetime and annual limits, consumer cost-sharing requirements, and prescription drug coverage.

- *Personnel and provider selection*, which included factors used in hiring or selecting providers.
- *Payment methods and risk sharing*, which included vendor payment mechanisms (administrative services only, capitation), level of financial risk, and practitioner payment methods.

The clinical module examined the following areas:

- *Entry into specialty treatment*, which included direct self-referral and phone center referral, as well as primary care or employee assistance program gatekeeping approaches.
- *Utilization management techniques*, which included the services requiring prior authorization, organizational responsibility for different levels of review, the appeals process, types of personnel used to conduct utilization management, and case management programs.
- *Treatment process* for behavioral health in primary care settings, which inquired about required screening and use of primary care-oriented practice guidelines. In the specialty treatment section, informants were asked about which types of clinicians provide treatment, standards for maximum wait time to first appointment, follow-up after discharge policies, specialty practice guidelines, and prescription drug formularies.
- *Quality assurance/improvement*, which included the use of patient satisfaction surveys, clinical outcomes assessment, and performance indicators.

A complete summary of the Brandeis survey content may be found in Appendix A.

### *Statistical Analysis*

The results presented here are weighted for selection probability and nonresponse to be representative of MCOs' commercial managed care products in the continental United States. Statistical analyses were implemented using SUDAAN software (Shah, Barnwell, & Bieler, 1997) to allow correction of standard errors for our complex survey design. To test the significance of bivariate differences in means or distributions, *t* tests (for continuous variables) and chi-square tests (for categorical variables) were conducted. When conducting pairwise tests for product type and contracting arrangement differences, multiple comparisons were corrected for by using the Bonferroni correction; only corrected *p* values are reported. Most analyses were conducted at the product level.

### *Case Studies*

Team members conducted six case studies in order to place findings from the Brandeis survey in context. We selected organizations that represented a range of contractual arrangements, organizational structures, product offerings, and geographic locations. Organizations were also chosen because of previous connections with senior personnel on their staff, ensuring cooperation and a willingness to express opinions candidly. Because of the small sample size, findings from these case studies cannot be generalized; but they do contain some important insights from significant players in managed care. The information that these experts shared was used both to illustrate specific points in this report and to add insight to the general discussion of findings.

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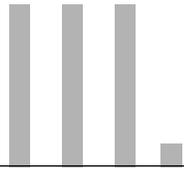
## **Organization of the Report**

The chapters that follow present major findings from the Brandeis University *Survey on Alcohol, Drug Abuse, and Mental Health Services in Managed Care Organization*.

Chapter III examines MCOs' product offerings and behavioral health contracting arrangements. Chapter IV describes mental health benefits, including limits and cost-sharing features. Chapter V reports on MCOs' policies regarding mental health screening and treatment guidelines in primary

care settings. Chapter VI focuses on entry into specialty treatment, including gatekeeping mechanisms and prior authorization.

Chapter VII describes aspects of the treatment process, such as standards for time to first appointment, types of clinicians providing services, and utilization management and appeals procedures. Chapter VIII presents findings on MCOs' behavioral health quality management activities. Chapter IX summarizes the conclusions of the study and discusses implications for various stakeholders.



# Products and Contracting

Consumers' experiences in receiving mental health care are influenced by key characteristics of how care is organized, such as the type of insurance product and whether their mental health care is managed through an external contract. The main types of products offered by MCOs include HMOs, POS products, and preferred PPOs. For each product, the MCO must choose whether to deliver mental health services within the MCO (internal arrangements) or to contract with an outside organization, such as an MBHO. Understanding these two basic concepts—product type and contracting arrangement—will be key to understanding the findings from this study and to appreciating the often unseen forces that affect consumers' experiences with seeking and receiving mental health treatment.

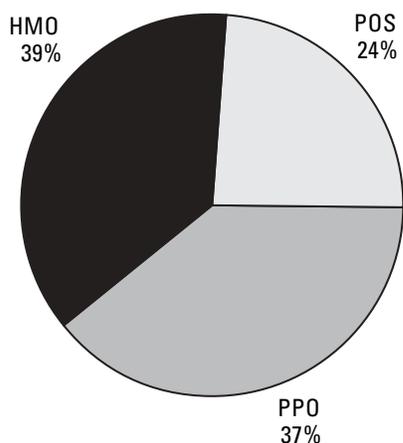
## “Product” Definitions

Within the broad spectrum of managed care, three general “product” types are most commonly discussed: HMO, POS, and PPO products. The Brandeis survey employed the same definitions used by the Community Tracking Study (Kemper et al., 1996):

- HMO: A product in which enrolled individuals are provided health care services by a network of affiliated providers. Services provided to enrollees outside the network are generally not covered, other than for some specialized services or in emergencies.
- POS: A product in which enrollees may select in-network or out-of-network physicians at the “point of service,” usually with significant differences in coinsurance or deductibles.
- PPO: A product in which enrollees are given a financial incentive to use a “preferred” network of providers, usually through differences in coinsurance or deductibles.

The differences between HMO, POS, and PPO products have become blurred over time, but often they are described as points on a continuum ranging from more managed to less managed according to a series of dimensions (Grembowski et al., 2000; Horgan & Merrick, 2001). HMOs generally are seen as exerting a greater degree of control by restricting enrollees to a particular list (often called a network) of participating providers, requiring assignment to primary care gatekeepers, or using preauthorization for specific services. POS products fall in the middle of the continuum, with enrollees similarly restricted to a provider network but with the option to seek care from

**Figure III.1: Frequency of Commercial Managed Care Product Types (Percentage of Products)**



out-of-plan providers for an additional cost. PPO products generally manage care by creating incentives for enrollees to use in-network providers but typically do not use primary care gatekeepers or manage referrals to specialists (Greenberg, 2001). The issue of product definitions is made more complex by the fact that differences also exist within each product type. For example, HMOs can operate using a salaried staff, can contract with a single large provider group, or can use a network of providers. Previous research has shown that most MCOs offer more than one type of product, although they may use the same provider networks to service the various products (Gold & Hurley, 1997).

In sum, the type of product an individual enrolls in can affect choice of providers, level of copayment and coinsurance rates, steps needed to access care, and degree to which entry into and continuation in treatment are managed.

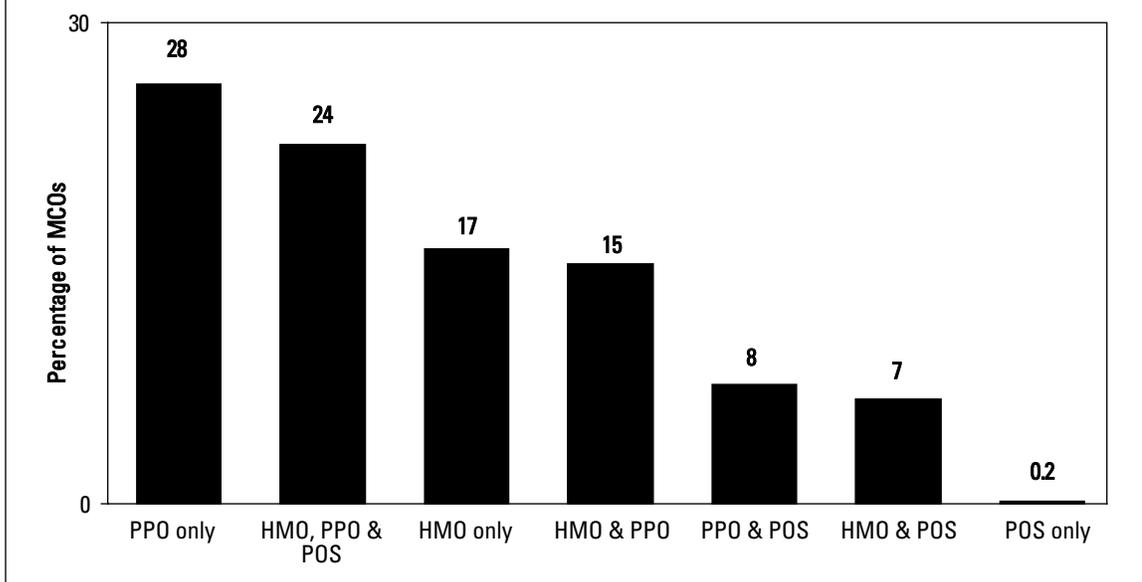
This report focuses on HMO, POS, and PPO products, since they are the three predominant managed care products. MCOs were asked about only their commercial products—that is, products serving Medicare and Medicaid populations were excluded. (See Chapter II.) Figure III.1 shows the distribution of commercial managed care product types across MCOs. HMOs are the most commonly offered product (39%), followed by PPOs (37%) and POS products (24%). Most MCOs offer multiple types of products, with 28% offering PPO only, 17% offering HMO only, and only 0.2% offering a POS product alone (Figure III.2). Almost a quarter of MCOs (24%) offer all three product types.

### **MCOs' Choice to Either "Make" or "Buy" Mental Health Services**

The contractual arrangements MCOs use also can influence the access to, delivery of, and quality of mental health services. MCO decisions regarding contractual arrangements can involve all covered services or be limited to certain types of specialty care. This section examines elements within contractual arrangements that can affect consumer experiences in seeking and receiving specialty mental health care.

Both employers and MCOs have the option of contracting with specialty MBHOs for the management of mental health services (generally along with substance abuse services), as illustrated in Figure II.1. This study focuses on MCOs, so the relevant decision is depicted on the right-hand side of the figure: whether to provide mental health services internally or to contract externally for these services. When MCOs contract with another external organization for behavioral health, this may be part of a wider contract for all medical services called a "comprehensive"

Figure III.2: Types of Commercial Products Offered by MCOs



contract, or it may be a contract with a specialty MBHO, which is often called a carve-out of behavioral health services.

The prevalence of the different contracting arrangements that MCO products use in the provision of behavioral health services was assessed by applying these concepts and using the following three categories:

- *Specialty contracting arrangements*, in which MCOs carve out mental health services to a vendor, such as an MBHO, that specializes in the delivery and management of behavioral health services
- *Comprehensive contracting arrangements*, in which MCOs contract with a single vendor or network for both behavioral health and general medical services
- *Internal arrangements*, in which MCOs provide behavioral health services and medical services within the organization, either through salaried providers or through a network managed by the MCO

Note that an MCO may have contracts with individual facilities, an arrangement still

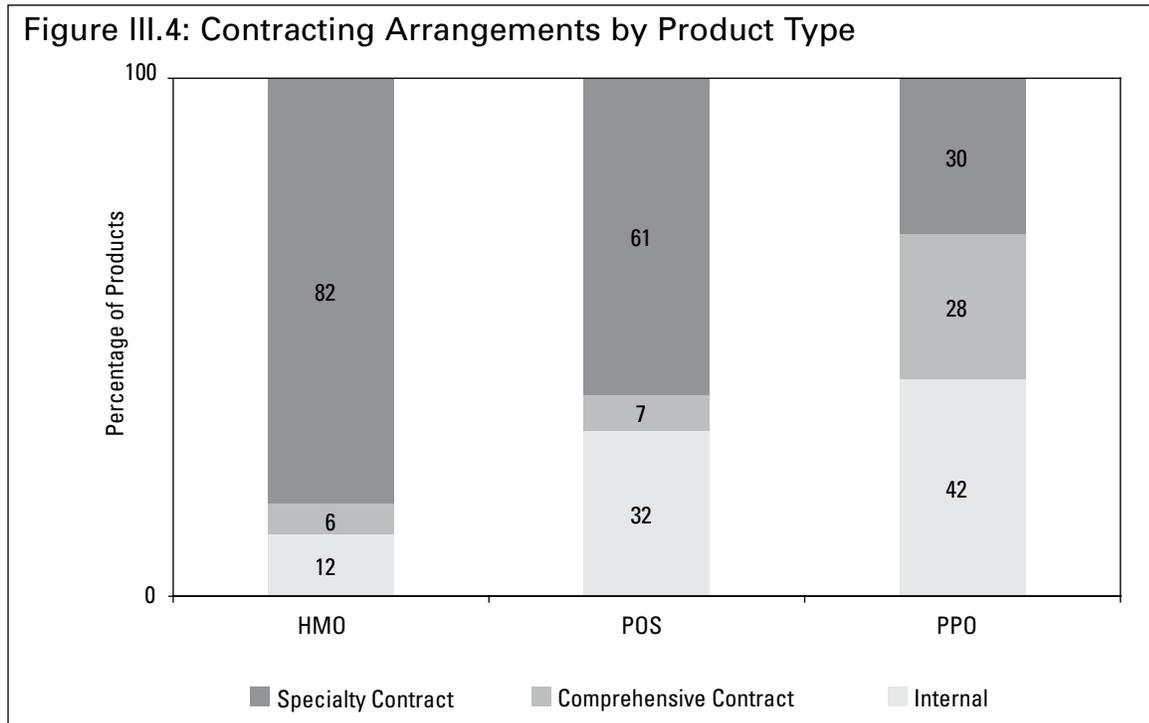
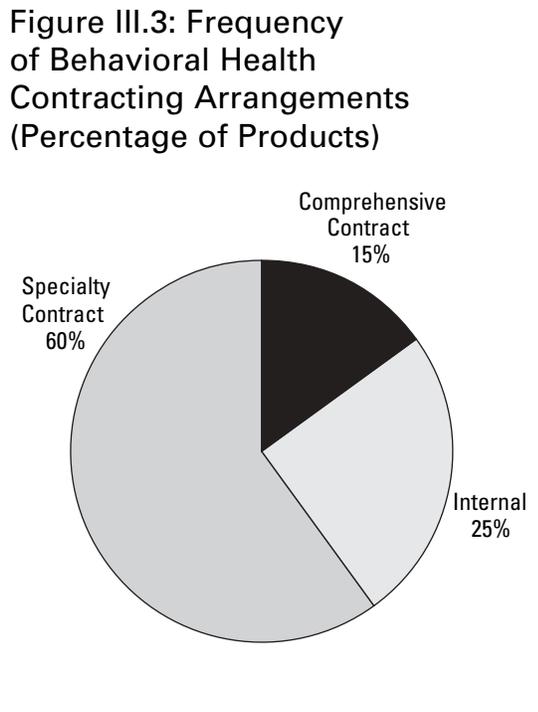
classified as an internal arrangement, since the MCO retains the overall management of mental health.

Depending on how seamless the process is for accessing mental health care, consumers may never be aware that their services are being managed and provided by an organization other than their health plan. Contractual arrangements, however, can affect consumers' experiences, and each approach has its potential advantages. For example, specialty contracts, because of their focus on behavioral health, may offer the opportunity to improve the quality of mental health services. This could occur if the MBHO has established specialty provider networks, offers experience in matching clients with providers and at the appropriate treatment levels, and uses practice guidelines to support providers' decisions (Mihalik & Scherer, 1998). Alternatively, because they do not focus exclusively on behavioral health, comprehensive contracts and internal arrangements offer the potential for greater coordination

of general medical and mental health services, although sharing a similar network of providers or administrative entity does not necessarily guarantee integration of these services (Jeffrey & Riley, 2000).

### Contracting Arrangements for the Delivery of Mental Health Services

Figure III.3 shows the frequency of different contracting arrangements across all products. Specialty contracts (60%) are the most commonly reported arrangements, followed by internal arrangements (25%) and comprehensive contracts (15%). The contracting approach chosen differs markedly by type of product (Figure III.4). HMOs are the most likely to report using specialty arrangements (82% of HMO products), while PPOs are the only product type that makes extensive use of comprehensive contracting arrangements (28% of PPO products).

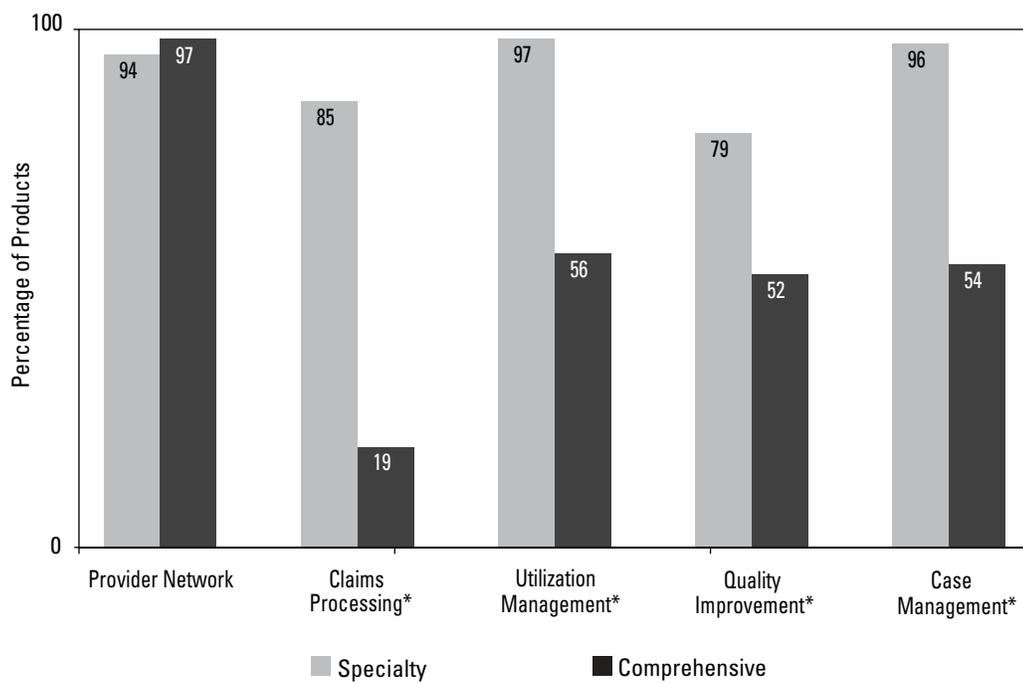


## Functions Delegated in Contracting Arrangements

Even within a particular contracting approach, MCOs often vary in terms of which administrative and clinical functions to delegate, how much financial risk to hold or to transfer, and which, if any, performance standards to include. MCOs may choose to delegate the following functions to external organizations:

- *Formation and Maintenance of Provider Networks.* This function can entail identifying mental health and substance abuse providers who will be available to enrollees, negotiating payment arrangements, checking provider credentials, profiling patterns of care, and maintaining up-to-date information for enrollees about how to access their providers.
- *Processing of Enrollees' Claims for Payment.* This administrative function involves payment for services rendered.
- *Utilization and Case Management.* Utilization management is an approval process for patients' entry into treatment, amount of treatment, and mode of treatment. Case management provides a more intensive clinical review of care and tends to focus on high users of care.
- *Operation of Quality Improvement Programs.* These programs, which vary widely, may include external accreditation by organizations such as the National Committee for Quality Assurance, in-house monitoring of adherence to clinical guidelines and best practices, and periodic review of outcomes.

Figure III.5: Functions Included by Different Contracting Arrangements



\*Significantly different,  $p < 0.01$ .

Note: Based on the 75% of products with external contracts.

Almost all products with specialty contracts delegate all of the functions described above to MBHOs, while products with comprehensive contracts almost always delegate the formation and maintenance of provider networks (97%). Under comprehensive contracts, delegation of claims processing, utilization management, quality improvement, and case management services is far less frequent than under specialty contracts (Figure III.5).

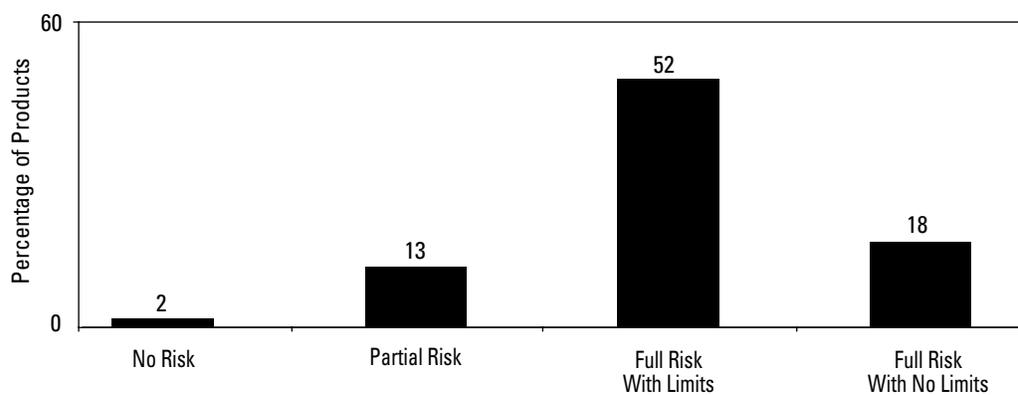
### Risk Sharing

Risk sharing in mental health contracts refers to the degree of the vendor’s responsibility for cost overruns or cost savings (Frank et al., 1996). The sharing of financial risk in carve-out contracts can be classified both by the amount of risk shared and by whether claims costs are included. Contracts often are referred to as “risk based” when some degree of risk for the costs of claims above a target is transferred from the MCO to the MBHO. When claims costs exceed targeted amounts, the contract may require the MBHO to bear all or none of the cost overruns, or they may opt to share risk,

based on the MBHO’s performance and the extent of losses incurred. Similarly, when costs of care fall below annual targets, MCOs may opt to allow MBHOs to keep all, none, or a portion of any savings. For example, a partial risk contract might stipulate that for every dollar spent above the target, the MBHO must bear 50 cents. Even under administrative services only (ASO) contracts, the MBHO also may bear some risk if claims costs exceed the target. Moreover, some portion of MBHOs’ payments may be tied to meeting specific performance standards.

Contracts involving risk may also place a limit on the MBHO’s liability for costs over a specified amount. With respect to savings and profits, contracts may specify that an MBHO will be allowed to keep all savings without a cap, all savings with a cap, or some or none of the savings (Garnick et al., 2001). A “full risk with limits” contract might specify that if total spending exceeds the target by \$1 per member per month, the MBHO must bear that cost, but if it exceeds the target by more than \$3, the MBHO bears only the first \$3.

Figure III.6: Risk-Sharing Arrangements in MCO Specialty Contracts



Note: Based on the 51% of products that had specialty contracts for claims and administration; this question was not answered for 15% of eligible products.

An examination of risk-sharing arrangements in MCO products' contracts with MBHOs shows that a majority of products (52%) place the MBHO at full risk with some limits (Figure III.6). A smaller number of products place the MBHO at full risk with no limits (18%) or at only partial risk (13%). Only rarely (in 2% of products) do MCOs report that their products retain responsibility for all financial risk for mental health care.

### Performance Standards

In behavioral health contracts, performance standards identify acceptable levels of performance for various aspects of service

delivery, including both administrative and clinical responsibilities. The standards may range from requirements for the scope and timing of reports on utilization to the achievement of specific levels of satisfaction rates in patient surveys. Performance standards serve to formalize purchaser expectations and MBHO accountability. Further, they may be used to monitor and to counter any incentives to limit access or otherwise contain costs that might emerge from the contractual risk-sharing arrangements.

Among products with specialty contracts, 93.7% report at least one standard of any type (Table III.1). The ten standards included

**Table III.1. Percentage of Specialty Contracts for Claims and Administration<sup>1</sup> With Written Performance Standards**

|   | <i>HMO</i>  | <i>POS</i>  | <i>PPO</i>   | <i>Total</i> |
|---|-------------|-------------|--------------|--------------|
| <b>Administrative</b>   |             |             |              |              |
| Claims processing (if yes to claims processing function)  | 50.9%       | 32.4%**     | 12.5%**      | 40.4%        |
| Staffing/network (if yes to provider network function)  | 71.7        | 84.3**      | 16.6**       | 66.4         |
| Administrative reporting  | 91.9        | 90.9        | 22.8**       | 80.5         |
| Member services phone response  | 87.6        | 85.8        | 15.3**       | 75.6         |
| Any administrative  | 93.2        | 90.9        | 24.5**       | 81.6         |
| <b>Quality Related</b>  |             |             |              |              |
| Quality assurance system  | 73.3        | 87.4**      | 15.8**       | 67.6         |
| HEDIS behavioral health measures  | 66.9        | 78.9*       | 12.6*        | 61.2         |
| Patient satisfaction  | 85.4        | 78.8        | 14.3**       | 72.4         |
| Provider satisfaction   | 81.1        | 74.9        | 8.3**        | 67.8         |
| Any quality related   | 92.6        | 90.6        | 18.0**       | 80.1         |
| <b>Enrollee Focused</b>   |             |             |              |              |
| Disenrollment   | 33.0        | 5.3*        | 2.5*         | 21.3         |
| Complaints and appeals  | 87.6        | 82.2        | 94.9         | 87.4         |
| Any enrollee focused  | 87.6        | 82.2        | 94.9         | 87.4         |
| <b>Total (any performance standards)</b>  | <b>93.2</b> | <b>90.9</b> | <b>100.0</b> | <b>93.7</b>  |
| <p><sup>1</sup>The answer category "don't know" was under 2.0% with the exception of claims processing in HMOs (14.6%); claims processing in total (8.3%); staffing in HMOs (3.6%), POS plans (7.2%), and total (3.8%); provider satisfaction in PPOs (2.6%); and disenrollment in HMOs (3.6%).</p> <p>*Different from HMO value at <math>p &lt; 0.05</math> level.</p> <p>**Different from HMO value at <math>p &lt; 0.01</math> level.</p> <p>Note: HEDIS = Health Plan Employer Data and Information Set.</p> <p>Source: Garnick et al., 2001.</p> |             |             |              |              |

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in this survey were classified by three broad areas: administrative, quality related, and enrollee focused. Overall, 81.6% had one or more administrative performance standards, with the two most common being administrative reporting (80.5%) and member services phone response (75.6%). Across all administrative performance measures, PPO products were significantly less likely to include performance standards in their contracts with MBHOs, while the percentages of HMO and POS plans were more often similar.

Eighty percent of products had at least one quality-related standard, with patient satisfaction standards most commonly used. Again, PPOs were significantly less likely to report quality-related performance standards. Standards for handling enrollees' complaints and appeals also were very common, being used by 87.4% of products overall, and 94.9% of PPO products.

## Discussion

The type of managed care product, and that product's contracting approach, can have important implications for consumers' experiences in obtaining mental health care. This chapter demonstrates that different products are more or less likely to choose certain contracting approaches. These systematic differences can make it challenging to interpret some results in this report. For example, HMOs are the most likely to contract with specialty MBHOs. Thus, the fact that HMOs are more likely than PPO or POS products to require a specific action may be a characteristic of HMOs per se or of specialty MBHOs that those HMOs contract with. In the report, results often are presented separately by product type and by contracting status. The issue of distinguishing these separate effects is revisited in Chapter IX.

MCOs' contracts with MBHOs often contain cost-savings incentives, but these may be tempered by some protections for enrollees. Nationwide, three-quarters of MCO products contract externally for mental health care, mostly with specialty MBHOs. Specialty contracts are particularly common among HMO products. These findings are surprising given the original ideology of HMOs, which stressed integration and internal provision (which is now used by only 25% of MCO products). However, one industry observer explains that HMOs have more to lose when mental health costs go up, because employers usually buy HMO products on a capitated basis. He also notes that if mental health costs go up for PPOs and POS plans, they have less to worry about because they are often paid ASO, which protects them from financial risk.

The rapid growth of specialty contracting may reflect the emergence of specialized techniques for managing mental health care that MCOs do not regard as part of their "core technologies." MCOs also are concerned about their own ability to manage mental health costs (particularly in response to parity laws). One industry expert indicated that state parity laws are driving the trend toward MCO carve-outs: "Requiring unlimited parity is scaring the health plans, makes [sic] them more likely to carve out, because they are worried about increased demand and higher costs."

Most MCOs place the MBHO at full risk for cost overruns, albeit with upper limits on profits and/or losses. If MBHOs respond to profit opportunities by using overly strict review criteria and overmanaging providers, individuals with mental health problems may be undertreated. On the other hand, MCOs with internal provision may face

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these same incentives if they are themselves capitated by employers. Also, the effect of strong risk incentives may be partially counterbalanced by national accreditation requirements or the retention of final decision-making authority by MCOs in cases of disputes over treatment authorization (Hodgkin et al., 2000; Sturm, 2000).

In addition, the widespread use of performance standards in contracts suggests that MCOs are typically attempting to monitor vendor performance in selected areas, although few of the common standards are closely tied to clinical quality of

care. Lower use of performance standards in PPO products may occur because until recently PPOs were not being accredited by the National Committee on Quality Assurance and therefore had less need to monitor their contractors. In the future, however, more attention may be focused on performance measures for mental health in carve-out contracts as more national attention is focused on quality of care in general (Institute of Medicine, 2001) and new consumer survey approaches to monitoring the quality of mental health services are adopted (e.g., ECHO™, 2002).



# IV. Benefits

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The kinds of mental health services that managed care enrollees receive, and the amounts they must pay out of pocket, are influenced by what their insurance covers. In private insurance plans, the benefits package remains an important determinant of service availability, although its impact on access to services has become increasingly influenced by other insurer activities, such as utilization management (Frank & McGuire, 1998), described in Chapters VI and VII. This chapter reports on the types of services covered, the generosity of the benefits offered in terms of annual or lifetime limits, and the level of out-of-pocket expenses (cost sharing) that an enrollee must pay for services. It also discusses the extent to which mental health coverage is less generous than general medical coverage—the “parity” question—which has been a focus of legislative initiatives at the Federal level and in many States (Gitterman, Sturm, & Scheffler, 2001). Finally, the chapter reports on the extent of coverage for prescription drugs, which have become increasingly central to mental health treatment in recent years as a result of pharmaceutical innovations.

## **Types of Mental Health Services Covered**

The great majority of managed care organization (MCO) products (96% or more) cover inpatient hospital, intensive outpatient (including day treatment and partial hospitalization), and regular outpatient care (Figure IV.1). The proportion covering nonhospital residential care, such as group homes or acute residential care, is somewhat lower (71%).

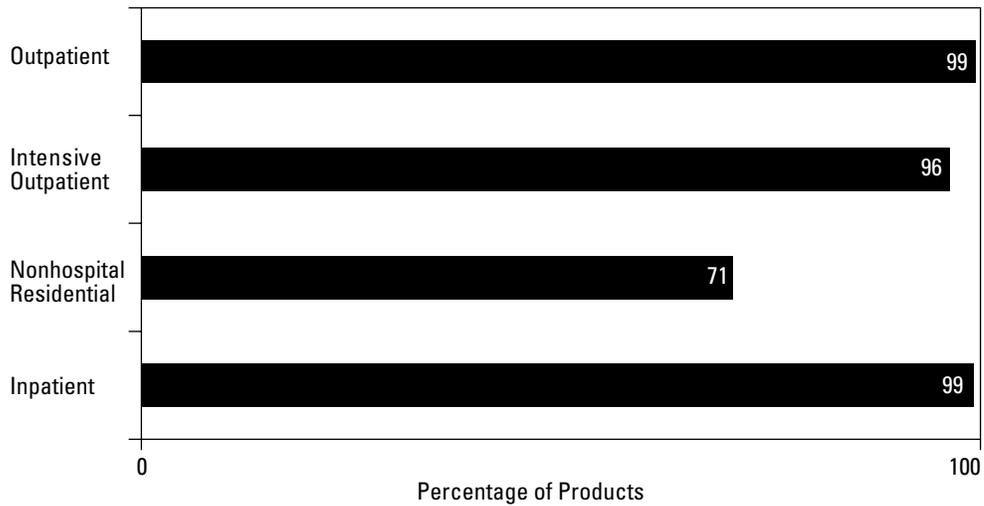
## **Coverage Limits**

Insurers typically only pay for types of care covered in the benefit package, but inclusion

does not guarantee that the full cost of treatment will be covered for a particular episode of care. This is because benefit packages often have limits, including annual and lifetime limits, for behavioral health services. These limits can be defined in terms of episodes, days of treatment, or dollar amounts. Limits also may be imposed on specific service types, such as inpatient hospital and regular outpatient care.

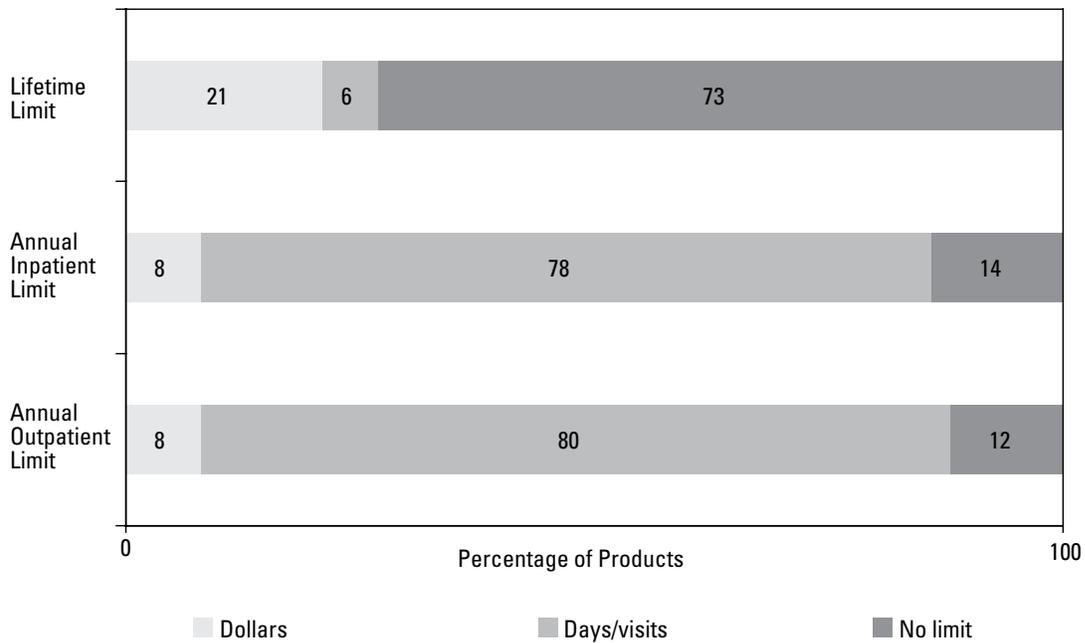
About 27% of products use a lifetime limit on mental health benefits: 21% have a lifetime dollar limit, and 6% have a lifetime limit on covered inpatient days (Figure IV.2). Annual limits are imposed by 92% of products and are much more commonly used

**Figure IV.1: Percentage of Products Covering Selected Mental Health Services**



*Note:* Percentages are based on products for which these questions were answered; missing data are less than 5%.

**Figure IV.2: Types of Limits on Mental Health Benefits**



*Note:* Based on products for which limits were reported; missing data are 9% for lifetime, 13% for annual inpatient, and 8% for annual outpatient.

than lifetime limits. Annual limits for inpatient care usually restrict the number of days (78% of products) rather than the total spending (8% of products). A similar pattern is observed for outpatient care, with limits on visits much more common than limits on spending. These patterns may reflect plans' responses to the Federal 1996 Mental Health Parity Act, which regulated dollar limits but not day and visit limits. The act prohibited insurers from applying lower dollar limits on covered services for mental health than for general medical care (General Accounting Office, 2000).

For this report, variation in the three most commonly used types of limits (outpatient visits, inpatient days, lifetime spending) was examined. Among plans applying annual limits to outpatient visits, the most common

limits are 20 visits (found in 41.0% of products) and 30 visits (46.1% of products). Only 2.3% of these products have limits of fewer than 20 visits (Table IV.1). Among products that limited inpatient days, the most common limit is 30 days (56.2% of products). However, 26.8% of these products have limits lower than 30 days (Table IV.2).

Among products with lifetime dollar limits, 14.5% have limits of more than \$1 million, but most have much lower limits, with 41.3% of these products having limits of \$25,000 or less (Table IV.3).

### **Copayment and Coinsurance Requirements for Outpatient Care**

Private insurers often require enrollees to pay part of the cost of care, either as coinsurance (a set percentage of charges) or as

**Table IV.1. Distribution of Annual Limits on Outpatient Mental Health Visits**

| <b>Visits Covered</b> | <b>Percentage of Products With Limit*</b> | <b>Percentage of All Products</b> |
|-----------------------|---|-----------------------------------|
| Less than 20          | 2.3                                       | 1.9                               |
| 20                    | 41.0                                      | 32.8                              |
| 21–29                 | 3.8                                       | 3.0                               |
| 30                    | 46.1                                      | 36.9                              |
| More than 30          | 6.8                                       | 5.4                               |
| Total                 | 100.0                                     | 80.0                              |

\*Based on the 80% of products that had annual limits on outpatient visits.

**Table IV.2. Distribution of Annual Limits on Inpatient Mental Health Days**

| <b>Days Covered</b> | <b>Percentage of Products With Limit*</b> | <b>Percentage of All Products</b> |
|---------------------|---|-----------------------------------|
| 10 or less          | 7.4                                       | 6.0                               |
| 12–16               | 8.9                                       | 7.2                               |
| 20                  | 9.3                                       | 7.5                               |
| 21–25               | 1.2                                       | 1.0                               |
| 30                  | 56.2                                      | 45.6                              |
| More than 30        | 17.0                                      | 13.8                              |
| Total               | 100.0                                     | 81.1                              |

\*Based on the 81% of products that had annual limits on inpatient days.

**Table IV.3. Distribution of Lifetime Dollar Limits on Plan Payments for Mental Health**

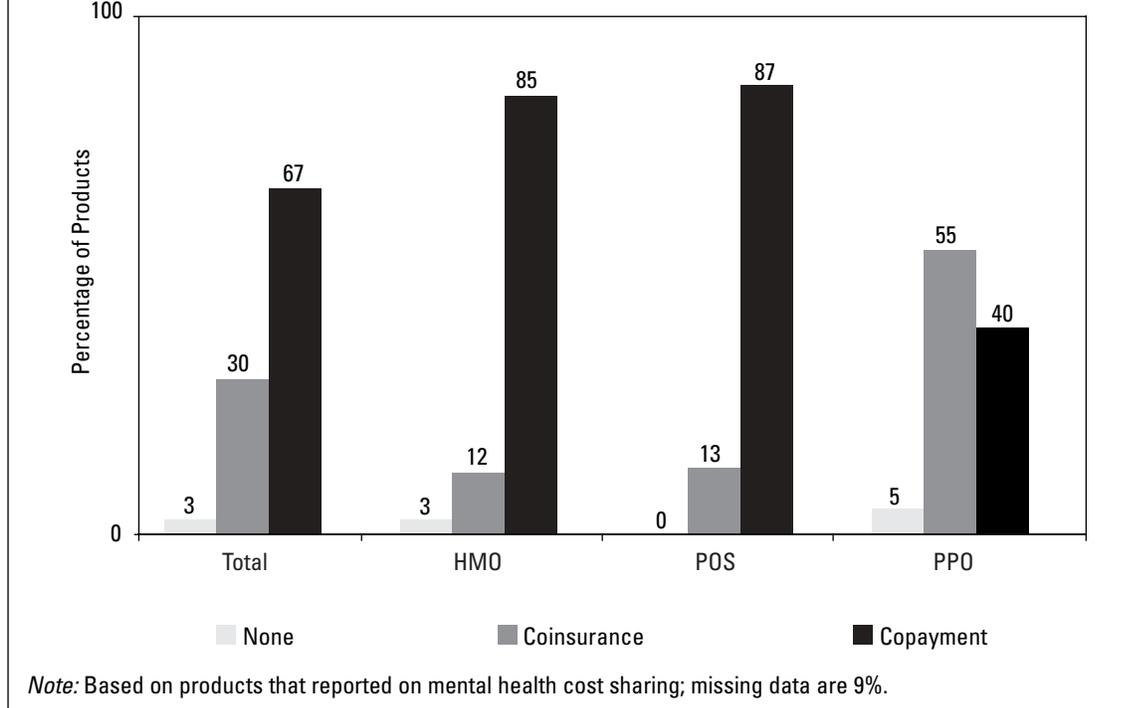
| Maximum Plan Payment  | Percentage of Products With Limit* | Percentage of All Products |
|-----------------------|------------------------------------|----------------------------|
| \$5,000 or less       | 17.1                               | 3.6                        |
| \$10,000-\$20,000     | 12.7                               | 2.7                        |
| \$25,000              | 11.5                               | 2.4                        |
| \$30,000 or \$50,000  | 4.4                                | 0.9                        |
| \$1 million           | 39.8                               | 8.3                        |
| More than \$1 million | 14.5                               | 3.0                        |
| Total                 | 100.0                              | 20.9                       |

\*Based on the 21% of products that had lifetime dollar limits on plan payments.

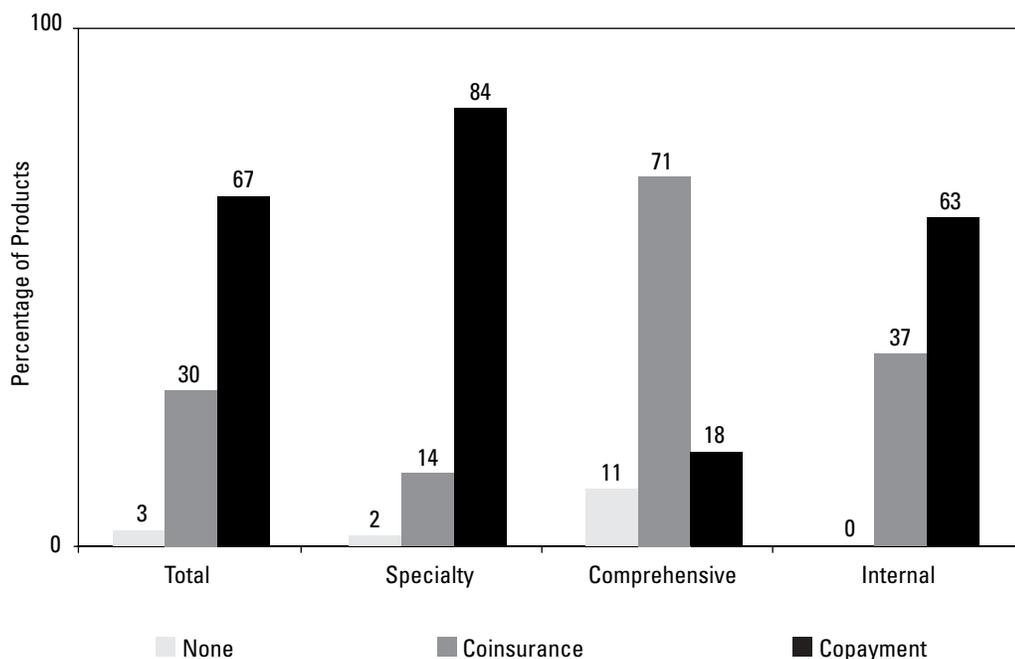
copayments (a flat dollar amount per encounter or prescription). Several studies have shown that demand for mental health services is affected by the level of cost sharing (Horgan, 1986; Keeler, Manning, & Wells, 1989; Simon et al., 1996), suggesting that the burden created by high levels of cost sharing may deter enrollees from seeking needed care.

The vast majority of MCO products (97%) require either copayments or coinsurance for outpatient visits (Figure IV.3). Cost sharing varies widely by product type. Coinsurance is much more common in PPOs (55% of products use it) than in HMOs (12%). Conversely, HMOs and POS plans are much more likely to use copayments. POS plans do not differ significantly from

**Figure IV.3: Percentage of Products Using Copayment or Coinsurance for Outpatient Mental Health Visits (by Product Type)**



**Figure IV.4: Percentage of Products Using Copayment or Coinsurance for Outpatient Mental Health Visits (by Contracting Arrangement)**



*Note:* Based on products that reported on mental health cost sharing; missing data are 9%.

HMOs with respect to the use of coinsurance or copayments for mental health services. Figure IV.4 shows that those products with specialty contracts for mental health care report a greater use of copayments (84%) than do products with comprehensive (18%) and internal (63%) arrangements.

Among plans with coinsurance for mental health services, consumers were required to pay an average of 35.7% (Table IV.4). Among plans requiring copayments, the

mean copayment was \$18. Differences in mean cost-sharing by product type are not statistically significant.

### Comparison of Cost Sharing for Mental Health and General Medical Care

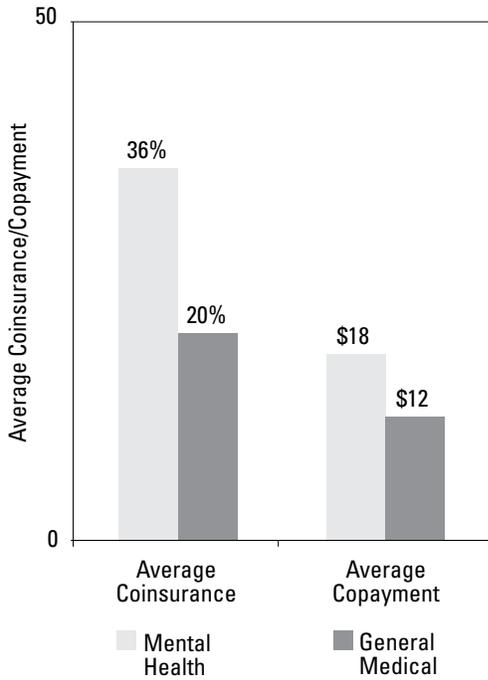
For outpatient general medical care, the average coinsurance rate is 20% and the average copayment is \$12 (Figure IV.5). These levels are substantially lower than those for outpatient mental health care detailed above.

**Table IV.4. Average Coinsurance and Copayment Rates for Outpatient Mental Health (by Product Type)**

| Product Type | Average Coinsurance | Average Copayment |
|--------------|---------------------|-------------------|
| HMO          | 40.1%               | \$17.67           |
| POS          | 35.1%               | \$18.00           |
| PPO          | 35.0%               | \$18.62           |
| All          | 35.7%               | \$18.00           |

*Note:* Average coinsurance is the average (across products using coinsurance) of the consumer's share of cost, expressed as a percentage of total cost. Average copayment is the average across products using copayments.

**Figure IV.5: Average Coinsurance and Copayments for Outpatient Mental Health and General Medical Visits**



*Note:* Average coinsurance is computed for plans using coinsurance. It is the average (across products) of the consumer's share of cost. Average copayment is computed for plans using copayment.

Given policy concerns about the impact of high cost sharing, one should consider not only the mean levels but also the distribution of copayments and coinsurance, including a comparison with coinsurance and copayments for medical services. Forty-six percent of all products require copayments of \$20 or more for mental health care, as compared with only 9% of products that have copayments this large for general medical care (Table IV.5). Similarly, 18% of products require enrollees to pay 30% or more for mental health services, compared with only 2.5% of products requiring this much coinsurance for general medical care. These findings highlight the potentially higher

burden placed on enrollees seeking mental health services compared with general medical services depending upon the actual cost of services (Hodgkin et al., 2003).

### **Prescription Drug Cost Sharing**

Prescription drugs are an important part of mental health care because of significant advances in the use of pharmaceuticals in the treatment of mental disorders over the past several years, with a corresponding increase in their use and costs (Foote & Etheredge, 2000). Thus, any discussion of the extent of mental health insurance coverage must include information about how prescription drugs are covered.

For prescription drugs, as for other services, plans can choose whether to require enrollees to pay a share of the cost (coinsurance) or a fixed amount (copayment), usually per prescription. Another key issue is that many plans use different cost-sharing levels for brand-name and generic drugs. More recently, many plans have been identifying one brand in a drug class as “preferred,” relegating the other brands to a “third tier” with even higher copayments (e.g., \$25 rather than \$10). This practice was not addressed in this survey, as it was not yet widespread at the time of survey design.

In the study sample, copayments for prescription drugs were much more common than coinsurance. Among products with drug cost sharing, 93% require copayments for generic drugs and 92% for brand-name drugs. Most of the remainder require coinsurance. Cost-sharing arrangements are consistently higher for brand-name drugs. Among products requiring copayments, the mean is \$8 for generic drugs and \$13 for brand-name drugs (Figure IV.6). This reflects a widespread practice among health insurers

Table IV.5 Distribution of Outpatient Coinsurance and Copayment Amounts Across All Products

| <b>Cost-Sharing Approach</b> | <b>Mental Health<br/>(Percentage of Products)</b> | <b>General Medical<br/>(Percentage of Products)</b> |
|------------------------------|---|---|
| <b>No Cost Sharing</b>       | <b>3.0</b>  | <b>3.3</b>  |
| 10% coinsurance              | 2.6   | 4.0   |
| 15% coinsurance              | 1.5   | 3.6   |
| 20% coinsurance              | 7.1   | 13.7  |
| 30%–35% coinsurance          | 1.8   | 0.5   |
| 40% coinsurance              | 0.9   | 0.0   |
| 50% coinsurance              | 15.6  | 2.0   |
| <b>Coinsurance Total</b>     | <b>29.6*</b>                                      | <b>23.8</b>   |
| \$5–\$7 copayment            | 1.1   | 3.0   |
| \$10 copayment               | 12.6  | 39.9  |
| \$15 copayment               | 7.8   | 10.2  |
| \$20 copayment               | 39.2  | 8.3   |
| \$25 copayment               | 5.3   | 0.9   |
| \$35–\$50 copayment          | 1.3   | 0.0   |
| <b>Copayment Total</b>       | <b>67.4*</b>                                      | <b>62.4*</b>  |
| <b>Not Known</b>             | <b>0.0</b>  | <b>10.4</b>   |
| <b>Grand Total</b>           | <b>100.0</b>                                      | <b>100.0</b>  |

*Note:* Based on products that reported on mental health cost sharing; missing data are 9%.  
 \*Sum of individual entries may not match reported subtotals or totals exactly, due to rounding.

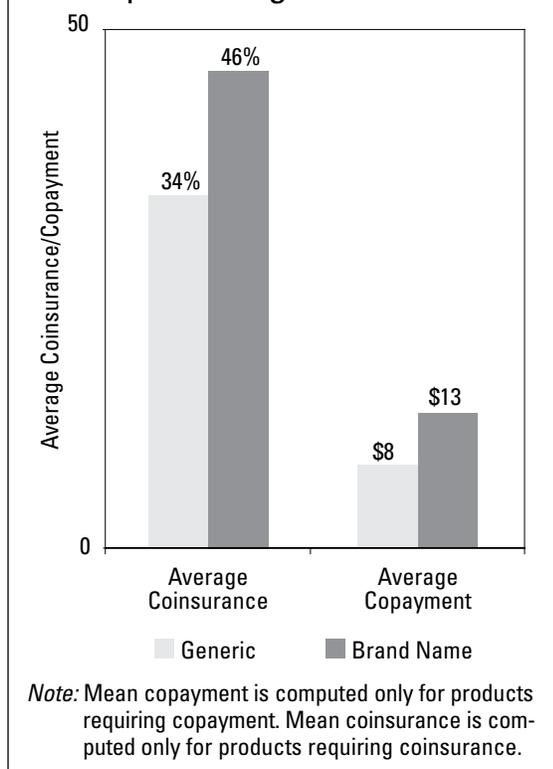
of using differential cost sharing to steer consumers toward generic drugs. Similarly, the mean coinsurance rate is considerably higher for brand-name drugs (46%) than for generics (34%), although as noted, coinsurance is much less common. The distribution of copayment amounts shows that 93% of products with copayments charge consumers \$10 or less per generic prescription, but only 50% charge \$10 or less for brand-name prescriptions (Figure IV.7). At the other end, 20% of products charge more than \$15 for a branded prescription, but only 1% of products do so for a generic prescription.

### Discussion

Substantial restrictions on mental health benefits coverage are common in many

managed care plans. This chapter reports that about one-third of products do not cover mental health care in residential facilities. A majority of plans have annual limits on outpatient visits (most often 20 or 30 visits) and on inpatient days (most often 30 days), and dollar limits are less common than was reported in previous studies. Furthermore, outpatient visits are subject to substantial cost sharing, which is notably higher for mental health than for general medical care. Most plans require copayments for prescription drugs, averaging \$13 for brand drugs and \$8 for generics. These restrictions and limitations exist despite the presumed ability of MCOs to control costs by other means (e.g., precertification, network selection).

**Figure IV.6: Average Coinsurance and Copayment Rates for Prescription Drugs**



### *Covered Services*

It is noteworthy that nearly one-third of products do not cover mental health care in residential facilities. This is an improvement compared with at least one other study, which found that two-thirds of employers in a 1995 survey did not cover nonhospital residential care (Buck & Umland, 1997). The persistence of noncoverage may be because mental health insurance evolved from medical insurance, and not all insurers adapted the benefits to cover settings unique to behavioral health care. In contrast, almost all products cover inpatient and outpatient settings, which are part of traditional medical coverage.

### *Limits*

The study reports less use of dollar limits than in previous research conducted before

implementation of the Federal parity law in 1998 (the law was passed in 1996). Only 8% of products in this study used annual dollar limits for inpatient care and for outpatient care; in contrast, a previous study found that in 1997 around a quarter of plans used annual dollar limits in their most prevalent product (Buck et al., 1999). Continued use of dollar limits for mental health was legal under federal law as long as they were not tighter than limits for medical care. It appears that, as reported elsewhere, many plans have moved from using dollar limits to using day or visit limits (Sturm & Pacula, 2000).

MCOs also are subject to State regulation of benefits for their non-self-insured products, and many States have passed their own parity laws. In interviews, one respondent from a multistate MCO expressed concern about the “patchwork” character of State regulation of benefits and that these differences provided an incentive to contract out, allowing the contractor to worry about compliance within States.

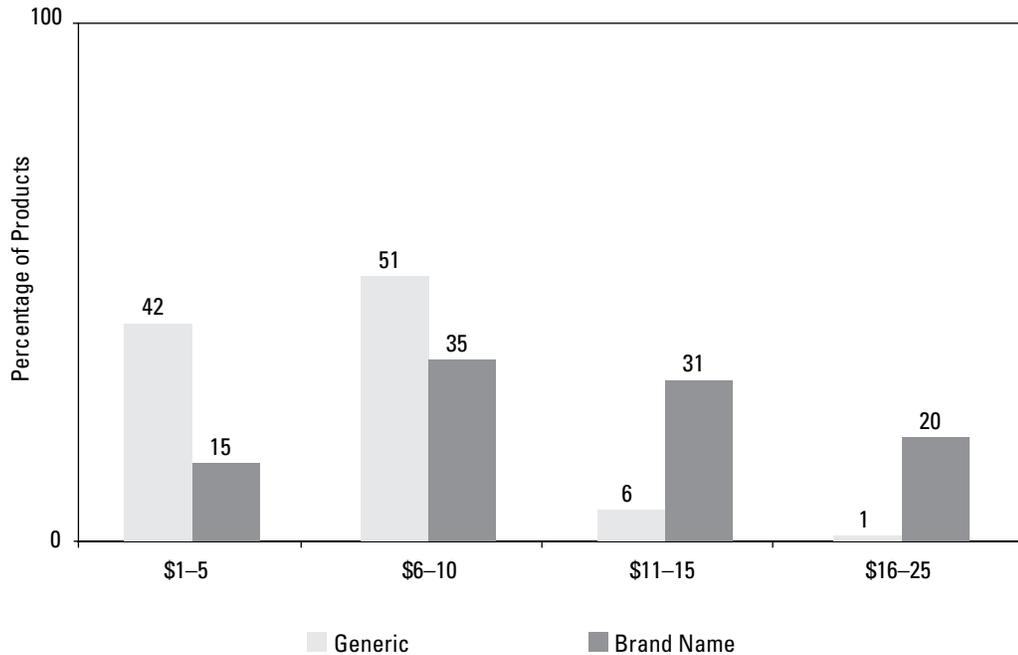
### *Copayments and Coinsurance*

The cost-sharing requirements documented here for outpatient mental health care are substantial, with around 46% of products requiring copayments of \$20 or more and another 15% of products requiring enrollees to pay half the cost of care (50% coinsurance). Both types of cost sharing tend to discourage people from seeking or continuing treatment, or impose sizable burdens if treatment does continue for long.

### *Mental Health Versus General Medical Outpatient Cost Sharing*

It is not surprising that outpatient cost-sharing requirements are considerably lower for general medical care than for mental health.

Figure IV.7: Distribution of Copayment Amounts for Prescription Drugs



Note: Based on the 53% of products for which questions about drug cost sharing and required copayments were answered.

Cost-sharing differences were not addressed by the 1996 Federal parity law, and although some States have laws that require equal cost sharing, the laws do not apply to self-insured employer plans.

#### *Prescription Drug Cost Sharing*

This study finds that among plans that require cost sharing for prescription drugs to treat mental health conditions, most require copayments rather than coinsurance. Apparently, many products require copayments for drugs even though they use coinsurance for visits to providers. The dominance of copayments may have eroded somewhat since our survey, as some plans are reportedly turning to coinsurance for drugs as a way to increase consumer cost-consciousness (Katz, 2001). Copayments in this study were \$5 higher on average for

brand-name drugs than for generics, foreshadowing the more recent emergence of three-tier plans that charge even higher copayments for nonpreferred brands. One informant noted in an interview that “mental health drugs are more likely to be in the third [i.e., costliest] tier of three-tier programs.”

Through a variety of routes—ranging from exclusion of some services from coverage, to limits, to cost sharing—MCOs continue to exercise control on the type and amount of services their enrollees receive. Despite systematic variation in their approaches (with health maintenance organizations and point-of-service products more likely than preferred provider organizations to use copayments, for example), all MCOs use the benefit structure to influence mental health treatment.



# V.

# Screening and Treatment in Primary Care

**T**his study is one of the first to explore MCOs' policies on the screening and treatment of mental health disorders in primary care settings, including the requirements for screening, conditions that trigger screening for mental health disorders, and support for primary care practitioners (PCPs) through the distribution of relevant practice guidelines (Garnick et al., 2002). MCO medical directors were asked whether PCPs are required to use standard screening questionnaires, such as the Zung Depression Index, or questionnaires on mental health developed by their MCO.

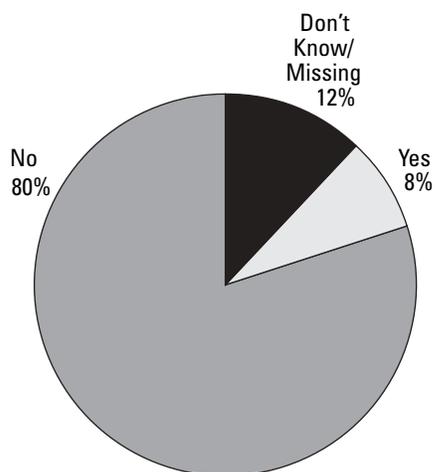
Primary care offers the opportunity to identify mental health problems at early stages and to treat or refer patients for care. Estimates suggest that 20% to 40% of all patients seen in primary care settings have a diagnosable mental disorder or distress that could interfere with daily functioning (Higgins, 1994; Barrett, Oxman, & Gerber, 1998). In 1996, the U.S. Preventive Services Task Force found insufficient evidence to recommend for or against routine screening for depression with standardized questionnaires (U.S. Preventive Services Task Force, 1996). In May 2002, however, the updated recommendation by the task force is for "screening adults for depression in clinical practices that have systems in place to assure diagnosis, effective treatment and follow-up" (Pignone et al., 2002; U.S. Preventive Services Task Force, 2002). Moreover, formal screening tools increas-

ingly are available to assess mental health problems (e.g., Zung Self-Assessment Depression Scale, Beck Depression Inventory, General Health Questionnaire, or Center for Epidemiological Study Depression Scale [Williams et al., 2002]), and a recent review article recommends screening of select patients whose profiles suggest increased risk (Whooley & Simon, 2000). These instruments are not widely used, however, and PCPs generally have a difficult time detecting mental disorders such as anxiety and depression (Von Korff et al., 1987; Wells et al., 1989; Heneghan et al., 2000).

## **Requirements for Mental Health Screening in Primary Care**

Overall, 21% of products require PCPs to conduct screening for mental health disorders, including 2% that require specific mental health screening only,

**Figure V.1: Percentage of Products Reporting Screening for Mental Health Problems**



13% that require general screening instruments that include mental health, and 6% that require both approaches. It is also important to note that for 12% of products, respondents did not know if specific mental health screening was required (Figure V.1). Of the small number of products that require screening for mental health disorders, 93% report allowing PCPs' clinical judgment to determine what types of patients to screen. Around 63% report requiring screening of all new patients and 67% report relying on specific conditions to trigger screening. Only 28% of those products that require any screening for mental health problems in primary care settings also report that they require such screening for all patients on a periodic basis. For the 5% of products that report screening requirements as a result of trigger conditions, the most commonly cited conditions are chronic pain, the presence of a substance abuse problem, and sleep problems.

## **Practice Guidelines for Mental Health Treatment in Primary Care**

Practice guidelines, defined as “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical services” have been published in recent years for the primary care treatment of mental disorders in both children and adults (Birmaher, Brend, & Benson, 1998; ICSI, 1999). Practice guidelines can offer direction and support to PCPs in providing appropriate mental health care or referring patients to mental health specialists. While MCOs were not asked what organization wrote the practice guidelines for primary care, the study did find that most MCOs with specialty behavioral health guidelines used self-developed ones. (See Chapter VIII.) It also examined the distribution of behavioral health practice guidelines to PCPs, the topics covered by those practice guidelines, and whether there were differences in the distribution of guidelines depending on screening requirements.

Overall, guidelines were distributed in 51% of products, with PPO products less likely to do so (Table V.1). In addition, products with comprehensive contracts were less likely than either products with specialty contracts or those with internal provision of mental health services to distribute guidelines. For products that distribute practice guidelines, we compared the topics covered in the guidelines for those products that require screening and those that do not (Table V.2). Among products with required mental health screening, 85% or more distribute guidelines addressing the provision of brief interventions, consultations with specialty practitioners, and patient education. Only 66% distribute guidelines addressing the prescribing and monitoring of psychotropic medications. The proportion of

Table V.1. Percentage of Products That Distribute Practice Guidelines to PCPs, by Product Type and Contracting Arrangement

|                        |          |       | Product Type      |                   |                      | Contracting Arrangement |                   |                   |
|------------------------|----------|-------|-------------------|-------------------|----------------------|-------------------------|-------------------|-------------------|
|                        | <i>N</i> | Total | HMO               | POS               | PPO                  | Specialty               | Comprehensive     | Internal          |
| Yes                    | 3,091    | 51.0  | 62.0 <sup>a</sup> | 61.2 <sup>b</sup> | 31.7 <sup>a, b</sup> | 64.4 <sup>a, b</sup>    | 28.2 <sup>a</sup> | 32.8 <sup>b</sup> |
| No                     | 2,348    | 38.8  | 17.0              | 32.7              | 67.4                 | 18.8                    | 71.0              | 66.9              |
| Don't know/<br>missing | 620      | 10.2  | 20.9              | 6.1               | 0.8                  | 16.8                    | 0.7               | 0.3               |
| Total                  | 6,059    | 100.0 | 100.0             | 100.0             | 100.0                | 100.0                   | 100.0             | 100.0             |

*Note:* Pairs that share superscript letter within row and section are significantly different,  $p < 0.01$ . Not all totals equal 100% owing to rounding.

Table V.2. Percentage of Products With Practice Guidelines That Address Specific Topics, Among Those Requiring Guideline Distribution

| Screening Required for Mental Health | Provision of Brief Interventions (%) | Prescribing and Monitoring Medications (%) | Consulting With Specialty Practitioners (%) | Criteria for Referring Out to Specialty Care (%) | Provision of Educational Materials to Patients (%) |
|--------------------------------------|--------------------------------------|--|---|--|--|
| Yes                                  | 84.9                                 | 65.5                                       | 92.7  | 60.7   | 92.5   |
| No                                   | 93.6                                 | 80.8                                       | 96.0  | 52.8   | 85.1   |

*Note:* Based on the 51% of products that distribute guidelines.

products distributing each guideline topic was not significantly different between products that did and did not require screening.

## Discussion

Few MCO commercial products require mental health screening activities in primary care settings. MCO executives did not find the national statistics on screening to be surprising. According to an MCO executive, “There is very low attention to the detection of mental health and substance abuse problems. Welcome to the real world.”

The medical literature includes recent review articles supporting the effectiveness of primary care screening in identifying individuals with mental health problems such as depression (Williams et al., 2002) and providing guidance for treatment in primary care settings (Whooley & Simon, 2000; Pignone et al., 2002). Thus, the infrequent

requirement for mental health screening by MCO products represents a lost opportunity to identify people whose mental problems otherwise may go unnoticed and untreated.

Discussions with MCO representatives also shed light on why mental health screening is not more often required. Among reasons for low screening rates, MCO executives reported that many believe that it is difficult to find a screening instrument that is brief, easy to score, and easy to interpret. Also, they reported that it is difficult to monitor whether screening is done in primary care and that PCPs may not feel competent to address mental health issues once those issues are detected. Nonetheless, with the recent publication of national recommendations endorsing screening for depression in primary care, MCOs may now feel a stronger imperative to require screening than they did at the time of our survey in 1999.



# VI. Entry Into Specialty Treatment

Previous studies have documented the overall use of specialty mental health care (Regier et al., 1993; Kessler et al., 1999) and examined the effects of various managed care approaches on behavioral health services. (See review articles by Mechanic, Schlesinger, & McAlpine, 1995; Grazier & Eselius, 1999; Sturm, 1999.) However, no national estimates of specialty mental health treatment entry arrangements in commercial managed care plans have been documented. This chapter reports key findings regarding referral and prior authorization procedures for enrollees in managed care products.

Facilitating entry into mental health care is important, since two-thirds of people with mental disorders do not obtain treatment (Regier et al., 1993). Possible reasons for this unmet need include stigma, lack of recognition of mental disorders by both individuals and providers, discriminatory and inadequate insurance benefits, lack of awareness that effective treatments exist, added barriers for subgroups such as racial and ethnic minorities, and confidentiality concerns (DHHS, 1999).

MCOs use a variety of managed care techniques to structure access to specialty mental health services. MCOs may allow enrollees to self-refer to specialty mental health care by calling specialty providers directly for an appointment, have telephone referral centers, or require enrollees to obtain referrals from a primary care physician (PCP) or an employee assistance program (EAP). Furthermore, prior authorization or precertification may be required for treatment to be covered.

## Referral Process

### *Direct Self-Referral and Phone Center Referral*

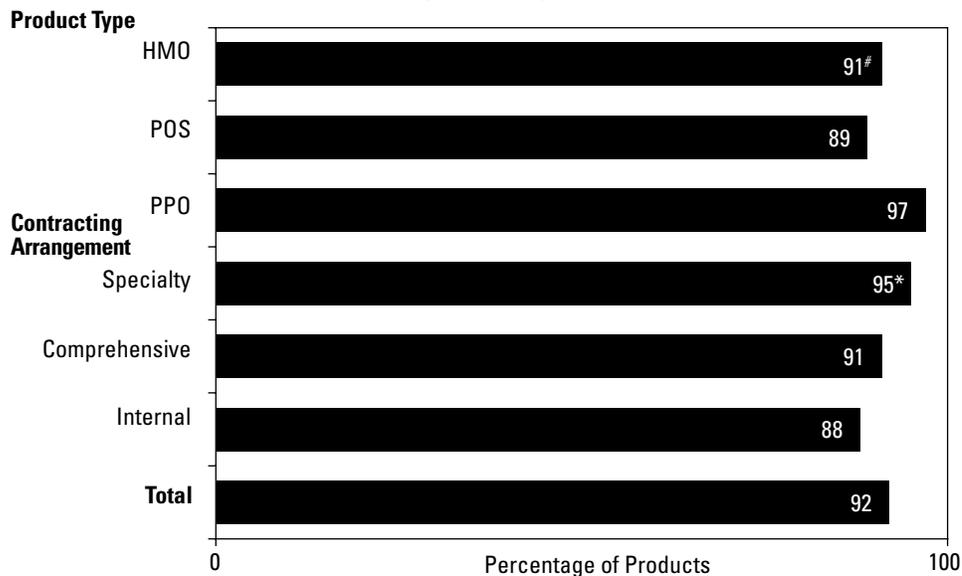
Overall, 90% of products allow direct self-referral or require enrollees to call a designated phone number for referral (Figure VI.1). Enrollees' opportunity to self-refer or access specialty mental health treatment via a phone center is significantly more likely in PPO products (97%) than in HMO products (91%), although the large majority of all product types have one of these features. A greater proportion of products with specialty contracts (95%) than products with comprehensive contracts (91%) or internal arrangements (88%) report these approaches.

### *Primary Care and EAP*

#### *Gatekeeping Mechanisms*

Although primary care gatekeeping was a hallmark of HMOs earlier in the evolution of managed care, we found that only about 8% of products overall and 11% of HMO products require enrollees to obtain a

**Figure VI.1: Percentage of Products With Direct Self-Referral or Phone Center Referral for Specialty Mental Health Services (by Product Type and Contracting Arrangement)**



<sup>#</sup> HMO different from PPO,  $p < 0.05$ .

<sup>\*</sup> Specialty different from comprehensive and internal,  $p < 0.05$ .

Note: Missing data are less than 5%.

referral from a PCP in order to access specialty mental health treatment (Figure VI.2). Another 2% of all products required EAP referral for access to specialty mental health services. HMO products are significantly more likely than PPOs to report the need for a referral from a PCP or an EAP. No significant differences were found by contracting arrangement.

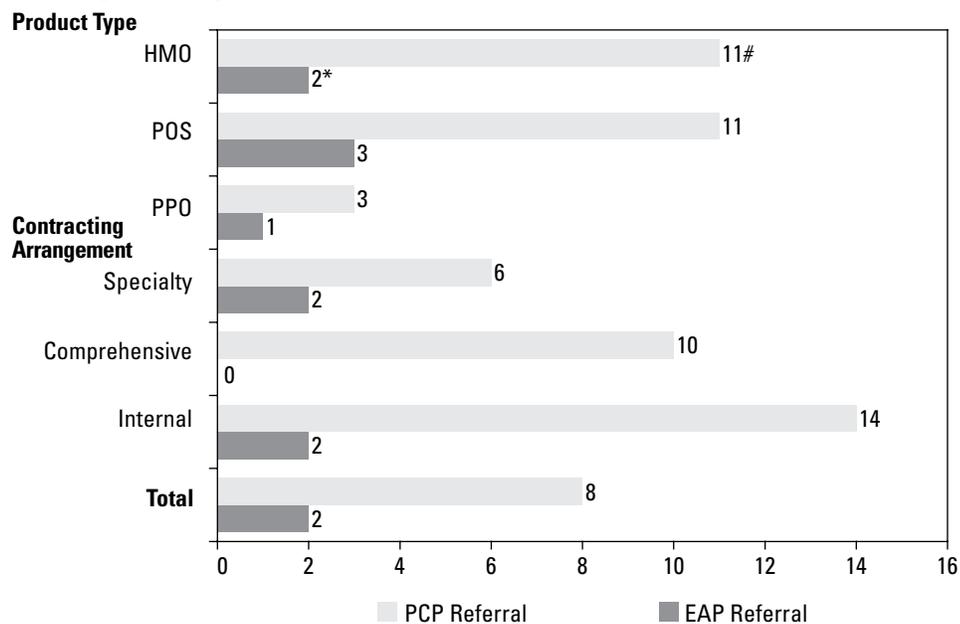
### Prior Authorization Requirements

Regardless of the referral process, prior authorization or precertification may be required for different levels of care. This may involve providers, rather than patients, needing to seek authorization for services before initiating them. Prior authorization may include a range of procedures, from calling a phone center for essentially automatic authorization of outpatient care to

undergoing a clinical assessment and triage process prior to accessing care.

The study asked about four levels of mental health care: inpatient hospital, non-hospital residential, intensive outpatient (including day treatment), and outpatient counseling. Prior authorization for inpatient hospital care is virtually universal, regardless of product type (Table VI.1), while for most other levels of care, PPOs are significantly less likely to require prior authorization. For instance, among products that cover outpatient counseling, 90% of HMOs require prior authorization, compared with 74% of point-of-service (POS) products and 40% of PPOs. Requirements for prior authorization also differ by contracting arrangement. Products with specialty contracts are much more likely to require prior authorization than comprehensive contract

Figure VI.2: Percentage of Products With PCP or EAP Gatekeeping for Specialty Mental Health Services (by Product Type and Contracting Arrangement)



# HMO different from PPO,  $p < 0.01$ .

\*HMO different from PPO,  $p < 0.05$ .

Note: Missing data are less than 4% in all categories.

Table VI.1. Percentage of Products Requiring Prior Authorization for Mental Health Services

|                         | Total | Product Type      |                   |                     | Contracting Arrangement |                   |                   |
|-------------------------|-------|-------------------|-------------------|---------------------|-------------------------|-------------------|-------------------|
|                         |       | HMO               | POS               | PPO                 | Specialty               | Comprehensive     | Internal          |
| Inpatient hospital      | 93.1  | 94.8              | 90.0              | 93.3                | 93.8                    | 93.5              | 91.2              |
| Nonhospital residential | 69.7  | 69.8 <sup>a</sup> | 91.2 <sup>a</sup> | 58.1 <sup>a</sup>   | 80.7 <sup>a</sup>       | 45.0 <sup>a</sup> | 50.0              |
| Intensive outpatient    | 75.8  | 90.7 <sup>a</sup> | 83.9 <sup>b</sup> | 53.2 <sup>a,b</sup> | 93.1 <sup>a</sup>       | 37.9 <sup>a</sup> | 55.9 <sup>a</sup> |
| Outpatient counseling   | 68.4  | 90.3 <sup>a</sup> | 73.9 <sup>a</sup> | 39.8 <sup>a</sup>   | 90.6 <sup>a,b</sup>     | 36.2 <sup>a</sup> | 35.0 <sup>b</sup> |

Note: Products not covering service are excluded. Missing data are less than 15% for each category except: nonhospital residential, PPO (23.3%), internal (45.8%); intensive outpatient, internal (26.4%); outpatient counseling, internal (20.4%). Products within row and section that share superscript letters are significantly different,  $p < 0.01$ .

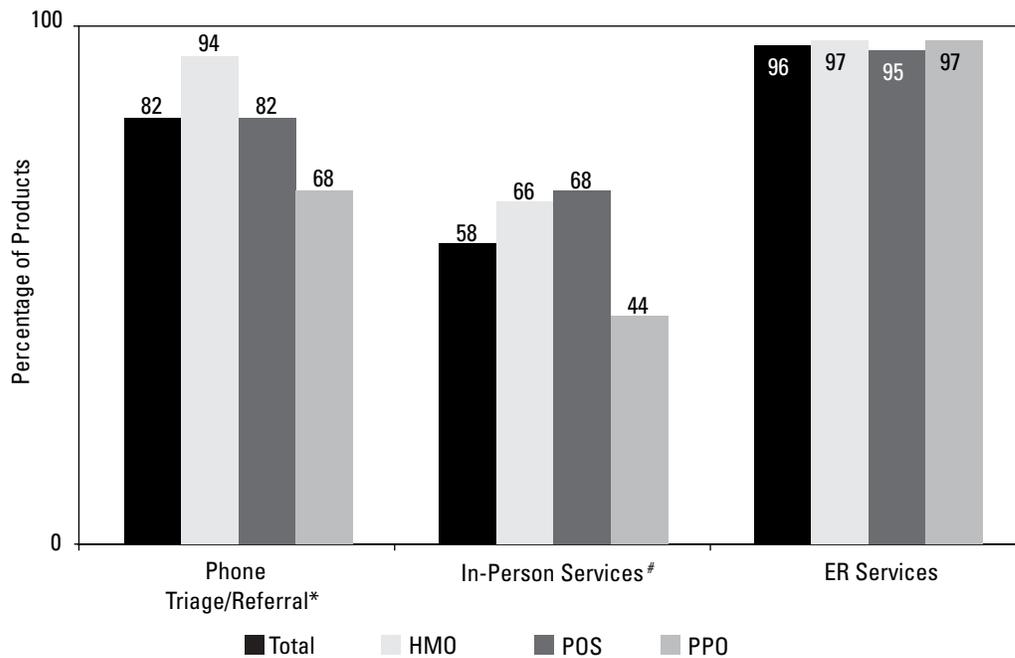
or internal products, for all settings except inpatient hospital care.

### Availability of 24-Hour Crisis Services

Entry into mental health care may be precipitated by (or ongoing treatment marked by) a sudden crisis. The vast majority of

products offer emergency room (ER) (96%) and telephone triage (82%) services (Figure VI.3). A smaller number of products, 58%, report having in-person crisis services available. HMO products were significantly more likely to offer phone triage/referral and in-person services compared with PPOs.

Figure VI.3: Availability of 24-Hour Mental Health Crisis Services



\*All pairs different,  $p < 0.01$ .  
<sup>#</sup>PPO different from HMO and POS,  $p < 0.01$ .  
 Missing data are less than or equal to 5% in all categories.

## Discussion

The large majority of products feature either direct self-referral or referral through a phone center. This was true for all product types and contracting arrangements. While the HMO model often is associated anecdotally with primary care gatekeeping, this survey found that this approach was infrequent for mental health, probably due to the high rate of specialty contracting among HMOs. Required EAP referral also was rare. Prior authorization is usually required for all levels of care but is most prevalent among HMO and specialty contract products.

For some enrollees, the possibility of referral to specialty mental health providers without primary care or EAP gatekeeping will be experienced as freedom from constraints or privacy concerns and may increase the

likelihood of seeking needed care. As one managed behavioral health care organization executive said, “There are already too many barriers preventing people from seeking mental health treatment. The best thing to do both clinically and economically is to remove the barriers that limit access to care.” However, we do not know how direct self-referral differs from phone center referral from the enrollee point of view. Furthermore, some may benefit from the triage that phone centers or primary care gatekeepers can provide. One industry expert reported: “When someone calls the phone center number for a mental health referral, it is virtually guaranteed that they will get a referral for care. The only question is what type of treatment. The goal is to connect the person with appropriate care, not to deny care.”

**T**he treatment process is multifaceted and is shaped by both administrative and clinical factors. For managed care enrollees who need mental health services, their experiences can be greatly affected by MCO policies and practices. For example, the time an enrollee must wait until a first appointment may influence whether he or she follows through. The kinds of questions asked when an enrollee calls a phone center referral line may hinder or facilitate getting needed care. Because of the potential impact on enrollees, therefore, it is critical to understand the range of MCOs' approaches to policies that influence care for people with mental health problems.

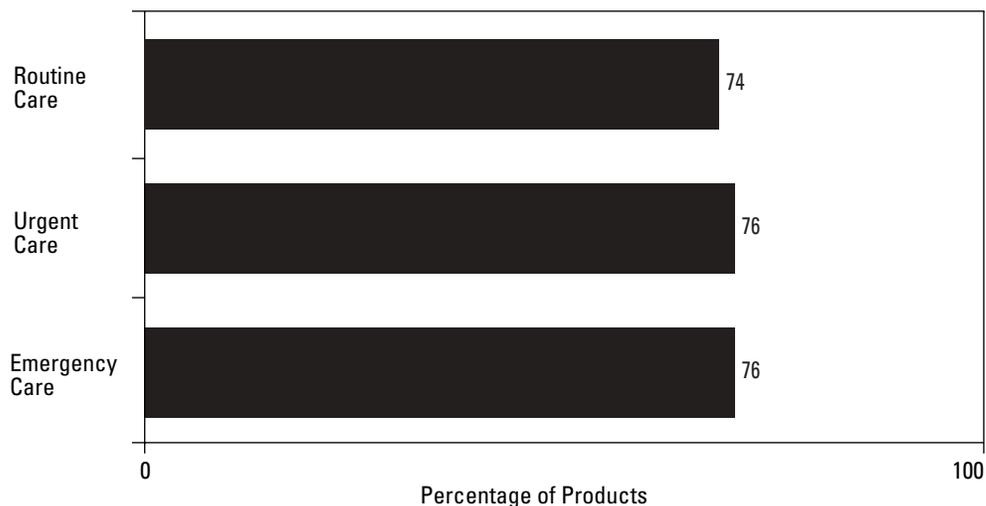
The survey inquired about aspects of the treatment process that MCOs have direct influence over, including policies setting standards for timely first appointments, the types of clinical personnel providing treatment, standards regarding prompt follow-up after discharge from inpatient care, and special services for patients with dual diagnoses of mental health problems and substance abuse. Another area that can affect the specialty mental health treatment process—the use of practice guidelines—is discussed in Chapter VIII as a quality management activity.

Data also were collected regarding utilization management, “a set of techniques used by or on behalf of purchasers of health care benefits to manage mental health costs by influencing patient care decision-making through case-by-case assessments of the appropriateness of care prior to its provision” (Institute of Medicine, 1989). These techniques may include mechanisms to control initial access to care (such as the

gatekeeping and precertification procedures discussed in Chapter VI), periodic or concurrent review and authorization for treatment, and case management for specific categories of patients. MCOs vary by the type of professionals and organizations used to perform initial review and by who has authority to deny care for outpatient and inpatient treatment. There is also variation in the types of case management programs, the types of professionals working as case managers, and the different functions that case managers perform.

A number of studies have examined the process and effects of utilization management for behavioral health services. (Recent examples include Frank & Brookmeyer, 1995; Howard, 1998; Wickizer & Lessler, 1998; Liu, Sturm, & Cuffel, 2000.) These studies generally suggest that certain strategies do result in a lower quantity of treatment—sometimes directly through denials or approving less treatment than requested,

**Figure VII.1: Percentage of Products With Standards for Maximum Time to Initial Appointment**



*Note:* Missing data are less than 4% per category.

but sometimes through a “sentinel effect” in which the very existence of the utilization management system seems to deter higher use of services. However, this study is the first to describe the prevalence of a variety of treatment process factors within MCOs on a national basis. This chapter presents some key findings on this topic.

### **Providers of Mental Health Treatment**

Mental health practitioners have different training and backgrounds. They include psychiatrists, doctoral-level psychologists, clinical social workers, clinical nurse specialists, nurse practitioners, marriage and family therapists, and master’s-level psychologists and counselors. For both individual and group counseling, master’s-level clinicians and doctoral-level psychologists were most often reported to “frequently” provide these services. The lower frequency of psychiatrists in both categories may reflect a decreasing role for psychiatrists

in the provision of psychotherapy and an increasingly exclusive focus on providing psychopharmacology services.

### **Standards for Wait Time to Appointments**

An important aspect of access to treatment is to provide timely initial appointments once individuals request services. About three-quarters of all products report having formal standards for maximum wait time from request for treatment to initial appointment (Figure VII.1). Continuing treatment in an outpatient setting following discharge from a psychiatric hospitalization is also generally accepted as necessary. Close to half of all products (43%) reported having standards regarding time limits for follow-up mental health visits after discharge from hospital or residential care (Figure VII.2). HMOs and specialty contract products are most likely to have both types of standards (data not shown).

### **Services for Patients With Both Mental Health and Substance Abuse Problems**

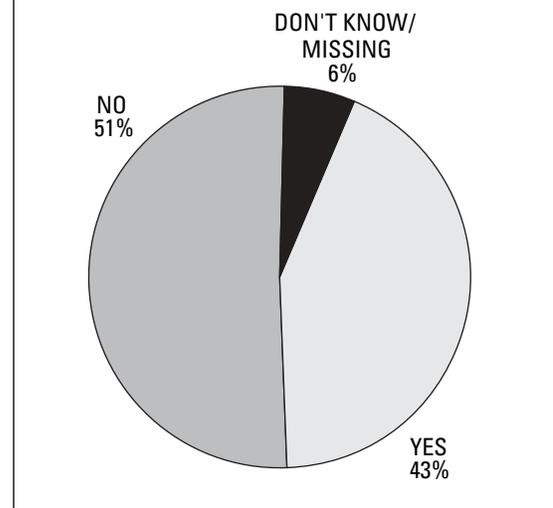
A substantial proportion of people with mental health problems also have substance abuse disorders. For patients with mental disorders who are seen in specialty treatment settings, about one-fifth have had a substance abuse disorder within the past six months (Regier et al., 1990). For those persons with co-occurring mental illness and substance abuse, diagnosis and treatment can be especially complex, and integrated treatment approaches are promising, although additional research is needed on their effectiveness (RachBeisel, Scott, & Dixon, 1999; Herman et al., 2000; Primm et al., 2000; Watkins et al., 2001).

We found that about half of all products reported having specialized providers or treatment programs to treat this dually diagnosed population (Figure VII.3). HMOs were more likely (71%) to have these compared with PPOs (39%) or POS products (35%). Comprehensive contract products were less likely to have specialized providers or treatment programs (data not shown). One-sixth of all products had specific treatment guidelines for the dually diagnosed, and one-quarter had special criteria or procedures for treatment authorization.

### **Utilization Review Personnel**

This study asked about the types of personnel who conduct initial reviews of requests for additional mental health care. Master's-level clinicians were most often reported to "frequently" perform this review, followed by registered nurses. Only 2% of products report that administrative staff perform this function. As it is generally known that physicians rarely perform this first level

Figure VII.2: Percentage of Products With Standards for Time to Follow-up Visits After Inpatient/Residential Discharge



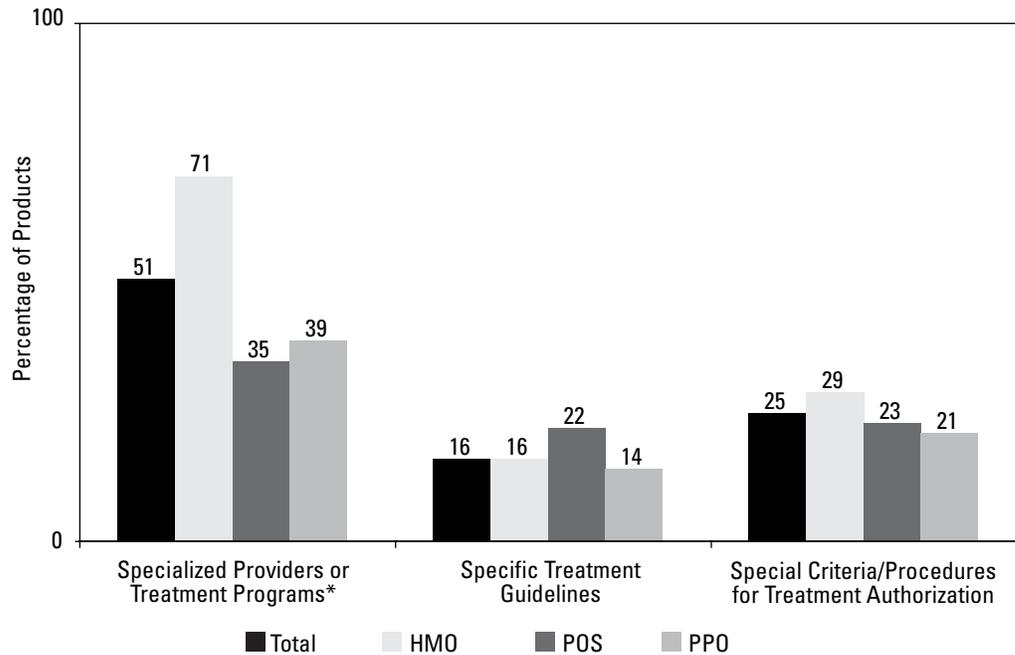
of review, the study did not ask with what frequency they do so.

If reviewers decide that the treatment requested is inappropriate or unnecessary, often they do not have authority to implement that denial themselves. Psychiatrists are the professionals most often "frequently" granted authority to deny care for both inpatient and outpatient treatment, followed by other physicians and doctoral-level psychologists. In about two-thirds of products, master's-level clinicians and registered nurses are never authorized to deny care for either inpatient or outpatient treatment. HMO products are less likely to authorize nonpsychiatrist physicians, and comprehensive contract products are less likely to authorize psychiatrists.

### **Organizational Responsibility for Initial Utilization Review and Appeals**

Across all products, more than half delegate initial utilization review MBHOs (Figure VII.4). The MCO retains direct responsibility for initial review for roughly one-quarter of

**Figure VII.3: Percentage of Products With Specialized Approaches to Dually Diagnosed Patients**



\*HMO different from POS and PPO,  $p < 0.01$ .

Note: Missing data are less than or equal to 8% except specialized providers or treatment programs/POS are 12%, specialized providers or treatment programs/PPO are 9%, and special criteria/procedures for treatment authorization/POS are 10%.

all products, and about 11% use a utilization review vendor for this purpose.

When a denial results from this initial review, an enrollee or provider may appeal. External review programs to provide an independent review of an MCO's decision to deny, reduce, or terminate treatment have been proliferating quickly and have been the focus of attention from managed care accrediting organizations (Dallek & Pollitz, 2000). Overall, MCOs usually delegate initial appeals to other organizations; only about one-third decide initial appeals themselves (Figure VII.4). Among products with specialty contracts, over half report that MBHOs review initial appeals. For products with comprehensive contracts and internal products, more than half delegate this responsi-

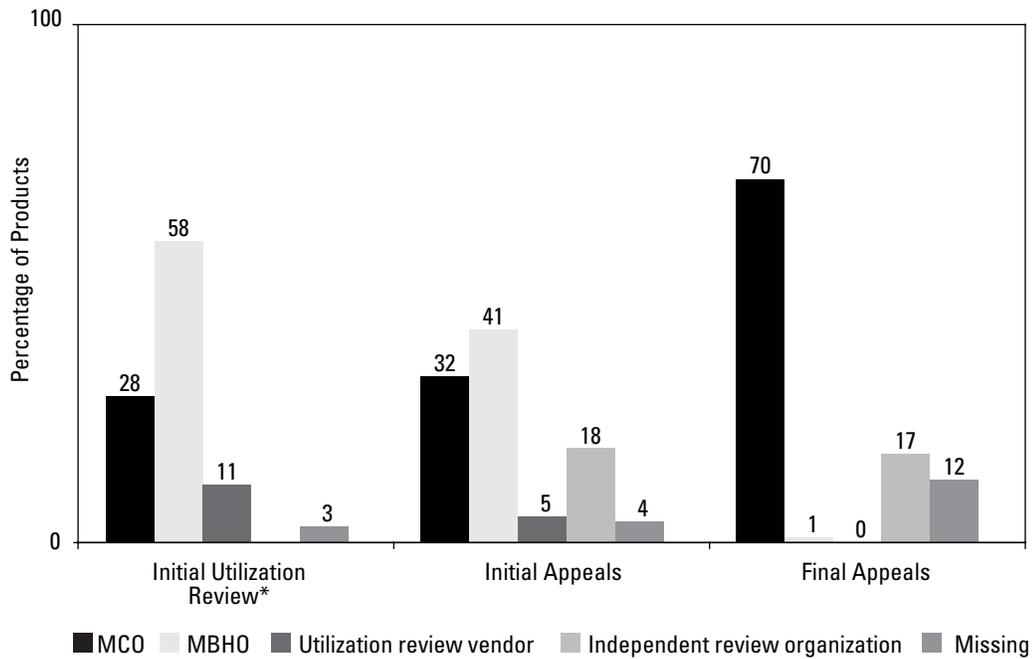
bility to utilization review vendors or other external organizations, including independent review organizations (data not shown).

While products typically allow an external vendor or MBHO to rule on initial appeals of the denial of care, 70% of products retain the responsibility for final appeals decisions. There is little variation by product type, although there is variation for products with different contractual arrangements. Products with specialty contracts are most likely to report that the MCO is the organization responsible for the final appeals decision.

### **Mental Health Case Management Programs**

Case management for persons with mental disorders is common. Overall, 87% of

**Figure VII.4: Organizational Responsibility for Utilization Review and Appeals**



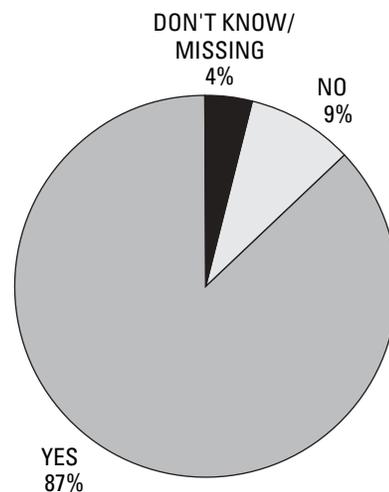
\*Not asked regarding independent review organization.

products report having a case management program (Figure VII.5). Coordination of services is the most commonly provided case management activity (85% of all products), followed by helping patients to access community resources (76%), flexing or extending client benefits (62%), and finally, meeting regularly with clients in person or over the phone (46%) (Figure VII.6). Across all products, master’s-level clinicians are “typically” used more often than doctoral-level psychologists or registered nurses to provide case management services.

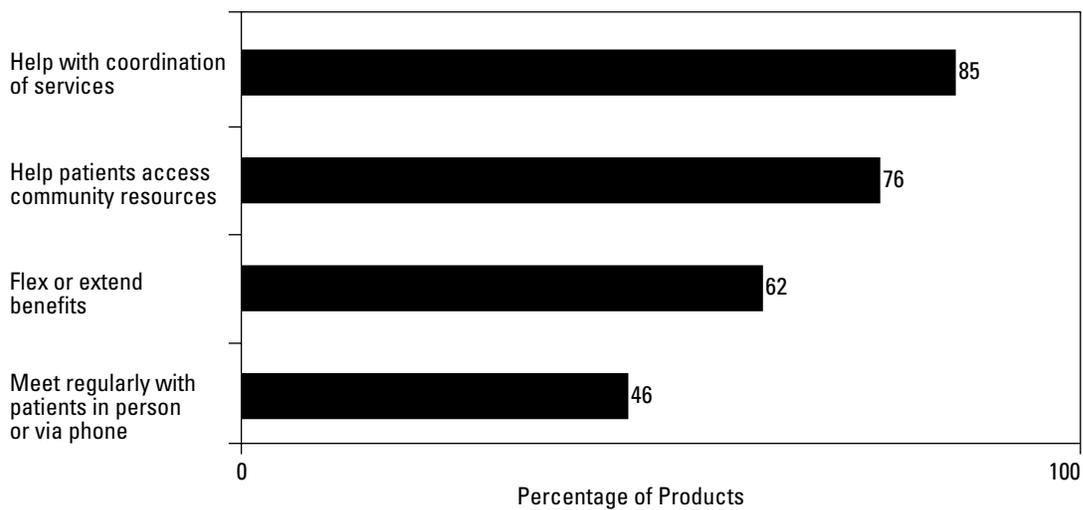
**Discussion**

The study found that MCOs implement a number of measures to influence aspects of the treatment process, including standards for maximum time to first appointment, timely follow-up after inpatient discharge,

**Figure VII.5: Percentage of Products With a Mental Health Case Management Program**



**Figure VII.6: Percentage of Products Providing Specific Case Management Functions**



*Note:* Missing data are less than 5% except 15% for flex or extend benefits.

and special services for patients with co-occurring mental and substance abuse disorders. Utilization review responsibilities vary considerably depending on the level of review and appeals. In terms of issuing denials of care, psychiatrists and other physicians are far more likely to carry out these functions than other professionals. Organizationally, the higher the level of review and appeal, the more common it is for responsibility to be found with the MCO rather than delegated to external organizations. Regarding treatment provision, master’s-level clinicians and doctoral-level psychologists “frequently” provide treatment more often than psychiatrists.

The degree of control exerted over the treatment process may be positive in some cases—for instance, in ensuring that

enrollees have timely access to care. On the other hand, some providers and patients may find tight utilization review systems to be an obstacle rather than a useful assurance of appropriate care. However, it is clear that the range of treatment process factors can have potentially important effects. An industry expert pointed out: “In many ways, individual providers cannot control how patients are treated. You have to consider the effects of utilization management, benefits, payment mechanisms, and other factors in the overall system.” While an organization-level survey such as this study cannot describe what happens in the actual clinical encounter, the results provide a picture of the degree to which MCOs attempt to influence important aspects of the treatment process.

# VIII. Quality Management

In recent years, the health care industry has focused on assessing health care quality in behavioral health and other arenas (Edmunds et al., 1997; McCorry et al., 2000; Merrick et al., 2002). This stems in part from the move to managed care in general and the growth of the managed behavioral health care industry, which have both raised concerns and held out the promise of improved quality. Accreditation organizations such as the National Committee for Quality Assurance (NCQA), MBHO industry groups such as the American Managed Behavioral Healthcare Association, consumer- and purchaser-oriented organizations such as the Foundation for Accountability, and purchasers themselves have played a role in driving the adoption of quality management approaches through accreditation and performance measurement systems (FACCT, 2001; NCQA, 2001). While a literature on specific quality improvement initiatives exists, this study is the first to provide estimates of MCOs' use of a range of behavioral health quality management activities based on a nationally representative sample (Merrick et al., 2002).

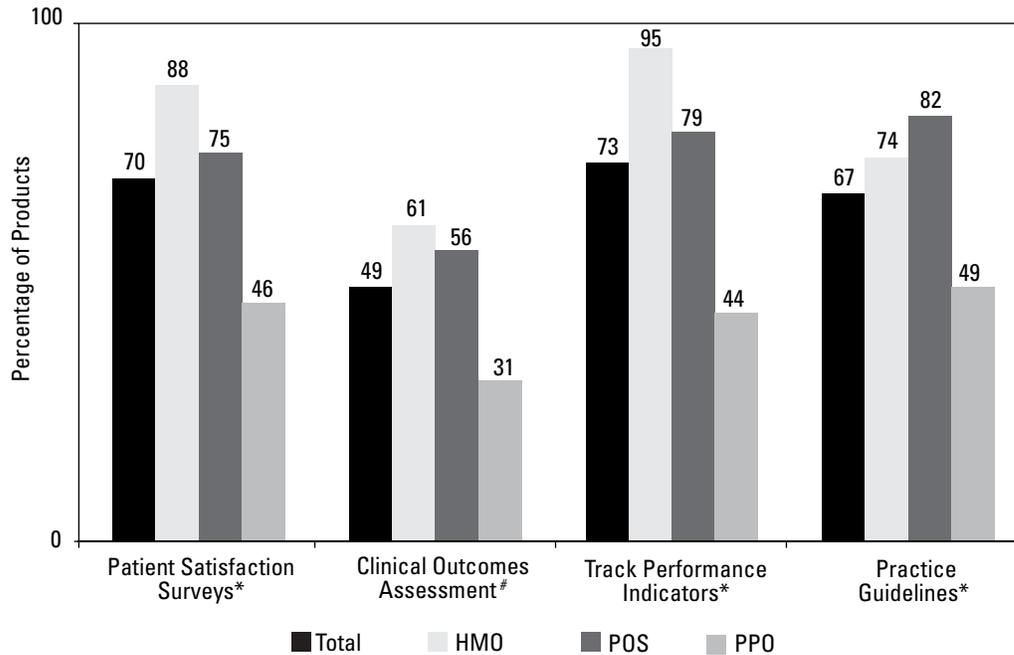
Out of the range of possible activities that MCOs can conduct to measure and ultimately improve quality, we asked about four commonly mentioned activities: whether patient satisfaction surveys that ask about behavioral health services are conducted at least annually, whether clinical outcomes are assessed for at least some behavioral health patients, whether behavioral health performance indicators are tracked, and whether there are practice guidelines for major depressive disorder, schizophrenia, and panic disorder. This chapter reports key findings regarding these quality management activities.

## **Prevalence of Behavioral Health Quality Activities**

Most products use at least one of these four quality-related activities (Figure VIII.1). More than two-thirds of products conduct patient satisfaction surveys that ask about behavioral health services (70%), track behavioral health performance indicators (73%), and have practice guidelines for at least one of the three mental disorders selected (67%). Fewer than half (49%) conduct clinical outcomes assessments.

The prevalence of quality activities differs across product types. Significantly fewer PPOs than HMOs participate in quality-

**Figure VIII.1: Prevalence of Quality Management Activities by Product Type**

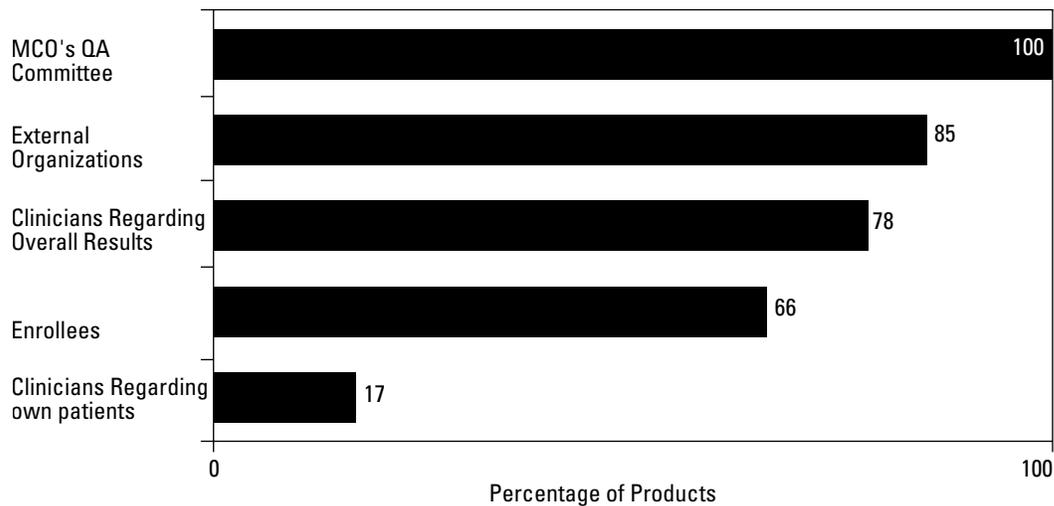


\*All pairs significantly different,  $p < 0.05$ .

# PPO significantly different from HMO and POS,  $p < 0.01$ .

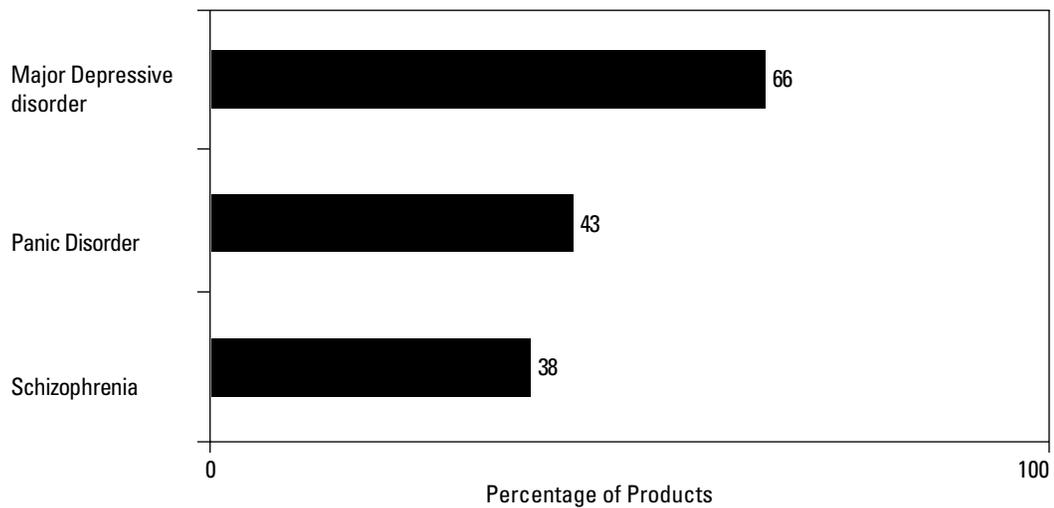
Note: Missing data are less than 7% within categories. POS = point-of-service plan.

**Figure VIII.2: To Whom Patient Satisfaction Survey Results Are Reported**



Note: Based on the 70% of products conducting patient satisfaction surveys. Missing data are less than 5% in each category except "clinicians regarding own patients" missing data are 15%. QA = quality assurance.

**Figure VIII.3: Provision of Practice Guidelines for Selected Mental Health Disorders**



*Note:* Missing data are less than 5% except 8% for panic disorder and schizophrenia.

related activities. For example, less than half of PPOs conduct patient satisfaction surveys, compared with almost 90% of HMOs. With respect to contracting arrangements, products with specialty contracts are most likely to conduct each of the quality activities (data not shown).

### **MCOs' Reporting of Results**

MCOs report quality-related findings to a variety of stakeholders (Figure VIII.2). When patient satisfaction surveys are conducted, for example, results most frequently are reported to the MCO's quality assurance committee (100%), followed by external organizations (85%), clinicians (regarding overall results, 78%), and enrollees (66%). Few of the products that conduct these surveys (17%) report providing patient satisfaction results to individual clinicians regarding their own clients.

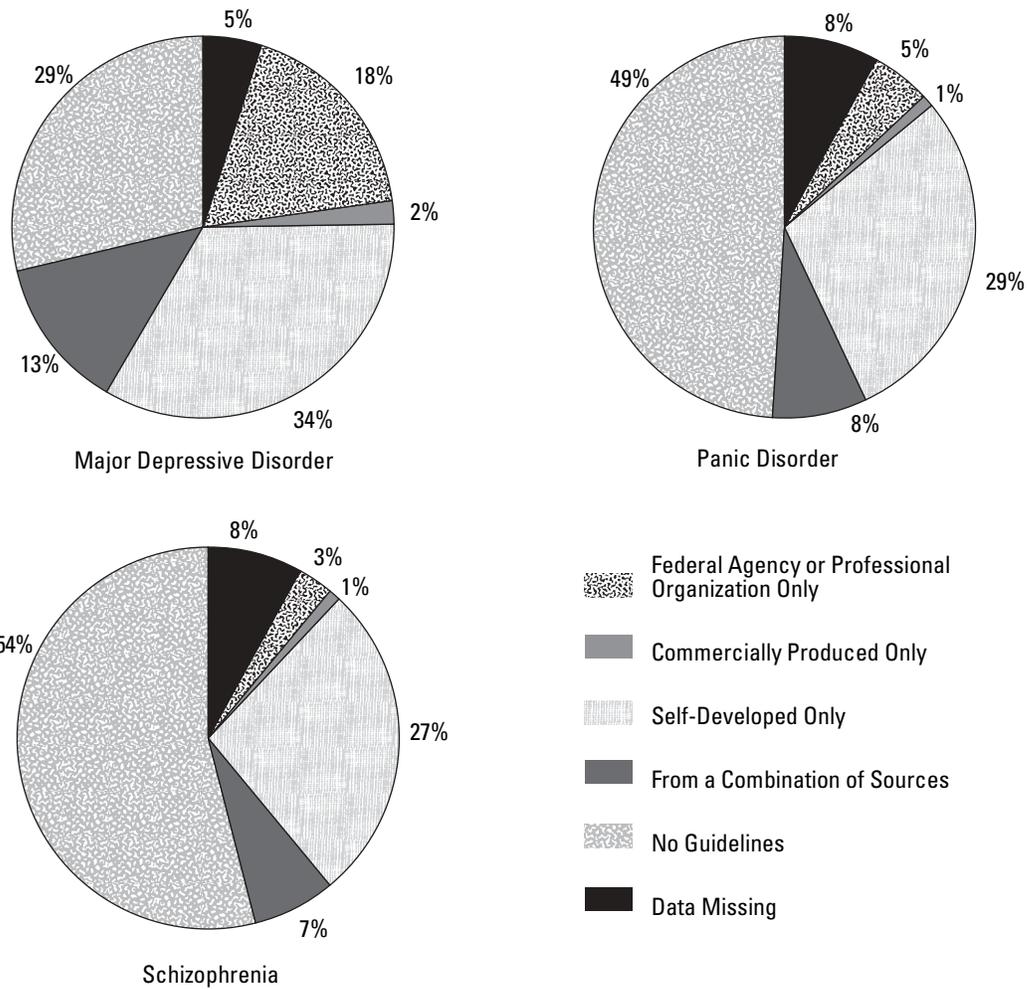
### **Practice Guidelines for Selected Mental Health Disorders**

The study asked whether MCOs had practice guidelines for any of three mental disorders. Most products (66%) provide guidelines for major depressive disorder (Figure VIII.3). Less than half report having guidelines for the treatment of panic disorder and schizophrenia. The most common source of guidelines for each disorder is self-developed guidelines only (Figure VIII.4). Very few products report using only commercially developed practice guidelines, while substantial proportions use federal agency or professional organization guidelines only, or a combination of sources.

### **Quality Assurance Committees for Mental Health Services**

Three-quarters of all products reported having an MCO-level committee to oversee quality

**Figure VIII.4: Sources of MCOs' Mental Health Practice Guidelines (Percentage of Products)**



**Table VIII.1: Participation in MCO Quality Assurance Committees Overseeing Behavioral Health Services**

| <b>Committee Participants</b>  | <b>Products With Listed Participants (%)</b> |           |                           |
|--|--|-----------|---------------------------|
|  | <b>Yes</b>                                   | <b>No</b> | <b>Missing/Don't Know</b> |
| Specialty mental health and substance abuse providers                  | 90.9   | 8.3       | 0.9                       |
| Primary care practitioners   | 47.7   | 51.3      | 1.0                       |
| Enrollees who are behavioral health consumers, or their family members | 5.2  | 93.9      | 0.9                       |
| Other enrollees  | 3.5  | 95.7      | 0.9                       |

*Note:* Based on the 75% of products that had an MCO-level quality assurance committee overseeing mental health and substance abuse treatment. Not all totals equal 100% owing to rounding.

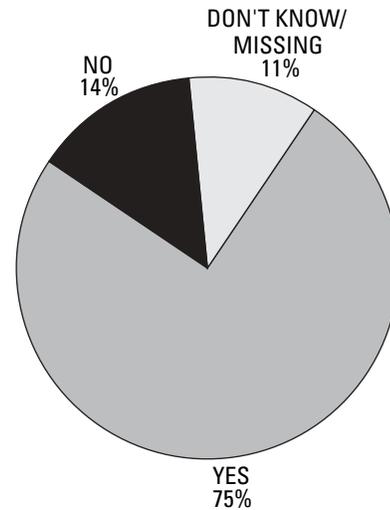
assurance programs for mental health and substance abuse services (Figure VIII.5). Nearly all such committees include specialty mental health and substance abuse providers, while close to half include primary care providers (Table VIII.1). Very few include consumers or other enrollees.

### Discussion

Most managed care products conduct patient satisfaction surveys, track performance indicators, and have practice guidelines for the mental health disorders the study asked about. Clinical outcomes assessment was less common. One MBHO executive told us: “It’s no wonder that less emphasis is placed on measuring outcomes. Outcomes are difficult to measure, members and providers are often reluctant to participate, and outcomes measurement can be very costly.”

The higher proportion of HMOs using these activities suggests that the traditionally “more managed” products may have structures that facilitate quality management, or that these products have responded to external pressures such as accreditation organizations, which until recently focused on mainly HMOs. Alternatively, the fact that specialty contract products more often

**Figure VIII.5: Percentage of Products With Quality Assurance Committee for Mental Health and Substance Abuse Services**



conduct these activities raises the possibility that this contracting arrangement (more common in HMOs) affects the prevalence of activities. It is also important to understand that while these activities seem useful by providing tools with which quality can be improved, our results cannot tell us about differences in the actual quality of care that may result from quality management efforts.



**T**he study has reported on a nationally representative survey of MCOs and described in detail differences in the provision of services by product type and contracting arrangement. To understand the impact of managed behavioral health care on patients, it is important to understand the structure and rules under which services are provided.

The major conclusion from this study is that there is diversity in the mental health services that MCOs provide. MCOs must decide whether to carve out to a specialty vendor or to provide services internally, which utilization review responsibilities to delegate and which to retain, whether to require primary care providers to screen patients for mental health problems, and which quality of care activities to conduct. Because MCOs answer these and other important questions differently, MCO products vary greatly. Therefore, managed behavioral health care should not be viewed generically. Understanding issues related to the access to, the cost of, and the quality of mental health treatment services requires knowledge about the variation in the provision of services owing to both product type and contractual arrangements.

In this chapter, selected key findings are reviewed and related to the interests of particular stakeholders. Overall limitations to the study are described, and suggestions are offered for future studies.

## **Key Findings and Stakeholder Perspectives**

MCOs' provision of mental health services varies across a broad range of dimensions, each of which has important implications for the numerous stakeholders in the delivery system: enrollees, purchasers, policy-makers, providers, and MCOs or MBHOs themselves. Key findings of particular interest to various stakeholders include the following:

- *Behavioral health contracting arrangements vary greatly depending on the managed care product type.* The study found that HMOs are far more likely to contract with specialty MBHOs, while PPOs are the only product type to frequently contract with comprehensive vendors. Employers and other purchasers, as well as consumers, will find this information useful in going beyond traditional managed care labels to consider the specific structures through which mental health care is delivered.

- *Mental health benefits generally include a broad continuum of care but are typically subject to limits and to cost sharing that is greater than for general medical care.* Purchasers, consumers, and policy-makers with an interest in parity will be interested to know that all managed care product types still (in 1999) rely substantially on benefit restrictions to contain costs.
- *MCOs seldom require standardized screening for mental health problems in primary care settings but frequently provide practice guidelines for mental health treatment in primary care.* This should provide important data for dialogue among providers, MCOs, and others concerning how best to improve the diagnosis and treatment of mental health disorders within primary care settings.
- *Primary care gatekeeping is unusual but does vary by product type.* HMOs are most likely to require this, but for all products direct self-referral and phone center referral are typical. Employers and other purchasers as well as consumers should be aware of these differences as they consider which plans best meet their needs.
- *A substantial proportion of MCOs aim to control aspects of the specialty treatment process such as time to initial appointment and follow-up after inpatient discharge.* HMOs and specialty contract products are generally more likely to have such policies. Providers, consumers, employers and other purchasers, and MCOs or MBHOs themselves, can factor this into their assessments of mental health care delivery systems.

Thus, the main findings cover a broad spectrum of areas related to mental health services in MCOs, each particularly salient

to certain groups of stakeholders, and all results should prove useful as a benchmarking tool for MCOs themselves. The survey results can shed light on many aspects of the debate about the changing landscape of mental health services under managed care.

## Service Delivery Models

As shown, product type and contracting arrangement are associated with certain features of the specialty mental health delivery system. To illustrate, here are two common scenarios based first on product type and then on contracting arrangement.

If an enrollee in a *typical* PPO product seeks specialty mental health services, he or she will—

- Have those services delivered through the PPO's internal network or through a contracted comprehensive network (in contrast to other product types, which usually have specialty contracts).
- Not need prior authorization for outpatient care (while HMOs almost always require this).
- Lack access to specialized providers or treatment programs for dual mental health and substance abuse disorders (in contrast to HMOs, where this access is more common).
- Not be provided some 24-hour crisis services such as phone triage/referral assistance (again in contrast to other product types).

If an enrollee in a *typical* managed care product with a specialty MBHO contract seeks mental health services, he or she will—

- Need prior authorization to access all levels of care (which is more stringent than in other contracting arrangements).

- Find that the MBHO is responsible for initial utilization review.
- Have access to 24-hour services such as telephone triage/referral.

These are examples of prevalent patterns that the study results have revealed, although there is variation within each product type or contracting arrangement. Thus, it is important to recognize both the general differences and the individual variations that exist.

### **Interaction of Product Type and Contracting Arrangement**

This report has examined separately the effects of product type and of contracting arrangement, capturing the decisions that consumers, employers, and MCOs need to make. For example, when selecting commercial health insurance plans, usually coordinated through their employer, consumers will find it helpful to know how HMO, PPO, and POS plans are likely to operate. Consumers also may wish to inquire further into the mental health contracting arrangements for the health plan, knowing that there are likely to be differences based upon that variable as well.

However, because different product types are more or less likely to choose particular contracting arrangements, the differences observed may be inherent in the product type itself, driven by the contracting arrangement, or affected by both factors. As seen in Chapter V, the distribution of practice guidelines in primary care is lower in PPOs than in HMOs, for instance, but it is not possible to discern whether this is due to some aspect of PPOs themselves or due to PPOs' different contracting arrangements. To explore this issue for targeted topics, we used statistical techniques that allow the

effects of both product type and contracting arrangement to be taken into account simultaneously and the independent effect of each to be estimated. Using either logistic or ordinary least-squares regression as appropriate, we analyzed cost-sharing level, primary care screening, availability of dual-diagnosis programs, and use of specialty mental health practice guidelines. In all cases, both product type and contracting arrangement variables had significant independent effects. Thus, both product type and contracting arrangement make a difference across a range of mental health system features.

### **Limitations**

The study is subject to various limitations that should be considered when interpreting its results. First, the study focused on organizational respondents, not individual clients, and therefore cannot address how client experiences and outcomes may vary across the different organizational arrangements. However, information from organizational surveys like this one can be helpful to those designing client studies by focusing on key structural aspects of care delivery. Second, the survey does not include indemnity health plans. Given their dwindling market share, this limitation may be of decreasing importance. Third, on some topics, arrangements may have evolved further since 1999, when this survey was done; for example, prescription drug benefits have changed rapidly with the emergence of three-tier benefit designs. This is one reason for the planned resurvey in 2003.

### **Future Research**

Two major directions are needed in terms of future research. First, an updated examination of the same issues reported on here

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is needed because of the rapid changes in the context in which MCOs operate, including changes in legislation on parity for mental health care, downturns in the economy, and new developments in the clinical treatment of mental health problems. Second, this project has focused on an organizational level by

surveying managed care plans and talking with management and clinical decision makers at each MCO. Clearly, the next step will be to relate the findings reported here directly to enrollees' experiences in accessing mental health services, by linking these results with information from surveys of enrollees.



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# XI. Appendix A. Summary of Survey Content

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## SURVEY ON ALCOHOL, DRUG ABUSE AND MENTAL HEALTH SERVICES UNDER MANAGED CARE

### EXECUTIVE DIRECTOR SURVEY—SUMMARY

This survey is designed as a telephone survey lasting approximately 30 minutes. To provide an overview of the topics covered, this summary presents the main questions and answer categories. During the actual survey, the interviewer often will:

- Inquire about mental health as well as substance abuse services;
- Ask if responses apply similarly to multiple **PRODUCTS** (e.g. HMO, PPO, POS) within a managed care organization;
- Provide explanations about terms or abbreviations used in some questions;
- If applicable, allow a respondent to refer the interviewer to a specialty behavior healthcare vendor or provider organization;
- Focus answers specific to the managed care organizations operations in particular **SITES** (e.g. Boston, Syracuse, Portland, etc.).

#### I. DELIVERY/MANAGEMENT OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The first series of questions is designed to establish if a managed care organization (MCO):

- Provides behavioral health services directly, either by administering the network of providers or by employing the providers that enrollees use
- Contracts with a managed behavioral health care vendor, a specialty network or provider organization, or integrated provider group for:
  - delivery of services
  - management of services

If the MCO holds any contracts, the next set of questions determines the names of vendors and which services are provided. This section of the interview determines the flow of the remaining questions about contract features, benefits, service provision, and quality assurance.

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## II. CONTRACTING WITH MBHC VENDORS, PROVIDER ORGANIZATIONS, AND INTEGRATED NETWORKS (only asked if MCO holds any contracts)

1. In your current contract, which of the following functions are provided with regard to substance abuse services?
  - a. a provider network
  - b. claims processing
  - c. utilization management
  - d. quality improvement
  - e. case management
  
2. In your current contract, for which of the following areas are written performance standards specified in the contract?
  - a. Claims processing
  - b. Patient satisfaction
  - c. Staffing/Network
  - d. Clinical referral speed
  - e. Quality assurance system
  - f. HEDIS behavioral health measures
  - g. Disenrollment (patient disenrollment)
  - h. Complaints and appeals
  - i. Administrative reporting
  - j. Provider satisfaction
  - k. Member Services phone response
  
3. Do you pay a capitated amount to cover both claims and administrative costs?

[IF PAYS CAPITATED AMOUNT] If claims costs exceed the capitated amount, how much of the additional costs are [MBHC VENDOR/PO] required to pay, according to the contract?

  - a. All of the cost
  - b. Part of the cost
  - c. None of the cost
  
4. Does the contract specify that you will reduce [MBHC VENDOR/PO] payment if performance standards are not met? (e.g., patient satisfaction, clinical referral speed, etc.)
  
5. What is the maximum amount that [MBHC VENDOR/PO] could forfeit by failing to meet performance standards?

## III. BENEFIT DESIGN

1. Does the substance abuse treatment covered by your MCO provide for the treatment of both alcohol problems and drug abuse problems, alcohol problems only, or drug abuse problems only?
  
2. IF BOTH COVERED: Are the benefits your enrollees receive the same for alcohol treatment as for drug abuse treatment?

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3. Which of the following substance abuse services are covered?

- a. Inpatient or residential detoxification
- b. Inpatient or residential rehabilitation
- c. Intensive outpatient treatment (partial hospital or day treatment)
- d. Outpatient detoxification
- e. Outpatient methadone maintenance
- f. Outpatient rehabilitation (non-methadone)

**Lifetime Limits**

- 4. In the most commonly purchased package, what is the maximum lifetime dollar amount, number of inpatient episodes and/or number of **inpatient** days specifically for substance abuse services?
- 5. Is there an overall combined lifetime limit for all medical services, including substance abuse and mental health services?

**Annual Limits**

- 6. In the most commonly purchased package, what is the maximum annual dollar amount and/or number of substance abuse **outpatient** visits covered per year?

**Deductible/Copayments**

- 7. In the most commonly purchased plan, is there a deductible that must be met before enrollees can access mental health and substance abuse services?
- 8. In the most commonly purchased package, what is the co-payment or co-insurance rate that enrollees pay for OUTPATIENT VISITS? If cost sharing varies by the number of visits, please indicate the initial level.
- 9. Within the covered visits, is there any change in the co-pay or co-insurance depending on the number of visits?
- 10. What is the new co-pay or co-insurance rate once initial visits are used up?
- 11. Is there an out-of-network option?
- 12. What is the co-pay or co-insurance for out-of-network mental health and substance abuse outpatient visits?
- 13. Is a co-pay or out-of-pocket payment ever required for prescription drugs prescribed by in-network providers for substance abuse and/or mental health problems?
- 14. And is this co-pay or out-of-pocket payment the same for substance abuse and mental health prescriptions?
- 15. Does this product have an open or closed formulary?
- 16. [IF CLOSED] What level of coverage do enrollees have for non-formulary drugs?
  - a. No coverage for the prescription
  - b. Reduced coverage or increased co-pay

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#### **IV. STAFFING AND PROVIDER PAYMENT**

1. [IF A CONTRACT] Which organization has primary responsibility for recruiting and selecting individual specialty practitioners: your organization or [MBHC VENDOR/PO]?
2. [IF A CONTRACT] Which organization has primary responsibility for setting individual practitioner payment policies: your organization or [MBHC VENDOR/PO]?
3. [IF A CONTRACT] Which organization has primary responsibility for selecting facilities, for example, clinics or rehabilitation centers: your organization or [MBHC VENDOR/PO]?
4. Which of the following factors are used in decisions over hiring or selecting, and retaining providers specializing in mental health or substance abuse care?
  - a. Direct verification of current licensure
  - b. History of liability claims
  - c. Profiling of provider utilization rates
  - d. Provider's agreement to take panels of predetermined numbers of patients
  - e. Need for coverage in the specific geographic areas
5. How many mental health and substance abuse specialty providers deliver services in [SITE]?
6. As a practical matter, is there steerage to a group of your highest quality behavioral health providers?
7. What percentage of physicians are in this core group?
8. What percentage of non-physicians are in this core group?
9. Please tell me by what payment mechanism your vendor pays for each of the following substance abuse services. (Discounted Fee for Service basis, a Per Diem basis, a Per Case or DRG basis, or a capitation arrangement)
  - a. Inpatient hospital or residential detoxification
  - b. Inpatient hospital or residential rehabilitation
  - c. Intensive outpatient treatment (partial hospital or day treatment)
  - d. Outpatient detoxification
  - e. Outpatient methadone maintenance
  - f. Outpatient rehabilitation (non-methadone)
10. What percent of your enrollees used any substance abuse services in 1998 in [SITE]?

#### **FAX BACK ENROLLMENT INFORMATION**

Finally, respondents are sent a short form asking the number of enrollees in each PRODUCT (e.g., HMO, PPO) in the SITE (e.g., Boston, Syracuse etc.) and are asked to return their responses by fax.

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## SURVEY ON ALCOHOL, DRUG ABUSE AND MENTAL HEALTH SERVICES UNDER MANAGED CARE

### MEDICAL DIRECTOR SURVEY—SUMMARY

This survey is designed as a telephone survey lasting approximately 30 minutes. To provide an overview of the topics covered, this summary presents the main questions and answer categories. During the actual survey, the interviewer often will:

- Inquire about mental health services in addition to substance abuse services;
- Ask if responses apply similarly to multiple **PRODUCTS** (e.g. HMO, PPO, POS) within a managed care organization;
- Provide explanations about terms or abbreviations used in some questions;
- If applicable, allow a respondent to refer the interviewer to a specialty behavior healthcare vendor or provider organization;
- Focus answers specific to the managed care organizations operations in particular **SITES** (e.g. Boston, Syracuse, Portland, etc.).

#### I. PRESCRIPTION DRUGS FOR MENTAL HEALTH AND SUBSTANCE ABUSE DISORDERS

1. First, does [PRODUCT] have an open or closed formulary?
2. [IF CLOSED FORMULARY] Which of the following medications are included in the formulary?
  - a. Naltrexone
  - b. Buprenorphine
  - c. LAAM
  - d. Antabuse
  - e. Clonidine
  - f. Prozac
  - g. Wellbutrin
  - h. Paxil
3. How are exceptions granted to the closed formulary list?
  - a. Prescriptions are allowed only by selected providers
  - b. Approval by the medical director is required
  - c. Approval by clinical quality committee is required
  - d. Approval by an appeals committee is required
4. [IF OPEN FORMULARY] Is preauthorization required for any mental health or substance abuse medications?

- 
5. Which of the following medications require preauthorization?
- a. Naltrexone
  - b. Buprenorphine
  - c. LAAM
  - d. Antabuse
  - e. Clonidine
  - f. Clonidine
  - g. Prozac
  - h. Wellbutrin
  - i. Paxil
6. Are there any restrictions on the use of the following groups of medications as a first-line treatment?
- a. Risperdal
  - b. Olanzapine
  - c. Prozac
  - d. Paxil
  - e. Zoloft
  - f. Naltrexone

## II. SCREENING OF PRIMARY CARE PATIENTS

1. Are primary care practitioners required to use standard screening questionnaires for detecting **alcohol problems** among at least some of their patients? (By “standard screening questionnaires,” we mean questionnaires such as the Michigan Alcoholism Screening Test or questionnaires on alcohol abuse developed by your MCO.)
2. Are primary care practitioners required to use standard screening questionnaires for detecting **drug abuse problems** among at least some of their patients? (By “standard screening questionnaires,” we mean questionnaires such as the Substance Abuse Subtle Screening Inventory or questionnaires on drug abuse developed by your MCO.)
3. [IF YES TO SCREENING] Are primary care practitioners required to conduct **substance abuse** screenings on:
- a. All patients on a periodic basis (e.g., annually)?
  - b. New patients at first visit?
  - c. Patients with specified symptoms or TRIGGER CONDITIONS?
  - d. Patients within specified AGE GROUPS?
  - e. Patients identified by clinical judgment?
4. [IF YES TO TRIGGER CONDITIONS] Which of the following are trigger conditions for substance abuse screening:
- a. Pregnancy
  - b. Traumatic injuries
  - c. Emergency room visits
  - d. G.I. or liver symptoms
  - e. Smoking
  - f. AIDS or HIV
  - g. Presence of a mental health disorder
  - h. Other (please specify)
5. [IF YES TO AGE GROUPS] Please indicate whether each of the following age groups is screened for substance abuse.
- a. Adolescents, 12–17 years old
  - b. Young adults, 18–35 years old
  - c. Middle-age adults, 36–64 years old
  - d. Adults 65 years or older

- 
6. Are primary care practitioners required to use general health screening questionnaires that include questions on mental health and substance abuse problems?
  7. Apart from the primary care-based screening we've asked about, does MCO conduct any substance abuse or mental health screenings through telephone or mail surveys?

### **III. TREATMENT OF MH/SA DISORDERS BY PRIMARY CARE PROVIDERS**

1. Are there written guidelines specifically for primary care treatment of substance abuse disorders?
2. [IF YES] Are these guidelines distributed to the primary care practitioners?
3. Which of the following topics are addressed in these guidelines?
  - a. Provision of brief interventions
  - b. Referral to mutual help resources, such as AA or NA
  - c. Prescribing and monitoring medications for alcohol or drug abuse problems
  - d. Consulting with specialty abuse practitioners
  - e. Criteria for referring out to specialty care
  - f. Provision of educational materials to patients
4. Are most primary care practitioners paid on a salaried basis?
5. Do primary care practitioners bear any risk for the cost of mental health and substance abuse services, mental health services only, substance abuse services only, or neither service?

For which services do they bear risk? (inpatient services only, outpatient services only, inpatient and outpatient services)

Is that full risk or partial risk?

### **IV. ENTRY INTO SPECIALTY MH/SA TREATMENT**

1. Can enrollees receive specialty substance abuse treatment by means of direct self-referral to a provider?
2. Which of the following are required in order for enrollees to receive specialty substance abuse care?
  - a. Get authorization from their primary care practitioner
  - b. Get a referral by an employee assistance program
  - c. Call a designated phone number (e.g., toll-free) to get an authorized referral
3. For outpatient substance abuse services, when enrollees phone to request a referral, which of the following takes place?
  - a. Referral is given automatically; no clinical assessment is involved
  - b. Clinical assessment is conducted over the phone.
  - c. Other (please specify)

- 
4. Please indicate how frequently each of the following practitioners speak with patients when patients call the designated number for a substance abuse referral:
    - a. Psychologist, doctoral level
    - b. Masters level clinician (e.g., clinical social worker or clinical nurse specialist)
    - c. Registered nurse (RN)
    - d. Certified or licensed substance abuse counselor
    - e. Administrative staff
  
  5. What crisis services are available to patients 24 hours a day?
    - a. Phone triage or referral
    - b. In-person services operated or contracted the MCO
    - c. Emergency room services

## **V. INITIAL TREATMENT AUTHORIZATION**

1. Which of the following substance abuse services require pre-certification or prior authorization in order to initiate the service? And, what is the typical number of days or visits initially approved?
  - a. Inpatient or residential detoxification
  - b. Inpatient or residential rehabilitation
  - c. Intensive outpatient treatment (partial hospital or day treatment)
  - d. Outpatient detoxification
  - e. Outpatient rehabilitation (non-methadone)
  - f. Outpatient methadone maintenance
  
2. What organization conducts the initial utilization review for mental health care and substance abuse treatment?
  - a. The managed care organization
  - b. A specialty provider organization
  - c. A managed behavioral health care vendor
  - d. A leased or contracted integrated network
  - e. A utilization review vendor
  
3. How frequently do each of the following practitioners perform the initial utilization review for substance abuse treatment?
  - a. Psychologist, doctoral level
  - b. Masters level clinician (e.g., clinical social worker or clinical nurse specialist)
  - c. Registered nurse
  - d. Certified or licensed substance abuse counselor
  - e. Administrative staff

- 
4. How frequently does each of the following practitioners have the authority to deny services for **outpatient substance abuse treatment**?
    - a. Psychologist, doctoral level
    - b. Masters level clinician (e.g., clinical social worker or clinical nurse specialist)
    - c. Registered nurse
    - d. Certified or licensed substance abuse counselor
    - e. Administrative staff
  
  5. How frequently do each of the following have the authority to deny services **for inpatient or residential substance abuse rehabilitation or mental health care**?
    - a. Psychiatrist or physician specializing in addictions medicine
    - b. Other physician
    - c. Psychologist, doctoral level
    - d. Masters level clinician (e.g., clinical social worker or clinical nurse specialist)
    - e. Registered nurse
    - f. Certified or licensed substance abuse counselor
    - g. Administrative staff
  
  6. What organization reviews appeals when initial requests for treatment are denied?
    - a. The managed care organization
    - b. A managed behavioral health care vendor
    - c. A specialty provider organization
    - d. A leased or contracted integrated network
    - e. A utilization review vendor
    - f. An external, independent review organization
  
  7. If there is a dispute regarding the appeal decisions, which organization has the final decision-making authority?
    - a. The managed care organization
    - b. A managed behavioral health care vendor
    - c. A specialty provider organization
    - d. A leased or contracted integrated network
    - e. A utilization review vendor
    - f. An external, independent review organization

## **VI. PROVISION OF SPECIALTY MENTAL HEALTH AND SUBSTANCE ABUSE TREATMENT**

1. Are there formal standards for the maximum waiting time from request for treatment to the initial appointment for each of the following types of treatment?
2. [IF YES] What is the maximum amount of time specified for:
  - a. Routine treatment
  - b. Urgent treatment
  - c. Emergency treatment

- 
3. Is assessment of a mental health or substance abuse disorder typically conducted separately from treatment; that is, by a different practitioner or in a different location?
  4. How are assessments usually conducted?
    - a. In person only
    - b. By phone
    - c. Both
  5. How often are routine substance abuse assessments conducted by each of the following practitioners?
    - a. Psychiatrist or physician specializing in addictions medicine
    - b. Psychologist, doctoral level
    - c. Masters level clinician (e.g., clinical social worker or clinical nurse specialist)
    - d. Registered nurse
    - e. Certified or licensed substance abuse counselor
    - f. Administrative staff
  6. How frequently does each of the following practitioners provide individual outpatient substance abuse counseling services?
    - a. Psychiatrist or physician specializing in addictions medicine
    - b. Psychologist, doctoral level
    - c. Master's level clinician (e.g., clinical social worker, clinical nurse specialist)
    - d. Certified or licensed substance abuse counselor
  7. How frequently does each of these practitioners provide outpatient substance abuse group counseling services?
    - a. Psychiatrist or physician specializing in addictions medicine
    - b. Psychologist, doctoral level
    - c. Master's level clinician (e.g., clinical social worker, clinical nurse specialist)
    - d. Certified or licensed substance abuse counselor
  8. Are there written practice guidelines for treatment of \_\_\_\_\_ and, Who or what organization developed these guidelines?
    - a. Alcohol dependence
    - b. Cocaine dependence
    - c. Major depressive disorder
    - d. Panic disorder
    - e. Schizophrenia
  9. For patients dually diagnosed with mental health and substance abuse disorders, are there:
    - a. Specialized providers or treatment programs?
    - b. Specific treatment guidelines?
    - c. Special criteria or procedures for treatment authorization?
  10. Does the MCO require that outpatient substance abuse follow-up visits occur within a set time limit after discharge from hospital or residential care?
  11. What is the time limit for substance abuse follow-up visits?

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## VII. AUTHORIZATION FOR CONTINUED TREATMENT AND CASE MANAGEMENT

1. Using concurrent review, how often is care typically evaluated for **substance abuse** patients who are receiving the following types of care?
  - a. Inpatient or residential detoxification
  - b. Inpatient or residential rehabilitation
  - c. Intensive outpatient treatment (partial hospital or day treatment)
  - d. Outpatient detoxification
  - e. Outpatient rehabilitation (non-methadone)
  - f. Outpatient methadone maintenance
2. Is there a case management program?
3. Do case managers typically do each of the following activities:
  - a. Meet regularly with patients, either in person or on the phone
  - b. Help patients access community resources, e.g., housing, vocational rehabilitation
  - c. Flex or extend benefits
  - d. Help with coordination of services
4. What criteria are used to assign substance abuse patients to case management services?
  - a. Discharge from an inpatient or residential facility?
  - b. Diagnosis?
  - c. Functioning level?
  - d. Frequent readmissions or high costs?
  - e. Request of practitioner?
5. Who typically conducts case management services for substance abuse patients?
  - a. Psychologist, doctoral level
  - b. Masters level clinician (e.g., clinical social worker or clinical nurse specialist)
  - c. Registered nurse
  - d. Certified or licensed substance abuse counselor

## VIII. QUALITY ASSURANCE AND IMPROVEMENT

1. Are patient surveys conducted at least annually that ask specifically about satisfaction with **mental health** and **substance abuse** services?
2. To whom are the results of patient satisfaction surveys reported?
  - a. Enrollees
  - b. Individual clinicians, regarding their own patients
  - c. Individual clinicians, regarding overall results
  - d. QA committee at the MCO level
  - e. A QA committee associated with an MBHC vendor or specialty provider organization
  - f. A QA committee associated with a leased or contracted integrated network
  - g. Other external organizations, such as NCQA

- 
3. Are standardized instruments used to assess clinical outcomes for at least some of the patients receiving mental health or substance abuse treatment?
  4. Using these standardized instruments, for which patients are clinical outcomes assessed?
    - a. A general sample of all patients in mental health or substance abuse treatment
    - b. Patients in specific diagnostic categories
    - c. Patients receiving certain service types or levels of care (e.g., inpatient, day treatment)
  5. Who reviews the results of the outcome measures?
    - a. Individual clinicians, regarding their own patients
    - b. Individual clinicians, regarding overall results
    - c. A QA committee at the MCO level
    - d. A QA committee associated with an MBHC vendor or specialty provider organization
    - e. A QA committee associated with a leased or contract network
    - f. Other external organizations, such as NCQA
  6. Which mental health or substance abuse performance indicators are tracked?
    - a. HEDIS behavioral health measures
    - b. PERMS measures
    - c. Other (please specify):
  7. Who reviews the results of performance indicator measures?
    - a. Clinicians
    - b. A QA committee at the MCO level
    - c. A QA committee associated with a MBHC vendor or specialty provider organization
    - d. A QA committee associated with a leased or contracted network
    - e. Other external organizations, such as NCQA
  8. Is there an MCO-level committee that oversees quality assurance programs for mental health and substance abuse treatment?
  9. Who belongs to this committee?
    - a. Specialty providers in mental health and substance abuse
    - b. Primary care practitioners
    - c. Enrollees who are behavioral health care consumers or their family members
    - d. Other enrollees



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Center for Mental  
Health Services

DHHS Publication Number (SMA 03-3790)

Printed 2003

**SAMHSA**

Substance Abuse and Mental  
Health Services Administration