The Behavioral Health Center: A Model for Academic Managed Care

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Insurers are asking health care systems, including academic centers and teaching hospitals, to accept lower reimbursement rates and achieve greater effectiveness at the same time. These competing tasks have created financial crises for many academic medical institutions, but for academic departments willing to embrace new models of service delivery, they have also created opportunities.

The University of California, Davis, Health System (UCDHS) consists of the School of Medicine, the University Hospital, and the Medical Group, the latter composed of physicians in the hospital, its associated onsite clinics, and ten recently acquired primary care clinics located throughout the greater Sacramento area. When UCDHS acquired its network of primary care clinics in an effort to capture fully capitated health maintenance organization (HMO) contracts and referrals into specialty clinics, the situation presented an opportunity for mental health providers in several departments to come together in an effort to "carve-in" behavioral health coverage for UCDHS capitated patients. Over the past four years, that original vision has developed into a successful multidisciplinary strategy that integrates the institutional goals of education, clinical care, and fiscal responsibility. Academically based managed care programs provide a valuable opportunity for learning how to provide high-quality care within reasonable resource limits, and the UCDHS experience can contribute to the knowledge base necessary for developing such quality care (1).

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Founding and vision of the Behavioral Health Center

The Behavioral Health Center was formed in 1996 as a care-managing entity administratively contained within the department of psychiatry. It is run by an executive committee made up of faculty from the departments of psychiatry and family and community medicine and administrative staff from the departments of psychiatry, social services, and institutional planning. The center's mission is to provide managed behavioral health care for the approximately 65,000 enrollees who have behavioral health benefits served by UCDHS, a population that contains members of several large HMOs and approximately 15,000 managed Medicaid recipients.

The Behavioral Health Center was founded with the belief that a multidisciplinary coalition of behavioral health providers, researchers, and administrators within the UCDHS academic community could provide cost-effective managed behavioral health care (2). The founders believed that such a group could provide a wide range of behavioral health services of a quality equal to or higher than was available in the local commercial market and that this arrangement could improve access and continuity of care for patients with UCDHS primary care physicians. Services that UCDHS could not provide from within could be readily arranged through contracts with local providers.

Several advantages were gained by developing the Behavioral Health Center as a multidisciplinary, multidepartmental effort. Primarily, the use of UCDHS providers made it easier to recruit and manage the network. In addition, carving in care ensured that trainees in participating departments would continue to have access to patients without the restrictions often placed on unlicensed providers by commercial managed care organizations. Maintaining accreditation for trainees has required occasional negotiations with health plans and has not been universally accepted; however, most HMOs have respected UCDHS's training mission as well as its reputation for quality and commitment to continuity of care.

Reimbursement

In order to integrate management functions and clinical service provision more closely, the Behavioral Health Center developed a case rate reimbursement system. Providers within UCDHS receive a "case rate"– about $500 minus anticipated copayments– for each outpatient they accept and treat for a period of

one year. This allows a measure of flexibility in the type and length of treatment that providers can initiate, from brief medication consultations to extended psychotherapy training cases. It also allows UCDHS providers to manage their own caseloads by making decisions about medical necessity and appropriate preventive care while also reducing management overhead. Community providers– those outside UCDHS– are paid a contracted fee-for-service rate, with the Behavioral Health Center taking a more traditional utilization management role.

Because UCDHS has no inpatient or partial hospitalization programs, contracts were developed with community facilities for these services. Inpatient professional fee contracts were written to reimburse these services on a case-rate basis per inpatient stay, thus giving providers an incentive to use less restrictive levels of care whenever appropriate. Case management for inpatient and partial hospitalization services is the responsibility of the Behavioral Health Center and is provided by a nurse administrator.

Case rate reimbursement has been well received by UCDHS providers. It frees providers from the need to repeatedly justify continuing care for their higher-need patients, and, at the same time, it provides ample reimbursement when averaged across patients. Internal analyses have indicated that case rate reimbursement costs the Behavioral Health Center about $50 to $70 per case more than strict fee-for-service reimbursement, but the center views this as a reasonable price to pay for the increased access to care it can provide. These costs are also offset somewhat by decreased time lost to clinician paperwork and administrative overhead, both of which are often the responsibility of clinician-administrators involved in managing the center.

Utilization

The greater Sacramento region is one of the most heavily penetrated managed care markets in the country. UCDHS currently holds fully capitated health care contracts for approximately 95,000 members throughout this region, approximately 65,000 of whom have mental health benefits that are subcapitated to the Behavioral Health Center. Full risk (all inpatient and outpatient care) is assumed for 40 percent of members with mental health benefits, and partial risk (outpatient care only) for another 40 percent. Outpatient care and inpatient professional fees are covered for the remaining 20 percent.

For the fiscal year from July 1998 through June 1999, the Behavioral Health Center received 2,440 outpatient referrals. This number was equivalent to 37.5 annual cases or about 270 annual outpatient visits per 1,000 members, a utilization rate in line with that achieved by aggressively managed commercial managed care organizations (3). During the same year, the 40 percent of the population covered for inpatient care used 679 inpatient days and 219 partial hospitalization days (27.9 inpatient days and nine partial days per 1,000 inpatient lives). The managed Medicaid population, which makes up 23 percent of the total number of enrollees, was responsible for 20 percent of the annual referrals and about 25 percent of annual outpatient visits.

Integration with primary care

The Behavioral Health Center has sought to integrate behavioral health services into primary care, thus placing the management focus on coordinating care rather than restricting it. Aside from the center's insistence on having well-documented referrals and insurers' insistence on having benefit limits, primary care physicians' referrals for behavioral health care are not restricted. Likewise, patients are given a significant voice in determining the discipline and location of the assigned mental health provider. Providers are allowed to treat patients according to their clinical judgment, with the understanding that health plan benefit limits (usually 20 outpatient visits per year) provide a general guide for longer-term cases.

Referrals between behavioral health providers of different disciplines are not uncommon and add to the scope and quality of care. For example, patients who receive primary care in the UC Davis family medicine clinic are routinely referred to psychologists in the clinic for their behavioral health care. These psychologists can make direct referrals to the psychiatry clinic if they believe a medication evaluation is warranted. Likewise, psychiatrists can arrange individual or group psychotherapy for their medication management patients when indicated.

Outcomes assessment

Pre- and post-treatment quantitative outcome assessment has recently been implemented as a standard of care. The intake screening includes well-researched and validated instruments (the Patient Health Questionnaire, Outcomes Questionnaire–45, and Medical Outcomes Study Short Form–12) that are repeated eight to ten weeks after starting treatment along with a satisfaction instrument. Clinicians are sent intake summary scores for each of their patients within a week after the initial visit.

Providers in both the psychiatry and the family medicine clinics anecdotally report that these instruments have increased their diagnostic thoroughness and raised their awareness of the benefits of brief quantitative measures in outpatient treatment planning. Implementing outcomes assessment has added complexity to the case flow process, but over time it will result in the accumulation of a rich population-based clinical data set.

Risks and benefits associated with capitation

Capitation does not reduce the cost of health care directly; it merely shifts the risks associated with underwriting care to those more closely associated with the provision of care and influences their care delivery choices. The Behavioral Health Center has been successful in accepting capitation risk not only because it provides a necessary service at a fair price, but also because it is in a unique position to provide mental health management services to UCDHS patients. The departments of psychiatry and family and community medicine were able to create the Behavioral Health Center within their existing academic

structures, and UCDHS was willing to pay about 25 percent more than the lowest commercial bid in order to have an in-house mental health management company that would protect clinical teaching programs and have a strong commitment to providing integrated behavioral health services. UCDHS was also able to insulate its services from some of the vicissitudes of the local health care market, a benefit that was underscored when the lowest bidder went bankrupt within a year after submitting its bid.

The benefits of moving to subcapitation have been numerous, including a predictable source of revenue, increased efficiency in service provision, enhanced training opportunities for residents and interns, and enrichment of the professional roles of faculty and administrators involved in the Behavioral Health Center. This has added a new dimension to the educational and training mission of the participating departments and broadened the scope of faculty academic interests and research. Although it does not address all of the difficulties of surviving in an era of managed care, UCDHS's move to subcapitation for behavioral health has provided one example of a way to change the threat of managed care into an opportunity for growth and development. ♦

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Psychiatric Services Institute to Be Held in Philadelphia, October 25–29, 2000

The American Psychiatric Association's 52nd Institute on Psychiatric Services will be held October 25–29, 2000, at the Philadelphia Marriott Hotel, in the heart of the city's business and historic districts. The preliminary program for the institute appeared in the June issue. It provides information about travel and registration and lists the lectures, symposia, workshops, discussion groups, and multimedia sessions scheduled for the meeting. An advance registration and course enrollment form is provided. Advance registrants receive substantial discounts. For a copy of the preliminary program, call the APA's answer center toll free at 888-357-7924.

The theme for the 2000 institute is "Psychodynamic Psychotherapy," and the program committee has selected a spectrum of clinical topics. For example, the symposia will feature presentations on clinical and services research, therapeutic family education, community psychiatry, and child and adolescent issues. Debates will address outpatient commitment and prescribing privileges for psychiatric nurses.