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Calculating Treatment Costs in an MBHO

To the Editor: In an article in the January 2007 issue, Zuvekas and colleagues (1) suggested that the introduction of management practices via a managed behavioral health care organization (MBHO) does not shift "treatment" costs. We wish to take issue with the rather broad conclusion of the authors that "treatment" costs are unaffected.

At best the authors' findings would support the conclusion that during the introduction of MBHO practices, use of psychotropic medications increased (6% to 10% for large employers and 5% to 9% for medium-small employers). Further, for patients who used psychotropic medications, general mental health specialty service use increased but only to the point that the percentage of patients receiving a psychotropic medication and mental health specialty treatment rose from 24% to 31% for employees of a large company and from 16% to 24% for those in medium-small companies. Little can be said of other treatment costs experienced by employees with treatment needs for mental health or substance use disorders.

A recent study showed that 80% of health care costs for patients with psychiatric illness treated in a health care environment that handled mental health and substance use disorders independent of physical health were primarily related to physical health service use and nonpsychiatric medications (2). Perhaps more importantly, a study by Rosenheck and colleagues (3) suggested that higher medical costs are associated with the introduction of MBHO business practices in an employee population. In fact, the net increase of medical and pharmacy costs in that study was in excess of cost reductions for use of mental health and substance abuse services. Although the data did not permit these authors to assign a causal relationship between the introduction of MBHO business practices and high total health care costs, the health care cost differences were robust and the association was consistent.

In addition to our suggestion that Zuvekas and colleagues' conclusions are broader than they should be, we also have questions about the accuracy of the conclusions themselves. The authors do not identify who the prescribing physicians were at the beginning and the end of the data collection period. Becauase a majority of psychotropic prescriptions are written by nonpsychiatrists (4), there is no way to confirm that psychotropic prescriptions by nonpsychiatrist physicians did not increase from baseline to the end of the study, even with the increase in general mental health service use. Psychiatrists—mental health professionals with prescription privileges—were not separated from other mental health professionals in the study, so there is no way to confirm that increased mental health treatment translates to increased psychiatrist visits and prescriptions.

We have written this letter because Zuvekas and colleagues' article gives the impression that carving out mental health and substance abuse treatment services from the rest of medical care is acceptable from a cost perspective. On the basis of the comments above, we do not think that the real costs associated with carving out these services were addressed. Perhaps more importantly, independent management of physical and behavioral health by health plans necessarily segregates the delivery of general medical services from the delivery of mental health and substance abuse treatment services (5), leading to our current situation in which 70% of patients with mental health and substance use problems get no treatment and two-thirds of those who do get treatment receive interventions with less efficacy and effectiveness because they are provided by non–mental health providers without psychiatric support in the medical setting.

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In Reply: Dr. Kathol and Dr. Kishi raise an important, but fundamentally different, issue in asking whether the implementation of the MBHO in

our case study led to an increase in total health care costs. Such an increase would clearly offset any gains from reductions in mental health treatment costs and would also imply poorer outcomes for patients with needs for mental health and substance abuse treatment. We more narrowly considered whether this particular MBHO shifted direct costs for such treatments—an important question in its own right. Several lines of evidence we presented in this and earlier publications suggest that this particular MBHO did not. Whether the implementation of the MBHO directly led to increases in other health care costs is a more difficult question to answer.

Others have tried to answer the question of whether increases in mental health and substance abuse treatment lead to corresponding decreases in other health care costs and vice versa. The idea of such a cost-offset effect is both seductive, for obvious reasons, and intuitive at some levels. Unfortunately, the evidence for it is much weaker than Kathol and Kishi imply. Although some studies do indeed show associations between mental health and other health care costs, these studies suffer from deep conceptual and empirical problems (1).

Kathol and Kishi also raise questions about our specific methods and findings regarding the narrower question of whether the MBHO shifted costs. The data set that we used is similar to almost all administrative and health claims data sets in that it did not allow us to identify who prescribed medications. The very fragmentation and lack of coordination of mental health and substance abuse treatment that concerns Kathol and Kishi—and us—also explains why there are so few studies of the cost-shifting behavior of MBHOs. We were quite fortunate to have access to all behavioral claims made under the MBHO, as well as to medical claims and to prescription drug claims from the third-party pharmacy benefit manager. In the absence of a direct link between prescriptions and prescribers, we view our test of whether there was an increase in use of psychotropic medications without concurrent use of specialty treatment as entirely reasonable.

We note that implementation of the MBHO took place during a period of rapid increases in prescribing by nonpsychiatrists and psychiatrists alike. In marked contrast to the MBHO experience in the study by Rosenheck and colleagues (2) that is cited by Kathol and Kishi, the number of people using outpatient specialty mental health and substance abuse treatment in our study also increased substantially with no change in treatment intensity (3).

Finally, Kathol and Kishi leap to much broader conclusions than we ourselves made. They state that we "suggested that the introduction of management practices via a managed behavioral health care organization (MBHO) does not shift 'treatment' costs" and that our "article gives the impression that carving out mental health and substance abuse treatment services from the rest of medical care is acceptable from a cost perspective." There is considerable variation in experience with MBHOs, and we described how the MBHO we studied might differ from others. We concluded that although in this case there was no evidence of cost-shifting, strong incentives remain for MBHOs to shift treatment costs.

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Agnes Rupp, Ph.D.
Grayson Norquist, M.D., M.S.P.H.

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Shared Decision Making and Humanistic Care

In the November Open Forum, Deegan and Drake (1) make a compelling case to replace the compliance model of medication management with a shared decision-making model that is consistent with person-centered care and evidence-based medicine. There are additional benefits of a shared decision-making model that need mention.

Building a relationship at a deeper and meaningful level with an individual who is in profound psychological distress is professionally very satisfying for psychiatrists. The shared decision-making model helps in building and maintaining such a relationship with clients and can enhance the professional satisfaction of psychiatrists. From clients' perspective, it is extremely affirming to their sense of self to have a physician who respects them as an individual and treats them as an equal partner. Also, the positive and mutually respectful relationship that is the basis of shared decision making is a very good corrective emotional experience for the stigma and discrimination experienced by individuals with psychiatric disabilities, even at the hands of some treatment providers.

However, two factors need to be addressed so that physicians will embrace and practice such a model. The first factor is the lack of training in medical schools about the values inherent in the humanistic approach and person-centered care. Medical training places an undue emphasis on biomedical aspects of client care, generally ignoring psychological and humanistic aspects (2). Senior clinicians should be good role models in the practical implementation of a shared decision-making model in various clinical settings, such as psychiatric emergency services and inpatient and outpatient settings. However, medical students and residents find that a significant number of their teachers do not practice client-centered care and are not good role models for humanistic care (3).

A second factor is the focus of the psychiatric field on symptom identification and management, with very little attention to individual functioning, quality of life, and recovery (4). Most of the funding for research comes from the pharmaceutical in-

dustry, and its main focus is evaluating and disseminating information on the efficacy of pharmaceutical strategies. The primary outcome measure in pharmaceutical research trials is symptom reduction or remission, whereas other outcome measures that are more meaningful for clients, such as improvement in functioning, quality of life, and reclamation of lost roles, are not routinely evaluated. Also, there is very limited research on self-initiated, nonpharmaceutical coping strategies (personal medicine) used by clients and on the most effective ways for clinicians to identify and strengthen these strategies. In addition, various payers, such as health maintenance organizations and publicly funded agencies, evaluate the efficacy of pharmacological management on the basis of its ability to reduce symptoms, thereby reinforcing the focus on symptom management.

Medical schools should emphasize teaching and modeling humanistic aspects of providing care. More research is needed to evaluate and strengthen the natural coping abilities of individuals with psychiatric illnesses. The field of psychiatry should also shift its focus from symptoms to factors that are relevant to clients—for example, quality of life and recovery—so that the shared decision-making model of providing care becomes the norm.

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