A Physician-Owned and -Operated Behavioral Managed Care Company

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Introduction by the column editor: **In 1985, guided by clinical and social values, two of the authors of this column, Dr. Halper and Dr. D'Agostino, along with a group of their colleagues established a psychiatrist-led organization that set out to manage care in a clinically and ethically responsible manner. By embracing responsibility for reasonable cost containment as well as the provision of excellent clinical care, they became leaders in, not passive respondents to, third-party management. This is an inspiring article. The approach they have taken provides us with an excellent example of responsible professionalism.**

Managed care has taken center stage in psychiatry and will continue to do so for the foreseeable future. Some psychiatrists see managed care as the work of evil and greedy individuals who have banded together to subvert the mental health of the American people with profit as their only motive, pursued with ruthless abandon under a smoke screen of cost control.

A more balanced view has been presented by Jellinek and Nurcombe (1) in a paper entitled, "Two Wrongs Don't Make a Right." They describe a two-stage evolution of the mental health delivery system that occurred over a period of about 15 years. The first stage was characterized by a major expansion of inpatient services, particularly by the hospitalization of adolescents in for-profit psychiatric hospitals. It is easy to forget this first stage of the evolution in light of the sweeping changes brought about by the second stage—managed care—which has dramatically decreased the use of psychiatric hospitalization. In their paper, Jellinek and Nurcombe identified a common theme in the two stages of evolution. They wrote, "It was profit that filled psychiatric beds in the 1980s, and it is profit that empties them in the 1990s."

About 15 years ago, a small group of psychiatrists in the Chicago area, including the first two authors, became interested in peer review and insurance reform. They noted that in their practices, most patients could be treated effectively in the office with short-term, regular visits. All of these psychiatrists had chronically ill patients in their practices who required long-term care, and they believed that selected patients required long-term psychotherapy in the office. They noted that good results could be achieved for most patients with short-term hospitalization. Their orientation was biological, and their view of psychotherapy was pragmatic.

The group believed that to counter discrimination against psychiatric patients in health insurance coverage, expansion of insurance benefits had to be linked to more realistic standards for lengths of stay in the hospital and in outpatient psychotherapeutic treatment. One of the psychiatrists in this group, the second author, conceived of the idea of a physician-owned and -operated managed care company that would specialize in services to psychiatric and chemically dependent patients and that would have a medical orientation. In 1985 he and 12 other psychiatrists founded such a company, which they called Behavioral Health Systems.

The founders of Behavioral Health Systems had a vision of how psychiatry should be practiced. They believed that the diagnostic evaluation of psychiatric illnesses should be done by a psychiatrist and that treatment plans should be developed by a psychiatrist. Thus an initial visit in the system is with a psychiatrist whenever possible. Patients' access to a psychiatrist is not restricted by gatekeepers. Psychotherapy is seen as the responsibility of both psychiatrists and nonmedical therapists. Some patients are treated with psychotherapy and medication by psychiatrists. In other cases, the treatment can reasonably be split between a psychiatrist and a nonmedical therapist. Nonmedical therapists do not operate in isolation but are supervised by psychiatrists.

Decisions about certification for

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treatment are made by a psychiatrist. Physician-to-physician contact creates a collegial relationship, minimizes misunderstandings, and shortens the time spent on reviews. Behavioral Health Systems believes that most patients need (and want) only short-term hospitalizations and short courses of regular visits in the office. Physician-to-physician contact makes it possible to make exceptions for those patients who should be in the hospital or in outpatient treatment for a longer period of time. Certification is given for office visits for chronically ill patients to receive medication management and supportive psychotherapy.

Psychotherapy is often controversial in managed care systems. Behavioral Health Systems is rather atheoretical in its approach to psychotherapy, except in cases where good scientific studies document the superiority of one form of psychotherapy over another. Behavioral Health Systems does ask that the psychotherapy in most cases be active, structured, and directed (not necessarily directive). In most cases, Behavioral Health Systems believes that psychotherapy should be short term, but it recognizes the value of long-term weekly psychotherapy visits for a minority of patients.

During the past 13 years, Behavioral Health Systems has successfully provided high-quality services to both white-collar and blue-collar workers. The company has had contracts for services for hospital employees, steel workers, Illinois state employees, priests and nuns of the Chicago archdiocese, individuals covered by Medicare, and individuals covered by Medicaid.

Behavioral Health Systems has offered the same quality of care to patients on Medicaid that is offered to middle-class patients. Providing psychiatric care to persons on welfare is challenging. Clinicians have had to deal with missed appointments and with patients who do not follow through with treatment recommendations. The quality of care for this group of patients has been enhanced by an extensive support system coordinated by Behavioral Health Systems that includes shelters and other residential facilities, bus tokens, and much staff involvement. Unnecessary emergency room visits and bouncing from hospital to hospital have been discouraged; office visits have been encouraged. Clearly the outcomes for Medicaid patients are not as good as those observed in a middle-class population without major socioeconomic problems. Nevertheless, some of these patients have gotten good results in terms of symptomatic relief and functioning.

Behavioral Health Systems currently delivers and manages mental health and chemical dependency services to approximately 120,000 lives in the Greater Chicago Metropolitan area, Central Illinois, northwestern Indiana, and Cleveland and Toledo, Ohio, through 28 contracts. About 46 percent of these lives are covered on a full-risk capitation basis, with Behavioral Health Systems assuming both the institutional and the practitioner risks. About 44 percent of the managed lives are covered by partial risk contracts for practitioner risk only. Behavioral Health Systems serves the remaining 10 percent of its members through nonrisk contracts that combine utilization management and a preferred provider organization. Clients include a hospital (for its employees and their dependents), three health maintenance organizations (HMOs), three independent practice associations (IPAs), six physician-hospital organizations, several manufacturing companies, and the archdiocese of Chicago.

Behavioral Health Systems is one of four equal owners of a partnership with the University of Illinois at Chicago Advocate Healthcare, a large hospital system, and the Advocate Medical Group, a large physician-owned IPA. Behavioral Health Systems is the managing partner. It also manages the Behavioral Health Division and product line of Accord Health Network, a consortium of Catholic hospitals, Catholic Charities of Chicago, and Accord Health Plan HMO.

Staff are available 24 hours a day, seven days a week, to refer patients to care. Referrals are made to about 400 credentialed clinicians representing the disciplines of psychiatry, psychology, social work, psychiatric nursing, and addiction treatment. The Behavioral Health Systems provider network includes about 160 psychiatrists, 120 psychologists, and 120 social workers, addiction counselors, and registered nurses. Its institutional network includes 28 hospitals, 23 chemical dependency programs, and 23 partial hospitalization programs.

In collaboration with a computer systems designer, Behavioral Health Systems has developed a customized software package that blends utilization management and claims payment functions into a single operating system. This system also has the capacity to generate more than 40 standard reports, including the Health Plan Employer Data and Information Set (HEDIS), developed by the National Committee for Quality Assurance (NCQA). (NCQA has developed a methodology for accrediting managed care organizations, in addition to developing the HEDIS report card.)

Clients benefit because Behavioral Health Systems manages care fairly and safely, but with an emphasis on efficacy as well as on efficiency. Some patients benefit from an expansion of benefits. At the same time the company has been able to save several self-insured corporate clients substantial sums of money on claims; it has been able to eliminate deductibles, reduce copayments, and expand outpatient coverage.

Behavioral Health Systems has data for the two HEDIS performance indicators for mental health care—outpatient follow-up within 30 days of hospital discharge for patients with a major mood disorder and readmission rates within 12 months for chemical dependency. For the 1995 reporting period, the ambulatory follow-up rate within 30 days after discharge for major affective disorder was 72.4 percent, and the readmission rate to the hospital for detoxification of chemically dependent patients was 15.8 percent.

In an outcome study of patients with mood disorders who were covered by contracts with Behavioral Health Systems and who were treated during 1995, most patients report-

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of social withdrawal also explained some cost variance, but withdrawal explained more than did a diagnosis of schizophrenia. This finding suggests that it is not simply the diagnosis of schizophrenia that is associated with higher costs but that form of the illness in which withdrawal is evident—schizophrenia with prominent negative symptoms.

Discussion and conclusions

Our first finding for this sample of 200 clients in the Melbourne public psychiatric system was that costs for hospital care were far greater than for mixed hospital and community care, which in turn were far greater than costs for community care only. Of interest are the relative magnitudes of the costs: a three-month episode of hospital care cost nearly 40 times as much as a similar episode of outpatient care. An episode of mixed inpatient and outpatient care cost about 20 times more than one of outpatient care alone.

A corollary of the wide differences between inpatient and outpatient costs is that from the perspective of the total psychiatric system, accurate estimation of costs depends largely on the prediction of hospitalization. Antisocial and bizarre behavior and a diagnosis of schizophrenia were associated with hospitalized status, and additional analyses suggested that antisocial and bizarre behavior were the primary determinants. The fact that measures of functioning were able to account for nearly 15 percent of the variance in log-transformed costs is particularly impressive given that use of DRGs to account for cost variance in mental health care has rarely exceeded 20 percent, and then usually by the exclusion of outliers, or cases for which costs far exceed the usual limits.

In the study reported here, when the focus of attention was restricted to episodes of community care without hospital involvement, the correlates of cost changed markedly. The most time-consuming and therefore most costly clients treated in the community were those with a personality disorder, closely followed by those with a high level of social withdrawal, whether or not they also had a diagnosis of schizophrenia. The maximum proportion of variance accounted for was nearly 14 percent, with personality disorder and withdrawal each accounting for around 6 percent.

These results must be interpreted in light of certain assumptions and limitations. First, we took no account of indirect costs (9), such as costs to relatives and other caregivers and charitable and nongovernmental organizations. It is unclear whether the numerous assumptions made in our calculation of costs were adequate. Although we have reasonable confidence in the reliability of the Life Skills Profile, we do not know how reliable the diagnostic information was. Despite these factors, this study found clear and interpretable relationships between client characteristics and costs, accounting for a reasonable proportion of the cost variation across both hospital and community locations and without recourse to the exclusion of outliers. ♦

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ed feeling better and functioning better than they did before the treatment. Most patients were satisfied with both the referral process and the care they received.

In 1985, when Behavioral Health Systems was founded, a physician-owned and -operated managed care company was an oddity. In 1998 more physicians are refusing to accept a helpless and hopeless position. The headline of a recent article in the newspaper of the American Medical Association read, "HMOs dominate, shape the market; opportunities seen for small doctor-led plans" (2). In some ways 1998 is a more favorable time for the formation of physician-owned and -operated managed care companies than was 1985. Behavioral Health Systems is beginning to form joint ventures with groups of psychiatrists in other communities who are interested in replicating its model.

What conclusions can be drawn from more than a decade of experience with Behavioral Health Systems? Behavioral Health Systems has demonstrated that a physician-owned and -operated managed care company can save money for corporate and public purchasers, enhance benefits for patients, make a modest profit for its owners, and at the same time deliver high-quality care with good outcomes. It has also shown that it is possible for a determined group of physicians to control at least part of their destiny and maintain a leadership position in decision making about psychiatric care. ♦

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