Psychiatric Provider Practice Management Companies: Adding Value to Behavioral Health Care?

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Psychiatrists and other mental health providers are facing reduced fee structures and declining income as a result of managed care (1). Although most mental health practitioners have experienced this trend, psychiatrists have lost the most ground. Their practice income decreased 16.7 percent in just one year, between 1996 and 1997. Simultaneously, many providers have experienced a significant loss of autonomy as managed care plans have sought to contain costs through direct constraints on reimbursable treatment choices.

Most recently, managed care plans have introduced risk-sharing contracts as an alternative way to manage utilization and costs. The tendency of managed care plans to delegate financial risk along with clinical responsibility threatens the financial viability of solo, office-based practice. Behavioral health providers are effectively being pushed to make a choice between treating only private-pay patients or organizing to form managed care delivery systems. The latter choice involves consolidation and development of the capability to manage risk contracts, allowing clinicians to reclaim clinical control.

To meet this challenge, a new class of behavioral health care organizations has emerged: the psychiatric provider practice management company. Like the physician practice management companies on which they are modeled, psychiatric provider practice management companies are adopting a wide range of strategies to allow behavioral health clinicians to control a larger share of the premium dollar.

To understand psychiatric provider practice management companies, it is necessary to see them in the context of the larger physician practice management industry. Physician practice management companies initially had broad appeal in markets with high levels of managed care penetration, where physicians recognized the need to develop a new set of capabilities. Practice management companies offer two resources that physician groups traditionally lack: access to investment capital and management expertise (2). Although contractual relations other than ownership are theoretically possible, physician practice management companies have generally built their networks through purchasing the assets—both with cash and equity—of physician groups.

Having effectively ceded control of their practices, some physician groups are now wondering whether the decision to integrate through a practice management company was a wise one. In particular, both physicians and Wall Street remain skeptical about the value added by such companies. This lack of performance and the ensuing erosion of investor confidence have placed physician practice management companies and the physicians they bring together in a precarious financial position. As these companies look for ways to survive and regain profitability, some observers have suggested that more focused "specialty" physician practice management companies are the answer.

In this column we describe the conditions that may have fostered the emergence of the psychiatric provider practice management (PPPM) industry, the types of organizations that are presently in the market, and the different approaches they take to managing behavioral health practices. We conclude with a discussion of economic and policy issues that are likely to be important determinants of whether PPPM companies have a long-term role in behavioral health care delivery.

The organization of behavioral health providers

Only about 8 percent of psychiatrists and 20 percent of all psychotherapists in private practice identify their primary practice setting as a group, compared with about 50 percent of self-employed physicians (1,3,4). Given the lack of organized delivery systems in existence before the diffusion of

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managed behavioral health care, it is not surprising that many managed behavioral health organizations and hospitals seeking managed care contracts decided to build outpatient capacity through a staff-model approach.

For a number of reasons, however, the strategy of vertical integration through clinic ownership, which was undertaken by many managed behavioral health organizations in the early 1990s, did not prove successful. The list of such organizations that have subsequently divested themselves of their affiliated clinics, named in parentheses, includes Green Spring (Group Practice Affiliates), Merit (Continuum), and MCC (MCC clinics). The failure of vertical integration to take hold may be evidence of a lack of synergy between running a managed behavioral health organization and managing an ambulatory provider organization. Managing a network through contracting and utilization management does not inherently help in managing staff-model organizations.

Although less integrated forms of managed care are being favored by the market for the reasons cited above, pressures to control costs and demonstrate quality have only increased. Moreover, the arm's-length control mechanisms that managed behavioral health organizations have typically used to reduce costs, such as prospective and concurrent utilization review, are costly to implement and abrasive to providers. The alternative that is being adopted by an increasing number of health plans and some managed behavioral health organizations is delegation of management authority and a portion of the insurance risk to provider groups that can wield a broader array of financial and nonfinancial tools to influence practice patterns.

This model of managed care has the advantage of locating utilization management authority and clinical decision making at the same level of the organization. Until recently, few behavioral health provider organizations have had the requisite skills and infrastructure to accept financial risk and perform utilization management. A handful of PPPM companies have appeared to fill this void and enable behavioral health providers to accept "delegated" contracts from managed care plans and medical groups whose capitation arrangement includes behavioral health services. In the long run, if these organizations are successful in managing care in a cost-effective manner that is also more palatable to clinicians, PPPM companies may be positioned to bypass managed behavioral health organizations and medical groups and contract directly with employers and other purchasers.

Although the objectives of all PPPM companies are similar—to accept risk-sharing contracts for behavioral health care—the business strategies employed by the pioneering companies vary considerably. The approaches taken by the PPPM companies we have observed include

- Exploiting economies of scale
- Introducing innovative clinical management
- Acquiring a network of existing practices to gain market share
- Creating contractual partnerships between health plans or hospitals and behavioral health group practices.

These strategies are not necessarily mutually exclusive, but the PPPM companies we have observed have pursued them to differing degrees. In emphasizing a particular strategy, each company has conveyed a different perception of where the market opportunities lie in managed behavioral health care. Each firm, along with the venture capitalists that fund it, is literally banking on a different view of what is "good" for the market, inclusive of providers, payers, and consumers.

Case examples

In this section we describe four examples of PPPM companies that are currently operating in several markets around the country. Besides describing their origins and key features, we highlight how each company is pursuing its objectives by focusing on one of the strategies listed above.

Company A

Company A began operations with the support of venture capital in early 1996. The company has adopted a strategy of buying existing practices and managed behavioral health organizations, which it overhauls by introducing sophisticated management information and business systems. Company A, which calls itself a consolidator, currently operates more than 100 clinics with a total of more than 1,000 providers. Through regional networks, the company offers managed care companies access to a wide range of providers and treatment modalities. In addition, the company believes that economies of scale in information systems and claims processing will yield significant cost advantages for companies that contract with Company A rather than through individual group practices. Company A represents a strategy of seeking business efficiencies through scale economies, without a unified clinical approach.

Company B

A second model is represented by Company B. Company B evolved from a staff-model behavioral group practice that was founded more than a decade ago. As of early 1998, Company B owned 22 clinics, each of which employed from one to eight clinicians. Unique among the four case companies, Company B is geared toward clinical efficiency rather than economies of scale in administration. In particular, this company emphasizes the use of brief treatment and group therapy among outpatients and the substitution of intensive outpatient treatment for inpatient treatment.

Besides emphasizing the clinical model, Company B has been successful in increasing clinician productivity (visits per week) to more than 50 percent above the industry average. Increased productivity may partly result from organizing practices so that clinicians are relieved of a majority of nonclinical, or administrative, tasks. Because the strategy of this company involves tight control of clinical practices, careful selection of clinicians and development of group norms among newly acquired providers will be critical to the success of Company B.

Company C

One of the newest companies in the PPPM industry, Company C is building integrated delivery systems for psychiatric outpatient care in a single regional market. Both through ownership and through contractual rela-

tionships with independent practices, Company C brings information technology, contracting expertise, and marketing to psychiatric group practices. Although it is still in a formative stage, it appears that company C sees its competitive advantage in offering providers bargaining power through consolidation across the continuum of outpatient treatment modalities while taking advantage of scale economics in service delivery and practice management.

Company D

Company D, formed in 1997 by executives of a regional managed behavioral health organization, takes a different approach to developing provider-sponsored networks. Rather than purchasing or creating wholly owned practices, Company D sells management services to existing behavioral practices. Company D's hopes for success are tied to its strategy of creating partnerships between behavioral health groups and health systems. Although Company D also provides capital and management services to its affiliates, its focus is on aggressive marketing to health plans and other potential sources of risk contracts, such as capitated medical groups or physician practice management companies.

Where is the potential for added value?

Which of these PPPM companies is likely to add value to the behavioral health industry in the long run? Company B's strategy of instituting substantial change in the clinical model of treatment and the ways in which clinicians organize their time appears to have the most promise for creating value. Both through enhancing cost-effectiveness of treatment modality choices and through improving efficiency in human resource allocation, this approach should result in added value both to consumers and investors. However, because major behavioral changes among providers are part of the model, Company B is also likely to experience the greatest resistance from providers. Even if brief treatment brings greater health benefits to patients, clinicians may be reluctant to accept a change that affects the way they practice.

It is more difficult to identify the long-term benefits of the other PPPM companies based on their strategies. Both horizontal and vertical integration will help providers manage risk contracts by expanding the number of providers and patients over which risk may be pooled. However, horizontal merger of groups (Company C) without true integration primarily serves to change the balance of power between providers and managed behavioral health organizations, which will not necessarily benefit consumers or the industry as a whole.

Similarly, joint ventures between managed behavioral health organizations and provider groups like those arranged by Company D represent a loose type of vertical integration that is more likely to reallocate market power (and profits) than to bring about underlying change. Finally, improving back-office operational efficiency, as Company A proposes, would appear to be limited to one-time gains. However, relieving clinicians of administrative burden and empowering them with sophisticated information systems may allow them to be more productive and may improve the quality of care. At the very least, good accounting and clinical information are valuable resources for risk management.

Conclusions

Rarely do we have an opportunity to witness the genesis of an industry. Although the movement toward consolidation of behavioral health care providers makes sense for both economic and clinical reasons, it remains unclear which, if any, of the various strategies adopted by psychiatric provider practice management companies will pass the market test.

The necessary, but not sufficient, condition for survival is that value is added to the health care system by the PPPM industry. The physician practice management industry has provided a clear illustration of this principle with recent failures of several public companies and massive reorganization of others. Such failure is even more likely to occur in the behavioral health sector, where revenues and profit margins are a small fraction of what they are for physical health care.

From a policy perspective, the potential impact of PPPM companies on patients and providers is the key issue. These companies may benefit consumers by enhancing coordination across providers as well as standardizing care through clinical management. Because these companies work directly and cooperatively with providers, they may be better equipped than managed behavioral health organizations to implement innovative and effective clinical management strategies.

In addition, as proponents of physician practice management companies have noted, PPPM companies may provide a vehicle for the diffusion of best practices across behavioral health groups (2). Enhancing diffusion may be an especially important function because behavioral group practices, even more than medical groups, are still at a relatively low point on the learning curve with respect to effective clinical and business management practices.

On the other hand, this new industry may just be a participant in a shell game where profits are swapped from one administrative entity to another with no gains in patient care. If PPPM companies simply mimic managed behavioral health organizations with no innovation in either quality of care or clinical efficiency, then their costs can only reduce the share of the overall budget available for treatment. Similarly, if PPPM companies are not prepared to manage the financial risk associated with delegated contracts, they may find themselves insolvent, with the accompanying displacement of providers and patients as integration cedes to disintegration. Either scenario could have significant human costs given the small and dwindling amount of money available for behavioral health care. ♦

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