Commentary

Can HMOs Manage The Mental Health Benefit?
by Mary L. Durham

It is widely acknowledged that mental health services are a poor stepchild to medical services under virtually all insurance arrangements. This is certainly true in health maintenance organizations (HMOs). Specialized mental health services are relative newcomers to the benefit package offered by HMOs. In large part, this is because providers have been ambivalent toward mental health problems, and managers and employer/sponsors have feared the potential for out-of-control costs, or moral hazard, associated with mental health services. These concerns have been compounded by the stigma attached to mental illness and the reluctance of the public, HMO staff, employers, and enrollees to deal with the issues surrounding it.

Despite rather strict limitations on covered benefits relative to traditional indemnity coverage, HMOs provide a large amount of mental health care to their enrollees. Almost all HMOs offer in-house or contracted mental health services. The rapid growth of individual practice associations (IPAS) and other prepaid models has shifted movement away from more traditional staff- or group-model arrangements (in which mental health services are often provided in house) to contracts with networks of independent providers or group practices. An InterStudy report relying on data from the late 1980s stated that 54 percent of all HMOs contract with specialty mental health organizations for enrollee services. This figure is likely to be much higher now, and it will surely climb in the future.

Management of mental health services encompasses far more than specialty mental health benefits. Just as in the fee-for-service world, at least half of all persons who receive mental health services are treated exclusively within primary care. Their symptoms may be identified explicitly as mental health problems (for example, depression or anxiety) or disguised as physical complaints. Regardless of primary care’s preparedness for the task,

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persons with mental health problems—ranging from minimal to severe—seek treatment from primary care providers at least as often as from mental health specialists.

The stakes for HMOs in managing the care of persons with mental disorders are high because the costs associated with mental health problems such as depression are enormous. Yet primary care providers often fail to recognize psychiatric disorders and, even when they do, fail to refer patients to specialty mental health providers. Primary care physicians in HMOs appear even less likely than fee-for-service physicians to detect depression in their patients. Despite this, Michael Von Korff and Lafe Myers found that most primary care physicians in one large HMO felt that they should assume responsibility for care of persons with adjustment disorders, mild-to-moderate anxiety, or depressed mood. Their confidence in treating severe cases or more serious disorders was much lower, however.

Given this backdrop, there is good reason to ask whether HMOs can manage the mental health benefit in an environment with extraordinary pressure to do more with less. Will HMOs be able, in a highly competitive health care environment, to focus on “managed care” instead of “managed reimbursement?” What have we learned, and what challenges might we anticipate that could serve as guideposts for improving mental health services in HMOs?

What Have We Learned?

The 1990s has brought a flurry of attempts to control mental health care costs. Solutions within managed care have included higher copayments and deductibles, aggressive utilization review, and outright termination of mental health coverage. In many instances, HMOs appear to have spent more time and energy managing reimbursement and utilization than managing the overall care of their enrollees.

Prepaid reimbursement provides the best and worst incentives for the delivery of services for persons with chronic problems—especially psychiatric care. Capitated prepayment has the potential to reduce institutional care, improve coordination of services, and promote the prevention of future illness or episodes of care. This potential is less likely to be realized, however, if preventive technologies are not available or the efficacy of available treatments is unknown, as is the case with some chronic diseases, particularly mental illness. This places an already vulnerable population at even greater risk for being managed toward the bottom line rather than toward improved clinical outcomes.

A crucial part of care management is the avoidance of high-cost/high-intensity treatment. When treatment is required over an indefinite (or
unpredictable) period of time and there is little clinical consensus on the exact constellation of required services, HMOs will be tempted to restrict services through limitations and ceilings on benefits. The incentives to cut losses incurred under such unpredictable circumstances require an aggressive effort within HMOs to scrutinize the essentials of the mental health care delivery system through population-based care management and experiments with financial incentives that reward improvements in health status (including mental health status) rather than strict adherence to policy exclusions and limits.

**Population-based management of care.** HMOs have a unique opportunity to provide health care services for a defined population that has a known set of epidemiologic characteristics. Clinical information systems and, more commonly, administrative databases are powerful care management tools for organizations that have recognized the pivotal role of information in the delivery of patient care. Clinicians in HMOs can use population-specific data to design a range of treatment alternatives that match the needs of enrollees. Patient- and system-level interventions then can be activated to meet the needs of untreated or at-risk persons. Primary care providers can routinely screen for depression, identify unusual patterns of service use (for example, high use in the absence of other indications), and pursue alternative etiologies, such as undiagnosed mental disorders, among their patients. Population-based programs can be designed to provide a spectrum of treatment alternatives for enrollees who are mentally healthy (such as employee assistance programs, stress management, and family counseling) or mentally ill (such as partial hospitalization, day care, and medication management).

Staff can monitor patient outcomes such as improvements in functioning, lapses in treatment, noncompliance with medication orders, or unexpectedly high use of services in other parts of the system. Patients who require follow-up for medication management or simple telephone checkbacks can be flagged; automatic reminders and follow-up appointments can be generated through automated protocols that are activated at designated intervals.

In-house program evaluators and academic researchers can study the cost-effectiveness of a variety of treatments for persons with a range of mental health complaints. They can demonstrate to the host organizations the costs of untreated depression or the impact of premature termination of benefits or changes in copayments, so that benefits and direct patient care services can be based on effectiveness, rather than on the fear of uncontrollable costs. In fact, many of the larger, more established HMOs are taking a tougher look at the efficacy of their services. Already, HMOs such as Group Health Cooperative of Puget Sound, Harvard Community Health
Plan, the Fallon Clinic, Health Partners, and Kaiser Permanente have active research programs in the areas of public domain outcomes research and cost analyses.

Population-based management means that primary care physicians are more likely to look for untreated mental health problems (such as depression and anxiety) in their practices.\textsuperscript{16} Managing a panel of patients (and the resources associated with that panel) means anticipating the longer-term needs of persons whose health care problems are acute, intermittent, and chronic. Responsibility for patient outcomes rather than single episodes of care dampens the incentive of prepaid systems to “dump” high-cost patients on public systems.

Equally important, organizations are more likely to plan the “carrying capacity” of their specialized mental health services if they are engaged in population-based management of care. We have seen from previous research that perceived (and actual) lack of service capacity is a significant deterrent to referrals to specialty mental health services in HMOs.\textsuperscript{17} Population-based care allows organizations to better plan staffing levels and the mix of professionals who will provide those services, because they know whom they are expected to see.

There are few, if any, treatment environments in which aggressive care management can be monitored as thoroughly as in HMOs. However, it would be naive to conclude that the powerful technologies of population-based management could not be used to deny necessary services to high-cost or at-risk patients. The potential power of the technology must be mediated by explicit financial disincentives (or the lack of incentives) to skimp on services.

\textbf{Financing.} Systems of care that give direct salary incentives, bonuses, or penalties to providers based on the volume of care they produce should be carefully scrutinized. Financial self-interest simply should not be played against obligations to patients.\textsuperscript{18} On the other hand, reimbursement experiments (or full-fledged programs) based on rewards for good patient outcomes related to patients’ functional status and symptom remission provide promising models for restructuring delivery systems. Network models now exist in which payment for services is withheld (or prorated) based on the success of treatment or management of symptoms. These programs, which are now entering the marketplace, may revolutionize the way we reimburse mental (and physical) health services.

Even without such a radical departure from current reimbursement methods, it is clear that we discourage many people with serious mental disorders from obtaining services from HMOs through high initial copayments, low benefit limits, and inadequate risk adjustment methodologies that underestimate the cost of their care.
To address some of these concerns, the Harvard Community Health Plan (HCHP) eliminated copayments for mental health services so that high-risk patients would not be discouraged from seeking needed services.\(^\text{19}\) HCHP has chosen to encourage early contact with enrollees who have mental health problems rather than presume a priori that persons who need services badly enough will have the resources and persistence to make contact with appropriate providers. This is an excellent example of managing the care rather than the benefit.

Lower benefit limits for mental health services are probably an inevitable feature of health care coverage. Most HMOs, however, have developed care management techniques that allow unlimited visits for medication management; others have developed day care programs and/or partial hospitalization alternatives that help to avoid costly inpatient stays. As a result, inappropriate hospitalizations have been minimized, and less restrictive treatment programs have been established.

It is widely acknowledged that inadequate risk models exist to reimburse providers for costs associated with the care of persons with chronic, severe mental disorders. A growing number of states are experimenting with capitated payments for Medicaid clients who are mentally ill. The more successful of these experiments should provide a fertile testing ground for innovations in managed care for severely ill populations, including persons who are civilly committed.\(^\text{20}\)

### The Changing Scene Within Managed Care

As the scenery changes throughout the health care community, the delivery of care within HMOs is changing as well. HMOs need to be more cost-competitive and more responsive to patient satisfaction. These cross-currents have pushed HMOs in opposing directions.

Mental health benefits are not included in many state health care programs and are missing from some health care reform proposals. Cost pressures may lead policymakers and employers to sharply curtail mental health coverage. Aggressive utilization management and precertification could result in dumping of high-cost psychiatric patients into public systems and jettisoning successful community-based programs of care. These are shortsighted “solutions” that may do significant damage to the continuum of care.

Even the most progressive systems of care management will experience difficulty in accomplishing population-based management when alternative delivery models such as point-of-service plans and carve-out programs represent a larger and larger portion of the enrolled population.\(^\text{21}\) This means that HMOs will have multiple populations to “manage,” rather than
a single target group. A broader set of providers will be involved in care management for HMOs than in the past. Consequently, clinical information systems must accommodate the need for uniform data; key outcome measures must be negotiated and carefully thought out. The importance of population-based management is likely to increase because services will be integrated through a complex network of providers who will be rewarded by avoiding duplication of services while maintaining high levels of quality.

HMOs have been quick to adopt clinical guidelines, which can be incorporated into clinical information systems to prompt providers to pursue recommended follow-up appointments, laboratory tests, and medication reviews. Clinical guidelines for conditions such as depression, anxiety, or even schizophrenia can give primary care providers who are reluctant to treat mental illness a better road map for treatment and/or referral to specialty mental health providers.

Clinical guidelines for depression, as for other disorders, vary somewhat among HMOs. However, they tend to focus on reminding clinicians to be alert to the possibility of the condition in primary care patients, emphasizing the use of screening instruments, and stressing the usefulness of medical history, physical examinations, and routine laboratory testing. After diagnosis, the guidelines provide a triage scheme based on the nature of depression and comorbidities and then a protocol for treatment, consultation, and follow-up. This should expand the quality and availability of treatment throughout the HMO while putting appropriate pressure on primary care to acknowledge the role it plays in the treatment of mental illness.

Another market force is changing the scenery within HMOs. As the marketplace grows more and more competitive, HMOs are contracting with new groups of patients, including persons who previously may have been unacceptable to managed care because of their potential financial risk (for example, small groups or disabled workers).

As noted above, states are developing prepaid contracts with HMOs for their Medicaid clients, and larger numbers of Medicare recipients are enrolling in prepaid care. The result is an explosion in the number of high-risk persons in managed care. HMOs may not be ready for the unique challenges posed by these populations—especially Medicaid clients with severe mental disorders or other disabling conditions. Bringing new groups of persons with severe mental disorders into HMOs and acknowledging mentally ill enrollees who are already there will require high-quality data systems for managing care and tracking the financial and clinical success of these service arrangements. Organizations will need to assess the cultural elements of their care, including language barriers, flexibility of hours, and locations of operation. New service components may be necessary to support these groups; attitudes of providers, staff, and other enrollees may have
to change to be receptive to these groups’ service needs.

An important challenge to HMOs today is whether they can manage the care of persons with mental health needs and resist the temptation to manage only the financial risk. Organizations that successfully address this challenge will reap benefits throughout their delivery systems and reclaim the main competitive advantage of managed care.

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NOTES

2. Moral hazard is the assumption made by insurers that persons will consume more services if they are insured than if they had to pay the entire price themselves. P.J. Feldstein, Health Care Economics, 4th ed. (New York: Delmar Publishers, 1993). A recurring fear of insurers in providing mental health benefits is that the benefit will be misused with unnecessary use of services (for example, therapy for nonserious problems or beyond the time that therapy could be terminated).
3. M. Peterson, J. Christianson, and D. Wholey, National Survey of Mental Health, Alcohol, and Drug Abuse Treatment in HMOs: 1989 Chartbook (Minneapolis: InterStudy Center for Managed Care Research, 1992).
5. Peterson et al., National Survey of Mental Health, Alcohol, and Drug Abuse Treatment in HMOs.
9. Wells et al., “Detection of Depressive Disorder for Patients Receiving Prepaid or
Fee-for-Service Care.”
10. Von Korff and Myers, “The Primary Care Physician and Psychiatric Services.”
17. Von Korff and Myers, “The Primary Care Physician and Psychiatric Services.”
21. Point-of-service plans allow enrollees to see any provider they wish outside their HMO for a higher out-of-pocket cost than if they receive services from an HMO-contracted provider. Carve-out programs establish a separate benefit structure through contract providers for certain services, such as mental health care, rather than “mainstreaming” those services into the broader service structure of the HMO.
22. A greater number of elderly persons are enrolling in prepaid care through Medicare, including many who have multiple medical and psychiatric disabilities. In 1985 fewer than 500,000 seniors were enrolled in risk-model HMOs; by 1995 that number had grown to more than 2.3 million. Health Care Financing Administration, Office of Managed Care, 1995.