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'CARVE-OUT' MENTAL HEALTH PLANS CREATE WIN-WIN SITUATION

BHS IS THE ENDORSED BEHAVIORAL HEALTH AND SUBSTANCE ABUSE VENDOR OF AHC

Q *What are 'carve-outs' and how many employers are using them?*

A Carve-out plans entail the removal of mental health and substance abuse (MHSA) benefits from an employer's medical plan and its separate administration through a specialty mental health organization. Good carve-out MHSA programs are comprehensive in scope and include the following: benefit plan re-design; full case management services, (I/P and O/P) including a face to face assessment; access to a preferred provider network across a broad continuum of care; claims processing; management reporting; and quality assurance/ effectiveness monitoring. An employee assistance program can be integrated for effective dove-tailing of short and long-term treatment. Some vendors provide treatment services directly to employees, other utilize independent network providers.

The popularity of carve-out MHSA plans is growing rapidly. A recent survey found that 78% of companies with more than 250 employees engage in MHSA utilization review programs, and 62% use a dedicated provider network (OPTIONS).

Q *Why are stand-alone MHSA programs popular?*

A Results are proving that carve-out MHSA plans promote early intervention, offer a broad scope of treatment alternatives, provide continuity of care and follow-up, ensure access to qualified professionals, allow for a generous benefit plan, reduce the patient's out-of-pocket costs and improve the quality/outcome achieved. All this, and companies are saving on average 25-50% of their MHSA costs.

Companies choosing no carve-out generally are either continuing to experience annual cost increases in the 20+% range, or are cutting their mental health benefits to the bone in an effort to contain costs. (This last approach has the reverse effect, because if MHSA benefits are unavailable, the cost of care will show up under a medical diagnosis; also, companies usually reduce outpatient benefits first, which eliminates the incentive for cost-effective treatment alternatives and actually induces high cost inpatient treatment.)

There are some significant advantages to handling the MHSA plan separate from the full-service case manager/HMO/insurer. One relates to the level of commitment given to the area of behavioral health. Full-service companies generally see it as a sideline product, which is reflected in the attention and expertise level dedicated to this area. MHSA benefits are usually held to a minimal level and "case management" is handled via low annual day maximums. There is usually no interface with an employee assistance program, and provider selection/choice of services is usually poor. Full-service review programs do not typically review outpatient services, which is an important element in MHSA treatment, and what review is performed is generally retrospective and performed by non-mental health professionals. The simple truth is that those who manage *medical* care well do not necessarily manage *mental health* care well.

Q *How does a carve-out plan benefit the employee/patient?*

A Carving out allows an employee to receive more benefits rather than fewer, usually with better reimbursement, and an employee assistance program can be integrated at minimal additional cost. The patient is referred to the most appropriate treatment setting within a full-care continuum, rather than automatic admission to a hospital. A good managed care program provides for an independent assessment and on-going support system which is distinct from the actual care-giver, allowing for an unbiased treatment planning process. Most patients and families welcome the hands-on support of experts in the field when they experience a behavioral health problem. And under a carve-out plan, MHSA patients are given top priority, which may not be the case under an overall medical plan.

And, while employees might be more restricted in their choice of a provider under a carve-out program, they have the assurance that the providers used have passed a "credential" process.

Q *How does the employer benefit?*

A The employer benefits through reduced costs, via negotiated fees with providers and a focused case management program which reduces the

incidence of inappropriate admissions, extended stays, and non-productive outpatient therapy. Average savings can be as high as 50-70% in the first year. Employee assistance programs are greatly enhanced when integrated with a managed care plan under a single vendor. Plus, multi-site employers can offer one uniform MHSA benefit plan throughout their locations. A pre-screened panel of providers gives the employer the assurance that credentials, performance and cost-effectiveness have been evaluated. Finally, a good managed care program will provide the employer with comprehensive reports on cost and utilization, which previously was unavailable.

Q *Does a reduction in cost translate to a reduction in care or quality?*

A Not when treatment plans and case management services are determined on an individual, case by case basis rather than on pre-defined diagnostic criteria. Assessments should be performed face to face, as opposed to a telephone review process.

Saving dollars should not be the only goal of a managed care program. Rather, it should: 1) Ensure a quality provider network; 2) Make access to care easy and timely; 3) Offer a strong support mechanism; 4) Provide a full continuum of treatment alternatives; and 5) Render expert case management and outcome analysis.

In the process of finding that managed care can reduce costs, employers and employees are discovering that the care is more appropriate also. A good managed care program will offer equal focus to quality, employee satisfaction and cost effectiveness.

A study by Milliman & Robertson, Inc., for Healthcare Management Guidelines analyzed inefficiencies and waste in both inpatient and outpatient settings. Their findings were that more than 50% of inpatient services are unnecessary in the MHSA area. Similar inefficiencies were found in the outpatient setting. In today's managed care environment, providers who cannot demonstrate that their service produces a positive outcome delivered in a cost-effective manner will have trouble competing.

Q *What are some valid concerns regarding MHSA carve-outs and what should an employer look for in a vendor?*

A There are some absolutely valid concerns regarding the managed MHSA industry which an employer should address when establishing such a program. These include the following:

1. That denial decisions happen without ever having seen the patient face-to-face. Make sure that the program provides for a face-to-face assessment, preferably by an independent (non-employee) practitioner, prior to any denial decision. This will keep the system honest and ensure that the resulting opinion will be objective and unbiased. Physician reviews should be performed by a psychiatrist or other physician who has a specialty in that diagnosis.

2. That financial incentives exist to "under-treat." Care should be taken in the structure of fees and treatment practices so that not even the appearance of this claim exists, let alone the reality. Neither the managed care company nor the providers used should directly benefit from the curtailment of care.

3. That an adversarial relationship must exist between PPO treatment providers and managed care companies. An employer should check the provider references of a managed care company as it would their customer references. While their provider relationship is generally arms-length, the network should be able to attract and retain highly qualified and respected clinicians/physicians.

4. That employees perceive it as taking away a fundamental right to freedom of choice and unlimited access to care. This concern is not as easy to alleviate, and requires a long-term commitment to employee education about quality of care/outcomes/and alternative treatment choices. Avoiding the suggestion of "care ratcheting" through the employer's fee arrangement can help. More important, however, is the patient's realization that "a hospital is a place rather than a treatment" and that the long held belief that the inpatient setting represents "an omnipotent, omniscient source of protection and nurture, an immediate and definitive solution to their problems" is not valid, and can, if used inappropriately, become an extreme intervention with far-reaching consequences.

—by Deborah L. Stephens, President & CEO, Behavioral Health Systems, Inc.

BHS PRODUCES SAVINGS FOR AHC MEMBERSHIP

Several AHC members inquired about the savings that can be expected through the implementation of Behavioral Health Systems (BHS), AHC's endorsed Behavioral Health and Substance Abuse vendor. Deborah Stephens, president of BHS, was proud to report that AHC members are currently receiving a 60% savings in the first year. Furthermore, Deborah reports that approximately 8% of that savings is due to the additional discount negotiated by the AHC on behalf of its members. We are pleased to report that the savings generated is more than enough to justify the AHC membership dues. Based on a tiered pricing structure, the more companies that participate with BHS the more savings AHC members share. For more information, please call the AHC at 995-9922.