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# The Organization of Substance Abuse Managed Care

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**Abstract.** Managed care came to dominate the delivery of substance abuse services during the 1990s. This paper uses literature and new data to describe and analyze the set of arrangements it implies. The description suggests that substance abuse managed care typically is “carved out” of the general health care plan and treatment is coordinated by a behavioral health managed care company that manages treatment access, length, type, and intensity. This administrative agent is provided financial incentives to keep costs low and otherwise faces such mandates as to ensure timely access to treatment and to deliver reports. A typical agent has some interest in improving the quality of decision-making, but has few incentives for controlling the treatment technology. In contrast, agents tend to control treatment providers through relatively rigid rules that substitute outpatient for inpatient care, regulate the length and intensity of services, provide limited social services, mandate accreditation, allow limited clinician discretion, administer an entire “network” of providers as an only slightly differentiated mass, and rarely shape the details of the treatment process. These patterns are analyzed in terms of transaction cost economics and institutional and resource dependency theories. In general, it is argued that managed care reflects an interest in controlling costs but also in ensuring access within an environment where there is uncertainty accompanying competing demands, varying conceptions of the client, and controversies over the efficacy of specific treatment technologies.

## 1. Introduction

Most substance abuse health care benefits in the United States are delivered under a managed care arrangement—an administrative system where rules and incentives are consciously structured to govern treatment access, length, or character. This system is commonly the province of a specialized *administrative agent*, who may be an insurance company, employer, or even a network of providers, but more typically is a specialized, generally for-profit, behavioral health managed care organiza-

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tion (BHMCO). From the point of view of clinicians and organizations that provide substance abuse services, the resulting managed care arrangements can interfere with professional autonomy due to the agent's influence over the initiation and course of treatment. Yet, agents typically claim to promote preventative care and appropriate service use. From the point of view of the payer—usually an insurance company, employer, or government agency—the arrangements provide more of a choice over the nature and cost of covered treatment. Yet, choices of all except for the largest payers are limited by an agent's managed care plans. From the point of view of the client or plan enrollee, care is governed by a set of rules that are meant to make their health care dollar stretch further, but that also limit input into the receipt of care.<sup>2-6</sup> In other words, managed care has its ambiguities.

It is likely that such ambiguities reflect fundamental obstacles to building a rational administrative system in substance abuse managed care.<sup>7</sup> For example, there are many influential groups and actors whose preferences and interests are too diverse to easily be resolved in a single, uniform system. In simple terms, employers may wish to see individuals return to work or be conditionally excluded from the workforce, providers and professionals may desire the complete elimination of drinking and drug use, and clients and their families may wish to ameliorate family disruption.<sup>8</sup> Preferences also vary because professional organizations emphasize divergent standards of care, while clients are referred from sources with disparate interests, like the justice system, other government programs, and employers.

As this implies, there also are conflicting goals. These in part reflect preferences and interests and in part reflect the varying conceptions of the client; historically, substance abuse has been viewed as a moral failing, a disease, or a social disorder.<sup>9,10</sup> Perhaps more fundamentally, goals conflict because of disputes over which “technology,” or treatment process, to pursue. A wide variety of technologies are used, including everything from paraprofessionally based twelve step programs, to psychotherapy, to cognitive behavioral models, to social service models. It is difficult to obtain a consensus about these technologies because each has its adherents, some are rarely tested in the research literature, and none always proves itself superior. There also are unresolved controversies over the relative merits of inpatient and outpatient care, intensive and traditional services, and short-term and long term interventions, so that preferences vary. There is similar disagreement over the best way of matching individuals to types of services—even though it seems clear that different individuals require somewhat divergent treatment strategies and that treatment success also sometimes depends upon confronting various other highly individualized problems like comorbidities, family difficulties, or financial destitution.<sup>10-12</sup> Finally, given the novelty of the system, there are debates over the impact of any given administrative arrangement.

All this leads to the classic dilemma of “human service organizations”<sup>3</sup>—that of administering an organized system despite uncertainty over what techniques work best, which goals should be pursued, and which administrative structure is most useful and legitimate. Organizational theorists suggest that such uncertainty places the relevant leaders under stress. It becomes difficult to satisfy all parties, and orga-