

Running head: MANAGED BEHAVIORAL HEALTH CARE IMPACTS

How Managed Behavioral Health Care Impacts Psychotherapeutic Practices

by

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Dedication

This dissertation is dedicated to my grandmother, Rose, who was only eleven days shy of learning that I was accepted to graduate school, my parents, Rosanne and Ira, and my soon to be husband, Anthony. Without their support, I would not have had the courage or resources to achieve my goals. Also, to four-legged my boys, Toby and Gus, who were literally right next to me during the countless hours I sat at my computer.

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Abstract

The cost of health and mental health care is a growing problem for the United States. Managed care evolved as a way to continue providing quality services in a cost-effective fashion. In the mental health field, some individuals believe managed care reduces the quality of treatment. This exploratory study investigates current sentiments among mental health clinicians regarding managed care's impact on mental health treatment and looks at how clinicians practice in light of managed care's guidelines for treating patients. This study explores the current impact of managed care compared with managed care's first detectable impact in the 1980s.

Keywords: managed care, managed behavioral health, ethics and managed care,
attitudes and managed care

Chapter 1: Introduction

A 23 year-old male was in treatment for a history of self-injurious behavior, substance abuse, interpersonal difficulties, and sexually inappropriate behavior subsequent to a traumatic past. His symptoms, as measured by the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR; American Psychological Association [APA], 2004), were stabilized for the first time in three years, and he was beginning to develop a meaningful relationship with a female peer. During a routine quarterly utilization review with the managed care company, it was determined that the patient no longer qualified for reimbursable treatment. Without treatment, there was concern that he could quickly relapse and become a safety risk to himself as well as to others. This highlights the concern of who should determine that risk, the therapist or the managed care company. One wonders whether it would be more cost effective and/or ethical to end treatment suddenly. The potential financial and ethical consequences include having to reimburse future crisis center and hospital visits for that individual, as well as potential medical and psychiatric treatment for a possible victim of his sexual abuse. Alternatively, it could be more cost effective and/or ethical to maintain treatment, as potential related costs are purely speculative.

Clinicians face this dilemma when working with managed care companies in both outpatient and inpatient settings. Managed care's stringent criteria for reimbursable treatment often conflicts with how mental health clinicians would otherwise provide the treatment of choice for their patients. On the other hand, without insurance, many individuals who receive mental health treatment at little to no cost would otherwise not be able to afford that care.

Statement of the Problem

Managed care, including managed behavioral health care, has expanded rapidly over the last 20 years and imposed numerous changes on the practice of psychotherapy (Alexander & Lemak, 1997b; Cohen, Marecek, & Gillham, 2006; Findlay, 1999; Liu, Sturn, & Cuffel, 2000; Oss, 1994; Stein, Orlando, & Sturn, 2000; Sturn, 1999, 2000). In health, mental health, substance abuse, and social service venues, practitioners and clients have reported appalling anecdotes related to the implementation of managed care policies (Davis & Meler, 2000; Robinson, 2001; Yedidia, Gillespie, & Moore, 2000). Managed care has been described as mismanaged care, unmanaged care (Geller, 1998), mangled care, managed cost (Robinson, 2001), and care-management of profits (Davis & Meler, 2000). Yet, the reaction to this trend is mixed, especially in the behavioral health sector.

Benefits of managed care. There are many who welcome managed care in behavioral health, including health maintenance organizations (HMOs), vendors of managed behavioral health services, policy makers, and employers. They believe that it benefits patients, providers, payers, and society. Some think that not only could managed care increase access to health and behavioral health services, but also is morally preferable because it expands access to care, uses dwindling health care resources more responsibly, and cuts down on unneeded services. Furthermore, it can be argued that utilization management strategies can serve to triage patients into appropriate care, facilitate access to services, and eliminate inappropriate or unnecessary care, thereby allowing limited resources to be used efficiently, containing costs, and facilitating service delivery (Merrick et al., 2006).

Proponents of managed care argue that it has the capacity to reduce costs while improving the quality of services (Broskowski, 1991; Callahan et al., 1995; Frank & McGuire,

1997; Ma & McGuire, 1998; Mechanic, Schlesinger, & McAlpine, 1995; Walfish & Barnett, 2009; Wells et al., 1995). They highlight how it prevents abuse of the system by health care providers, reduces inappropriate care, decreases fraudulent and abusive practices among providers, and possibly increases referrals among providers. Furthermore, many believe that managed care does not harm the patient-provider relationship. Specifically, several managed care models, such as those stressing continuity of care, prevention, and early intervention, are applauded by health care practitioners and patients (Mechanic et al., 1995; Walfish & Barnett, 2009).

Managed care presented many opportunities for the mental health field (Cantor & Fuenetes, 2008). Clinicians working with managed care have been encouraged to focus on prevention, develop a continuum of mental health services, integrate mental health services into the general health care delivery system, and increase collaboration between psychologists and primary care providers. The mental health field could highlight its strengths. Supporters argue that therapists will not have incentives to do less and suggest that managed care companies disclose their incentives to patients, limit disincentives, and base financial incentives on the quality of care or adherence to best practices (Boyle & Callahan, 1995).

Negative consequences of managed care. Despite the noted benefits of managed care for the mental health profession, there are many concerns regarding its impact (Alleman, 2001; Cantor & Fuenetes, 2008; Fox, 1995; Karon, 1995; Walfish & Barnett, 2009). Skeptics feel managed care results in reduced access to and quality of care, disrupts the provider/patient relationship, limits patients' choice of providers and treatments, reduces reimbursement rates, and increases administrative demands (Boyle & Callahan, 1995; Cohen et al., 2006; Walfish &

Barnett, 2009; Scheid, 2003), thereby negatively affecting utilization and outcome of treatment (Alexander & Lemark, 1997b; McCarthy et al., 2001; Rivers, 1998).

Access to treatment could be affected in a number of ways. In behavioral health care, it has been noted that managed care rejects elective outpatient care and inpatient days, and has increased co-payments for outpatient visits (Jellinek & Nurcombe, 1993). Additionally, there is concern that the mechanism of capitation will motivate providers to reduce services (McFarland, 2000; Sosin & D'Aunno, 2001; Steenrod et al., 2001). Early hospital discharge, the use of financial incentives to control referrals (which may make clinicians too cautious about sending patients to specialists), and reduced intensity of services have yielded concerns that patient care may be compromised by these managed care cost-cutting strategies (Jellinek & Nurcombe, 1993; Orin, 2001). Furthermore, critics of managed care have argued that therapists will have incentives to do less, thereby affecting the quality of services (Cantor & Fuentes, 2008; Emanuel & Dubler, 1995).

The negative impact on access to services and quality of care has direct consequences on the patient-provider relationship (Jellinek & Nurcombe, 1993). The use of non-psychiatrists for mental health care, other than medication management, could negatively impact the quality of treatment as well as limit the continuity of care. In general, the rise of managed care has shifted decision-making power away from plan members, who are limited in their choices of providers, and away from clinicians, who must concede to managed care administrators regarding what is considered a medically necessary procedure (Sparer, 2003), thus limiting patient choice and increasing negative attitudes towards managed care by both patients and providers.

Reimbursement rates are more controlled under managed care versus the previous fee-for-service system. Under the managed care system, the incentives for seeing, or not seeing,

patients are different than under the fee-for-service system. Unlike the fee-for-service system, the managed care system benefits providers to not see patients (Holmes, 1997). HMOs contract with mental health provider groups to pay the group a small fee per member per month to handle all of the mental health needs for a certain population (Holmes, 1997). If the providers see the patient, they will collect a small additional copayment. A group of providers can make the most money by seeing as few patients as possible for as few sessions as possible.

Providers have had to adapt to new management policies. Managed care requires specialized utilization reviews, also known as utilization management techniques, and has established gatekeepers. There is concern that utilization management techniques may prevent people from receiving needed care, incur major time costs, affect confidentiality, fail to be cost effective for outpatient care, and focus excessively on cost at the expense of quality (Borenstein, 1990; Hennessy & Green-Hennessy, 1997; Merrick et al., 2006; Miller, 1996). While the purpose of utilization reviews is to limit unnecessary spending, some would argue that this monitoring has been too strict.

Description of Topic

Background. Prior to managed care, the predominant form of health care was known as a fee-for-service or indemnity model. In a fee-for-service model, practitioners are the sole determiners of how and what services should be delivered to their clients based on their expertise and professional values (Egan & Kadushin, 2007; Mechanic, 2007). Specifically, doctors and hospitals were financially rewarded for using a plethora of expensive tests and procedures to treat patients (Bartlett, 1994), and providers were paid for each individual service rendered to a patient. The client is required to pay the fees set by the practitioner (Walfish & Barnett, 2009).

This system, where clinicians had a great deal of autonomy over their practices and rates, presented with many problems financially (Scheid, 2003). For example, psychiatric inpatient facilities were known for keeping patients until their insurance ran out (Holmes, 1997). One reason that 28-day inpatient treatment programs became a standard for substance abuse treatment is that most insurance companies wrote 28 days of coverage into the policies. Additionally, under the fee-for-service system, therapists were paid only to see patients (Holmes, 1997). This encouraged clinicians to see patients for as many sessions as necessary, and it could be argued that this encouraged too many sessions. Some services provided were unneeded or provided inefficiently, were marginally beneficial, and perhaps even caused further illness (England & Vaccaro, 1991). In this system, providers received more payments, and there was concern that services were delivered that were not actually needed (Willging, Waitzkin, & Nicado, 2008). Evidence indicated health care and mental health/substance abuse treatment costs were burdening businesses in the United States under the fee-for-services system, possibly affecting international competition (Oss, 1994).

Under the fee-for-service system, health care was becoming increasingly costly. Furthermore, the public health advances following World War II lengthened the average lifespan of Americans, further contributing to the increasing costs of health care (Kongstvedt & Knight, 2002). At that time, many companies began looking for ways to attract employees without increasing salaries. One way to do this was to offer benefit plans in which employers contributed to health care for their employees. These employer plans, however, grew more costly as medical costs increased. When other countries nationalized their health care systems into a single payer system subsidized by the government, the United States continued on its unique course, and employers and insurance companies struggled to find ways to cut health care

costs. Managed care emerged in some ways because there were not enough internal controls within the profession (Walfish & Barnett, 2009), and it has largely stopped this practice by carefully monitoring inpatient care. Currently, managed care is the dominant method of cost-cutting.

Definition of managed care. The managed care era began in the late 1980's in response to the skyrocketing cost of health, mental health, and social services (Beinecke, Goodman, & Lockhart, 1998; Elias & Navon, 1998; Kongstvedt & Knight, 2002; Scheid, 2003; Veeder & Peebles-Wilkins, 1998). Managed care plans are defined as health care delivery systems that integrate the financing and delivery of health care (Kongstvedt & Knight, 2002; Sanchez & Turner, 2003). The complex system coordinates and administers health care while managing and dispersing health benefits (Cantor & Fuentes, 2008). Regardless of the structural or organizational differences, according to Corcoran, Gorin, and Moniz (2008) and Wernet (1999), managed care plans have five essential elements of implementation: (a) set up contracts based on performance and capitation costs, (b) have policies that direct members to less expensive services, such as clinical social workers rather than psychiatrists, (c) require preauthorization of services to determine medical necessity for treatment, (d) have utilization reviews to assess quality of care and the need for continuing care, and (e) have case management for high-volume and high-cost users of services. While these authors have indicated these five criteria, there is greater flexibility of the definition of managed care in practice. For example, many individuals working in a managed care system do not work in a capitated system.

Description of managed care models and applications. There are generally three basic types of managed care plans: Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and Point of Service (POS) plans (Kongstvedt & Knight, 2002).

Corcoran, Gorin, and Moniz (2008) identified two additional types: Management Service Organizations (MSOs) and Employee Assistance Programs (EAPs). As managed care has evolved, models have become more diverse and now use a combination of strategies to manage care (French et al., 1996).

HMOs have actually existed for more than 50 years. They are the best known and oldest form of managed care. HMOs are capitated systems in which clients must see a primary care physician first, either a physician or an advanced practice nurse (APRN), who will then authorize treatment with a specialist, such as a therapist (Fabius, 1997). Often, financial incentives are offered to physicians for limiting such authorizations (Cohen et al., 2006). There are five types of HMOs: Staff Model, Group Model, Network Model, Independent Practice Association (IPA), and a combination of these four (Corcoran, Gorin, & Moniz, 2008; Kongstvedt & Knight, 2002). The Staff Model hires clinicians to work onsite, while the Group Model contracts with group practice physicians on an exclusive basis. Additionally, the Network Model resembles the group model, except participating physicians can treat patients who are not plan members, and the IPA contracts with physicians in private practice to see HMO patients at a prepaid rate per visit as a part of their practice (Sanchez & Turner, 2003). See Table 1.

PPOs are more flexible than HMOs. Like HMOs, they negotiate with networks of physicians and hospitals to get discounted rates for plan members (Kongstvedt & Knight, 2002), but unlike HMOs, PPOs allow plan members to seek care from specialists without being referred by a primary care practitioner (Cohen et al., 2006). These plans use financial incentives to encourage members to seek medical care from providers inside the network, and providers must usually accept reduced fees in order to participate, often additionally agreeing to some degree of outside

review (Cohen et al., 2006). PPOs provide services at reduced fees in exchange for consistent referrals from the insurance company (Sanchez & Turner, 2003). See Table 1.

POS plans are a blend of the other types of managed care plans. They encourage plan members to seek care from providers inside the network by charging low fees for their services, but they add the option of choosing an out-of-plan provider at any time and for any reason (Kongstvedt & Knight, 2002). POS plans carry a high premium, a high deductible, or a higher co-payment for choosing an out-of-plan provider. See Table 1.

Objective. Overall, the goal of managed care is to contain reimbursement of services, not access to care, while holding practitioners accountable for their interventions (Berkman, 1996; Corcoran & Vandiver, 1996; Edinburg & Cottler, 1995; Mechanic, 2004; Volland et al., 1999). Managed care attempts to control health care costs, while increasing access to and quality of services (Merrick & Reif, 2010). The intended purpose of managed care plans is to reduce the cost of health care services by stimulating competition and streamlining administration (Brokowski, 1991; Cantor & Fuentes, 2008; Kongstvedt & Knight, 2002; Managed Care-INFO, 2009).

Cost containment strategies. Managed care uses many techniques to contain costs (Merrick et al., 2006). Generally, managed care can influence clinicians through strategies known as utilization management, offering financial incentives, structural characteristics, and information on normative influences.

Table 1

The basic types of managed care plans, similarities and differences

HMO	PPO	POS
Oldest form of MC, 50+ years old	More flexible than HMOs	Blend of HMO and PPO
Negotiate with physicians and hospitals to get discounted rates for members	Negotiate with physicians and hospitals to get discounted rates for members	Encourage care from in-network providers with low service fees
First see PCP, then get referral for a specialist	Do not need a referral from a PCP to see a specialist	Can choose out-of-plan provider at any time
4 types: Staff Model, Group Model, Network Model, IPA	Use financial incentives to encourage use of in-network providers	High premiums, deductibles, +/-or copayment for choosing out of plan provider

Note. HMO = Health Maintenance Organizations; PPO = Preferred Provider Organizations; POS = Point of Service Plans; MC = managed care; PCP = primary care provider; IPA = Independent Practice Association

Utilization management is thought to have the most immediate impact on care (Tischler, 1990), and consists of prior authorizations, concurrent reviews, gatekeeping, case management, medical necessity criteria, and practice guidelines. Prior authorization requires clinicians to get approval from the managed care company prior to initiating treatment, such as hospitalizing a patient, except in the case of an emergency (Merrick et al., 2006; Mihalik & Scherer, 1998; Sparer, 2003). Concurrent reviews are periodic reviews of ongoing treatment that are conducted to determine whether to authorize additional treatment (Merrick et al., 2006; Mihalik & Scherer, 1998; Sanchez & Turner, 2003). “Gatekeeping” refers to gaining access to services only after the approval of the managed care company (Sanchez & Turner, 2003, p. 553). Case management focuses on actual and potential high-cost users (Merrick et al., 2006; Mihalik & Scherer, 1998). In the private sector, case management refers to focusing on high-cost or

high-utilizing enrollees, and in the public sector, it focuses on individuals with serious and persistent mental illness and often uses community-based treatments that are intensive and assertive (Merrick et al., 2006). Medical necessity criteria are used to determine if and what treatments should be authorized (Merrick et al., 2006; Mihalik & Scherer, 1998). Practice guidelines require providers to develop standards of treatment for specific diseases (Merrick et al., 2006; Mihalik & Scherer, 1998; Sparer, 2003). Research on practice guidelines shows frequently low rates of guidance-concordant treatment, inconsistent evidence for improved outcomes in some diagnostic groups, and the need for comprehensive, ongoing adherence interventions (Fortney et al., 2001; Wang et al., 2000).

Prior authorization, concurrent review, and case management have generated significant controversy. Merrick et al. (2006) found that 43-87% of managed care companies used treatment management techniques (prior authorization, standards for time to initial appointment, concurrent review, standards for follow-up after discharge, case management, and practice guidelines) for outpatient mental health care. Furthermore, they found that HMOs and products with specialty behavioral health contracts were more likely to use these techniques. Some utilization management strategies are associated with lower cost and quantity of treatment (Frank & Brookmeyer, 1995; Hodgkin, 1992; Liu, Sturn, & Cuffel, 2000; Mechanic, Schlesinger, & McAlpine, 1992; Wickizer & Lesser, 1998), although Frank and Brookmeyer (1995) found these effects to be short-term.

Offering financial incentives is another way to control costs. Managed care companies attempt to reduce costs by negotiating lower fees with clinicians and hospitals in exchange for a steady flow of patients (Orin, 2001; Willging et al., 2008). Managed care organizations generally negotiate agreements with providers to offer packaged health care benefits to covered

individuals. Many managed care plans offer financial incentives to clinicians who minimize referrals and diagnostic tests, and some even apply financial penalties, or disincentives, for clinicians who are considered to have ordered unnecessary care (Merrick et al., 2006).

Structural characteristics refer to specific strategies that result in lower costs. These include authorizing certain types of treatment, while other care is not reimbursed, and the amount of treatment is usually limited (Cohen et al., 2006), lowering rates of reimbursement (Mechanic, 2004; Hudson, 2008), limiting or reducing length of hospital stays (Mechanic, 2004; Hudson, 2008), which can result in larger outpatient caseloads (Cohen, 2003; Egan & Kadushin, 2007; Feldman, 2001; Keefe & Hall, 1998; Lu et al., 2002; Mechanic, 2007; Shera, 1996; Stone, 1995; Sanchez & Turner, 2003; Tyler & Cushway, 1998), limiting the number of outpatient sessions (Sanchez & Turner, 2003), being more careful about using expensive diagnostic tools (Mechanic, 2004; Hudson, 2008), minimizing specialist referrals while not preventing access to hospital admission or general medical care (Mechanic, 2004; Hudson, 2008), enforcing a fixed monthly capitation payment for each client (Willging et al., 2008), encouraging clinicians to prescribe less expensive medications (Sparer, 2003), and substituting less trained providers (for example, social workers instead of psychologists; Cohen, 2003; Egan & Kadushin, 2007; Feldman, 2001; Keefe & Hall, 1998; Lu et al., 2002; Mechanic, 2007; Shera, 1996; Stone, 1995; Sanchez & Turner, 2003; Tyler & Cushway, 1998).

Using information on normative influences is another cost containment strategy. This includes practice profiling (Sanchez & Turner, 2003), or providing services to less costly clients rather than to those who require intensive and long term services (Cohen, 2003; Egan & Kadushin, 2007; Feldman, 2001; Keefe & Hall, 1998; Lu et al., 2002; Mechanic, 2007; Shera,

1996; Stone, 1995; Tyler & Cushway, 1998), and patient and provider risk sharing (Sanchez & Turner, 2003).

Rationale. In the context of an economic crisis and the skyrocketing costs of health care and mental health treatment, it is easy to see how a more cost effective health insurance system would benefit all Americans. Managed care has been the current solution to this problem. Unfortunately, as managed care currently functions in mental health treatment, it also creates blocks to what clinicians would see as best treatment for their clients. Because mental health professionals intend to have their clients' best interests in mind, treatment becomes a tension between what clinicians believe is best treatment and what managed care companies will allow.

There is research documenting how mental health professionals feel about working in a managed care system (Boyle & Callahan, 1995; McClure et al., 2005, Borenstein, 1996, Alperin, 1997, Lawless et al., 1999, Seligman & Levant, 1998, & Smith, 1999); however, there is little research looking at how clinicians have to alter their treatment for the purposes of managed care (Berliner & New, 1999 & Morgan & Holstein, 1992), and even less regarding the frequency that clinicians falsify diagnoses for the purposes of managed care. There was considerable research concerning how managed care impacted the profession in the 1980s and 1990s (Ackley, 1997; Alexander & Lemak, 1997; Alexander & Lemak, 1997b; Alperin, 1997; Applebaum, 1993; Arches, 1997; Austad et al., 1992; Bartlett, 1994; Beinecke et al., 1998; Berkman, 1996; Berliner & New, 1999; Birne-Stone, Cypress, & Winderbaum, 1997; Blumenthal, 1996; Borenstein, 1990; Borenstein, 1996; Boyle & Callahan, 1995; Broskowski, 1991; Burns et al., 1999; Callahan et al., 1995; Carleton, 1998; Chambliss, Pinto, & McGuigan, 1997; Comarow, 1999; Corcoran & Vandiver, 1996; Edinburg & Cottler, 1995; Elias & Navon, 1998; Emanuel & Dubler, 1995; England & Vaccaro, 1991; English & Freundlich, 1997; Etheridge, Craddock, &

Duteman, 1995; Farley, 1994; Fieldler & Wright, 1989; Findlay, 1999; Fox, 1995; Frank & Brookmeyer, 1995; Frank, & McGuire, 1997; Freeman, Rathore, & Weinfurt, 1999; French et al., 1996; Galanter et al., 1999; Gawande et al., 1998; Geller, 1998; Gold & Shapiro, 1995; Harbin, 1994; Hennessy & Green-Hennessy, 1997; Hodgkin, 1992; Hojat, et al., 1999; Holmes, 1997; Howard, 1998; Jellinek & Nurcombe, 1993; Jones & Vischi, 1979; Karon, 1995; Keefe & Hall, 1998; Kremer & Gesten, 1998; Leigh, et al., 1999; Lindey & Paul, 1989; Lurie, 1992; Ma & McGuire, 1998; McKusik, Mark, & King, 1998; Mechanic, 1999; Mechanic et al., 1995; Motenko, et al., 1995; Murphey, DeBernardo, & Shoemaker, 1998; Onyett & Pillinger, 1997; Oss, 1996; Perloff, 1998; Phelps, Eisman, & Kohout, 1998; Rivers, 1998; Rosenberg, 1998; Rothbaum, et al., 1998; Schlesinger, et al., 1983; Seligman & Levant, 1998; Shera, 1996; Smith, 1999; Storm-Gottfried, 1997; Stone, 1995; Stroul et al., 1988; Sturn, 1999; Veloski, 1996; Vernon, 1998; Wells et al., 1995; Wernet, 1999). Current research relies heavily on these early studies.

Scope of Impact. Managed care affects many Americans. Financially, managed care impacts taxpayers, consumers of managed care, employees of insurance companies and third party payers, employers, organizations, and treatment providers. From a safety perspective, managed care provides coverage for health and mental health treatment for many who could not afford it without insurance. This affects society as a whole. Mental health professionals are influenced from both the financial and safety perspective.

For professional psychologists, managed care has affected many aspects, including training, professional practice, continuing education, state psychological affairs, national stances taken by the American Psychological Association (APA; Bobbitt, 2006), and delivery of services by psychologists (Cantor & Fuentes, 2008; Rupert & Baird, 2004). Carleton (1998) found that

for graduate programs, 33% defined themselves as cognitive-behavioral, 33% as eclectic, and only 9% as psychodynamic, and they concluded these results indicate a shift towards theoretical perspectives consistent with managed care. Another study found that almost 60% of graduate programs offered some training in managed care, and doctoral programs were significantly more likely to offer training in managed care compared with master's programs (Daniels, Alva, & Olivares, 2002). There is concern that managed care will drastically reduce the ability for psychologists to do assessments because of the expense involved (Cantor & Fuentes, 2008).

Paradigm shift. The emergence of managed care as the dominant form of health care delivery has created a dramatic shift in the way mental health professionals work with clients with mental illness (Hall & Keefe, 2000; Storm-Gottfried, 1997). Rosenberg and DeMasse (2008) believe that managed care has changed the way mental health providers practice and think. This new paradigm focuses on short-term services, limited access to necessary but costly services, reduced resources, increased accountability, strict practice guidelines, reduced autonomy, and subsequent new management skills (Cohen, 2003; Egan & Kadushin, 2007; Feldman, 1997; Feldman, 2001; Hall & Keefe, 2000; Keefe & Hall, 1998; Koeske & Koeske, 1993; Lu et al., 2002; Scheid, 2000; Shera, 1996; Stone, 1995; Tyler & Cushway, 1998).

There is some concern that managed care changes the terms under which therapy is practiced, as well as the fundamental activities, practices, and social relations that constitute therapy (Cohen et al., 2006). Cushman and Guilford (2000) argue that managed care reconfigures both therapy clients' and therapists' identities. They argue that clients become "complacent recipients of expert knowledge and technique" (p. 987), and therapists become an "impersonal... dispenser of a predetermined set of technical maneuvers" (p. 989). Gold and Shapiro (1995) worry that managed care may undermine what therapists believe constitutes

effective clinical practice. Donald (2001) referred to managed care as the “Walmart-ing” of psychotherapy. Furthermore, Ware et al. (2001) found that therapists believed that conforming to managed care’s policies would be violating their philosophy regarding good clinical practice.

Ethics. A growing body of research indicates that managed care is having a negative impact on mental health workers’ professions, especially due to a conflict of interest and ethical dilemmas (Daniels, 2001; Feldman, 1997; Hall & Keefe, 2000). Specifically, clinicians struggle to provide treatment they believe most appropriate and effective, yet they are forced to provide services that are the most cost effective (Daniels, 2001). Additionally, the use of deception (Freeman et al., 1999; Rosenberg & DeMasso, 2008) or alternate diagnostic strategies (Rushton, Felt, & Roberts, 2002) to get authorization for services has been documented. Furthermore, communicating private information to insurance companies raises the question of confidentiality (Chambliss et al., 1997; Cohen et al., 2006). However, the question of best practice, as viewed through a cost effectiveness lens by managed care companies, may differ largely from best practice as perceived by the clinician.

Conceptual Framework

History. Managed care began as a series of alternative healthcare arrangements in various communities across the United States as early as the nineteenth century (Mechanic, 2004; Tufts Managed Health Care Institute, 1998). The goal was to meet the healthcare needs of select groups of people, such as rural residents and employees in the lumber, mining, and railroad industries. A health care clinic that offered a wide range of medical services was developed in Tacoma, Washington in the 1910s, where prepaid physician services were arranged for the lumber industry (Cantor & Fuentes, 2008; Managed Care-INFO, 2009). In these early models, enrollees paid a set fee to physicians, who then delivered services under the agreed

terms (Tufts Managed Health Care Institute, 1998). In urban areas, generous societies often paid these groups to provide care to their members (Tufts Managed Health Care Institute, 1998).

Political and market forces caused the evolution of commercial health insurance. By the 1930s, there were two emerging approaches to health insurance: the fee-for-service model (indemnity) and the managed care model (Sanchez & Turner, 2003; Managed Care-INFO, 2009). The first managed care plans in the 1930s were prepaid group practices. In 1929, Dr. Michael Shadid started a rural farmers' cooperative health plan in Elk City, Oklahoma (Tufts Managed Health Care Institute, 1998). Although he met with significant opposition from other physicians, with help from the Oklahoma Farmers' Union, he succeeded in enrolling several hundred families who paid a predetermined fee, and Dr. Shadid rendered his patient care. Also in 1929, the Los Angeles Department of Water and Power contracted with Dr. Donald Ross and Dr. H. Clifford Loos at the Ross-Loos clinic to provide comprehensive services for approximately 2,000 workers and their families (Tufts Managed Health Care Institute, 1998). Within five years, they enrolled 12,000 workers plus 25,000 dependents, at a cost of \$2.69 per subscriber per month.

In 1933, also in LA, Dr. Sidney Garfield and other physicians were providing medical care on a prepaid basis for 5,000 workers on an aqueduct construction project (Mechanic, 2004; Tufts Managed Health Care Institute, 1998). The men contributed five cents out of their wages for medical services, while the workmen's compensation insurance companies paid Garfield a percentage of their premium income to take care of accident cases. In 1938, Dr. Garfield did the same for workers at the Grand Coulee Dam for Henry J. Kaiser (Mechanic, 2004). Impressed with Dr. Garfield's program, Henry Kaiser, whose name became synonymous with prepaid healthcare, set up two medical programs, known as The Kaiser Foundation Health Plan (Corcoran et al., 2008; Managed Care-INFO, 2009), on the West Coast to provide

comprehensive health services to workers in his shipyards and steel mills during World War II (Glasser, 2010; Managed Care-INFO, 2009; Mechanic, 2004; Tufts Managed Health Care Institute, 1998). At the same time, for the purposes of curbing high hospital and medical costs, the Group Health Association (GHA) formed in Washington, D.C. (Managed Care-INFO, 2009), the Group Health Cooperative in Puget Sound, and the Health Insurance Plan in New York (Corcoran et al., 2008). Believing that he could reorganize medical care to provide millions of Americans with prepaid and comprehensive services at prices they could afford, Kaiser opened his plans to the public when the war ended (Corcoran et al., 2008). Ten years after the war, there were nearly a half million people enrolled in the plan, as well as a growing network of hospitals and clinics (Tufts Managed Health Care Institute, 1998).

Beginning around the 1940s and continuing through the late 1960s, independent prepaid group practices were emerging (Managed Care-INFO, 2009), many of which were considered group health cooperatives, and they became precursors to the modern HMO (Tufts Managed Health Care Institute, 1998). In 1937, employees of the Federal Home Loan Bank organized Group Health Association in Washington, DC as a nonprofit cooperative. Members of the Grange, the Aero-Mechanics Union, and local supply and food cooperatives established Group Health Cooperative of Puget Sound in Seattle, Washington at the end of the war. With the support of Mayor Fiorello, La Guardia, The Health Insurance Plan (HIP) of Greater New York was launched in 1947 to provide care to city employees after a study found that the major source of their financial distress was debt caused by illness, and later extended to other cities (Mechanic, 2004).

These early prepaid group practice plans, or medical service plans, differed in their corporate structures (Tufts Managed Health Care Institute, 1998). While the enrolled members,

who elected trustees, owned Group Health Cooperative, the Kaiser family and its company executives held the power, and subscribers had no governing role. Furthermore, at HIP, a self-perpetuating board with representatives from business, labor, medicine, and government made the decisions. However, they all shared a commitment to comprehensive and coordinated health care, including a major emphasis on preventive care, outpatient care, well-child care services, immunizations, and other services not covered by other insurance (Tufts Managed Health Care Institute, 1998). Even though their premiums were as expensive or more expensive than other insurance, their coverage and benefits were superior. In group practice plans, there were relatively few exclusions, limits, or copayments for members, and especially if they were affiliated with hospitals, they could create incentives for physicians that reinforced cost-effective and high quality care (Tufts Managed Health Care Institute, 1998). Prepaid group practice plans were quite successful at attracting members, causing physicians to become concerned about their own patient base. In 1954, due to the competition with Kaiser, the San Joaquin County Medical Society in California formed the San Joaquin Medical Foundation (Tufts Managed Health Care Institute, 1998). The foundation paid the affiliated independent physicians and hospitals according to a value-based fee schedule with capitation payments from its subscribers. Additionally, it heard grievances against physicians, developed peer review procedures, and monitored quality of care (Tufts Managed Health Care Institute, 1998), and it is considered the earliest example of an independent practice association (IPA) model prepaid health plan.

In the early phases of managed care's development, the American Medical Association (AMA) strongly opposed the prepaid cooperative plans and any form of lay control (i.e., non-physician control) over medical professionals and rejected anything resembling the corporate practice of medicine (Corcoran et al., 2008; Glasser, 2010; Tufts Managed Health Care

Institute, 1998). Furthermore, the AMA considered prepaid plans that were controlled by physicians' unethical practice. During the 1930s and 1940s, the AMA did what it could to suppress the growth of prepaid plans and cooperatives by expelling participating physicians from local medical societies, persuading hospitals to deny them admitting privileges, and preventing them from obtaining consultations and referrals (Glasser, 2010; Tufts Managed Health Care Institute, 1998). As a result, the AMA was convicted of violating the Sherman Antitrust Act (Corcoran et al., 2008; Glasser, 2010), which opposes the combination of entities that could potentially harm competition. In 1947, the Supreme Court rejected the AMA's claims that medicine was a profession, not a trade, to which antitrust laws did not apply. Nevertheless, the AMA's campaigns largely succeeded. The AMA's lobbying efforts resulted in numerous state laws that required plans to allow members free choice of physician, granted authority to state medical societies to approve or deny new plans, barred consumer run medical service plans, or otherwise limited prepayment plans (Tufts Managed Health Care Institute, 1998). As a result, prepayment plans were a small presence in healthcare by the 1950s, and the AMA changed its position from opposition of prepaid group practice to "watchful coexistence (Glasser, 2010, p. 54)." In 1960, the AMA dropped the ban against prepaid group medical plans (Glasser, 2010), and the first health maintenance organizations (HMOs) became established in the United States. This became the model for future managed care insurance plans.

Prepaid health care was not overly popular until the 1970s (Glasser, 2010). By the 1970s, health care costs continued to inflate and were perceived as a national problem with few solutions (Corcoran et al., 2008; Glasser, 2010; Mechanic, 2004), and the United States government began to study alternative ways of delivering health care at a lower cost. Some specialty areas in the fee-for-service models were especially high cost, including radiology,

obstetrics/gynecology, behavioral health, pharmacy, and vision (Glasser, 2010). Research from 1950 to 1970 showed that prepaid practices of managed care companies performed as well, if not better, than fee-for-service practices, and at the same time provided care at a lower cost (Mechanic, 2004). Improved patient outcomes were even seen in some populations, including poor pregnant women and the elderly (Mechanic, 2004). Politicians and a range of interest groups promoted various proposals for reforming the nation's healthcare system, taking into consideration issues of cost containment, coverage for the uninsured, access to services for the poor and minorities, consumer rights, and efficient delivery systems (Tufts Managed Health Care Institute, 1998).

The term “Health Maintenance Organization” was coined by Paul Elwood (Cantor & Fuentes, 2008). The Health Maintenance Organization Act (HMO) was passed by Congress and signed into law by Richard Nixon in 1973 to provide specific grants to support the development of HMOs and attempt to set health care standards throughout the industry (Cantor & Fuentes, 2008; Corcoran et al., 2008; Glasser, 2010; Managed Care-INFO, 2009; Sanchez & Turner, 2003). The goals were to improve the quality and decrease the cost of health care and make it more affordable (Glasser, 2010), while allowing Federal funds to be used to promote HMOs (Cantor & Fuentes, 2008; Sanchez & Turner, 2003). What was previously known as prepaid group practices became known as health maintenance organizations. While the majority of people have unfavorable views of HMOs, most people who are enrolled in managed care plans actually report reasonable levels of satisfaction (Mechanic, 2004).

Furthermore, the Employee Retirement Income Security Act (ERISA) was passed (Corcoran et al., 2008; Managed Care-INFO, 2009). It offered financial incentives to employers to carry health insurance and promoted rapid growth in the self-insurance industry, systems

where employees pay a flat rate into a private pool managed by the employer and receive money to cover medical costs (Sanchez & Turner, 2003). Administrative Services Organizations (ASOs) rapidly increased because self-insurance companies had to process claims and provide administrative services (Managed Care-INFO, 2009).

Health care inflation exceeded all other types of inflation, and by 1977, it was nearly double the Consumer Price Index (Managed Care-INFO, 2009). Again, employers began to look at ways to stop this inflation and moved towards reducing fee-for-services. HMOs increased in number from 30 in 1970, to 1,700 by 1976 (Tufts Managed Health Care Institute, 1998, Glasser, 2010). By 1980, managed care programs were well established, becoming a staple in the health care business (Tufts Managed Health Care Institute, 1998, Glasser, 2010) and enrolling 40 million people (90% of the population) (Glasser, 2010). The Federal government began to recognize HMOs as cost containment entitlement programs and started to set up Medicaid and Medicare HMOs. HMOs were starting to be known as profit making companies in the mid-1980s, and in 1984, HMOs went public (Managed Care-INFO, 2009). The HMO industry grew to over one million members, with gross revenues reaching over one billion dollars (Managed Care-INFO, 2009). As the cost of providing services has increased and consumers have demanded more choice in choosing providers, managed care organizations now offer more products and have larger networks of clinicians (Bobbitt, 2006).

HMOs attempted to reduce health care costs by reducing the use and length of stay associated with mental health treatment (Glasser, 2010). Specialized companies, known as carve-outs, emerged to improve the quality of treatment and reduce the cost of care for the then poorly managed, high cost, and high volume areas of health care (pharmacy, vision, mental health, radiology; Glasser, 2010; Merrick & Reif, 2010; Sanchez & Turner, 2003). Mental

health care costs doubled compared with health care from 1980 to 1995 (American Psychological Association, 1992; Sanchez & Turner, 2003), due in part to the introduction of psychotropic medication and costly assessment procedures (Cummings, 1995; Hayes et al., 1999; Sanchez & Turner, 2003; Strosahl, 1994). In a carve-out plan, mental health and substance abuse services and benefits are managed separately from general medical benefits and have separate budgets and administrative and provider networks (Corcoran et al., 2008; Sanchez & Turner, 2003). The mental health carve-outs were managed by mental health professionals, and there was significant concern regarding the lack of standards and oversight in terms of the way they denied care (Glasser, 2010).

The American Psychiatric Association confronted this ethical issue, highlighting concerns that practitioners could not use the most recent clinical parameters and financial incentives were given to not refer patients to specialists. This led to the creation of accreditation agencies in the 1990s that could monitor quality and care within managed care organizations (Glasser, 2010; Merrick & Reif, 2010). The first of these agencies was the National Committee for Quality Assurance (NCQA). Originally, NCQA did not represent mental health services. In the mid 1990s, NCQA initiated a specialized set of standards known as the Managed Behavioral Health Organization Standards (Glasser, 2010). NCQA is responsible for establishing an appeals process for any decision made by managed care organizations, and it has been a pioneer in the industry for increasing the quality of care (Merrick & Reif, 2010), yet there is still concern that the emphasis is on evidence-based practice more than on the quality of care (McFarland, 2001; Scheid, 2003)

Table 2

Historical trends in managed care history

Time Period	Trends
19 th Century	<ul style="list-style-type: none"> • Early evidence of managed care • Particularly for employees in the lumber, mining, and railroad industries
1910s	<ul style="list-style-type: none"> • Tacoma, Washington health care clinic • Prepaid physician services were arranged, employees paid a set fee to physicians
1930s	<ul style="list-style-type: none"> • Evolution of commercial health insurance • Two models emerged: fee-for-service (indemnity) model and managed care • First managed care plans were prepaid group practices • Kaiser opened his plans to the public after WWII
1940s-1960s	<ul style="list-style-type: none"> • Independent prepaid group practices were emerging • Precursors to the modern HMO • Early plans differed in their corporate structures • All committed to comprehensive and coordinated health care (preventative care, outpatient services, well-child visits, immunizations) • Relatively few exclusions or copayments • Development of capitation payments, physician grievances, peer review procedures, monitoring of quality of care • AMA strongly opposed prepaid plans and corporate practice of medicine, succeeded in reducing number of prepaid plans
1970s	<ul style="list-style-type: none"> • Growth of prepaid health care • Health care cost inflation seen as national problem with few solutions • Managed care companies found to perform as well and at a lower cost than fee-for-service models • HMO Act passed in 1973 – goal was to improve the quality and decrease the cost of health care • Prepaid group practices became known as HMOs
1980s	<ul style="list-style-type: none"> • HMOs well established, staple in the health care business • Federal government set up entitlement programs (Medicaid, Medicare) • 1984 – HMOs went public • Carve-outs emerged to improve the quality of treatment and reduce costs for specialty services • Mental health care costs doubled compared with health care • Concerns regarding lack of standards and oversight in terms of the way care was denied
1990s	<ul style="list-style-type: none"> • Accreditation agencies emerged to monitor quality of care

- Did not have mental health standards until mid-1990s
- Development of PPOs

Note. HMO = Health Maintenance Organization; AMA = American Medical Association; PPO = Preferred Provider Organization

Insurers started to develop new insurance products called Preferred Provider Organizations (PPOs). They became possible after 1982, when California first enacted legislation allowing for selective contracts with Medicaid and private insurance, and then other states followed (Cantor & Fuentes, 2008). The PPO offered greater choice for consumers than the HMO, and it was promoted as an alternative to the traditional HMO, reimbursing providers on a discounted fee-for-service basis, allowing for cost containment. PPO enrollment reached over one million by 1985 and added to the success of the managed care industry. The employers became the sponsor, instead of the licensed insurance company, leading to the sudden increase of the PPO. Many HMOs suffered heavy financial losses and mergers began (Managed Care-INFO, 2009). With the growth of PPOs and the merging of HMOs, the insurance industry assumed a leadership role in managed care.

Summary. Managed care has evolved to provide quality services, contain health care costs, and monitor treatment allotted. Its growth has been due partially to the lack of alternative solutions. Table 2 summarizes the historical trends discussed above.

Current trends. Managed care is currently the predominant method of financing mental health care in the United States (Holmes, 1997), and the majority of Americans with health insurance belong to a managed care plan (Managed Care-INFO, 2009; Sanchez & Turner, 2003), yet healthcare premiums have still increased over 80% since 2000 (Feinberg, 2007). Since the 1980s, the managed care industry has enrolled millions of individuals and experienced high percentages of growth (Managed Care-INFO, 2009). The average premium for mental health and substance abuse benefits increased by almost 100% from 1997 to 1992 (Sanchez & Turner,

2003; Strosahl, 1994). Saturation of HMOs and PPOs has started to occur, and new products are being introduced to allow companies to remain competitive. Fee-for-service coverage decreased from 90% of those covered in 1970 to 60% of those covered in 1992, and by 1995, 80% of insured individuals were covered by some form of managed care (Glasser, 2010). Between 1970 and 1990, there was also an increasing awareness of the importance of mental health and substance abuse problems, and many private and public insurances now cover these services (Mechanic, 2004). In the 1990s, managed care still seemed new and controversial (Merrick & Reif, 2010), yet by the late 1990s, 75% of Americans with health insurance were enrolled in managed care plans (Kiesler, 2000) and 84% of psychologists in private practice reported that they were members of HMOs or PPOs (Murphey et al., 1998). A 2006 study found that mental health benefits offered on the same basis as medical benefits did not increase total insurance costs (Feinberg, 2006).

In the last ten years, managed care organizations have consolidated and reduced the number of mental health carve-outs and attracted more members (Glasser, 2010). At this time, approximately 95% of privately insured individuals are in a managed care plan (Gabel et al., 2005), nearly 30% of the general public is enrolled in HMOs, 50% in PPOs and Point of Service (POS) plans, and only about 20% in indemnity plans (Managed Care-INFO, 2009). As of 2006, there were approximately 67.7 million Americans enrolled in HMOs and 108 million in PPOs (Cantor & Fuentes, 2008). Approximately 70% of practicing psychiatrists participate in some form of managed care organization (Glasser, 2010). However, public confidence in managed care has decreased over time. From 1997 to 2000, public confidence fell from 51% to 29% (Mechanic, 2004). Glasser (2010) argues that many of the early obstacles affecting managed

care have been worked out, creating a system that embraces the best of both early HMO designs and fee-for-service plans.

Private versus public funding. Managed health care and behavioral health care is funded privately and publically (Kane, Hamlin, & Hawkins, 2000; Motenko et al., 1995; Oss, 1996; Perloff, 1998; Rosenberg, 1998; Vernon, 1998). State mental hospitals were funded by state governments to house and care for mentally ill individuals. Other individuals paid out-of-pocket for treatment. This combination of public and private funding continued until the period following World War II (Holmes, 1997). Initially, the public sector (Medicare and Medicaid) lagged behind the private sector in adopting managed care, but it is now prevalent in almost all states (Merrick & Reif, 2010). Almost all behavioral health care in both the private and public sector is managed by large, private, and for-profit organizations (Acker & Lawrence, 2009). More than two-thirds of the population have private insurance, and over 90% of them have some coverage for behavioral health services, yet private insurance pays for only 24% of mental health expenses (Mark et al., 2007).

General health care versus behavioral health care. The entry of managed care into behavioral health lagged behind primary care by approximately ten years (Isett et al., 2009). Mental health care is particularly affected by managed care (Rosenberg and DeMasso, 2008). Specifically, there are factors affecting the use of clinicians rather than physicians, the stigma associated with mental illness and the characteristics of some mental illnesses, which affect patients' ability to advocate for themselves, and the criteria used to review cases is less clear or predictable than other disciplines. Schlesinger, Wynia, and Cummins (2000) found that psychiatrists are more than twice as likely as other medical specialists or primary care physicians to report intensive prior authorization requirements and three times as likely to get denied.

Psychiatrists report more concern than other physicians regarding making the best decisions for their patients without the possibility of reducing their income (Stern & Ringel, 2003).

Parity. Mental health advocates struggle with the fact that there is a relative lack of proof of the effectiveness of mental health treatments (Wells & Brooks, 1989). There is little consensus about the etiology of mental illness, the appropriate treatments, or the effectiveness of various treatment alternatives (Cook & Wright, 1995; Mechanic, 1999; Scheid, 2003). It is often thought that the severe and persistently mentally ill are not treatable, while treatment for the “worried well” is discretionary. Furthermore, mental health treatment in general is thought to be lengthy and expensive. These arguments are somewhat overstated, yet with the lack of convincing research on mental health treatment, it is difficult to distinguish established interventions from the latest fad. Mental health advocates disagree among themselves regarding the most effective treatments. Some areas of conflict include psychotherapy as compared to medically oriented services, the appropriateness of involuntary or other hospitalization, and the effectiveness of family-based or group interventions.

Biases and misconceptions surrounding mental illness and its treatment persist. Unlike those with a physical illness, it is thought that individuals with mental illness are often perceived to be the cause of their own problems and should be, therefore, less entitled to generous benefits. Additionally, many believe individuals with a mental illness are predominantly severely and persistently ill, while in actuality, many suffer only infrequent and mild episodes. Furthermore, individuals who use outpatient mental health services typically use fewer than ten visits a year (Boyle & Callahan, 1995). Because mental illness is often seen as a dichotomy between mind and body, it is easy to minimize the physical suffering and disability associated with it (Kender et al., 1993). Even within the mental health field, some try to distinguish biological from non-

biological mental disorders, giving priority to biological mental disorders in hopes of gaining access to better medical benefits.

Historically, behavioral health services have been neglected compared with general health care. They have not received the same public or corporate support as physical health services (Bobbitt, 2006; Grob, 1991); therefore, private and public funding often limits behavioral health coverage and provides fewer benefits than those allowed for physical illnesses of the same scope and intensity. Traditional insurance plans and HMOs have restricted mental health services more stringently than medical care benefits by setting limits on numbers of hospital days or outpatient visits or by imposing annual or lifetime dollar caps. While measures of quality have improved significantly in the medical field, there have been only modest improvements in behavioral health quality measures (Bobbitt, 2006).

In 1996, Congress passed legislation requiring managed care organizations to provide equivalent coverage for behavioral health treatment as they do for other forms of care (Corcoran et al., 2008; U.S. General Accounting Office, 2000). This became possible because with the containment of other health care costs, there was space to expand for behavioral health benefits. The Mental Health Parity Act was implemented in 1997 (Merrick & Reif, 2010). It prohibited private health plans from using dollar limits that were lower for mental health care than for general medical care. However, it did not require equal visit limits, day limits, or cost sharing, and it did not apply to substance abuse. According to the Bureau of Labor Statistics (2007), in 2005, 90% of individuals with private insurance had different coverage for behavioral health services than for general medical care. Then, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 was passed (Merrick & Reif, 2010). It ensured that companies with 50 or more employees provide equal coverage for mental health and

substance abuse as they do for general medical care in terms of limits, cost-sharing, and other features. Unfortunately, inequities have not disappeared, and many employers are exempt from state parity requirements.

Managed care and behavioral health. Managed behavioral health care encompasses managed mental health and substance abuse services (Merrick & Reif, 2010). If psychotherapists want access to clients who subscribe to managed care policies, they would have to become providers for the managed care organizations (Walfish & Barnett, 2009). Managed care techniques have been applied to mental health care because of the unprecedented, and often unwarranted, expansion of mental health services in the 1980s. During this time, there was large growth in profit-making programs, such as drug and alcohol abuse treatment centers and adolescent psychiatric programs. It was suspected that there was misuse and abuse of intensive mental health treatments, especially for children and adolescents (Jellinek & Nurcombe, 1993). Furthermore, many believed that most outpatient psychiatric services were for the self-indulgent “worried well” (Jellinek & Nurcombe, 1993, p.1737).

Impact. Managed care was introduced to better manage the quality and cost of care and to curb the perceived misuse of behavioral health services. Additionally, it reduced the scope of services, for example, by limiting treatment for substance abuse and inpatient acute care in general, as well as limiting long-term inpatient care when there seemed to be little benefit for the patient (Harbin, 1994). It also limited funds for psychological testing, causing clinicians to have difficulty purchasing the most recent testing materials and increasing the likeliness of ethical violations (Cantor & Fuentes, 2008). Likewise, there is disagreement surrounding managed care and its effects on the access to behavioral health treatment, quality of services, the patient-provider relationship, attitudes of providers, burnout, the fairness of reimbursable benefits,

clinician responsibility and liability, special populations, needed adaptations, substance abuse treatment, and ethical concerns (Wells & Brooks, 1989).

Chapter 2: Literature Discussion

Access

Some studies indicate that managed care can improve access to mental health services (Burns et al., 1999; Hutchinson & Foster, 2003), while others found reduced access (Mandell, Boothroyd, & Stiles, 2003) or no change (Mitchell & Gaskin, 2004). Managed care might offer increased access to services for those with more chronic symptoms who would be unable to afford services without insurance, but not for those seeking more elective enhancement. For many populations, managed care might offer increased access to treatment in a timely and appropriate manner, in contrast to the financially restrictive fee-for-service system. However, these services may still seem underused because many individuals with mental illness do not seek treatment (Bartlett, 1994). The U.S. General Accounting Office (1993) found that there was equal or improved access with managed care, while Lu et al. (2008) found that managed care does not increase access as much as one would expect. In general, carve-outs most often preserve access to services while reducing the intensity of care (Merrick & Reif, 2010).

Other evidence indicates reduced access to treatment. Because reimbursement rates influence the participation of providers, it is likely that an insufficient supply of mental health providers, such as psychiatrists, psychologists, and social workers, contributes to reduced access to care (Tang et al., 2008). There is concern that managed care limits access to care and results in lower levels of care (Scheid, 2003). Fried et al. (2000) found that providers in managed care felt their clients had less access to long-term services. Therefore, access to treatment under the managed care system is likely to vary for different care systems, vendors, benefits, and populations.

There is concern that managed care reduces access to some services, including psychological testing, the number of therapy sessions, long-term treatments, and safety net institutions. Camara, Nathan, and Puente (2000) found that only 40% of psychologists had conducted testing under managed care, and moreover, managed care had negatively impacted the number of testing referrals and fees for testing. Borenstein (1996) expressed concern about how managed care could impact mental health services, particularly by limiting the amount of sessions. Seligman and Levant (1998) expressed concern that managed care's insistence on restricting the number of sessions and the use of less well-trained providers threatens the effectiveness of psychotherapy. One study found that the median number of sessions needed to produce significant change was 11, but clients with higher levels of distress needed as many as eight more sessions (Anderson & Lambert, 2001). Furthermore, Novey (2002) confirmed that therapy lasting more than six months was 40% more effective than that lasting for less than six months. One study found that clinicians working under managed care contracts reported seeing clients for significantly fewer sessions (Gold and Shapiro, 1995). Armbruster et al. (2004) found in one study that children in managed care settings were seen for fewer sessions, but there was no difference in clinical outcomes, suggesting that more sessions are not necessarily better.

Some research has found that the number of outpatient visits initially authorized correlated with total utilization and termination at the time of reauthorization (Howard, 1998; Liu et al., 2000). Another study found that clients frequently had to discontinue treatment early due to managed care limitations (Chamblis et al., 1997). Similarly, 46% of mental health counselors reported that under managed care, they would have to terminate clients before they were ready (Danzinger & Welfel, 2001).

Despite statistics that most clients end therapy within eight sessions, managed care guidelines pressure clinicians to keep therapy short (Garfield, 1978; Shilkret, 2008). There is concern that managed care policies might lead to the end of some treatment modalities and therapeutic orientations, such as psychoanalytic and long-term therapy (Alperin, 1997; Pyles, 2003). Some clients, such as those with more significant impairments, early trauma, and character pathology, can only make progress in therapy slowly (Shilkret, 2008). Shilkret discusses one case study of a man with early trauma who was in therapy for ten years and remarked that he cancelled more sessions than any other client throughout 30 years of practice. With managed care, this man's cancelled sessions would result in the clinician not receiving payment, and treatment likely would not have continued for such a long duration given the financial constraints of most clinicians. Some argue that psychoanalytic or psychodynamic treatment modalities can be adapted for brief treatment (Curtis & Silberschatz, 1986; Gardner, 1991; Safran, 2002; Silberschatz & Curtis, 1986). Pyles argues that psychoanalysis is getting washed away by managed care, and he states, "Unfortunately, what is useful clinically does not always translate into what is needed to deal with rapid and profound social and political change (pp. 27)." He argues that before the growth of managed care, analysts had full patient case loads and an endless number of individuals who wanted to be trained, and psychoanalytic ideas were a large part of the culture.

Pyles (2003) believed that managed care has impinged on psychoanalytic treatment for several reasons. Managed care organizations will not pay for treatment that is not clearly defined as an illness. Beginning in the 1970s, APA developed diagnostic criteria with specific behavioral guidelines, changing the goal from treating a person to treating a diagnosis. Rupert and Baird (2004) found that the clinicians who had high involvement with managed care worked

more hours per week, provided extra therapy hours, engaged in less supervision, and were more likely to have a cognitive-behavioral orientation and less likely to have a psychodynamic orientation compared with those who had little involvement with managed care.

Seligman and Levant (1998) stated that managed care policies rely on inadequate science. Specifically, they state that research on the effectiveness of manualized short-term treatments shows a 65% success rate and no difference based on the level of the therapist's education. It is less easy to measure effectiveness of treatment as it is actually practiced in the field, yet preliminary studies indicated a 90% success rate from non-manualized treatments with better results from Doctoral level therapists as compared to Master's level therapists. Managed mental health care has relied on what is thought to be more efficacious treatments, specifically treatments with observable goals, often using manuals and protocols, to assure quality (Corcoran et al., 2008).

Safety net institutions are organizations that provide services, such as public and non-profit hospitals and community mental health centers, to low-income populations at little to no cost who might not otherwise have access to care (Waitzkin et al., 2002). They rely heavily on public and private funding and are greatly dependent on public insurance programs (Cunningham, McKenzie, & Taylor, 2006; Ormond et al., 2000; Willging et al., 2008). The growth of managed care has created new administrative requirements, lowered reimbursement rates, and greatly restricted the delivery of care for safety net institutions (Felland et al., 2003; Horton et al., 2001; Sparer & Brown, 2000). One study found that managed care models might compromise rural mental health safety nets (Willging et al., 2008).

Quality of Care

Quality of care should not be mistaken for quantity of care. More services do not necessarily mean better outcomes. Some argue that more services may actually increase the potential for undesirable medical, psychological, and social consequences (Boyle & Callahan, 1995; Callahan et al., 1995; Mechanic & McAlpine, 1999). Therefore, some individuals feel that lower intensity or quantity might mean better quality. Callahan et al. (1995) found that Massachusetts succeeded in lowering costs by about 20% without lowering quality in 1992 after they developed the first mental health and substance abuse carve-out. According to Mechanic and McAlpine (1999), managed care has succeeded in reducing Medicare costs without affecting the quality of care. Lu et al. (2008) found that managed care itself decreases rates of mental health treatment.

Critics of managed care assert that containing or cutting costs of mental health care will adversely affect the quality of care (Merrick et al., 2006; Scheid, 2003). Pyles (2003) argues that under managed care, there is no limit to how low the quality of care will go in the interest of cutting costs and maximizing profits. This could happen because managed care uses less costly providers and treatments and a lower intensity or quantity of services (Boyle & Callahan, 1995). The quality of care could also be harmed by the use of non-psychologically educated mental health gatekeepers who may be unaware of, insufficiently trained in, or unconcerned about the effect of their decisions on the treatment quality (Boyle & Callahan, 1995). Furthermore, there is concern that the heavy reliance on outcome data and practice guidelines supported by managed care has not been sufficiently established to demonstrate improved quality of treatment (McCarthy et al., 1993). Research has raised concerns regarding quality of care, specifically citing increased readmission rates (Frank & Brookmeyer, 1995; Wickizer & Lesser, 1998).

Cantor and Fuentes (2008) argue that the focus of controlling cost compromised patients' rights to competent and quality care.

Patient-Provider Relationship

The patient-provider relationship is more tied to outcome in mental health treatment than in any other medical specialty (Rosenberg & DeMasso, 2008). Those opposed to the managed care system worry that the patient-provider relationship will be harmed because therapists are required to disclose confidential information to managed mental health care organizations to obtain approval for treatment (Emanuel & Dubler, 1995; Pyles, 2003). One study found that clients and potential clients were less willing to self-disclose when managed care was a factor than in other circumstances (Kremer & Gesten, 1998). Similarly, Cohen et al. (2006) found that many clinicians believed working with managed care organizations required practices that violate typical standard of care and professional ethics. They found that managed care personnel misrepresented the nature of therapy, therefore undermining the patient-provider relationship.

Reporting information about mental illness to managed care companies means there is documentation in medical records regarding a patient's diagnosis, risk, and treatment history. There is some fear that this information can be used in determining either eligibility or rates of life insurance. A significant portion of clients will readily switch to a fee-for-service practice when a clinician decides to stop working with managed care companies (Walfish & Barnett, 2009), and many would rather pay for treatment in order to have real privacy, customized attention, and no psychiatric diagnosis on record (Ackley, 1997).

In contrast, others believe that this disclosure is necessary for the companies to ensure their patients' protection from harmful treatments, the best management of limited resources, and the treatment is guided by the patient's condition rather than benefits.

Walfish and Barnett (2009) warn that clinicians determine their ability to tolerate someone inspecting their credentials, having influence on their treatment decisions, defining appropriate goals of psychotherapy, and deciding a client's length of treatment. They found that a clinician's relationships with managed care companies was the most stressful factor in private practice, and worry that clinicians who have anger towards how managed care is, versus what they would like it to be, are likely to pass this resentment on towards their patients, interfering with the patient-provider relationship.

One study suggested that if patients know the therapist has negative perceptions of managed care, they changed their own expectations of therapy (Pomerantz, 2000). The patients became more likely to believe that managed care would negatively impact treatment, less likely to pursue treatment using insurance benefits, less likely to expect to benefit from treatment, less likely to expect to form a strong working relationship, and less likely to trust that the therapist would work in their best interest.

Furthermore, critics feel that continuity of care will be disrupted, especially when gatekeepers direct patients to preferred mental health professionals (Emanuel & Dubler, 1995). It is thought that patients are persuaded to switch to providers credentialed by managed mental health care, and they are only directed to psychiatrists when they need medications or hospitalization. Compared with other physicians, psychiatrists are less likely to agree that it is possible to maintain continuing relationships with patients over time that promote high-quality care (Rosenberg & DeMasse, 2008; Sturm & Ringel, 2003), partially due to the concern that psychiatrists prescribe medication while non-physicians provide psychotherapy. In contrast, supporters believe that the therapeutic bond is not necessary for the treatment of mental illness, and disruptions in the sequence of care are traditional in mental health counseling (Emanuel &

Dubler, 1995). Satisfied practitioners are more likely to stay in a given position (Isett et al., 2009), and a stable group of employees within an organization will positively affect the patient-provider relationship through continuity of care (Murray et al., 2001; Warren et al., 1998). Continuity of care is particularly important for individuals with severe and persistent mental illness, who tend to have more difficulty maintaining a therapeutic relationship (Isett et al., 2009).

Clinicians' Attitudes towards Managed Care

The U.S. General Accounting Office (1993) found greater patient satisfaction with managed care than with fee-for-service care; however, negative attitudes towards managed care have been well documented in medicine (Barzansky, 1996; Blumenthal, 1996; Coggan, 1997; Comorow, 1999; Fletcher, 1999; Hojat et al., 1999; Nordgren, 1996; Veloski, 1996). Berger and Ai (2000) report that professional social work holds a generally negative attitude towards managed care, and Kane et al. (2003) argue that these attitudes may affect behavioral performances. Kane et al. found that overall, mental health workers had negative attitudes towards managed care. Specifically, those who were less likely to have positive attitudes towards managed care were those who believed mis-diagnosis or over-diagnosis was necessary to obtain clinical services, that documentation ensures that agencies get paid for services, and that special advocacy skills are needed in managed care. They found that those who understood what managed care environments expect of practitioners held more positive views of managed care.

One survey concluded that 80% of psychologists reported that managed care was negatively affecting their practices (Phelps et al., 1998), and another survey that same year concluded that the more involvement practitioners had with managed care organizations, the

greater adverse effects there were on morale, professional identity, approach to psychotherapy (Rothbaum et al., 1998). A survey of 442 psychologists in private practice found that 86% reported being negatively effected by managed care (Murphey et al., 1998). McClure et al. (2005) surveyed licensed professional counselors and psychologists. They found that the majority of both types of practitioners had a negative opinion of managed care (56% of counselors and 70% of psychologists) and indicated that it had adversely impacted the way they provided counseling services.

In a survey of licensed professional counselors, Smith (1999) found that 47% of practitioners were “somewhat dissatisfied” to “very dissatisfied” regarding their experiences with managed care. He suggested it would be more beneficial for therapists to work on improving their relationships with managed care companies. One way to do this would be to learn new skills to adjust and minimize the negative impact of managed care policies (Lawless, Ginter, & Kelly, 1999).

A nationwide survey of 15,918 psychologists found that 79% reported that managed care negatively impacted their professional work (Phelp et al., 1998). This study highlighted concerns related to limiting the number of sessions, decreased flexibility and space for clinical judgment, early termination, decreased time for assessment, restrictions on clients, increased pressure to refer for medication, requirements to follow specific treatment protocols, and demands to use treatments outside the clinician’s primary orientation. Shaw et al. (1992) found an increase in the effectiveness of therapy; however, there was a decrease in concern for patients and satisfaction with clinical load and an increase in looking forward to cancellations after starting to work with managed care companies.

An early fear around managed care was that it did not sufficiently promote informed patient choice (Boyle & Callahan, 1995). This could happen during enrollment, for example, without providing sufficient information regarding the scope and limits of the benefits, or during service, for example, by not being offered a service that is not covered under the plan but is available elsewhere. Managed mental health care complicates this issue further because of the concerns regarding the degree of the patient's psychological impairment as it affects his or her judgment. A study showed that consumers were significantly unhappier with the performance of their health plan when they did not choose the plan, and consumers without choice had more negative opinions about managed care (Gawande et al., 1998), highlighting that it is not only the type of insurance plan that contributes to satisfaction with managed care, but also whether the consumer has a choice in the matter.

Burnout

There is considerable burnout, turnover, and general job dissatisfaction among psychiatrists, social workers, psychiatric nurses, and clinical psychologists (Acker, 1999; Farley, 1994; Onyett & Pillinger, 1997; Reid et al., 1999; Sturn, 2001). Burnout describes a subjective experience involving feeling stressed, emotionally overextended, and drained by one's work (Acker, 2003; Acker, 2010a), resulting in depersonalization (impersonal, detached, and cynical responses towards clients), low personal accomplishment, job dissatisfaction, lack of professional efficacy, and turnover (Acker, 2003; Maslach & Jackson, 1986). Burnout can be mitigated by social support and supervision, but this has been diminishing in mental health settings due to dwindling resources and funding (Acker, 2003).

Rupert and Baird (2004) found that clinicians with high involvement with managed care reported less overall satisfaction with their work, emotional exhaustion, and burnout. Isett et al.

(2009) explored the influence of managed care on job satisfaction in mental health settings. They found that in contrast to results reported in primary care settings, where managed care significantly negatively impacted job satisfaction, job satisfaction was minimally impacted by managed care. Acker (2010b) found that conflict with managed care companies was significantly correlated with emotional exhaustion.

Competence refers to one's ability to master organizational and work demands effectively (Acker & Lawrence, 2009; Hall & Keefe, 2000; Wagner & Morse, 1975; White, 1967). Some argue that an individual's belief that he is not competent or properly trained to do his job increases his risk of becoming burnt out (Acker, 1999; Arches, 1997; Bandura, 1989; Cherniss, 1993; Feldman, 2001; Lu et al., 2002; Mechanic, 2007; Shera, 1996; Stone, 1995, Tyler & Cushway, 1998). Hall and Keefe argue that clinicians have not been properly trained to work to provide services in a managed care environment, resulting in feelings of stress, anxiety, and lack of competence. There is very little empirical research regarding mental health workers' competence when working with managed care organizations (Cohen, 2003; Feldman, 2001; Hall & Keefe, 2000; Keefe & Hall, 1998; Shera, 1996; Stone, 1995). Acker & Lawrence (2009) explored the relationship between self-perceived competence and burnout and found that social workers who felt competent in their abilities to practice in a managed care setting reported lower levels of burnout. They argue that burnout relates to negative attitudes workers have about their job. Additionally, Acker (2010a) found that mental health workers who reported higher levels of self-perceived competence in the context of managed care reported lower levels of emotional exhaustion and burnout.

Reimbursable Benefits

Among different managed care organizations, the breadth of benefits may vary in terms of whether mental health services are covered, the types of services covered, annual or lifetime dollar or visit/day limits, and cost-sharing features (Merrick & Reif, 2010). Most large employers report annual limits on inpatient days or outpatient visits (Teich & Buck, 2007), and certain ancillary services, such as case management or occupational therapy, may be excluded from coverage. While most managed care plans have always covered inpatient, intensive outpatient, and regular outpatient mental health care, fewer, but still most, cover residential services (Horgan et al., 2009).

Some managed mental health care organizations have been criticized for the secrecy surrounding their coverage policy and benefit design. Managed mental health care plans initially kept their decision protocols and criteria secret, but later, most made these criteria available (Boyle & Callahan, 1995). What mental illnesses are covered by plans is important.

In order to receive reimbursement, managed care companies must determine “medical necessity” (Scheid, 2003, p. 146). If a mental health problem meets established diagnostic criteria, results in impaired social functioning, and can be treated efficaciously, then the conditions of medical necessity are met (Birne-Stone et al., 1997; Mechanic, 1999).

Interestingly, plans are often designed to give greater preference to biologically based mental illnesses. Most plans require a psychiatric diagnosis to receive treatment. However, individuals with subclinical symptoms might not meet criteria for benefits and must either pay out-of-pocket to reduce symptoms, wait until the symptoms cross a clinical threshold, or get treated for a diagnosis for which they do not actually meet criteria. Ironically, if they did not get treatment

until the symptoms progressed to the level of a formal diagnosis, they may be more difficult to treat and cost more money to do so than if they were treated earlier.

Karon (1995) stated that the American managed care system aims at short-term cost savings, even if it means higher costs in the long run, making patients go outside the managed care health plan for help, or forgoing getting psychological help at all. Struggling with even subclinical symptoms can lead to physical problems associated with stress, including, for example, migraines, heart disease, diabetes, and hypertension (Hudson, 2008; Kabat-Zinn, 1990). This also, ironically, costs more money to treat. It has been observed over the past 2,000 years that many people who visit a doctor are actually suffering from symptoms that are emotionally rather than physically based (Shapiro, 1971).

There is a significant link between psychological symptoms and medical expenses (Hudson, 2008). For example, depression and anxiety are often central to the cause of many physical conditions, and some mental illnesses complicate recovery from other diseases that have physical causes. Increased coping skills are linked to reducing the incidence of disease and accidents. While the prevalence of mental illness in the general population is 16%, in medical outpatient populations it is 21-26%, and in in medical inpatient populations it is 30-60% (Hudson, 2008; Kiesler, 1979; Reigier, 1978).

Studies prior to the growth of managed care have explored how utilizing psychiatric and psychological services reduces subsequent medical expenses. Follette and Cummings (1967) found that patients receiving psychotherapy showed a significant decline in medical utilization compared to those in a control group. A meta-analysis of 11 studies found that psychotherapy resulted in a 20% decrease of medical utilization (Jones & Vischi, 1979), and a meta-analysis of 34 studies found that cardiac patients receiving psychotherapy had a minimized need for

analgesic and sleeping medication, shortened hospital stays, and an easier recovery (Mumford, Schlesinger, & Glass, 1982). Additionally, Schlesinger et al. (1983) found that patients with medical conditions who received psychotherapy utilized 56% fewer medical services than patients with medical conditions who did not receive psychotherapy. Hudson (2008) noted that this effect in net cost reduction is greatest when patients receive short-term therapies, and less noticeable in patients who suffer from chronic mental illness. In one study, Fieldler and Wright (1989) found that mental health treatment reduced net medical costs by an average of \$392 for patients with mild mental disorders and an average of \$296 for patients with severe mental disorders. Some fear that the implementation of managed care and subsequent decreased hospital stays, reduced reimbursement rates, and increased utilization review will eliminate the net financial savings by implementing mental health treatment. In a recent study, Hudson (2008) found that psychiatric inpatient care does offset medical utilization (10-55% reduction in medical services following psychiatric care), but this effect is suppressed by the provision of managed care.

Liability

There was criticism in the earlier years of managed mental health care that insurance companies removed decision making from the clinicians and gave it to managers or utilization reviewers, yet those held responsible were individual providers. Therefore, if the managed care organization determines that treatment is no longer necessary and does not agree to reimburse further sessions and the clinician disagrees with that evaluation, the clinician is responsible for continuing treatment and appealing the utilization review decision (Walfish & Barnett, 2009). A significant number of legal cases have held the therapist liable for not appealing the denial for treatment instituted by the managed care company (Appelbaum, 1993). Walfish and Barnett

(2009, p. 189) state that “the psychologist’s responsibility for each client’s welfare remains regardless of payment decisions by managed care organizations.”

Special Populations

Certain populations are affected differently by managed care, including those with severe and persistent mental illness (SPMI), children, minorities, sexual assault victims, and gender differences.

Severe and persistent mental illness. For those with SPMI, state mental health agencies typically provide a continuum of services designed for long-term support and recovery. State governments retained some ability to fine tune regulations and have allowed for higher capitations for the seriously mentally ill (Willging et al., 2008). Individuals with SPMI frequently utilize mental health services and are thus costly as they require multiple hospitalizations, frequent and long outpatient services, and community based care with an emphasis on coordination of services and long-term psychosocial rehabilitation (Acker & Lawrence, 2009; Scheid, 2003). The managed care model that aims at minimizing services and focuses on short-term treatments might disproportionately affect those with SPMI. Because managed care companies’ strategy is to avoid hospitalizations or reduce stays, those working in outpatient settings have increasingly large caseloads, contributing to burnout.

Some research indicates that this population is unharmed by managed care. Lurie et al. (1992) found no consistent evidence that chronically mentally ill patients were harmed in the short run by managed care. Managed care gives priority to individuals with more severe mental illness, and insurance companies spend a lot of time and resources to determine the severity of symptoms and the failure of previous treatments (Boyle & Callahan, 1995), with the hope of not further disadvantaging those populations who are already underserved.

Conversley, while others report that even though managed care has been effective in increasing access and managing costs for most of the population, it is likely problematic regarding the intensity and quality of services for those who are the most seriously mentally ill (Cantor & Fuentes, 2008; Mechanic, 2004; Rosenberg & DeMaso, 2008). Chang et al. (2003) found that in a trial managed care project, outcomes were significantly worse for patients with SPMI compared to a fee-for-service program.

Children. Children involved in the child welfare system have a disproportionately high need for, and use of, mental health services (Burns et al., 2004; Harman, Childs, & Kelleher, 2000; Landsverk, Garland, & Leslie, 2002; Raghavan et al., 2005; Zima et al., 2000), and they rely heavily on Medicaid to pay for these services (English & Freundlich, 1997). Medicaid managed care affects children in the welfare system in a number of ways. Because managed care companies allot a fixed sum of money per member per month, and children in the welfare system are high need and use a considerable amount of mental health services, plans lose money on them, creating strong incentives for plans to control mental health service use (Raghavan et al., 2006). Additionally, behavioral health carve-outs have been reported to reduce inpatient use among children with mental health needs (Burns et al., 1999; Dickey et al., 2001; McCarthy, 2003; Stroul et al., 1988). This reduction is especially worrisome for the child welfare system. Specifically, McMillen et al. (2003) found that up to one third of children aging out of foster care had reported inpatient mental health stays. Raghavan et al. (2006) found that children under Medicaid managed care had lower rates of inpatient mental health service use. Greater rates of service use were related to older age, greater need for mental health services, and higher levels of caregiver education. Tang et al. (2008) found a greater reported unmet need for mental health

care among Medicaid pediatric behavioral health managed care programs, particularly those with emotional problems, compared with fee-for-service programs.

Minorities. Early studies reported higher rates of hospitalizations for minority groups (African Americans, unmarried individuals, and those with less education and income; Barker et al., 2004; Krohn & Akers, 1977; Lindsey & Paul, 1989; Milazzo-Sayre et al., 2001; Rosenfield, 1984; Sanguineti et al., 1996; Scheff, 1974; Snowden & Holschuh, 1992). However, when this was analyzed by Thoits and Evenson (2008), they found that rates of hospitalization were not higher in lower status and disadvantaged groups before managed care, during the rise of managed care, or currently while managed care is the dominant system. They found that over the past 30 years, socioeconomic inequalities in hospitalization rates disappeared, and by the 2000s, those hospitalized resembled the pool of mentally ill individuals in the community (Thoits & Evenson, 2008). One study found that in Puerto Rico, managed care did not affect the rates of psychiatric hospitalizations and produced only a nonsignificant reduction in the average length of psychiatric hospitalization stay (Torres & Alegria, 2010).

Historically, African Americans and Hispanics have reported poorer access to mental health and substance abuse treatment and use fewer services (Daley, 2005). One study found that only 11% of Hispanics with mood disorders and 9% with anxiety disorders had received treatment (Vega et al., 1999). Several factors contribute to these findings, including lack of health insurance, poverty, and unemployment. That said, once minority groups access the right kind of treatment, their outcomes seem to be similar to those of non-minorities (SAMHSA, 1998). Medicaid and Medicare have improved the quality of treatment for racial minority groups (Leigh et al., 1999). Daley found that managed care had a beneficial effect on the quality of treatment for minority groups. Specifically, he found that while managed care increased access

to services for both minorities and non-minorities, access among Hispanics increased more than for other racial groups. Additionally, he found that managed care improved continuity of care for all racial groups; however, the percentage of those who achieved continuity of care was lower each year for minorities compared with Caucasians. Furthermore, he found that managed care increased rapid readmission rates, and this was the same among all racial groups.

Sexual assault victims. Managed care has also impacted some specialized treatment. In one study of providers of mental health treatment to sexual assault victims and sexual offenders, it was found that 46% of clinicians reported having made changes in the type of client or treatment approach, and 43% reported seeing fewer clients as a result of managed care (Berliner & New, 1999). Additionally, 68% stated that the requirements for documentation or reports had increased. Overall, 75% of respondents indicated that managed care had at least a moderate impact on their practice, and therapists who worked with sexual assault victims perceived significantly greater impact. Reductions in the number of sessions, increases in administrative expectations, and compromised confidentiality were considered significant threats to the delivery of effective services.

Gender. In some respects, men and women have different experiences with managed mental health care. Women have a higher prevalence of some of the most common mental health problems (Hasin et al., 2005; Kessler et al., 2005; Merrick & Reif, 2010), are more likely to seek treatment for mental health concerns (Wang et al., 2005), and are disproportionately eligible for certain publicly funded insurances (Merrick & Reif, 2010). Because depression and anxiety rates are higher among women, they are more likely to be eligible for disease management programs (Merrick & Reif, 2010) and programs that coordinate care interventions for populations where self-care efforts are important, and to be impacted by pharmacy benefit

management (Merrick & Reif, 2010). Furthermore, because women are less likely to be in the work force and more likely to have jobs in the service sector, nonunion companies, and low wage companies (Bureau of Labor Statistics, 2007), they may have less access to EAPs. However, women are more likely than men to seek help through EAPs (Merrick & Reif, 2010). Women are more likely to be covered as a dependent, thus having less control over their insurance choices (Kaiser Family Foundation, 2007). Compared with men, women are more likely to have a usual source of healthcare and are more likely to make office based visits (Agency for Healthcare Research and Quality, 2004), therefore have greater opportunity to identify and treat mental health problems. Additionally, women are more likely to prefer counseling to medication (Dwight-Johnson et al., 2000), make suicide attempts, or have severe eating disorders, thus may be more likely to be hospitalized (Savoie et al., 2004).

Adaptations

Walfish & Barnett (2009) state that not all psychotherapists will be a good fit for managed care companies. Specifically, those who practice long-term insight oriented treatment are not going to be a good fit, whereas those who primarily practice short-term treatments, such as cognitive behavior therapy or solution focused therapy, will be better fit for becoming managed care providers (Walfish & Barnett, 2009). Other changes to the practice of psychotherapy include shifting focus from intrapsychic problems to behavioral symptoms, changing the perception of what psychotherapy is intended to do, and changing assumptions about what successful treatment means (Cantor and Fuentes, 2008). Austad et al. (1992) suggested that alternative health care settings might serve as catalysts by creating an atmosphere that shapes and influences therapists to develop more eclectic, short-term, problem focused

psychotherapy practice habits. They found that 59% of psychologists and 52% of counselors indicated that they had made changes, such as having fewer sessions.

A necessary adaptation is learning the management skills that are required to complete paperwork. In the early years of managed care, many insurance companies seemingly discouraged providers to request further care (Holmes, 1997). One company required a two-page form to be filled out after every four sessions with a client, while another company later "improved" their system by replacing their two-page form with a six-page form. To make things even more difficult, every company has a different set of forms. More recently, managed care organizations are likely to authorize an initial four to ten sessions. If more are needed, the clinician needs to complete a more streamlined form for the managed care organization, outlining information regarding the client's diagnosis, severity of symptoms, number and frequency of sessions being requested, a treatment plan, and an estimated prognosis for treatment completion (Walfish & Barnett, 2009).

Rupert and Baird (2004) found that clinicians ranked managed care aspects of their job as most stressful. Interestingly, although those with high involvement with managed care completed paperwork for the same amount of time as those with low managed care involvement, they reported more stress related to excessive paperwork, suggesting that the nature of the managed care paperwork is more stressful than the quantity of paperwork (Cantor & Fuentes, 2008).

Substance Abuse

The co-occurrence of substance abuse and mental health disorders is common, and unless both issues are addressed, it is likely that recovery from either problem will be obstructed. However, these two treatment systems have historically been separate in terms of funding, types

of provider, and treatment approaches (Merrick & Reif, 2010). Substance abuse treatment services are provided in a variety of settings; however, specialized outpatient facilities have tended to be the predominant form of delivery (SAMHSA, 1995). Substance abuse treatment is funded by a variety of sources, including Federal, State, and private (Zarkin et al., 1995); however, individuals with substance abuse problems rely heavily on public funding for treatment (Coffey et al., 1997; Mark et al., 2003; McKusick et al., 1996). One study estimated costs associated with drug abuse and alcoholism exceeded 276 billion dollars in 1995 (U.S. Department of Health and Human Services, 1998). From 1995 to 2000, managed care activity has increased among substance abuse treatment organizations (Alexander, Lemak, & Campbell, 2003). While public managed care activity has increased in these settings, private managed care activity has decreased.

One concern about managed care is how it will influence substance abuse treatment. French et al. (1996) found that Program Directors (PDs) believed that managed care would result in increased administration costs and decreased drug treatment services. McNeese-Smith (1998) reported that while PDs greatest concern regarding managed care was being forced to provide the least costly service rather than the best care, they also had concerns relating to limiting the amount of staff, while they were positive about the increased focus on outcomes, outreach, marketing, and follow-up after care. McNeese-Smith et al. (2006) found that PDs reported changes secondary to managed care, including decreased treatment length, limiting inpatient and outpatient services, and delayed treatment, and needed adaptations, including varying treatment length, modality, and subspecialty care.

Managed care affects aspects of substance abuse treatment, including quality, access, continuity, and rapid readmissions, and this varies among different populations. While some

studies have shown that managed care successfully cut costs while maintaining or increasing access to and satisfaction with behavioral health services in general (Alterman, Randall, & McLellan, 2000; Carlson & Gabriel, 2001; Deck et al., 2000; McCarty & Argeriou, 2003; Steenrod et al., 2001), studies that looked at just substance abuse treatment found decreased access to and utilization of inpatient and outpatient substance abuse services (Steenrod et al., 2001). McFarland et al. (2005) found no differences in treatment retention, completion of treatment, and abstinence at discharge after the onset of managed care, but there was an increase in readmissions. They argue that Medicaid managed care does not have an adverse effect on outcomes for clients with substance abuse problems. Etheridge et al. (1995) found a significant reduction in the number and range of services that substance abuse clients received. In Iowa and Maryland, there was a shift from inpatient and residential services to outpatient treatment, and there was no difference in outcomes in Maryland (Ettner et al., 2003). One study found that while managed care increased the number of services offered in methadone maintenance facilities, it decreased the number of services for drug-free outpatient facilities (Sindelar & Olmstead, 2005).

Research suggests that there is a minimum effective duration for substance abuse treatment (Finney & Moos, 2002; National Institute on Drug Abuse, 1999; Simpson & Brown, 1997). The National Institute on Drug Abuse (1999) has suggested that significant improvement is reached after three months of treatment. One study found that managed care led to increased treatment duration (Ettner et al., 2003), but this has not yet been replicated.

There is concern that the impact of managed care on substance abuse treatment will disproportionately affect youth and those with more severe and persistent mental illness and special needs (Galanter et al., 1999; McCarthy et al., 2001). As discussed earlier, there are

concerns that capitation increases incentives to focus less on severely impaired patients; however, one study found that the severity of clients entering publicly funded substance abuse programs before and after managed care was about the same (Deck & McFarland, 2002), and another study found that it actually increased (Ettner et al., 2003).

The research regarding managed care and youth is mixed (Deck & Carlson, 2004; Callahan et al., 1995), and the impact of managed care on the intensity, outcomes, or satisfaction with treatment among adolescents is not well understood (Carlson et al., 2005). Carlson et al. found that managed care is capable of delivering substance abuse treatment services for adolescents that is comparable in quality to state-administered substance abuse treatment services. Compared with the fee-for-service system, another study found that with managed care, youth with alcohol problems had reduced contact with juvenile justice authorities (Scott, Snowden, & Libby, 2002).

Among women of childbearing age, substance abuse and dependence is the second most common psychiatric disorder (Robins et al., 1984). The National Institute on Drug Abuse (1996) found that 9.4% of pregnant women had used an illicit drug in the past year. Consequences for fetal drug exposure include developmental lags, language problems, emotional/behavioral problems, and attention difficulties (Hans, 1996; Kaltenbach, 1996). Medical costs for drug-exposed infants are higher than for non-drug exposed infants (Behnke et al., 1997; Mena, Corvalan, & Bedragal, 2002). Research has consistently shown positive outcomes for individuals engaged in substance abuse treatment and a subsequent reduction in cost to society (Galanter et al., 2000) that more than offset the cost of substance abuse treatment (Langenbucher, 1994), particularly for pregnant drug-dependent women. Unfortunately, this population is largely ignored by policy makers (Jansson et al., 2007). One study comparing

substance abuse treatment programs under managed care and fee-for-service plans found that although both groups had similar birth parameters, the managed care group had more fetal and infant deaths, decreased immunization rates, and greater incidents of social services intervention (Jansson et al., 2007).

Ethics and Managed Mental Health Care

Daniels (2001) argues that mental health workers' negative views of managed care come from conflict of interest and ethical decision making. Conflict occurs when clinicians desire to provide the most appropriate and effective treatment, but contrary to their professional decision-making, they have to provide services that are less costly and at times harmful to their patients. Research indicates that there is a culture clash between managed care companies and therapists (Cohen et al., 2006).

Rosenberg and DeMasso (2008) remark that it can be tempting for mental health providers to say anything, even lie, to the managed care reviewer in order to obtain authorization for the treatment that he "knows" is the best for his patient (p. 57). One study found that many physicians permit the use of deception to obtain care when insurance companies deny authorization (Freeman et al., 1999). Physician support of deception was higher when the situation presented with greater clinical severity and immediate patient risk.

Because not all diagnoses and procedures are covered by insurance, physicians are hindered in their efforts to code diagnoses and procedures accurately if they want their patients to be able to access their benefits. One study found physicians evaluating children with mental health conditions routinely used alternate diagnostic coding strategies (Rushton, Felt, & Roberts, 2002). This was most common when there was diagnostic uncertainty or when the symptoms were mild, borderline, or sub-threshold; however, less common reasons included obtaining

services and physician reimbursement. Furthermore, under diagnosing was reported as a way to avoid labeling and stigmatization, as well as to address concerns about confidentiality and parental acceptance. This study highlighted physicians' beliefs that managed care created a system that fosters the use of alternative diagnoses.

Surveys of therapists have found that many have ethical concerns about managed care, particularly related to privacy and confidentiality (Chambliss et al., 1997; Cohen et al., 2006). Danzinger and Welfel (2001) found that 75% of mental health counselors reported that managed care presented ethical problems. Murphey et al. (1998) found that 70% of respondents reported more ethical problems associated with managed care than with their general practice, 75% reported that working with managed care compromised patient confidentiality, and 53% doubted that managed care personnel kept clinical information confidential. Additionally, Rothbaum et al. (1998) found that psychologists with a higher proportion of managed care caseloads were more likely to report pressure to compromise quality of care and ethical principles.

Summary

Managed care has potential consequences for numerous aspects of behavioral health treatment, including access to care, quality of care, the patient-provider relationship, clinicians' attitudes, rates of burnout, reimbursement, liability, special populations, needed adaptations, substance abuse, and professional ethics. Table 3 summarizes the many ways behavioral health care is impacted by managed care as described in detail above.

Table 3

Summary of managed care's impact on behavioral health care

Elements of MH Treatment	Consequences of MC	Examples
Access to services	Increased access	<ul style="list-style-type: none"> • Affordability • Timely
	Reduced access	<ul style="list-style-type: none"> • Reduced number of providers • Long-term services • Psychological testing • Number of sessions • Early termination • Limiting theoretical approach/orientation • Safety net programs
Quality of care	Reduced quality of care	<ul style="list-style-type: none"> • Cost containment/cost cutting • Less costly providers • Reduced services
	Quality versus quantity	<ul style="list-style-type: none"> • Lower intensity/quantity could be better quality
Patient-provider Relationship	Confidentiality	<ul style="list-style-type: none"> • Can harm relationship • Less willing to disclose • Violate privacy ethics • Diagnosis in medical record • Could protect clients from mistreatment
	Relationship with MC	<ul style="list-style-type: none"> • Most stressful aspect of practice • Could pass resentment on to clients

Patient-provider Relationship(cont.)	Continuity of care	<ul style="list-style-type: none"> • Directed towards preferred providers • Only see psychiatrists for medication • Satisfied clinicians are more likely to stay in a position
Clinicians' attitudes	Negative attitudes	<ul style="list-style-type: none"> • May affect performance • Belief in mis/over diagnosis • Adverse effects on morale, professional identity, and approach to therapy
	Satisfaction with MC	<ul style="list-style-type: none"> • Large percentage of clinicians dissatisfied
	Impact on work	<ul style="list-style-type: none"> • Limiting number of sessions • Decreased flexibility/space for clinical judgment • Early termination • Decreased time for assessment • Restrictions on clients • Pressure to refer for medication • Specific treatment protocols • Treatment orientation limits
	Patient choice	<ul style="list-style-type: none"> • Enrollment • Services
Burnout	Job satisfaction	<ul style="list-style-type: none"> • High involvement with MC correlates with decreased job satisfaction
	Competence	<ul style="list-style-type: none"> • Increased sense of incompetence can lead to burnout

Reimbursement	Secrecy	<ul style="list-style-type: none"> • Some MC plans keep their benefits secret (ex: what diagnoses are covered)
	Medical necessity	<ul style="list-style-type: none"> • Problem must meet diagnostic criteria, result in impaired functioning, and can be treated • Plans designed to give preference to biologically based illnesses (ie: schizophrenia)
	Short-term vs long-term cost	<ul style="list-style-type: none"> • Even subclinical symptoms can lead to migraines, heart disease, diabetes, and hypertension • Long-term medical costs are significantly higher • Link between psychological symptoms and medical expenses
Liability	Where responsibility falls if treatment is stopped due to reimbursement	<ul style="list-style-type: none"> • If clinician believes ending treatment is inappropriate, treatment must continue and MC should be challenged • Clinician is responsible for clients' welfare
Special Populations	SPMI	<ul style="list-style-type: none"> • Higher capitation • More costly population • High rates of inpatient, outpatient, and community based treatment
	Youth	<ul style="list-style-type: none"> • High need and use of MH treatment • MC attempts to reduce number of hospital stays

Special Populations (cont.)	Minority	<ul style="list-style-type: none"> • Early studies suggested higher hospitalization rates among minorities • MC does not seem to affect these rates
	Sexual assault victims	<ul style="list-style-type: none"> • Clinicians made changes in type of client and/or treatment approach • Clinicians reported seeing fewer clients • MC had at least a moderate impact
	Gender	<p>Women compared with men:</p> <ul style="list-style-type: none"> • Higher prevalence of MI • More likely to seek treatment • Disproportionately eligible for public insurance • More likely eligible for disease management programs • Less access to EAPs • More likely to use EAPs • More likely to be a dependent and have less control/choice over plan • More likely to have routine appts • More likely to prefer counseling to medication • More likely to be hospitalized
Adaptations	Delivery of treatment	<ul style="list-style-type: none"> • Short-term vs. long-term treatments • Shift from intrapsychic to behavioral problems • Change assumptions about what successful treatment means • Fewer sessions
	Management skills	<ul style="list-style-type: none"> • Learn management skills needed to complete paperwork

Substance Abuse	Historically been separate treatments	<ul style="list-style-type: none"> • Funding • Type of provider • Treatment approach
	Limits in services	<ul style="list-style-type: none"> • Increased administration costs • Decreased services • Least costly vs best care • Decreased treatment length • Limiting inpatient and outpatient services • Delayed treatment
Ethics	Conflict of interest	<ul style="list-style-type: none"> • Between providing most appropriate and effective treatment and having to provide the least costly, possibly harmful services
	Deception	<ul style="list-style-type: none"> • Can be tempting to lie to get authorization for treatment • Higher when client is at greater risk
	Alter diagnosis	<ul style="list-style-type: none"> • Not all diagnoses/procedures are covered by insurance • Most common with diagnostic uncertainty or subclinical symptoms • Under diagnosis as a way to avoid labels/stigma
	Privacy	<ul style="list-style-type: none"> • MC compromises patient confidentiality

Note. MH = Mental health; MC = Managed care; SPMI = Severe and persistent mental illness; MI = Mental illness; EAP = Employee Assistance Plan

Research Questions

Previous research shows how managed care has significantly affected the mental health care system. This study will seek to answer the following questions: (a) Currently, what percent of clinicians alter treatment due to managed care? (b) Currently, in what ways do clinicians alter treatment because of managed care? and (c) Currently, how do clinicians believe these alterations impact their clients?

Chapter 3: Methodology

Procedure

Sample. Participants were selected based on a convenience sample (Kazdin, 2003) from an anonymous Internet survey using “SurveyMonkey,” a free tool to create surveys and collect responses. Directors of mental health clinics in Massachusetts were contacted for permission to email the survey link to the clinicians working at the agencies. Those who reported they worked in a capitation system of managed care were excluded from the study.

Total participants for this study were 139 mental health clinicians. Of the 139 participants, 105 participants reported that they do not work in a capitation model of managed care, and of those, 82 participants completed the entire survey. Those 82 participant surveys yield the following results. There were 66 female respondents (80.5%) and 16 male respondents (19.5%). There were 11 (25.6%) who had been practicing 0-2 years, 17 (20.7%) who had been practicing 3-5 years, 15 (18.3%) who had been practicing 6-10 years, 12 (14.6%) who had been practicing 11-20 years, 9 (11%) who had been practicing 21-30 years, and 8 (9.8%) who had been practicing 31 or more years. There were 11 (13.4%) respondents who worked in an inpatient setting, 70 (85.4%) who worked in an outpatient setting, 22 (26.8%) who worked in private practice, 51 (62.2%) who worked in mental health, 17 (20.7%) who worked in substance abuse, and 19 (23.2%) who worked in another type of setting (in-home therapy, school or college setting, court clinic/community corrections, neuropsychology, child welfare agency, and residential treatment). There were 20 (24.4%) who identified as Master’s level psychology, 36 (43.9%) who identified as Doctoral level psychology, 20 (24.4%) who identified as Master’s level social workers, and 6 (7.3%) who identified as Other (marriage and family therapist,

counseling, Master's in mental health counseling, licensed mental health counselor, M.Ed. in counseling psychology).

Measures. Participants each completed a structured cross sectional survey (see Appendix C) designed by this author. The survey looks at the extent to which participants deal with managed care in their work, in what ways managed care affects treatment, whether they have ever altered treatment, to what extent they have shortened treatment, used different treatment modalities, made intentional incorrect diagnoses, or made other changes in treatment, and the ways and reasons they have made these changes. The structured survey also looks at the perceived pros and cons of these changes for the patient. It is designed to gather information on participants' current behavior while working in a managed care setting that can be compared to past research on behavior while working in a managed care setting.

According to Antioch University New England's Human Research Committee (HRC) Policy, this study was exempt from formal review by the HRC because it is an anonymous survey; however, it required an expedited review. This author followed Antioch New England's procedures regarding HRC approval (i.e., completed required training modules, filled out HRC application, got application approval from the dissertation chair, then the department, and then the HRC Chair). A copy of the approved email for communication with clinic directors and an informed consent is included (see Appendix A and B).

Data Analysis

An exploratory research design (Howell, 2008) was used and the data was analyzed using descriptive statistics to provide a summary and comparison of all major factors studied. In this type of research, the goal is to learn what is going on and investigate phenomenon without preconceived expectations. The research can often lead to the development of formal

hypotheses. Exploratory research can draw conclusions only with extreme caution, and it helps determine the best research design, data collection method, and selection of subjects for future research. The goal of this exploratory study was to gain a general sense about the current sentiments regarding managed mental health care and its impact on how clinicians practice, as well as to identify the extent to which clinicians intentionally made incorrect diagnoses to accommodate managed care. This study exposes and demonstrates the percentage of mental health clinicians who currently are impacted by managed care, believe that managed care hinders treatment, have shortened treatment as a result of managed care, have altered treatment modalities in order to get authorization from managed care, have made an intentional incorrect diagnosis, and/or have made other changes to satisfy managed care. Furthermore, it explores the percentage of clinicians who believe these changes affect their clients positively or negatively, stigmatization, quality of care, and/or the patient provider relationship. These findings will be compared with early research in order to understand how the evolution of managed care has impacted behavioral health treatment and attitudes.

Chapter 4: Results

Most of the research on managed care and psychotherapy practice was conducted in the earlier years of managed care. Results have been mixed historically, some yielding a positive impact from managed care and most yielding a negative impact. The results from this study will explore the following questions: (a) Currently, what percent of clinicians alter treatment due to managed care, (b) Currently, in what ways do clinicians alter treatment because of managed care, and (c) Currently, how do clinicians believe these alterations impact their clients?

Influence and Impact of Managed Care

Respondents indicated that most of their practice is predominantly influenced by managed care. Specifically, when asked about the percentage of their work that involves using managed care, 57.3% (47) of respondents indicated 81-100% of the time, 13.4% (11) indicated 51-80% of the time, 11% (9) indicated 11-50% of the time, 6.1% (5) indicated 1-10% of the time, and 12.2% (10) indicated they do not use managed care. No respondents were unsure whether or not they worked with managed care.

Overall, most respondents indicated that managed care impacts their work most of the time (34.1%). Others indicated that it impacts their work some of the time (22%), about half the time (32.9%), and all of the time (11%). No respondents indicated that it never affects their work. Figure 1 illustrates the percentage of respondents who indicated the extent to which managed care impacts treatment based on how much involvement with managed care they have.

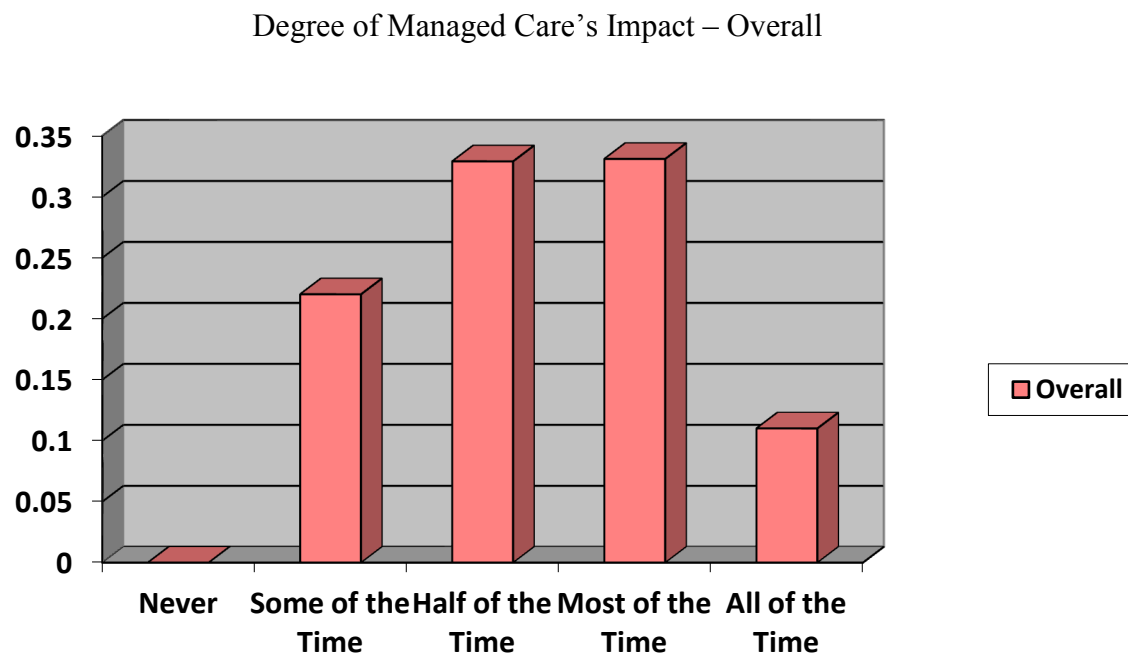


Figure 1: The overall impact of managed care on mental health treatment.

Managed care's impact was further examined based on how much the clinician's work involves managed care and how many years the clinician has been in practice. The results are illustrated in Figures 2 and 3.

Degree of Managed Care's Impact – Involvement with Managed Care

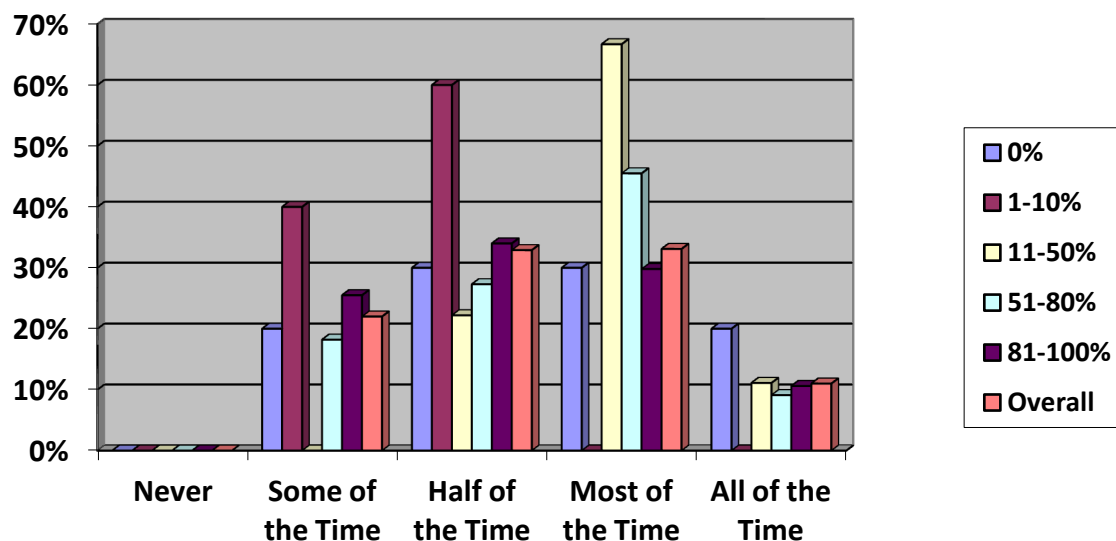


Figure 2: The overall impact of managed care on mental health treatment based on how much time the respondent works with managed care.

Degree of Managed Care's Impact – Years of Practice

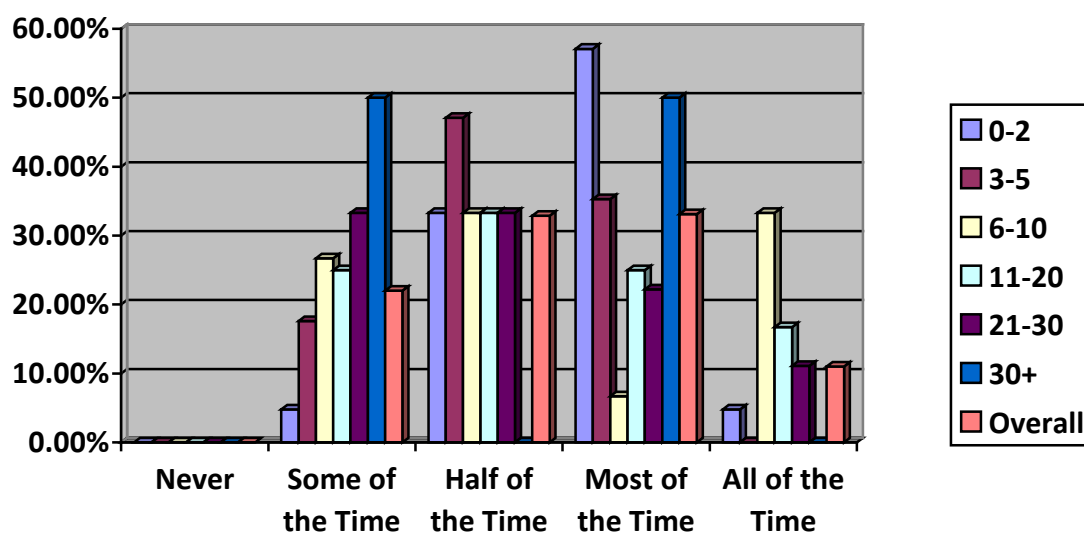


Figure 3: The overall impact of managed care on mental health treatment based on the clinician's years of practice.

They indicated that this impact is positive none of the time (28%), some of the time (40.2%), about half the time (24.4%), most of the time (7.3%), and harmful none of the time (1.2%), some of the time (47.6%), about half of the time (30.5%), most of the time (19.5%), and all of the time (1.2%). None of the respondents indicated a positive impact all of the time. Figures 4 and 5 illustrate the percentage of respondents who indicated the extent to which managed care improves and harms mental health treatment based on how much involvement with managed care they have.

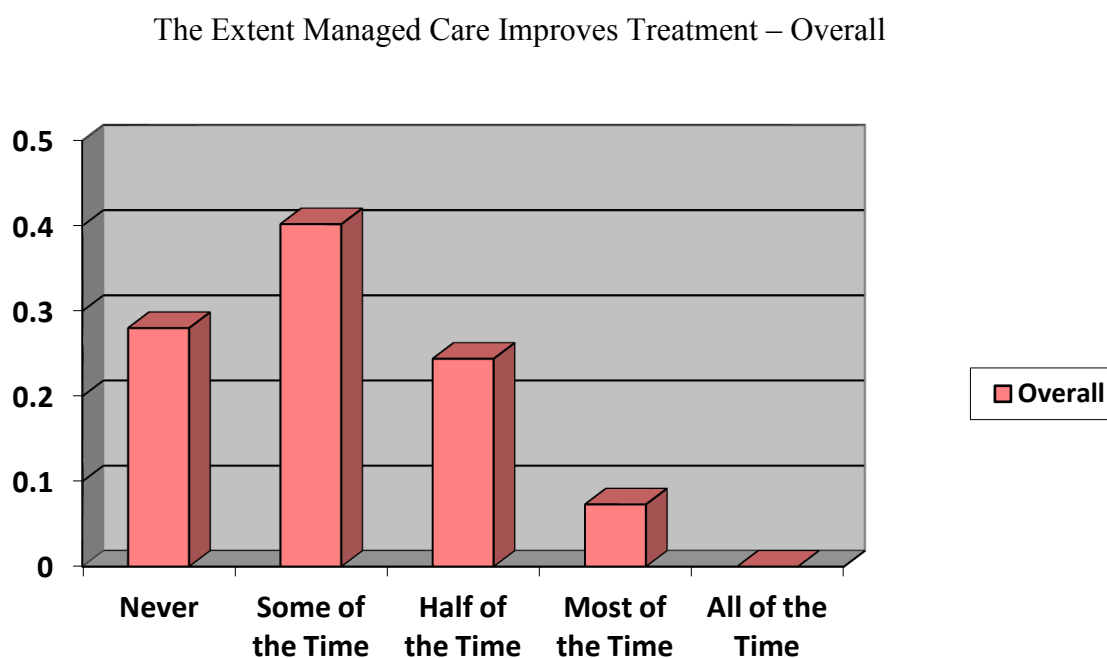


Figure 4: The extent to which managed care improves mental health treatment overall.

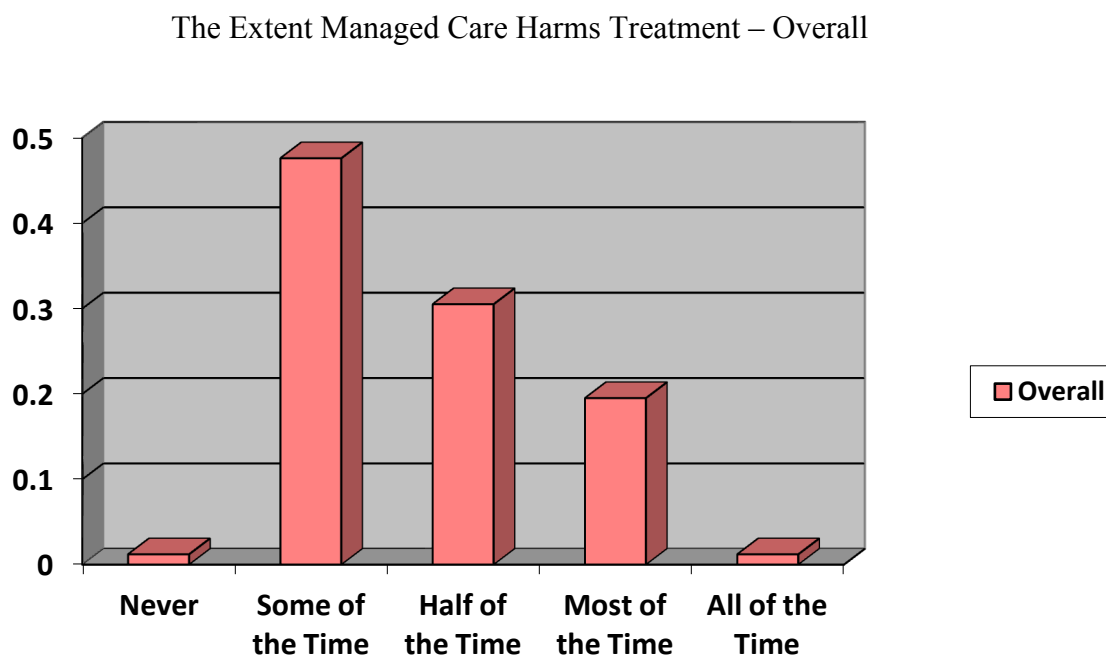


Figure 5: The extent to which managed care harms mental health treatment overall.

The extent to which clinicians indicated that managed care improves and harms mental health treatment was examined based on how much the clinician works with managed care and how many years the clinician has been practicing. The results are illustrated in Figures 6 - 9.

The Extent Managed Care Improves Treatment – Involvement with Managed Care

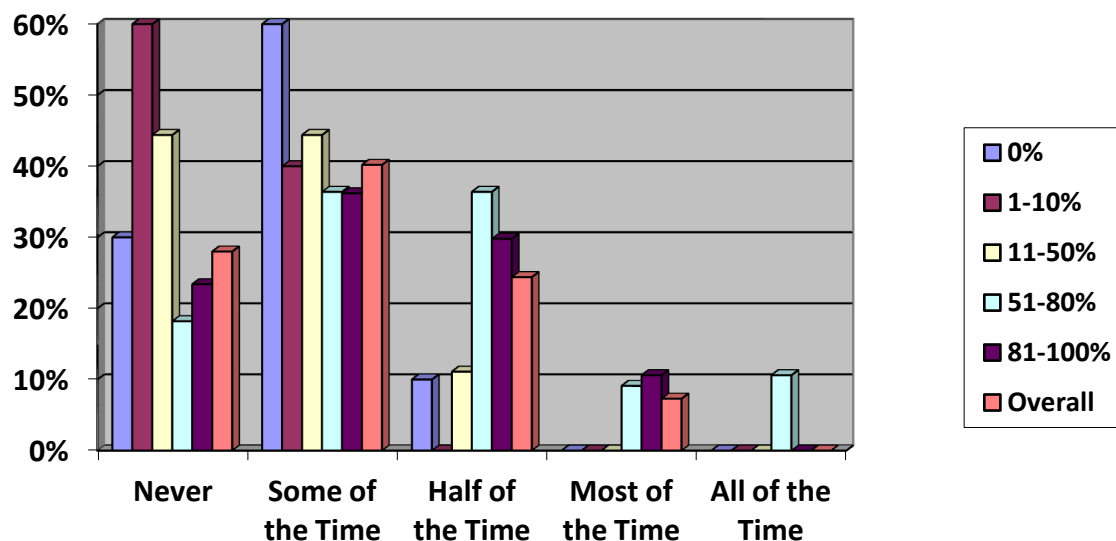


Figure 6: The extent to which managed care improves mental health treatment based on how much time the respondent works with managed care.

The Extent Managed Care Improves Treatment – Years of Practice

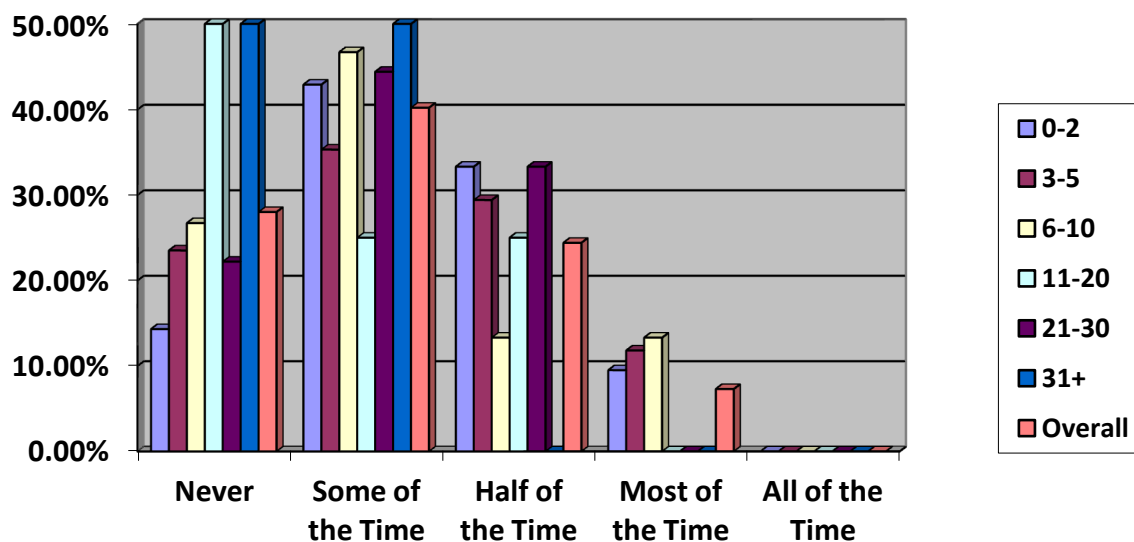


Figure 7: The extent to which managed care improves mental health treatment based on the clinician's years of practice.

The Extent Managed Care Harms Treatment – Involvement with Managed Care

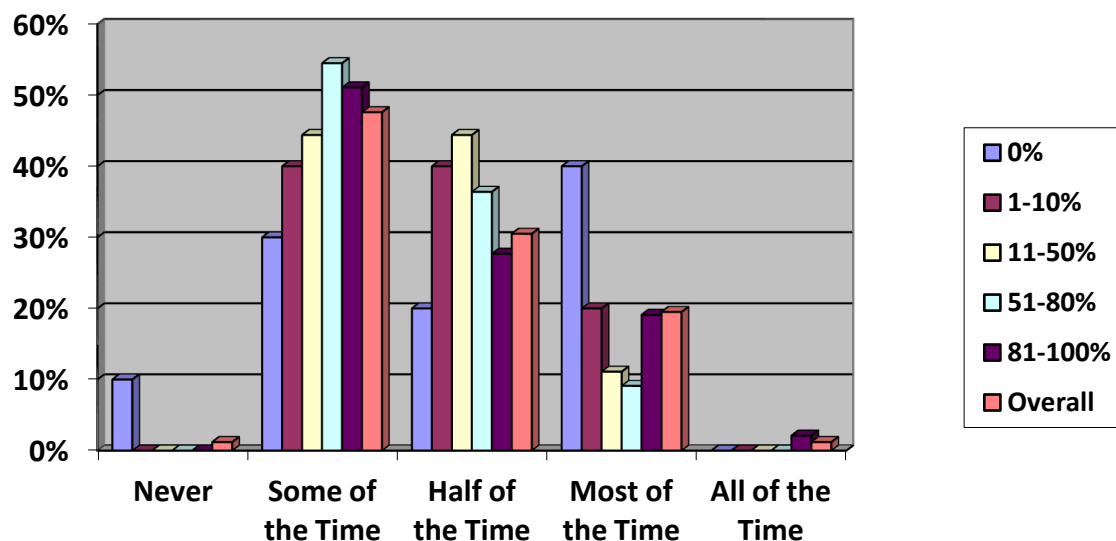


Figure 8: The extent to which managed care harms mental health treatment based on how much time the respondent works with managed care.

The Extent Managed Care Harms Treatment – Years of Practice

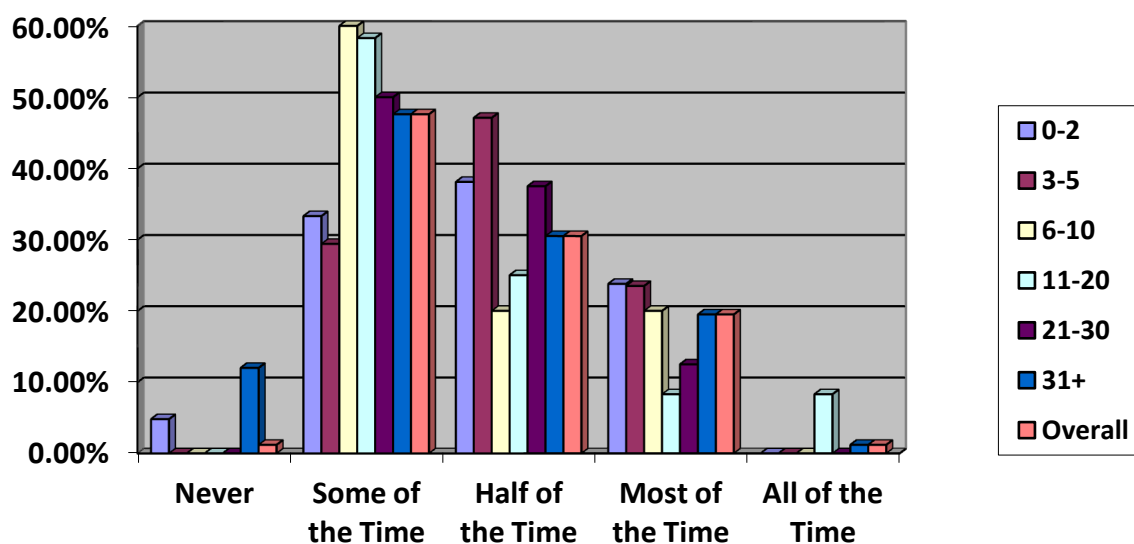


Figure 9: The extent to which managed care harms mental health treatment based on the clinician's years of practice.

Who Alters Treatment due to Managed Care?

Most respondents (37.8%) indicated that they conduct treatment differently under managed care than they would without managed care some of the time. Others indicated they conduct treatment differently none of the time (20.7%), about half of the time (23.2%), most of the time (15.9%), and all of the time (2.4%). Figure 4 illustrates the distribution of respondents who conduct treatment differently under managed care than they would without managed care based on their level of involvement with managed care.

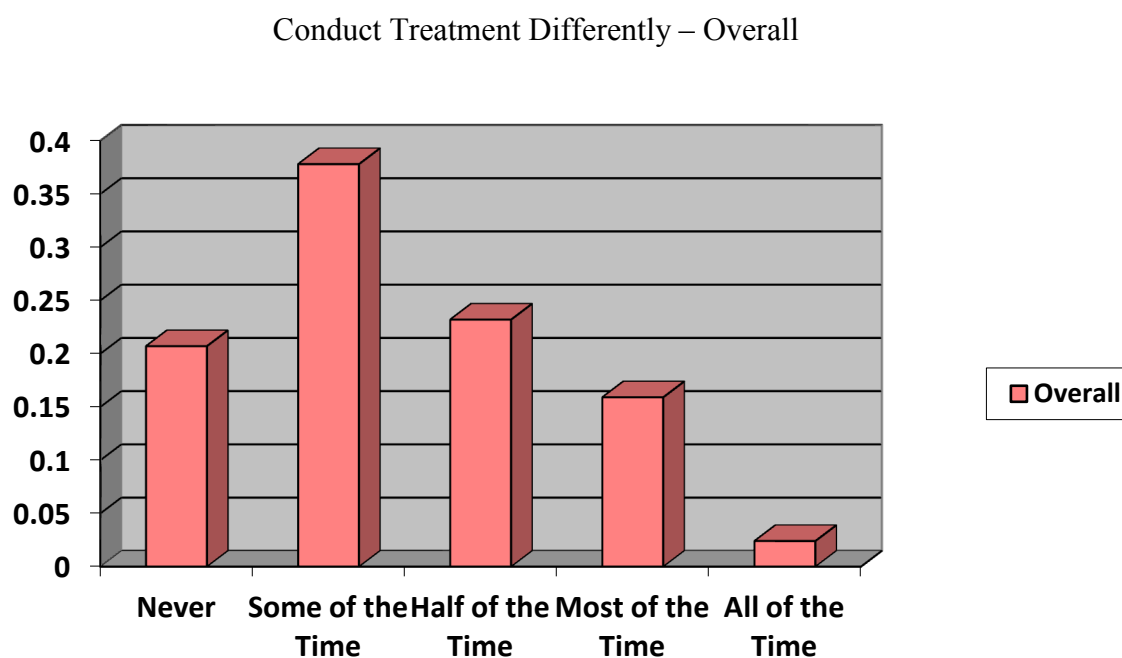


Figure 10: Respondents who conduct treatment under managed care differently than they would without managed care overall.

Whether or not clinicians conduct treatment differently under managed care was examined based on how much the clinician works with managed care and based on how many years the clinician has been in practice. These results are illustrated in Figures 11 and 12.

Conduct Treatment Differently – Involvement with Managed Care

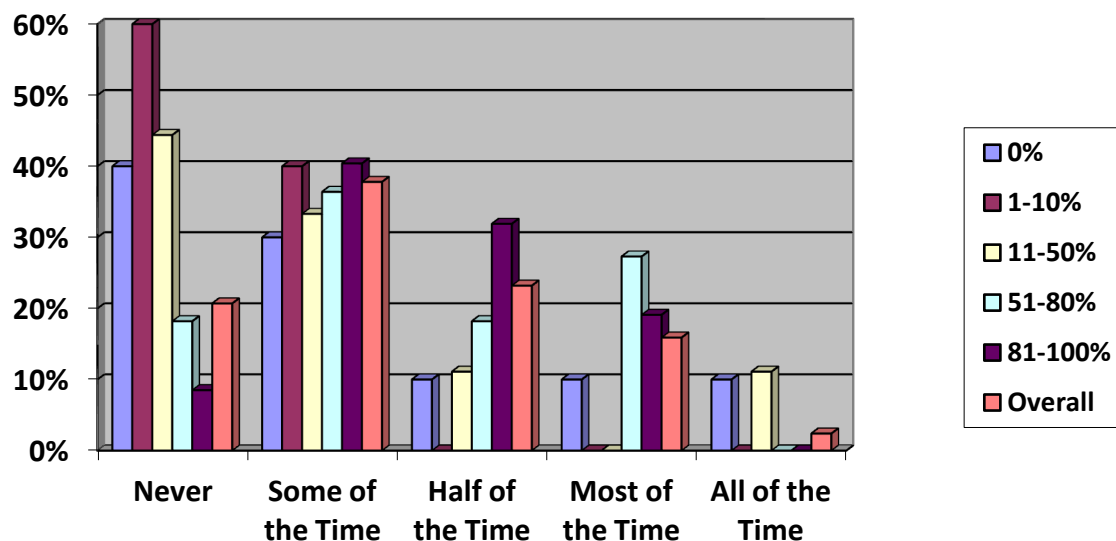


Figure 11: Respondents who conduct treatment under managed care differently than they would without managed care based on their level of involvement with managed care.

Conduct Treatment Differently – Years of Practice

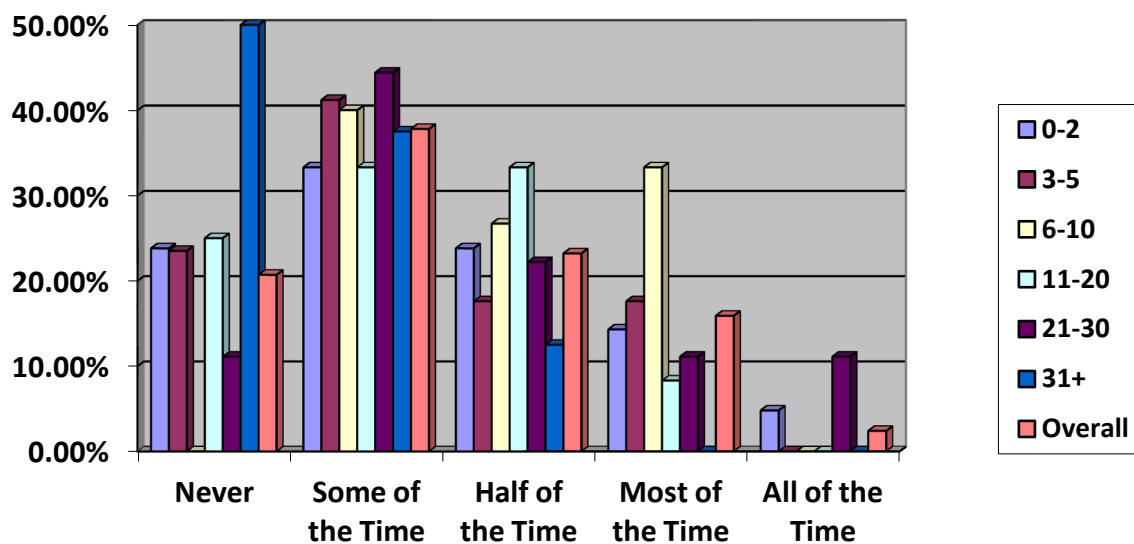


Figure 12: Respondents who conduct treatment under managed care differently than they would without managed care based on the clinician's years of practice.

In what Ways do Clinicians Alter Treatment due to Managed Care?

Most say they shorten treatment as a result of managed care some of the time (48.8%). Others indicate they shorten treatment as a result of managed care none of the time (34.1%), about half the time (11%), most of the time (6.1%). None indicated that they shorten treatment all of the time. Figure 5 illustrates the distribution of respondents who indicated they shorten treatment due to managed care based on how much they work with managed care.

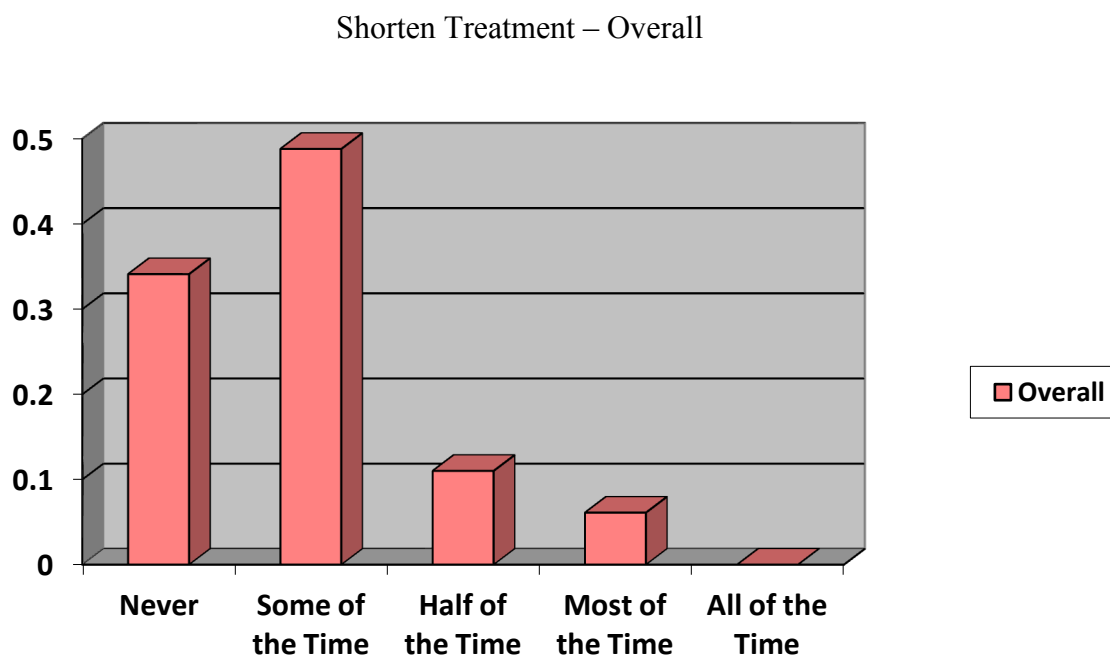


Figure 13: Respondents who shorten treatment due to managed care overall.

The frequency clinicians indicated they shorten treatment was further examined based on how much the clinician works with managed care and based on how many years the clinician has been in practice. The results are illustrated in Figures 14 and 15.

Shorten Treatment – Involvement with Managed Care

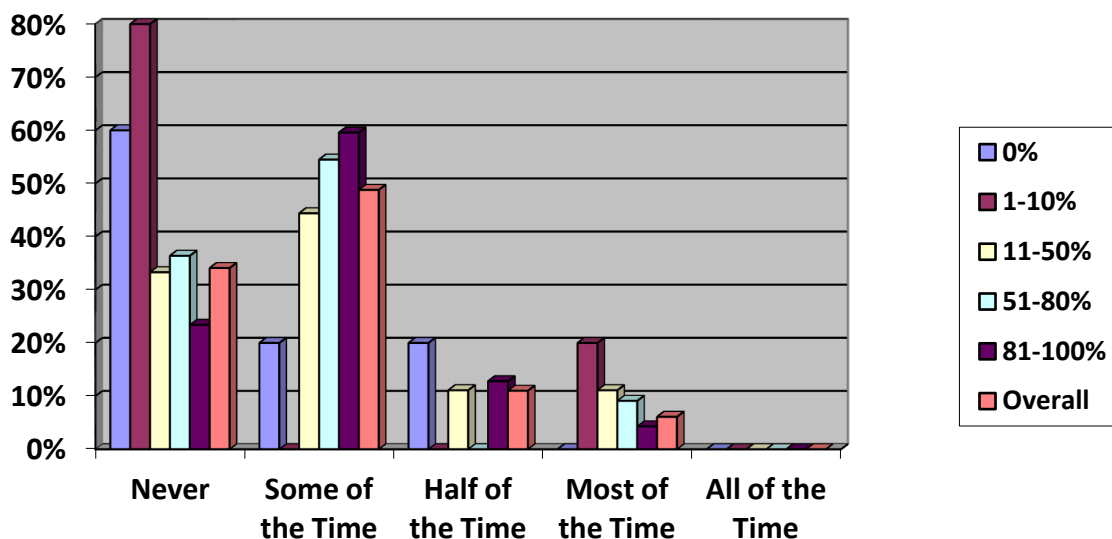


Figure 14: Respondents who shorten treatment due to managed care based on their level of involvement with managed care.

Shorten Treatment – Years of Practice

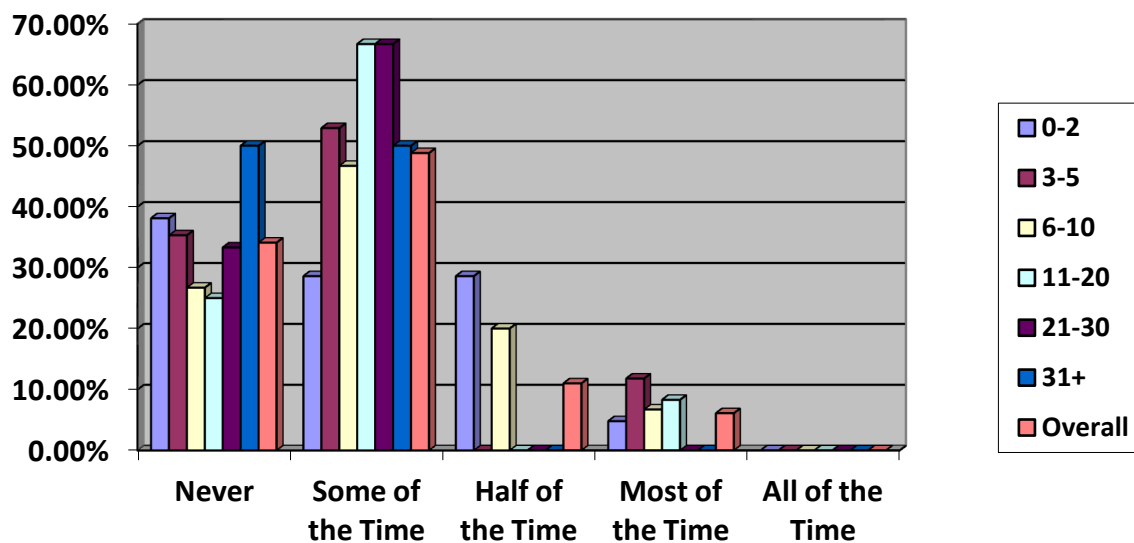


Figure 15: Respondents who shorten treatment due to managed care based on the clinician's years of practice.

The most common reason for shortening treatment was due to an inability to get reimbursement from managed care companies (51.2%). Other reasons given were because the

client's diagnosis was not severe enough (31.7%), there were too many supports already reimbursed or provided (19.5%), there was not enough documentation to support the need (13.4%), the diagnosis was not reimbursable for another reason (9.8%), and other reasons (12.2%):

- *"They say there is not enough documentation to support need when there clearly is- they treat people terribly."*
- *"Billing department handles this generally."*
- *"I have, however, fought in order to keep my clients covered on many occasions."*
- *"Clients may not be able to continue to afford it, even with a reduced fee."*
- *"As part of my contract with younger patients and parents, I stipulate that they agree that treatment will not end or be adversely impacted by the pressures or whims of managed care which do not or only seldom parallel clinical needs."*
- *"Also offer sliding scale fee so usually is when no reimbursement and patient can't pay reduced fee. Would then be referred to community mental health care."*
- *"Diagnosis assumed by managed care not to be "biologically based" and therefore does not fall under fictional umbrella; results in not being able to treat real symptoms and illness simply because medical model often poorly applies to mental health conditions."*
- *"Been seeing the person in the same capacity for "too long" and was no longer considered acute for the type of service."*
- *"I work for an agency and have little to do with billing. I do authorizations and I am aware of a preference for biweekly meetings for therapy unless therapist can meet requirements of meeting medical necessity. I might see more clients weekly without having to document need. I think clients might benefit from more frequent meetings."*

- *“Lack of clear medical necessity for continued treatment. Clients most need ongoing support which could be provided by group therapy, self-help, or AlAnon.”*

None indicated that they shorten treatment because the diagnosis was too severe, and 34.1% of respondents indicated that they have never shortened treatment.

Most respondents (47.6%) indicated that they use a different treatment orientation/modality to satisfy the requirements of managed care compared to what they would use without managed care some of the time. Others indicated they used a different treatment modality/orientation none of the time (32.9%), about half of the time (13.4%), most of the time (3.7%), and all of the time (2.4%). Figure 6 illustrates the distribution of respondents who indicated they used a different treatment orientation/modality due to managed care based on how much they work with managed care.

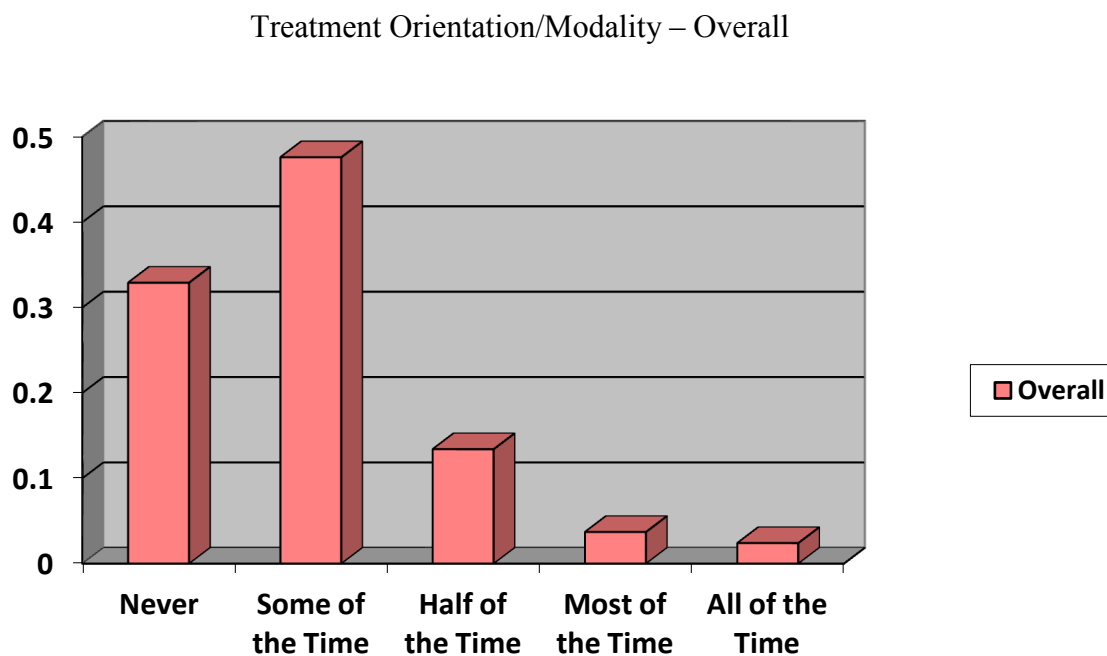


Figure 16: Respondents who used a different treatment orientation/modality due to managed care overall.

The frequency that clinicians indicated they use a different treatment modality or orientation due to managed care was further examined based on how much they work with managed care and based on how many years they have been practicing. The results are illustrated in Figures 17 and 18.

Treatment Orientation/Modality – Involvement with Managed Care

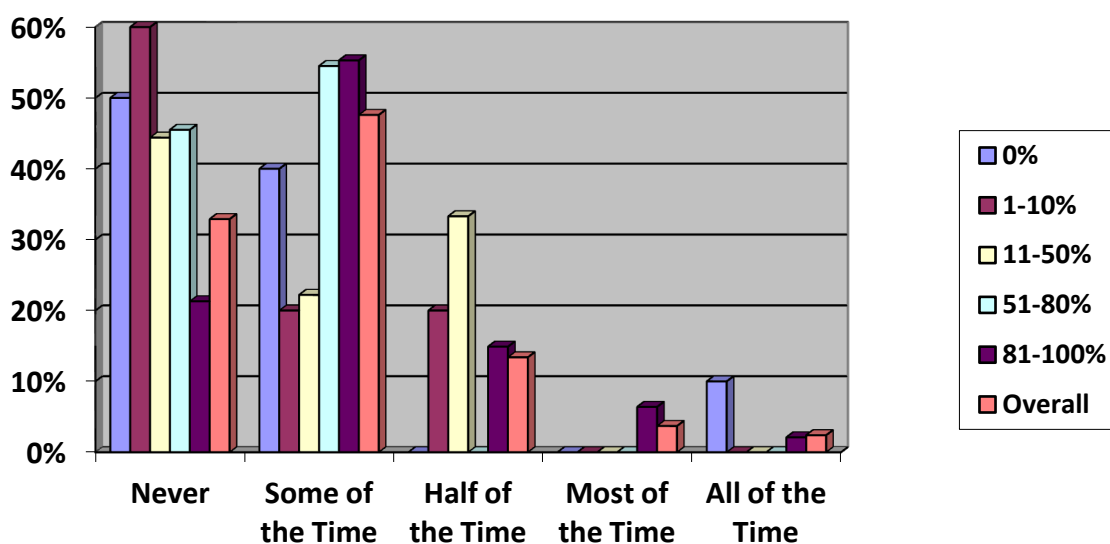


Figure 17: Respondents who used a different treatment orientation/modality due to managed care based on their level of involvement with managed care.

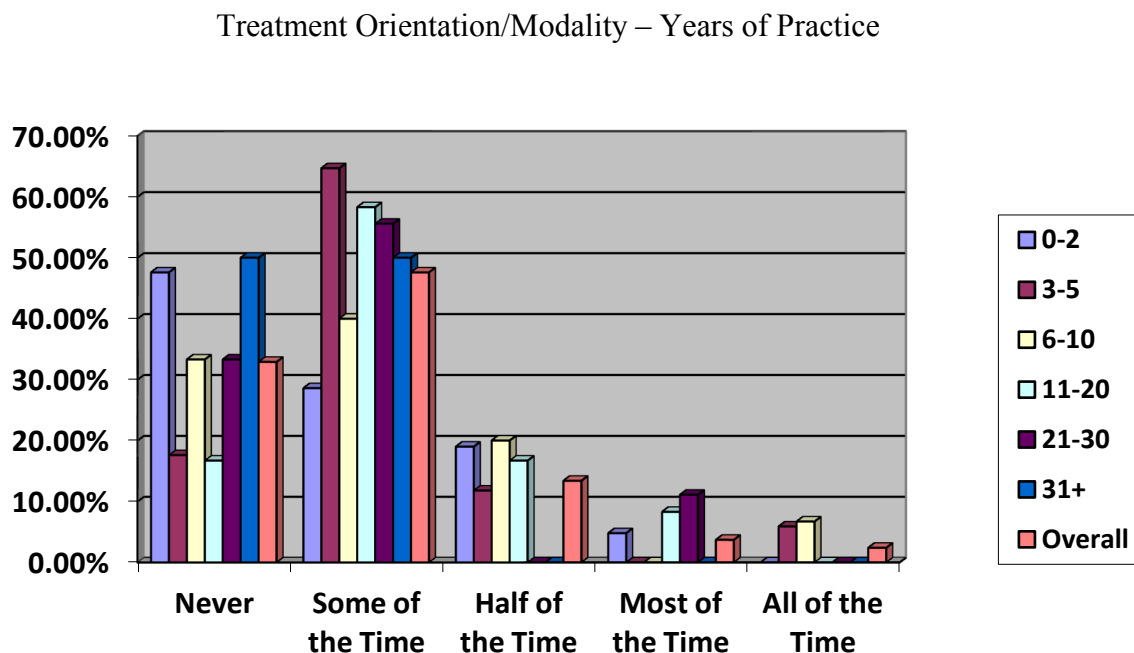


Figure 18: Respondents who used a different treatment orientation/modality due to managed care based on the clinician's years of practice.

The most common reason for using a different treatment orientation/modality was due to needing behavioral goals/measurable objectives (40.2%). Other reasons given were because a diagnosis needed to be given (39%), treatment needed to be short-term (28%), treatment limited to weekly or bi-weekly sessions (28%), and other reasons (7.3%):

- *"I should be able to meet with parents alone when I begin working with children, but I can't because I need to evaluate for diagnosis in the first session."*
- *"Was unable to get approval for weekly DBT group."*
- *"I use CBT, so there is no conflict."*
- *"Necessity of short term view in managed care models results in poor treatment of many individuals whose anxiety may interfere with getting to some sessions (thus leading to less time in therapy and therapy that could be very successful being cut short). Additionally, many individuals take time before they develop a level of trust in the*

therapeutic relationship that is a large contributor to treatment success and managed care interferes with this process by requiring fast improvement. However, mental health conditions are not the same as medical conditions and do not follow the same course of steady improvement expected with them.”

- *“Referred for psychiatry and individual therapy when I don't think the client needs it (she needed her family to participate in family therapy).”*
- *“Need to work on a more solution focused fashion.”*

34.1% of respondents indicated that they have never used a different treatment orientation/modality.

Most respondents (81.7%) indicated that they never intentionally soften diagnoses to satisfy the requirements of managed care. Others indicated they soften diagnoses some of the time (17.1%), and most of the time (1.2%). None indicated they soften diagnoses about half of the time or all of the time.

Intentionally Soften Diagnosis – Overall

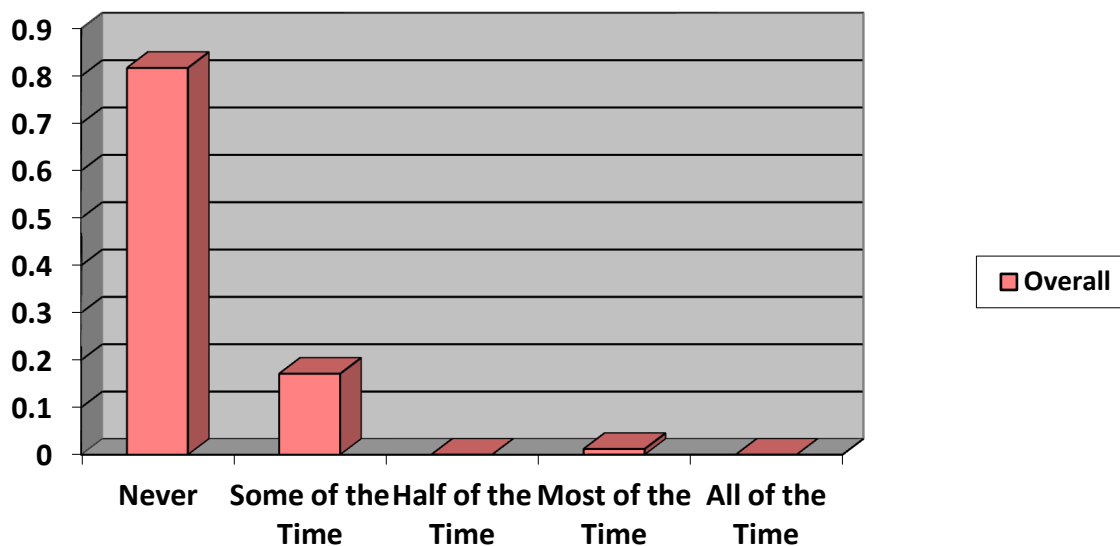


Figure 19: Respondents who intentionally soften a diagnosis due to managed care overall.

The frequency that clinicians indicated they intentionally soften diagnoses to satisfy the requirements of managed care was further examined based on how much the clinician works with managed care and the number of years the clinician has been in practice. The results are illustrated in Figures 20 and 21.

Intentionally Soften Diagnosis – Involvement with Managed Care

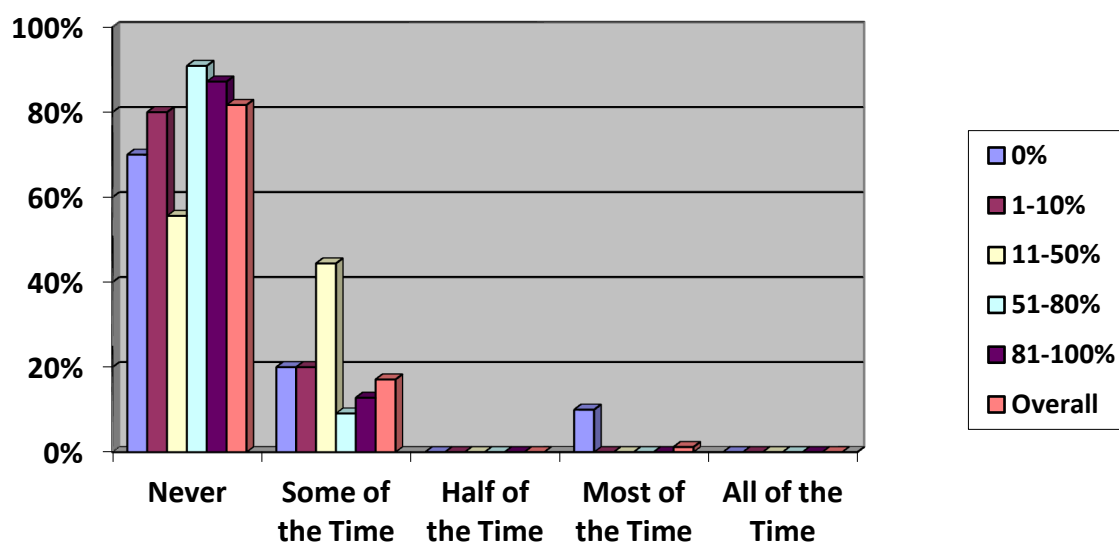


Figure 20: Respondents who intentionally soften a diagnosis due to managed care based on their level of involvement with managed care.

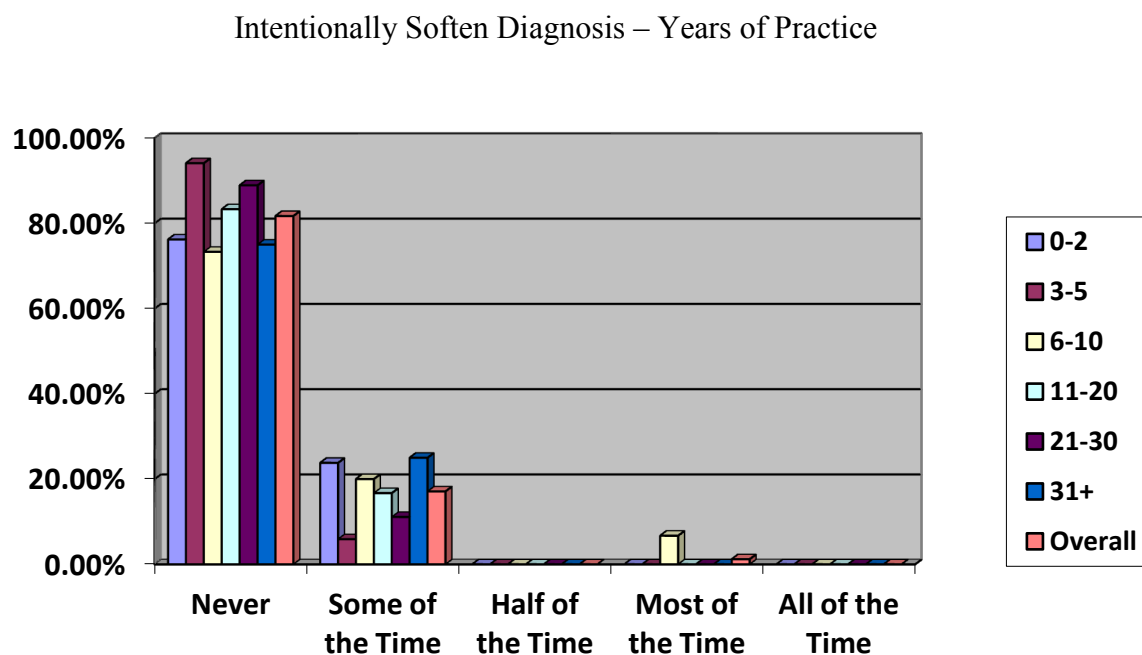


Figure 21: Respondents who intentionally soften a diagnosis due to managed care based on the clinician's years of practice.

Most respondents (50%) indicated that they intentionally give more severe diagnoses to satisfy the requirements of managed care some of the time. Others indicated they give more severe diagnoses none of the time (36.6%), about half of the time (11%), and most of the time (2.4%). None indicated they give more severe diagnoses all of the time.

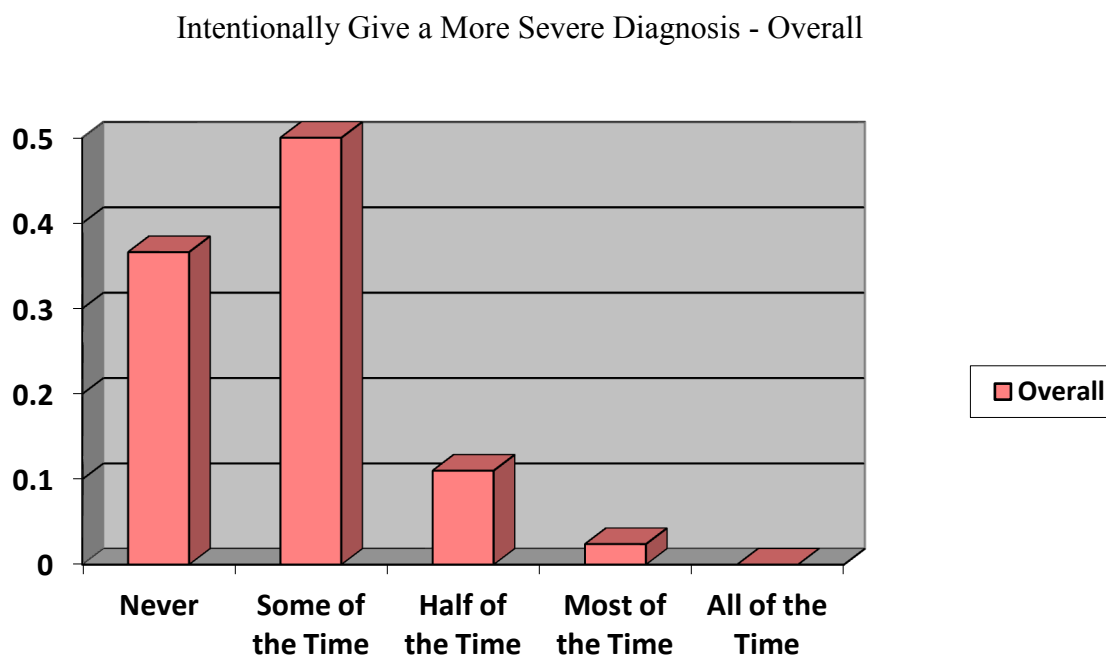


Figure 22: Respondents who intentionally give a more severe diagnosis due to managed care overall.

The frequency that clinicians indicated they intentionally give a more severe diagnoses to satisfy the requirements of managed care was further examined based on how much the clinician works with managed care and the number of years the clinician has been in practice. The results are illustrated in Figures 23 and 24.

Intentionally Give a More Severe Diagnosis - Involvement with Managed Care

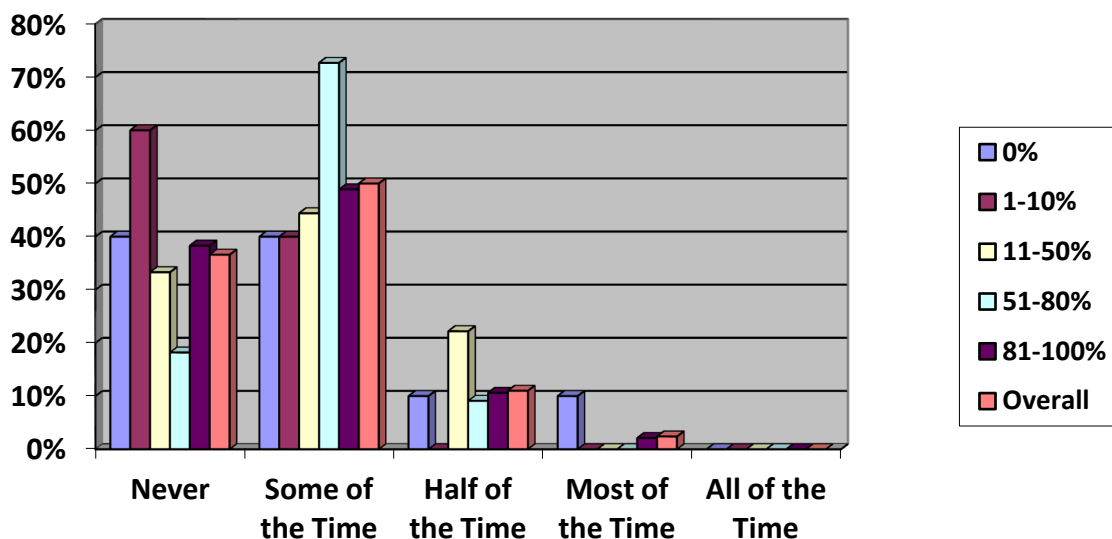


Figure 23: Respondents who intentionally give a more severe diagnosis due to managed care based on their level of involvement with managed care.

Intentionally Give a More Severe Diagnosis – Years of Practice

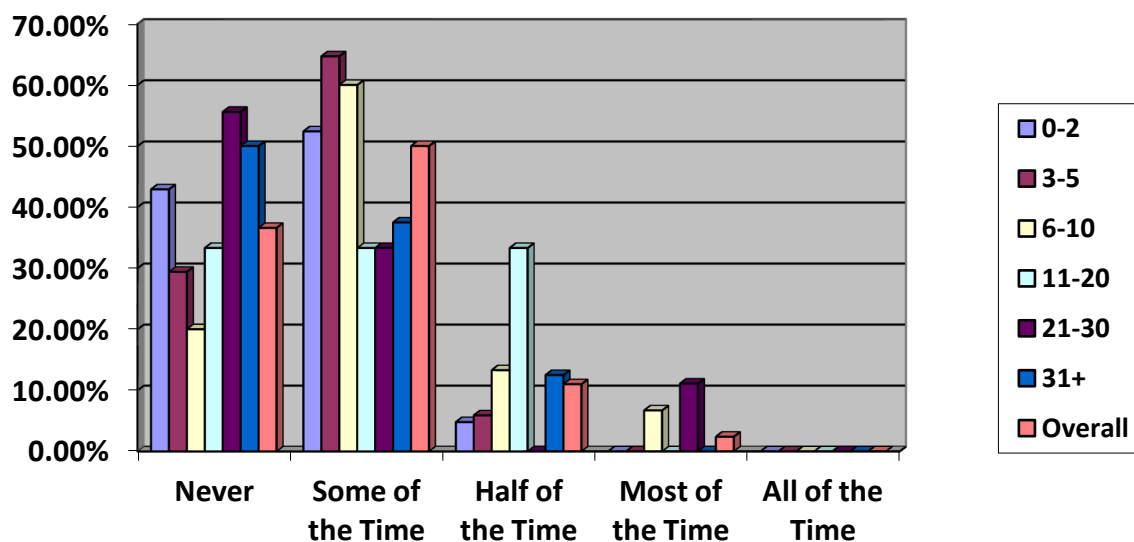


Figure 24: Respondents who intentionally give a more severe diagnosis due to managed care based on the clinician's years of practice.

Respondents indicated that working in a managed care setting affects diagnosis not at all (17.1%), somewhat (64.6%), mostly (14.6%), and always (3.7%).

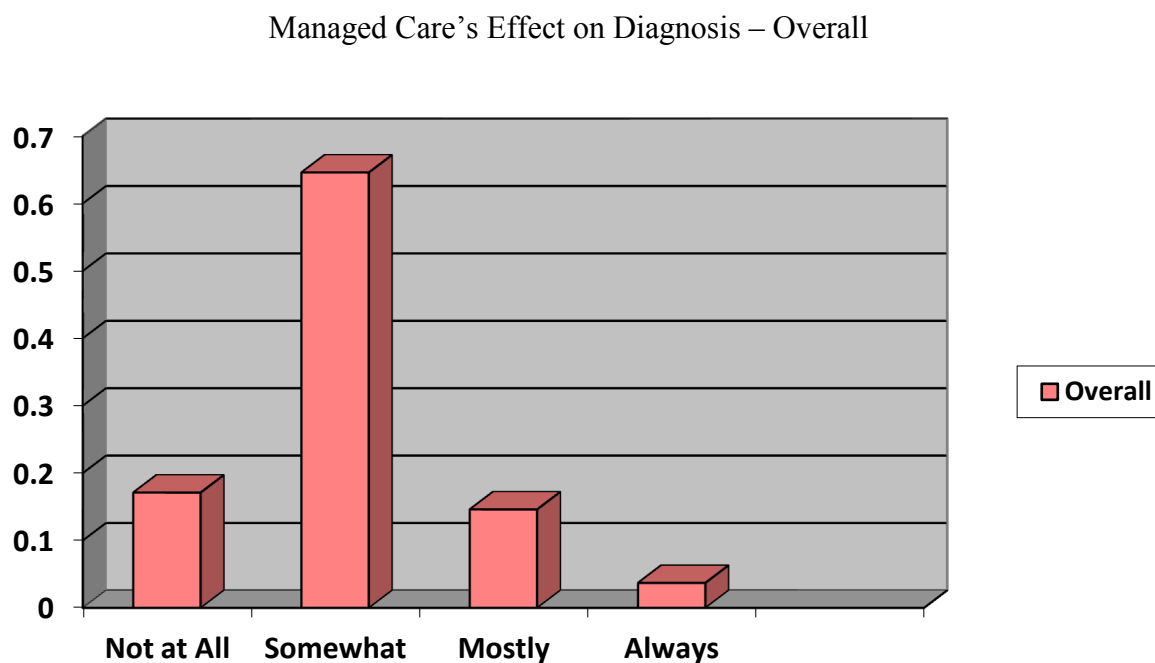


Figure 25: Respondents who indicated the extent to which managed care affects diagnosis overall.

The extent to which clinicians indicated that working in a managed care setting affects diagnosis was further examined based on how much the clinician works with managed care and the number of years the clinician has been in practice. The results are illustrated in Figures 26 and 27.

Managed Care's Effect on Diagnosis – Involvement with Managed Care

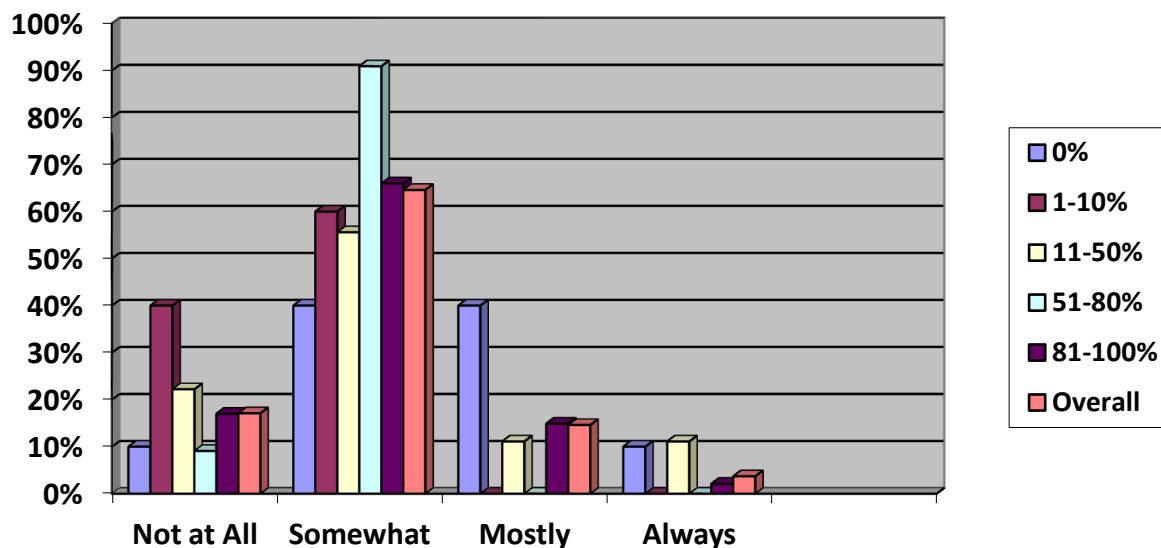


Figure 26: Respondents who indicated the extent to which managed care affects diagnosis based on their level of involvement with managed care.

Managed Care's Effect on Diagnosis – Years of Practice

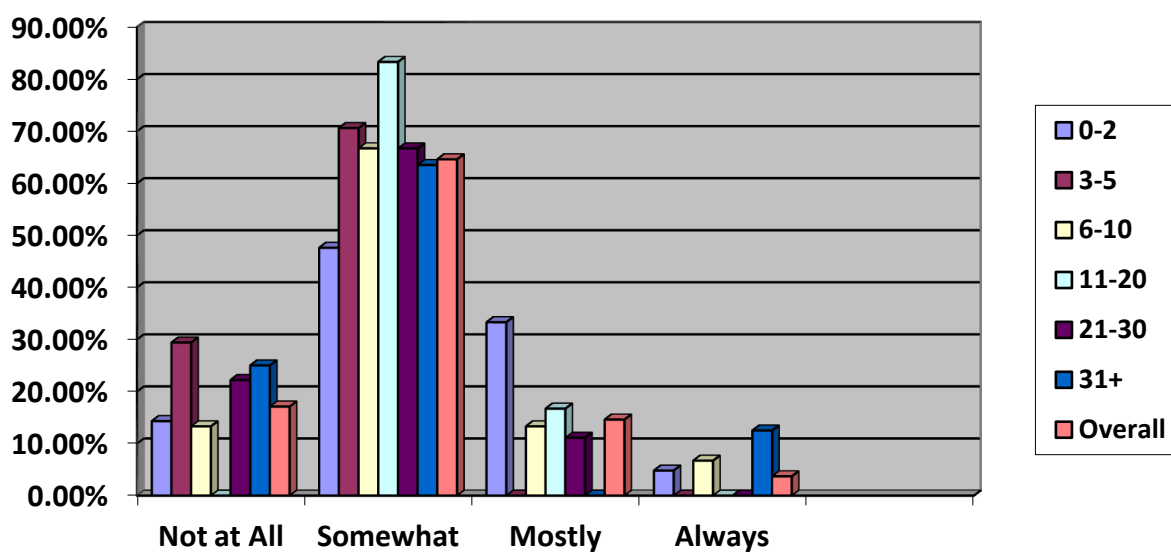


Figure 27: Respondents who indicated the extent to which managed care affects diagnosis based on the clinician's years of practice.

The most common reason for intentionally making an incorrect diagnosis was because symptoms don't fall neatly into one diagnosis (42.7%). Other reasons given were to increase eligibility for additional services (35.4%), symptoms were subclinical (25.6%), to obtain reimbursement (22%), to lessen the stigma for the patient (17.1%), to validate the patient's symptoms (7.3%), and other reasons (6.1%):

- *"Diagnosis has not been "incorrect"; rather I have highlighted client's weaknesses vs. strengths."*
- *"Diagnosis was not necessarily "incorrect," that makes it sound fraudulent. In some cases, families have a difficulty in their relationship and interactions, but a diagnosis is required to provide services. This is when the symptoms must be looked at more carefully than for those families that I see that are sponsored by a social services agency, for example."*
- *"I have never intentionally made an incorrect diagnosis but I do believe it is rare that symptoms fall neatly into one diagnosis."*
- *"I have never made intentional incorrect diagnoses, but i have omitted some and emphasized others."*
- *"I never make an incorrect diagnosis. That would be unethical. There are times managed care stimulates me to rethink the initial diagnosis such as adjustment disorder. I may ask why the person is still experiencing symptoms. It often leads to a more complex diagnosis such as underlying anxiety disorder that appeared initially to be an adjustment disorder."*

32.9% of respondents indicated that they have never intentionally given an incorrect diagnosis.

Most respondents (53.7%) indicated that they alter treatment in other ways to satisfy the requirements of managed care none of the time. Others indicated they alter treatment in another way some of the time (45.1%), and about half of the time (1.2%). None indicated they alter treatment in another way most of the time or all of the time. Figure 10 illustrates the distribution of respondents who indicated they alter treatment to satisfy the requirements of managed care based on how much they work with managed care.

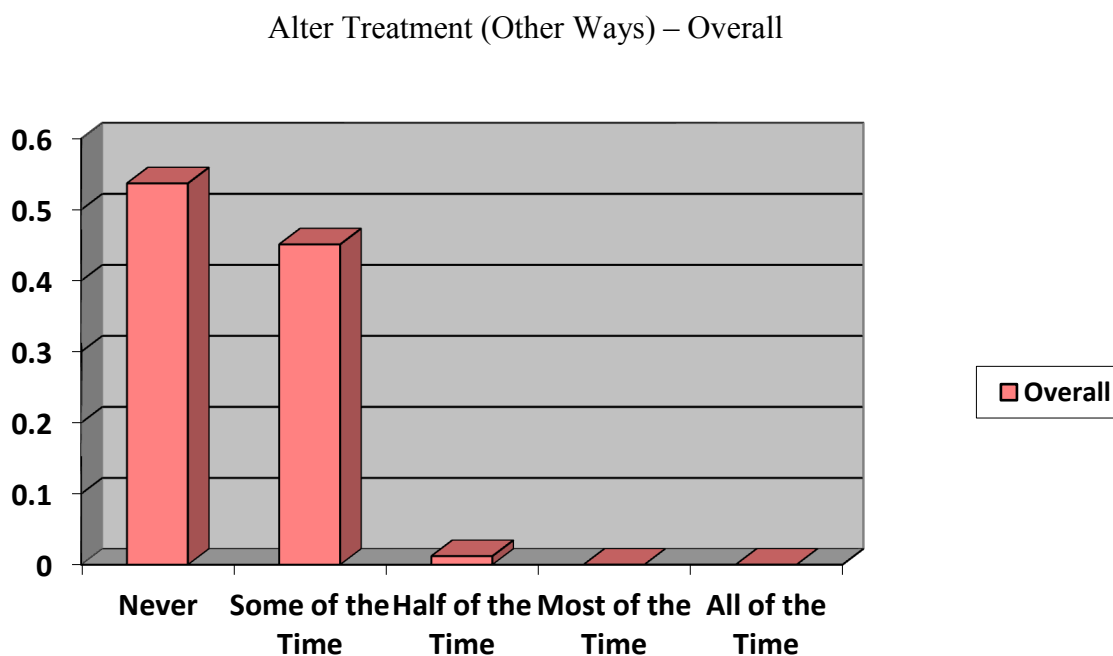


Figure 28: Respondents who indicated they alter treatment to satisfy the requirements of managed care overall.

The frequency that clinicians indicated they alter treatment in other ways was further examined based on how much the clinician works with managed care and the number of years the clinician has been in practice. The results are illustrated in Figures 29 and 30.

Alter Treatment (Other Ways) – Involvement with Managed Care

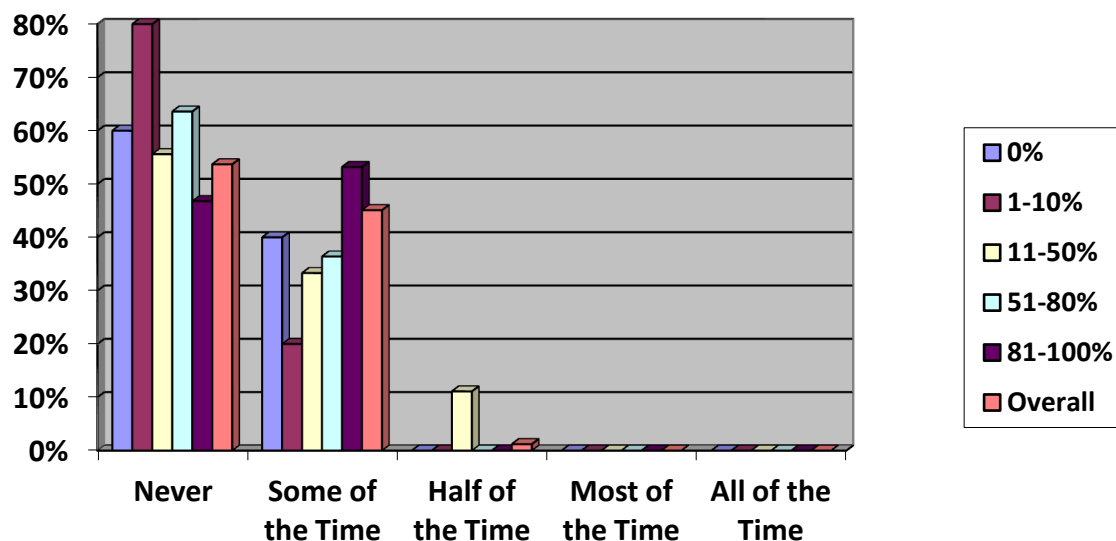


Figure 29: Respondents who indicated they alter treatment to satisfy the requirements of managed care based on their level of involvement with managed care.

Alter Treatment (Other Ways) – Years of Practice

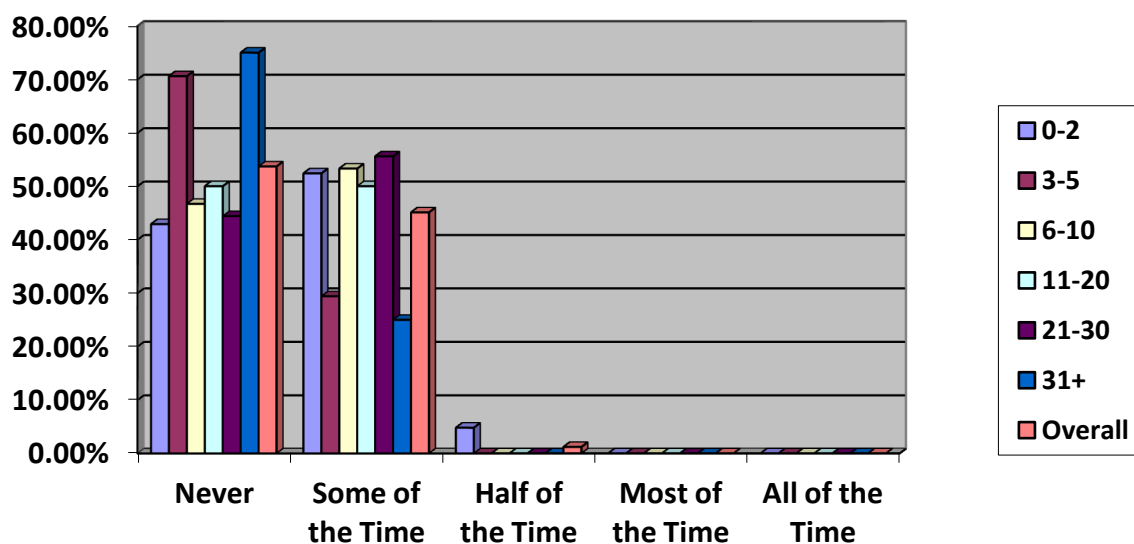


Figure 30: Respondents who indicated they alter treatment to satisfy the requirements of managed care based on the clinician's years of practice.

The most common reason for altering treatment in another way was due to limiting or excluding assessment measures (19.5%). Other reasons given were to terminate suddenly (15.9%), delay treatment (13.4%), and other reasons (13.4%):

- *“What happens is that I have to give more severe diagnosis and low GAF to get sessions. I don't out right give incorrect diagnosis, it's more like the longevity ends up looking more severe. I do raise the GAF scores over treatment plans and that does not seem to limit my sessions.”*
- *“See client every other week, to stretch out treatment episode if client wants treatment all year, but only has 24 sessions.”*
- *“Use of more measurable outcome tools (e.g., quarterly CANS Reviews)... than I would see necessary.”*
- *“I don't terminate suddenly because I believe it to be unethical. Patients, however, have terminated suddenly because their insurance company will not recognize me as a provider. Also, I have severely reduced my fee for a period of time while I helped them find another provider or wrapped up treatment when their insurance company wouldn't authorize treatment.”*
- *“Meet less frequently than I might if more resources.”*
- *“If client loses insurance coverage, I will delay or reschedule session.”*
- *“Refer for services I didn't believe were necessary.”*
- *“Termination due to lack of authorizations or approvals that were not allowed, such as within CBHI, in which the child no longer meets qualifications for services.”*
- *“When a client's insurance becomes ineligible, which happens with regularity within the population I work I do not see the client. This can be abrupt.”*

- *“I have not altered treatment because I don't know the other modalities of care that managed care reimburses.”*
- *“Clients needed longer sessions (1 1/2 or 2 hours) but insurance will not pay for these.”*

53.7% of respondents indicated that they do not alter treatment in other ways.

How do the Alterations Impact Clients?

Most respondents (56.1%) indicated that the adaptations they make affect their clients somewhat negatively. Others indicated the adaptations do not affect their clients (29.3%), affect their clients somewhat positively (13.4%), and affect their clients very positively (1.2%). None indicated the adaptations they make affect their clients very negatively. Figure 31 illustrates the distribution of respondents who indicate the extent to which their adaptations due to managed care affect treatment.

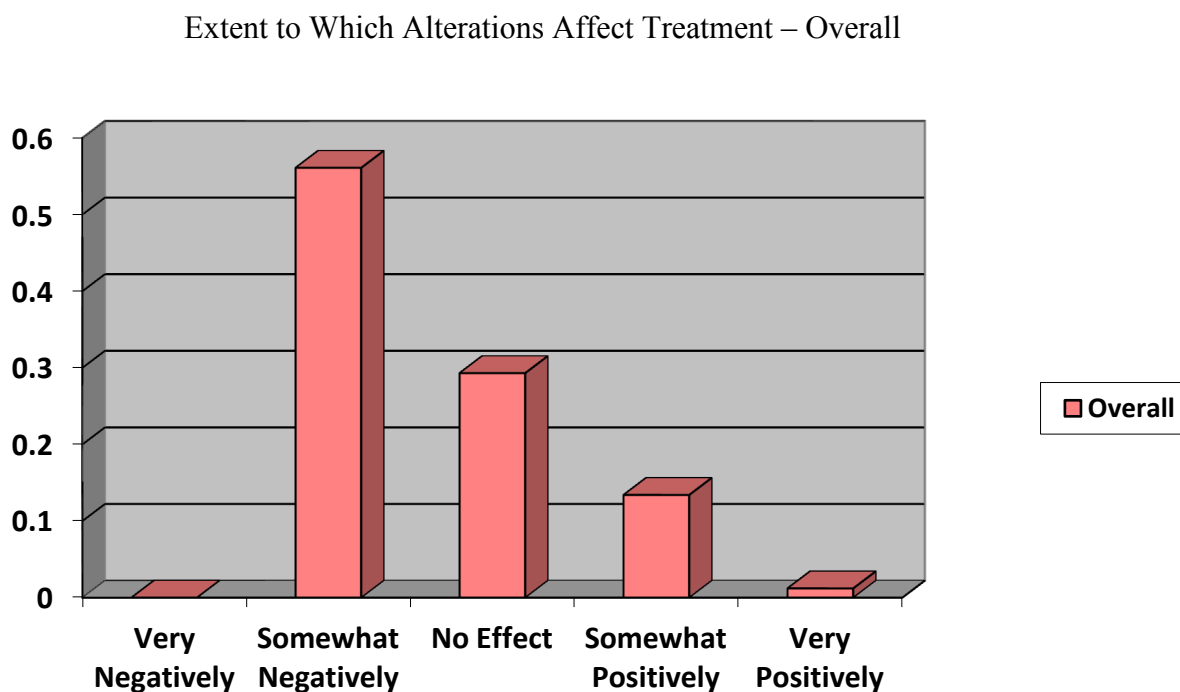


Figure 31: The extent to which respondents alterations due to managed care affect their treatment overall.

The extent to which clinicians indicated that managed care impacts their clients was further examined based on how much the clinician is involved with managed care and based on how many years the clinician has been practicing. The results are illustrated in Figures 32 and 33.

Extent to Which Alterations Affect Treatment – Involvement with Managed Care

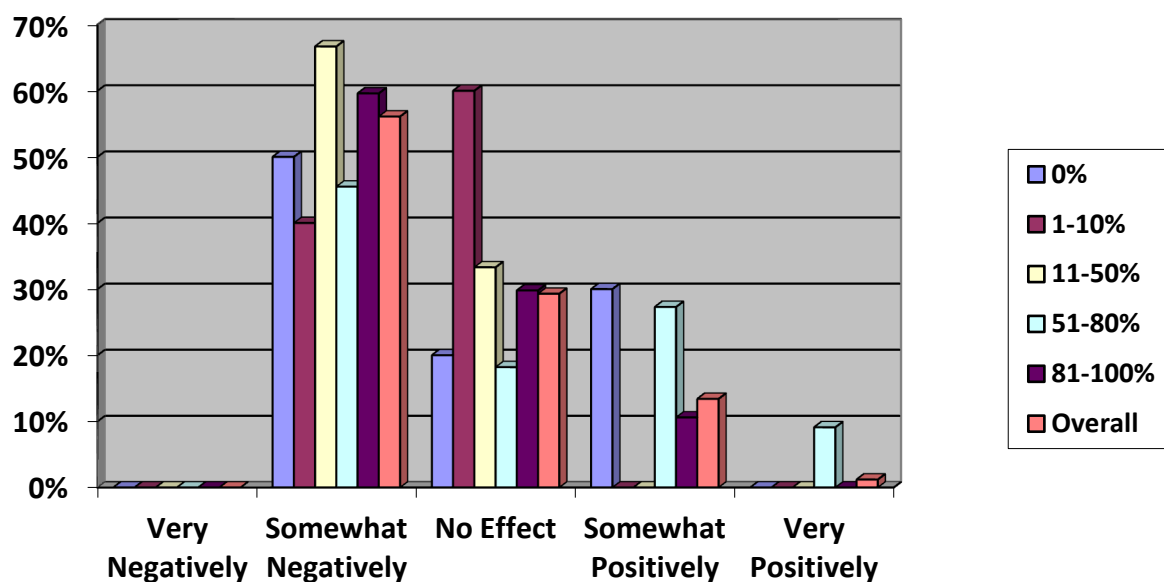


Figure 32: The extent to which respondents alterations due to managed care affect their treatment based on their level of involvement with managed care.

Extent to Which Alterations Affect Treatment – Years of Practice

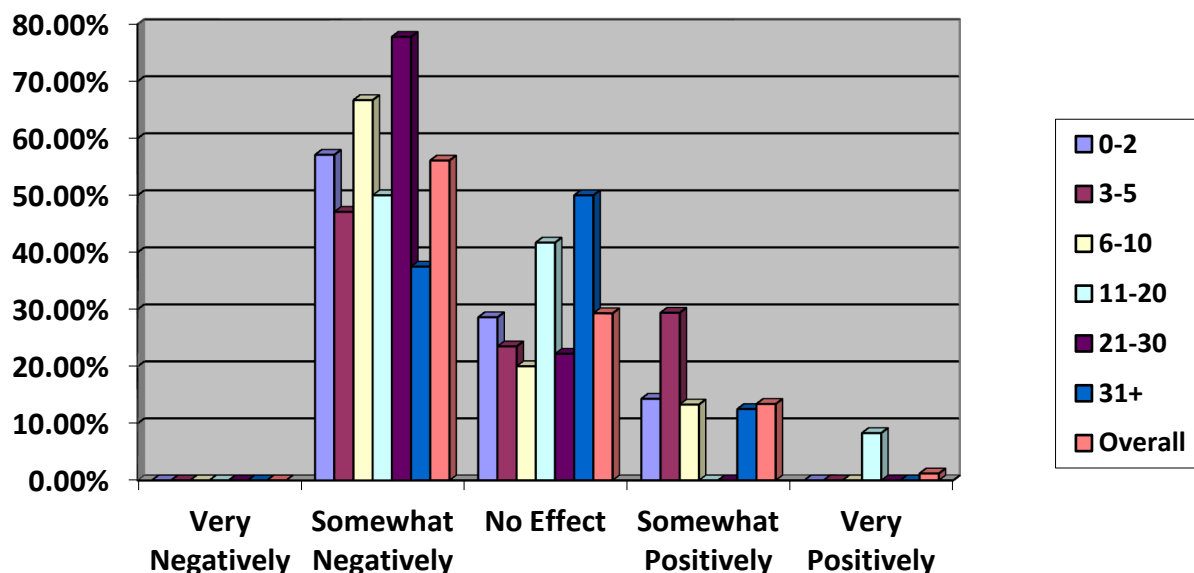


Figure 33: The extent to which respondents alterations due to managed care affect their treatment based on the clinician's years of practice.

The most common way adaptations affected clinicians' work was by reducing access to treatment (54.9%). Other reasons given were by harming the continuity of care (47.6%), decreased space for clinical judgment (43.9%), changed assumptions about what successful treatment means (36.6%), reduced quality of care (29.3%), increased access to treatment (22%), pressure to refer for medication (22%), harmed the patient-provider relationship (17.1%), compromised ethical standards regarding confidentiality (13.4%), improved continuity of care (12.2%), helped the patient-provider relationship (7.3%), increased space for clinical judgment (6.1%), improved quality of care (3.7%), pressure not to refer for medication (1.2%), and other reasons (6.1%):

- *"It is a mixed bag--more often working with managed care means feeling more restricted or having services rejected, but from time to time it actually helps, e.g. with very severe*

clients who get a managed care case manager that is able to give flexible authorizations, single case agreements, advocate for needed services, etc.”

- *“There is one choice in Question 22 that I don't see: my adaptations have been both positive and negative for my patients. For example, some patients have a massive deductible (\$2,500/year). While they are paying off their deductible, I can only charge them the managed care rate, which is about 15% lower than my actual rate per session. This is a benefit to them - they have to pay out of pocket for 100% of the session, but they don't have to pay my full fee. They've gotten a reduced fee without having to ask for it.”*
- *“My clients would not have care if it were not for Mass Health. Still, their insurance limits their access to treatments. For ex: I have a client who would benefit from CSP services but her insurance does not cover this service.”*
- *“I have not worked under managed care for over 12 years. The answers herein about managed care affecting my practice pertain to that time when I did work under managed care in a clinic setting.”*
- *“I am more solution focused which most clients appreciate. Therapy is much less ambiguous and passive. Many people benefit from taking charge of their lives and using therapy intermittently as ongoing support. Also, much less dependency and defining selves as "problems" and "patients". Generally MC has improved the quality of the work and opened up access for new clients.”*

12.2% of respondents indicated that they have not made any adaptations.

Satisfaction

Most respondents (45.1%) were somewhat dissatisfied with managed care. Others were very dissatisfied (23.2%), neither satisfied nor dissatisfied (25.6%), mostly satisfied (4.9%), and very satisfied (1.2%).

Satisfaction with Managed Care – Overall

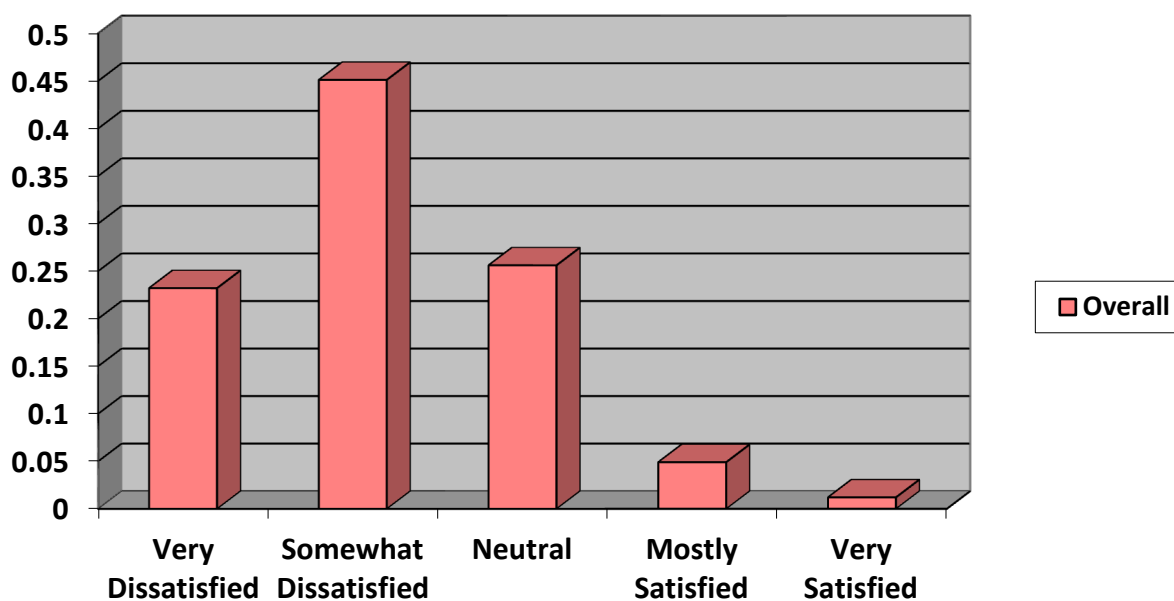


Figure 34: The extent to which respondents indicated satisfaction with managed care overall.

The extent to which clinicians indicated that they were satisfied with managed care was further examined based on how much involvement they have with managed care and how many years they have been practicing. Results are illustrated in Figures 35 and 36.

Satisfaction with Managed Care – Involvement with Managed Care

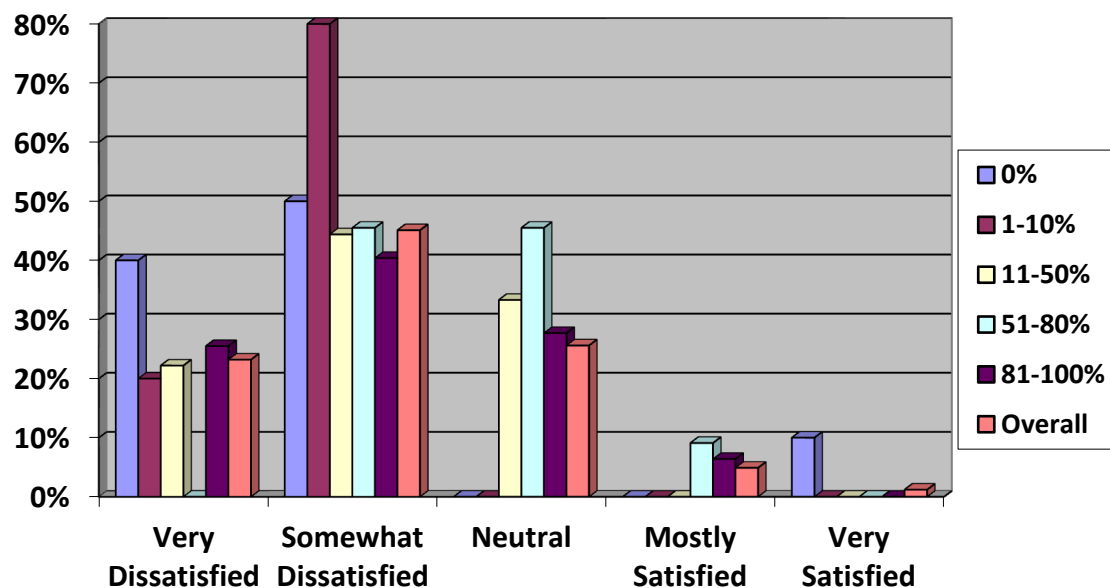


Figure 35: The extent to which respondents indicated satisfaction with managed care based on how much they work with managed care.

Satisfaction with Managed Care – Years of Practice

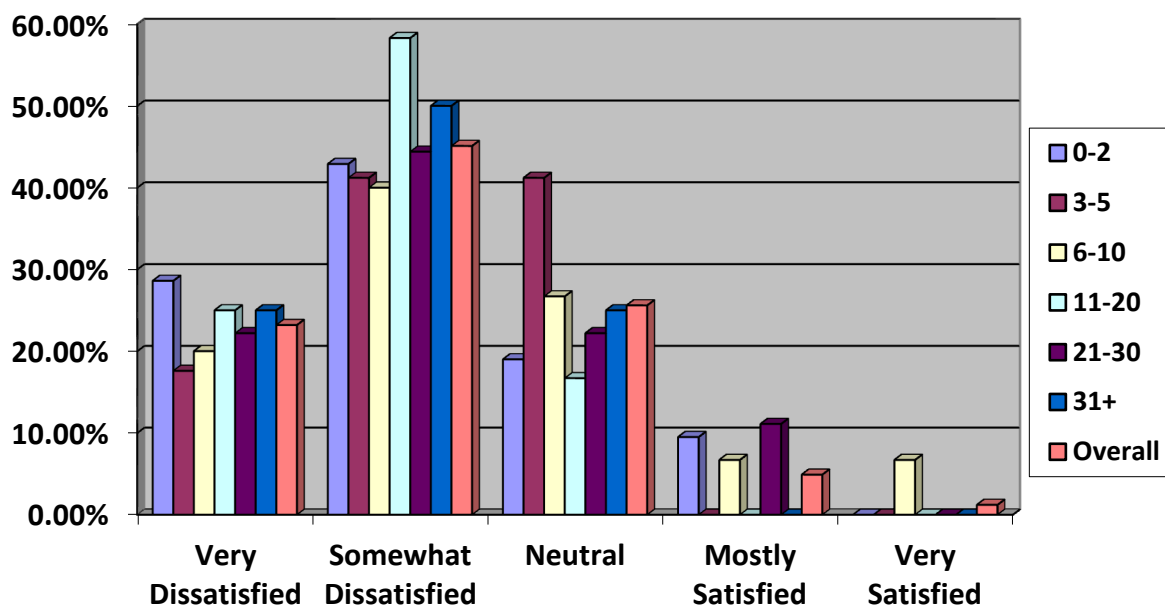


Figure 36: The extent to which respondents indicated satisfaction with managed care based on the clinician's years of practice.

Most respondents (59.8%) were mostly satisfied with their jobs. Others were very dissatisfied (2.4%), somewhat dissatisfied (13.4%), neither satisfied nor dissatisfied (4.9%), and very satisfied (19.5%).



Figure 37: The extent to which respondents indicated satisfaction with their jobs overall.

The extent to which clinicians indicated that they were satisfied with managed care was further examined based on how much involvement they have with managed care and how many years they have been practicing. Results are illustrated in Figures 38 and 39.

Satisfaction with Your Job – Involvement with Managed Care

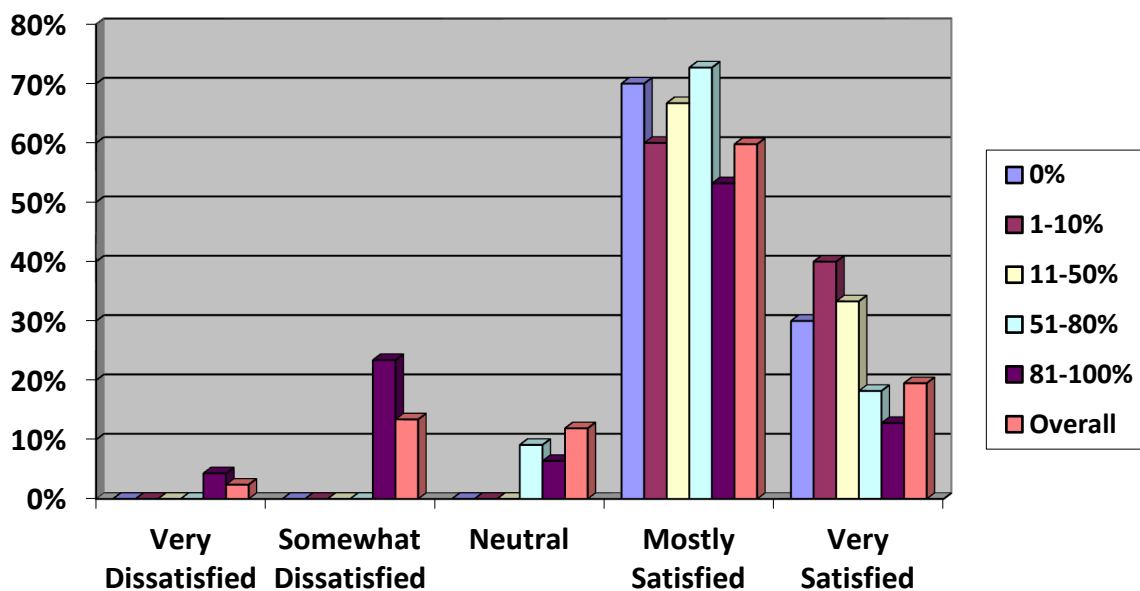


Figure 38: The extent to which respondents indicated satisfaction with their jobs based on how much they work with managed care.

Satisfaction with Your Job – Years of Practice

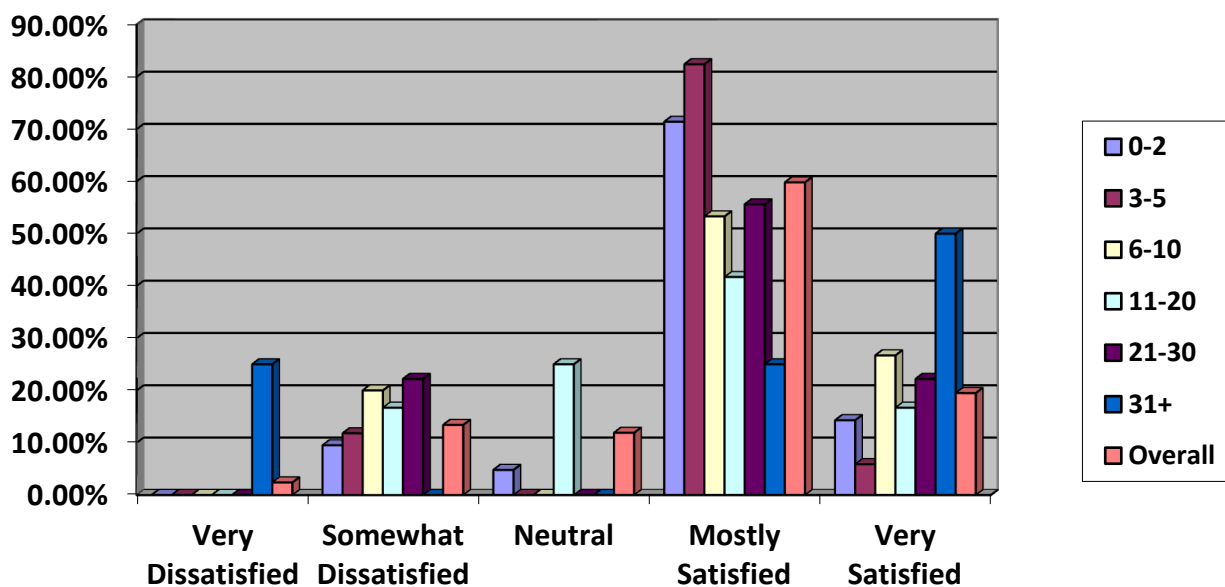


Figure 39: The extent to which respondents indicated satisfaction with their jobs based the clinician's years of practice.

Chapter 5: Discussion

Discussion of Results

Previous research that was conducted in the earlier stages of managed care surveyed participants who had experienced managed care and what it was like to practice prior to the onset of managed care. In this study, while the majority of clinicians work predominantly in managed care settings, there are still practitioners who work independently of managed care. This likely occurs in school or college settings, correctional or residential facilities, and at times for private practice clinicians. For those who indicated they worked completely with managed care at the time of the survey, there is no data to determine whether they have worked previously in a setting that was not dominated by managed care. Additionally, most (67.2%) respondents have been practicing ten years or fewer, during a time when managed care was more prevalent in the field of psychology. It is likely that the majority of respondents in this study have only worked in a managed care setting, and therefore the results of this study would largely be based on individuals who cannot compare working with managed care to working without managed care. This differs from early research that is largely based on clinicians who can make that comparison.

This study sought to explore the following research questions: (a) Currently, what percent of clinicians alter treatment due to managed care? (b) Currently, in what ways do clinicians alter treatment because of managed care? and (c) Currently, how do clinicians believe these alterations impact their clients? Additionally, information was gathered about managed care's impact, both positive and negative, as well as clinician's overall satisfaction with both managed care and their job.

Overall, clinicians indicated a strong impact from managed care. Most respondents believed that impact to occur most of the time, and no one indicated that there was no impact. Furthermore, results of this study indicate an overall dissatisfaction with managed care. Most respondents did not indicate that managed care improves treatment at least half the time or more, while most respondents indicated that managed care harms treatment at least half of the time or more. It was found that the majority of clinicians indicated that treatment is affected by managed care at least half of the time or more.

The first research question explored the percentage of clinicians who alter treatment due to managed care. Results of this study indicate that the majority of clinicians indicate that they conduct treatment differently due to managed care half of the time or less. Those who work with managed care the least (50% of the time or less) are less impacted by managed care as to how they conduct treatment.

The second research question explored the ways clinicians alter treatment because of managed care. Results of this study indicate that most clinicians state that they do not conduct treatment differently, shorten treatment, use a different treatment modality or orientation, intentionally soften diagnoses, intentionally give more severe diagnoses, or alter treatment in other ways under managed care than they would without managed care at least half of the time or more.

The third research question explored how clinicians believe these alterations impact their clients. Results of this study indicate that the majority of clinicians believe that these alterations affect their clients somewhat negatively, while some believed there was no affect, and very few indicated an affect that was positive. While more emphasis was placed on the negative impacts of managed care through a number of categories (i.e., quality of care, access to treatment, effect

on the patient-provider relationship, continuity of care, space for clinical judgment, input into referring for medications), some respondents indicated that the consequences have benefits.

Additionally, the majority of respondents are dissatisfied with managed care, yet mostly satisfied with their jobs. This is contrary to the early research that predicts that the greater the dissatisfaction with managed care, the greater the dissatisfaction with your job. According to the research discussed earlier, this finding could indicate reduced rates of burnout in clinicians subsequent to managed care.

Implications and Reactions

It is interesting to note that there were not observable trends or patterns when the data was examined based on either how much the clinician works with managed care or the number of years the clinician has been practicing. Furthermore, it was surprising that the impact and dissatisfaction with the current managed care system observed was not as strong as this writer would have predicted. This could have occurred for a number of reasons.

First, it is possible that most clinicians practicing today have always worked within the managed care system. Without a comparison, managed care would be synonymous with mental health treatment. It is possible that clinicians do not realize the extent managed care affects various aspects of treatment because it happens all the time and is integral to treatment.

Furthermore, there is likely a tension between following the rules of managed care and providing the best treatment for individuals. This causes a moral and ethical dilemma. This survey asked questions that pulled for responses that would be unethical and to some immoral. There was a defensiveness and rationalization reflected in the responses where respondents indicated “Other.” This might have reflected how respondents chose their response. For example, in regards to intentionally giving an incorrect diagnosis, someone stated that if the

diagnosis initially given was not appropriate for adequate reimbursement, they would think harder for one that could also be true. Also, in regards to shortening treatment, respondents pointed out that this would be unethical and indicated that clients choose to stop attending treatment when the benefits run out. While “cheating the system” is unethical and illegal, not being able to provide the best services for clients is also unethical and immoral.

Additionally, some responses indicate that clinicians might not be aware of the managed care guidelines and restrictions because they do not deal with them directly. For example, a couple of respondents indicated that their agencies have a billing department that must attend to the guidelines. This is likely the case for most respondents who are in training programs, either for practicum or internship placement.

Given the response size, the defensiveness and rationalizations indicated in the responses, and the phrasing of the questions that allowed for wiggle room in interpretation, it is difficult to draw clinical implications from this study.

Limitations

This study fell short of the 200 anticipated participants with a total of 82 participants. Although the survey was not lengthy or time consuming, it is suspected that there is an abundance of Internet surveys in which to participate that most people do not take the time to complete them. Furthermore, it was difficult to widely disperse them. Clinical Directors did not reply to emails or return voicemails. It is difficult to reach Clinic Directors, as they are often extremely busy and carry very large caseloads. Those that received the surveys were the clinics that could be reached in person or those with whom this writer had a previous connection.

Furthermore, results of this study cannot be widely generalized. The sample was based on convenience and generally collected from clinics in Massachusetts and/or the surrounding

New England area. Smaller, geographically restricted samples can be limiting with regard to the variation of participant characteristics and might have a larger focus on variables unique to that geographical area. The sampling bias of this study greatly limits its ability to generalize to a larger and more diverse population. Therefore, the information from this study should be taken as exploratory and not generalized to more diverse populations without further study.

This study explored themes of behavior that one could interpret as fraudulent and/or unethical. There was concern from the start that participants would be reluctant to share this information honestly, even under the umbrella of anonymity. Therefore, the results reported could be skewed in the direction that reduces unethical and/or fraudulent behavior.

Future Research

Moving forward continued research on clinicians' attitudes and behaviors towards managed care would be indicated. Future research should pay closer attention to defining terms that are not given (i.e.: capitation, managed care). Also, narrowing the margin of defensiveness and rationalization in the responses would yield more valid implications. Therefore, narrowing the scope of the questions would reduce this result. Furthermore, the response rate from the Internet survey was very low. This could reflect fatigue with both Internet surveys as well as the topic of managed care. A different approach, such as using paper/pencil, might help increase the response rate. Offering an incentive could increase the rate, but this becomes challenging due to the importance of anonymity within the topic.

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Appendix A

Email Communication with Clinic Directors

My name is Beth Abramson and I am a student in the Clinical Psychology department at Antioch University New England. I am conducting research for a Doctoral dissertation and am requesting that you consider participating in this study.

I am collecting data from Master's level and Doctoral level clinicians regarding their clinical practice under managed care.

The questionnaire should take between 10 and 15 minutes to complete. You will not be asked to disclose any identifying data, apart from your gender, years of practice, type of work/setting, and profession. All survey data will be secured within a password-protected file in a password-protected computer.

Clicking on the link that follows will take you to an online consent form. Once you have indicated consent, you may proceed with the survey. Please note that you may stop at any point in the survey if you feel uncomfortable with the questions.

Survey Link:

<https://www.surveymonkey.com/s/HQJY2PG>

This study has been approved by the Human Research Committee at Antioch University New England. Please contact me with any questions or concerns at babramson@antioch.edu. My dissertation chairperson, Victor Pantesco, Ed.D, is available as well, at vpantesco@antioch.edu.

Thank you, in advance, for your willingness to participate.

Beth Abramson, M.S.
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Clinical Psychology
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Appendix B

Informed Consent Document

This survey is for Master's and Doctoral Level clinicians who have experienced clinical practice under managed care. You are invited to participate in this anonymous, online survey to learn more about clinical practice under managed care. If there are any questions that you believe may cause discomfort or that you do not want to answer for any reason, please feel free to skip over these questions. We hope that you will respond honestly to all of the items, as this will give us the most accurate results. The process should take approximately 10-15 minutes to complete. Your responses to this survey are anonymous and cannot be traced back to you. You should not include any identifying information about yourself on this survey (such as your full name or address). Participation is voluntary and may be withdrawn at any time. This study is being conducted by Beth Abramson, M.S., a Doctoral candidate in the Clinical Psychology Department at Antioch University New England under the supervision of Victor Pantesco, Ed.D. If you have any questions about this study, please contact Beth Abramson (babramson@antioch.edu) or Victor Pantesco (vpantesco@antioch.edu). If you have any questions about your rights as a research participant, you may contact Kevin P. Lyness, Chair of the Antioch University New England Human Research Committee, (603) 283-2149, or Stephen Neun, AUNE Vice President for Academic Affairs, (603) 283-2150. This study has been approved by Antioch University New England's Institutional Review Board. Statement of Consent: I am satisfied that I understand what will be expected of me as a participant in this study. Any data I provide will remain anonymous with respect to my identity. Additionally, I will not include any self-identifying information (such as my full name or mailing address) in my answers to open-ended questions. Furthermore, I understand that I am free to withhold answers to any specific

questions, and I am free to withdraw from the survey at any time. Do you agree with this statement?

Appendix C**DEMOGRAPHICS**Gender:

Male _____ Female _____ Other _____

Years of Practice:

0-2 _____ 6-10 _____ 21-30 _____

3-5 _____ 11-20 _____ 30+ _____

Type of Work: (check all that apply)

Inpatient _____ Outpatient _____ Private Practice _____

Mental Health _____ Substance Abuse _____ Other _____

Profession

Psychology (Master's Level) _____ Social Work (Master's Level) _____

Psychologist (Doctoral Level) _____ Other _____

Do you currently work with a capitation model of managed care?

Yes _____ No _____

STRUCTURED INTERVIEW QUESTIONS

1. What percentage of your work involves using managed care? You will recognize managed care if you deal with authorizations, preauthorizations, utilization reviews, and/or proving medical necessity. Most private health insurances are managed care (i.e., Blue Cross Blue Shield). Mass Health is all managed care.

- (a) 0%
- (b) 1-10%
- (c) 11-50%
- (d) 51-80%
- (e) 81-100%
- (f) I am unsure whether my work is managed care.

2. In your experience, to what extent does managed care improve mental health treatment?

- (a) Not at all
- (b) Some of the time
- (c) About half of the time
- (d) Most of the time
- (e) All of the time

3. In your experience, to what extent does managed care harm mental health treatment?

- (a) Not at all
- (b) Some of the time
- (c) About half of the time
- (d) Most of the time
- (e) All of the time

4. Overall, in your experience, to what extent does managed care affect mental health treatment?

- (a) Not at all
- (b) Some of the time
- (c) About half of the time
- (d) Most of the time
- (e) All of the time

5. Do you conduct treatment under managed care in a way that is different than you would conduct treatment without managed care?

- (a) Never
- (b) Some of the time
- (c) About half of the time
- (d) Most of the time
- (e) All of the time

6. How often do you shorten treatment to satisfy the requirements of managed care?

- (a) Never
- (b) Some of the time
- (c) About half of the time
- (d) Most of the time
- (e) All of the time

7. What are the reasons you have shortened treatment to satisfy the requirements of managed care? (Check all that apply)

- (a) Could not get reimbursement for additional sessions
- (b) Diagnosis was too severe
- (c) Diagnosis was not severe enough
- (d) Diagnosis not reimbursable for another reason
- (e) Not enough documentation to support need
- (f) Too many supports already reimbursed/provided
- (g) Other (Please describe) _____
- (h) I have never done this

8. Do you use a different treatment modality/orientation to satisfy the requirements of managed care compared to what you would use without managed care?

- (a) Never
- (b) Some of the time
- (c) About half of the time
- (d) Most of the time
- (e) All of the time

9. What are the reasons you have used a different treatment modality/orientation to satisfy the requirements of managed care compared to what you would use without managed care? (Check all that apply)

- (a) Forced to give a diagnosis
- (b) Needed behavioral/measurable goals and objectives
- (c) Treatment needed to be short-term
- (d) Treatment limited to weekly or bi-weekly sessions
- (e) Other (Please describe) _____
- (f) I have never done this

10. Do you intentionally soften diagnoses to satisfy the requirements of managed care?

- (a) Never
- (b) Some of the time
- (c) About half of the time
- (d) Most of the time
- (e) All of the time

11. Do you intentionally give more severe diagnoses to satisfy the requirements of managed care?

- (a) Never
- (b) Some of the time
- (c) About half of the time
- (d) Most of the time
- (e) All of the time

12. To what degree does working in a managed care setting affect diagnosis?

- (a) Not at all
- (b) Somewhat
- (c) Mostly
- (d) Always

13. What are the reasons you have made intentional incorrect diagnoses? (Check all that apply)
- (a) To lessen stigma for the patient
 - (b) To obtain reimbursement
 - (c) To increase eligibility for additional services
 - (d) To validate patient's symptoms
 - (e) Symptoms don't fall neatly into one diagnosis
 - (f) Symptoms were subclinical
 - (g) Other (Please describe) _____
 - (h) I have never done this
14. Do you alter treatment in other ways to satisfy the requirements of managed care?
- (a) Never
 - (b) Some of the time
 - (c) About half of the time
 - (d) Most of the time
 - (e) All of the time
15. In what other ways have you altered treatment to satisfy the requirements of managed care? (Check all that apply)
- (a) Limited/excluded assessment measures
 - (b) Terminated suddenly
 - (c) Delayed treatment
 - (d) Other (Please describe) _____
 - (e) I have never done this
16. How have your adaptations in working in a managed care setting affected your patients?
- (a) Very negatively
 - (b) Somewhat negatively
 - (c) They do not impact my clients
 - (d) Somewhat positively
 - (e) Very positively

17. In what ways have these adaptations affected your work? (Check all that apply)

- (a) Reduced quality of care
- (b) Improved quality of care
- (c) Reduced access to treatment
- (d) Increased access to treatment
- (e) Harmed patient/provider relationship
- (f) Helped patient/provider relationship
- (g) Compromised your ethical standards regarding confidentiality
- (h) Harmed continuity of care
- (i) Improved continuity of care
- (j) Decreased space for clinical judgment
- (k) Increased space for clinical judgment
- (l) Pressure to refer for medication
- (m) Pressure not to refer for medication
- (n) Changed assumptions about what successful treatment means
- (o) Other (please describe) _____
- (p) I have not made any adaptations

18. Overall, how satisfied are you with managed care?

- (a) Very dissatisfied
- (b) Somewhat dissatisfied
- (c) Neutral
- (d) Mostly satisfied
- (e) Very satisfied

19. Overall, how satisfied are you with your job?

- (a) Very dissatisfied
- (b) Somewhat dissatisfied
- (c) Neutral
- (d) Mostly satisfied
- (e) Very satisfied