**Literature Review: Mental Health Systems**

Health care reform offers opportunities to improve the care of persons with serious mental illness, but it also can lead to the disruption of innovative systems of care that have been developed in recent years through Medicaid and other public programs. The care of mentally ill persons must be organized to maximize possible trade-offs between inpatient and other community services in a way that will promote function and satisfactory adjustment. An indemnity approach emphasizes controls on demand; instead, better design of supply-side approaches is required, using incentives to integrate services through case management and other methods (Mechanic). Considerable capacity development is needed to integrate long-term care appropriately into the mainstream, but serious barriers include control of risk selection and the difficulties of fairly adjusting capitation rates for high-utilization patients (Andersen). Issues in mental health care are paradigmatic of many other areas of medical care and reflect changing family and community organizations and new challenges in care and rehabilitation.

The heterogeneity of mental health problems, the demographic shifts in populations at risk, and the realities of designing and implementing effective programs, were often overlooked (Mechanic). Components essential for maintenance of function and rehabilitation have yet to be linked into a responsible alternative to long-term or episodic hospital care.

Mental health law traditionally focuses on preserving the civil and constitutional rights of people labeled mentally ill. However, because of fundamental changes in the public mental health system, most people labeled mentally ill no longer reside in state
psychiatric hospitals. As a result, the core policy issue in mental health today is assuring access to community based services, supports, and housing which enable people to live successfully in the community (Petrila). Because of this different environment, the definition and scope of mental health law must be expanded dramatically if those interested in the subject are to continue to influence mental health policy.

Trevino focuses on American Public Health Association's advocacy efforts focused on two major issues: the adoption of a national health program that features universal coverage with a comprehensive set of benefits for all our nation's residents, and the enhancement of the federal, state, and local public health infrastructure (Trevino). Both medical care services and public health programs must be expanded if we are to improve the nation's overall health status.

Mental health policy has evolved haphazardly, reflecting fragmentation of authority, competing ideologies, limitations of current knowledge and technologies, and changes in entitlements and insurance associated with health and welfare programs (Mechanic). The stigma of mental illness affects both intergovernmental cooperation and public response. Health reform provides an opportunity to address neglected areas and to build a closer connection with general health services. New coalitions of advocates for the mentally ill, the elderly, and persons with disabilities could construct a coherent long-term-treatment orientation that would benefit all.

The Institute of Medicine's The Future of Public Health calls for a strengthening of linkages between public health and mental health, with a view to integrating the functions at the service delivery level (Collier). In 1977, mental health and addiction services were merged into the Department of Health. More recently, in 1988, adult
mental health services were split off into a quasi-public corporation. Children's mental health, however, was retained as a distinct service within the Department of Health in order to enhance coordination with other health services for children. Replication of such coordinated-care models is certainly feasible (Zimmerman).

Organizational change for local mental health systems has been advanced as an important aspect of improving the performance of public mental health systems. Fiscal decentralization is a central element of many proposals for organizational change. Data from the states of Ohio and Texas were used in one study to examine some of the consequences of fiscal decentralization of public mental health care (Frank). The data analysis shows that local mental health systems respond to financial incentives, even when they are modest; that fiscal decentralization leads to increased fiscal effort by localities; and that decentralization also results in greater inequality in service between poorer and wealthier localities.

State agencies are charged with ensuring the productive use of resources in the ambiguous and controversial mental health segment of the public health sector. Equity, efficiency, and effectiveness are difficult for these agencies to measure because of undefined system boundaries, decentralized control of resources, conflicting outcome expectations, and uncertainty about the most appropriate technology (Arrington).

REFERENCES


Health Care in the United States

In an attempt to curb runaway health costs, the concept of managed care was introduced: no longer would medical services be fee-for-service. Rather, the managed care entity would authorize, and by extension, ration, medical services for its patients. The resulting networks would become ubiquitous in the American health care systems, and seemingly overnight, the system was reinvented. The question of course, was whether or not the care remained efficacious – and the answer to the question would be less forthcoming for a mother with a sick child at three in the morning than it would be for the director of any particular HMO. The following articles examine the state of managed care in the United States, with particular attention paid to areas of interest for policymakers.
Blendon (1998) considers the rise of managed care and the resulting backlash against the widespread belief that consumers will lose control of their health care. The authors attempt to determine whether this backlash is real (as opposed to being a product of the media) and if it is, whether it is justified, and efficacious. They find that it is real, and that it is influenced by “a significant proportion of Americans reporting problems with managed health care plans,” and also that “the public perceives threatening and dramatic events in managed care that have been experienced by just a few.” Moreover, fear of managed care efficacy in an unforeseen future disability are widespread. Thus, while Americans are generally satisfied with their health insurance plans (regardless of the type), they also want regulation of managed care plans, even if it raises costs. Though poorly written, the reader can infer that the problem lay with the media and over-anxious (read: litigious) Americans, and not with the health care industry.

In a well-written piece, Caronna (2004) uses an “institutional perspective to analyze the history and current state of the American health care system in terms of the alignment of its normative, cognitive, and regulatory elements.” By examining three different eras of healthcare (professional dominance, federal government involvement, and managerial control and market mechanisms), the author argues that consumer and provider dissatisfaction with managed care has resulted in the emergence of a new era that “renews alignment between normative beliefs and values, cognitive models, and regulation.”

Deal, et al (1998) focus on the rationing of medical care via managed health care and its effect on children. They argue that a lack of choice hurts those who need it the most – the seriously ill, and that the needs of children (a large percentage of enrollees)
are being overlooked. The authors offer several recommendations, such as ensuring that benefits meet children’s changing needs, that they offer appropriate pediatric access, that care can be coordinated with other child-serving organizations, encouraging active participation of the parents, and using risk-adjusted capitation rates, or special reinsurance pools. Finally, the authors argue that health care plans should be rewarded for improving the health of children.

Hellinger (1998) examines the relationship between managed care and quality, and finds that managed care has not decreased quality, although this may not be the case with some vulnerable subpopulations. Hellinger also confirms other studies that indicate consumer satisfaction with managed care is on the decline, especially when trying to access specialized care. Dissatisfaction is most common among older, poorer, and sicker persons than with their younger, wealthier and healthier cohorts. Finally, the author argues that generalizability is a problem, and new maintenance rules may have a large impact on the future of health care.

McGlynn, et al. (2003) offers a highly-cited piece that attempts to determine the quality of health care in the United States via a random sample telephone survey and medical records examinations that measured performance on 439 indicators of quality of care for 30 acute and chronic conditions as well as preventative care, which were then constructed into aggregate scores. They find that participants received only 54.9% of recommended processes in care, with only slight differences between care provided for acute and chronic conditions. The variation occurred according to the particular medical condition: 78% for senile cataracts; 10% for alcohol dependence. The authors argue that
while there is no simple solution, an overhaul of current health information systems, and a national base line for performance are steps in the right direction.

Mechanic (2001) argues that public focus is incorrectly focused on managed care issues, which he argues are peripheral to the central question, and that the public should be focused on overall health care reform, and ideally, universal health care. The problem, Mechanic argues, is that there is a distorted understanding of the relation between financial constraints and the provision of accessible and competent health care, and that public trust in the “system” has decreased as a result. Public trust in managed care systems is also declining due the realization that services that patients want or need may be denied. This trust is further compromised by physician unhappiness with managed care organizations who may prohibit doctors from discussing treatment with patients prior to obtaining an authorization for that treatment, although this practice is rumored more than actually done. Thus, the author argues that future health care reform should focus on building the public trust. The problems with healthcare reform, however are numerous: policymakers have too many concerns to keep at bay, and to many people to make happy. The only solution is to “muddle through” with a system that sets constraints on spending but also has the flexibility to deal with complexity in people’s lives, and the government can best contribute to this goal by establishing a “universal decent minimum standard for health care.”

Miller and Luft (1997) examine managed care and consider whether this leads to better or worse care, and conclude that managed care does not automatically equate to worse care, although Medicare HMO enrollees with chronic conditions showed worse quality of care. Quadagno (2004) argues that while political theorists attribute the failure
of the national health insurance in the US to broader forces of American political development, the real obstacle is actually “stakeholder mobilization,” with the stakeholder being, of course, organizations such as the AMA, insurance companies, and employer groups who have been able to help defeat every effort to enact national health insurance across an entire century. The author seeks out a successful reform organization in search of a possible tactic, and argues that “prospects for reform are enhanced when a coalition is organized in ways that closely mirror the representative arrangements of the American state.” In other words, this means an organizational structure with a federal framework, that used a top-down/bottom-up approach to health care reform.

The authors examine managed health care plans administered by Medicare in an effort to determine the equivalency in care received by blacks and whites. Their unit of analysis is the individual level observations (N = 1.8m), taken from 183 health plans over a six year period from 1997-2003. For each measure, they assess the magnitude of the racial disparities that had changed over time with the use of multivariate models that adjust for the age, sex, health plan, Medicaid eligibility, and socioeconomic position of beneficiaries on the basis of their area of residence. They find that not only did clinical performance improve for both race of enrollees, the racial disparity decreased over time for seven of nine measures. The authors attribute the decrease to increases in the consistency of delivery of care, although they authors wisely self-deprecate their study by citing several weaknesses, such as a lack of examination into location of care, the lack of other ethnic groups in the study, and most importantly, the authors did not seek to isolate the causal mechanism at work.
Finally, Chassin, et al.,(1998) via an “Institute of Medicine National Roundtable on Health Care Quality,” argue that the problem with American health care is not managed care, it is the quality of the care itself. The authors discussed the problem with a wide variety of experts and concluded that serious problems exist with the misuse, overuse, or the underuse of recommended care practices, and also argue that the quality of health care can be precisely defined and measured with a degree of scientific accuracy comparable with that of most measures used in clinical medicine.

In conclusion, it seems pretty clear that the managed health care system works great, except in the cases in which you need to use it. Policymakers are going to have a tough time working out a solution that has the consensus and approval of all parties involved.

Works Cited

Blendon, Robert J., et al. 1998. “Understanding the Managed Care Backlash.” *Health Affairs.* 17(4): 80-95


Reformation of health care in the United States has been a topic of dissention among policy makers and consumers for several decades. Secondary to the issue of health care is the need for adequate behavioral health care funded by insurance and public assistance programs. The debate surrounding the issue of how to deliver the services is prevalent in scholarly research. Mental health care should be available to consumers in the same format as physical health care and should be provided by the local entity most capable of managing the providers, funds, and customers. The literature around this topic encompasses three common themes: ample time to develop a transition from fee for service to managed health companies, carve-out versus carve-in models for behavioral health care, and appropriate capitation or financing rates for the mental health care provision. The evolution of Medicaid- federal funding to American states for indigent health care, has forced states to depart from fee for service and move toward managed care organizations. The fee for service model allowed providers to take advantage of the system financially while delivering inadequate care to the indigent (Giles & Marafiote 1998). With cost containment as the focus for state budgets, managed health is the only feasible solution. The question as to who should manage the care, a public or private entity, and how the behavioral health components should be provided has proponents on both sides of the issue.

One crucial warning came in from pro-private and pro-public management policy makers- avoid a rapid roll out of the reformed plan. The state of Florida made dramatic changes in the state health care plan and customers experienced major disruptions in care because of a failure to ensure adequate contracts were executed in a timely manner (Ridgely, Giard, & Shern 1999). Excellent service was received once an appropriate number of providers had entered the contractual agreement. David Mechanic (1993) suggests that States take at least one decade to build capacity of providers of mental health care in order to adequately address the supply side approach. A Kansas study by Johnston and Romzek (1999) refer to a rapid move to managed care as the Kettl model “to maximize certainty rather than competition”. The authors argue that Kansas legislators verbalize the use of the market model where competition makes efficient
production but failed to realize the need to pay for staff as well as services (pgs 390-391). Oregon’s health care reform raised national criticism but they painstakingly approached the categorization and prioritization of care for the indigent over several years and then planned to implement a two-year phase-in approach (Pollack, McFarland, Georg, & Angell 1994). The need to balance the health care budget should not create a crisis for the medically fragile and underserved by creating chaos with poor planning and rapid change.

Affordable health care for Americans has become an illusive dream over the past three decades while adequate health care for the indigent and disabled seems implausible. Insurance companies have migrated toward health maintenance organizations “HMO’s” and Preferred Provider Options “PPO’s” in order to purchase blocks of health care from accredited professionals for their customers. Many state Medicaid plans also moved into an HMO plan for health care but the behavior health component has been excluded due to the cost (Callahan, Shepard, Bieinecke, Larson & Cavanaugh 1995, Giles & Marafiote 1998), difficulty for consumers to access due to restrictions (Pollack et al. 1994, Callahan et al. 1995), or caps of service at unreasonable quantities (Ridgely et al. 1999, Ettner & Johnson 2003, Benko 2006). The solution for the issue in Medicaid plans is to either provide the behavior health component through the HMO or a “carve-in model”, or to contract outside the HMO professionals for care as a “carve-out model”.

The argument against the carve-in model for mental health care is captured in the Oregon study (Pollack et al. 1994) as the four “uns”, “undefinable, un treatable, unpredictable, and unmanageable”. Since the HMO plan uses a forecast schedule and capitation rate to predict the utilization of mental health services of customers, these factors lead to the exclusion of care directly from providers. The services must be rendered by highly credentialed professionals that are in short supply. Mental health care has largely been the responsibility of the state (Mechanic 1993, Callahan et al. 1995, Johnston et al. 1999, Ridgely et al. 1999) while health care, for the body, has been the responsibility of the private sector. The fear of bankruptcy for HMO’s lead many states to leave the mental health care of Medicaid recipients in a carve-out plan (Callahan et al. 1995, Johnston et al. 1999, Ridgely et al. 1999, Ettner et al. 2003) with a referral necessary from the health provider to access a contracted mental health professional. Kansas’ reform plan included contracting with a private non-profit to case-manage the mental health patients before and during the provision of mental health care (Johnston & Romzek 1999). The states that chose a carve-out revealed in the literature review are Florida (Ridgely et al. 1999), Maryland (Ettner & Johnson 2003), Massachusetts (Callahan et al. 1995), Minnesota (Christianson, Lurie, Finch, Moscovice, & Hartley 1992) and Kansas (Johnston & Romzek 1999).

States that chose a carve-in model were the foci of research about utilization rates. Research of services in California (Beattie, McDaniel & Bond 2006) compared three counties’ substance abuse and dual diagnosis mental health care visits to determine if forecasts were a plausible measurement under an inclusive managed care plan. Oregon (Pollack et al. 1994) strategically planned through a three tiered process for a carve-in plan that allowed universal access, reasonable rates, and cost containment. Mechanic
(1993) argues for carve-in as the only equitable way to deliver mental health services and proposes managed care companies strike a balance between acute care and restorative care typically needed for chronic mentally ill persons. Giles and Marafiote (1998) raise the issue of ethical consideration for professionals and caution against the HMO’s goal of reducing inpatient stays and capping utilization rates for mental health care. With the evolution of managed mental health care companies, they urge (pg 48) the inclusion of practitioners in the decision of forecasting treatment services for various diagnosis. This method is precisely what Oregon did in the tiered approach of decision making for their care plan (Pollack et al. 1994). Research revealed no statistical increase in use rates from a fee for service model to the managed care model in six of seven factors measured (Beattie et al. 2006) and an eventual reduction in visits under managed health care (Christianson et al. 1992).

The ability to forecast use of services in order to properly budget for the care is the main impetus for selection of a reform plan. The issue is appropriately summarized by Mechanic (1993) “The Mental Health sector has been shaped substantially, albeit unintentionally, by general health and welfare policies that were not designed to accommodate the mentally ill.” States want to ensure the providers are willing to deliver the service for the rate allowed and to avoid a health crisis in the state that would put the task back into the safety net of the state. Failure to appropriately forecast use rates resulted in bankruptcy of an HMO in Florida (Ridgely et al. 1999) and the final four HMO’s backing out of the state plan in Colorado (Benko 2006).

With proper forecasting of use rates, effective treatment was accomplished in Massachusetts (Callahan et al. 2003) and Maryland (Ettner & Johnson 2003) by determining newly diagnosed mentally ill required more services than those customers with an older or existing diagnosis. Florida (Ridgely et al. 1999) and Maryland (Ettner et al. 2003) used an automatic enrollment process to spread the cost of patient’s care out evenly to various providers. A categorical analysis of costs of mental health services revealed substance abuse patients required more visits than patients with other mental health diagnosis (Callahan et al. 1995, Ettner et al. 2003) resulting in lower profits for the companies serving those clients (Ettner et al. 2003). Several states realized a reduction from the forecasted use rates as compared to fee for service statistics per capita enrolled (Christianson et al. 1992, Callahan et al. 1995).

These studies are irrespective of the managing entity being public or private for Medicaid. There were successes and failures on public and private management of the funds as well as problems with the carve-in and carve-out models for mental health services. The most critical failures of the system seem to rest on the selection of a managed care organization that does not have experience with Medicaid and mental health care (Christianson et al. 1992, Callahan et al. 1995, Johnston & Romzek 1999, Ridgely et al. 1999, Beattie et al. 2006, Benko 2006). Mechanic (1993) argues for a separate HMO for mental health care and to take one decade to develop this new entity. Johnston et al. (1999) wants mental health care to remain under the state if competition among providers isn’t possible and referred to the state transfer of care to a sole non-
profit as “a monopoly transfer to an interest group”. The selected non-profit lobbied for the contract in the same way as the case study’s non-profit agency.

The subsets of carve-in or carve-out models seem to solve the transition phase dilemma but the inclination to balance state budgets while providing critical mental health care to the indigent on Medicaid seems to rest on inclusion in managed health rather than exclusion from the providers. The call for ethical considerations by Giles et al. (1998) is a necessary policy change to address, from a professional vantage point, the needs of the mentally ill and the mandate to care for the patient throughout the course of a crisis. Non-profits can run human service provision more efficiently than government (Christianson et al. 1992, Johnston et al. 1999, and Ridgely et al. 1999) but capitation rates for mental health services must be adjusted to prevent bankruptcy of the agency (Christianson et al. 1992, Mechanic 1993, Pollack et al. 1994, Callahan et al. 1995, Giles et al. 1998, Johnston et al. 1999, Ridgely et al. 1999). Government entities are forced to focus on the bottom line of a financial statement or risk brisk scrutiny by constituents (Ridgely et al. 1999) while non-profit organizations adeptly manage the care of the human being first while maintaining openly public budgets connected to the care of the ill.

References


Will Mental Health Costs Drive Us All Crazy?

Mental health care and its subsequent costs are rarely, if ever, brought to the forefront in the discussion of American health care. Insurance companies have lagged notoriously behind in their benefit design provisions for mental healthcare when compared with other medical benefits in private insurance. This lack of parity in essence discriminates against people with mental illness and substantially increases their financial risk. (Barry, Frank and McGuire, 2006). Many mental health advocates call for the expansion of such services on the basis that insuring or providing them would actually reduce costs—or at least would allow them to pay for themselves (Gabbard 1997). In addition, differences of opinion regarding the validity of the cost offset model (treatment of mental health to reduce overall medical costs) continues to complicate this debate.
Insurance companies have commonly discriminated against the treatment of mental illness. Very few insurance policies have customarily reimbursed outpatient psychiatric services at the same level that they reimburse outpatient nonpsychiatric medical treatment (Sharfstein, Stoline and Goldman, 1993). Researchers note the contributing stigma attached to psychotherapy that they believe may come from several myths: 1) psychotherapy is not a real treatment; 2) psychotherapy is simply hand-holding that any nontrained professional could do; 3) there is no evidence supporting the efficacy of psychotherapy; and 4) if psychotherapy is available to the public as a component of a standard benefits package, “everyone” will use it and it will “break the bank” (Mumford, et al., 1997).

Private health insurance is generally more restrictive in coverage of mental illness than in coverage for somatic illness. Insurers fear that coverage of mental health services would result in high costs associated with long-term and intensive psychotherapy and extended hospital stays. They also were reluctant to pay for long-term, often custodial, hospital stays that were guaranteed by the public mental health system, the provider of “catastrophic care.” These factors encouraged private insurers to limit coverage for mental health services.

Many employers already believe the bank is near its breaking point. According to a recent article in Health Affairs, employers have largely been ineffective and unenthusiastic managers of the health benefits they sponsor. Health care, in general, is viewed as a distraction from their core mission, yet they cannot manage costs effectively nor can they stop delivering such benefits for obvious reasons (Galvin and Delbanco, 2006). Mental health care makes them want to lose their minds, figuratively speaking, of course.
Some private insurers refused to cover mental illness treatment; others simply limited payment to acute care services. Those who did offer coverage chose to impose various financial restrictions, such as separate and lower annual and lifetime limits on care (per person and per episode of care), as well as separate (and higher) deductibles and co-payments. As a result, individuals paid out-of-pocket for a higher proportion of mental health services than general health services and faced catastrophic financial losses (and/or transfer to the public sector) when the costs of their care exceeded the limits. (Report of the Surgeon General, 2007).

Federal public financing mechanisms, such as Medicare and Medicaid, also imposed limitations on coverage, particularly for long-term care, of “nervous and mental disease” to avoid a complete shift in financial responsibility from state and local governments to the Federal government. Existence of the public sector as a guarantor of “catastrophic care” for the uninsured and underinsured allowed the private sector to avoid financial risk and focus on acute care of less impaired individuals, most of whom received health insurance benefits through their employer (Goldman 1999).

There is a growing acceptance that good mental health can lead to good physical health. Researchers are connecting the relationship in more significant ways. According to one study, the widespread evidence of reduced rate of increase of medical expense following mental health treatment argues for the “inseparability of mind and body in health care”, and it strengthens the assertion that mental health treatment may improve patients’ ability to stay healthy enough to avoid hospital admission for physical illness (Mumford, et al., 1997).

Interestingly enough, while the demand for psychiatric treatment has increased over the past ten years, with the proportion of the population receiving treatment for depression
alone more than tripling (Olfson, Marcus and Druss, 2002), the number of psychiatrists in the United States has plateaued and is expected to lag behind population growth (Cooper, 2002). The implications of such a shortage of psychiatrists is further compounded by the reluctance of a growing number of them to accept new patients whose coverage requires a great deal of administrative activities, such as those covered by privately managed plans and Medicaid (Wilk, et al, 2005).

Mental health care is obviously in a state of concern. Stigmatization of not only those seeking assistance, resistance of employers and insurance companies to cover such assistance as well as the disturbing current trends in the psychiatric workforce all must be aggressively addressed. These conditions are reversible through education and effective public policy; the costs if we are unsuccessful are simply too great to bear.

References


Managed Health Care and Children
Literature Review

Health care, with its associated high costs and less than universal access, often dominates political debates in the United States. Children suffer from a lack of advocacy and therefore face even greater challenges in utilizing this already complicated system. Although managed health care possesses the potential for improved access, lower costs and coordinated care, it currently fails to achieve these lofty expectations. Before diving into the ups and downs of managed health care, one should explore its history. This type of care goes back to the 1920’s and group payment plans such as Ross-Loos, Kaiser, and Group Health. Even further back, in 1850’s California, immigrant settlers banded together to arrange for health care provision. The issue pops up again in the 1970’s as the Nixon administration pushed HMO’s as a way of cutting the costs of health care. In the 1980’s, offshoots of these organizations were placed under the category of “managed care”. Hughes and Luft, in their article entitled, Children and Managed Health Care, 1998, defined managed care as:

…..a variety of financing and delivery arrangements. The single unifying characteristic of these various approaches is that those enrolled in managed care plans are encouraged or required to obtain care through a network of participating providers, who are selected by the managed care organization and who agree to abide by the rules of that organization. This is in contrast to fee-for-service arrangements, in which patients
typically may seek care from any licensed health care professional or organization, and providers may
perform services based on their individual judgments about what is appropriate or needed.¹
As we will see, there is little available data on children as consumers of managed care. Deal and Shiono’s article, Medicaid Managed Care and Children: An Overview, 1998, focuses on one area with existing data.
The use of managed care arrangements to deliver health services to Medicaid beneficiaries has increased in recent years as states and the federal government have sought new ways to control escalating health care expenditures associated with the Medicaid program. Low-income and children, who represent the great majority of Medicaid beneficiaries but account for only a fraction of total program expenditures, have been the primary groups enrolled in Medicaid managed care.²
Based on data from this group, many observers believe that some of the major challenges facing managed care include complete care of children, coordination of care, and costs of care. Jonathan Finkelstein argues, in Defining the Challenge and Opportunities for Children in Managed Health Care: A Pediatrician’s Perspective, 1998,
The first attribute of care systems that promote child health is the assignment to a specific provider (or group) of the responsibility to provide complete care for a population of children. This responsibility includes not just the treatment of disease when a sick child is brought to the office, but monitoring outreach, and disease prevention activities. I believe that managed care has made us confront the real challenges in operationalizing the concept of a medical home. It is always much easier to treat the child in front of you than to develop effective outreach for those families who do not seek care.³
In Defining the Challenge and Opportunities for Children in Managed Health Care: A Parent’s Perspective, 1998, Carol Gleason adds,
Another opportunity for managed care is motivation and flexibility to create special ancillary or supportive services for children with complex needs. …..Yet another opportunity for managed care lies making available a network of providers that includes appropriate pediatric specialists, as well as mechanisms for out-of-plan referrals when warranted.⁴
Managed care held the promise of increased access to these specialists by way of the primary care provider. It has not fulfilled that promise. According to Freund and Lewitt, Managed Care for Children and Pregnant Women: Promises and Pitfalls, 1993,
Findings from the few studies that attempted to measure separately the effect of managed care on use of specialists and primary care physicians suggest that managed care is associated with a reduction in the use of specialists by children without a commensurate increase in the use of primary care physicians.⁵
These effects are magnified in special needs children. Stroul, Pires, Armstrong, and Meyers, in The Impact of Managed Care on Mental Health Services for Children and Their Families, 1998, projected that,
Rather than expanding the array of covered services, the advent of managed care could result in a regression to the traditional insurance model of covering a limited number of services for a limited amount of time.⁶
Overall, child health care is different from adult health care and needs recognition of that fact by managed care providers. Szilagyi, in Two Commentaries: Managed Care for Children: Effect on Access to Care and Utilization of Health Services, 1998, outlines these differences.
Most children are physically healthy. Their health care needs include preventive services; acute services for frequent illness and injuries; management of developmental, school-related, psychosocial, and emotional problems; and the occasional use of specialty, emergency, or inpatient care. Evaluation of access and utilization should focus on these types of services.⁷
Tied into complete care is coordination of care, and this is addressed by Gleason.
Another major opportunity for managed care lies in the coordination role of the primary care provider, who functions as a case manager to ensure that preventive interventions occur and that coordinated referrals for specialty care are made.⁸
Stroul adds,
The loss of an interagency focus is another concern. Interagency planning at the system level and interagency service planning for children are both integral aspects of systems of care. Both of these elements could be lost if they are not directly incorporated into managed care plans, requests for proposals, and contract requirements for MCOs.9

Cost-saving potential in managed care has not been borne out by experience. Freund and Lewitt state that,

Not only does the available literature not show that managed care improves health status or the quality of medical care, it is also not encouraging regarding the cost-saving potential of most forms of managed care. It also appears that managed care has had very little, if any, effect on the rate of growth in health care costs.10

Managed care influences costs in five basic areas, according to Bergman and Homer, Managed Care and the Quality of Children’s Health Services, 1998.

1) Limiting inappropriate use of health care services 2) Controlling access to health care services 3) limiting care by restricting benefit packages 4) limiting the provider network, and 5) manipulating clinicians’ financial incentives to reduce utilization of expensive services.11

There are serious limitations to the data analyzed in these studies. Szilagyi enumerates these.

Experts have noted methodological difficulties in evaluation the effects of managed care plans. These constraints are a major reason for the dearth of studies evaluating managed care effects, and perhaps for the inconsistent and often contradictory findings. Managed care plans differ widely in their structure, financial arrangements, and utilization management, and it is difficult to make generalizations about even theoretical effects on access or utilization of care. The effect of managed care depends on the extent of financial incentives and disincentives placed on the providers, and on the structural and financial arrangements of the comparison groups. Consequently, it is possible to observe even greater variability among different types of managed care plans than between managed care plans and fee-for-service arrangements….Overall, studies have yielded mixed results, with no consistent improvement in access to care resulting from Medicaid managed care.12

Deal, Shiono, and Behrman, in Children and Managed Health Care; Analysis and Recommendations, 1998, offer the following recommendations for child care in a managed care system. They approach the problem at four levels, individual, family, community, and provider to create an integrated approach to the problem which addresses the problems of complete, coordinated, and cost-effective coverage for children.

Bibliography


Bergman, David A.; Charles J. Homer, *Managed Care and the Quality of Children’s Health Services*, The Future of Children, Vol. 8, No. 2, pp. 60-75


Managed Healthcare

Elected officials can hardly go a day without addressing issues related to managed healthcare. The question is; what is the appropriate role of government in guaranteeing the highest levels of standards in quality of care? Do we leave healthcare in the realms of the free market or is government involvement a necessity? Changes in managed healthcare are constantly being sought by consumers, physicians, politicians, healthcare workers, and the health plans themselves. The end result for any major changes in managed healthcare always fall on the consumer, this is not too often a positive result. Policymakers are forced to remember who donated to their campaigns and most often are not qualified to make decisions regarding health care and reform. The debate on healthcare reform has many sides and can be consumer focused, managed plan focused, employer mandated, or deal with prescription drug issues. The healthcare debate has recently focused on management problems, private vs. government (local, state, or federal). The healthcare debate is so multifaceted that most elected officials give up without ever passing any type of real reform. One area that is often forgotten in the health care debate is mental health. Mental health policy, as it pertains to serious and chronic mental illness, represents an arena so badly served by much of the social and preventive care ideology which is still commonly espoused today (Mechanic. 1987). It is estimated that 15% of the population suffers from some form of mental disorder and that we are facing a pandemic of mental disorders, so we are compelled to do something about it (Wagenfeld. 1983). A national study of adolescents and adults found that 48% of the respondents reported that they had experienced a mental disorder in their life time.
When people seek health care regarding mental health issues they are usually misdiagnosed and mistreated and some treatments work on certain groups, but not others (Takeuchi, Kim. 2000). This leads to a move to diversify treatments for diversified populations, this is when managed health care and local clinics are best.

California created a task force to address the issues facing the State which found that any long term solutions to the profound problems in the system would, “require fundamental cultural and systematic change” (Enthoven, Singer. 1998). The taskforce found a backlash amongst consumers due to the fact they were forced from a fee-for-use type plan into a HMO plans which utilized cost containment measures. In a study by Steve Findlay, he explains the trends in managed behavioral healthcare. By focusing in California, Findlay estimates that 78% of Americans in a private or public health plan are also enrolled in some type of managed behavioral health plan. This is taxing the system and in 1996 forced 27 states to develop a managed care plan for mental health patients in efforts to serve the Medicaid effectively (Findlay. 1999). Medicaid works best when it is used in conjunction with community-based systems of care, private sector for profit companies (Stroul, Pires, Armstrong, Meyers. 1998). These community-based systems of care, which are financed largely by Medicaid, are most effective at meeting the needs of juvenile patients and their families. The study finds that those suffering from emotional and behavioral disorders are best served in a managed health care system that utilizes approaches that control for service utilization and contain costs. These community-based systems are just another step in the ever evolving process of mental health care. During the 1850s States began to build asylums in an attempt to treat those with mental disorders
in a more humane way than the confines of the local jails at the time (McPheeters. 1977). According to McPheeters these hospitals led from treatment to custody and rarely made any attempt to bring about healing. Mental health was not considered a federal government concern until the passage of the Community Mental Health Centers Act of 1963 (McPheeters. 1977).

In a study headed by Dr. Dane Wingerson, M.D., he gives us a statistical model of the numbers of patients visiting hospital triages (emergency rooms) instead of having consistent mental health treatment. This places burdens on the medical community and their ability to treat seriously injured. In his conclusion, Wingerson found that patients who were enrolled in a mental health plan were consistently less likely to be homeless and abuse drugs (Wingerson. 2001).

Not all players in the mental health debate agree on the managed care solution. Traditionally the state has been charged with the responsibility for policy formulation, resource distribution, and monitoring functions (Arrington, Biskin. 1982). In an article by S. Arrington and D. Biskin we are given the opportunity to see how private entities do not mix well with state regulations. The authors of the article also cite the problems cause by conflicting expectations from politicians, professionals, parents, the press, and the public at large. Another area of concern in mental health issues is who is going to pay and what is considered a medical problem and what is a mental health problem? Advocacy groups contend that research demonstrates mental condition s like schizophrenia and bipolar disorders are diseases and are more properly addressed in a health care system (Pollack 1994). The insurance companies like to argue what Pollack
call the four “uns”: undefinable, untreatable, unpredictable, and unmanageable (Pollack1994).

Bibliography


A managed care and a traditional (non managed care) substance abuse treatment program were compared to see if there were significant differences in access, costs, outcomes, and cost effectiveness. Predisposing, enabling, and reinforcing variable mean scores were compared to determine whether or not there were significant differences between the two samples. The results of the study demonstrated that the managed care program was cheaper and more cost effective, although utilization of programs was not as different as expected.


This article is about helping people who are homeless. The homeless population is increasing in numbers with complex medical issues. Health care reform must include a mechanism to ensure this population does not get left behind.


Mental health care is typically provided by state mental health agency (SMHA). Unlike other health care services, the state is the primary provider of mental health care. Initially, the state provided services internally. However, over time, the state system for managing mental health care evolved to become more of a manager of a variety of services provided by multiple entities. The purpose of this paper is to analyze the factors that define managed behavioral health systems and to identify the typical game plan to manage care. The factors presented include contracting, utilization, review, and monitoring of services. One of the primary goals of SMHA’s is to provide the best services for the least amount of money. Many are forced to look to outside entities to achieve this goal.

A significant number of the American population is uninsured. Access Health is a community-based approach that intends to reduce the number of uninsured in Muskegon, Michigan. This paper describes the program today along with key issues involved in the origination of the program. The program was founded by the Kellogg Foundation. The program was created in part with the help of local doctors and community funding was one of the most significant issues discussed.


School-based health centers may be the best way to reach disadvantaged youth who would not otherwise have access to care. Two primary issues for the sustainability of school-based health centers are the generation of funding and quality of services provided. The Colorado Association for School-Based Health Care (CASBHC) was founded in 1996. It quickly became evident that quality of care would need to be documented in order to obtain reimbursement. A statewide initiative was undertaken to strengthen and improve school-based health centers. Certification standards and quality of care indicators were established. A survey was conducted to determine patient satisfaction since this is a measure of the quality of service provided. Access to care was the most important factor influencing the quality of care.


This study sought to identify the factors that influence policy-makers to utilize specific research to inform their decisions. The results highlighted that interaction between researchers and policy makers and timing are two important factors that influence the use of information by policy makers. It was noted that it is beneficial for policy makers to be informed of the critical issues relative to specific policy so that they can make informed decisions. The analysis also demonstrated that although recommendations are frequently provided, less information is provided on contextual factors that could help inform decisions. It was recommended that researchers could help policy makers by highlighting the contextual factors relevant to decisions.


The process of privatization of health care in eight countries was the focus of the paper. Evidence that privatization of health care is increasing was presented. The factors that influence the process of privatization or that serve as barriers preventing privatization were examined. Lengthy discussions of the characteristics of public and private were undertaken. A pragmatic approach was taken from four perspectives: health care
financing, health care provision, health care management and operations, and health care investment.


The evaluation of the American healthcare system typically excluded cost analysis. Instead, health care is typically evaluated based on clinical outcomes. In 2005 over half of medical expenditures in the United States were funded by federal or state programs. This article cites the reasons that cost effectiveness has not been popular as an analysis of health care in the United States and predicts it will become more popular in the future.


This study attempted to measure the impact of managed care on vulnerable populations served by community health centers. Community centers utilizing a managed care model were compared to those that did not. The results of the study demonstrated that managed care facilities provided service to a smaller number of uninsured and a greater number of Medicaid patients compared to their counterparts. It was concluded that managed care may present a barrier for the indigent to receive services.


The relationship between health care centers and physicians, hospitals, teaching centers, specialty physicians, networks, and other providers is examined. Health centers serve as providers of primary and preventive care to their patients. Still, there are limitations to the services a health center can provide. This is especially true when patients are uninsured. Since health centers may not be able to provide services to everyone, their relationship to other service providers is critical. Managed care programs may help ensure the survival of health centers by collecting payment in advance or connecting patients to government funding programs such as Medicaid and Medicare.

**Public vs. Private**

Regarding the case study of the “Philadelphia Behavioral Health System,” the city was wedged in a difficult situation trying to figure out the most efficient and beneficial
way to improve and take care of its impoverished and mentally ill population. According to the case study, “nearly 90 percent of the [city’s homeless population] were estimated to have problems with mental illness and substance abuse.” (C16-02-1649, p. 1). The current public health system in place was not efficient and cost worthy. With minimal funds and improper organization, many residents were unable to get medical treatment for their various ailments or were repeatedly diagnosed for the same illness resulting in a waste of money and time. Residents complained of the “jumble of funders and treatment providers.” (C16-02-1649, p. 2).

Throughout tumultuous years of reorganizing and many patients suffering, the city decided to convert its public behavioral health care for a private health maintenance organization (HMO). They were seen as cost effective and much better at organizing appropriate care. However, Philadelphia soon realized that this private entity was much more concerned with profit maximizing rather than adequate and beneficial care. The federal government granted the HMO a certain amount of dollars to spend per patient, which in turn, the HMO farmed out their patients to other organizations. These organizations were termed “carve-out companies because they handled behavioral health money that had been ‘carved out’ of the original contract.” (C16-02-1649, p. 9). The HMO would allow these companies a small fraction of the money the federal government lent and pocketed the rest for their shareholders. These types of contracts were not uncommon in the “managed behavioral health care industry.” (Sturn, 1999, p. 360).

The residents were unhappy because the HMO were unwilling to treat numerous ailments due to pricing and were only interested in their profits. The community rose up and terminated the private system. Later, a new entity emerged that was community
based and specialized only in behavioral health care. They would handle the federal
government money for that specific group and would create a system that not only cared
for the patient’s needs but also were also efficient and organized in order to keep costs
down.

In the literature, this problem was faced in many states as well as countries all
over the world. The central problem associated with the feud between public and private
health care systems is cost efficiencies. Other problems include “inadequate coverage,
relatively high levels of public dissatisfaction, and expensive, complex administrative
requirements.” (McPhee, 1995, p. 69). According to the literature, health care reform
models can be categorized into three groups: “private marketplace insurance, employer-
based health insurance, and centralized or single-payer health care models.” (McPhee,
1995, p. 69). Within these three groups, public satisfaction is a primary component.
However, the main focusing question for the reform is whether the majority of the
population most affected by the reform enjoys a high level of health. In addition,
American Medical Association sponsored surveys have “reported that both the people, as
well as physicians in the U.S., consider cost as the first concern facing the health care
system today.” (McPhee, 1995, p. 69). Following that question, the second largest
concern for health care reform is the accessibility for the patients.

There is also an argument against those two central concerns. In other literature,
cost and accessibility are vital to a health care system, but are not enough. Feingold
suggests that other concerns that have been the driving force behind reform are the “high
and rapidly increasing costs…and lack or inadequacy of private or public insurance
coverage for a substantial part of the population.” (Feingold, 1994, p. 727).
Another case study, similar to the Philadelphia study, was done in Fort Bragg. It followed the “transition from a demonstration project for child mental health services to a capitated managed behavioral health care contract with a for-profit managed care company.” (Heflinger & Northrup, 2000, p. 390). The purpose of this study was to understand the impact on the individuals and community with the implementation and start up of a capitated managed behavioral health care program, similar to the Philadelphia system. The various problems the system incurred ranged from “access to services decreased …difficult to treat children were shifted to the public sector, [to] ratings of service system performance and coordination fell.” (Heflinger & Northrup, 2000, p. 390).

Managed health care systems are frequently what cities and counties turned to try to handle the rising Medicaid costs. Originally, managed care was used for healthy populations but within the last decade or so, it has been moving into non-traditional markets. These include managing health care for part of the population with disabilities. (Donegan Shoaf, 1999, 240). Managed health care systems also focus on drug and alcohol abuse as well.

Throughout the literature, there are so many varying opinions concerning which sector would be best handling a community’s need for a health care system. There are corporations fighting to have the private sectors managing health care. A qualification they always employ exemplifies their years of experience managing large populations. Contrarily, publicly managed health care systems declare their attention to the patient’s needs and well-being. Private corporations seem to do best in healthy populations whereas public health systems are necessary in parts of the country where accessibility
and costs are primary concerns. The debate is on going and a consensus has yet been found.

References

C16-02-1649.0 Public Takes on Private: The Philadelphia Behavioral Health System. The Kennedy School of Government, Case Program.


Healthcare

Philadelphia, like many other cities in the United States, found itself struggling with their healthcare systems. During the mid-1980s, health care costs had been rising at a rate of 13% per year – double the rate of inflation – for the past decade (Wunsch 71). Many health care systems appeared to be failing, and with a growing “anti-government” sentiment, cities, like Philadelphia, began considering other alternatives. By 1996, the Philadelphia city council was tasked with how to reorganize their behavioral health services. The council was considering two proposals: one would allow private sector health maintenance companies to manage the system and the second would allow the city to create its own managed care organization.

The issue of HMOs versus publicly managed healthcare is a heated debate, one that we are still dealing with over a decade after the Philadelphia city council tackled the issue. The literature on the matter, however, seems fragmented into pro and anti-HMO, with both sides, at least, willing to acknowledge their own weaknesses. The policy analysis studying the market approaches to health cost containment have “suffered from
confusion over the differences among fact, hypothesis, and evidence. This confusion has made the analysts’ assessments …even more provisional and personal than they must unavoidably be (Brown 185). Much of the literature focused on three areas: 1) the quality of care given by HMOs, 2) the actual savings HMOs can offer, and 3) recommendations for policy makers.

Prepaid medical service plans in the United States have existed for over a century, but came into prominence during the Great Depression. The current HMOs, however, “operate with a markedly different set of incentives…” and are often exempted from the restrictions and regulations placed upon public-sector care systems (Luft 531). This can create obvious discrepancies in the types of care received in publicly versus privately owned healthcare facilities. According to Lawrence Brown, “everyone knows what everyone knew before the HMO strategy was launched: HMOs have impressively low rates of hospital use. But the extent of savings…is disputed…and little is known about the quality of care…” (Brown 186).

The fact that HMOs are privately managed, and the private sector is typically primarily concerned with profit has been an enormous criticism of HMOs. Veach and Collen cite a situation in which a doctor and patient decided upon a treatment regimen, but once the doctor consulted the HMOs financial ledger, he noticed by changing drugs, which might not have been as effective and have caused unwanted side effects, the doctor could reduce the HMOs payment from $430 to $30 (Veatch 13). Baker and Corts contend that there is some evidence that supports the claim that HMOs cost less than traditional healthcare systems because they “use fewer expensive tests and procedures…” (Baker 389). They go on to say, however, that “HMOs have lower costs…simply because they
enroll consumers who are healthier than average…” (Baker 389). James Ligon finds a similar conclusion: “mean outpatient expenditures under HMO and FFA delivery systems do not differ…” (Ligon 105). Dana Golman, et al, puts it even more bluntly saying that there are “little if any savings from the HMO.” (Goldman 61). While HMOs are touted to be a more streamlined, cost effective method, this doesn’t appear to be the case.

Finally, several conclusions were offered for policy makers debating the use of HMOs. Dana Goldman states that “policymakers who are considering managed care as a potential vehicle for covering broad segments of the population should be careful about designing a benefits package that induces large movements down a demand curve.” (Goldman 294.) Fredric Wolinsky states that much of the data is contradictory in nature and that very little can be concluded about the performance of HMOs. He does, however, make several statements, most importantly “the major factor involved in reducing the costs of HMO care is the lower level of hospitalization” but that “we do not know how or why” that is the case (Wolinsky 578).

With the preponderance of conflicting data, perhaps the guidance of Richard McNeil, Jr. and Robert E. Schlenker is the most sound of all: “No single delivery mode can incorporate incentives for achieving all the quality, cost, and distribution goals our society has set for health care delivery in the United States…we feel the best approach is a system which uses different delivery modes—based on different incentive structures—actively competing with one another” (MnNeil, Jr. 220).

**Bibliography**


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**Health Care Literature Review**

The American health care system has many conflicts of interest, the most important is the ability of health care providers to provide quality care while attempting
to make a profit. They might resort to hyping new and expensive drugs when other, cheaper drugs exist, due to their relationship with pharmaceutical companies. They also might attempt to deny care to the sickest people, because their care costs the most money. Managed care organizations attempt to make these decisions.

Reshma Jagsi examines conflicts of interest due to the prevalence of direct to patient drug advertising. The article begins with a listing of hypothetical conflicts of interest wherein a patient specifically requests a drug he had seen advertised in some fashion. The researcher suggests that there is a “glaring lack of guidelines” for direct to patient advertising, and the ability of doctors to suggest the best treatment options when they have a financial conflict of interest. The researcher suggests a ban on pharmaceutical gifts to doctors, stronger disclosure rules, and more stringent regulation of advertising as possible solutions (Jagsi 2007).

A group of researchers also analyze the practice of managed care organizations to offer certain incentives to doctors based on their actions. The most common incentives are to offer a bonus based on a low number of referrals to specialists, and for seeing a high number of patients each day. A survey of California doctors found that they felt that these incentives could compromise quality of care, and that they had lower feelings of job satisfaction than those who had incentives based on quality of care (Grumbach, Osmond, Vranizan, Jaffe, and Bindman 1998).

Another aspect of the American health care system is the use of primary care doctors who serve as “gatekeepers” to specialists. Christopher Forrest compares the US and UK system of referrals to specialists and finds that the British are more satisfied with the gatekeeper role that their primary physicians take for two reasons: the British know
that specialists are limited, while Americans believe specialist care is essentially unlimited, and Americans perceive primary care physicians to be potentially withholding referrals due to financial considerations. Americans are referred to specialists at twice the rate as the British, and is one of the reasons for the higher cost of American health care (Forrest 2003).

One extremely important question is if managed care provides quantitatively better or worse care than non-HMO plans. Miller and Luft examine a group of studies examining the effects of managed care plans and find that overall, no clear trends can be drawn. Some patients vehemently disliked their managed care plan, while others felt that it provided good coverage. The one area that the researchers found that patients involved in a Medicare HMO with chronic health problems did consistently get worse care. However, they used data collected prior to 1992, so HMOs could overall be worse than non-HMO plans (Miller and Luft 1997).

One case study of a large company that “carved-out” their mental health care plan from their standard coverage to a managed care system that actually showed high quality results with significantly lower prices. Goldman, McCulloch and Sturm studied a large company over nine years and found that by having a 24 hour hotline staffed by mental health professionals to serve as the “gatekeeper” to further service, the company was able to keep costs down, and provide good treatment options. This system reduced the number of inpatient stays at mental health facilities, and shifted more patients to outpatient facilities for treatment, but there was no significant quality of care decline (Goldman, McCulloch, and Sturm 1998).
Health care providers and practitioners must also have a high level of trust with their patients to insure quality care. Thom, Kravitz, Bell, Krupat, and Azari surveyed patients immediately after, and then two weeks after, a visit to the doctor. They found that high levels of trust in a doctor did not equate to better quality of care, however low levels of trust were strongly correlated with a perception of inadequate service, services being withheld from the patient, and a refusal to follow doctors’ orders explicitly (Thom, Kravitz, Bell, Krupat, and Azari 2001).

Another article focusing on patient trust in physicians examined differences in racial attitudes. The researchers found that Latinos and blacks had lower levels of trust in their physicians than whites, and that they did not believe that there was enough interaction in their visits. The researchers also found that black and Latino men were the least trusting. Those enrolled in HMOs had some of the lowest levels of satisfaction and trust. They did not find a reason for the outcome, and say that further study is needed (Doescher, Saver, Franks and Fiscella 2000).

One group of researchers examined attitudes of the public on a physician deceiving a managed care group in order to procure care for a patient that would not necessarily be covered. Overwhelmingly, 70% of people think physicians should follow the proper channels and appeal processes. However, those who have actually experienced a physician deceiving a managed care group for their care supported this practice in much higher numbers than the rest of the survey respondents (Alexander, Werner, Fagerlin, and Ubel 2003).

Attempting to balance quality health care, patient choice, and low prices might be an impossible juggling act under the current US health care system. HMOs and managed
care have “revolutionized” the market, and a backlash is building. Another group of researchers have examined this backlash, and have found that many states are passing laws protecting patient choice and quality of care when dealing with managed care entities. The authors found that people are clamoring for protections because they have heard anecdotal evidence of managed care horror stories, where patients do not get the care they need due to bureaucratic mismanagement and red tape. There is a strong backlash against managed care’s perceived poor quality of service (Blendon, et al, 1998).

The future of managed care is uncertain. A group of researchers examined current trends in managed care, and found that managed care groups have changed tactics in the recent past. Previously, HMOs focused on either drastically increasing market share by offering low prices, or by limiting doctor choice, referrals and other care choices in order to keep low prices. They are now moving to more choice in physicians, and increased care options, due to consumer demand, but the tradeoff is skyrocketing premiums and other costs. By emphasizing higher quality healthcare, regardless of cost, HMOs lose some of their reason for being: low prices (Draper, Hurley, Lesser, and Strunk 2002).

Works Cited


Blendon, Robert J.; Brodie, Mollyann; Benson, John; Altman, Drew E.; et al. 1998. Understanding the Managed Care Backlash. *Health Affairs.* Vol. 17, No. 4.

The article discusses the findings of a test called the Pediatric Symptom Checklist or PSC. Its purpose is to determine possible early warning signs of behavioral disorders for children younger than 18 years old. The test was conducted in an urban neighborhood in Massachusetts.

Several hundred children at 3 HMO facilities were surveyed through questionnaires completed by their parents or guardians. Out of this, a further sample was randomly singled out for a more detailed analysis. The results showed that the PSC was
a useful guide for pediatricians in their behavioral diagnoses, showing a strong reliability during a second round of tests for the same children in follow-up visits. The in-depth sample analysis interviews further revealed that some of the possible contributors to the behavioral diagnoses were the children’s social and family setting.

The Pediatric Symptom Checklist discussed in the article could serve as a guide for preventative care in the Philadelphia case study. If possible behavioral disorders cases can be diagnosed and treated early, less money would be spent in the mental health system for what could be future patients if early treatment is withheld.


In this article, the merits of using a Balanced Scorecard (BSC) in the mental health field are discussed. While mainly used by businesses to determine their progress implementing certain programs, the author suggests the use of BSC’s to asses the quality of care in the mental health field.

He begins discussing various attempts to define quality and measure it. He believes that such efforts are not focused enough to truly determine the effectiveness of treatment of the mentally ill. The end result for the current tests designed to assess quality is the comparison of patient outcomes to standards determined in advance by medical committees.

The author proposes using the Balanced Scorecard as an alternative to these tests because of its cyclical nature. Four indictors, as well as a proposed fifth added by the author for this analysis, are evaluated to determine the effectiveness of the treatment rendered. Cause and effect relationships between the indicators can then be compared to guide future treatment.

The author concludes that, while such a test is a step-up from previous proposals, more money is needed to conduct the evaluations and refine the techniques.

The HMOs in Philadelphia using capitation policies to generate profits would be best suited for such an evaluation system. If profits are used in this way, the HMOs could attract more people, including those who had been disillusioned with their care, by demonstrating to them that a proactive response to their healthcare is being undertaken.


This article is a historical analysis of the benefits and negative effects of public-sector mental health management. The final conclusions of the authors, after having gone through the evolution of public mental health management in the United States, are the need for better planning and implementation of treatment, better monitoring of treatment and the patients, and better funding for services that treat those with serious mental health problems.
The article would best serve the Community Behavioral Health non-profit in Philadelphia. It would help guide the non-profit in addressing some of the concerns being brought up by the opposition HMOs concerning the service and efficiency problems government-related health services are usually associated with.


This paper does a statistical analysis associated with social distance and healthcare. Some of the variables tested were race, education, and income.

The study finds a marked difference in the way healthcare and quality are believed to be administered. Whites and those with a higher income reported a better quality of care in regards to perceived respect and time spent in the evaluation of the patient’s condition.

This paper, while not specifically addressing the concerns of the mental health community, is still relevant in that such issues as race and economic status can play a role in the way healthcare can be administered. If diagnosis is not done properly due to prejudice, the problems of the mentally ill may continue in the direction they were going at the beginning of the article with a large number of them in the homeless population.


This is a paper that explores the availability of mental health services, through HMOs, based on location. It finds that access and care availability are stronger in higher income communities than in lower income communities. This is due to the location of the HMOs and community access to their providers for mental health services.

The policy implications for Philadelphia would influence the quality of care and reach to those who are in need of the services of both CBH and HMOs in the area. Furthermore, it would serve the state government and the regional commissions that disburse Medicaid in the state and guide their decisions on where money should go to really make a difference in treatment for individuals with mental illnesses.


This article would better serve the HMOs in saving face while still allowing them to make a profit. By using risk-sharing policies, HMOs would allow their carve-outs to focus less on the total risk they would assume for patient care and let them focus more on better treatment with shared risk from the HMO. In exchange for risk-sharing, the carve-outs receive payment from the HMO according to costs on an established risk-premium level. This approach allows patients the opportunity to receive better care and allow the HMO to save on costs with a flexible payment system.

The article addresses problems that developed in Philadelphia at the beginning of the article, namely, the complex system of healthcare providers and the need for consolidation and the transition to HMOs. The authors suggest the integration of better communications technologies to assist in the treatment of patients through knowledge of patients being passed between health providers.

In addition, the implementation of better lines of communication would allow for better quality care by the HMOs. It would help in coordinating treatment and care among the large numbers of providers within the HMO system. The possible savings from this integration would also provide incentives for the use of future innovations to come and allow HMOs to provide quality care and still work for the interests of their stockholders.


This paper from Canada addresses the signs that waiting lines in hospitals may indicate. It could help in guiding some kind of cooperation between HMOs and the government. As a means of preserving efficiency, the CBH of Philadelphia could take over some of the mental health services HMOs in the area may be over-burdened with. This would allow the HMOs to cut costs and allow the CBH to work and gain information on its own practices, allowing them to adapt and make a better case to the city of their ability to handle cases of the mentally ill.


This paper should serve as a guide to the CBH, HMOs, and the city concerning the severely mentally ill. With the infighting between these organizations, they need to take into account the plight of those who are in desperate need of their services. Some of the most severely mentally ill are poor, likely to be African American, and are lacking in the education needed to gain access to proper mental health care. These organizations could use these findings to help identify those who are in most need and possibly coordinate their efforts to determine who would be able to give the best care, under the individual circumstances, to the severely mentally ill.

Druss, Benjamin G., Carolyn L. Miller, Robert A. Rosenheck, Sarah C. Shih, and James E. Bost. May 2002. “Mental Health Care Quality Under Managed Care in the United
This is a brief report on the status of mental health care by HMOs in 1999. The results found a lack of high performance in the treatment of mental health based on the Health Employer Data and Information Set, a “report card” on the performance of HMOs that provides information on plan quality and a guide for employers in purchasing and rating health plans.

This could serve to benefit the CBH concerning the imperfections found in HMOs, giving them some kind of chance at making the case of their ability to operate. It could also serve as an incentive for HMOs in Philadelphia to improve their administration of healthcare and quality to save face in the community and serve their stockholders.

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**Mental Health Care**

HMO is a term often associated with the healthcare industry in the United States. Specifically, HMO is an acronym for Health Management Organization, a term which was introduced to the American market in the early 1970s. HMOs were a means by which to restructure the current system in order to provide a cost-effective tool for the distribution of healthcare services as opposed to the traditional fee-for-service methods that were in place. Rather than pay each the physician for each visit or procedure, the HMO allowed the consumer to pay a monthly fee to have access to a myriad of healthcare options.

According to Welch, HMOs may be typified in the four following categories: the staff model, the group model, IPA, and the network model. The staff model type is one in which the HMO hires the physician as well as pays them directly whereas the group model is one where they are contracted with a single physician group practice. IPA is a business model in which the HMO contracts directly with the individual physicians in
private practices, and the network model is one in which the health management organization contracts with two or more practices (Welch 222).

At the end of 1969, 37 HMOs were in existence in the United States and by 1974, the number had exploded to 183 (McNeil 195). Additionally, over 25 states had an HMO in place by 1973 which further strengthened the notion that the HMO was a new method by which consumers could get affordable healthcare (McNeil 198).

By 1978, the health plan market consisted of 4 types of the following: government (Medicaid), commercial insurers, private health insurers (BlueCross), and alternative delivery systems (HMOs). Demographically, the Western portion of the United States was more likely to have HMOs, commercial insurers were popular in the Midwest and South, and those with healthcare coverage such as BlueCross were primarily located in the Northeast (Hay 832).

States that had HMOs tended to share certain characteristics as opposed to those states that did not. States with higher incomes, larger and urbanized populations, more physicians per capita, and states with higher hospital costs more than often had health management organizations in place. These characteristics would indicate that HMOs were more likely to locate to areas in which competition with traditional forms of healthcare was more feasible (McNeil 200). Moreover, HMO popularity was likely to be a result of federal policy in addition to the favorable market conditions that were previously mentioned. These factors in tandem allowed the HMO to gain prominence in the healthcare market.

In an increasingly complicated society, proponents of HMOs regard its utilization as a means to lower the cost of the distribution of healthcare. Currently, affordable
healthcare is a difficult commodity for many Americans and policy makers have attempted to reform the system. Many case studies have chronicled the efforts of lawmakers to induce change hoping that reforms will lead to a better condition for all parties involved.

In a case study done by the Kennedy School of Government, Guckenberger analyzes how behavioral health services are delivered to the public and the implications of how HMOs and managed health care systems operate in an otherwise troubled system in Philadelphia. The state believes that a major problem of state provided healthcare assistance is that it offers a broad number of services at the expense of efficiency. The city views the main issue to be a lack of coordination of all those involved in the system, one in which there is no central authority or accountability. From the perspective of the consumer, the problem is viewed as the inability of the city, state, Medicaid, and HMOs to have standardized requirements. Therefore, it becomes difficult for a patient to go from one system to another without having to face a new set of rules and regulations to abide by (Guckenberger 3, 4).

According to the study, 6.9% of mental health Medicaid users accounted for over 44.5% of all Medicaid funded psychiatric care (Guckenberger 4). If structural problems and lack of coordination continue to be endemic to the system, statistics such as these will continue to spiral out of control. As a result, the study suggests that the consolidation of financial support in addition to the cooperation of the city, state, and HMO level will lead to a condition in which healthcare is distributed in a better manner.

Many healthcare reform proposals attempt to reduce the cost by utilizing HMOs. Costs are kept to a minimum due to the HMOs oversight of a physician’s decisions, the
use of a capitated payment which takes into consideration the physician’s incentives as well as the health care plan. Furthermore, HMOs tend to have lower hospitalization rates, stays, in addition to having fewer tests and procedures done. It would seem that HMOs are the solution to the growing problem of affordable health care, but there are those that do not wholly agree. Some argue the success of HMOs are attributed to questionable practices and must be looked at more thoroughly. For instance, opponents contend that HMOs enroll healthy consumers and very little at-risk patients. Also, the lack of competition in a highly controlled HMO market would lead to less consumer choice and high costs (Baker 390).

It is evident by the increasing cost of healthcare in the United States that efforts for reform need to be taken more seriously. Whether one supports having universal healthcare provided by the government, or more choice in coverage, reform in the current system is a necessary precursor for Americans to have more affordable healthcare. HMOs may be a tool in which to achieve change and should be looked upon as a viable option in any case of actual reform.

**Bibliography**


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Managed Health Care in the Public Sector

In the struggle to ensure adequate health care for as many people as possible state, local and federal government agencies are increasingly looking for options to reorder the administration of public health systems. The literature on these options is diverse and anything but cohesive in its recommendations. Given the vast divergence in policy recommendations it is interesting to note the striking consistency of the findings of these studies regarding the rationale for implementing different policies, the expectations of those implementing new systems, and the results of these changes.

There are many policy alternatives for politicians and bureaucrats to consider. The public sector can simply turn over management to HMO or PPO providers, they can
create their own management organizations to administer funding, or they can use a mix of publicly administered and privately managed care. The literature suggests that most states are tending to lean toward private management of public health systems (Findlay 117). Given this trend it is most practical to consider the effects of this type of policy alternative.

The literature suggests the benefits of managed care can be derived from three basic types of interactions between public and private health care providers. First, there can be contractual agreements between the private and public sector for the care of segments of the public health population. In this case care is provided through private managed care and these companies are paid from public funding by state and local governments. Second, there are situations in which the private and public sector relationship is deeper than contractual obligations and a formal joint venture exists. In this situation the public and private sector share both operating control and responsibility for the health care system in place. The final model is a relationship in which “managed care plan performs an activity that is central to the public health mission of the health department” that is referred to as the stakeholder model or sole ownership model (Halverson 118, 128). This system provides the most systematic integration of public and private health care management.

Public entities rationalize their decision to involve private managed care programs in the administration of public health systems in a variety of ways. Some of the reasons given include, collaborating and expanding outreach and education, improving case management, and improving the efficiency of public health care (Halverson 122). The literature suggests that no matter what model a particular city follows there are certain
expectations that are central to the decision to privatize or centralize the public health system. The bottom line for cities and states across the United States seems to be cost. Every study cited in this review indicates that the foremost expectation of government entities looking to integrate managed care companies on any level in their public health systems is a reduction in operating costs. Nearly every other expectation is related in some way to the overall cost of administering health care to the uninsured. As Goldman explains, “Managed care attempts to control these costs through a strategy that relies on coordination, rationing, and market power to limit expenditures (Goldman 279).

Goldman sums up the expectations that most public systems have when they turn to managed care. They expect that costs will be substantially decreased through a variety of organizational and management differences.

John Iglehart, A.P. Schinnar, and Frank Richard both summarize the expectations that come with the adoption of managed care that contribute to lower costs. Managed care is said to give greater flexibility in service, reduce the reliance on inpatient care, reduce hospitalization rates, and increase preventative care measures that may reduce hospital and doctor visits. In the end all of these measures reduce costs to providers. Private entities have an incentive to reduce cost because they need to make a profit in order to continue to exist in the private market (Iglehart 131, Frank 106, Shinnar 258).

The concern that arises out of this emphasis on lowering costs is that the corporate emphasis on profits will lead to a decline in the quality of care. In fact, studies find that there are substantial decreases in costs in privatized systems. Frank reports that in Colorado, Massachusetts, North Carolina, Tennessee, and Utah the inclusion of managed care has reduced Medicaid costs by fifteen to forty percent. At the same time, however,
care for the most needy of the patients served by Medicaid was reduced by an average of thirty percent (106). This reduction in costs is echoed in studies by Goldman and Shinnar. What is disputed is the effect of these systems on the quality of care. Robert Miller argues in his study that “most quality of care results were favorable to HMOs or showed similar quality of care” (14). Miller disputes claims made by Frank and by Steven Findlay about the quality of care in managed care settings. Findlay points out, “the industry was hired to lower those costs. It did. These declines are largely attributable to…reducing outpatient care, cutting provider payments, a greater use of non-physician providers…and the use of psychoactive drugs instead of psychotherapy” (120). Findlay goes on to point out that while costs have been reduced it has not occurred without any declines in quality of care.

Additionally, Miller points out that, despite lower costs, managed care has little motivation to sustain high quality care, that there is little information available to consumers, and that managed care is hindered by slow clinical changes. All of these are obstacles to effective public health management. Furthermore, many in the field are concerned about continuity in care. This concern takes two forms. First, as Jeffery Geller explains, under managed care programs it increasingly unlikely that patients will be seen by the same doctor every time they receive medical services. Managed care providers give restrictive lists of covered providers and this list changes frequently. Also, Geller shows in his study that readmission to the same hospital decreased with managed care while repeat users were increasingly, “admitted to new facilities where patients were unknown” (5). The second type of discontinuity is related to coverage in general. A 1998 study conducted by Olveen Carrasquillo found that nearly two out of three
Medicaid enrollees lost coverage within twelve months and that within this population one out of three still had no coverage four months later (467). This study found that, “uninsured patients rarely have access to managed care providers…moreover, the rapid turnover of Medicaid enrollees hampers monitoring of quality care” (468).

A review of this literature suggests that it is entirely appropriate for public health systems to utilize managed care companies to lower costs but they must be cognizant of the possibility that the quality of care will decline and take steps to prevent this from happening. Furthermore, it seems clear that it is necessary for the state or local government to work with managed care companies to ensure that patients can be treated by the same doctor or at least the same facility over the duration of their treatment even when leaving Medicaid programs and obtaining private insurance on their own. The discontinuity in care is a serious threat to the patient and the integrity of the health care system. There are issues that need to be mediated between the public an private sector but these do not preclude the use of managed care as effective way of dealing with the inefficiency that exists in many publicly managed health care systems.

Works Cited


Findlay, Steven. “Managed behavioral health care in 1999: An industry at a crossroads.” Health
Mental Health Care

Introduction

The way in which public and private mental health care is provided has undergone significant change since the 1980’s. Thirty years ago, state sponsored institutions were
the status quo. However since then, behavioral care has evolved into a variety of highly complex systems. The overarching evolutionary change has been one of transition from generic state care to specialized private management\(^1\). In the earlier model, federal and state funding was channeled directly to state hospitals, which in turn provided care directly to patients. In modern models, funding streams are directed to secondary and tertiary private firms that manage the delivery of care for a profit.

The primary concern continues to be the tension between care delivery costs and quality of care. Experts, however, disagree over which methodologies are optimal. A wide variety of organizational structures, finance methods, and care delivery modes can be found across the country, each with supporters and detractors. No final conclusion has yet been drawn. Even now, policy makers are questioning the effectiveness of approaches that were favored only a few years ago. One finds an overwhelming number of articles on the subject, the vast majority of which were written at least a decade ago and very few of which agree.

**An Overview Before Tackling the Details**

Before tackling the task of exploring behavioral health delivery methodologies, researchers will find an excellent overview of the evolution of this over the past few decades in an article entitled, The Evolution of Behavioral Primary Care (Gray, Brody, and Johnson, 2005). The authors have provided an excellent overview of how and why changes have unfolded from the perspective of physicians themselves. A valuable reference of commonly used terminology, organizational structures, finance methods, and care delivery modes, as well as arguments for and against these models is provided. In

\(^1\) Commonly referred to as carve-outs
addition, the authors describe very recent trends from what is termed a ‘carve-out’ to ‘carve-in’ services. A second article is also recommended as a primer to the topic; Protecting the Public Interests: Issues in Contracting Managed Behavioral Health (Robinson and Clay, 2003). Here, the authors explain the issues of transition to private administration from the perspective of impacts to the public sector. It suggested that researchers then proceed by dividing their studies into two categories; those of Cost and Risk and Quality of Care. Because they remain the primary drivers of behavioral health care policy, most academic literature addresses one of these two fundamental issues.

Beginning with the topic of Quality of Care, Mechanic (2003) found through use of multivariate analysis that the process of transition from one administrative model to another may negatively impact a patient’s adherence to medication regimes. This supports the author’s conclusion that it is essential to ensure that the introduction of a new program does not disrupt continuity of care.

Using data from the Vermont Department of Corrections and Department of Developmental and Mental Health Services, Pandini, Banks, and Schacht (1998) describe a research methodology known as probabilistic population determination. This methodology provides a way to statistically identify common data between data sets that do not possess common identifiers. The authors employ this method to measure mental health program performance in the area of program accessibility to people with a history of criminal justice involvement. Probabilistic population determination has the added advantage of protecting client confidentiality and personal privacy. Sabin and Daniels

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2 A “carve-out” in managed care terminology refers to any managed care approach in which a separate system of care is contracted out either because of the need from distinct services or in order to serve a defined population. (Robinson and Clay, 2005).
(1999) conclude that care quality depends a great deal on the specific language employed in contract documents between government, care providers and insurers. Precise wording in these contracts ultimately determines the expectations and values of care programs.

Following with articles addressing **Cost and Risk**, Ridgely, Giard and Shern (1999) provide a case study of a carve-out implementation to explore its impact on the local mental health sector. Their study raises concern about system stability, patient access, efficiency, and the shifting of risk and public responsibility to private health providers. Frank, McGuire, and Newhouse (1995) address a similar topic in their economic and cost-effectiveness study of what is termed ‘risk contracting’ in behavioral health care. The authors conclude that a strategy that optimizes incentives and treatment is a fundamental component of an economically successful behavioral health program.

Rosenthal (1998) explores the economic impact of transitioning from a fee-for-service system to a case-rate (captitated) system. Rosenthal observed a 25 percent reduction in patient visits per episode that varied with the dollar amount of the captitated rate.

In another case study, Burns, Teagle, Schwartz, Angold, and Holtzman (1999) evaluate a pilot public sector managed Medicaid mental health carve-out for North Carolinian youth. Over a five year period, significant shifts from costly inpatient care to less costly outpatient services were observed. This was coupled with a decreased rate of growth in mental health costs. Sturm (1999) finds a trend indicating that the “traditional dichotomy of public and private systems of care is quickly disappearing” and that overlap between public and private providers is evident. He also points out the importance of information systems.
References


Sabin, James, and Daniels, Norman. Managed Care: Public-Sector Managed Behavioral Health Care: II. Contracting for Medicaid Services-the Massachusetts Experience. Psychiatric Services 50:39-41, January 1999


Lit Review: Managed Health Care
Managed Health Care is a very controversial topic and a hot topic in today’s political arena as well. There are champions on both sides of the argument who state reasons why it is both good and bad and both sides have viable reasons and experiences to prove their case. Before one can debate the topic, one must first understand Managed Health Care. One definition states: “managed care is an organized effort by health insurance plans and providers to use financial incentives and organizational arrangements to alter provider and patient behavior so that health care services are delivered and utilized in a more efficient and lower-cost manner” (Williams, 125). This definition included the core principles of managed care: “it is an organized effort that involved both insurers and providers of health care; it uses financial incentives and organizational structures in reaching its goal; and its purpose is to increase efficiency and reduce health care costs” (Williams, 125). Again, there are champions on both sides of the argument, but central to the debate is determining whether managed health care is more efficient and effective than other forms of health care?

In order to help answer this question one can look at the specific case of Philadelphia and its health care system throughout the latter part of the past century. Philadelphia attempted to reorganize its system of care because it was seen as uncoordinated, inefficient and ineffective for it’s users and too costly. The city debated long and hard to in an attempt to come up with the best solution.

Those in favor of managed care had many valid concerns and points to argue their case. They found that with the current system Philadelphia used, “the most ‘challenging’ patients—those least equipped to navigate the system in the first place—were most likely to experience ruptures in the continuity of their care” thus ultimately leading this patients
to stop receiving the care they desperately needed (Guckenberger, 4). They also pointed out that, “without access to coordinated, long-term care, heavy users showed up in emergency rooms time and time again, seeking help for recurring problems. Authorities and mental-health advocates concurred that the repetitious use of emergency-room intervention did not qualify as adequate “treatment” in anybody’s book. Moreover, it was expensive” (Guckenberger, 4). According to the research done by the officials in Philadelphia, “‘pre-paid’ health maintenance organizations (HMO’s) were cost efficient, promoted better monitoring of serves than their fee-for-service counterparts. It seemed ‘managed care’ was better suited to providing more appropriate and less expensive care” (Guckenberger, 5).

The other side of the argument, against managed care, has as valid of points as those in favor of it. Access to care is a key point in a health care system, and “from an access end of things, folks had a very difficult time getting authorized for services…and disenchanted patients fell back into the public system or dropped out completely” (Guckenberger, 10). The core techniques of managed care include “authorizing only approved providers under contract with the managed-care company to treat enrolled clients, reviewing their decisions as they provide services and monitoring high-cost cases closely” (Iglehart, 131). Also, “most managed-care plans do not cover chronic mental illness in their standard benefit package” which is a huge downfall to the idea of managed care because this is often the most serious type of service needed by patients and they do not have easy access to it, making it likely that they do not receive treatment. (Iglehart, 131). Another huge concern for those opposed to managed care is that “private managed-care companies are in business to serve their shareholders. While the provide good care
to the majority of the people, they profit by controlling the delivery of services. ‘The incentive for these companies is to deliver as little services to as few people as possible’” (Guckenberger, 11).

One official in Philadelphia thought she had come up with the perfect solution to the problem but in the end it was difficult for her to find people to back her plan. She developed community health plan, a non-profit, where savings would be put back into the system rather than given to the shareholders, which would help improve care and expand the services provided. Many people did not believe this community system could work because “private sector managed-care companies, for their part, were equipped to assume huge legal and financial risk-including those connected with malpractice lawsuits” the city on the other hand could not afford such problems if and when they occurred (Guckenberger, 17).

Both sides of the argument have compelling points which illustrates that some type of reform needs to take place within the health care system. For better or worse, “the greatest contributors to the development of managed mental health, a development they now bemoan, have been the service providers themselves (fee for service), practitioners and facilities. By not paying sufficient attention to or not caring about costs and length of treatment, they killed or at least seriously wounded the goose that laid the golden egg” (Iglehart, 132). Serious problems revolving around quality of care exist in the health care system today and “a large number of Americans are harmed as a direct result. Quality of care is the problem, not managed care. Current efforts to improve will not succeed unless we undertake a major, systematic change to overhaul how we deliver
health care services, educate and train clinicians and assess and improve quality”
(Chassin, 1000).

Works Cited


