1997

Managed Care: The Questionable Triumph of Financial Management

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Managed Care is a generic label for a broad and constantly changing mix of health insurance, assistance and payment programs which seek to retain quality and access while controlling the cost of physical and mental health services. One essential feature of virtually all managed care regimes is protection of reimbursement decisions from the economic incentives affecting both patient and care provider. Under managed care, such decisions are routinely placed in the hands of neutral "third parties" with a presumed incentive for enhancing cost-effective delivery of services. "Capitation", "co-insurance' and "co-payment", "deductibles", "fee-for-service", "formularies", "HMO", "PPO" "risk contracts" and "utilization review". Cynics may be forgiven for mistaking managed care for bureaucratic medicine; or for suspecting that the central dynamic of managed care involves a massive realignment of power in the health industry away from medical and other professional care providers and to legal and financial professionals.

To date, the movement towards managed care in the public mental health system has surpassed efforts to develop a systematic literature concerning its theory, practice, and outcome (Cuffel, Snowden, Masland, and Piccagli, 1996). The remainder of this article is concerned with a selective review of recent literature on managed care as it is impacting social work and related professional services in health and mental health. Coverage is by no means exhaustive or comprehensive. (A number of additional articles, letters to the editor and editorial comments are listed in the supplementary bibliography.) Discussion is not limited to articles appearing in social work publications, but throughout the health care industry and professions.

The present implications of managed care for social work practice can be distinguished programmatically. Health care social workers, like all other professionals in health and mental health services, have already seen the nature of professional decision-making transformed. Decreased professional autonomy and the redefinition of service delivery as a commercial transaction are two of the central dynamics of that transformation. For social workers practicing in all other venues, managed care may also soon be synonymous with public support. (C.f., Mordock, 1996)

Managed Care Transforms Practice

The introduction of managed care fundamentally transforms the traditional "agency" relationships on which modern social work was built. In the agency model, social workers provided service free from the practical burdens of finance, which

were isolated as separate administrative responsibilities. Administrators, in the traditional model, served as intermediaries who explained the actions of social workers to funding agencies and negotiated continued support for services, usually in the forms of grants, or open-ended "purchase of service" contracts.

Managed care introduces an utterly new division of labor in which, like it or not, financial management sophistication is an assumed characteristic of social worker and client alike. Such a fundamental transformation has already been underway for some time and will obviously take longer to complete. Again, cynics may be forgiven for suggesting that managed care will ultimately mean the complete demise of traditionally recognizable forms of social work practice. Indeed, long-term therapy, most forms of group work, and virtually all types of community practice have already proven equally difficult to justify under managed care rubrics and been seriously curtailed.

The stakes in the managed care arena are tremendous. In 1992, the United States spent an estimated $820 billion on health care while as many as 15 percent of the U.S. population, approximately 43 million people, were uninsured. As costs continue to rise, the number of people able to afford even basic health service continues to decline, while the indirect costs of health care bureaucracies continue to rise. (French, Dunlap, Galinis, Rachal and Zarkin, 1996; Geller, 1996). A key issue in the health reform debate is whether insurance coverage to the uninsured should be voluntary or mandatory. (Madden, Cheadle, Diehr, Martin, Patrick, and Skillman, 1995)

Lambrew, Defriese, Carey, Ricketts, and Biddle (1996) claim, based on analysis of more than 30,000 cases, that policies that promote the doctor-patient relationship will increase access to health care, although the gains may be negligible for individuals who use mainstream primary care sites (physician's office, clinic, or health maintenance organization) versus sites such as walk-in clinics or emergency rooms. Since many traditional social work clients do precisely that, it is quite plausible that negligible gains from managed care for social work clients can be anticipated.

"Managed Care" is the current label in health and mental health for an interrelated set of contractual, accounting, and management assumptions and expectations for practitioners ("providers") and clients ("consumers"). Managed care plans and health maintenance organizations (HMOs) in particular, rely on a variety of financial incentive systems to induce providers to control health care expenditures. (Kwon, 1996) Yet, concern is evident in many parts of the present day health care delivery system whether cost savings attributed to managed care are real and whether the unintended effects on health care may be adverse. (C.f., Kovner, 1996) Despite these concerns, nearly every state now encourages or requires its Medicaid beneficiaries to enroll in managed care. (Sparer, 1996)

At least part of the scramble for the adoption of managed care plans may be explained by the shield established by the federal Employee Retirement Income

Security Act (ERISA) which protects managed care organizations from liability when they are part of an employee group health plan governed by ERISA. Unlike patients with other types of Insurance, patients in ERISA health plans do not have a malpractice remedy for a managed care organization's negligence. (Mariner, 1996)

At any rate, Managed Care is changing the health care system in the United States in fundamental ways. (Landry and Knox, 1996) It has the potential to completely refashion the relationship between social workers and their clients, and also the social workers' relations to agencies and communities by reshaping the traditional "powers of the purse." Kwon (1996) claims, for example, in an analysis based on the theory of incentive contracts, that the group incentive scheme upon which HMO's are based provides an essential control over the perverse incentives associated with excessive referrals by primary care physicians.

The effects are not just limited to social work. The Managed Care model is having similar impacts across the entire range of health and mental health professions. (Brayman, 1996; Broskowski and Eaddy, 1994; Elias and Navon (1996) Further, the effects may also not just limited to health and mental health. For example, Mordock (1996) argues that the successful operation of agencies serving children and families will increasingly rely on the ability of those agencies to market their services in a managed care environment.

The traditional basis on which social work services were delivered was an uneasy blend of "social liberalism", built up over decades of experience and practice. (For an attempt to bring financial and programmatic concerns together, see Chapter 1 of Lohmann, 1980.) This practice model recognized as real the rights and agencies of individuals, but also such social collectivities as families, neighborhoods, agencies and communities. "Systems theory" in social work has been an on-going effort to regularize and integrate the diverse and somewhat inconsistent understandings of these diverse phenomena into something like a unified whole.

With financial management, these concerns have always been partial, at best. Social work systems approaches of the last two decades assumed (although seldom explicitly discussed) the role of financial management as a necessary, if uninteresting, technical support service far removed from the central relation between worker and client. There is no attempt in the DSM-IV, for example, to link cost considerations to any substantial aspect of client diagnosis and assessment. Managed care is likely to change that, by bring considerations of cost directly into the worker-client relationship, and by strengthening the case for the private or independent practice of social work.

Independent practice association (IPA) model health maintenance organizations (HMO's) represent one of the fastest growing segments of managed care in the United States. (Johnstone, 1995) Wolf and Gorman (1996) and Zarabozo, Taylor and Hicks (1996) discuss some of the "cutting edge" financial management practices emerging in the managed care environment.

Thus, for social workers in health and mental health care settings, the rise of managed care represents the complete (and seemingly sudden) triumph of financial management concerns over virtually all other professional considerations. The seeming suddenness is more apparent than real, however, since Managed Care represents the culmination (so far) of nearly three decades of gradually accelerating efforts to transform health care delivery in the U.S., and introduce effective cost controls.

Managed health and mental health care represents a highly individualistic and laissez-faire "reform strategy" embraced by lawyers, cost accountants, politicians and insurance companies which is being imposed upon the interdisciplinary, multi-professional community of health and mental health providers, which includes social workers, physicians, psychiatrists, nurses and others. The managed care practice model is at the opposite end of the communitarian spectrum from the systems approaches most familiar in social work: It recognizes only individuals (providers and consumers) and the "fictive individuals" of contract law, (corporations and partnerships) which employ them.

Managed care is zealously liberal (in the original meaning of that word) in that it explicitly allows no place for social systems or other "social fictions" whether families, groups, agencies, neighborhoods or communities. Its apparent sole purpose is to improve the aggregate "bottom line" cost of public health and mental health care in the U.S., regardless of the social cost in lives, "inconvenience", pain and suffering or any other non-fiscal consideration. Managed care is the latest of a growing list of signs that in the long-term struggle between profession and bureaucracy noted decades ago in the social work literature, the latter is emerging supreme. (Vinter, 1959) The apparent success of managed care is premised directly upon practice models in which the activities of psychotherapists are being micromanaged by insurance companies. (Chipman, 1995)

Schlesinger, Dorwart, and Epstein (1996) conclude that the increasing involvement of insurers and hospitals in monitoring patient care is encroaching on psychiatrists' autonomy in making clinical decisions. The same might be said (and undoubtedly will be) for social workers. In a survey of 2,500 psychiatrists, these authors found that more than three quarters of those surveyed reported pressure from insurers for early discharge. Nearly two-thirds of respondents said hospitals limited length of stay; and about half said they had been discouraged from admitting severely ill patients, the uninsured, or Medicaid recipients. These basic findings square with the experiences of every social worker I have taked with on the subject as well.

This is occurring on top of the "procedural revolution" in policy (Sandel, 1996), whereby substantial degrees of professional autonomy have already been yielded to legal "advisors". It is possible to "paper over" obfuscate and qualify this fundamental, unpleasant truth in a variety of ways, but it would be nearly impossible at present to refute it directly.

Untested Managed Care Model

The managed care revolution is still so new and unfolding so swiftly that little research on its impact on social services is currently available. Social work contributions to the managed care discussion have been relatively few in number and on relatively tangential issues. (Alperin, 1994; Corcoran and Gingerich, 1994; Kanter, 1996; Munson, 1995; and Weimer, 1996. More to the main point are: Brown, 1994; Cornelius, 1994; Elias and Navon, 1996; Geller, 1996; Katz, 1996; Trugerman, 1996.) It appears as of this writing that there are no empirical studies of managed care impacts or implications in the social work literature.

It is interesting and disturbing to note that despite its revolutionary impact, the assumptions underlying the managed care model are largely untested and perhaps not yet even standardized. In this, it bears a certain uncanny resemblance to "supply side (voodoo) economics" which was similarly untested when undertaken by the Reagan Administration and subsequently shown to be threadbare.

There is, however, a growing body of literature expressing concerns of various types. (Morreim, 1995a; 1995b; Pipal, 1995; Rutman, 1995; Sabin, 1994a, 1994b, 1995a, 1996, 1994c, 1995b; et. al.) Boyle and Callahan (1995) point to allegations that managed care may adversely affect quality of care, access to care, provider/patient relationships, and informed patient choice. Watanabe (1995), argues that managed care could also undermine the research enterprises which undergird professional practice. Academic scientists are worried that managed-care organizations' refusal to pay for ancillary tests and procedures performed in the course of clinical trials will lead to decreased patient participation in these studies. Butcher and Rouse (1996) raise similar concerns about the future of research in clinical psychology. Any concerns one might have for basic bio-medical research are likely to hold as well for research in social work where research support is already even more tentative and elusive.

Sumerall, Oehlert, and Trent, (1995) concluded that reorganizations of the type associated with managed care have the potential of adversely impacting psychological practices in organizations. They recommended that psychologists (and the advice seems to extend to social workers and other professionals as well) need to take a proactive stance in the rapidly changing health care landscape: Research regarding empirically validated treatments and effects of psychological interventions on overall health-care costs needs to be disseminated to health care administrators and other decision-makers.

Rather than reducing costs, managed care may actually raise them. Goldman, Hosek, Dixon, and Sloss (1995) compared changes in costs over two years at sites that implemented a Department of Defense HMO/PPO hybrid initiative (named CRI) and compared them with changes at matched control sites. They found that CRI substantially raised per beneficiary government costs for providing benefits (as compared to predicted costs in the absence of CRI). They attribute the difference to

the higher overhead of managed care and increased expenditures by HMO participants.

Not all the evidence about managed care is negative by any means. Callahan, Shepard, Beinecke, Larson and Cavanaugh (1995) found in a study of the Massachusetts Medicaid program for mental health services, over a one year period expenditures were reduced by 22 percent, without any overall reduction in access or relative quality, due primarily to reduced lengths-of stay, lower prices, and fewer inpatient admissions. Summerfelt, Foster, and Saunders (1996) found that a managed care demonstration served over three times as many children as the traditional (CHAMPUS) comparison service . In addition to serving more children, the managed care project also provided more and different types of services to each child treated. Finally, the demonstration delivered services in a more timely fashion and made a seemingly greater effort to match children's and families' needs with services.

Despite a growing body of evidence supporting its effectiveness, managed care has raised a large number of value questions and ethical concerns. (Boyle and Callahan, 1995; Brown and Kornmayer, 1996; Bursztajn and Brodsky, 1994; Christensen , 1995; Emanuel, 1995; Gosfield, 1995; Howe, 1995; Johnson, 1995; Mariner, 1995; Miles and Koepp, 1995; Morreim, 1995; Munson, 1995; Orentlicher, 1995; Pellegrino, 1995; Petrila, 1995; Pipal; Plows, 1995; Rimler and Morrison, 1993; Sabin, 1994b; Sulmasy, 1995; Surles, 1995; Zolothdorfman and Rubin, 1995) In one of the most interesting of these articles, Petrila (1995) lays out six strategies for dealing with the dilemma posed by insurers' unwillingness to pay for civil commitment services which providers are legally obligated to provide.

There are also at least a few pioneering studies pointing to the financial and professional impact of the managed care model. (C.f., Rissmiller, Steer, Ranieri, Rissmiller, and Hogate (1994); Robinson, 1993)

There is also little current understanding of how managed care strategies affect hospital inpatient psychiatric care for mentally ill patients. There is a need for careful study of the effects of managed care on outcomes and quality of psychiatric care. (Wickizer, Lessler, and Travis, 1996)

Trugerman (1996) reminds us that not all managed care systems are identical. Sparer (1996) detects great variation among state managed care plans in mental health. Noting the untested nature of managed care, Wickizer and Feldstein (1995) set out to test the model. They analyzed the competitive effects of health maintenance organizations (HMOs) on the growth of fee-for-service indemnity insurance premiums over the period 1985-1992 using premium data on 95 groups that had policies with a single, large, private insurance carrier. Their conclusion is that "competitive strategies, relying on managed care, have *significant potential* (emphasis added) to reduce health insurance premium growth rates, thereby resulting in substantial cost savings over time."

Brown (1996) argues that these relentless pressures to build regional systems of health services has transformed the health care industry from a charitable, community orientation to one of business, market shares, and profits. Weil (1995) explored the possibility that the geographically linked health networks of integrated health maintenance organizations (HMOs) that are now gaining such awesome market penetration and fiscal power, together with projected cutbacks in Medicare and Medicaid reimbursement could conceivably set the stage for the kind of financial machinations that led in the late 1980s to the savings and loan (S&L) debacle.

Expect Real Savings in the Cost of Care?

One of the real ironies is that, for all the emphasis on cost reduction, several early studies have found that quality can be maintained under managed care but costs may not be reduced. The most massive evaluative effort of managed care to date, according to its investigators, is the Fort Bragg Managed Care Experiment, a 5-year, $80 million effort to evaluate the cost-effectiveness of a full continuum of mental health services for children and adolescents. (Bickman, 1996a; Breda, 1996; Lambert & Guthrie, 1996;) In a study of cost-effectiveness, the researchers also sought to evaluate two aspects of the quality of services provided -- intake assessment and case management. (Bickman, Summerfelt and Bryant, 1996) They concluded that these two components of care were implemented with sufficient quality to have the theoretically predicted effects on mental health. The "bottom line" on the Fort Bragg experiment is that the continuum of care provided a high-quality system of care but was more expensive and produced no better clinical outcomes than traditional services. (Bickman, 1996b)

In a review of the Massachusetts Mental Health/Substance Abuse Program from the viewpoints of the providers Beinecke, Callahan, Shepard, Cavanaugh, and Larson (1996) found that even though the severity of illness of most clients in the program was greater than before managed care, most providers believed that the quality of care and access to services for these clients was the same or better than before managed care. The providers interviewed were also concerned that savings in a managed care program primarily occur in its initial stages and that future reductions have greater potential for negative impacts upon clients and providers.

A randomized trial of the Florida Program for Prepaid Managed Care established that the health maintenance organization was able to limit members' utilization. Thus, cost savings were in the form of lower likelihood of using care. The amount of services received, once care was initiated, was the same in both fee-for service Medicaid and health maintenance organizations. (Buchanan, Leibowitz and Keesey, 1996)

Given the generally poor track record of cost monitoring in mental health and other social services, it may be well to keep in mind that other strategies may also prove effective, Thus, in a comparative cost-effectiveness study, Jerrell, (1995) found that a Program of Assertive Community Treatment (PACT) model for

delivering care to chronically mentally ill patients was not significantly more expensive in terms of the costs of providing supportive services compared with the clinical team approach and the intensive broker model of care.

Methodology

A small portion of the managed care literature speaks directly to issues of research and/or financial analysis methodology. For example, Fedorowicz and Kim (1995) examine the impact of data analysis as critical tools for tracking costs, allowing managers to set priorities and develop strategies to manage and contain costs. Bowles and Fleming (1996) addresses the issue of breakeven analysis as applied to managed care under capitation by expanding the traditional two-dimensional breakeven analysis into a three dimensional graphic analysis using cost, enrollment, and utilization.

Brown and Kornmayer (1996) report on the development of computerized decision support technologies for the management of patient care. They report being in the midst of implementing a computerized decision support system for care management in their managed care organization. Glazer and Gray (1996) report the psychometric properties (reliability and validity) of a decision-support scale designed to evaluate the level of care needed for patients requiring psychiatric treatment in a health maintenance organization (HMO) setting.

Conclusion

Regardless of the cases which can be made for and against the managed care model, three things are clear: 1) Managed care has arrived. Although the buzz-words may shift in the next few years, the aged of brokered decision-making in care provision has arrived and is not likely to leave again soon; 2) Managed care is and will continue to transform the practice of social work, particularly by bringing the formerly specialized cost considerations of financial management directly into the worker-client transaction; and 3) The managed care model, with its distinctive external patterns of accountability, raises serious questions about the continuing viability of the "social agency" model of practice to which social work has been committed for most of this century.

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